National Strategic Plan

For HIV, TB and STIs 2023-2028

REPUBLIC OF SOUTH AFRICA

SOUTH AFRICAN NATIONAL AIDS COUNCIL
OUR ACTIONS COUNT

2030 NDP

"The People's NSP"

National Strategic Plan

For HIV, TB and STIs

2023-2028


ALL
LOVE,ONE

Preface

National Strategic Plan for HIV, TB and STIs: 2023-2028

The National Strategic Plan (NSP) for HIV, TB and STIs for the period 2023 to 2028 comes at a critical time in our public health efforts as we move closer to Agenda 2030, where the global community must account against commitments made to end HIV and TB as public health threats. South Africa is among the United Nations member states that committed to the agenda to improve the quality of life of all our citizens. SA is also a signatory to other important local and international Declarations on HIV and TB and it is time for ordinary South Africans to experience the full benefit of these commitments. The country's commitments for improving people's lives are further demonstrated in our nation's own National Development Plan (NDP) 2030 and the NSP is a strategic framework that guides the multi-stockholder HIV, TB and STIs contribution towards the NDP, and ultimately Agenda 2030.

This particular NSP is the last one to see the country through the 2030 finish line. It is therefore important to ensure that it is guided by hard evidence informed by global trends and emerging priorities, but always intentionally taking the country's epidemiological profile into context, as we address the three epidemics. This NSP has also been informed by lessons learnt from the COVID-19 pandemic which caused significant disruptions of access to HIV, TB and STIs prevention, screening, testing and treatment services. The disruptions resulted in the deferment of the 2017-2022 NSP by an additional year in order to implement Catch-Up Plans to mitigate against the negative impact thereof. The proper implementation of the new NSP will require strong political will, robust civil society and private sector involvement, efficient government services, as well as a coordinated support by development partners and, above all, an active participation by all South Africans. In brief, we will only get it right with shared leadership and shared accountability among all stakeholders.

Although we have made considerable strides in certain areas, such as HIV-testing, we are still lagging behind on initiating and retaining infected people on antiretroviral therapy. Among the nearly 8 million people living with HIV, about 5,7 million of them are on treatment, leaving us with a 5.7 gap of over 2 million people who should be on treatment but are not. It is also concerning that the percentage and levels of viral suppression are not enough to reap the full benefits of treatment as prevention. There are similar challenges with TB – the data indicates that in 2021, South Africa had a TB incidence of 304 000, however, only 187 375 notifications were recorded, thus leaving us with a gap of 111 625 missing people with TB. We must work harder to scale up awareness, screening and testing, treatment adherence and to combat TB-related stigma and discrimination. There is also an increasing trend of people infected with TB who are asymptomatic and are not picked up with routine screening – this calls for an urgent move to utilise advanced testing tools such as digital chest X-rays, which are game changers in the detection of asymptomatic TB. Involvement of communities remains a key factor in managing and combating TB to minimise the development of MDR/XDR TB.

As we begin the implementation of this NSP until 2028, it cannot be business-as-usual. We must find innovative ways of providing quality health services to people and we must ensure that our health

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systems are resilient and responsive. Our approaches must be grounded on human rights principles, gender-sensitive and tailored for the specific needs of key and priority populations.

This is "The People's NSP", and all our endeavours must demonstrate that our people are placed at the centre of every effort.

Let Our Actions Count!

Dr. Joe Phaahla
Minister: RSA Department of Health
Member of the SANAC Inter-Ministerial Committee

Foreword

Message from the RSA Deputy President and SANAC Chairperson

The National Strategic Plan for HIV, TB, and STIs serves as a blueprint and roadmap to guide and inform the country's response to HIV, TB and STI epidemics.

Through the implementation of the four previous National Strategic Plans, South Africa has made notable progress with respect to the HIV-prevention and treatment programme, with over 5.7 million people on treatment. Of those on treatment and tested for viral-load suppression, about 92% were virally suppressed as of November 2022.

New HIV infections have been declining and continue to do so. Successes have also been recorded in the prevention of mother-to-child transmission of HIV.

At the centre of implementing the National Strategic Plans since 2000, has been partnerships and collaboration among government, civil society, organised labour and business sectors of SANAC. These partnerships have been strengthened over time, resulting in the development and launch of the SANAC Partnerships Strategy in 2020 and the adoption of the Policy-in-Action approach, which ensures multi-sectoral provision of integrated services to communities, including those that are most vulnerable and hard to reach.

As a result of the negative impact of the COVID-19 pandemic on the delivery of HIV and TB services, SANAC extended the NSP 2017-2022 by one year, to end in March 2023. This extension allowed the country to accelerate service provision towards the attainment of both national and global targets, through catch-up plans developed at national and provincial-levels.

This fifth National Strategic Plan (NSP) for HIV, TB and STIs NSP 2023-2028 provides the strategic framework for a multi-sectoral approach that is people-and communities-centred to overcome these three epidemics as public health threats and social challenges.

This new NSP provides a review of the burden of disease for HIV, TB and STIs; outlines some of the progress we have made; as well as several challenges that need to be addressed with urgency.

The bold strategic objectives and targets described in the NSP followed from extensive analysis of literature, the South African disease burden, lessons from the COVID-19 epidemic, review of other global HIV, TB and STI strategic documents and extensive multi-sectoral consultations. These consultations extended to key and other priority populations such as sex workers, people with disabilities and the LGBTQI+ community to mention a few. The development of this NSP was, therefore, driven by the support and contributions of many dedicated people and organisations across the country, from all walks of life. We are appreciative of their efforts, which have resulted in a comprehensive strategic plan, dubbed "The People's NSP", with clear priority actions and accountability mechanisms supported by available resources.

In this NSP, we have emphasised the need to break down barriers and maximise equitable access to HIV, TB and STI services. This strategic plan also has a

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dedicated comprehensive component of STIs as well as solutions through resilient health systems. The plan further elevates the importance of multi-sectoral partnerships in response to the epidemics.

The effective implementation of this NSP will require strong governance and leadership, and the involvement of all sectors of society including government, business, organised labour, civil society, development partners, research institutions and communities in general.

The objectives and planned priority actions of this NSP are closely aligned with the National Development Plan: Vision for 2030, locating the fight against HIV, TB and STIs within the broader agenda for economic and social development. These are interlinked efforts as progress in reducing the burden of disease contributes to development, while faster development reduces social barriers and enhances equitable access to HIV, TB and STI services and solutions.

We remain resolute in the mission to eliminate HIV, TB and STIs in the country.

This National Strategic Plan (NSP) is about the people and communities of South Africa, and how they can be supported to achieve optimal health and social outcomes. Let us work together to implement it to end inequalities and barriers to accessing HIV, TB and STI services and solutions, so that we are on track to eliminate the three epidemics as public health threats by 2030.

This is the last NSP ahead of the 2030 target of ending HIV and TB, and we dare not fail.

Deputy President David Mabuza
Chairperson: South African National AIDS Council (SANAC)

Message from the Chairperson of the Civil Society Forum (CSF)

The 5th National Strategic Plan on HIV, TB and STIs (NSP) NSP 2023-2028 is "The people's NSP" and will be launched by Deputy President of the Republic of South Africa on 24 March 2023 during the commemoration of World TB Day. The NSP is a very important plan that guides the country's approach and commitment to achieve the set goals to respond to HIV, TB and STIs in the country.

