LET OUR ACTIONS COUNT

SOUTH AFRICA'S NATIONAL STRATEGIC PLAN FOR HIV, TB and STIs 2017-2022

2030 NDP

SOUTH AFRICAN NATIONAL AIDS COUNCIL
OUR ACTIONS COUNT

It is in our hands to end AIDS and TB

When our lives have been cut short,
Fighting an invisible enemy in the dark
When our burden causes us to question
Just remember, in our veins runs blood filled with resilience

On this journey we have made a mark
As much as we have seen the fall, together we stand
Embracing the future in our hands

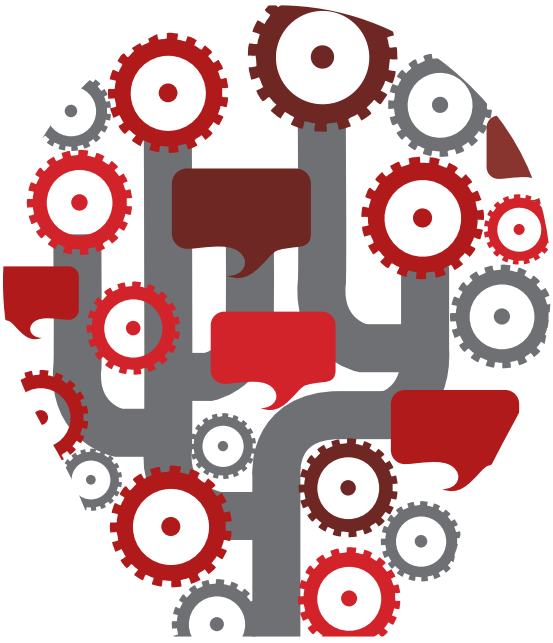
The mothers who have felt the blood of their children turn cold in their hands
The daughters who look for and give love relentlessly
The men who yearn for company and embrace
The sons who helplessly look for role-models and guidance

On this journey we continue to make a mark
As much as we have regressed
Today and tomorrow we shall progress
Knowing that the future is in our hands

When you clinch your fist with fear,
Fighting for your one and only life,
Remember You are a victim no more
You are embraced by the spirit of humanity

Compassion tears through the core of the spillage
Collective action triumphs against this invincible enemy
Be strong for others even as the burden is weighing heavy on your back,
Just remember it is in our hands to end AIDS and TB

Mr Cyril Ramaphosa
Deputy President of South Africa



NATIONAL STRATEGIC PLAN

on HIV, TB and STIs

2017 - 2022

Acknowledgements

A National Strategic Plan that is geared for success must reflect the insights and expertise of all stakeholders, and be owned by everyone who will need to work together in partnership to achieve its goals and objectives. This robust and forward-looking Strategy reflects the collective wisdom for achieving our vision of a South Africa free from the burden of HIV, TB and STIs.

This NSP has benefitted from the exceptional commitment and contributions of too many people to mention by name. Special thanks go to:

- Participants in the two national multi-stakeholder and the sectoral consultations
- Key informants and respondents to the open calls for inputs, the public health community and the voices from the community
- The NSP Steering Committee and its technical working groups and the writing teams
- The AIDS Councils and their Secretariats
- The UN Family

The in-depth NSP process would not have been possible without the generous support of The Global Fund to Fight AIDS, TB and Malaria; GIZ, Gates Foundation, WHO, UNAIDS, UNICEF and HST.

Ms Malebona Precious Matsoso

Chairperson, SANAC Programme Review Committee

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Acronyms

3PH	a short-course therapy for latent TB
ABET	Adult Basic Education and Training
AGYW	adolescent girls and young women
AIDS	Acquired Immune Deficiency Syndrome
ANC	antenatal care
APP	Annual Performance Plan
ART	antiretroviral therapy
BRICS	Brazil, Russia, India, China and South Africa
CBO	community-based organisation
CCMDD	Central Chronic Medicine Dispensing and Distribution
CG	Conditional Grant
CHW	community health worker
COGTA	Co-operative Governance and Traditional Affairs
COP	Country Operational Plan (PEPFAR)
CSE	comprehensive sexuality education
CSIR	Council for Scientific and Industrial Research
CSTL	Care and Support for Teaching and Learning
CTOP	Choice of Termination of Pregnancy
CXR	Chest X Ray
DBE	National Department of Basic Education
DCS	Department of Correctional Services
DHA	Department of Home Affairs
DHET	Department of Higher Education and Training
DHIS	District Health Information System
DIP	District Implementation Plan
DIRCO	Department of International Relations and Co-operation
DMR	Department of Mineral Resources
DoH	Department of Health
DOJ	Department of Justice
DOW	Department of Women
DPME	Department of Planning, Monitoring and Evaluation
DPSA	Department of Public Service and Administration
DPW	Department of Public Works
DREAMS	Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe initiative
DR-TB	drug-resistant tuberculosis
DSD	Department of Social Development
DST	Department of Science and Technology
DS-TB	drug-sensitive tuberculosis
ECD	early childhood development
EDR	Electronic Drug-Resistant Tuberculosis Register
EID	early infant diagnosis
EIS	Enterprise Information System
EMIS	Education Management Information System
EML	Essential Medicines List
EPI	Expanded Programme on Immunisation
ESA	Eastern and Southern Africa, ESA Ministerial Commitment
ETR	Electronic TB Register
ETR.Net	Electronic Register
FPC	family planning and contraception
FSW	female sex workers
GBV	gender-based violence
GDP	Gross Domestic Product
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GWME	Government-wide Monitoring and Evaluation Framework
HCT	HIV counselling and testing
HEAIDS	Higher Education HIV/AIDS Programme
HEI	higher education institution
HIE	Health Information Exchange
HIV	Human Immunodeficiency Virus
HIVDR	HIV drug resistance
HNSF	National Health Normative Standards Framework
HPRS	Health Patient Registration System
HPV	Human Papillomavirus
HSRC	Human Sciences Research Council
HSS+	HIV sentinel surveillance and behavioural assessment
HTA	high-transmission area
HTS	HIV Testing Services
ICESCR	Covenant on Economic, Social and Cultural Right
IEC	Information, Education and Communication
IOM	International Organisation of Migration
IPT	isoniazid preventive therapy
KP	key population
KZN	KwaZulu-Natal
LGBTI	lesbian, gay, bisexual, transgender and intersex
LPA	line probe assay
M&E	monitoring and evaluation
MDR-TB	multi-drug resistant tuberculosis
MEC	Member of the Executive Council of a Province
MIS	Management Information System
MMC	medical male circumcision
MSM	men who have sex with men
MTSF	Medium-Term Strategic Framework
NAPHISA	(Planned) National Public Health Institute of South Africa
NDoH	National Department of Health

NDP	National Development Plan – Vision 2030
NEDLAC	National Economic Development and Labour Council
NGO	non-governmental organisation
NHI	National Health Insurance
NHLS	National Health Laboratory Service
NICD	National Institute of Communicable Diseases
NPA	National Prosecuting Authority of South Africa
NSP	National Strategic Plan for HIV, TB and STIs
OVC	orphans and vulnerable children
PBPR	patient-based partner referral
PCA	Provincial Council on AIDS
PDP	product development partnership
PDPM	patient-delivered partner medication referral
PEP	post-exposure antiretroviral prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PIP	Provincial Implementation Plan
PITC	provider-initiated testing and counselling
PLHIV	people living with HIV
PLTB	people living with TB
PMTCT	prevention of mother-to-child HIV transmission
PPT	periodic presumptive treatment
PrEP	pre-exposure antiretroviral prophylaxis
PTB	people with TB
PTU	Preventive Therapy Uptake
PWDs	people with disabilities
PWID	people who inject drugs
QI	quality improvement
R	Rand
Rif	rifampicin
Rif-R	rifampicin-resistant
RPT	rifapentin
SA	South Africa
SABCOHA	South Africa Business Coalition on Health and AIDS
SADC	Southern African Development Community
SAG	South African Government
SAHPRA	South African Health Regulatory Products Authority
SALGA	South African Local Government Association
SAMRC	South Africa Medical Research Council
SANAC	South African National AIDS Council
SAPS	South Africa Police Service
SASQAF	South African Statistical Quality Assurance Framework
SBCC	social and behaviour change communication
SCWs	social care workers
SDGs	Sustainable Development Goals
SHIP	Strategic Health Innovation Partnership
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
SSD	social and structural driver
STATS SA	Statistics South Africa
STGs	Standard Treatment Guidelines
STI	sexually transmitted infection
SW	sex workers
TB	tuberculosis
TCC	Thutuzela Care Centre
Tier.Net	Electronic ARV Treatment Register
TVET	Technical and Vocational Education and Training
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
UTT	Universal Test and Treat
VCT	voluntary counselling and testing
VP	vulnerable population
WBOT	Ward-based Outreach Teams
WHO	World Health Organization
WSW	women who have sex with women

Foreword

This is the fourth National Strategic Plan (NSP) that South Africa has adopted to guide its response to HIV, Tuberculosis and sexually transmitted infections. Viewed together, the plans set out in the NSP provide insight into the path we have travelled as a nation to overcome one of the most devastating human challenges of our time.

They show how our response to HIV, TB and STIs has evolved over the last two decades as we have come to understand the nature and impact of the epidemics with regard to the factors that contribute to their spread, and the interventions that work best in reducing infection, morbidity and mortality.

This NSP is a clear demonstration of the outstanding progress we have made. It is also a stark reminder of how far we still need to go.

Importantly, it provides an excellent illustration of what South Africans can achieve when working together towards the realisation of a shared objective. The Plan has been made possible through the dedicated participation of individuals and organisations from across the country. We are grateful to the people who have dedicated time, resources and great effort to develop a plan that is clear and ambitious, comprehensive and possible. The effective implementation of this Plan will require the involvement of all sectors – government, business, labour, civil society, development agencies, research institutions and communities.

It is significant that the NSP is closely aligned with the National Development Plan, locating the struggle against HIV, TB and STIs within the broader struggle for economic and social development. These are mutually reinforcing efforts: progress in reducing the burden of disease contributes to development, while faster development improves our ability to address the social and structural drivers of HIV, TB and STIs.

The Plan recognises the need to ensure that our response is both comprehensive and focused. It seeks to address the many factors that contribute to the persistent high rates of infection, illness and death. It significantly increases our focus on prevention, treatment uptake, coverage and adherence, and ending discrimination and stigmatisation. At the same time, it recognises the need to direct specific programmes to those areas of the country with the highest burden and to those populations that are disproportionately affected.

The Plan is inclusive, both in the process of its development and in the range of its priorities and key activities. It is evidence-based, making effective use of the better data, greater knowledge and more advanced tools we have for analysis, monitoring and evaluation.

Most importantly, this NSP is people-centred, recognising that these epidemics are not simply about viruses, bacteria and medicine, but about the society in which we live, the relationships we form, the work we do, the places in which we live, the way we treat each other, the way we treat ourselves, and the aspirations we have for our children and their children.

This National Strategic Plan is about life, how we protect it, how we prolong it, how we value it and how we improve it.

Let us work together to ensure that this NSP is one of the last.

Mr Cyril Ramaphosa

Deputy President of the Republic of South Africa

Preface

The next 5 years is pivotal for the health of our people. Whilst we have made significant progress in the past 5 years, much more needs to be done by government and every stakeholder in our country to end AIDS, TB and STIs as public health threats.

The gains we have made in our responses to the HIV epidemic in particular are reflected in the significant gains in life expectancy — which STATS SA reported as follows: male life expectancy in 2010 was 56.5 years which increased to 61.9 years in 2015; female life expectancy was 61.2 years in 2010 and rose to 67.7 years in 2015. As can be seen female life expectancy is edging close to 70 years, which is what we are targeting for everyone by 2030!

These increases in life expectancy are driven by declines in maternal, infant and under 5 mortality rates which were also reported by STATS SA. In 2011 maternal mortality was 214/100 000 live births, infant mortality was 24/1000 live births and under 5 mortality was 32/1000. By 2015 these figures were 119/100 000, 19/1000, and 26/1000 for maternal, infant and under 5 mortality respectively. Similarly, there has been a significant decline in TB as a cause of mortality (from 41 904 deaths in 2013 to 33 063 in 2015 — a 21% decline in 2 years), even though TB continues to be the single largest contributor to death in South Africa.

Whilst there are many contributors to these very significant gains, our responses to the HIV and TB epidemics are the largest factor behind these increases in life expectancy as well as the declines in mortality rates. This conclusion is supported by researchers, writing in Lancet HIV, who noted that the increase in life expectancy in KwaZulu-Natal has been "three times faster (than in post-World War 2 Japan), and is almost exclusively driven by reductions in HIV-related Mortality" (Reniers, et al., 2017).

Challenges however remain, with the large number of people (7 million) that are HIV positive and an estimated 270 000 new HIV infections and 450 000 new TB infections annually. This means that we have to redouble our efforts in the next 5 years in an "all of government and all of society response" to these epidemics. We have to ensure that coverage of our services for prevention as well as treatment, care and support, together with their quality, improves in every corner of our country. Key will be to improve the involvement of communities in planning and implementation of solutions. Every person in South Africa must know their HIV status, know the symptoms of TB, as well as STIs , and get treatment as soon as possible. It is through knowledge and action that we will be able to prevent new HIV and TB infections and STIs and ensure that they are successfully treated. These actions, for which we each have to take individual and collective responsibility, will ensure that we can stop HIV and TB being public health threats by 2022 or earlier!

I request every stakeholder in every corner of our country to take action, as reflected in this National Strategic Plan. For our part, the Department of Health, working with other departments and civil society organisations, we will do everything we can to ensure that we successfully implement the NSP, 2017-2022.

Dr Aaron Motsoaledi

Minister of Health

Message from the SANAC Vice-chairperson

The National Strategic Plan on HIV, TB and STIs 2017-2022 is a very important plan that guides the country's approach and commitment to help achieve the goals that are set out in the NSP. This will be launched by the Deputy President, Cyril Ramaphosa, with the SANAC Community on 31 March 2017, as part of the World TB Day commemoration.

The SANAC community has invested in a robust consultation process towards development of South Africa's 4th generation NSP on HIV, TB and STI's 2017-2022. As a result SANAC is charged with new responsibilities that are clearly guided and requires functional and accountable Councils at all levels that will monitor and coordinate this 5-year plan.

The SANAC community has spoken through the NSP. It is evident that we must accelerate progress in reducing new HIV, TB and STI infections. A robust prevention agenda is key and is the core foundation of this 5-year plan. The NSP clearly calls for a reduction of mortality and morbidity associated with HIV, TB and STIs. The focus on universal Test and Treat is prioritised; this is to ensure that those who are tested and found to be positive have continuous uninterrupted access to treatment when and where they need it. The NSP calls for optimal links to and implementation of the adherence programme to ensure that no patient is left behind, and everyone has their viral load monitored and suppressed.

This NSP is explicit in the targeted populations, the Key and Vulnerable populations, for HIV, TB and STIs. They will be focused on in an intensified way that will see and yield results and realise a call to ensure that competent services are provided to those who have for a very long time been marginalised and discriminated against. This NSP clearly demonstrates the level of effort required of a collective approach in various spheres and by various Sectors (Government, Civil Society, Private Sector and Donor community). It calls for accountability, shared responsibility and leadership that is complemented by investments of knowledge, information and financial backing that hopes to maximise efforts to deliver on targets and goals agreed in the NSP. It is indeed time to ACT, as it is in our hands, we must deliver on this mandate, and the new NSP calls on less talk, more ACTION and results for impact.

This NSP indicates the importance of the Provincial Implementation Plans and restructuring of the AIDS Councils. Radical efforts are required at all levels to ensure leadership and programmes speak to the goals of the NSP. Investment in Civil Society Sectors remains key, as they will help bridge the gap, bring the needs and challenges of the constituencies to the table and help respond. This NSP has new leadership in place for the new term 2017-2022, the leaders elected must put people first and there should be good governance in place to ensure the structure is fit for purpose.

As we are all charged with this responsibility, we should take certain things into consideration; (i) The call to multi-sectoral interventions and collaboration; (ii) The protection and promotion of civil society participation, we must reject the ideology of contributing to shrinking the civil society space; (iii) Ensure that we create an enabling environment by continuing to raise the importance of decriminalisation, acting on commitments to ensure we protect rights for all and careful consideration of laws and their impact must be continued and guidance provided; (iv) A more willing and political commitment followed through by actions in all spheres; (v) Accountability and good governance; (vi) Fully funding the SANAC Secretariats in all spheres, civil society Sectors and Government programmes in various departments; (vii) Recognising that SANAC is an association where many members are volunteers and must be recognised for their expertise, time and contribution; (viii) The co-ordination and monitoring arm of the SANAC Secretariat must be strengthened.

It is 2017, the clock is ticking on the 2020 prevention agenda and the 2030 ambition to end HIV and TB as public health threats is around the corner. Everything we do requires that we upscale key interventions, we focus on return on investment, we become more vigilant in what we do, we reach out to those groups left behind, and address stigma and discrimination.

We must overcome the hurdle of inequality and repair the injustices of the past. We must dismantle the inequalities and focus on communities. Let communities be involved in the response from the beginning to the end, as true partners and not as tokens. This will be the start of a fresh collective and political momentum towards ending AIDS, TB and STIs. This can be achieved as it is in our hands.

Mmapaseka Steve Letsike

Executive Summary

Introduction

The National Strategic Plan on HIV, TB and STIs (NSP) 2017-2022 is South Africa's fourth plan. It builds on the significant progress achieved to date, addresses gaps identified during the past five years and seeks to scale up best practice to ensure that quality and innovation underpins service provision. The NSP outlines the strategic framework for a multi-sectoral partnership to further accelerate progress in reducing the morbidity (illness) and mortality (death) associated with HIV, TB and STIs in South Africa. Provinces will develop context specific Provincial Implement Plans (PIP) to operationalise in greater detail the broad strategic directions and approaches planned. This decentralised process will enable the national strategies for HIV, TB and STIs to be tailored to the specific needs and conditions in provinces and communities. Government departments, civil society sectors and the private sector will also develop their own sectoral implementation plans.

The NSP is aligned to the MTSF and embedded in the NDP. Development of this Plan was grounded in a thorough review of available evidence and consultation with all stakeholders. A multi-sectoral Steering Committee guided its development, deeply informed by many inputs and by sectoral and national consultations. The NSP has been endorsed by the Plenary of the South African National AIDS Council (SANAC) and by the national Cabinet.

The epidemics in perspective

The country has made important gains in responding to the epidemics of HIV and TB and to STIs, but the national response needs to be accelerated if the country is to achieve the global health community goal of ending these as public health threats by 2030. Nearly one in five people living with HIV worldwide are in South Africa; tuberculosis (TB) is the leading cause of death in the country; and more than 1.1 million new cases of sexually transmitted infections (STIs) are treated each year.

More than 19% of adults (ages 15-49) in South Africa are living with HIV. The HIV burden varies widely by geography, age and gender and for key and vulnerable populations. New HIV infections declined from 360 000 in 2012 to 270 000 in 2016, with marked progress in preventing mother-to-child HIV transmission. Adolescent girls and young women as well as other key and vulnerable populations remain most heavily affected by the epidemic. South Africa has the world's largest HIV treatment programme, with 3.7 million people initiated on antiretroviral therapy as of December 2016, resulting in a sharp increase in national life expectancy from 58.3 years in 2011 to 62.4 years in 2015. Although less detailed epidemiological information is available on STIs, the evidence underscores the seriousness as a public health problem and as a risk factor for HIV infection.

South Africa has the sixth highest TB incidence in the world, with more than 450 000 new cases diagnosed in 2015, 63% in people living with HIV. There has been only a modest decline in new cases since 2012. Multidrug-resistant TB (MDR-TB) is a growing problem; with the number of MDR-TB cases doubling from 2007 to 2012.

During 2012 -2016 South Africa advanced its efforts to address the needs of key and vulnerable populations and continued to address the social and structural drivers of HIV, TB and STIs, enhance human rights and reduce stigma, resource the response and provide effective leadership. However, the pace of impacting on the epidemics will need to be speeded up if we are to achieve the global targets signed up to and the national targets set. More of the same will not be enough.

Towards epidemic control: What is new in this NSP

At the heart of this NSP is the strategy to "focus for impact" using the more detailed information and insights now available. While comprehensive prevention and care will be provided countrywide, intensified, concentrated efforts will be made in the 27 districts that account for 82% of all people living with HIV and for the majority of new infections and in the 19 districts with the highest TB burden. In these high-burden districts, redoubled efforts will draw on detailed, innovative data sources (such as geospatial mapping) to identify those most at risk. The purpose is saturation of high-impact prevention and treatment services and strengthened efforts to address the social and structural factors that increase vulnerability to infection. Nationally, but especially within these high-burden districts, key and vulnerable populations most heavily affected by the epidemics will receive intensified focus to empower them, improve service access and reduce barriers to service uptake. The "focus for impact" approach represents a new, transformative way to achieve reductions in the morbidity and mortality associated with HIV and TB and morbidity from STIs. In line with the evidence, there will be a substantially stronger focus on adolescent girls and young women and on key and vulnerable populations, not forgetting adolescent boys and young men.

To maximise the impact of efforts, the NSP introduces this more intensified, more strategic focus at provincial, district and ward levels. There will be a greater priority on primary prevention and on strategies to address the social and structural drivers of the three infections in a thoroughly multi-sectoral manner. South Africa's recent success in scaling up prevention and treatment programmes will

be complemented by an equivalent focus on improving service quality and on reducing loss to follow-up among people who initiate care, while simultaneously implementing the new "Test and Treat" policy. Recognising that different people require different prevention approaches, differentiated care models will be scaled up to tailor interventions to each person's needs, including enhanced use of proven community-centred service delivery. Priority is given to ensuring that treatment programmes are holistic, addressing each person's health needs, including co-morbidities. The need for innovative new sources of funding is identified. A higher priority is placed on the collection and timely use of high-quality data to guide and inform programmes and policies.

NSP vision, mission and principles

The vision: A South Africa free from the burden of HIV, TB and STIs

The mission: South Africa on track to eliminate HIV, TB and STIs as public health threats by 2030

Principles include:

- A reliance on sound evidence
- Commitment to protecting and promoting human rights
- A multi-sectoral approach
- A people-centred approach
- A response that is inclusive and participatory
- Ensuring that no one is left behind

NSP goals

Eight goals are set, each supported by clear objectives and sub-objectives and activities to realise them. (The activities are enunciated in the narrative and in greater depth in the tables in Appendix B.)

Goal 1: Accelerate prevention to reduce new HIV and TB infections and STIs

While valuing the progress made in prevention, this NSP aims to reduce new HIV infections by more than 60% – from an estimated 270 000 in 2016 to below 100 000 by 2022, including elimination of mother-to-child HIV transmission and a reduction in new infections among adolescent girls and young women from 2000 a week to less than 800; to cut TB incidence by at least 30% (from 450 000 to 315 000) and to reduce new gonorrhoea and syphilis infections.

Goal 1: Accelerate prevention to reduce new HIV and TB infections and STIs	
Objective 1.1	**Reduce new HIV infections to less than 100 000 by 2022 through combination prevention interventions**
Sub-objective 1.1.1	Revitalise Information, Education and Communication programmes in school, health, workplace and community setting
Sub-objective 1.1.2	Implement targeted biomedical prevention services tailored to setting and population
Sub-objective 1.1.3	Provide sensitive and age-appropriate sexual and reproductive health services and comprehensive sexuality education
Sub-objective 1.1.4	Provide pre-exposure prophylaxis (PrEP) to identified risk populations
Sub-objective 1.1.5	Provide targeted services to prevent mother-to-child transmission of HIV and syphilis in the prenatal and postnatal period
Objective 1.2	**Reduce TB incidence by at least 30%, from 834/100,000 population in 2015 to less than 584/100,000 by 2022**
Sub-objective 1.2.1	Increase coverage of Preventive Therapy Uptake
Sub-Objective 1.2.2	Promote TB infection control
Objective 1.3	**Significantly reduce T. Pallidum, gonorrhoea and chlamydia infections, virtually eliminate congenital syphilis, and maintain high coverage of HPV vaccination**
Sub-Objective 1.3.1	Scale up STI prevention by providing high quality health information and timely health services for persons at risk
Sub-Objective 1.3.2	Scale up and maintain high levels of HPV vaccination in grade 4 learners
Sub-Objective 1.3.3	Develop and implement effective STI partner-notification strategies

Goal 2: Reduce morbidity and mortality by providing HIV, TB and STI treatment, care and adherence support for all

Progress in treatment has been impressive, but it will require much more to achieve the 90-90-90 targets for HIV and TB by 2020 i.e. to provide 90% of people with an HIV diagnosis (including 175 000 children) antiretroviral therapy and ensure that 90% of them (including 158 000 children) achieve HIV viral suppression, and attain a 90% treatment success rate for drug-sensitive and 70% for multi-drug resistant TB.

Goal 2: Reduce morbidity and mortality by providing HIV, TB and STI treatment, care and adherence support for all	
Objective 2.1	**Implement the 90-90-90 strategy for HIV**
Sub-objective 2.1.1	90% of all people living with HIV know their HIV status
Sub-objective 2.1.2	90% of all people with diagnosed HIV infection receive sustained antiretroviral therapy
Sub-objective 2.1.3	90% of all people receiving antiretroviral therapy are virally suppressed
Objective 2.2	**Implement the 90-90-90 strategy for TB**
Sub-objective 2.2.1	Find 90% of all TB cases and place them on appropriate treatment
Sub-objective 2.2.2	Find at least 90% of the TB cases in key populations (the most vulnerable including people living with HIV with low CD4 counts, under-served, at-risk) and place them on appropriate treatment
Sub-objective 2.2.3	Successfully treat at least 90% of those diagnosed with DS TB (and 75% of those with DR TB)
Objective 2.3	**Improve STI detection, diagnosis and treatment**
Sub-objective 2.3.1	Increase detection and treatment of asymptomatic STIs by 50%
Sub-objective 2.3.2	Increase the detection and treatment of STIs

Goal 3: Reach all key and vulnerable populations with customised and targeted interventions

Goal 3: Reach all key and vulnerable populations with customised and targeted interventions		
Key populations for HIV and STIs	**Key populations for TB**	**Vulnerable populations for HIV and STIs**
Sex Workers	People living with HIV	Adolescent girls and young women
Transgender people	Household contacts of TB index patients	Children including orphans & vulnerable children
Men who have sex with men	Health care workers	People living in informal settlements
People who use drugs	Inmates	Mine workers
Inmates	Pregnant women	Mobile populations, migrants and undocumented foreigners
	Children < 5 years old	People with disabilities
	Diabetics	Other LGBTI populations
	People living in informal settlements	
	Miners and peri-mining communities	

*With respect to HIV, the 90-90-90 target, as recommended by UNAIDS, provides that by 2020:
(a) 90% of all people living with HIV will know their HIV status;
(b) 90% of all people with an HIV diagnosis receive sustained antiretroviral therapy; and
(c) 90% of all people receiving antiretroviral therapy achieve viral suppression.
The 90-90-90 target requires that 81% of all people living with HIV receive antiretroviral therapy and that 73% of all people living with HIV are virally suppressed.

As set forth in the Global Plan to End TB 2016–2020, the 90-90-90 target for TB provides that:
- 90% of all people who need TB treatment are diagnosed and receive appropriate therapy — first-line, second-line and preventive therapy, as required;
- 90% of people in key and vulnerable populations are diagnosed and receive appropriate therapy; and
- Treatment success is achieved for at least 90% all people diagnosed with TB.

To ensure that no one is left behind, efforts to maximise access to high-quality services for key populations will be enhanced. The strategy prioritises efforts to build the capacity of both mainstream and community-based service providers, community- and peer-led programming will be implemented and expanded, and enabling environments created so that hard-to-reach groups advocate for their health and human rights and increase their uptake of life-saving services.

Goal 3: Reach all key and vulnerable populations with comprehensive, customised and targeted interventions	
Objective 3.1	**Increase engagement, collaboration and advocacy of key and vulnerable populations in the development and implementation of social and health support activities**
Sub-Objective 3.1.1	All national and provincial AIDS Councils will include at least one representative from a key and vulnerable population group
Sub-Objective 3.1.2	Support key and vulnerable population social capital by encouraging community networks that include advocacy agendas for equal health and human rights
Sub-Objective 3.1.3	All key and vulnerable population programmes should adopt a peer-led approach to implementation
Objective 3.2	**To provide an enabling environment to increase access to health services by key and vulnerable populations**
Sub-Objective 3.2.1	Enable increased access to tailored health information through differentiated service delivery approaches that are tailored for the populations served
Sub-Objective 3.2.2	Enable increased access to health information and social and behaviour change communication interventions
Sub-Objective 3.2.3	Expand the provision of rehabilitation, comprehensive psychosocial support and mental health services for people living with and affected by HIV and TB
Sub-Objective 3.2.4	Further train and sensitise healthcare professionals in the identification and delivery of appropriate services for key and vulnerable populations
Sub-Objective 3.2.5	Integrate rights-based components in all health and social programmes to holistically serve key and vulnerable population clients and patients

Goal 4: Address the social and structural drivers of HIV, TB and STIs, and link these efforts to the NDP

Reducing vulnerability to HIV, TB and STIs as well as efforts to address them do not occur in a vacuum. They are heavily affected by specific factors in the social and economic environment. Therefore a multi-department, multi-sector approach to addressing the social and structural determinants that increase risk and vulnerability to HIV, TB and STIs is envisaged for all South Africans, with particular attention to the needs of adolescent girls and young women. Over the next five years, the following social and structural drivers will be addressed:

Goal 4: Address the social and structural drivers of HIV, TB and STIs, and link these efforts to the NDP	
Objective 4.1	**Implement social and behaviour change programmes to address key drivers of the epidemics and build social cohesion**
Sub-Objective 4.1.1	Reduce risky behaviour through the implementation of programmes that build resilience of individuals, parents and families
Sub-Objective 4.1.2	Comprehensive and age-specific and appropriate support for learners and out-of-school youth
Sub-Objective 4.1.3	Strengthen the capacity of families and communities
Objective 4.2	**Increase access to and provision of services for all survivors of sexual and gender-based violence in the 27 priority districts by 2022**
Sub-Objective 4.2.1	Increase access to provision of services for all survivors of sexual and gender-based violence.
Sub-Objective 4.2.2	Provide support for survivors of sexual assault
Objective 4.3	**Scale up access to social protection for people at risk of and those living with HIV and TB in priority districts**

Goal 4: Address the social and structural drivers of HIV, TB and STIs and link them to the NDP Goals	
Sub-Objective 4.3.1	Ensure that all HIV- and TB-infected persons who are eligible have access to social grants
Sub-Objective 4.3.2	Scale up access to food security and nutritional support
Objective 4.4	**Implement and scale up a package of harm reduction interventions to address the harmful use of alcohol and drugs in all districts**
Sub-Objective 4.4.1	Scale up access and provision of in- and out-patient rehabilitation services for all who use alcohol and drugs
Objective 4.5	**Implement economic strengthening programmes with a focus on youth in priority districts**
Sub-Objective 4.5.1	Economically empower targeted groups of young people by increasing the availability of economic opportunities
Objective 4.6	**Address the physical structural impediments for optimal prevention and treatment of HIV, TB and STIs**
Sub-Objective 4.6.1	Improve ventilation and indoor air quality in congregate settings
Sub-Objective 4.6.2	Develop advocacy campaign for health promotion specific to TB control
Sub-Objective 4.6.3	Improve structural accommodation for people with disabilities

Goal 5: Ground the response to HIV, TB and STIs in human rights principles and approaches

South Africa's legal framework is guided by a progressive Constitution which guarantees a broad range of rights and these are incorporated into the HIV and TB response. Intensified efforts will be made to close gaps in full implementation of rights-related legal and policy commitments, in care by service providers and in access to legal redress for people who experience stigma and discrimination. The aim is to reduce externalised and internalised stigma among people living with HIV and TB by at least 50%.

Goal 5: Ground the response to HIV, TB and STIs in human rights principles and approaches	
Objective 5.1	**Reduce stigma and discrimination among people living with HIV or TB by half by 2022**
Sub-Objective 5.1.1	Revitalise community-based support groups to deal with internalised stigma
Sub-Objective 5.1.2	Reduce stigma through community education
Objective 5.2	**Facilitate access to justice and redress for people living with and vulnerable to HIV and TB**
Sub-Objective 5.2.1	Improve legal literacy about human rights and laws relevant to HIV and TB
Sub-Objective 5.2.2	Make HIV- and TB-related legal services available and accessible
Objective 5.3	**Promote an environment that enables and protects human and legal rights and prevents stigma and discrimination**
Sub-Objective 5.3.1	Implement a Human Rights Accountability Scorecard
Sub-Objective 5.3.2	Monitor implementation of laws, regulations and policies relating to HIV and TB and identify areas for reform
Sub-Objective 5.3.3	Sensitise law makers and law enforcement agents
Sub-Objective 5.3.4	Train health care providers on human rights and medical ethics related to HIV

Goal 6: Promote leadership and shared accountability for a sustainable response to HIV, TB and STIs

Leadership, mutual accountability and commitment remain key ingredients for a successful response. The next phase of the NSP will focus on strengthening a decentralised approach which places districts at the hub of quality services across all sectors and departments. Efforts at strengthening SANAC structures will continue. Through the revised Intergovernmental Relations Framework co-operation and collaboration among government departments will be improved, inclusive AIDS councils at provincial and district levels will be empowered and leadership at the ward level will be mobilised. Involvement of the private sector and organised labour will be deepened and civil society sectors and community networks capacitated. The vision of leadership reflected in the NSP requires the transparent sharing of essential information on the epidemics and the response, as well as inclusive dialogue on performance nationally and locally. The following will be done:

Goal 6: Promote leadership and shared accountability for a sustainable response to HIV, TB and STIs	
Objective 6.1	**Strengthen AIDS Councils to provide effective co-ordination and leadership of all stakeholders for shared accountability in the implementation of the NSP**
Sub-Objective 6.1.1	Formally establish the structures of AIDS Councils at national, provincial, district and local level
Sub-Objective 6.1.2	Ensure representation of all stakeholders in decision-making structures at all levels
Sub-Objective 6.1.3	Strengthen the role of the private sector and labour in AIDS Councils
Sub-Objective 6.1.4	Ensure a central role for civil society and community groups
Sub-Objective 6.1.5	Monitor annually the implementation of the accountability framework through an Accountability scorecard
Objective 6.2	**Improve collaboration and co-operation between government, civil society, development partners and the private sector**
Sub-Objective 6.2.1	Ensure that the plans of government and the non-government sector are aligned with the NSP
Sub-Objective 6.2.2	Strengthen collaboration between and co-ordination of government departments
Sub-Objective 6.2.3	Establish/ strengthen regional collaboration

Goal 7: Mobilise resources to support the achievement of NSP goals and ensure a sustainable response

Investments in HIV programmes generate eight Rand in economic returns for every Rand invested. Building on the momentum from the marked increases in recent years in financing for HIV and TB, the Government of South Africa will grow its financing for HIV and TB activities from R 17.3 billion in 2016/17 to R 24.7 billion in 2019/20, providing a substantial foundation for the response. However, this will not fully finance implementation of the NSP.

In the face of low economic growth, Government should fully use available fiscal space to increase budgetary investments and international partners will need to remain engaged. The roll-out of National Health Insurance will be effectively leveraged to generate new financing for HIV, TB and STI services. Private sector partners must step forward to help in closing financing gaps, while non-health government sectors can finance the broad-based social and economic interventions that impact on HIV and TB and incorporate preventive actiivites into their programmes. Innovative financing options, such as social impact bonds, will be actively explored.

Goal 7: Mobilise resources to support the achievement of NSP goals and ensure a sustainable response	
Objective 7.1	**Improve efficiency and mobilise sufficient resources to achieve the goals, objective and targets of the NSP**
Sub-Objective 7.1.1	Maximise the funds available for implementation of the NSP and the impact of these funds

Goal 8: Strengthen strategic information to drive progress towards achievement of the NSP goals

South Africa has routinised public health monitoring and evaluation; surveillance systems; epidemiologic, laboratory and programmatic research and highly capable research institutions. Capacity will be built, co-ordination of strategic information achieved and findings better disseminated through:

Goal 8: Strengthen strategic information to drive progress towards achievement of the NSP goals	
Objective 8.1	**Optimise routinely collected strategic health information for data utilisation**
Sub-objective 8.1.1	Implement master patient index for use in all service delivery settings
Sub-objective 8.1.2	Link clinical, laboratory and pharmacy data
Sub-objective 8.1.3	Establish health information (HIE) exchanges for real-time data availability
Sub-objective 8.1.4	Increase data utilisation
Objective 8.2	**Rigorously monitor and evaluate implementation and outcomes of the NSP**
Sub-Objective 8.2.1	Strengthen and promote multi-sectoral ownership and accountability of the NSP and PIP M&E systems
Sub-Objective 8.2.2	Strengthen M&E capacity to effectively use available data to monitor NSP and PIP performance and HIV, TB and STI at all levels
Sub-Objective 8.2.3	Ensure harmonised, timely and comprehensive routine systems to provide quality health data at national, provincial and district levels and across sectors
Sub-Objective 8.2.4	Disseminate timely, relevant HIV, TB and STI information to the public
Sub-Objective 8.2.5	Generate and disseminate NSP Monitoring and Evaluation Reports
Objective 8.3	**Further develop the national surveillance system to generate periodic estimates of HIV, TB and STI measures in the general population and in key and vulnerable populations**
Sub-Objective 8.3.1	Institutionalise HIV, TB and STI surveillance within the Department of Health
Sub-Objective 8.3.2	Conduct routine HIV, TB and STI surveillance activities
Sub-Objective 8.3.3	Conduct routine HIV, TB and STI surveillance activities among key and vulnerable populations
Sub-Objective 8.3.4	Implement facility- and laboratory-based surveillance
Sub-Objective 8.3.5	Implement non-routine surveillance activities and surveys at the population level
Objective 8.4	**Strengthen strategic research activities to create validated evidence for innovation, improved efficiency and enhanced impact**
Sub-Objective 8.4.1	Develop a coordinated research agenda for the NSP

Critical enablers

Systems will need to be strengthened to reach the ambitious goals and objectives of this NSP. The "cross-cutting systems enablers" needed to ensure successful implementation are therefore prioritised:

- Focus on social and behaviour change communication to ensure social mobilisation and increasing awareness;
- Build strong social systems, including strengthening families and communities, to decrease risks of transmission and to mitigate the impact of the epidemics;
- Effectively integrate HIV, TB and STI interventions and services;
- Strengthen procurement and supply chain systems; and
- Ensure that the human resources required are sufficient in number and mix, trained and located where they are needed.

Monitoring implementation and success of the NSP

A rigorous action plan for monitoring and evaluation has been developed, consistent with the "accountability for results" on which South Africa's response to HIV, TB and STIs is built. Using baselines derived from available evidence, indicators to measure progress towards each of the objectives and sub-objectives will be measured. In addition to a final review, a mid-term assessment of achievements will be undertaken to enable stakeholders to identify where actions are working, where they are falling short, and what needs to be done to get the response on track.

Conclusion: A healthy future is within our grasp

With the launch of this new NSP there is renewed hope and optimism about the national response to HIV, TB and STIs. We have the ingredients we need to achieve our mission of ending HIV, TB and STIs as public health threats in our country by 2030, but if we do not build on the substantial gains that have been made and significantly increase investment in our response now, these epidemics will rebound. The 'focus for impact' approach outlined in this NSP offers a roadmap for fully leveraging scientific advances, while greater engagement of affected communities and all sectors frames the response. Through this NSP we can set a path that ensures that our country will be free from the burden of HIV, TB and STIs.

INTRODUCTION

South Africa's National Strategic Plan for HIV, TB and STIs 2017-2022

Introduction

The National Strategic Plan on HIV, TB and STIs 2017–2022 (NSP) provides the strategy and framework of a multi-sector partnership for South Africa to overcome HIV, TB and STIs as public health and social challenges. National, provincial and local government, civil society sectors, the private sector, development partners and other stakeholders all collaborate in its development and implementation. This NSP outlines the goals, objectives and activities that give expression to South Africa's vision and mission for the period April 2017 – March 2022, identifying how to strengthen social, health and other systems to enable success. All stakeholders will use the Plan to guide their implementation plans. Together, this constitutes the national response.

Vision:

A South Africa free from the burden of HIV, TB and STIs

Mission:

South Africa on track to eliminate HIV, TB and STIs as public health threats by 2030

Principles guiding this NSP include:

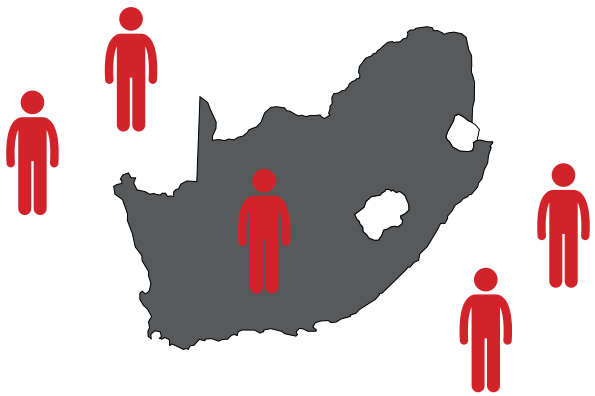
- A reliance on sound evidence
- Commitment to protecting and promoting human rights
- A multi-sectoral approach
- A people-centred approach
- A response that is inclusive and participatory
- Ensuring that no one is left behind

1.1 The process leading to this NSP

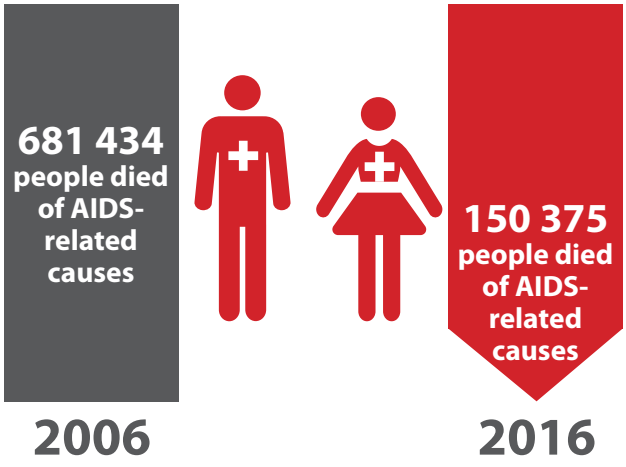
Preparation of this Strategic Plan started with an analysis of progress made and challenges faced during the implementation of the previous Plan. Under the umbrella of the South African National AIDS Council (SANAC) and guided by a Steering Committee, the Plan has been developed through a process of extensive consultation with civil society, government, provinces, the private sector and development partners, and at two national multi-stakeholder consultations. An open call for submissions and

HIV, TB AND STIs Status

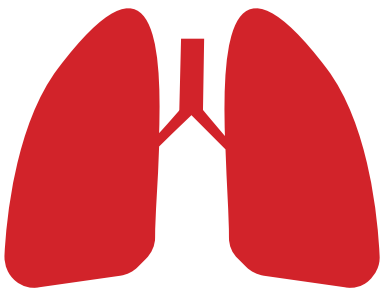
South Africa = 1 in 5
people living with HIV globally



HIV Mortality



TB = Nation's leading cause of death



New STIs treated

comments was also made and a number of technical working groups provided support. The NSP has been endorsed by SANAC's Programme Review Committee, Plenary, and Inter-Ministerial Committee. Finally, Cabinet approval of the Plan was obtained at the end of March 2017.

1.2 The South African context – Exceptional progress, but much still to be done

South Africa has come a long way since the first NSP was published for the period 2000–2005. The 2007–2011 NSP made the decisive move to massive expansion of antiretroviral treatment, while the 2012–2016 Plan laid the foundation for further expansion in line with new treatment guidelines. Furthermore, goals related to the protection of human rights and addressing social and structural drivers have been included, as work around these constitutes 'unfinished business'.

