SANAC NEWS

The official newsletter of the South African National AIDS Council • Issue 15 • July 2016

AIDS 2016 SPECIAL EDITION

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Editorial

- Kanya Ndaki

Welcome to this special edition of SANAC News to mark the 21st International AIDS Conference, which takes place in Durban from 18-22 July 2016. The theme of the conference this year is "Access Equity Rights Now". We hope that this special edition we have put together will give some insights into what this theme means for SANAC.

This is not the first time that the world's largest AIDS gathering will be held in South Africa. Sixteen years ago, in 2000, Durban hosted the International AIDS Conference – this was the first time it was held in the developing world and on the African continent. At the time, antiretroviral treatment was not yet available in the country, stigma and discrimination were widespread, and the outlook was bleak.

South Africa now has an entirely different story to tell: the country treats an estimated 3.4 million people living with HIV - the largest treatment programme in the world. The mother-to-child-transmission rate is now less than 2 percent and our life expectancy rate has risen by 8 years over the past decade –as a direct result of ARV treatment.

SANAC will be hosting a number of exciting satellite sessions, to reflect on the progress the country has made, so use our handy 'SANAC at AIDS2016' roadmap to map out your conference schedule.

We pose some tough and frank questions in this edition – around the war on drugs and the need to consider a more health and human rights centred approach to tackle this problem; as well as the relevance of high profile gatherings such as the UN High Level Meeting on AIDS that took place recently in New York. In addition, we reflect on the campaign for girls and young women, recently launched by the Deputy President and share some key features of the campaign. The Global Fund grant for the country has been approved, and we unpack the grant and look at some of the innovations of this investment. As the National Strategic Plan draws to a close, we share some of the key findings from the progress report on the NSP.

We hope you enjoy this issue, please share your feedback with us by dropping us an email: ***communications@sanac.org.za***
Come and pay us a visit at the Exhibition Hall – we have lined up some great activities at the South Africa stand!

SANAC at AIDS2016 – a roadmap

AIDS 2016
21ST INTERNATIONAL AIDS CONFERENCE
DURBAN, SOUTH AFRICA JULY 18–22, 2016

SANAC Satellite Sessions:

- **Addressing HIV and Human Rights in the LGBTI Community in South Africa**
- **Monday 18 July, 12:30 - 14:30 Session Room 11**

SANAC has brought together LGBTI stakeholders and government departments to address the HIV and Human Rights needs of the LGBTI community. This session describes ambitious plans to address all aspects of the LGBTI communities' needs and rights including peer education, condoms and lube, PrEP and UTT, psychosocial support and dealing with stigma and discrimination including responding to hate crimes.

- **South Africa's National Sex Worker HIV Plan: Are you coming?**
- **Monday 18 July, 14:45 - 16:45 Session Room 11**

This satellite will take the format of a panel discussion where topics including access and roll out to PrEP and Universal Test and Treat will be tackled as well as a discussion on the legal position on sex work and the implications for the effective implementation of the recently launched Plan.

- **From General Population to Key Populations: South Africa's Global Fund Grant Moves with the Times**
- **Monday 18 July, 17:00 - 19:00 Session Room 11**

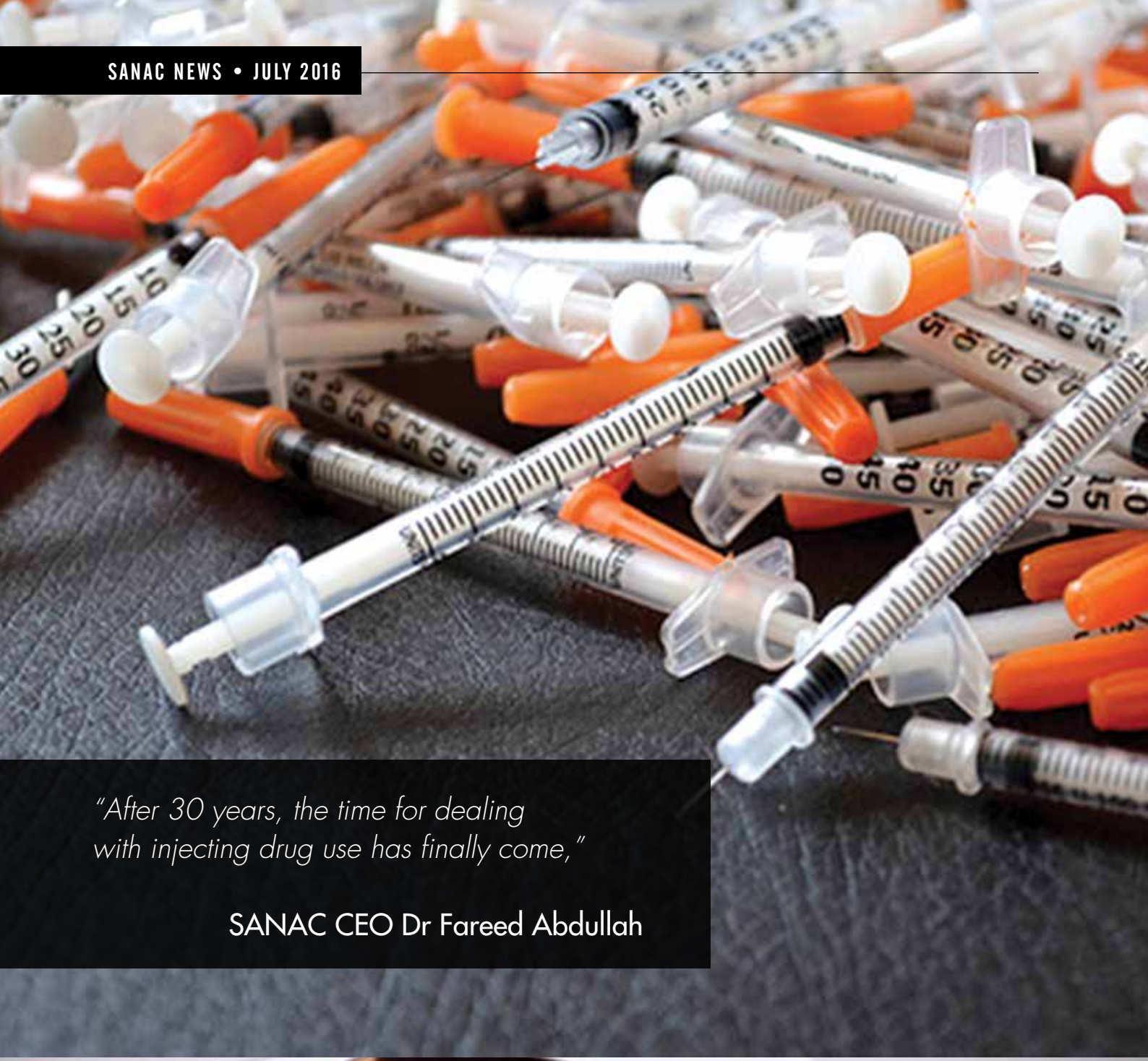
This session will unpack the programmes that will be prioritized in South Africa's new grant and provide information on the role of civil society and the CCM in the grant process. The session will also shed more light on the Global Fund's shift from general populations to key populations.