In the past two decades of implementation of the previous generations of the NSP, we have evolved as a country in continuing to understand the nature and the impact of our epidemics, also given that in the last three years we collided with other public health threats such as COVID-19, and in this regard understanding the factors that colliding epidemics contribute to the challenge we have around HIV, TB and STIs response, including Gender-Based Violence and Femicide.

We have overcome in our country. From the health response, we have learnt to understand the pandemic, and now we are looking at comprehensive, strategic, and progressive approaches to reduce infections, morbidity, and mortality in our response and responsibility as a country.

The goals in the NSP speak to shared objectives, shared responsibility, shared leadership, and shared accountability. It is an excellent illustration of what South Africans can achieve. It speaks to the work that Government, Civil Society, Labour, the Private Sectors and Development Agencies are doing and how every stakeholder can leverage from each other. But significantly it speaks to the aspirations of our country, locating the struggle against HIV, TB and STIs within the broader struggle for economic and social development.

It speaks to faster developmental approaches that improve our ability to address the social and structural drivers and it pays attention to the people and beneficiaries. It recognises the need to ensure our response is both comprehensive, focused and yields the results we envisaged from a rights-based approach.

It seeks to address the main factors that contribute to the high rates of infections, we saw in the last NSP and the current one that we are closing out, that we still have not reached the targets that we set for ourselves, that we wanted to see less than 8 800 new infections in the country annually. We are still not close to that target; we are investing our efforts on increasing prevention efforts and interventions that speak to people. Additionally, to that we do not want to see more people getting sick or dying from HIV and TB when we can actually eliminate all these challenges, including reaching the target of putting people on treatment and also reaching the target of suppressing the viral load. Which is the end goal! As a country, we seek to achieve the Undetectable equals Untransmittable (U = U) status!

To do so, our significant progress and agenda must prioritise our increased efforts and focus on

prevention, treatment, uptake, coverage, adherence and ending stigmatisation and discrimination.

At the same time, we must have specific programmes that address and reach the highest burden experienced by key and other priority populations that are affected by many of these diseases that we are dealing with. These programmes must be evidence-based, we must make use of data and greater knowledge – including linking this work to what SANAC has established which is called "the situation room", a place where we as a Council would be banking our information and knowledge – and that's where we will analyse, monitor and evaluate ourselves as a country to ensure we know our progress and what needs to happen next.

Our motto as the country is to leave no one behind, so we are paying a closer look on inclusivity at the level on which we engage. The NSP is about saving lives, in particular, the work entails that we undergo as a collective a process that improves the lives of ordinary South Africans and those in the country.

The SANAC community has invested in a robust consultation process towards development of this NSP. 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. In that way all stakeholders must perform to the best of their ability and ensure collective effort at all times. No stakeholder can achieve this work alone. Our co-existence will make us a winning nation.

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. Communities Matter! Make it your business to ensure that transformation and sustainable approaches are adopted. In this way communities become and remains the agents of change!

The people in South Africa and the rest of the world deserve better services, for better health outcomes. The need for continuation of collective and political momentum towards ending HIV, TB and STIs will be required and can be achieved as it is in our hands to get to 2030 agenda. Make it count!

Steve Letsike
Chairperson – Civil Society Forum

Message from the Chairperson of the Private Sector Forum (PSF)

South Africa currently faces the monumental task of combating HIV, TB and STIs while simultaneously confronting an array of complex socioeconomic challenges. International conflict and economic instability have certainly contributed to this, but perhaps the most profound impact was made by the COVID-19 pandemic. Indeed, by the beginning of February 2023, the National Institute for Communicable Diseases reports that there have been over 4 million COVID-19 cases and more than 102 000 related-deaths in South Africa since the beginning of the pandemic. The impact on our health systems has also been devastating – from overworked, exhausted and under-resourced health professionals to the redirection of crucial resources from other priorities to acutely focus on this global health emergency.

Whilst we are slowly moving towards the recovery phase, we need to urgently catch-up in our fight against the HIV, TB and STIs in South Africa. As 2030 looms ever closer, this date is of great relevance not just to the vision set for the promotion of health in our country in the National Development Plan, but also to the Sustainable Developments Goals and, specifically, targets 3.2 and 3.7 (which relate to infectious diseases and sexual and reproductive health, respectively).

Against this backdrop, we welcome the new National Strategic Plan (NSP) and HIV, TB and STIs for 2023-2028. Moreover, we believe this plan has the potential to galvanise a "whole-of-society" effort as we strive towards accessible and quality healthcare for all.

The new NSP is grounded on a robust situational analysis and sets four clear goals, with a cascade of targets, to address key priorities. Importantly, this NSP emphasises an inclusive community-based approach while broadening its scope to encompass other important communicable diseases (such as viral hepatitis and COVID-19), mental health and cancer of the cervix. Emphasis is also placed on the joining-up of social services and healthcare to ensure integrated and effective delivery at scale.

In order to accomplish the four laudable goals of the NSP, all sectors of society must come to the table. This includes the private sector as a critical stakeholder group, and it is in this regard that SANAC's Private Sector Forum (PSF) has a crucial role to play.

The PSF has, from its inception, closely aligned itself with NSP implementation. Indeed, the first PSF Strategic Plan (launched in March 2022) was deliberately set to cover one year only; this was to ensure that its subsequent, full five–year Strategic Plan could run in tandem with the NSP 2023-2028 so as to maximise synergies between the two plans.

As the newest member of the SANAC family, the PSF is ready to take up its role as an ally in the battle against HIV, TB and STIs. This pertains not only to resource mobilisation, but also to working as a strategic partner and fully-engaged stakeholder. We will join hands with civil society, government, and the many communities across our country for the purpose of accomplishing the NSP's vision of a "South Africa free from the burden of HIV, TB and STIs".

Nompumelelo Zikalala
Chairperson – SANAC Private Sector Forum

Acknowledgements

The South African National AIDS Council (SANAC) is mandated to bring together government, civil society and all other stakeholders to provide an exceptional country-wide response to the major public health challenge of HIV, TB and STIs. Therefore, this NSP positions people and communities at the centre of the response effort and was developed through multiple dialogues and consultations at various levels with stakeholders. It was developed by the people, for the people and the communities affected by TB, HIV and STIs to leave no one behind in the implementation of evidence-based interventions through a multi-sectoral approach that is inclusive and participatory.

This NSP has benefited from the remarkable commitment and contributions of several people, departments, and organisations to mention all by name. Special appreciation goes to the following groups for their contributions and dedication to the in-depth NSP processes.

1. All participants in the dialogues and consultations.
2. The NSP Steering Committee and its technical working groups, and the writing teams.
3. The AIDS Councils and their Secretariats.
4. The funding agencies and their partners.
5. The UN Agencies, PEPFAR and their partners.
6. All SAG Departments.
7. SANAC Council Structures, Constituancies, Staff & Stakeholders.

