P.O. Box 13912, HATFIELD, 0028 | 2nd Floor, Block E, Hatfield Gardens, 333 Grosvenor Street, Hatfield, PRETORIA, 0028, Tel: +27 012 748 1000, Fax: +27 086 667 8894

VAT No.: 496 026 5751

BID/RFQ NUMBER:	**RFQ0002147**
CLOSING DATE:	**07 April 2022**
CLOSING TIME:	**14:00 P.M**
BID VALIDITY PERIOD:	**90 DAYS (COMMENCING FROM THE BID CLOSING DATE)**
DESCRIPTION OF BID:	A CONSULTANT TO FINALIZE THE KEY POPULATIONS HEALTH IMPLEMENTATION PLAN
Please Indicate whether the bidder is a: Service Provider or Independent Consultant	
RFP/ RFQ TO BE EMAILED TO THE FOLLOWING EMAIL ADDRESSES: Email address: Beullah@sanac.org.za Copied: Jabulile@sanac.org.za Copied: Mbali@sanac.org.za	
Only Email submission is Accepted for this request due to COVID-19 Lockdown restrictions	

Contents

Tables

List of Figures

Abbreviations

ART	Antiretroviral treatment
BBS	Biological behavioural survey
CCMDD	Chronic medication dispensing and distribution
CDC	Centers for Disease Control and Prevention
DHIS	District health information system
DOH	Department of Health
DORA	Division of Revenue Act
GBV	Gender-based violence
Global Fund	The Global Fund to fight AIDS, tuberculosis, and malaria
HAST	HIV/AIDS, STIs and TB
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HSRC	Human Sciences Research Council
HTA	High transmission area
HTS	HIV testing services
IP	Implementing partner
KP	Key population
LGBTI	Lesbian, gay, bisexual, transgender, intersex
M&E	Monitoring and evaluation
MDIP	Multi-sectoral district implementation plan
MMC	Medical male circumcision
MSM	Men who have sex with men
MUS	Male urethritis syndrome
NDOH	National Department of Health
NIDS	National Department of Health Data Dictionary indicators
NSP 2017-2022	South Africa's National Strategic Plan for HIV, TB and STIs 2017-2022
OST	Opioid substitution therapy
PCA	Provincial AIDS council
PEP	Post-exposure prophylaxis
PEPFAR	President's emergency plan for AIDS relief
PIP	Provincial implementation plan
PMTCT	Prevention of mother-to-child transmission of HIV
PPT	Presumptive periodic STI treatment
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
PWUD	People who use drugs
SANAC	South African National AIDS Council
SBCC	Social and behaviour change communication
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
SW	Sex worker
TB	Tuberculosis
TG	Transgender people
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

Glossary

Definitions of some terms used in this document

Best practice: A technique or methodology that through experience and research has proven reliably to lead to the desired result (World Health Organization, 2017a).

Biomedical factors: Biomedical factors relate to human physiology and its interaction with medicine (UNAIDS, 2015; SANAC, 2017a).

Combination prevention means the number of clients (with unknown or negative HIV status) reached with at least one of the following services *IN ADDITION to* offering, providing, or referring HTS. Known HIV-positive clients must receive at least one intervention (PEPFAR, 2017):

- Offer, provide, or refer to HTS (Required)
- Targeted information, education, and communication (IEC)
- Outreach, empowerment, or other support group activities
- Male and female condoms and lubricant in adequate quantities
- Link or refer to ART (if HIV-positive) or PrEP (if HIV-negative)
- Offer or refer for screening (using the TB questionnaire), prevention, diagnosis, and treatment of TB
- Offer or refer for STI screening (using the STI questionnaire), prevention, and treatment
- Offer or refer for screening for common mental health disorders (using the Brief mental health questionnaire), prevention and treatment
- Offer or refer for screening and treatment or vaccination for viral hepatitis
- Offer or refer for reproductive health services (contraception; antenatal care, prevention of mother to child transfer of HIV, termination of pregnancy services), if applicable
- Refer for OST, if applicable. Support on OST or take-home doses of OST if the client is ready
- Offer or refer to needle-syringe programme, if applicable
- Offer or refer to reproductive health (Contraception; pregnancy, PMTCT), if applicable

Condomless sex refers to a sex act which is not protected by male or female condoms. The term avoids confusion with the protection from pregnancy that is provided by other means of contraception and prevention HIV infection by oral PrEP (and if topical or injectable PrEP is introduced) (UNAIDS, 2015).

Discrimination refers to any form of arbitrary distinction, exclusion or restriction affecting a person, usually (but not only) because of an inherent personal characteristic or perceived membership of a particular group (UNAIDS, 2015; SANAC, 2017a).

Drivers, Social derives from factors such as poverty, inequality, inadequate access to education, poor nutrition, migration, gender inequality and gender-based violence, and substance use that increase exposure to HIV, TB and STIs; deter key populations from seeking needed services early; and interfere with the ability to receive services and to adhere to treatment (SANAC, 2017a).

Drivers, Structural are factors in the physical, legal, and social environment that influence individual and group behaviour (UNAIDS, 2015; SANAC, 2017a).

Gender refers to the social attributes and opportunities associated with being male and female and the relationships between women and men and girls and boys, as well as the relations between women and those between men. In most societies, there are differences and inequalities between women and men in responsibilities assigned, activities undertaken, access to and control over resources, as well as decision-making opportunities (UNAIDS, 2015; SANAC, 2017a).

Gender affirming refers to medical procedures that enable a trans person to live more authentically in their gender identity (UNAIDS, 2016).

Gender-based violence (GBV) describes violence that establishes, maintains, or attempts to reassert unequal power relations based on gender. It encompasses acts that inflict physical, mental, or sexual harm or suffering, threat of such acts, coercion and other deprivations of liberty (UNAIDS, 2015; SANAC, 2017a).

Gender identity refers to a person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth. It includes both the personal sense of the body – which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means – as well as other expressions of gender, including dress, speech and mannerisms. (UNAIDS, 2015; SANAC, 2017a).

Harm reduction refers to a comprehensive package of policies, programmes, and approaches that seeks to reduce the harmful health, social, and economic consequences associated with the use of psychoactive substances. A harm reduction package consists of needle and syringe programmes; opioid substitution therapy; HTS; HIV care and ART; prevention of sexual transmission; outreach (information, education and communication; hepatitis diagnosis, treatment, and vaccination (where applicable); and TB and STI prevention, diagnosis, and treatment (UNAIDS, 2015; SANAC, 2017a).

Hotspot means a public or semi-public place where key population members gather in significant numbers such as places where sex workers solicit clients, places where men commonly seek sex with other men, places where people who use drugs gather to use and inject drugs together (Bill & Melinda Gates Foundation, 2013).

Human rights: The South African Constitution guarantees a broad range of civil, political, cultural, and socio-economic rights, including the rights to equality and non-discrimination, privacy, dignity, freedom and security of the person, access to health care and access to justice (SANAC, 2017a).

Key populations are those groups most at risk for acquiring or transmitting HIV, TB, and STIs. In South Africa these groups were identified as sex workers, men who have sex with men, transgender people, people who use drugs, and inmates (SANAC, 2017a).

Key population facility (previously HTA facility) refers to an identified facility where tailored and comprehensive prevention, diagnosis, treatment, and care services for key populations are delivered. The key population site is usually a fixed facility from where outreach and other services are coordinated (Adapted for South Africa).

Mapping: Peer educators identify the 'hotspot' or sites in the areas where services will be implemented, where key populations congregate, stay, solicit, or work. This local mapping activity is often best done in a workshop with the peers. The number of key population members in the area is referred to as a local population size estimation (NACOSA, 2018).

Men who have sex with men refers to males who have sex with males regardless of whether they also have sex with women or have a personal or social gay or bisexual identity. This concept is inclusive of men who self-identify as heterosexual but have sex with other men (Department of Health, 2014; UNAIDS, 2015; SANAC, 2017a).

Needle-syringe programme: The term needle–syringe programme replaced the term needle exchange programme, which has been associated with unintended negative consequences compared with distribution. Needle-syringe programmes aim to increase the availability of sterile injecting equipment (UNAIDS, 2015; SANAC, 2017a).

Opioid substitution therapy (OST) is the recommended form of treatment for people who are opioid dependent. It is effective in the prevention of HIV transmission, and in the improvement of adherence to antiretroviral therapy. The most common drugs used in OST are methadone and buprenorphine (UNAIDS, 2015; SANAC, 2017a).

