REPUBLIC OF SOUTH AFRICA

GLOBAL AIDS RESPONSE PROGRESS REPORT

Mid-term Review of Progress in achieving the 2011 UN General Assembly Political Declaration on HIV/AIDS targets and elimination commitments in South Africa

REPUBLIC OF SOUTH AFRICA

FOREWORD

South Africa is signatory to the 2001 UNGASS Declaration of Commitment, the 2006 Political Declaration on Universal Access and 2011 Resolution 65/677: Intensifying our Efforts to Eliminate HIV and AIDS. It is with pride that we submit the Country Report on South Africa's contribution to the Global Response to AIDS and Tuberculosis.

The report provides feedback with respect to goals agreed upon and progress made in the South African response to HIV, AIDS and TB using global indicators for the period ending 31 March 2013 and projections to the end of 2015. The period under review coincides with year 1 of implementation of our National Strategic Plan for HIV, STIs and TB, 2012 - 2016.

During this reporting period, we have developed new policies to increase universal access to free antiretroviral therapy. From 1st April 2013 further amendments have increased access to ART for all pregnant women who are HIV positive for the period of breastfeeding (after which those with a CD4 count of less than or equal to 350 will continue treatment), for all infants born to mothers who are HIV positive (irrespective of CD4 count or staging), for all persons with CD4 of less than or equal to 350 CD4 Cells/mm3 and for all persons diagnosed with HIV who are co-infected with TB.

The acceleration of our HIV interventions since 2009 have resulted in substantial increases in public sector expenditure that, even in the face of a global recession and excluding the financing of these recent changes to the guidelines, have already seen South Africa increase its national investment in HIV by 500% since 2009.

We are proud to say that there are now more than 2 million South Africans on antiretroviral treatment and our National HIV Counselling and Testing Campaign saw more than 20 million South Africans tested for HIV over the course of 20 months. Besides increasing awareness of testing for HIV this campaign, which was led by the country's President, also aimed to decrease HIV-related stigma. Measuring HIV-related stigma continues to be a challenge but the increased uptake of HIV counselling and testing – including a further 9 million South Africans tested for HIV between April 2012 and March 2013 – is an indication of the significant inroads made in reducing HIV-related stigma and associated discrimination.

FOREWORD

Preliminary data from our 2012 national household population survey points to the success of the ART programme in keeping those with HIV alive and healthy. According to this survey, the country has 6.4 million people living with HIV. HIV prevalence in 2012 is estimated at 12.3%, up from 10.6% in 2008. The increase in prevalence is explained by a recent review of mortality data that has revealed an increase in life expectancy from 56 to 60 years over just the last three years. The authors argue that so dramatic is the turn-around that it can only be attributed to the accelerated expansion of ART. The same report further identifies a 25% decrease in both infant- and under-five mortality, which the authors attribute to the PMTCT programme and to the provision of ART for children.

The country's accelerated programme for the elimination of vertical transmission has resulted in significant declines in mother-to-child transmission of HIV: from 8.5% in 2008 to 3.5% in 2010 and down to 2.7% in 2011.

This report has been compiled with the full participation of government, civil society, business and development partners in accordance with the *Guidelines on the Construction of Indicators* for 2012 reporting.

We would like to acknowledge the enormous contribution and efforts that went into the preparation of 2013 Country Report. The report benefited from data and information provided by national and provincial governments, civil society organisations including non-governmental organisations, the business sector and our development partners.

The report drafting process was coordinated by the South African National AIDS Council (SANAC) which ensured multi-sectoral stakeholder participation.

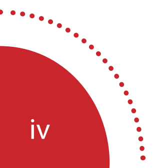
MR KGALEMA MOTLANTHE
DEPUTY PRESIDENT: REPUBLIC OF SOUTH AFRICA
CHAIRPERSON: SOUTH AFRICAN NATIONAL AIDS COUNCIL

We are proud to say that there are now more than 2 million South Africans on antiretroviral treatment and our National HIV Counselling and Testing Campaign saw more than 20 million South Africans tested for HIV over the course of 20 months.

ACKNOWLEDGEMENTS

The 2013 South African Mid-term Review of the 2011 UN General Assembly Political Declaration on HIV/AIDS targets and elimination commitments was compiled by a team of consultants under the guidance and direction of the South African National AIDS Council (SANAC) with technical support from the UNAIDS Country Office in South Africa and local experts on each of the target areas. The *2013 Global AIDS Response Progress Report* has benefited from wide consultations and data collection processes which took place between January and May 2013.

This report would not have been possible without the active participation of scientists, activists, health providers and many of the HIV and TB stakeholders, and representatives from government, civil society, business and our development partners. We thank them for their support and active engagement during this process.



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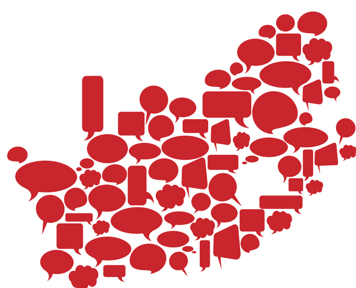

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Executive Summary

EXECUTIVE SUMMARY

Thirty years into the AIDS epidemic, and 10 years since the landmark UN General Assembly Special Session (UNGASS) on HIV/AIDS, leaders came together at the 2011 UN General Assembly High Level Meeting on AIDS from 8–10 June 2011 in New York. They reviewed progress and adopted a new Political Declaration that includes new commitments and bold new targets to accelerate momentum in the AIDS response.

The 2011 Declaration builds on two previous Political Declarations: the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS. In 2001, Member States unanimously adopted the UNGASS Declaration of Commitment on HIV/AIDS. This Declaration reflected global consensus on a comprehensive framework to achieve Millennium Development Goal Six: halting and beginning to reverse the HIV epidemic by 2015. It recognised the need for multi-sectoral action on a range of fronts and addressed global, regional and country-level responses to prevent new HIV infections, expand health care access and mitigate the epidemic's impact. The 2006 Political Declaration recognised the urgent need to achieve universal access to HIV treatment, prevention, care and support.

The United Nations General Assembly 2011 Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS set ambitious targets to be achieved by 2015. The framework provides a core set of indicators to reflect the new targets and elimination commitments. The Declaration requested that the UN Secretary General report to the General Assembly on progress in implementation, in accordance with the global reporting on the Millennium Development Goals at the 2013 and subsequent Millennium Development Goal (MDG) reviews.

In 2013, the international community will **review midpoint progress towards reaching the Ten Bold Targets** set in the Political Declaration for 2015; notably:

1. To reduce sexual transmission of HIV by 50%;

2. To reduce transmission of HIV among people who inject drugs by 50%;

3. To eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths;

4. To reach 15 million people living with HIV with lifesaving antiretroviral treatment;

5. To reduce tuberculosis deaths in people living with HIV by 50%;

6. To close the resource gap;

7. To eliminate gender inequalities, gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV infection;

8. To eliminate stigma and discrimination against people living with HIV;

9. To eliminate HIV-related restrictions on entry, stay and residence; and

10. To eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in health and development efforts.

Intensifying Our Efforts to Eliminate HIV and AIDS set ambitious targets to be achieved by 2015.

Results of the Mid-term Review

The mid-term review is a stocktaking exercise that assesses each target and provides a consolidated analysis and summary report (see Annex 1). Targets 1, 2, 3, 4, 5, 6, 7, 8 and 10 have been prioritised and South Africa's National Strategic Plan on HIV, STIs and TB, 2012-2016 (The NSP) explicitly addresses these. Across each of the 'Ten Targets' this review notes that South Africa **has achieved target 9** and is **on track to reach targets 1, 3, 4, 6, 8, and 10.**

With respect to the remaining targets (5, 7 and 8):

With regard to **target 5**, South Africa is behind target. The reduction by 50% of TB deaths among people living with HIV is, however, a strategic priority and receives strong emphasis in the NSP. Adjusted for population, South Africa's TB incidence rate is the highest among the 22 countries listed by the WHO as 'TB high burden countries'. Moreover, South Africa has among the world's highest levels of TB/HIV co-infection. In spite of being behind target, South Africa has made significant gains

EXECUTIVE SUMMARY

since 2008 in reducing TB prevalence and mortality and in improving the TB cure-rate. 2012 saw the unveiling of a new strategy to intensify case finding at community and household level, the implementation of a massive national GeneXpert roll-out to improve diagnosis and a programme for improving the management of MDR-TB. South Africa has also spearheaded regional TB control efforts in the form of the *SADC Declaration on TB in the Mining Sector*, and the incorporation within national policy of the findings of the Thibela TB study to provide at least 36 months of IPT to PLHIV.

Progress against **target 7** – eliminating gender inequalities and sexual violence as well as increasing capacities of women and girls – is more nuanced. Again this target is difficult to measure and while South Africa has made significant progress – and has been lauded internationally for this progress – we continue to feel that more can be done to reduce gender-inequality and violence against women.

In respect of **target 8**, eliminating stigma and discrimination against people living with HIV, this target **is a significant priority for South Africa and one that we are working hard towards**, but it is a target that is difficult to measure objectively. **Significant progress has been made** over the last three to four years to significantly reduce self-reported stigma and previously high levels of HIV-related discrimination for people living with HIV, although the country still experiences high levels of violence towards sexual minorities. South Africa is working hard to implement a Stigma Index to objectively monitor efforts to reduce stigma and discrimination. While the country asserts that it is on track to achieve Target 8, we also recognise that much more needs to be done to reduce discrimination towards sexual minorities and stigma in general.

The review identifies and discusses the main achievements to date with regard to these targets and commitments. Within the assessment of each target the review presents key gaps and opportunities for delivering services more efficiently. Key recommendations that were outlined and agreed during the review process include increased and/or more strategic investment, the need to improve the efficiency of service delivery and options for sustaining progress on the 10 priority targets beyond 2015.

ACRONYMS

APP	Annual Performance Plan
CDA	Central Drug Authority
CHAI	Clinton Health Access Initiative
CSO	Civil Society Organisations
SW	Sex Worker
DBE	Department of Basic Education
DOH	Department of Health
DHIS	District Health Information System
DSD	Department of Social Development
GFATM	Global Fund for HIV, TB and Malaria
HCT	HIV Counselling and Testing
HE²RO	Health Economics and Epidemiology Research Office
HLM	High level meeting
HSRC	Human Sciences Research Council
IDU	Injection Drug Use
KYE	Know Your Epidemic
KYR	Know Your Response
MTEF	Medium Term Expenditure Framework
MDG	Millennium Development Goal
MATCH	Multi-Country Analysis of Treatment Costs for HIV
MMC	Medical Male Circumcision
MTR	Mid-term Review
NACM	National ART Cost Model
NASA	National AIDS Spending Assessment
NCPI	National Commitments and Policy Instrument
NDOH	National Department of Health
NDMP	National Drug Master Plan
NDP	National Development Plan
NHI	National Health Insurance

ACRONYMS

NHLS	National Health Laboratory Services
NHIRD	National Health Information Repository Data warehouse
NIMART	Nurse Initiated Management of ART
NSP	National Strategic Plan
NTCM	National TB Cost Model
NTP	National TB Programme
OVC	Orphans and Vulnerable Children
PETS	Public Expenditure Tracking Survey
PEPFAR	President's Emergency Plan for AIDS Relief
PIC	Programme Implementation Committee of SANAC
PLHIV	People Living with HIV
PSP	Provincial Strategic Plans
PWID	People who Inject Drugs
PWUD	People Who Use Drugs
SANAC	South African National AIDS Council
SRH	Sexual Reproductive Health
STI	Sexual Transmitted Infections
SW	Sex Worker
TB	Tuberculosis
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organisation

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FORMINAL
Metformin HCl

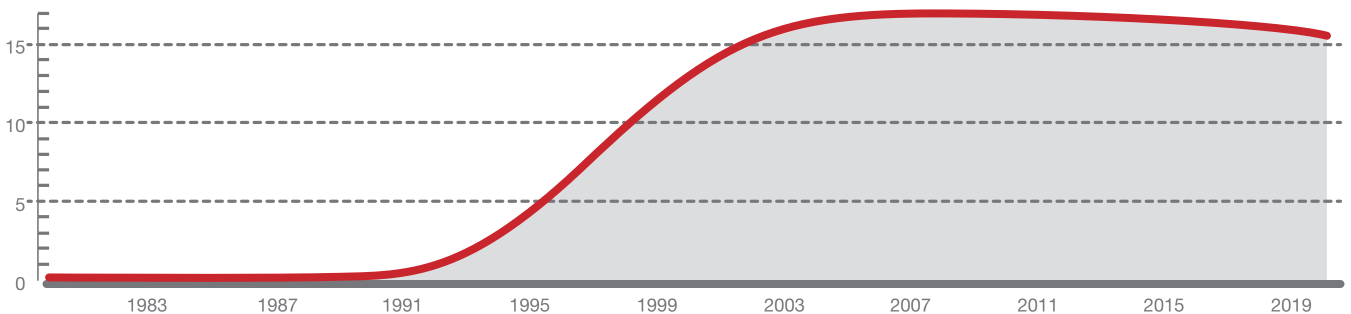
Background

SECTION 1: BACKGROUND

Overview of the HIV epidemic in South Africa

South Africa has a generalised HIV epidemic driven largely by heterosexual transmission. Data from population-based surveys and sentinel surveillance of pregnant women suggest that the HIV epidemic has reached a plateau, although HIV prevalence rates are rising as a result of an extensive ART programme. According to modelling using the 2013 UNAIDS Spectrum model the estimated national HIV prevalence among the general adult population aged 15-49 years old peaked in 2008 at 16.9% and then declined slightly and is levelling off at around 17.9% [17.3%-18.4%] 2012. The estimated number of adults and children living with HIV in South Africa rose from 5,200,000 in 2005 to 6,100,000 [5,800,000-6,400,000] in 2012. According to preliminary data from the 2012 HSRC National HIV Prevalence and Behavioural Risks Household Survey, HIV prevalence as a result of the ART programme could be as high as 6,4 million.

Figure 1: South Africa Adult HIV Prevalence (15 – 49 years), 2012

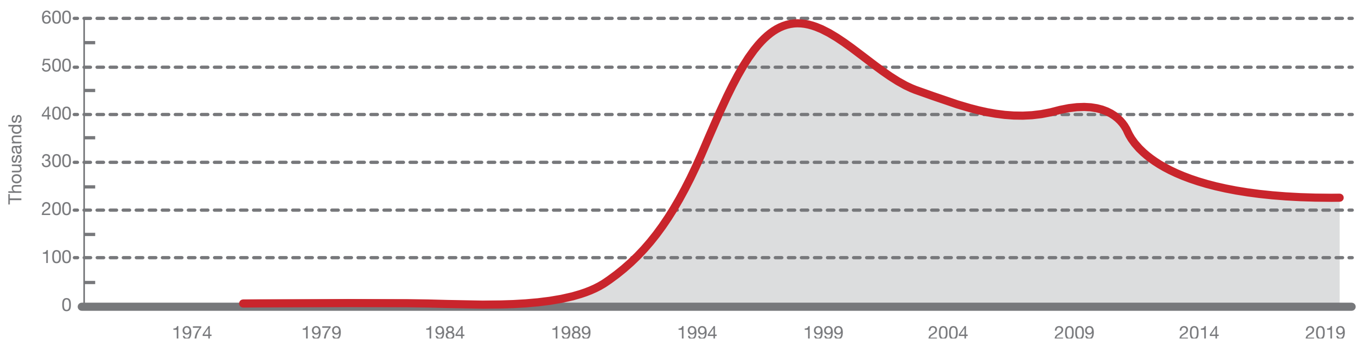


[Source: UNAIDS Spectrum, 2013]

Rates of HIV infection – HIV incidence – in South Africa continue to decrease. The number of new infections among adults aged 15 – 49 years is estimated to decrease from 460,000in 2010 to 215,000 in 2016 – representing a 48% decline in new infections. Between 2011 and 2012, the number of new infections declined by 79,000. Spectrum modelling estimates that HIV incidence in adults 15 -49 years has declined by 22% between 2009 and 2012, from 1.75% in 2009 to 1.37% in 2012, and is expected to decline further to 1.03% by 2016 representing a 40% decline). HIV incidence for 15-24 years dropped from 2.2% in 2009 to 1.7% in 2012 and is estimated to drop to 1.3% by 2016.

SECTION 1: BACKGROUND

Figure 2: South Africa Adult HIV Incidence (15 – 49 years), 2012

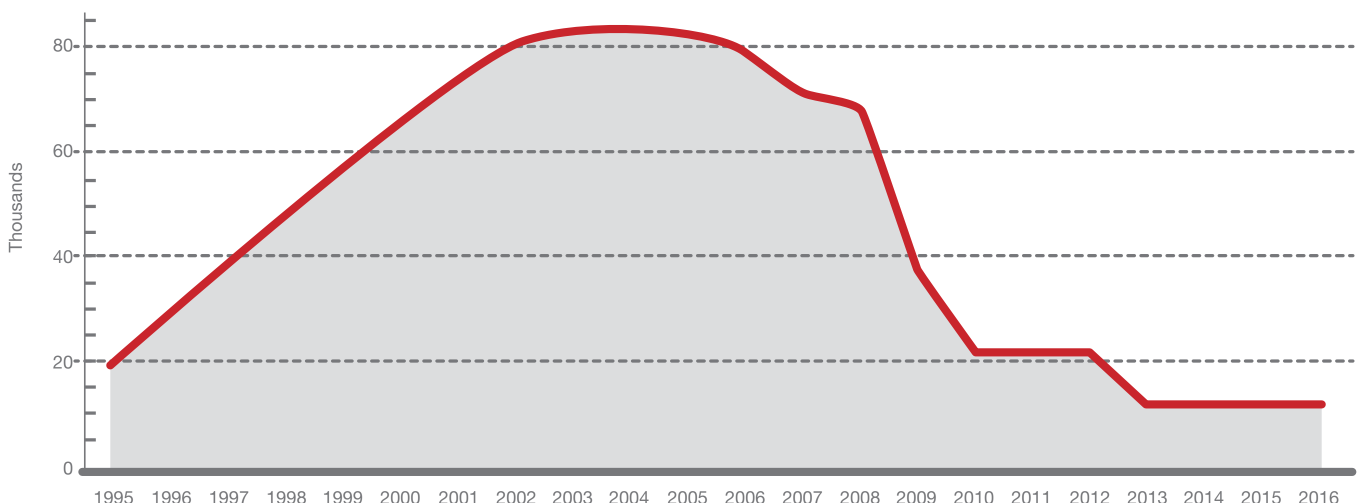


[Source: UNAIDS Spectrum, 2013]

The most dramatic declines in HIV incidence in recent years is due to the acceleration of Prevention of Mother-to-Child Transmission (PMTCT) services. A National survey of the PMTCT programme measured the perinatal MTCT rate at 4-8 weeks of infant age and found transmission rates to be below 2.7%.

The number of new infections among children (0-14 years) dropped by 80% from 82,000 in 2005 to an estimated 21,000 [19,000-32,000] in 2012 (UNAIDS Spectrum, 2013). Matching HIV prevalence among children ages 2-14 from Spectrum to the 2008 HSRC survey show a fairly close match (2.6% from Spectrum compared to 2.5% from 2008 HSRC population survey).

Figure 3: South Africa New Infections among Children (birth – 14 years), 2012



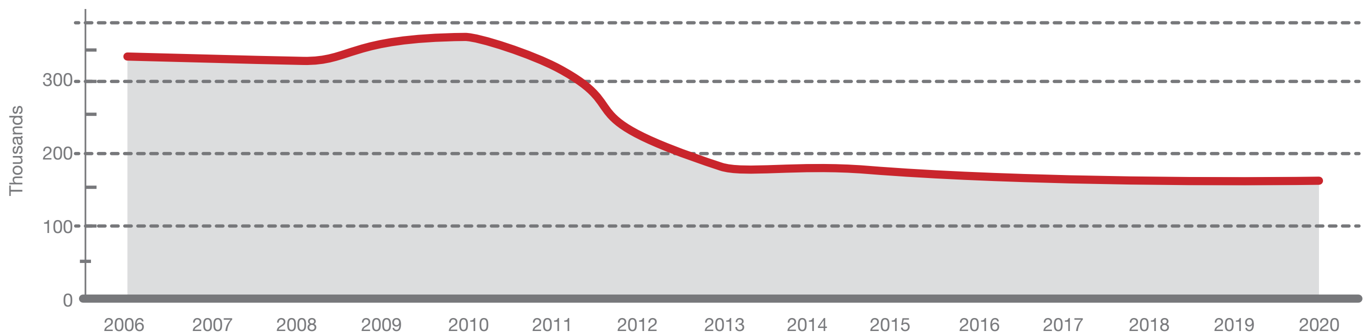
[Source: UNAIDS Spectrum, 2013]

SECTION 1: BACKGROUND

There are also encouraging signs that the number of young females aged 15-24 years living with HIV has decreased from 870,000 [810,000 – 1,100,000] in 2005 to 710,000 [660,000 – 860,000] in 2012. However, women 15 years and older are estimated to constitute 3,400,000 [3,200,000 -3,600,000] of the total number of adults living with HIV in 2012.

There is a substantial decrease in AIDS related mortality from 2010, with the annual number of AIDS deaths reduced from about 350,000 [330,000 -390,000] in 2005 to about 240,000 [220,000 – 270,000] in 2012. Mortality however remains high among HIV+ adults who are not receiving ART in 2012. This is estimated at 150,000 in 2012 compared 50,000 deaths among those who are receiving ART (UNAIDS Spectrum, 2013).

Figure 4: South Africa Annual AIDS Deaths, 2012



[Source: UNAIDS Spectrum, 2013]

South Africa currently has the third highest Tuberculosis (TB) burden globally, with a reported incidence that has increased by over 400% over the past 15 years. Close to 80% of the South African population has TB bacilli, but most people who are infected will not develop active TB disease from the dormant bacterium. Certain populations are, however, at higher risk of developing active TB infection and/or re-infection, including those living with HIV as well as healthcare workers, mineworkers, populations in correctional facilities, correctional service officers and household contacts of confirmed TB patients.

SECTION 1: BACKGROUND

The highest prevalence of latent TB infection (around 88%) occurred among people aged 30–39 years living in townships and informal settlements. This underscores the fact that TB thrives in conditions of overcrowding and poverty. Certain groups are particularly vulnerable to progressing from TB infection to disease such as children, people living with HIV, diabetics, smokers, alcohol and substance users, people who are malnourished or have silicosis, mobile, migrant and refugee populations, and people living and working in poorly ventilated environments.

TB is the leading cause of death in South Africa and is the leading preventable cause of death among people living with HIV. HIV and TB co-infection rates in South Africa exceed 60%, with TB being the most common opportunistic infection among PLWHIV. Furthermore, children aged 0-7 years represent 16% of all new TB cases, and 25% of children with TB are HIV positive.

TB is the leading cause of death in South Africa and is the leading preventable cause of death among people living with HIV.

MID-TERM REVIEW PROCESS AND METHODOLOGY

This review assessed South Africa's progress towards achievements the Ten Targets of the 2011 United Nations General Assembly Political Declaration on HIV/AIDS.

Purpose

There were three key purposes to conducting the mid-term review:

1. Reaffirm and strengthen the **leadership commitment** necessary to achieve the Political Declaration targets and elimination commitments.

2. **Strengthen accountability** and country ownership of the Global AIDS Progress Reporting and increase transparency on progress made to achieve the targets and commitments of the Political Declaration on HIV/AIDS.

3. Promote principles of **shared responsibility and global solidarity** regarding HIV investments and identify solutions for the long term sustainability of national AIDS responses.

Questions

The South African review process was guided by the overarching question of "are we on track to achieve the 2015 Political Declaration targets?" Five specific review questions guided the review process at country level. The questions were:

1. Are the national HIV targets aligned with the Political Declaration?

2. Is the country on track to reach the targets?

3. What actions have been taken or planned to reach the targets?

4. What are the key challenges preventing the "Ten Targets" from being reached?

5. What policy changes and/or new investments are required to reach the targets?

MID-TERM REVIEW PROCESS AND METHODOLOGY

Is the country on track to reach the targets?