Acronyms

ABYM	Adolescent Boys and Young Men
AGYW	Adolescent Girls and Young Women
AHD	Advanced HIV Disease
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
AYFS	Adolescent and Youth-Friendly Service
AYP	Adolescents and Young People
CBO	Community-Based Organisation
CCMDD	Central Chronic Medicines Dispensing and Distribution
CHCW	Community Healthcare Worker
COGTA	Department of Cooperative Governance and Traditional Affairs
CONTRALESA	Congress of Traditional Leaders of South Africa
CSE	Comprehensive Sexuality Education
CSIR	Council for Scientific and Industrial Research
DBE	Department of Basic Education
DCS	Department of Correctional Services
DED	Department of Economic Development
DHA	Department of Home Affairs
DHET	Department of Higher Education and Training
DHIS	District Health Information System
DIRCO	Department of International Relations and Cooperation
DOA	Department of Agriculture
DOJ	Department of Justice
DOL	Department of Labour
DSAC	Department of Sport, Arts and Culture
DPME	Department of Planning, Monitoring and Evaluation

Acronyms

DPSA	Department of Public Service and Administration
DS-TB	Drug-Sensitive TB
DSBD	Department of Small Business Development
DSD	Department of Social Development
DSI	Department of Science and Innovation
dtic	Department of Trade, Industry and Competition
ECD	Early Childhood Development
EIMC	Early Infant Male Circumcision
EPI	Expanded Programme for Immunisation
EPWP	Expanded Public Works Programme
FBO	Faith-Based Organisation
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HCW	Healthcare Worker
HIV	Human Immunodeficiency Virus
HPRS	Health Patient Registration System
HPV	Human Papillomavirus
HSRC	Human Sciences Research Council
HTS	HIV-testing Services
HW	Health Worker
IBBS	Integrated Bio-Behavioural Survey
ICRM	Ideal Clinic Realisation and Management
IEC	Information, Education and Communication
IT	Information Technology
LGBTIQ+	Lesbian, Gay, Bisexual, Trans, Intersex, and Queer or Questioning

LMIC	Low- and Middle-Income Country
MDR-TB	Multidrug-Resistant TB
M&E	Monitoring and Evaluation
MSM	Men Who Have Sex with Men
MTCT	Mother-To-Child Transmission
MTEF	Medium-Term Expenditure Framework
MUS	Male Urethritis Syndrome
NCD	Non-Communicable Disease
NDA	National Development Agency
NDOH	National Department of Health
NDP	National Development Plan
NHI	National Health Insurance
NHLS	National Health Laboratory Services
NICD	National Institute for Communicable Diseases
NPA	National Prosecuting Authority
NRF	National Research Foundation
NSP	South Africa's National Strategic Plan for HIV, TB and STIs
NTP	National TB Programme
PBAW	Pregnant and Breastfeeding Adolescents and Women
PCA	Provincial Council on AIDS
PEP	Post-Exposure Prophylaxis
PFM	Public Financial Management
PHC	Primary Healthcare
PITC	Provider-Initiated Counselling and Testing
PLHIV	People Living with HIV
PPE	Personal Protective Equipment

Acronyms

PrEP	Pre-Exposure Prophylaxis
PSE	Population-Size Estimation
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
PWTB	People with TB
OST	Opioid Substitution Therapy
SADC	Southern African Development Community
SAHPRA	South African Health Products Regulatory Authority
SAHRC	South African Human Rights Commission
SALRC	South African Law Reform Commission
SANAC	South African National AIDS Council
SANC	South African Nursing Council
SBCC	Social and Behaviour Change Communication
SGBV	Sexual and Gender-Based Violence
SI	Strategic Information
SIB	Social Impact Bond
SOP	Standard Operating Procedure
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TPT	TB-Preventive Treatment
THPCSA	Traditional Health Practitioner Council of South Africa
TWG	Technical Working Group

UNAIDS	Joint United Nations Programme on HIV and AIDS
U=U	Undetectable = Untransmittable
UHC	Universal Health Coverage
ULAM	Urine Lipoarabinomannan
VDS	Vaginal Discharge Syndrome
VEP	Victim Empowerment Project
VMMC	Voluntary Medical Male Circumcision
WBOT	Ward-Based Outreach Team

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Introduction

The 5th generation NSP for HIV, TB and STIs launches at a time when the COVID-19 pandemic has affected access and the provision of services and solutions for HIV, TB and STIs and amplified inequalities. Consequently, this NSP outlines comprehensive multi-sectoral strategic objectives and priority interventions to be carried out to get the HIV, TB and STI response on track to eliminate these diseases as public health threats by 2030.

The emphasis in the NSP 2023-2028 has been to provide innovative, people- and communities-centred interventions and multi-sectoral approaches to reduce the barriers and enhance access to equitable HIV, TB and STI-prevention and treatment services.

A multi-sectoral Steering Committee under SANAC guided the process of creating this NSP. The processes followed in developing NSP 2023-2028 objectives and priority interventions comprised a review of the epidemics in South Africa, evidence-based interventions in literature and international guidelines, global strategies and extensive consultations with multiple stakeholders and communities. The strategic framework and objectives are also aligned with the NDP. The NSP has been endorsed by the SANAC Plenary and the national Cabinet.

The epidemics in perspective

South Africa has made progress in reducing the disease burden of HIV, TB and STIs. However, these diseases remain a major public health problem, especially in key and other priority populations.

The COVID-19 pandemic widened the underlying inequalities, reversed some gains and added additional strain on the already overburdened health system. Equitable and equal access to solutions and services for HIV, TB and STIs will require all sectors, at all levels of society, to implement evidence-based policies and practices that actively address the root causes of health disparities. Human rights and gender-related barriers continue to have a negative impact on the effectiveness of the response and impede progress.

South Africa remains the epicentre of the HIV epidemic. Although new HIV infections are on a downwards trend, they are not declining fast enough, and we did not achieve the globally agreed fast-tracked target of 75% reduction by 2020 from the 2010 baseline. Inequalities continue to drive HIV in South Africa. Adolescent girls and young women (AGYW) have disproportionately high HIV risks.

South Africa has the largest HIV-treatment programme in the world. Progress has been made in finding people living with HIV (PLHIV) who are not on treatment and ensuring they access HIV-testing and treatment services and are virologically suppressed. This was made possible by the massive scale-up of HIV-treatment by adopting the HIV Universal Test and Treat (UTT) approach in 2016. Using innovative, differentiated models of HIV care and the UTT policy, South Africa adopted the WHO's recommended tenofovir disoproxil fumarate-lamivudine-dolutegravir (TLD) as first-line antiretroviral therapy (ART) for both ART-naive and for some ART-experienced individuals. This has resulted in over five million people on ART, many of whom are doing well and living a normal lifespan with treatment.

Executive Summary

However, South Africa is still facing challenges across the HIV-treatment cascade, aggravated by human resource shortages and disruptions caused by the COVID-19 pandemic. Across all provinces, many are being left behind. Children and adolescents continue to lag behind adults in the AIDS response. The stagnation seen in the past three years is unprecedented, putting too many young lives at risk of sickness and death. AIDS-related mortality has declined largely because of the success of the HIV-treatment programme. Whereas women are the face of the HIV epidemic, men are the face of AIDS-related deaths. Men account for only a third of South Africa's 210 000 new HIV infections in 2021. They account for more than half of the approximately 51 000 HIV-related deaths in the same period.

TB is also a major cause of morbidity and mortality, with a total of 172 200 people diagnosed with TB in 2021. Among these, 4% had multidrug-resistant TB (MDR-TB). The treatment success rate is 78% for drug-sensitive TB (DS-TB) and 65% for MDR-TB. There is high HIV-TB coinfection, with 53% of TB patients also infected with HIV. There has been a significant decline in the prevalence of syphilis. However, there

has been no substantial decrease in gonorrhoea and chlamydia cases for the past 30 years. In 2017, there were an estimated 4.5 million people diagnosed with gonorrhoea, 5.8 million people with chlamydia and 70 675 with syphilis. Hepatitis B test positivity was 6.8% in the general adult population over the past five years, and hepatitis C prevalence, particularly among people who inject drugs, remains high. The HIV, TB and STI incidence and prevalence vary by province and population group. Key and other priority populations at high risk of disease or that experience barriers to accessing services are described and offered tailored services.

