



The Global Alliance Plan 2030

MPUMALANGA, SOUTH AFRICA



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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.

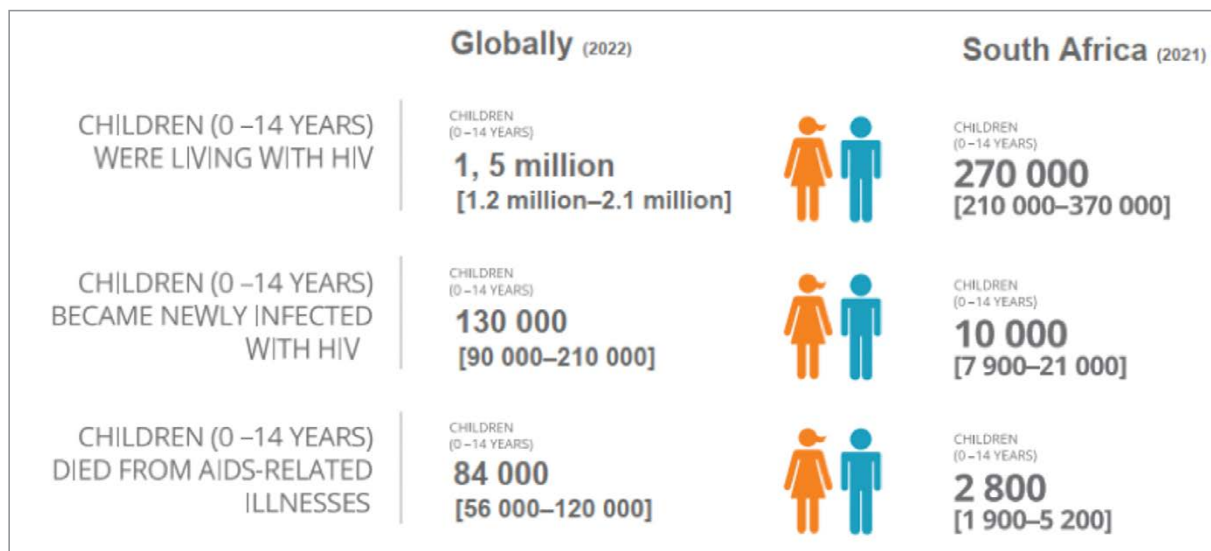


Figure 1. The HIV burden of disease in children

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 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 related 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

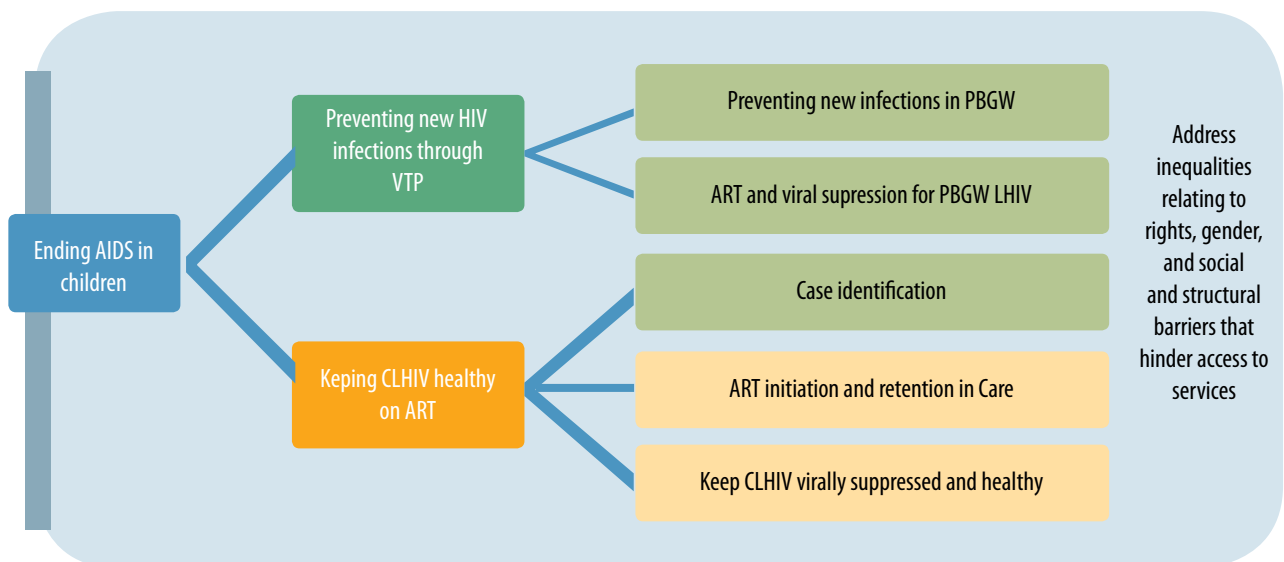


Figure 2. Overview of the path to ending AIDS in children

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 years)² 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 VT 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

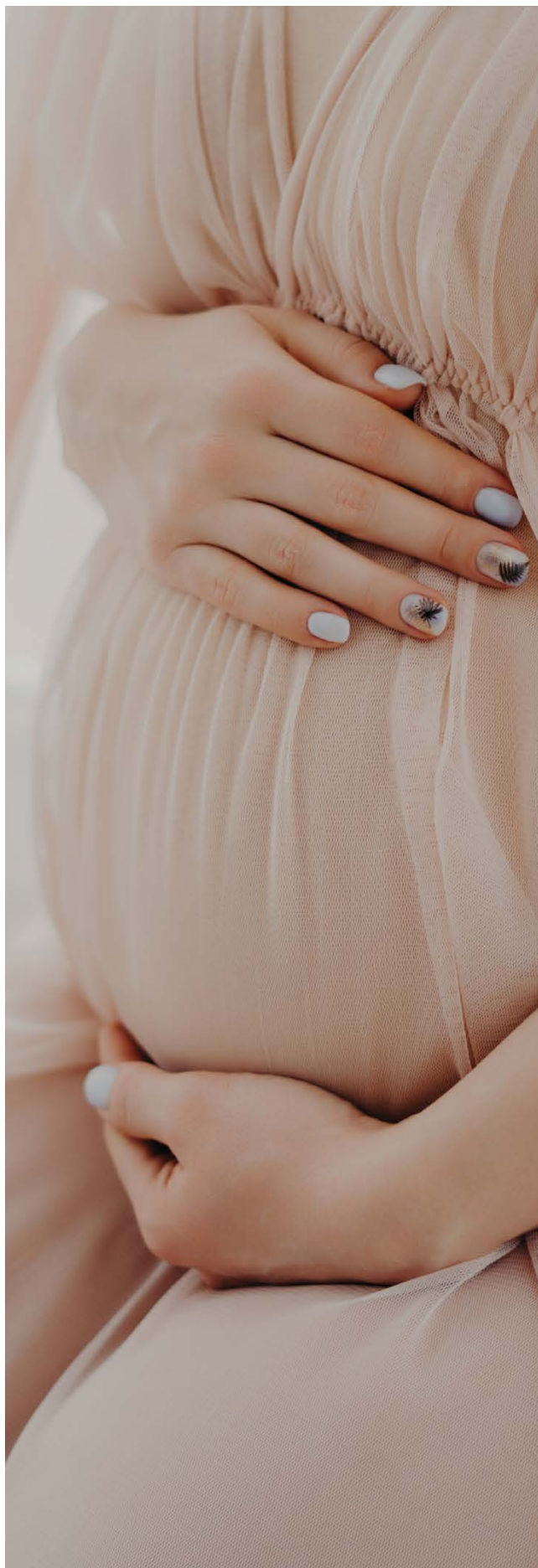
Young people (aged 15–24 years) represent about 15% of the global population but accounted for an estimated 28% of new HIV infections in 2019. The epidemic continues to impose a heavy burden on adolescent girls and young women. Every week, about 4,500 young women aged 15–24 years acquire HIV. In sub-Saharan 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 living with HIV (WLHIV). By the end of 2021, 12 countries in sub-Saharan Africa reached the target of 95% ART coverage in pregnant women, including South Africa.

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 WLHIV 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 has reduced by 64% between 2010 and 2022, the HIV pandemic still claimed the lives of approximately 84,000 children in 2022.

4.3. Addressing inequalities related 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

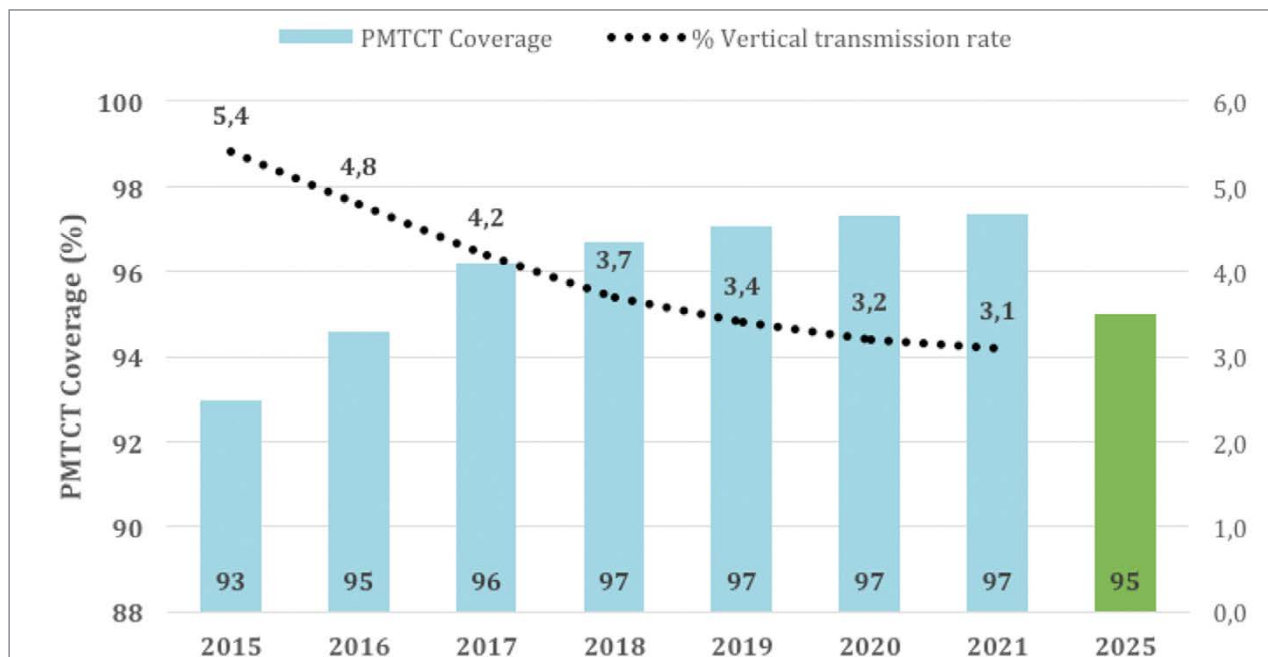
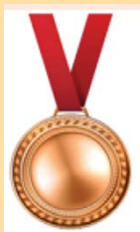


Figure 3. ART coverage (%) and HIV VT rate (%), 2015–2021

As illustrated in Figure 4 below, Thembisa estimates⁵ and programme data from the National Institute For Communicable Diseases (NICD) and istrict 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.



