



The Global Alliance Plan 2030

GAUTENG, SOUTH AFRICA



GAUTENG
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA



unicef 
for every child

 World Health Organization

 **UNAIDS**

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1. Introduction

In the global quest to end the AIDS epidemic as a public health threat by 2030, meeting the HIV-related needs of children, adolescents, and pregnant and breastfeeding women represents a critical piece of unfinished business. Progress towards eliminating new HIV infections among children (aged 0–14 years) has stalled as countries grapple with going the last mile to eliminate vertical transmission (VT). Our most vulnerable younger populations suffer glaring disparities when it comes to accessing HIV testing and effective treatment. As a result, a disproportionate number of children continue to die of AIDS-related illnesses.

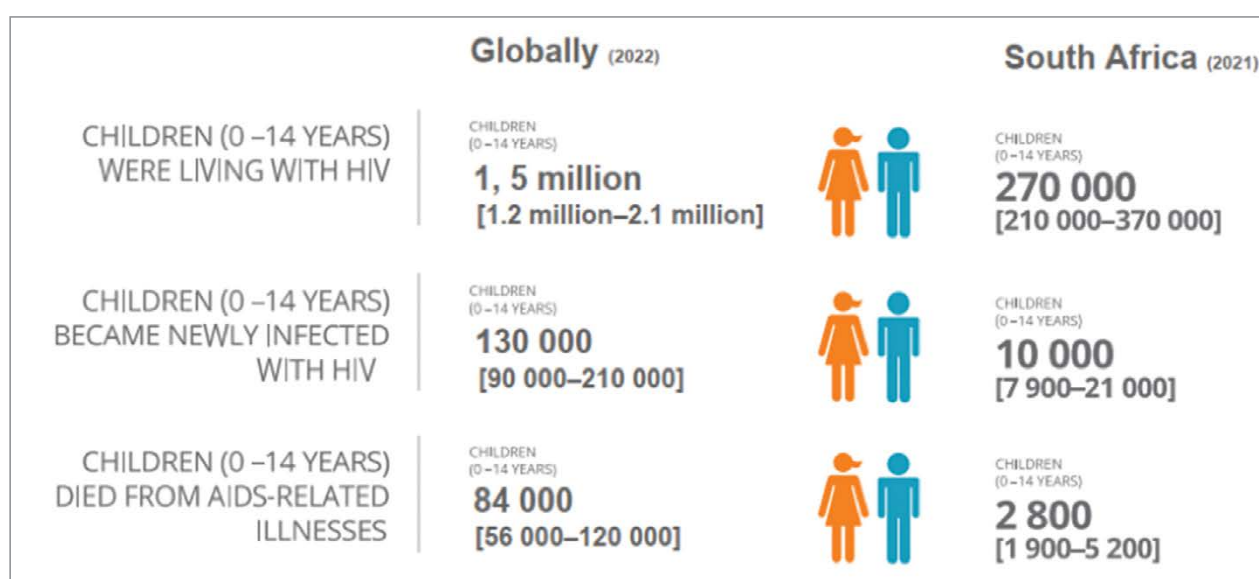


Figure 1. The HIV burden of disease in children

Planned solutions need to extend beyond medical treatment and the healthcare system; they require a whole-of-society approach to address the social and environmental drivers of ill health and create supportive environments that enable children to thrive.

Ending AIDS in children requires the following main approaches:

1. **Preventing new infections** in children by vertical transmission prevention (VTP).
2. Keeping **children who are already living with HIV** (LHIV) on antiretroviral therapy (ART), virally suppressed, and healthy.

Preventing VT requires that **new infections are prevented** in pregnant and breastfeeding girls and women (PBGW) who are HIV-negative but at risk of HIV, and that PBGW who are LHIV, including marginalised and key populations, access ART and achieve viral suppression.

Keeping children LHIV (CLHIV) healthy requires that their HIV status be known, that they are initiated on ART and retained in care, and that they achieve and remain virally suppressed and healthy.

Achieving these two main approaches requires that inequalities be addressed, including those relating to rights, gender, and social and structural barriers that hinder access to health and social protection services.

In a country beset by poverty, inequality, social exclusion, and violence, our most important responsibility is to our children and adolescents. We need to identify and support those who face difficulties early on so that they can continue their lifelong journey with health, strength, and resources. Therefore, it is essential that our laws and policies, our services for children and families, our leaders and their decisions, and our everyday interactions with one another help to foster physical and mental health and well-being.¹

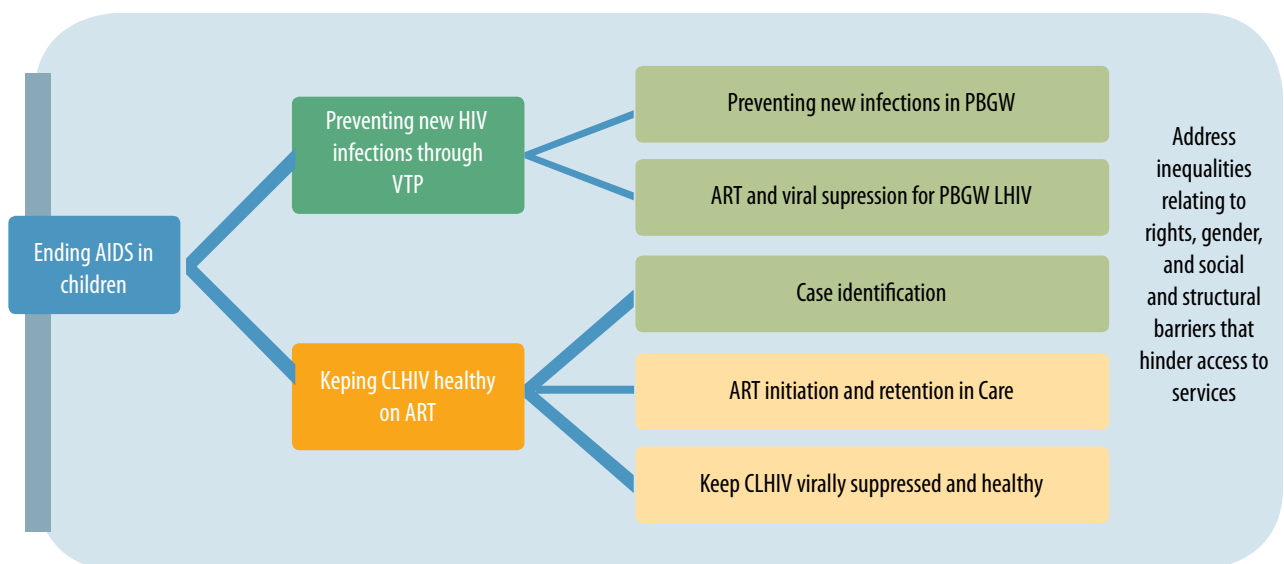


Figure 2. Overview of the path to ending AIDS in children

¹ Richter, L *et al.* 'A longitudinal perspective on violence in the lives of South African children from the Birth to Twenty Plus

2. The journey so far

2011 to 2015

Global Plan towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive ("Global Plan")

2016 to 2021

Start Free, Stay Free, AIDS Free Partnership (3-Frees)

2021 to 2026

Global Aids Strategy 2021 - 2026
End inequalities: End AIDS



As a strategy to focus on priority actions for children defined in the new **Global AIDS Strategy 2021-2026**, the South African Government is teaming up with UNAIDS, networks of people living with HIV, UNICEF, WHO, PEPFAR, and global Fund to form a new

**Global Alliance to
End AIDS in Children by 2030**

The Global Alliance will seek to apply the lessons learned from the Global Plan and the Start Free Stay Free AIDS Free Partnership (3-frees) framework to amplify what worked and avoid some of the pitfalls of past initiatives.

End AIDS in
Children by 2030



SUSTAINABLE DEVELOPMENT GOALS
17 GOALS TO TRANSFORM OUR WORLD

Zero Discrimination
Zero new HIV Infections
Zero AIDS-Related Deaths

3. The new Global Alliance to End AIDS in Children by 2030

3.1. The Global Alliance's vision

An end to AIDS in children, achieved through a strong, strategic, and action-oriented alliance of multisectoral stakeholders at national, regional, and global levels that works with women, children, and adolescents LHIV, national governments, and partners to mobilise leadership, funding, and action to end AIDS in children by 2030.

3.2. Populations of focus

- Children (0–14 years) and Adolescents (15–19 years²) LHIV
- Children exposed to HIV
- PBGW who are LHIV, including marginalised and key populations.
- PBGW who are HIV-negative but at risk of HIV

3.3. What will the alliance do?

In line with the commitments and recommendations of the Global AIDS Strategy and the 2021 Political Declaration of the UN High-Level Meeting, and in keeping with the findings of the stakeholder survey that was distributed globally to inform the need for a new initiative for children, the alliance will:

Advocate for and mobilise worldwide leadership, political commitment, and resources for urgent action to address inequities and end AIDS in children

Galvanise action in partner countries at national government and community levels by assessing and addressing inequalities, programme gaps, and structural barriers across the four pillars of work

Stimulate innovation and technical excellence within and among countries by promoting the sharing of knowledge and experience among affected communities and country programmes and across relevant sectors

Create and implement a mutual accountability framework around shared targets and commitments

² The age that defines a 'child' as per the Health Act of 2003, is 0–18 years. However, monitoring systems for health disaggregate data in age groups < 15 years and 15–19 years. This is under review, but at the time of this plan, data had to be used as per available groupings, i.e. 15–19 years.

4. Where are we globally on the journey to end AIDS in children?

4.1. Preventing new infections in children

Globally, there has been a **58% drop in the annual number of new infections in children** between 2010 and 2022, to 130 000, largely due to fewer new HIV infections in women and higher coverage of treatment among people LHIV. It is estimated that VTP programmes have averted **3,4 million new HIV infections** in children since 2000. However, we are far from ending new HIV infections in children.

Preventing new HIV infections in PBGW

Young people (aged 15–24 years) represent about 15% of the global population but accounted for an estimated 28% of new HIV infections in 2019. The epidemic continues to impose a heavy burden on adolescent girls and young women. Every week, about 4,500 young women aged 15–24 years acquire HIV. In sub-Saharan Africa, five out of every six newly infected adolescents aged 15–19 years are girls. Young women are twice as likely to be LHIV than men.

ART and viral suppression for PBGW LHIV

Some countries have made remarkable progress in providing ART to pregnant women LHIV. By the end of 2021, 12 countries in sub-Saharan Africa, including South Africa, reached the target of 95% ART coverage in pregnant women.

However, at a global level, maternal ART coverage was around 81% in 2021³. In several HIV high-burden countries and settings, progress in preventing VT has flatlined since 2015. Challenges with the quality of care persist, in the antenatal period and more so in the period after birth, with

³ The path that ends AIDS: UNAIDS Global AIDS Update 2023. Geneva: Joint United Nations Programme on HIV/AIDS; 2023



poor uptake of testing, gaps in ART initiation, low retention rates, and poor adherence to HIV treatment. The COVID-19 pandemic threw efforts further off track, and between 2019 and 2021, ART coverage among pregnant and breastfeeding women declined in some countries.

4.2. Keeping CLHIV healthy on ART

One of the most glaring disparities in the AIDS response to date **is the failure to provide life-saving treatment to children and adolescents LHIV**. While 81% of pregnant women LHIV and 76% of adults overall were receiving antiretrovirals in 2021, only 52% of children 0–14 years and 60% of adolescents have access to the HIV treatment that will save their lives (UNAIDS Global Alliance Document). Although the number of AIDS-related deaths among children decreased by 64% between 2010 and 2022, the HIV pandemic still claimed the lives of approximately 84 000 children in 2022.

4.3. Addressing inequalities relating to rights, gender, and social and structural barriers

Inequalities have been deemed the key reason why the 2020 global targets were missed, and reducing inequalities in the HIV response is, therefore, a fundamental approach of the new Global AIDS Strategy, 2021–2026. Structural inequalities and determinants of health – education, occupation, income, home, and community – all have a direct impact on health and HIV outcomes. The lower someone’s social and economic status, the poorer their health is likely to be.



5. Where are we in South Africa along the journey to end AIDS in children?

5.1. Preventing new infections in children

South Africa has made great strides in reducing new HIV infections in children through preventing VT, largely by increasing ART coverage for pregnant women. ART coverage in pregnant women has surpassed the 95% target. In 2021, the final VT rate measured 3,1% in South Africa, as illustrated in Figure 3.⁴

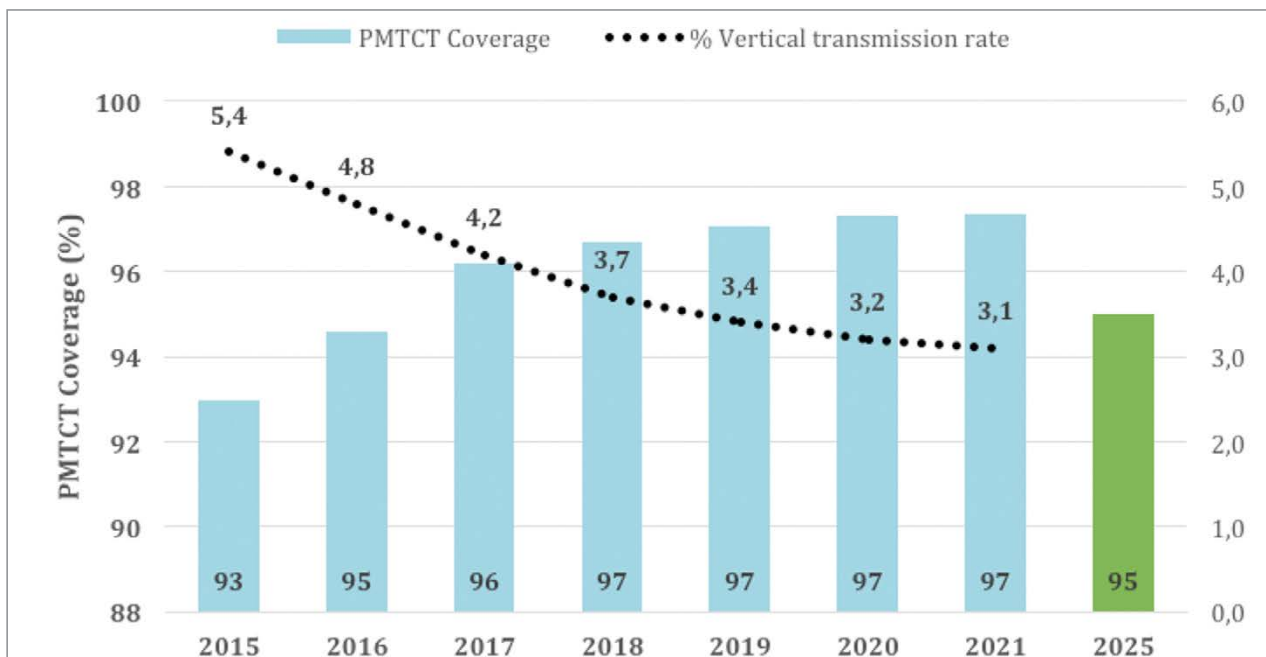
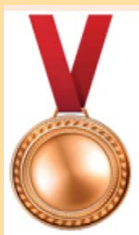


Figure 3: ART coverage (%) and HIV vertical transmission rate (%), 2015-2021

As illustrated in Figure 4 below, Thembisa estimates⁵ and programme data from the National Institute For Communicable Diseases (NICD) and District Health Management Information System⁶ suggest an ongoing slow decline in VT case rates between 2022 and 2024, in keeping with the bronze tier path to elimination impact target.