Peer educators are representative members of a key population who serve as a link between the programme and the key population. They manage the programme on the ground through outreach and serve a population with whom they have a similar occupational, behavioural, social, or environmental experience and among whom they are trusted and serve as a role model (Bill & Melinda Gates Foundation, 2013).

People in prisons and other closed settings refers to all places of detention within the country, and the terms "inmates" and "detainees" refer to all those detained in criminal justice and prison facilities (World Health Organization, 2016b).

People who inject drugs refers to people who inject psychotropic (or psychoactive) substances for non-medical purposes. These drugs include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypno-sedatives, and hallucinogens. Injection may be through intravenous, intramuscular, subcutaneous, or other injectable routes (World Health Organization, 2016b).

People who use drugs include people who use psychotropic substances through any route of administration, including injection, oral, inhalation, transmucosal (sublingual, rectal, intranasal), or transdermal. Often this definition does not include the use of such widely used substances as alcoholic and caffeine-containing beverages and foods (World Health Organization, 2016b; SANAC, 2017a).

Psychosocial support (PSS) addresses the ongoing psychological and social problems of HIV infected individuals, their partners, families and caregivers (SANAC, 2017a).

Sex worker refers to consenting male, female and transgender adults, and young people (18 years or older) who work in different settings with the primary intention of exchanging money for sexual services, either regularly or occasionally (UNAIDS, 2015).

Sexual orientation refers to each person's capacity for profound emotional, affectional, and sexual attraction to (and intimate and sexual relations with) individuals of any sex. SOGI is an often used abbreviation, and stands for sexual orientation, gender identity (UNAIDS, 2015).

Social and behaviour change communication (SBCC) promotes tailored messages, personal risk assessment, greater dialogue, and an increased sense of ownership of the response by the individual and the community. It uses a mix of communication channels to encourage and sustain positive, healthy behaviours (UNAIDS, 2015).

Social network strategy is a recruitment activity to reach unidentified key populations. Recruiters identify their 'network associates'. Network associates are people in their social networks (e.g., friends, sex or drug partners, family members, etc.) who may be at risk for HIV exposure. Typically,

recruiters identify network associates whom they believe would benefit from HIV testing. The recruiters then talk with the network associates they identified, and refer them to HIV testing (CDC, no date).

Stigma: The term stigma is derived from a Greek word meaning a mark or stain, and it refers to beliefs and/or attitudes. Stigma can be described as a dynamic process of devaluation that significantly discredits an individual in the eyes of others, such as when certain attributes are seized upon within cultures or settings and defined as discreditable or unworthy. When stigma is acted upon, the result is discrimination (UNAIDS, 2015; SANAC, 2017a).

Transgender is an umbrella term to describe people whose gender identity and expression does not conform to the norms and expectations traditionally associated with their sex at birth. Transgender people include individuals who have received gender reassignment surgery, individuals who have received gender-related medical interventions other than surgery (e.g. hormone therapy) and individuals who identify as having no gender, multiple genders, or alternative genders. Transgender individuals may self-identify as transgender, female, male, transwoman, or transman, trans-sexual or one of many other transgender identities, and they may express their genders in a variety of masculine, feminine and/or androgynous ways. Due to this diversity, it is important to learn and use positive local terms for transgender people, and to avoid derogatory terms. (SANAC, 2017a)

Acknowledgements

This plan has been collectively developed by several stakeholders and expert knowledge holders. The National Department of Health acknowledges the strong collaboration among Provincial DOH colleagues, civil society organisations and individuals who contributed to this process through attending meetings and focus groups or drafting and commenting on the different versions. To all the organisations and individuals who contributed to the development of this plan, we extend our utmost appreciation.

In particular, the Department of Health would like to thank Centres for Disease Control and Prevention (CDC) in South Africa for funding the development and design process.

We sincerely believe that the successful implementation of the key populations health implementation plan will prevent new HIV and other STI infections amongst key populations as well as address stigma and discrimination of key populations in health facilities.

1. Introduction

1.1. HIV Epidemic in South Africa

South Africa remains the epicentre of the HIV epidemic, accounting for more than a quarter of new HIV infections in East and Southern African countries and an estimated 8 million people living with HIV (PLHIV) in 2018. The country has made significant progress in reducing new HIV infections and AIDS related deaths by 39% and 50% respectively since 2010 (UNAIDS, 2018). Access to HIV testing and effective antiretroviral therapy (ART) has also improved substantially with the implementation of the test and treat initiative, and increased availability of affordable drugs with fewer side effects. The country remains committed to the Joint United Nations Programme on HIV/AIDS (UNAIDS) 90−90−90 targets which aim to ensure 90% of PLHIV know their HIV status, 90% of people with diagnosed HIV receive sustained ART, and 90% of people on ART are virally suppressed by 2020, with these targets increasing to 95% by 2030 (UNAIDS, 2018). HIV prevalence among the general population is high at 20.4%. Prevalence is even higher among men who have sex with men, transgender women, sex workers and people who inject drugs.

Although South Africa has made progress in reducing the incidence of HIV, the progress is not sufficient to meet the United Nations Sustainable Development Goal (SDG 3.3) global target of ending AIDS as a public health threat by 2030. Much still needs to be done to ensure that targeted populations are reached with tailored packages that are relevant, acceptable, and accessible at the community level.

The major drivers of HIV in the country are heterosexual multiple concurrent partnerships, low or inconsistent condom usage, migration, low perceptions of risk, intergenerational sex, and low rates of male circumcision, and the excessive use of alcohol. Although South Africa has a generalized HIV epidemic with an HIV prevalence exceeding 15% in the adult population, key populations are at higher risk of acquiring and /transmitting HIV.

1.2. Background on key populations and HIV in South Africa

More than seven million people in the Republic of South Africa are currently living with HIV. Despite the fact that South Africa is home to the largest antiretroviral treatment programme globally, HIV prevalence remains high at 19%. Prevalence varies markedly between populations and key populations experience a disproportionate burden of HIV due to barriers to accessing services. These barriers include stigma, discrimination and criminalisation that leads to unsafe behaviours. *South Africa's National Strategic Plan for HIV, TB and STIs 2017-202*2 (NSP 2017-2022) characterises key

populations as gay men and other men who have sex with men; sex workers; people in prisons and other closed settings; transgender people; and people who use drugs.

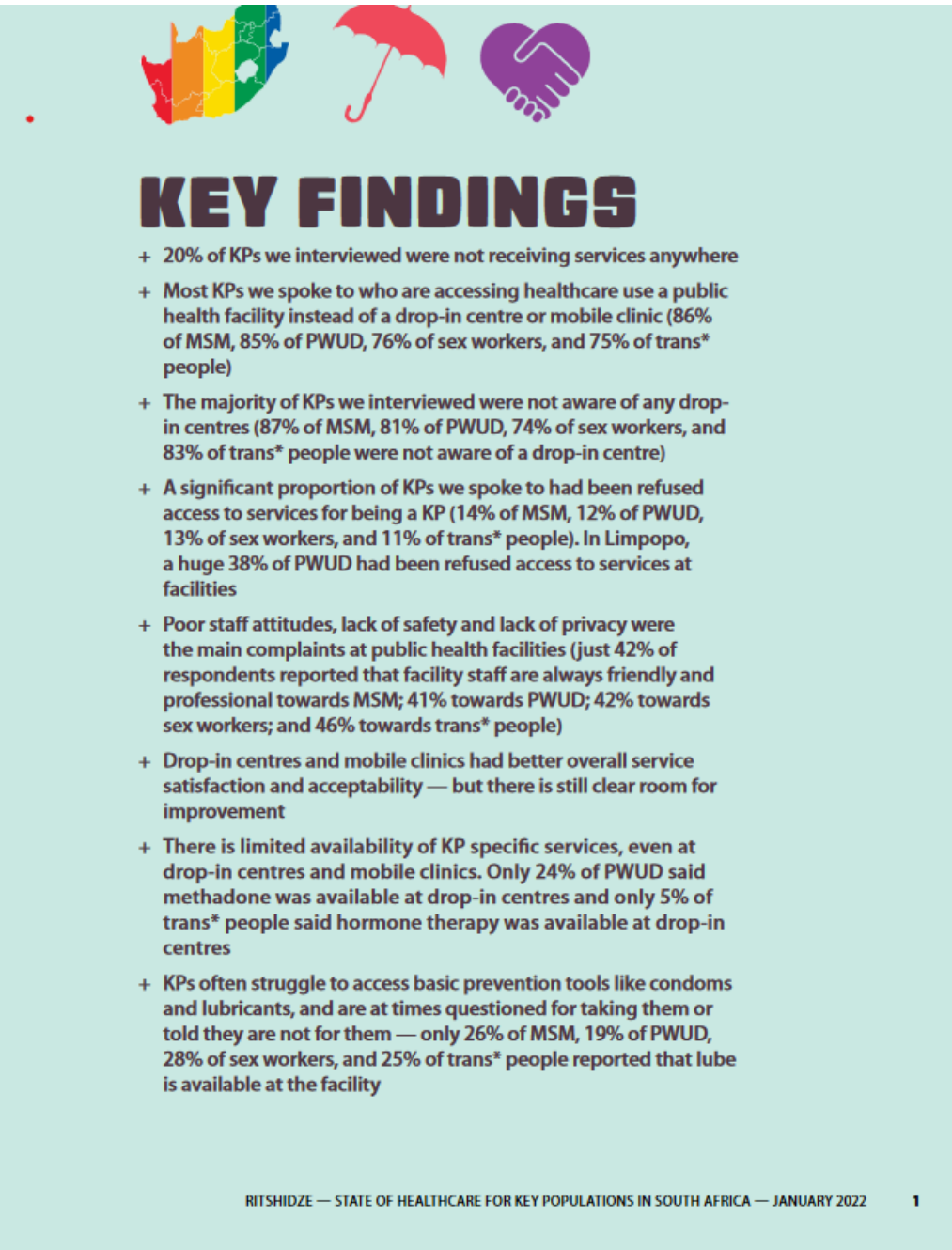
Key populations uptake of HIV services is dependent upon quality, as well as actual and perceived stigma and discrimination on the part of health providers. While recognising the critical role played by targeted HIV prevention and treatment initiatives, primary health care services for key populations in South Africa remain inadequate. Key populations are not receiving services due to pervasive stigma, discrimination, and disapproving attitudes from both clinical and support staff at primary health care facilities. Insufficient training on key populations for health workers have left providers ill-equipped to address the health needs of key groups and perpetuates stigmatising and discriminating practices.