The NSP for 2017–2022 has been informed by the successes and challenges of the 2012–2016 Plan, extensive consultation with all stakeholders, the latest evidence, including that gleaned from the AIDS 2016 Conference, and an analysis of the epidemiology of the epidemics in South Africa.

Among the successes recognised are the following:

- Sexual transmission of HIV among those aged 15–49 has declined from 410 000 per annum in 2011 to an estimated 270 000 in 2016, denoting a decline of 34%
- Mother-to-child transmission of HIV (at six weeks) declined from more than 3.5% in 2010 to 1.8% in 2014
- 10 million people voluntarily test annually for HIV
- 2.4 million medical male circumcisions were performed in the last four years
- 3.7 million people are on antiretroviral treatment (ART), making South Africa's the largest such programme in the world
- Implementation of the World Health Organization (WHO) evidence-based Universal Test and Treat (UTT) guidelines from September 2016
- GeneXpert technology was introduced for faster diagnosis of TB
- The TB treatment success rate rose to 83% in 2016
- Life expectancy recovered from 58.3 years in 2011 to 62.4 years in 2016
- Interventions and policies that respect human rights and an enabling legal framework have been developed and implemented
- The National Sex Worker Plan for HIV and draft Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Strategy were developed and implementation of the Guidelines for the Management of TB in Correctional Services Facilities commenced
- The 'Families Matter' and 'Yolo' Programmes were introduced and GBV Command Centres were implemented
- The Higher Education and Training HIV/AIDS Programme (HEAIDS) drove HIV testing for students
- The Strategic Health Innovation Partnership (SHIP) and other support were garnered for research into new drugs and diagnostics

Not surprisingly, given the scale of the epidemics, there have also been challenges. These include:

- HIV, TB and STIs are not reducing quickly enough – there are still 270 000 new HIV infections annually
- The rate of infections remain high among young women and girls, in key and vulnerable populations and in particular districts
- The effectiveness of programmes to deal with the social and structural determinants of HIV and TB risk, including poverty, unemployment, gender inequality, and alcohol abuse and substance use must be improved
- Externalised and internalised stigma around HIV and TB must be minimised

Indeed, the NSP recognises that past successes should not lead to complacency, lest the gains made are reversed. Acknowledging the challenges, this Plan, as the next phase of the national response, adopts an approach that moves the country towards epidemic control. The groups identified as most vulnerable to HIV (such as adolescent girls and young women and the men who infect them), and groups at higher risk of TB infection (such as mine workers and inmates), will be the focus of the strategy going forward.

The key aspects of the NSP are:

- a multi-sectoral response that elevates community and civil society responses;
- geographic targeting, with profiling of community needs and strengths and refining and building capacity for geospatial mapping and profiling, so that districts will be in a better position to allocate resources strategically and achieve positive impacts;
- the prioritisation of prevention in all its facets to ensure that the 'tap' of new infections is turned off;
- a national campaign to find the missing 150 000 people who need to receive TB treatment and their contacts, tied to the introduction of new regimens for TB will contribute significantly to reducing the current burden whilst improving quality of life for those on treatment;
- building on the significant progress made in HIV treatment, efforts to enrol more people living with HIV (PLHIV) on life-saving medication will be ramped up;

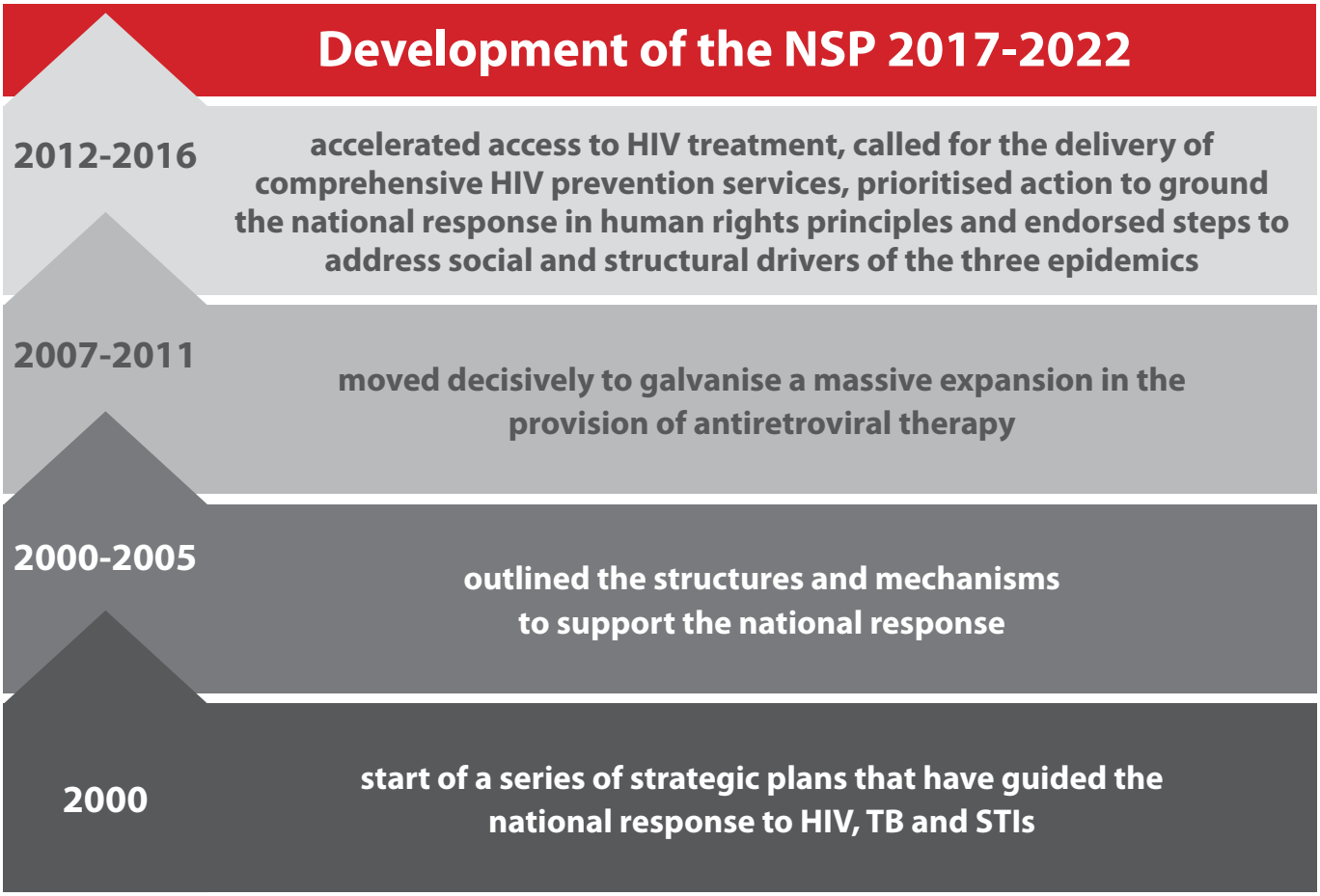


Figure 1: Changes in the NSP over the years

- closing gaps in the treatment cascade, with dedicated resources applied to improving quality and strengthening adherence support, which are critical for achieving viral suppression;
- linking HIV, TB and STI care to mitigating services such as rehabilitation, palliative care and mental health services, and addressing co-morbidities;
- customising prevention packages and differentiated care for HIV and TB for key and vulnerable populations, to ensure a people-centred approach which will also contribute to the reduction of stigma and discrimination;
- effecting a paradigm shift in deeply entrenched social and cultural practices and concepts such as patriarchy that expose women to risk, in order to address the challenging and complex social and structural drivers of the epidemics;
- applying vigour to factors that drive exposure to TB infection, including ventilation in congregate settings (which is often overlooked);
- overcoming the triple challenges of poverty, inequality and unemployment and in so doing, supporting the country's capacity to achieve the goals of both the NSP and NDP; and
- ongoing vigilance on the human rights agenda in the context of the NSP to ensure that the rights and safety of all vulnerable people, including the LGBTI community, are protected.

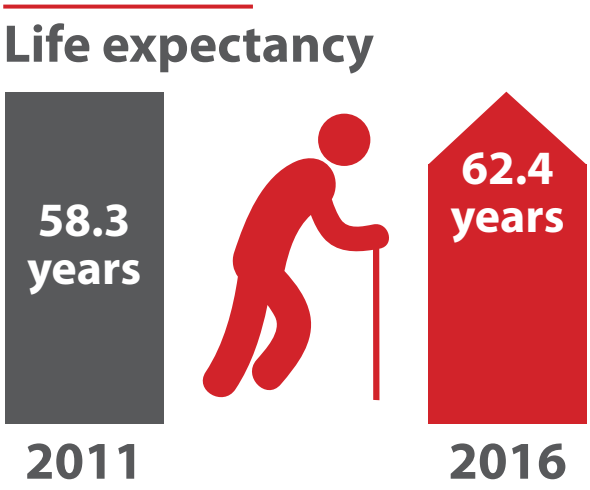
Achieving the NDP objective of an HIV-free generation of under-20s by 2030 is possible only if the NSP is embraced by all members of society.

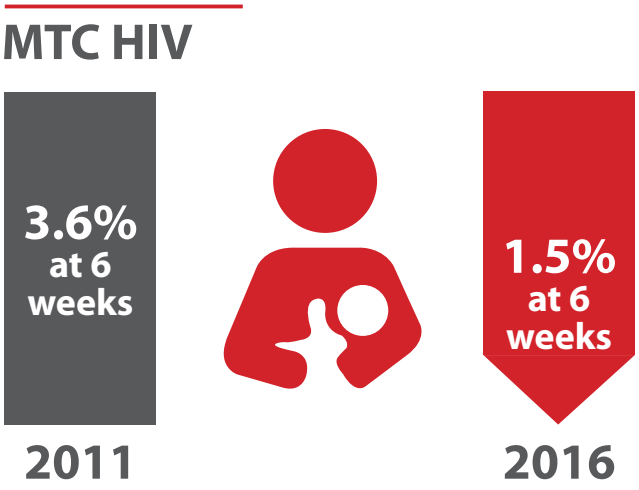
1.3 The epidemiology of the HIV, TB and STI epidemics guides our focus for the future

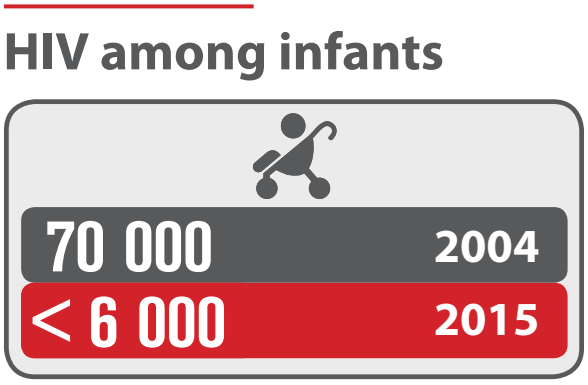
The HIV, TB and STI epidemics are characterised by distinct sub-epidemics that are apparent geographically and among key and vulnerable populations. This understanding of the HIV, TB and STI epidemics guides the Plan to focus for impact where the burden of disease is and on what needs to be done to bring about the change that is needed.

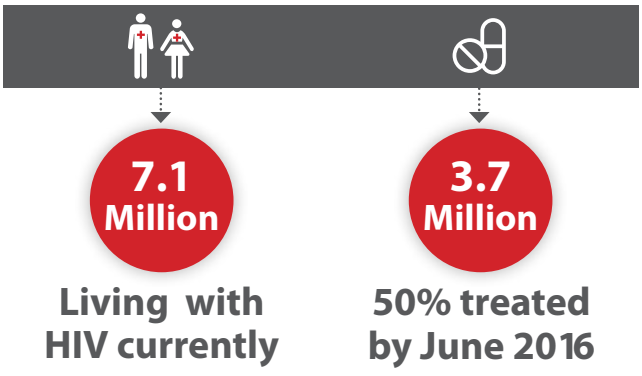
1.3.1 HIV

South Africa has an estimated 7.1 million people living with HIV (PLHIV) according to Thembisa model estimates of mid-2016.[2] Nearly 270 000 people were newly infected in 2016. This reflects a prevalence rate of about 12.8% among the entire population, or 19.1% among those aged 15 to 49 years. HIV prevalence among pregnant women has hovered around 30%, but reaches towards 50% in some districts. The successful roll-out of antiretroviral therapy, thereby supporting PLHIV to live longer, healthier lives has resulted in a rising prevalence over recent years, even though the number of people being infected annually has been dropping.









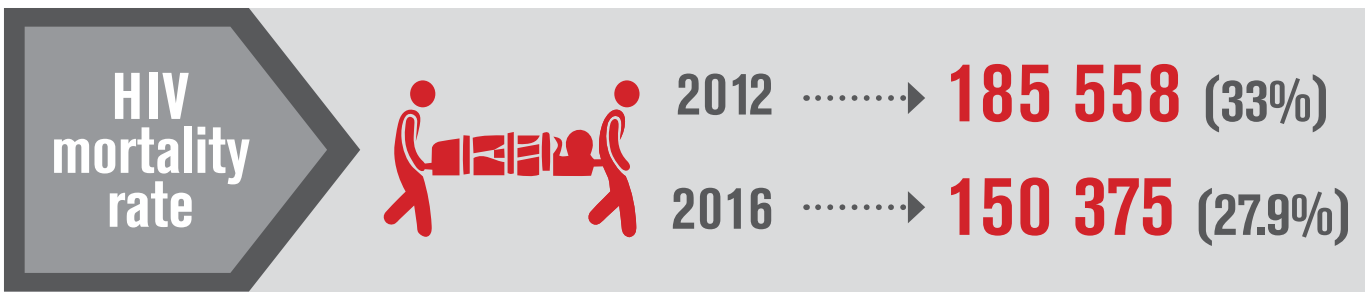


Figure 2: HIV incidence, prevalence and mortality

Figure 3: Graphic of HIV in young women and girls

The epidemiology of HIV in South Africa has evolved from an emergency with high mortality, to one showing the benefits of a huge expansion of treatment services and wide coverage. What is now evident is that the epidemic is not homogenous, but rather that some geographic areas (provinces and districts), young women and girls, and some key populations like sex workers, have high rates of HIV transmission that call for a targeted focus to achieve the impact needed.

There is substantial variation in HIV by province, with KwaZulu-Natal having the highest prevalence (18%), followed by Mpumalanga (15%). The Northern Cape and Western Cape have the lowest HIV prevalence, at 6.8% and 6.6%, respectively.[3] Within provinces, people living in urban informal areas have the highest HIV prevalence (19.9%), followed by residents in rural informal areas (13.4%).[4]

Young women (aged between 15 and 24 years) have the highest HIV incidence of any age or sex cohort, at 2.01% in 2015.[3] Young women in their early 20s have a four-fold burden compared to their male peers, with approximately 2 000 new HIV infections occurring every week, or 100 000 of the 270 000 new infections a year,[3] and one third of teenage girls become pregnant before the age of 20[5]. Responding to the social and structural drivers of this vulnerability (which leads young women towards having sexual relationships – many of which are transactional in nature – with men who are five to 10 years older than they are) is key to controlling the epidemic.

HIV prevalence among the approximately 150 000 female sex workers[6] ranges from 48% to 72%, compared to 14.4% among adult women in the general population.[7]

There is higher HIV prevalence (28%) among the 1.2 million[8] men who have sex with men (MSM)[9], the 67 000 people[10] who inject drugs (PWID) (14%)[11], inmates (23%)[12], and people with disabilities (17%)[4].

Children require a renewed focus, as for every child initiated on ART, there are approximately 1.4 new HIV infections.

1.3.2 Tuberculosis (TB)

TB is the leading cause of death in South Africa, accounting for 8.4% of all natural deaths in 2015. In 2015, the incidence of TB was 834 cases per 100 000 population, resulting in an estimated 450 000 new TB infections, 63% of which were among people living with HIV.[13] The TB burden is also driven by poor living conditions and late presentation to health facilities. Treatment success was low. Although this has improved, the TB prevalence rate has not been reducing much since 2010.

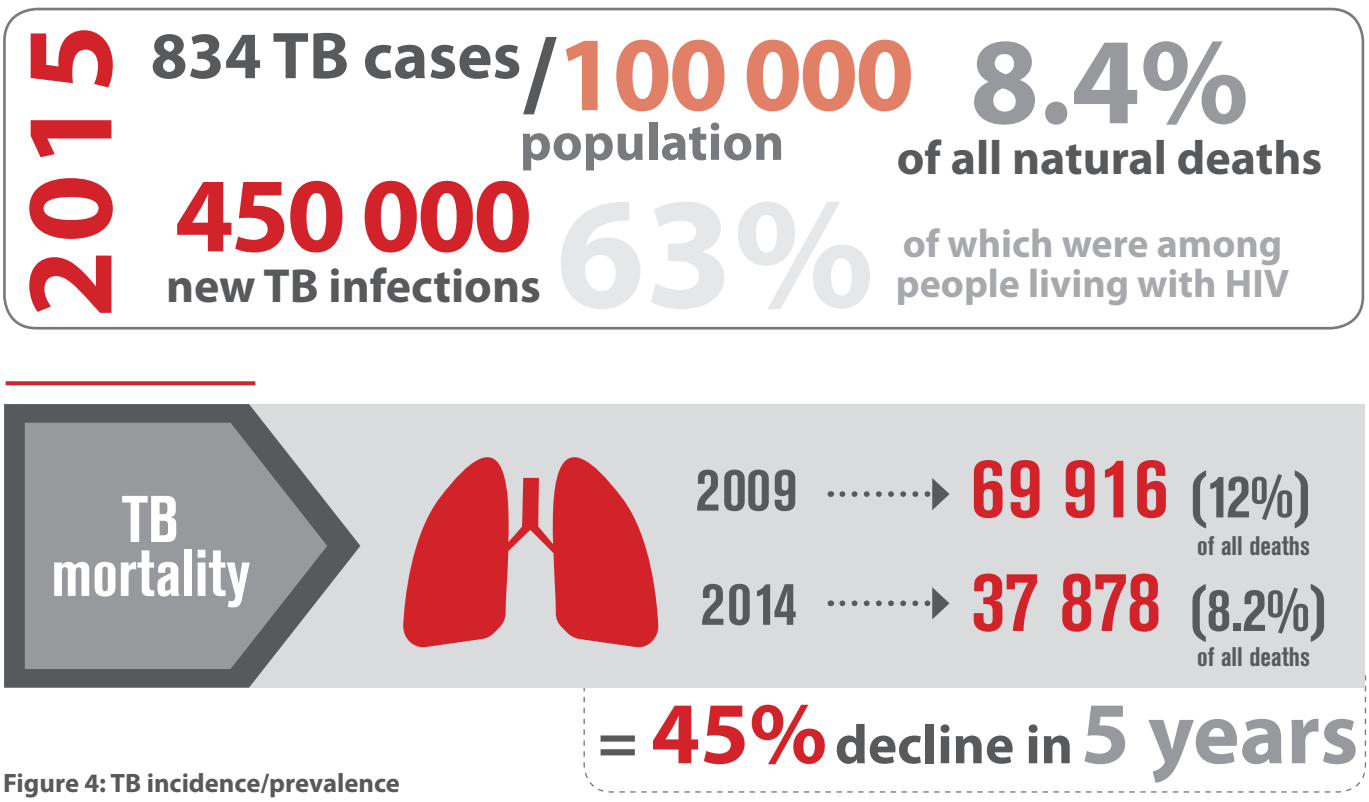


Figure 4: TB incidence/prevalence

- High-risk groups for TB are characterised by a 2.1% prevalence in inmates[14], a rate of 3 000–7 000 per 100 000[15] in gold mine workers, and 2 760 per 100 000[16] among diabetics. There is also a higher incidence of TB, including of drug-resistant TB, among healthcare workers. [17]

- The number of multi-drug-resistant TB (MDR-TB) cases has doubled, from 7 350 cases in 2007 to 14 161 in 2012. [18]

1.3.3 Sexually Transmitted Infections (STIs)

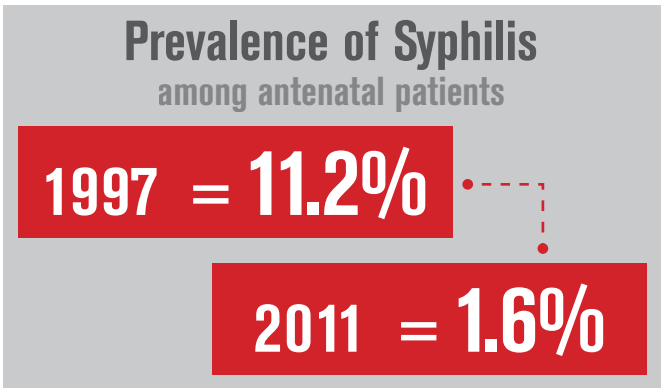
While the prevalence of syphilis among antenatal clients decreased from 11.2% in 1997 to 1.6% in 2011,[19,20] STIs overall remain a serious problem and add to the risk of HIV infection.

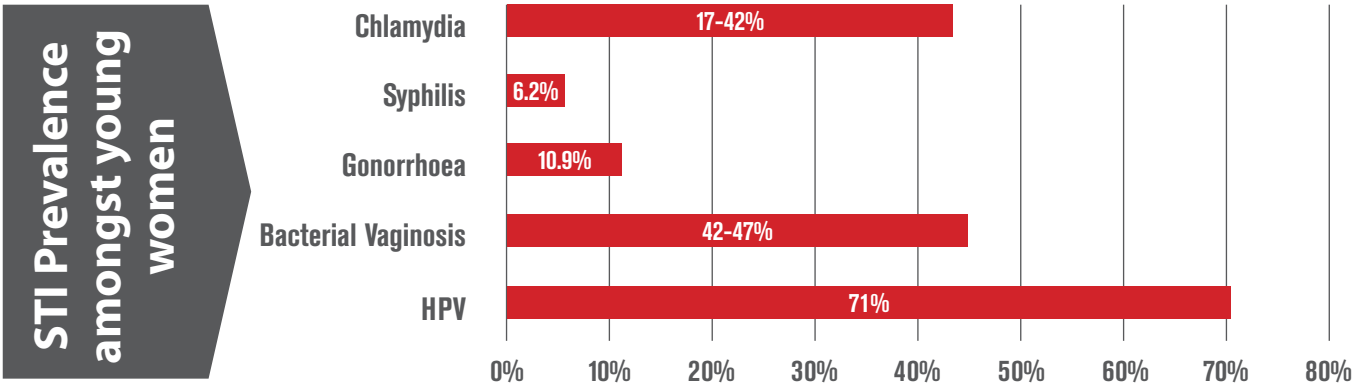
- Young women have STI prevalence rates of 17–42% for chlamydia, 71% for HPV, 6.2% for syphilis, 10.9% for gonorrhoea and 42–47% for bacterial vaginosis. [21]

- More than a third of MSM have reported STI symptoms.[22]

- The prevalence of HSV-2 infection among antenatal women in Gauteng, KwaZulu-Natal, the Northern Cape and the Western Cape was 55.8% in 2012. [23]

- Syphilis prevalence among sex workers was 19.6% in Cape Town and 16.2% in Johannesburg.[7]





1.4 The Goals of the NSP 2017–2022

The consultative process and situation analysis has led to eight Goals being conceptualised for the period 2017 to 2022.

Goal 1

Accelerate prevention to reduce new HIV and TB infections and STIs

– *'Breaking the cycle of transmission'*

Goal 2

Reduce morbidity and mortality by providing HIV, TB and STI treatment, care and adherence support for all

– *'Reaching 90-90-90 in every district'*

Goal 3

Reach all key and vulnerable populations with customised and targeted interventions

– *'Nobody left behind'*

Goal 4

Address the social and structural drivers of HIV, TB and STIs, and link these efforts to the NDP

– *'A multi-department, multi-sector approach'*

Goal 5

Ground the response to HIV, TB and STIs in human rights principles and approaches

– *'Equal treatment and social justice'*

Goal 6

Promote leadership and shared accountability for a sustainable response to HIV, TB and STIs

– *'Mutual accountability'*

Goal 7

Mobilise resources and maximise efficiencies to support the achievement of NSP goals and ensure a sustainable response

– *'Spend now, to save later'*

Goal 8

Strengthen strategic information to drive progress towards achievement of NSP Goals

– *'Data-driven action'*

1.5 Enablers of success

This NSP also recognises the importance of building the social and service delivery systems needed for its successful implementation and to overcome bottlenecks. These "crosscutting systems enablers" entail:

- focusing on social and behaviour change communication to ensure social mobilisation and increased awareness;
- building strong social systems, including strengthening families and communities, to decrease the risks of transmission and to mitigate the impact of the epidemics;
- effective integration of HIV, TB and STI interventions and services;
- strengthening procurement and supply chain systems; and
- ensuring that the human resources required are sufficient in number and mix, and trained and located where they are needed.

1.6 Strategic approach during 2017 to 2022: Focus for impact

The eight Goals of the NSP, described in subsequent chapters, aim to build on lessons learnt and achievements to date, to close gaps that persist in the national response, and to build a strong foundation to end the HIV and TB epidemics and STIs as public health threats. To successfully implement these Goals, a much more strategic and focused effort will be needed, applying the detailed understanding and insights gained in regard to epidemic dynamics in order to maximise the impact of available resources and efforts.

How these goals are implemented in Provincial Implementation Plans will be as important as the substance of the Goals themselves. Although the NSP is national in scope, its ultimate success will depend on effective implementation at the provincial, district and ward levels. From the national to the local context, three levels of focus will accelerate implementation of the Plan and optimise its impact:

- ***Spatial location:*** The NSP calls for steps to ensure the delivery of comprehensive services to all who need them, regardless of where they live. However, cognisant of the marked geographic variation in disease burden, the NSP endorses particularly intensified action in the 27 districts (these include metros and district municipalities) that account for 82% of all people living with HIV, and in the 19 districts with high TB burdens. This is as a starting point until geospatial mapping is fully implemented and able to give more information on more localised areas of high burden for intensified action.

In each of these high-burden areas:

1) ambitious coverage targets will be set;
2) current and new programmes will focus strategically on those in greatest need; and
3) other strategies will be intensified to address the social and structural factors that increase individual and community vulnerabilities which contribute to the disease burdens.

- ***Population:*** In each of these high-burden districts and cities, programmatic efforts will be strategically targeted towards the populations among whom the need is greatest, and where the impact of efforts will be most pronounced. Given the degree to which transmission among adolescent girls and young women is driving HIV across the country, every province, district and ward must take steps to intensify efforts to reduce new HIV infections and increase service access for adolescent girls and young women, including addressing the social and structural factors that increase their vulnerability. Guided by local data and circumstances from geospatial mapping and profiling, provincial and local responses should prioritise key and vulnerable populations.

BOX 1: Background for selecting high-burden districts

The process for identifying high-burden districts for intensification of efforts dates back to September 2015, when the SANAC Secretariat established the Hotspot Mapping Advisory Committee. The Committee – including government and non-governmental epidemiological experts as well as international partners – was tasked with developing a transparent, multi-sectoral, locally informed and user-friendly approach to hotspot mapping.

The Committee developed an approach to geospatial mapping and risk profiling that allows stakeholders to obtain a more detailed understanding of geospatial variations in HIV burden – and this was later expanded to cover TB and STIs as well. The model aims to answer key questions:

(a) Where in a particular district are the areas with the highest burden?

(b) Why does a specific area have a higher burden (i.e. what are the contributing factors)?

(c) Which multi-sectoral interventions should be deployed in the high-burden area to reduce HIV, TB and STI risks?

This approach is now being piloted in two districts: uMgungundlovu District in KwaZulu-Natal and the Cape Winelands District in the Western Cape.

To identify the high-burden districts for prioritisation at the outset of this NSP, the Committee examined key epidemiological and service indicators (e.g. infant first PCR test at around 10 weeks, antenatal client first HIV positive test, HIV prevalence among testing clients aged 15–49). To complement service data, the Committee consulted secondary data to identify populations at risk of or living with HIV in an area. In addition, feedback was provided at the local level through stakeholder and community workshops, which proved to be an excellent vehicle for local participatory involvement.

*The high-burden districts specified here are those prioritised at the outset of the NSP in 2017, based on the latest available data. The epidemiological situation in terms of HIV, TB and STIs will be regularly assessed, taking into account the scale-up of 'hotspot' profiling. As the HIV and TB epidemics continue to evolve, the specific districts prioritised in the 'focus for impact' approach may change over time (as may the total number of districts targeted for intensified effort).

- ***Interventions:*** Enhanced focus will also be on the combination of interventions that are prioritised for scale-up. Priority will be placed on implementing the right mix of high-value, high-impact interventions that will maximise the number of new infections and deaths averted.

To ensure strategic focus for impact, the SANAC Secretariat will support provinces for a step wise approach to implementation:

- ***Use data:*** Provinces will use data, including geospatial mapping, to strategically focus and intensify responses in high-burden areas. Within these areas, spatial mapping data will be used to identify 'hotspots' where interventions are most needed. Profiling of communities in these areas will be undertaken to develop a clearer, more detailed understanding of the local contextual drivers of the epidemics, the individual and community resources and strengths, and the location of available and needed services.

- ***Scale up high-impact interventions:*** Focused efforts in high-burden areas should achieve saturation coverage of high-impact prevention and treatment interventions and of multi-sectoral strategies to address the social and structural drivers of HIV and TB. Rigorous efforts will be made to expand the reach and impact of interventions conducted in these areas through strengthening the critical systems enablers.

- ***Ensure an integrated, multi-sectoral response:*** Strategic integration of programmes and approaches will be prioritised, from planning to service delivery. Building on the co-operation and collaboration of key departments, more focused efforts will ensure that responses at all levels are fully multi-sectoral in order to address the social and structural factors that increase vulnerability and limit service uptake.

- ***Monitor results and take corrective action where needed:*** From the individual service site to the district, provincial and national levels, improved data – including unique client health identifiers (the master patient index) and strengthened monitoring and evaluation – will be used to track outcomes and improve performance over time. These data and analytics will serve as a continual 'feedback loop', allowing stakeholders at all levels to address problems as they arise and identify weaknesses requiring intervention.

To operationalise this approach, provinces – led by Provincial AIDS Councils and supported by the SANAC Secretariat – will develop Provincial Implementation Plans (PIPs) that describe in detail how to implement the NSP in each province. These PIPs will focus for impact by tailoring the strategic approach to the specific epidemiological patterns, needs and challenges within each province. While taking account of the comprehensive services to which every community and person is entitled, regardless of location and disease burden, the PIP will elaborate how the provincial response will intensify efforts in high-burden areas. Building on the Provincial Implementation Plan, District AIDS Councils will use a broadly inclusive, participatory approach to the development of local interventions, with targets, to guide the intensification of efforts.

Focusing for impact seeks not only to implement validated interventions but also to maximise their reach and impact. In this regard, the critical system enablers outlined in the NSP are essential to leverage high-impact, high-value interventions to reach the goals and objectives envisaged in the Plan. In particular, social and behaviour change communication (SBCC) has a pivotal role to play in promoting safer behaviours, increasing demand for services, mobilising communities, and increasing service retention and adherence.

'Focus for impact' is a fundamentally new 'way of doing business' as South Africa works to achieve a decisive transition from disease control to eliminating HIV, TB and STIs as public health threats. These focus areas and strategic approaches apply across the Goals outlined in this NSP.

In summary, the Plan strives for even better integration, decentralisation, responsibility and ownership. It will enable intersectoral planning and integrated service delivery, especially at community level. The NSP has been costed and looks to innovative financing strategies to ensure that it is fully funded. An indicator matrix has been built into a results-based framework, which is at the heart of a commitment to effectively monitor implementation and success and to making any adjustments necessary to achieve the set goals and objectives.

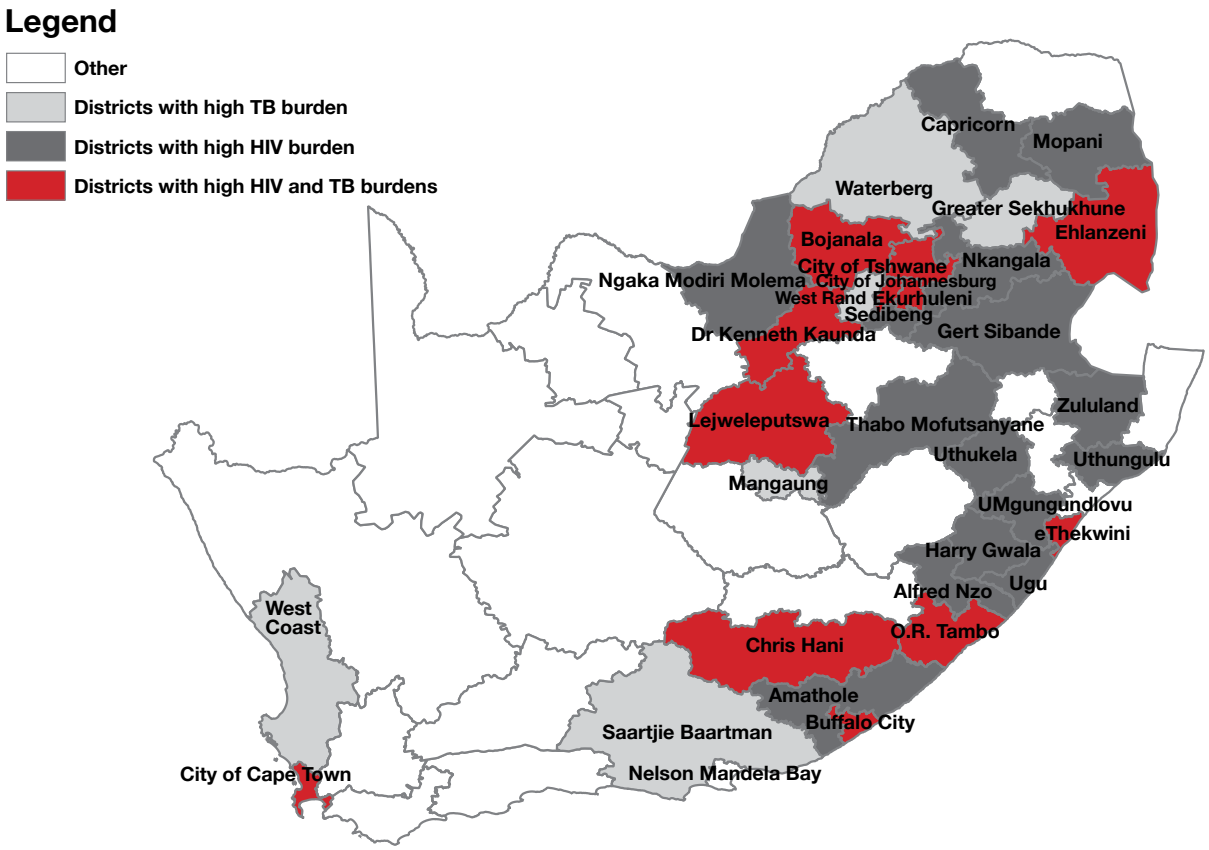


Figure 5: Districts with high HIV and TB burdens

Table 1: Districts with high HIV burden

Province	Districts
Gauteng	City of Johannesburg, Ekurhuleni, City of Tshwane, and Sedibeng
KwaZulu-Natal	eThekwini, Umgungundlovu, Uthungulu, Zululand, Ugu, uThukela, and Harry Gwala
Mpumalanga	Ehlanzeni, Nkangala, and Gert Sibande
Eastern Cape	Oliver Tambo, Amathole, Alfred Nzo, Chris Hani and Buffalo City
Free State	Thabo Mofutsanyane, Lejweleputswa
North West	Bojanala, Ngaka Modiri Molema, and Dr Kenneth Kaunda
Limpopo	Capricorn and Mopane
Western Cape	City of Cape Town

Table 2: Districts with high TB burden

Province	Districts
Gauteng	City of Johannesburg, Ekurhuleni, City of Tshwane, West Rand
KwaZulu-Natal	eThekwini
Mpumalanga	Ehlanzeni
Eastern Cape	Oliver Tambo, Nelson Mandela Metro, Chris Hani, Buffalo City, Saartjie Baartman
Free State	Mangaung Metro, Lejweleputswa
North West	Bojanala, Dr Kenneth Kaunda
Limpopo	Greater Sekhukhune, Waterberg
Western Cape	City of Cape Town, West Coast

1

"I am calling for 2000 men to join me in getting circumcised so we can minimise the risk of HIV and STI infection."

– Kagiso Modupe, Brothers for Life Ambassador

Goal 1:

Accelerate prevention to reduce new HIV and TB infections and STIs

"Breaking the Cycle of Transmission"

Goal 1: Accelerate prevention to reduce new HIV and TB infections and STIs

"Breaking the Cycle of Transmission"

1.1 Strategic context

Although the number of new HIV and TB infections has declined, the pace fell short of the 50% reduction envisaged in the NSP 2012–2016.[24] Consequently, the number of new HIV, TB and STIs remains higher than our ambitions. South Africa aims, by 2022, to reduce the number of new HIV infections from 270 000 to under 100 000; eliminate new HIV infections among children; reduce TB incidence by 30% (from 834/100 000 to no more than 584/100 000); reduce the incidence of T pallidum and N gonorrhoea by 90%; virtually eliminate congenital syphilis by reducing incidence to 50 or fewer cases per 100 000 live births; and maintain national coverage of HPV vaccination above 90% for Grade 4 girls.

Achieving this sharp fall in the number of new HIV and TB infections will only be possible through a combination of interventions. This includes a combination of biomedical interventions, including 'treatment-as-prevention' achieved through viral suppression, and widespread uptake of TB preventive therapy. In addition, a robust strategy for addressing social and structural determinants, social behaviour change communication, and customised interventions for key and vulnerable populations for HIV and TB – all underpinned by a rights-based approach – are central to success. Strategies to successfully identify the missing TB clients will move us closer to epidemic control by 2030. Achieving a decrease in STIs will include the implementation of the new NDoH STI Strategy that deals comprehensively with this challenge.

While investments in the response have increased significantly over time [25], more resources will have to be allocated for HIV and TB prevention, especially among key and vulnerable populations [25], and an increased emphasis on prevention is essential if the ambition of this NSP is to be achieved. The targeted approach highlighted herein will result in a better return on investments in prevention programmes.

1.2 Strategic approach: Breaking the cycle of transmission

A clearer understanding of the HIV transmission pathways as identified in the research conducted in KZN will inform strategies to identify adolescent girls and young women who are highly vulnerable [26]. Targeting these women and the men who infect them will contribute to breaking the cycle of transmission. More research is required to understand emerging social phenomena (such as 'blessers') to better target prevention programmes. Thus this Plan prioritises:

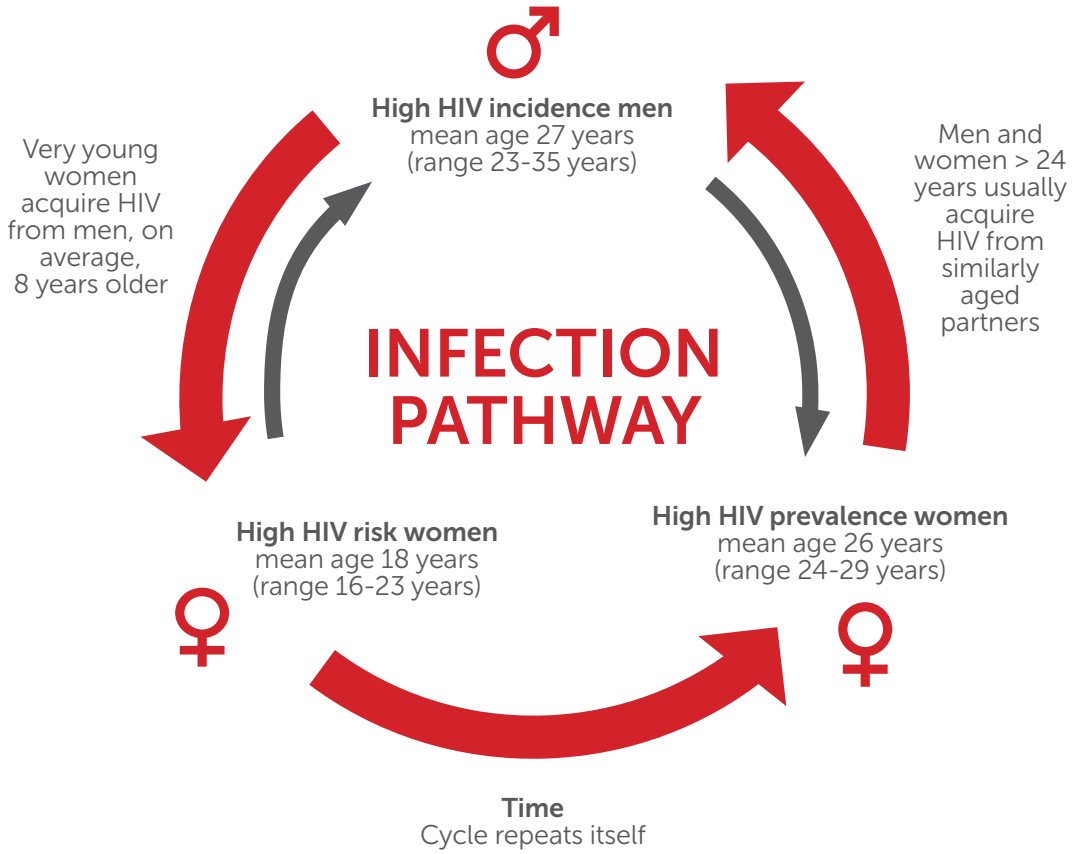


Figure 6: Understanding the infection pathway to target prevention

- ***Achieving 90-90-90 by 2020 for HIV and TB:*** According to modelling by UNAIDS, attainment of these HIV treatment targets will enable the world to end the AIDS epidemic by 2030. Whilst the Global Plan to End TB 2016–2020 sets targets for 2025, the Communiqué of the Fourth Meeting of BRICS Health Ministers in December 2014 called for an accelerated investment to end TB, and for these targets to be met by 2020 – hence South Africa's adoption of this timeline. The country's strategies to achieve these '90-90-90' identification and treatment targets is the focus of Goal 2, the measures of which are supported by those in all the other goals and enablers of this NSP. Treatment that suppresses viral load is a major preventive measure.

- ***Implement the new National Sexually Transmitted Infections Strategy*** [20] issued by the NDoH that is aligned with the WHO Global Health Sector Strategy on STIs [27]. The overarching framework of this South African strategy includes: universal coverage for all people, especially key and vulnerable populations. There is a focus on key STI syndromes and aetiologies (maternal and congenital syphilis, gonococcus, chlamydia, syphilis, HSV-2, HPV); and a public health approach ensuring that the strategy is based on standardised guidelines and treatment regimens. A continuum of care for STIs will ensure that individuals screened and diagnosed with STIs receive and complete treatment and are cured, making a significant contribution to prevention.

- ***Scale up high-impact prevention interventions:*** A comprehensive package of high-impact, context-tailored, carefully targeted combination prevention interventions will be provided in all districts. In the high-burden districts for HIV and TB and in settings and populations with elevated risk of STI acquisition, intensified efforts will achieve saturation coverage of targeted interventions, including provision of appropriate social support. Over the duration of this NSP, 2.5 million men will be medically circumcised. PrEP will be offered to those who are most likely to benefit, including adolescents and sex workers and services for MSM and people who inject drugs will be scaled up. At least 90% coverage of full HPV vaccination for Grade 4 learners will be maintained. Post-exposure antiretroviral prophylaxis (PEP) will be made available on demand for all HIV exposures, particularly for survivors of sexual assault. To stimulate the uptake of PrEP and PEP services, specific efforts to raise awareness and create demand will be undertaken.

  TB Preventive Therapy Uptake (PTU) will be ensured for all household contacts and other vulnerable groups. Identification will be promptly followed by screening and early initiation of therapy where indicated. TB infection control will be improved in households, healthcare facilities and other congregate settings. Efforts will be intensified to ensure the tracing of contacts of all cases of drug-resistant TB. IPT or newer regimes such as the isoniazid and rifapentine combination – commonly known as 3HP – will reach 90% of people living with HIV by 2022.