However, despite this progress, South Africa had approximately 6,000 new VTs in full year (FY) 2023/24.⁵



South Africa has likely achieved the bronze tier as per the **path to elimination criteria** by achieving:

- VT rate < 5%
- Maternal ART coverage rates > 90%
- A population case rate of new HIV infections of < 750 per 100,000 births

The country is awaiting World Health Organization (WHO) validation for this achievement.

⁴ SA National and Provincial Dashboard

⁵ Thembisa 4.7

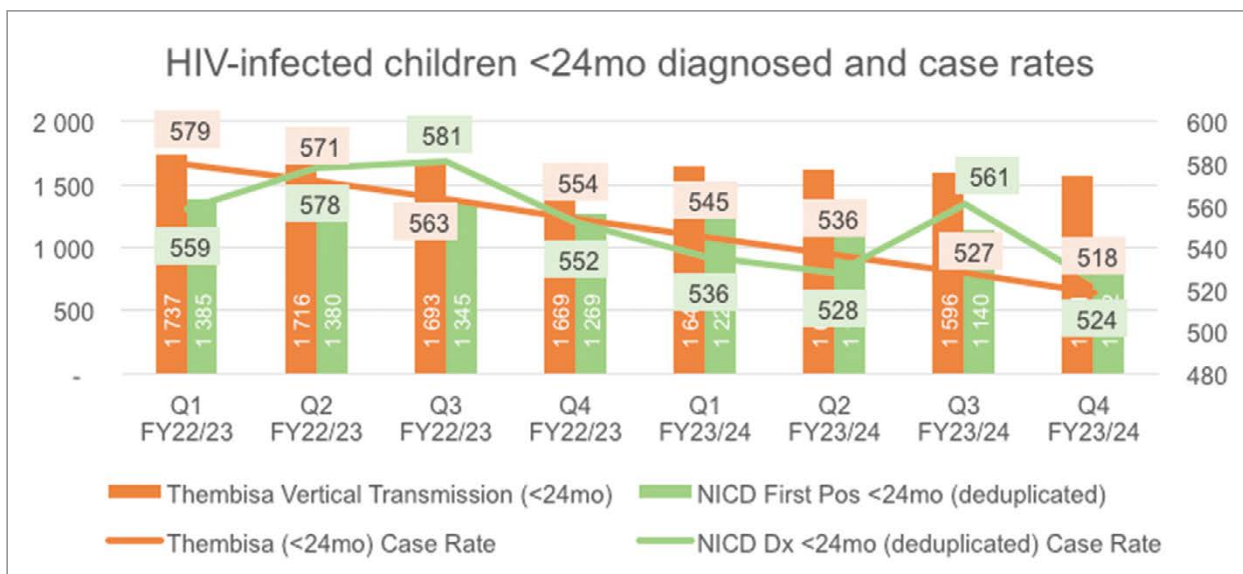


Figure 4 HIV-infected children < 24mo diagnosed and case rates, South Africa

5.2. When and why are new VTs happening?

Approximately 70% of new vertical HIV transmissions occurred in the **breastfeeding period**⁷, and approximately 80% of these VTs during breastfeeding took place in the first six months after birth.⁸

New maternal HIV infections

There has been encouraging progress in preventing adolescent girls and young women from acquiring HIV. From 2015 to 2020, the annual number of adolescent girls and young women acquiring HIV in South Africa fell by 29%.⁹

However, Figure 5 illustrates that new maternal HIV infections during breastfeeding, where the mother was not diagnosed positive, accounted for approximately 67% of postnatal VTs,⁷ mandating an increased focus on HIV retesting and providing pre-exposure prophylaxis (PrEP) as part of an integrated HIV prevention package throughout pregnancy and breastfeeding.

⁷ Thembisa 4.7

⁸ Goga, A, Jackson, C. 'Highest risk of mother-to-child transmission of HIV or death in the first 6 months postpartum: Results from 18-month follow-up of an HIV-exposed national cohort, South Africa'. 2016

⁹ UNAIDS Epidemiological Estimates 2021

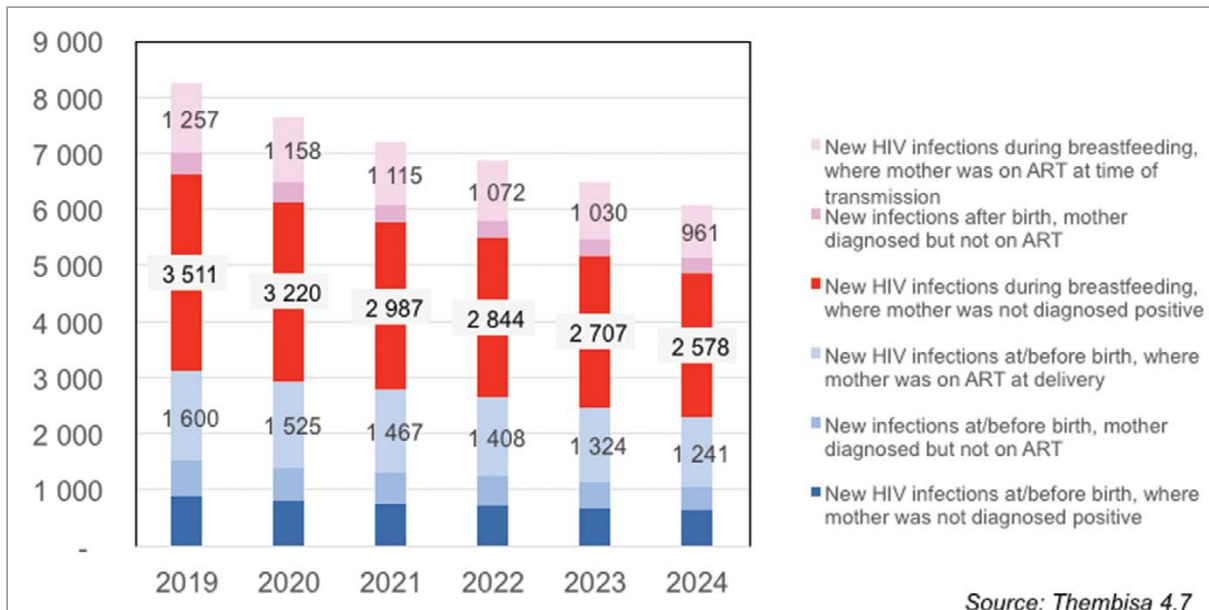


Figure 5. Annual cases of VTs by source of infection, South Africa

ART coverage for PBGW LHIV

Figure 6 below illustrates the significant successes that South Africa has achieved by providing an **integrated package of reproductive health services during the antenatal period** that includes HIV testing and access to ART. As of the first quarter (Q1) of 2024/25, antenatal ART coverage measured 99% in South Africa, and approximately 77% of women LHIV (WLHIV) were already on ART when they fell pregnant.¹⁰

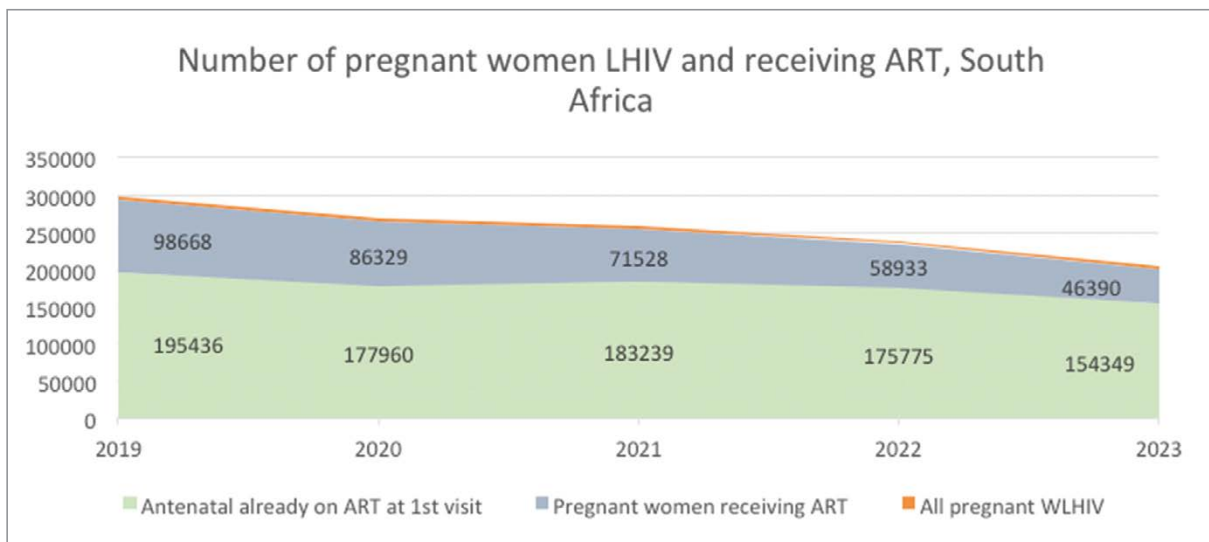


Figure 6. Number of pregnant WLHIV and receiving ART, 2019–2023

As expected, the HIV polymerase chain reaction (PCR) positivity rate at birth, which indicates in-utero transmissions, was reported at 0,7%.¹¹

¹⁰ Global Alliance Dashboard, Oct 2024

¹¹ NICD PCR data, 2023

Despite this progress, Figure 5 further illustrates that issues around access to ART and quality of care still accounted for approximately 2,800 VTs, with 57% occurring during antenatal care and 43% after birth.¹² **This highlights the need for improvements in retention in care, adherence support, and viral suppression during pregnancy and breastfeeding.**

Viral suppression for PBGW LHIV

Using the electronic gate-keeping (EGK) code system, South Africa has the novel ability to monitor viral load (VL) testing coverage and suppression rates in PBWG. This facilitates action to regain viral suppression at the individual patient level and the programmatic monitoring level. However, **this potentially game-changing mechanism is still very underutilised.** EGK-code use during antenatal care in FY2023/24 remained low, with only 52,4% of women receiving a viral load (VL) during pregnancy with an EGK code on the laboratory request form. Around 59,4% of women received a VL at delivery, but only 31,8% of women received a VL that could be identified as a delivery VL due to the use of the delivery EGK code.¹³

Using available NICD reports, suppression rates (< 1000 c/ml) for VLs done at delivery measured 89,9% as of Q1 2024/25.¹³

In contrast, **very little data on VL coverage and suppression is available postnatally** for breastfeeding women for several reasons, including the following:

1. Lack of enabling environment that facilitates the provision of an integrated package of HIV testing and treatment services for breastfeeding mothers:
 - Care after delivery for a breastfeeding mother does not yet have an explicitly outlined **package of care** nor an explicit **'location' for care**
 - Inadequate mechanisms exist to support **continuity of care** from antenatal care (ANC) and delivery through to care in the breastfeeding period
 - **Poor integration of VTP and ART services into maternal and child health (MCH) services after delivery** results in missed opportunities to provide integrated care to the mother-infant pair, including maternal VL monitoring six months post-delivery
 - Unnecessary and uncoordinated visits for the breastfeeding mother and child result in disengagement from care
 - Women who return to general primary healthcare (PHC) ART services post-delivery are not identified as breastfeeding or in need of VTP interventions, including VL monitoring
2. The few VL tests that do get done postnatally cannot be
 - identified as a postnatal VL due to the low coverage of EGK code use at delivery; and
 - cannot be linked to the infant's results to facilitate mother-infant pair cohort monitoring.

¹² Thembisa 4.7

¹³ Global Alliance Dashboard, Oct 2024

These data indicate that a key strategic focus needs to be the provision of an integrated package of care for the mother-infant pair in the period after birth.

This package should include HIV retesting, improved ART access, VL monitoring, and other sexual and reproductive health (SRH) services for all WLHIV in the postnatal period, as well as HIV testing and relevant integrated care for all HIV-exposed infants, as outlined in the Road to Health Book (RTHB).

5.3. Keeping CLHIV healthy on ART

Keeping children healthy on ART and AIDS-free requires that they know their status, that they initiate ART, and that they achieve viral suppression. Along each step of this 95-95-95 cascade, the plan has considered which evidence-based interventions are likely to ‘close the gap’.¹⁴ Along each step of the cascade, interventions need to target children and PBWG **who attend facilities** (issues related to supply and quality) and those who are not accessing facilities and need to be **reached in communities** (by increasing access at the community level and through demand generation).

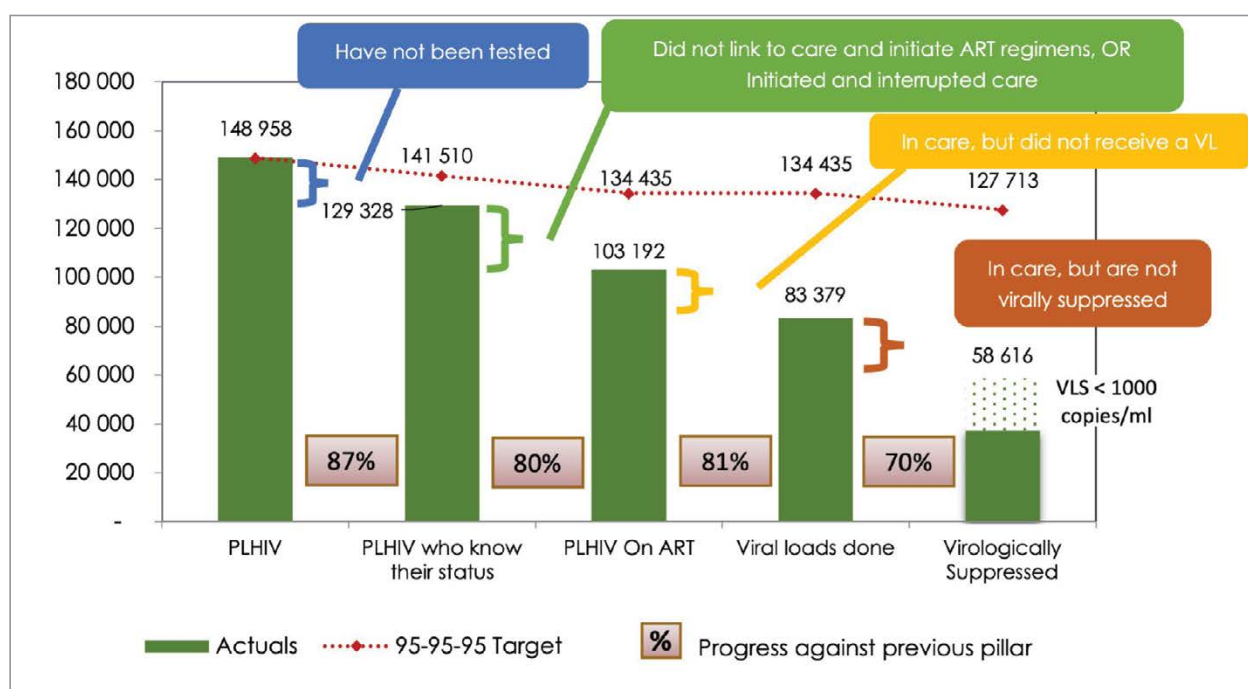


Figure 7. The 95-95-95 cascade for children <15 years in South Africa, June 2023 HIV case finding

14 Operation Phuthuma Pyramid Cascade, July 2024

HIV case finding

In South Africa, 87% of all children under 15 years and 83% of adolescents 15–19 years LHIV know their status.¹⁵

The age distribution of those who do not know their status is illustrated in Figure 8, as follows:

- The smallest proportion of children who do not yet know their status (7,3%) are in the 0–4 years category. These children will routinely access health services as part of well-child visits, including immunisations, and a key strategy is to offer an integrated package of services for all children under five years (and their caregivers).
 - A comparison of Measles 1 coverage at six months of age to HIV PCR testing coverage at six months indicates that only 41% of HIV-exposed infants (HEIs) who received their measles vaccinations also received HIV-PCR tests.¹⁶ The provision of integrated care needs significant strengthening to ‘pick the low-hanging fruit’, i.e. offer HIV testing to children who do come to our health facilities.
- The percentage of children who do not know their status (92,7%) fall into age groups of five years and older.¹⁷
 - These older children are less likely to access routine care (except for immunisations at ages six and 12 years).
 - These children may access care if they become unwell or have other chronic conditions, and therefore key entry-point testing at primary care and hospital level becomes a crucial entry point to offer HIV testing.
 - The majority of these children who do not access care in a health facility will need to be reached through community-based structures, including community care centres, children’s homes, early childhood development centres (ECDs), within schools and colleges, at South African Social Security Agency (SASSA) pay points and within outreach programmes.