Methods and Key Steps

In order to address the review's questions, four methods were employed through a five step process. The methods used included a: (1) desk review, (2) key informant interviews, (3) group meetings and a (4) national stakeholder meeting. The approach included several steps. *First*, the initial desk review included empirical documents that were collected for each target area, reviewed against the mid-term review questions, and summarised. *Second*, these findings were triangulated through key informant and group interviews. During this step key informants reflected on current findings, and then provided additional documents, expert interpretation of all data, and informed recommendations. *Third*, these revised findings were then consolidated into a report, organised by each target. These reports focused on the progress and impediments for reaching each target. *Fourth*, each report was then vetted with relevant stakeholders at an intensive National Stakeholders' Consultation and revised based on written and verbal feedback. *Fifth*, the drafts were then provided to key stakeholders for a final review. The National Stakeholder Consultation process is discussed further below.

National Stakeholders' Consultation

South Africa's national stakeholders' consultation was held on 16th April 2013. The country consultation involved the main stakeholders that lead, manage and implement the national HIV and TB response. This consultation included SANAC, key implementing partners, relevant government departments, civil society representatives (including PLHIV and representatives of other key populations) as well as relevant development partners.

The main purpose of the consultation was to create an opportunity for:

- Appraising progress made in addressing the "Ten Targets" of the 2011 UN General Assembly Political Declaration on HIV and AIDS at mid-course;
- Identifying and discussing issues of target setting, prioritisation of interventions and allocation of resources; and
- Formulating and agreeing upon a set of recommendations to change course, accelerate action and re-programme resources.

MID-TERM REVIEW PROCESS AND METHODOLOGY

More specifically, participants undertook the following during the national consultation:

- Reviewed and validated the findings from the stocktaking exercise, including progress made target-by-target, as well as key challenges and constraints in addressing the targets;
- Assessed whether the country is on track to reach the priority targets;
- Defined a set of recommendations to:
    i. adopt or accelerate key programmatic actions necessary to stay on track and/or achieve priority targets;
    ii. trigger the changes in policy and/or enabling environment actions necessary to stay on track and/or achieve priority targets;
    iii. encourage the new investments necessary to stay on track and/or achieve priority targets;
- Developed a clear roadmap to ensure the implementation of proposed recommendations by end of 2013;
- Discussed and proposed a way forward to sustain progress along the priority targets beyond 2015.

Through the national review:

- National **priorities and targets through the end of 2015** were reconfirmed;
- Main **achievements** to date with regards to "Ten Targets" were identified and analysed
- **Key gaps, and opportunities for innovative and more efficient service delivery and increased domestic investment** were also identified;
- Changes in **policies** and the focus of key programmes were proposed;
- **Accelerated actions in under-performing targets** were identified; and

- Recommendations for **increased and/or more strategic investments and efficient service delivery** were agreed upon by all stakeholders.

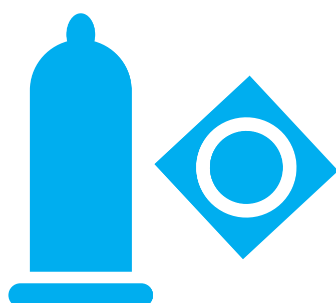
This national report summarises the **key findings and recommendations** to improve the likelihood of South Africa achieving the targets of the 2011 United Nations General Assembly Political Declaration on HIV/AIDS which are targets relevant to the country and addressed by the NSP. The report provides a critical appraisal of progress towards the **Ten Targets**. It identifies constraints and gaps and proposes a course of action to achieve each of the HLM targets and reports on the Global AIDS Response Progress Reporting (formerly UNGASS) indicators and WHO Universal Access indicators.

The report provides a critical appraisal of progress toward the Ten Targets.

Stocktaking Exercise:
TARGET-BY-TARGET REVIEW

SECTION 2: STOCKTAKING EXERCISE: TARGET-BY-TARGET REVIEW

TARGET 1: Reduce Sexual Transmission by 50% by 2015



- Is this a priority target for the country?
  YES
- Does the National Strategic Plan address this target?
  YES
- Is the country on track to reach the target and commitment?
  YES

1. What key actions have been taken to reach this target since 2011?
   As can be seen from the Deputy President's foreword to this review the increased focus on scaling-up and improving the efficiency and precision of national HIV and TB prevention interventions is driven by strong political commitment from the highest levels of government.

   The most important change since 2011 has been the adoption of the 2012-2016 National Strategic Plan for HIV, STIs and TB (the NSP). Whereas earlier iterations of the NSP focused on accelerating the roll-out of ART the latest NSP emphasises HIV prevention at the level of the structural drivers as well as interventions to address primary and secondary prevention. Moreover, prevention interventions gained momentum during the consensus building approach adopted for the development of the NSP.

   HIV counselling and testing (HCT) services are considered the backbone of the response as knowledge of one's HIV and TB status is essential for triaging each client into the appropriate treatment and/or prevention programme. Today, HCT services are available in more than 90% of public health facilities.

   South Africa's ART programme provides anti-retroviral treatment to more than 2 million patients. While this has already led to dramatic improvements in life expectancy it is anticipated that early initiation and then retention on the ART programme will assist in reducing the

Reduce Sexual Transmission by 50% by 2015

sexual transmission of HIV. In spite of the treatment programme the focus of the national effort has now been redirected to preventing new infections.

A recent statement of intent has been the revision by the National Department of Health (NDoH) of the 2016 national target for male medical circumcision. The NSP target has been revised upwards from 1.6 million to 4.2 million. At present 55% of South African men are circumcised. 4.2 million circumcisions will achieve "full coverage" – or 80% – of all adult males being circumcised. If this new target is achieved, and the NDoH and development partners have directed efforts and resources to ensure that it is, the estimates are that this will prevent half-a-million new HIV infections and avert 100,000 deaths within a decade. By 2016, each circumcision performed will avert 5 new HIV infections. Towards this target a total of 422,009 male medical circumcisions were conducted in 2012, with a target of 900,000 in 2013 and each subsequent year.

In an effort to better target prevention interventions on the basis of the *Know Your Epidemic* and *Know Your Response* reviews the prevention response has directed efforts towards addressing the needs of key populations. Within this, attention is being paid to the needs of sex workers, men-who-have-sex-with-men (MSM), inmates in correctional facilities and awaiting trial prisoners. For example, the national sex workers programme will be launched later in 2013.

To enhance the prevention effort among the youth and to try to ensure that they remain HIV negative, the National Department of Basic Education and the NDoH have collaborated to implement the Integrated School Health Programme (ISHP). This programme aims to increase the provision of accessible HIV prevention and sexual reproductive health (SRH) services (as well as youth-friendly health services) within the school context. The key activities are focused on the provision of comprehensive sexual education and SRHR services that include referral and linkages to appropriate community services.

2. What key challenges or constraints have been encountered in addressing this target?

There are a number of factors that constrain reaching this target: (1) socio-cultural determinants or risk-enhancing factors such as alcohol abuse, violence against women, and socio-economic insecurity; (2) sexual behaviours such as multiple concurrent sexual partnerships and inter-generational sex; (3) the impediments which limit the

effectiveness of interventions aimed at addressing the vulnerability to HIV, STIs and TB of key populations such as inmates, migrant and mobile populations and rural communities; (4) the need to increase domestic funding of HIV prevention programmes.

A lack of data also affects this target in multiple ways. While the specific measurement of HIV incidence remains difficult and continues to be achieved through modelling on the basis of prevalence, other general programme-management and finance data could be improved. Furthermore, achieving coverage in remote rural communities and amongst hard-to-reach populations is an on-going challenge. Innovative service delivery approaches such as the use of roving teams and mobile services are being tested.

Finally, sustainable prevention interventions require a paradigm shift in perceptions amongst all sectors of society with regards to sexuality and established social norms and culture.

3. What are the key programmatic actions necessary to stay on track and/or achieve this target?

The single biggest prevention priority for South Africa is to reduce new infections among young women and girls between the ages of 15 and 24 through, inter alia, reducing inter-generational and transactional sex. Specific programmes to tackle this priority should be customised for various categories of young women and girls including those in school, out-of-school, in informal settlements and rural areas, in universities and FET colleges and those engaged in sex work. There are significant plans underway to target each of these groups of young women and girls. A key intervention is to reduce the high dropout rate of young women and girls from schools and the Integrated School Health Programme will significantly address the provision of reproductive health services in schools.

Planners and implementers need to know where and why HIV infections are occurring, what the current response is and what the additional resources and other needs are to prevent these infections. Enhanced data collection and analysis will support achievement of this. For example, identifying gaps in services and areas of high HIV infection will support an effective response to the next 1000 infections. Finally, there should be continued support provided to civil society to strengthen their role in the HIV prevention response.

SECTION 2: STOCKTAKING EXERCISE: TARGET-BY-TARGET REVIEW

There are three key programme areas in which to focus. *First*, delivery of tailored combination prevention packages in rural, urban, prison and school-based settings that are viewed as 'friendly' by the target key population and will facilitate increased access. (This will include the scale-up of current programmes that address risks and vulnerabilities of key populations). *Second*, comprehensive condom programming is needed that generates demand for condoms and their effective and consistent use as a dual method for family planning and STI and HIV reduction. This will also require strengthening procurement, supply-management and logistics systems so as to ensure adequate distribution and stock-control. *Third*, scale up of implementation of the Integrated School Health Programme.

More general recommendations include strengthening linkages between HCT programmes and care; bringing together traditional and medical approaches for MMC interventions; expanding programmes currently underway for key populations (including the farming community, mineworkers, people in detention and mobile populations); establishing and maintaining efficient referral systems (particularly between the health sector and the community) and improving programmes that address the needs of other key populations. Finally, there should be continued support provided to civil society to strengthen their role in the HIV prevention response.

...sustainable prevention interventions require a paradigm shift in perceptions...

4. **What policy and enabling environment changes are required to reach the targets?**

The first step in improving the coordination and management of South Africa's HIV prevention response across all sectors is to prepare from the NSP a single overarching national HIV Prevention "Marshall Plan". Structural drivers identified in the NSP need to be converted within this Prevention "Marshall Plan" into effective programmes that tackle poverty, gender norms, gender-based violence, alcohol & substance abuse and sexuality education.

In general, prevention responses need to consider the social and cultural context in which they are attempting to create change. HIV prevention efforts must be grounded in evidence and human rights and targeted at overcoming endemic gender inequality. To achieve this there needs to be a well-coordinated multi-sectoral response where HIV is integrated into appropriate government departments' annual *Progress Plans* and where Provincial Strategic Plan (PSP) activities are integrated into departmental Work Plans. These will require sufficient resources and a robust monitoring and evaluation framework.

5. **What new investments are necessary to keep on track and/or achieve this target?**

   There needs to be increased commitment to funding HIV prevention programmes. *First*, a specific focus should be on young women and girls as this group continues to face an increased risk of HIV infection. *Second*, there is an urgent need to invest in the scale-up of evidence-informed HIV prevention efforts. The long-term success and sustainability of the national ART programme is dependent upon the effectiveness of national efforts to significantly reduce the incidence of new infections.

   Investments will be made to address the gaps identified above, including funding research – particularly towards gaining a better understanding of the social and structural determinants. Furthermore investments will be directed towards the development of improved programmes for the disabled and other populations at higher risk of HIV infection. This means: collect, compile and disseminate data on all relevant *Global AIDS Response Progress Reporting* indicators, including more specific strategic information, with age and sex-disaggregated data.

6. **What are the recommendations to national stakeholders to ensure implementation of suggested changes?**

   National stakeholders should continue to support further civil society involvement in the HIV prevention response at sub-national levels. Enhanced collaboration is needed among government departments, NGOs and economic and financial institutions to harness HIV prevention efforts directed at key populations. In support of such collaboration, the national HIV Prevention "Marshall Plan" should include a supportive information and communication strategy that draws on and actively engages established networks so as to harmonise, unify and thereby strengthen the overall national response. National stakeholders should support the identification of empirically based programmes and advocate for their scale-up, and concomitantly, consider the scaling-down of programmes that are not evidence-informed. On-going review and monitoring of programmes will contribute significantly to programme success. Finally, leaders in the HIV prevention response should identify key policies, frameworks, and guidelines that, if addressed, will significantly influence the achievement of the '50% reduction in HIV incidence' target.

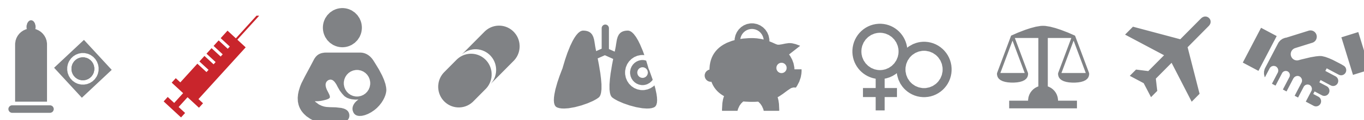
7. What are the recommendations for sustaining progress along this target beyond 2015?

   South Africa will continue to increase its investments in prevention programming, particularly in innovative interventions that contribute to a reduction in new infections. Indeed, as called for in South Africa's National Development Plan (NDP), the county must "set mid-term targets towards the 2030 [HIV reduction] objectives". This NDP goal of dramatically reducing new HIV infections by 2030 must dominate the HIV prevention agenda post-2015.

   Efforts to address the structural drivers and socio economic root causes of HIV transmission will be strengthened. The government will increase investments in HIV vaccine research given the pivotal role of South Africa in vaccine development. Energies will also be directed at improving the measurement of HIV incidence and the identification of the sources of new HIV infections with a view to greater precision and monitoring in prevention programming. New incidence testing technologies hold significant potential for this.

There needs to be increased commitment to funding HIV prevention programmes.

SECTION 2: STOCKTAKING EXERCISE: TARGET-BY-TARGET REVIEW



Target 2: Reduce Transmission of HIV among People who Inject Drugs by 50% by 2015

- Is this a priority target for the country?
  NO
- Does the National Strategic Plan address this target?
  YES
- Is the country on track to reach the target and commitment?
  NO

In 2010, South Africa conducted an in-depth analysis of the HIV epidemic. The findings of this review contained in the Know Your Epidemic Report (KYE) highlight that Injecting Drug Use does not contribute significantly to HIV transmission in South Africa. Nevertheless, South Africa's NSP identifies "people who use illegal substances, especially those who inject drugs" as among the key populations at higher risk of acquiring and transmitting HIV. Indeed, the NSP itself highlights research that 65% of surveyed injecting drug users practise unsafe sex. Injecting drug use and unprotected sex are both taking place within a rising tide of substance abuse in South Africa in general.

The country currently addresses the inter-linkage between People Who Inject Drugs (PWID) and HIV as a component within a broader strategy to address substance abuse. Regulations under the Prevention of and Treatment for Substance Abuse Act (No 70 of 2008) came into effect on 2 April 2013. Substance-abuse prevention and treatment models for adults are being implemented. Operational Guidelines for key populations have also been developed and include elements relating to a needle-exchange programme and opioid substitution therapy (UNAIDS internal report, 2012).

The KYE review, however, highlighted that only limited data is available on PWID and that HIV prevalence among PWID is unknown. It has thus reinforced the need to incorporate within South Africa's existing

Reduce Transmission of HIV among People who Inject Drugs by 50% by 2015

national drugs legislation and policy interventions, measures to reduce HIV transmission among people who inject drugs. As a starting point SANAC has initiated a size-estimation and prevalence survey and will work with the United Nations Office on Drugs and Crime (UNODC) and other partners to strengthen the HIV prevention response among IDU and other drug users.

1. What key actions have been taken to reach this target since 2011?

   The National Strategic Plan 2012-2016 (NSP) recognised the growing problem of illegal substance use including injecting drug use and associated HIV vulnerability risks. It noted the need to scale-up harm-reduction programmes and remove barriers preventing provision of services to people who use drugs.

   The second Biennial Summit on Substance Abuse held in 2011, supported South Africa's Central Drug Authority (CDA) to develop the National Drug Master Plan (NDMP), 2013-2017, [in terms of the Prevention and Treatment of Drug Dependency Act (20 of 1992), as amended as well as the Prevention of and Treatment for Substance Abuse Act (70 of 2008), as amended].

   The NDOH Mini Drug Master Plan (2011/2012-2013/14) supports harm reduction interventions. While no South African guidelines exist, the Department of Social Development (DSD) and the CDA are in the process of reviewing the definition of 'harm reduction' to fit the South African context (DSD – National Drug Master Plan (2013 – 2017) and NDOH Mini Drug Master Plan (2011/12-2013/14).

   Two key programmes were implemented in 2012. Based on an extensive mapping effort a database that lists key stakeholders (national and provincial substance abuse policy influencers, decision makers and policy beneficiaries) was established. Secondly, a multifaceted pilot harm reduction programme was launched for Men who have Sex with Men (MSM) who use drugs, including those who inject drugs.

   A NGO led process facilitated the development of sensitisation training manuals and an operational guideline for People Who Inject Drugs (PWID) and Other People Who Use Drugs (PWUD) for Health Care Workers (HCW) and the training and sensitization of 400 Health Care Workers. Other sensitisation efforts include the initiation of a combined MSM, PWID and Sex Worker (SW) health worker

sensitisation training, and planned development of manuals and audio visual tools that will be piloted with 500 health workers. This training will eventually be integrated into the NDOH training curricula. Operational Guidelines for key populations have also been developed that include elements relating to needle syringe programme and opioid substitution therapy.

In terms of research, the UN Joint Team on AIDS, in collaboration with the Central Drug Authority and the NDOH, plans to conduct a Rapid Assessment and Response (RAR) of PWID and HIV-related risks in 3 Provinces and 4 cities. The protocol is currently awaiting ethics committee approval and recruitment has started in anticipation of the protocol being approved.

2. **What key challenges or constraints have been encountered in addressing this target?**
   As stated above, Injecting Drug Use is currently not a significant factor in HIV transmission. An integrated substance abuse prevention strategy is in place.

3. **What are the key programmatic actions necessary to stay on track and/or achieve this target?**
   Generating strategic information would greatly support achievement of this target. *First*, activities that will generate PWUD and PWID size estimates and provide HIV surveillance information needed to inform the scope and nature of substance abuse in South Africa and its relationship to HIV and TB. *Second*, research based on government and NGO information-needs would inform a strategic harm-reduction strategy that would underpin programme planning.

4. **What policy and enabling environment changes are required to reach the targets?**
   Operationalising the Mini Drug Master Plan and reassessing the NDOH treatment policy on OST and methadone for its relevance and usefulness would further guide programmatic actions, as would the development and implementation of a national harm reduction policy in line with the Comprehensive Package of Services of HIV Prevention and Care among PWID.

5. **What new investments are necessary to keep on track and/or achieve this target?**
   Funds need to be committed in several areas. Primarily, funds are needed to support HIV prevention for PWID programmes identified as effective and efficient, particularly in 'hot spot' areas. Funding is needed to establish PWID and PWUD baseline population size estimates and HIV prevalence and risk behaviour estimates.

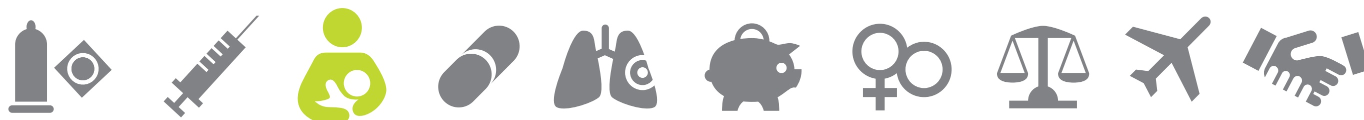
   There should be investment in developing IEC materials on Drug Use and HIV for different stakeholder groups that support raising awareness and sensitisation programmes on PWID/PWUD, HIV and TB and human rights.

6. **What are the recommendations to national stakeholders to ensure implementation of suggested changes?**
   SANAC needs to work closely with the NDOH, DSD, UNODC and other partners to estimate the size of the PWID problem in South Africa and to locate pockets of high prevalence. SANAC should also work with its partners to strengthen programming in these areas of high prevalence, including making substitution therapy available at least in the three largest cities where there are established PWID communities.

7. **What are the recommendations for sustaining progress along this target beyond 2015**
   Specific gaps in monitoring and evaluation data should be addressed, and key research carried out where data is currently not available. These data can then be continually used to inform policy and programmes. Appropriately informed government departments and a knowledgeable civil society will help to ensure that HIV and TB interventions targeting PWID/PWUD are included in the NSP implementation plan and that identified interventions in relevant departmental Annual Performance Plans (APPs) are funded.

...Injecting Drug Use is currently not a significant factor in HIV transmission.

SECTION 2: STOCKTAKING EXERCISE: TARGET-BY-TARGET REVIEW



TARGET 3: Eliminate Mother-to-Child Transmission of HIV by 2015 and Substantially Reduce AIDS-related Maternal Deaths

- Is this a priority target for the country?
  YES
- Does the National Strategic Plan address this target?
  YES
- Is the country on track to reach the target and commitment?
  YES

South Africa rapidly scaled up its Mother-to-Child Transmission of HIV (MTCT) programme with the introduction of 'Dual Therapy' when AZT was commenced from 28 weeks of gestation and single-dose Nevirapine was given in labour whilst HAART was being provided for women with CD4 counts of less than 200. Government also scaled up its efforts to improve Early Infant Diagnosis (EID) by increasing the capacity for PCR testing at primary health care facilities. By 2010, the South African government revised the MTCT guidelines to include AZT from an earlier start from 14 weeks of gestation and HAART for all pregnant women with CD4 cell counts less than or equal to 350, and infant Nevirapine prophylaxis for six weeks (if the mother is on HAART or not breastfeeding) or until one week post cessation of breastfeeding (similar to WHO Option A). This change was followed by a decision to implement an exclusive breastfeeding policy nationwide, with antiretroviral cover for breastfeeding HIV positive women, in April 2013, to improve infant HIV-free survival. Between 2010 and 2011 early MTCT dropped from 3.5% to 2.7%. Results from the 2012 transmission survey will be available by the end of the year.

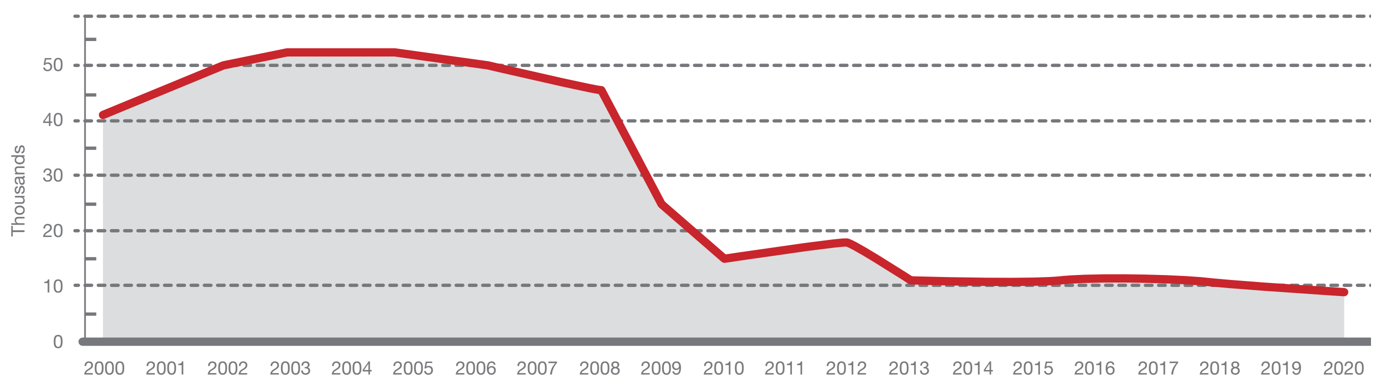
In 2010, MTCT services were offered in 98% of health facilities and by 2011 approximately 274,000 pregnant women were tested. Public data sources show that around 87% of eligible women are receiving ART nationally, an increase on 83% in 2009.