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

⁶ Global Alliance Dashboard, Oct 2024

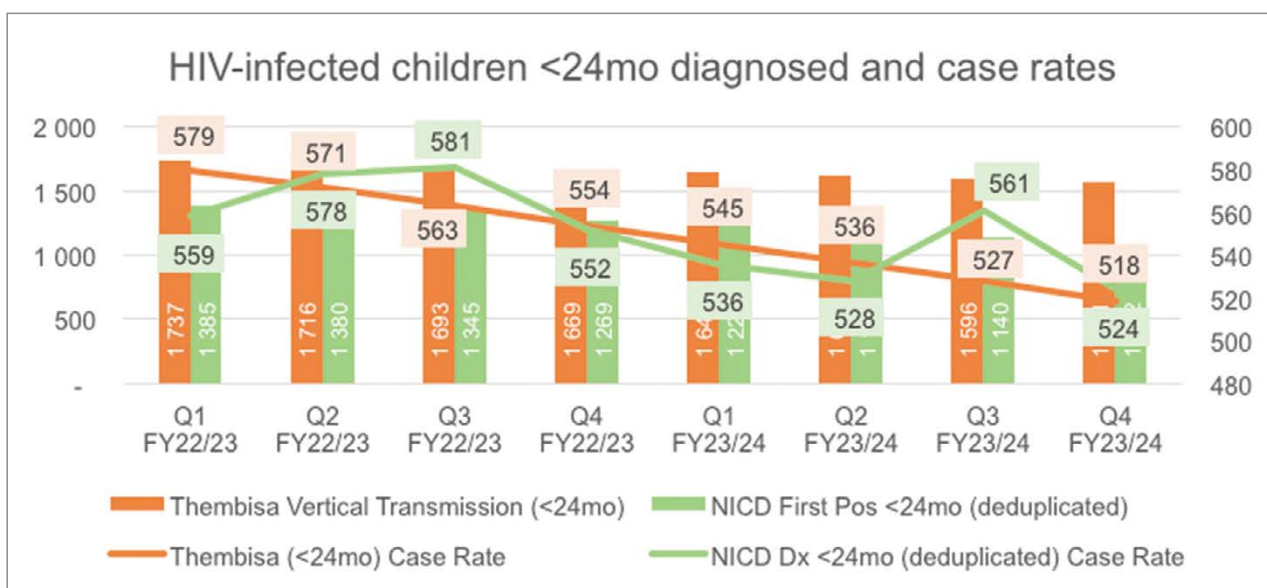


Figure 4. HIV-infected children < 24mo diagnosed and case rates, South Africa

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 VT 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 re-testing 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

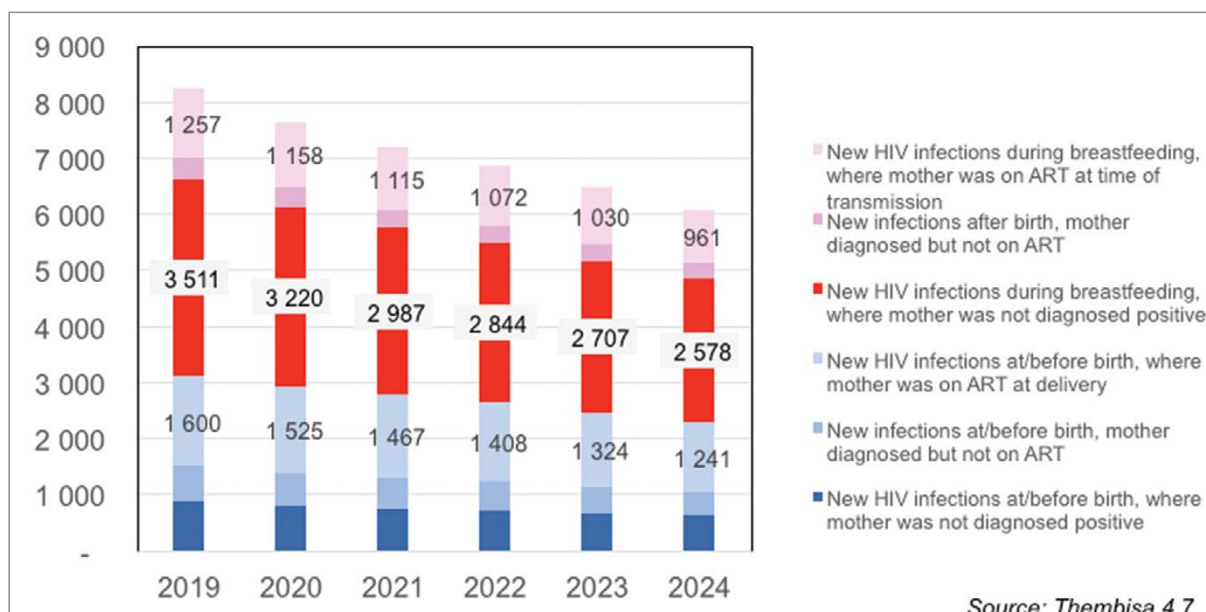


Figure 5. Annual cases of VTs by source of infection, South Africa

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 WLHIV were already on ART when they fell pregnant.¹⁰

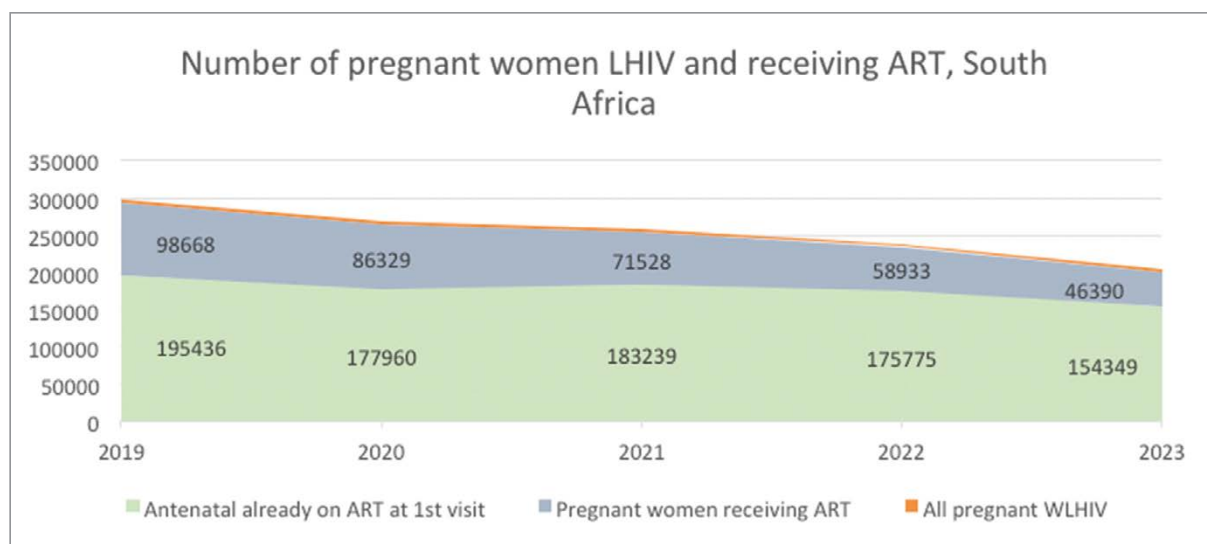


Figure 6. Number of pregnant WLHIV and receiving ARVs, 2019–2023

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 VL testing coverage and suppression rates in PBWG. This facilitates action to regain viral suppression at the individual patient level and also at 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.

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).

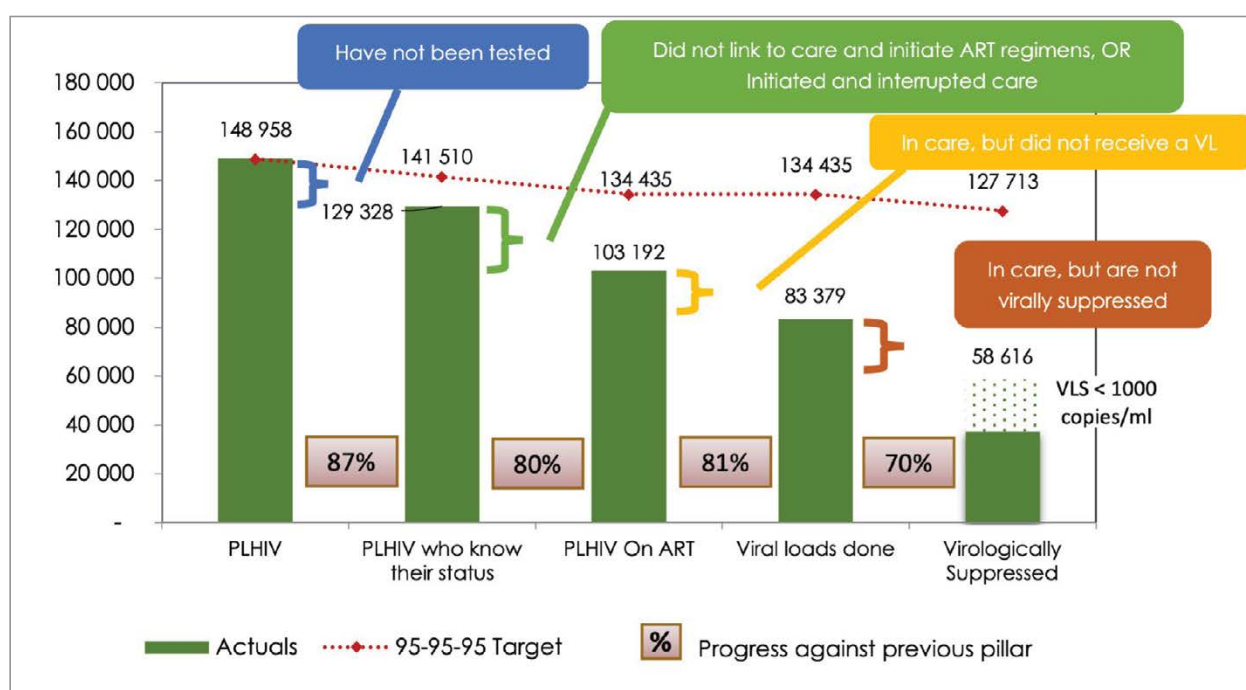


Figure 7. The 95-95-95 cascade for children < 15 years in South Africa, June 2023

HIV case finding

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

¹⁴ Operation Phuthuma Pyramid Cascade, July 2024

¹⁵ Operation Phuthuma Pyramid Cascade, July 2024

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

- 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.

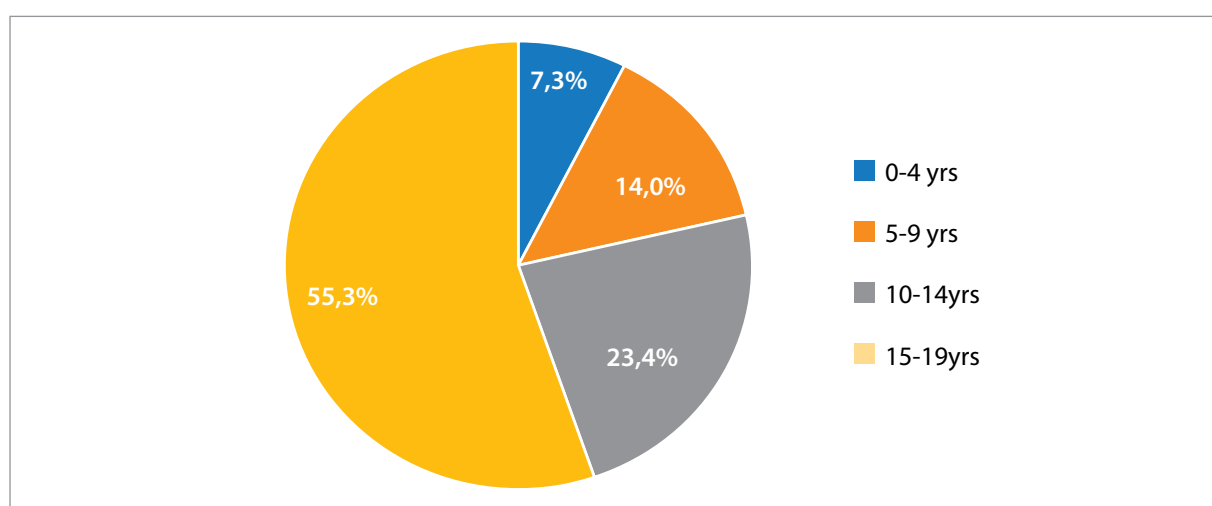


Figure 8. The age distribution of children in South Africa who do not know their status