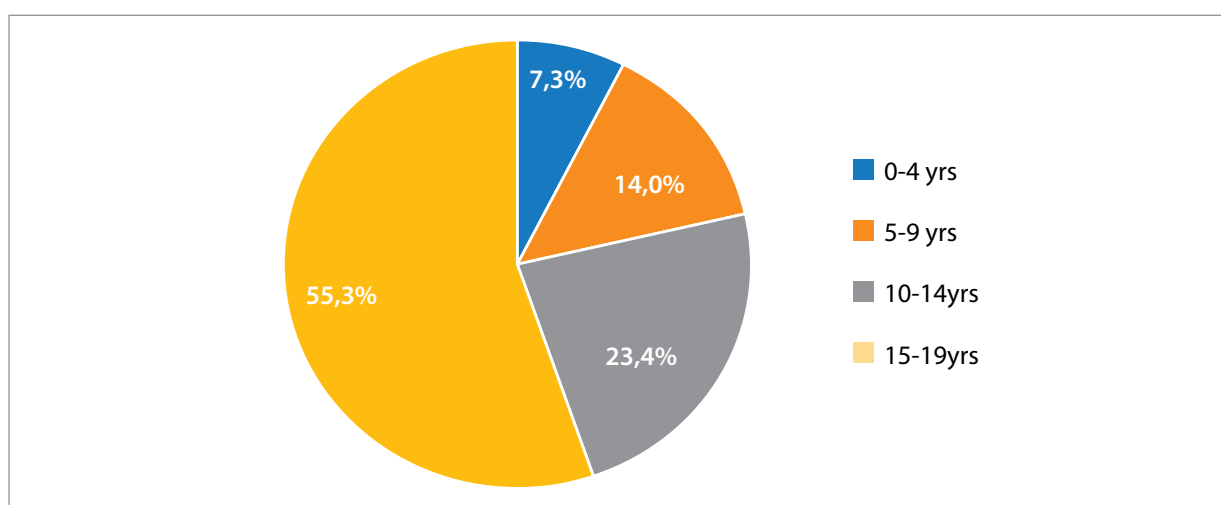


Figure 8. The age distribution of children in South Africa who do not know their status

¹⁵ Operation Phuthuma Pyramid Cascade, July 2024

¹⁶ Global Alliance Dashboard, Oct 2024

¹⁷ Operation Phuthuma Pyramid Cascade, June 2023

ART COVERAGE IN CHILDREN

Significant and persistent differences exist in ART coverage across the different age groups. Children of all ages have significantly lower ART coverage than adults, with ART coverage being the lowest in the youngest two age categories.¹⁸

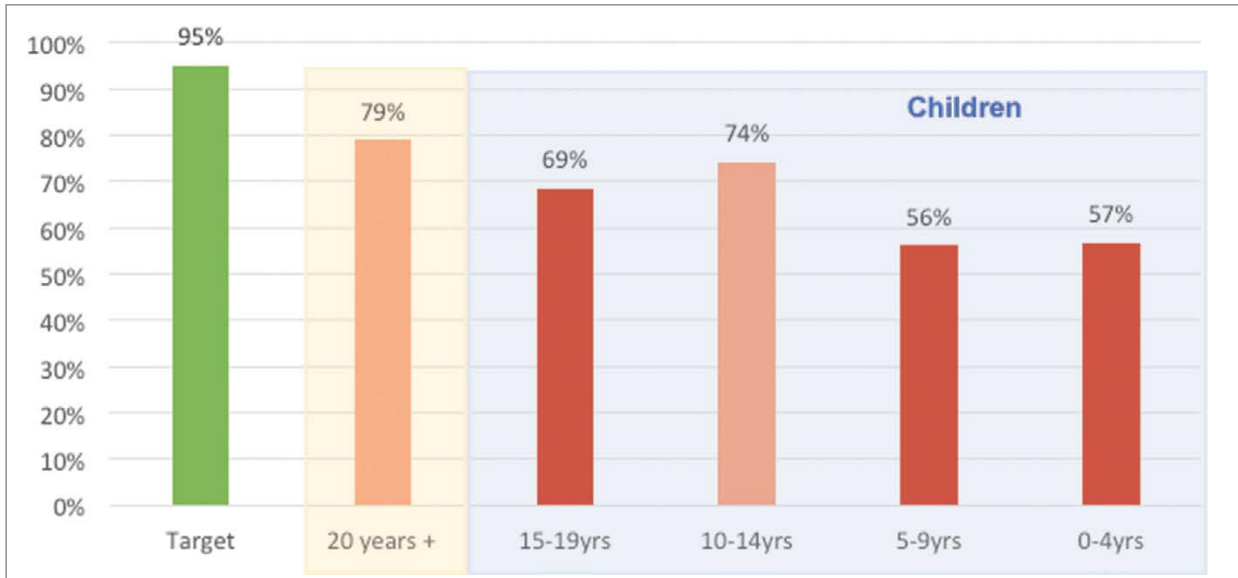


Figure 9. ART coverage by age group, South Africa, July 2024

For females aged 15–19 years, the percentage of ART coverage is at 55%, whereas 58% of males aged 15–19 years are on treatment. However, while the proportions of girls and boys on ART appear similar, the raw number of girls in need of ART (56,599) are significantly greater than the number of boys (31,064).

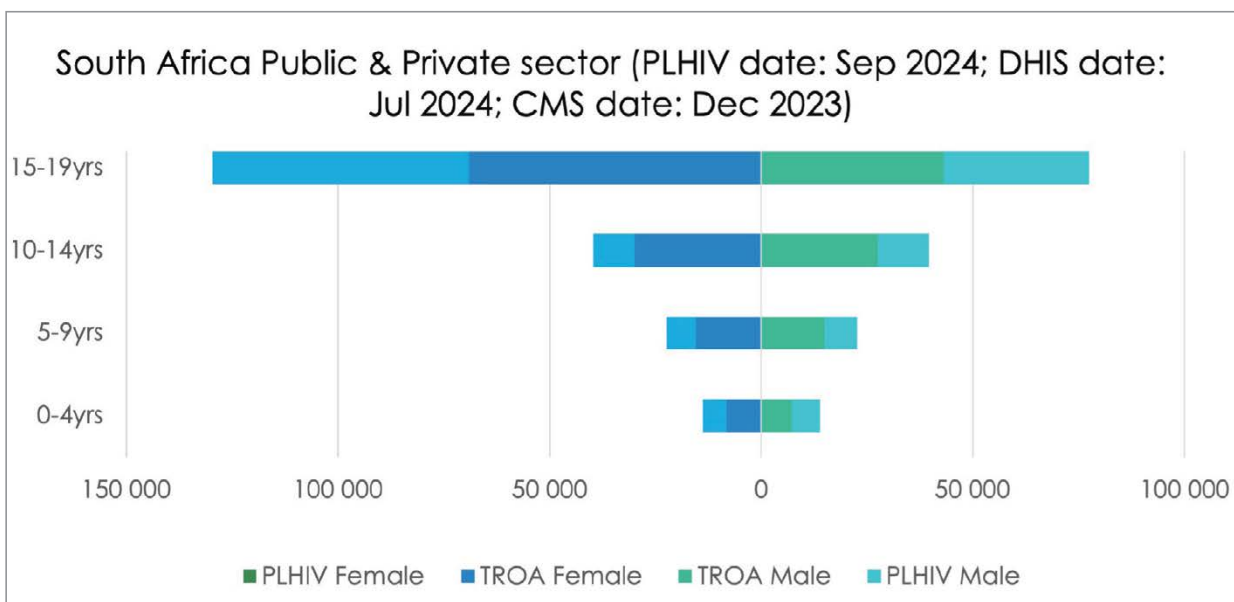


Figure 10. ART coverage in children and adolescents by age and gender, South Africa

¹⁸ Operation Phutuma Pyramid Cascade, July 2024

VIRAL SUPPRESSION IN CHILDREN

Using available NICD reports, suppression rates (< 1000 c/ml) for VLs done in children < 15 years and 15–19 years measured 70% and 78%, respectively, as of July 2024¹⁹. Age-disaggregated suppression rates are illustrated in Figure 11 below. VL suppression rates are significantly lower in children of all ages compared with the total population (94%) and lowest in the 0–4 years group (61%).

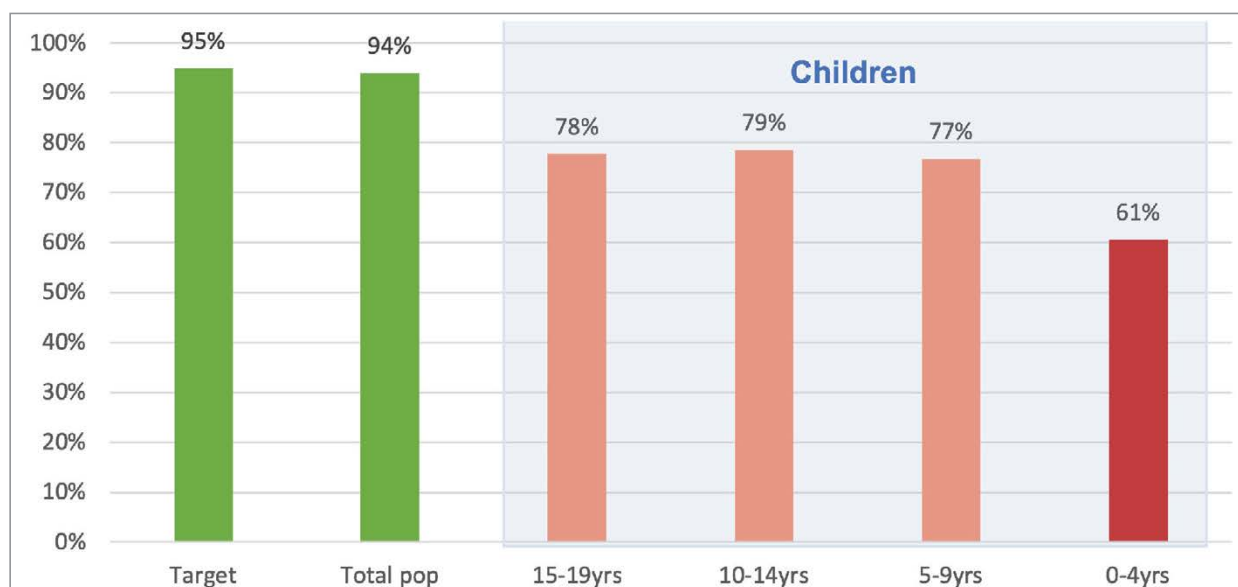


Figure 11. VL suppression rates by age group, South Africa, July 2024

Factors contributing to lower suppression rates in children include:

- Poorly tolerated and unpalatable drug formulations impact adherence in younger children.
- Children and their caregivers are not sufficiently equipped with the knowledge and skills to adhere to treatment.
- Child services providers do not have the knowledge or are not confident to assess and manage children with elevated VLs.
- Limited availability of and unclear access mechanisms to psychosocial support services for children with elevated VLs.

There are gaps across the cascade for children (< 19). Case finding, ART initiation, retention in care, and viral suppression have all underperformed and should be addressed through focused interventions for each sub-population.

¹⁹ Operation Phuthuma Pyramid Cascade, July 2024

5.4. Addressing inequalities related to rights, gender, and social and structural barriers

Inequalities underpin poverty, stigma, and discrimination, and enhance people's vulnerability to acquiring HIV and the likelihood of dying from an AIDS-related illness.

Poverty rates are higher for women than for men, and higher for children than adults.

For adolescent girls and women, multiple factors – including age-disparate sex, low condom use, sexual violence and coercion, gender norms, and early sexual debut – contribute to the heightened risk of acquiring HIV. Women exposed to physical or sexual intimate partner violence in the previous year were 3,2 times more likely to have acquired HIV recently than those who had not experienced such violence.

In South Africa:²⁰

- two-thirds of South African children (63%) live below the upper-bound poverty line;
- over one-quarter of South African children under five years are stunted – too short for their age due to chronic undernutrition. This stunting rate is very high for a middle-income country and an outlier in global terms. Undernutrition in turn hinders physical growth and brain development;
- frequent infections caused by overcrowding and poor access to water, sanitation, and healthcare services further increase the risk of undernutrition, which further undermines children's immunity. The percentage of in-hospital child deaths associated with moderate or severe acute malnutrition is 51%.
- of the 20 million children in South Africa, over 13 million receive the Child Support Grant (CSG) every month. However, over seven million children in South Africa (37%) were living below the food poverty line in 2021;
- while the CSG has been especially successful at reaching large numbers of poor children with relative ease, its biggest weakness is that the value of the CSG, at R500 per month in 2023, is too small to protect the poorest children from hunger, malnutrition, and stunting. The CSG is currently under review;
- nearly one in every two children (42%) has experienced violence, including physical violence (35%) and sexual abuse (35%).
- violence in many areas remains all-pervasive, with 99% of children in a large South African township having either experienced or witnessed violence in their homes, schools, and/or communities.²¹

20 Data sources: Global AIDS Strategy 2021–2026; UCT Child Gauge. 2022; Start Free, Stay Free, AIDS Free Report. 2021; UNAIDS 2022, The path to end AIDS; UCT Child Gauge, 2020; Statistics South Africa. 'General Household Survey 2020'. Pretoria. Statistics South Africa. 2021; Ward, CL et al. 'Sexual violence against children in South Africa: A nationally representative cross-sectional study of prevalence and correlates'. The Lancet Global Health. 2018; Hall, K, Proudlock, P & Budlender, D. 'Reducing Child Poverty: A review of child poverty and the value of the Child Support Grant'. 2023.

21 Richter, L et al. 'A longitudinal perspective on violence in the lives of South African children from the Birth to Twenty Plus cohort study in Johannesburg-Soweto'. *South African Medical Journal*. 2018

Table 1 below summarises certain demographic indicator²²s that impact on children's health in South Africa.