- **Stigma and Discrimination: From Research to Action**
- **Tuesday 19 July, 18:30 - 20:30 Session Room 1**

SANAC undertook South Africa's first National Stigma Index Survey, interviewing more than 10 000 HIV-positive people in 18 districts, the largest survey of its kind in the world. The survey was an initiative driven by people with HIV, for people with HIV. This session will discuss the national stigma campaign and report on projects that are addressing the levels of stigma and discrimination in South Africa.

- **Developing the Next South African National Strategic Plan for HIV, TB and STIs (2017 - 2022)**
- **Wednesday 20 July, 18:30 - 20:30 Session Room 1**

For the next five years the NSP will set the stage for the country to attain the goals of the 2030 National Development Plan: an AIDS free generation and a concomitant reduction in TB deaths and TB cases. So what are your ideas of the "game-changers" and your views on the successes that need to be scaled up and the innovations to be tested? Join us to share these.



"After 30 years, the time for dealing with injecting drug use has finally come,"

SANAC CEO Dr Fareed Abdullah

Time for a rethink on drug policy?

- Kanya Ndaki

Billions of dollars later, countless lives lost and disfigured, policymakers are now coming round to the idea that the war on drugs has been at best a misguided endeavor, and are beginning to consider a more human rights and health-based approach.

Latin American countries – which have borne the brunt of the violence and dislocation - are spearheading the demand for new thinking. Even in the United States, which for years had led the global crusade to stop the drugs trade by curbing supply, enthusiasm is waning. Some of its states are pursuing their own experiments in decriminalization of marijuana.

"International drug policies are supposed to pursue the health and welfare of humankind, but the current regime has shown it is incapable of achieving these goals," said Ann Fordham, Executive Director of the International Drug Policy Consortium.

In South Africa, Deputy Minister for Social Development Deputy Hendrietta Bogopane-Zulu has been advocating for an approach based on human rights, health and "harm reduction", through her role as chairperson of the African Union technical team on drugs.

A recent position paper by the country's Central Drug Authority recommended focusing on harm reduction and decriminalization as approaches to cannabis use. But local drug policy activists are pushing for this to extend to all drugs.

In April 2016, world leaders gathered at the United Nations (UN) for the UN General Assembly Special Session (UNGASS) on the world drug problem. This was the first meeting since 1998 when member states committed themselves to policies aimed at eliminating illegal drugs by 2008. Ahead of the meeting, many hoped that UNGASS would provide an opportunity to rethink the war on drugs. However the final statement issued by the UNGASS on the world drug problem did not live up to expectations.

The case for reform is clear. According to the UNAIDS report, 'Do no harm: health, human rights and people who use drugs' the world has missed the UNGASS target set in 2011 to reduce HIV transmission among people who inject drugs by 50% by 2015.

The report cautions that insufficient coverage of harm reduction programmes and policies that criminalize and marginalize people who inject drugs are failing to reduce new HIV infections.

The vast majority of the 246 million people who use drugs have been criminalized by national legislation and marginalized by society. Many have been traumatized by violence, imprisoned for possession of small quantities of drugs for personal use or coerced to undergo drug dependence treatment. Women who use drugs have been forced to undergo sterilization or abortions, separated from their children and denied public housing and other benefits. As a result, people who use drugs, especially those who inject drugs, have been isolated and often denied the means to protect themselves from HIV, hepatitis C virus, tuberculosis and other infectious diseases.

UNAIDS estimates that people who inject drugs and their sexual partners accounted for about 30 percent of the people newly infected with HIV outside sub-Saharan Africa.

SANAC and CDA partnership

The evidence is in place, we know what the right things to do are. The tools and strategies required to improve the health and lives of people who use drugs are well known and readily available. Needle–syringe programmes reduce the spread of HIV and other blood borne viruses. Opioid substitution therapy and other evidence-informed forms of drug dependence treatment curb drug use, reduce vulnerability to infectious diseases and improve uptake of health and social services.

While most HIV infections in South Africa occur through sexual transmission, the country cannot afford to be complacent on the growing drug problem. The Medical Research Council estimates that there are 67,000 people who inject drugs in the country, however data remains limited. However, a 2015 size estimation study of key populations in South Africa, conducted by SANAC and NACOSA found that there were over 75,000 people who inject drugs. In addition, a recent rapid assessment of HIV prevalence and HIV-related risks among 450 people who inject drugs across five cities in South Africa estimated a 14 percent HIV prevalence.

In response to this, the South African National AIDS Council (SANAC) has partnered with the Central Drug Authority (CDA) and is embarking on a national advocacy campaign to mitigate the incidence of HIV infection among people who inject drugs. This campaign will lead to the development of a national drug and HIV plan, as well as a national harm reduction strategy.

"After 30 years, the time for dealing with injecting drug use has finally come," SANAC CEO Dr Fareed Abdullah admitted. ■

"Young people with the support of their parents, caregivers, communities and government, will be at the centre of national efforts to keep girls in school until matric".

Deputy President

Young women and girls matter!

- Relebohile Motana

In his 2016 State of the Nation Address President Jacob Zuma announced that young women and girls will receive HIV Prevention support. Deputy President Cyril Ramaphosa revealed that the support will come through the Young Women and Girls (YWG) Campaign launched by the Deputy President on the 24th June 2016 in KwaZulu-Natal.

The Campaign comes after studies found that 2363 young women are infected with HIV every week. There is a greater emphasis on adolescent and young women in South Africa because, they are 8 times more likely to be infected with HIV than their male peers. This rate is the highest in the world and calls for a robust intervention.

SANAC Executive Manager for NSP Implementation Dr Connie Kganakga: "At SANAC we have identified this phenomenon as the single biggest prevention priority if we want to turn the tide against this epidemic of new infections. Changing this pattern of sexual behaviour will prove to be extremely difficult as it has as much to do with structural factors such as poverty, gender inequality, circular migration, the breakdown of family structure and alcohol and substance abuse as it has to do with sexual behaviour change. We ignore this crisis at our peril!"

The US government made $68 million available for the Campaign to be implemented in 19 municipalities in Gauteng and KwaZulu-Natal. The decision was strategically made as these are the provinces that have the highest prevalence in the country, according to the 2012 South African National HIV Prevalence, Incidence and Behaviour Survey. Other provinces are not given a blind sight. There are other programmes that are implemented nationwide to address similar issues that the Campaign is looking to address.