Eliminate Mother-to-Child Transmission of HIV by 2015 and Substantially Reduce AIDS-related Maternal Deaths

SECTION 2: STOCKTAKING EXERCISE: TARGET-BY-TARGET REVIEW

The graph below shows that the number of infants needing ART has declined steadily since 2004. In 2012, approximately 17,000 infants were in need of ART, a reduction from 26,000 in 2009 (UNAIDS Spectrum, 2013).

Figure 5: South Africa: Infants needing ART



1. **What key actions have been taken to reach this target since 2011?**
   The DOH is leading the effort to meet the goals of elimination of MTCT with joint technical support and strong partnerships with multiple partners. Donor agencies, civil society partners and community organisations worked together to identify the bottlenecks and priority action areas for MTCT. This informed the development of the South Africa action framework: "No child born with HIV by 2015 in South Africa and Improving the Health and Well-being of Mothers, Partners and Babies." The action framework is linked to the NSP and has four components: (1) strategic, (2) financial, (3) management, and (4) monitoring. These are efforts to improve other routine paediatric services, including early infant diagnosis and paediatric ART.

   The PMTCT Action Framework is being implemented and managed at national, provincial and district levels through annual business plans. The business plans are financed by the government and the monitoring framework defines clear targets and timelines. The monitoring framework guides various data collection and analysis exercises at multiple levels, thus enabling planners and programme managers to prioritise actions. Three key priority areas are early antenatal booking, retesting HIV negative women during pregnancy and post-delivery and updating antiretroviral regimens based on current evidence.

SECTION 2: STOCKTAKING EXERCISE: TARGET-BY-TARGET REVIEW

District-based Data for Action Workshops and Reports:
The National Department of Health and United Nations Children's Fund (UNICEF) have held workshops on how to use data for action in all districts. Data for action reports are generated monthly using the District Health Information System (DHIS) and the National Health Laboratory Service (NHLS) data for provinces and districts. The MTCT dashboard highlights progress in key indicators and scores. The National Department of Health (NDOH) approved the 'Blueprint for Action: addressing paediatric and adolescent (0-19 years) HIV and TB, prevention, early identification of HIV and TB, treatment, care and support 2012-2016." Monitoring tools have been developed to monitor data from nutrition, social protection, education and related child health programmes. This will provide a more holistic approach to understanding challenges and gaps in the paediatric and adolescent approach to HIV and TB treatment. Improved data has informed MTCT planning. This is evident in the Data for Action (D4A) reports and dashboards. The midyear stock taking exercise had a multiplicity of key stakeholders from all key MTCT focal points. This resulted in all 9 provinces and 52 districts understanding progress at decentralised levels. D4A and dashboard data information is now used during each quarter in all provinces and districts to inform priority actions, identify challenges and gaps, and track progress towards meeting the MTCT goal.

Civil society is engaged in the response to MTCT. The meeting of Women Living with HIV (WLHIV) resulted in a two-year Plan of Action, focusing on policy, advocacy, & Sexual Reproductive Health right for Women Living with HIV. The meeting also engaged the Regional Women and Girls Task Force and advocated for government to pay more attention to 'keeping mothers alive' through advocacy. PLHIV organisations have convened to build their capacity for engaging in the national policy dialogues on changes to the MTCT regimens. The SANAC Children's sector (Yezingane Network) has been a key civil society participant in the programme. From as early as 2007 and continuing to date the sector has provided technical assistance with the PMTCT policy and its implementation. The children's sector has mobilised its members across the country providing IEC material as well as workshops on PMTCT in order to improve the uptake of this programme.

The next steps to strengthen community engagement include: (1) capacity building in leadership and management for WLHIV, including representatives of civil society organisations, leading towards development of a feasible action plan, (2) workshops at

province and district levels across the country that share the MTCT action framework, identifying bottlenecks and seeking to improve participation in the MTCT response and (3) development of a 'user friendly' version of the MTCT action framework for members of civil society and communities.

New MTCT regimen options have been introduced. The Minister of Health announced the introduction of fixed-dose combination and it is expected that the rate of Mother-to-Child transmission will drop even further during the breastfeeding period. Revised guidelines on the regimen changes have been implemented as of the 1st of April 2013. The NDOH has successfully negotiated substantial reductions in the prices of ARVs from the manufacturers in the last year and this has been a major component to the introduction of simpler regimens that involve FDCs.

Communication materials have been developed to support the implementation of the new regimen, including the fixed dose combination (FDC) of Tenofovir, Lamivudine/Emtricitabine and Efavirenz). The next steps include building capacity at provincial and district level to enable comprehensive and linked communication plans between prevention, treatment, and care programmes.

Finally, functional structures are in place to support forward movement. There is a MTCT technical working group and a steering committee at national level that meets quarterly. Provinces have established MTCT steering committees that meet regularly. A paediatric and adolescent HIV and TB technical working group exists at the national level. There is a Joint United Nations Elimination of Mother to Child Transmission (EMTCT) working group. Government is supported by several hundred local South African technical experts across the country chiefly based in its academic institutions and mostly organized through the Southern African HIV Clinicians Society which is the largest association of healthcare practitioners of its kind. This expertise covers all aspects of the HIV programme not least of which is the PMTCT programme.

2. **What key challenges or constraints have been encountered in addressing this target?**

Barron et.al highlighted several challenges to PMTCT implementation and attainment of targets, viz. (1) some health districts have been more effective than others in ensuring that good quality data are collected routinely and that data are used by health workers and

...it is expected that the rate of Mother-to-Child transmission will drop even further during the breastfeeding period.

managers to continuously monitor and improve the programme (2) there is a need for mentoring and supportive supervisory systems that can help facilities use data effectively on a regular basis (3) a large proportion of pregnancies (≈60% - Goga et.al. 2012) are unplanned thus hindering early uptake of antenatal HIV diagnosis and early treatment (4) early attendance at antenatal clinic, and acceptance of pregnant women for antenatal care early in pregnancy which will require interventions at both the individual and community level to raise demand for services, and amongst health care providers so that they do not turn women away early in pregnancy.

3. What are the key programmatic actions necessary to stay on track and/or achieve this target?

Programmatic action should focus on improving implementation of the MTCT programme by fully integrating MTCT needs in the MCH programme. This approach should address issues related to primary prevention and improving overall MCH services, to include family planning and social support services.

The NDoH has launched the National Contraception and Fertility Planning Policy and Service Delivery Guidelines and National Contraception Clinical Guidelines in 2013, aimed at reprioritising contraception and fertility planning in South Africa, with an emphasis on dual protection.

Actions should focus on improving early infant diagnosis, improving accessing paediatric treatment, monitoring of mixed feeding and transmission post breastfeeding, and addressing how to better implement the infant feeding policy changes. There needs to be an emphasis on early booking during pregnancy, repeat testing for HIV negative women during pregnancy and lactation. This repeat testing needs to be monitored to ensure optimal outcomes.

Four additional actions are needed to reach this target. *First*, implement focused integrated training (e.g. ART, MTCT, TB, HCT, and Family Planning) for all health care personnel including community health workers and lay health workers. *Second*, engage with relevant sectors for the implementation of MTCT policies and programmes. *Third*, support for stronger programme monitoring and use of data to inform key policy and programme decisions. *Fourth*, including training in PMTCT and the updated guidelines into all pre-service training is critical.

SECTION 2: STOCKTAKING EXERCISE:
TARGET-BY-TARGET REVIEW

4. **What policy and enabling environment changes and/or new investment are required to reach the targets?**

   There needs to be investment in creating demand for services. This can be supported by supporting an enabling environment that focuses on addressing stigma and disclosure issues and encourages communities to support a mother and child to access services. Other sectors engaged resulting in a holistic approach to a multidimensional and socially complex challenge.

   The development of a national communication advocacy strategy that focuses on social bottlenecks will address many of the challenges. Setting up a tracking system of both mothers and infants would be useful.

   There needs to be greater public awareness of the programme and its benefits. Much work has to be done on a well-run sophisticated media campaign on this programme.

   Greater civil society mobilization around this policy is required. Investment in civil society organisations and structures should improve the uptake of this programme and ultimately the desired outcomes.

   There needs to be greater health care personnel awareness of the programme so that all health care personnel initiate or refer women for PMTCT-related care at all service delivery points, thus reducing missed opportunities.

5. **What new investments are necessary to keep on track and/or achieve this target?**

   There are four identified investments. These include:

   i. Health system strengthening that creates a more friendly community based approach in line with Primary Health Care (PHC) reengineering and supports the recent changes in treatment, feeding and other policies and frameworks.
   ii. National Health Insurance implementation of the PHC creates unique identifiers for follow up for mothers and infants through the NHI.
   iii. Community support structures for adherence to ARTs to support mothers to disclose and adhere to treatment as well as retention in care.
   iv. Engagement with strategic leadership such as parliament, religious leaders, faith based and other leaders that have strong influence in creating an enabling environment, and reaching the intended target.

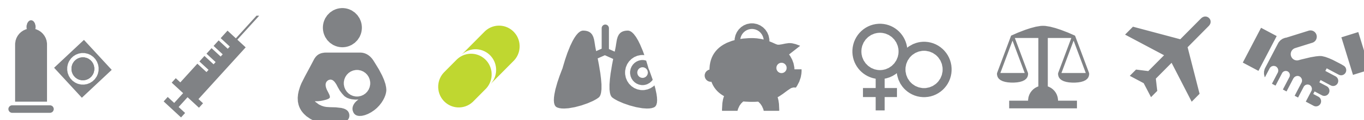
Actions should focus on improving early infant diagnosis, improving accessing peadiatric treatment...

6. **What are the recommendations to national stakeholders to ensure implementation of suggested changes?**
   Recommendations to national stakeholders:
   i. Internal (Government departments) suggestions in this review should be discussed and specific actions identified. These can be tabled at national and provincial Department of Health PMTCT technical working group and Steering committee meetings.

7. **What are the recommendations for sustaining progress along this target beyond 2015?**
   MTCT is the Fourth Zero in the 2012-2016 NSP. The MTCT process should be closely monitored. An improvement in data collection, analysis and use is needed to encourage informed decision-making at the programme and policy level.

   Recommendations for beyond 2015
   i. Enhanced data systems to accurately display problem areas so as to provide a rapid response to fixing programmatic weaknesses
   ii. Greater use of technology to retain women and children in care such as cellphone messaging
   iii. Investment in messages and strategies to improve family planning so that HIV positive women have planned pregnancies with adequate early ARV cover
   iv. Improving the state of antenatal services so that women can be seen as early in pregnancy as possible and receive the best ARV regimen recommended at the time
   v. To consider treatment as prophylaxis and treating all HIV infected people with CD4 cell counts <500 to reduce horizontal HIV transmission as proposed in the latest WHO treatment guidelines
   vi. To partner with the private healthcare industry as the country gears up for the National Health Insurance in developing new or strengthening existing initiatives on implementing the PMTCT programme.

SECTION 2: STOCKTAKING EXERCISE: TARGET-BY-TARGET REVIEW



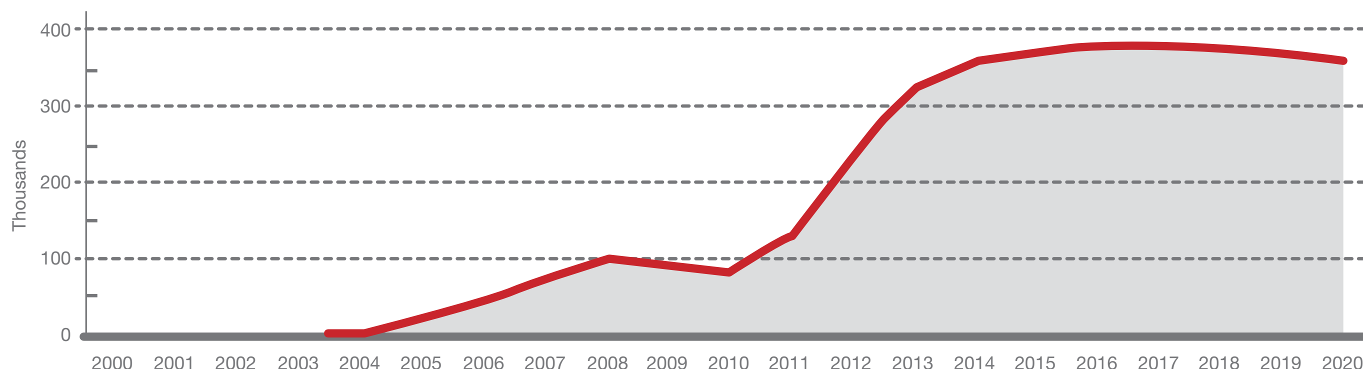
TARGET 4: Have 15 Million People Living with HIV on Anti-retroviral Treatment by 2015

- Is this a priority target for the country?
  YES
- Does the National Strategic Plan address this target?
  YES
- Is the country on track to reach the target and commitment?
  YES

Over the past 5 years, political commitment, funding (especially domestic investment), and the scale and quality of HIV interventions have increased dramatically. South Africa now has the largest antiretroviral (ART) programme in the world, with approximately 2,150,880 million people on HIV treatment. A massive HIV testing campaign, in which close to 20 million HIV tests were conducted over a 20-month period between early 2010 and late 2011, underpinned the acceleration of enrolment onto the programme. More than 2.1 million people discovered that they are HIV-positive, and 400 000 of them started on ART (UNAIDS, South Africa Progress Report, 2012.) According to Spectrum, approximately 780,000 deaths have been averted between 2003 and 2012 Based on current status, it is estimated that 2.2 million deaths will be averted by 2016.

Have 15 Million People Living with HIV on Anti-retroviral Treatment by 2015

Figure 6: South Africa deaths Averted by ART



[Source: UNAIDS Spectrum, 2013]

SECTION 2: STOCKTAKING EXERCISE: TARGET-BY-TARGET REVIEW

1. **What key actions have been taken to reach this target since 2011?**
   A key action in 2012 is that **access to treatment** has increased to over 3400 facilities, the majority of which are primary healthcare facilities. This improved access is supported by the development and implementation of the **ART guidelines**, in line with the new policy of ART for all adult patients with CD4 cell counts < 350 cells/micro and all children ≤ 5 years of age, as well as for all HIV and TB co-infected adults and all pregnant women on ART irrespective of CD4 count.

   ARVs have a lower associated cost. In November 2012 a tender was awarded for a fixed-dose antiretroviral (ARV), one pill a day treatment in SA. The R5.9 billion tender means that the majority of South Africans on state-sponsored ARV treatment for HIV would, from April 2013, need only one tablet instead of the current three per day. The NDOH also managed to reduce the cost of the tender for both the fixed-dose combination (reducing the cost of a single dose of the triple combination of Tenofovir, Entricitabine and Efavirenz by 38%) as well as for most traditional ARV formulations, resulting in an estimated saving of R2.2-billion between 2013 and end 2014.

   The **establishment of structures and systems** have supported achievement of this target. There has been the establishment of a National HIV Drug Resistance (HIVDR) steering committee and technical working group in charge of the development of the national HIVDR strategy. The establishment of a National Pharmacovigilance System will result in the development of a pharmacovigilance midterm plan that is considered as a priority.

   In an attempt to standardise facility-level **ART data management**, the National Health Council approved **the adoption of a three-tiered strategy for monitoring provision of ART in all provinces.** This strategy comprises a paper-based ART registers (tier 1); an electronic non-networked system called TIER.net (tier 2); and electronic networked systems using a patient information system (tier 3), called SmARTer. The system is being implemented throughout the country in phases and all facilities are using standardised patient stationery. Tier.net is progressing and the first national cohort data set will be available this year.

2. **What key challenges or constraints have been encountered in addressing this target?**
   Strengthening community systems to support adherence: Improving routine strategic information systems in the national ART programme

has proved challenging and attempts are underway to strengthen information on treatment coverage rates and outcomes. M&E is possibly the weakest dimension of South Africa's ART response at the moment. Challenges include a lack of a unique identifier and poor data management in health facilities and between most health facilities. This is a particular challenge in relation to clinical patient management, especially the absence of an efficient follow-up system for defaulters and those lost to follow-up. In addition, absence of a common reporting system for non-public sector ART programmes leaves a gap in fully determining ART coverage. This is compounded by the very real conditions under which some patients live. These conditions, which include the existence of a very mobile population, make it nearly impossible to trace patients that have defaulted on treatment.

Data management and data use remains a challenge. Unavailability of data capturers in some primary health facilities is a major hindrance in data management and poses a threat to the sustainability of the ART data strategy in South Africa. The management of paper-based data systems is a huge challenge in terms of integrity of cohort data analysis.

Insufficient capacity of human resources in some health facilities has led to challenges of 'over-demand' when implementing new guidelines in the primary health care level, with inefficient utilisation of human resources in others as a result of inadequate supervision. This is compounded by poor mentoring of staff, as well as difficult working conditions, such as inadequate infrastructure (e.g. limited working space, equipment in poor condition). This contributes to poor staff morale, negatively impacting on programme results. There is also a substantial loss of patients, including patients who do not return for their initial CD4 count results and those who do not initiate ART despite eligibility.

Adolescent patients pose a specific challenge to ART programmes. Most adolescents have acquired HIV perinatally, with a subset of adolescents, in particular young women, acquiring HIV during their late teens. Attempts to provide specialised adherence, psychological and treatment services are hampered by the wide distribution of this age group throughout the country (HST, 2013). Further, children are more complex to manage due to late diagnosis, dosing and adherence, which often have to be negotiated with a caregiver. These challenges have led to this sector of the population being underserved.

Insufficient capacity of human resources in some health facilities has led to challenges of 'over-demand' when implementing new guidelines...

Aspects of treatment are also differentiated along **gender** lines. Women test for HIV more often than men do (in 2012, 37.3% of men versus 51.6% of women expressed being aware of their HIV status) – though this can expose them to violence and neglect by their male partners. The ratio of men to women in ART services is low relative to rates of HIV infection. Men also present at a more advanced stage of AIDS than women do, and are generally older and have higher levels of early mortality on treatment. These differences would seem more related to social norms than health system factors.

Other challenges include the late initiation of people on treatment due to late diagnosis and poor pre-ART programmes, lack of a structured pre-ART programme due in part to limited staff resources at facility level, and the decentralisation of primary health care to be managed by nurses without any additional human or infrastructural resources. It should, however, be noted that the average CD4 initiation level is now>200, almost double what it was prior to the launch of the national HCT campaign.

3. What are the key programmatic actions necessary to stay on track and/or achieve this target?

There are several areas of focus that should be prioritised for South Africa to stay on track to achieving their target. A key focus should be on **effective promotion** to encourage South Africans especially key populations, to take up early HIV counselling and testing as an entry point to HIV care.

Strengthened longitudinal **health information systems** that allow patients to be tracked between service delivery points are needed to properly evaluate pre-ART loss to care, including increasing the number and support of clinic-level data staff and implementing adequate feedback loops between clinic and higher level M&E structures. In support of improving the health system, the implementation of an existing policy regarding a national unique identifier should be accelerated. Additional systems need to be developed in private sector ART programmes and linked through SANAC M&E structures.

The existing **pre-ART system** will be assessed to identify gaps and to draw lessons learnt for further strengthening. Introducing and maintaining a three-tiered longitudinal data system in the public sector, full time employment of data capturers at health facilities, better management of these data capturers at facility-level, and

the use of data by health professionals and facility managers would improve quality of data.

There will be a focus on strengthening all aspects related to patient management which includes skilled health care workers, a supportive environment for patients enrolled on ART, and efficient drug and data management systems. This also includes establishment of and/or strengthening permanent data capturers for all facilities that provide support for HIV and ART services and, most importantly, agreement on and quick implementation of a unique identifier that will improve not only patient management but the cross-border tracking of both HIV and TB patients. Further, the private sector data systems need to be linked to the public M&E infrastructure.

Harmonising treatment protocols with other SADC countries will also strengthen the ability to track patients and improve the accessibility of data.

Strengthening nurses' capacity with NIMART and doctors' capacity in HIV case management would enable doctors to support and guide nurses involved in ART initiation through regular supervision and mentorship. Those studying to be nurses will have access to a NIMART module in nursing colleges. This will ensure that newly qualified nurses are adequately equipped to manage both HIV positive adults and children. This will then support the expansion of NIMART to ensure that all facilities have nurses who are able to manage HIV-positive patients, including those requiring treatment. Also, the Supervision and Mentorship Guidelines will be updated to address the new National ART Guidelines for adults, paediatric and PMTCT. To enhance the implementation of Supportive Supervision and Mentorship, Standard Operational Procedures (SOPs) will be developed and updated periodically. In both technical guidelines and SOPs, feedback and follow up mechanisms with health facilities will be emphasised.

South Africa will also focus on improving the current supply chain management for ARVs and diagnostics for HIV, and ensuring that the quality and availability of current Primary Health Care (PHC) services is maintained in the light of the ART expansion to all PHC facilities coupled with an increase resources at primary health care level where HIV services are now being rendered.

Other challenges include the late initiation of people on treatment due to late diagnosis and poor pre-ART programmes...

4. **What policy and enabling environment changes and/or new investment are required to reach the targets?**
   While all health workers have been introduced to the updated National ART guidelines, a follow up through regular technical visits and supervision and mentorship will be needed to make sure that all aspects of the new **National ART guidelines are rigorously implemented** in both public and private health facilities. Further, there will be a focus on how to **strengthen coordination** among all levels and partners of the public health system (national, provincial, and district) and between government, civil society, and non-governmental organisations that deliver health services. This will include improved consultation of implementers during the policy development stage and reaches to include improved allocation and use of staff.

5. **What new investments are necessary to keep on track and/or achieve this target?**
   The scaling up of ART to HIV-infected adults requires a sizeable investment of resources in the South African public health care system. There needs to be an exploration of innovative funding mechanisms to address this need and exploring how to better involve the private sector in service delivery and funding. Investing in a stronger Health Management Information Systems (HMIS), an improved financial management and accountability system, and a multi-sectoral M&E framework will be a major step forward in supporting the achievement of this target.

   There is also a need for the NDOH to identify realistic solutions that will resolve longstanding backlogs and to explore different models of care and service delivery (e.g. stable patients receiving multi-month scripts rather than having to present to a facility monthly). At the same time, the local supply chain management systems require further investment. Finally, expansion of treatment coverage will be guaranteed by ensuring that all municipal clinics also provide HIV and TB services.

6. **What are the recommendations to national stakeholders to ensure implementation of suggested changes?**
   National stakeholders must prioritise the exploration of how to increase testing, linkage and retention of key population groups. More specifically, NIMART supervision and mentoring must be scaled up, and community mobilization increased by actively encouraging PLHIV to increase ART uptake. Stakeholders must also ensure that

the NHI community outreach teams actively engage in identification and follow-up activities for treatment.

Renewed focus will concentrate on how to strengthen local systems for supply chain management, related physical infrastructure, strengthening the health management information systems (HMIS), budget forecasting and strategic planning will all contribute to achieving this target.

Introduction of fixed-dose combination is expected to strengthen the ART programme significantly by simplifying treatment regimens, reducing treatment complications and further improving adherence. This approach should be fully supported by national stakeholders. Finally, continuing to sustain high level of domestic funding (76%) is critical to achieving this target.

7. What are the recommendations for sustaining progress along this target beyond 2015?

Continued focus on regular HIV testing is required to ensure that treatment is initiated as close to the CD4 350 thresholds as possible. This can be supported through effective community mobilization, with involvement of PLWHIV to increase uptake of ART. In addition, expanding treatment access up to the CD4 count of 350 cells/ul thresholds should remain a priority for the ARV programme. This will realise the benefits of 'treatment as prevention', decreased maternal mortality and paediatric infections, decreased burden on outpatient and inpatient clinical care, and decreased community-wide TB.

Further, it is imperative to continue to evaluate pilots and scale up successful strategies for retaining stable patients in care to ensure treatment success among HIV patients.