Demographic indicators for South Africa	South Africa
Formal dwellings	79,2%
Female-headed households	41,3%
No schooling (age 20+)	7,1%
Matric (age 20+)	43,7%
Higher education (age 20+)	7,8%
Unemployment rate	29,8%
Youth unemployment rate	38,4%
Flush toilet connected to sewerage	60,6%
Piped water inside dwelling	44,4%
Electricity for lighting	90,3%
Source: South African Health Review, 2020	

Table 1. Demographic indicators for South Africa



²² South African Health Review, 2020

6. Where are we in Gauteng along the journey to end AIDS in children?

6.1. Preventing new infections in children

Gauteng has made great strides in reducing new HIV infections in children by preventing VT, largely by increasing ART coverage for pregnant women. ART coverage in pregnant women has surpassed the 95% target. In 2021, the final VT rate measured 2,9% in Gauteng, as illustrated in Figure 12 below.²³

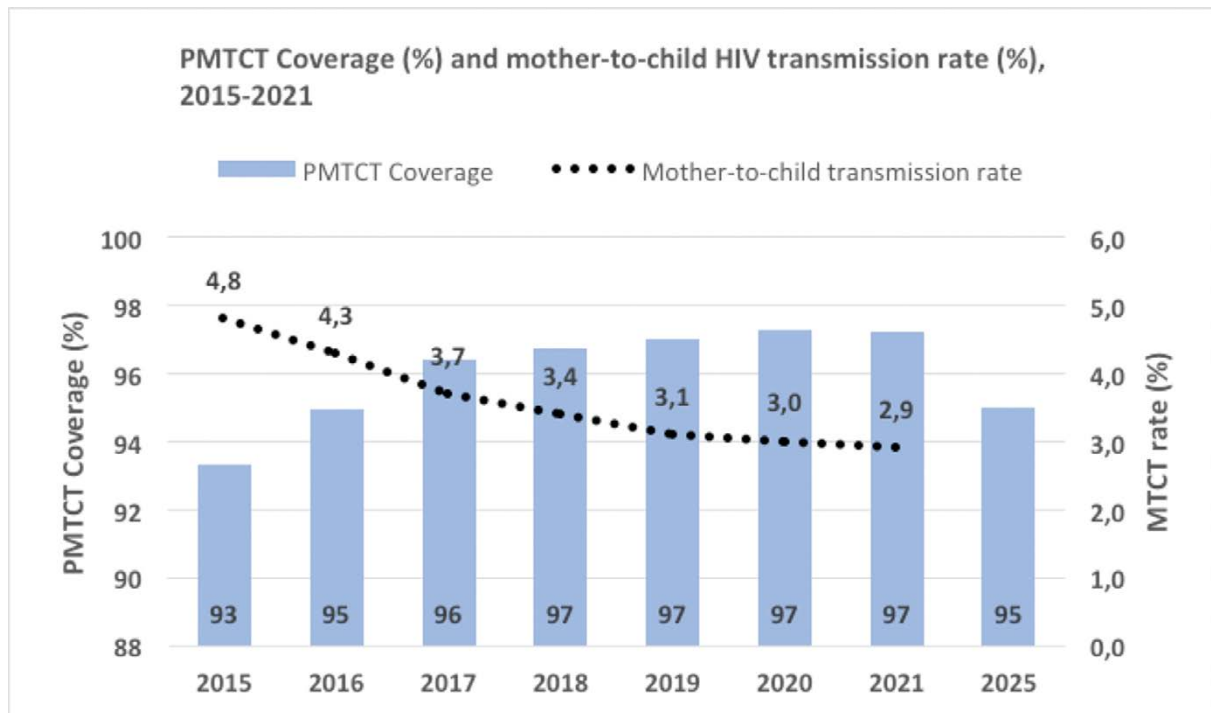
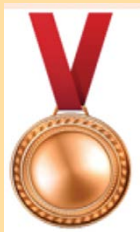


Figure 12. ART coverage (%) and HIV VT rate (%), 2015–2021, Gauteng

As illustrated in Figure 13, Thembisa estimates²⁴ and programme data from the NICD and District Health Management Information System²⁵ suggest an ongoing slow decrease in VT case rates between 2022 and 2024, in keeping with the bronze tier path to elimination impact target.

However, despite this progress, Gauteng had approximately 1,500 new VTs in 2024.²⁴



South Africa has likely achieved the bronze tier as per the **path to elimination criteria** by achieving:

- VT rate < 5%
- Maternal ART coverage rates > 90%
- A population case rate of new HIV infections of < 750 per 100,000 births

The country is awaiting World Health Organization (WHO) validation for this achievement.

²³ SA National and Provincial Dashboard

²⁴ Thembisa 4.7

²⁵ Global Alliance Dashboard, Oct 2024

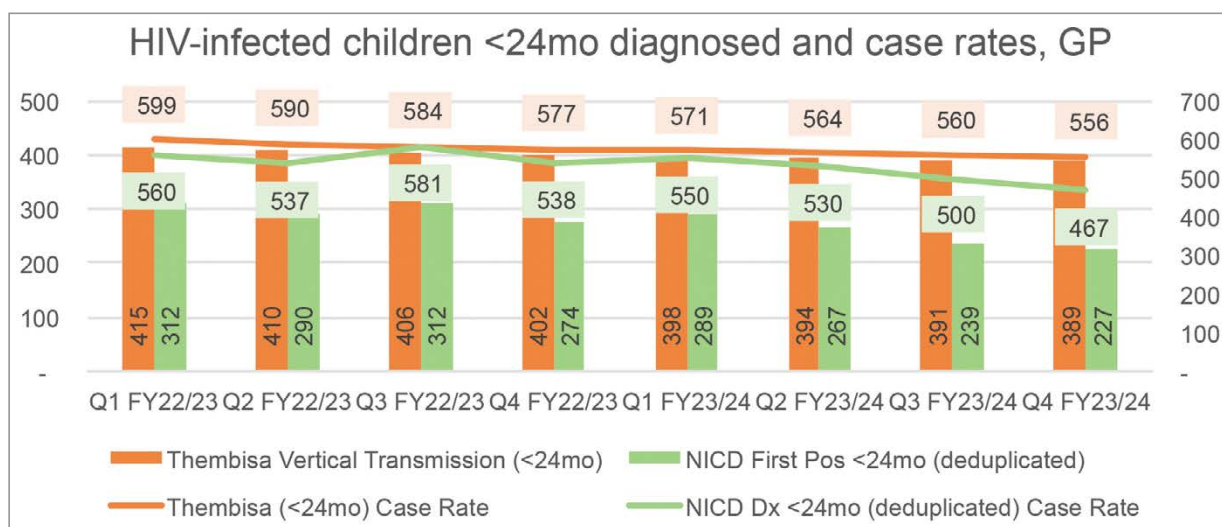


Figure 13. HIV-infected children < 24mo diagnosed and case rates, Gauteng

6.2. When and why are new VTs happening?

Approximately 64% of new vertical HIV transmissions occurred in the breastfeeding period, and approximately 80% of this VT during breastfeeding took place in the first six months after birth.²⁶

New maternal HIV infections

Figure 14 illustrates that **new maternal HIV infections** during breastfeeding, where the mother was not diagnosed positive, accounted for approximately **70% of postnatal VTs²⁷**, mandating an increased focus on HIV retesting and providing PrEP as part of an integrated HIV prevention package throughout pregnancy and breastfeeding.

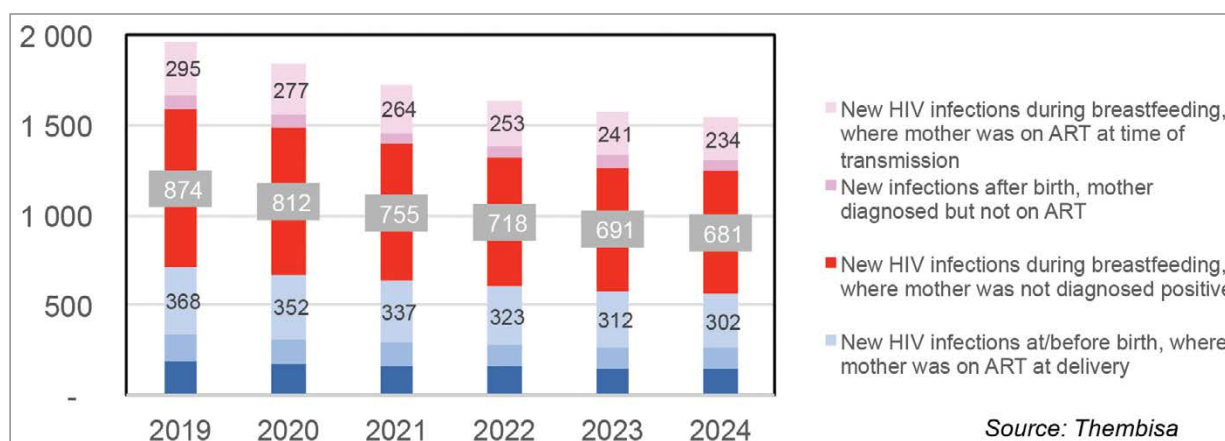


Figure 14. Number of new HIV infections among children by source of infection, 2024, Gauteng

26 Goga A, Jackson, C. 'Highest risk of mother-to-child transmission of HIV or death in the first 6 months postpartum: Results from 18-month follow-up of an HIV-exposed national cohort, South Africa'. 2016

27 Thembisa 4.7

ART coverage for PBGW LHIV

Gauteng has achieved significant success by providing an **integrated package of reproductive health services during the antenatal period** that includes HIV testing and access to ART.

As expected, the HIV PCR positivity rate at birth, which indicates in-utero transmissions, was reported at 0,7%.²⁸

Despite this progress, Figure 14 further illustrates that issues around access to ART and quality of care still accounted for approximately 711 VTs, with 58% occurring during antenatal care and 42% after birth.²⁹ **This highlights the need for improvements in retention in care, adherence support and viral suppression during pregnancy and breastfeeding.**

Viral suppression for PBGW LHIV

Using the EGK code system, South Africa has the novel ability to monitor VL testing coverage and suppression rates in PBWG. This facilitates action to regain viral suppression at the individual patient and programmatic monitoring levels. However, **this potentially game-changing mechanism is still very underutilised**. EGK code use during antenatal care in Gauteng in FY2023/24 remained low, with only 67,9% of women receiving a VL during pregnancy with an EGK code on the laboratory request form. Only 41,8% of women received a VL that could be identified as a delivery VL due to the use of the delivery EGK code.³⁰

Using available NICD reports, suppression rates (< 1000 c/ml) for VLs done at delivery measured 88,8% as of FY2023/24.

In contrast, **very little data on VL coverage and suppression is available postnatally** for breastfeeding women for several reasons, including the following:

1. Lack of enabling environment that facilitates the provision of an integrated package of HIV testing and treatment services for breastfeeding mothers:
 - care after delivery for a breastfeeding mother does not yet have an explicitly outlined package of care nor an explicit 'location' for care;
 - inadequate mechanisms exist to support continuity of care from ANC and delivery through to care in the breastfeeding period;
 - poor integration of VTP and ART services into MCH services after delivery results in missed opportunities to provide integrated care to the mother-infant pair, including maternal VL monitoring six months post-delivery;
 - unnecessary and uncoordinated visits for the breastfeeding mother and child result in disengagement from care;
 - women who return to general PHC ART services post-delivery are not identified as breastfeeding

²⁸ NICD PCR data, OP Report, Oct 2024

²⁹ Thembisa 4.7

³⁰ Global Alliance Dashboard, Oct 2024

or in need of VTP interventions including VL monitoring.

2. The few VL tests that do get done postnatally cannot be:
 - identified as a postnatal VL due to the low coverage of EGK-code use at delivery;
 - cannot be linked to the infant's results to facilitate mother-infant pair cohort monitoring.

These data indicate that a key strategic focus needs to be the provision of an integrated package of care for the mother-infant pair in the period after birth.

This package should include HIV retesting, improved ART access and VL monitoring for all WLHIV in the postnatal period, as well as HIV testing and relevant integrated care for all HEIs, as outlined in the RTHB.

6.3. Keeping CLHIV healthy on ART

Keeping children healthy on ART and AIDS free requires that they know their status, that they initiate ART, and that they achieve viral suppression. Along each step of this 95-95-95 cascade, the plan has considered what evidence-based interventions are likely to 'close the gap'. Along each step of the cascade, interventions need to target children and PBWG who **attend facilities** (issues related to supply and quality), and those who are not accessing facilities and need to be **reached in communities** (by increasing access at community level and through demand generation).

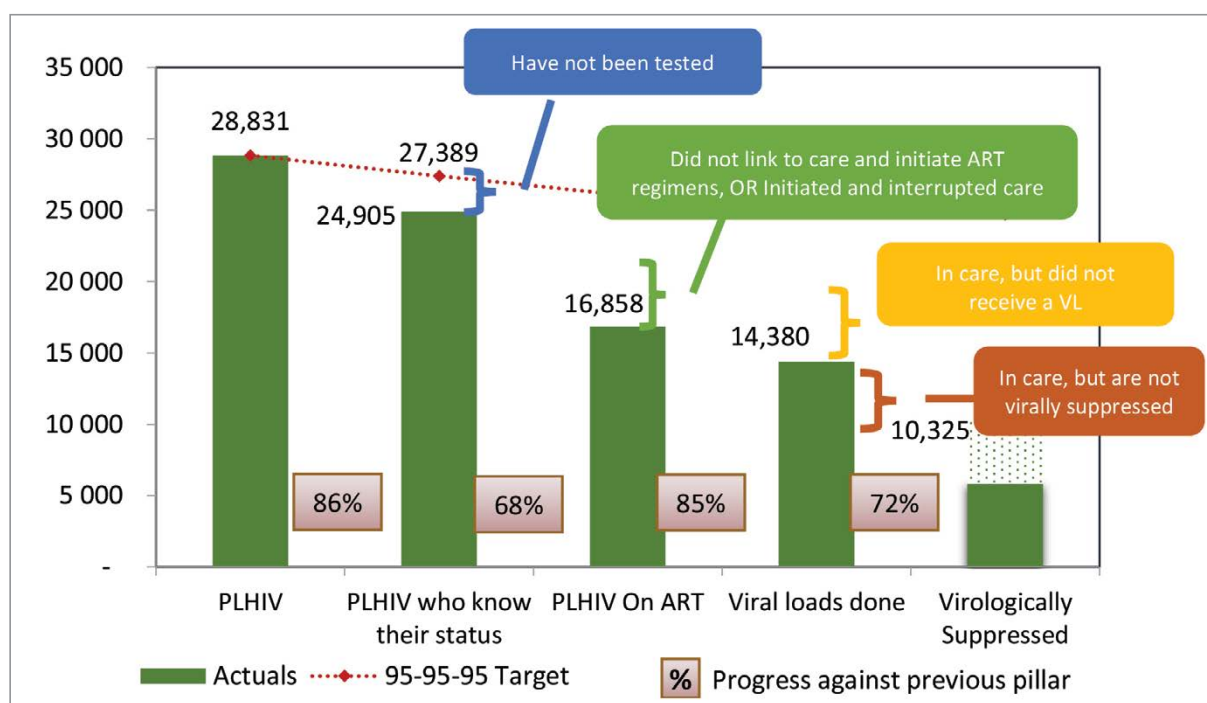


Figure 15. The 95-95-95 cascade for children < 15 years, Gauteng, July 2024

HIV case finding

In Gauteng, 86% of all children under 15 years and 83% of all adolescents 15–19 years LHIV know their status.³¹

The age distribution of those who do not know their status is illustrated in Figure 16. The age distribution of children in South Africa who do not know their status is as follows:

- The smallest proportion of children who do not yet know their status (6,3%) are in the 0–4 years category. These children will routinely access health services as part of well-child visits, including immunisations, and a key strategy is to offer an integrated package of services for all children under five years (and their caregivers).
 - In Gauteng, in FY2023/24, only 36% of HEIs who attended a facility for their measles vaccination also got their six-month HIV-PCR test.³² Therefore, integration of care needs significant strengthening to ‘pick the low-hanging fruit’, i.e. offer HIV testing to children who *do* come to our health facilities.
- The percentage of children who do not know their status (93,7%) fall into age groups of five years and older.³³
 - These older children are less likely to access routine care (except for immunisations at ages six and 12 years).
 - These children may access care if they become unwell or have other chronic conditions, and therefore, key entry-point testing at primary care and hospital level becomes a crucial entry point to offer HIV testing.
 - The majority of these children who do not access care in a health facility will need to be reached through community-based structures, including community care centres, children’s homes, ECDs, within schools and colleges, at SASSA pay points, and within outreach programmes.