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

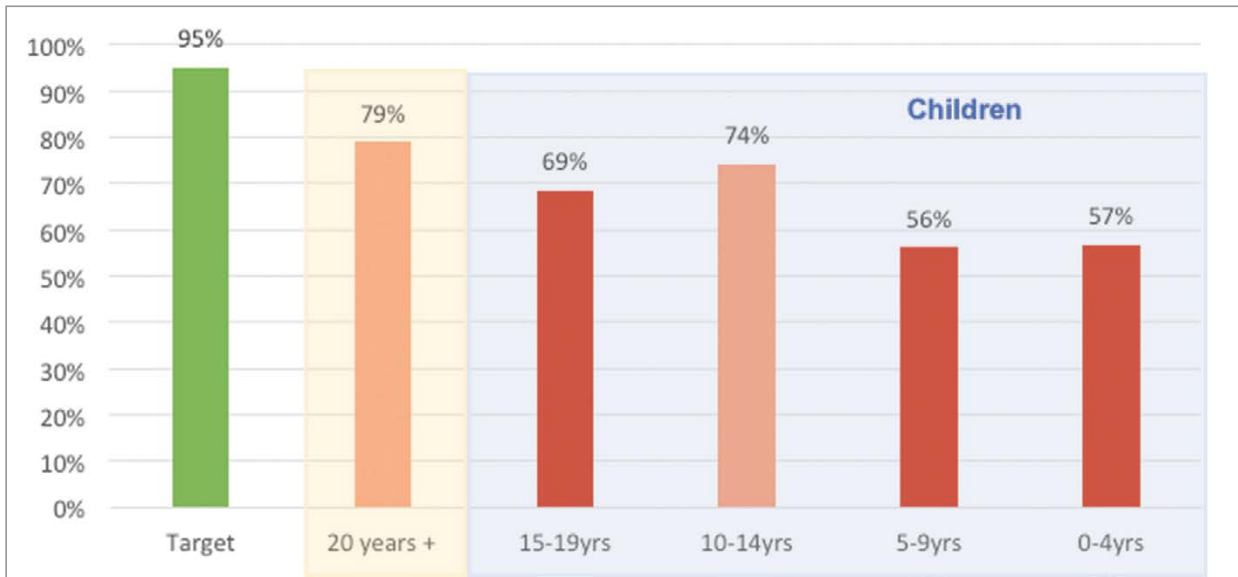


Figure 9. ART coverage by age group, South Africa, July 2024

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) is significantly greater than the number of boys (31,064).

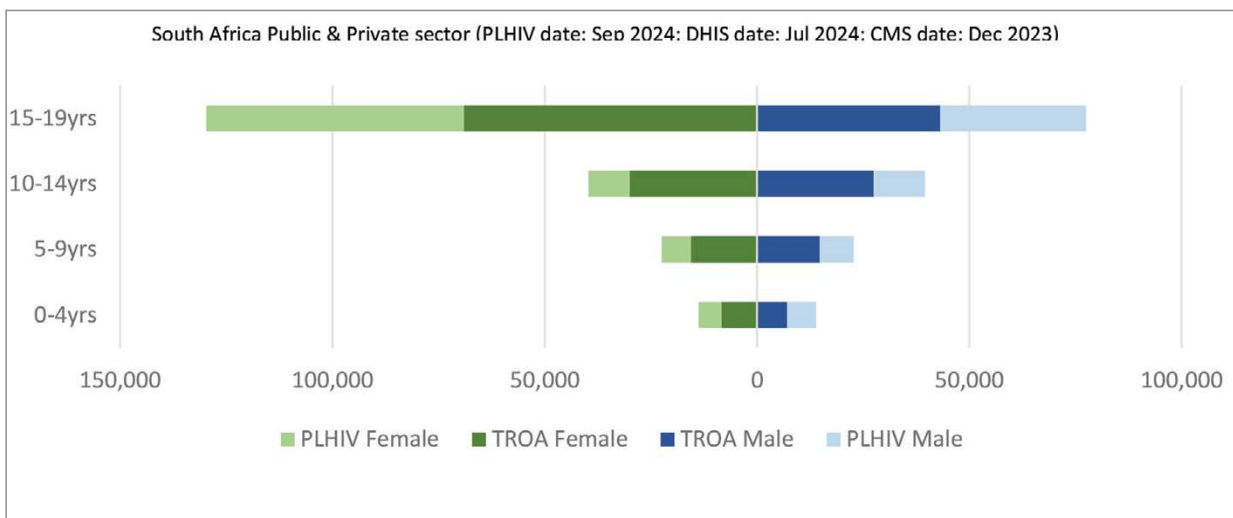


Figure 10. ART coverage in children and adolescents by age and gender, South Africa

¹⁸ Operation Phuthuma Pyramid Cascade, July 2024

Viral suppression in children

Using available NICD reports, suppression rates (< 1000 c/m;) for VLs done in children < 15 years and 15–19 years measured 70% and 78%, respectively, as of July 2024.¹⁹ 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%).

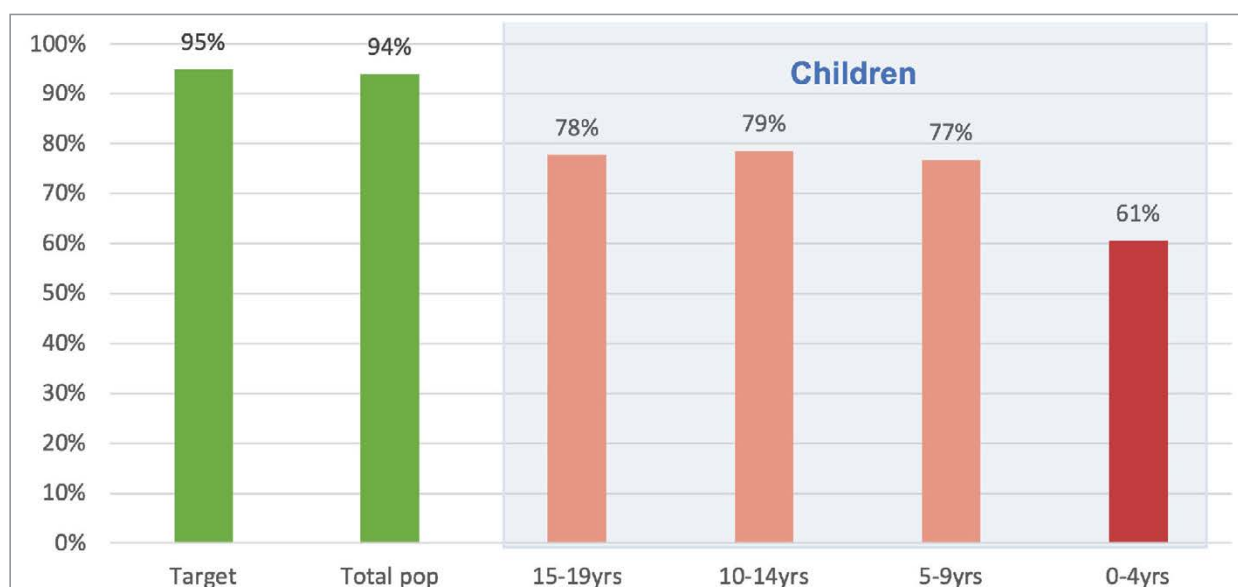


Figure 11. VL suppression rates by age group, South Africa, July 2024

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 Africa's 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%) have 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

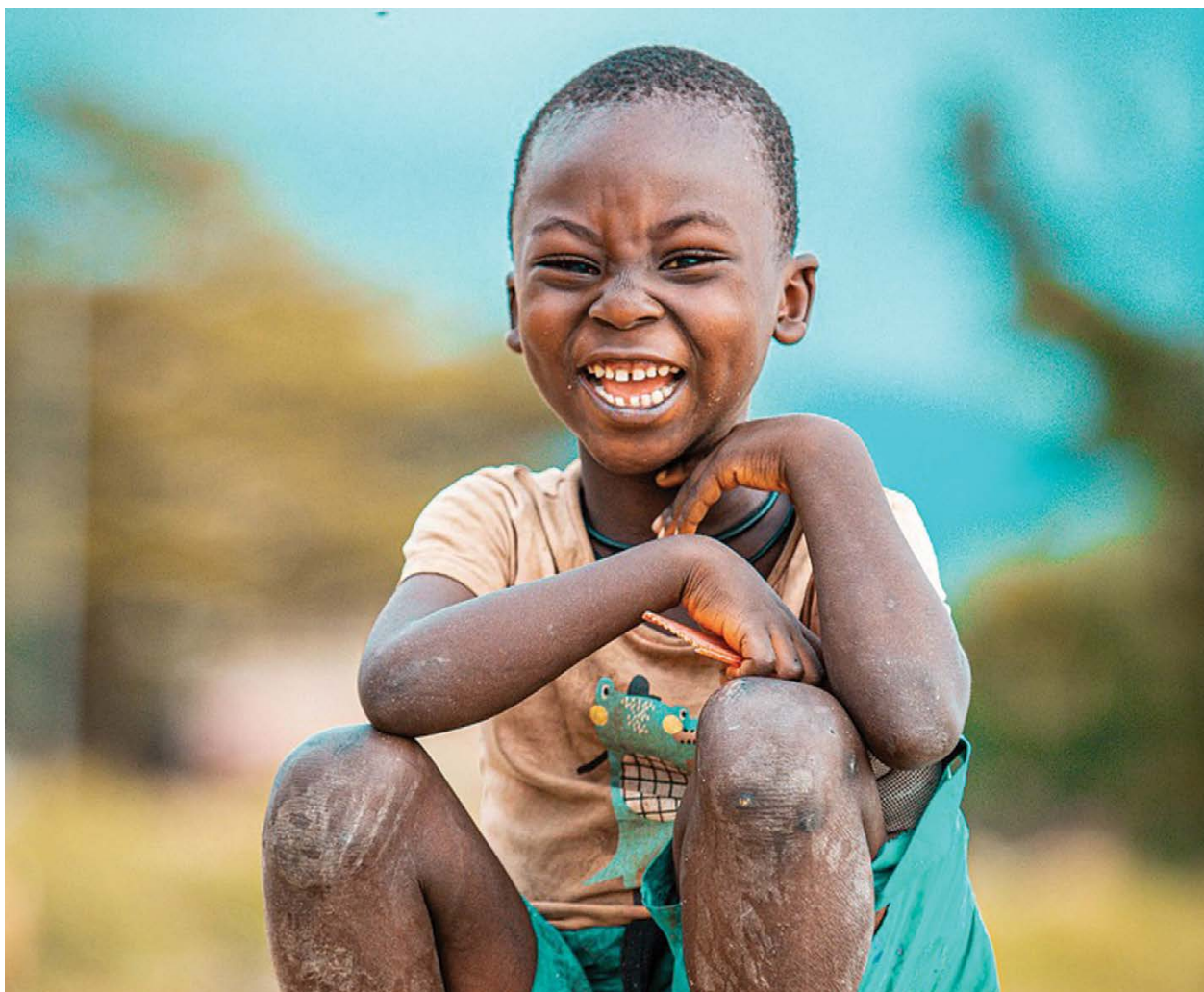
21 Richter L, Mathews S, Kagura J, Nonterah E. 'A longitudinal perspective on violence in the lives of South African children from the Birth to Twenty Plus cohort study in Johannesburg-Soweto'. *South African Medical Journal*. 2018.

Table 1 below summarises certain demographic indicators²² that impact on children's health in South Africa.

Table 1. Demographic indicators for 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*



²² South African Health Review, 2020.