The Global Fund committed $62 million towards reducing new infections amongst young women, while the German government availed €12 million to implement a similar programme targeting young women in Buffalo City Municipality, Eastern Cape.

The South African National AIDS Council together with the South African Government designed the Campaign to target young women and girls aged 15-24 years. The secondary target group are adolescent boys and young women aged 15-35 years. Males aged 15-35 years are targeted because they also contribute to new infections, pregnancies, sexual and gender based violence which further strains the government from managing the HIV epidemic.

The Campaign will be implemented over three years (2016 – 2019) with set objectives:

1. Decrease new HIV infections in girls and young women
2. Decrease teen pregnancies
3. Keep girls in school until matric
4. Decrease sexual and gender based violence
5. Increase economic opportunities for young people

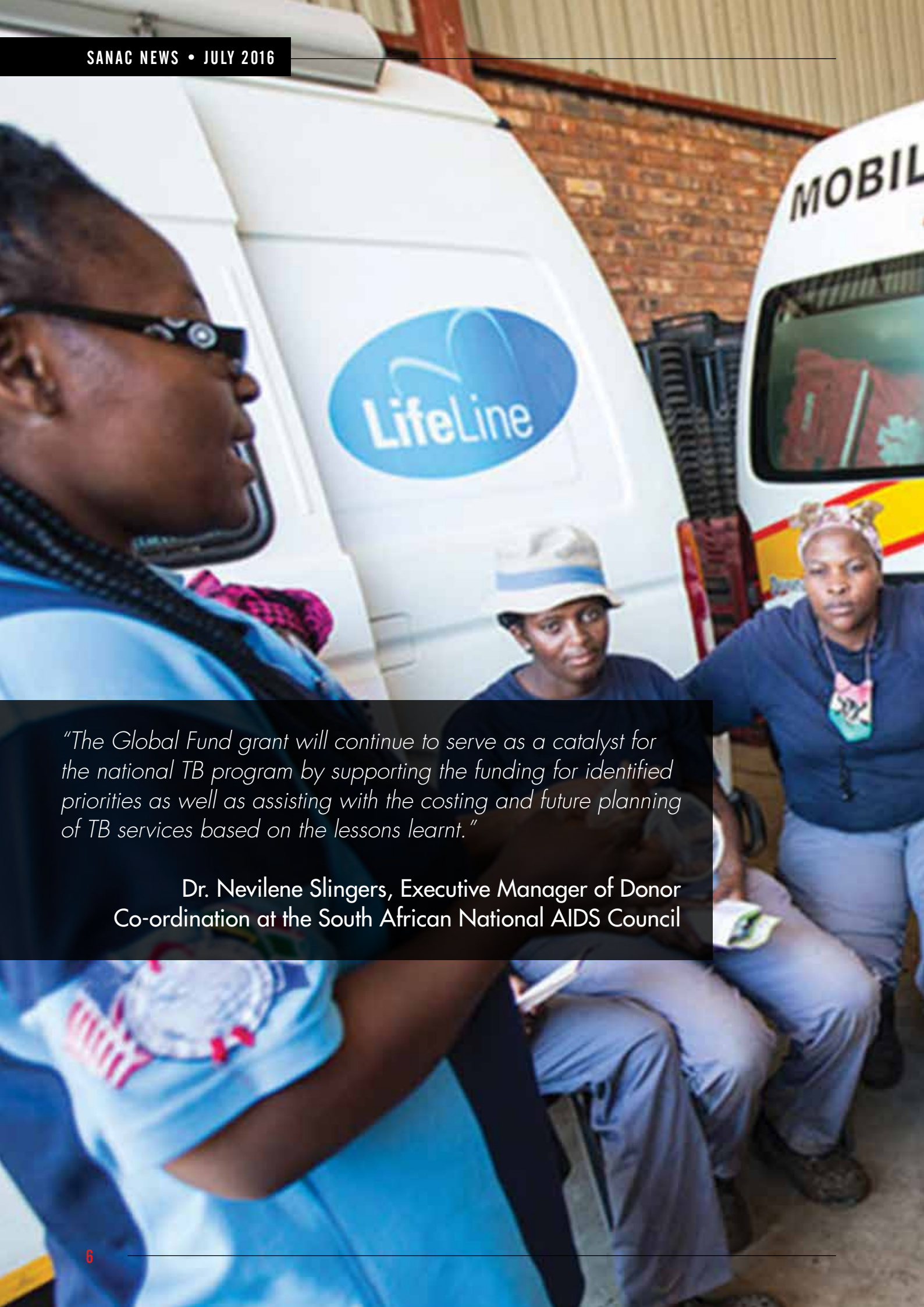
The success of the Campaign lies in the Comprehensive Packages of Interventions that will empower young women with knowledge and skills to overcome their challenges. The Comprehensive Packages consists of biomedical, socio-behavioral and structural interventions. These interventions are holistic in the manner that they address young women and girls needs of social, health and economic support.

Youth were part of the development process of the YWG Campaign and will take the lead in implementing it. Youth activist and campaign member Lerato Lagamorulane noted: "We are not the leaders of tomorrow, we are leaders of today, and this is why we are pushing policy leaders to listen to us".

Partners hope that the Campaign will empower young women and girls to take charge of their future through participating in programmes. The partners do acknowledge that youth presence and commitment is not always guaranteed. To overcome this barrier, the National Department of Health are running a competition for youth to name the Campaign. This will instill ownership and drive commitment.

However, the Deputy President emphasised that the success of the Campaign is everyone's responsibility as he said, "Young people with the support of their parents, caregivers, communities and government, will be at the centre of national efforts to keep girls in school until matric".

The Campaign presents the youth and the country an opportunity to escalate the intentions of creating an AIDS free generation. The Comprehensive Packages of interventions will be availed to release possibilities of a better future. ■



"The Global Fund grant will continue to serve as a catalyst for the national TB program by supporting the funding for identified priorities as well as assisting with the costing and future planning of TB services based on the lessons learnt."

Dr. Nevilene Slingers, Executive Manager of Donor Co-ordination at the South African National AIDS Council

New approach in South Africa's Global Fund grant

- Gemma Oberth

South Africa was awarded $314.5 million in TB/HIV grants to be implemented by eight principal recipients. The Board approved this amount based on the recommendation of its Grant Approvals Committee (GAC). Of the total amount approved, $49.8 million was an incentive funding award.

Global Fund investment makes up a small proportion of total TB and HIV spending in South Africa – approximately 5%. The majority of the national response is funded by the government.