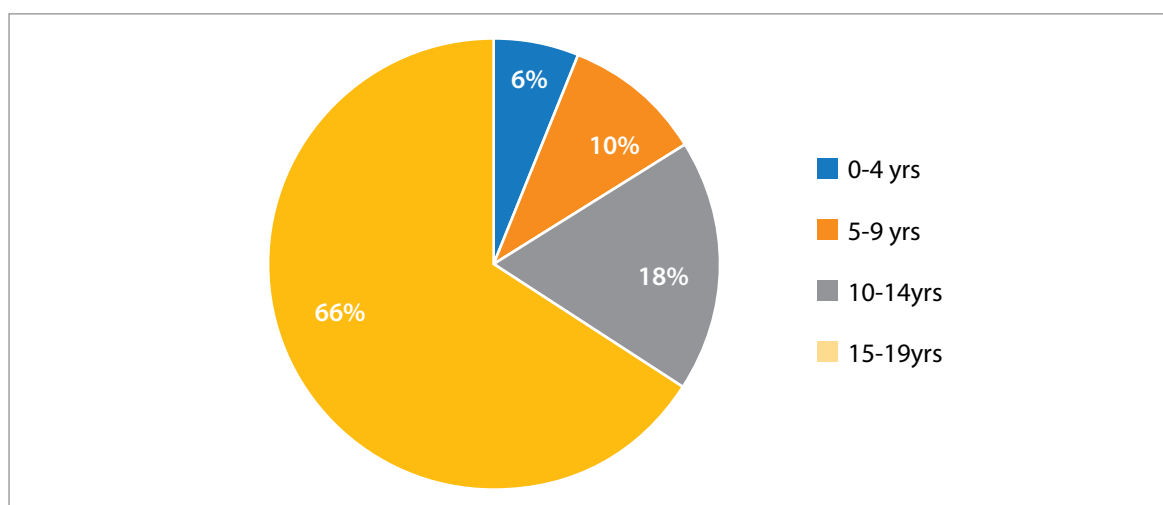


Figure 16. The age distribution of children in Gauteng who do not know their status

31 Operation Phuthuma Pyramid Cascade, July 2024

32 Global Alliance Dashboard – FY2023/24.

33 Operation Phuthuma Pyramid Cascade, July 2024

ART coverage in children

Significant and persistent differences exist in the ART coverage across the different age groups. Children of all ages have significantly lower ART coverage (42%–63%) compared with adults (76%), with ART coverage being the lowest in adolescents aged 15–19 years (42%).³⁴

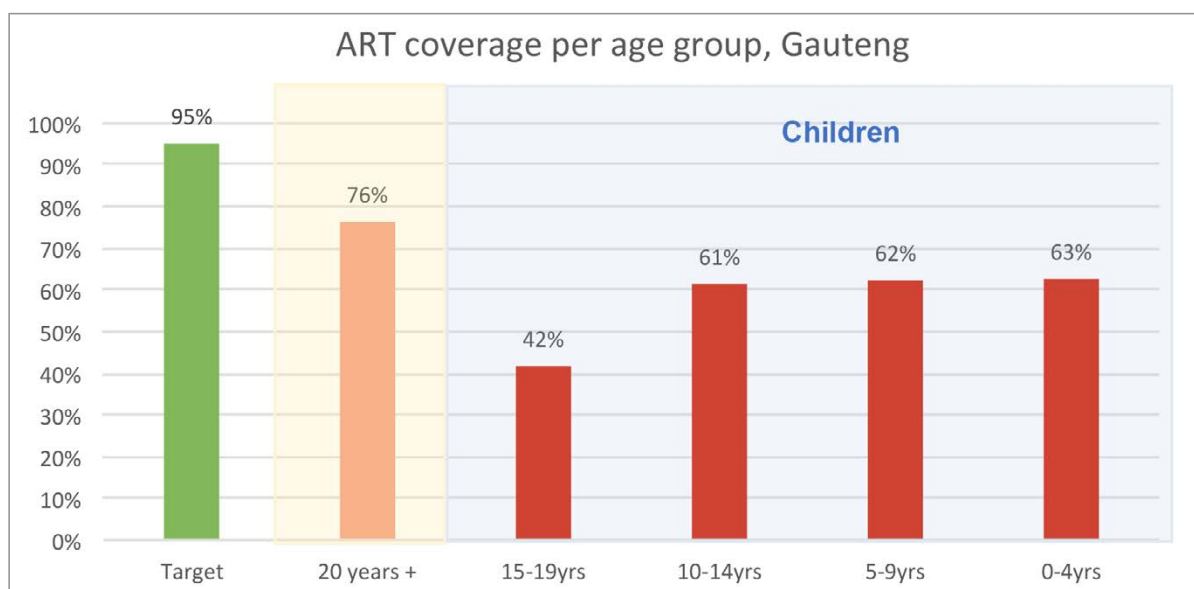


Figure 17. ART coverage by age group, Gauteng, July 2024

For females aged 15–19 years, ART coverage is 42%, whereas 46% of males aged 15–19 years are on treatment. However, while the proportions of girls and boys on ART are not vastly different, the raw numbers of girls in need of ART (16,215) is significantly greater than the number of boys (8,708).

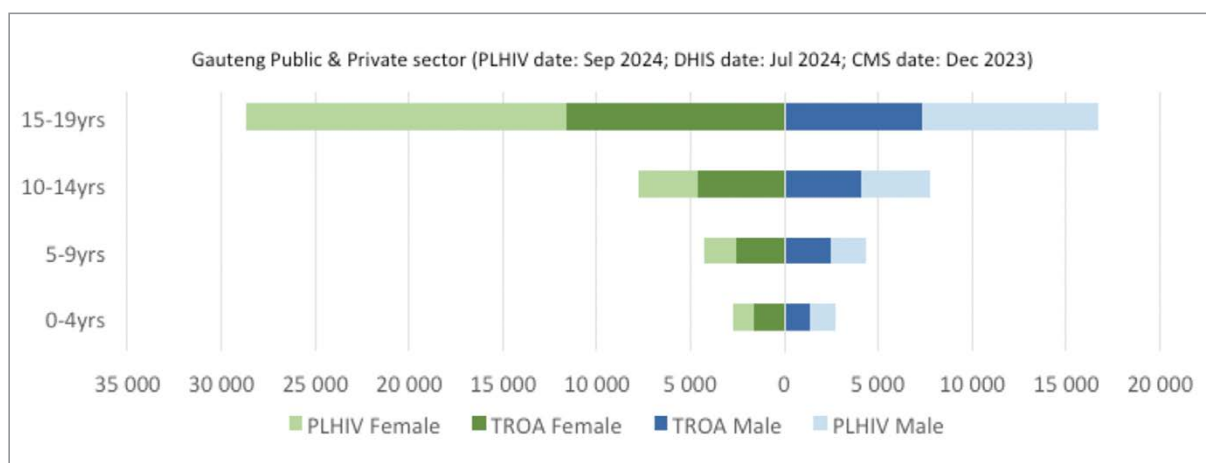


Figure 18. ART coverage in children and adolescents by age and gender

There are gaps across the cascade for children (< 19 years). Case finding, ART initiation and retention have all underperformed and should be addressed through focused interventions for each sub-population.

³⁴ Operation Phuthuma Pyramid Cascade, July 2024

Viral suppression in children

Viral suppression rates (< 1000 c/ml) for VLs done in children < 15 years and 15–19 years measured 72% and 84%, respectively, as of July 2024.³⁵ Age-disaggregated suppression rates are illustrated in Figure 19 below. VL suppression rates are significantly lower in children compared with adults (> 15 years) at 92% and lowest (60%) in the 0–4 years group.³⁶

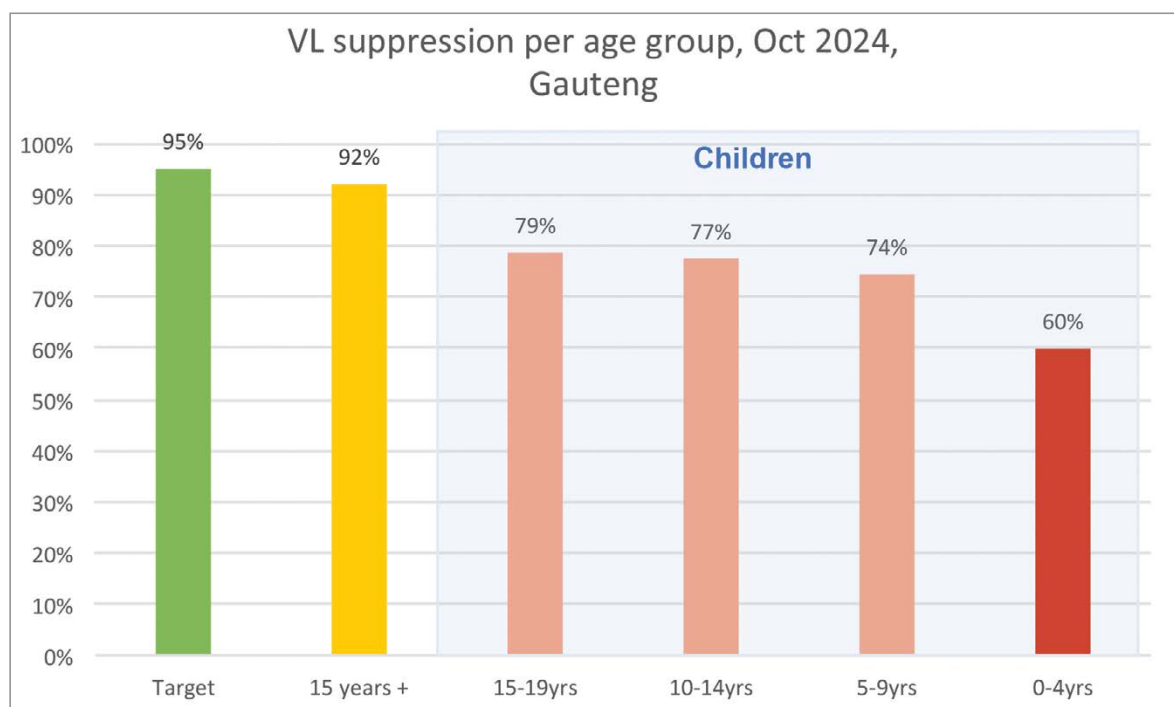


Figure 19. VL suppression rates by age group, October 2024

Factors contributing to lower suppression rates in children include:

- Children who have not yet been transitioned off poorly tolerated and unpalatable drug formulations that impact adherence in younger children.
- Children and their caregivers are not sufficiently equipped with the knowledge and skills to adhere to treatment.
- Child services providers do not have the knowledge or are not confident to assess and manage children with elevated VLs.
- Limited availability of and unclear access mechanisms to psychosocial support services for children with elevated VLs

³⁵ Operation Phuthuma Cascade – July 2024

³⁶ NICD Operation Phuthuma report – Oct 2024

7. Where do we need to go?

7.1. Targets for VT prevention

South Africa is striving towards the goal of eliminating the VT of HIV, as defined in Box 1. The Global Validation Advisory Committee has developed milestones along the path to elimination. South Africa has likely achieved bronze status as per the path to elimination criteria, and has set the goal of silver status to be achieved by 2026.



The criteria for **elimination** of the VT of HIV include:

- A population case rate of no more than 50 per 100,000 live births.
- A VT rate of:
 - no more than 5% in breastfeeding countries;
 - no more than 2% in non-breastfeeding countries.

Box 1. The criteria for elimination of the VT of HIV

Table 2. Milestones on the path to elimination of the VT of HIV

	VTP rates and maternal ART coverage	Status	Case rate (number of children acquiring HIV per 100,000 births)
Path to elimination	VT rate < 5% Maternal ART coverage	Bronze	< 750
		Silver	< 500
		Gold	< 250
Elimination	rates > 90%	Elimination	< 50



	Global target (Global Strategy 2021–2026)	Target for South Africa	Current performance South Africa Year 2023/24
Preventing VT – Targets related to the care of the mother			
WLHIV are receiving ART before their current pregnancies	90%		76% ^a
Pregnant WLHIV are diagnosed and receiving ART	95%	95%	99% ^a
Pregnant women have suppressed VLs	95%	95%	87% ^b
HIV-negative women are retested for HIV after delivery	95%		Not currently measured at the national level
Pregnant women have suppressed VLs after delivery (to be measured at 6–12 months after birth)	95%	95%	Insufficient data ^c
Preventing VT – Targets related to the care of the HEIs			
HEIs receive virological tests, and caregivers are provided with the results by the time the infants are two months old (birth PCR testing)	95%	95%	102% ^a

a Global Alliance Dashboard, Oct 2024

b NICD, Jan–Dec 2023, measured using VLs done at delivery

c NICD, insufficient data to be representative



7.2. Targets for testing and treatment of children and adolescents LHIV

South Africa is striving to achieve the 95-95-95 targets for testing, ART coverage, and viral suppression, shaded in yellow in the cascade graphs in Figure 20 and Figure 21 below.

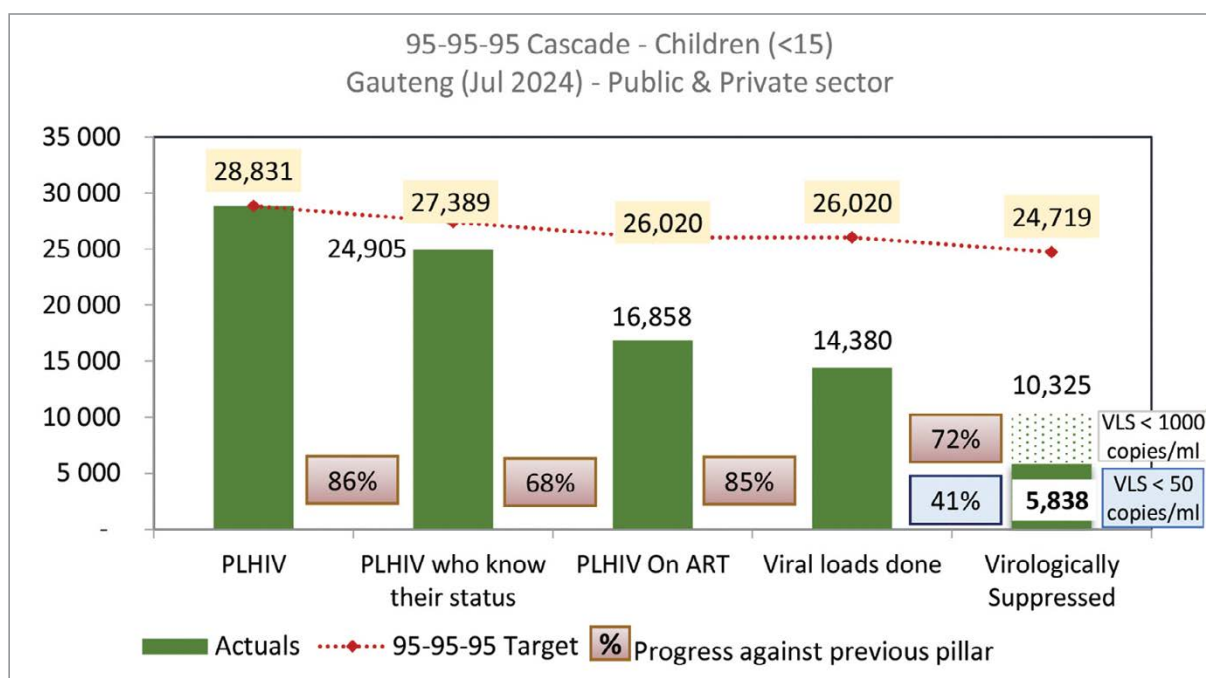


Figure 20. Gauteng targets as per 95-95-95 Cascade – Children (< 15 years)