Efforts to address STIs will also include a focus on the detection and management of asymptomatic STIs, strengthened syndromic management, and the provision of periodic presumptive treatment for high-risk groups.

- ***Focus for impact through the use of detailed data to guide programme design and targeting:*** Ongoing surveillance through regular programme data analysis, modelling and epidemiological assessment has led to the identification of high-burden districts where implementation will be intensified. Capacity for undertaking geospatial high-burden mapping and profiling to optimise decision-making at a local level will be strengthened. Geospatial profiling seeks to inform programme design and implementation by answering the questions identified in the strategic approach, i.e. where and who should be targeted, with what optimal package of services, and by whom? This work will be supported by the work described in Goal 8 (Strategic Information) where, over time, the monitoring and evaluation results framework and ongoing surveillance will feed more disaggregated refined data into the information platform, thus continuously improving the information available for decision-making.

- ***Increase the priority placed on primary prevention:*** To achieve the NSP targets for reduction of new HIV and TB infections, the priority given to programmes for preventing infection among those not infected will increase. This will be done through programmes that will be strategic combinations of evidence-based behavioural, biomedical and structural interventions as described under Goals 2, 3, 4 and 5, with the leadership imperative described in Goal 6, and the critical systems enablers.

- ***Renew momentum for sexual risk reduction:*** This requires close linkages between SBCC programmes described under the Enablers, and the prevention interventions described in Table 7 to ensure that services are targeted and accessed, e.g. condoms, PrEP, MMC.

- ***Drive a major national push to scale up comprehensive sexuality education and linkage to sexual and reproductive health services:*** This entails fully implementing the bold and progressive new Department of Basic Education (DBE) National Policy on HIV, TB and STIs to provide comprehensive sexuality education in all schools using the enhanced curriculum developed. In high-priority districts, this will be coupled with access to sexual and reproductive health services (SRHS) through the Integrated School Health Programme (ISHP) and

*As provided in the 2016 NDoH Health Sector HIV Strategy, 'combination prevention' refers to the strategic, simultaneous use of different classes of prevention interventions (biomedical, behavioural and structural) that operate on multiple levels (individual, couple, community and societal) to respond to the specific needs of particular audiences and modes of HIV transmission, and to make efficient use of resources through prioritising partnerships and engagement of affected communities.
Fast track: Ending the AIDS epidemic by 2030: By reaching the 90-90-90 target by 2020 and 95-95-95 by 2030, modelling suggests that we will end AIDS by 2030. The target reflects 90%/95% of people who are HIV-infected being diagnosed, 90/95% of those diagnosed being on antiretroviral therapy, and then 90/95% of those on antiretroviral therapy having a suppressed viral load.

partners. The package of SRH services will include counselling on contraception and voluntary medical male circumcision (VMMC), provision of contraception and condoms, pregnancy testing, HIV Testing Services (HTS) and PrEP. In addition, TB literacy will be markedly improved through co-curricular activities, including campaigns and working with the NDoH and municipalities to use schools as sites for TB screening and contact tracing. In order to promote and protect the health and wellbeing of educators and officials, Employee Health and Wellness programmes will be improved.

- ***Implement the 'last mile' plan to achieve the elimination of mother-to-child transmission of HIV:*** While the number of children born with HIV has markedly declined, mother-to-child transmission persists, especially during the breastfeeding period. To reach the elimination target, all leakages in the service cascade of prevention of mother-to-child transmission must be closed. Strategies must ensure universal uptake and consistent use of antiretroviral therapy during the breastfeeding period, as well as provision of a birth dose of Hepatitis B vaccine for all babies exposed to HIV. An option under consideration is universal screening of all pregnant women and provision of tenofovir prophylaxis in the last trimester. Follow-up and monitoring of the mother–baby dyad will be strengthened through the Ward-based Outreach Team at primary health care level. The NSP calls for actions to ensure that the rate of mother-to-child transmission of HIV will be held below 2% at 18 months.

The services that form part of the comprehensive package of services for the general population are elucidated in Table 7 and will be supplemented and customised for the age group and target population as described in Table 8 and in Goal 3 for key and vulnerable populations.

Table 8 lists the services that form part of the comprehensive package of services for the general population, which will then be supplemented and customised to the age group and population being served. This is further supplemented by additional interventions for key and vulnerable populations as enunciated in Goal 3.

2

"Strict adherence to treatment is important in order to enjoy a healthier, longer life."

– Gerry Elsdon, Global TB Champion

Goal 2:

Reduce morbidity and mortality by providing treatment, care and adherence support for all

"Reaching 90- 90- 90 in every district"

Goal 2: Reduce morbidity and mortality by providing treatment, care and adherence support for all

"Reaching 90-90-90 in every district"

2.1 Strategic context

South Africa made many notable advances in the treatment of HIV, TB and STIs in the 2012–2016 period. These include massively scaling up antiretroviral therapy (ART) and adopting the HIV Universal Test and Treat (UTT) approach in September 2016. The country rolled out implementation of GeneXpert for TB diagnosis, developed focused TB initiatives for peri-mining communities and correctional facilities, and provided concentrated care for people with drug-resistant TB. More recently, the development of the STI National Strategic Framework was accomplished. However, much more remains to be done, especially as steps are taken to fully scale up Universal Test and Treat (UTT), and to find everyone with symptoms of TB and provide them with treatment. Particular barriers to ART and TB treatment are experienced by children, adolescents, men, people with disabilities, and other key and vulnerable populations, which need to be addressed under this NSP.

Too many people living with HIV and/or TB remain unaware of their disease status, face unacceptable delays between diagnosis and treatment initiation, and discontinue or, in the case of TB and STIs are unable to complete their treatment. Dramatically lowering rates of loss to follow-up for HIV and TB care is a critical priority for the next five years. Tracking patients through the continuum of care remains a challenge in the absence of a fully implemented universal master patient index that can track the movement of

BOX 2: Global priorities for HIV and TB

With respect to HIV, the UNAIDS 90-90-90 targets provide that by 2020:

- 90% of all people living with HIV will know their HIV status;
- 90% of all people with an HIV diagnosis will receive sustained antiretroviral therapy; and
- 90% of all people receiving antiretroviral therapy will achieve viral suppression.

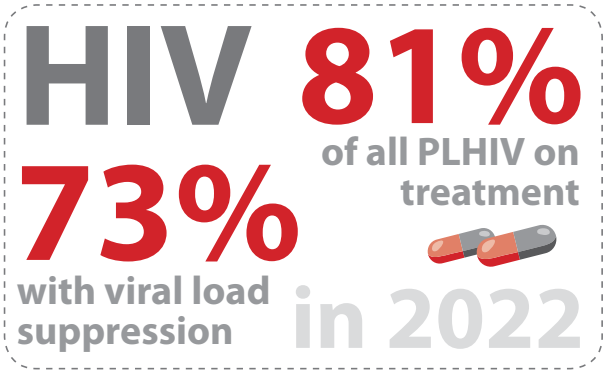
The 90-90-90 targets require that 81% of all people living with HIV receive antiretroviral therapy and that 73% of all people living with HIV are virally suppressed.

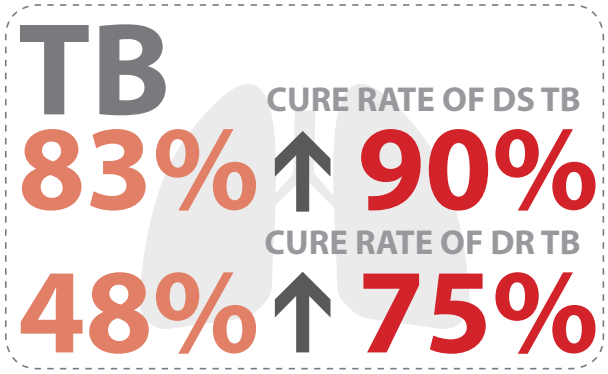
As described in the Global Plan to End TB 2016–2020, the 90-90-90 targets for TB provide that:

- 90% of all people who need TB treatment are diagnosed and receive appropriate therapy as required;
- 90% of people in key and vulnerable populations are diagnosed and receive appropriate therapy; and
- treatment success is achieved for least 90% of all people diagnosed with TB.

The WHO Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection (Second edition, 2016) for the first time recommended the provision of antiretroviral therapy to all people when they are diagnosed with HIV, irrespective of their CD4 count, when they are willing and ready for treatment. This has become known as the 'Universal Test and Treat' (UTT) approach.

In September 2016, UTT has become policy for the NDoH, together with differentiated care for stable patients to improve support and reduce the number of visits required to health facilities.





patients between health facilities, providers and districts. This gap is being addressed, as elaborated later in the Plan. Although existing therapies are highly effective, focused research is needed to develop shorter, more tolerable TB therapies, as well as a greater array of child-appropriate and long-acting antiretroviral regimens that can help improve treatment adherence.

The 90-90-90 targets for HIV and TB provide the cornerstone for the national commitment to achieve Goal 2 and will substantially contribute towards achievement of Goal 1. To reach the 90-90-90 HIV target by March 2022, the end of the period that this NSP covers, the number of people receiving antiretroviral therapy in South Africa will need to rise dramatically. The targets will need to be disaggregated by age and sex to track access and uptake of services by all. With respect to TB, the 90-90-90 targets can only be attained if there are marked improvements in rates for case detection, treatment initiation and treatment success. As this NSP covers the years 2017-2022, Goal 2 objectives and activities aim to reach the 90-90-90 target by 2022, and to begin progress towards the 2030 HIV outcome targets of 95-95-95.

STIs persist as a major source of morbidity in South Africa. Barriers to reducing STI morbidity include inadequate diagnosis (including for STIs that are asymptomatic) and cure rates and the emergence of drug-resistant STIs. The STI National Strategic Framework, 2017-2022 aims for a 70% reduction of new STIs (gonorrhoea, syphilis), elimination of congenital syphilis and 90% national HPV vaccination coverage of Grade 4 learners. As no data exists to provide a baseline for STI service coverage, studies to be conducted in 2017 will be used to establish the baseline.

In order to improve patient care and to track success in implementation of the 90-90-90- strategies for HIV and TB, the widespread use of a master patient index as a 'unique patient identifier' is essential. This will ensure that patients' records are available at their discretion, to health workers wherever they choose to seek care and early identification of those needing adherence support. This is important as patients change clinics for many reasons. In this regard, the National Department of Health is implementing the Health Patient Registration System (HPRS) which includes the use of a unique patient identifier. The South African Identification Number or passport number will be used as the primary identifier. A national programme to deploy this model in all public health facilities by 2019 is under way, and the software will allow for the integration of patient information, including electronic health records.

2.2 Strategic approach: Achieving 90-90-90 for HIV and TB and addressing STIs comprehensively

This NSP aims to accelerate the decline in HIV and TB related mortality by 50%. In addition to attainment of 90-90-90 targets for HIV and TB in children and adults, reaching these Goals will require ensuring access to rehabilitation, psychosocial and mental health support in every district for people living with HIV and TB; and scaling up access to social grants, food security and nutritional support for those in need. This will include focusing particular attention on addressing the unique challenges that children face in accessing HIV and TB diagnosis and treatment services. Achieving the STI targets will require increased STI detection and effective treatment.

Realising the targets will require the robust participation of diverse actors in and out of the health system: not only the public sector, but also private providers, pharmacies and other health service providers, as well as all the sectors of civil society and affected communities. Districts and facilities will receive clearly communicated performance indicators and targets for 90-90-90, use results to improve programme performance, and report results more frequently and in a timely manner through their District Implementation Plans. Optimal uptake and outcomes of all the biomedical interventions will be supported by robust SBCC efforts for improved service retention and adherence, and individuals and

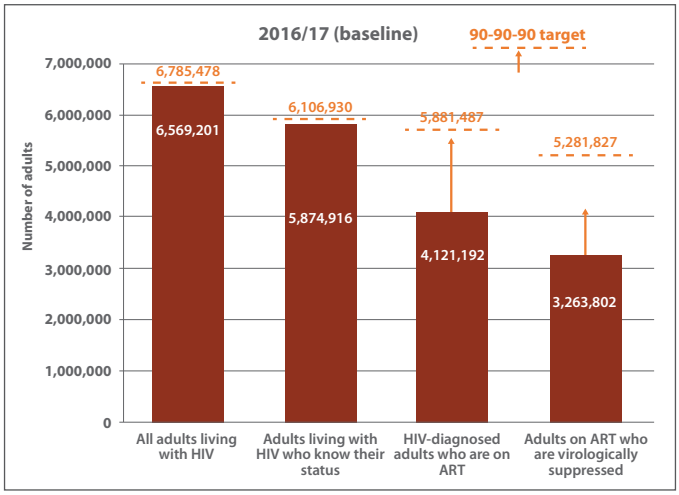


Figure 7: National HIV Care and Treatment Cascade at baseline (2016/17) [2, 25]

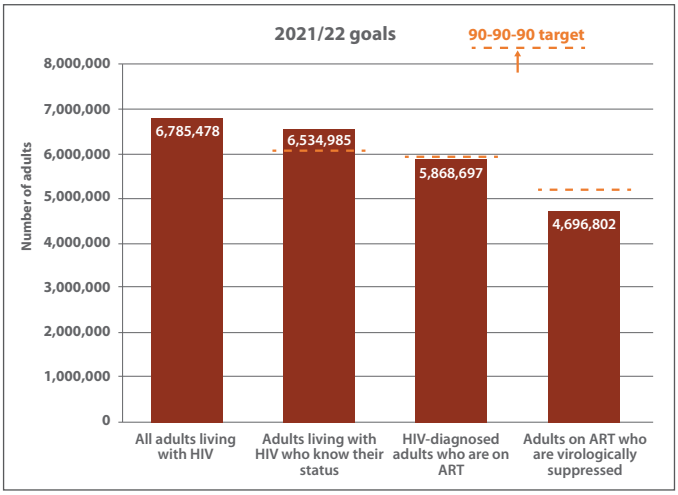


Figure 8: National HIV Care and Treatment Cascade 2021/22 goals [2, 25]

communities will be empowered to overcome impediments to service utilisation. To accomplish these aims, South Africa will take the following strategic steps:

- ***Increase the proportion of people living with HIV who know their HIV status to 90%:*** Consistent with the 90-90-90 approach, a new national HIV testing effort to find the remaining people who don't know their status and those who become newly infected will be strategically focused on optimising testing yield. Testing will be decentralised and expanded testing services will be delivered in and outside health facilities, e.g. in workplaces and community settings. Specific efforts will be made to close testing gaps for men, children, adolescents, young people, key and vulnerable populations and other groups that are not currently accessing HIV testing at sufficient levels. The importance of at least annual HIV testing will be emphasised, especially for young people. Self-screening will be rolled out as part of the strategy to expand HIV testing and to close testing gaps. A major push will be made to ensure 100% birth testing of newborns exposed to HIV and of provider-initiated counselling of mothers and testing for all children up to 18 months to identify those that have acquired HIV through breastfeeding. All children of HIV positive parents will be tested for HIV. Every person that is tested for HIV will also be screened for other STIs as well as for TB.

- ***Increase TB case detection to 90%:*** Consistent with the 90-90-90 approach, every person who is tested for HIV must also be screened for TB, as must all TB contacts. Tracing of TB contacts is especially urgent for DR-TB and will be prioritised. This Plan envisages intensified TB case-finding in key populations, including household contacts of people with TB disease, healthcare workers, inmates, and people living in informal settlements. People with diabetes and every child contact of an adult TB patient will be screened. All patients suspected to have TB will receive appropriate diagnostics, including GeneXpert MTB/RIF as an initial diagnostic and rapid confirmation of results. The activities to reach this TB case-detection target are described in Table 3 and are closely linked to the success of the health, social and community systems-strengthening efforts described in the 'Enablers' section.

- ***Strengthen screening and diagnosis of STIs:*** The STI targets of this Plan cannot be met by treating only symptomatic STIs. Screening for asymptomatic STIs will be scaled up, especially in pregnant women, adolescents and people living with HIV. Expanding the integration of STI screening into existing programmes such as ART and TB programmes, MMC, antenatal screening, and as part of the adolescent- and youth-friendly services, is also envisaged. The accessibility of STI services for men will be improved, including through mobile outreach and extended hours for STI service providers.

- ***Increase antiretroviral treatment coverage from 53% to 81%:*** The 90-90-90 approach demands that at least 81% of people living with HIV receive antiretroviral therapy by 2020. To achieve this target, South Africa will fully implement its Test and Treat approach, focusing on rapid treatment initiation for adults and children, with treatment starting on the same day as diagnosis for those ready to do so. Roll-out of superior regimens will be prioritised as safer, more effective antiretroviral medicines, such as dolutegravir, become available. Concerted efforts will be made to further simplify regimens for children and ensure access to third-line adult and paediatric regimens. The implementation of differentiated service delivery models for people-centred care will be accelerated to support early and sustained treatment. The Central Chronic Medicines Dispensing and Distribution Programme will be expanded, supplying 3 month ARV drug refills and supplying to alternative pick up points or clubs. Improved tracking of mother-infant pairs will be undertaken to ensure ongoing access to care. Clear guidelines will be developed to support community-based workers to optimise their role in health facilities and in communities and households, as part of the differentiated care strategy to support achievement of the 90-90-90 targets.

- ***Increase treatment coverage for TB:*** The 90-90-90 targets for TB will serve as the unifying focus in every district and in the currently identified high-burden districts in particular. In combination with intensified prevention efforts, this NSP's treatment provisions for TB aim to significantly reduce deaths from TB. To reach this target, each district will have focused attention on TB and will closely monitor their results and outcomes, using a quality improvement methodology to help close the gaps in the treatment cascade. Reaching the treatment target will be further facilitated by updating the national TB electronic monitoring record system to track DR- and DS-TB patients from the point of diagnosis rather than from the point of initiation of treatment, and by the rapid implementation of new drugs and regimens as they are approved for use in South Africa. Short-course therapy for MDR-TB will be established, as will rapid decentralisation of MDR-TB treatment, including the training and mentorship of nurses and Ward-based Outreach Teams. Referral protocols will be prepared. Services for children will be boosted, and the new TB paediatric formulations will be implemented as soon as they are registered in South Africa.

- ***Improve treatment for STIs:*** Improvements in STI treatment will be built on increased access to appropriate management of STIs, including: further care for individuals where first-line syndromic management has been unsuccessful; detection and treatment of asymptomatic STIs; comprehensive management of STIs in key populations; increased laboratory support and use of point-of-care testing methods for the common STIs; and strengthened STI surveillance, including for STI antimicrobial resistance and for emerging STIs.

- ***Ensure that 90% of all patients receiving antiretroviral therapy are virologically suppressed:*** At least 90% of all ART patients will receive viral load testing in accordance with clinical guidelines compared to the 52% to 75% who do so now. [28] To drive progress towards the goal of universal access to routine viral load monitoring, constant improvement will be one of the

foci in District Implementation Plans, which will also contain strategies to strengthen adherence to treatment and care.

- ***Scale up and strengthen implementation of adherence strategies for chronic diseases:*** Adherence is a key element of reaching the 90-90-90 targets as well as optimising differentiated care as described in the national guidelines. The implementation of the Health Patient Registration System will contribute significantly to improved health outcomes. The NSP aims to increase retention in care through a combination of approaches. These will include community education and awareness initiatives, patient tracking systems, routine patient counselling, the use of PLHIV and PTB to encourage adherence and access to services and age-appropriate psychosocial support. Implementation of a pregnancy registry, including postnatal follow-up of infants and improved tracking of mother–infant pairs is envisaged. TB awareness will increase demand for services, and new recording and monitoring tools will be rolled out to ensure that initial loss to follow-up for TB is held below 5% for both drug-sensitive and drug-resistant TB patients.

- ***Improve cure rates for drug-susceptible and drug-resistant TB and STIs:*** In order for drug-susceptible TB cure rates to move from 83% to at least 90%, and for drug-resistant TB cure rates to improve from 48% to at least 75%, in addition to strengthening adherence, priority will be given to early detection, early initiation on treatment after diagnosis, and the rapid introduction of new drugs as they are approved. Examples include bedaquiline, delamanid, pretomanid and other new, novel, and shorter options for XDR-TB. Improvements to supply chain management and training and mentorship of staff for optimal quality service delivery will expedite improvements.

- ***Prevent and/or minimise the emergence of HIV, STI and TB drug resistance:*** Beyond the strenuous efforts to ensure adherence to treatment that will prevent or minimise the emergence of drug resistance, specific efforts will focus on strengthening surveillance systems for monitoring emergence of antimicrobial resistance and taking appropriate action early. HIV drug-resistance surveillance will be intensified, with the standardisation of HIVDR testing practices and development of a national drug resistance database. Systems to strengthen monitoring and prevention of TB and gonococcal antimicrobial resistance will also be put in place. The national Antimicrobial Resistance Strategy will be fully implemented to address the emergence of resistance to HIV, TB, STIs and other infections. Support for patients and health professionals will also be expanded and strengthened.

- ***Expand pharmacovigilance for HIV and TB:*** The depth and coverage of pharmacovigilance will be expanded through capacitating staff at primary health care facilities to identify, report and respond to adverse events timeously. The National Centre for Pharmacovigilance will be strengthened to be able to more effectively collect, collate and review the information to guide decision-making and contribute to the optimisation of treatment guidelines and policies.

- ***Provide holistic, integrated, people-centred care and support:*** All people living with one or more of the three diseases covered by this NSP will have access to differentiated service delivery, including facilities that are friendly and suitable for children, adolescents, young people, men, people with disabilities and survivors of sexual assault. Services provided will be people-centred, integrated and comprehensive in scope. They will not only address HIV, TB and STIs, but also non-communicable diseases and other health conditions experienced by individuals, including access to palliative care. Services will include treatment and support for functional limitations or disabilities that people living with HIV and TB may increasingly experience as they age. People with HIV and TB will have access to age-appropriate psychosocial and treatment adherence, counselling and support, mental health screening and treatment and harm reduction services, including rehabilitation services for alcohol abuse and substance use.

- ***Promote innovation:*** This NSP encourages the roll-out of innovative approaches to increase treatment uptake and improve treatment outcomes, such as use of self-testing technologies; male- and adolescent-friendly clinic hours; community- or home-based initiation; provision of after-hours and weekend services for the management of patients on ART and TB treatment; contracting of general practitioners; increased use of mHealth solutions; expansion of treatment sites to include more workplaces; and presumptive STI treatment for individuals at high risk of STI acquisition. Implementation research on these innovations will guide national standards that will be developed and updated in line with the latest evidence that emerges.

3

"Addressing the unique and specific challenges faced by key and vulnerable populations is important in curbing the spread of HIV, TB and STIs."
– Nelson Medeiros, Step-Up Project Co-ordinator and former drug user

Goal 3:

Reach all key and vulnerable populations with customised and targeted interventions

"Nobody left behind"

Goal 3: Reach all key and vulnerable populations with customised and targeted interventions

"Nobody left behind"

3.1 Strategic context

South Africa has generalised HIV and TB epidemics and high rates of STI infection, which underscores the critical importance of universal access to a comprehensive package of prevention and treatment services for all. However, some groups are much more heavily affected than the general population and need special attention. These key and vulnerable populations for HIV, TB and STIs are captured in Box 3.

Investments in research have augmented the body of strategic information on key and vulnerable populations, including size estimations for several of these groups, but this remains an area in need of greater understanding.

In recent years, important strides have been made in addressing the health needs of key and vulnerable populations. Examples include the 'She Conquers' campaign that focuses on adolescent girls and young women and is supported by the DREAMS and Global Fund young women and girls programmes; the Sex Worker Strategy for HIV 2016–2020 [29], the draft South African National LGBTI Framework for 2017–2022 [30]; and the NDoH Guidelines for the Management of HIV, TB and STIs in Correctional Facilities.[31] This is supplemented by a number of small-scale programmes that are currently being implemented to address the needs of men who have sex with men (MSM), sex workers, people who inject drugs (PWID), inmates, and adolescent girls and young women (AGYW). These programmes will be scaled up and targeted to ensure starting in high-burden districts. Efforts to address structural and social factors which increase vulnerability among these groups must be reinforced for sustainability, as described in Goal 4.

3.2 Strategic approach: Ensuring that no one is left behind

All services related to HIV, TB and STIs, as described in Goals 1 and 2, will be provided to everyone who needs them. In addition to these, specific strategies to reach key and vulnerable populations with packages tailored to their needs will be implemented. Table 10 describes the customised and targeted interventions that focus on service delivery methods, whilst Table 11 describes the inclusive package of services to be delivered to all key and vulnerable populations. The latter includes general services that apply to all, as well as special interventions that are specific to each population.

To substantially reduce new infections, and the morbidity and mortality associated with HIV, TB and STIs among key and vulnerable populations, the following interventions will be implemented during the period 2017–2022:

- ***Tailor health and social services and the mode of delivery:*** Services and information will be customised to address the unique needs of key and vulnerable populations, including steps to ensure that services are designed to provide accessibility for persons with physical, mental and intellectual disabilities. Respect for and protection of the human rights of key and vulnerable populations is a fundamental principle of the NSP. Scale-up will aim to ensure that, by 2022, at least 90% of all key and vulnerable people have access to comprehensive, integrated services, including targeted social and behaviour change communication. There will be increased access to health services through differentiated service delivery approaches that are tailored for the populations served. Particular efforts will be made to expand access to peer-involved and/or peer-led psychosocial support, information-sharing, adherence support and risk-reduction counselling, with reasonable access being provided for people with disabilities. Innovative methods will be used to deliver these services, including comprehensive and holistic 'one-stop shop' approaches, dedicated services, and alternative hours and days. Physical and virtual 'safe spaces' will be created to serve as entry points to social and health services for key and vulnerable populations.

BOX 3: Key and vulnerable populations

Key populations for HIV and STIs

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

Key populations for TB

People living with HIV
Household contacts of TB index patients
Health care workers
Inmates
Pregnant women
Children < 5 years old
Diabetics
People living in informal settlements
Mine workers and peri-mining communities

Vulnerable populations for HIV and STIs

Adolescent girls and young women
Children including orphans and vulnerable children
People living in informal settlements
Mobile populations,
Migrants and undocumented foreigners
People with disabilities
Other lesbian, gay, bisexual, transgender and intersex (LGBTI) populations

- ***Sensitise providers to address the needs of key and vulnerable populations:*** Capacity-building programmes designed to improve the skills of health providers to address the needs of key and vulnerable populations will be developed. These will strengthen the providers' ability to deliver services in a compassionate, non-discriminatory manner. There will be a focus on occupational health and infection control for health providers.

- ***Ensure multi-sectoral engagement:*** Broad-based collaboration and the engagement of multiple sectors, including government departments and other stakeholders, will ensure an optimally coherent and holistic response for and by key and vulnerable populations. A number of sector-specific campaigns and plans that are already under way will be scaled up. These include the National Sex Worker HIV Plan, the National LGBTI HIV Framework, the 'She Conquers' campaign, the Roadmap to Reducing HIV Infection Among PWID in South Africa, the Framework and Strategy for Disability and Rehabilitation Services in South Africa, and the new national workplace HIV and TB policy for health workers.

- ***Engage communities in the development and implementation of social and health support activities:*** Peer-involved and peer-led interventions will be substantially expanded; key and vulnerable population representatives will be included in all national, provincial, district and local AIDS Councils and other crosscutting working and advocacy groups. Civil society and community networks will be encouraged to support and mobilise key and vulnerable populations. This is explored further in Goal 6.

- ***Build robust household and community capacity, engagement and inclusion:*** Community-level capacity among key and vulnerable populations is still weak. Inadequate community capacity and meaningful involvement of key and vulnerable populations at all levels of decision-making regarding HIV, TB and STIs diminishes the ability of these communities to play their optimal role. This Plan outlines an array of strategies and activities to build strong capacity for key and vulnerable populations, including the development of social capital by encouraging community networks that include advocacy agendas for equal health, social services and human rights. The latter is explored further in Goal 5.

- ***Eliminate stigma, discrimination and punitive laws that burden key and vulnerable populations:*** Key and vulnerable populations are often highly marginalised, which diminishes their access to health information and deters them from seeking services. This is especially so for people with disabilities who often have the double stigma of disability and HIV. In a national survey of South Africans, while 51% said that gay people have the same human rights as others, 72% said that same-sex sexual activity is "morally wrong".[32] Under this NSP, actions will be taken to implement validated anti-stigma initiatives, including broad and localised anti-stigma communication campaigns. Access to services will be monitored to identify any inequities or bottlenecks as they occur, and greater attention

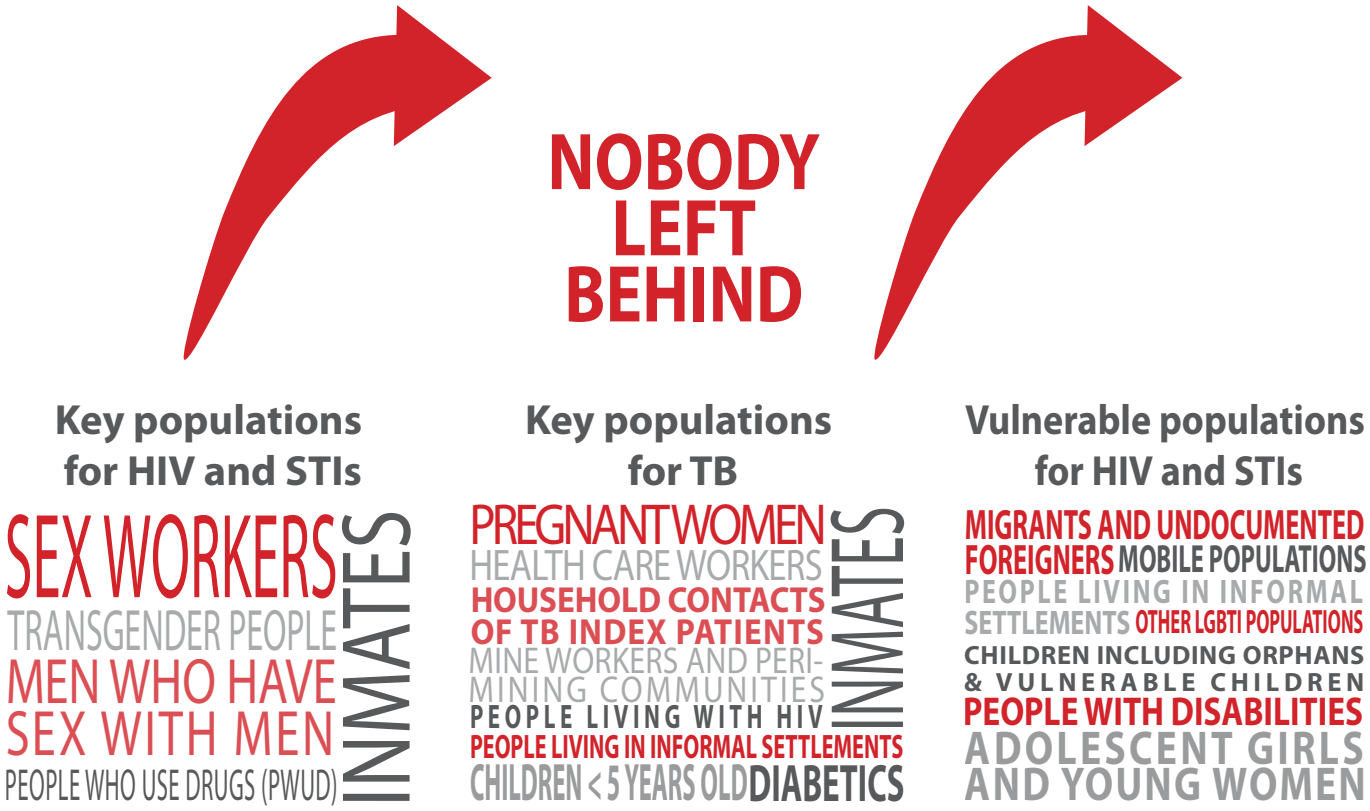


Figure 9: Key and vulnerable populations

to implementation will help in improving service access. Table 13 describe interventions that specifically promote the realisation of human rights and access to justice. These are complemented by the interventions described in Goal 5, where there is a focus on monitoring the implementation of laws and policies, and identifying areas of improvement that would influence key and vulnerable populations' access to services. Notably, this Plan urges that the process to resolve the legal reform matters related to the Sexual Offences Act be addressed as soon as possible.

- ***Strengthen strategic information for action on key and vulnerable populations:*** Concerted efforts will be made to advance reliable size estimations, additional mapping and qualitative information of key and vulnerable populations. Through implementation of the 'focus for impact' approach, these data will be used for programme development and more effective programmatic targeting. Data collection and reporting will be disaggregated, taking into account age, gender, disability and specific key and vulnerable populations.

4

"My goal as a young woman is to encourage positive change within my society through specific programmes which are interlinked with the NSP in decreasing the number of new HIV infections among adolescent girls and young women across South Africa."

– Koketso Rathumbu, She Conquers

Goal 4:

Address the social and structural drivers of HIV, TB and STIs and link these efforts to the National Development Plan (NDP)

"A multi-department, multi-sectoral approach"

Goal 4: Address the social and structural drivers of HIV, TB and STIs, and link these efforts to the National Development Plan (NDP)

"A multi-department, multi-sectoral approach"

4.1 Strategic context

The social and structural context in which the epidemics of HIV and TB occur is continually evolving, shaping the manner in which these epidemics are unfolding. As highlighted in the National Development Plan (NDP),[33] South Africa currently confronts the linked challenges of poverty, inequality and long-term unemployment, with especially high jobless rates among young people. Under the Medium-term Strategic Framework (MTSF) 2014–2019, the country has prioritised national action to address these interrelated challenges to national well-being.[34]

Social and structural factors such as poverty, inequality, inadequate access to quality education, poor nutrition, migration, gender inequality, gender-based violence, and alcohol and drug use increase vulnerability to HIV, TB and STIs. These factors impact on health-seeking behaviour and adherence to prescribed regimens.[35] The poorest 40% of the population bears 65% of the TB burden,[36] and people with lower socio-economic status also experience the greatest barriers to accessing health care.[36] Lower-income households are more vulnerable to economic shocks generally as well as those specifically associated with HIV, TB or other chronic diseases.[37] The physical environment – the availability of safe and secure housing with good ventilation; the number of people in the household; the spatial location and distribution of health services; and access to and type of transportation – also has a powerful impact on the risks of disease acquisition or transmission, as well as on access to health services.[38]

Unless these social and structural factors or drivers are addressed in the context of disease control, public health goals for HIV, TB and STIs will be undermined and gains achieved will not be sustainable. Addressing these drivers demands not only specific action by the health sector, but, even more importantly, integration of health into broader development efforts. Efforts already undertaken by national government, including social security, nutrition and food security measures, support for early childhood development, and developmental social service interventions, must be fully utilised to accelerate progress in reducing vulnerability to HIV, TB and STIs.

The basic education sector has a unique role, as it contains almost all the nation's children in 12-year cycles that bridge the most vulnerable years of their lives. More than sexuality education, the greatest contribution that the basic education sector can make is to provide quality education, particularly for girls. Every year in school provides successive benefits and the Department of Basic Education (DBE) has committed to stemming the school drop-out rate and improving performance in the National Senior Certificate Examinations.

During the NSP 2012–2016, in response to the HSRC survey,[4] South Africa began to place a particularly high priority on addressing the social and structural factors that increase risk and vulnerability among adolescent girls and young women.[39] The 'She Conquers' campaign launched in September 2016 complemented the Yolo and Zazi programmes of the Department of Social Development (DSD), the multi-partner DREAMS initiative, and the young women and girls' programmes funded by the Global Fund. These programmes prioritise action to decrease teenage pregnancies, prevent gender-based violence, keep girls in school, and increase economic opportunities for young people, especially young women. The Department of Women champions the advancement of women's socio-economic empowerment and the promotion of gender equality, co-ordinating, monitoring and supporting implementation of the soon-to-be-finalised National Gender-based Violence strategy.

Gender-based violence continues to impact on HIV and STI risk. At the time the NSP was developed, the Justice, Crime Prevention and Security Cluster was reviewing the national policy framework for sexual offences, with one of its aims being to bolster prevention of sexual violence, including through public education and communication. In addition, actions are envisaged to enable intersectoral planning and integrated service delivery for women, especially at the community level, and to achieve more resilient social systems and strengthened service delivery systems. In Table 12 the interventions for survivors of gender-based violence are complemented by interventions outlined under Goals 3 and 5 that address gender norms and roles.

The impact of harmful use of alcohol and drugs continues to ravage families, communities and society, with the youth being particularly hard hit. This leads directly to HIV and STIs arising from risky sex and needle injection, and indirectly through exacerbating gender-based violence, long-term unemployment, dropping out of school and being ostracised from families and communities. The next National Drug Master Plan, to be launched in June 2017, is complemented by the strenuous efforts of the Inter-Ministerial Committee on Alcohol and Substance Abuse that seeks to address these challenges through policies, laws and strategies. This includes guiding government departments in their role to reduce the demand for and supply of drugs, and the harm associated with their use and abuse. The Drug Master Plan will contain a substantial focus on harm reduction services.

4.2 Strategic approach: Reducing vulnerability, enhancing sustainability and linking the response to HIV, TB and STIs to the broader development agenda

Addressing social and structural drivers is a priority across all departments and is firmly embedded in the MTSF of government. Every government department at national, provincial and local level has a role to play in achieving the HIV, TB and STIs goals, in particular using opportunities in their sector for advancing interventions that contribute to prevention (e.g. transport hubs, sporting events) and dealing with the social and structural drivers. As explained further in Goal 6, government departments must work together to optimise and co-ordinate responses. In line with the 'focus for impact approach', extraordinary effort will be placed on improving co-ordination, joint planning and integrated service delivery in high-burden districts. Rigorous implementation science methodology with a robust monitoring framework will underpin programme implementation. The focus will be the social and structural drivers that impact most heavily on HIV, TB and STIs, for which the following strategic approach will be implemented:

Expansion of SBCC campaigns and programmes that build the resilience of individuals, parents and families:

These will focus on, among others, mobilisation and capacity-building of individuals, families and communities; advocacy; early childhood development; parental/caregiver support; prevention of violence and abuse; sustaining health-promoting behaviour; and facilitating the deconstruction of gender norms and roles. The approach to SBCC is explained in Enabler 1.

Reduce poverty and vulnerability through scaled-up social protection:

To reduce poverty and financial insecurity linked to HIV, TB and STIs, social protection packages will be scaled up to reduce the proportion of households experiencing catastrophic income loss due to HIV or TB. The Social Protection Cluster will review how to respond to the call for comprehensive social protection.

Scale up access to food security:

While surveys indicate that the proportion of the South African population experiencing food insecurity has declined since 1999, the share of the population at risk of food insecurity has remained largely unchanged.[37] Poor nutrition weakens the immune system; increases the risk of TB infection, progression to disease and TB reactivation; and worsens TB outcomes.[40, 41] In addition, TB can lead to malnutrition.[40] Food insecurity is also correlated with reduced rates of HIV treatment adherence.[42] Taking account of these links between nutrition and health, the NSP provides for nutritional screening for all people living with HIV and/or TB, as well as scaled-up access to food and nutritional support where required, including through a stronger, expanded National School Nutrition Programme.

Expand a comprehensive package of interventions through the 'She Conquers' campaign:

The 'She Conquers' campaign delivers biomedical, socio-behavioural and structural interventions to increase access to information, services and support for adolescent girls and young women. The biomedical interventions seek to increase access to sexual and reproductive health (SRH) information and services through adolescent and youth-friendly clinics and the Integrated School Health Programme. Socio-behavioural interventions focus on increasing community mobilisation and support, keeping girls in school, and access to peer groups and clubs. They also provide opportunities for awareness and information on gender, violence against women and girls, alcohol and drug use, and stigma and discrimination. Access to parenting programmes for parents of teenagers and for teenage and young parents are also made available. Structural interventions seek to increase access to grants and other forms of social assistance, bursaries and access to post-school education and opportunities for employment, mentorship and internships.

Change gender norms and prevent and address gender-based violence:

Whilst acknowledging that changing gender norms and entrenched cultural practices is a long and complex process, efforts to empower women and engage men and boys will be strengthened. The completion and implementation of a comprehensive plan to address gender-based violence is critical to move the country closer to epidemic control and safe communities. The coverage of programmes and initiatives will be expanded and linked at local level to achieve sufficient scale. Further nurse training to provide appropriate services for adolescent girls and young women generally and specifically for survivors of gender-based violence will be undertaken.

Better define and scale up harm reduction services:

Alcohol abuse and drug use increases HIV, hepatitis B and C, and TB risk and vulnerability, and also undermines adherence. The National Drug Master Plan deals with demand and supply issues, as well as a comprehensive approach to rehabilitation and harm reduction. Interventions to prevent HIV, TB and STIs among young people who use drugs will be scaled up and harm reduction services will be expanded. These efforts will be supported by SBCC campaigns that include information about the harmful effects of alcohol and drug use. Targeted provision of condoms and other biomedical prevention commodities and, as appropriate, testing, screening, vaccination and treatment for HIV, TB, STIs and hepatitis B and C will be delivered. Linkage to services will include adherence and psychosocial support and rehabilitation services.

Implement environmental interventions for TB control:

Overcrowding, indoor air pollution and poor ventilation contribute to TB transmission. Households where someone has infectious TB, health and correctional facilities, mines (especially with silica exposure), public transport and congregate settings such as schools, are potential TB transmission 'hotspots'. Smoking, including secondary exposure to tobacco smoke, also increases the risk of TB infection, disease and recurrence. Multi-sectoral collaboration with the Departments of Environmental Protection, Human Settlements, Basic Education, Transport and others is key. The Presidential Infrastructure Co-ordination Committee will be requested to provide guidance on strategies for environmental interventions to reduce TB.

5

"Grounding HIV response efforts in human rights principles will enable us to address challenges associated with stigma discrimination and exclusion."