The national response to HIV, TB and STIs needs to be strengthened to reduce the morbidity (illness) and mortality (death) associated with HIV, TB and STIs in South Africa.

What is new in this NSP

NSP 2023-2028 highlights the bold strategic objectives that aim to reduce barriers to accessing health and social services. It builds on lessons from the previous NSP and promotes a new and urgent focus to reduce inequalities for all people living with HIV, TB and STIs who are not benefiting from treatment and care services. The inclusion of mental health services and social support is based on the strong association between HIV, TB, STIs, sexual and gender-based violence (SGBV), human rights violations, inequalities, and mental health. Viral hepatitis has also been included in this NSP as a neglected infection of high prevalence linked to HIV and STIs.

In this NSP there is a new focus on improving the quality of life beyond HIV suppression. In the era of modern ART people living with HIV can expect to live a normal lifespan. However, substantial barriers to accessing non-HIV-related care exist and impact the well-being of this population. Therefore, interventions that include integration of HIV care with Non-Communicable Diseases (NCDs) such as diabetes, and hypertension, cervical cancer and mental health issues have been included.

The STIs section of the NSP has been expanded compared to the previous NSP, with a strong focus on access to diagnostic tests and vaccines to overcome the burden of disease associated with these infections. Also, the inclusion of the cervical cancer cascade is new.

Furthermore, there is a greater emphasis on multi-sectoral partnerships, commitment, and accountability in implementing the NSP. This includes community-based and community-led interventions.

Lastly, NSP 2023-2028 recognises that evidence-based tools and interventions are already being employed. However, to accelerate the fight against HIV, TB and STIs, innovation is urgently needed.

Special considerations for key and other priority populations are illustrated through text boxes that point out relevant interventions at the end of each section.

NSP vision, mission, and principles

Vision

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.

Guiding principles

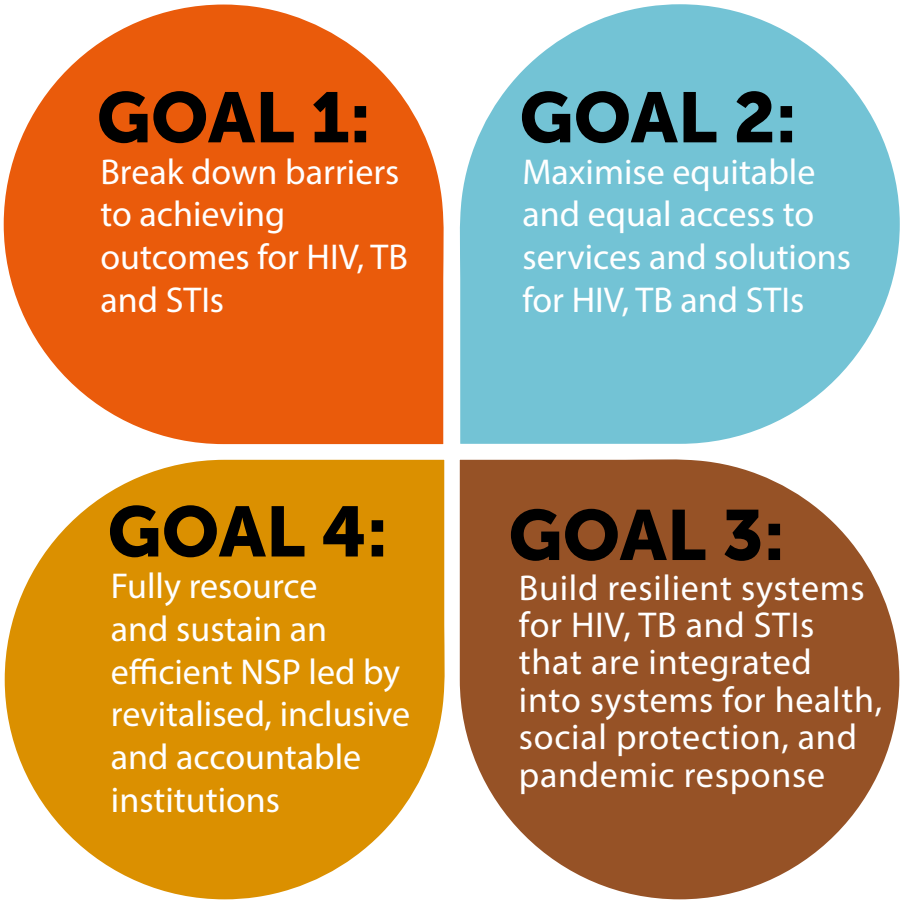
Several key principles guide the development and implementation of this NSP.

- The objectives and interventions in this NSP have been designed to place people and communities at the centre, providing people-centred health and social services.
- Universal health coverage (UHC) and comprehensive responses that integrate prevention, treatment, care and support ensure that no one is left behind.
- A response that is inclusive and participatory.
- A substantial proportion of measurable community-led and community-based interventions driven by empowered communities, including key and other priority populations.
- A multi-sectoral approach in addressing inequalities that drive the epidemics.
- A commitment to protecting and promoting human rights and gender equality.
- Evidence-based innovation in the processes and tools to reduce HIV, TB and STIs.

National Strategic Plan for HIV, TB, and STIs Goals

This comprehensive strategy that aims to place the country on track to eliminate HIV, TB and STIs as public health threats by 2030 has been devised into **four** interlinked goals, and **28** objectives.

The four strategic goals are:



Goal 1

Break down barriers to achieving outcomes for HIV, TB and STIs

Social and structural enablers improve the effectiveness and efficiencies of HIV, TB and STIs programmes by removing barriers to service availability, access, and uptake in communities.

The objectives of Goal 1:

Objective 1.1	Strengthen community-led responses to HIV, TB, and STIs.
Objective 1.2	Contribute to poverty reduction through the creation of sustainable economic opportunities.
Objective 1.3	Reduce stigma and discrimination to advance rights and access to services.
Objective 1.4	Address gender inequalities that increase vulnerabilities through gender-transformative approaches.
Objective 1.5	Enhance non-discriminatory legislative frameworks through law and policy review and reform.
Objective 1.6	Protect and promote human rights and advance access to justice.
Objective 1.7	Integrate and standardise delivery and access to mental health services.

Goal 2

Maximise equitable and equal access to services and solutions for HIV, TB and STIs

NSP 2023-2028 adopts a people- and communities-centred approach to prevention, treatment and care programmes for HIV, TB and STIs. The participatory and inclusive priority actions consider the people and communities as equal partners in the fight against TB, HIV and STIs.

The objectives of Goal 2:

Objective 2.1	Increase knowledge, attitudes and behaviours that promote HIV-prevention.
Objective 2.2	Reduce new HIV infections by optimising the implementation of high-impact HIV-prevention interventions.
Objective 2.3	Eliminate vertical transmission of HIV.
Objective 2.4	Ensure that 95% of PLHIV, especially in key and other priority populations, know their status and 95% of them are on treatment, and 95% of those on treatment are retained in care and achieve long-term viral suppression.
Objective 2.5	Improving the quality of life beyond HIV suppression by reducing HIV-related death and comorbidities, coinfections, and complications.
Objective 2.6	Strengthen TB-prevention interventions for key and other priority populations and implement airborne infection-prevention and control in health facilities and high-risk indoor places where people congregate.
Objective 2.7	Strengthen TB diagnosis and support for people with TB (PWTB), and accelerate the scale up of innovative processes, diagnostic tools and regimens for the diagnosis, treatment, and care for PWTB.
Objective 2.8	Increase detection and treatment of four curable STIs through systems strengthening, service integration and diagnostic testing; achieve elimination targets for neonatal syphilis; and scale up human papillomavirus (HPV) vaccination and cervical cancer screening.
Objective 2.9	Reduce viral hepatitis morbidity through scale up of prevention, diagnostic testing, and treatment.