There is also a need for clinicians to develop the knowledge and skills necessary to conduct a comprehensive risk assessment for members of key populations. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), "failure to provide adequate HIV services for key groups, such as gay men and other men who have sex with men, people in prison, people who inject drugs, sex workers and transgender people, threatens the global progress of the HIV response". Individuals at increased risk of acquiring HIV in South Africa are not obtaining the services they need. The World Health Organization (WHO) has called for the implementation of strategies and activities that aim to improve uptake, availability, quality, and effectiveness of HIV interventions for key populations through improvement and maintenance of provider attitudes, knowledge, and skills. "Health care workers should be given the necessary resources, training, and support to provide services to key populations. At the same time, health care providers should be held accountable when they fail to meet standards based on professional ethics and internationally agreed human rights principles." The NSP 2017-2022 is the guiding document for the Department of Health's approach to epidemic control, provides strategic direction regarding HIV prevention, care, and treatment initiatives to curb the epidemic, and promotes the department's mission of a long and healthy life for all South Africans. Goal Three of the NSP 2017-2022 is to reach all key and vulnerable populations with customised and targeted interventions, including capacity-building programmes to improve the skills of health providers to address the needs of key and vulnerable populations, and strengthen their ability to deliver services in a compassionate, non-discriminatory manner.

1.3. Aim and Objectives of the Key Populations Health Implementation Plan

The aim of the key populations health implementation plan is to guide Department of Health and Province, District, subdistrict and health facility level, to increase demand and supply of key

population-friendly HIV prevention, care, and treatment services, to improve primary care health outcomes and achieve UNAIDS 95-95-95 targets. The Key population Health implementation plan is also aimed at guiding the provision of integrated services within the general health system with the goal of achieving universal sustainable access to HIV prevention, treatment care and support as well as other services key populations need.



The objectives of the document are:

- To provide guidance on implementation of HIV prevention, care and treatment services for Key populations in public health facilities.

- Address barriers to scaling up comprehensive key populations programming
- To advocate for meaningful involvement of Key Populations in the HIV response in health facilities.
- Facilitate the generation and synthesis of information on sub populations for evidence based key populations programming
- Increase access to scaled up and comprehensive services for key populations

The World Health Organization (WHO) defines key populations as populations who are at higher risk for HIV irrespective of the epidemic type or local context and who face social and legal challenges that increase their vulnerability. They include sex workers (SW), men who have sex with men (MSM), transgender (TG) people, people who inject and use drugs (PWID/PWUD), and people in prisons and other closed settings. In addition to experiencing elevated HIV risk and burden and facing legal and social issues, these populations have not received adequate priority in the response to the HIV epidemic, especially in countries with generalised HIV epidemics. Without addressing the needs of key populations, a sustainable response to HIV will not be achieved (WHO

The *Key Populations Health Implementation Plan* is informed by a review of the *HTA Guidelines* and programme, and consultation with stakeholders. The plan was developed under the guidance of the National Department of Health (NDOH) and aims to ensure that quality, evidence, and innovation underpin rights-based key population service provision in South Africa.

The plan is aligned with the goals of the *NSP 2017-2022*, enabling provinces and districts to incorporate activities easily into provincial implementation plans (PIP) and multi-sectoral district implementation plans (MDIP). The plan reflects the goals and objectives within the scope of the Department of Health (DOH) and recognises that key population services require a multi-sectoral response. Progress against goals, objectives and activities will be closely tracked through a monitoring and evaluation framework supported by a research and surveillance agenda.

Sustainable access to health services is when key populations:

- Know the services exist (approachable)
- Are treated in a friendly and safe wat (acceptable)
- Can reach the services and get the care they need (available)
- Are financially able to use the services (affordable)
- Receive quality services (appropriate)
- Are not hindered by stigma and discrimination and violence (accessible)

1.4. Target audience

The Key Populations Health Implementation plan is intended to provide guidance to DOH Provincial and District managers, Health care Providers, Program Managers, developmental partners and support partners involved in the provision of HIV prevention, care and treatment services for Key Populations in South Africa. The documents outlines basic HIV package of care services to be provided for each key population group within public health facilities.

1.5. Guiding principles

Human rights

Access to quality health care

Health literacy

Respect and non-discrimination

Beneficence and do no harm

Meaningful participation of Key Populations

2. HIV and Key Populations in South Africa

South Africa has generalized HIV and TB epidemics and high rates of sexually transmitted infections (STI), which underscores the critical importance of universal access to a comprehensive package of prevention and treatment services for all. The target groups for the *Key Populations Health Implementation Plan* focuses on the five key populations as identified by WHO, but it should be noted

that the vulnerable groups identified in the NSP 2017-2022 should be provided with relevant and sensitive services to ensure that "NOBODY IS LEFT BEHIND".

TABLE 1. KEY POPULATIONS

KEY POPULATIONS
• Sex Workers • Transgender people • Men who have sex with men • People who use drugs • Inmates

2.1. Key Populations

Key populations make up a small proportion of the general population, but they are at extremely high risk of acquiring HIV infection. Available data suggest that the risk of HIV acquisition among gay and other men who have sex with men was 22 times higher in 2018 than it was among all adult men. Similarly, the risk of acquiring HIV for people who inject drugs was 22 times higher than for people who do not inject drugs, 21 times higher for sex workers than adults aged 15–49 years and 12 times higher for transgender women than adults aged 15–49 years.

2.1.1. Sex Workers

A sex worker is defined as a consenting adult over the age of 18 who receives money or goods in exchange for sexual services. In South Africa, the number of female, male and transgender sex workers is estimated between 132 000 and 182 000, with an intermediate estimation of 153 000. Sex workers carry the highest HIV burden of all key populations in the country. Globally, HIV prevalence amongst sex workers and their clients is up to 20% higher than the general population. Nationally, HIV prevalence among sex workers ranges from 40% in Cape Town, 80% (UCSF,ANOVA,WRHI 2014). The NSP reflects a rate of annual new infections associated with sex work as high as 20%, of which around 6% are directly associated with sex workers. The additional 14% are associated with sex workers' partners and clients. Sex workers experience abnormally high levels of stigma, discrimination and violence. A study in Soweto found that 50% of female sex workers had experienced some form of physical assault in the past 12 months; of these 55% had been raped or sexually assaulted (Coetzee, 2017). Exposure to high levels of violence and poverty and low educational levels can increase the risk of HIV infection.

Compounding to an already vulnerable position, sex workers face chronic vulnerability to mental health issues due to the high rate of violence, stigma and discrimination, HIV and trauma. Mental health issues faced by sex workers are only exacerbated by the abuse of alcohol, with the IBBS survey finding that hazardous alcohol use amongst female sex workers ranged between 43% and 81.5%.