– Judge Edwin Cameron, Human Rights Activist

Goal 5:

Ground the response to HIV, TB and STIs in human rights principles and approaches

"Equal treatment and social justice"

Goal 5: Ground the response to HIV, TB and STIs in human rights principles and approaches

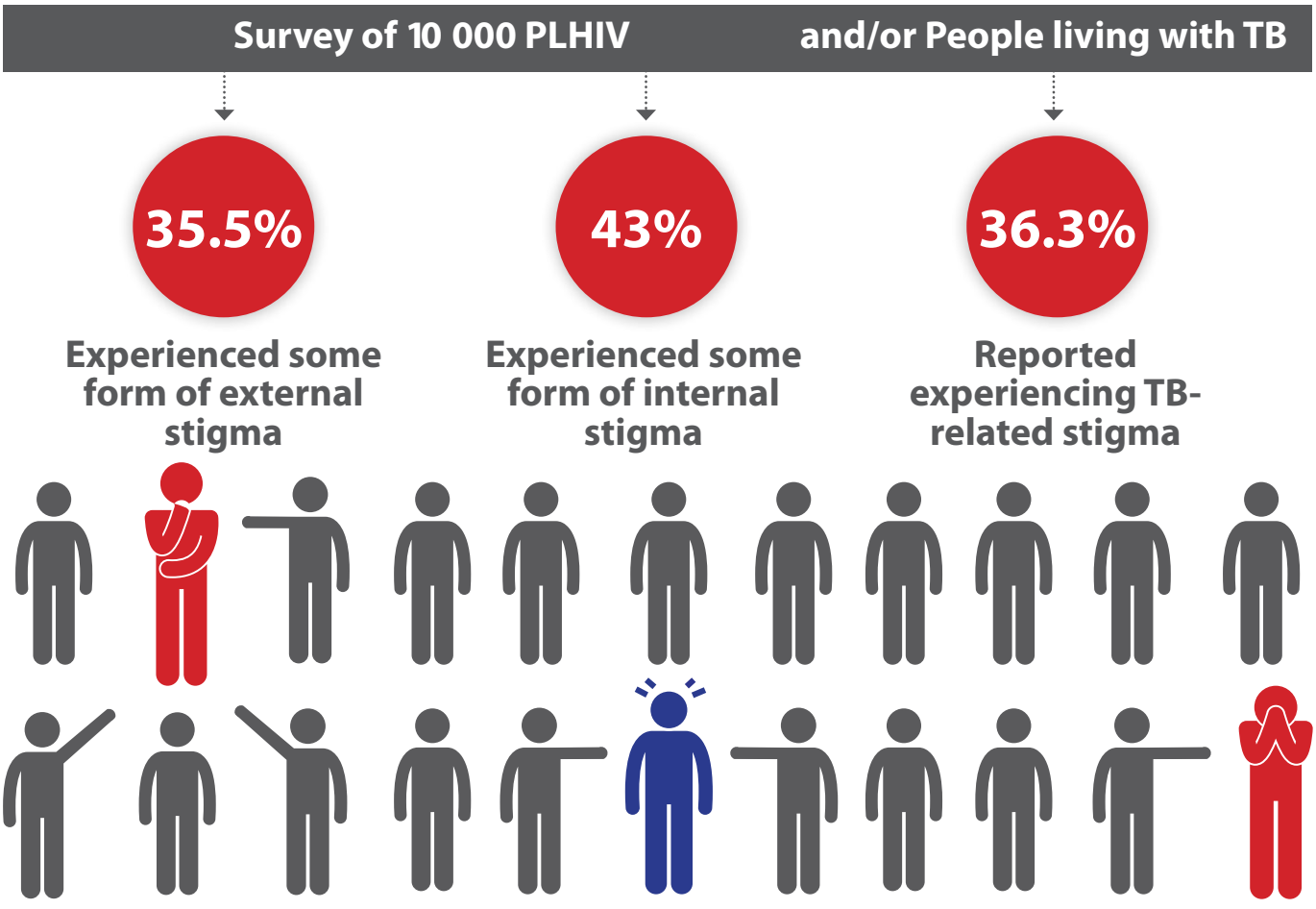
"Equal treatment and social justice"

5.1 Strategic context

South Africa's legal framework is guided by a progressive Constitution and Bill of Rights, which guarantees a broad range of civil, political, cultural and socioeconomic rights. This includes the rights to equality and non-discrimination, privacy, dignity, freedom and security of person, access to health care and access to justice. The Government of South Africa has also signed the International Covenant on Economic, Social and Cultural Rights(ICESCR). In this way, the Government has reaffirmed its commitment to achieving socio-economic justice in South Africa. Accession to the ICESCR also provides enhanced opportunities for citizens to shape dialogue and actions around the realisation of socio-economic and cultural rights. Accession also strengthens Government's ability to play a meaningful role as one of the key advocates for social, economic and cultural rights in the international arena. The ICESCR aims to ensure the protection of economic, social and cultural rights through its articles including:

- the right to self-determination of all peoples (article 1);
- the right to non-discrimination based on race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status (article 2);
- the equal right of men and women to enjoy the rights in the ICESCR (article 3);
- the right to work (articles 6–7);
- the right to form and join trade unions (article 8);
- the right to social security (article 9);
- protection and assistance to the family (article 10);
- the right to an adequate standard of living (article 11);
- the right to health (article 12);
- the right to education (articles 13–14); and
- the right to cultural freedoms (article 15).

The 2013 Joint Review of HIV, TB and PMTCT Programmes in SA, commissioned by the NDoH and led by a multi-stakeholder Steering Committee, confirmed that the policy framework for the national response to HIV and TB has incorporated the human rights principles reflected in the national law, but identified gaps in implementation, including that key populations were not adequately accessing services. [43] This reflects that action is often needed to ensure that all the rights in legal and policy frameworks are translated into practice.



During the implementation of the NSP 2012-2016, a survey to better understand stigma and discrimination was conducted – the People Living with HIV index, a national survey of more than 10 000 people living with HIV and/or TB. The survey found that 35.5% of people living with HIV and 36.3% with TB reported experiencing externalised stigma, and 43% and 27% respectively experienced internalised stigma.[43]

At the time of the development of this NSP, the Department of Justice and Constitutional Development, in conjunction with the Justice, Crime Prevention and Security Cluster, was planning for the development of Victim Support and Empowerment Norms and Standards that are HIV-Responsive, integrating both national and international human rights standards. This document will provide guidance to front-line workers and policy-makers on the provision of services in a manner that responds to the realities faced by people living with HIV and TB, including those in the criminal justice system.

The NSP recognises that, in spite of SA being recognised globally for its positioning and response to human rights, there are still important gaps to close with respect to full implementation of the human rights agenda. Among these is the need to translate key policies into implementation, and to ensure that all people know their rights and where to seek redress when rights are violated. Stigma must be reduced, including stigma at the family, community, facility and societal levels as well as internalised stigma. Barriers that prevent people from accessing services must be removed, in particular for women, youth, sex workers, people who use drugs, inmates, LGBTI persons and people with disabilities. People with HIV, TB and STIs and key and vulnerable populations will lead in driving the human rights and access-to-justice agenda.

5.2 Strategic approach: Protecting and promoting human rights to enable a strong, effective and equitable response

The strategies to protect and promote human rights to enable a strong, effective and equitable response will be achieved by the implementation of interventions described in Table 13. These interventions are based on the UNAIDS guidance for developing human rights programmes in the context of HIV. The key components of the programme include: reduction of stigma and discrimination; monitoring and reforming laws, regulations and policies with specific attention to HIV and TB; improving legal literacy; making legal services available and accessible; sensitisation of law-makers and enforcers; training for healthcare providers on human rights and medical ethics; and reducing harmful gender norms and violence against women and increasing their legal, social and economic empowerment. Some of these programmes are already being implemented and should be scaled up. Together, these actions are expected to address both internalised and external stigma, facilitate access to justice, and promote an environment that enables and protects human and legal rights and prevents HIV and TB-related stigma and discrimination.

To reduce both externalised and internalised stigma by 50% and ensure that human rights principles are reinforced across the response to HIV and TB, the following strategic approaches will be used:

- ***Monitor and respond to human rights abuses:*** Under the NSP, the capacity to respond to human rights abuses in the context of HIV and TB will be built. The human rights sector within SANAC will be strengthened and a Human Rights Accountability Charter and Score-card on HIV and TB will be developed. SANAC will advocate for full implementation of protective laws and policies to ensure meaningful and equal access to services, and protection against discrimination or other human rights abuses. Mechanisms will be in place to monitor human rights violations related to HIV or TB. The South African Human Rights Commission and the Commission for Gender Equality will continue to refer cases of human rights violations to Equality Courts for redress and accountability. Access to legal services will also be scaled up, and investments will be made in community-centred rights and legal literacy programmes.

- ***Scale up SBCC initiatives to reduce stigma:*** This NSP calls for the development and implementation of a national multi-sector, multi-faceted strategy to reduce both internalised and external stigma. An essential role will be played by SBCC programmes, which highlight stigmatising behaviours, provide information to address myths, and increase knowledge on HIV and TB. Community-based support groups will be revisited and a key part of their role will be to deal with internalised stigma through community education.

- ***Invest in expanding training and sensitisation programmes to reduce stigma:*** Programmes will inform and sensitise those who make the laws and those who enforce them about the important role of the law in the response to HIV, TB and STIs, e.g. to protect those affected by HIV against discrimination and violence and to support access to HIV prevention, treatment, care and support. In addition, human rights and ethics training will be provided for healthcare providers. The training will strengthen the Batho Pele principles.

- ***Specific interventions to address the added vulnerability of key and vulnerable populations to stigma and discrimination and human rights abuses:*** Whilst some of the specific vulnerability of key and vulnerable populations is dealt with in programme content and delivery in Goal 3, Goal 5 expands on how to establish an environment that is cognisant of and responsive to this special vulnerability. These include improvements in legal literacy about human rights and laws relevant to HIV and TB, and making HIV- and TB-related legal services available and accessible.

"A strong and multisectoral leadership approach is important in realizing the goals of the NSP."
– Steve Letsike, SANAC Dep. Chair / CSF Chair

Goal 6:

Promote leadership and shared accountability for a sustainable response to HIV, TB and STIs

"Mutual accountability"

Goal 6: Promote leadership and shared accountability for a sustainable response to HIV, TB and STIs

"Mutual accountability"

6.1 Strategic context

Political leadership and commitment of civil society, development partners and the private sector to work with government has yielded many gains in the fight against HIV and TB. This social compact is more critical as the country gears up for the implementation of a new strategic approach towards epidemic control. The South African National AIDS Council (SANAC) has been leading the response since 2000 after its establishment by Cabinet. At the national level, there is a strong platform and collaboration, but more attention has to be paid to the provincial- and district-level systems where implementation is key.

A clear legislative framework is in place to govern and promote co-operation between the three spheres of government. However, government alone cannot meet the challenges posed by HIV, TB and STIs, nor fully capitalise on the opportunities to accelerate reductions in new infections and deaths. A wide range of stakeholders should commit to making a full contribution to the successful implementation of the NSP. The broader vision of the NDP will also be better served by such a solid compact. Leaders across all spheres of government, communities, the private sector, organised labour and civil society must be part of this huge effort. The research community and development partners are important for the generation of evidence to inform policy. Most importantly, people living with HIV, those infected with TB, and key and vulnerable populations must be front and centre in informing programme development and implementation strategies. An agile, well-resourced civil society is better positioned to contribute to stronger community systems and to ensure a seamless continuum of care from the health to the community system. (The civil society sectors are listed in Box 4).

This multi-faceted approach will require greater decentralisation, underscoring the NSP's emphasis on strengthening leadership at the community level, where multi- and inter-sectoral programmes are best implemented. Therefore, Premiers, Members of Executive Councils (MECs) and mayors will strengthen their HIV, TB and STI leadership and programmes. Tailoring the response to specific locations and populations is critical to optimise outcomes. Districts must define their own responses for implementing the NSP, with provincial and national leadership supporting this decentralised approach. Development partners must also respond to local priorities. Particular efforts are needed to cultivate greater engagement by sectors that to date have been underutilised in the response, including the private sector, organised labour and women's organisations.

Genuine leadership on HIV, TB and STIs is people-centred, transparent and committed to mutual accountability for concrete results. In working to build and fast-track mutual accountability for achievement of the ambitious goals and targets of this NSP, two key principles will underpin the approach to the Accountability Scorecard:

- ***Transparency:*** All stakeholders – including people living with, affected by and vulnerable to HIV, TB and STIs – must have sufficient and equal access to relevant data. These data must encompass all aspects of implementation of the NSP, including but not limited to data on representation on AIDS Councils, information on progress against targets, budgets and expenditure, and data on the community response. To make joint leadership meaningful, these data must be presented in a manner that enables all stakeholders to use the information to draw conclusions.

- ***Dialogue on performance:*** AIDS Councils at all levels, providing leadership and co-ordination and using data generated by the monitoring and evaluation system, must engage diverse stakeholders in periodic reviews of the performance of NSP implementation. This approach permits identification of progress against targets, as well as gaps, weaknesses and emerging trends. To ensure the broadest possible participation in this dialogue, an annual scorecard will track engagement. To make this dialogue meaningful and productive, civil society and the private sector must prepare and participate fully in this information-sharing process and in scrutinising the data.

Box 4: The civil society sectors in the Civil Society Forum

Children	LGBT	Sex workers
Disability	Men	Sports and culture
Health professionals	NGO	Traditional healers
Higher education	PLHIV	Traditional leaders
Labour	Religious/Faith-based	Women
Legal and human rights	Research	Youth

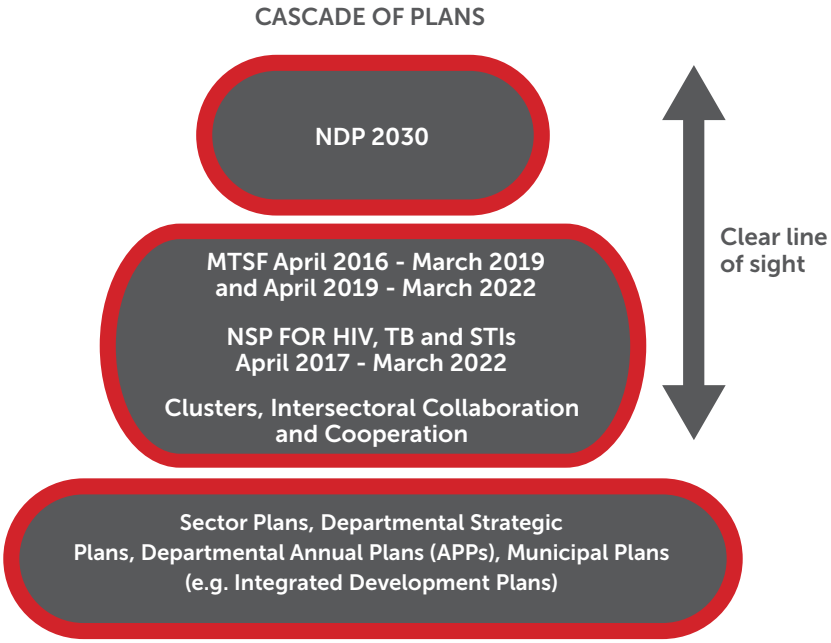


Figure 10: Cascade of South African Sectoral, Performance, Strategic and Development Plans

6.2 Strategic approach: Implementing the action framework for leadership and accountability

The ambitious nature of the NSP requires coherence and optimal co-ordination, and regular monitoring with continual feedback to enable change as needed.

The NSP unites broadly diverse sectors in a common undertaking to address an overriding national priority. Reaching the goals and targets set forth in the NSP will demand strong co-ordination and collaboration in order to maximise the coherence and impact of the efforts of diverse partners. The NSP will be embedded in all plans of government and aligned with the MTSF. This alignment will ensure that sufficient resources are allocated and that monitoring is undertaken in line with established processes.

To translate into action the framework for leadership and accountability, the following strategic steps will be taken:

- ***Strengthen the SANAC Secretariat:*** The SANAC Secretariat needs sufficient capacity to be able to fully implement its mandate, including technical support to SANAC structures, building the capacity of PCAs, building multi-sectoral collaboration, implementing the accountability scorecard and resource mobilisation. To ensure that SANAC is fit for purpose, the structure and governance of SANAC will be aligned with the NSP.

- ***Strengthen civil society participation and leadership:*** Steps will be taken to build on the work of SANAC's Civil Society Forum to further strengthen civil society engagement and leadership at all levels of the response. A framework will be developed for civil society and community responses, including clear definitions of roles, scope, activities and deliverables.

- ***Strengthen private sector engagement:*** Particular efforts will focus on increasing private sector engagement in provincial and district AIDS Councils and better reach into the informal and agricultural sectors. Steps will be taken to improve collaboration with private healthcare providers including general practitioners, pharmacies and traditional health practitioners.

- ***Engage organised labour:*** Organised labour will be better engaged and its role more sharply defined to realise its full contribution and involvement. Commitment of union leadership to raise the profile of HIV, TB and STIs and implement programmes in their structures will take the NSP into the workplace. Commitments to the NSP by the private sector and labour should be formalised through the National Economic Development and Labour Council (NEDLAC).

- ***Improve collaboration and cooperation among national and provincial government departments:*** This NSP needs every department in the tiers of government to recognise the value of the unique role they can play. Achieving epidemic control requires an all-of-government approach, with each department contributing in line with departmental mandates, and co-ordinating and collaborating across the three tiers of government. The Department for Planning, Monitoring and Evaluation will support inclusion of assessment of HIV- and TB-related interventions, including development of a joint accountability framework.

- ***Improve collaboration and cooperation between government, civil society and private sector:*** Each non-governmental sector (e.g. civil society, the private sector, development partners) should develop an NSP-aligned implementation plan to feed into the NSP and Provincial Implementation Plans. All provincial, district and ward-level AIDS Councils must have

representation of all key sectors, including civil society, the private sector, organised labour and people with HIV and TB.

- ***Strengthen the capacity of AIDS Councils to contribute towards implementation of the NSP and achievement of its goals and objectives:*** Sufficient resources should be allocated for AIDS Councils and the SANAC Secretariat, to enable them to fulfil all their functions. Well-governed AIDS Councils will be in place in all provinces and districts. Efforts will focus on broadening and optimising participation in these AIDS Councils by all key provincial and local government departments and the local leadership of national departments e.g. SAPS and Correctional Services. This approach should be cascaded to the ward level. The Councils will be supported to adopt an integrated service delivery model to address HIV, TB and STIs. Each provincial AIDS Council's work will be costed and funded through the provincial government and its partners.

- ***Build local leadership:*** Steps will be taken to ensure that municipal mayoral committees work together alongside civil society and the private sector to institutionalise an inter- and multi-sectoral approach. Traditional leaders will be engaged at local level, in particular to serve as champions of behaviour change and to facilitate uptake of locally tailored HIV prevention, treatment and care services. HIV and TB programmes should become part of the agenda of established local development structures.

- ***Develop implementation plans:*** Converting the strategies and activities encompassed in this NSP into implementation plans is vital. Government departments, provinces, districts, the private sector and civil society sectors will all develop their specific implementation plans.

- ***Increase cross-border co-operation:*** To improve responses for migrant labourers, especially with respect to TB, South Africa will continue to strengthen cross-border co-operation with neighbouring governments and other stakeholders.

7

"We need to spend now to save later in order to achieve our targets"

– Maurice Radebe, Sasol

Goal 7:

Mobilise resources and maximise efficiencies to support the achievement of NSP goals and ensure a sustainable response

"Spend Now, to Save Later"

Goal 7: Mobilise resources and maximise efficiencies to support the achievement of NSP Goals and ensure a sustainable response

"Spend Now, to Save Later"

7.1 Strategic context

Achieving the goals and objectives of the NSP will only be possible if sufficient resources are available to government departments, SANAC sectors and other stakeholders to implement the NSP. Given the ambitious nature of the NSP, resources for the response to HIV, TB and STIs need to increase for the period 2017-2022, while available funds must be used optimally. According to the South African HIV and TB Investment Cases, early additional investments in these diseases will reduce longer-term health consequences and costs, but sustained financing will still be required. The Investment Cases identified strategies to maximise economic returns from investments and minimise long-term costs, including through scaling up evidence-based interventions in the short-term, allocating resources towards high-impact interventions and delivering services more efficiently.[25]

Total financing from public sources for HIV, TB and STIs programmes as well as for interventions addressing social and structural drivers (SSDs) of the 3 diseases was estimated at approximately R 22.1 billion in 2016/17. Significantly, Government has increased its health allocations for HIV and TB over the 2017/18 Medium Term Expenditure Framework (MTEF) period by R 1.7 billion, despite tight fiscal constraints and general budget reductions. According to the most recent national budget (Estimates of National Expenditure, 2017), public funding for HIV, TB and other programmes that directly support the NSP will increase to R 30.1 billion per annum by 2019/20 (Table 3).

The Department of Health is the largest spender on HIV, TB and STI services, primarily via the Comprehensive HIV/AIDS and TB conditional grant, with a budget increasing from R 15.2 billion in 2016/17 to R 22 billion by 2019/20, specifically to support the implementation of the HIV and TB Investment Cases. In addition, the Provincial Departments also allocate funds from the provincial equitable share to HIV, TB, STIs and cross-cutting health promotion interventions.

Some of the HIV prevention spending in the Department of Health's Comprehensive HIV/AIDS and TB conditional grant also benefits STI prevention, for instance through its condom programme. Other funds for STI programmes are incorporated into the general primary health care budgets of the national and provincial health departments, making them difficult to single out. The spending of the Department of Health on testing and treating STIs is estimated to increase from R 1.1 billion in 2016/17 to R 1.3 billion in 2019/20, including the grant for HPV vaccination for girls.

The Department of Social Development allocated R 0.9 billion to HIV related interventions in 2016/17, increasing to R 1.1 billion by 2019/20. In addition, the Department also allocates funding to a number of programmes that address the social and structural drivers identified in this NSP. The share of these budgets attributable to supporting NSP interventions has been estimated at R 1.4 billion for 2017/18, increasing to R 1.6 billion in 2019/20. Other government departments' allocations to HIV and TB are also indicated in Table 3 below.

Overall, the South African Government has committed R 78.2 billion over the 2017/18 - 2019/20 MTEF period for HIV, TB and STI programmes which increases to R 82.6 billion for the 3 year period, after the inclusion of the budget estimates for social and structural drivers (Table 3).

Regarding external sources of funding, development partners committed approximately R 5.3 billion directly to the national response in 2016/17. Another R 1.4 billion was paid by voluntary medical insurance for private ART patients. The United States President's Emergency Plan for AIDS Relief (PEPFAR) has increased its HIV and TB commitments to South Africa in its most recent Country Operational Plan (2017) to US$ 535 million from US$ 443 million in 2016/17. Given the uncertainty regarding American foreign aid policies, a conservative position has been taken in assuming that PEPFAR commitments to South Africa will decline to US$ 100 million by 2021/22. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) allocated US$ 312 million for HIV and TB programming in South Africa for the period 2016/17 to 2018/19, and recently gave an indicative allocation of another US$ 353 million for the 3-year funding cycle thereafter.

It is difficult to estimate what the private sector, comprising medical insurance schemes, workplace programmes and corporate social investments, might contribute to the national response. However, the insurance costs for private ART patients alone is estimated to reach R 1.6 billion in 2017/18 and R 2.3 billion in 2019/20. The total projected trends in HIV, TB, STIs and SSD financing in South Africa, from government revenue, Global Fund, PEFPAR and some private insurance contributions are illustrated in Figure 11, showing an increase from R 28.8 billion in 2016/17 to R 38.5 billion in 2021/22.

Table 3: Government funding for HIV and TB: Departmental budget allocations and estimated spending (2016/17-2019/20, R millions)

Public budgets by Department	2016/17	2017/18	2018/19	2019/20	% of total MTEF
Department of Health HIV	16 028	18 404	20 863	23 011	76%
Department of Health STI (estimated, including HPV & cervical cancer screening)	1 251	1 320	1 393	1 471	5%
Department of Health TB treatment (estimated)	2 139	2 258	2 385	2 518	9%
Department Social Development – HIV sub-programme	901	954	1 017	1 069	4%
Department Social Development – other SSD contributions	1 332	1 408	1 487	1 570	5%
Department of Basic Education -Provincial Life Skills CG & national	234	249	264	278	1%
Other Departments	200	220	245	258	1%
Total public budgets for HIV, TB, STI and SSDs	**22 084**	**24 812**	**27 654**	**30 177**	**100%**

Notes:
- Public MTEF budgets are nominal amounts that include the annual increments made by National Treasury.
- Figures include national and provincial budgets.
- TB treatment costs that are embedded in DOH budgets were estimated based on TB Think Tank estimates.
- STI and HPV costs were also estimated, and include the new HPV grant (2018/19 onwards).
- Social Development HIV allocation includes national and provincial HIV sub-programmes, as well as national transfers to SANAC for SBC programmes.
- Social Development social and structural driver (SSD) contributions include an estimated share of the following programmes: Care & Support to Families (20%), Community Based Care for Children (100%), Substance Abuse, Prevention and Rehabilitation (20%), Community Nutrition Distribution (estimated costs).
- SANAC's APP 2017/18 budget was assumed to be fully funded, in part from the NDoH transfer and the remainder from other departments or donors.
- PCA funds were estimated as only the salaries being paid to key staff. Their source was assumed to be other departments, such as the Premier's Office.

Sources: Estimates of National Expenditure (ENE) 2017, National Treasury.
Smaller departmental budgets sourced from National Treasury (internal document, 2016). [44]
TB Think Tank (2017) Costing of the South African National TB Plan 2017-2021. DOH & LSHTM [45].

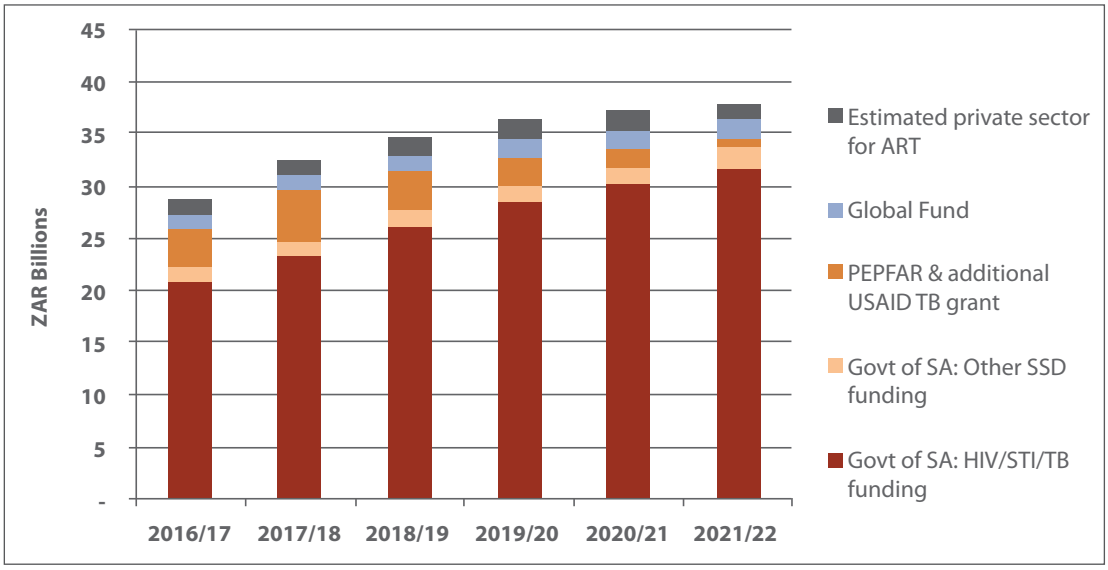


Figure 11: Current and anticipated HIV, TB and STI funding from all sources - South Africa Government, Global Fund, PEPFAR and estimated private sector ART contributions (2016/17-2021/22) (R billions)

Sources: ENE 2017, National Treasury.
Current spending on TB based on TB Think Tank (2017) Costing of the South African National TB Plan 2017-2021, DOH & LSHTM. Projected spending by Department of Social Development includes programmes that address social and structural drivers of the 3 diseases.

Total Available Funds (ZAR million)	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Govt of SA: HIV/STI/TB funding	20 749	23 401	26 163	28 602	30 204	31 895
Govt of SA: other SSD funding	1 335	1 412	1 491	1 575	1 663	1 756
PEPFAR & additional USAID TB grant	3 915	4 795	3 815	2 855	1 895	952
Global Fund	1 411	1 384	1 339	1 555	1 555	1 555
Estimated private sector for ART	1 430	1 630	1 875	2 057	2 223	2 329
Total Available Funds	**28 840**	**32 621**	**34 682**	**36 644**	**37 540**	**38 487**

Sources: Estimates of National Expenditure 2017, National Treasury [44] and estimated 5.6% annual growth for 2020/21 and 2021/22

PEPFAR: COP 17 direct investment and assumed reductions to US$100 million by 2021/22. GF: Concept Note (2016) and recent allocation letter (2017-19). Private sector: only estimated spending on private ART patients.

Other smaller donor amounts have been omitted.

TB Think Tank (2017) Costing of the South African National TB Plan 2017-2021. DOH & LSHTM. [45]

Mapping the available funds for 2017/18 to the NSP goals shows that the bulk of the resources are currently allocated to Goal 2, as it captures the costs of treatment and care for people with HIV, TB and STIs. It is anticipated that once departments and SANAC sectors have developed implementation plans for the NSP, there may be some re-prioritisation during budgeting processes (Figure 12).

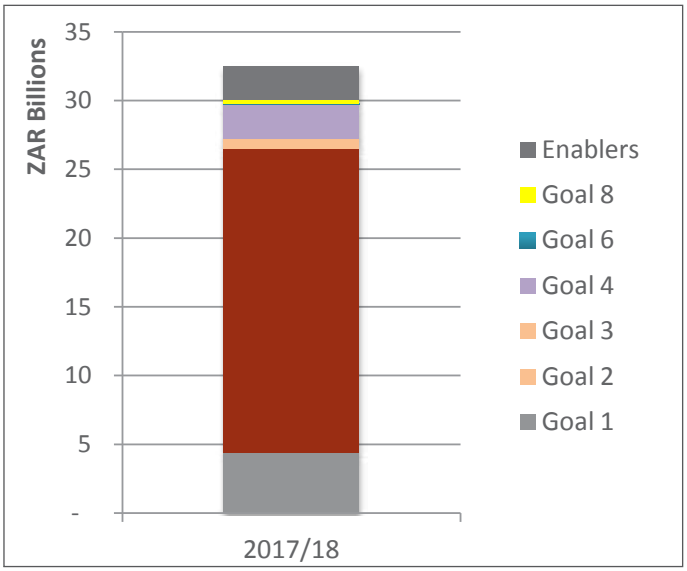


Figure 12: Total available resources by NSP Goal 2017/18 (R billions)

Sources:
SAG: ENE (2017/18)[44]
PEFPAR: COP 17 [46]
GF: Concept Note (2016)
Private sector: only estimated spending on private ART patients, based on NACM estimates.
TB Think Tank (2017) Costing of the South African National TB Plan 2017-2021. DOH & LSHTM. [45]

7.2 Estimated resources needed to fund the NSP

The NSP is a strategic document that presents broad goals, objectives and priority actions to guide the country's response to HIV, TB and STIs. The cost estimates for the NSP should similarly be viewed as a high level estimation of financial resource needs, driven by the ambitious targets that have been set. The NSP cost estimates have not fully accounted for a number of factors that can only be considered at an operational planning and budgeting level, such as detailed operational resourcing, absorptive capacity of implementing agents and available government and development partner funding. When sectors and spheres of government develop and cost their implementation plans, they should use the NSP costing outputs as a central reference point. These costed priorities should then inform the public sector and development partner budgeting processes.

The total cost of implementing the NSP is estimated at R207 billion over five years. The annual cost estimate rises from R35.1 billion in 2017/18 to R45.7 billion in 2021/22, as more people access treatment and as prevention and other supportive interventions are scaled up.

The increase from year 1 to year 2 of approximately R 4.6 billion is driven by the enrolment of an additional 575 255 clients on ART, the

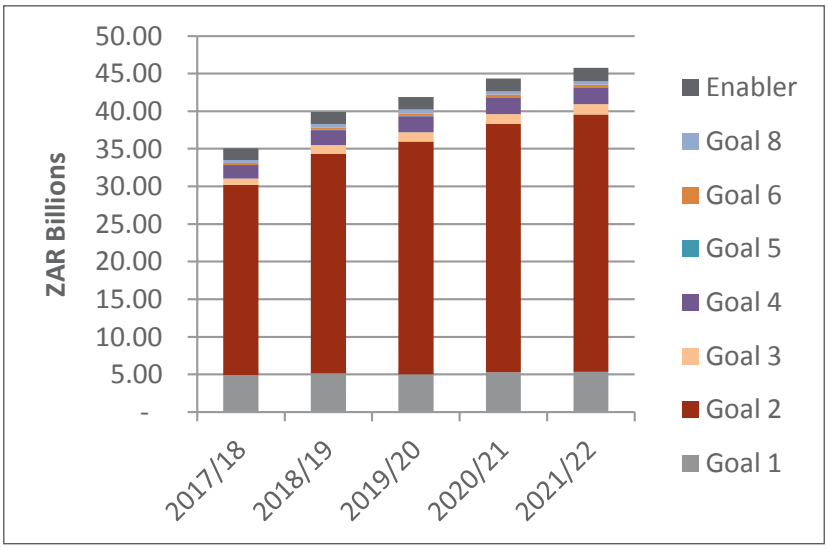
implementation of the intensive phase of the national adherence strategy and the scale up of most interventions after more conservative implementation targets for 2017/18 (due to public sector budgets having already been finalised for the first year).

Goal 2, which comprises treatment and care for people with HIV, TB and STIs, makes up by far the largest portion of the total 5-year cost of the NSP at 74%. Goal 1's evidence-based prevention interventions make up 12.5%, Goal 3's programmes for key and vulnerable populations 3% and Goal 4's array of social and structural interventions, 5% of total costs. Enablers, comprising inter alia Social and Behaviour Change Communication and strengthening the capacity of the health workforce, accounts for 4% of the total cost (Figure 13).

Although Goal 1 cost estimates for "accelerate prevention" do not increase considerably from years 1 to 5, it should be noted that the year 1 cost estimate is an appreciable increase from the 2016/17 budget baseline and this is carried through into future years. The increased costs are for, inter alia, Comprehensive Sexuality Education, PrEP, syphilis screening, TB preventive therapy and demand creation activities. Coverage targets and associated costs for certain biomedical prevention interventions, namely medical male circumcision, HIV testing services and condom programming do not increase significantly for the NSP period from the current 2016/17 baseline coverage, although delivery of these services is expected to become more targeted and quality assured. Other prevention-related interventions including social and behaviour change communication and combination prevention packages targeting key and vulnerable populations are included in other goal areas but also contribute to the acceleration of prevention efforts.

Although it appears that there will be funding shortfalls in certain programme areas if all the interventions articulated in the NSP are implemented, it is difficult to estimate the magnitude of potential financial gaps without further robust analysis.

It is recommended that a systematic funding gap analysis be undertaken for the NSP that presents estimated funding shortfalls by sub-programme. Thereafter an iterative process of prioritisation and optimisation of interventions taking into account available resources could be undertaken to inform public sector and development partner budgeting processes.



All cost estimates use 2017/18 prices and exclude inflation.

Figure 13: Total annual cost estimates by NSP Goal 2017/18 – 2021/22 (R billions)

Sources: The NSP costing exercise drew from a number of sources, including national costing models, published and unpublished literature and national government policy and strategy cost analyses. The exercise also constructed ingredients based unit costs from various sources, including government and development partner programme budgets and interviews with key informants. Further details are found in the NSP 2017-2022 Costing Model. Main sources include:

- National ART Cost Model, March 2017 outputs. NDoH and HE²RO[47]
- TB cost estimates (non-discounted): TB Think Tank (2017) Costing of the South African National TB Plan 2017-2021. NDoH & LSHTM.[45]
- South African HIV Investment Case. SANAC. 2016[25]
- The Costs of Managing Cervical Cancer in South Africa, DOH, HE²RO et al, 2017[48]

Table 4 provides further detail of the estimated costs per NSP objective. The acceleration of prevention interventions to reduce new HIV and TB and other STIs, under objective 1.1, comprise 9% of the estimated total cost. The estimated cost of implementing the 90-90-90 strategy for HIV under objective 2.1 comprises 58% and the 90-90-90 strategy for TB under objective 2.2 comprises 14% of the total NSP cost. The two objectives for key and vulnerable populations comprise 3% of total costs. The 5 objectives responding to social and structural drives together comprise 5% of the total estimated cost of the NSP.

Table 4: Total cost estimates by objective 2017/18 – 2021/22 (R Millions)

Objective	2017/18	2018/19	2019/20	2020/21	2021/22
1.1 Reduce new HIV infections to less than 100 000 by 2022 through combination prevention interventions	3 424	3 615	3 678	3 935	4 001
1.2 Reduce TB incidence by at least 30%, from 834/100,000 population in 2015 to less than 584/100 000 by 2022	787	772	559	550	544
1.3 Significantly reduce T. pallidum, gonorrhoea and chlamydia infection, to achieve the virtual elimination of congenital syphilis, and maintain high coverage of HPV vaccination	701	792	803	814	824
2.1 Implement the 90-90-90 Strategy for HIV	19 488	22 844	24 159	25 853	26 906
2.2 Implement the 90-90-90 Strategy for TB	5 000	5 425	5 766	6 102	6 120
2.3 Improve STI detection, diagnosis and treatment	783	859	996	1 065	1 175
3.1 Increase engagement, collaboration and advocacy of key and vulnerable populations in the development and implementation of social and health support activities	382	421	444	473	509
3.2 To provide an enabling environment to increase access to health services by key and vulnerable populations	468	761	793	822	855
4.1 Implement social and behaviour change programmes to address key drivers of the epidemic and build social cohesion	915	1 035	1 165	1 194	1 211
4.2 Increase access to and provision of services for all survivors of sexual and gender based violence in the 27 priority districts by 2022	126	127	128	129	130
4.3 Scale up access to social protection for people at risk of and those living with HIV and TB in priority districts	663	695	714	749	749
4.4 Implement and scale up a package of harm reduction interventions for alcohol and substance use in all districts	67	84	89	94	99
4.5 Implement economic strengthening programmes with a focus on youth in priority districts	29	53	56	58	61
5.1 Reduce stigma and discrimination among people living with HIV or TB by half by 2022	1	2	3	3	3
5.2 Facilitate access to justice and redress for People living with and vulnerable to HIV and TB	4	6	6	6	7
5.3 Promote an environment that enables and protects human and legal rights and prevents stigma and discrimination	13	20	29	29	29
6.1 Strengthen AIDS Councils to provide effective co-ordination and leadership of all stakeholders for shared accountability in the implementation of the NSP	37	38	39	39	39
6.2 Improve collaboration and co-operation between government, civil society, development partners and private sectors	242	284	297	297	297

Objective	2017/18	2018/19	2019/20	2020/21	2021/22
8.1 Optimise routinely collected strategic health information for data utilisation	105	153	150	69	26
8.2 Rigorously monitor and evaluate implementation and outcomes of the NSP	84	94	104	104	104
8.3 Further develop the national surveillance system to generate periodic estimates of HIV, TB and STI measures in the general population and in KVPs	172	193	215	236	258
8.4 Strengthen strategic research activities to create validated evidence for innovations, improved efficiency and enhanced impact	14	14	14	14	14
9.1 Health system enablers	928	969	1 012	1 058	1 107
9.2 Social enablers	631	657	663	670	677
Grand Total	**35 064**	**39 912**	**41 882**	**44 365**	**45 747**

A review of costs at the intervention level reveals that approximately 90% of the estimated 5-year cost of the NSP is driven by 14 interventions (Table 5). The antiretroviral treatment programme is the largest driver of costs in the NSP. The estimate was produced by the National ART Cost Model and assumes no change in current drug regimens. Total costs are driven by enrolling an additional 1.2 million people on treatment over the 5 year period and ensuring that 6 million people are adhering to treatment by 2021/22.

Table 5: Resources required by the 14 interventions with highest costs (R millions), 2017/18-2021/22)

No	Intervention area	2017/18	2018/19	2019/20	2020/21	2021/22
1	Antiretroviral Treatment	16 300	18 753	20 572	22 230	23 289
2	TB screening and diagnosis	2 759	3 144	3 462	3 764	3 802
3	Adherence strategy	1 801	2 715	2 222	2 265	2 265
4	TB treatment	2 167	2 200	2 222	2 247	2 220
5	HIV Testing Sevices (HTS)	1 361	1 396	1 396	1 431	1 431
6	Treatment care & support	1 347	1 335	1 325	1 317	1 312
7	Psychosocial support	750	1 006	1 040	1 057	1 074
8	Medical Male Circumcision	978	978	902	902	752
9	Vulnerable children and youth	802	842	924	933	934
10	Key and vulnerable populations	702	826	885	942	1 012
11	STI screening and diagnosis	633	688	795	850	935
12	Programme Management	691	732	775	821	870
13	HPV vaccination	676	770	780	791	801
14	Social and Behaviour Change Communication (SBCC)	649	694	709	725	732

All cost estimates use 2017 prices and exclude inflation.

In should be noted that the Department of Health is planning the replacement of Efavirenz with Dolutegravir in the first-line treatment of adults. This regimen change, expected to be introduced into the Public Sector in 2018/19 is calculated to lead to a 15% reduction in annual per patient costs of ART and a 12-16% reduction in the total cost of the ART programme between 2018/19 and 2020/21 (expected R 9.3 billion reduction). This is the result of the new regimen being cheaper and fewer people needing to be switched to second-line treatment. However, as the roll out plan for the new regimen has not been finalised, the expected reduction in costs has not yet been factored into the NSP cost estimates.

The implementation of the national adherence strategy will intensify from 2018/19 and will involve training for the current cadre of health workers, fast tracking treatment initiation, expansion of adherence clubs and scaling up the convenient delivery of chronic

medicines under the Central Chronic Medicine Delivery and Dispensing Programme (CCMDD).

The TB cost estimates were based on the National TB Plan recently developed by NDoH and which looks at five different interventions along the TB control cascade, as well as a number of cross-cutting interventions. The TB costing and impact model, developed by the TB Think Tank included the following interventions:

1. Targeted facility-based screening (intensive case finding - ICF)
2. Improved household contact tracing for key populations
3. Scaled-up appropriate short course treatment for MDR-TB
4. Reduced initial loss to follow-up (ILTFU) for DS-TB and DR-TB cases
5. Scaled-up 3 month preventive course of high-dose Isoniazid and Rifapentine (3HP) for PLWHIV and household contacts of PTB.

The ICF, screening and diagnostics form the greatest share of the total TB costs (49%), followed by treatment costs (39%) of first line and second line treatment regimens, which include monthly collection of medication (80% of patients) or DOTS visits (20% of patients), as well as the costs of hospitalisation during the intensive phase for MDR-TB patients. Importantly, the short course treatment for 70% of MDR-TB patients and the modified MDR-TB regimen with Bedaquiline (for 10% of patients), will lead to a net cost saving over the period (TB Think Tank, 2017). This saving is factored into the costing. Preventive interventions comprise only 11% of total TB costs, yet form a high-impact intervention for reducing new infections.

Setting the STI targets and estimating the costs of STI screening, diagnosis and treatment were particularly challenging due to limited data on the prevalence of the different types of STIs and their severity (with many cases being asymptomatic and undiagnosed), as well as limited data on their treatment costs. Hence the STI cost estimates are probably an underestimation, and highlight the need to improve the information on STIs and to develop a detailed costing model. Nevertheless, the largest driver anticipated will be scaling-up the diagnosis of STIs, including asymptomatic STIs, while their treatment costs will remain relatively small.

The NSP cost estimates also include the costs of the response to prioritised social and structural drivers (SSD) of the three diseases. These responses include programmes to build the resilience of vulnerable children and youth, estimated at R 4.4 billion over 5 years. This is driven largely by the cost of providing community based prevention and early intervention services to vulnerable children through Isibindi sites and drop-in centres in priority districts. Other SSD programme costs include the cost of strengthening parenting and families (R 380 million), psychosocial support and mental health services (R 4.9 billion), gender based violence (R 640 million), food security for people living with or affected by HIV or TB (R 1.1 billion), harm reduction for alcohol abuse and substance use (R 433 million) and economic empowerment (R 257 million).

7.3 Strategic Approach: Mobilising sufficient resources to achieve the goals and objectives of the NSP

The traditional means of mobilising resources for the response – through budgetary allocations by the national government and international assistance – while substantial (Table 3/Figure 11), are likely on their own to be insufficient to cover the full implementation cost of the NSP. Although government funding for HIV and TB has increased, the fiscal space for the mobilisation of even greater domestic resources is limited by low economic growth, the weakened Rand, high levels of government debt and low credit ratings.

Prospects for an increase or even retention of current levels of foreign development assistance during 2017-2022 are uncertain. While it is currently projected that the Global Fund will maintain its investments at a steady level in the coming years, the political changes in the United States make the PEPFAR contributions particularly uncertain, and even the Global Fund could be affected by geo-political changes. The above constraints notwithstanding, the pressure for additional funds may not be as great as estimated for the first year of the NSP (2017/18) as it may take time to implement new strategies and scale up effective interventions. This may provide a short window of opportunity to mobilise additional resources through alternative channels.

Meeting the challenge of fully funding the NSP will require a combination of approaches, namely maximising funding from existing government and international sources, leveraging innovative mechanisms to generate new sources of funding and improving the efficiency of service delivery.