Goal 3

Build resilient systems for HIV, TB and STIs that are integrated into systems for health, social protection, and pandemic response.

Robust and resilient systems for HIV, TB and STIs integrated into systems for health, social and pandemic response are essential for an effective response and optimal health outcomes. The effects of the COVID-19 pandemic and ongoing challenges of low-resource availability and difficulty with access to services continue to affect many services. Therefore, NSP 2023-2028 will strengthen local organisations and institutions by identifying policies, institutions and technologies that enable the locally driven design of resilient systems.

The objectives of Goal 3:

Objective 3.1	Engage adequate human resources to ensure equitable access to services for HIV, TB, STIs and other conditions that contribute to these diseases.
Objective 3.2	Use timely and relevant strategic information for data-driven decision-making.
Objective 3.3	Expand the research agenda for HIV, TB and STIs to strengthen the national response.
Objective 3.4	Harness technology and innovation to fight the epidemics with the latest available tools.
Objective 3.5	Leverage the infrastructure of HIV, TB and STIs for broader preparedness and response to pandemics and various emergencies.
Objective 3.6	Build a stronger public health supply chain management.
Objective 3.7	Strengthen access to comprehensive laboratory testing for HIV, TB and STIs, including molecular diagnostics, serology, and culture.
Objective 3.8	Support the acceleration of the approval of new health products.

Goal 4

Fully resource and sustain an efficient NSP led by revitalised, inclusive and accountable institutions.

Financial and political support with a resolute commitment to eradicate HIV, TB and STIs by political heads of departments and their teams are critical in translating the aspirations and goals of this NSP into concrete action and results.

Despite increasing resource needs for this ambitious NSP, fiscal space for increased spending on health over the period will remain constrained. South Africa and its partners will need to invest smarter and in harmony, based on economic evidence, and just as importantly, spend efficiently to ensure that the NSP's targeted outcomes are achieved.

The objectives of Goal 4:

Objective 4.1	Sufficient domestic and external funds are mobilised and allocated to facilitate the efficient implementation and coordination of HIV, TB and STI programmes and address the underlying associated risk factors that have direct consequences for these conditions.
Objective 4.2	Sustainability and transition plans and actions are routinely developed and implemented to ensure that NSP interventions remain on track to achieve short-, medium- and long-term goals.
Objective 4.3	Reset and reposition SANAC, all AIDS Councils and civil society organisations for optimal, efficient, and impactful execution of NSP 2023-2028.
Objective 4.4	Optimisation of synergies through forging mutually rewarding partnerships and alliances across the entire response value chain.

Introduction

1

Background

The NSP is the framework for a multi-sectoral approach for South Africa to overcome HIV, TB and STIs as public health concerns. The fifth NSP for HIV, TB and STIs 2023-2028 builds on the lessons learnt from previous strategies and the latest evidence-based innovations and broad-based inclusive consultations with stakeholders. Since 2000, when a series of strategic plans to guide the national response to HIV, TB and STIs started, the illnesses and deaths from these diseases have been significantly reduced.

However, this NSP also comes at a time when the COVID-19 epidemic has derailed the response to HIV, TB, and STIs because of reduced access to services, interrupted vaccination programmes, diversion of funds for the pandemic response and volatility of the economy. COVID-19 also exposed persisting inequalities in the country. Therefore, an urgent strategic course modification is needed to get South Africa's response back on track to eliminate HIV, TB, STIs and viral hepatitis as public health threats by 2030. This NSP for HIV, TB and STIs 2023-2028 outlines the goals, objectives and priority actions that constitute a national response to get the country back on track. The emphasis in this NSP is a people- and communities-centred response to reduce inequalities and increase access to health and social services.

NSP 2023-2028 is aligned with international and regional responsibilities, commitments and targets related to HIV, TB and STIs and aims to guide priority actions for government, civil society, development partners and the private sector. International and local development partners will use the NSP to plan and support the country in its efforts to end HIV, TB, and STI epidemics. SANAC will use NSP 2023-2028 as a framework to coordinate and monitor implementation by all sectors, provinces, districts and municipalities.

The success in the implementation of this NSP will rely on a coordinated multi-sectoral approach to strengthen health and social systems. High-impact and proven tools remain the mainstay of ending the HIV, TB, STI and viral hepatitis epidemics once barriers to access are removed. Furthermore, investment in capacity building of the health workers, communities and other stakeholders will be essential to support the implementation of NSP 2023-2028.

Vision

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.

Goals

To create healthy and equitable societies without the burden of diseases through four integrated goals.

- **Goal 1:** Break down barriers to achieving solutions for HIV, TB and STIs.
- **Goal 2:** Maximise equitable and equal access to services and solutions for HIV, TB and STIs.
- **Goal 3:** Build resilient systems for HIV, TB and STIs that are integrated into systems for health, social protection, and pandemic response.
- **Goal 4:** Fully resource and sustain an efficient NSP led by revitalised, inclusive and accountable institutions.

Although objectives for some of the goals are very disease-focused, the implementation of screening, prevention, treatment and support for HIV, TB and STIs is to be integrated.

Guiding principles

Several key principles guide NSP 2023-2028.

- The objectives and interventions in this NSP have been designed to place people and communities at the centre. This includes providing people-centred health and social services.
- UHC and comprehensive responses that integrate prevention, treatment, care and support ensure that no one is left behind. All people must have equal access to services irrespective of their geographical location and who they are.
- An inclusive and participatory response through broad-based consultations and a multi-sectoral approach in the implementation of the NSP.
- A substantial proportion of measurable community-led and community-based interventions are driven by empowered communities, including key and vulnerable populations.
- A multi-sectoral approach in addressing structural and social inequalities that drive the epidemic.
- A commitment to protecting and promoting human rights and gender equality.
- Evidence-based innovation in the processes and tools to fight HIV, TB and STIs.

The process of developing NSP 2023-2028

NSP 2023-2028 was developed through inclusive and transparent broad-based consultations with government departments, provinces, communities, civil society, the private sector, international stakeholders and development partners. In addition, an extensive analysis of progress made and observed challenges in the implementation of the NSP 2017-2022 was conducted to inform the development of this NSP. The process was led by SANAC and guided by the NSP 2023-2028 Reference Group and expert Technical Task Teams.

Reviews of the previous NSPs, existing guidelines, policies, laws, and local and international strategic documents and literature assisted with creating an evidence-based strategy adapted to the South African context. An extensive costing of the strategy assures the NSP is realistic and sustainable.

The NSP 2023-2028 has been endorsed by SANAC's Programme Review Committee, Plenary, and Inter-Ministerial Committee. Finally, Cabinet approval of the NSP was obtained.

What is new in NSP 2023-2028?

The focus of this NSP for HIV, TB and STIs 2023-2028 is the bold strategic objectives and vision to reduce inequalities. There are deliberate efforts to remove barriers to accessing health and social services for people affected by HIV, TB and STIs, irrespective of age and geographical location. This is supported by objectives that address stigma-reduction and promote and protect gender equality and human rights principles.