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

6.1. Preventing new infections in children

Mpumalanga 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 3,2% in Mpumalanga, as illustrated in Figure 12 below.²³ However, despite this progress, Mpumalanga had approximately 900 new VTs in 2024.²⁴

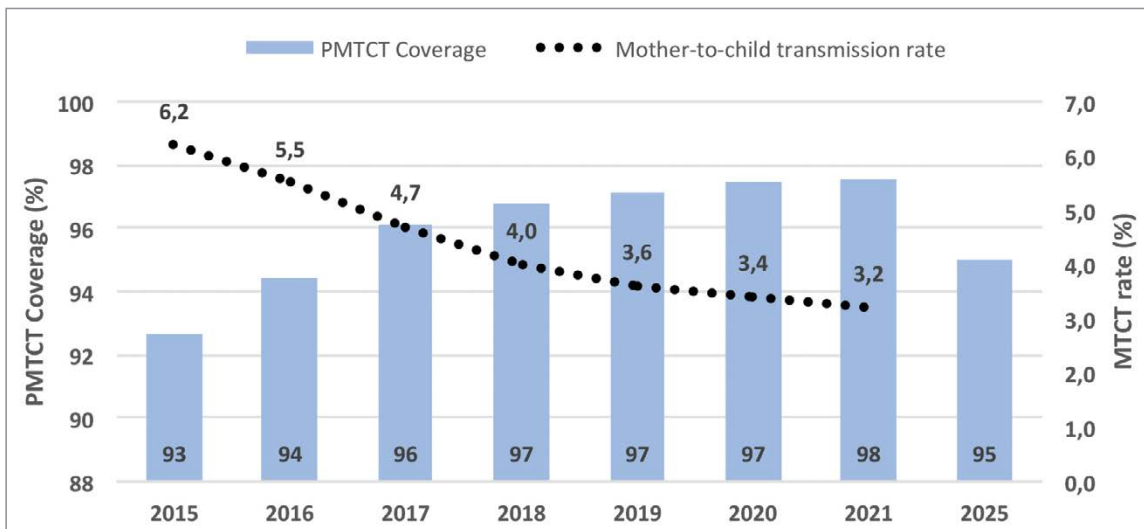
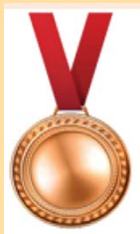


Figure 12. ART coverage (%) and HIV VT rate (%), 2015–2021, Mpumalanga

As illustrated in Figure 13, NICD data suggest that the province is achieving the bronze tier path to elimination impact target. However, Thembisa estimates suggest an ongoing slow decrease in VT case rates between 2022 and 2024, but not yet in keeping with the bronze tier threshold of a case rate < 750 per 100,000 births.²⁵



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 Global Alliance Dashboard, Oct 2024

²⁵ Thembisa 4.7

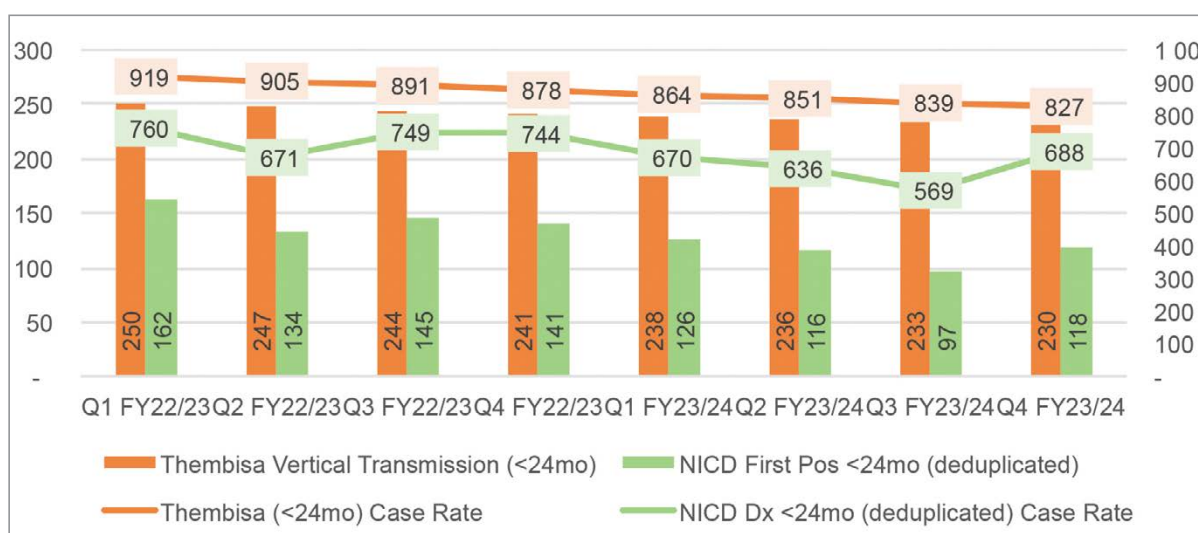


Figure 13. HIV-infected children < 24mo diagnosed and case rates, Mpumalanga

6.2. When and why are new VTs happening?

Approximately 69% of new vertical HIV transmissions occurred in the **breastfeeding period**, and approximately 80% of these VTs 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 **76% of postnatal VTs**²⁷, mandating an increased focus on HIV re-testing and providing PrEP as part of an integrated HIV prevention package throughout pregnancy and breastfeeding.

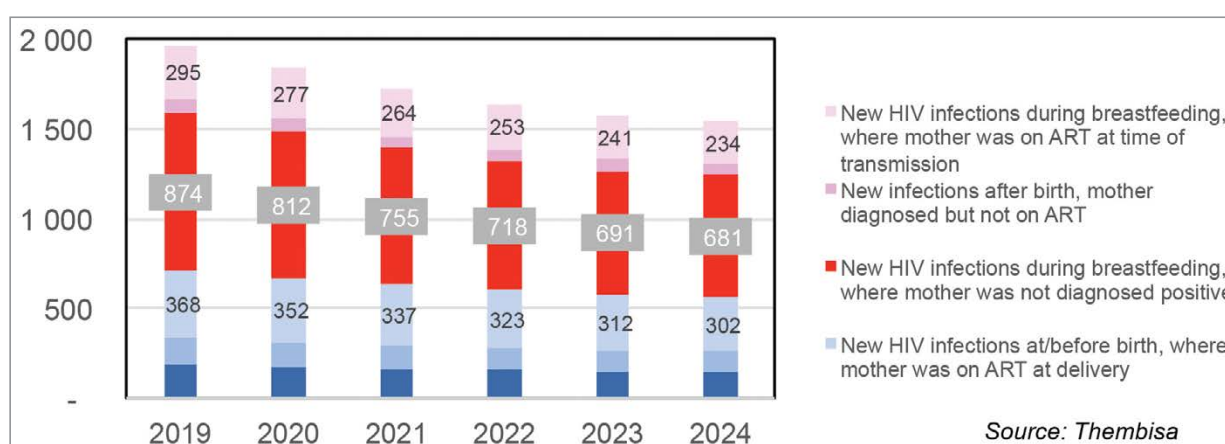


Figure 14 Number of new HIV infections among children by source of infection, MPL

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

Mpumalanga 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 0,8%.²⁸

Despite this progress, Figure 14 further illustrates that issues around access to ART and quality of care still accounted for approximately 338 VTs, with 56% occurring during antenatal care and 44% 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 Mpumalanga in FY2023/24 was the highest in the country, with 95,4% of women receiving a VL during pregnancy with an EGK code on the laboratory request form. However, only 52,7% of women received a VL that could be identified as a delivery VL due to the use of the delivery EGK code.

Using available NICD reports, suppression rates (< 1000 c/ml) for VLs done at delivery measured 89,6% as of Q1 FY2024/25.³⁰

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 or

²⁸ NICD PCR data, OP Report, Oct 2024

²⁹ Tembisa 4.7

³⁰ Global Alliance Dashboard, Oct 2024

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.

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 which 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).

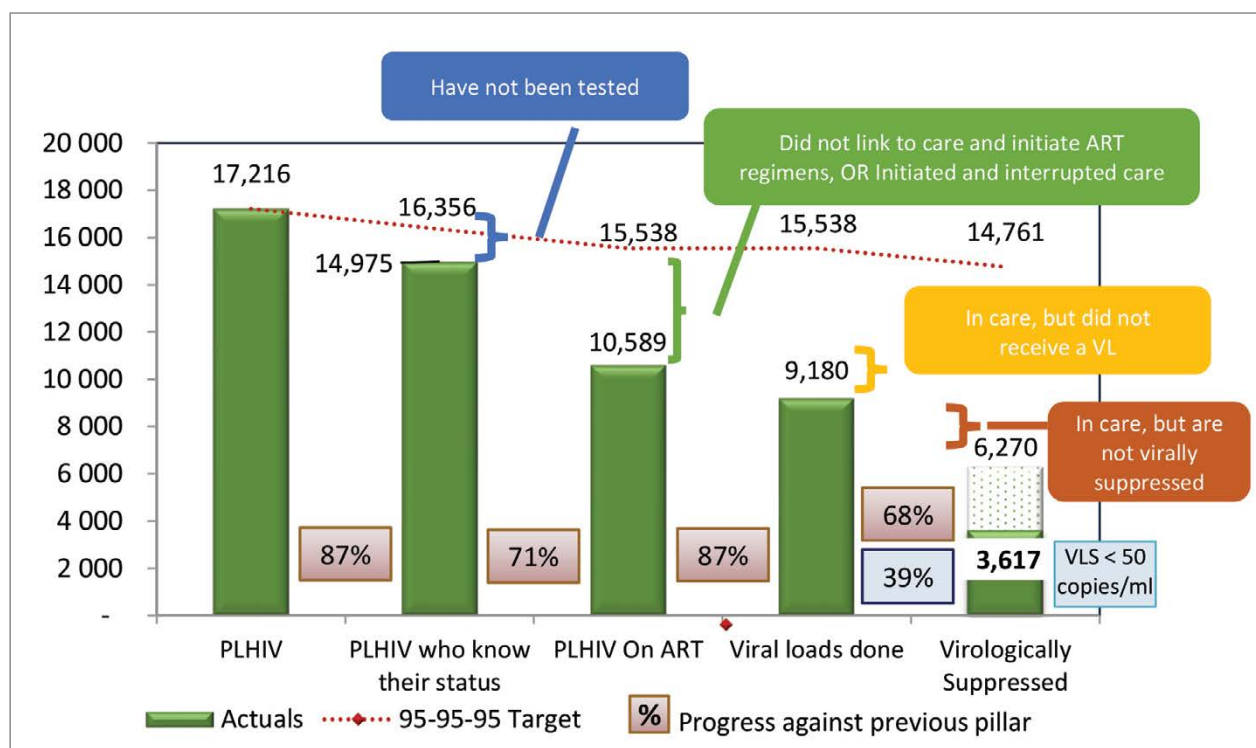


Figure 15. The 95-95-95 cascade for children < 15 years, Mpumalanga, July 2024

HIV case finding

In Mpumalanga, 87% 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, as follows:

- The smallest proportion of children who do not yet know their status (7%) 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 Mpumalanga, in FY2023/24, only 47% of HEIs who attended a facility for their measles vaccination also got their six-month HIV-PCR tests.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%) 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, ECDCs, within schools and colleges, at SASSA pay points, and within outreach programmes.