More specifically, the strategies for mobilising sufficient resources and maximising efficiencies are:

- ***Optimise investments:*** The health, social and economic returns on investment will be maximised by strategically selecting the optimal combination of high-value, high-impact interventions. Modelling undertaken as part of the South Africa HIV and TB Investment Case found that maximising prevention efforts (specifically condom provision, medical male circumcision and social and behaviour change communication) were more cost-effective than treatment, and that an approach that combines treatment and prevention is necessary to sharply reduce new infections and deaths associated with HIV and TB as well as reducing costs (and gaining economic returns) into the future. [25]
- ***Increase efficiencies:*** Using data to strategically target high-value, high-impact interventions towards spatial locations and populations where impact will be greatest will increase the efficiency of the response to HIV, TB and STIs. [49] The targeted areas include the 27 HIV and 19 TB high burden districts. Other strategies that will be prioritised to achieve greater technical efficiencies and thereby improve the return on investments include more targeted community based testing, expanding

the CCMDD Programme, speeding up registration and use of cheaper effective medicine combinations and establishing additional adherence clubs in facilities and communities. Efficiencies of this kind are the golden thread that underpins the strategies of this NSP that will be carried through into implementation activities.

- ***Frontload investments:*** While front-loading investments during 2017-2022 will intensify fiscal demands in the short run, the HIV and TB Investment Cases found that this approach maximises the reduction of future costs.[25] Increases in investment over the next five years may enable HIV programme costs to fall relative to baseline after 10 to 15 years, but the failure to make needed increases in investment now will mean that costs will continue to increase as more and more people are infected and require treatment.[25] The modelling and costing of the National TB Plan done by the TB Think Tank indicates that by immediately expanding preventive efforts (including 3HP, contact tracing and intensified case finding) and the new MDR-TB regimens, there will be savings in TB treatment costs within the five year NSP period.

- ***Roll out and fully leverage National Health Insurance:*** National Health Insurance (NHI) will pool health funding nationally and will be the single purchaser of all personal health services (including HIV and TB services). This is expected to lead to efficiencies in the use of funding and improvement in performance and health outcomes. However, the expected time frame for NHI to be fully functional and generating the revenues anticipated is longer than the 5-year time period for this NSP.

- ***Increase multi-sector engagement to address social and structural drivers:*** Government departments other than health are typically responsible for financing and administering approaches that focus on structural issues e.g. community development, education, poverty reduction, food and nutrition, employment, access to justice and other social development challenges. However, there is a risk that these approaches may be insufficiently prioritised or inadequately HIV and TB-focused if they are planned and implemented in isolation. Integrating HIV and TB into multi-sectoral planning and fully leveraging the benefits of non-health sector efforts has the dual benefit of enhancing the effectiveness of the response and diminishing pressures on the health sector to fund wider activities of the NSP. To enable the scale-up of under-resourced social and structural interventions, evidence-based budget bids or business cases should be developed, demonstrating how these approaches will improve HIV and TB outcomes while also advancing the broader development aims outlined in the NDP.

- ***Departments to use their own budgets and staff for HIV, TB and STI activities:*** Every government department at national, provincial and local government levels, as well as every business, has a role and should be making a contribution to the response to HIV, TB and STIs. This could come from earmarking funds in their regular budget and also from integrating HIV, TB and STIs into their workplace wellness programmes, service delivery programmes and into the work of their outreach staff. For example, every event run or funded by the Department of Sport and Recreation, every contract for a major construction project and all outreach programmes delivered by the Departments of Agriculture, Human Settlements, Labour, Mineral Resources and Transport are opportunities for HIV, TB and STI engagement.

- ***Identify and leverage innovative financing mechanisms:*** South Africa will aggressively explore innovative options to generate new funding sources. Options include:
  - Government co-investment, whereby multiple departments agree to co-finance priority interventions. This approach is particularly well-suited to structural interventions, which have broader, cross-cutting benefits.
  - Partner co-investment, whereby the government joins with development partners, the private sector and others to co-finance efforts to achieve specific programme outcomes.
  - Social impact bonds, a contracting and financing mechanism whereby socially motivated investors pay for social services upfront and are repaid by outcomes funders (such as government departments or development partners) only if pre-agreed outcome targets are achieved.

- ***Improve financial information systems and management*** Fully resourcing the NSP and maintaining strong oversight during its implementation will demand rigorous financial management and accountability, which in turn depends on key action steps:
  - The further development of existing management information systems within the public sector, with advanced analytical and reporting capabilities of financial and non-financial data and human resources. This will enhance government's ability to collate and review all expenditures against programme outcomes, so as to identify potential technical inefficiencies for interventions.
  - Budgeting, as well as financial and non-financial reporting frameworks, for HIV, TB and STIs should be harmonised across departments and development partners.
  - The mapping and reporting of all HIV, TB and STI expenditures should be simplified, standardised and routinised through mandatory reporting by all involved in the HIV and TB responses. Specifically, the National Health Accounts (NHA) is a process of consolidating all health spending and will be undertaken by the Department of Health on a routine basis. This will provide valuable data on the health-related spending on HIV and TB, according to the NHA health categories, and will greatly enhance the co-ordination and direction of efforts, reducing duplication and fragmentation.

8

"Continuous research and data analysis forms the operational backbone of the "focus for impact" approach to NSP implementation."

– Dr. Mookho Malahleha, Researcher

Goal 8:

Strengthen strategic information to drive progress towards achievement of NSP Goals

"Data-Driven Action"

Goal 8: Strengthen strategic information to drive progress towards achievement of NSP Goals

"Data-Driven Action"

8.1 Strategic context

South Africa has a range of information systems in place (e.g. health, education, social development), including routinised public health monitoring and evaluation activities; varied and robust surveillance activities and rigorous epidemiologic, laboratory and programmatic research. Highly capable research institutions and universities undertake ground breaking research, including clinical trials. However, while South Africa generates substantial data on HIV, TB and STIs, the country lacks a nationally cohesive and planned approach to the generation and use of strategic information. This gap diminishes the country's ability to fully leverage strategic information to drive progress towards NSP Goals, improve programmes over time, maximise efficiencies and close research gaps.

There are three key components to strategic information:

1. ***Monitoring and evaluation (M&E)*** involves the on-going collection, reporting and evaluation of programmatic and service delivery data. In 2012-2016, all government departments at national, provincial and district level continued to improve their M&E systems. The SANAC secretariat, which is responsible for the monitoring and evaluation of the NSP, established an M&E Unit. The Unit developed an M&E framework for the NSP 2012-2016 and published a first progress report on it and completed Provincial Strategic Plan reports for 2013/14 and 2014/15. The M&E system still needs much development to realise its full role.

   This NSP calls for M&E data to be produced and reported by all levels and sectors that deliver services. Data needs to be better refined to guide decision-making through disaggregation by age, gender and key and vulnerable populations and by identifying service utilisation gaps and outcomes. For this NSP, M&E will include two dimensions – the results framework that will track the overall performance of the implementation of the NSP and regular, more detailed information on programme implementation, indicating any gaps or challenges with quality.

2. ***Surveillance and surveys*** entail the systematic collection, analysis, interpretation and dissemination of health data. Standardised surveys that are repeated enable tracking over time. This data enables stakeholders to better understand the HIV, TB and STI situation, including the populations and geographic locations most affected. Surveillance data is also essential for modelling the impact of various interventions and informing decision making. Second Generation Surveillance [50] is used to track the course of the HIV and TB epidemics, assess the burden of disease and identify where most new infections are likely to occur. Biological and behavioural probability surveys, population size estimation of key populations, facility-based sentinel surveillance, and longitudinal household surveys are undertaken. Numerous surveillance activities and surveys have been conducted since the last NSP and have provided valuable information on prevalence, mortality, treatment and drug resistance and also social and behavioural information. Lack of consensus on optimal data sources, delayed release of results and financial constraints have occurred.

3. ***Research*** helps develop new prevention and treatment technologies and drugs, optimise the delivery of interventions and strategies, and answer key implementation questions not fully addressed through surveillance and surveys. South African researchers have been involved in many multi-country and local studies including those being used to inform this NSP. These include the Investment cases for HIV and TB, the use of PrEP, sexual transmission pathways, short course preventive therapy for TB, treatment choices for MDR TB, programmes that reach adolescent girls and young women, and models to improve differentiated care. Think Tanks for HIV, TB and STIs established by the National Department of Health are further vital assets in driving innovation and interpreting new knowledge to address the three epidemics.

   In 2013, the South African Medical Research Council (SAMRC) and the Department of Science and Technology (DST) established the Strategic Health Innovation Partnership (SHIP) unit to support the development of home-grown innovation, with the goal of developing new diagnostic tools, drugs, vaccines and medical devices to address priority health issues in South Africa.

   Much research is still needed to find new options and guide choices, including the development of new and improved prevention, treatment and diagnostic tools and interventions, and on optimising multidisciplinary strategies to deliver validated interventions.

8.2 Strategic approach

This NSP capitalises on the strategic information resources that South Africa already possesses, but foresees improved co-ordination, prioritisation, funding, capacity building and dissemination of findings. The areas of research most needed will be captured in a formal research agenda and best practices better shared to inform policy, guidelines and service delivery.

This NSP seeks to reinvigorate capacitated, special-focus and multi-sectoral general technical working groups (TWGs) that focus on the different elements of strategic information, including identifying gaps and weaknesses. The SANAC Secretariat will facilitate these TWGs to build a unified vision. This will complement the statutory responsibilities of the SAMRC, HSRC, NRF and the planned NAPHISA.

Particular efforts will be made to strengthen routine and novel HIV, TB and STI data collection, dissemination and utilisation, with particular emphasis on key and vulnerable populations. Steps will be taken to determine the appropriate timing of strategic information activities, improve the collection of disaggregated data (by age, gender, geographic location, and other factors) and develop prevention cascades and dashboards to monitor progress and outcomes along the treatment cascades. Consistent with the vision of a single, coherent, synergistic strategic information system, the NSP prioritises steps to ensure that monitoring and evaluation, surveillance and surveys and research activities complement each other.

8.2.1 Monitoring and evaluation

Monitoring the response relies on the collection and reporting of disaggregated data on services and programmes delivered to children, adolescents, and adults, including key and vulnerable populations. Routine data monitoring helps quantify service coverage measures, such as uptake, loss to follow-up, linkage between programmes and services, and health and other outcomes. This requires harmonised information, baselines and clear targets, accountability for reporting and reports being shared broadly and timeously. The M&E system (and also patient care) will benefit from the full implementation of the master patient index as soon as possible. This will enable tracking of service utilisation across facilities and programmes, and monitoring of outcomes.

To promote accountability and transparency and to drive progress towards achieving the goals and objectives of the NSP, there will be an M&E framework, supplemented by a detailed M&E plan based on a "whole of government" and "whole of society" approach for tracking progress.

The M&E Framework contains a core set of indicators that cover all the goals and objectives of the NSP (Annexure B). It will be used to monitor, track and evaluate the outputs, outcomes, and impact of the NSP, and to inform decision-making at national, provincial and district levels. The core indicators, baselines and targets in the Framework are drawn from existing policy and planning documents, including the NDP, MTSF, and relevant HIV-, TB- and STI-related strategies and plans. National, provincial and local government departments will reflect relevant NSP indicators and targets in their Annual Performance Plans (APP) and Integrated Development Plans (IDPs). Each Provincial AIDS Council will reflect their contribution to the national targets of the NSP in their Provincial Implementation Plans (PIPs), which they could supplement with extra indicators to meet their additional information requirements.

To close identified gaps in the monitoring and evaluation system for HIV, TB and STIs and to generate the information needed for effective monitoring and evaluation of the NSP, the following strategies will be implemented:

- ***Strengthen and promote multi-sectoral ownership and accountability of the NSP M&E system:*** M&E relies on multiple systems and data sources, which are supported and maintained by various stakeholders. Greater co-ordination of public, private, civil society and development partner implementing agencies will optimise available resources and ensure continuous learning through sharing of experiences. In support of greater multi-stakeholder ownership, accountability and responsiveness, a national five-year, costed M&E Implementation Plan will be developed to accompany the M&E Framework of this NSP. The Plan will detail the roles and responsibilities of all stakeholders and the reporting timelines and will define core indicators, data sources, collection tools and flow mechanisms.

  SANAC will coordinate the M&E Plan at the national level, with provincial AIDS councils and sectors assuming similar responsibilities at provincial and sectoral levels. These coordinating structures will oversee capacity development, data quality assurance, resource mobilisation for M&E and data archiving. These activities will need to be fully funded and supported.

- ***Strengthen capacity to generate and use available data effectively to monitor NSP performance:*** An overriding aim of the M&E Plan is to strengthen support to stakeholders to be effective in generating, interrogating and using data to adapt and improve programmes and service delivery on a continuous basis. The SANAC Secretariat will facilitate support to sectors and localities that require it.

- ***Conduct independent reviews of progress:*** Independent evaluators will conduct robust and inclusive mid-term, end-term and programme evaluations of the NSP and PIPs. The mid-term review, scheduled for 2019, will assess the implementation of the NSP against its goals and objectives. This review will allow for adjustments in programming and resource allocation for the second half of the NSP and will also provide an opportunity for stakeholders to revise NSP and PIP targets. The final evaluation is scheduled to report in December 2021 and the findings will inform the development of the next NSP. The results of these reviews will be produced timeously and made available widely.

- ***Develop and conduct the accountability scorecard annually:*** The accountability scorecard is an important tool to support the leadership activities described in Goal 6. This will be developed and then conducted and published annually by the SANAC Secretariat.

8.2.2 Surveillance and surveys

The NSP aims to better extract the benefits of and address the weaknesses in the surveillance system and more systematically identify and prioritise what surveillance and surveys are necessary to inform decision-making, including those that review quality of services (Table 15). Additional funds will be raised for surveillance and surveys. Funding of the Demographic and Health Survey will be prioritised. Standards will be assured and results made timeously and widely available to inform decision making and drive improvements in service choices and delivery. An annual

epidemiological update that includes national consensus estimates on HIV, TB and STI prevalence, incidence, mortality, patterns of resistance and other related indicators will be produced. The NSP envisages the following surveillance and survey activities:

- ***Institutionalise HIV, TB and STI surveillance to ensure co-ordination and capacity:*** A coordinated, time-bound, planned approach is essential to identify possible synergies, avoid duplications and inefficiencies, and establish ethical and scientific standards for surveillance.

- ***Continue and expand general population surveillance:*** Routine population-based surveillance activities will determine the HIV, TB and STI burden at the national, provincial and district-level by geographic area, age and gender.

Table 6: Priority surveillance and survey activities

Populations Surveillance	Sentinel Surveillance
HIV prevalence survey	Antenatal sentinel surveillance
HIV incidence modelling	Surveillance of acquired and pre-treatment HIV drug resistance
Antenatal HIV survey	Surveillance of transmitted HIV drug resistance, every 3 years
TB prevalence survey	HIV drug resistance sentinel surveillance
TB case reporting	HIV pharmacovigilance
Demographic and Health Survey	Surveillance of acquired and transmitted TB drug resistance
Rapid mortality surveillance	TB pharmacovigilance
HIV, TB and syndromic STI case reporting	Syndromic STI case reporting
Aetiological STI case reporting and surveillance of antimicrobial resistance	Sentinel surveillance of STI antimicrobial resistance
Surveys focused on quality of services	

- ***Conduct routine HIV, TB and STI surveillance among key and vulnerable populations:*** Integrated Bio-Behavioural Surveillance (IBBS) and population size estimation activities will be conducted. These will generate size estimates and other strategic information about key populations, including MSM, people who use drugs, sex workers and transgender people. In addition, special focus will be placed on characterising the vulnerabilities and burden of disease among adolescent girls and young women, healthcare workers and persons with disabilities.

- ***Implement facility- and laboratory-based surveillance activities to monitor HIV, TB and STI antimicrobial drug resistance:*** These activities are even more vital in view of the anticipated increased uptake of antiretroviral therapy under the Test and Treat approach, the expansion of adherence programmes, the expanded use of PrEP, the increase in person-to-person transmission of drug-resistant TB and emergence of STI-related anti-microbial resistance. Survey results which demonstrate the emergence of antimicrobial drug resistance will be used to inform selection of first, second and third line HIV, TB and STI treatment, training, revision of tools and efforts to prevent further drug resistance. Although they can be costly, delays in these surveillance activities could impact on mortality and morbidity and escalate future costs.

- ***Implement non-routine surveillance activities and surveys to monitor populations exposed to comprehensive prevention/ treatment programmes:*** Special surveys, demographic surveillance systems and community-based survey activities will help monitor the burden of disease among specific populations, such as those exposed to comprehensive prevention and treatment programmes and those in high-burden districts and/ or hotspots.

8.2.3 Research

Focused research to support the NSP encompasses innovations like new drugs, operational research and evaluation, implementation science and investigations that build the evidence base for improved action. This includes new treatment regimens, service delivery optimisation to strengthen availability, access and adherence and optimisation of cost-effectiveness and efficiency.

International donors provide additional funding for research to complement local funding for innovation and to support targeted HIV, TB and STI research networks. Strategic partnerships with the international institutions and product development partnerships (PDPs) will be developed in collaboration with the SAMRC and DST with the purpose of leveraging expertise and facilitating further investment.

The NSP will strengthen strategic research activities to create validated evidence for innovation, improved efficiency and enhanced impact:

- ***Develop, fully resource and implement a coordinated research agenda for the NSP:*** South Africa will fully maximise

its substantial research expertise by enhancing co-ordination, knowledge sharing, planning and implementation of all research efforts. This will aid in identifying national research priorities and gaps, mobilising resources for priority research projects and undertaking research across the country. The research Technical Working Group will help build relationships and support co-ordination among diverse stakeholders and facilitate multi-disciplinary research. Specific efforts will be made to ensure rapid and widespread dissemination of research findings. Research will adhere to best practices for community engagement and participation, consistent with international guidelines on Good Participatory Practice in Research.

- ***Fill critical research gaps:*** The research agenda under the NSP will determine and address critical gaps in knowledge in order to accelerate progress towards achieving the Goals, objectives and targets of the NSP.

  - **Social and anthropological research** priorities will be reviewed upon establishment of an inter-disciplinary Social Science Think Tank. Research priorities will include efficacy of anti-stigma interventions, piloting customised strategies for adolescent girls and young women and key and vulnerable populations, and validating additional social and behaviour change communication campaigns.

  - B**asic and clinical research** activities, plans and findings will be reviewed and better disseminated to policy makers, health system managers, service providers and other stakeholders to enhance care and to encourage transparency and understanding of the full research portfolio in South Africa.

  - **New biomedical breakthroughs** will continue to be encouraged, including but not limited to vaccines, microbicides and shorter, simpler, more effective and safer treatment options for the three diseases. There will be a particular emphasis on treatment options for TB and DR-TB; child-friendly TB and HIV medicines, with a focus on easy-to-take fixed dose combinations; improved HIV and TB diagnostics; and new prevention technologies.

  - **New research on the prevention of TB** will be supported e.g. identifying the impact of overcrowding in public transport where the windows are not open on the spread of TB and how to mitigate the risks.

- ***Support implementation research and develop best practice models:*** The NSP seeks to catalyse implementation research for real-time learning and programme and service delivery improvements. Coordinated impact evaluations on implementation of perceived best practices will be undertaken and answers sought to priority research questions, with dissemination of findings to achieve implementation of best practices. The National Implementation Research Advisory Committee recently drafted a prioritised list of important implementation research questions, ranked by seven key measures: impact, cost/cost-effectiveness, sustainability, scalability, available findings, resources and alignment. Experience from the intensified approaches undertaken in high-burden districts, particularly to address social and structural drivers, will be documented to inform efforts in other parts of the country. Communities will be consulted, engaged and fully informed of implementation research on HIV, TB and STIs.

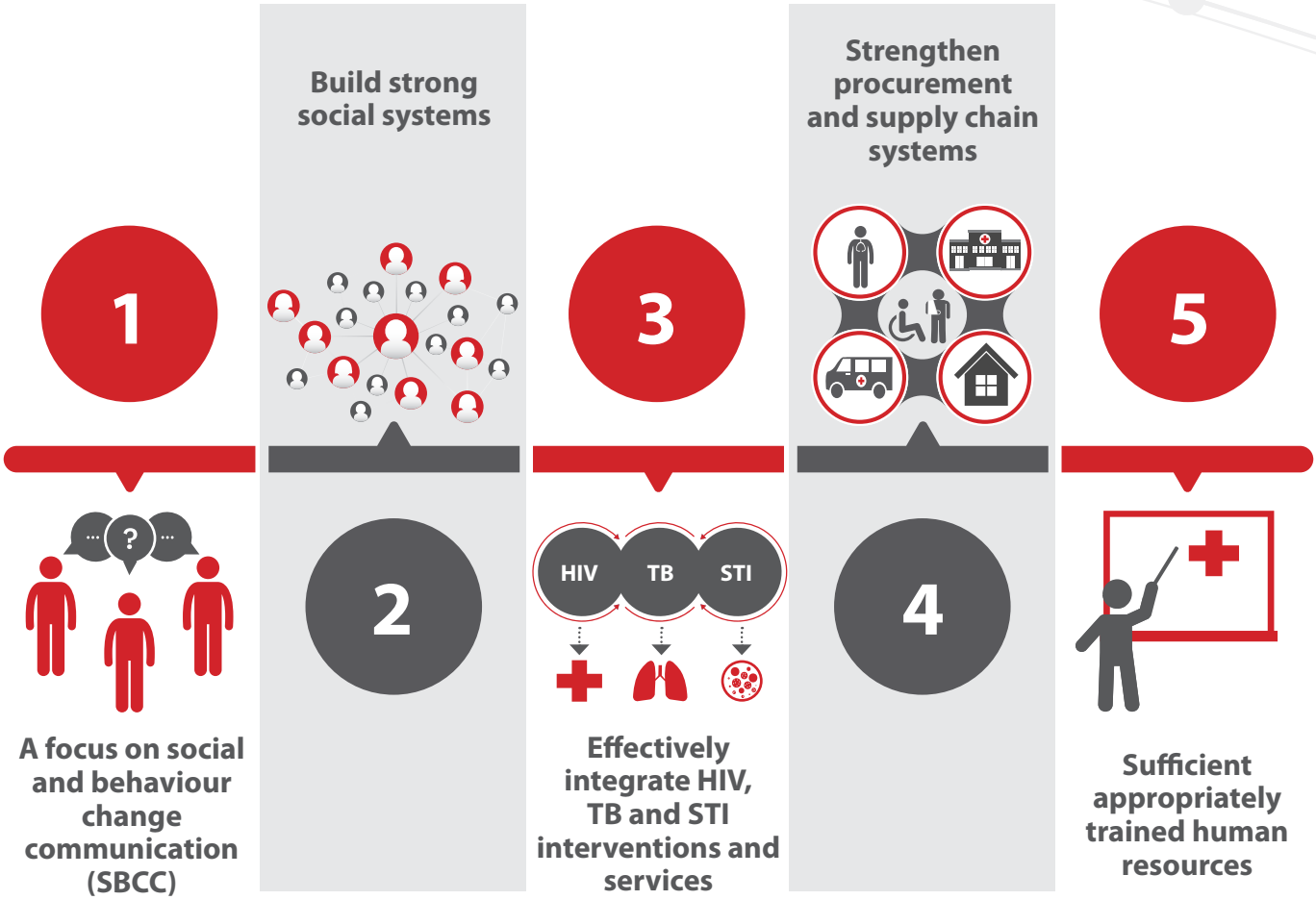
- ***Support research on the safety and efficacy of traditional and complementary medicines:*** The NSP calls for a national strategy to foster the appropriate integration, regulation, availability and use of traditional and complementary medicine. Consistent with WHO guidance, this research strategy will build the knowledge base for formulating national policy and enabling evidence-based regulation on the safety, quality and effectiveness of traditional and complementary medicine as the basis for access to validated interventions. The specific partners that will drive this are the NDOH, DST and SAMRC, together with other research institutions and the MCC/SAHPRA.

- ***Enable research:*** Steps will be taken to increase local research capacity, in close collaboration with the SAMRC, HSRC and National Research Foundation (NRF), including the creation of fellowships for tertiary education students and the development of communities to participate actively. Through revitalising research networks, scientific capacity will be mobilised for identified strategic information activities.

Critical enablers

to maximise the reach and impact of South Africa's response to HIV, TB and STIs

Critical enablers to maximise the reach and impact of South Africa's response to HIV, TB and STIs



For the achievement of the eight NSP goals and their objectives and targets, systems must be strengthened to ensure delivery of services and for programmes to be both effective and optimally efficient. Critical enablers are those vital to strengthening and configuring systems to meet the strategies outlined in the NSP, helping maximise the reach and impact of programmes. The enablers are not merely ancillary to essential services, but are critical to the success of their delivery. In furtherance of the NSP, Provincial Implementation Plans should specifically describe concrete actions to address these enablers.

Enabler 1: A focus on social and behaviour change communication (SBCC) to ensure social mobilisation and increasing awareness

Effective communication is a central element and determining enabler of each and every aspect of the NSP. Social and behaviour change communication (SBCC) helps individuals to reduce HIV, TB and STI risk behaviours, builds demand for services, and assists people to remain engaged in HIV and TB services and to adhere to prescribed prevention and treatment regimens. According to a recent analysis by the World Bank and other partners, changes in sexual behaviour played a decisive role in the substantial declines in HIV incidence that have reversed the AIDS epidemic in many African countries.[51]

SBCC is an especially important component of an effective response to HIV, TB and STIs now, as growing evidence suggests that young people are less informed about HIV than in the past and less likely to take steps to reduce sexual risks. Results from three national surveys indicate that fewer South Africans are reached by SBCC interventions, with the proportion of people reporting having been reached falling from 92.5% in 2006 to 82% in 2012.[4]

To be effective, SBCC approaches must be of quality, achieve high coverage of the target population and include measures to reinforce messages through multiple channels. Effective SBCC is characterised by strong stakeholder participation, capacity-building for programmes, geospatial mapping to inform targeting, risk profiling of communities, and the tailoring of national campaigns to local communities. SBCC programmes should be theory-based, client/community-centred, participatory, oriented

around the benefits of key behaviours, and linked to services. SBCC should use multiple channels (e.g. advocacy, mass media); be scaleable, sustainable, results-oriented and cost-effective; and recognise that social and behaviour change is seldom a linear process.

To support full implementation of the NSP, an evidence-informed national SBCC strategy will be developed and steps taken to align existing SBCC initiatives with the goals and objectives of the NSP. The new SBCC strategy will support a national 360˚ communication campaign to enable achievement of the NSP. SANAC Secretariat will increase its capacity to lead and facilitate this national SBCC campaign and will build the capacity of key stakeholders to empower them to leverage the campaign for advocacy. Planning for the campaign will be inclusive, involving members of the targeted audience, skilled communicators, content experts (programme managers and co-ordinators) and researchers, and be informed by focus groups and other research efforts. Government-operated toll-free lines must be made accessible to people using mobile phones in order to increase the reach and impact of the SBCC campaign.

To implement a stronger, sustained SBCC effort to support achievement of the NSP goals and objectives, SANAC Secretariat will review existing SBCC interventions (e.g. 'She Conquers', GBV campaigns) to identify gaps while the DoH and other Departments will ensure sustained SBCC interventions in support of the NSP. As the campaign will aim to increase use of key commodities (e.g. male and female condoms, test kits), the national government must ensure a robust, continuous and reliable supply of commodities at the local level.

In support of the SBCC intent of the NSP, provincial and district AIDS Councils will engage opinion leaders and influential individuals in local communities to support the campaign. Provincial and local leaders should ensure an enabling environment to support local actors in leveraging the campaign. Community-based co-ordinating structures, such as the War Rooms established under Operation Sukuma Sakhe in KwaZulu-Natal, should be established in each community, with particular attention to high-burden districts. In this way HIV and TB programmes become part of the agenda of established development structures. Community health care workers and caregivers should be trained to undertake household wellness assessments and to make referrals to integrated HIV/TB/STI/SRHR and GBV services.

Enabler 2: Build strong social systems, including strengthening families and communities, to decrease risks of transmission and to mitigate the impact of the epidemics

The NSP recognises that social systems are vital to supporting and enabling its prevention and treatment goals. In particular, these social systems are pivotal to the NSP's ambitions for key and vulnerable populations, for addressing social and structural drivers and for promoting and protecting human rights. Concerted efforts will be made to empower and strengthen households and parents as key actors for the achievement of NSP targets and indicators. The Department of Social Development will play the lead role in building strong social support systems, supported by other government departments, the SANAC Secretariat, civil society (including faith-based and traditional leaders), and private sector wellness programmes. Integration with and co-ordination by diverse sectors will be central to hopes of fully leveraging stronger social systems to accelerate progress of the NSP.

Under the NSP, community-based responses will be strengthened through the implementation of a core package of multi-sectoral services to address the social, physical, educational and emotional needs of children and families. The role of parents and caregivers will be addressed in all prevention and early intervention programmes. Safe spaces will be provided for families or individuals who experience or are at risk of gender-based violence, including linkages to appropriate social support services.

Community engagement, dialogue and direct support will be prioritised to permit the most pressing needs of communities to be identified and addressed. Targeted risk assessments and measures to ensure early detection, treatment and adherence support will focus on reducing the vulnerability of children and families, with particular attention to adolescent girls and young women. At risk children, families and caregivers will be referred to screening for HIV, TB and STIs, and psychosocial support services will enable the uptake of testing. Existing platforms, institutions and structures will be fully leveraged to build strong, durable social systems for sex workers and other key and vulnerable populations.

The capacity, competencies and capabilities of government, civil society and NGO and CBO service providers will be increased to support the roll-out of quality HIV, TB and STI interventions and services. At the local level, improved community co-ordination forums and networks will strengthen integration and collaboration between health and social service providers.

Enabler 3: Effectively integrate HIV, TB and STI interventions and services

Service integration is a critical aspect of strengthening the quality and coverage of health and social systems. Offering services and information in an integrated manner is more efficient and friendly, as integrated systems require fewer service visits and also help diminish stigma. Service integration has been shown to generate concrete health benefits; for example, early antiretroviral therapy initiation among people co-infected with HIV and hepatitis B or C virus can generate approximately 10% greater health benefits per year.[52]

While service integration is a broader imperative, it is especially critical in the case of HIV and TB, given the high levels of HIV/TB co-infection. South Africa has had some important successes in integrating HIV and TB services; the proportion of TB patients who know their HIV status rose from 25.9% in 2007 to 89.9% in 2013. There are signs that service integration may be contributing to

public health gains, as the proportion of TB patients who are also HIV-positive fell from 69.6% in 2009 to 63.3% in 2013. [53] Building on these advances, further steps are needed to ensure integration of HIV, TB and STIs in all prevention and treatment programmes, enabling entry points to address all three diseases at the point of care.

In addition to needed service integration in healthcare settings, additional efforts are required to ensure thorough integration of health and non-health sectors. Healthcare settings should ensure appropriate referral and linkage of patients to enabling social services, and policy-makers in other sectors should also aim to ensure that their programmes are optimally HIV-sensitive. For example, in the case of food and nutrition programmes, prioritising services to children and households orphaned or made vulnerable by HIV and/or TB offers a path towards simultaneously reducing hunger and accelerating implementation of the NSP.

Enabler 4: Strengthen procurement and supply chain systems

This NSP requires ready, uninterrupted access to essential prevention, diagnostic and treatment commodities. While South Africa's procurement and supply chain system has largely functioned well in response to HIV, TB and STIs, the gaps that have sometimes occurred have undermined effective use of essential health commodities as well as adherence to prescribed prevention and treatment regimens.

In 2017–2022, South Africa will take additional steps to strengthen procurement, supply chain and associated information systems and ensure quality throughout. The country will further strengthen its stock monitoring system at national and local levels, supported by a rapid response system for shortages, to ensure consistent and adequate supplies of medicines, testing kits, TB personal protective equipment, female and male condoms and lubricants at all service delivery sites. Steps will be taken to strengthen and enhance efforts to reduce the occurrence of medicines stock-outs, including improved case and stock management at health facilities. Improved, transparent information systems will identify the causes of stock-outs. An early warning system will identify impending shortages, and a distribution plan will respond in a timely manner. There will be a roll-out to all communities of a direct distribution system for delivery of medicines for chronic diseases (including HIV and TB) delivery in venues outside of health facilities. In addition to the Central Chronic Medicine Dispensing and Distribution Programme, other approaches will be implemented to provide antiretroviral and TB medicines and other health supplies outside of health facilities, bringing HIV and TB treatment and services for other chronic diseases closer to where people live and work.

Continued efforts will work towards optimising access at the lowest possible prices to drugs that people with HIV, TB or STIs need. Towards this end, South Africa will further improve the capacity of the Medicines Control Council/SAHPRA to rapidly review for approval generic versions of medicines and new combinations and medicines that become available. Vigilance will be needed to ensure that South Africa benefits from the most favourable prices possible for medicines, diagnostics and other health commodities.

Enabler 5: Ensure that there are sufficient, appropriately trained human resources where they are needed

HIV, TB and STI prevention, treatment and care is labour-intensive and requires diverse cadres of human resources from multiple disciplines in both the public and private for-profit and not-for-profit sectors. Human resources needs range from professionals to volunteers and from disease specialists to generalists. Given the ambitious nature of the NSP's service targets and the imperative to expand efforts to address social and structural drivers, human resource needs under this NSP undoubtedly grow and further diversify. This is true not only for health and social service systems generally, but for their sub-systems (e.g. mental health services) that will be needed to effectively implement the NSP. Only a robust, resilient system of human resources – one that prepares every worker to serve in a caring, people-centred and competent manner – will ensure that the workforce is sufficiently capacitated and that all actors are working in harmony to support the goals and objectives of the NSP.

The NSP requires an increase in the number of primary health care nurses who have the skills to administer antiretroviral therapy, manage drug-resistant TB, and address STIs beyond syndromic management, as well as a sufficient number of doctors to support services. Healthcare workers must be trained and proficient in occupational health and infection control standards and practices. Health and social development workers will benefit from training and technical support on working with key and vulnerable populations. Community health workers should be formalised as a cadre, appropriately trained and supported, and fully integrated into the health system. The social work auxiliary programme must be fully implemented and cadres in other sectors (e.g. agriculture, sport) trained for their role in HIV, TB and STIs. Community Development and Extended Public Works Programme Workers should include HIV, TB and STI related action in their scope of work. The need for expanded human resources is pertinent not only to the public sector but also in the private sector, including but not limited to incorporating HIV, TB and STIs in the training and practice of wellness co-ordinators.

Under this NSP, South Africa will invest greater resources and effort in the training and mobilisation of peer educators, lay counsellors and support personnel. Peers have an especially vital role to play in contributing to the response for young people and for other key and vulnerable populations. To play their optimal role, peer workers require effective training, support and supervision, and stipends or other compensation.

Conclusion: A healthy future is within our grasp

Over the course of the last three decades, South Africa has experienced the devastating effects of HIV and TB. As a result of these epidemics, national life expectancy plummeted, millions of children lost one or both parents, households and communities were riven, and local economies suffered. Persistently high levels of STIs further added to the country's health burden.

With the launch of this new NSP, however, there is renewed hope and optimism about the national response to HIV, TB and STIs. People from all walks of life have joined together to respond to these epidemics, national investment in prevention and treatment programmes have dramatically increased, and the array of prevention and treatment tools continues to expand. Indeed, we have the ingredients we need to end HIV, TB and STIs as public health threats in our country.

However, if we do not build on the gains and significantly increase investment in our response now, these epidemics will rebound. If we fail to act – if we do not seize the historic opportunities we have – the human and financial costs of HIV, TB and STIs will grow much worse in the coming years.

The 'focus for impact' approach outlined in this NSP offers a roadmap for fully leveraging scientific advances and for averting the inevitable costs of complacency. The 'focus for impact' approach will only be possible with renewed commitment, sufficient resources and an inclusive, data-centred approach. Through such smarter action, especially at the local level, and with greater engagement of affected communities and all sectors, we can by 2030 ensure that our country is free from the burden of HIV, TB and STIs.

Former President Nelson Mandela said: "A new world will be won not by those who stand at a distance with their arms folded, but by those who are in the arena." With such critical health and economic benefits within our grasp, our challenge now is to remain in the "arena" and work together towards a South Africa that is healthier and better able to thrive in the decades to come.

Annexure A: Goals, Objectives and Activities

Table 7: Goal 1: Prevention - Goals, Objectives and Activities

GOAL 1: Accelerate prevention to reduce new HIV and TB infections and STIs			
	Comprehensive approach	**Intensified approach, encompassing comprehensive plus**	**Accountable parties**
Objective 1.1: Reduce new HIV infections to less than 100 000 by 2022 through combination prevention interventions			
Sub-objective 1.1.1 Revitalise Information Education Communication (IEC) programmes in school, health, workplace and community settings	Provide prevention IEC materials and messages through interpersonal communication, mass media, social media *Materials to include:* • Basic information on HIV, TB and STIs • Prevention modalities for all three diseases • Prevention benefits of all modalities • Risks of alcohol and substance use • Information on PrEP, PEP, PMTCT • Health empowerment: health literacy, health rights and responsibilities, guarantee of confidentiality • Gender norms and equality, including gender-based violence (GBV) prevention, care and support • Justice for persons facing stigma, discrimination and legal injustices, and how to access legal support • Principles of universal design and reasonable accommodation to enable access by persons with disabilities	• Target IEC approaches by risk profile • Strategically implement IEC campaigns to support health and social service campaigns • Distribution outlets to include taxi ranks, all forms of transport, churches, schools, soccer stadia, taverns, workplaces, etc.	• DoH • DBE • DSD • CBOs • DHET • DOT • NGOs • Private healthcare providers • Private schools • Health insurance schemes
Sub-objective 1.1.2 Implement targeted biomedical prevention services tailored to setting and population	• PITC in all health facilities • Outreach HTS in high-transmission areas (HTAs) • Promote access to self-screening • Ensure quality assurance of HTS services • Monitor positivity rate of testing services being offered to ensure optimal yield • MMC services in public and outreach facilities • Support initiation practices with MMC services • Provide male and female condoms, compatible lubricant and condom programmes in all public and private health facilities, in secondary schools, tertiary institutions, non-traditional community settings	• Focused PITC for AGYW and their partners • Focused outreach HTS for key and vulnerable populations • Youth-friendly SRH in schools, community settings • Promote self-screening • Explore innovative ways to improve uptake of testing • Focused, age-targeted MMC services in public and private facilities, with social mobilisation and outreach and after-hours services to expand access • Condom distribution through non-traditional outlets: hair salons, petrol stations, spaza shops, hotels, toll plazas, truck stops, brothels	• DoH • DBE • DCS • DSD • DoT • CBOs • NGOs • Retail pharmacies • Private employers • Private healthcare providers • Health insurance schemes • Organised labour • Private and public institutions workplaces • SANAC sectors • Hospitality industry
Sub-objective 1.1.3 Provide sensitive and age-appropriate sexual and reproductive health services (SRH) and comprehensive sexuality education (CSE)	• Provision of contraception and fertility planning commodities as per NDoH guidelines • Implement core components of CSE • Develop and implement a quality assurance protocol for CSE programmes and monitor to ensure fidelity and quality • Train educators to deliver sexuality education curriculum	• Implement CSE curriculum with linkage to youth-friendly SRHS • Provide youth- and gender-friendly SRH clinics in non-healthcare settings (schools, mobile sites) • Train and support healthcare workers (HCWs) to provide sensitive, non-discriminatory SRH to youth, AGYW, sex workers	• DoH • DBE • DHET • DSD • CBOs • NGOs • Private healthcare providers • Private schools • Health insurance schemes • NHLS • SAQMEC • HSRC

GOAL 1: Accelerate prevention to reduce new HIV, TB, and STIs

	Comprehensive approach	Intensified approach, encompassing comprehensive plus	Accountable parties
Sub-objective 1.1.4 Provide pre-exposure prophylaxis (PrEP) to identified risk populations	• Educate intended beneficiaries • Implement PrEP in line with NDoH guidelines • Pilot PrEP in KP groups (high-risk MSM, AGYW, discordant couples and others) and conduct implementation science and demonstration projects to determine best programmatic practices	• Implement PrEP using best practices and lessons learnt from demonstration projects using established sex worker (SW) and MSM service delivery sites • Develop comprehensive PrEP guidelines that address identification, recruitment, adherence support, drug delivery mechanisms	• DoH • DBE • DCS • DSD • CBOs • NGOs • DOT • Retail pharmacies • Private employers • Private healthcare providers • Health insurance schemes
Sub-objective 1.1.5 Provide targeted services to prevent MTCT of HIV and syphilis in the prenatal and postnatal period	• Ensure full implementation of PMTCT programme including HTS and syphilis testing • Include HIV self-screening for partners • Ensure access to MomConnect and other supportive programmes	• Accelerated implementation of 'last mile' focus on the five pillars: Leadership, Management and Co-ordination; Scaling up coverage and improving the quality of care; Integration of PMTCT programmes into MNCWH services; Strengthen monitoring and evaluation of PMTCT programmes; and Increase awareness and community involvement • Intensified partner testing for pregnant women living with HIV, including disclosure support • Intensified GBV and alcohol screening and support • Innovations to ensure timely Early Infant Diagnosis and birth testing and the tracking thereof	• DoH • DSD • CBOs • NGOs • Private healthcare providers • Health insurance schemes
Objective 1.2: Reduce TB incidence by at least 30%, from 834/100 000 population in 2015 to less than 584/100 000 by 2022			
Sub-objective 1.2.1 Increase coverage of Preventive Therapy Uptake (PTU) This refers to promptly finding people who have been exposed to TB or who are at higher risk of TB (like PLHIV), accurately excluding TB disease, assessing whether the exposed individual has been infected with TB, and providing optimal treatment of incipient (latent) TB	• Expand implementation and demand for preventive therapy for PLHIV and household contacts of people with DS-TB • Implement current guidelines for contact tracing of DS-TB and providing Isoniazid Preventive Therapy (IPT) • Include school-based screening and provision of IPT • Continue to support the development of new diagnostics for incipient (latent) TB	• Include Preventive Therapy Uptake as an essential component of Universal Test and Treat (UTT), intensified HIV testing measures and linkage to care • Develop simplified screening algorithms for TB-exposed children • Implement community education and mobilisation programmes • Implement mHealth solutions and care facilitators • Strengthen routine M&E • As new evidence becomes available consider preventive therapy for all high-risk groups regardless of immune or infection status	• DoH • Provincial and District AIDS Councils
	• Scale up 3HP (weekly high-dose isoniazid/rifapentine for three months) for PTU • 3HP is not yet routinely used, but the aim is to make this routine by 2022	• Submit to MCC for RPT approval / negotiate a volume-based reduction in RPT price / include RPT in the essential medicines list (EML) • Identify domestic funds or alternate donor funding, to procure 3HP / obtain importation waiver to pilot 3HP • Revise South Africa's guidelines to include 3HP • Generate and disseminate lessons learnt	• NDoH • TB Think Tank
	• Preventive Therapy Uptake for contacts of patients with DR-TB • Randomised control trials are under qay to determine best preventive therapy if South Africa	• Develop an interim policy for Preventive Therapy Uptake after exposure to drug-resistant TB based on available evidence (while waiting for RCT results) to include algorithms for adults and children	• NDoH