Adding mental health services integration responds to the clear two-way link between HIV, TB, SGBV, human rights violations, inequalities and mental health. To reduce harm in communities, persons and groups made vulnerable by inequalities are supported with health information, dignity packs, sensitised health facilities and personnel, law reform and redress for human rights violations.

Viral hepatitis prevention, treatment and care objectives and interventions have been included in this NSP as a neglected infection of high prevalence that causes significant illness and death that is also associated with HIV and STIs. In addition, because of the high burden of cervical cancer in South Africa and its strong link with HPV infection, a section on the cervical cancer care cascade has been included.

Multi-sectoral commitment and accountability of financial and human resources combined with services delivered in communities ensure that key and other priority populations have access to comprehensive high-impact solutions and services. Furthermore, there is a greater emphasis on community-based and community-led interventions.

This NSP also builds on evidence-based tools and interventions already employed. However, to accelerate the elimination of HIV, TB and STIs, new tools for diagnosing HIV, TB, STIs and viral hepatitis are needed, as well as more innovative processes such as test and treat strategies for TB and STIs.

The next sections cover the situational analysis: progress and trends in response to HIV, TB and STIs; key and other priority populations that should be specifically considered with interventions; and the goals of this NSP. The goals are introduced in summary, followed by sections for each goal that further describe the objectives and priority actions for each goal.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Situational analysis: Progress and trends in the HIV, TB and STIs response

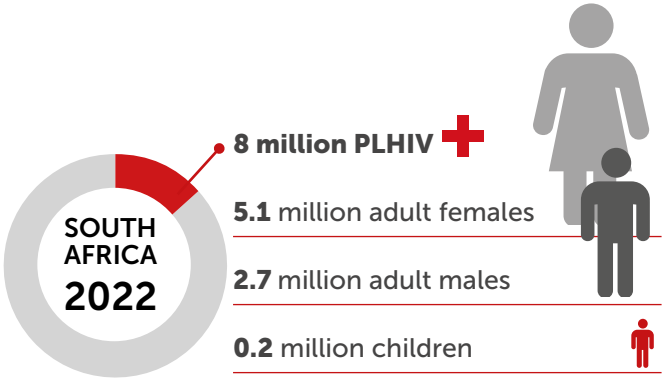
There has been good progress in the response against HIV, TB and STIs since the first NSP was launched in 2000, but much still needs to be done. In South Africa, the HIV, TB and STI epidemics are characterised by distinct sub-epidemics that are apparent geographically and among key and other priority populations. The situational analysis of HIV, TB, and STIs guides the strategic plan to focus on impact and informs the required interventions to bring the country on track to eliminate HIV, TB and STIs as public health challenges by 2030.

The COVID-19 pandemic heightened underlying inequalities, reversed some gains and added additional strain on already overburdened health, social, economic and legal systems. Non-COVID-related services were deprioritised, causing interruptions and delays in access to prevention, care and treatment services, which negatively affected mental and physical health.[1] Lockdowns led to many people in South Africa losing their source of income, directly affecting levels of food security and access to resources and social protection systems to reduce the impact of the pandemic. Comparing employment rates before (January to March 2020) and during the COVID pandemic (October to December 2020) shows that the number of women in formal employment reduced from 35% to 27% compared to a reduction from 44% to 36% among men in formal employment.[2]

Key and other priority populations were worst affected, as demonstrated by the increase in economic hardship, out-of-pocket healthcare spending, mental health conditions, orphans and SGBV.[3,4,5] Globally, it has been estimated that an additional 31 million cases of SGBV occurred as a direct impact of COVID-related lockdown regulations.

In South Africa, domestic violence cases increased by 37% per week compared to 2019.[6] At the same time, helplines saw an increase of 67% in SGBV-related calls in 2020[7] and shelters for survivors of violence were turning survivors away.[8]

Service availability disruptions ranged from clinics operating with limited staff, temporary clinic closures because of COVID infections, lockdown measures limiting the number of people allowed on clinic premises and cessation of outreach services for people who use drugs (PWUD) and other key populations.[9,10] Mobile units providing primary healthcare and sexual and reproductive health services, especially in rural areas were transitioned to provide COVID-related services, leaving many women without access to otherwise available services, including contraceptives.[11] HIV-testing uptake declined by 57% during the first month of lockdown because of the restriction of movement and fear of contracting COVID-19. Many people disrupted treatment. For example, in Gauteng, approximately 11 000 patients did not collect their HIV-treatment, and 1 000 patients did not collect their TB treatment during Level 5 lockdown.[12] The uptake of TB tests halved during the Level 5 lockdown.[13]



Barriers to achieving outcomes for HIV, TB and STIs

Achieving health equity requires all sectors at all levels of society to engage in policies and practices that actively address the root causes of health disparities. To determine what needs to change, individuals and communities must apply an equity lens to assess how social, built and natural environments influence health.[14] Societal enablers improve the effectiveness of health and social services by removing barriers to service availability, access and uptake in communities, while service and system enablers improve efficiencies in and expand the reach of health and social services and systems. This approach changes harmful social and gender norms, reduces inequalities and improves institutional and community structures to create societies with supportive legal environments and access to justice, gender-equal societies, societies free from stigma and discrimination, and multi-sectoral action across sectors to reduce exclusion and poverty.[15]

Human rights and gender-related barriers continue to adversely impact the effectiveness of the response and halt progress. These barriers include stigma; multiple and intersecting forms of discrimination, violence, and other rights abuses; discriminatory laws and practices; gender-based inequalities and violence; as well as HIV, TB and other diversity-based human rights violations that limit access to comprehensive and inclusive services.

Gender, gender inequalities and violence are intrinsically linked to the risk of HIV, TB and STI acquisition, barriers to services and adherence to treatment. Harmful gender norms limit the access of adolescent girls and women to rights and services; heighten risks for illness; and increase exposure to multiple and intersecting forms of stigma, discrimination and violence. Masculine identities adversely affect health-seeking behaviour and health outcomes for boys and men.[16-20]

HIV Disease Burden

Despite significant progress towards HIV control, the incidence remains high, especially among key populations, women and other priority populations. ART coverage is trailing diagnosis, and prevention efforts are ineffective in reaching national and global goals.

HIV prevalence: The proportion of PLHIV in South Africa was 13.5% in 2022, which equates to approximately 8 million PLHIV.[21] Of these, 5.1 million were adult females; 2.7 million were adult males; and 248 605 were children under 15.[21] HIV prevalence has been stable over the past five years because of the success of ART in improving survival and reducing mortality across all age groups. However, women continue to bear a disproportionate burden of the HIV epidemic. Almost a quarter (24.1%) of South African women aged between 15 and 49 years are HIV-positive compared to 13.1% of men[21]. Children and adolescents are falling through the cracks because we fail to find and test them and get them on life-saving treatment. South Africa registered a decline in HIV prevalence in pregnant women from 27% in 2017 to 23.9% in 2022.[22] Successes recorded in the prevention of vertical transmission in the NSP 2017-2022 include increasing the number of pregnant women living with HIV reporting already being on ART before their first antenatal visit from 52% in 2017 to 73% in 2021. The highest rates were reported in KwaZulu-Natal, and the lowest rates in the Northern Cape. This demonstrates the success of community mobilisation approaches and health facilities' engagements to identify people who are infected with HIV before they visited antenatal care facilities. Such successes help to prevent children living with HIV and must be strengthened to eliminate vertical transmission of HIV. HIV prevalence varies across provinces. KwaZulu-Natal and Gauteng constitute almost half of the total burden of HIV in the country. The prevalence is 11.8% in Gauteng and 17.6% in KwaZulu-Natal.[21] The top 12 districts with the highest prevalence of HIV are found

in KwaZulu-Natal and Mpumalanga, while those with the lowest HIV prevalence are in the Western Cape and the Northern Cape. HIV prevalence is highest in key and priority populations.