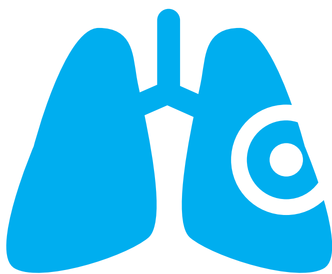
Major external support – most of it directed towards treatment and care – is either decreasing service provision in favour of "health systems strengthening" or being redirected. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) has been an important source of investment, particularly in the ART programme. However, it is shifting its support from direct clinical care and treatment services to health systems strengthening (including the overhaul of the primary healthcare model), HIV prevention and health services innovation. The U.S. and South African Governments have agreed on a framework to

There is also a need for NDoH to identify realistic solutions that will resolve longstanding backlogs...

guide this evolving partnership. PEPFAR implementing partners will now report expenditures in a standardised format, making it easier to align the support with South Africa's planning and budgeting processes. Steering and management committees (with high-level participation) have been created to oversee implementation of this new Partnership Framework and ensure mutual accountability. As domestic funding increases and PEPFAR funding declines over the next five years, new funding opportunities will need to be identified and evaluated.

SECTION 2:
STOCKTAKING EXERCISE:
TARGET-BY-TARGET REVIEW

TARGET 5: Reduce Tuberculosis Deaths in People Living with HIV by 50% by 2015



- Is this a priority target for the country?
  YES
- Does the National Strategic Plan address this target?
  YES
- Is the country on track to reach the target and commitment?
  NO

South Africa has one of the highest levels of TB and HIV co-infection and growing multidrug-resistant TB infections worldwide (Sissolak, 2011). According to the latest TB Global report compiled by the World Health Organisation in 2011, South Africa's TB incidence, adjusted for population was the highest among the 22 TB high burden countries. The report indicates that, approximately 65% of TB patients were living with HIV in 2011 (WHO Global TB report, 2012). Despite this challenge, the report highlights that South Africa has made significant gains in controlling the epidemic. The cure rate was is 74% in 2011, compared to 64% in 2008. TB mortality and the prevalence of the disease have significantly reduced in the general population – the first sizable reductions since the late 1990s. Among registered TB cases in 2011, the mortality rate was 6.1% compared to 7.8% in 2008. Although mortality was still high at 17% among registered MDR-TB patients in 2011, this was in line with the downward trend from the 20% peak observed in 2008.

1. **What key actions have been taken to reach this target since 2011?**
   There were significant changes in policies, strategies and plans. The National Strategic Plan for HIV, STI and TB 2013-2017 (NSP), which for the first time addresses both TB and HIV, sets out a multi-sectoral plan that aims to halve TB incidence and deaths. Provincial health implementation plans that are based on the NSP exist in all 9 provinces and across key national government departments such as the Department of Correctional Services, the Department for Basic Education and the Department of Defence. Efforts to mainstream TB Control Programmes in all departments are under way.

Reduce Tuberculosis Deaths in People Living with HIV by 50% by 2015

SECTION 2: STOCKTAKING EXERCISE: TARGET-BY-TARGET REVIEW

Raising the CD4 cell count threshold for starting people living with HIV on ART from 200 to 350 will have a major impact on the likelihood of people living with HIV progressing to active TB disease. In April 2012, South Africa adopted a policy of giving ART to all HIV positive TB patients, regardless of their CD4 count. This policy is likely to reduce TB deaths in PLHIV who have started on TB treatment. A review of the *National Infection Prevention and Control (IPC) Policy* was undertaken for TB, MDR-TB and XDR-TB. As a result, policy guidelines were aligned to the new WHO policy recommendations on *TB Infection Control in Health-Care Facilities, Congregate Settings, and Households.*

A new DOH strategy unveiled by the Minister of Health in 2012 has the following key elements for intervention:

- Intensified case finding at community and household level (this includes tracing contacts of known TB cases)
- Improved diagnostics (using GeneXpert technology)
- Improving management of MDR-TB through refurbishment/construction of management units that meet infection control standards

At the same time, an action plan focusing on expansion of paediatric TB and HIV services was developed to improve prevention, diagnosis, treatment care and support. This was achieved through the *Blueprint for Action for Paediatric and Adolescent HIV and TB, Early Diagnosis, Treatment, Care and Support*. Furthermore, Guidelines for the provision of HIV and TB services in Correctional Services/Prisons have been developed and are being implemented.

A National Roll-out plan for GeneXpert is being implemented to facilitate earlier and more accurate diagnosis of TB. GeneXpert allows for detection of TB (including resistance to Rifampicin – a proxy measure for and drug-resistant TB) in less than two hours and is significantly more effective at diagnosing TB in people living with HIV. Currently, South Africa accounts for more than 50% of all GeneXpert tests conducted in the world. Some districts are already reporting improved turn-around times as a result of the availability of GeneXpert technology. The national GeneXpert plan is being rolled out, and 100% coverage is expected to be reached before the end of 2013, meaning, all TB suspects will be tested for diagnosis using GeneXpert, and not microscopy.

SECTION 2:
STOCKTAKING EXERCISE:
TARGET-BY-TARGET REVIEW

Efforts to expand and sustain a multi-sectoral response to TB control are underway across all sectors. Better integration and sharing of lessons learnt across the sectors will improve TB control across the country, in line with the NSP. The partners include: the Departments of Correctional Services, Agriculture, Forestry and Fisheries, Basic Education; and Social Development, SABCOHA and the mining sector, and the unions.

South Africa has spearheaded regional TB Control efforts through the Southern African Development Community (SADC) Declaration on TB in the Mining Sector, adopted by the SADC Heads of State in November 2012. With funds anticipated from the Global Fund, the Department of Health will – in partnership with the Department of Mineral Resources, Organised Labour and Employers – institute interventions that will ensure that routine and regular screening for TB is undertaken among both current and former mineworkers in line with the provisions of the NSP.

A more integrated health system approach has ensured that TB screening is included in the HCT campaign and that all people living with HIV in care or on treatment are regularly screened for TB. This will increase early diagnosis of TB and reduce TB deaths. TB disease can be prevented in people who are living with HIV with isoniazid preventive therapy (IPT). On the basis of South Africa's own Thibela TB study, national policy has recently been expanded on the basis of new evidence to provide at least 36 months of IPT to people living with HIV, rather than the standard 6 months, offering greater protection against TB disease.

2. What key challenges or constraints have been encountered in addressing this target?

A key challenge to reaching this target is directly related to the epidemiology of TB and its hyper-endemic nature amongst the people of South Africa. High levels of mobility across provinces and intra-provincially undermines efforts to trace contacts of index patients. Gaps in data collection also contribute significantly to lower levels of success in contract-tracing. Efforts are already underway to address these challenges through the national roll out of GeneXpert technology.

Surveillance for community burden of TB prevalence requires more resources and is an area which will receive sharper focus in the renewed effort to achieve the targets set for the elimination of TB in people living with HIV.

A National Roll-out plan for GeneXpert is being implemented to facilitate earlier and more accurate diagnosis of TB.

SECTION 2: STOCKTAKING EXERCISE: TARGET-BY-TARGET REVIEW

The National Infection Prevention and Control Policy has yet to be rolled out nationally and more resources will be required to achieve national coverage. Improving the quality of data collected at facility level is an area which requires additional focus. On the ground there are additional challenges that revolve around inadequate data quality, recording and reporting. Quantification of the actual community burden of TB prevalence and deaths has also been identified as an area for further interrogation. Furthermore monitoring of adherence to IPT needs to be improved through a stronger community health system and referral. High levels of internal migration present a challenge in tracking patients who have TB infection, especially where laboratory diagnosis is required. The introduction of GeneXpert technology will improve the response to some of the challenges highlighted above.

There are high rates of primary loss to follow up for patients who have a laboratory diagnosis of TB and then never begin treatment. A seamless tracing system that targets contacts and defaulters is still to be put in place. At the same time, there is poor uptake of ART in HIV positive TB patients. TB screening during HCT is not linked to diagnosis and care. Community screening, contact tracing, and case finding, is challenged.

Regarding drug resistance, there are increasing numbers of multi-drug resistant (MDR) and extensively drug resistant (XDR) TB cases (the widespread availability of GeneXpert technology has led to more cases being detected than before). There are a low number of MDR/XDR cases on treatment, low cure rates, and a high mortality rate. Additional challenges of preventing, diagnosing and treating drug-resistant TB in children have also been identified.

Global efforts to eradicate TB have been hampered by lack of investment in research and development for new drugs with better potency and effectiveness. Treatment is still based on old drugs, with some undermined by compound instability from unstable fixed dose combinations. However, *Bedaquiline*, a phase 2 clinical trial drug with an interim clearance for use under controlled conditions by the FDA and WHO, has given a new hope. South Africa is among the few countries involved in evaluations to ascertain its effectiveness.

Additional constraints include delayed implementation of the Provincial Strategic Plans. In most provinces, Provincial Councils on AIDS and TB have focused predominantly on HIV and lack capacity in TB prevention, diagnosis and treatment. Government departments are also at different

stages of addressing TB, which indicates a lack of a uniform approach to dealing with the disease. Despite global ILO guidance, there is also limited integration of TB into work place programmes.

3. What are the key programmatic actions necessary to stay on track and/or achieve this target?

A **greater focus on TB prevention in people living with HIV** is needed, including early detection and treatment. This can be guided by the "*Three I's for HIV and TB.*" This combination package of simple, inexpensive, and cost effective measures will be scaled up as the country prepares to re-launch the successful HIV counselling and Testing Campaign in 2013 and should be scaled-up and integrated into other programmes, such as maternal and child health and PMTCT programmes.

Improved implementation of TB infection control policy and practices is also needed in communities, health facilities, correctional facilities and other congregate settings. Implementation of the new isoniazid preventive therapy (IPT) policy will support changes in implementation and reduce the risk of TB disease in people living with HIV.

Decentralization of TB care and support to communities will also improve access to care, reduce delays in treatment initiation, reduce transmission of DR-TB in hospital and reduce the need for hospitalisation. This will be further reduced by provision of short term inpatient care in district hospitals, thus allowing for more appropriate use of specialised hospital beds (e.g. complex and clinically unstable patients, treatment failures).

For improved treatment of TB in PLHIV, **more intensified and regular TB screening** for people living with HIV is needed, plus earlier detection of all people living with HIV. This can be addressed through a strong HCT campaign and integrated health services. This will detect both HIV and TB earlier, increasing the chance of successful treatment. Early antiretroviral therapy for all HIV positive TB patients will reduce the risk of death during TB treatment.

A **better understanding of TB epidemiology in South Africa** is needed. A series of systematic reviews of TB in high risk populations in South Africa is being conducted. These reviews will be combined with an analysis of the matched NHLS and National TB Programme (NTP) data 2004-2011 to produce the first KYE/KYR report on TB in South Africa.

Additional constraints include delayed implementation of the Provincial Strategic Plans.

Strengthened data quality and use are needed. Links to NHLS data needs to be strengthened. HIV and TB clinical and programmatic monitoring and evaluation systems should be fully integrated within the 'Three Tier' system, along with maternal and child health. Implementation of the *South African National Tuberculosis Drug Resistance Survey* will improve the collection, analysis and use of TB and TB/HIV data for programme management. The planned national TB prevalence survey will be essential to understanding the actual community burden of TB in the country. An evaluation of the impact of GeneXpert on improved programme performance is also important. Annual national TB reports should be produced in addition to regular quarterly provincial and national reports. These reports should then inform policy and programmatic decision-making.

Expanding the **multi-sectoral response to TB** will be critical to increasing access to TB prevention, diagnosis and treatment. In line with the SADC declaration, there needs to be a concentrated focus on the mining sector that encourages intensified efforts to control TB in this sector.

Finally, efforts to expand community knowledge and engagement in TB prevention, diagnosis and treatment through advocacy, communication, and social mobilization efforts will be essential to a comprehensive national TB response.

4. What policy and enabling environment changes are required to reach the targets?

In order to reach the targets, a multi-layered and linked approach needs to be adopted. This requires stronger integration between TB and HIV programmes, including a fully integrated monitoring and evaluation system. This should include electronic patient records, registration, and reporting with unique identifiers to allow patient tracking between key programmes and over time. Further strengthening of the multi-sectoral response to TB and HIV is also required.

There needs to be a focus on creating enabling environments for specific populations at higher risk of contracting TB. In the *mining sector*, stronger interventions to control TB and HIV in the mines are needed (including reductions in silica dust exposure). In the *prisons*, significant investment in infection control procedures and health care provision is needed. In *informal settlements*, a clear plan of action by the Department of Human Settlements to improve social conditions for informal settlements is needed, including the provision of

comprehensive health services in these high transmission areas for HIV and TB. For *children*, there is a need for strengthened implementation of improved guidelines for TB prevention, diagnosis and treatment for children, especially those in contact with MDR TB patients.

5. **What new investments are necessary to keep on track and/or achieve this target?**
   Investment in TB research needs to be prioritised, with a focus on developing new vaccines, drugs, and diagnostics for TB, especially for PLHIV and children and to address the challenge of MDR-TB. There also needs to be investment on how to better reach and treat key populations. Further investments should be made in the ward based Primary Health Care outreach teams. This will strengthen the process of intensified TB and HIV case finding and tracing contacts. Additional factors critical to achieving this target include: (1) increased support to a multi-sectoral approach, especially in the prisons and mining sectors that links the existing data systems; (2) continued investment in GeneXpert; and (3) strengthened prevention and treatment of drug resistant TB. Finally, a greater focus on TB prevention is required, including the upstream risk factors for TB such as poverty, smoking, diabetes and HIV as well as strengthened infection prevention and control.

6. **What are the recommendations to national stakeholders to ensure implementation of suggested changes?**
   Healthcare system inadequacy is a major influence on TB-IPC. IPC provision and practices, TB training for staff and patients, and cross-cultural communication should all be addressed. National stakeholders should consider the implementation and evaluation of a comprehensive contextually appropriate TB-IPC policy, with the setting and auditing of standards for appropriate IPC provision and practice across all wards in TB burdened hospitals. Stigma attached to TB should also be addressed among healthcare providers and patients.

   A focused approach to reach identified target groups is needed. This includes research that identifies the most critical needs for reaching each target group, the resources needed to address those needs and the management and structures in place to support the implementation of recommendations. Finally, stakeholders need to support a multi-sectoral and integrated approach that: (1) identifies how to ensure linkages exist in the health system and (2) how to better manage an integrated approach at the health system and human resources level.

Expanding the multi-sectoral response to TB will be critical to increasing access to TB prevention...

7. What are the recommendations for sustaining progress along this target beyond 2015?

   In order to progress, the most critical element should be sustained political commitment to ensuring a multi-sectoral response to TB and HIV. Significant investment in focused research is also required, for (1) the development of new vaccines, drugs and diagnostics for TB, especially for PLHIV and children and to address MDR TB, (2) improving the current health system by tighter integration of TB and HIV management within a broader PHC system, and (3) the establishment of a robust tracing system needed to ensure rapid detection, enrolment on treatment and adherence.

SECTION 2:
STOCKTAKING EXERCISE:
TARGET-BY-TARGET REVIEW

TARGET 6: Reach a Significant Level of Annual Global Expenditure in Low and Middle Income Countries

- Is this a priority target for the country?
  YES
- Does the National Strategic Plan address this target?
  YES
- Is the country on track to reach the target and commitment?
  YES

South Africa has increased its level of annual expenditure for HIV leading up to and after 2011. South Africa has the highest domestic investment on HIV treatment and care among all low- and middle-income countries. Over a three-year period, public funding towards HIV and TB increased by 27% on average, from ZAR 6 billion in 2007/08 to ZAR 8 billion in 2008/09, reaching ZAR 9.8 billion (US$1.2 billion) in 2009/10 (SANAC: NASA 2012).

The public funds come either from the Conditional Grants from National Treasury, given to the Department of Health (DOH) through the Comprehensive HIV/AIDS grant and Education Life-Skills grant, or from the province's Equitable Share (Voted) funds which are allocated from the DOH, Department of Social Development (DSD) and other departments' budgets (NASA, 2012).

In 2011 South Africa examined the fit between its allocation of resources and the epidemic's trends and patterns. The NSP cost estimates report suggested that the resources required to achieve the objectives of South Africa's National Strategic Plan for HIV AIDS, STIs and TB (2012-2016) is estimated to cost $9.5 billion over the next 3 years. In 2013/14 the annual cost of the required response is $2.3 billion, rising to $3.5 billion in 2015/16 (using an exchange rate of 8.5 to 1).

Reach a Significant Level of Annual Global Expenditure in Low and Middle Income Countries

1. What key actions have been taken to reach this target since 2011?
   According to National Department of Health Annual Planning Tool,

funding for HIV from the NDOH rose from ZAR9.1 billion to ZAR9.8 billion between 2010/11 and 2012/13 fiscal years (CHAI, 2013). This represents a real increase of approximately 8%. When looking at the multi-sector government response to HIV, funding rose over the same period from ZAR11.2 to ZAR13.6 billion (an increase of 21%). South Africa continues to prioritise its HIV response through mobilising domestic resources, both at national and provincial levels. During the same time period, the number of patients remaining on ART in the country increased, showing fruits from South Africa's efforts to achieve more with the money it spends, elaborated on below, as well as to increase its overall funding basket. HIV treatment represents roughly 40% of the cost of South Africa's HIV response at present (CHAI, 2013).

The South African HIV programme is amongst the best-costed in the world. Some 30 publications alone report on the cost of different aspects of ART provision in South Africa over the last 10 years. Drawing in part on this body of work, a group of local health economists costed the NSP and a financial gap analysis was undertaken to produce the evidence required for prioritising interventions. Most recently, provincial costed operational plans were prepared, as well as a financial and output gap analysis for the Global Fund grant renewal application.

Government introduced a new tender process to increase competition among suppliers. In 2010 the NDOH was successful in negotiating a 53% average reduction in ARV prices and a 36% reduction in the price of TB medicines, while in 2012 the government negotiated savings over the next two years on its ARV products equating to a 27% saving (ZAR 2.2 billion). This means that the average annual cost of treatment provision has dropped below ZAR5 000 (HST, 2013).

Integrating approaches is expected to benefit from synergies that may lower costs and improve efficiency. Integrating approaches of HIV prevention, care, and support services into the primary health care system and school education curriculum are on-going. Integrating care and support services into poverty reduction programmes brings several sectors together to develop sustainable interventions to reduce poverty and address HIV, and is in line with the multi-sector approach of the NSP. As such, SANAC is exploring integration in its strategies for increasing the national HIV programme's sustainability.

The NDOH launched an Aid Effectiveness Framework in 2011 to align development partner assistance more closely with departmental

processes, reduce transaction costs and enhance the efficiency of planning and implementation. Following on from the establishment of the framework, NDOH has started an annual resource tracking process known as the Annual Planning Tool (APT) to track donor and government expenditure with the aim of improving value for money and alignment of health sector investments. In addition, parliament has introduced an HIV Committee with the purpose of improving government accountability in HIV spending and targets.

In August 2012, U.S. Ambassador to South Africa and the South Africa Minister of Health signed the Partnership Framework Implementation Plan (PFIP). The PFIP provides the roadmap for the transition in the PEPFAR program in South Africa from an emergency initiative to a sustainable long-term program with the SAG in the lead. This joint plan lays out how the transition of care and treatment programs into the South African primary healthcare system will be managed in order to preserve quality of care, maximize efficiency in the use of resources, and strengthen the overall human and institutional capacity of the South African health system.

Over the last few years, the completeness and reliability of financial data has increased significantly in South Africa, from two perspectives: (1) estimating resource needs and (2) tracking expenditure through exercises including the NASA, APT and Public Expenditure Tracking Survey (PETS). For example the World Bank's PETS & Quantitative Service Delivery surveys—already completed in one province and planned for several others—are helping determine whether resources and programmes are reaching the intended beneficiaries and are being used efficiently and effectively. South Africa has also been improving its health information system through TIER.net rollout, which is in place in several hundred facilities, as well as through standardising the indicators it collects through its National Indicator Data Set (NIDS). This has resulted in improvements in measuring the number of patients remaining on ART. The Integrated Planning Unit is also currently rolling out its National Health Information Repository Data warehouse (NHIRD), which will serve as a central repository for all health information under the planned National Health Insurance (NHI), which aims at introducing universal health coverage.

In addition, SANAC has established a Costing Technical Task Team (TTT) to analyse HIV and TB programme costs, track expenditure and package information for decision makers. So far the TTT has been involved in compiling the country's Global Fund application, and

Government introduced a new tender process to increase competition among suppliers.

hosted a workshop in partnership with CHAI to share a database of health sector unit costs from the past ten years for planning purposes. SANAC is planning another NASA that would capture all spending, as well as allow for easy reporting on the progress towards the NSP targets as well as the HLM target all leading to efforts to routinely monitor resources for HIV and TB.

2. What key challenges or constraints have been encountered in addressing this target?

The **costing of the NSP** was undertaken using 2011 prices and unit costs for some services were somewhat dated and may be less reliable due to guidelines or norms and standards for a particular service having changed (for instance task shifting in HCT and TB treatment).

While the cost of the programme might be higher in real terms some of this increase will be mitigated by the decrease in ARV prices in the November 2012 ARV tender. While the NSP costing projects the size of the overall funding envelope, the HIV budget will be defined by the nine Provincial Strategic Plans (PSPs) which can introduce new interventions, set new targets, and potentially use different unit costs for each intervention. As a result, the total funding requested in these PSIPs and the provincial business plans could be larger (or smaller) than the total calculated in the NSP costing.

In addition, certain NSP targets have since been superseded by new sectoral planning processes that translate into new operational targets. For instance, for VMMC, the annual targets over the next 2 years have been increased as the NDOH plans to scale up earlier than what was earlier anticipated as possible.

Another contributing challenge is the lack of routine reporting by development partners of their planned activities and allocations, by province, to assist with a more accurate funding gap analysis, and improved coordination.

Finally, there a few funding gaps. According to APT gap analyses, the sub-programmes that are expected to have the greatest financial gaps between funding requirements and available funding are ART, TB and HCT. The financial gap between need and funding for ART in 2012/13 was $542 million, for TB it was $167.1 million and for HCT it was $124 million. The gap for HCT is likely to be overstated due to recent cost savings achieved in HCT services, although it is still

estimated that there will be a material financial gap over the next 3 years as South Africa increases its operational targets for HCT. It is anticipated that large financing demands face the country over the coming years as the cost of the HIV programme is estimated to grow from around ZAR19 billion to ZAR32 billion annually (NSP 2011). The prevention gap has not been costed.

3. What are the key programmatic actions necessary to stay on track and/or achieve this target?

In light of increasing funding needs and declining donor support the South African government will likely need to diversify funding mechanisms. This could be achieved by increasing the number of patients receiving testing and treatment in the private sector, such as through workplace programmes that have been shown to have a positive return-on-investment for companies (Meyer-Rath 2012) and through innovative financing mechanisms. Further, NDOH should consider implementing the Health and HIV Financing Strategy identified in the NSP as part of the Aid Effectiveness Framework.

Sustained focus on prevention is key to maintaining the successes that have emerged from the investments made over the last two decades. In addition to the investments made in the health sector, the government has a considerable portfolio of social interventions such as grants, free education, subsidised housing and free access to basic amenities, which all contribute to decreasing vulnerability to ill health. Such investments will continue in order for the country to realise the objectives of the development agenda. .

Finally, a **strategic investment framework** should be developed that: (1) incorporates major efficiency gains through community mobilisation, (2) identifies synergies between programme elements, and (3) benefits of the extension of antiretroviral therapy for prevention of HIV transmission.

Increasing investments in prevention programmes that are known to work, at scale is an important aspect of the response. (3) Benefits of the extension of antiretroviral therapy for prevention of HIV transmission.

4. What policy and enabling environment changes and/or new investment are required to reach the targets?

The existing policy environment needs to be sustained and the focus on ensuring that the new health reforms such as the NHI,

Another contributing challenge is the lack of routine reporting by development partners of their planned activities and allocations...