GOAL 1: Accelerate prevention to reduce new HIV, TB, and STIs

	Comprehensive approach	Intensified approach, encompassing comprehensive plus	Accountable parties
Sub-objective 1.3.3 Develop and implement effective STI partner-notification strategies	• Counselling for partner treatment • Assess best method for notification – patient-delivered partner medication (PDPM) and referral (PBPR) • Active provider-oriented/-initiated partner notification and case-finding • Introduce provider-oriented partner notification with a focus on key populations and AGYW, and improve the use of partner notification slips • Monitor results of partner notification and explore other effective methods for partner notification through implementation research • Capacitate non-health workers working at community level to provide for assisted partner notification	• Introduce provider-oriented partner notification with a focus on KPs and AGYW • Explore other effective methods for partner notification through implementation research	• DoH • DBE • DCS • CBOs • NGOs • Private healthcare providers • Retail pharmacies
Objective 1.3: Significantly reduce T. pallidum, gonorrhoea and chlamydia infection, to achieve the virtual elimination of congenital syphilis, and maintain high coverage of HPV vaccination			
Sub-objective 1.3.1 Scale up STI prevention by providing high-quality health information and timely health services for persons at risk	• Comprehensive health information, STI education and health promotion programmes • Adequate STI screening and diagnostic services, including point-of-care technology for KPs and VPs • Syndromic management in all health facilities • Improved surveillance of the viral and bacterial causes of STIs (gonorrhoea, syphilis, and HPV), as well as microbial resistance • Ensure STI components of SRH and CSE programmes are fully capacitated and accurate • Train and support health workers to provide comprehensive STI screening and diagnosis, including reverse testing algorithm • Provide periodic presumptive treatment (PPT) for high-risk groups including sex workers	• Develop routine support to ensure healthcare workers include STI screening and diagnosis in all HIV testing and care settings • Active partner tracing, case-finding and treatment • Conduct STI aetiological and antimicrobial resistance studies • Establish effective referral and diagnostic system for cases of suspected treatment failure and complicated STIs: include recommendations in primary health care and hospital-level STGs • Train and support health workers in STI data capturing and data utilisation • Establish adolescent- and youth-friendly services • Train and support health workers in STI data capturing and data utilisation	• DoH • DBE • DCS • DSD • DOT • CBOs • NGOs • Private healthcare providers • Health insurance schemes
Sub-objective 1.3.2 Scale up and maintain high levels of HPV vaccination in grade 4 learners	• Continue high coverage of full HPV vaccination of targeted girls in public schools, including schools for people with disabilities • Encourage HPV vaccination in private schools	• Implement awareness-raising for HPV vaccination • Strengthen curriculum in primary and high schools on HPV	• DoH • DBE • DCS • DSD • CBOs • NGOs • Retail pharmacies • Private healthcare providers • Health insurance schemes

GOAL 1: Accelerate prevention to reduce new HIV, TB, and STIs			
	Comprehensive approach	**Intensified approach, encompassing comprehensive plus**	**Accountable parties**

Sub-objective 1.3.2
Promote TB Infection control
	• Implement existing guidelines:
	  • Annual assessments against a set of quality standards for infection control
	  • Finalise and implement draft NDoH guidelines for healthcare workers (HCWs)
	  • TB screening at entry, biannually and at exit as per existing guidelines for inmates
	  • Isolation of symptomatic patients and TB patients
	  • Promote TB infection control in health facilities
	  • Promote TB infection control in correctional facilities and detention centres
	  • Establish robust TB infection control in communities and households
	  • Promote TB infection control in taxis and other forms of public transport
		• Implement FAST: 'Finding cases Actively by cough surveillance and rapid molecular sputum testing, Separating safely, and Treating effectively based on rapid drug susceptibility testing'
		• Formalise programmes for HCWs to reduce TB risk, provide access to regular TB screening and TB preventive therapy
		• Record and monitor TB and DR-TB disease in HCWs
		• Aggressive TB screening including chest X-ray and TB culture where appropriate
		• Institute infrastructural changes to improve ventilation
		• Introduce appropriate legislation and building regulations
		• Develop norms and standards for housing and congregate settings including schools and public transport
		• Develop guidelines for TB infection control in congregate settings and households
			• DoH
			• Employers of healthcare workers
			• OHSC
			• DCS
			• DHA
			• DPW
			• Department of Housing
			• Department of Transport

Table 8: Goal 1: Prevention - Activities by Population

Comprehensive package of services for the general population, that will then be supplemented and customised to the age and population served	
• Accessible, friendly, comprehensive service delivery and health education, customised to client needs • HIV screening, testing, treatment • STI screening, testing, treatment • TB screening, testing, treatment and contact tracing for DS- and DR-TB • Medical male circumcision, referral • Comprehensive SRH services (including: cervical cancer screening, Pap smears, access to emergency contraception, choice of termination of pregnancy) • Prevention of mother-to-child transmission (PMTCT) of HIV • Mental health screening and psychosocial support • Access to PEP and post-sexual assault support • Alcohol and drug-use screening, referral • Violence screening, referral • Condom promotion and provision • Targeted social and behaviour change communication	• All implementing agencies • DoH • DSD • NPA • DBE • NGOS • SANAC Secretariat

Population	Services/Interventions/Approaches	Setting	Accountable parties
Children	• Child abuse screening • Age-appropriate HIV testing, treatment, adherence support • Support for disclosure of HIV status • HIV testing of household adult or adolescent index client • Contact tracing from adult, adolescent TB cases • Sputum induction for TB testing • Update hospital admission requirements for DR-TB treatment • Comprehensive sexuality education: Sexuality, puberty education, gender and empowerment, GBV, reproductive health, contraception, alcohol and drug use prevention, decision-making, self-esteem	• Health facility-based • School-based • Community-based • Mobile services	• DoH • DBE • DSD • CBOs • NGOs • Private employers • Private healthcare providers • Health insurance schemes
PLHIV (adults, adolescents)	• Hearing and vision screening, referral, treatment • Partner HIV testing, disclosure support, treatment, adherence support • Hepatitis B and HPV vaccine where eligible • PMTCT and enhanced adherence support through pre- and post-natal period, including breastfeeding • Gender norms • Health and health rights literacy • Economic empowerment and health promotion • School retention • Accelerated nutritional and social grant support, if indicated • Targeted demand creation for services • Targeted, PLHIV-friendly IEC materials and SBCC, including social media and materials for those with vision and hearing impairment • Service delivery points in community, non-traditional settings	• Health facility-based • School-based • Community-based • Mobile services	• DoH • DBE • DCS • DSD • CBOs • NGOs • Private employers • Private healthcare providers • Health insurance schemes
Persons with TB (adults, adolescents)	• TB contact tracing, testing and post-exposure management • Partner HIV testing, disclosure support, treatment, adherence support • Enhanced health education about HIV/TB co-infection, reinfection • Hearing and vision screening, referral, treatment • Hepatitis B and HPV vaccine where eligible • PMTCT and enhanced adherence support through pre- and post-natal period, including breastfeeding, if indicated • Mental health screening • Gender norms education • Health and health rights literacy • Economic empowerment and health promotion • School retention • Accelerated nutritional and social grant support, if indicated • Targeted, TB-friendly IEC materials and SBCC, including social media and materials for those with vision and hearing impairment • Service delivery and treatment delivery points in community, non-traditional settings	• Clinic-based • School-based • Community-based • Mobile services	• DoH • DBE • DCS • DSD • CBOs • NGOs • Private employers • Private healthcare providers • Health insurance schemes
Discordant couples	• Partner HIV testing, disclosure support, treatment, adherence support • Hepatitis B and HPV vaccine where eligible • PMTCT and enhanced adherence support through pre- and post-natal period, including breastfeeding if pregnant and HIV-positive • Gender norms • Health and health rights literacy • Economic empowerment and health promotion • Accelerated nutritional and social grant support, if indicated • Targeted demand creation for services	• Clinic-based • Community-based • Mobile services	• DoH • DCS • DSD • CBOs • NGOs • Private employers • Private healthcare providers • Health insurance schemes

Table 9: Goal 2: Treatment - Goals, Objectives and Activities

Goal 2: Reduce morbidity and mortality by providing treatment, care and adherence support for all		
	Comprehensive package	**Accountable parties**
Objective 2.1: Implement the 90-90-90 Strategy for HIV		
Sub-objective 2.1.1 90% of all people living with HIV know their HIV status	Expand HIV testing through diversifying testing approaches and services by combining provider-initiated testing (adults, children and adolescents), community-based testing and self-screening, promoting decentralisation of services to reach underserved populations and those with high HIV burden while ensuring equity. ***This will be supported and strengthened by:*** • Advocacy • Facility linked targets for testing in and outside of facilities • Guidelines to support expanded HIV testing strategy with information on referral pathways and monitoring and evaluation • Strengthened early infant diagnosis of HIV through annual monitoring of HIV testing rate at 10 weeks and 18 months to identify districts that need extra managerial support • Optimisation of the use of the Road to Health Card by ensuring the inclusion of the HIV status on each card • Use of the Transport Industry infrastructure to expand testing	• All government departments • Private Sector • Civil Society (all sectors to play a role) • NGOs
Sub-objective 2.1.2 90% of all people with diagnosed HIV infection receive sustained antiretroviral therapy	Update national guidelines and tools on HIV Treatment for health providers and community health workers. ***This will be supported and strengthened by:*** • Including information on referral pathways and monitoring and evaluation • Specific guidance on improving adherence for children by addressing the pill burden. Fully describing the differentiated service delivery model and the roles played by different partners for patient-centred care of individuals - adults, pregnant women, adolescents, children, people with disabilities, and other key and vulnerable populations at different stages of HIV disease and with different treatment needs (advanced disease vs well on presentation / diagnosis, and "stable" with virological suppression vs "not stable") for the whole continuum of care • Development of supporting treatment literacy materials with information that is relevant to context, age and population and information on the management of adverse events and how to access support for queries	• NDOH
	Improve linkage to care to ensure quick and easy initiation on ART of all people diagnosed with HIV, as soon as they are ready for treatment. ***This will be supported and strengthened by:*** • Support to districts to fast track the implementation of the Test and Treat policy and the use of indicators and targets to track their performance at a facility level as part of the DIP and identify where further support is needed • Evaluation of the quality of the service being provided including the timeliness • Expansion of implementation strategies to include community based ART initiation demonstration projects for well patients, prioritisation of same day initiation, extended hours to improve access for working people, adolescents and men • Use of PLHIV to enhance linkage to care, innovative ways to link people with services including for mobile populations	• NDoH • District Management Teams • Civil Society (PLHIV sector)

Goal 2: Reduce morbidity and mortality by providing treatment, care and adherence support to all

	Comprehensive package	Accountable parties
	Strengthen the monitoring system to enable better tracking of patients between services and facilities and of their outcomes. ***This will be supported and strengthened by:*** • Expanding the rollout of the third phase of Tier.Net to all health facilities • Fast tracking the integration of Tier.Net with EDR.Net as a first step whilst the unique identifier is being rolled out (as this will then include the integrated services)	• NDoH
	Improve pharmacovigilance to enable increased timeous reporting of adverse events, detect trends and respond to them. ***This will be supported and strengthened by:*** • Expansion of the National Pharmacovigilance Plan for HIV and TB to all districts • Implementation of a national pregnancy registry, starting in selected sentinel sites before expanding to other sites	• NDoH • Private Sector • Civil Society (PLHIV sector)
Sub-objective 2.1.3 90% of all people receiving antiretroviral therapy are virally suppressed	Improve viral load monitoring through systems strengthening. ***This will be supported and strengthened by:*** • Using the District Implementation Plan to monitor and evaluate progress against targets and track ongoing quality improvement • Strengthen treatment literacy in health facilities, adherence clubs and in communities • Decentralised point of care viral load testing	• NDoH • District Management Teams • Civil Society (PLHIV sector)
	Promote retention in care for all PLHIV on ART. ***This will be supported and strengthened by:*** • Increased efforts to implement the Test and Treat policy at facility level through the DIP process • Increased quality assurance to promote adherence to guidelines • Expansion of implementation strategies to include community based ART initiation demonstration projects for well patients, including the use of GPs • Prioritise rapid and same day ART initiation • Implement extended hours services for working people and adolescents • Use PLHIV in health facilities and communities to encourage linkage to care • Explore innovative ways to improve patients' linkage to services • Differentiated ART delivery for stable patients, including a minimum of 3 months drug supply and optimised prescription periods to meet the needs of key and vulnerable populations and improve adherence • Ensure a functional fast lane for collection of repeat drug prescriptions at all pharmacies • Use of approved patient representatives to collect ART refills • Expansion of the Central Chronic Medicine Dispensing and Distribution programme • MHealth interventions to communicate VL results, drug stock outs and appointments • Implementation of a return-friendly system in all facilities • Track and improve the management of chronic diseases and their complications, as the population on ART ages	• NDoH • DoT • Dept. of Agriculture • Private Sector • Civil Society (PLHIV sector)
	Improve adherence support. ***This will be supported and strengthened by:*** • Implementation of a comprehensive and age appropriate psychosocial package to enhance adherence • Promoting the establishment of peer-led differentiated support groups for new and stable patients • Ensuring their linkages to psychosocial support.	• DSD • NDoH • Private Sector

Goal 2: Reduce morbidity and mortality by providing treatment, care and adherence support to all

	Comprehensive package	Accountable parties
Objective 2.2: Implement the 90-90-90 Strategy for TB		
Sub-objective 2.2.1 Find 90% of all TB cases and place them on appropriate treatment	Intensified facility-level TB case-finding. ***This will be supported and strengthened by:*** • Passive case-finding (test individuals presenting with symptoms of TB) • Routine symptom screening for all adult clinic attendees • Undertaking Xpert MTB/RIF test for symptomatic individuals not tested for TB in the last 3 months and undertaking culture test for HIV+, Xpert-negative cases	• NDoH • Private healthcare providers • Health insurance schemes
	Improve laboratory diagnostics to deliver optimal DS and DR-TB services. ***This will be supported and strengthened by:*** • Universal implementation of Xpert MTB/RIF as initial diagnostic tests • Monitoring and optimising implementation of all existing algorithms • Implementing robust reflex testing for samples found to be Xpert RIF resistant • Developing a platform for introduction of new diagnostics • Prepare and train on guidelines and algorithms in advance of Xpert Ultra introduction • Upgrade the laboratories to ensure sufficient second line LPA coverage to ensure optimal implementation of MDR-TB short regimen • Implement lessons learnt from Xpert rollout • All labs doing second line LPA should be either able to conduct phenotypic second line drug sensitivity testing or have easy referral to a lab that has this capability	• NDoH • NHLS
Sub-objective 2.2.2 Find at least 90% of the TB cases in key populations (the most vulnerable including PLHIV with low CD4 counts, under-served, at-risk populations) and place them on appropriate treatment	Active case-finding for key and vulnerable populations. ***This will be supported and strengthened by:*** • Screening of household contacts under 5 years of age • Intensified TB screening and access to appropriate treatment in correctional facilities, mines, informal settlements and antenatal clinics and for diabetics, PLHIV, health care workers and all household contacts • Contact tracing for all household members of TB index cases • Routine screening for health care workers • TB screening and testing among pregnant women to reduce congenital and perinatal TB transmission • Improved paediatric sputum induction at PHC and hospital level	• NDoH • NGOs and CBOs working in this area • DBE • DSD • Private healthcare providers • Health insurance schemes
Sub-objective 2.2.3 Treat successfully at least 90% of those diagnosed with DS TB (and 75% for those with DR TB)	Reduce initial loss to follow-up rates for DS and DR TB cases. ***This will be supported and strengthened by:*** • Changing the Electronic TB Register to track patients progress from the time of diagnosis rather than initiation of treatment to better track early loss to follow up. Strengthen defaulter identification, tracing and recall at facilities • Retrain staff and implement on-going clinical governance using QI approach • Establish initial loss to follow-up rate as a management priority as part of the DIP process • Reduce duration and number of visits from symptom onset to treatment initiation	• NDoH • NHLS • PDoH • Districts • Facilities • Development partners
	Provide standard care for DS-TB cases. ***This will be supported and strengthened by:*** • Provision of adherence support and retention of patients in care for treatment duration including referral for psychosocial support as needed • Bacteriological monitoring of treatment outcomes and implementation of recommendations from reviews • National research priority studies to determine what health facility and programme management interventions impact on treatment outcomes, whether alternative drug dispensing strategies affect adherence and patient outcomes and what clinical management and adherence support strategies improve treatment outcomes? • The multi-sectoral TB Think Tank using the findings to timeously review and update policies	• NDoH • Civil Society (PLHIV, PTB sectors) • NGOs

Goal 2: Reduce morbidity and mortality by providing treatment, care and adherence support to all

	Comprehensive package	Accountable parties
Objective 2.3: Implement the 90-90-90 Strategy for TB		
	Scale up short-course MDR-TB treatment and provide decentralised MDR-TB care. ***This will be supported and strengthened by:*** • Updating MDR-TB policies and guidelines including referral pathways and monitoring and evaluation to track adherence • Training and mentoring of staff on these at PHC level and referral centres • Adaptation of the EDR to accommodate new regimens • Monitoring the initiation rate of patients on the new regimen as part of the DIP process to optimise uptake • Provision of psychosocial support to patients who need it	• NDoH
	Implement a quality improvement (QI) initiative to close gaps in the TB care cascade and improve programme outcomes. ***This will be supported and strengthened by:*** • Development of DoH capacity to undertake QI (national, provincial, district and sub-district teams established; leadership and QI skills developed; tools and guidelines developed; learning networks established) with demonstration sites for QI established • All implementing partners to implement TB QI projects • Then undertake district baseline assessments and set targets for national scale-up based on successful models including nurse initiated care	• NDoH • PDoH • Districts • Support partners
	Review and improve supply chain management. ***This will be supported and strengthened by:*** • Reviewing initial anticipated demand shifts and impact on current contract commitment • Analysing provincial stock situation regularly • Ensuring capacity to distribute stock to provincial depots timeously in response to stock information • Meeting regularly with partners to get feedback and optimise planning	• NDoH • Provincial DoH Pharmacy/depot managers and TB directorates • Civil Society (PLHIV and PTB sectors)
	Continuously train staff and implement on-going clinical governance. ***This will be supported and strengthened by:*** • Converting new guidelines into training materials for all cadres of staff • Conducting training per province and then re-enforcing at the site level • Conducting regular clinical audits including chart reviews to ensure adherence to guidelines	• NDoH • Key stake-holders
Objective 2.3: Improve STI detection, diagnosis and treatment		
Sub-objective 2.3.1 Increase detection and treatment of asymptomatic STIs by 50%	Implement the National STI National Framework guidance on the detection and treatment of asymptomatic STIs. ***This will be supported and strengthened by:*** • Developing, testing and validation of the sexual history tool for different populations and different ages as the basis for screening tests and / or presumptive treatment • Building capacity of health workers on the use of the tool and integrating it into all customised delivery sites. • Improved ACSM in high burden districts through targeted STIs messages. • Using the sexual history tool to screen and treat priority populations (pregnant women, AGYW and SW) for asymptomatic STIs	• NDoH, NICD ,NHLS • Dept. of Transport • Civil Society (key population sectors) • District Management Teams • Private health sector
Sub-objective 2.3.2 Increase the detection and treatment of STIs	Appropriate syndromic management of STIs. ***This will be supported and strengthened by:*** • Ensuring appropriate management of cases non-responsive to the syndromic approach • The use of mobile outreach services for men with extended hours • Implementation of strategies to strengthen partner notification and contact tracing especially for key populations • Training and re-training of HCWs on syndromic management • Quality assurance programmes and advanced level STI management in secondary hospitals and CHCs with the necessary tools and training	• NDoH • District Management Teams • DHET/HEAIDS • Private health sector • DHET, TVET

Goal 2: Reduce morbidity and mortality by providing treatment, care and adherence support to all		
	Comprehensive package	**Accountable parties**
Objective 2.3: Implement the 90-90-90 Strategy for TB		
	Screening of all pregnant women for syphilis at first ANC visit. ***This will be supported and strengthened by:*** • Screening for syphilis at birth for all infants born to syphilis positive women or to women who were unbooked or untested • Linking all children diagnosed with congenital syphilis to care and ensuring they receive treatment • Intensified notification process • Routine congenital syphilis monitoring and tracing and management of confirmed syphilis clients	• NDoH • NICD • NHLS • District Management Teams • Private health sector
	Promote integration of STI prevention care and treatment into HIV, TB, ANC, sexual and reproductive health services. ***This will be supported and strengthened by:*** • Strengthened ART initiation at STIs services or linkage to ARV services	• NDoH • District Management Teams • Private health sector

Table 10: Goal 3: Key and Vulnerable Populations - Goals, Objectives and Activities

GOAL 3: Reach all key and vulnerable populations with customised and targeted interventions			
	Comprehensive approach	**Intensified approach, encompassing comprehensive plus**	**Accountable parties**
Objective 3.1: Increase engagement, collaboration and advocacy of key and vulnerable populations in the development and implementation of social and health support activities			
Sub-objective 3.1.1 All national and provincial AIDS Councils will include at least one representative from a key and vulnerable population group	Inclusion of population representatives in national and provincial AIDS Councils, and other crosscutting working and advocacy groups	Build and sustain capacity for KP and VP representatives to undertake leadership roles	• SANAC Secretariat • AIDS Council Secretariats at all levels • Advocacy groups
Sub-objective 3.1.2 Support key and vulnerable population social capital by encouraging community networks that include advocacy agendas for equal health and human rights	Develop an advocacy strategy to promote human rights for key and vulnerable populations	Provide social marketing support to drive the advocacy agenda	• SANAC Secretariat • AIDS Councils at all levels • Advocacy groups • Sex work sector
Sub-objective 3.1.3 All key and vulnerable population programmes should adopt a peer educator-led approach to implementation	Ensure implementation of a comprehensive peer-led programme	Build the capacity of the peer-led programmes to offer a broad range of services	• NGOs • DoH • CDSD • AIDS Councils • Advocacy groups
Objective 3.2: To provide an enabling environment to increase access to health services by key and vulnerable populations			
Sub-objective 3.2.1 Enable increased access to health services through differentiated service delivery approaches that are tailored for the populations served	• Ensure access to services through public sector, non-traditional and outreach service points • Ensure alternative hours/days of operation of service delivery sites • Ensure access for persons with disabilities	• Implement dedicated mobile service delivery sites in strategic locations (hotspots, workplaces, truck stops, etc.) with services customised to the target populations • Implement dedicated service delivery fixed sites in strategic locations, including mines and correctional services	• DoH at every level • DCS • DBE • Private Sector • Department of Transport • DSD • NGOs • DoH
Sub-objective 3.2.1 Enable increased access to tailored health information and social and behaviour change communication interventions	• These have to address the needs of the population group (including language, accessible formats for visual/auditory/ intellectual impairment) and promote the adoption of protective behaviours and uptake of health services • Content is focussed on needs of key and vulnerable populations	• Include information on where to access what package of services in that district • Customise and contextualise SBCC interventions for the local context and specific key and vulnerable population	• NGOs • SANAC Secretariat • DoH at every level • DBE • Advocacy groups • DSD • DOT

GOAL 3: Reach all key and vulnerable populations with customised and targeted interventions			
	Comprehensive approach	**Intensified approach, encompassing comprehensive plus**	**Accountable parties**
Sub-objective 3.2.3 Expand the provision of rehabilitation, comprehensive psychosocial support and mental health services for people living with and affected by HIV and TB	• Provide comprehensive psychosocial services in health facilities, communities, schools and institutions of higher learning • Strengthened and scaled-up access to a comprehensive range of rehabilitation services • Strengthened and scaled-up access to a comprehensive range of in- and out-patient mental health services	• Expand access to services through traditional and non-traditional service points	• DoH • NGOs • DSD
Sub-objective 3.2.4 Further train and sensitise healthcare professionals in the identification and delivery of appropriate services for key and vulnerable populations	• Develop comprehensive screening tools for specific health challenges, including violence, gender-based violence (GB), alcohol and drug use, mental health, disabilities that require rehabilitation, and psychosocial support • Identify referral protocols • Improve implementation of occupational health and infection control measures	• Institute robust staff support systems, including supervision, mentoring, support, skills review and refresher training to promote staff skills	• NGOs • DoH at every level • DSD • DOT
Sub-objective 3.2.5 Integrate rights-based components in all health and social programmes to holistically serve KP and VP clients and patients	• Strengthen Batho Pele principles across all service delivery points • Programmes to include: o Economic empowerment – advocate for access to economic opportunities for AGYW, people with disabilities o Justice for persons facing stigma, discrimination, legal injustices; and expand and strengthen access to legal support, including legal literacy and access to legal aid o Principles of universal design and accommodation that enable reasonable access of persons with disabilities o Specific programmes for people with disabilities to inform them of the intersection of disability and HIV, and of their health rights	• This is supplemented by interventions described in Goals 4 and 5	• NGOs • DoH • DSD • DBE • DCS • Advocacy groups

Table 11: Goal 3: Key and vulnerable populations: specific comprehensive prevention services and interventions

Goal 3: Reach all key and vulnerable populations with customised and targeted interventions	
Inclusive package of services for all key and vulnerable populations that will be customised to age and population served	
Services	**Accountable parties**
• Service delivery in non-traditional settings, including after-hours and weekends • Health information customised to client needs • Sexual and reproductive health services • HIV screening, testing and treatment • STI screening, treatment • TB screening, treatment (including preventive therapy) and contact tracing for DS- and DR-TB • Mental health screening and psychosocial support • Access to PEP and post-sexual assault support • Alcohol and drug use screening and referral to harm reduction services • Violence screening and referral to psychosocial and other support services • Condom and lubricant promotion and provision • Targeted social and behaviour change communication	• NGOs • DoH • DSD • DBE • NPA • SANAC Secretariat • SAPS • DOT

Goal 3: Reach all key and vulnerable populations with customised and targeted interventions

Services		Accountable parties
• Core rights-based programme components: o Human rights and constitutional protection o Health empowerment o Economic empowerment o Gender norms and equality o Justice o Principles of universal design and accommodation that enables reasonable access for persons with disabilities		
Population-specific additions to the inclusive package of services described above		
HIV key populations		
Inmates (also a key population for TB)	• Lubricant, condom options • PrEP • PEP • Integrated HIV,TB and STI prevention and treatment services • Entry, exit and biannual TB screening and regular offer of HIV testing • Detention and home contact-tracing for persons diagnosed or exposed to TB • Support groups for inmates living with HIV and TB • Peer education and support for HIV and TB programmes	• DoH • DCS
Men who have sex with men	• Peer-led outreach • PrEP • Lubricant, condom options • Hepatitis B screening and immunisation • Rectal care and treatment	• DoH • DSD • NGOs • SANAC Secretariat
People who use drugs, including people who inject drugs	• Harm reduction counselling • Linkage to rehabilitation centres • Case management to ensure a continuum of care • Needle and syringe programmes • Opioid Substitution Therapy • Accelerated nutritional and social grant support, if indicated • Hepatitis B screening and immunisation • Hepatitis C screening and treatment when policy is developed	• DoH • NGOs • DSD • SANAC Secretariat
Sex workers	• Peer-led outreach • PrEP • Female and male condoms and lubricant • Intensified psychosocial support • Periodic presumptive treatment for STIs • Social mobilisation, use of formal/informal peer networks to create demand • PMTCT • Hepatitis B screening and immunisation • Annual Pap smears • CTOP (Choice of Termination of Pregnancy) • Screening for and protection from the sexual exploitation of children • Community empowerment	• DoH • DSD • SANAC Secretariat • NGOs

Goal 3: Reach all key and vulnerable populations with customised and targeted interventions

Services		Accountable parties
Transgender persons	• Peer-led outreach • Specialised counselling support • PrEP • Female condoms and lubricant • Rectal care and treatment	• DoH • DSD • NGOs • SANAC Secretariat
TB key populations		
Children <5 years	• Household TB and HIV screening, immediate linkage to treatment • Improved diagnostic and treatment capacity for paediatric TB • Promote activism for child-friendly TB formulations and introduce as soon as they are available • Improve sputum induction at PHC and hospital level • Screening for and protection from the sexual exploitation of children	• DoH • NGOs • Civil Society • Medical/Nursing training • DSD
Healthcare workers	• Finalise and implement guidelines for TB in HCWs • Institute regular TB screening and offer HIV testing for all HCWs • Offer TB preventive therapy to all HCWs who are living with HIV • Develop a recording and reporting system for TB and DR-TB in HCWs • Appoint a DoH-led task force to monitor implementation and further elucidate the effort–effect ratio of screening all HCWs annually with symptom screening and CXR, and to investigate the role of preventive therapy for HCWs • Implement the FAST model in facilities (finding cases actively by cough surveillance and rapid molecular sputum testing, separating safely, and treating effectively, based on rapid drug susceptibility testing)	• DoH • NDoH
Household contacts of TB index patients	• Develop simplified screening algorithms for TB-exposed children • Implement community education and mobilisation programmes to improve acceptance of contact investigations and to create awareness of the benefits of preventive therapy • Strengthen routine M&E for TB contact investigations, HIV testing, TB preventive therapy including outcomes, and pharmacovigilance	• DoH • NGOs
Miners (also a vulnerable population for HIV and STIs) and peri-mining communities	• Peer education and support for TB programme • Specialised health education on risk of and vulnerability to TB, particularly regarding work and close-contact living conditions • Routine TB screening and treatment with intensified contact-tracing at home, at the workplace and at workplace accommodation. • Silica-exposed mine workers to receive TB preventive treatment per guidelines and screening which includes CXR • Improve linkage and access to cross-border care • Workplace HIV, TB and STI treatment services and the monitoring of these services for coverage, comprehensiveness and quality • Intensified psychosocial support	• DoH • Private sector • Chamber of Mines • NGOs • Mining houses • Multilateral agencies • DME

Goal 3: Reach all key and vulnerable populations with customised and targeted interventions

Services		Accountable parties
	• Education regarding annual benefit examinations and compensation for Occupational Lung Disease during life and post-mortem • Expand the focus on provision of services to miners who are not covered by wellness programmes • Expand the prevention, screening, diagnosis and linkage to care for HIV, TB and STIs in peri-mining communities • Improve the implementation of a holistic response to TB as set out in the 'TB in the mines' programmes being implemented across 10 countries in Southern Africa	
People living in informal settlements (also a vulnerable population for HIV and STIs)	• Facilitate access and demand creation to increase community HIV, TB and STI service provision • Intensify GBV programmes and screening • Accelerate social support • Community education • Provide mobile services to improve accessibility • Infection control strategy for TB	• DoH • DSD • NGOs
People living with HIV	• Prompt ART initiation as a component of TB prevention • Adherence and psychosocial support • Peer education and support for TB prevention and treatment • Optimal uptake of preventive therapy for TB • Infection control in facilities, communities and households • TB symptom screening at each visit, linkages to treatment and care • HIV screening for household members, including partners and children • Cohort monitoring of HIV/TB co-infected patients • Support groups specifically addressing internalised stigma	• DoH • SANAC Secretariat
Pregnant women and neonates	• Full access to PMTCT services • Household TB and HIV screening, immediate linkage to treatment • Improve mother–child pair tracing and service delivery • Improve TB screening and testing among pregnant women to reduce congenital and perinatal TB transmission • Improve diagnostic and treatment capacity for neonatal TB	• DoH • NGOs • Research institutions • DSD
HIV and STI vulnerable populations		
Adolescent girls and young women	• Peer-led outreach • Youth-friendly sexual and reproductive health services in schools and community settings which include: o PrEP (for over 18 years olds) o Complete two dose HPV vaccine (Grade 4 learners) o PMTCT o Choice of termination of pregnancy o Family planning services o Male and female condom provision in school o Sanitary towels	• DBE • DHET • DoH • DSD • NGOs • DoL • Private sector

Goal 3: Reach all key and vulnerable populations with customised and targeted interventions

Services		Accountable parties
	• Programmes to keep girls in schools, including support for pregnant learners • Access to peer groups and clubs • Access to parenting programmes • Economic empowerment programmes • Increased access to further education opportunities • Increased access to mentorship and internships • Comprehensive sexuality and gender education • Provide reasonable accessibility for girls and young women with disabilities • Age-specific support to HIV-positive adolescents (support for disclosure, adherence)	
Children and orphans and vulnerable children	• Health education, with a particular focus on sexual exploitation in the absence of primary caregivers • Accelerated nutritional and social grant support • Youth-friendly sexual and reproductive health services in schools and community settings which include: o HPV vaccination o Contraceptives including condoms o Choice of termination of pregnancy • Comprehensive sexuality education in residential, school and non-school and youth-friendly settings • Intensive psychosocial support • Gender norms education, including risk reduction in relation to age-disparate relationships • School retention	• DSD • DBE • DoH
Mobile populations, migrants and other undocumented foreigners	• Mobile populations include those involved in big infrastructure and construction projects, agriculture, all four modes of transport, road, rail, civil aviation and maritime e.g. truck drivers, sea farers, long distance taxi drivers, pilots and cabin attendants • Provision of health services along the transport corridors • Flexible service delivery options including provision of condoms, HTS, provision of ART refills and TB treatment • Focused prevention messages and SBCC that addresses their specific challenges e.g. GBV, drug and alcohol use • Intensified psychosocial support • Cross border collaboration on HIV, TB and STI policy and programming • Utilise informal networks to raise awareness about services • Accelerated access to official papers to access services • Places of safety • Implementation of social impact plans that mitigate the impact of HIV,TB and STIs, for organisations involved in big infrastructure and construction projects e.g building power stations, major roads	• SADC • DIRCO • Multilaterals • NGOs • DSD • SAPS • DHA • DOA • DOT • DoH
Other lesbian, gay, bisexual, transgender and intersex (LGBTI) populations	• Peer-led outreach • Empowerment programmes including skills-building, ABET, and facilitation of post-school training and employment • Enhanced programmes for legal and counselling support	• NGOs • DHET • DSD • DoJ • NPA • Private sector

Goal 3: Reach all key and vulnerable populations with customised and targeted interventions		
Services		**Accountable parties**
People with disabilities	• Peer-led or peer-supported outreach • Specialised health education regarding risk and vulnerability to HIV, TB and STIs , particularly regarding sexual exploitation • Accelerated nutritional and social grant support • Comprehensive sexuality education accessible to learners with disabilities • Intensive psychosocial support • Intensified TB screening, treatment and care due to increased exposure typically caused by confined living conditions • All people with disabilities have ready access to prevention services • Move to mainstreaming of the policy that 7% of all programmes target people with disabilities • PrEP available • Ensure universal accommodation of people with disabilities	• NGOs • DoH • DSD • DoH, DBE • DSD • DoH

Table 12: Goal 4: Social and Structural drivers - Goals, Objectives and Activities

Goal 4: Address the social and structural drivers of HIV, TB and STI infections and linking them to NDP goals				
	Interventions	**Approaches**	**Populations**	**Accountable parties**
Objective 4.1: Implement social and behaviour change programmes to address key drivers of the epidemic and build social cohesion				
Sub-objective 4.1.1 Reduce risky behaviour through the implementation of programmes that build resilience of individuals, parents and families	• Prevention and early intervention programmes, e.g. Buddy systems, Zazi, Masidlale programmes, Positive parenting • Quality early childhood development programmes	• Develop integrated service delivery models across the social cluster in high-burden districts • Establish community-based parent support programmes • Strengthen holistic programmes for OVC, teenage mothers, street children • Build capacity of CBOs to provide appropriate support • Review and strengthen DSD, NPO and CBO interventions	• Children and OVC • Parents and families of vulnerable children • Out-of-school youth, • AGYW 15–24 • Boys and men • Adolescents living with adults with HIV/TB • Older persons • People with disabilities • People who abuse alcohol and substances	• DSD • NDoH • DBE • Civil Society including NGOs and CBOs
Sub-objective 4.1.2 Comprehensive age-specific and appropriate support for learners and out-of-school youth	• Implement the new DBE policy on HIV and TB in secondary schools and higher education institutions (HEIs) • Strengthen the Integrated School Health Programme • Implement DBE policy for pregnant learners	• Train educators on use of HIV, TB and STI-related materials • Provide ongoing support in communities • Support and education materials for PWDs • Strengthen collaboration between DSD/DBE/DoH to ensure continuum of care for teenage mothers and their families	• Learners and students and out-of-education youth • Learners with disabilities • HIV-positive adolescents, children and OVC • TVETs, colleges, universities	• DBE • DSD • DHET/HEAIDS • DoH • Civil Society including NGOs and CBOs
Sub-objective 4.1.3 Strengthen the capacity of families and communities	• Comprehensive support for families affected by HIV/TB • Provision of support for parents and carers of people with disabilities • Community capacity-enhancement and dialogue programmes	• Strengthen capacity for profiling households • Mobilisation, advocacy, capacity building and monitoring • Develop context-specific programmes in language appropriate for communities	• Families, primary caregivers with pre- adolescents • Families and communities affected by HIV and TB	• DSD • NDoH • DBE • Faith-based sector • CBOs

Goal 4: Address the social and structural drivers of HIV, TB and STIs, and link these efforts to the NDP

	Interventions	Approaches	Populations	Accountable parties
Objective 4.2: Increase access to and provision of services for all survivors of sexual and gender-based violence in the 27 priority districts by 2022				
Sub-objective 4.2.1 Increase access to provision of services for all survivors of sexual and gender-based violence	• Expand access to appropriate services • Finalise and implement National Gender-based Violence Plan • Develop SGBV policy for HEIs, TVETs and colleges, implement SGBV peer education clubs	• Link existing Thuthuzela Centres to non-traditional, well-resourced CBOs • Design software programmes for tracking survivors to enable support • Provide access to counselling and psychosocial support for survivors	• General population • Students • AGYW in informal settlements • Rural communities	• DoW • DSD • DoH • Justice, Police • DHET/HEAIDS • Civil Society sectors
	• Strengthened child protection systems and provide comprehensive responses to victims	• Implement child-specific national plan including parenting support and home, health and school-based care and support	• Children and OVC	• DSD • DBE • DoH • Justice, Police • Civil Society
	• Maintain the 24-hour GBV Command Centre	• Expand telephonic counselling services that are free to the user	• Adults • Women • Children • Persons with disabilities • Older persons • LGBTI community • People with albinism	• DSD • NGOs • DOT
	• Scaled-up implementation of the victim empowerment programme	• Advocacy strategies to promote the programme • IEC to promote the programme • Link programme to HIV/TB/STI prevention programmes	• General community	• DSD
Sub-objective 4.2.2 Provide support for survivors of sexual assault	• Strengthened and scaled-up provision of services through Thuthuzela Centres and health facilities	• Ensure access to comprehensive package for survivors of sexual assault that includes case management and linkage to care • Ensure access to ongoing psychosocial support programmes especially for children who may present much later • Ensure that all services are accessible to all, including people with disabilities	• Survivors of sexual and gender based violence • Child abuse victims	• DSD • DoH • Justice • NPA • Civil Society groups • KP sectors • SAPS • FCS • DOT
	• Strengthened and scaled-up community based one-stop Khuseleka Centres	• Integrate community support programmes in one-stop centres	• Survivors of crime and violence • Victims of child abuse	• DSD • SAPS • DoH • Justice
	• Strengthened and scaled-up community-based 'white-door' shelters	• Provide short-term (72-hour) places of safety and shelter within communities and referral/integration with HIV/TB/STI services	• Survivors of gender-based violence • Victims of child abuse	• DSD • SAPS • DoH • Justice
Objective 4.3: Scale up access to social protection for people at risk of and those living with HIV and TB in priority districts				
Sub-objective 4.3.1 Ensure that all HIV- and TB-infected persons who are eligible have access to social grants	• Identify and speedily allocate social grants to all who are eligible	• Link PLHIV, TB clients to social security programmes for access to social relief distress grants	• PLHIV • PTB	• DSD • Civil Society including NGOs

Goal 4: Address the social and structural drivers of HIV, TB and STIs, and link these efforts to the NDP

	Interventions	Approaches	Populations	Accountable parties
Sub-objective 4.3.2 Scale up access to food security and nutritional support	• Scaled-up provision of food parcels, and nutritional supplementation to all eligible PLHIV and PTB	• Strengthen capacity of HIV/TB providers to screen for food insecurity • Ensure access to sufficient food in particular for PLHIV and PTB • Expand drop-in centres especially in high-burden districts • Expand access through Isibindi model	• People at risk and those living with HIV and TB • OVC • People with DR-TB	• DSD • NGOs • SANAC sectors
Objective 4.4: Implement and scale up a package of harm reduction interventions for harmful use of alcohol and drugs in all districts				
Sub-objective 4.4.1 Scale up access and provision of in- and out-patient rehabilitation services for all who use alcohol and drugs	• Expand inpatient and outpatient rehabilitation facilities	• Develop adolescent-friendly practices • Sensitise and capacitate HCWs to screen for and refer and provide interim support for people with harmful use of alcohol and drugs • Expand availability of inpatient rehabilitation facilities	• People who use alcohol or drugs • Healthcare workers, especially community-based HCWs	• DSD • DoH • DBE • NGOs
	• Implementation of harm reduction services to identify and support people with harmful use of substances and alcohol	• The Drug Master Plan harm reduction interventions including the provision of Opioid Substitution Therapy • Needle and syringe exchange programmes by NGOs • Identify for referral to in- and out-patient rehabilitation services	• People with harmful use of substances and alcohol	• DSD • DoH • NGOs • DBE • DHET
	• Community awareness and advocacy programmes	• Implement programmes to increase awareness of services	• Primary: children and youth in and out of school • Secondary: caregivers and parents	• DSD • Civil Society including NGOs
Objective 4.5: Implement economic strengthening programmes with a focus on youth in priority focus districts				
Sub-objective 4.5.1 Economically empower targeted groups of young people by increasing the availability of economic opportunities	• Combination socio-economic programmes	• Strengthen economic capacities through support to access further education, training, job placements and entrepreneurial activities, including for PWDs	• Out of school and further education and job placement • Youth, especially 15–18-year-old OVC who are recipients of the Child Support Grant	• DSD • DPSA • Private sector • DHET • Civil Society including NGOs
	• Training for adolescent girls and young women	• Empower young women, such as through SABCOHA's BizAIDS programme, to start and improve their own businesses • Encourage companies to support the programme through co-funding and job opportunities	• Adolescent girls and young women out of school	• SABCOHA and other private sector • Organised labour • DOT
Objective 4.6: Address the physical building structural impediments for optimal prevention and treatment of HIV, TB and STIs				
Sub-objective 4.6.1 Improve ventilation and indoor air quality in congregate settings	• Adequate ventilation and indoor air quality in congregate settings, including schools, education institutions, public transport and correctional settings to minimise transmission of TB	• Establish a multi-stakeholder task team to review relevant legislation and norms and standards • Support implementation of environmental controls in	• All stakeholders	• DoH • Environmental Health • DHS • Transport (public, private) • DPW

Goal 4: Address the social and structural drivers of HIV, TB and STIs, and link these efforts to the NDP				
	Interventions	**Approaches**	**Populations**	**Accountable parties**
Objective 4.6: Address the physical building structural impediments for optimal prevention and treatment of HIV, TB and STIs				
		facilities, including ultraviolet, germicidal disinfection and appropriate ventilation		• DST • CSIR • Built Environment professional associations • COGTA, municipalities • Eskom
Sub-objective 4.6.2 Develop an advocacy campaign for health promotion specific to TB control	• Awareness and education to promote behaviour change	• Implement target-specific advocacy programme	• All stakeholders	• DoH • SALGA • COGTA • PCAs
Sub-objective 4.6.3 Improve structural accommodations for people with disabilities	•Appropriate access for people with disabilities including those developed due to HIV and/or TB or side effects of treatment	• Develop and implement a funded plan of action to address shortcomings in living and working spaces including schools, further education institutions and public transport	• PWD including HIV- and TB-affected people with disabilities	• DoH • SANAC Secretariat • Environmental Health • DHS • Transport (public and private sector) • DPW • CSIR • Built environment professional associations • COGTA • Eskom • Municipalities