2.1.2. Men who have Sex with men

The national HIV prevalence among men who have sex with men (MSM) is estimated at 25.7%, with higher burden in major cities such as Johannesburg (43%), eThekwini (30%) and Cape Town (27%). HIV prevalence among men who have sex with men varies considerably between urban and rural areas and according to socio-economic status. Aurum Institute found that 26.8% in Cape Town, 44, 3% in Johannesburg, and 16.7% in Mafikeng were HIV positive (Aurum Institute, 2019). The HIV cascade for MSM reveals that knowledge of one's HIV status is the main gap, signalling the need for innovative HTS strategies. About 65-70% of South African MSM are undiagnosed.

Despite a constitution that protects the rights of lesbian, gay, bisexual, transgender and intersex (LGBTI) communities, many men who have sex with men face high levels of social stigma and homophobic violence. One study found that 24.5% of men who have sex with men in Cape Town reported experiencing at least one human rights violation in their lifetime. There is also a lack of knowledge around the issues faced by men who have sex with men.

2.1.3. Transgender people

Transgender is an umbrella term to describe people whose gender and identity and expression does not conform to the norms and expectations traditionally associated with their sex at birth. Transgender people include individuals who have received gender reassignment surgery, individuals who have received gender-related medical identity as having no gender, multiple genders or alternative genders. Transgender individuals may identify self-identify as transgender, female, male, transwoman or transman, trans-sexual or one of many transgender identities, and they may express their diversity, it is important to learn and use positive local terms for transgender people, and avoid derogatory terms.

Transgender women in Sub-Saharan Africa are twice as likely to have HIV as men who have sex with men. The situation of transgender women in South Africa is especially serious, with a Human Sciences Research Council (HSRC) study finding HIV prevalence levels of over 50% across three urban centers. This is partly because the social conditions and poverty in which transgender women live, together with the high levels of stigma and social isolation make it difficult for them to maintain safe sexual practices, and if HIV positive to remain in HIV care and treatment. Global data suggests that ART initiation and treatment adherence improves among transwomen in a gender affirming context. Any

effort to address transgender people's health needs to be transactional. Research has demonstrated that engaging transgender women in services is difficult due to transphobic stigma, discrimination and low self-efficacy amongst transgender women. The lack of gender affirming healthcare remains a problem.

However, transgender women are often neglected by both policy and research in South Africa. It is common for this KP group to either be excluded from participating in studies or to be categorized as men who have sex with men. The South African National AIDS Council's (SANAC) *LGBTI HIV Framework* recognizes transgender women as a key affected population. It aims to address this through peer-led interventions, in which members of the transgender community will identify other at-risk individuals and help to provide them with psycho-social support as well as better targeted information and services.

2.1.4. People who Use and Inject Drugs

In South Africa, the use of drugs is criminalised, despite limited possession, caltivation and personal use of cannabis recently decriminalised. This results in the use of drugs being illicit and undercover with the population using and injecting drugs being largely stigmatised and isolated. Data collected indicates that Cannabis, Cocaine, Heroin (and its related concoction such as Whoonga and Nyaope), Over-The-Counter (OTC) and prescription medicines, Amphetamine and type stimulants (Ecstasy), Crystal-Methamphetamine (Tik) are the most used drugs in South Africa.

Injecting drug use has increased in South Africa over the last two decades. It is estimated that around 75,000 people in the country inject drugs. The World Health Organisation (WHO), and the Joint United Nations Programme on HIV and AIDS (UNAIDS) and the UNODC recognises that HIV, TB and viral hepatitis occur, often concurrently, among people who inject drugs (PWID). In 2018, results of a population-level survey suggest 21.8% of people who inject drugs are living with HIV. A 2016 study of people who inject drugs in five South African cities found 32% of men and 26% of women regularly shared syringes and other injecting equipment and nearly half reused needles. The HIV prevalence is estimated to be higher amongst women who inject due to the likely prevalence of sex work amongst women that inject drugs (51%) as well as community norms that women should be "second on the needle". People who inject drugs are also associated with other high-risk behaviours such as sex work and unsafe sexual practices. For example, the same study reported fewer than half of those surveyed used a condom during their last sexual encounter. In addition to HIV, viral hepatitis is concern amongst PWID in South Africa, with viral hepatitis passing very efficiently through the sharing of needles and other injecting commodities. Recent studies show very high rates of hepatitis among PWID, with 5% prevalence of Hepatitis B virus and 44% prevalence of the Hepatitis C virus. There are multiple

intersections of PWID with other key populations such as sex workers and men who have sex with men, through chemsex. The PWID population have also been associated with high risk sexual practices, including condomless sex, multiple sex partners, transactional sex and sex work. The UNODC survey confirmed the risk of sexual transmission of HIV and STI among PWID and their sexual partners, particularly among women who inject drugs.

2.1.5. People in Prisons

South Africa has the highest prison population with 157,402 incarcerated people, and 335 prisoners per 100,000 of the national population. Contributing factors to HIV transmission range from social stigma, institutional and societal neglect, lack of resources for maintenance of existing penal institutions, poor food and nutrition, lack of health care, overcrowding, mixing of un-sentenced and convicted persons, high-risk sexual and other behaviour (such as injecting drug use and blood mixing) and lack of conjugal visits. In male prisons, Same-sex activity is not uncommon though the reported number of instances is likely to be much lower than the actual numbers due to the denial or criminalization of homosexuality, stigmatization of prisoners by society at large, and under-reporting of rape and sexual abuse among male prisoners. Prison population also suffer from high rate of TB and HIV co-infection.

Furthermore, people in prisons experience high stigma resulting with poor integration and access to health facilities upon release from correctional facilities. HIV positive Inmates who are on treatment often miss their treatment due to lack of information on how to reintegrate in to society and access health services outside of the prison.

A combination of interventions is required to respond effectively to HIV among key populations. The following comprehensive HIV package of interventions is provided for key populations Department of Health facilities. The department's mandate is to deliver evidence-based biomedical and psychosocial HIV prevention, care and treatment services grounded in human rights principles to meet the needs of every person, including key populations. Services and information will be customized to address the unique needs of key populations, including steps to ensure that services are designed to provide accessibility for persons with physical, mental, and intellectual disabilities.

3. Delivering HIV Services for Key Population

3.1. Integration of Services for key populations

Service integration is a distinct method of service delivery that provides Key Populations with access to services from multiple programmes in one location. In this model, various components of the HIV/STI/TB package are offered in the same location (i.e. clinic). If possible, services should be

integrated or at least co-located as it gives key populations access to a range of services in one location without logistical barriers.

3.2. WHO Critical enablers to improve access to HIV services for key populations

CRITICAL ENABLERS
Laws and policies
Moving towards decriminalizing the behaviour of key populations Age of consent to services Recognition of transgender people in the law Access to justice and legal support for key populations
Stigma and discrimination
Anti-stigma, antidiscrimination and protective policies Provision of "key populations friendly services" Training and sensitization of health workers
Community empowerment
Programme led by key population organizations Meaningful participation
Violence against key populations
Prevention of violence against key populations Support for persons experiencing violence

3.3. Determinants of health affecting key populations:

Key populations are at an increased exposure to HIV,TB , STI and violence. All key populations experience high levels of stigma, discrimination, violence and other rights abuses, creating barriers to accessing health care and other essential services. These not only affect their overall wellbeing, health, and rights, but also impact their decision-making power and opportunities to seek and adhere to treatment. Realities, risks and needs are further influenced by discriminatory laws, policies and practices affecting their ability to make informed choices about all aspects of their lives.

Biological	Social and cultural (Non-biological)	Behavioural
Anatomy STIs Acute HIV infection	Stigma, discrimination Policy/legal issues Poverty and economic hardship	Condom use PrEP use Contraceptive use Substance use

(e.g. newly/ recently infected) Viral hepatitis TB	Violence Power imbalance Family and social support	Unsafe sexual practices Risk perception Lack of health literacy

3.4. The Role of Health Workers

All health workers should endeavour to make health services available, accessible, and acceptable to key populations, and offer sensitive services of high quality. All facilities should adopt principles

friendly to key populations, paying particular attention to accessibility and the expertise and attitudes of staff members.

Health workers should provide routine screening, counselling, treatment, and referral for common mental health disorders or any health-related challenges. Support groups and small group workshops help to promote mental well-being and coping skills. Sites should implement individual-level behavioural interventions and community level activities.