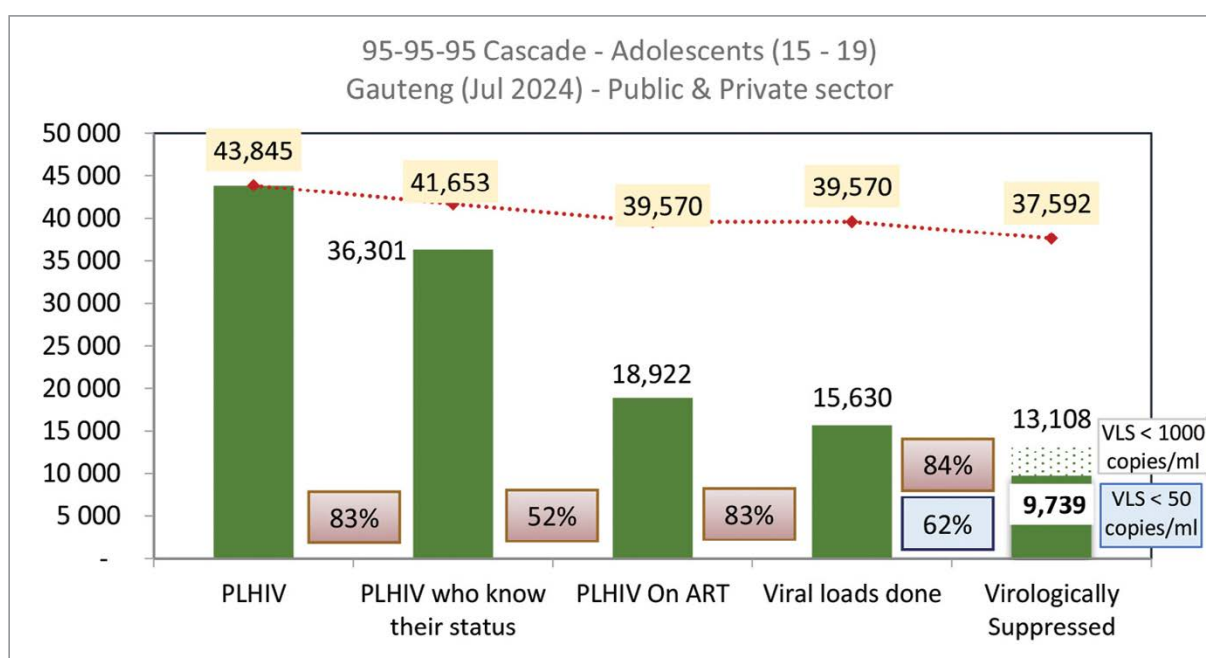
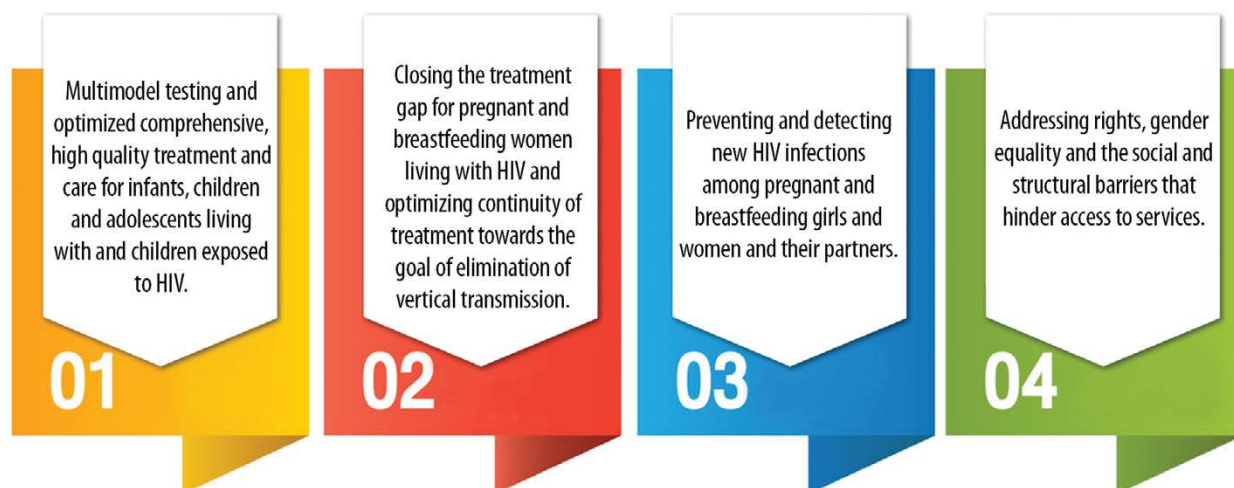


Figure 21. Gauteng targets as per 95-95-95 Cascade – Adolescents (15–19 years)

8. How will we get there?

The work of the alliance will be aligned to four pillars:



8.1. What interventions will be prioritised?

Pillar 1. Accessible testing, optimised treatment, and comprehensive care for infants, children, and adolescents living with and exposed to HIV

- multi-modality testing programmes to find and link all infants, children and adolescents LHIV;
- optimal ART, including paediatric dolutegravir (pDTG) formulations, for children and adolescents;
- increased access to ART for vulnerable and hard-to-reach communities, including migrant communities;
- data-driven differentiated and integrated service delivery;
- improving the quality of care, including VL monitoring, integrated comprehensive care, and mental health services;
- addressing the needs of adolescents LHIV;
- promoting cross-sectoral collaboration, such as ECD, nutrition, education, mental health, child protection, and social protection.

Pillar 2. Closing the treatment gap for pregnant and breastfeeding adolescent girls and women LHIV and optimising continuity of treatment

- Promoting integrated 'triple elimination' of the VT of HIV, syphilis, and hepatitis B;
- providing optimal ART with DTG-based regimens for pregnant and breastfeeding girls and women;
- adopting differentiated and patient-centred approaches to increase VTP coverage and improve continuity of care;
- developing a structured and integrated primary-care-level package of care for the breastfeeding mother after delivery, located at the same service delivery point as care for her infant, and focused on the first 1,000 days;

- improving quality of care, including VL testing and mental health;
- addressing the needs of pregnant and breastfeeding adolescents LHIV;
- strengthened interdepartmental collaboration for improved psychosocial support for HIV-positive pregnant and breastfeeding girls and women;
- sharpening longitudinal data collection and promoting VL monitoring.

Pillar 3. Preventing and detecting new HIV infections among pregnant and breastfeeding adolescent girls and women

- implementing HIV retesting and partner testing in HIV-negative pregnant and breastfeeding girls and women;
- scaling up integrated and differentiated service delivery models for PrEP as part of a comprehensive HIV prevention package for pregnant and breastfeeding girls and women;
- for adult men, increasing access to and uptake of HIV testing and HIV prevention information and services.

Pillar 4. Addressing inequalities related to rights, gender, and the social and structural barriers that hinder access to services

- using gender- and age-disaggregated data on coverage to adapt and transform programmes;
- increase the capacity of social services practitioners to provide social protection services that address vulnerabilities and promote access to HIV treatment;
- improve access to nutritional support for vulnerable households, ECDs, schools, and communities;
- empower adolescent girls and boys and their caregivers through education on HIV prevention and SRH and rights, and mental health, including a focus on adolescents with disability;
- accelerate the implementation of programmes that support pregnant and parenting adolescents to remain and complete school and/or continue tertiary education, including economic empowerment and skills development;
- address gender-based violence and femicide, sexual assault and abuse, for example, in infants, children, adolescents, and women;
- strengthen the meaningful representation of women, children, and adolescents LHIV in decision-making processes.

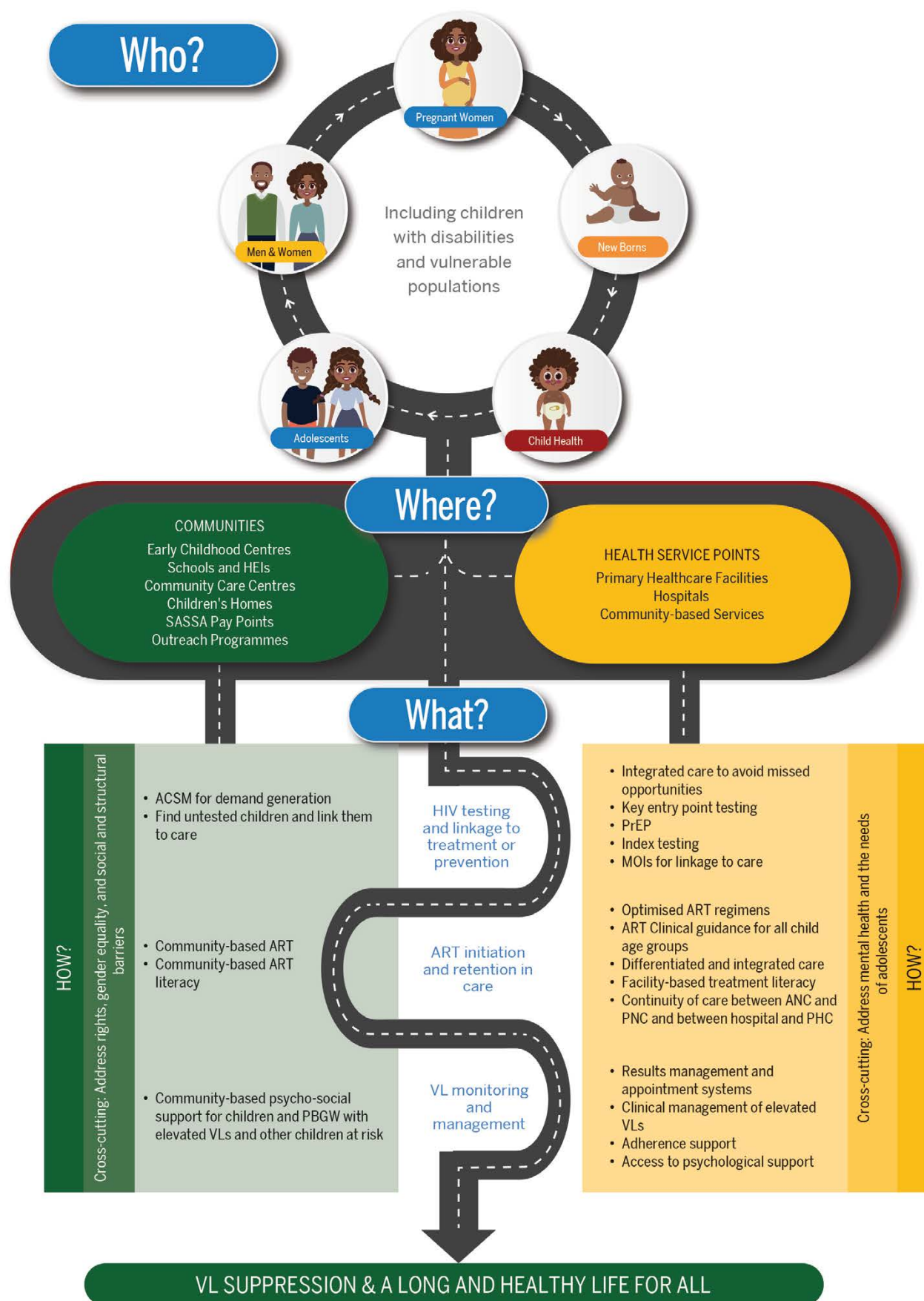


Figure 22. Interventions along the patient's journey

9. Activity Plan

9.1. Pillar 1

Pillar 1: Accessible testing, optimised treatment and comprehensive care for infants, children and adolescents living with and exposed to HIV									
What do we need to achieve?	Size of the gap?	Component of care	What is the problem we are trying to solve?	Domain	Intervention	Activities (Processes) for the Provincial TWG	Output measure	Responsible sector	Timelines
Pillar 1 Cross cutting activities to improve the quality of clinical care	95% of children living with HIV should know their status CLHIV <15yrs: Target 95%, Baseline 86%, Gap 9% ALHIV 15-19yrs: Target 95%, Baseline 83%, Gap 12%	Intensified Case Finding	Capacity Building across all components of care to reach the 95-95-95 targets	Quality	Disseminate, train (as per a needs assessment) and mentor all implementers on the 2023 ART Clinical Guidelines, Vertical Transmission Prevention (VTP) guidelines (including routine testing for HEI, key entry point testing, and integrated care). HTS, HIVSS, PREP and STI guidelines, and drive rapid, comprehensive implementation through Operation Phuthuma Nerve Centres. Implementers to be capacitated include: • HCWs, • CHWs, SSPs, teachers, LSAs and SLOs • Clinic committee members (to cascade the knowledge to the community) • Engage nursing colleges and universities on updated guidelines	Support capacity-building efforts by encouraging nurses to enrol on HealthConnect , and attend KnowledgeHub webinars to receive re-informing messages and other relevant content. Work closely with District-level PHC managers and their supervisors/ LSA managers to enable quality supportive supervision to facilities on issues e.g. providing integrated care, results management processes, links with WBOTs, clinic committees, etc.	Reflected in measures below	DoH, partners, DSD, DBE	Y1-2
					Strengthen routine HIV testing for HIV Exposed Infants (HEIs) as per VTP Guidelines	Support implementation of the VTP visit integration tables to reduce missed opportunities to test children who access facilities for immunisation services. (See also Pillar 2)	Increased testing among HIV-exposed infants and children	DoH (VTP/MNCWH)	Y1
					Support scale-up of targeted case finding strategies for children and families accessing services	Improve implementation of Matrix of Interventions (MOI) SOPs: Index Testing by developing a provincial training plan, conducting training, and distributing job aids Improve implementation of MOI SOPs: Key Entry Point testing (and recording) at PHC level (IMCI, EPI, TB, malnutrition services, and Youth Zones) and at hospital level (acute care and children admitted for diarrhoea, malnutrition and pneumonia).	Measure: Number of HIV exposed infants and children tested	DoH, Partners	Y1-2
					Provide guidance and tools on obtaining consent for HIV testing in children	Develop and distribute a provincial tool and capacitate HCWs & SSPs to define a caregiver/legal guardian as per the Children's Act and enable them to confidently obtain consent for HIV testing.	Increased case finding among HIV-exposed infants and children	DoH, Partners	Y1
			Caregivers are not seeking/prioritising HIV testing services for children in their care	Demand	Implement demand-creation activities to increase caregiver awareness to prioritise HIV testing for children.	Build on existing content in the province to develop a provincial job aid to assist service providers in managing a caregiver who refuses to give consent	Measure: Number of HIV exposed infants and children tested positive	DoH, Partners	Y1
						Develop a campaign on "know your own, and your child status" and implement campaigns (align to Provincial health calendar months). Include information on the safe spaces where testing can be accessed.		DoH, Partners, GAC, CSF	Y1-3
						Review, refine and distribute supporting IEC materials for primary caregivers on HIV testing, giving consent, and linkage to care for ART		DoH, Partners	Y1-2
			Vulnerable children or children in hard to reach communities or at-risk populations are not accessing testing (and other) services	Supply	Support scale-up of targeted case finding strategies for children and adolescents in hard to reach communities or within vulnerable populations	Revive enrolment of mothers/caregivers onto MomConnect as a mechanism to receive message related to HIV testing and other elements of care		DoH, DSD, DBE	Y1-3
						Ensure sufficient safe spaces where testing can be accessed, especially if testing cannot happen in a school. Link with learner support programmes in schools, and DREAMs, CBOs & other testing partners.		DoH, Partners, DBE, DSD	Y1-3
						Improve implementation of MOI SOP: Community-based screening and referral for testing • Map at-risk populations (linking to ideal clinic facility profiles) • Working with DSD, identify community resources that can serve as key entry points for screening & referral for testing, including WbPHCOTs, CBOs, Community Care Centres, Children's Homes, and Early Childhood Centres, CSF/DVCs and within outreach programmes.		DoH, DSD Partners, Children's sector	Y1-3
						Support scale-up of assisted HIVSS for adolescents (15-19 years old) across all districts, and also during community testing, and as part of index testing (see also Pillar 3)		DoH, Partners DBE, DSD, Higher Health (DHET)	Y1-3