HIV incidence: There has been marked progress in reducing the number of new HIV infections in South Africa. The number of new HIV infections in 2010 (401 608) compared to 2021 (198 311), reduced by 51% (Figure 1).[21] New HIV infections among younger children (0-14 years) dropped by 52% between 2010 and 2021, and new infections among adolescents (15-19 years) dropped by 40%.

However, from 2016 to 2021, the decline was 31%, which means that South Africa did not achieve the 63% reduction target in the NSP 2017-2022 to have new HIV infections less than 100 000 by 2022.[23] In addition, South Africa fell short of the global target set in 2010 to reduce HIV by 75% by 2020.[22] To achieve the global target of ending AIDS by 2030, South Africa must reduce new HIV infections from 189 000 in 2022 to 40 000 per annum. Almost two-thirds of all new infections (64%) occur in women. Of these, AGYW constitute more than a third (37%).[22] Notably, across all age groups, the incidence rate was highest in AGYW (1.14%), which was four times higher than the rate in adolescent boys and young men (ABYM) (0.35%).[21]

A provincial analysis shows that the top five provinces (Gauteng, Eastern Cape, Mpumalanga, KwaZulu-Natal and Limpopo) constitute almost 80% of all new HIV infections in 2021.[22] Most of the new infections were in Gauteng (21%), followed by KwaZulu-Natal (19%) and the Eastern Cape (16%).

South Africa registered a substantial reduction in the vertical transmission of HIV between 2010 and 2021. At birth, vertical transmission declined from 4.2% in 2010 to 1.3% in 2016 and 0.96% in 2021. The success is attributed to the high coverage of services targeted at vertical transmission prevention, from 44% in 2010 to 97% in 2021. The highest vertical transmission infections come from postnatal mother-to-child transmissions, which accounts for 67% of the 8 334 babies infected with HIV in 2021. Vertical transmission elimination must therefore target the postnatal period with innovative interventions.

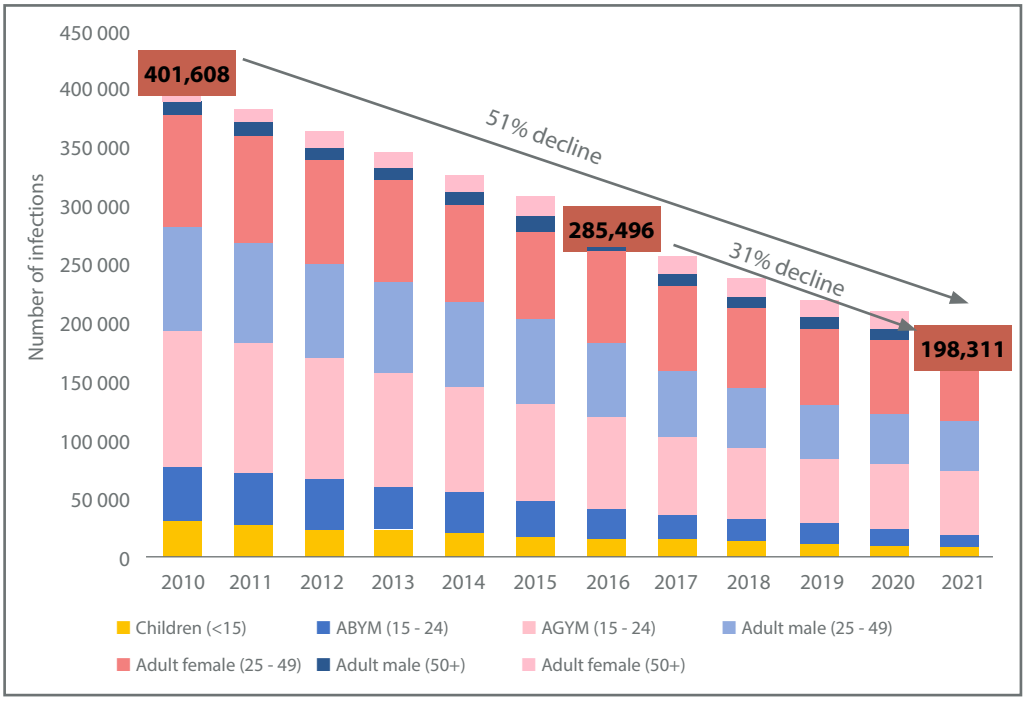
AIDS-related deaths: AIDS-related deaths have reduced dramatically over the past two decades, largely because of the success of the HIV-treatment programme. However, in 2022, there were still 51 000 AIDS-related deaths – only a slight decrease (10%) from 2019. Of these deaths, most were caused by TB and cryptococcal meningitis, preventable causes of HIV-related mortality. Advanced HIV disease (AHD) contributes to a third of AIDS-related deaths, as patients with AHD who present themselves for or re-enter care are at a higher risk of opportunistic infections and death. While men account for only a third of South Africa's 198 000 new HIV infections in 2021, they account for more than half of the approximately 51 000 HIV-related deaths in the same period. Children and adolescents are more vulnerable than adults to infection, morbidity and rapid disease progression and mortality. In South Africa at least seven children die of AIDS-related causes every day (Table 1) and an estimated 32 000 adolescents died of AIDS-related causes in 2021. The trend in AIDS deaths shows that the country did not achieve the fast-tracked target – a 75% reduction in AIDS deaths by 2020 relative to the 2010 baseline. [24] The "greying of HIV" – the ageing of PLHIV who benefit from ART and the emergence of age-related non-communicable diseases (NCDs), undiagnosed and untreated TB coinfection and limited nutritional and psychosocial support are other contributors to AIDS-related mortality. As is the case with new HIV infections, there is a need for critical analysis of factors accounting for AIDS deaths and to develop approaches to reduce AIDS deaths.

Table 1 AIDS-related deaths in South Africa by age group in 2021[24]

Indicator	Number of people
Adult and child deaths due to AIDS	51 000
Deaths due to AIDS among adults aged 15 and over	48 000
Deaths due to AIDS among women aged 15 and over	26 000
Deaths due to AIDS among men aged 15 and over	23 000
Deaths due to AIDS among children aged 0 to 14	2800

The latest data shows that 94.2% of all PLHIV know their status, and 75% of the people diagnosed were on treatment, which translates to 71% ART coverage.[21] Among those on treatment, 92% were virologically suppressed. This results in achievement of 94-78-89 against the UNAIDS 90-90-90 target. Women and girls are doing better across the HIV cascade than men and children living with HIV. Adult females are at 95-80-93, and adult males at 94-67-92, while children under 15 years are at 81-70-69.[21]

Figure 1: *Annual number of new HIV infections by sex and gender, 2010 to 2021*



Source: Thembisa Model 4.5[21]