The activities under South Africa's new Global Fund grants will focus on key populations and high-impact interventions, including a comprehensive package of integrated services to young women and girls, sex workers, men who have sex with men, transgender people, people who inject drugs, inmates, and people who live in informal settlements and peri-mining communities. In addition, activities will be implemented to address structural and environmental vulnerabilities and barriers to access, including gender-based violence and stigma. Finally, the program will focus on strengthening community and health systems to build capacity among civil society, promote treatment adherence and integrate data management and information systems.

Innovative approaches

As part of the grant, South Africa will be piloting some new and innovative approaches. Two PRs will be engaging a total of 30,000 young women aged 19-24 in a cash transfers program called "cash plus care." The cash transfers will be conditional rewards-based incentives that serve to stimulate health-seeking behaviour and behaviour change to minimize the risk of HIV infection. The "care" element includes linking eligible young women to the appropriate health services as well as linking the young women and their families to social protection such as government welfare grants, as appropriate. Combining cash transfers with additional care components has been shown to be even more effective at reducing HIV incidence than programs which offer cash alone.

The funding approved for South Africa also includes programs based on innovative finance mechanisms. With catalytic investment from the Global Fund grant, a social impact bond will be introduced for prevention of HIV among sex workers These bonds are contractual agreements whereby results-based donors only pay for delivery of agreed outcomes. This model provides upfront working capital to service providers while promoting accountability.

The aim of the social impact bonds is to leverage additional contributions from domestic and other sources to complement the government's existing investment in HIV treatment and prevention programs for sex workers and their clients. In March 2016, South Africa launched a groundbreaking new National Sex Worker HIV Plan for 2016–2019. The Plan includes providing immediate antiretroviral treatment to all sex workers with HIV, regardless of CD4 count (sometimes called "test and treat"). In addition, at least 3,000 HIV-negative sex workers will be eligible to begin taking the combination antiretroviral pill Truvada as pre-exposure prophylaxis.

The cash transfer and social impact bond pilots are part of South Africa's incentive funding award. Further scale-up of these activities is contingent upon adequate operations research to establish effectiveness, document lessons learned and evaluate impact of the proposed innovations.

The GAC also welcomed South Africa's plans to expand the multi-drug-resistant tuberculosis (MDR-TB) program through a decentralized model. The grant will support the work of linkage officers who operate at the community level to improve TB surveillance and link MDR-TB patients to care. South Africa will also continue to roll out trainings on nurse-initiated treatment for MDR-TB and ensure that these nurses are supported to be able to provide these services.

According to Dr. Nevilene Slingers, Executive Manager of Donor Co-ordination at the South African National AIDS Council, "the Global Fund grant will continue to serve as a catalyst for the national TB program by supporting the funding for identified priorities as well as assisting with the costing and future planning of TB services based on the lessons learnt."

The eight PRs who will implement the grants are: the National Department of Health; Right to Care; the Networking HIV/AIDS Community of South Africa; the Soul City Institute for Health and Development Communication; the Western Cape Department of Health; the KwaZulu-Natal Treasury; Kheth'Impilo; and the AIDS Foundation South Africa.

The last three of these PRs are new. The Global Fund country team for South Africa will closely monitor them to ensure that minimum requirements are met before the grant is signed, and that systems are functioning at a satisfactory level before the first disbursement is made. During the first six months of implementation, efforts will be made by all partners – the Global Fund country team, the local fund agent and the CCM secretariat – to ensure that these new PRs are supported to implement as quickly and effectively as possible.

An edited version of this story was first published on ***www.aidspan.org*** ■

Is the UN High Level Meeting on HIV still relevant?

- Kanya Ndaki and Fareed Abdullah

The UN High-Level Meeting (HLM) on AIDS in New York is always one of the biggest events on the HIV/AIDS calendar. At the meeting, a political declaration that will guide the global response to HIV/AIDS is released, but opinion is divided on the impact of such declarations.

SANAC News interviewed SANAC CEO Dr. Fareed Abdullah, SANAC Co-Chair Steve Letsike and Deputy Chair of the Civil Society Forum Prudence Mabele for their take on the impact of the UN High Level Meeting on AIDS. Abdullah, Letsike and Mabele were part of the South Africa delegation, led by the Minister of Health Dr. Aaron Motsoaledi that participated in this year's meeting. The delegation also included Dr. Nono Simelela, Advisor to the Deputy President, and Director General Dr. Precious Matsoso.

Do we still need a meeting on this scale?

It's easy to be cynical about the value of such high-profile gatherings, which seem far removed from the coalface of the AIDS epidemic, but it was after a similar meeting 15 years ago - the landmark 2001 UN General Assembly Special Session on AIDS - that countries began to take HIV/AIDS more seriously. Had it not occurred, it remains doubtful whether a lot of heads of state would have moved on AIDS. This was also where the idea to set up a Global Fund to finance the HIV response was discussed.

The 2001 HLM occurred in the afterglow of the Durban 2000 AIDS Conference and set the AIDS response on a level of ambition never seen before. It also fed into the Millennium Development Goals (MDG) set the year before by the UN with MDGs 4, 5 and 6 directly linked to AIDS.

At the 2006 UN High-Level Meeting on AIDS, world leaders committed to providing universal access to treatment, prevention, care and support by 2010 and agreed to set national targets. By the end of 2010, very few countries had achieved these ambitious goals. The tide turned however, when the target to treat 15 million people by 2015 – set by the 2011 UN High Level Meeting – was met 8 months ahead of schedule.

The Political Declaration at the HLM in 2016 committed all countries to ending AIDS by 2030 and made a clarion call to reach the 90-90-90 targets by the year 2020 especially in cities where the response should be fast tracked.

According to Dr. Fareed Abdullah the 2016 HLM was a more sedate affair and the global message was mixed. On the one hand, it claimed that AIDS was unfinished business and yet on the other the world was congratulating itself that great progress has been made especially with treatment and the prevention of mother to child transmission (PMTCT) with 4 countries announcing that they had eliminated mother to child transmission.

Activists such as Prudence Mabele argue that a large high-level meeting is vital at such a crucial point in the global HIV response. "We need to bring HIV and AIDS back on to the global agenda, and we need to keep fighting to make sure the voices of those we represent, are heard at such meetings."

Steve Letsike believes that the HLM is "still a very relevant political space" that brings civil society and member states together. "The tricky part is what goes into the report, how much influence the meeting still wields and how best civil society can feed into the consultations."

What was on the agenda?

The goals and targets agreed by member states in 2011 expired at the end of 2015 so the 2016 High-Level Meeting had to come up with a bold new strategy to overcome the remaining challenges and sustain the global AIDS response.