Our clinic should be inclusive of everyone in our community. After all, health is a human right.

In addition, health facilities should:

- Integrate HIV, TB, STI, sexual and reproductive health services
- Cross-train providers to deliver comprehensive services
- Schedule service hours that are regular, dependable, and convenient
- Locate services strategically where key populations congregate or transit and provide services during outreach
- Involve the key populations community in service implementation, promotion, delivery, and monitoring and evaluation
- Train staff to work with different key populations
- Ensure that law enforcement do not interfere with clients' access to services

3.5. Minimum package of services for key populations at health facilities

Services for key populations should be delivered with sensitivity, respect for human rights, confidentiality and ethical considerations. All facilities should provide the following core interventions targeted to key populations.

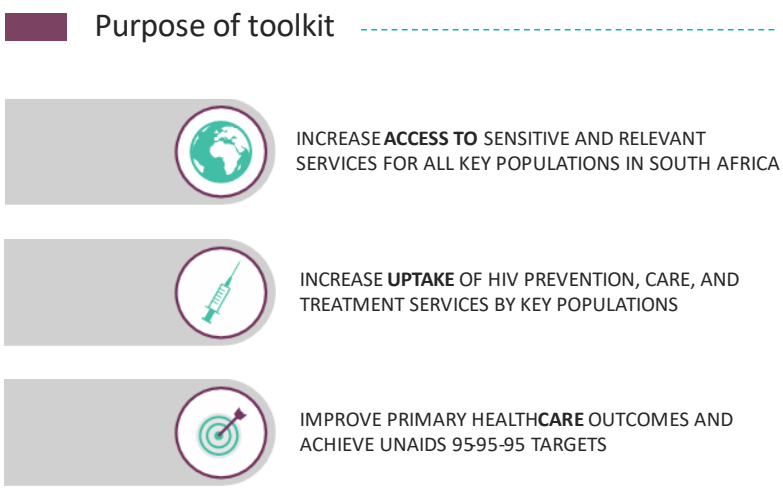
- HIV testing services;
- Condom and lubricant provision and education;
- HIV prevention package including behavioural interventions;
- HIV treatment and care;
- Prevention, and treatment for co-infections including viral hepatitis, TB and mental health conditions;
- PrEP;
- Harm reduction interventions on substance use;
- Gender based violence screening services;
- Sexual and reproductive health services;
- Covid 19 ICP;

- Referrals to appropriate services and next level of care without any delays.

3.6. Sensitization Training

Sensitization training provides training to health care workers (HCW) on the issues and vulnerabilities specific to key populations and how to address these groups in a sensitive manner.

Sensitization training should be provided to all service provides to ensure that facilities are Key Population-friendly. Service providers are not only health care staff nurses, peer educators, counsellors, but include broader stakeholders, such as community and social services. Health is multi-sectoral and police and other key stakeholders (such as traditional leaders/healers and community-based and faith-based organisations, traditional courts, and schoolteachers) should be included in these trainings. This will also promote access to health services to Key Populations. Sensitisation trainings should always include key population representatives. The Department of Health has developed KP sensitization toolkit



The objectives of the sensitization training is to:

1. Sensitize clinical and support staff to stigma and discrimination as they relate to the 5 key populations
2. Provide health care workers with knowledge and skills to perform a comprehensive and sensitive risk assessment of key populations

3. Provide health care workers with tools and resources to treat, care for, and refer individuals from the key populations to appropriate services.

3.7. Key population specific services

3.7.1. Sex Workers

A sex worker is a consenting adult over the age of 18 who receives money or goods in exchange for sexual services.

I know there are sex workers and men who have sex with men coming to our clinic but I'm not sure my staff know how to deliver the sexual health services they need as well as their ART. I think we should try to integrate these services.

• Sex workers may not seek health care due to concerns about poor treatment by staff.

• Because sex work is criminalised, it is also difficult for a sex worker to report sexual assault and abuse.

• Once at the clinic, a sex worker may be stigmatised or denied care for a health complaint because of a

staff member's belief that he/she "brought it on herself".

• An unequal balance of power between sex workers and clients may make it difficult for sex workers

to insist on condom use. A client's offer of extra payment for condomless sex may serve as a barrier to
consistent condom use .

• Sex workers must be provided with the number of condoms they request without being judged or questioned.

• Sex workers must not be judged for reporting to the clinic with repeated STIs.

• Some law enforcement officials consider finding condoms in a woman's bag as evidence that they are
doing sex work. This can also be an additional barrier to consistent condom use.

• Sex worker clients often have other sex partners which may be at risk of exposure to HIV.

• In addition to screening for HIV and STIs, sex workers should be screened for cervical cancer, contraception needs, MTCT services if HIV-positive, mental health screening, and screening for violence
and trauma.

• Sex workers vary in age, race, and economic background. Sex workers may sell sex regularly or on occasion; some may not identify as sex workers.

• Risk assessment questions should focus on unsafe behaviours and practices, rather than his or her occupation or appearance.

The interventions below aim to reduce morbidity, harms and mortality associated with HIV, TB and STIs among female, male and transgender sex workers in South Africa. The Department recognises the importance of strong partnerships with the Departments of Social Development, Justice and Police Services to ensure sex workers receive services which support their working environments. In line with the NSP and the National Sex Worker Plan for HIV, TB and STIs 2019-2022, the Department strives towards the delivery of a comprehensive package for male, female, and transgender sex workers.

FIGURE 1: SERVICES FOR SEX WORKERS

3.7.2. Men who have Sex with Men

Some providers of sexual and reproductive health services require that patients disclose their sexual orientation. But for men who have sex with men (MSM), this simple act can worsen the stigma and discrimination they already face on a regular basis. Health care providers must screen MSM for sexually transmitted infections (STIs) and gender-based violence, and provide HIV counselling and

testing services. HIV-positive MSM must be provided linked to services that are known to be friendly toward MSM and other key populations.

Men who have sex with men should be provided with a core package of services, but U=U messaging and PrEP should be highlighted to ensure viral load suppression and prevention of new HIV infections respectively.

MSM who also engage in vaginal sex should be offered voluntary medical male circumcision.

FIGURE 2: SERVICES FOR MEN WHO HAVE SEX WITH MEN

3.7.3. Transgender people

'Transgender' is an umbrella term to describe people whose gender identity and expression does not conform to the norms and expectations traditionally associated with their sex at birth. Transgender people include individuals who have received gender reassignment surgery, individuals who have received gender-related medical interventions other than surgery (e.g. hormone therapy) and individuals who identify as having no gender, multiple genders, or alternative genders. Transgender individuals may self-identify as transgender, female, male, transwoman, or transman, trans-sexual or one of many other transgender identities, and they may express their genders in a variety of masculine, feminine and/or androgynous ways. Due to this diversity, it is important to learn and use positive local terms for transgender people, and to avoid derogatory terms (SANAC, 2017a).

A survey conducted in Cape Town metro, Johannesburg metro, and Buffalo City metro in 2018/19 showed HIV prevalence of 45.5%, 63.4% and 46.1% respectively (Human Sciences Research Council, 2019).

Most transgender women – 91.1% in Cape Town; 91.0% in Johannesburg; and 78.1% in Buffalo City - were tested for HIV in the 12 months preceding the survey (Human Sciences Research Council (HSRC), 2019). High levels of condom use were reported at last anal sex with a man in all three South African cities: 73.1% in Cape Town, 76.7% in Johannesburg and 80.0% in Buffalo City (Human Sciences Research Council, 2019).

Transgender peoples experience high levels of stigma and discrimination from the community, their families, and from health workers. This leads to a high risk of unemployment, homelessness, isolation, and unsafe behaviour. Community discrimination often leads to homophobic violence including rape

The Department commits to providing HIV prevention services aligned to the core package of services defined in the NSP. Adequate training and support to healthcare workers will be prioritized to ensure that the delivery of services is gender-affirming which supports gender healthcare goals holistically.

Data on transgender women in South Africa remains scarce and HIV prevalence for this group has been undocumented before 2019. Globally data shows transgender woman to be at 49 time's higher risk for HIV infection than other adults of reproductive age.