Re-engineering Primary Health Care support better integration and sustain the focus on health systems strengthening. The National AIDS Spending Assessment (NASA) process encountered **several weaknesses** in the financial information systems in South Africa, which are limiting the ability of all actors to be transparent and accountable. More work is required on sharpening the financial skills at the local level. Several key recommendations have been made for improving the expenditure tracking systems and linking these to routine M&E systems. This includes a focus at the level of the provinces, so as to institutionalise this process as routine data collection, rather than one-off, expensive survey-style collections. A SANAC-supported project is currently under way to work with financial and HIV programme managers in the nine provinces to improve their budgeting, financial reporting, and expenditure tracking against key performance indicators.

Detailed health expenditure data from all funding sources (government, development partners, and private sector) will be essential to understanding the overall landscape of funding and identifying opportunities for more efficient allocations. NDOH is planning to use the APT to take this process forward with regards to health-related expenditure, while efforts outside the department of health should be equally tracked and measured.

5. **What new investments are necessary to keep on track and/or achieve this target?**

It is vital to ensure that the available resources are used to maximum effect by focusing on evidence-based, cost-effective activities, by taking them to scale and demonstrating their impact. Efficiency gains are being used to extend savings in ART programmes.

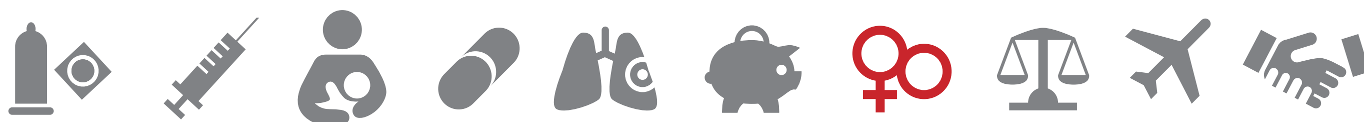
Continued investments in costing data that inform government spending are critical, as well as improving the link between expenditure data and outcomes achieved by government, donors, and the private sector. Alongside cost data, there needs to be better data on the coverage and frequency of interventions across the country, improving the geographic granularity of such information for improved planning at the sub-provincial level. The NDOH, in collaboration with UNAIDS and CHAI, for example, recently estimated ART coverage by district informed by Spectrum, data which are being used to set paediatric ART coverage targets for the country.

6. **What are the recommendations to national stakeholders to ensure implementation of suggested changes?**
   National stakeholders should work with donor institutions, civil society, people living with HIV, faith-based organisations, the private sector, foundations, and multilateral institutions to effectively mobilize coordinate, and efficiently utilize resources to expand high-impact strategies. The country's ODA Planning Forum should also be considered as, and used for, a vehicle for such coordination.

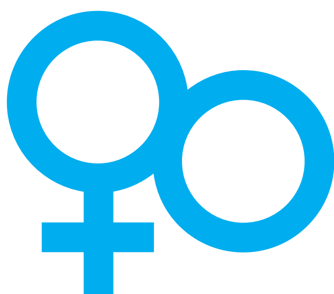
7. **What are the recommendations for sustaining progress along this target beyond 2015?**
   Key outcomes need to be better linked to expenditure. At the same time the government will work with their development partners to ensure that spending better aligns towards government priorities.

It is vital to ensure that the available resources are used to maximum effect by focusing on evidence based, cost-effective activities...

SECTION 2: STOCKTAKING EXERCISE: TARGET-BY-TARGET REVIEW



TARGET 7: Eliminate gender inequalities and sexual violence & increase capacities of women and girls



- Is this a priority target for the country?
  YES
- Does the National Strategic Plan address this target?
  YES
- Is the country on track to reach the target and commitment?
  NO, BUT MAKING PROGRESS

South Africa's national HIV and TB response is driven by strong political commitment from the highest levels of government. It is this commitment and leadership that has underpinned the acceleration of improved performance against HIV specific indicators and this same level of commitment and leadership is being directed at the more stubborn social and structural drivers of the HIV and TB epidemics, including gender inequalities and sexual violence.

Performance against target 7 is difficult to measure and while the analysis below will elaborate on South Africa's performance, the overarching assessment is one of the country making measured and sustained progress, keeping us on track to meet our 2015 commitments but still firm in its belief that yet more must be done to reduce gender-inequality and violence against women.

The evaluation of South Africa's performance against this target is based on an assessment on three levels of eliminating gender inequalities and sexual violence and increasing capacities of women and girls:

1. At the policy level and in terms of the country's legislative framework;
2. At the level of implementation;
3. At community level.

Eliminate gender inequalities and sexual violence & increase capacities of women and girls

SECTION 2: STOCKTAKING EXERCISE: TARGET-BY-TARGET REVIEW

The *first* of these, the policy and legislative framework level, has seen strong performance. Gender equality is enshrined as a fundamental Right in the *Constitution of South Africa* (1996). This *Constitutional Right* has been weaved throughout the national overarching policy framework but has received specific emphasis recently in the form of the August 2012 tabling in Parliament of the draft *Women Empowerment and Gender Equality Bill*. The objective of the draft Bill is to give effect to the values of non-sexism enshrined in the *Constitution* by ensuring that corrective measures are put in place to address all aspects of inequality. When promulgated, the *Women Empowerment and Gender Equality Act* will apply to all organs of the state, to the private sector and to all institutions and will assist in enforcing compliance with gender equality, particularly with regard to respecting, promoting, protecting and advancing the rights of women.

A further effort within the ambit of the policy and legislative environment has been the reinstatement of the dedicated Sexual Offences Courts as well as the strengthening of the Equality Courts. Aware that for as long as there is a climate where any person in our society feels threatened on account of their gender, sexual orientation or HIV status it is going to impact on the response to HIV & AIDS the Department of Justice and Constitutional Development is developing a 'hate crimes' Bill and is currently engaged in national consultations on the matter. Finally, the Department of Justice and Constitutional Development is reviewing a number of current pieces of legislation that seek to strengthen the legislative and policy environment related to inequality and discrimination and a number of new laws are under development.

South Africa's national leadership is keenly aware that while the policy and legislative environment relating to gender inequality, discrimination, sexual violence and empowerment are strong and receive consistently reinforcing attention it is at the *second* level, that of implementation, where the country experiences significant challenges to improving performance against this target. The legislative review and strengthening of the policy environment in particular are premised upon awareness at the most senior level of government that current legislation is not being enforced and policy measures put in place are impeded by capacity challenges. There is also keen awareness that enforcement of *Constitutional Rights* is dependent upon the broader popularisation of the *Constitution* and the *Rights* contained therein. Dedicated attention is being trained upon increasing implementation capacity and in improving implementation overall.

SECTION 2: STOCKTAKING EXERCISE: TARGET-BY-TARGET REVIEW

The *third* level of analysis of South Africa's performance in eliminating gender inequality, addressing sexual violence and increasing capacities of women and girls is the community level. It is at the community level that South Africa experiences its most intractable challenges. As is the case in many other countries across the world, patriarchy is entrenched in South Africa and gender hierarchy and dominant constructions of South African masculinities legitimise the control of women by men (UNAIDS, 2012).

Challenging social conditions in South Africa further contribute to entrenched inequalities. For example, unemployment remains stubbornly high and South Africa features among the most unequal societies on earth. While these challenges are receiving dedicated attention differences vulnerability to and the impact of HIV on women and girls versus men and boys are intrinsically related to gender inequality and unequal power relations, to gender-based violence (GBV) and to stigma and discrimination.

Furthermore, the prevalence of violence has contributed to the exposure of young people in South Africa to a culture of sexual violence. At the individual level, a positive relationship has been identified between the perpetration of violence and HIV infection. This is particularly evident in women and girls living with HIV. These present major obstacles for women and girls in accessing HIV prevention, treatment, care, and support services (UNAIDS, 2012).

In line with the 2011 Political Declaration on HIV/AIDS, South Africa is advancing gender equality, human rights and zero tolerance for violence through the *Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV*.

1. What key actions have been taken to reach this target since 2011?
   There have been several key actions that support reaching the diverse target. The National Council against Gender Based Violence (GBV) was launched. The Department of Justice and Constitutional Development (DoJCD) has put steps in place to review the Sexual Offences Act and the re-introduction of the 'Sexual Offences Courts'. The UNAIDS Accelerated Country Action for Women, Girls, Gender Equality and HIV was integrated as part of the NSP for 2012 – 2016. This encourages the South African National Aids Council (SANAC) to ensure inclusion (and implementation) of programmes that address gender inequalities and the needs of women and girls. In October 2012 the government undertook a midterm review of the implementation

of the Accelerated Agenda, which indicated that South Africa has several programmes and policies in place to address the needs of women and girls in the context of HIV.

Recent reports on the brutal rape and murders of women and children in the mass media have resulted in increased civil society action and have encouraged the government to take stronger action. New programmes and partnerships have been launched and existing programmes have gained more prominence, as shown by the multitude of forums, discussions, high level dialogues and parliamentary discussions.

The Government Women's Justice and Empowerment Initiative (WJEI) programme supported by PEPFAR has supported the DOJCD to continue with the rollout of its service delivery model to manage sexual violence cases. The *Thuthuzela Care Centre* (TCC) model was expanded by 23 centres under WJEI. *TCCs* are one-stop facilities that aim to reduce secondary victimisation, improve conviction rates, and reduce the cycle time for finalisation of cases. As a follow-on project, the Increasing Services to Survivors of Sexual Assault in South Africa (ISSASA) programme has several supporting objectives. First, it ensures that communities across South Africa are aware of essential services. Second, it is a community based approach expanding and improving services of TCC's through education, training, research and infrastructure support. Assistance to the Department of Correctional Services has also ensured that correctional service medical personnel were trained in the management of sexual assault, as this is a challenge within prison environments.

The High Level Taskforce for Women, Girls, Gender Equality and HIV for Eastern and Southern Africa (HLTF) visited South Africa. The HLTF noted that there was a huge disjuncture between macro level legislation and policy and realities at community and grassroots levels where attitudes and practices were not aligned to the constitution and other policies.

2. What key challenges or constraints have been encountered in addressing this target?

Social Constraints identified include the fact that GBV fosters the spread of HIV by limiting a women or girls ability to negotiate safe sexual practices, disclose their HIV status, and access services due to fear of reprisal. From another perspective, the burden of care of HIV often falls on women and has spiralling negative effects on

Challenging social conditions in South Africa further contribute to entrenched inequalities.

their realistic choices and their future. In addition, a key challenge to addressing this target is the lack of development of appropriate, proven interventions to address the root causes of sexual and gender based violence.

3. What are the key programmatic actions necessary to stay on track and/or achieve this target?

HIV and sexual and reproductive health and rights need to be linked in all interventions (e.g. clinics, messaging). Actions to prevent and respond to violence against women and girls must be an essential part of the HIV response. The dual needs of women in preventing HIV and stopping unintended pregnancy need to be addressed by supporting programmes that aim to address women's equitable access to HIV programmes and services thereby reducing gender inequalities.

Young women (aged 15 to 24) represent a significant portion of new HIV infections. Age appropriate HIV and sexuality education and services in a supportive environment are essential, especially for adolescent girls.

Educated and informed women and men, as well as programmes that address harmful male behaviour, are non-negotiable elements of effective HIV and TB response. Education programmes need to encourage women and men to be advocates, leaders, and decision-makers and therefore programmes need to have multiple foci. *First*, programmes such as Brothers for Life should continue to engage men and boys in order to address harmful gendered norms and behaviour. *Second*, programmes to educate women and girls so that they understand how to inform services to better meet their needs and/or how to advocate for development and access to those services should be accelerated. *Third*, programmes should focus on educating women about their sexual and reproductive rights and bringing men on board to support women in their choices.

4. What policy and enabling environment changes are required to reach the targets?

Challenges to achieving this target include structural, behavioural, cultural and social barriers and economic realities that in turn influence individual behaviour, beliefs, and practices. These factors need to be practically addressed in any and all programs in order to sustain positive progress and promote the sexual and reproductive health rights (SRHR) of its women and girls. A comprehensive national,

costed, and implemented HIV/SGBV prevention strategy which involves every government department and civil society collaboration toward zero HIV infection is critical.

5. What new investments are necessary to keep on track and/or achieve this target?

There are four identified areas for investment that will support achievement of this target. *First*, South African should invest in the policy framework and guidelines mentioned above that will support a more enabling environment. *Second*, programmes that aim to address women's equitable access to HIV programmes and services through strategic integration and linking services should be supported. *Third*, resources for community based organisations to conduct transformative work at community level that addresses gender norms and gender inequality should be supported. *Fourth*, investments in education programmes and long term community dialogues for men and women should be a priority. One example would be investing in large scale training programmes for women and girls that explain their legal rights and where to obtain needed services. A second example is investing in gender, health, and human rights programmes that engage young children and shape the next generation's gender perspectives.

Young women (aged 15 to 24) represent a significant portion of new HIV infections.

6. What are the recommendations to national stakeholders to ensure implementation of suggested changes?

Key civil society groups should identify strategically placed policymakers and government officials that can work to develop a strategy to create an enabling policy environment and to strengthen implementation and enforcement of polices and laws that exist. Further, civil society and government should identify one key challenge and focus a majority of resources on that issue (e.g. rape) addressing it at all levels (policy, law, training and advocacy). This intensive intervention should have adequate budget support.

Specific and focused programmes and communication that encourages traditional leaders to support and promote positive behavioural change is an important part of reaching this target. Addressing gender disparities in community care and support and challenging harmful cultural and traditional practices and attitudes can be more effective when men and traditional leaders are involved. Traditional leaders play an important role in challenging and changing some of the traditional and cultural attitudes, beliefs and practices related to care (SADC, 2012).

7. What are the recommendations for sustaining progress along this target beyond 2015?

   Expanding and strengthening existing economic empowerment and social protection programmes is a critical factor for success. Programmes that provide women with skills and cash transfers to improve their economic status will improve women's options for safe choices and reduce their vulnerability to HIV and gender-based violence.

   A national GBV Plan of Action will be developed in 2013 which aims to sustain future progress, and this needs to be supported. Further, it needs to be recognised that policy and frameworks often take considerable time to change, and then even more time to trickle down to the community level. Therefore tangible actions should be identified that immediately aim to reduce the burden of care, which often falls on women and young girls. Community mobilisation and male involvement are examples of interventions that could help reduce the burden of HIV care on women while national policies, guidelines and frameworks are being developed, reviewed and revised (SADC, 2012).

SECTION 2:
STOCKTAKING EXERCISE:
TARGET-BY-TARGET REVIEW

TARGET 8: Eliminate stigma and discrimination

- Is this a priority target for the country?
  YES
- Does the National Strategic Plan address this target?
  YES
- Is the country on track to reach the target and commitment?
  YES

1. What key actions have been taken to reach this target since 2011?

   The most important change that has taken place has been the provision of ART to more than 2 million South Africans. This has enhanced a generally high level of openness about HIV in the general population due to the advocacy and activism of PLHIV organisations such as the Treatment Action Campaign, NAPWA and SANERELA. A sign of the progress that has been made to reduce stigma is that more than 20 million South Africans have tested for HIV in the last 24 months since the national testing campaign was launched by the President of South Africa.

   There has been significant progress with reducing stigma experienced by key populations such as sex workers, MSM and prisoners. The country will launch national programmes for these three key populations once the application to the Global Fund is approved.

   There have been a significant number of programmes targeting health workers to sensitise them to the special needs of key populations. Programmes specifically addressing stigma have been implemented reaching thousands of healthcare workers. Historically, these programmes have been funded by PEPFAR. The National Department of Health now has dedicated programmes reaching more than 600 'hot-spots' throughout the country to reach key populations through peer education programmes.

This progress does not detract from on-going stigma. This has taken a particularly brutal form in a series of murders of gays and lesbians. South Africa's Constitution is the only one on the continent that protects the rights of sexual minorities and the South African Justice System prosecutes the breach of these rights, though the wheels of justice often turn slowly.

SANAC is working with the PLHIV sector to implement the Stigma Index to develop an objective indicator for monitoring stigma. It should be noted that there are many who believe that not enough is being done to address stigma but in the absence of an objective monitoring this report argues that South Africa has made major progress and is determined to make even more progress under the new NSP.

The SANAC '*Ensuring Protection of Human Rights and Improving Access to Justice'* Technical Task Team (SO4 TTT), which provides strategic technical guidance on policies addressing human rights and access to justice, has been revitalised and strengthened through the co-chairing of this committee by the Deputy Minister for Justice and Constitutional Development.

Data sources are slowly improving. Through advocacy from the PLHIV sector, the People Living with HIV Stigma Index was included as a key programme in the NSP 2012-2016. The NSP also calls for implementation of the *Stigma Mitigation Framework*. The HSRC has developed a research protocol and the sector is currently mobilising resources for implementation. The protocol builds on the results of the Stigma Index study, undertaken in 2011 by the National Association of People Living with HIV (NAPWA) in the Eastern Cape. As part of the same programme, NAPWA has also produced other research projects in the Eastern Cape. These have produced strategic information which is now being used to advise programmes addressing stigma. Nationally, NGO's and government departments continue to deliver stigma and discrimination programmes.

2. What key challenges or constraints have been encountered in addressing this target?

The target is not easy to quantify and tools to enable such a measure will have to be developed. These will be context-specific given the wide variations in social and cultural practices and norms. Uptake of HIV Counselling and Testing can be used as a proxy to assess the levels of stigma and acceptance of HIV status. The successful

implementation of the national HCT campaign indicates increased awareness of the importance and impact of anti-retroviral treatment.

Furthermore, effective political leadership has contributed positively to demystifying HIV and creating an enabling environment for disclosure and support. More work needs to be done to address the attitudes of health providers and programmes are already in place to build capacity across the health sector.

3. What are the key programmatic actions necessary to stay on track and/or achieve this target?

SANAC needs to provide strong coordination and leadership to achieve this target. The SO4 TTT should inform SANAC decision making through clear and practical policy and programmatic recommendations that address HIV related stigma and discrimination. A national level M&E framework that measures stigma should be developed and implemented. The framework should contain comprehensive indicators that are collected, analysed, and used to inform policy and programmes.

Current data suggests several specific actions. *First*, stigma programmes should be developed that sensitise healthcare workers, police and members of the judiciary and other groups in positions of authority of the rights of women, LGBTI, sex workers, People with Disabilities and other key populations. *Second*, conducting an audit of the legal system will identify gaps in laws that protect against discrimination and violence based on actual or assumed sexual orientation and/or gender identity.

4. What policy and enabling environment changes are required to reach the targets?

South Africa has an enabling policy environment required to eliminate stigma and discrimination. The NSP is premised on the South African Constitution and recognises the centrality of constitutional values and human rights. Laws such as the *Promotion of Equality and Prevention of Unfair Discrimination Act* are in place. The biggest challenge is how to practically implement laws and policies.

5. What new investments are necessary to keep on track and/or achieve this target?

Resources should be committed to implement the People Living with HIV Stigma Index and enable collection of baseline data on the experience of stigma encountered by PLHIV. Greater investment is

SANAC is working with the PLHIV sector to implement the Stigma Index to develop an objective indicator for monitoring stigma.

required in stigma-related research, monitoring, and evaluation. This includes supporting the creation or refinement of current policies that address stigma, developing practical frameworks and approaches that are socially and culturally appropriate, and identifying entry points for addressing stigma. This should be done in coordination with all key target areas. Resources should be allocated for NGO-led stigma and discrimination programmes through institutions such as the Global Fund against AIDS, TB, and Malaria.

6. What are the recommendations to national stakeholders to ensure implementation of suggested changes?

Government and civil society should focus their efforts to address stigma on youth, including those youth living with HIV. Civil society should support the knowledge and skills development of PWDs so that they can advocate for the rights to access HIV services, as well as galvanize their community to demand access to essential HIV services. Leadership in government should send an "unequivocal message" for ending discrimination and violence, and support a continued dialogue on discrimination based on sexual orientation and gender identity.

7. What are the recommendations for sustaining progress along this target beyond 2015?

Research, monitoring, strategic programming and adequate resource allocation are required at all levels to address stigma and discrimination. Gender based violence, gender inequality, and inequitable access of health resources and programmes, and human rights abuses all fall within this target area. Each requires focused and specific attention to reach the 2015 target.

SECTION 2: STOCKTAKING EXERCISE: TARGET-BY-TARGET REVIEW

TARGET 9: To eliminate HIV-related restrictions on entry, stay and residence

- Is this a priority target for the country?
  YES
- Does the National Strategic Plan address this target?
  YES
- Is the country on track to reach the target and commitment?
  YES

1. **What key actions have been taken to reach this target since 2011?**
   South Africa's Constitution provides that "everyone has the right to freedom and security of the person which includes the right not to be treated or punished in a cruel, inhuman or degrading way."

   South Africa does not have HIV-related restrictions (in the form of a law or administrative function that requires people to indicate their HIV-status) on entry, stay, and residence. According to the publication Mapping of Restrictions on the entry, stay and residence of people living with HIV (UNAIDS, May 2009), and latest developments as of January 2013, South Africa is one of the 133 countries, territories and areas which have no HIV-specific restriction on entry, stay and residence.

   South Africa is also a party to the core international treaties dealing with non-refoulement including the International Covenant on Civil and Political Rights (ICCPR) and the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT).

   Since the emergence of the HIV epidemic in the 1980s, migrant populations have repeatedly been recognised by the international community as a vulnerable group in the risk, spread, and prevention of HIV.

   To address migrant and mobile population challenges there are various Technical Task Teams spearheaded up by the Department of Transport.

To eliminate HIV-related restrictions on entry, stay and residence

2. **What key challenges or constraints have been encountered in addressing this target?**
   South Africa will maintain its current policy framework which supports and enables access to services for migrants from other countries. There are on-going efforts to foster dialogue and integration of people in communities where the needs arise. The Constitution promotes and protects the rights of migrants and this enables access to health services when these are needed. A wide variety of stakeholders and departments work collaboratively with relevant UN Agencies to support efforts to ensure the well-being of migrants.

3. **What are the key programmatic actions necessary to stay on track and/or achieve this target?**
   Improved regional collaboration across all borders and sustained international efforts through the UN. Furthermore, strengthening existing programmes that promote social cohesion and interventions that seek to ensure a continuum of care across the region.

4. **What policy and enabling environment changes are required to reach the targets?**
   South Africa must sustain all efforts to promote the values espoused in the Constitution and pursue regional efforts to ensure harmonisation of protocols for treatment as well as ensuring continuity of care as people move from country to country.

5. **What new investments are necessary to keep on track and/or achieve this target?**
   South Africa must invest in strengthening regional efforts to maintain and sustain collaboration and peace.

6. **What are the recommendations to national stakeholders to ensure implementation of suggested changes?**
   Government and civil society should focus their efforts to address migrant and mobile population challenges, including deportation and post-deportation. Civil society should support the knowledge and skills development of migrant and mobile populations to ensure that they can advocate for the rights to access to entry, stay, residence and health, despite their HIV status.

7. **What are the recommendations for sustaining progress along this target beyond 2015?**
   On-going dialogue and further refinement of agreements and protocols to promote the rights of all persons across the continent.

SECTION 2: STOCKTAKING EXERCISE: TARGET-BY-TARGET REVIEW

TARGET 10: Eliminate parallel systems, for stronger integration

- Is this a priority target for the country?
  YES
- Does the National Strategic Plan address this target?
  YES
- Is the country on track to reach the target and commitment?
  YES

1. **What key actions have been taken to reach this target since 2011?**

   The most important change in the last 12 months has been the integration of PEPFAR programmes throughout the country into the public health service. Almost all services provided by PEPFAR have now been transitioned to the health services in the provinces. This transition was managed jointly by a team from PEPFAR and the National Department of Health. Almost 1.5 million patients that were receiving services from PEPFAR funded programmes have now become fully integrated in the public health services.