Among many of the civil society representatives who participated in and spoke at the meeting, Loyce Maturu, a young woman living with HIV from Zimbabwe, shared her inspiring story during the opening plenary about growing up living with HIV. "I want young people living with HIV to be able to realize their dreams and hopes for the future," she said.

Ndaba Mandela, a grandson of Nelson Mandela, spoke passionately about his own family's experience of HIV and urged everyone present to stand together to end AIDS by 2030. "I'm here to ask you to continue the legacy of my grandfather, Nelson Mandela: a legacy of unity and leadership."

In addition to the plenary sessions around 600 participants, including 10 Heads of State and Government and more than 60 ministers, people living with HIV, representatives of civil society, representatives of international organizations and the private sector, scientists and researchers took part in five official panels and more than 30 side events to translate the new Political Declaration into action and results.

The final declaration to end the AIDS epidemic by 2030 includes a set of specific, time-bound targets and actions that must be achieved by 2020 if the world is to get on the Fast-Track and end the AIDS epidemic by 2030 within the framework of the Sustainable Development Goals.

The extent to which key populations - sex workers, men who have sex with men (MSM), injecting drug users - are mentioned in these declarations has long been a bone of contention, particularly in more conservative countries. The 2016 declaration was no different, and civil society organisations were particularly disappointed by the final declaration, Mabele acknowledged.

The 2016 declaration was weaker than its 2011 version when it came to key populations and sexual and reproductive health rights. This is unfortunate as the role of these populations in a time when the global epidemic is contracting is even more important than before. The Declaration was almost silent on the need for increasing investments in the AIDS response, especially over the next five years, if we are

to fast track the response to bring epidemic control by 2030. "This meeting didn't ignite the energy of people, like previous High-Level Meetings. The 2011 Declaration was much stronger and bolder than the current one," Letsike commented.

Promises, promises?

The theory of the approach contained in the 2016 declaration rests on the idea that frontloading investments in the AIDS response is the key to achieving the medium term impact of epidemic control by 2030. Yet the message was not called out explicitly and no specific calls were made on governments to increase their investments in the short term nor were there calls for increased donor funding in ways that we have seen at previous HLM meetings, Abdullah noted.

The only explicit call was for donor governments to ensure a successful replenishment of the Global Fund. More, much more will be needed as stated by Jeffrey Sachs, in what was considered the most flamboyant and entertaining speech at the HLM, when he called for an additional US$10 billion per year and convincingly argued that this was a drop in the ocean for the advanced economies. 'Ending AIDS by 2030 is simply a question of money; and no one can convince me that the world cannot afford to fund it,' claimed the world's most foremost economist.

The true test of whether the 2016 meeting will be of any value to global AIDS efforts will be in the outcomes. When the promises have been made and the hoopla has come to an end, will governments deliver? ■

National Strategic Plan (2012 – 2016) – Where are we now?

South Africa's National Strategic Plan (NSP) 2012-2016, is the third plan outlining how the country will respond to the epidemics of HIV, sexually transmitted infections (STIs) and tuberculosis (TB) over a five-year period. The responsibility to monitor the implementation of the NSP lies with the SANAC Secretariat.

The NSP guides and informs the development of national, provincial, district and community-level implementation and is also used by the South African National AIDS Council as a framework for coordinating and monitoring implementation by sectors, provinces, districts and municipalities. The NSP guides South Africa's response and progress, allowing all partners to coordinate their efforts among themselves and with the South African Government.

SANAC recently released a progress report on the NSP, here are some highlights of the report, as described in the five main goals of the NSP.

Goal 1

Reducing new HIV infections by at least 50 percent using combination prevention approaches.

On track to target? Sexual Transmission (15-49 years) has declined but the target has not been achieved. PMTCT (at 6 weeks) target reached. This is a major achievement.

HIV incidence

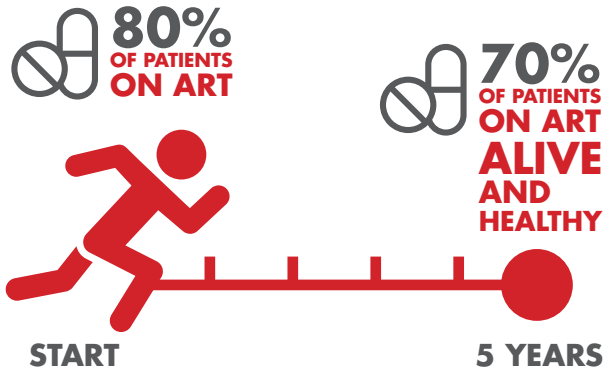
There are various measures of HIV incidence in South Africa including estimates made by the Human Sciences Research Council (HSRC), the UNAIDS Spectrum Model and the THEMBISA model. HIV incidence for all ages using the Spectrum Model is estimated to have been 500 000 in 2004; 430 000 in 2009, and 330 000 in 2014. For persons 15 years and older, incidence is estimated to have been 330 000 in 2014, indicating a decrease of 17.5% from 410 000 in 2011. The model also indicates that 6.8 million South Africans were living with HIV in 2014.13 The HSRC study found HIV incidence in 2012 to be 0.71 for males aged two years and older, and 1.46 for females in the same age range. The highest HIV incidence overall was found for females aged 15-24 at 2.54. Currently, South Africa's new HIV infections are more than a quarter of the world's new HIV infections. As such, efforts to address the persistent sexual transmission of HIV need to be intensified through evidence-based combination prevention interventions.

HIV Prevalence

HIV prevalence among girls and young women aged 15-24 in national surveys has consistently been found to be many times higher in comparison to boys and young men in the same age group, contributing over 30 percent towards new infections. In 2012, for example, HIV prevalence among males was 2.9 percent and nearly four times higher among females at 11.4 percent. According to the 2013 National Antenatal Sentinel HIV Prevalence Survey, the overall HIV prevalence amongst pregnant women who presented for their first antenatal care visit at public health facilities was 29.7 percent in 2013, an increase of 0.2 percent from 29.5 percent reported in 2012. Mother to Child Transmission (MTCT) has markedly improved over the recent period, with the NSP 2012-2016 target for vertical transmission at six weeks already reached. There has been a marked decline from >3.5% in 2010 to the targeted <2% being achieved by end of 2014.

Goal 2

Initiating at least 80 percent of eligible patients on ART, with 70 percent alive and on treatment five years after initiation.