Pillar 1: Accessible testing, optimised treatment and comprehensive care for infants, children and adolescents living with and exposed to HIV									
What do we need to achieve?	Size of the gap?	Component of care	What is the problem we are trying to solve?	Domain	Intervention	Activities (Processes) for the Provincial TWG	Output measure	Responsible sector	Timelines
3rd 95	95% of those on ART should be virally suppressed	VL Monitoring	Deficiencies persist in VL monitoring processes incl. taking of blood, ensuring results are available for actioning during clinical consultations, capturing results in Tier.net	Supply	Improve the quality of phlebotomy services	Expand training for phlebotomy (drawing bloods) for children amongst clinicians	Increased coverage of viral load testing among CLHIV retained on ART	DoH	Y1-3
					Support districts to establish efficient results management processes	Support districts to establish efficient blood results management processes. SOP	Measure: Viral load done rate at 12 months for CLHIV on ART	DoH	Y1-3
					Implement interventions at facility level to support treatment adherence	Incorporate monitoring of NHLS Results for Action usage reports through Operation Phuthuma Nerve Centres		DoH, NICD	Y1-3
		Clinical and psychosocial management to promote viral suppression	Children and their caregivers are not sufficiently equipped with the knowledge and skills to adhere to treatment	Quality	Implement interventions at facility level to support treatment adherence	Strengthen understanding and implementation of DMOG SOP 3 on Disclosure counselling	Increased viral suppression rates among CLHIV on ART	DoH	Y1-3
					Implement interventions at community level to support treatment adherence	Develop and implement an HIV disclosure programme for children 5-17 years and their primary caregivers	Measure: Viral load suppressed rate at 12 months for CLHIV on ART	DSD, CSF	Y1-3
						Review/develop and distribute supporting IEC materials to build treatment literacy knowledge of the primary caregivers of children living with HIV		GAC	Y1-3
						Support and facilitate the launch and implementation of U=U campaign in districts		GAC	Y1-3
						Incorporate treatment literacy in the development of the district implementation plans for HIV, TB and STIs 2023-28		GAC	Y1
		Clinical and psychosocial management to promote viral suppression	Service providers in child services do not have the knowledge, or are not confident to, assess and manage children with an elevated VL	Quality	Strengthen the clinical management of children with an elevated VL	Enhance the use of the VL non-suppression algorithm in the 2023 ART Clinical Guidelines	Increased viral suppression rates among CLHIV on ART	DoH, partners	Y1
						Strengthen understanding and implementation of the DMOG SOP 2 on Enhanced Adherence Counselling for caregivers of CLHIV	Measure: Viral load suppressed rate at 12 months for CLHIV on ART	DoH, partners	Y1-3
						Ensure CLHIV have access to psychosocial support services through DSD offices.		DSD, DoH	Y1-3
						Develop interdepartment referral systems and SOPs		DSD, DBE, DoH	Y1-2
						Improve capacity for community-based psychosocial support through CSF/OVCs, CBOs, and WBOTs.		DoH, DSD	Y1-3

9.2. Pillar 2

Pillar 2: Closing the treatment gap for pregnant and breastfeeding adolescent girls, and women living with HIV optimising continuity of treatment.									
What do we need to achieve?	Size of the gap?	Component of care	What is the problem we are trying to solve?	Domain	Priority interventions to be implemented	Activities for the Provincial TWG	Output measure	Sector Responsible	Timeliness
Reduction of new HIV vertical transmissions in children	Less than 500 new HIV infections per 100,000 live births	Continuity of Care Postnatally	Inadequate mechanisms exist to support continuity of care from ANC and delivery through to care in the breastfeeding period	Demand		Use MomConnect reminders to promote continuity of care. Encourage enrolment in ANC and notification of "Baby has been born" on the system to start receiving postnatal messages.	Increased retention of PBGW on ART	DoH	Y1-3
						Strengthen continuity of care from antenatal care, through delivery and into the breastfeeding period	Measure: Loss to follow-up rates at 3, 6, 12 months for PBGW on ART	DoH, Partners	
						Expand community education and social mobilization campaigns focused on mothers and WCBP to include knowledge of health services available, where to access them, and the care journey in order to promote continuity of care		DoH, CSF	Y1
			Service providers are not yet integrating VTP and ART services into MCH services for the breastfeeding mother, resulting in missed opportunities to provide integrated care to the mother-infant pair	Quality	Target clinicians in MCH stream (incl clinicians in child care services) for VTP trainings including use of EGK codes and management of elevated VLS		DoH	Y1	
					Conduct training sessions for community health workers, health promoters, counsellors and social service practitioners across all districts on the ART, VTP and HTS guidelines, as relevant to their scope of work		DoH, DSD	Y1	
	Target: <500 new infections per 100,000 live births, Baseline: <750 new infections per 100,000 live births, Gap: 250new infections per 100,000 live births	Retention in Care	Unnecessary and uncoordinated visits for the breastfeeding mother and child result in disengagement from care	Supply/Quality	Implement patient-centred and differentiated models of care for eligible breastfeeding mothers to increase convenience and reduce cost to families	Implement the provincial SOP for the provision of an integrated package of care for the baby-mother pair (as a "one-stop shop") at the child health service points.		DoH, partners	Y1-3
						Support implementation of the integrated visit schedules to align ART, contraception, immunisations, and other care for the mother and child.		DoH, partners	Y1-2
						Strengthen use of DMOG SOP 1 on Fast track Initiation Counselling (FTIC) at time of ART initiation in postnatal care (as part of the integrated package of care for the mother delivered at child health services)		DoH	Y1-3
			Clients are not sufficiently equipped with the information they need to remain engaged in care and adhere to treatment	Supply	Ensure that women are provided with the basic knowledge, skills and support to adhere to ART	Establish peer-led treatment support groups/postnatal clubs specifically for pregnant and breastfeeding adolescent girls and women living with HIV to provide differentiated ART services and emotional support and encourage adherence to treatment.	DoH, CSF, COGTA, DSD, Partners	Y1	
					Demand	• Map partners that are able to provide community-based psychosocial support to pregnant and breastfeeding women. • Use M2M model to create community support groups at either the facility or in the community, where the need exists • Ensure that community groups are linked to a facility with clear referral pathways		DoH, CSF	Y1-2

Pillar 2: Closing the treatment gap for pregnant and breastfeeding adolescent girls, and women living with HIV optimising continuity of treatment.												
What do we need to achieve?	Size of the gap?	Component of care	What is the problem we are trying to solve?	Domain	Priority interventions to be implemented	Activities for the Provincial TWG	Output measure	Sector Responsible	Timelines			
Reduction of new HIV vertical transmissions in children	Less than 500 new HIV infections per 100,000 live births	VL Monitoring and Management to Achieve Viral Suppression	Women that return to general PHC ART services post delivery are not identified as breastfeeding or in need of VTP interventions	Quality	Strengthen integration of SRHR services in all PHC ART service points	Target clinicians in general PHC and contraception services for VTP trainings	Increased coverage of viral load testing among PBGW retained on ART	DoH	Y1-3			
	Target: <500 new infections per 100,000 live births, Gap: 250new infections per 100,000 live births		Service providers in MCH services do not have the knowledge, or are not confident to, assess and manage pregnant or breastfeeding women with an elevated VL	Quality	Improve the clinical management of PBGW with an elevated VL at facility level	Strengthen use of the VL non-suppression algorithm in the 2023 VTP Guidelines to manage elevated VLS	Measure: Viral load done rate for PBGW on ART	DoH	Y1-3			
			Limited availability of, and unclear access mechanisms to psychosocial support services for PBGW with elevated VLs	Supply	Strengthened inter-department collaboration for improved psycho-social support for HIV positive pregnant and breastfeeding women and girls.	Strengthen understanding and implementation of the DMOC SOP 2 on Enhanced Adherence Counselling , and the Mental Health Screening Tools	Increased viral suppression rates among PBGW on ART	DoH	Y1-3			
				VL coverage and suppression rates cannot be used to their full potential for quality improvement because of limited use of the VTP EGK codes	Supply					Improve EGK code coverage and VL management at facility level	Map partners that are able to provide psycho-social support and economic opportunities to pregnant and breastfeeding women.	Measure: Viral load suppressed rate at 12 months for PBGW on ART
									Strengthen interdepartmental referral systems and SOPs for improved psycho-social support.		DSD	
						Conduct in-service training on the use of EGK codes at facility level for clinicians working in antenatal and child health services		DSD, DoH, CSF, DBE	Y1 -2			
						Strengthen use of the VL RfA reports to identify PBWG with elevated VLs		DoH, NICD, Partners	Y1 -2			
								NHLS, DoH, Partners	Y1 -2			
Cross cutting activities to create an enabling environment for service delivery			Late bookings in PBFW (after 20 weeks)		Develop a coordinated awareness campaign to create demand for SRHR services, including messages on pregnancy screening and early booking into antenatal services. Messages should form part of a SRH IEC package that includes HIV testing, PREP, STIs, contraception, early booking in ANC, and VMMC (See Pillar 3)	- WBOTs to conduct community mobilisation and provide education and pregnancy testing in homes - Strengthen universal pregnancy testing for women attending health facilities - Strengthen SRH education, community mobilisation, and pregnancy screening in hard-to-reach communities, such as townships, informal settlements and hostels (TISH programme)	Reflected in measures above	DoH DSP / CSF (mens sector), DSD, DBE	Y1-2			
									Y1-3			
			Data quality and use of data for action		Capacitate districts and subdistricts on all aspects of data management (as per the DHIMS), including indicator definitions and uses, available NCD data, the use of EGK codes, how to monitor and interpret coverage and outcome data, and how to use data for action and improvement		Capacitate antenatal and delivery sites on the importance of quality data to support linkage to care, clinical management, and cohort monitoring of the MIP (including relevance of completing the NHLS requisition blood form accurately and comprehensively e.g. not using 'baby to' labelling and birth dates as folder numbers; using delivery EGK code etc.)		Provide education to WCBP in communities on the importance of deciding on a name for their baby before delivery		PDoH	Y1-2
												Y1-2
											CSF	Y1-3
Migration of MIP across provincial borders		Establish cross border committees to discuss issues with patients accessing care in different provinces at different times in their care journey.		DoH	Y1-3							

Pillar 3

Pillar 3: Preventing and detecting new HIV infections among pregnant and breastfeeding adolescent girls and women and their partners											
What do we need to achieve?	Size of the gap?	Component of care	What is the problem we are trying to solve?	Domain	Priority interventions to be implemented	Activities for the Provincial Technical Working Group (TWG)	Output Measure	Sector Responsible	Timelines		
Identify new HIV infections in PBGW and girls who initially tested HIV-negative during antenatal care, and prevent new HIV infections in PBGW and girls who test HIV-negative	Approximately 70% of all new vertical HIV transmissions happened during the postnatal period	Cross cutting	Service providers do not have the knowledge and skills to provide a comprehensive package of HIV prevention services	Quality	Facilitate the implementation of a comprehensive package of HIV Prevention Services within maternal and child, SRH and school health services	Capacitate master trainers at district levels to train health care workers (ind-enrolled nurses) and SSPs on the HTS, HIVSS, PrEP and STI guidelines, as per provincial Human Resource Development (HRD) Plans. Community health workers, CSF, DSD and DBE also to be trained.	Increased retesting coverage of PBGW during Antenatal and Breastfeeding periods	Doh, DSD, DBE, CSF	Y1		
						Encourage HCWs (including school health nurses and health promoters) to enrol on HealthConnect for HCW messages related to HIV testing and PrEP for PBGW, and other topics	Measure: HTS retesting coverage rates in HIV-negative PBGW	Doh	Y1-3		
						Develop and disseminate existing job aids and IEC materials on the HTS, HIVSS, STI, and PrEP guidelines (including the PrEP fact sheet) to all district teams, and IEC material to DSD and DBE		Doh, DSD, DBE	Y1-3		
		Case Finding	New HIV seroconversions in pregnant and breastfeeding women and their partners are not detected	Supply	Improve regular HIV retesting of pregnant and breastfeeding women and adolescent girls to ensure timely identification of PBGW/HIV and those at risk of getting HIV	Strengthen HIV re-testing for PBGW attending postnatal and child health services with their babies.		DOH, DSP	Y1-3		
				Demand	Strengthen testing of partners of PBGW attending antenatal and postnatal services using HIVSS	Track and trace contacts identified through index testing . Provide psychosocial support to women to disclose to their partners, screen for IPV and GBV, and provide access to safe spaces if needed. Establish referrals to OVC where not already in place.		DOH, DSP/DSD, CSF	Y1-3		
Supply	Encourage partner involvement in at least one antenatal visit for HIV and RPR testing and psychosocial support for the mother. Review and build on existing templates for male invitations to facilitate male involvement					DOH, DSP	Y1-3				
Identify new HIV infections in PBGW and girls who initially tested HIV-negative during antenatal care, and prevent new HIV infections in PBGW and girls who test HIV-negative	Approximately 70% of all new vertical HIV transmissions happened during the postnatal period	Prevention of new HIV maternal infections	PREP is under-utilised by HIV-negative PBGW and other WCBP at risk of getting HIV	Demand	Develop a coordinated plan for an awareness campaign to create demand for PrEP PrEP messages should form part of an SRH IEC package that includes HIV testing, PrEP, STIs, contraception, early booking in ANC, and VMMC	• Train community cadres such as WBOTs, health promoters, CHW, school health nurses, peer educators, CSF and CBOs on PrEP key messaging for PBGW and other young WCBP on HIV prevention services available and how to access them • Engage the community through various social media platforms, radio, community dialogues, and awareness campaigns at the community as information Blitz. • Engage the working community through employ health and wellness programmes • Advocate with parents and School Governing Bodies • Work alongside traditional healers and faith-based organisations • Conduct men's health promotion activities targeting hotspot areas (e.g., taverns, sports grounds and taxi ranks) and support the link to male-friendly health services.	Measure: Percentage of HIV-negative PBGW on PrEP	Doh DSP , CSF (Mens sector), DSD, DBE	Y1		
						Support implementation of the integrated visit schedules (2023 VTP guideline) to align PrEP, contraception, immunisations, and other care for the mother and child at the same appointment.				Doh	Y1-3
						Support implementation of the DMOC SOP 4 on multi-month dispensing from the facility for eligible breastfeeding women from 6 months after delivery				Doh	Y1-4
						Increase access to HIVSS, PrEP, PEP, condoms, lubricants, pregnancy testing, etc., by scaling up Digital Health Solutions that increase remote access to information (e.g. Bwise) and services (e.g. Lovellife)				DOH, DHET, DBE, Partners	Y1-3
						Establish men-friendly services and strengthen programs targeting men (eg: MINA Campaign, World of Work), linked to health promotion activities (see above)				DOH, DSP , CSF (Mens sector), Private sector	Y1-3