   As a result of the extension of HIV treatment to all positive pregnant women, every facility that offers antenatal care does or will soon offer ART as well. This is essentially every fixed facility in the country as ANC is basic PHC service. At last count some 3100 facilities were offering ART (need to get the exact number) out of around 3600. HIV (art) is now integrated with maternity services. Similarly PMTCT has forced the integration of maternity, HIV and child health as there is a continuum of care along these three.

   As far as representation goes regarding PMTCT (including maternal ART) and paediatric ART, the policy makers from maternal and child health are either in charge of decision and policy making or are well represented when these decisions are made.

Eliminate parallel systems, for stronger integration

SECTION 2: STOCKTAKING EXERCISE: TARGET-BY-TARGET REVIEW

HIV and TB continue to be integrated although full integration has not yet been achieved. There is integration in the sense that all the services are offered at one facility on the same day. Virtually all TB patients are now screened for HIV and vice versa.

In 2012, government showed its support through the Minister of Health public insistence on better integration between the HIV, TB and antenatal programme. In 2012 a new Re-engineered Primary Health Care (PHC) model was developed which aimed to strengthen the health systems, enhance task shifting and expand access to PHC outreach services. At the same time, the re-engineering of primary health care has underlined the need to strengthen facilities. A functional community and primary health-care system increases use of high-level hospital services.

The reengineered PHC model has also highlighted the need to integrate health services. Innovations for maternal, neonatal, and child health have received specific attention. For example, in some provinces, community health workers visit pregnant women and new mothers in their homes, and also mentor community teams on maternal, neonatal, and child health. This mentoring approach is now being introduced nationally and aims to address quality of care for mothers, new-borns and children.

A National Health Insurance (NHI) scheme is also being developed that aims to increase access to more effective and affordable health services. Initiation of NHI provides a potential platform for innovation of integrated activities at scale.

The Regional Consensus Building Workshop on SADC Minimum Standards for Child and Adolescent HIV, TB and Malaria Continuum of Care and Support had two key results. First, there was technical validation of the minimum standards for paediatric HIV, TB and Malaria. Second there was consensus on core M&E indicators. In 2012, South Africa agreed on a national programme to improve quality of emergency obstetric and neonatal care, a programme that is now implemented in 25 districts.

The Campaign to Accelerate the Reduction in Maternal Mortality in Africa launched in 2012, integrates antenatal, family planning, child health and school health services with HIV risk reduction and ART strategies. It goes beyond PMTCT because, in addition to ART

initiation irrespective of CD4 count, it also invests in prevention of unwanted pregnancies in adolescence—a key contributor to maternal and neonatal deaths. Additionally, the campaign introduces an approach to prioritise 'hotspots' with high disease burden as priority points for service delivery.

A National Consultative workshop to facilitate the engagement of CBOs in community TB activities led to the establishment of a NGO coalition forum for TB/HIV integration.

2. What key challenges or constraints have been encountered in addressing this target?
   South Africa is data rich but information poor. The data systems do not necessarily provide nationally representative, good-quality information in a timely manner. For example, programmes for maternal, neonatal, and child health still do not have comprehensive data that provide information on the coverage of child survival interventions. Additionally, the Non-Communicable Disease surveillance system needs to be defined and established. There is no validated tool for reporting on the degree of service integration, making it difficult to state how integrated the services are at a specific site.

3. What are the key programmatic actions necessary to stay on track and/or achieve this target?
   There are five identified key programmatic actions needed. *First*, TB and HIV services need to be integrated. *Second*, there needs to be wider TB and HIV service delivery for maternal, neonatal, and child health. Non-Communicable Diseases (NCDs) still need to be addressed. *Third*, integrated food and nutrition services at both health sector and community levels are critical in helping overcome barriers to treatment adherence. Food and nutrition should be considered as part of a comprehensive package of care. *Fourth*, programmes that support food security are needed to reduce the likelihood of negative coping strategies such as selling household assets (e.g. livestock, agricultural equipment), which lead to even worse poverty and migration. *Last*, a comprehensive surveillance project is needed. This will assess the prevalence of NCDs and their risk factors, the health status of children, and the behavioural and social determinants of health.

Strategic investment in the health information system is needed to develop the capacity to prepare, manage, and use data for decision

A National Health Insurance (NHI) scheme is also being developed that aims to increase access to more effective and affordable health services.

making. Information about health-system function needs to be developed and coordinated. The district health barometer provides information for the 53 health districts in the country, and it will be important to supplement these data with information about different initiatives as they are implemented.

4. What policy and enabling environment changes are required to reach the targets?

   Technical guidance is needed to support standardising terms and care delivery strategies. Further, targeted research is needed to strengthen the evidence base of integrating HIV and MNCH programmes. Empirical information can then inform the policy changes that are needed to support an enabling environment for integration.

5. What new investments are necessary to keep on track and/or achieve this target?

   The DOH response to HIV and TB should be balanced with increased spending on integrated HIV and TB services to other government departments, particularly the Department for Social Development (DSD) and the two Departments of Education (DBE and DHET).

   There also needs to be an investment in Integrated HIV and cervical cancer services.

6. What are the recommendations to national stakeholders to ensure implementation of suggested changes?

   Integrating services for HIV, family planning (FP), and MNCH – and delivering them in a single setting – would address patients' multiple needs at once, potentially enhancing programme effectiveness and efficiency. By maximizing the use of available human resources, integration may be more cost-effective than delivering separate programmes in different setting. *First*, it allows people living with HIV to access both HIV and other services in the same facility, increasing the opportunities for a continuity of care without being externally referred. *Second*, it expands the range of clinical services provided beyond HIV treatment and care to include management and treatment of STIs, family planning, cervical cancer screening and treatment, infertility treatment, PMTCT and other related services. *Third*, it reduces the frequency and costs of health-related costs for patients, such as time off work, transportation, and other costs.

Further, integrating HIV into broader development planning processes and frameworks is critical to ensure that the national HIV response works coherently – and not at cross-purposes – with other health and development objectives. The ability to integrate HIV meaningfully into other development sectors will not only create opportunities for increasing the effectiveness of the national AIDS response but also broadens and diversifies its financing base, helping to promote sustainability.

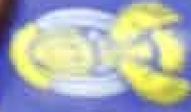
Additional recommendations include focus on a client-centred approach at facility level. Patient management and programme recording and reporting tools must be simplified and community systems integrated into the community. There should also be local high quality drug and commodity production and supply chain management for procurement systems. Adherence support should be integrated and collaboration between research and programmes facilitated. Finally, multiple reporting requirements should be addressed and rectified.

7. What are the recommendations for sustaining progress along this target beyond 2015?

Sustaining progress requires integration of the private and public sectors into services for HIV, tuberculosis and non-communicable diseases. At the same time, surveillance and information systems need to improve and reporting refined. Experiences with successful integrated care should be shared and adopted. Finally, district and provincial management structures should be supported so that they work seamlessly to address HIV health needs.

There also needs to be an investment in Integrated HIV and cervical cancer services.

AIDS HELPLINE
0800-012-322



Government HIV and AIDS Policies

SECTION 3:
GOVERNMENT HIV AND AIDS POLICIES

This section is informed by responses from government and civil society to the special *National Composite Index* questionnaire.

PART A: GOVERNMENTAL SOURCES

Question 1:
Have you performed population size estimations for key populations?

Currently there are no baselines (population size estimation and HIV surveillance) for MSM or, PWID; The UCSF will be conducting surveys to estimate key population sizes, amongst other measures, for MARPS. This effort is being funded by PEPFAR. A national sex worker size estimation has recently been concluded.

Key population	Size estimation performed (yes/no)	If yes, when was the latest estimation performed? (year)	If yes, what was the size estimation?
a) Men who have sex with men	No		
b) People who inject drugs	No		
c) Sex workers		Yes	153 000
d) Other key populations. Please specify which key population in the comment box.	No		

Question 2:
Are health facilities providing HIV services integrated with other health services?

Area	Many	Few	None
a) HIV Counselling & Testing with Sexual & Reproductive Health	X		
b) HIV Counselling & Testing and Tuberculosis	X		
c) HIV Counselling & Testing and general outpatient care	X		
d) HCT and chronic Non-Communicable Diseases	X		
e) ART and Tuberculosis	X		
f) ART and general outpatient care	X		

SECTION 3:
GOVERNMENT HIV AND AIDS POLICIES

Area	Many	Few	None
g) ART and chronic Non-Communicable Diseases	X		
h) PMTCT with Antenatal Care/Maternal & Child Health	X		
Other comments on HIV integration: *The large scale PEPFAR funded programmes have been integrated into the public health service.*			

While there are capacity challenges that differentiate facilities and impose on the optimal delivery of services, facilities are providing HIV services integrated with other services in all 9 combinations indicated in the NCIP questionnaire.

Question 3:
Are there any key policy changes in the AIDS response since early 2012 when your last National Commitments and Policies Instrument (NCPI) were submitted? If yes, please highlight these.

The approval and adoption of the new NSP has been significant and has directed the development of numerous sector strategies and other efforts to operationalise its provisions. The progress on the roll-out of the PHC re-engineering effort is beginning to and will ultimately have a significant impact on the manner and, it is anticipated, the impact of service delivery. This is especially pertinent in term of the school health PHC teams and their provision of a comprehensive care package at school level.

Key treatment policy initiatives that have been implemented include:

- Changes in eligibility criteria for treatment in terms of PMTCT. Specifically the introduction of a more effective treatment protocol for children under 5; and the fixed dose combination for pregnant women that dictates ART for CD4 counts below 350.

- The introduction of the treatment protocol for TB co-infection regardless of CD4 count.

Monitoring and evaluation also benefits from some significant developments. This includes the indicator review of DHMIS, which occurs every 2 years and was conducted in 2012, and the mandatory transition to an electronic register on Tier.net for all facilities with capacity to service 1000 or more patients.

PART B: NON-GOVERNMENTAL SOURCES

Question 1:
Are there any key policy changes in the AIDS response since early 2012 when your last NCPI was submitted? If yes, please highlight these here.

The revitalisation of SANAC and the 16 civil society sectors has been a significant improvement over the last 12 months. Some sectors – such as the Children's Sector, Sport and Entertainment, Men's Sector and Sex Workers – are already implementing programmes whilst others are finalising their sector plans.

Disability sector response

There have been no major changes regarding implementing of the NSP which reflect key policy changes in the AIDS response. As the disability sector, an action plan was developed relating to the NSP, but as yet, nothing has been implemented. The key reason for the lack of action is the matter of financial constraints – the disability sector does not have the resources to engage with the NSP. Nonetheless, the NSP itself does not reflect policy change. There is also no real change regarding the engagement of the private sector and the engagement of the AIDS alliance.

Higher education sector response

Stakeholders from South African universities were consulted as part of this mid-term review. The Higher Education Sector has developed its own *Policy and Strategic Framework on HIV/AIDS for Higher Education*. This framework was launched in 2011 on World AIDS Day, and is a pledge – as the Higher Education sector (which is the country's next economy) – of scientists, researchers and students to lead the HIV policy process in the sector. The framework lays out an actionable response on behalf of the 1.6 million South African people in the Higher Education sector. The three objectives for the Higher Education sector are strategically aligned to the objectives of NSP in order to contribute to vision and goals of the national strategic plan. Higher Education uses its key strengths to address HIV namely, teaching/learning, and research, innovation and community engagement. This is partly achieved by addressing social structure and preventing infection.

The sector responds to the drivers of the HIV epidemic by asking HOW this can be done. Teaching modules are developed to address whether teachers are equipped to deal with individuals living with HIV. Modules in every discipline are developed to ensure understanding/ safeguarding against HIV infection, and sending key messages through

the community. HIV-related research questions for the sector include whether Higher Education aligned to national research goals in HIV? This encourages further research and campaigns.

NGO sector response

Imminent PEPFAR transition from supporting direct service delivery to support through technical assistance is now gathering momentum and will have a substantial impact on the national HIV response. In particular, NDOH capacity will be augmented as health workers employed externally are integrated into government structures. The impact of the transition has already been keenly felt in the OVC response.

In the past year, there has not been anything of great significance in terms of policy response, particularly regarding the NGO sector. The reengineering of health system was a welcome initiative but it will have an impact on the NGO sector. Community health workers employed within NGOs are part of a health system strengthening approach. These workers belong to PHC teams – but currently not all of them can be absorbed into this particular model. NGOs are beginning to feel the pressure of this and a gap is emerging related to community work. The responsibility of this gap rests upon the NGO community; the key question is how it can smoothly manage the transition?

Sex workers response

There have been definite internal changes regarding approach and policy response to sex work – there has been more activity and commitment to addressing sex worker's needs. Efforts to change government policy regarding sex work/law reform have shown no progress. Last year, with the launch of the NSP, the Sex Workers Education and Advocacy Taskforce (SWEAT) was active in participating in various policy and programme discussions to ensure provision of services for sex workers. All sectors supported SWEAT's input – regarding the call for the decriminalisation of sex work. When the NSP was taken to Cabinet, content was removed from strategic objective 4 (regarding Human Rights and the decriminalisation of sex workers). For the NSP implementation to rescue its Human Rights approach, it must ensure service related issues are responded to.

The National sex work programme, drafted with SANAC is a positive document. It asks that we bring together services across country in consistent approach to deliver services to sex workers. If there are policy changes to progress Human Rights, sex workers can take up services offered.

The revitalisation of SANAC and the 16 civil society sectors has been a significant improvement over the last 12 months.

SECTION 3:
GOVERNMENT HIV AND AIDS POLICIES

People Living with HIV sector response

The Health Minister at the last SANAC Plenary meeting announced the introduction of fixed dose combination drugs. This was a great achievement in terms of people who will adhere to treatment – there was previously great difficulty around the treatment issue.

There has been an integration of a means of dealing with stigma relating to HIV in the NSP. There has also been meaningful involvement of people living with HIV as representatives in the sub-committees of SANAC. There are also representatives within the SANAC *Programme Review Committee (PRC)* – elected leaders represent the sector. Within the SANAC plenary committee, there are five representatives of PLWHIV.

Remaining challenges include the scaling up access to treatment and hospitals and clinics. The PLWHIV sector plans to continue to hold the Minister of Health accountable for scaling up treatment and to promote accessibility to fixed dose combination treatment.

Religious sector response

The national response from the National Religious Leaders has always been respect for individual pockets of denomination regarding condoms, human sexuality, ARVs. In principle, there is agreement and support for government in its latest developments and provision of ARV packages. Condoms, from a doctrinal view, are respected and regarded by other faith leaders. Issues are around care and support, counselling and testing, providing ARVs and mobilising congregations in understanding what the pandemic is about. Current trends and policy around discrimination and stigma need attention. There were key interventions in early days, but now the religious sector needs to reintroduce policies and strengthen current policies. How do we treat our staff? How does the workplace in church environment adopt policies? In terms of debate, the problem is far from over. Church leaders need to look afresh at how they mobilise and mainstream policy into church administration/awareness programs and advocacy. There is movement but not enough in terms of awareness. This varies from congregation to congregation but AIDS needs to be on front burner, in terms of advocacy, statements, implementation of real programmes to that effect.

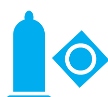
Regarding the workplace, discrimination and sex workers, we are grappling with guidelines/policies. Sex workers have requested a need to work with church and the religious sector needs to develop guidelines

– putting theory to practice. It could be in some denominations that the policy is to work together. There is support for government initiatives as far as possible but we consider religious sector as an integral role player in delivering of services – a key implementer of programs. The Church is still providing food, caring for Orphans and Vulnerable Children – the national policy should always put most vulnerable first in providing resources for OVC. If outside funders cease to provide resources, then church and government must provide policy that puts the voiceless and the marginalised first. We must ensure that policies are in play and are of priority but must be kept as priority.

Annexes

ANNEX 1

Targets and elimination commitments of 2011
UN Political Declaration on HIV/AID:
Summary Matrix of key findings and recommendations for South Africa

	Target 1: Reduce Sexual Transmission of HIV by 50% by 2015		
Is this a priority target for South Africa?	Yes	Does the NSP address this target?	Yes
What key actions have been taken to reach this target since 2011?	• National HCT campaign has scaled up availability of HCT services in more than 90% of public health facilities • Scaling up medical male circumcision in areas of high population density • Integrated School Health Programme to increase the provision of comprehensive sexual education & SRHR services that include referral & linkages to community services • Significant increase in addressing new infections in young women with the launch of a new campaign • Addressing key populations with a special focus on sex workers, MSM and sentenced and awaiting trial prisoners in correctional facilities		
What key challenges or constraints have been encountered in addressing this target?	• Decreased funding for HIV prevention programmes due to competing funding priorities has led to inadequate investment in BCC • Socio-cultural determinants such as alcohol abuse, violence against women & socio-economic insecurity • Policy environment that negatively affects key populations & weak information to inform or monitor programmes • Taboos surrounding sex & sexuality & stigma remain a major hindrance, discouraging people from taking full advantage of the HIV & TB services • Lack of programme scale up for targeted groups such as young people		
Is South Africa on track to reach this target?			Yes
What are the key programmatic actions necessary to stay on track and/or achieve this target?	• Single biggest prevention priority for South Africa is to reduce new infections in young women between the ages of 15 and 24 through, inter alia, intergenerational and transactional sex • Continued scale up of programmes that address stigma, & intensifying strategic data generation & analysis • Continued support to civil society to strengthen their role in the HIV prevention response. • Delivery of tailored combination prevention packages in various settings. • Comprehensive condom programming that generates demand for condoms as a dual method for family planning, STI & HIV • Strengthening linkages between HCT programmes and care & support		
What policy and enabling environment changes are required to reach the targets?	• Engagement of key populations and people living with HIV in order to address contextual factors, prioritise high-burden areas, & increase & sustain investments for HIV prevention • Ground HIV prevention efforts in human rights & address gender equity • Enabling policies to reach sex workers & prison populations		

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What new investments are necessary to keep on track and/or achieve this target?	• Scale-up of evidence-informed HIV prevention efforts for girls & young women • Implementation of the Stigma Mitigation Framework & implementation of the Stigma Index • Investment in young people to enhance their leadership skills & encourage their participation in policy, programme & funding decisions
What are the recommendations to national stakeholders to ensure the implementation of suggested changes?	• Support further civil society involvement in the prevention response at sub-national levels • Enhanced collaboration among government departments, NGOs, economic & financial institutions to address needs of key populations • Develop a supportive communication strategy that draws on and actively engages established networks that will strengthen the overall response. • Identification of evidence informed based programmes & advocate for their scale up.
What are the recommendations for sustaining progress along this target beyond 2015?	• Strengthen health systems & improve universal access to health care. • Harmonise reporting systems across sectors & improve data collection & analysis of research & programme data • Encourage private sector participation in the scale up of the multi-sectoral approach. • Focus on stigma reduction programmes

	Target 2: Reduce Transmission among People who Inject Drugs by 50% by 2015		
Is this a priority target for South Africa?	No	Does the NSP address this target?	YES
What key actions have been taken to reach this target since 2011?	• NSP formally recognises the growing problem of illegal substance use including injecting drug use & associated HIV vulnerability risks & the need to scale-up harm-reduction programmes & remove barriers preventing provision of services to PWUD • NDOH Mini Drug Master Plan (2011/2012 - 2013/14) supports harm reduction interventions. • Launch of a multifaceted pilot harm reduction programme for MSM who use drugs, including those who inject drugs. • Operational guidelines for key populations that includes elements relating to needle syringe programme and OST • On-going Rapid Assessment & Response on PWID and HIV-related risks in 3 Provinces & 4 cities.		
What key challenges or constraints have been encountered in addressing this target?	• Lack of strategic information on drug use. This hinders the governments and other's ability to develop evidence based and relevant national policy and programmes.		

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What key challenges or constraints have been encountered in addressing this target?	• Limited national policy and programme support. The NSP does not specifically include objectives and indicators addressing PWID issues, only illegal substance abuse in general. • No committed government funding to operationalize the harm reduction guidelines of the DOH Mini Drug master plan. • Limited support from potential implementers and other key stakeholders in PWID initiatives. Public health care facilities currently do not implement OST. There is no support provided to networks of PWID & no integration of HIV prevention & treatment services at the drug rehabilitation centres that provide detoxification and promote abstinence based approach.
Is South Africa on track to reach this target?	N/A
What are the key programmatic actions necessary to stay on track and/or achieve this target?	• Generate PWUD and PWID size estimates and HIV surveillance information is needed to inform the scope and nature of substance abuse in South Africa, and its relationship to HIV. • Research would inform a strategic harm reduction strategy that would underpin programme planning. Supporting evidence-based harm reduction programmes for PWID should be piloted, tested and where they are effective and efficient, rolled out. • Build knowledge among government departments regarding HIV prevention & care among PWID is critical. In support of this, creating a general awareness on drug use and HIV and TB and human rights should be initiated.
What policy and enabling environment changes are required to reach the targets?	• Operationalise the Mini Drug Master Plan & reassess the NDOH treatment policy on OST & methadone. • Government department accountable for HIV prevention among PWID must be clearly identified.
What new investments are necessary to keep on track and/or achieve this target?	• Commit funds to support HIV prevention for PWID programmes identified as effective and efficient, particularly in 'hot spot' areas • Establish PWID and PWUD baseline population size estimates & HIV prevalence & risk behaviour estimates. • Investment in developing IEC materials on Drug Use & HIV for different stakeholder groups that support raising awareness and sensitisation programmes
What are the recommendations to national stakeholders to ensure the implementation of suggested changes?	• Strengthened Technical Working Group on HIV and Drug Use to ensure implementation of the MTR recommendations & improve stakeholder coordination, collaboration, research & strategic information sharing & advocacy for funding to scale-up the national response. It would support implementation of the NDOH Mini Drug Master development & implementation of national harm reduction policy.
What are the recommendations for sustaining progress along this target beyond 2015?	• Specific research on programme gaps to inform policy and programmes. • An active technical working group consisting of government departments & CSOs to ensure interventions on PWID/PWUD and HIV and TB are included & funded in relevant departmental Annual Performance Plans

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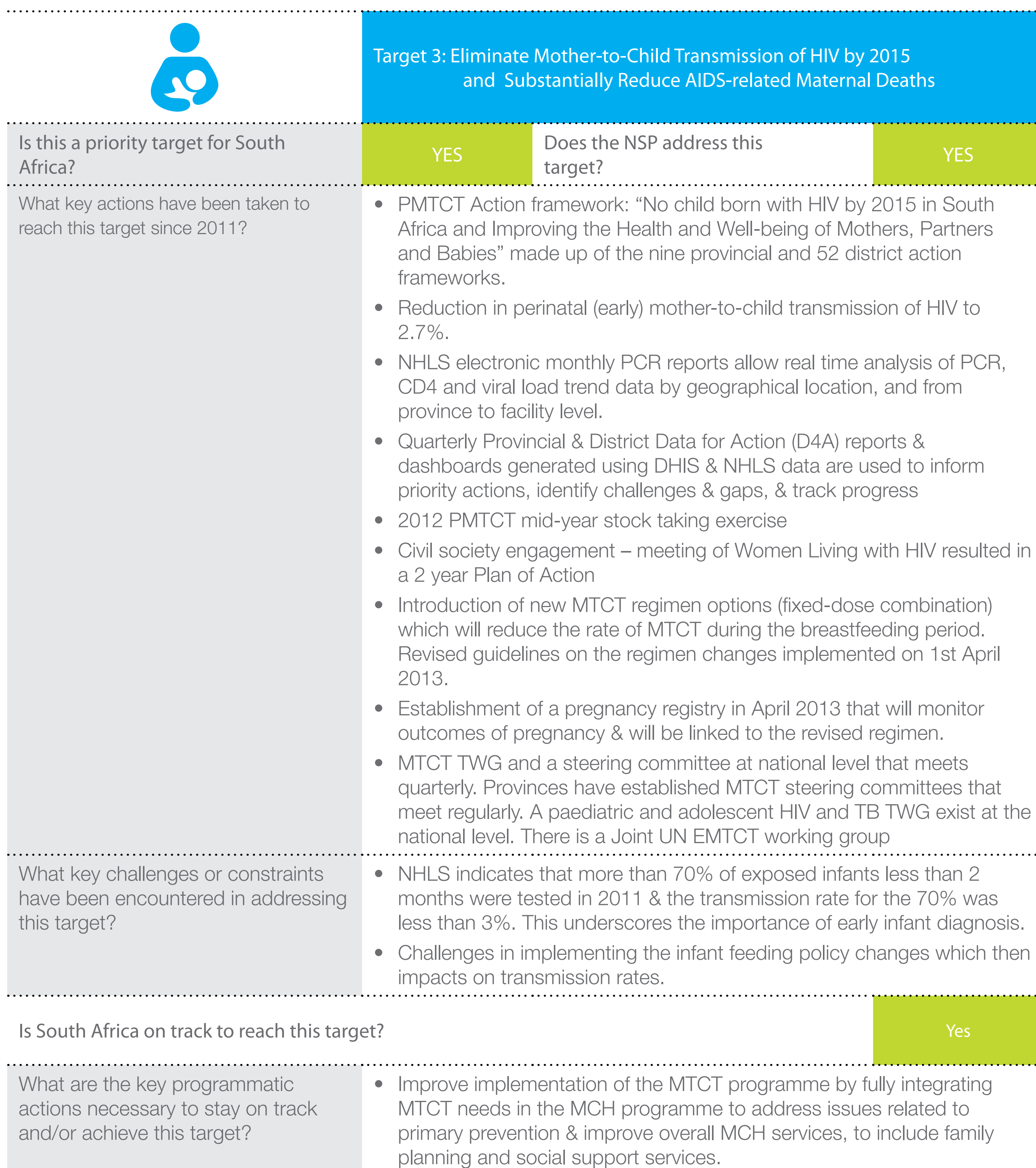