FIGURE 3. SERVICES FOR TRANSGENDER PEOPLE

3.7.4. People who Use and Inject drugs

People who use drugs include people who use drugs that affect a person's mental state (psychotropic substances) through any route of administration, including injection, oral, inhalation, trans mucosal (sublingual, rectal, intranasal), or through the skin. Often this definition does not include the use of such widely used substances as alcohol and caffeine-containing beverages and foods (World Health Organization, 2016) People who inject drugs refers to people who inject psychotropic (or psychoactive) substances for non-medical purposes. These drugs include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypno-sedatives, and hallucinogens. Injection may be through intravenous, intramuscular, subcutaneous, or other injectable routes (WHO, 2016b). Stigma and discrimination against people who use drugs has contributed significantly to the high prevalence of HIV in South Africa due to the sharing of needles and other injecting equipment among PWID.

Methadone is a synthetic drug that mimics the effects of opioids without creating dependency. Methadone maintenance therapy (MMT) is a treatment program that involves the long-term prescription of methadone as well as counseling, case management, and health services. In addition to its positive effects on opioid addiction, MMT has been shown to reduce HIV risk behaviors (sharing needles, exchanging sex for drugs or money) and increase adherence to antiretroviral therapy among PWID who are living with HIV. Fear of stigma and arrest can discourage KPs from accessing health care, programs must find ways to make health services safe and accessible for them.

Services delivered by KP-led/assisted organizations and by KP community members themselves hold promise as an effective way to engage and retain KPs in health services. In fact, MMT clients who are

already retained in care can be used to encourage testing among those who may be HIV positive but are unaware of their status.

Ian thinks: I now access OST at a community health centre with the support of a nurse. I can also get my ART at the community health centre and it works so much better to get everything I need in one place.

FIGURE 4: SERVICES FOR PEOPLE WHO INJECT DRUGS

3.7.5. People in Prisons

People in prisons and other closed settings refers to all places of detention within the country, and the terms “inmates” and “detainees” refer to all those detained in criminal justice and prison facilities (World Health Organization, 2016b)

Risk factors for exposure to HIV, TB and STIs

- Use of unsterile needles increasing exposure to HIV and hepatitis C
- Sexual violence
- Stigma and discrimination from health workers

FIGURE 5: SERVICES FOR PEOPLE IN PRISONS

3.8. Referral Networks and Linkage to Services

A referral network describes the pathway by which patients are sent from one facility/service to another to ensure that they access all the components of care which they require. Referral networks are usually developed for a defined, smaller geographic area (e.g., district or metro area) and not for the entire country or province. A referral network includes making and tracking referrals,

establishing a referral directory, and monitoring the referral process. Referrals are strengthened when a structured understanding describing the relationship between organisations/service providers is developed (program collaboration). A structured understanding ensures organisations/ providers work together and avoid duplication of services improving the efficiency of program delivery. The referrals process ensures the HIV/STI/TB related needs of the patient are assessed and s/he is helped to access the identified services.

Effective referral networks ensure that the client receives all the services necessary if they are not all provided in one setting. Key populations should be referred for legal services, psychosocial support services and other relevant services.

3.7.1 Establishing a Referral Network

Each health facility should establish referral networks by following the steps below:

- Identify and sensitize a cadre of Organisations to provide “Key Population services”
- Develop a structured understanding between Organisations within the referral network (MOU or other formalized relationship)
- Produce a referral listing the location, contact details, hours of operation, services provided, cost and point person of each organization within the referral network
- Produce a standard referral form and register to be used by all organisations within the referral network to track referrals
- Create a feedback loop for client and program follow-up on the referral service and process. The feedback loop could include phoning or mailing referral documentation between sites; getting a peer educator to take a patient from one service to another; or a coordinating body being set up between services.
- Monitor the referral system, documenting the number of successful referrals (number of Key Population individuals who are successfully linked to the service they were referred to and received the service)

To ensure successful implementation of a referral network it is important that service providers:

- Implement strategies to encourage the target population to use the services within the referral system
- Ensure that organisations in the referral network can provide services that are relevant and friendly to that specific Key Population, including addressing issues of capacity, accessibility, and acceptability
- Ensure confidentiality within and between organisations

- Ensure documentation of the referral process (who was referred, from where, to where, and was the referral successful)
- Enlist feedback on services from the target population and organisations in the referral network
- Establish quality assurance and quality improvement strategies
- Provide comprehensive patient folder to ensure continuity of care. This should include a Health Passport for cross-border migrants and mobile populations

3.9. Involvement of key population in service delivery

Meaningful participation of representatives of the KP community is critical to ensure the appropriateness and acceptability of services to the targeted population. It is also important for building trusting relationships between the community and service providers, who may be accustomed to establishing the parameters by which services are provided and prescribing how relationships and partnerships are to be conducted.

Lerato thinks: I really appreciate the support I receive from the peer counsellor when I collect my ART refills at the clinic. She understands the challenges that I have faced.

The peer education programme is part of a comprehensive prevention strategy including community mobilization, prevention, HTS, promotion and referral, condom promotion and skills for personal protection.

Peer

- A peer is a member of a group of people sharing the same characteristics. For example, people of the same age and backgroundor similar lifestyle, experience or beliefs.

HIV peer education

- This involves selecting, training and supporting members of a group to educate their peersabout HIV and related topics
- Information is shared among peers through dialogues, paper pamphlets, and other channels of communication.

Peer educator

- A person who belongs to a group on an equal basis as other group members but who is trained (and supervised) to bring about a change in knowledge attitudes, beliefs and behaviours

Minimum Package for Peer Educators

- The peer education programme is part of a comprehensive prevention
- Continuous uninterrupted funding for peer education programme is desirable
- Trained staff should supervise and support peer educators
- There should be an adequate ratio of peer educators to the target population (minimum of one peer educator to 20 – 50 peers)

Peer Educators Role in Behavioural interventions

- Behavioural interventions provide information, motivation, education and skills-building to help individuals reduce risky behaviours and sustain this positive change.

The goal of peer education and outreach is to:

- Reduce HIV/STI risk behaviours (i.e. unprotected sex, unsafe injecting practices, high number of sexual partners)
- Promote safe practices (e.g. correct consistent condom use, safe injecting practices),
- Increase the number of peers who access HIV/STI/TB and related service,
- Provide an opportunity for the sharing of information between peers around HIV/ STIs and TB and as well as a source for prevention commodities (condoms, lubrication, safe injecting packs)
- Empower peer educator and peers to advocate for their own health needs by creating a sense of solidarity and collective action within the community can occur through peer based programming

Table 2. Roles of peer educators/ Peer Navigators

Roles of Peer Educators	Gap/Barriers
• Communicate key messages, provide psychosocial support and linkages • Provide Initial and on-going contact with peers	• Insufficient funding • Inadequate training and supervision • No clear career pathing

Roles of Peer Educators	Gap/Barriers
• Provide correct health information (verbally and through the distribution of IEC material) • Demonstrate, promote use of, and increase access to condoms, lubricants, and other HIV prevention tools such as harm reduction packages • Provide Information on sexual and reproductive health including family planning • Provide counselling and motivational interviewing • Encourage and motivate peers to know their HIV status • Assess risk profile and encourage HIV/STI risk reduction behaviours • Refer peers to additional components of the HIV/STI package of services such as STI screening and treatment and HIV testing and counselling	• Non-acceptance by the community members/community leaders • • Burn-out

All key populations services should involve key population individuals and designed to suit the needs of the different groups. This may include hours of operation. All key population sites should have a peer educator that acts as a liaison officer onsite and links with sites to support linkage and integration into facilities. All peers should be provided with the opportunity to participate meaningfully. This means that key populations 1) choose whether to participate; 2) choose how they are represented, and by whom; 3) choose how they are engaged in the process; and 4) have an equal voice in how partnerships are managed.

Peer educators must be equipped through systematic training, mentoring, coaching, and certification to provide comprehensive HIV, TB and STI prevention and treatment services, including point-of-care HIV and STI testing, PrEP, PEP, treatment service linkages, and case management support (Vannakit *et al.*, 2020).

Trusted peers can help programs reach those at greatest risk of HIV infection and advocate for the most needed services.

4. Monitoring and Evaluation

M&E is uniquely oriented towards providing its users with the ability to draw conclusions regarding relationship between the programme's objectives and the interventions, set priorities for the programme, correlate the relevance of the programme design to the services actually delivered and their ultimate impact on communities. It helps to provide an evidence base for resource allocation decisions and helps to identify how challenges should be addressed and successes replicated. It also helps to track the reduction of infection amongst KP who HIV are positive and also ensuring that those HIV negative remains negative, it also monitors STIs, SRH, Hepatitis screening amongst KPs

The Development of M&E Framework

A need for comprehensive monitoring and evaluation framework which allows for the monitoring of interventions and progress is also recommended by the Gap Analysis and Recommendation for Key Populations. Commitment to strengthening of regular monitoring through data use for the High Transmission Areas (HTA) and KP programme will respond to Goal 8 of the National Strategic Plan (NSP) on HIV, TB and STIs 2017-22, which calls for strengthening of strategic information to drive progress towards achievement of NSP goals. With the NSP focus on the 90-90-90 strategy for HIV and TB, there is great need for monitoring of HTA activities to track the programme's contribution towards the prevention strategy. A comprehensive monitoring and evaluation framework which allows for the monitoring of interventions and progress is needed to ensure that all stakeholders take ownership of interventions and the data pertaining to HIV responses.