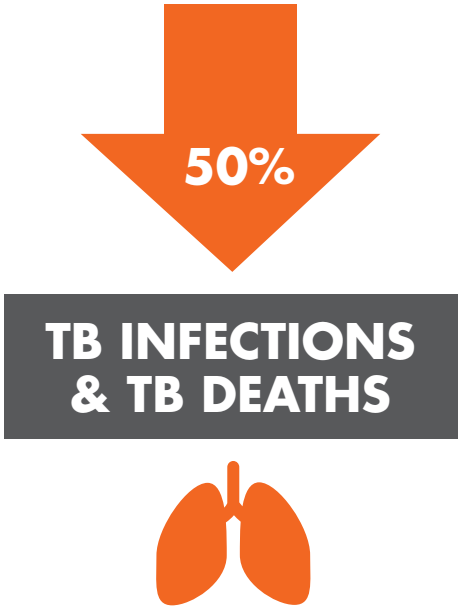
On track to target? ART Initiation target has been reached. This is a major achievement. However, survival on treatment is low, therefore second part of the target not reached (difficult to estimate due to lack of unique identifier).

- By the end of 2014/2015, South Africa had 3 078 57018 persons living with HIV (PLHIV) on ART.
- The rate of loss to follow up was 27% at 12 months on ART and the viral load done among active patients on ART was 59.6% in 2014.
- It is estimated that life expectancy improved from 42.6 years in 2004 to 52.5 years in 2013. The number of PLHIV receiving ART in South Africa rose from 616 337 in 2009 to 3 078 570 in 2014.

South Africa has one of the largest HIV-treatment programmes' globally, and this is commensurate with the high burden of HIV and AIDS in the country. Over the past five years – 2010-2014, the annual target of initiating 500 000 PLHIV on ART has consistently been exceeded. South Africa has also contributed about 20% towards the global target of PLHIV on ART. In 2014, AIDS related deaths were estimated at 140 000 for all ages, with 130 000 (93%) being among PLHIV aged 15 years and older.19 There has been a progressive drop in the AIDS deaths for all ages, and this is attributable to increased access to ART. AIDS deaths have declined from 320 000 in 2010 to 140 000 in 2014.

Goal 3

Reducing the number of new TB infections and deaths from TB by 50 percent.



On track to target? New TB infections and TB death rates beginning to decline but targets not reached.

- In 2014/15, there were an estimated 270 000 new TB infections that occurred among PLHIV out of a total of 450 000 new TB infections. This translates into an overall incidence of 834 cases per 100 000 in 2014.
- A total of 318 193 TB cases were notified in 2014. The number of multidrug resistant (MDR) TB cases have doubled from 7 350 cases in 2007 to 14 161 in 2012.
- TB is the principal cause of death for PLHIV in South Africa, with an estimated 72 000 TB-related deaths occurring among PLHIV in 2013.
- The TB case fatality rate was 8.4% in 2013.26 South Africa has over 300 GeneXpert machines deployed countrywide and over 2.1 million GeneXpert tests have been conducted, considerably exceeding the 2013/14 target of 800 000.

Globally, South Africa had the third highest TB burden after China and India for the period 2009-2012. After the TB programme data review in 2013, the country ranked six after India, China, Nigeria, Pakistan and Indonesia. South Africa's TB epidemic is linked to HIV prevalence, with a co-infection rate of more than 60%. There has, however, been a gradual decline in TB incidence from 2008 to 2013. Treatment outcomes for new smear-positive pulmonary TB (PTB) are encouraging, with the cure rate improving from 57.6% in

2005 to 75.8% in 2012.The treatment success rate for all TB forms has also increased from 60.9% in 2004 to 76.1% in 2012.

In general, the TB mortality rate has varied over time. However, TB mortality (excluding HIV+ TB) appears to have stabilised over the recent period (2010-2013).

Goal 4

Ensuring an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the NSP.

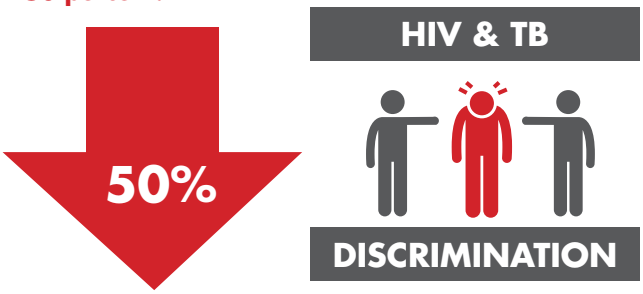
On track to target? Good progress made towards target.

According to the 2013 HIV and TB review, South Africa's interventions and policies respect human rights in their conceptualization and implementation. It was found that HIV Counselling and Testing (HCT) was taking place with informed consent, PLHIV eligible for ART were referred appropriately, patients with drug-resistant TB were managed as per guidelines, women were not denied their sexual and reproductive health, and rape survivors were provided with appropriate Post-Exposure Prophylaxis (PEP) services.

Health care guidelines and policies follow a rights-based approach, and there are examples of provision for rights-based responses such as prevention of stigma and discrimination campaigns, provision of human rights training and improving enforcement of rights in programmatic responses for vulnerable and key populations. There is also a strong commitment to addressing Gender-Based Violence (GBV) and ensuring women and girls have access to health and legal services following sexual violence.

Goal 5

Reducing self-reported stigma and discrimination related to HIV and TB by 50 percent.



On track to target? Good progress made towards target though unanticipated high internalised (self) stigma was discovered in the survey.

National population-based surveys have shown low levels of stigma-related attitudes among the general population. For example, the National Communication Survey found that 87% of respondents would remain friends with a person who was known to be HIV positive, while 16% said they would be embarrassed being seen with a person known to have HIV. The perspectives of PLHIV were explored through a national Stigma Index Survey carried out in 2014 which found that 36% of PLHIV had experienced some form of external stigma and discrimination and 43% some form of internal stigma respectively. Experiences of most formats of external stigma were low.

South Africa has achieved a great deal during the course of this NSP. The country has reduced mother to child transmission of HIV to very low levels, at least during pregnancy and delivery. Millions of lives have been saved as a result of the widespread expansion of the ART programme, with over 3 million people now on treatment. Some of the country's TB indicators are improving, with treatment success among new TB cases getting close to the international benchmark of 85%.

Despite these successes, significant challenges remain. HIV incidence remains stubbornly high, especially among young women. While there is a renewed focus on key populations, coverage of these populations with HIV programmes remains too low. Retention of people in the ART programme remains below target, and too many people are being lost to follow up. In terms of the TB programme, ensuring TB completion remains a priority, especially given the country's burden of MDR and XDR TB. More should be done to diagnose and treat TB in children.

South Africa could also be doing more to have good, reliable data to inform programme planning and implementation. M&E and surveillance need to be given greater priority, based on up to date indicators and targets. Resource mobilisation efforts will need to be increased to find the additional funding needed to scale up treatment and to address prevention efforts as described by the Investment Case. ■

Have you been treated unfairly because of your HIV or TB status?

People living with HIV and TB often suffer discrimination and are stigmatised based on their HIV or TB status.

Such discrimination occurs in their places of employment, health care facilities and even by family members.