Table 13: Goal 5: Human Rights - Goals, Objectives and Activities

Goal 5: Ground the response to HIV, TB and STIs in human rights principles and approaches				
	Interventions	**Approaches**	**Populations**	**Lead agencies**
Objective 5.1: Reduce stigma and discrimination among people living with HIV or TB by half by 2022				
Sub-objective 5.1.1 Revitalise community-based support groups to deal with internalised stigma	Revitalise community-based support groups and explore merging support groups across health challenges, e.g. TB and HIV group	• Develop and implement plans for revitalisation of community-based support groups • Train peer outreach workers on stigma and discrimination	• PLHIV • People living with TB • All key and vulnerable populations	• Civil Society sectors (PLHIV, PTB or aftected by TB, KVP) • SANAC Secretariat • DSD • DoH
Sub-objective 5.1.2 Reduce stigma through community education	Develop community-centred social mobilisation strategy with a specific focus on stigma	• Community dialogues on stigma and discrimination • Integrate stigma into all programmes for key and vulnerable populations	• Society and PLHIV • PTB • Key and vulnerable populations	• HSRC and other researchers • SANAC Secretariat • Civil Society sectors, especially key and vulnerable populations, human and legal rights
Objective 5.2: Facilitate access to justice and redress for people living with and vulnerable to HIV and TB				
Sub-objective 5.2.1 Improve legal literacy about human rights and laws relevant to HIV and TB	• Awareness-raising campaigns • Community mobilisation and education on these rights and laws • Training of peer outreach workers	• Implement media awareness campaigns on rights and laws related to HIV and TB • Incorporate human rights in all programmes for KPs, VPs • Train outreach workers on human rights and legal literacy	• PLHIV • PTB • People vulnerable to HIV and TB • KPs • VPs	• Civil Society (PLHIV, legal and human rights sectors and all other sectors) • DOJ • DSD • DoH

Goal 5: Ground the response to HIV, TB and STIs in human rights principles and approaches

	Interventions	Approaches	Populations	Lead agencies
Objective 5.2: Facilitate access to justice and redress for people living with and vulnerable to HIV and TB				
Sub-objective 5.2.2 Make HIV- and TB-related legal services available and accessible	Access to legal services	• Build capacity of NGOs and CBOs to provide information and referrals • Expand access to affordable legal advice • Increase support to Legal Aid to expand access to services to those who cannot afford them	• PLHIV • PTB • People vulnerable to HIV and TB • KPs • VPs	• Civil Society (PLHIV, communities, traditional leaders, legal and human rights sectors, and all other sectors) • DoJ • NPA
	Access to appropriate information on legal service	• Collaborate with institutions who provide information on legal services • Implement telephone hotlines		• DoJ, SACHR, CGE, Legal Aid South Africa
Objective 5.3: Promote an environment that enables and protects human and legal rights and prevents stigma and discrimination				
Sub-objective 5.3.1 Implement a Human Rights Accountability Scorecard	Human Rights Accountability Scorecard to promote protection of human rights	• Strengthen the human and legal rights sector of SANAC • Develop an accountability charter and framework • Develop the accountability scorecard and implement annually	• PLHIV • PLTB • Key and vulnerable populations • People vulnerable to HIV and TB	• Civil Society (PLHIV, legal and human rights sectors, key and vulnerable populations and all other sectors) • DoJ
Sub-objective 5.3.2 Monitor implementation of laws, regulations and policies relating to HIV and TB and identify areas for reform	Policy reform and implementation	• Promote enactment and implementation of laws, regulations and guidelines that prohibit discrimination and support access to HIV and TB prevention, treatment, care and support • Audit laws and law enforcement practices to assess impact on the response to HIV and TB • Advocate for policy reform when gaps are identified	• PLHIV • PLTB • People vulnerable to HIV and TB • KPs • VPs	• Civil Society (PLHIV, legal and human rights sectors and all other sectors) • DoJ • NPA
Sub-objective 5.3.3 Sensitise law-makers and law enforcement agents	• Sensitisation of decision-makers and agents • Engage leaders across all sectors on human rights and stigma in the context of HIV and TB	• Advocate for high-level dialogues for leaders • Identify and support role models to drive advocacy programmes • Promote dialogue and debates on HIV and the law with the judiciary • With the collaboration of parliamentarians and all organs of the State, a comprehensive campaign to promote respect for the rights of the most vulnerable, especially people with HIV and TB and KPs and VPs • Build the capacity of employees in the public sector on human rights and provision of services, e.g. police and correctional services	• PLHIV • PTB • People vulnerable to HIV and TB • KPs • VPs	• SABCOHA • Labour unions • Government departments including: DoH, DSD, DCS, SAPS, DoJ, NPA • Civil Society sectors (Faith-based, PLHIV, PLTB, traditional healers and leaders, health professions, legal and human rights) • Lawyers' associations
Objective 5.3: Promote an environment that enables and protects human and legal rights and prevents stigma and discrimination				
Sub-objective 5.3.4 Train healthcare providers on human rights and medical ethics related to HIV	Build capacity of public sector on human rights and provision of services	• Advocate for the inclusion of human rights and ethics in all training programmes for the public sector • Specific programmes for SAPS on human rights providers	• PLHIV • PTB • People vulnerable to HIV and TB	• DoH • DHET/HEAIDS • DBE • Civil Society (legal and human rights sector, health professions sector)

Table 14: Goal 6: Leadership and accountability - Goals, Objectives and Activities

Goal 6: Promote leadership and shared accountability for a sustainable response to HIV, TB and STIs			
	Interventions	**Approaches**	**Lead agencies**
Objective 6.1: Strengthen AIDS Councils to provide effective co-ordination and leadership of all stakeholders for shared accountability in the implementation of the NSP			
Sub-objective 6.1.1 Formally establish the structures of AIDS Councils at national, provincial, district and local level	Functioning AIDS Councils at national level, provincial, district and local levels with agreed operational guidelines to govern implementation and co-ordination	• Review membership of SANAC and other Council structures in line with NSP • Develop a clear funded plan to strengthen the SANAC Secretariat and the sectors of the SANAC Civil Society Forum • Ensure that AIDS Council structures are adequately resourced and capacitated • Develop Provincial and District Implementation Plans • Establish the Provincial Councils on AIDS in the Premier's office and local Councils in the Mayor's office	• SANAC Plenary • SANAC Trust Board • Provincial Executive Committees • Mayoral Committees • SALGA • COGTA • SANAC Secretariat
Sub-objective 6.1.2 Ensure representation of all stakeholders in decision-making structures at all levels	Broadly representative AIDS Councils	Ensure representation of all stakeholders in national, provincial, district and local AIDS Councils	• SANAC Secretariat • PCA Secretariat
	Participation of private sector in all AIDS Councils	SABCOHA to co-ordinate private sector and the engagement and participation of all business co-ordinating structures in all AIDS Councils	• SANAC Secretariat • PCA Secretariat • SABCOHA • Co-ordinating structures for the private sector, e.g. Chamber of Mines, Black Business Council
Sub-objective 6.1.3 Strengthen the role of the private sector and labour in AIDS Councils	SABCOHA-led Private Sector Engagement Strategy	• Implement the Private Sector Engagement Strategy	• SANAC Secretariat • PCA Secretariat • SABCOHA
Sub-objective 6.1.4 Ensure a central role for Civil Society and community groups	• Sustainable funding for high-quality civil society and community services towards meeting the NSP targets • Framework to monitor and evaluate the contribution of community-based organisations	• Develop a clear framework for civil society and community responses and how this will be evaluated • Enable NGOs to enter into multi-year service-level agreements to reach priority populations	• SANAC Secretariat • NDoH • Treasury • Civil Society Forum • DSD • DBE
	• Involvement and leadership by key and vulnerable populations in the response	• Leadership roles in programmes and at focal points of delivery	• PCAs • COGTA • DoH • DSD • DBE • Police services • Civil Society Forum
Sub-objective 6.1.5 Monitor annually the implementation of the accountability framework through an Accountability Scorecard	• Accountability Framework	• Develop and implement an accountability framework, with a scorecard, to track performance	• Plenary • PECs • SANAC Secretariat

Goal 6: Promote leadership and shared accountability for a sustainable response to HIV, TB and STIs			
	Interventions	**Approaches**	**Lead agencies**
Objective 6.2: Improve collaboration and co-operation between government, civil society, development partners and the private sector			
Sub-objective 6.2.1 Ensure that the plans of government and the non-government sector are aligned with the NSP	Fully NSP-aligned departmental Annual Performance Plans	• Departmental plans aligned with mandate • Encourage joint planning and monitoring in high-burden districts	• DPME • PECs
	Sectoral implementation plans aligned with NSP and PIPs	• Civil society, private and development partner sectors to develop an NSP-/PIP-aligned implementation plan	• SANAC Secretariat • PCA Secretariat
Sub-objective 6.2.2 Strengthen collaboration between and co-ordination of government departments	Ensure adherence to Inter-Governmental Relations Framework	• Ensure ongoing alignment of NSP with MTSF • Ensure full participation of relevant departments in provincial and district AIDS Councils	• DPME • IMC • DPSA
Sub-objective 6.2.3 Establish/strengthen regional collaboration	Adherence to regional protocols (SADC and ESA)	• Ensure timely submission of data for international reporting obligations	• DPSA • DPME • DIRCO • SADC

Table 15: Goal 7: Resources - Goals, Objective and Activities

Goal 7: Mobilise resources and maximise efficiencies to support the achievement of NSP Goals and ensure a sustainable response				
	Interventions	**Approaches**	**Populations**	**Lead agencies**
Objective 7.1: Improve efficiency and mobilise sufficient resources to achieve the goals, objective and targets of the NSP				
Sub-Objective 7.1.1 Maximise the funds available for implementation of the NSP and the impact of these funds	• Cost NSP implementation plans	• Accurately cost all implementation plans to support budgeting and resource mobilisation efforts	• All stakeholders	• SANAC structures • Government departments • SABCOHA • PCAs
	• Innovative funding mechanisms	• Design, implement and evaluate new and innovative funding mechanisms. • Prioritise mobilisation of previously untapped sources of funding (such as private investors) and co-investment in shared outcomes (development synergies). • Leverage new funding to enhance efficiency and impact		• SANAC Secretariat • National Treasury • Provincial Treasuries • Municipalities
	• Technical efficiencies to generate cost savings	• Achieve higher technical efficiencies in service delivery and health and other systems	All stakeholders	• SANAC structures • All government departments
	• Location targeting	• Improve the precision of spatial targets for investments		• SANAC structures • All government departments

Table 16: Goal 8: Strategic Information - Goals, Objectives and Activities

Goal 8: Strengthen strategic information to drive progress towards achievement of NSP Goals		
	Key Activities	**Accountable parties**
Objective 8.1: Optimise routinely collected strategic health information for data utilisation in decision making		
Sub-Objective 8.1.1 Implement master patient index for use in all service delivery settings	• Scale up implementation of the master patient index as part of the Health Patient Registration System • Undertake public awareness campaign on use of the master patient index and data confidentiality	• DoH • NHLS • Private sector providers • Implementing partners
Sub-Objective 8.1.2 Link clinical, laboratory and pharmacy data	• Audit existing systems for compliance to the National Health Normative Standards Framework (HNSF) for interoperability in eHealth, the Protection of Personal Information Act and other legal prescripts • Develop inter-operability framework and implement software changes to enable system linkages • Include the linkage of the DHIS, ETR, EDR, Tier.net, NHLS CDW systems	• DoH • NHLS
Sub-Objective 8.1.3 Establish health information (HIE) exchanges for real-time data availability	• Establish HIE infrastructure in provinces • Develop dashboards and reporting systems at each level of the health system (from facility to national), including for TB and HIV care cascades • Generate routine exception reports for action on patients not receiving appropriate services	• DOH
Sub-Objective 8.1.4 Increase data utilisation	• Develop computer and data analysis skills at all levels of the health and social systems • Develop data science capacity in National and Provincial DoH and DSD and also in DBE • Provide automated quarterly facility cascade reports to District Implementation Teams • Produce national/provincial annual reports	• All government departments • NHLS
Objective 8.2: Rigorously monitor and evaluate implementation and outcomes of the NSP		
Sub-Objective 8.2.1 Strengthen and promote multi-sectoral ownership and accountability of the NSP and PIP M&E systems	• Coordinate use of a core set of multi-sectoral indicators for the M&E Framework • Establish National and provincial multi-sectoral M&E Technical Task Teams to coordinate the M&E plan • Develop a well-defined and managed national Enterprise Information System (EIS) for the NSP	• SANAC • PCAs • All government depts • Implementing partners
Sub-Objective 8.2.2 Strengthen M&E capacity to effectively use available data to monitor NSP and PIP performance and HIV, TB and STI at all levels	• Conduct M&E capacity assessments at national, provincial and district levels • Strengthen skilled M&E human resources through training and coaching • Reinforce data use to monitor programme performance	• SANAC • PCAs • DoH, Provinces • SAMRC • HSRC • Implementing partners
Sub-Objective 8.2.3 Ensure harmonised, timely and comprehensive routine systems to provide quality health data at national, provincial and district levels and across sectors	• Determine baseline values of key NSP indicators at national, provincial and district levels • Institutionalise routine M&E supervision and data quality audits • Link EIS to social sector information systems • Promote use of strategic information to inform policy and programming	• SANAC • PCAs • All government depts • CSIR • Implementing partners
Sub-Objective 8.2.4 Disseminate timely, relevant HIV, TB and STI information to the public	• Ensure timely dissemination of accurate progress reports • Key populations to lead on their specific reports	• SANAC • PCAs • All government depts • Municipalities
Sub-Objective 8.2.5 Generate and disseminate NSP Monitoring and Evaluation Reports	• Timely review of PIP and NSP implementation for multi-sectoral stakeholder review • Revision of strategy as required	• SANAC Secretariat • National government • Provincial, Local, District governments • Development partners

Goal 8: Strengthen strategic information to drive progress towards achievement of NSP Goals

	Key Activities	Accountable parties
Objective 8.3: Further develop the national surveillance system to generate periodic estimates of HIV, TB and STI in the general population and in key and vulnerable populations		
Sub-Objective 8.3.1 Institutionalise HIV, TB and STI surveillance within the Department of Health	• Strengthen capacity for surveillance • Conduct periodic reviews of surveillance activities to identify and fill gaps • Reinforce co-ordination of surveillance with research institutions and other stakeholders • Synthesise data from multiple surveillance sources	• DoH • NHLS/NAPHISA • SAMRC, HSRC • SANAC Secretariat • Development partners
Sub-Objective 8.3.2 Conduct routine HIV, TB and STI surveillance activities	• Prioritise the HIV, TB and STI surveillance activities specified in Table 15 • Determine the surveys on health and social systems quality to undertake regularly to inform policy and practice	• DoH • Others in 8.3.1
Sub-Objective 8.3.3 Conduct routine HIV, TB and STI surveillance activities among key and vulnerable populations	• Conduct Integrated bio-behavioural surveillance and population size estimation, with separate studies for SWs, MSM, PWID, transgender and other vulnerable populations • Conduct key population HIV sentinel surveillance and behavioural assessment (HSS+)	• DoH • Others in 8.3.1
Sub-Objective 8.3.5 Implement facility- and laboratory-based surveillance	• Prioritise the sentinel surveillance activities in Table 15	• DoH • SAMRC • NHLS/NAPISA • Development partners
Sub-Objective 8.3.6 Implement non-routine surveillance activities and surveys	• Special surveys and non-routine sentinel surveillance activities • Demographic surveillance systems in priority geographic areas • Patient care and patient satisfaction surveys	• DoH • Others in 8.3.1
Objective 8.4: SStrengthen strategic research activities to create validated evidence for innovation, improved efficiency and enhanced impact		
Sub-Objective 8.4.1 Develop a coordinated research agenda for the NSP	• Survey existing research projects and then identify and prioritise research gaps and plan how to fill them • Strengthen local research capacity and further enable the environment to conduct research in South Africa • Share research evidence and emerging best practice to strengthen policy and practice	• DoH • DST • DSD • DBE • SANAC Research TWG • SAMRC • SHIP • HSRC • Development partners

Annexure B: Monitoring and Evaluation Framework - Core Indicators

GOAL 1: ACCELERATE PREVENTION TO REDUCE NEW HIV AND TB INFECTIONS AND STIS										
	INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET		REPORTING FREQUENCY	RESPONSIBLE
							FY 2018/19	*FY2021/22*		
Objective 1.1 Reduce new HIV infections to less than 100,000 by 2022 through combination prevention interventions										
1.	Number of new HIV infections	Impact	Modelled	Geographic area Sex, Age (15 – 24, 25 – 49 years)	Thembisa Model	Total: 267,000 Adults (25-49): 120 000 Adult women: 62 000 Adult men: 58 000 Young people (15-24): 107 000 Young women: 80 000 Young men: 27 000 (Thembisa model, 2016)	66% reduction from baseline Total: 176 220 Adults (25 – 49): 79 000 Adult women: 41 000 Adult Men: 38 000 Young People (15 -24): 71 000 Young women: 53 000 Young men: 18 000	50% reduction from baseline Total: <100,000 Adults (25 – 49): 43 000 Adult women: 22 000 Adult Men: 21 000 Young People (15 -24): 40 000 Young women: 30 000 Young men: 10 000	Annual	SANAC PCA
2.	Mother-to-Child transmission rate at 10 weeks	Impact	**Numerator:** Infant PCR test positive around 10 weeks **Denominator:** Total Infant PCR test around 10 weeks	Geographic area	DHIS PMTCT surveillance (MRC)	1.47% (2015/16) (NDOH APP 2017/18-2019/2020)	1.26% (2019/20) (NDOH APP 2017/18-2019/20)	0.8% (2021) (PMTCT Last Mile Plan 2016 – 2021)	Annual	NDOH
3.	Mother-to-Child transmission rate at 18 months	Impact	Children born to HIV-positive women who tested positive for HIV antibodies around 18 months after birth	Geographic area	DHIS	18 months: 4.3% (MRC SAPMTE, 2012) 2.02% (Spectrum, 2015)	18 months: <3.2% (2019/20) (75% reduction)	18 months: <2% (2021)	Annual	NDOH
4.	Delivery in 10 to 19 years in facility rate	Outcome	**Numerator:** Delivery in facility 10 to 19 years **Denominator:** Total number of deliveries in facility	Geographic area Age: 10-14 years; 15 -19 years	DHIS	7.3% (2015/16) (NDOH APP 2017/18-2019/2020)	7.2% (NDOH APP 2017/18-2019/20)	6.7% (2019/2020) (NDOH APP 2017/18-2019/20)	Annual	NDOH

GOAL 1: ACCELERATE PREVENTION TO REDUCE NEW HIV AND TB INFECTIONS AND STIS									
	INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET		REPORTING FREQUENCY	RESPONSIBLE
							FY 2018/19	*FY2021/22*		
5.	Couple year protection rate	Outcome	**Numerator:** Women protected against pregnancy by using modern contraceptive methods **Denominator:** Population females 15–49 years	Geographic area	DHIS	51% (205/16) (NDOH APP 2017/18-2019/2020)	70%	74% (2020/21)	Annual	NDOH
6.	Number of medical male circumcisions performed	Output	**Numerator:** Number of medical male circumcisions performed **Denominator:** N/A	Geographic area Age (10-14; 15+)	DHIS CMS	Total: 612,648 (NDOH Annual Report 2015/16) baseline should be cumulative from inception (2011) 2.4 million as at end of 2015/16	Targets for individual years: 2016-2017: 700 000, 2017-2018: 650 000, **2018-2019: 600 000,** 2019-2020:550 000	**2020-2021:500 000** 3000 000 cumulatively (between 2016 and 2021)	Annual	NDOH, DCS, DHET/ HEAIDS Private sector (Council of Medical AID Schemes), Traditional sector
7.	Number of people tested for HIV	Output	**Numerator:** Number of people tested for HIV **Denominator:** N/A	Geographic area Sex, Age (15+)	DHIS	11 898 308 (NDOH Annual Report 2015/16)	10 million	10 million	Annual	NDOH, DCS, DHET/HEAIDS DOT, DPSA, SAPS
8.	Number of male condoms distributed	Output	**Numerator:** Male condoms distributed **Denominator:** N/A	Geographic area, Sex, Age (15+)		839,532,901 (NDOH Annual Report 2015/16)	850 million	850 million	Annual	NDOH, DCS, SAPS, DHET/ HEAIDS, DPSA, SABCOHA
9.	Number of female condoms distributed	Output	**Numerator:** Number of female condoms distributed **Denominator:** N/A	Geographic area, Sex, Age(15+)	DHIS	27,005,805 (NDOH Annual Report 2015/16)	40 million	40 million	Annual	NDOH, DCS, SAPS, DHET/ HEAIDS, DPSA SABCOHA
10.	Number of AGYW, FSW, MSM, IDU receiving oral PrEP for the first time during the reporting period	Output	**Numerator:** Number of AGYW, FSW, MSM, IDU receiving oral PrEP for the first time during the reporting period **Denominator:** N/A	Total, Sex, Age, AGYW, FSW, MSM, IDU	NDOH PrEP M&E report	2003 (2016/2017)	18215	85858	Annual	NDOH

GOAL 1: ACCELERATE PREVENTION TO REDUCE NEW HIV AND TB INFECTIONS AND STIS

	INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET		REPORTING FREQUENCY	RESPONSIBLE
							FY 2018/19	*FY2021/22*		
11.	Number of learners reached through combination prevention interventions aimed at retention of learners in schools	Outcome	**Numerator:** Number of learners reached through functional peer education programmes **Denominator:** N/A	Geographic area	DBE Provincial reports	85 000 (DBE Annual report 2015/16)	86 250	87 500	Annual	DBE
12.	Percentage of schools that are providing enhanced comprehensive sexuality education (CSE) life	Output	**Numerator:** Number of schools that are providing enhanced CSE **Denominator:** Number of selected schools	Geographic area	DOE Provincial reports	5%	30% of schools in high-burden areas	50% of schools in high-burden areas	Annual	DBE
Objective 1.2: Reduce TB incidence by at least 30%, from 834/100,000 population in 2015 to less than 584/100,000 by 2022										
13.	Percentage of children screened for TB symptoms	Output	**Numerator:** Total number of children screened for TB symptoms in health facilities	Geographic area Age: <5 years; 5 years+	DHIS	36.1% (NDOH Annual Report 2015/16)	80%	90%	Annual	NDOH
14.	Proportion of household contacts <5 years started on 3HP	Output	**Numerator:** Number of household contacts <5 years started on 3HP **Denominator:** Number of household contacts <5 years	Geographic area Age Drug Resistance	TBD	2016 – 0% (TB Strategy 2017/21)	2019- 54% (TB Strategy 2017/21)	2021 >90% (TB Strategy 2017/21)	Annual	NDOH

GOAL 1: ACCELERATE PREVENTION TO REDUCE NEW HIV AND TB INFECTIONS AND STIS										
	INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET		REPORTING FREQUENCY	RESPONSIBLE
							FY 2018/19	*FY2021/22*		
15.	Proportion of eligible PLHIV on ART started on 3HP (weekly high dose Isoniazid/ rifapentene for 3 months)	Output	**Numerator:** Number of eligible PLHIV on ART started on 3HP **Denominator:** Number of eligible PLHIV	Geographic area, Age	TBD	2016 – 0% (TB Strategy 2017/21)	2019- 54% (TB Strategy 2017/21)	2021 >90% (TB Strategy 2017/21)	Annual	NDOH
16.	Number of household contacts screened for TB	Output	**Numerator:** Number of household contacts screened for TB **Denominator:** N/A	Household contacts of TB clients	TBD	60% (TB Strategy 2017/21)	80%	90%	Annual	NDOH
Objective 1.3: Significantly reduce T.Pallidum, gonorrhoea, and chlamydia infection, to achieve the virtual elimination of congenital syphilis, and maintain high coverage of HPV vaccination										
17.	New Male Urethritis syndrome episodes treated rate	Output	**Numerator:** Male Urethritis Syndrome treated – new episodes **Denominator:** Male population 15-49 years	Geographic area, Age 15 – 49 years	DHIS	TBD	TBD	TBD	Annual	NDOH
18.	Percentage of women accessing antenatal care services who were tested for syphilis	Output	**Numerator:** Number of women attending antenatal care services who were tested for syphilis during the first prenatal visit (<13 weeks gestation) **Denominator:** Number of women attending antenatal care services	Geographic area, Age	Clinical sentinel sites reports	36% (for three doses, 71% for one dose)	80%	100%	Annual	NDOH, NICD
19.	HPV coverage	Output	**Numerator:** Number of girls 9 years and older that received HPV dose **Denominator:** Number of grade 4 learners ≥ 9 years	Geographic area, Age, Type of dose	DHIS	HPV 1st dose –85% HPV 2nd dose - 63.8% (NDOH Annual Report 2015/16)	HPV1st dose: 90% HPV 2nd dose: 90%	90% coverage nationally And at least 80% in every district	Annual	NDOH

GOAL 2: REDUCE MORBIDITY AND MORTALITY BY PROVIDING TREATMENT, CARE AND ADHERENCE SUPPORT FOR ALL

	INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET		REPORTING FREQUENCY	RESPONSIBLE
							FY 2018/19	*FY2021/22*		
Objective 2.1: Implement the 90-90-90 Strategy for HIV										
1.	Adult AIDS Mortality	Impact	**Numerator:** Adult mortality attributable to HIV **Denominator:** Total adult mortality from all causes	Geographic area, Age, Sex	STATS SA	27.9% (STATS SA MYE, 2016)	TBD	50%	Annual	STATS SA
2.	Percentage of people living with HIV who know their HIV status	Outcome	Modelled	Geographic area, Age, Sex	Thembisa model	Adults: 85.4% Men: 80.6% Women: 88.3% (Thembisa - 2015)	87%	90%	Annual	SANAC PCA
3.	Number of adults and children living with HIV on ART (TROA)	Outcome	**Numerator:** Total adults and children remaining on ART	Geographic area, Age, Sex, Institution	Programme reports Private sector Survey	3 407 336 (NDOH Annual Report 2015/16) Private sector: 287 408 (June 2015) - Thembisa report)	5 363 013	6.1 million	Annual	NDOH DPSA, DHET/ HEAIDS, DCS Private Sector (Council of Medical AID Schemes-CMS)
4.	Percentage of adults and children living with HIV known to be on ART 12 months after starting **(Retention)**	Outcome	**Numerator:** Number of adults and children who are still alive and receiving ARVs 12 months after initiating treatment **Denominator:** Total number of adults and children initiating ART	Geographic area, Age, Sex	DHIS CMS	78%	90%	95%	Annual	NDOH Private Sector (CMS)

GOAL 2: REDUCE MORBIDITY AND MORTALITY BY PROVIDING TREATMENT, CARE AND ADHERENCE SUPPORT FOR ALL										
	INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET		REPORTING FREQUENCY	RESPONSIBLE
							FY 2018/19	*FY2021/22*		
5.	People living with HIV viral load suppressed rate (VLS) at 12 months	Outcome	**Numerator:** People living with HIV viral load under 400 cps/mL **Denominator:** Total number of People living with HIV	Geographic area Age, Sex	DHIS CMS	85%	90%	90%	Annual	NDOH CMS
Objective 2.3: Implement the 90-90-90 Strategy for TB										
6.	TB Incidence	Impact	**Numerator:** Number of new and relapse cases of TB (all forms) estimated to occur in a given year **Denominator:** Total population per 100 000	Geographic area, Age, Sex	WHO report	2015 baseline: 834/100 000 (WHO TB report,2016)	700/100 000 16% reduction by 2019 (TB Strategy 2017/21)	617/100 000 26% reduction by 2021 (TB Strategy 2017/21) 30% by 2022	Annual	SANAC
7.	TB Mortality	Impact	**Numerator:** Number of deaths caused by TB in HIV-negative people (TB deaths among HIV-positive people are classified as HIV deaths in ICD-10) TB deaths in PLHIV are reported separately **Denominator:** Total population per 100 000	None	WHO report	2015 baseline: 46/100 000 (WHO TB report, 2016)	28% (TB Strategy 2017/21)	43% (TB Strategy 2017/21)	Annual	SANAC

GOAL 2: REDUCE MORBIDITY AND MORTALITY BY PROVIDING TREATMENT, CARE AND ADHERENCE SUPPORT FOR ALL

	INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET		REPORTING FREQUENCY	RESPONSIBLE
							FY 2018/19	*FY2021/22*		
8.	TB death rate	Outcome	**Numerator:** TB death during treatment **Denominator:** TB client start on treatment	Geographic area	DHIS	4.4% (2015/16) NDOH Annual report 2015/16	4.65% (NDOH APP 2017/18 – 2019/20)	4.31% (2019/20) (NDOH APP 2017/18 – 2019/20)	Annual	NDOH
9.	Percentage of all people/clients started on TB treatment	Outcome	**Numerator:** Number of people/clients started on TB treatment **Denominator:** TB symptomatic clients 5 years and older who test positive	Geographic area Age: <5, 5 years and older	DHIS	5 year+: 92.4% (NDOH Annual Report 2015/16)	95%	97%	Annual	NDOH
10.	TB treatment success rate	Outcome	**Numerator:** TB people/ clients cured and completed treatment **Denominator:** Total TB clients initiated on treatment	Geographic area, Drug sensitive, drug resistant TB	DHIS	83.3% (2014 cohort) MDR: 47.2% (2013 cohort) (NDOH Annual Report 2015/16)	86.93% MDR: 65%	90%	Annual	NDOH
11.	TB clients lost to follow-up rate	Outcome	**Numerator:** TB people/clients lost to follow-up **Denominator:** TB clients started on treatment	Geographic area, Drug resistant TB	DHIS	6.1% (2014 cohort) MDR: 22.3% (2013 cohort) (NDOH Annual Report 2015/16)	4.9% MDR: 10% (NDOH APP 2017/18 – 2019/2020)	<5% of laboratory diagnosed cases with initial loss to follow-up	Annual	NDOH
12.	Proportion of TB/ HIV co-infected patients on ART	Outcome	**Numerator:** Number of registered HIV+TB co-infected patients on ART **Denominator:** Number of registered HIV / TB co-infected patients	Geographic area Sex	DHIS	87.5% (NDOH Annual Report 2015/16)	90%	90%	Annual	NDOH

GOAL 3: REACH ALL KEY AND VULNERABLE POPULATIONS WITH CUSTOMISED AND TARGETED INTERVENTIONS

	INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET		REPORTING FREQUENCY	RESPONSIBLE
							FY 2018/19	*FY2021/22*		
1.	Number of key population surveillance activities conducted	Output	**Numerator:** Number of key population surveillance activities conducted **Denominator:** N/A	SW, MSM, PWID, Inmates	Reports	FSW IBBS 2014 MSM IBBS 2015/16	SW IBBS 2017 MSM IBBS 2017 PWID IBBS 2017 Inmates IBBS 2017	SW IBBS 2020 MSM IBBS 2020 PWID IBBS 2020 Inmates IBBS 2020	Every 3-years	SANAC
2.	HIV prevalence among specific key and vulnerable populations	Impact	**Numerator:** Number of specific key and vulnerable populations who test positive for HIV ***Denominator:*** Total number of specific key and vulnerable populations tested for HIV	Geographic area, Sex, Age, SW, MSM, PWID, People with disabilities, Inmates	Thembisa model IBBS Special surveys	MSM (HSRC Marang Men's Study) Total: 28% Johannesburg: 26.8%, Cape Town: 22.3%, Durban: 48.2% FSW (IBBS, 2014) JNB-72.0% CPT-40.0% DUR-55% MSM (IBBS 2015/16) JNB- 43.4% MAF- 18.2% BLO- 18.1% CPT-26.7% POL-22.3% (IBBS Clinical results, 2015) PWID 14% (RAR study) Inmates 23% (NSP) People with disabilities 17% (NSP)	TBD	TBD	Every 3-years	SANAC
3.	Percentage of specific key populations who correctly identify risks of HIV, STI and TB transmission and how to prevent them and reject major misconceptions about HIV	Outcome	**Numerator:** Number of respondents who gave the correct answer to all five questions **Denominator:** Total Number of all respondents	Geographic area, Sex, Age, SW, MSM, PWID, People with disabilities, Inmates	IBBS	FSW (IBBS, 2015) JNB: 32.8% CPT: 19.6% DUR: 4.6% MSM (HSRC Marang Study 2015) JNB: 48.7%, CPT: 40.0%, DUR: 42.3%	TBD	TBD	Every 3-5 years	SANAC

GOAL 3: REACH ALL KEY AND VULNERABLE POPULATIONS WITH CUSTOMISED AND TARGETED INTERVENTIONS

	INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET		REPORTING FREQUENCY	RESPONSIBLE
							FY 2018/19	*FY2021/22*		
4.	Percentage of specific key and vulnerable populations reporting using a condom	Outcome	**Numerator:** Number of specific key and vulnerable populations who reported using a condom **Denominator:** Total number of respondents	Geographic area, SW, MSM, PWID, Inmates, People with disabilities	IBBS	FSW (IBBS, 2015) Johannesburg: 76.4% Cape Town: 89.4% Durban: 84.5% MSM - condom use during last anal intercourse JNB-85.7% MAF-83.4% BLO-88.5% CPT-63.6% POL69.1% PWID - 38.9% (HSRC 2012) (Data for inmates not collected for this indicator)	TBD	TBD	Every 3-years	SANAC, NDOH, DCS
5.	Percentage of specific key and vulnerable populations living with HIV who know their HIV status (1st 90)	Outcome	**Numerator:** Number of specific key and vulnerable populations who know their HIV status **Denominator:** Total number of respondents who answered the question "Do you know your HIV status from an HIV test?"	Geographic area, SW, MSM, PWID, Inmates People with disabilities	IBBS	PWID (RAR, 2013) Reported having HIV test in last 12 months and know result: Gauteng: 49% (n=150); KZN 54% (n=150); WC: 61% (n=150) FSW: (IBBS, 2015) JNB=73.8% CPT=56.7% DUR=77.0% MSM: (IBBS 2015/16) JNB- 55.7% MAF-29.35% BLO-31.82% CPT-50.34% POL-24.71% INMATES DCS=100%	TBD	90%	Every 3-years	SANAC, NDOH, DCS

GOAL 3: REACH ALL KEY AND VULNERABLE POPULATIONS WITH CUSTOMISED AND TARGETED INTERVENTIONS

	INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET		REPORTING FREQUENCY	RESPONSIBLE
							FY 2018/19	*FY2021/22*		
6.	Percentage of specific key and vulnerable populations living with HIV receiving ART (2nd 90)	Outcome	**Numerator:** Number of respondents living with HIV who report receiving ART in the past 12 months **Denominator:** Total number of respondents living with HIV	Geographic area, SW, MSM, PWID, Inmates, People with disabilities	IBBS	FSW (IBBS, 2015) Johannesburg: 19.1% Cape Town: 25.6% Durban: 27.7% MSM: (IBBS 2015/16) JNB-43.04% MAF-29.35% BLO-36.36% CPT-40.00% POL-22.35% INMATES DCS=98%	TBD	81%	Every 3-years	SANAC, NDOH, DCS
7.	Percentage of specific key and vulnerable populations living with HIV who have suppressed viral loads (3rd 90)	Outcome	**Numerator:** Number of specific key and vulnerable populations living with HIV on ART with suppressed viral loads (≤400 copies/mL) **Denominator:** Estimated number of key and vulnerable populations living with HIV	Geographic area, SW, MSM, PWID, Inmates, People with disabilities	IBBS	FSW: Not VL tests conducted MSM: (IBBS 2015/16) JNB-57.81% MAF-33.70% BLO-38.64% CPT-39.31% POL-32.94% INMATES **END JUNE 2016 = 81% (≤ 1000)** **End June 2016 = 63% (≤ than 40**	TBD	TBD	Every 3-years	SANAC, NDOH, DCS
8.	Percentage of specific key and vulnerable populations with access to core package of HIV,TB and STI services	Output	**Numerator:** Number of specific key and vulnerable populations with access to core package of HIV,TB and STI services **Denominator:** Estimated number of key and vulnerable population	SW, MSM, PWID, Transgender, Inmates, Miners, OVC	IBBS	TBD	46.7% (70,000/150,000) INMATES DCS = 87.7%	Global Health Sector strategy towards ending STI (2016 -2021) – target 70% (Suggestion is that a 10% annual increment be applied) INMATES DCS= 100%	Every 3-years	DCS, DSD

GOAL 3: REACH ALL KEY AND VULNERABLE POPULATIONS WITH CUSTOMISED AND TARGETED INTERVENTIONS

	INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET		REPORTING FREQUENCY	RESPONSIBLE
							FY 2018/19	*FY2021/22*		
9.	Percentage of inmates screened for TB at different time points	Output	**Numerator:** Number of inmates screened for TB at different time points **Denominator:** Total number of inmates screened for TB	Screened t entry, exit and biannually	DCS Programme report	2014/15 On entry: 92.8% Biannually: 64.9% Exit: 91.08% (NSP Enhance progress report)	90%	90%	Annual	DCS
10.	Percentage of controlled mines providing routine TB screening at least once a year	Output	**Numerator:** Number of controlled mines providing routine TB screening **Denominator:** Total number of controlled mines	Geographic area	TB programme report	83%	80%	100%	Annual	NDOH
11.	Percentage of people who inject drugs receiving opioid substitution therapy (OST)	Output	**Numerator:** Number of people who inject drugs and are on OST at a specified date **Denominator:** Total number of opioid-dependent people who inject drugs	PWID High burden Areas	PWID IBBS	40 –To be established in 2017 in 3 cities for PWID	70 0.4%	100 0.6%	Every 3- years	SANAC
12.	Percentage of specific key populations who ever experienced human rights violations	Outcome	**Numerator:** Number of key populations who ever experienced human rights violations **Denominator:** Total number of specific key populations who responded	MSM, SW, Transgender, PWID	IBBS	SW Police violence: 55% Client violence: 57% (SWEAT, 2013)	50 % reduction	50% reduction	Every 3-years	SANAC

GOAL 4: ADDRESS THE SOCIAL AND STRUCTURAL DRIVERS OF HIV, TB AND STIs, AND LINK THESE EFFORTS TO THE NDP

	INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET		REPORTING FREQUENCY	RESPONSIBLE
							FY 2018/19	*FY2021/22*		
Objective 4.1: Implement social and behaviour change programmes to address key drivers of the epidemic and build social cohesion										
1.	Percentage of beneficiaries receiving Social Behaviour change programmes	Outcome	**Numerator:** Percentage of beneficiaries receiving Social Behaviour change programmes **Denominator:** Total number of survey respondents	Geographic area, Gender, Age	HSRC survey	To be established in 2017 HSRC Survey	TBD	TBD	Every 3 - 5 years	SANAC
2.	Number of children accessing services through drop in centres	Output	Count	Drop in Centre and Isibindi Centres	NFD Indicator`s report 2015/16	152 531 (DSD NFD report 2015/16)	188 309	2 15 6585	Annual	DSD
3.	Number of beneficiaries receiving DSD Social Behaviour Change programmes	Output	**Numerator:** Number of beneficiaries receiving SBC programmes **Denominator:** N/A	Geographical area, Gender	DSD report	47 135	600 000	1 500 000	Annual	DSD
Objective 4.2: Increase access to and provision of services for all survivors of sexual and gender based violence in the 27 priority districts										
4.	Proportion of ever-married or partnered girls or young women aged 15-24 who experienced physical or sexual violence from a male intimate partner in the past twelve months	Outcome	**Numerator:** Number of respondents responding positively to question of ever-married or partnered girls or young women aged 15-24 who experienced physical or sexual violence from a male intimate partner in the past twelve months **Denominator:** Total number of respondents who responded to the question	Geographic area, Age	HSRC survey	Ages 15-19: 7.7% Ages 20-24: 7.3% (HSRC 2012)	7.3% 6.9%	Decrease by 10% (6.9% and 6.6%)	Every 3 -5 years	SANAC

GOAL 4: ADDRESS THE SOCIAL AND STRUCTURAL DRIVERS OF HIV, TB AND STIs, AND LINK THESE EFFORTS TO THE NDP										
	INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET		REPORTING FREQUENCY	RESPONSIBLE
							FY 2018/19	*FY2021/22*		
Objective 4.3:Scale up access to social protection for people at risk of and those living with HIV and TB in priority districts										
5.	Number of beneficiaries receiving social grants	Output	Count	Geographic area, Type of Grant	SASSA	17 453 848	17 523 737	18 315 461	Annual	DSD
6.	Number of people accessing food through community nutrition and development centres (CNDC)	Output	Cumulated over a 5 year period	Drop in Centres and CNDC	DSD Non-Financial Indicator Performance report 2015-16	142 266	177 825	254 035	Annual	DSD
Objective 4.4: Implement and scale up a package of harm reduction interventions for alcohol and substance use in all districts										
7.	Number of people reached through substance abuse prevention programmes	Output	**Numerator:** Number of people reached through substance abuse prevention programmes **Denominator:** N/A	Age: children 18 years and below 19 and above	DSD Annual report	1 565 541	2 795 608	5 993 372	Annual	DSD, DHET/ HEAIDS
Objective 4.5: Implement economic strengthening programmes with a focus on youth in priority focus districts										
8.	Percentage of learners from ordinary) public schools that attend no-fee schools	Output	**Numerator:** Number of learners from ordinary public schools that attend no-fee schools **Denominator:** Total number of learners from ordinary public schools	Geographic area, Sex, Age, schools categorised as no-fee paying schools (Quintile 1-3)	DBE report	78%	80% (2017/18)	TBD	Annual	DBE

GOAL 4: ADDRESS THE SOCIAL AND STRUCTURAL DRIVERS OF HIV, TB AND STIs, AND LINK THESE EFFORTS TO THE NDP										
	INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET		REPORTING FREQUENCY	RESPONSIBLE
							FY 2018/19	*FY2021/22*		
Objective 4.6: Address the physical building structural impediments for optimal prevention and treatment of HIV, TB and STIs										
9.	Percentage of TB affected families facing catastrophic costs due to TB	Outcome	**Numerator:** Number of TB affected families facing catastrophic costs due to TB ***Denominator:*** Total number of TB affected families	Geographic area	HSRC TB survey 2017/18	To be determined in 2017/18	TBD	TBD	Every 3-5 years	NDOH
10.	Proportion of health facilities accessible to people with physical disabilities	Outcome	**Numerator:** Number of health facilities accessible to people with physical disabilities **Denominator:** Total number of health facilities	Geographic area Type of health facilities	Facility Assessment reports	1 313 (37 percent) of 3 583 PHC facilities have access for people with disabilities (DPME June 2016)	80% of all health facilities meet the 5 compulsory criteria of accessibility by 2019 (NDoH APP 2016/17)	100%	Annual	NDOH

GOAL 5: GROUND THE RESPONSE TO HIV,TB, AND STIs IN HUMAN RIGHTS PRINCIPLES AND APPROACHES

	INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET		REPORTING FREQUENCY	RESPONSIBLE
							FY 2018/19	*FY2021/22*		
Objective 5.1: Reduce stigma and discrimination among people living with HIV or TB by half by 2022										
1.	Percentage of people living with HIV who report stigma and discrimination	Outcome	**Numerator:** Number of people living with HIV who report external or internalised stigma **Denominator:** Total number of respondents	Geographic area Type of stigma	Stigma Index, SANAC	35.5% External Stigma among PLHIV 43% Internal Stigma among PLHIV 36.3% TB related Stigma 21.7% of PLHIV experiencing discrimination (Stigma Index, 2015)	No funding for the survey to determine targets	27.8% 22 % 18 % 11 %	Every 2- years	SANAC
2.	Percentage of population expressing accepting attitudes towards People Living with HIV and/ or TB	Outcome	**Numerator:** Number of all respondents with accepting attitudes towards People Living with HIV and/or TB **Denominator:** Total number of all respondents	Geographic area, TB, HIV.	HSRC Survey	To be established in 2017 HSRC SABSSM V survey	TBD	TBD	Every 3- 5 years	SANAC

GOAL 6: PROMOTE LEADERSHIP AND SHARED ACCOUNTABILITY FOR A SUSTAINABLE RESPONSE TO HIV, TB AND STIs

	INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET		REPORTING FREQUENCY	RESPONSIBLE
							FY 2018/19	*FY2021/22*		
Objective 6.1: Strengthen AIDS councils to provide effective co-ordination and leadership of all stakeholders for shared accountability in the implementation of the NSP										
1.	SANAC Accountability performance score	Outcome	Score card to be developed	Scorecard to be developed	Scorecard report	Baseline to be established in 2017	TBD	TBD	Annual	SANAC
2.	PCA and District AIDS Councils Accountability performance score: (5-year PIP aligned to the NSP, relevant PIP; representation)	Outcome	Score card to be developed	Geographic area: Province, District, Local Municipality; Type of AIDS Council	Scorecard report	Baseline to be established in 2017	TBD	TBD	Annual	PCA
3.	Number of PCA Secretariats that are allocated sufficient funds to coordinate the PIP	Output	**Numerator:** Number of PCA Secretariats that are allocated sufficient funds to coordinate the PIP **Denominator:** Total number of PCA Secretariats	Provincial AIDS Councils	SANAC Report	33%	60%	100%	Annual	PCA
4.	Number of Premiers and Mayors who Chair AIDS Councils	Output	**Numerator:** Number of Premiers and Mayors who chair AIDs councils **Denominator:** Total number of Premiers and Mayors	Geographic area	SANAC Report	55%	100%	100%	Annual	Office of the Premier and Mayor, PCA and DAC