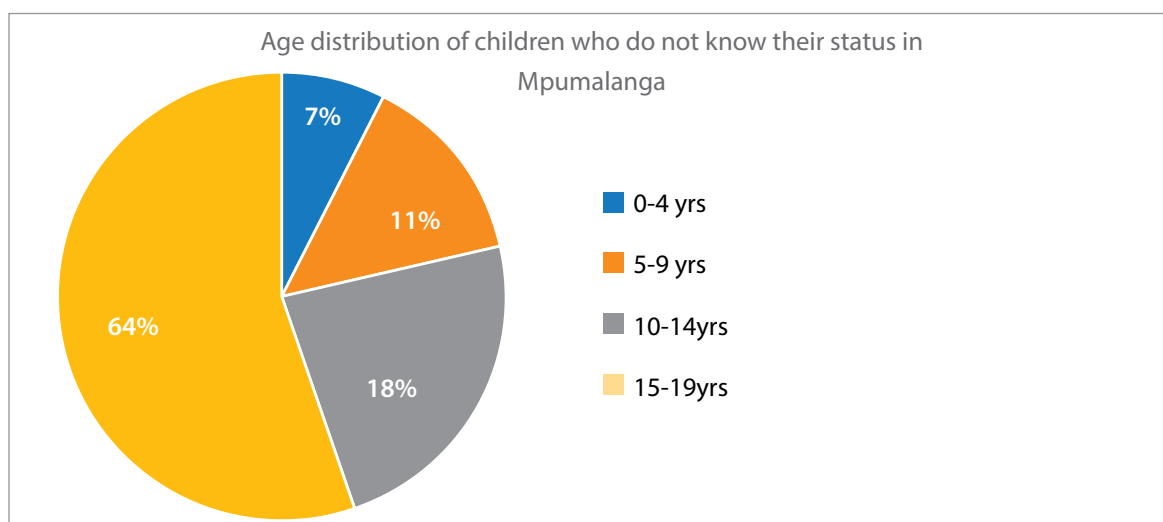


Figure 16. The age distribution of children in Mpumalanga who do not know their status

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 ART coverage across the different age groups. Children of all ages have significantly lower ART coverage (52%–73%) compared with adults (77%), with ART coverage being the lowest in children aged 0–4 years (51%) and adolescents aged 15–19 years (52%).³⁴

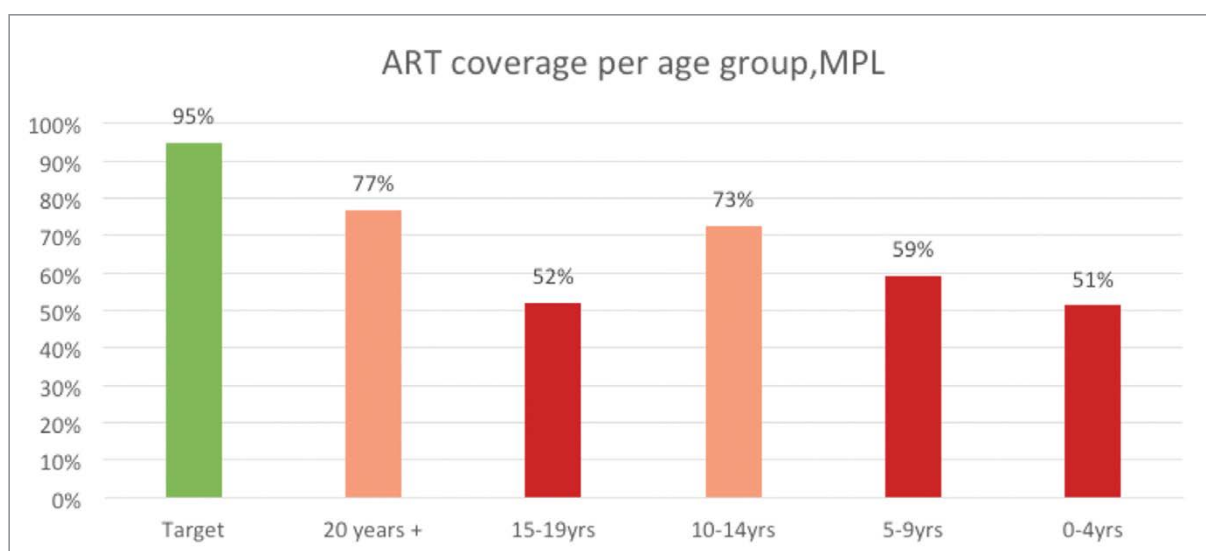


Figure 17. ART coverage by age group, Mpumalanga, July 2024

For females aged 15–19 years, ART coverage is 52%, whereas 60% 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 number of girls in need of ART (7,322) is significantly greater than the number of boys (3,532)

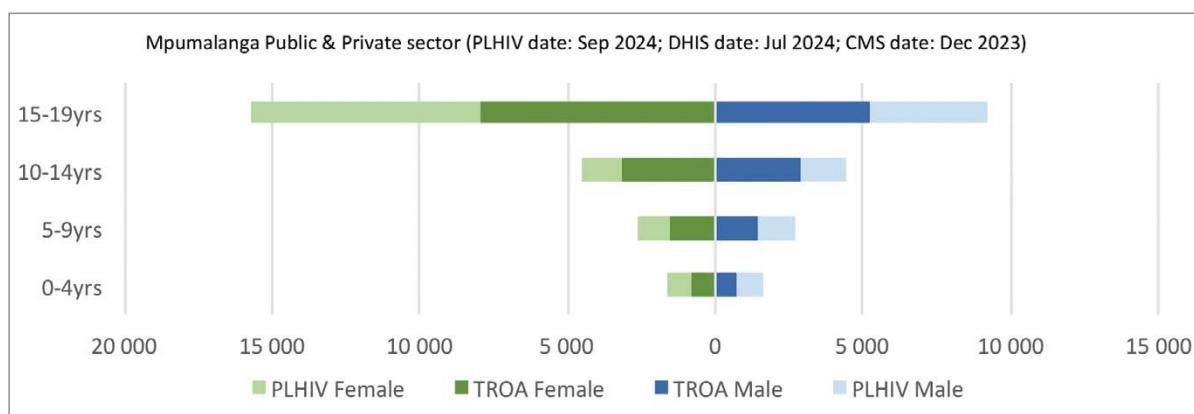


Figure 18. ART coverage in children and adolescents by age and gender, Mpumalanga

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 87% 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 90% and lowest (68%) in the 0–4 years group.³⁶

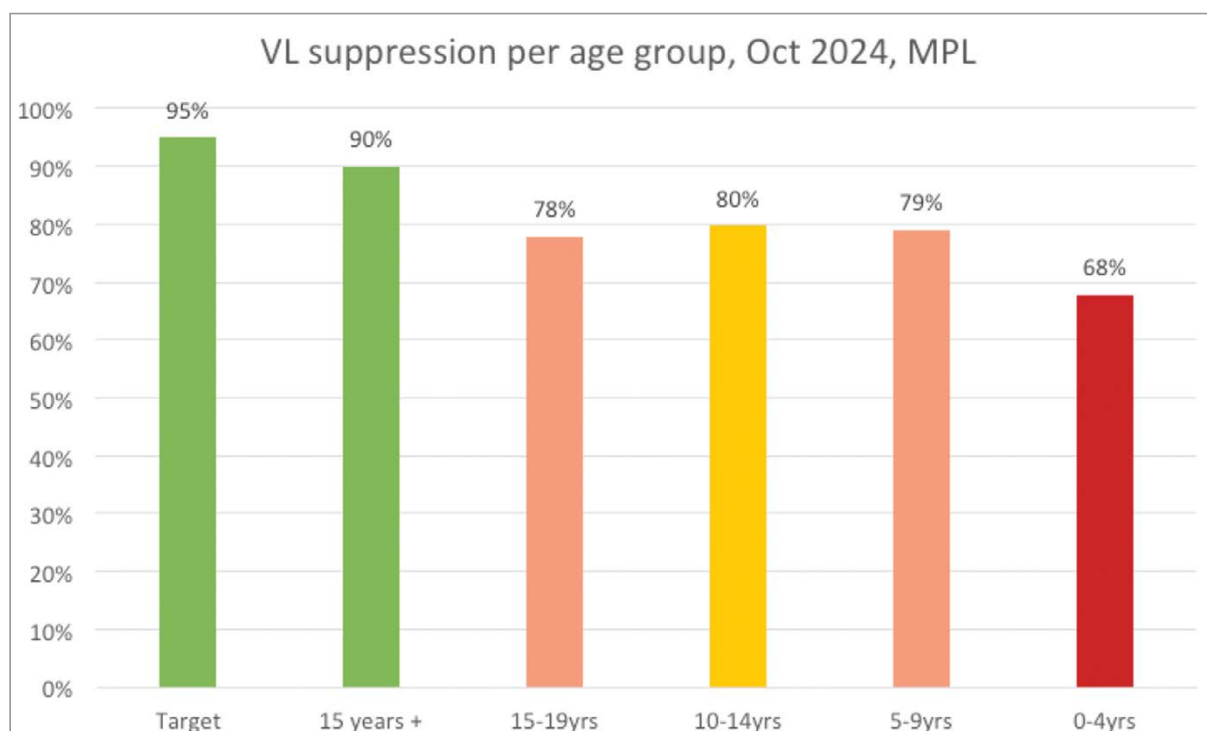


Figure 19. VL suppression rates by age group, October 2024, Mpumalanga

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.

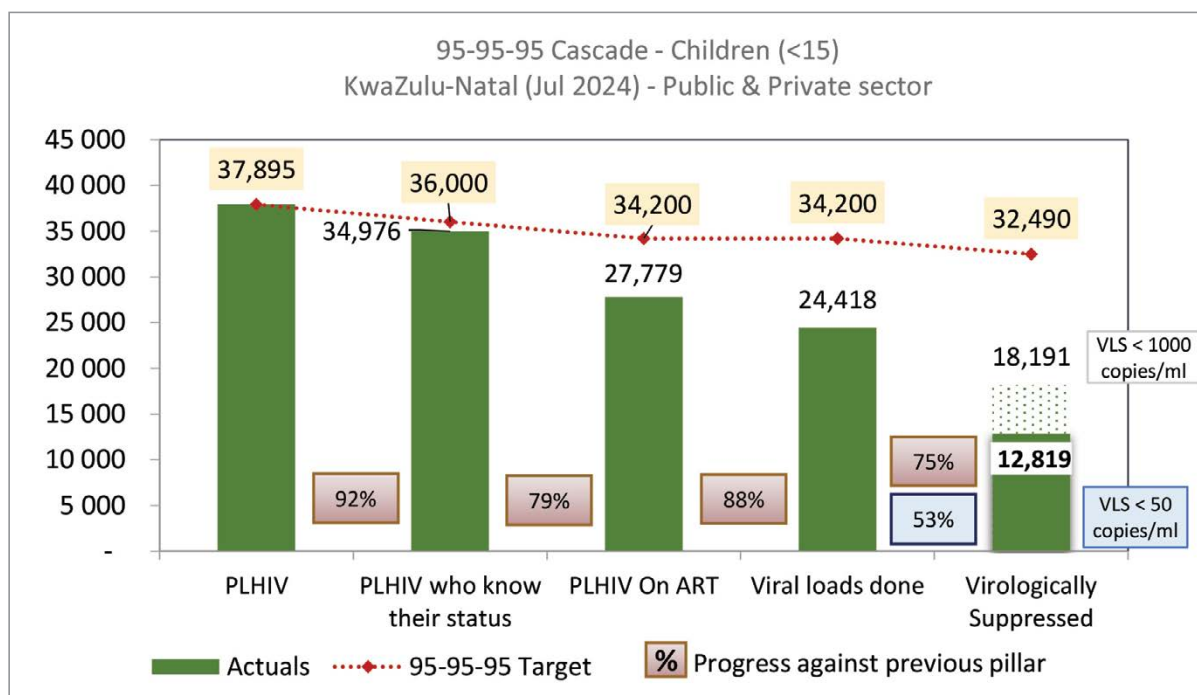


Figure 20. Mpumalanga targets as per 95-95-95 cascade – Children (< 15 years)