<table>
<tr><td></td><td colspan="3">Target 3: Eliminate Mother-to-Child Transmission of HIV by 2015 and Substantially Reduce AIDS-related Maternal Deaths</td></tr>
<tr><td>Is this a priority target for South Africa?</td><td>YES</td><td>Does the NSP address this target?</td><td>YES</td></tr>
<tr><td>What key actions have been taken to reach this target since 2011?</td><td colspan="3">
PMTCT Action framework: “No child born with HIV by 2015 in South Africa and Improving the Health and Well-being of Mothers, Partners and Babies” made up of the nine provincial and 52 district action frameworks.
Reduction in perinatal (early) mother-to-child transmission of HIV to 2.7%.
NHLS electronic monthly PCR reports allow real time analysis of PCR, CD4 and viral load trend data by geographical location, and from province to facility level.
Quarterly Provincial & District Data for Action (D4A) reports & dashboards generated using DHIS & NHLS data are used to inform priority actions, identify challenges & gaps, & track progress
2012 PMTCT mid-year stock taking exercise
Civil society engagement – meeting of Women Living with HIV resulted in a 2 year Plan of Action
Introduction of new MTCT regimen options (fixed-dose combination) which will reduce the rate of MTCT during the breastfeeding period. Revised guidelines on the regimen changes implemented on 1st April 2013.
Establishment of a pregnancy registry in April 2013 that will monitor outcomes of pregnancy & will be linked to the revised regimen.
MTCT TWG and a steering committee at national level that meets quarterly. Provinces have established MTCT steering committees that meet regularly. A paediatric and adolescent HIV and TB TWG exist at the national level. There is a Joint UN EMTCT working group
</td></tr>
<tr><td>What key challenges or constraints have been encountered in addressing this target?</td><td colspan="3">
NHLS indicates that more than 70% of exposed infants less than 2 months were tested in 2011 & the transmission rate for the 70% was less than 3%. This underscores the importance of early infant diagnosis.
Challenges in implementing the infant feeding policy changes which then impacts on transmission rates.
</td></tr>
<tr><td colspan="3">Is South Africa on track to reach this target?</td><td>Yes</td></tr>
<tr><td>What are the key programmatic actions necessary to stay on track and/or achieve this target?</td><td colspan="3">
Improve implementation of the MTCT programme by fully integrating MTCT needs in the MCH programme to address issues related to primary prevention & improve overall MCH services, to include family planning and social support services.
</td></tr>
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What are the key programmatic actions necessary to stay on track and/or achieve this target?	• Actions should focus on improving early infant diagnosis, improving accessing paediatric treatment, monitoring of mixed feeding and transmission post breastfeeding, and addressing how to better implement the infant feeding policy changes. • Develop a 'user friendly' version of the MTCT action framework for members of civil society & communities. • Implement focused integrated training (e.g. ART, MTCT, TB, HCT, & Family Planning) for health practitioners. • Engage with relevant sectors for the implementation of MTCT policies and programmes. • Support for stronger programme monitoring and use of data to inform key policy and programme decisions.
What policy and enabling environment changes are required to reach the targets?	• Creating demand for services by supporting an enabling environment that focuses on addressing stigma & disclosure issues and encourages communities to support a mother and child to access services. • Development of a national communication advocacy strategy that focuses on social bottlenecks. • Further linking EID to EPI & setting up a tracking system of both mothers and infants
What new investments are necessary to keep on track and/or achieve this target?	• Health system strengthening that creates a more friendly community based approach in line with Primary Health Care (PHC) reengineering and supports the recent changes in treatment, feeding and other policies and frameworks. • National Health Insurance implementation of the PHC that will create unique identifiers for follow up for mothers and infants. • Community support structures for adherence to ARTs to support mothers to disclose and adhere to treatment • Engagement with strategic leadership such as parliament, religious leaders, faith based and other leaders that have strong influence in creating an enabling environment, and reaching the intended target.
What are the recommendations to national stakeholders to ensure the implementation of suggested changes?	• Suggestions in this review should be discussed and specific actions identified. These can be tabled at national and provincial Department of Health PMTCT technical working group and Steering committee meetings.
What are the recommendations for sustaining progress along this target beyond 2015?	• MTCT is the Fourth Zero in the 2012-2016 NSP. The MTCT process should be closely monitored. • An improvement in data collection, analysis and use is needed to encourage informed decision-making at the programme and policy level.

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	Target 4: Have national target of People Living with HIV on Anti-retroviral Treatment by 2015		
Is this a priority target for South Africa?	Yes	Does the NSP address this target?	Yes
What key actions have been taken to reach this target since 2011?	• Access to treatment has increased to over 3,683 facilities (Public: 3,574 and Private: 109), the majority of which are primary healthcare facilities. • Development & implementation of the ART guidelines, in line with the new policy of ART for all adult patients with CD4 cell counts < 350 cells/micro & all children ≤ 5 years of age, as well as for all HIV and TB co-infected adults & all pregnant women on ART irrespective of CD4 • In 2012, a ZAR 5.9-billion tender was awarded for a fixed-dose antiretroviral. In April 2013, DOH launched FDC. Reduced cost of the tender for both the FDC (reducing the cost of a single dose of the triple combination of Tenofovir, Entricitabine and Efavirenz by 38%) as well as for most traditional ARV formulations, resulting in an estimated saving of ZAR 2.2-billion between 2013 and end 2014. • Establishment of a National HIV Drug Resistance (HIVDR) steering committee & TWG in charge of the development of the national HIVDR strategy. • National Health Council approved a three-tiered strategy for monitoring provision of ART in all provinces. This strategy comprises a paper-based ART registers (tier 1); an electronic non-networked system called TIER.net (tier 2); and electronic networked systems using a patient information system (tier 3), called SmARTer.		
What key challenges or constraints have been encountered in addressing this target?	• The management of paper-based data systems is a huge challenge in terms of integrity of cohort data analysis. • Lack of a unique identifier and poor data management in health facilities, and between most health facilities • Absence of an efficient follow-up system for defaulters and those lost to follow-up. • Absence of a common reporting system for non-public sector ART programmes leaves a gap in fully determining coverage. • Insufficient capacity of human resources in some health facilities has led to challenges of 'over-demand' when implementing new guidelines and 'out-crowding' of other services in the primary health care level, with inefficient utilisation of human resources in others as a result of poor supervision. • Lack of expansion of treatment to individuals, especially men, who need ART but are not receiving it due to various barriers including structural and social issues and stigma • Inadequate supply chain management (from depots to facilities) for medicine and other resources supply threatens the expansion of and access to treatment programmes. • Substantial loss of patients, including patients who do not return for their initial CD4 count results and those who do not initiate ART despite eligibility. • Complexity of managing children due to late diagnosis, dosing and adherence, which often have to be negotiated with a caregiver.		

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What key challenges or constraints have been encountered in addressing this target?	• The ratio of men to women in ART services is low relative to rates of HIV infection. Men also present at a more advanced stage of AIDS than women do, and are generally older and have higher levels of early mortality on treatment. • Late initiation of people on treatment due to late diagnosis and poor pre-ART programmes, lack of a structured pre-ART programme due in part to limited staff resources at facility level, and the decentralisation of primary health care to be managed by nurses without any additional human or infrastructural resources.
Is South Africa on track to reach this target?	Yes
What are the key programmatic actions necessary to stay on track and/or achieve this target?	• Effective promotion to key populations for early HCT for entry point to HIV care. • Strengthened longitudinal health information systems that allow patients to be tracked between service delivery points to properly evaluate pre-ART loss to care, including increasing the number and support of clinic-level data staff and implementing adequate feedback loops between clinic and higher level M&E structures. • Assessment of the existing pre-ART system to identify gaps and to draw lessons learnt for further strengthening. • Introducing and maintaining a three-tiered longitudinal data system in public sector and better management of data capturers at clinics would improve quality of data. • Development & use of a quick implementation of a unique identifier, improving the cross-border tracking for both HIV & TB, & harmonising treatment protocols with other SADC countries • Development and linking of private sector data systems to the public M&E structure. • Strengthening all aspects of patient management which include skilled health care workers, supportive environment for the patient on ART, efficient drug and data management systems. • Supervision & Mentorship Guidelines should be updated to address the new National ART Guidelines for adults, paediatric and PMTCT. • To prevent drug stock-outs, the tendering process should be revised to include flexible upper limits for drug quantities. • Ensure that the quality and availability of current PHC services is maintained in the light of the ART expansion to all PHC facilities and increase resources at PHC level where HIV services are now being rendered
What policy and enabling environment changes and/or new investment are required to reach the targets?	• Follow up through regular technical visits and supervision and mentorship to make sure that all aspects of the new National ART guidelines are rigorously implemented in both public and private health facilities. • Strengthen coordination among all levels and partners of the public health system (national, provincial, and district) and between government, civil society, and non-governmental organisations that deliver health services. • Management staff should be supported to implement sound project management principles to roll out national programmes.

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What new investments are necessary to keep on track and/or achieve this target?	• Exploration of innovative funding mechanisms to address scaling up of ART and how to better involve private sector in service delivery and funding. • Investing in a stronger HMIS, an improved financial management & accountability system, & a multi-sectoral M&E framework • Investment in human resources, material resources, and infrastructure that address the needs at primary health care facilities. • Identify solutions that solve backlogs & explore different models of care & service delivery • Further investment in the local supply chain management systems
What are the recommendations to national stakeholders to ensure the implementation of suggested changes?	• Prioritise the exploration of how to increase testing, linkage and retention of key population groups. • Scale-up of NIMART supervision and mentoring, and increase community mobilization by actively encouraging PLHIV to increase ART uptake. • Ensure that the NHI community outreach teams actively engage in identification and follow-up activities for treatment. • Renewed focus on how to strengthen local systems for supply chain management, related physical infrastructure, strengthening the HMIS, budget forecasting and strategic planning
What are the recommendations for sustaining progress along this target beyond 2015	• Continued focus on regular HIV testing to ensure that treatment is initiated as close to the CD4 350 thresholds as possible through effective community mobilization, with involvement of PLWHIV to increase uptake of ART • Expansion of treatment access up to the CD4 count of 350 cells/ul thresholds should remain a priority for the ARV programme in order to realise the benefits of 'treatment as prevention', decreased maternal mortality and paediatric infections, decreased burden on outpatient and inpatient clinical care, and decreased community-wide TB • Continue to evaluate pilots and scale up successful strategies for retaining stable patients in care to ensure treatment success among HIV patients. • As domestic funding increases and external funding declines over the next five years, new funding opportunities will need to be identified and evaluated_

	Target 5: Reduce Tuberculosis Deaths in People Living with HIV by 50% by 2015		
Is this a priority target for South Africa?	Yes	Does the NSP address this target?	Yes
What key actions have been taken to reach this target since 2011?	• In April 2012, South Africa adopted a policy of giving ART to all HIV positive TB patients, regardless of their CD4 count. This policy is likely to reduce TB deaths in PLHIV who have started on TB treatment. • A review of the *National Infection Prevention and Control (IPC) Policy* was undertaken for TB, MDR-TB and XDR-TB. As a result, policy guidelines were aligned to the new WHO policy recommendations on *TB Infection Control in Health-Care Facilities, Congregate Settings, and Households.*		

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What key actions have been taken to reach this target since 2011?	• An action plan focusing on expansion of paediatric TB and HIV services was developed to improve prevention, diagnosis, treatment care and support. This was achieved through the *Blueprint for Action for Paediatric and Adolescent HIV and TB, Early Diagnosis, Treatment, Care and Support*. • The NSP sets out a multi-sectoral plan that aims to halve TB incidence and deaths. Provincial Implementation Plans that are based on the NSP exist in all 9 provinces and across all national government departments and TB interventions are being mainstreamed in all departments. • GeneXpert is a new technology being implemented to facilitate earlier and more accurate diagnosis of TB. Plans are underway to ensure that each district has a GeneXpert machine. • The government helped to spearhead the development of the Southern African Development Community (SADC) declaration on TB in the mining sector. This was passed by the SADC Heads of State Summit in 2012. • A more integrated health system approach has ensured that TB screening is included in the HCT campaign and that all people living with HIV in care or on treatment are regularly screened for TB.
What key challenges or constraints have been encountered in addressing this target?	• National Infection Prevention and Control Policy has not been implemented and has not been adequately funded. • Inadequate data quality, recording and reporting. For example, there is a lack of knowledge about the actual community burden of TB prevalence and deaths and monitoring of adherence to IPT is poor. • There are high rates of primary default for patients who have a laboratory diagnosis of TB and then never begin treatment. At the same time, there is poor uptake of ART in HIV positive TB patients. TB screening during HCT is not linked to diagnosis and care. Community screening, contact tracing, and case finding, is challenged. • Increasing numbers of MDR and XDR TB cases and low number of MDR/XDR cases on treatment, low cure rates, and a high mortality rate. • Government departments are also at different stages of addressing TB, which indicates a lack of uniform approach to dealing with the disease. Despite global ILO guidance, there is limited integration of TB into work place programmes.
Is South Africa on track to reach this target?	No
What are the key programmatic actions necessary to stay on track and/or achieve this target?	• A greater focus on TB prevention in people living with HIV is needed, including early detection and treatment. • Improved implementation of TB infection control policy and practices is also needed in communities, health facilities, prisons and other congregate settings. • Support and implementation of the new isoniazid preventive therapy policy will support changes in implementation and reduce the risk of TB disease in people living with HIV. • Decentralization of TB care and support to communities will also improve access to care, reduce delays in treatment initiation, reduce transmission of DR-TB in hospital and reduce the need for hospitalisation.

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What are the key programmatic actions necessary to stay on track and/or achieve this target?	• More intensified & regular TB screening for PLWHIV is needed, plus earlier detection of all PLWHIV. • A better understanding of TB epidemiology in South Africa is needed. A series of systematic reviews of TB in high risk populations in South Africa is being conducted. These reviews will be combined with an analysis of the matched NHLS and NTP data 2004-2011 to produce the first KYE/KYR report on TB in South Africa. • Strengthened data quality and use are needed. Links to NHLS data needs to be strengthened. Implementation of the *South African National Tuberculosis Drug Resistance Survey* will improve the collection, analysis and use of TB and TB/HIV data for programme management. • An evaluation of the impact of GeneXpert on improved programme performance is also important. Annual national TB reports should be produced in addition to regular quarterly provincial and national reports. • Expanding the multi-sectoral response to TB will be critical to increasing access to TB prevention, diagnosis and treatment. In line with the SADC declaration, there needs to be a concentrated focus on the mining sector that encourages intensified efforts to control TB in this sector. • Finally, efforts to expand community knowledge and engagement in TB prevention, diagnosis and treatment through advocacy, communication, and social mobilization efforts will be essential to a comprehensive national TB response.
What policy and enabling environment changes are required to reach the targets?	• In order to reach the targets, a multi-layered and linked approach needs to be adopted. This requires stronger integration between TB and HIV programmes, including a fully integrated monitoring and evaluation system. • Further strengthening of the multi-sectoral response to TB and HIV is also required. • There needs to be a focus on creating enabling environments for specific populations. In the *mining sector, prisons, informal settlements* and for *children*.
What new investments are necessary to keep on track and/or achieve this target?	• Investment in TB research needs to be prioritised, with a focus on developing new vaccines, drugs, and diagnostics for TB, especially for PLHIV and children. • Investment on how to better reach and treat key populations. • Further investments should be made in the ward based Primary Health Care outreach teams. This will strengthen the process of intensified TB and HIV case finding and tracing contacts • Increased support to a multi-sectoral approach, especially in the prisons and mining sectors that links the existing data systems • Continued investment in GeneXpert • Strengthened prevention and treatment of drug resistant TB. • Greater focus on TB prevention is required, including the upstream risk factors for TB such as poverty, smoking, diabetes and HIV as well as strengthened infection prevention and control.
What are the recommendations to national stakeholders to ensure the implementation of suggested changes?	• IPC provision and practices, TB training for staff and patients, and cross-cultural communication should all be addressed. • Consider the implementation and evaluation of a comprehensive contextually appropriate TB-IPC policy, with the setting and auditing of standards for appropriate IPC provision and practice across all wards in TB burdened hospitals. Stigma attached to TB should also be addressed among healthcare providers and patients.

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What are the recommendations to national stakeholders to ensure the implementation of suggested changes?	• A focused approach to reach identified target groups is needed. This includes research that identifies the most critical needs for reaching each target group, the resources needed to address those needs and the management and structures in place to support the implementation of recommendations. • Need to support a multi-sectoral and integrated approach that: (1) identifies how to ensure linkages exist in the health system and (2) how to better manage an integrated approach at the health system and human resources level.
What are the recommendations for sustaining progress along this target beyond 2015?	• Sustained political commitment to ensuring a multi-sectoral response to TB and HIV. • Significant investment in focused research is also required, for (1) the development of new vaccines, drugs and diagnostics for TB, especially for PLHIV and children, (2) improving current health system and related data, and (3) addressing challenges at the ward level.

	Target 6: Reach a Significant Level of Annual Expenditure		
Is this a priority target for South Africa?	YES	Does the NSP address this target?	YES
What key actions have been taken to reach this target since 2011?	• Funding for HIV from the NDOH rose from ZAR9.1 billion to ZAR9.8 billion between 2010/11 and 2012/13 fiscal years (CHAI, 2013). This represents a real increase of approximately 8%. • HIV funding for the multi-sector government response rose over the same period from ZAR11.2 to ZAR13.6 billion (an increase of 21%). • South Africa continues to prioritise its HIV response through mobilising domestic resources, both at national and provincial levels • A costed NSP and a financial gap analysis was undertaken to produce the evidence required for prioritising interventions. Provincial costed operational plans were prepared including a financial and output gap analysis for the GFATM grant renewal application. • Multi-Country Analysis of Treatment Costs for HIV exercise identified several opportunities to expand ART coverage and improve patient outcomes without increasing costs. The potential savings could cover the treatment costs of an additional 350 000 patients (CHAI) • The national budget models (NACM and NTCM) have improved the estimation of resources required over the medium to long term to implement the national response. These models have been used directly in budgeting, as well as in GFATM applications. • Government introduced a new tender process to increase competition among suppliers. In 2010 the NDOH was successful in negotiating a 53% average reduction in ARV prices and a 36% reduction in the price of TB medicines, while in 2012 the government negotiated savings over the next two years on its ARV products equating to a 27% saving (ZAR 2.2 billion).		

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What key actions have been taken to reach this target since 2011?	• The NDOH launched an Aid Effectiveness Framework in 2011 to align development partner assistance more closely with departmental processes, reduce transaction costs and enhance the efficiency of planning and implementation. • Over the last few years, the completeness and reliability of financial data has increased significantly in South Africa, from two perspectives: (1) estimating resource needs and (2) tracking expenditure through exercises including the NASA, APT and PETS. • In addition, SANAC has established a Costing Technical Task Team (TTT) to analyse HIV and TB programme costs, track expenditure and package information for decision makers.
What key challenges or constraints have been encountered in addressing this target?	• Lack of routine reporting by development partners of their planned activities and allocations, by province, to assist with a more accurate funding gap analysis, and improved coordination. • By the end of the PEPFAR / Government of South Africa Partnership Framework Implementation Plan (PFIP) in April 2017, South Africa will take full responsibility for the care and treatment component of its national HIV response. Financially, this will mean a reduction in annual PEPFAR funding to approximately $250 million (ZAR 2 billion) by FY 2017, with a corresponding increase of the SAG's budget for HIV from $1.2 billion (ZAR 9.57 billion) in 2012 to $1.9 billion (ZAR15.2 billion) in 2017. However, the persisting HIV crisis, compounded by high levels of HIV and TB co-infection and a health system that has serious systemic and human resource challenges, presents challenges to realizing this goal. • According to APT gap analyses, the sub-programmes that are expected to have the greatest financial gaps between funding requirements & available funding are ART, TB and HCT. It is anticipated that large financing demands face the country over the coming years as the cost of the HIV programme is estimated to grow from around ZAR19 billion to ZAR32 billion annually (NSP 2011).
Is South Africa on track to reach this target?	YES
What are the key programmatic actions necessary to stay on track and/or achieve this target?	• The cooperation of development partners and potential reallocation of funds can address several problems. Several development partners are funding the same NGOs; sometimes in significant numbers. While this may result in duplication, it may also potentially enhance the NGO's financial sustainability. • Support financial and HIV provincial programme managers to improve their budgeting, financial reporting, and expenditure tracking against key performance indicators • South African government will need to diversify funding mechanisms by increasing the number of patients receiving testing and treatment in the private sector, such as through workplace programmes that have been shown to have a positive return-on-investment for companies & through innovative financing mechanisms including specific corporate taxes and an NHI tax. • While recognising the preventative effects of scaled-up ART access, it is equally critical that the DOH and the other departments ensure that prevention spending, and other key activities (e.g. mitigation, research) are not crowded out by ART. • Finally, a strategic investment framework and investment cases should be developed

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What policy and enabling environment changes are required to reach the targets?	• Strengthened coordination among all bilateral and multilateral development partners like the Global Fund and alignment to the national strategy and priorities are critical to ensure an effective, efficient, and durable response. • Institutionalisation of expenditure tracking as routine data collection and linking these to routine M&E systems at the level of the provinces, • Detailed health expenditure data from all funding sources (government, development partners, and private sector) will be essential to understanding the overall landscape of funding and identifying opportunities for more efficient allocations.
What new investments are necessary to keep on track and/or achieve this target?	• Ensure that the available resources are used to maximum effect by focusing on evidence-based, cost-effective activities, by taking them to scale and demonstrating their impact. • Continued investments in costing data that inform government spending are critical, as well as improving the link between expenditure data and outcomes achieved by government, donors, and the private sector. Alongside cost data, there needs to be better data on the coverage and frequency of interventions across the country, improving the geographic granularity of such information for improved planning at the sub-provincial level. The NDOH, in collaboration with UNAIDS and CHAI, for example, recently estimated ART coverage by district, data which are being used to set paediatric ART coverage targets for the country.
What are the recommendations to national stakeholders to ensure the implementation of suggested changes?	• National stakeholders should work with donor institutions, civil society, people living with HIV, faith-based organisations, the private sector, foundations, and multilateral institutions to effectively mobilize coordinate, and efficiently utilize resources to expand high-impact strategies. The country's ODA Planning Forum should also be considered as, and used for, a vehicle for such coordination.
What are the recommendations for sustaining progress along this target beyond 2015?	• Key outcomes need to be better linked to expenditure. At the same time the government should work with their development partners to ensure that spending better aligns towards government priorities. Ensuring less duplication will address current inefficiencies • Close attention needs to be paid where provinces and programmes appear over-funded and yet underperform. Information from expenditure reviews & planned studies, such as the NASA and annual resource-tracking tool that track HIV expenditures (at national, provincial and, where possible, district levels), should inform the government and development partners planning decisions

	Target 7: Eliminate gender inequalities and sexual violence & increase capacities of women & girls		
Is this a priority target for South Africa?	YES	Does the NSP address this target?	YES
What key actions have been taken to reach this target since 2011?	• Launch of the National Council against Gender Based Violence (GBV) • The Department of Justice and Constitutional Development (DoJCD) plans to review the Sexual Offences Act and explore the possibility of the re-introduction of the Sexual Offences courts.		