Guiding Principle of Monitoring and Evaluation framework

The key population monitoring is designed to help the high health care workers and partners to implement and monitor programs for HIV prevention, diagnosis, care, treatment, and viral load testing with key populations (KPs) sex workers (SWs), gay men and other men who have sex with men (MSM), transgender people, and people who inject drugs (PWID). KPs bear a disproportionate burden of HIV

but have much lower access to HIV-related services and other services than members of the general population.

The framework proposes a monitoring for HIV prevention services for key populations, monitoring these services will identify the bottlenecks that need to be addressed to achieve a more effective response to the 95-95-95 cascade goals in the country. The monitoring framework involves a longitudinal follow-up of HIV-negative persons from key populations: who, after being tested for HIV, are linked to prevention services, and remain HIV free. HIV positive persons from key populations: who, after receiving a confirmatory HIV diagnosis, are linked to HIV related care services, and maintain a suppressed

This framework provides a layout of the Department of Health's (DOH) KP Programme monitoring and evaluation plan as well as provide guidance on the core indicators of the program, reporting path, and role and responsibilities of the various stakeholders. This will assist the persons involved with the standardized collection, reporting, and analyses of the core indicator data to ensure consistent, timely, accurate and high-quality information are available to programme managers. Tracking systems must collect and monitor data from public, private, and non-profit programs to effectively track sites and KP individuals, regardless of the service delivery model. Only with this tracking can sites understand the extent to which they are serving KP, for scale up of the targeted response.

Objectives of the M&E framework

- Track progress on implementation of all the 95-95-95 pillars for HIV prevention
- Identify gaps and weaknesses in service provision.
- Plan, prioritize, allocate and manage resources.
- To guide and standardize monitoring and evaluation of key population programmes at the facility and community levels.
- Streamlined and standardized key population programmes at the facility and community levels (over 3000 facilities)
- Comprehensive M & E systems that caters for Key population to guide evidence-informed interventions.

KEY COMPONENTS OF MONITORING AND EVALUATION

- What does the programme want to achieve and how?
- What are the programme's specific objectives?
- What are the programme indicators?
- How to collect and analyse the data?

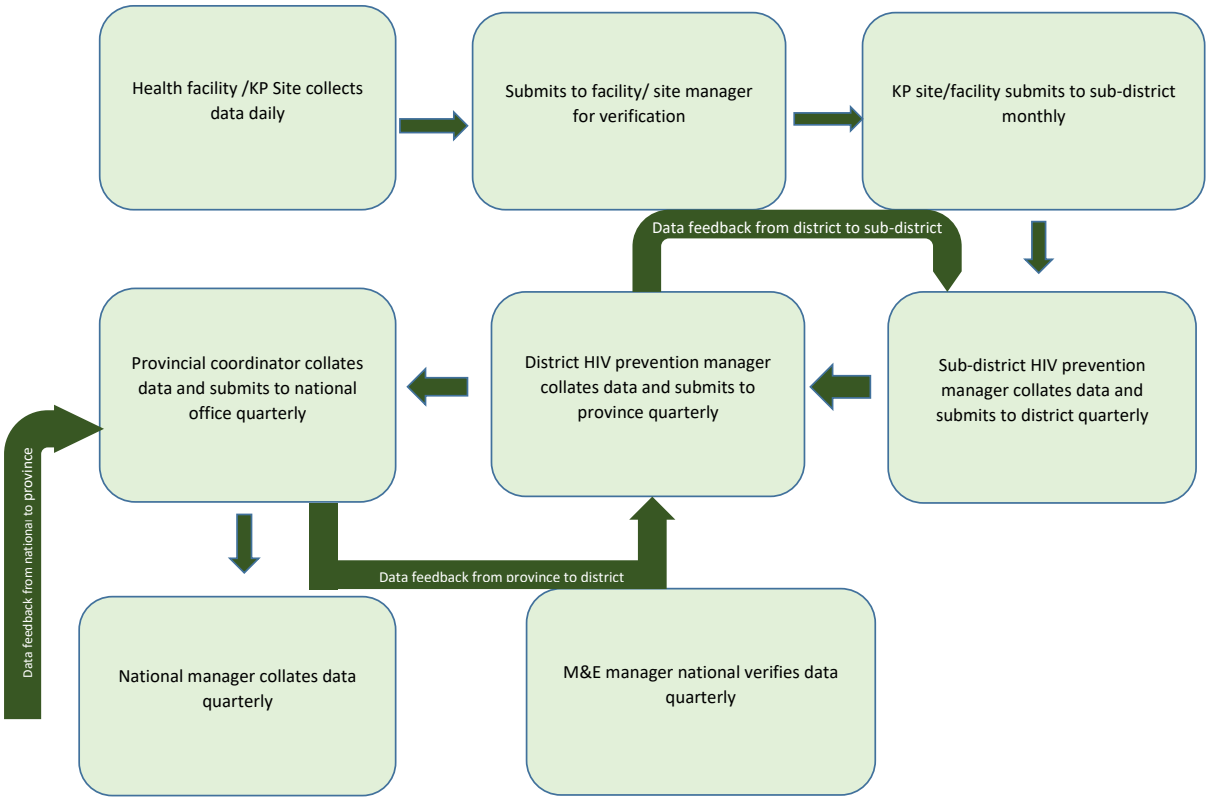
4.1. Proposed Indicators

PROPOSED INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET 21/22	REPORTING FREQUENCY
Number of KP tested for HIV	**OUTPUT**		KP GROUP, AGE, SEX				MONTHLY
Number of KP testing positive	**OUTPUT**		KP GROUP, AGE, SEX				MONTHLY
Number of HIV positive KP linked to care	**OUTPUT**		KP GROUP, AGE, SEX				MONTHLY
Number of KP started on ART	**OUTPUT**		KP GROUP, AGE, SEX				MONTHLY
Number of KP screened and treated for STI	**OUTPUT**		KP GROUP, AGE, SEX				MONTHLY
Number of clients screened for TB	**OUTPUT**		KP GROUP, AGE, SEX				MONTHLY
Number tested HIV negative	**OUTPUT**		KP GROUP, AGE, SEX				MONTHLY
Number of KP referred for prep	**OUTPUT**		KP GROUP, AGE, SEX				MONTHLY

Number of KP started on prep	**OUTPUT**		KP GROUP, AGE, SEX				MONTHLY
Number KP started on art	**OUTPUT**		KP GROUP, AGE, SEX				MONTHLY
Number of female KP referred for SRH services	**OUTPUT**		KP GROUP, AGE, SEX				MONTHLY
Number of PWID screened for Hepatitis	**OUTPUT**		KP GROUP, AGE, SEX				MONTHLY
% of MSM who received at least two HIV prevention interventions in the last 3 months	Output	**Numerator**: Number of MSM with access to core package of HIV, TB and STI services **Denominator**: Estimated number of sex workers	Total, Age	IBBS	New Indicator		Annual Every 3 years
% of PWID who received at least two HIV prevention interventions in the last 3 months	Output	**Numerator:** Number of PWID with access to core package of HIV, TB and STI services **Denominator**: Estimated number of PWID	Total, Age, Sex	IBBS			Annual
Number of individuals who received an	Output	**Numerator**: Number of key population	Geographic area Type of sex worker, Sex, Age	HTA programme DORA reports			Annual

HIV service or referral at HTA sites		members who received an HIV service or referral at HTA sites					
Individuals from key populations reached with individual/ small group HIV prevention and behaviour change interventions	Output	Numerator: Number of clients reached with HIV prevention programmes individual and or smaller group level interventions Denominator: N/A	Geographic area Type of sex worker	HTA programme Programme data DORA Reports	12 090		Annual
Percentage of specific key and vulnerable populations with access to core package of HIV, TB and STI services	Output	Numerator: Number people reached with a core package of HIV, TB and STI services Denominator: Total number of respondents	Geographic area, Target population	IBBS		100%	Every 3 years

KP DATA FLOW


Health facility /KP Site collects data daily
Submits to facility/ site manager for verification
KP site/facility submits to sub-district monthly
Data feedback from district to sub-district
Sub-district HIV prevention manager collates data and submits to district quarterly
District HIV prevention manager collates data and submits to province quarterly
Provincial coordinator collates data and submits to national office quarterly
Data feedback from national to province
Data feedback from province to district
National manager collates data quarterly
M&E manager national verifies data quarterly

References

Amin, A. (2015) 'Addressing gender inequalities to improve the sexual and reproductive health and wellbeing of women living with HIV', *Journal of the International AIDS Society*, 18(Suppl 5), pp. 1–6. doi: 10.7448/IAS.18.6.20302.