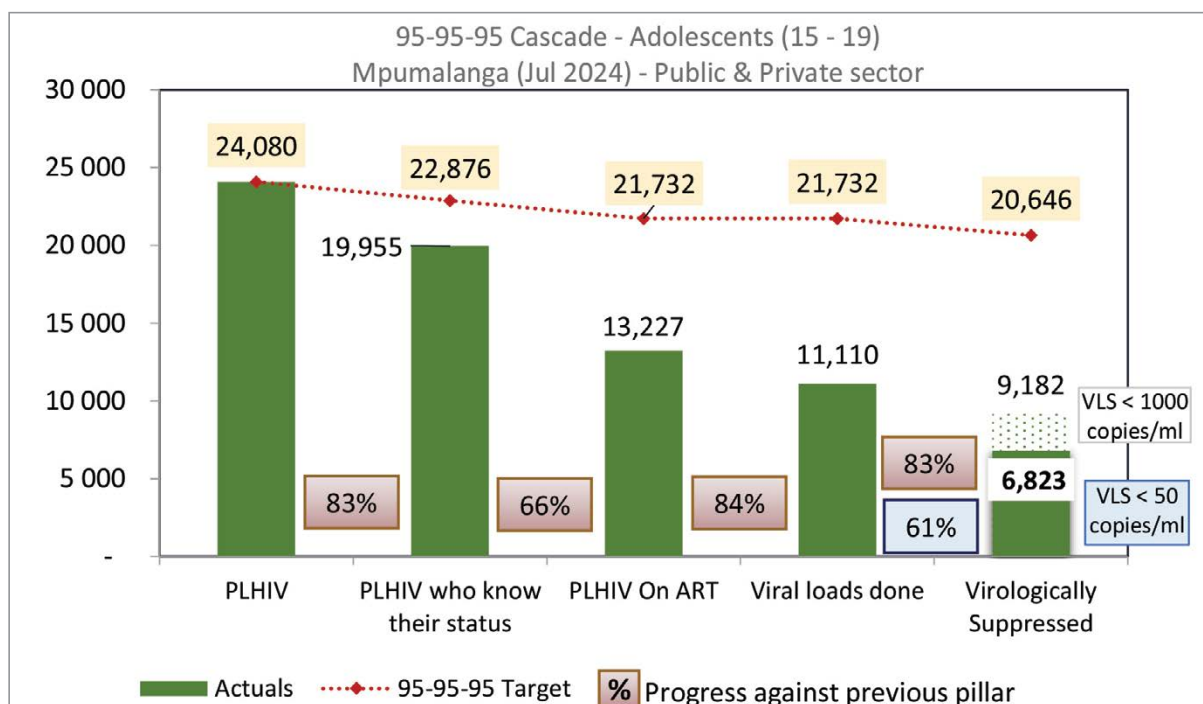
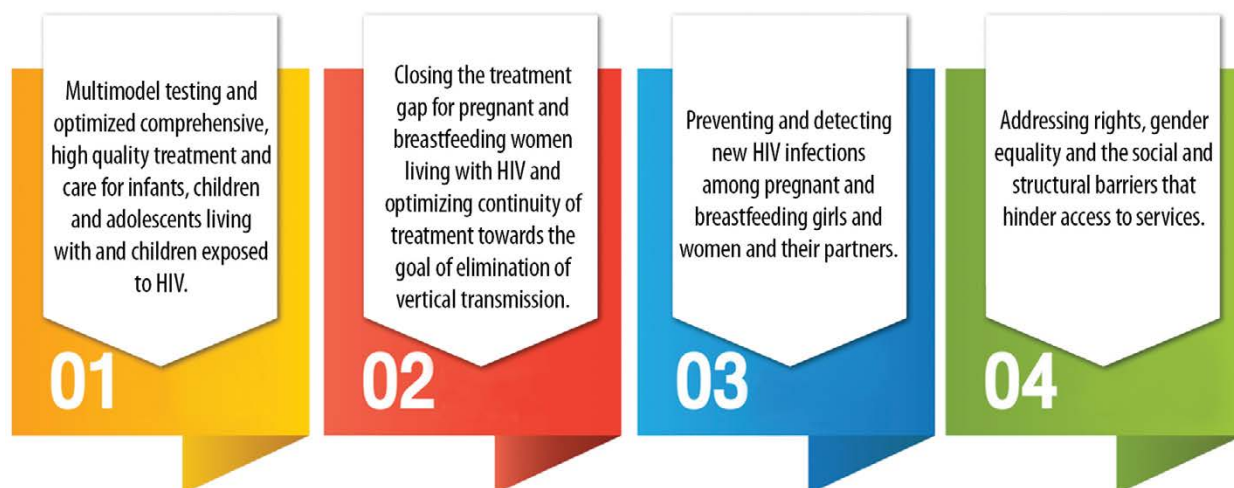


Figure 21. Mpumalanga targets as per 95-95-95 cascade – Adolescents (15–19 years)

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 WLHIV 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 PBGW;
- 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 PBGW;
- 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 PBGW;
- scaling up integrated and differentiated service delivery models for PreP as part of a comprehensive HIV prevention package for PBGW;
- 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 social and structural barriers that hinder access to services

- using gender- and age-disaggregated data on coverage to adapt and transform programmes;
- increasing 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
- empowering 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;
- accelerating 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;
- addressing gender-based violence and femicide, sexual assault and abuse, for example, in infants, children, adolescents, and women;
- strengthening the meaningful representation of women, children, and adolescents LHIV in decision-making processes.

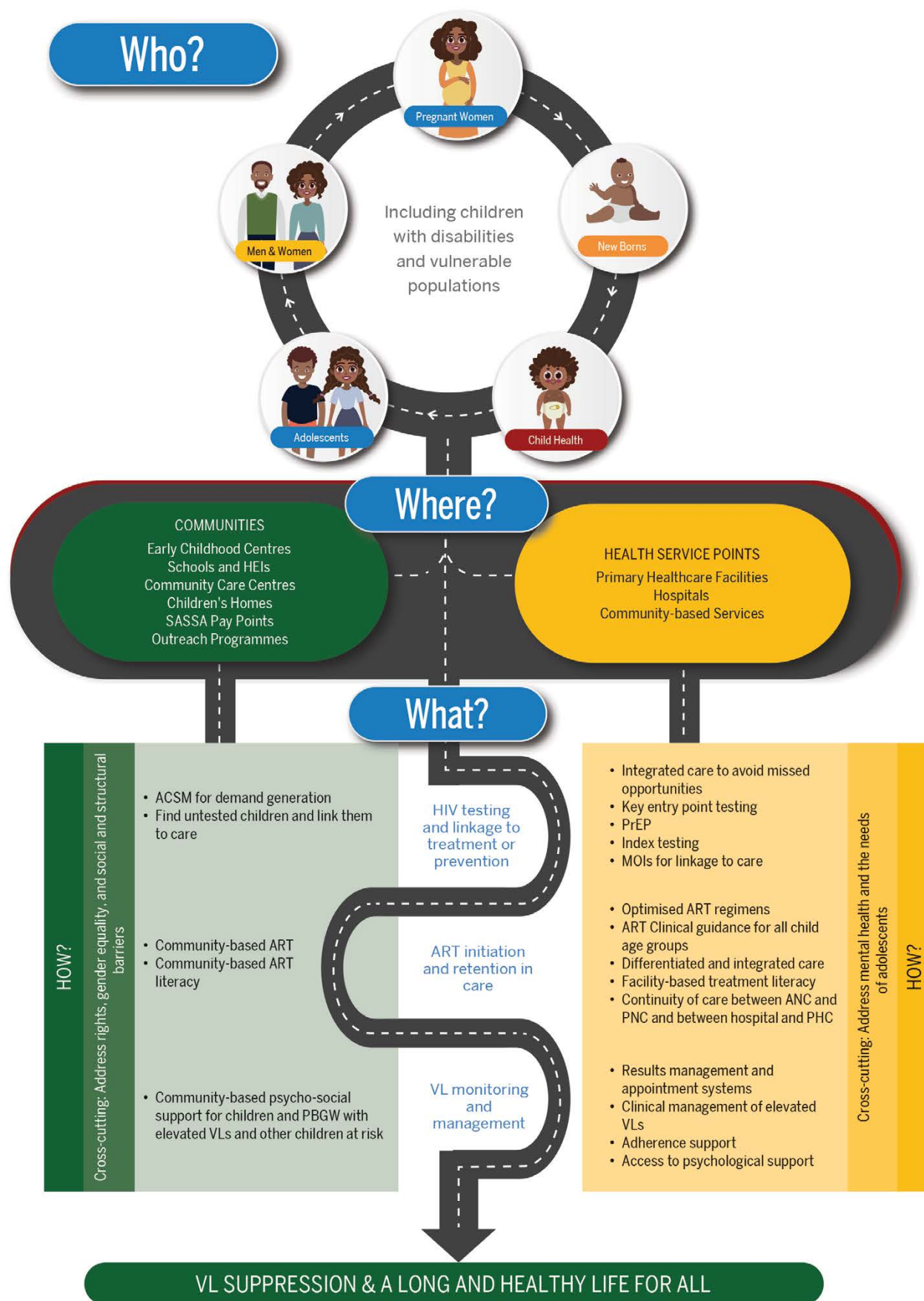


Figure 22 Interventions along the patient's journey

9. Activity Plan

9.1. Pillar 1

Pillar 1: Accessible testing, optimised treatment and comprehensive care for infants, children and +A1 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 National TWG
Pillar 1: Cross cutting activities to improve the quality of clinical care	95% of children living with HIV should know their status	Adol 15-19 yrs: Target 95%, Baseline 83%, Gap 12% CLHIV < 15 yrs: Target 95%, Baseline 87%, Gap 8%	Service providers within child services are not yet providing a fully integrated package of care inclusive of care to prevent and identify vertical transmission of infectious diseases	Quality	Strengthen routine HIV testing for HIV Exposed Infants (HEIs) as per VTP Guidelines Support scale-up of targeted case finding strategies for children and families accessing services Provide guidance on obtaining consent for HIV testing in children	Do refresher trainings (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, PEP 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) Print and disseminate the new ART 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 and DCSTs, 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
						Increased testing among HIV-exposed infants and children Measure: Number of HIV-exposed infants and children tested
						Increased case finding among HIV-exposed infants and children Measure: Number of HIV-exposed infants and children tested positive
1st 95	95% of children living with HIV should know their status	Adol 15-19 yrs: Target 95%, Baseline 83%, Gap 12% CLHIV < 15 yrs: Target 95%, Baseline 87%, Gap 8%	Service providers may lack confidence in determining who may give consent for HIV testing as per the Children's Act	Quality	Develop/adapt 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. Adopt, implement and disseminate a job aid to assist service providers in managing a caregiver who refuses to give consent. Implement the aligned HIV consent component of the Integrated School Health consent form and any other relevant consent forms.	DoH, partners, DSD, DBE
						DoH, partners
						DoH, DSD, partners
1st 95	95% of children living with HIV should know their status	Adol 15-19 yrs: Target 95%, Baseline 83%, Gap 12% CLHIV < 15 yrs: Target 95%, Baseline 87%, Gap 8%	Service providers within child services are not yet providing a fully integrated package of care inclusive of care to prevent and identify vertical transmission of infectious diseases	Quality	Strengthen routine HIV testing for HIV Exposed Infants (HEIs) as per VTP Guidelines Support scale-up of targeted case finding strategies for children and families accessing services Provide guidance on obtaining consent for HIV testing in children	DoH
						DoH, Partners
						DoH, Partners
1st 95	95% of children living with HIV should know their status	Adol 15-19 yrs: Target 95%, Baseline 83%, Gap 12% CLHIV < 15 yrs: Target 95%, Baseline 87%, Gap 8%	Service providers may lack confidence in determining who may give consent for HIV testing as per the Children's Act	Quality	Develop/adapt 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. Adopt, implement and disseminate a job aid to assist service providers in managing a caregiver who refuses to give consent. Implement the aligned HIV consent component of the Integrated School Health consent form and any other relevant consent forms.	DoH, Partners
						DoH, Partners
						DoH, Partners