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Pillar 4: Addressing rights, equality, social and structural barriers that hinder access to services								
What do we need to achieve?	Size of the gap?	What is the problem we are trying to solve?	Domain	Priority interventions to be implemented	Activities for the Provincial Technical Working Group (TWG)	Output measure	Sector Responsible	Timelines
(C) Reduce risks and vulnerabilities to HIV/STIs, gender-based violence, femicide, and unintended pregnancies	In 2020, adolescent girls and young women comprised 10% of the population but accounted for 25% of the people acquiring HIV	Adolescent girls and boys have limited information/education on SRHR and mental health services available and where to access them	Supply	Empower adolescents girls and boys and their caregivers through education on HIV prevention and sexual and reproductive health and rights, and mental health , including a focus on adolescents with disability.	Train SSPs and Implement Social and Behaviour Change (SBC) programmes relating to HIV prevention and SRHR, including: - Families matter - Chommy (10-14 yrs), Yolo (15-19 yrs), Boys Championing Change	Increased access to SRH and mental health services for Adolescent girls and boys	DSD, CSF, Development partners	Y1-3
					Strengthen the delivery of Comprehensive Sexuality Education in schools by: • Developing an updated CSE curriculum. • Training teachers and LSAs on the revised curriculum. • Monitor implementation and effectiveness of CSE.	Measure: Number of adolescent girls and boys who receive SRHR and mental health education	DBE	Y1-3
					Strengthen delivery of First Things First in TVET colleges through Higher Health programmes by: • Integrating First Things First into Higher Health programmes. • Providing training to educators and staff. • Monitoring uptake and impact of the programme.		Higher Health (DHET)	Y1-3
					Build the capacity for mental health screening amongst Student Liaison Officers (SLOs) at TVET colleges by: • Developing training modules on mental health screening. • Conducting training sessions for SLOs. • Monitoring screening activities and outcomes.		Higher Health (DHET), DoH	Y1-3
					Facilitate the transition of pregnant and parenting adolescents to enable access to economic strengthening opportunities and livelihoods.	Increased high school completion in pregnant and parenting adolescents who complete school	DBE, DSD CSF, CSOs, municipalities	Y1-3
		Pregnant and parenting adolescents are a vulnerable group that have unique psycho-social stressors that may result in poor outcomes	Supply	Accelerate the implementation of programmes that support pregnant and parenting adolescents to remain and complete school/ continue tertiary education including economic empowerment and skills development	Facilitate the implementation and roll-out of teen parenting programmes	Measure: Proportion of pregnant and parenting adolescents who complete high school	DSD, CSF	Y1-3

10. Monitoring framework

10.1. Introduction to the monitoring framework

The monitoring framework intends to track the progress of the activities of the Global Alliance Provincial Plan 2023–2026. The framework provides information on the indicators, data sources, responsible stakeholders, and the expected timelines for reporting on Global Alliance activities. This framework does not intend to replace the monitoring and evaluation (M&E) plan of the National Strategic Plan for HIV, TB, and STIs (2023–2028). Instead, this framework is designed to monitor progress on those selected activities specific to women and children in this plan that are considered ‘game-changers’ in South Africa’s HIV response. The indicators were chosen for their relevance within established data collection and reporting systems.

The objectives of this monitoring framework are to:

- guide data collection and reporting to monitor the province’s Global Alliance plan effectively;
- strengthen the focus on and the impact of accelerated interventions targeting women and children to achieve the goals of the Global Alliance;
- foster accountability for outcomes across the multiple programmes targeting children and women;
- link the implementation of program activities to the outcomes on women and children, thereby promoting and enhancing the use of data for impact;
- support the interval monitoring of the Global Alliance Provincial Plan by the Global Alliance Provincial Team and other stakeholders, including the sharing of progress, successes, and lessons learnt with other Global Alliance provinces and countries.

10.2. How the Global Alliance Plan will be monitored

Two elements of the Global Alliance Plan will be monitored through this framework: a) progress on the implementation of work plan activities, and b) output and outcome indicator results organised by pillar, to monitor progress in outcomes and provide feedback reports to stakeholders. The monitoring of these elements is described in this section.

Workplan activity tracking

Review and updating of the workplan will be a key activity of the Global Alliance Provincial Team during quarterly meetings. Activities will be reviewed and the workplan will be updated by the provincial team. These updates will be used to assess implementation progress and adherence to the planned activities according to the planned timelines. It will be used to identify areas needing improvement or more focused intervention. The provincial team should use this assessment process to make changes to planned interventions or other course corrections necessary to ensure that the provincial plan will achieve its objectives for the quarter, year, and entirety of the plan.

Changes to the workplan should then be fully communicated to the relevant implementers and stakeholders, and the Global Alliance Plan should be amended accordingly.

Each quarterly meeting must include a report on previously identified challenges or deviations. These identified issues should be followed until improvement is observed or they are otherwise resolved.

Workplan tracking looks at the short-term inputs and outputs of the workplan implementation and is done using two columns inserted in the Global Alliance workplan Microsoft Excel sheets. The first of these, titled 'Activity Status', presents a drop-down box (Figure 13) that allows a quick indication of the progress made, using the following pre-selected and color-coded options:

- a. Not started
- b. On track
- c. Off track with issues
- d. At risk
- e. Completed
- f. Cancelled

e care for infants, children and adolescents living with and exposed to HIV					
1	Activities (Processes) for the National TWG	Output measure	Responsible sector	Timeframes	Activity status
2					
3	ty of health care workers through HealthConnect messaging related to finding in children (routine testing for HEI, key entry point testing, integrated	Increased testing among HIV-exposed infants and children Measure: Number of HIV-exposed infants and children tested	NDoH	Y1	On track
4	y for implementation of Matrix of Interventions (MOI) SOPs: material development, master trainers, KH webinars, KH resources, job aids, provincial training plans, registers)		NDoH, Partners	Y1-2	Not started
5	y for implementation of MOI SOPs: testing (IMCI, EPI, Acute Care, TB, malnutrition services, and Youth Zones)	Increased case finding among HIV-exposed infants and children Measure: Number of HIV-exposed infants and children tested positive	NDoH, Partners	Y1-2	On track
6	ake available for download, a standardised consent form for HIV testing as per it for healthcare workers and social service practitioners		NDoH, Partners	Y1	Off track with issues
7	d to assist service providers in managing a caregiver who refuses to give		NDoH, Partners	Y1	At risk
					Completed
					Cancelled

Figure 23. Workplan activity status tracking

The 'Comments' column provides space for brief notes on progress, issues, actions taken, and the date the comment was logged (Figure 14).

e care for infants, children and adolescents living with and exposed to HIV					
Activities (Processes) for the National TWG	Output measure	Responsible sector	Timelines	Activity status	Comments
ty of health care workers through HealthConnect messaging related to finding in children (routine testing for HEI, key entry point testing, integrated	Increased testing among HIV-exposed infants and children Measure: Number of HIV-exposed infants and children tested	NDoH	Y1	On track	16 Nov: Activity progressing according to plan and timelines
ty for implementation of Matrix of Interventions (MOI) SOPs: material development, master trainers, KH webinars, KH resources, job aids, provincial training plans, registers)		NDoH, Partners	Y1-2	Not started	16 Nov: Awaiting TORs to be finalized
ty for implementation of MOI SOPs: testing (IMCI, EPI, Acute Care, TB, malnutrition services, and Youth Zones)	Increased case finding among HIV-exposed infants and children Measure: Number of HIV-exposed infants and children tested positive	NDoH, Partners	Y1-2	Off track with issues	16 Nov: Kick-off campaign delayed due to flooding
ake available for download, a standardised consent form for HIV testing as per ct for healthcare workers and social service practitioners		NDoH, Partners	Y1	At risk	16 Nov: funding was re-allocated.
d to assist service providers in managing a caregiver who refuses to give		NDoH, Partners	Y1	Completed	
n the HIV consent component of the Integrated School Health consent form and int consent forms		DBE	Y1	Cancelled	Activity found to be a duplication.
' campaign messages on "Know your child status" and implement campaigns (l health calendar months)		NDoH, Partners	Y1-3		

Figure 24. Workplan activity status and comments example

Output and outcome monitoring

At the provincial level, the output and outcome indicators will be monitored quarterly using the Global Alliance Dashboard.

Indicators in the Global Alliance Dashboard to measure Pillars 1 to 3 are summarised in Table 3. Measures for Pillar 4 are not yet available in the Global Alliance Dashboard and are summarised in Table 4.

Data review and use

The Global Alliance Provincial Team should review output and outcome results quarterly to reflect on the overall progress of the Global Alliance Plan and the data trends. The data review exercise should inform changes to planned interventions or other course corrections necessary to ensure that the provincial plan will achieve its objectives for the following years and the entirety of the three-year cycle.

Changes made to the workplan as a result of this data review exercise should then be fully communicated to the relevant implementers and stakeholders, and the plan itself should be amended accordingly.

Roles and responsibilities

Several stakeholders are represented in the multisector Global Alliance Provincial Team. The M&E subcommittee should develop terms of reference that outline the roles and responsibilities with regard to its contribution to South Africa's efforts in the Global Alliance initiative. This should identify subcommittee member institutions and a full list of responsibilities, including, for example, data collating, compiling, analysis, interpretation, and reporting; and the development of reporting or other templates, indicator reference sheets, and other documents, tools or templates as necessary.

Table 3. Indicators available in the Global Alliance Dashboard to measure Pillars 1 to 3

Pillar 1: Accessible testing, optimised treatment and comprehensive care for infants, children and adolescents living with and exposed to HIV					
What do we need to achieve?	Component of care	Overarching Measure in Plan	GA Dashboard Measures for HIV-exposed infants	GA Dashboard Measures for CLHIV < 15 years	GA Dashboard Measures for ALHIV 15-19 years
1st 95	Cross cutting	Increased testing among HIV-exposed infants and children Output Measure: Number of HIV-exposed infants and children tested Increased case finding among HIV-exposed infants and children Outcome Measure: Number of HIV-exposed infants and children tested positive		95-95-95 cascade for CLHIV < 15 years	95-95-95 cascade for ALHIV 15-19 years
			HIV Testing coverage: Birth PCR, 10 week PCR, and 6-month PCR testing coverage	1st 95 - Proportion of CLHIV that know their status	1st 95 - Proportion of ALHIV that know their status
			Missed opportunities: 10 wk PCR coverage vs 10 week Hexa2 coverage rates	HIV tests in children < 5 admitted to hospital as a proportion of children < 5 years admitted with diarrhoea, pneumonia or malnutrition. (proxy for key entry point testing)	
			Missed opportunities: 6-month PCR coverage vs 6-month Measles 1 coverage	# tests 5-14 years	
			Confirmatory testing: % positive rapid tests confirmed with an HIV PCR rate		
2nd 95	Linkage to care, ART Initiation and Retention in Care	Increased ART initiation for CLHIV after diagnosis Output Measure: Number of CLHIV initiated on ART Increased retention of CLHIV on ART Output Measure: Loss to follow up rates at 3, 6, and 12 months for CLHIV on ART	<1 year linkage rates	Linkage rate 5-14 years	
				2nd 95 - Proportion of CLHIV that know their status on ART	2nd 95 - Proportion of ALHIV that know their status on ART
				Gap to 2nd 95 - Number of CLHIV that know their status not on ART	Gap to 2nd 95 - Number of ALHIV that know their status not on ART
				Proportion of 0-9 years TROA on DTG	ART treatment gap by sex
				ART child LTFU rates at 6, 12 and 24 months	
3rd 95	Monitoring and Viral Suppression	Increased coverage of viral load testing among CLHIV retained on ART Output Measure: Viral load done rate at 12 months for CLHIV on ART Increased viral suppression rates among CLHIV on ART Outcome Measure: Viral load suppressed rate at 12 months for CLHIV on ART		ART child VLD rate at 12 months	
				3rd 95 - Proportion of CLHIV that know their status on ART have suppressed viral loads (1000 c/ml)	3rd 95 - Proportion of ALHIV that know their status on ART have suppressed viral loads (1000 c/ml)
				VL suppression < 1000 c/mL rates at 6, 12 and 24 months (Quarterly)	
				VL suppression < 50 c/mL rates at 6, 12 and 24 months	

Pillar 2: Closing the treatment gap for pregnant and breastfeeding adolescents, girls and women living with HIV and optimising continuity of treatment				
What do we need to achieve?	Size of the gap?	Component of care	VTP cascade for ANC in GA Dashboard	Other measures in GA Dashboard
Reduction of new HIV vertical transmissions in children Less than 500 new HIV infections per 100,000 live births	Target: <500 new infections per 100,000 live births, Baseline: <750 new infections per 100,000 live births, Gap: 250 new infections per 100,000 live births	Case-finding	Pregnant women LHIV who know their status	ANC HIV 1st test positivity
		ART Initiation and Retention in Care	Pregnant women LHIV on ART (ART coverage)	ANC Linkage to care
		VL Monitoring and Management	Maternal VL Testing Coverage during ANC (linked to EGK code)	Maternal ART coverage disaggregated by: Already on ART at ART start and receiving ART in ANC
		VL suppression	VL suppression at delivery (linked to EGK code)	Maternal VL Testing Coverage at delivery Missed opportunities for maternal VL testing: Maternal VL Testing Coverage at delivery vs Birth PCR coverage Maternal VL Testing Coverage at 6 months vs 6-month PCR coverage
VTP Outcomes		HIV-infected children < 24 months diagnosed and case rates		
		Annual cases of vertical transmission by cause of infection		

Pillar 3: Preventing and detecting new HIV infections among pregnant and breastfeeding adolescent girls and women and their partners			
What do we need to achieve?	Size of the gap?	Component of care	GA Dashboard measure
Identify new HIV infections in PBGW and girls who initially tested HIV-negative during antenatal care, and prevent new HIV infections in PBGW and girls who test HIV-negative	New HIV infections in PBGW were the source of 30% of all vertical transmissions in 2021. Approximately 70% of all new vertical HIV transmissions happened during the postnatal period	Case Finding	1st 95 - Proportion of pregnant women that know their status in ANC
		Prevention of new HIV maternal infections	Antenatal PrEP start coverage

Table 4. Indicators to measure Pillar 4

Pillar 4: Addressing rights, equality, social and structural barriers that hinder access to services		
What do we need to achieve?	Size of the gap?	Output measure
(A) Reduce poverty and persisting inequalities	In 2021, 63% of children in SA live below the upper-bound poverty line (< R1 417 per person per month)	Increased coverage of social protection services to vulnerable children (including CLHIV) Measure: Proportion of vulnerable children (including CLHIV) provided with social protection services through SSPs
(B) Reduce Food Insecurity	In 2016, only 23% of children 6–24 months receiving an adequate diet	Increased coverage of nutritional support to vulnerable households, ECDs, schools and communities Measure: Proportion of nutritional support to vulnerable households, ECDs, schools and communities provided with nutritional support
(C) Reduce risks and vulnerabilities to HIV, STIs, gender-based violence, femicide, and unintended pregnancies	In 2020, adolescent girls and young women comprised 10% of the population but accounted for 25% of the people acquiring HIV	Increased access to SRH and mental health services for adolescent girls and boys Measure: Number of adolescent girls and boys who receive SRHR and mental health education Increased high school completion in pregnant and parenting adolescents who complete school Measure: Proportion of pregnant and parenting adolescents who complete high school
(C) Reduce risks and vulnerabilities to HIV, STIs, gender-based violence, femicide, and unintended pregnancies	In 2020, adolescent girls and young women comprised 10% of the population but accounted for 25% of the people acquiring HIV	Reduced GBV and other human rights violations in children, adolescents and youth Measure: Number of GBV cases in children, adolescents and youth
Cross-cutting activities to create an enabling environment for improved HIV and TB service delivery		Increased coverage of CLM at health facilities Measure: Number of facilities monitored through CLM

11. Acknowledgements

The Global Alliance Plan to End AIDS in Children in Gauteng by 2030 was developed in collaboration with the following stakeholders:

- South African National AIDS Council
- Joint United Nations Programme on HIV/AIDS UNICEF
- Gauteng AIDS Council
- CSF
- Department of Health
- Department of Social Development
- Department of Basic Education
- Department of Higher Education and Training
- Mothers2Mothers
- Paediatric-Adolescent Treatment Africa
- Development partners
- US President's Emergency Plan for AIDS Relief

Notes

[illegible]

The Office of The Premier

55 Marshall Street

Marshalltown

Johannesburg

2001

www.gauteng.gov.za

Tel: 011 355 6138