Aurum institute (2020) 'South African Health Monitoring survey for MSM 2: BBS Summary Sheet_090420'. Pretoria.

Aurum Institute (2020) 'Sex worker bio-behavioural study (SAHMS 2) summary sheet_v4'. Pretoria.

Aurum Institute and NICD (2020) Socio-behavioural and structural factors driving HIV/AIDS, STIs and Hepatitis B & C infections among inmates in Correctional Facilities. HASH study 2019 V1. Johannesburg.

AVERT (no date) *HIV / AIDS Glossary*. Available at: https://aidsinfo.nih.gov/understanding-hiv-aids/glossary/845/pill-burden (Accessed: 16 November 2020).

Bhana, A. *et al.* (2019) 'Validation of a brief mental health screening tool for common mental disorders in primary healthcare', *South African Medical Journal*, 109(4), p. 278. doi: 10.7196/SAMJ.2019.v109i4.13664.

Bill & Melinda Gates Foundation (2013) *Micro-planning in peer led outreach programs - A handbook*. New Delhi. Available at: https://docs.gatesfoundation.org/documents/Microplanning Handbook (Web).pdf.

CDC (no date) 'Social Network Strategy for HIV testing recruitment'. Available at: https://effectiveinterventions.cdc.gov/en/care-medication-adherence/group-4/social-network-strategy-for-hiv-testing-recruitment.

Department of Correctional Services (2019) *Annual Report 2017/2018*. Pretoria. Available at: https://www.gov.za/sites/default/files/gcis_document/201810/correctional-services-annual-report-2017-18.pdf.

Department of Health (2014) *High transmission area guidelines*. Pretoria.

Department of Health (2016) *National HIV Testing Services: Policy*. Pretoria. Available at: http://www.hst.org.za/sites/default/files/HTS.

Department of Health (2019) 'Final NIDS data indicators'. Pretoria.

Department of Health (2020) 'Review of HTA programme and Recommendations'. Pretoria.

FHI 360 (2017) *Enhanced Peer Outreach Approach (EPOA)*. North Carolina. Available at: https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-enhanced-peer-outreach-implementation.pdf.

Hargreaves, J. R. *et al.* (2016) 'The HIV prevention cascade: integrating theories of epidemiological, behavioural, and social science into programme design and monitoring', *Lancet HIV*. Elsevier Ltd, 3(7), pp. e318--e322. doi: 10.1016/S2352-3018(16)30063-7.

HSRC (2019) Results of the first HIV prevalence survey conducted with transgender women in South Africa. Cape Town.

Lafort, Y. *et al.* (2017) 'Sexual and reproductive health services utilization by female sex workers is context-specific: results from a cross-sectional survey in India, Kenya, Mozambique and South Africa', *Reprod Health*. Reproductive Health, 14(13), p. 10. doi: 10.1186/s12978-017-0277-6.

NACOSA (2018) Micro Planning Manual: Sex work programme. Cape Town.

PEPFAR (2017) PEPFAR Monitoring, Evaluation, and Reporting (MER 2.0) Indicator Reference Guide. Washington DC.

Republic of South Africa (2017) Division of Revenue Act Amendment bill.

Research Working Group HIV Think Tank (2020) Review of CROI 2019 and IAS 2019 research to inform the South African HIV programme. Pretoria.

SANAC (2017a) *South Africa's National Strategic Plan for HIV, TB and STIs 2017-2022*. Pretoria. Available at: http://sanac.org.za/2018/09/26/download-the-full-version-of-the-national-strategic-plan-for-hiv-tb-and-stis-2017-2022/.

SANAC (2017b) 'The South African National LGBTI HIV Plan, 2017-2022'. Pretoria, pp. 2017–2022.

Scheibe, A., Brown, B. and dos Santos, M. (2015) Rapid assessment of HIV prevalence and HIV-related risks among people who inject drugs in five South African cities. Cape Town.

Scheibe, A., Richter, M. and Vearey, J. (2016) 'Sex work and South Africa's health system: addressing the needs of the underserved', in Padarath, A. et al. (eds) *South African Health Review*. Pretoria: Health Systems Trust, pp. 165–178. Available at: http://journals.co.za/content/healthr/2016/1/EJC189310.

SWEAT (no date) *A Low-Cost, Integrated Model for Sex Work Programming Report & Recommendations*. Cape Town. Available at: http://www.sweat.org.za/wp-content/uploads/2018/03/SWEAT-low-cost-model_final.pdf.

UCSF, Anova Health Institute and NICD (2018) 'Brief report on the TipVal study: An Integrated Biological Behavioral Surveillance Survey among People Who Inject Drugs'. Pretori.

UNAIDS (2014) *90-90-90 An ambitious treatment target to help end the AIDS epidemic*. Geneva. Available at: http://www.unaids.org/Sites/Default/Files/Media_Asset/90-90-90_En_0.Pdf.

UNAIDS (2015) 'Terminology Guidelines'. Geneva. Available at: https://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf.

UNAIDS (2016) 'Implementing comprehensive HIV and STI programmes with transgender people: Practical guidance for collaborative interventions', p. 212. Available at: http://www.unaids.org/sites/default/files/media_asset/UNDP-et-al_2016_transgender_practical_guidance_collaborative_interventions_en.pdf%0Ahttps://www.unfpa.org/sites/default/files/pub-pdf/TRANSIT_report_UNFPA.pdf.

UNDP (2012) *Risks, rights & health*. Geneva. Available at: http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf.

UNODC et al. (2017) Implementing comprehensive HIV and HCV programmes with people who inject drugs: Practical guidance for collaborative interventions. Vienna. Available at: https://www.who.int/hiv/pub/idu/IDUIT_2017.pdf.

Vannakit, R. *et al.* (2020) 'Give the community the tools and they will help finish the job: key population-led health services for ending AIDS in Thailand', *Journal of the International AIDS Society*, 23(6), pp. 1–3. doi: 10.1002/jia2.25535.

World Health Organization (2010) Monitoring the Building Blocks of Health Systems. Geneva.

World Health Organization (2016a) *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations: Update*. Geneva. Available at: https://apps.who.int/iris/bitstream/handle/10665/246200/9789241511124-eng.pdf?sequence=8.

World Health Organization (2016b) *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*. Geneva. Available at: https://apps.who.int/iris/bitstream/handle/10665/246200/9789241511124-annexes-eng.pdf?sequence=5.

World Health Organization (2017a) *A Guide to identifying and documenting best practices in family planning programmes*. Geneva: WHO. Available at: http://apps.who.int/iris/bitstream/10665/254748/1/9789290233534-eng.pdf?ua=1.

World Health Organization (2017b) *Consolidated guideline on sexual and reproductive health and rights of women living with HIV*. Geneva. Available at: http://apps.who.int/iris/bitstream/10665/254885/1/9789241549998-eng.pdf.

World Health Organization (2019) WHO consolidated guideline on self-care interventions for health: sexual and reproductive health and rights. Geneva. doi: CC BY-NC-SA 3.0 IGO.

Proposal Format

A detailed proposal in response to this ToR is due 07 April 2022 on **by 14h00pm** containing all the information required to evaluate the bid against the requirements stipulated in these terms of reference document. Please send your proposals to Beullah@sanac.org.za the following should be attached to the proposal as annexures:

i) Annexure A: Technical Proposal demonstrating ability to complete the assignment and produce a quality document as per scope of work detailedabove

ii) Annexure B: Summary of experience. Please attach CVs of proposed teammembers, where applicable which show the range of similar assignments they have undertaken and the size of these assignments, three letters of reference or other means of verifying experience

iii) Annexure C: Summary details of proposed team

iv) Annexure D: Pricing information. Price proposals should include VAT and should be fully inclusive of ALL costs to deliver the outputs indicated in theterms of reference**.**

v) **Annexure E: CSD Summary Report- with Complaint status**