When such an incident occurs most people are unable to understand their rights or cannot afford legal services. The HIV and TB legal clinic provides help by paralegals and lawyers at no cost to persons discriminated on the basis of their HIV/AIDS or TB status.

We share some stories of clients we assisted in the past after they suffered discrimination and have sought legal assistance...

Stories of Discrimination

Ms MM vs X Catering Company

Ms MM was employed at a catering company situated in Sharpsville as a food server during October 2014. At the time of her employment she was on ARV treatment. She was subsequently diagnosed with Tuberculosis ("TB") and she was put on medication. She informed her supervisor that she was on TB treatment and that there would be days when she would need to go to the clinic to collect her medication. Her supervisor then instructed her to go home and she would call her to tell her when to come back to work. This happened during the first week of March 2015. She did not receive any call even after she inquired she was told to stay home. In April 2015, she was called and told that her contract had been terminated. When she asked for the reason for the termination of her contract her employer gave her the following response "You see this thing, your problem/ TB, is going to affect people, that's why you can't continue working". Ms MM referred a claim of unfair dismissal to the CCMA. Ms MM mentioned that she believes that she would not have been dismissed and/or discriminated against had she not disclosed her medical condition to her employer.

Ms AU v Mr HB

A young woman was being harassed by her ex-boyfriend because of her HIV status. During the time they were romantically involved, they both decided to separately undertake an HIV test at a clinic where he worked as a security guard. When they received the results, he tested negative for HIV and shared his results with her. She tested positive for HIV and decided not to disclose her status choosing to end their relationship. She claimed that her ex-boyfriend became suspicious and accessed her medical file without her consent. Hereafter, he began to harass her. After seeking legal assistance the ex-boyfriend was reported to the employer based on his conduct in obtaining her girlfriend's medical results. The girlfriend was also assisted with obtaining a protection order to halt the harassment. She successfully obtained a protection order at the Magistrate's Court and her ex-boyfriend was suspended from the Hospital following an internal hearing.

ZERO STIGMA
ZERO DISCRIMINATION

Ms A and another vs SANDF

In July 2013, SECTION27 represented two former employees of the South African National Defence Forces (SANDF) who were unfairly dismissed solely on the basis of their HIV status in 2013. The two HIV positive applicants appeared in court to challenge the SANDF act of discrimination based on their HIV status. They were calling for the SANDF to abide by their HIV policies that do not unfairly discriminate, and to also comply with a previous court order which found such conduct to be unconstitutional. The SANDF's conduct towards HIV positive individuals is discriminatory in their refusal to offer them a contract without taking into account individuals' state of health or their competency to perform their jobs. The judgment was handed down on 26 September 2014 at the North Gauteng High Court. It was a resounding victory for the two former SANDF employees. The court made a powerful statement re-asserting that people living with HIV have rights in every sphere of life and work including in the military. The court denounced the SANDF for its violation of a 2008 court order reached with SECTION27's predecessor the AIDS Law Project, which asserted this right, but was ignored by the SANDF. The court also denounced the SANDF for infringing our clients' right to dignity and ordered their immediate reinstatement and awarding of employment contracts.

Ms AT vs Mr L

A 34-year-old mother of three was employed as a domestic worker in 2015. She worked everyday from 7am to 9:30pm and was paid R2000 a month for her services. In October 2015 she fell ill and started coughing whilst she was at work. Her employer immediately instructed his driver to take her to his private doctor to get treatment for the cough. When she arrived at the doctor, the driver registered her for an appointment. Around 1pm, she was called into the consulting room. When she entered the room the doctor immediately said to her "your boss has asked me to check you for all the diseases that you have including HIV & AIDS". She refused to take the battery of tests including an HIV test. The doctor told her to take a few minutes to re-think her decision. She left the room and immediately called her employer to find out why she had to take the tests because she had not been informed before leaving her place of employment. She could not get hold of her. After five minutes she decided there was nothing she could do because she feared loosing her job, so she agreed to take the tests. The doctor took out a form and asked her to sign it because her employer was paying for the medical examination. The doctor conducted the tests which included an eye check and blood tests. No examination was done relating to Ms AT's cough. After 30 minutes the doctor called her back into the consultation room and asked her how she would feel if she tested positive for HIV and then showed her the test results. She was given a letter to take to the clinic and left the office. The doctor followed behind her and went to the reception and handed a brown envelope to the receptionist before he made a phone call. The driver arrived to collect her and the receptionist handed the brown envelope to the driver. When she left the doctor, she was taken to her employer's place of work. On arrival, she was met by the senior manager whom the driver handed the brown envelope. She was then told to go to her employer's house and pack all her belongings and leave. After she left, she received a call from a colleague who told her that her employer had disclosed her status to the other employees. She approached the CCMA and lodged a complaint of unfair dismissal on the basis of her HIV status. The outcome was positive and the matter was settled in her favour.

Ms HM vs T & T Attorneys

Ms HM was employed as a filing clerk at a law firm in 2003. In 2015 she was diagnosed with multi-drug resistant TB and she was booked off from work for a period of 6 months in order for her to undergo treatment. After 6months she was declared medically fit to go back to work. When she returned to work her employer informed her that she could not return to work until she had undergone an incapacity inquiry and she was given a date to attend the inquiry, despite the fact that she had given him a medical note from the doctor. At this inquiry Ms HM produced a more detailed letter from the doctor explaining what treatment she had undergone and that she was fit to resume employment. Attached to this letter were lab results confirming that Ms HM was TB negative. The employer informed Ms HM that he would like to test her through his doctor to confirm that she was no longer TB infectious. Due to the fact that Ms HM did not want to lose her job she agreed to undergo the test. The employer advised her to return home and she would be given details of the when and where the test would take place. After a month of being at home Ms HM contacted Legal Aid SA since she was not sure whether the test was going to be scheduled and whether she was still employed. Legal Aid SA referred Ms HM to attorneys to assist her with her matter. Subsequent to a lengthy engagement with Ms HM's employer he advised that the company was restructuring and that Ms HM would be retrenched. The employer eventually scheduled the test but required that Ms HM undergo a full medical test including blood tests when Ms HM clarified that she was only consenting to a sputum culture test and not blood tests the employer cancelled the scheduled test and informed Ms HM that she was dismissed for operational reasons with immediate effect. Ms HM referred the matter to the CCMA and the matter is now at the Labour Court. ■

South Africa's National HIV Counselling and Testing (HCT) campaign – a success story

SANAC will be launching a booklet reflecting on the country's successful 2010 HIV Counselling and Testing campaign, at the International AIDS Conference. Here is an excerpt of the booklet, titled "15 million and more – Reflecting on the successes of the massive HIV Counselling and Testing Campaign in South Africa"

An overview of the campaign

South Africa's national HCT Campaign, the largest and most ambitious ever to have been conducted in any country, was launched under the 2009 World AIDS Day theme: "I am responsible, we are responsible, South Africa is taking responsibility".