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What key actions have been taken to reach this target since 2011?	• The Accelerated Country Action for Women, Girls, Gender Equality and HIV was integrated into the NSP. • Multitude of forums, discussions, high level dialogues and parliamentary discussions on the increased brutal rape and murders of women and children and launch and strengthening of programmes and partnerships • Cabinet approved the Development of the Women Empowerment and Gender Equality Bill aimed at enforcing compliance in both the government and the private sector in matters of gender mainstreaming and equality. • Government Women's Justice and Empowerment Initiative (WJEI) programme supported by PEPFAR facilitated the rollout of DOJCD *Thuthuzela Care Centre* (TCC) service delivery model to manage sexual violence cases. *TCCs* are one-stop facilities that aim to reduce secondary victimization, improve conviction rates, and reduce the cycle time for finalization of cases. • Research on Intimate Partner Violence and HIV Exposure and GBV indicator • The Her Rights Initiative (HRI) review of current policy and laws on gender based violence and women living with HIV in South Africa. • In May 2013, the Minister of Health announced plans to roll out HPV vaccines for girls starting with those in rural areas
What key challenges or constraints have been encountered in addressing this target?	• GBV fosters the spread of HIV by limiting a women or girls ability to negotiate safe sexual practices, disclose their HIV status, and access services due to fear of reprisal. • Lack of development of appropriate, proven interventions to address the root causes of sexual and gender based violence. • High prevalence of cervical cancer among HIV-positive women.
Is South Africa on track to reach this target?	NO
What are the key programmatic actions necessary to stay on track and/or achieve this target?	• Expansion of the availability of vital cervical cancer screening and treatment, especially for high-risk HIV-positive women, and expanded access to the HPV vaccine. • Expanded access to the HPV vaccine. HIV and SRH and rights need to be linked in all interventions. • Actions to prevent and respond to violence against women and girls must be an essential part of the HIV response. The dual needs of women in preventing HIV and stopping unintended pregnancy need to be addressed by supporting programmes that aim to address women's equitable access to HIV programmes and services thereby reducing gender inequalities. • Age appropriate HIV and sexuality education and services in a supportive environment are essential, especially for adolescent girls. • Programmes are needed that engage men and boys in order to address harmful gendered norms and behaviour.
What policy and enabling environment changes are required to reach the targets?	• A comprehensive national, costed, and implemented HIV/SGBV prevention strategy is critical. • The Domestic Violence Act should be amended so that it specifically guides the DOH's obligations towards the victims of domestic violence.

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What policy and enabling environment changes are required to reach the targets?	• A national policy on domestic violence and HIV should be developed. • The National Policy Guidelines for Victim Empowerment should be amended to list women living with HIV as a priority group in need of specific services following sexual offences. • Policy guidelines supporting the implementation of the sexual offences legislation should be amended to include specific reference to the needs of women living with HIV.
What new investments are necessary to keep on track and/or achieve this target?	• Invest in the policy framework & guidelines that will support a more enabling environment. • Investments in programmes that aim to address women's equitable access to HIV programmes and services through strategic integration and linking services should be supported. • Resources for CBOs to conduct transformative work at community level that addresses gender norms and gender inequality. • Investments in education programmes and long term community dialogues for men and women should be a priority.
What are the recommendations to national stakeholders to ensure the implementation of suggested changes?	• Key civil society groups should identify strategically placed policymakers and government officials that can work to develop a strategy to amend the policy and to strengthen implementation and enforcement of polices and laws that exist. • Civil society and government should identify one key challenge and focus a majority of resources on that issue (e.g. rape) addressing it at all levels (policy, law, training and advocacy). This intensive intervention should have adequate budget support. • Specific and focused programmes and communication that encourages traditional leaders to support, encourage and promote positive behavioural change • Addressing gender disparities in community care and support and challenging harmful cultural and traditional practices and attitudes through the involvement of men and traditional leaders
What are the recommendations for sustaining progress along this target beyond 2015?	• Economic empowerment & social protection programmes that provide women with skills to improve their economic status to improve women's options for safe choices & reduce their vulnerability to HIV & gender-based violence. • Support of the national GBV Plan of Action • Identify tangible actions that immediately aim to reduce the burden of care, which often falls on women and young girls while national policies, guidelines & frameworks are being developed, reviewed & revised e.g. Community mobilisation & male involvement interventions

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	Target 8: Eliminate Stigma and Discrimination		
Is this a priority target for South Africa?	YES	Does the NSP address this target?	YES
What key actions have been taken to reach this target since 2011?	• Revitalisation of the SANAC *'Ensuring Protection of Human Rights and Improving Access to Justice' Technical Task Team (SO4 TTT)*, which provides strategic technical guidance on policies addressing human rights and access to legal justice – led by the Deputy Minister of Justice & Constitutional Development. • Establishment of a platform for PLHIV organisations by the Treatment Action Campaign (TAC), National Association of People Living with AIDS (NAPWA), the Positive Women's Network, and South African National Association of Religious Leaders Living with AIDS (SANERELA). Cooperation in the sector is a positive step as past divisions have resulted in fragmented stigma and discrimination programmes. • Inclusion of the People Living with HIV Stigma Index as a key programme in the NSP. • Provincial Stigma Index study, undertaken in 2011 by NAPWA in the Eastern Cape. • Nationally, NGO's and government departments continue to deliver stigma and discrimination programmes.		
What key challenges or constraints have been encountered in addressing this target?	• Poor coordination in the health sector with other relevant sectors. • Chronic lack of funds allocated to stigma and discrimination reduction programmes. • Lack of empirical data with which to inform key programme and policy decisions. For example, there is no specific monitoring framework or related comprehensive list of indicators to measure implementation towards this target. • Few focused stigma programmes and existing programmes are often inadequate.		
Is South Africa on track to reach this target?			YES
What are the key programmatic actions necessary to stay on track and/or achieve this target?	• SANAC needs to provide strong coordination and leadership to achieve this target. The SO4 TTT should meet regularly to inform SANAC decision making with clear and practical policy and programmatic recommendations that address HIV related stigma & discrimination. • A national level M&E framework that measures stigma should be developed & implemented • Stigma programmes should be developed that sensitize health care workers, police, & members of the judiciary and other groups in positions of authority to the rights of women, LGBTI, Sex Workers, People with Disabilities & other key populations • An audit of the legal system will identify gaps in laws that protect against discrimination and violence based on actual or assumed sexual orientation and/or gender identity. This focus is also related to sex workers, where there should be a scale up of national and provincial dialogues that aim to decriminalize sex between consenting adults.		

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What policy and enabling environment changes are required to reach the targets?	• South Africa has an enabling policy environment. The NSP is premised on the South African Constitution and recognises the centrality of constitutional values and human rights. Laws such as the Promotion of Equality and Prevention of Unfair Discrimination Act are in place. The biggest challenge is how to practically implement laws and policies.
What new investments are necessary to keep on track and/or achieve this target?	• Resources should be committed to implement the People Living with HIV Stigma Index and enable collection of baseline data on the experience of stigma encountered by PLHIV. • Greater investment is required in research, monitoring, and evaluation. This includes supporting the creation or refinement of current policies that address stigma, developing practical frameworks and approaches that are socially and culturally appropriate, and identifying entry points for addressing stigma. • Resources should be allocated for NGO-led stigma and discrimination programmes through institutions such as the Global Fund against AIDS, TB, and Malaria.
What are the recommendations to national stakeholders to ensure the implementation of suggested changes?	• Government and civil society should focus their efforts to address stigma on youth, including those youth living with HIV. • Civil society should support the knowledge and skills development of PWIDs so that they can advocate for the rights to access HIV services, as well as galvanize their community to demand access to essential HIV services. • Leadership in government should send an "unequivocal message" for ending discrimination and violence, and support a continued dialogue on discrimination based on sexual orientation and gender identity.
What are the recommendations for sustaining progress along this target beyond 2015?	• Research, monitoring, strategic programming & adequate resource allocation are required at all levels to address stigma & discrimination. GBV, gender inequality, inequitable access of health resources & programmes, & human rights abuses. Each requires focused & specific attention to reach the 2015 target.

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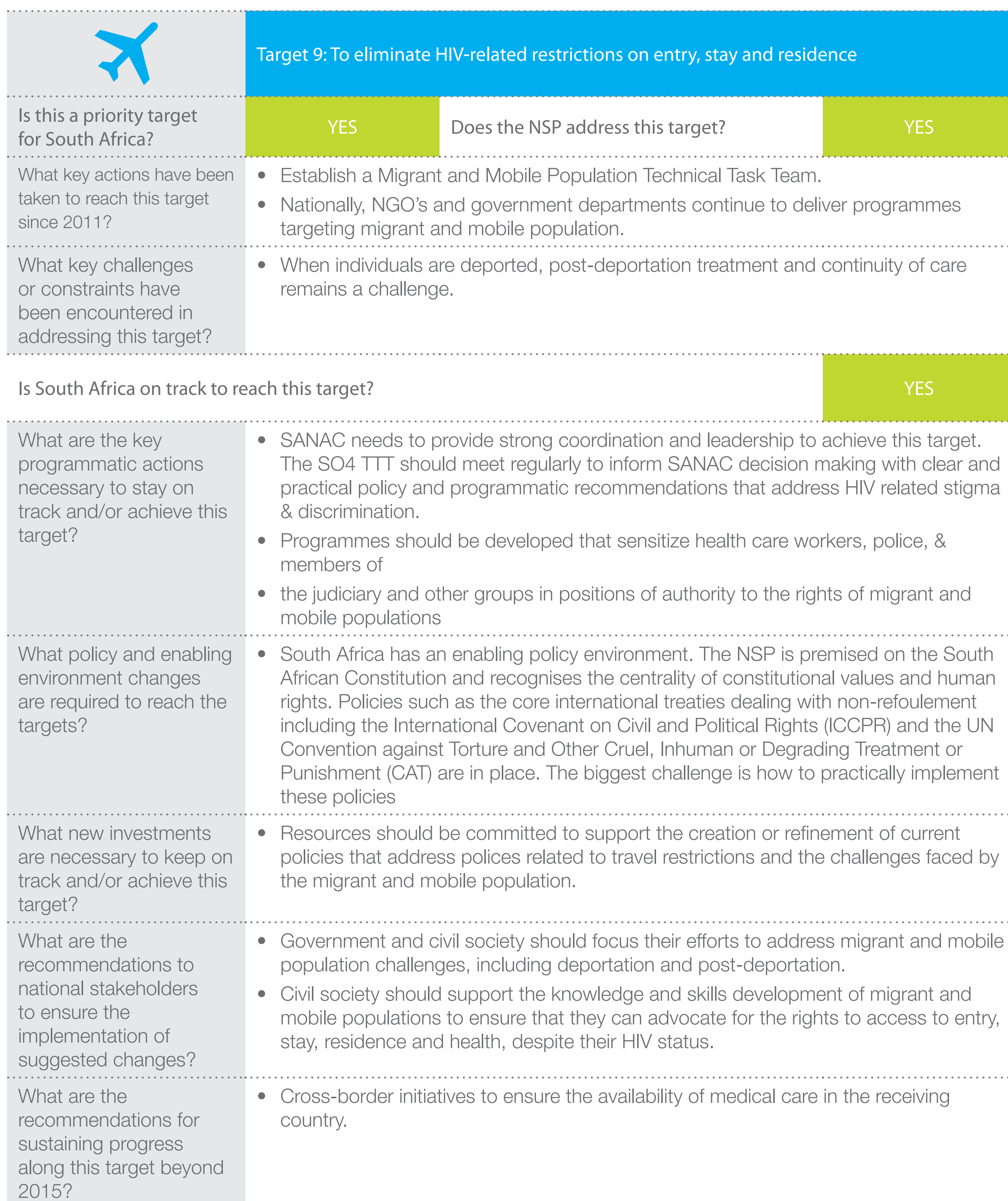

	Target 9: To eliminate HIV-related restrictions on entry, stay and residence		
Is this a priority target for South Africa?	YES	Does the NSP address this target?	YES
What key actions have been taken to reach this target since 2011?	• Establish a Migrant and Mobile Population Technical Task Team. • Nationally, NGO's and government departments continue to deliver programmes targeting migrant and mobile population.		
What key challenges or constraints have been encountered in addressing this target?	• When individuals are deported, post-deportation treatment and continuity of care remains a challenge.		
Is South Africa on track to reach this target?			YES
What are the key programmatic actions necessary to stay on track and/or achieve this target?	• SANAC needs to provide strong coordination and leadership to achieve this target. The SO4 TTT should meet regularly to inform SANAC decision making with clear and practical policy and programmatic recommendations that address HIV related stigma & discrimination. • Programmes should be developed that sensitize health care workers, police, & members of • the judiciary and other groups in positions of authority to the rights of migrant and mobile populations		
What policy and enabling environment changes are required to reach the targets?	• South Africa has an enabling policy environment. The NSP is premised on the South African Constitution and recognises the centrality of constitutional values and human rights. Policies such as the core international treaties dealing with non-refoulement including the International Covenant on Civil and Political Rights (ICCPR) and the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) are in place. The biggest challenge is how to practically implement these policies		
What new investments are necessary to keep on track and/or achieve this target?	• Resources should be committed to support the creation or refinement of current policies that address polices related to travel restrictions and the challenges faced by the migrant and mobile population.		
What are the recommendations to national stakeholders to ensure the implementation of suggested changes?	• Government and civil society should focus their efforts to address migrant and mobile population challenges, including deportation and post-deportation. • Civil society should support the knowledge and skills development of migrant and mobile populations to ensure that they can advocate for the rights to access to entry, stay, residence and health, despite their HIV status.		
What are the recommendations for sustaining progress along this target beyond 2015?	• Cross-border initiatives to ensure the availability of medical care in the receiving country.		

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	Target 10: Eliminate parallel systems, for stronger integration		
Is this a priority target for South Africa?	YES	Does the NSP address this target?	Yes
What key actions have been taken to reach this target since 2011?	• In 2012 a new re-engineered Primary Health Care (PHC) model was developed which aimed to strengthen the health systems, enhance task shifting and expand access to PHC outreach services and integrate health services. • Innovations for maternal, neonatal, and child health have received specific attention and are being introduced nationally to address quality of care for mothers, new-borns and children. • National Health Insurance (NHI) scheme is also being developed that aims to increase access to more effective and affordable health services. Initiation of NHI provides a potential platform for innovation of integrated activities at scale. • The Campaign to Accelerate the Reduction in Maternal Mortality in Africa which was launched in 2012 integrates antenatal, family planning, child health and school health services with HIV risk reduction and ART strategies. • A National Consultative workshop to facilitate the engagement of CBOs in community TB activities led to the establishment of a NGO coalition forum for TB/HIV integration.		
What key challenges or constraints have been encountered in addressing this target?	• Lack of process and impact (e.g. comparative studies) evaluations to assess integrated HIV and MNCH services. • Lack of data on: unintended pregnancies prevented, HIV positive births averted, increased and continued contraceptive use, reduction in stigma, cost-effectiveness, and trends in access to services. • The Non Communicable Disease surveillance system needs to be defined and set up. There is no validated tool for reporting on the degree of service integration, making it difficult to state how integrated the services are at a specific site. • There is poor structural representation of maternal new born and child health (MNCH) stakeholders in national HIV policy and coordination structures. This impedes opportunities to develop integrated policies and programmes.		
Is South Africa on track to reach this target?			Yes
What are the key programmatic actions necessary to stay on track and/or achieve this target?	• TB and HIV services need to be integrated. • Needs to be wider TB & HIV service delivery for maternal, neonatal and child health. • Integrated food and nutrition services at both health sector and community levels are critical in helping overcome barriers to treatment adherence. • Last, a comprehensive surveillance project is needed. This will assess the prevalence of NCDs and their risk factors, the health status of children, and the behavioural and social determinants of health. • Strategic investment in the health information system to develop the capacity to prepare, manage and use data for decision making.		

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What policy and enabling environment changes are required to reach the targets?	• Technical guidance to support standardising terms and care delivery strategies. • Targeted research to strengthen the evidence base of integrating HIV and MNCH programmes. Empirical information can then inform the policy changes that are needed to support an enabling environment for integration.
What new investments are necessary to keep on track and/or achieve this target?	• DOH response to HIV and TB should be balanced with increased spending on integrated HIV & TB services to other government departments, particularly the Department for Social Development (DSD) and the two Departments of Education (DBE and DHET). • Substantive investment in Integrated HIV and cervical cancer services.
What are the recommendations to national stakeholders to ensure the implementation of suggested changes?	• Integrating services for HIV, family planning, & MNCH—and delivering them in a single setting—would address patients' multiple needs at once, potentially enhancing programme effectiveness and efficiency. • Maximizing the use of available human resources, integration may be more cost-effective than delivering separate programmes in different settings • Integrating HIV into broader development planning processes & frameworks is critical to ensure that the national HIV response works coherently – and not at cross-purposes – with other health and development objectives. • Focus on a client-centred approach at facility level. Patient management and programme recording and reporting tools must be simplified and community systems integrated into the community. • Adherence support should be integrated and collaboration between research and programmes facilitated. Finally, multiple reporting requirements should be addressed and rectified.
What are the recommendations for sustaining progress along this target beyond 2015?	• Integration of the private & public sectors into services for HIV, tuberculosis &n non-communicable diseases. • Improve surveillance and information systems & refine reporting • Experiences with successful integrated care should be shared and adopted. • District and provincial management structures should be supported so that they work seamlessly to address HIV health needs.

ANNEX 2

Target-By-Target Review of Global Aids Response Progress Core Indicators

TARGET 1: Reduce Sexual Transmission by 50% by 2015

	INDICATOR	2012	SOURCE
1.1	Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	28.7%	HSRC 2008
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	8.5%	HSRC, 2008
1.3	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	10.5%	HSRC, 2008
1.4	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse*	Women 86.7% Men: No data	HSRC 2008
1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	44.8%	HSRC 2012
1.6	Percentage of young people aged 15-24 who are living with HIV*	8.86% (Male: 3.87%) (Female: 13.92%)	Spectrum , 2013
1.7	Percentage of sex workers reached with HIV prevention programmes	60%	SWEAT, 2013
1.8	Percentage of sex workers reporting the use of a condom with their most recent client	95%	SWEAT, 2013
1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	88%	SWEAT, 2013
1.10	Percentage of sex workers who are living with HIV	Not available	
1.11	Percentage of men who have sex with men reached with HIV prevention programmes	Not available	
1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Not available	
1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	27.2%.	HSRC, 2008
1.14	Percentage of men who have sex with men who are living with HIV	9.9% 10-50%	HSRC, 2008 Ref: 17; 18; 19
1.15	Number of women and men aged 15 and older who received HIV testing and counselling in the last 12 months and know their results	8,215,979	DHIS
1.16	Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit	No available	
1.17	Percentage of antenatal care attendees who were positive for syphilis	1.6%	ANC Survey 2012
1.18	Percentage of antenatal care attendees positive for syphilis who received treatment	Not available	

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	INDICATOR	2012	SOURCE
1.19	Percentage of sex workers (SWs) with active syphilis	Not available	
1.20	Percentage of men who have sex with men with active syphilis	Not available	
1.21	Percentage of men 16 – 49 that are circumcised	51.6%	JHEESA, 2012
1.22	Number of male circumcisions performed according to national standards during the last 12 months	422,009	DOH Program data

TARGET 2: Reduce Transmission of HIV among People who Inject Drugs by 50% by 2015

	INDICATOR	2012	SOURCE
2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	Not available	
2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	Not available	
2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	Not available	
2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	Not available	
2.5	Percentage of people who inject drugs who are living with HIV	Not available	

TARGET 3: Eliminate Mother-to-Child Transmission of HIV by 2015 and Substantially Reduce AIDS-related Maternal Deaths

	INDICATOR	2012	Source
3.1	Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission	87%	DHIS Spectrum, 2013
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	89%	DHIS Spectrum, 2013
3.3	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months (modelled)	2.73%	MRC
3.4	Pregnant women who know their HIV status	976,011	DHIS
3.5	Percentage of pregnant women attending antenatal clinics whose male partner was tested for HIV in the last 12 months	Not available	
3.6	Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing	76.8%	DHIS

	INDICATOR	2012	Source
3.7	Percentage of infants born to HIV-infected women provided with ARV prophylaxis to reduce the risk of early mother-to-child transmission in the first 6-weeks	88.6%	DHIS Spectrum, 2013
3.8	Percentage of infants born to HIV-infected women who are provided with antiretroviral to reduce the risk of HIV transmission during the breastfeeding period	Not available	
3.9	Percentage of infants born to HIV-infected women started on co-trimoxazole (CTX) prophylaxis within two months of birth	Not available	
3.10	Distribution of feeding practices (exclusive breastfeeding, replacement feeding, mixed feeding/other) for infants born to HIV-infected women at DTP3 visit	Exclusive 44% Replacement: 56.3%	MRC Study
3.11	Number of pregnant women attending ANC at least once during the reporting period	976,011	DHIS

TARGET 4: Have 15 Million People Living with HIV on ART by 2015

	INDICATOR	2012	SOURCE
4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy	2012: 2,150,880 2011: 1,406,650	DHIS
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Not available	
4.2b	24 months after initiating treatment among patients initiating antiretroviral therapy	Not available	
4.2c	60 months after initiating treatment among patients initiating antiretroviral therapy	Not available	
4.3	Number of health facilities that offer antiretroviral therapy	Total: 3,683 Public: 3,574 Private: 109	DOH Programme data
4.4	Percentage of health facilities dispensing ARVs that experienced a stock-out of at least one required ARV in the last 12 months	Not available	

TARGET 5: Reduce Tuberculosis Deaths in People Living with HIV by 50% by 2015

	INDICATOR	2012	SOURCE
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	40%	TB Programme data
5.2	Number of health-care facilities providing ART services for people living with HIV with demonstrable infection control practices that include TB control	Public: 3,574	DOH Programme data

	INDICATOR	2012	SOURCE
5.3	Percentage of adults and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT)	31%	DHIS
5.4	Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit	78%	DHIS

TARGET 6: Reach a Significant Level of Annual Global Expenditure in Low and Middle Income Countries

	INDICATOR	2012	SOURCE
6.1	Domestic and international AIDS spending by categories and financing sources	ZAR 18,678,509,395 Public: ZAR 15,481,920,391 International: ZAR 2,126,294,580	NASA 2007 -2010

TARGET 7: Eliminate gender inequalities and sexual violence and increase capacities of women and girls

	INDICATOR	2012	SOURCE
7.1	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	Not available	

TARGET 8: Eliminate stigma and discrimination

	INDICATORS	2012	SOURCE
8.1	Global Stigma indicator for general population planned to be ready for 2014 reporting	No data needed	None

TARGET 10: Eliminate parallel systems, for stronger integration

	INDICATOR	2012	Source
10.1	Current school attendance among orphans and non-orphans aged 10–14*	Orphans: 99.6% Non-Orphans: 99.1%	HSRC 2008
10.2	Proportion of the poorest households who received external economic support in the last 3 months	Not available	

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