Pillar 1: Accessible testing, optimised treatment and comprehensive care for infants, children and +A1 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 National TWG	Output measure	Responsible sector	Timelines
1st 95	95% of children living with HIV should know their status	Intensified Case Finding	Caregivers are not seeking/prioritising HIV testing services for children in their care	Demand	Implement ACSM activities to increase demand for HIV testing	Coordinate and conduct campaigns to "know your child status" (align to national health calendar months)	Increased testing among HIV-exposed infants and children	DoH, Partners, DSD	Y1-3
						Distribute IEC materials for primary caregivers on the HIV testing, giving consent, and linkage to care for ART	Measure: Number of HIV-exposed infants and children tested	DoH, Partners	Y1-2
						Collaborate with DSD and DBE to increase the demand for testing of children in Community Care Centres, Children's Homes, and Early Childhood Centres, at SASSA pay points and within outreach programmes.		DoH, DSD, DBE	Y1-3
						Increase caregiver enrolment onto MomConnect and monitor facility utilisation	Increased case finding among HIV-exposed infants and children	DoH, Partners	Y1-2
						Appoint health promoters	Measure: Number of HIV-exposed infants and children tested positive	DoH, Partners	Y1-2
2nd 95	95% of those who know their status should be on ART	Linkage to care	Facilities have not yet integrated available tools into their results management and tracking processes	Supply	Support scale-up of targeted case finding strategies for children and adolescents in hard to reach communities or at-risk populations are not accessing testing (and other) services	Improve implementation of MOI SOP: Community-based screening and referral for testing		DBE, DSD, DOJ, DoH, Partners	Y1-3
						Support scale-up of assisted HIVSS modality for adolescents (15-19 years old) across all districts (conduct training and disseminate the updated assisted HIVSS tools)		DoH, Partners DBE, DSD, DHET	Y1-3
						Disseminate and support implementation of the MOI SOP: Linkage to Care Through the Use of NHLS Results for Action Datasheets. Ensure that district and sub-district PHC supervisors, HAST & CCMT managers are signed up for the PCR-RFA (and VL) reports. Monitor district downloads and utilisation at provincial level.	Increased linkage to ART initiation for CLHIV after diagnosis	DoH, Partners, NICD	Y1-3
						Disseminate and support implementation of the MOI SOP: Digitisation of PCR Positive Results in the HTS Module on Tier.net. Monitor implementation by comparing TIER.Net infant PCR positives vs NHLS RFA infant PCR positives	Measure: Percentage of CLHIV linked to ART initiation after diagnosis	DoH, Partners, NICD	Y1-3
						Disseminate and support the implementation of the MOI SOP: Community Health Worker Tracking & Tracing for Initiations.		DoH, Partners	Y1-3
			Strengthen implementation of the Learner Support Programme at schools to identify and refer learners in need of additional services		Review referral tools to enhance the effectiveness of psycho-social support provided by Learner Support Agents (LSAs):			DBE	Y1-3
					</				

Pillar 1: Accessible testing, optimised treatment and comprehensive care for infants, children and +A1 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 National TWG	Output measure	Responsible sector	Timelines
1st 95	95% of children living with HIV should know their status	Intensified Case Finding	Caregivers are not seeking/prioritising HIV testing services for children in their care	Demand	Implement ACSM activities to increase demand for HIV testing	Coordinate and conduct campaigns to "know your child status" (align to national health calendar months)	Increased testing among HIV-exposed infants and children	Doh, Partners, DSD	Y1-3
						Distribute IEC materials for primary caregivers on the HIV testing, giving consent, and linkage to care for ART	Measure: Number of HIV-exposed infants and children tested	Doh, Partners	Y1-2
						Collaborate with DSD and DBE to increase the demand for testing of children in Community Care Centres, Children's Homes, and Early Childhood Centres, at SASSA pay points and within outreach programmes.		Doh, DSD, DBE	Y1-3
						Increase caregiver enrolment onto MomConnect and monitor facility utilisation	Increased case finding among HIV-exposed infants and children	Doh, Partners	Y1-2
						Appoint health promoters	Measure: Number of HIV-exposed infants and children tested positive	Doh, Partners	Y1-2
2nd 95	95% of those who know their status should be on ART	Linkage to care	Facilities have not yet integrated available tools into their results management and tracking processes	Supply	Support scale-up of targeted case finding strategies for children and adolescents in hard to reach communities or within vulnerable populations	Improve implementation of MOI SOP: Community-based screening and referral for testing		DBE, DSD, DOJ, Doh, Partners	Y1-3
						Support scale-up of assisted HIVSS modality for adolescents (15-19 years old) across all districts (conduct training and disseminate the updated assisted HIVSS tools)		Doh, Partners DBE, DSD, DHET	Y1-3
						Disseminate and support implementation of the MOI SOP: Linkage to Care Through the Use of NHLS Results for Action Datasheets. Ensure that district and sub-district PHC supervisors, HAST & CCMT managers are signed up for the PCR-RFA (and VL) reports. Monitor district downloads and utilisation at provincial level.	Increased linkage to ART initiation for CLHIV after diagnosis	Doh, Partners, NICD	Y1-3
						Disseminate and support implementation of the MOI SOP: Digitisation of PCR Positive Results in the HTS Module on Tier.net. Monitor implementation by comparing TIER.Net infant PCR positives vs NHLS RFA infant PCR positives	Measure: Percentage of CLHIV linked to ART initiation after diagnosis	Doh, Partners, NICD	Y1-3
						Disseminate and support the implementation of the MOI SOP: Community Health Worker Tracking & Tracing for Initiations.		Doh, Partners	Y1-3
			Learners LHIV and requiring additional care are not identified within the school system resulting in missed opportunities to link them to care		Strengthen implementation of the Learner Support Programme at schools to identify and refer learners in need of additional services	Review referral tools to enhance the effectiveness of psycho-social support provided by Learner Support Agents (LSAs): - Update the current ISHP consent form to include HIV screening (Province) - Revive SHE department collaborations (Province & District) on learner screening at school		DBE	Y1-3

Pillar 1: Accessible testing, optimised treatment and comprehensive care for infants, children and+A1 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 National TWG	Output measure	Responsible sector	Timelines		
95% of those on ART should be virally suppressed	CLHIV < 15 yrs: Target 95%, Baseline 68%, Gap 27% Adol 15-19 yrs: Target 95%, Baseline 83%, Gap 12%	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	Include phlebotomy training in the RTC schedule and expand targeted training to clinicians in facilities with high numbers of specimen rejections	Increased coverage of viral load testing among CLHIV retained on ART	DoH	Y1-2		
			Support districts to establish efficient results management processes		Disseminate and support implementation of blood results management SOPs	Measure: Viral load done rate at 12 months for CLHIV on ART	DoH	Y1-2			
					Implement interventions at facility level to support treatment adherence	Ensure that district and sub-district PHC supervisors, HAST & CCMT managers are signed up for the VL-RFA (and PCR) reports. Monitor district downloads and utilisation at provincial level.		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	Equip district master trainers to mentor facility and community cadres to strengthen understanding and implementation of DMOG SOP 3 on Disclosure counselling	Increased viral suppression rates among CLHIV on ART	DoH, partners	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
								Build treatment literacy knowledge of the primary caregivers of children living with HIV		MPAC, DoH Partners	Y1-3
								Support and facilitate the launch and implementation of U=U campaign to all sub-district and facility teams		MPAC, DoH Partners	Y1-3
								Enhance the use of the VL non-suppression algorithm in the 2023 ART Clinical Guidelines		DoH, partners	Y2
								Provincial Clinical Advisory Committee to review the current IMP EAC tool to align with DMOG SOP 2 on Enhanced Adherence Counselling.		DoH, partners	Y1-3
								Strengthen understanding and implementation of the EAC tool for caregivers of CLHIV with elevated VLs			
		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	Improve the clinical management of children with an elevated VL	Identify service providers that provide psychosocial support (including mental health assessments and support) to children and or their carers. Mobilise and coordinate these psycho-social support mechanisms to ensure that CLHIV can access PSS services through DSD offices or DOH	Increased viral suppression rates among CLHIV on ART	MPAC,DSD, DoH, DBE	Y1-3
							Strengthened inter-department collaboration for improved psychosocial support	Develop interdepartment referral systems and SOPs		DSD, DBE, DoH	Y1-2
								Improve capacity for community-based psychosocial support through CSF/OVCs, CBOs, WBOTs, etc		DoH, DSD	Y1-3

9.2. Pillar 2

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?	Comp-onent of care	What is the problem we are trying to solve?	Domain	Priority activities to be implemented	Activities for the MP Province	Output measure	Sector Responsible	Timelines
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, Gap: 250 new infections per 100,000 live births	Continuity of Care	Inadequate mechanisms exist to support continuity of care from ANC and delivery through to care in the breastfeeding period	Quality	Implement a structured package of care for the breastfeeding mother after delivery located at the same service delivery point as care for her infant.	Capacitate districts on the Roadmap for the First 1000 days Package as a job-aid for delivering an integrated package of care for the MIP	Increased retention of PBGW on ART Measure: Loss to follow-up rates at 3, 6, 12 months for PBGW on ART	DoH, DOE, DSD, Women sector, PLHIV sector,	Y2-3
						Implement the DMOC SOP 4 on multi-month dispensing from the facility for eligible breastfeeding women from 6 months after delivery			Y1-3
		Retention in Care	Unnecessary and uncoordinated visits for the breastfeeding mother and child result in disengagement from care	Quality	Implement patient-centred and differentiated models of care for eligible breastfeeding mothers to reduce cost to families	Implement the integrated visit schedules to align ART, contraception, immunisations, and other care for the mother and child			Y1-3
						Pilot Postnatal Clubs in select high volume CHCs to improve integrated care for the mother-infant pair			Y1-2
					Ensure that women are provided with basic knowledge and skills to adhere to ART	Strengthen use of DMOC SOP 1 on Fast track Initiation Counselling (FTIC) at time of ART initiation in antenatal and postnatal care			Y1-3
				Demand	Increase community-based treatment support	Implement treatment literacy campaign for a focus on PBGW and girls		Women's sector, PLHIV sector, DOE, DSD	Y2

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	What is the problem we are trying to solve?	Domain	Priority activities to be implemented	Activities for the MP Province	Output measure	Sector Responsible	Timelines
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	VL Monitoring and Management	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	Target clinicians in the MCH stream (incl clinicians in child care services & supported by DCST) for VTP training including VL monitoring and the management of elevated VLs	Increased coverage of viral load testing among PBGW retained on ART Measure: Viral load done rate for PBGW on ART	DoH	Y1-3
						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 Measure: Viral load suppressed rate at 12 months 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.	Mobilise and coordinate psycho-social support mechanisms to ensure that pregnant and breastfeeding women can access PSS services through DSD and DOE offices		DSD, DOE, DoH	Y1-3
						Strengthen interdepartmental referral systems and SOPs		DSD, DOE, DoH	Y1-2
			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	Capacity building on the use of EGK codes at facility level for clinicians working in antenatal and child health services		DoH, NHLS	Y1-2
						Improve capturing of EGK codes into NHLS systems		NHLS	Y1-2

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	What is the problem we are trying to solve?	Domain	Priority activities to be implemented	Activities for the MP Province	Output measure	Sector Responsible	Timelines		
Cross cutting activities to create an enabling environment for service delivery			Data quality and use of data for action		Capacitate districts and subdistricts on all aspects of data management (and as per the monitoring framework), incl. DoH indicator definitions and uses, available NICD data, the use of EGK codes, how to monitor and interpret coverage and outcome data, and how to use data for action and improvement (linked to supportive supervision below)		Reflected in measures above	DoH (information management unit and IT)	Y2		
					Capacity building for clinicians and DCs on standardised recording in the HTS register and clinical stationery and capturing on TIER.Net for newly initiated ANC clients.			DoH	Y1		
					Capacitate 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.)			DoH	Y2		
					Capacitate facilities on the unique health identifiers and maternal and child HPRN linkages at delivery built into HPRS (for MIP cohort monitoring)			DoH (Info Management unit)	Y2		
					HealthConnect			Build the capacity of health care workers through HealthConnect messaging related to VTP once rolled out by DoH		DoH	Y2