This joint campaign, led by the South African National AIDS Council (SANAC) and the National Department of Health (DOH), urged people to take the HIV test and determine their status, and to consent to receive treatment, if necessary. As such, it aimed to realise the treatment and prevention goals of the National Strategic Plan of 2007-2011.

This response to HIV had a transformative impact on the country through its mass mobilisation of the public, private and civil society sectors, which united to spread the message about HIV awareness and health-changing behaviour and to provide more accessible HIV-related services.

The campaign set out to test 15 million sexually active people, aged 15 years and older, in all of the country's nine provinces.

> *"15 million was basically 50 percent of the population in each province, which we then broke down by districts so that you could see that it was achievable; because it seemed like a very big number at first. And the provinces loved seeing how they could contribute to that big number."*
>
> **Dr Miriam Chipimo,**
> **Senior Programme and Policy Advisor for UNAIDS at the time of the campaign.**

HIV tests were offered free of charge at all public health facilities and some private sector facilities, such as pharmacies which partnered with the government on the campaign. Reports from SANAC reflect that just under 14 million tests were conducted in the first 15 months of the campaign. This was a considerably more than the previous rate of between one and two million tests per year conducted prior to the campaign. When the first phase of the campaign came to an end, some 20 million tests had been conducted.

The HCT Campaign had five key elements. It aimed to educate South Africans about the benefits of HIV testing by mobilising them to know their status; to support people with key prevention messaging in order to take proactive steps to a healthy lifestyle irrespective of HIV status; to increase the incidence of health-seeking behaviour; and to increase the number of HIV-positive people who could be linked to treatment, care and support services. It also aimed to address the stigma associated with the epidemic and create a more enabling environment for testing by encouraging open discussion about the issue.

1

Educate South Africans about the **benefits** of **HIV testing** by mobilising them to know their status.

2

Support people with key prevention messaging in order to take proactive steps to a **healthy lifestyle irrespective** of **HIV status.**

3

Increase the incidence of **health-seeking behaviour.**

4

Increase the number of **HIV-positive** people who could be linked to **treatment, care** and **support services.**

5

Address the **stigma** associated with the epidemic and create a more enabling environment for testing by encouraging open discussion about the issue.

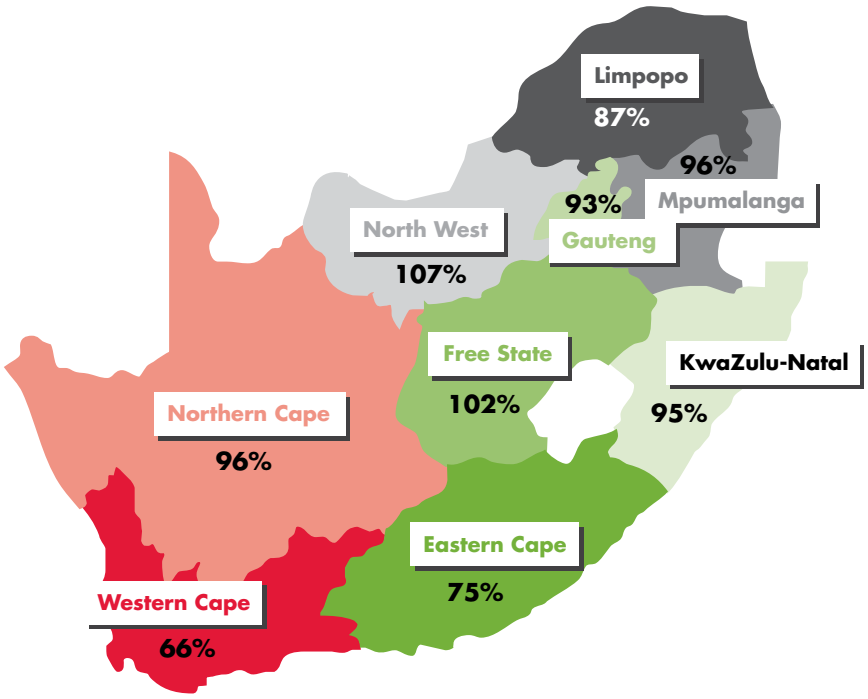
> *The campaign was a huge success. We managed to reach a huge number of people in a short space of time that otherwise we never would have reached without the campaign. As a result, we have saved a lot of lives and put people on treatment.*
>
> **Dr Miriam Chipimo.**

A review of the National Income Dynamics Study (a nationally representative cohort that enabled prospective identification of first-time testers) reflects that **the proportion of adults ever tested for HIV increased from 43.7% to 65.2% over the initial campaign period, from April 2010 to June 2011; with approximately 7.6 million first-time testers. This resulted in a 40% reduction in people who had never tested for HIV before[5].**

> *We celebrate the decisive nature of our leaders in terms of this process. Before this concerned effort, we had close to 800 000 people in KwaZulu-Natal who were testing for HIV, and after the campaign the numbers have improved to three million who have been treated nationally. The benefits thereof are enormous.*
>
> **Dr Sibongiseni Dhlomo, KwaZulu-Natal MEC for Health.**

5. Maughan-Brown B et al. Journal of the International AIDS Society 2016, 19:20658
http://www.jiasociety.org/index.php/jias/article/view/20658 I http://dx.doi.org/10.7448/IAS.19.1.20658

Provincial testing targets achieved in the first 15 months of the campaign



Province	15 Month Target	Pre-Test Counselling	Testing Rate	Tested	Target Achieved	Positive	Positivity
Eastern Cape	2,017,693	1,784,091	85%	1,511,670	75%	177,481	12%
Free State	957,889	1,160,997	84%	980,936	102%	157,667	16%
Gauteng	3,349,084	3,174,900	98%	3,119,145	93%	598,741	19%
KwaZulu-Natal	3,059,234	3,686,267	79%	2,920,433	95%	561,057	19%
Limpopo	1,540,604	1,498,031	89%	1,332,651	87%	154,328	12%
Mpumalanga	1,095,823	1,123,017	94%	1,055,899	96%	224,785	21%
North West	998,859	1,291,355	83%	1,066,832	107%	174,114	16%
Northern Cape	337,941	332,935	98%	324,741	96%	28,389	9%
Western Cape	1,607,594	1,089,721	98%	1,063,038	66%	91,364	9%
South Africa	**14,964,721**	**15,141,314**	**88%**	**13,375,345**	**89%**	**2,167,925**	**16%**

Source: SANAC HCT M&E Update – April 2010-June 2011

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