GOAL 6: PROMOTE LEADERSHIP AND SHARED ACCOUNTABILITY FOR A SUSTAINABLE RESPONSE TO HIV, TB AND STIs

	INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET		REPORTING FREQUENCY	RESPONSIBLE
							FY 2018/19	*FY2021/22*		
Objective 6.2: Improve collaboration and co-operation between government, civil society, development partners and private sector sectors										
5.	Percentage of SANAC sectors with implementation plans that align with the NSP and contribute to the PIPs	Output	**Numerator:** Number of SANAC sectors with Implementation plans that align with the NSP and contribute to the PIPs **Denominator:** Total number of SANAC sectors	SANAC Sectors	SANAC Report	Baseline to be established in 2017	100%	100%	Annual	SANAC Civil Society Sectors

GOAL 7:MOBILISE RESOURCES AND MAXIMISE EFFECENCIES TO SUPPORT THE ACHIEVEMENT OF NSP GOALS AND ENSURE A SUSTAINABLE RESPONSE

	INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET		REPORTING FREQUENCY	RESPONSIBLE
							FY 2018/19	*FY2021/22*		
1.	Total expenditure on HIV, TB and STIs	Outcome	**Numerator:** Total expenditure on HIV, TB and STIs **Denomination:** Total cost estimate	Funding source: Disease Programmatic area	Expenditure Review	R28.7 billion	110%	120%	Annual	SANAC
2.	Percentage of budget from sources other than government	Outcome	**Numerator:** Total budget from all sources other than government **Denominator:** Total budget on HIV, TB and STIs	Funding/Budget Sources	Investment case	25.9% (2016/17	20%	20%	Annual	SANAC SABCOHA PRIVATE SECTOR

GOAL 8: STRENGTHEN STRATEGIC INFORMATION TO DRIVE PROGRESS TOWARDS ACHIEVEMENT OF NSP GOALS

	INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET		REPORTING FREQUENCY	RESPONSIBLE
							FY 2018/19	*FY2021/22*		
Objective 8.2: Rigorously monitor and evaluate implementation and outcomes										
1.	NSP Five-year costed National M&E Plan	Output	NSP Five-year costed National M&E Plan	N/A	M&E Plan	n/a	NSP Five-year costed National M&E Plan		1st year	SANAC
2.	Functional National Enterprise Information System (EIS)	Output	Functional National Enterprise Information System	NSP and PIP indicators	SANAC M&E Report	None	EIS system which houses real-time data on NSP indicators		Annual	SANAC
3.	Percentage of core NSP and PIP indicators reported	Output	**Numerator:** Number of NSP and PIP core indicators reported **Denominator:** Total number of NSP and PIP core indicators	According to NSP Goal and Objective	SANAC M&E Reports	None	80%	100%	Annual	SANAC PCA
4.	Number of NSP Mid-term and end-term Evaluation conducted	Output	Count	National, Province	NSP reports	N/A	Annual NSP report NSP Mid-term report 9 PIP Mid-term Reports	NSP End-Term report 9 PIP End-Term reports	Mid and End term	SANAC PCA
5.	Number of provinces and districts with Annual HIV, TB and STI profiles/ implementation plans /quarterly reports/annual	Output	Count	Provinces Districts	Profiles		9 provincial profiles 52 district profiles		Annual	PCA
Objective 8.3: Establish a co-ordinated and funded National Surveillance System to generate periodic estimates of HIV, TB and STI measures in the general population and key/vulnerable populations to inform programme implementation										
6.	Adoption of 5-year NSP HIV, TB and STI Research Agenda	Output	Count	N/A	Research Agenda	None	5-year NSP HIV, TB and STI Research Agenda		1st year	SANAC

CRITICAL ENABLERS

	INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET		REPORTING FREQUENCY	RESPONSIBLE
							FY 2018/19	*FY2021/22*		
Enabler 1: A focus on social and behaviour change communication (SBCC) to ensure social mobilisation and increasing awareness										
1.	Percentage of individuals who correctly identify risks of HIV, STI and TB transmission and how to prevent them and reject major misconceptions about HIV, STI and TB	Outcome	**Numerator:** Number of respondents aged 15-24 years who gave the correct answer to all five questions **Denominator:** Total number of all respondents	Geographic area, Sex, Age	HSRC survey	26.8% (HSRC 2012)	TBD	TBD	Every 4-5 years	SANAC
2.	Percentage of men and women aged 15 years and older who report condom use at last sexual intercourse with most recent sexual partner	Outcome	**Numerator:** Number of respondents who report condom use at last sexual intercourse with most recent sexual partner **Denominator:** Total number of respondents who reported having had sexual intercourse in the last 12 months	Geographic area, Sex, Age	HSRC survey	Total: 36.2% Males 38.6% Females 33.6% Youth 15–24: 58.4% (HSRC 2012)	TBD	100%	Every 4-5 years	SANAC
3.	Percentage of women and men aged 15–49 years who have had sexual intercourse with more than one partner in the last 12 months	Outcome	**Numerator:** Number of respondents who reported having had more than one sexual partner in the last 12 months **Denominator:** Total number of respondents who reported having had more than one sexual partner in the last 12 months	Geographic area, Sex, Age	HSRC survey	12.6% (HSRC Survey, 2012)	TBD	<5%	Every 4-5 years	SANAC

CRITICAL ENABLERS										
	INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET		REPORTING FREQUENCY	RESPONSIBLE
							FY 2018/19	*FY2021/22*		
4.	Percentage of people reached by prevention communication at least twice a year	Outcome	**Numerator:** Number of people who recall being reached by two or more communications about HIV prevention **Denominator:** Total number of respondents	Geographic area, Sex, Age	HSRC survey	82% (NCS 2012)	TBD	95% (Investment Case)	Every 4-5 years	SANAC
Enabler 3: Effectively integrate HIV, TB and STI Interventions and services										
5.	Percentage of organisations with HIV, TB and STI workplace policies and programmes	Outcome	**Numerator:** Number of organisations with HIV and TB workplace policies and programmes **Denominator:** Total number of organisations	Government departments Private enterprise/ company	DPSA Employment Health and Wellness monitoring tool SABCOHA report	Government deptartments: 68% of 161 (2016/17) (DPSA EHW report) 30%	90% (20% increase in departments with annual operational plans 45%	100% 60%	Annual	DPSA, SABCOHA

Annexure C: Glossary

Term	Definition	Definition Source
Accountability	The key accountability principles outlined in the NSP are transparency and dialogue. Transparency involves access to meaningful data and analyses, representation on AIDS Councils, progress against targets set, budgeting and expenditure information and data on the community response. Dialogue includes engagement with diverse stakeholders in periodic reviews of the performance of the response to identify progress against targets, as well as gaps, weaknesses and emerging trends.	Customised for SA
Adolescent	Aged 10 to 19 years inclusive	National Consolidated Guidelines for PMTCT and the Management of HIV in Children, Adolescents, and Adults[54]
Adult	Older than 19 years of age	National Consolidated Guidelines for PMTCT and the Management of HIV in Children, Adolescents, and Adults[54]
Antiretrovirals (ARVs)/ antiretroviral therapy (ART)/ HIV treatment	Antiretroviral therapy is highly active in suppressing viral replication, reducing the amount of the virus in the blood to undetectable levels and slowing the progress of HIV disease. ARV refers to antiretroviral medicines. It should only be used when referring to the medicines themselves and not to their use.	UNAIDS Terminology Guidelines[55]
ARV-based prevention	ARV-based prevention includes the oral or topical use of antiretroviral medicines to prevent the acquisition of HIV in HIV-negative persons (such as the use of pre-exposure prophylaxis or post-exposure prophylaxis) or to reduce the transmission of HIV from people living with HIV (treatment as prevention).	UNAIDS Terminology Guidelines[55]
Behaviour change	The adoption and maintenance of healthy behaviours (with respect to particular practices) that reduce the chances of acquiring HIV.	UNAIDS Terminology Guidelines[55]
Behaviour change communication (BCC)	Behaviour change communication promotes tailored messages, personal risk assessment, greater dialogue and an increased sense of ownership of the response by the individual and the community. It is developed through an interactive process, and its messages and approaches use a mix of communication channels to encourage and sustain positive, healthy behaviours.	UNAIDS Terminology Guidelines[55]
Biomedical factors	Biomedical factors relate to human physiology and its interaction with medicine.	UNAIDS Terminology Guidelines[55]
Caregiver or carer	Carers are people who provide unpaid care for a family member, friend or partner who is ill, frail or living with a disability. This could include provision of unpaid care to a person living with HIV or TB.	UNAIDS Terminology Guidelines[55] modified
Child	10 years of age and younger	National Consolidated Guidelines for PMTCT and the Management of HIV in Children, Adolescents, and Adults[54]
Children, Adolescents, Youth, Young people	***Children:*** According to Article 1 of the Convention on the Rights of the Child, "A child means every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier". ***Adolescents:*** Individuals between the ages of 10 and 19 years are generally considered adolescents. Adolescents are not a homogenous group; physical and emotional maturation comes with age, but its progress varies among individuals of the same age. Also, different social and cultural factors can affect their health, their ability to make important personal decisions and their ability to access services. ***Youth:*** This term refers to individuals between the ages of 15 and 24. Young people: This term refers to those between the ages of 10 and 24.	Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations – 2016 Update[56]
Client-initiated testing and counselling (CITC)	Client-initiated testing and counselling (CITC) involves individuals actively seeking HIV testing and counselling at a facility that offers such services. CITC is one of three principal modalities of HIV testing – the other two modalities being provider-initiated testing and counselling (PITC) and HIV self-testing (HIVST). CITC can be undertaken or carried out in community or special purpose settings.	UNAIDS Terminology Guidelines[55]
Close contact	A person who has had prolonged, frequent or intense contact with a person with infectious TB. This group includes people who live together or spend a great deal of time together in close proximity. Close contacts, or household contacts, are more likely to become infected with tuberculosis than contacts who see the person with TB less often.	Global Plan to End TB 2016-2020[57]

Term	Definition	Definition Source
Combination HIV prevention	Combination HIV prevention seeks to achieve maximum impact on HIV prevention by combining human rights-based and evidence-informed behavioural, biomedical and structural strategies in the context of a well-researched and understood local epidemic. Combination HIV prevention also can be used to refer to an individual's strategy for HIV prevention – combining different tools or approaches (either at the same time or in sequence), according to their current situation, risk and choices.	UNAIDS Terminology Guidelines[55]
Community response	Community response refers to a collective of community-led activities in response to HIV, TB or other issues. These activities are not limited to service delivery and can also include: advocacy by civil society and community networks for policies, programming and investments that meet the needs of communities; participation by civil society in monitoring and reporting on progress made in delivering the national HIV and TB response; and work by community systems on addressing inequalities and social drivers that are barriers to universal access. Service delivery by community systems could include community-led HIV testing and counselling , TB screening, peer-to-peer adherence support, home-based care, delivery of harm reduction services and service delivery by community networks to key populations.	UNAIDS Terminology Guidelines[55], modified
Community systems	There is no singular understanding of community systems, but one way of defining them is as "community-led structures and mechanisms used by communities, through which community members and community-based organisations and groups interact, co-ordinate and deliver their responses to the challenges and needs affecting their communities". Community systems can be informal and small-scale, or they can be extensive networks of organisations.	UNAIDS Terminology Guidelines[57]
Community systems	Community systems are the structures, mechanisms, processes and actors through which communities act on the challenges and needs that they face. They are made up of different types of entities: community members, formal and informal community organisations and networks, and other civil society organisations. Such systems are usually less formalised and less clearly defined than health systems. Entities that make up community systems have close links with communities; therefore, they are in a position to better understand the issues faced by those who are most affected and to find smart solutions.	Global Plan to End TB 2016–2020[55]
Community systems strengthening (CSS)	Refers to initiatives that contribute to the development and/or strengthening of community-based organisations. This is done in order to increase knowledge of (and access to) improved health-service delivery, and it usually includes capacity-building of infrastructure and systems, partnership-building and the development of sustainable financing solutions. CSS promotes the development of informed, capable and co-ordinated communities and community-based organisations, groups and structures. It is the capacity-building and the actions that are needed to ensure that the community response can be delivered through community systems. CSS should reach a broad range of community actors, enabling them to contribute to the long-term sustainability of health and other interventions at the community level, including creating an environment in which these contributions can be effective. CSS should reach a broad range of community actors, enabling them to contribute to the long-term sustainability of health and other interventions at the community level, including creating an environment in which these contributions can be effective. As a systems approach, CSS aims to strengthen the role and effectiveness of key populations, community actors and organisations in the following areas: design, delivery, monitoring and evaluation of HIV and TB related services and activities; advocacy and policy; organisational management and development; capacity-strengthening; engagement in decision-making processes; and accountability and transparency.	UNAIDS Terminology Guidelines[55], modified
Comprehensive sexuality education	Sexuality education is defined as an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic and non-judgmental information. Sexuality education provides opportunities to explore one's own values and attitudes and to build decision-making, communication and risk reduction skills about many aspects of sexuality". The term 'comprehensive' indicates "that this approach to sexuality education encompasses the full range of information, skills and values to enable young people to exercise their sexual and reproductive rights and to make decisions about their health and sexuality. It is important to understand that comprehensive sexuality education offers the full range of possibilities for young people to practice safer sex and does not just promote messages about abstinence".	UNAIDS Terminology Guidelines[55]
Comprehensive social protection	Comprehensive social protection addresses a range of measures for policy and programming, such as legal reforms to protect the rights of people living with HIV, women and key populations. It also includes economic empowerment programmes, referrals and linkages to maximise the impact of investments in (and across) sectors.	UNAIDS Terminology Guidelines[55], modified

Term	Definition	Definition Source
Counselling	Counselling is an interpersonal, dynamic communication process between a client and a trained counsellor (who is bound by a code of ethics and practice) that tries to resolve personal, social or psychological problems and difficulties. In the context of an HIV diagnosis, counselling aims to encourage the client to explore important personal issues, identify ways of coping with anxiety and stress, and plan for the future (such as keeping healthy, adhering to treatment and preventing transmission). When counselling in the context of a negative HIV test result, the focus is exploring the client's motivation, options and skills to stay HIV-negative.	UNAIDS Terminology Guidelines[55]
Counselling, follow-up	Follow-up counselling after post-test counselling helps clients to identify their concerns and supports them in addressing these. Follow-up counselling is of particular importance for supporting prevention of HIV transmission in serodiscordant couples and for linking women of reproductive age with HIV to programmes for the prevention of mother-to-child transmission (which are key to eliminating new HIV infections among children and keeping their mothers alive).	UNAIDS Terminology Guidelines[55], modified
Counselling, post-test	Post-test counselling is used to explain the result of the test. It provides additional information on risk-reduction measures – including prevention options for individuals who have tested negative – and it encourages people with high-risk practices or who may have been tested during the window period to come again for testing. The aim of post-test counselling for those who have tested HIV-positive is to help them cope psychologically with the result of the test and understand the services (including treatment and care options) that are available to them. This serves to encourage HIV-positive people to adopt prevention measures to avoid transmission of HIV to their partners and to begin a discussion about issues around disclosure and partner notification. Post-test counselling should be linked to onward referral to care and support services, including antiretroviral therapy, tuberculosis services and family planning (if applicable).	UNAIDS Terminology Guidelines[55], modified
Coverage rate	The coverage rate is the proportion of individuals accessing and receiving a service or commodity at a point in time. The numerator is the number of people who receive the service and the denominator is the number of individuals who are eligible to receive the service at the same point in time. This is typically measured in surveys, but it also may be measured using service data (e.g. receiving clean needles or antiretroviral therapy).	UNAIDS Terminology Guidelines[55]
Critical enablers	Critical enablers are "activities that are necessary to support the effectiveness and efficiency of basic programme activities". Programmes that are critical enablers "should be primarily assessed in terms of their effectiveness in increasing the uptake, equitable coverage, rights-based delivery and quality of basic programme activities." Critical enablers also "overcome major barriers to service uptake, including social exclusion, marginalisation, criminalisation, stigma and inequity.	UNAIDS Terminology Guidelines[55]
Early adolescent	Aged 10 to 15 years	National Consolidated Guidelines for PMTCT and the Management of HIV in Children, Adolescents, and Adults[54]
Enabling environment	There are different kinds of enabling environment in the context of HIV. For instance, an enabling legal environment would not only have laws and policies against discrimination on the basis of sex, health status (including HIV status), age, disability, social status, sexual orientation, gender identity and other relevant grounds, but they would be enforced. In such an environment, people also would have access to justice – that is, a process and remedy if they are aggrieved. An enabling social environment is one in which social protection strategies (e.g. economic empowerment) are in place, and where social norms support knowledge, awareness and healthy behaviour choices.	UNAIDS Terminology Guidelines[55]
Epidemic (includes outbreak, pandemic, endemic)	An epidemic refers to a disease condition affecting (or tending to affect) a disproportionately large number of individuals within a population, community or region at the same time. The population may be all of the inhabitants of a given geographic area, the population of a school or similar institution or everyone of a certain age or sex (such as the children or women of a region). An epidemic may be restricted to one locale (an outbreak), be more general (an epidemic) or be global (a pandemic). Common diseases that occur at a constant but relatively high rate in the population are said to be endemic.	UNAIDS Terminology Guidelines[55]
Epidemiology	Epidemiology is the scientific study of the causes, spatial and temporal distribution, and control of diseases in populations.	UNAIDS Terminology Guidelines[55]
Extensively drug-resistant tuberculosis (XDR-TB)	Extensively drug-resistant tuberculosis occurs when the bacteria causing tuberculosis are resistant to isoniazid, rifampicin, fluoroquinolones and at least one injectable second-line drug. The emergence of XDR-TB underlines the necessity of managing tuberculosis programmes in a systematic way at all levels.	UNAIDS Terminology Guidelines[55]

Term	Definition	Definition Source
Extrapulmonary TB	TB disease in any part of the body other than the lungs (for example, the kidney, spine, brain or lymph nodes).	Global Plan to End TB 2016-2020[57]
Focus for Impact	The NSP uses the term 'focus for impact' to refer to intensified services, programmes, policies and interventions that will have the greatest impact. This includes implementing activities in locations with the highest burden of disease, with populations most affected and most at risk, and using evidence-informed interventions in the right combinations to maximise effect.	Customised for SA
Gender (2)	Gender "refers to the social attributes and opportunities associated with being male and female and the relationships between women and men and girls and boys, as well as the relations between women and those between men. These attributes, opportunities and relationships are socially constructed and are learned through socialisation processes. They are context-/time-specific and changeable. Gender determines what is expected, allowed and valued in a woman or a man in a given context. In most societies, there are differences and inequalities between women and men in responsibilities assigned, activities undertaken, access to and control over resources, as well as decision-making opportunities". Note that since many languages do not have the word 'gender', translators may have to consider alternatives to distinguish between the terms 'gender' and 'sex'.	UNAIDS Terminology Guidelines[55]
Gender equality	Gender equality – or equality between men and women – is a recognised human right, and it reflects the idea that all human beings, both men and women, are free to develop their personal abilities and make choices without any limitations set by stereotypes, rigid gender roles or prejudices. Gender equality means that the different behaviours, aspirations and needs of women and men are considered, valued and favoured equally. It also signifies that there is no discrimination on the grounds of a person's gender in the allocation of resources or benefits, or in access to services. Gender equality may be measured in terms of whether there is equality of opportunity or equality of results.	UNAIDS Terminology Guidelines[55]
Gender identity	Gender identity refers to a person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth. It includes both the personal sense of the body – which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means – as well as other expressions of gender, including dress, speech and mannerisms.	UNAIDS Terminology Guidelines[55]
Gender-sensitive	Gender-sensitive policies, programmes or training modules recognise that both women and men are actors within a society, that they are constrained in different and often unequal ways, and that consequently they may have divergent and sometimes conflicting perceptions, needs, interests, and priorities.	Global Plan to End TB 2016–2020[57]
Gender-based violence	Gender-based violence "describes violence that establishes, maintains or attempts to reassert unequal power relations based on gender." It encompasses acts that inflict physical, mental or sexual harm or suffering, threat of such acts, coercion and other deprivations of liberty. "The term was first defined to describe the gendered nature of men's violence against women. Hence, it is often used interchangeably with violence against women. The definition has evolved to include violence perpetrated against some boys, men and transgender persons because they challenge (or do not conform to) prevailing gender norms and expectations (e.g. they may have a feminine appearance), or to heterosexual norms".	UNAIDS Terminology Guidelines[55]
Harm reduction	The term 'harm reduction' refers to a comprehensive package of policies, programmes and approaches that seeks to reduce the harmful health, social and economic consequences associated with the use of psychoactive substances. The elements in the package are as follows: needle and syringe programmes; Opioid Substitution Therapy; HIV testing and counselling; HIV care and antiretroviral therapy for people who inject drugs; prevention of sexual transmission; outreach (information, education and communication for people who inject drugs and their sexual partners); viral hepatitis diagnosis, treatment and vaccination (where applicable); and tuberculosis prevention, diagnosis and treatment. For example, people who inject drugs are vulnerable to bloodborne infections (such as HIV) if they use non-sterile injecting equipment. Therefore, ensuring adequate supplies of sterile needles and syringes is a harm reduction measure that helps to reduce the risk of blood-borne infections.	UNAIDS Terminology Guidelines[55]
Health education	Health education is the provision of accurate and appropriately contextualised information on health (e.g. according to age, sex and culture) that is aimed at assisting individuals to make informed choices to improve their health.	UNAIDS Terminology Guidelines[55]
Health sector	The health sector encompasses a number of related organisations and services. These include organised public and private health services (including those for health promotion, disease prevention, diagnosis, treatment and care), health ministries, health-related non-governmental organisations, health-related community groups and health specific professional organisations. It also includes institutions that provide direct input into the healthcare system, such as the pharmaceutical industry and teaching institutions.	UNAIDS Terminology Guidelines[55]

Term	Definition	Definition Source
Health system	A health system consists of all organisations, people and actions whose primary intent is to promote, restore or maintain health. It involves the broad range of individuals, institutions and actions that help to ensure the efficient and effective delivery and use of products and information to provide prevention, treatment, care and support for those who need such services.	UNAIDS Terminology Guidelines[55]
Health systems strengthening	The term 'health systems strengthening' refers to a process that improves a health system's capacity to deliver effective, safe and high-quality services equitably. Areas that require strengthening are typically the service delivery system, health workforce, health information system, systems to guarantee equitable access to health commodities and technologies, and health financing systems. Leadership, governance and accountability also can be strengthened.	UNAIDS Terminology Guidelines[55]
HIV testing services (HTS)	HIV testing is the gateway to HIV treatment and care, and it is critical in the scale-up of universal access to HIV prevention, including in the context of medical male circumcision, elimination of new infections among children, and antiretroviral medicine-based prevention approaches (including pre-exposure prophylaxis or post-exposure prophylaxis). The term HIV testing services (HTS) is used to embrace the full range of services that should be provided together with HIV testing. HIV testing should be undertaken within the framework of the '5 Cs': consent, confidentiality, counselling, correct test results and connection/linkage to prevention, care and treatment.	UNAIDS Terminology Guidelines[55]
Homophobia	Homophobia is the fear or rejection of (or aversion to) homosexuals and/or homosexuality. This often takes the form of stigmatising attitudes or discriminatory behaviour, and it occurs in many settings in all societies, often beginning as early as school.	UNAIDS Terminology Guidelines[55]
Human rights	The South African Constitution guarantees a broad range of civil, political, cultural and socio-economic rights, including the rights to equality and non-discrimination, privacy, dignity, freedom and security of the person, access to health care and access to justice.	Customised for SA
Incidence	The number of new (HIV, TB or STI) infections over the number of people susceptible to infection in a specified time period.	UNAIDS Terminology Guidelines[55]
Infant	A child younger than one year of age	National Consolidated Guidelines for PMTCT and the Management of HIV in Children, Adolescents and Adults[54]
Intergenerational relationships, cross-generational relationships, age-disparate relationships	Terms that refer to relationships where there is a 10-year (or greater) age disparity between sexual partners	UNAIDS Terminology Guidelines[55]
Key populations	The South African NSP defines key populations as those most at risk for HIV, TB, and STI. The NSP follows the UNAIDS and WHO definition of key populations for HIV and STI: gay men and other men who have sex with men, sex workers and their clients, transgender people, people who inject drugs and prisoners and other incarcerated people as the main key population groups. These populations often suffer from punitive laws or stigmatising policies, and they are among the most likely to be exposed to HIV. Their engagement is critical to a successful HIV response everywhere – they are key to the epidemic and key to the response. Due to specific higher-risk behaviours, these groups are at increased risk of HIV irrespective of the epidemic type or local context. The key populations are important to the dynamics of HIV transmission. They are also essential partners in an effective response to the epidemic. In accordance with the Global TB plan, 'key populations' for TB are defined as people who are vulnerable, underserved or at risk of TB infection. These include people with increased exposure to TB due to where they live or work, people with limited access to quality TB services, and people at greater illness or risk due to biological or behavioural factors. The NSP defines key populations for TB as people living with HIV, household contacts of TB index patients, healthcare workers, inmates, pregnant women, children under five years of age, diabetics, and people living in informal settlements.	UNAIDS Terminology Guidelines 2015 [55], Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations – 2016 Update[56]
Late adolescent	Aged 15 to 19 years inclusive	National Consolidated Guidelines for PMTCT and the Management of HIV in Children, Adolescents and Adults[54]
Leadership	The NSP demands leadership from all spheres of government (national, provincial, local government) as well as communities, the private sector, organised labour, civil society, the general as well as key and vulnerable populations, academics, researchers, development partners and – most important of all – people living with HIV or infected with TB.	Customised for SA

Term	Definition	Definition Source
Line probe assay	WHO issued new recommendations on the use of a rapid diagnostic test – a line probe assay to detect resistance to second-line anti-TB drugs (SL-LPA)	WHO Molecular Line Probe Assays for Rapid Screening of Patients at risk of Multidrug-Resistant Tuberculosis (MDR-TB), Policy Statement [58]
Lost to follow-up	Someone who does not start or complete HIV, TB or STI treatment, generally because of poor quality health services or the lack of a patient-centred approach. Previously, people lost to follow-up were referred to as 'defaulters'. The term 'defaulters' should be avoided, however, as it unfairly places all the blame on patients.	Global Plan to End TB 2016–2020[57], modified
Men who have sex with men (MSM)	The term 'men who have sex with men' describes males who have sex with males, regardless of whether or not they also have sex with women or have a personal or social gay or sexual identity. This concept is useful because it also includes men who self-identify as heterosexual but who have sex with other men.	UNAIDS Terminology Guidelines[55]
M-health	An abbreviation for 'mobile health', a term used for the practice of medicine and public health supported by mobile devices.	Global Plan to End TB 2016–2020[57]
Mobile workers/ population	The term 'mobile worker' refers to a large category of persons who may cross borders or move within their own country on a frequent and short-term basis for a variety of work-related reasons. This is done without changing their primary residence or home base. Mobile work involves a range of employment or work situations that require workers to travel in the course of their work. Mobile workers usually are in regular or constant transit – sometimes in (regular) circulatory patterns and often spanning two or more countries – and they can be away from their habitual or established place of residence for varying periods of time.	UNAIDS Terminology Guidelines[55]
Multidrug-resistant tuberculosis (MDR-TB)	MDR-TB is a specific form of drug-resistant tuberculosis, due to a bacillus resistant to at least isoniazid and rifampicin, the two most powerful anti-tuberculosis drugs.	UNAIDS Terminology Guidelines[55]
Needle and syringe programme	The term 'needle and syringe programme' is increasingly replacing the term 'needle exchange programme' because the exchange of needles has been associated with unintended negative consequences compared with distribution. Both terms refer to programmes aimed at increasing the availability of sterile injecting equipment.	UNAIDS Terminology Guidelines[55]
Opioid Substitution Therapy	Opioid Substitution Therapy is the recommended form of drug dependence treatment for people who are dependent on opioids. It has proved to be effective in the treatment of opioid dependence, in the prevention of HIV transmission and in the improvement of adherence to antiretroviral therapy. The most common drugs used in OST are methadone and buprenorphine.	UNAIDS Terminology Guidelines[55]
Patient-centred approach to TB care	A patient-centred approach considers the needs, perspectives and individual experiences of people affected by TB, while respecting their right to be informed and receive the best quality of care based on individual needs. It requires the establishment of mutual trust and partnership in the patient–care provider relationship, and creates opportunities for people to provide input into and participate in the planning and management of their own care. A patient-centred approach improves treatment outcomes, while respecting human dignity.	Global Plan to End TB 2016-2020[57]
People affected by TB and/or HIV	This term encompasses people who are ill with TB and/or HIV and their family members, dependents, communities and healthcare workers who may be involved in caregiving or are otherwise affected by the illness.	Global Plan to End TB 2016–2020[57], modified
People who inject drugs	Refers to people who inject psychotropic (or psychoactive) substances for non-medical purposes. These drugs include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypno-sedatives and hallucinogens. Injection may be through intravenous, intramuscular, subcutaneous or other injectable routes. People who self-inject medicines for medical purposes – referred to as 'therapeutic injection' – are not included in this definition. The definition also does not include individuals who self-inject non-psychotropic substances, such as steroids or other hormones, for body-shaping or improving athletic performance. While these guidelines focus on people who inject drugs because of their specific risk of HIV transmission due to the sharing of blood-contaminated injection equipment, much of this guidance is relevant also for people who inject other substances.	Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations – 2016 Update [56]
Population and location	In the context of HIV, population and location or local epidemic is a concept that is used to help prioritise programme activities within the HIV response. It refers to the need to focus on specific areas and specific populations where there is high HIV prevalence or incidence. The result of using a population and location approach will be a more efficient HIV response based on a more distilled knowledge of the HIV epidemic in the country .	UNAIDS Terminology Guidelines[55]
Post-exposure prophylaxis (PEP)	Post-exposure prophylaxis refers to antiretroviral medicines that are taken after exposure (or possible exposure) to HIV. The exposure may be occupational (e.g. a needlestick injury) or non-occupational (e.g. condomless sex with a seropositive partner). The latter is sometimes referred to as non-occupational post-exposure prophylaxis (N-PEP).	UNAIDS Terminology Guidelines[55]

Term	Definition	Definition Source
Pre-exposure prophylaxis (PrEP)	Pre-exposure prophylaxis (PrEP) refers to antiretroviral medicines prescribed before exposure (or possible exposure) to HIV. Several studies have demonstrated that a daily oral dose of appropriate antiretroviral medicines is effective in both men and women for reducing the risk of acquiring HIV infection through sexual or injection transmission.	UNAIDS Terminology Guidelines[55]
Prevention of mother-to-child transmission (PMTCT) and mother-to-child-transmission (MTCT) of HIV	MTCT is the abbreviation for 'mother-to-child transmission'. PMTCT, the abbreviation for prevention of mother-to-child transmission, refers to a four-pronged strategy for stopping new HIV infections among children and keeping their mothers alive and families healthy. The four prongs are: helping reproductive-age women to avoid HIV (prong 1); rreducing unmet need for family planning (prong 2); providing antiretroviral medicine prophylaxis to prevent HIV transmission during pregnancy, labour and delivery, and breastfeeding (prong 3); and providing care, treatment and support for mothers and their families (prong 4).	UNAIDS Terminology Guidelines[55]
Provider-initiated testing and counselling (PITC)	Provider-initiated testing and counselling (PITC) refers to HIV testing and counselling that is recommended by healthcare providers to people attending healthcare facilities as a standard component of medical care. It is offered routinely to all people attending a service (such as pregnant women attending antenatal care) and is recommended as an opt-out approach; that is, it remains voluntary and the decision not to take the test is left with the patient. The purpose of provider-initiated testing and counselling is to enable specific clinical decisions to be made (or specific medical services to be offered) that would not be possible without knowledge of the person's HIV status. It also helps to identify unrecognised or unsuspected HIV infection among people attending healthcare facilities.	UNAIDS Terminology Guidelines[55]
Psychosocial support	Psychosocial support addresses the ongoing psychological and social problems of HIV infected individuals, their partners, families and caregivers.	HIV/AIDS Psychosocial Support [59]
Reproductive health	Reproductive health "is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. It implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility that are not against the law , and the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant".	UNAIDS Terminology Guidelines[55]
Reproductive rights	Reproductive rights "embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community".	UNAIDS Terminology Guidelines[55]
Risk	Risk is defined as the risk of exposure to HIV or the likelihood that a person may acquire HIV. Behaviours, not membership of a group, place individuals in situations in which they may be exposed to HIV, and certain behaviours create, increase or perpetuate risk. Avoid using the expressions groups at risk or risk groups – people with behaviours that may place them at higher risk of HIV exposure do not necessarily identify with any particular group.	UNAIDS Terminology Guidelines[55], modified
Second-generation surveillance	Second-generation surveillance for HIV is the regular and systematic collection, analysis, interpretation, reporting and use of information to track and describe changes in the HIV epidemic over time. In addition to HIV surveillance and AIDS case reporting, second-generation surveillance includes behavioural surveillance to track trends in risk behaviours over time in order to identify or explain changes in levels of infection and the monitoring of sexually transmissible infections in populations at risk of acquiring HIV. These different components achieve greater or lesser significance depending on the surveillance needs of a country, as determined by the nature of the epidemic it is facing.	UNAIDS Terminology Guidelines[55]
Sex (see also gender)	The term 'sex' refers to biologically determined differences that are used to label individuals as males or females. The bases for this classification are reproductive organs and functions.	UNAIDS Terminology Guidelines[55]

Term	Definition	Definition Source
Sex worker	Female, male and transgender adults (18 years of age and older) who receive money or goods in exchange for sexual services, either regularly or occasionally. Sex work is consensual sex between adults, can take many forms, and varies between and within countries and communities. Sex work also varies in the degree to which it is more or less 'formal', or organised. As defined in the Convention on the Rights of the Child (CRC), children and adolescents under the age of 18 who exchange sex for money, goods or favours are 'sexually exploited' and are not defined as sex workers.	Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations – 2016 Update [56]
Sexual and reproductive health package	Programmes, supplies and multi-integrated services to ensure that people are able to have not only a responsible, satisfying and safer sex life, but also the capability to reproduce and the freedom to decide if, when and how often to do so. It is particularly important that this decision be free of any inequality based on socio-economic status, education level, age, ethnicity, religion or resources available in their environment. A sexual and reproductive health package aims to guarantee that men and women are informed of (and to have access to) the following resources: safe, effective, affordable and voluntary acceptable methods of birth control; access to appropriate healthcare services for sexual and reproductive care, treatment and support; and access to comprehensive sexuality education. A package also includes (but is not limited to): pregnancy-related services (and skilled attendance and delivery), as well as emergency obstetric and post-abortion care; STI and HIV prevention, diagnosis and treatment; prevention and early diagnosis of breast and cervical cancers; and prevention of gender-based violence and care for survivors of gender-based violence.	UNAIDS Terminology Guidelines[55]
Sexual and reproductive health programmes and policies	Sexual and reproductive health programmes and policies include, but are not restricted to, the following: services for family planning; infertility services; maternal and newborn health services; prevention of unsafe abortion and post-abortion care; prevention of mother-to-child transmission of HIV; diagnosis and treatment of sexually transmitted infections, including HIV infection, reproductive tract infections, cervical cancer and other gynaecological morbidities; promotion of sexual health, including sexuality counselling; and prevention and management of gender-based violence.	UNAIDS Terminology Guidelines[55]
Sexual and reproductive health services	This includes services for family planning; infertility services; prevention of unsafe abortion and post-abortion care; diagnosis and treatment of sexually transmitted infections, including HIV infection, reproductive tract infections, cervical cancer and other gynaecological morbidities; and the promotion of sexual health, including sexuality counselling.	NSP 2012-2016[39], UNAIDS Terminology Guidelines [55]
Sexual rights	Sexual rights embrace a "human right that already are recognised in many national laws, international human rights documents and other consensus statements: the right of all persons to the highest attainable standard of sexual health, free of coercion, discrimination and violence. This includes the following: accessing sexual and reproductive healthcare services; seeking , receiving and imparting information related to sexuality; obtaining sexuality education; enjoying respect for bodily integrity; choosing a partner; deciding to be sexually active or not; participating in consensual sexual relations; engaging in consensual marriage; determining whether or not (and when) to have children; and pursuing a satisfying, safe and pleasurable sexual life" (19).	UNAIDS Terminology Guidelines[55]
Sexually transmitted infection (STI)	STIs are spread by the transfer of organisms from person to person during sexual contact. In addition to the traditional STIs (syphilis and gonorrhoea), the spectrum of STIs also includes: HIV, which causes AIDS; chlamydia trachomatis; human papillomavirus (HPV), which can cause cervical, penile or anal cancer; genital herpes; and cancroid. More than 20 disease-causing organisms and syndromes are now recognised as belonging in this category.	NSP 2012-2016[39], UNAIDS Terminology Guidelines [55]
Social drivers	The NSP highlights complex and multi-dimensional social drivers from factors such as poverty, inequality, inadequate access to education, poor nutrition, migration, gender inequality and gender-based violence, and alcohol and substance abuse that increase vulnerability to HIV, TB and STIs; deter individuals from seeking needed services early; and interfere with the ability of individuals to receive services and to adhere to prescribed regimens.	Customised for SA
Social protection	Social protection has been defined as "all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance social status and rights of the marginalised; with the overall objective of reducing the economic and social vulnerability of the poor, vulnerable and marginalised groups" (20). Social protection involves more than cash and social transfers; it encompasses economic, health and employment assistance to reduce inequality, exclusion and barriers to accessing HIV prevention, treatment, care and support services.	UNAIDS Terminology Guidelines[55], modified

Term	Definition	Definition Source
Sputum	Phlegm coughed up from deep inside the lungs. Sputum is examined for TB bacteria using smear microscopy, culture or molecular tests.	Global Plan to End TB 2016–2020[57]
Stigma and discrimination	Stigma is derived from a Greek word meaning a mark or stain, and it refers to beliefs and/or attitudes. Stigma can be described as a dynamic process of devaluation that significantly discredits an individual in the eyes of others, such as when certain attributes are seized upon within particular cultures or settings and defined as discreditable or unworthy. When stigma is acted upon, the result is discrimination. Discrimination refers to any form of arbitrary distinction, exclusion or restriction affecting a person, usually (but not only) because of an inherent personal characteristic or perceived membership of a particular group. It is a human rights violation. In the case of HIV, this can be a person' s confirmed or suspected HIV-positive status, irrespective of whether or not there is any justification for these measures. The terms stigmatisation and discrimination have been accepted in everyday speech and writing, and they may be treated as plural.	UNAIDS Terminology Guidelines[55]
Strategic approach	The NSP highlights a strategic approach for each goal. This includes the use of data to identify locations and populations in need of intensified responses, as well as the customisation of responses to the local context. Further, strategic approaches include the scale up of high-impact interventions, assurance of co-ordinated multi-sectoral approaches, and continuous monitoring of results to determine any needed corrective actions.	Customised for SA
Strategic information	For the purposes of the NSP, 'strategic information' includes three key components: monitoring and evaluation, surveys and surveillance, and research.	Customised for SA
Structural drivers	Structural drivers are factors in the physical, legal and social environment that influence individual and group behaviour.	UNAIDS Terminology Guidelines[55], modified
Structural interventions	Structural interventions are those that seek to alter the physical, legal and social environment in which individual behaviour takes place. They also can aim to remove barriers to protective action or to create constraints to risk-taking.	UNAIDS Terminology Guidelines[55]
Surveillance	Public health surveillance is the continuous systematic collection, analysis and interpretation of health-related data that are needed for the planning, implementation and evaluation of public health practice.	UNAIDS Terminology Guidelines[55]
TB disease	An illness in which TB bacteria multiply and attack a part of the body, usually the lungs. The symptoms of active TB disease include weakness, weight loss, fever, loss of appetite and night sweats. Other symptoms of TB disease depend on where in the body the bacteria are growing. If TB disease is in the lungs (pulmonary TB), the symptoms may include a bad cough, pain in the chest and coughing up blood. A person with pulmonary TB disease may be infectious and spread TB bacteria to others.	Global Plan to End TB 2016–2020[57]
TB infection	Also called 'latent tuberculosis infection'. This is a condition in which TB bacteria are alive but inactive in the body. People with latent TB infection have no symptoms; they do not feel sick, cannot spread TB bacteria to others, and usually test positive for infection – positive to a tuberculin skin test or a special test called IGRA test. In the Global Plan, people referred to as 'infected with TB' are people having such latent TB infection.	Global Plan to End TB 2016–2020[57]
TB prevention and care	The efforts of healthcare workers to provide TB services to the communities they serve. These terms are preferred over 'TB control', which may create the perception that TB experts are in full control of all aspects of prevention, treatment and care of people with TB. It is useful to examine the term 'control' critically so as to avoid neglecting community and patient resources and capacities.	Global Plan to End TB 2016–2020[57]
Transgender persons	'Transgender' is an umbrella term to describe people whose gender identity and expression does not conform to the norms and expectations traditionally associated with their sex at birth. Transgender people include individuals who have received gender reassignment surgery, individuals who have received gender-related medical interventions other than surgery (e.g. hormone therapy) and individuals who identify as having no gender, multiple genders or alternative genders. Transgender individuals may self-identify as transgender, female, male, transwoman or transman, trans-sexual or one of many other transgender identities, and they may express their genders in a variety of masculine, feminine and/or androgynous ways. Due to this diversity, it is important to learn and use positive local terms for transgender people, and to avoid derogatory terms.	UNAIDS Terminology Guidelines[55], modified

Term	Definition	Definition Source
Voluntary medical male circumcision (VMMC)	Voluntary medical male circumcision (VMMC) is the surgical removal of the foreskin, the tissue covering the head of the penis where cells highly receptive to the Human Immunodeficiency Virus are located. There is compelling evidence that circumcision can significantly reduce the risk of HIV transmission. Conventional surgery or more recently, the use of male circumcision devices, are methods of MMC. It should always be offered as part of a combination package of HIV prevention services that includes: active detection of symptomatic sexually transmitted infections and their treatment; provision and promotion of male and female condoms; safer sex and risk-reduction counselling; and HIV testing and (if the individual is found to be HIV-positive) linkage to antiretroviral therapy.	UNAIDS Terminology Guidelines[55]
Vulnerability, vulnerable populations	'Vulnerability' refers to unequal opportunities, social exclusion, unemployment or precarious employment (and other social, cultural, political, legal and economic factors) that make a person more susceptible to TB, STIs and/or HIV infection and developing AIDS. The factors underlying vulnerability may reduce the ability of individuals and communities to avoid HIV, TB or STI risk, and they may be beyond their control. These factors may include: lack of the knowledge and skills required to protect oneself and others; limited accessibility, quality and coverage of services; and restrictive societal factors, such as human rights violations, punitive laws or harmful social and cultural norms (including practices, beliefs and laws that stigmatise and disempower certain populations). The South African NSP defines vulnerable populations for HIV, TB and STIs as: adolescent girls and young women; children, including orphans and vulnerable children, people living in informal settlements, mine workers, migrants and undocumented foreigners, people with disabilities, and other LGBTI populations.	UNAIDS Terminology Guidelines [55], modified, The Global TB Plan [57]

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