9.3. 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?	Comp-onent of care	What is the problem we are trying to solve?	Domain	Priority activities to be implemented	Activities for the National Technical Working Group (TWG)	Output 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 during the postnatal period	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	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	Disseminate existing resources to support the training of health care workers and community health workers across all districts on the HTS, HIVSS, PrEP and STI guidelines , including face-to-face and online trainings, training of master trainers, conducting Knowledge Hub (KH) webinars, and disseminating job aids and IEC materials, etc	Increased retesting coverage of PBGW during Antenatal and Breastfeeding periods Measure: HTS retesting coverage rates in HIV-negative PBGW
		Case Finding	New HIV seroconversions in PBGW period are not detected due to deficiencies in continuity of care, and integration of HIV testing into MCH services, especially at child health service points and family planning services	Enabling environment	Improve regular HIV retesting of pregnant and breastfeeding women and adolescent girls and their partners 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 Encourage partner involvement in at least one antenatal visit for couples HIV and RPR testing and psychosocial support for the mother (encourage joint couple testing and disclosure) Strengthen testing of partners of PBGW attending antenatal and postnatal services through HIVSS for partners. Collaborate with CHWs and CBOs and partners to conduct partner testing in the community Train and provide tools (e.g., flipcharts) to index-case contact tracing teams to trace and test partners and children identified via index cases	
		Prevention of new HIV maternal infections		Supply	Scale up integrated and differentiated service delivery models for PrEP as part of a comprehensive HIV prevention package for pregnant and breastfeeding adolescent girls, women and their partners	Scale up and facilitate access to PrEP postnatally at child health service points as part of a comprehensive package of HIV Prevention and SRH services and according to the PrEP and HTS guidelines Support implementation of the Integrated Visit Schedules as per the 2023 VTP guideline to align PrEP, contraception, immunisations, and other care for the mother and child by including these in existing training curricula and including them in the package of job aids available for healthcare workers providing PrEP Scale up Digital Health Solutions delivered by partner organisations (e.g. Lovellife) that increase remote access to SRH and HIV prevention information and services such as HIVSS, PrEP, PEP, condoms, lubricants, pregnancy testing, etc.	Increased PrEP coverage in HIV-negative PBGW Measure: Percentage of HIV-negative PBGW on PrEP
				Demand	Create demand for PrEP by disseminating key messages around PrEP, its benefits and where to access PrEP through awareness campaigns , community dialogues, social media, TV screens in facilities, messages on billboards, shopping malls, radio podcasts, etc All demand-creation activities to include a comprehensive package of SRH messaging - HIV/TB, STIs, PrEP, contraception, pregnancy (screening and early booking for ANC), and risk reduction counselling Promotion (ACSM) of HIV Prevention interventions (PrEP, VMMC, HIV testing and condom programmes) to adolescent boys and adult men, increasing access to and uptake of HIV testing and HIV prevention information and services	DoH, DoE, Higher Health, DOH, RTC, DSD DoH, DoE, Higher Health DoH, DOE DSD Civils Society DoH, DoE DoH, DHET, DoE, partners DoH, CSF DSD, DoE DoH, CSF DSD, DoE	Y1 Y1-3 Y1-3 Y1-3 Y1-3 Y2-3

Pillar 4: Addressing rights, equality, social and structural barriers that hinder access to services

Pillar 4: Addressing rights, equality, social and structural barriers that hinder access to services

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 activities 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	Quality	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.	- All implementing stakeholders to develop multisectoral training modules on their social behaviour change (SBC) programmes relating to HIV prevention and SRHR -Train SSPs and other stakeholders on these Social and Behaviour Change (SBC) programmes relating to HIV prevention and SRHR, including: - Families matter - ChommiY (10-14 yrs) YOLO (15-24 yrs), - Boys Championing Change (14 - 18 yrs), - Men Championing Change (19 - Above), - Rock Leadership for traditional leaders, and - other Mens Sector and CSF activities - Implementing partners to review the integration of key programmatic interventions to ensure alignment between departmental guidelines. - Conduct sensitisation presentations through MPAC, DAC, and LAC structures to allow for the sharing of information, integration and leveraging of resources between implementing stakeholders.	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	CSF, DSD, DOH, DOE, Community Implementing partners, DACs, LACs.	Y1-3	
			Supply		- Strengthen delivery of Comprehensive Sexuality Education in schools - Train educators in CSE and children's rights (LO and LS) Grade 4 to 12 - Sensitization of school management teams (SMTs), school governing bodies (SGBs) - Conduct parental engagements - Support activities through the use of controlled digital spaces for information sharing (e.g., B-Wize) - Strengthen implementation of the policy on reporting of harassment and sexual abuse		CSF, DSD, DOH, DOE, Community Implementing partners, DACs, LACs.	Y1-3	
						Finalise MOU with Higher health and ensure delivery of First Things First in TVET colleges through Higher Health programmes		DHET Higher Health, CSF, DSD, DOH, DOE	Y1-3
						-Build the capacity for mental health screening amongst Student Liaison Officers (SLOs) at TVET colleges through Higher Health programmes. -Conduct a multistakeholder engagement to expand mental health screening solutions used in TVET colleges to other implementing entities to increase coverage.		DHET Higher Health, CSF, DSD, DOH, DOE	Y1-3

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 activities to be implemented	Activities for the Provincial Technical Working Group (TWG)	Output measure
(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	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	Establish mechanisms for identifying and referring pregnant and parenting adolescents (from DBE, DHET, DoH) into teen parenting programmes. Collaborate with local organisations and stakeholders to facilitate the implementation and roll-out of teen parenting programmes such as the Sinovuyo Project, which offers holistic support to address education, health, economic empowerment and personal development.	Increased high school completion in pregnant and parenting adolescents who complete school Measure: Proportion of pregnant and parenting adolescents who complete high school
						CSF, DSD, DOH, DOE, Community Implementing partners, DACs, LACs.
		Gender-based violence (GBV) and other human rights violations remain a threat to the mental and physical, health and wellbeing of women, adolescents and children, contributing to the HIV/AIDS crisis, and placing families at risk.	Enabling Envmnt	Scale-up advocacy efforts to address human rights violations that perpetuate violence, stigma and discrimination	When available, use recommendations from the pending 2025 Stigma Index survey report to influence programming decisions and develop interventions to address identified human rights violations. Also use digital surveys, CLM data and patient satisfaction surveys to monitor stigma against people living with TB/HIV. Utilize data collected through the Human Rights Portal (or other web-based case management systems) to monitor human rights violations and inform programming decisions. Ensure that key stakeholders are able to access data.	Reduced GBV and other human rights violations in children, adolescents and youth Measure: Number of GBV cases in children, adolescents and youth
						MPAC, CSF, DSD, DOH, DOE, Community Implementing partners, DACs, LACs.
					Conduct Human Rights sensitisation training for all stakeholders in the province concerning issues of TB/HIV/STIs affecting key and vulnerable populations, including children and youth, primary care givers.	MPAC, CSF, DSD, DOH, DOE, Community Implementing partners, DACs, LACs.
						Y1-3

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 activities 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 adolescents and children, contributing to the HIV/AIDS crisis, and placing families at risk.	Gender-based violence (GBV) and other human rights violations remain a threat to the mental and physical, health and wellbeing of women, adolescents and children, contributing to the HIV/AIDS crisis, and placing families at risk.	Quality / Supply	Address Gender Based Violence and femicide, sexual assault and abuse e.g., infants, children, adolescents and women	Development of a standardized training module for the province, and capacitate the child protection workforce (DSD, DBE, DoH, DHET, NPOs, CSF) on the Children’s Act, including mandatory reporting of child abuse and other violations		CSF, DSD, DOH, DOE, Community Implementing partners, DOJ, DACs, LACs.	Y1-3
					Facilitate implementation of the Intersectoral Protocol on Management of Violence Against Children, Child Abuse and Exploitation : '- Map local and district-level implementing partners and stakeholders that play a role in the implementation of the programme. '- Develop localised referral directories per district. '- Co-create communication and social mobilisation materials to publicise interventions in a bid to minimise vertical programming '- Monitor implementation of the Child Protection Register (including reporting of child abuse cases) and the process of managing reported cases. '- Capacitate SSPs to equip children and survivors of abuse to communicate effectively in court and use correct (and universally understood) terminology.		CSF, DSD, DOH, DOE, Community Implementing partners, DOJ, DACs, LACs.	Y1-3
					Strengthen prevention and early identification intervention services to create awareness of child abuse in the community		DSD, Community Implementing partners	
					Build capacity on the implementation of the psychosocial services policy in GBVF hotspot districts using cost-effective mechanisms such as YouTube and Tick Tock channels (using e.g., peer influencers)		CSF, DSD, DOH, DOE, Community Implementing partners, DACs, LACs.	Y1-3
					Increase the capacity for self-screening for GBV risk in adolescent girls and boys attending at TVET colleges and at risk of abuse		DHET Higher Health	Y1-3
					Use cost-effective mechanisms such as YouTube and Tick Tock channels to conduct integrated awareness campaigns on prevention and early intervention measures to curb social ills (GBV Victim Empowerment Programme (VEP) & Substance Abuse) in campuses		CSF, DSD, DOH, DOE, Community Implementing partners, DACs, LACs.	Y1-3
			Demand					
Cross-cutting activities to create an enabling environment for improved HIV and TB service delivery			Quality	Implement Community-Led Monitoring (CLM) to complement existing facility-based quality assurance and improvement mechanisms	Implement and refine approaches for community-led monitoring for key and vulnerable population sectors, including the Youth sector, as per the SA CLM Framework	Increased coverage of CLM at health facilities Measure: Number of facilities monitored through CLM	MPAC, CSF, DSD, DOH, DOE, Community Implementing partners, DACs, LACs.	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 programme activities to the outcomes of 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

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	
Capacity 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	
Capacity for implementation of Matrix of Interventions (MOI) SOPs: material development, master trainers, KH webinars, KH resources, job aids, provincial training plans, registers)	Increased case finding among HIV-exposed infants and children Measure: Number of HIV-exposed infants and children tested positive	NDoH, Partners	Y1-2	Not started	
Capacity for implementation of MOI SOPs: testing (IMCI, EPI, Acute Care, TB, malnutrition services, and Youth Zones)		NDoH, Partners	Y2,2	On track	
Make available for download, a standardised consent form for HIV testing as per protocol for healthcare workers and social service practitioners		NDoH, Partners	Y1	Off track with issues	
Develop 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)	Increased case finding among HIV-exposed infants and children Measure: Number of HIV-exposed infants and children tested positive	NDoH, Partners	Y1-2	Not started	16 Nov: Awaiting TORs to be finalized
ty for implementation of MOI SOPs: t testing (IMCI, EPI, Acute Care, TB, malnutrition services, and Youth Zones)		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.
l campaign messages on "Know your child status" and implement campaigns il 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	HIV Testing coverage: Birth PCR, 10 week PCR, and 6-month PCR testing coverage Missed opportunities: 10 wk PCR coverage vs 10 week Hexa2 coverage rates Missed opportunities: 6-month PCR coverage vs 6-month Measles 1 coverage Confirmatory testing: % positive rapid tests confirmed with an HIV PCR rate HIV infected children < 24 months diagnosed and case rates	95-95-95 cascade for CLHIV < 15 years	95-95-95 cascade for ALHIV 15-19 years
				1st 95 - Proportion of CLHIV that know their status	1st 95 - Proportion of ALHIV that know their status
				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)	
				# tests 5-14 years	
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	VL 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 (Quarterly)	

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 by 2030 in Mpumalanga was developed in collaboration with the following stakeholders:

- South African National AIDS Council
- Joint United Nations Programme on HIV/AIDS
- UNICEF
- Mpumalanga AIDS Council
- CSF
- Mpumalanga 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

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