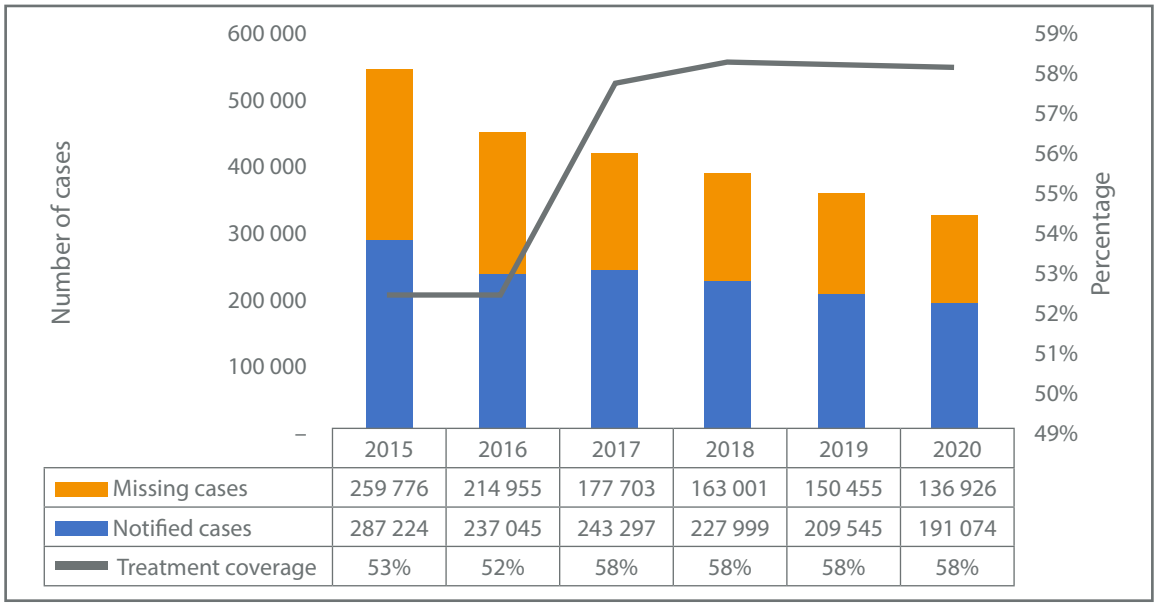
Tuberculosis Disease Burden

The country has made progress in the response to TB, as demonstrated by the declining TB incidence and mortality. However, missing cases remain high, and treatment outcomes are suboptimal. There is a dual burden of HIV and TB infections. The proportion of TB patients coinfected with HIV in 2021 was 53%, and 89% of these persons were already on ART.[25,26]

TB prevalence and incidence: South Africa is one of the 10 countries with the highest TB burdens in the world, accounting for two-thirds of all TB infections globally.[25,26] Based on a TB prevalence survey conducted between 2017 and 2019, South Africa's TB prevalence was 852 cases per 100 000.[25,27] In 2021, the incidence of TB in South Africa was 513 (CI: 348-709) per 100 000, a 48% reduction compared to 2015 but still well above the global average of 134 per 100 000.[25,26,28] A 48% reduction in TB incidence compared to 2015 is higher than the End TB Strategy target of a 20% reduction by 2020.[25] Among the people diagnosed with TB, 4.1% had MDR-TB/ rifampicin-resistant TB (RR-TB) and 0.4% had pre-extensively drug-resistant TB (XDR-TB) 25.26%. TB is also the leading cause of death in PLHIV, accounting for almost half of deaths.[29,6.]

Drivers of the TB epidemic: In South Africa, the TB burden is driven by poverty, socio-economic inequalities, migration and delayed or limited access to screening, TB investigations and treatment.[27,30,31] There is a strong link between undernutrition and low income and the TB incidence rate. Undernutrition weakens the body's immune system and is an important risk factor for active TB disease.

Figure 2: *Number of total TB notifications, missing cases, and case-detection rate, 2015 to 2020, for people ≥ 15 years*



	2015	2016	2017	2018	2019	2020
Missing cases	259 776	214 955	177 703	163 001	150 455	136 926
Notified cases	287 224	237 045	243 297	227 999	209 545	191 074
Treatment coverage	53%	52%	58%	58%	58%	58%

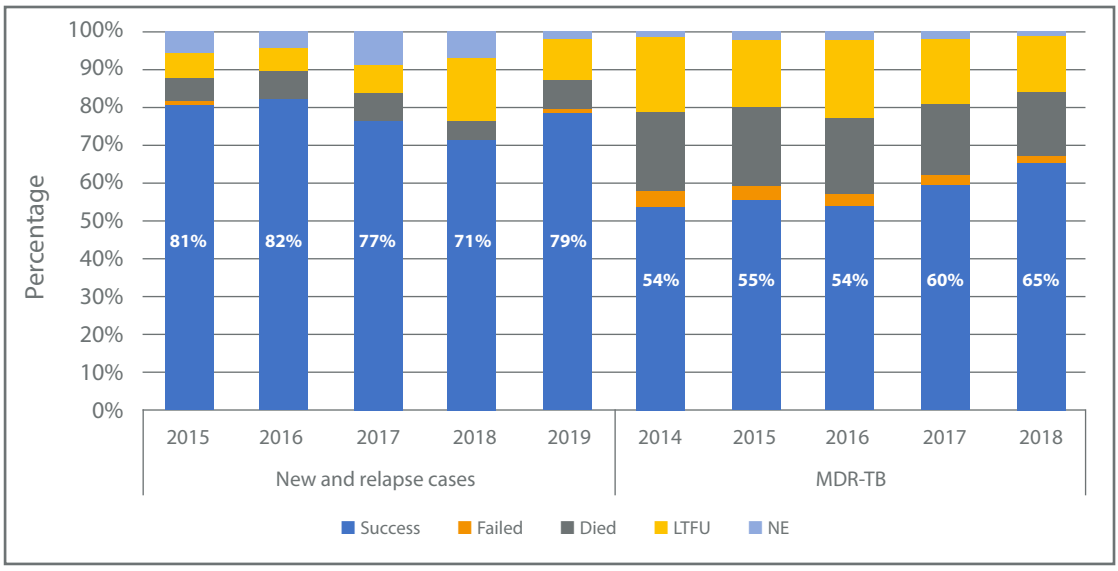
Source: WHO Global TB Report 2021[26]

In addition, living and working in crowded areas also increases the risk of acquiring TB.[26,3]

TB Testing-treatment gap: In South Africa, the estimated number of PWTB in 2021 was 304 (CI: 207-421) per 100 000 cases.[26] However, only 172 200 cases were reported in 2021, indicating that 40% of PWTB are neither diagnosed nor started on TB treatment.[25] This percentage of missing TB patients (estimated incidence of TB cases vs notified TB cases) has not changed much since 2015 (Figure 2).[26] The case-detection gap is higher for children (0-14 years) and MDR-/RR-TB.[25] Some reasons for the large case-detection gap include delayed health-seeking behaviour and low adherence to screening and diagnosis guidelines.

Treatment success rate in new and relapsed TB patients who initiated TB treatment in 2019 was 79% and thus falling short of the NSP 2017-2022 target of 90% for DS-TB.[23,26] Similarly, in the drug-resistant category there was a 65% treatment success rate, but this falls short of the NSP 2017-2022 target of 75% (Figure 3 – TB treatment success rate).[26] The case fatality ratio in adults initiated on TB treatment was 6.9% in 2016, which has declined from 10.4% in 2009, whereas in children and adolescents it decreased from 3.3% in 2007 to 1.9% in 2016.[26] Mortality in TB patients not linked to care or untreated TB is estimated at 17.1%.[26] A total of 56 000 people died of TB in 2021. This is a 15% reduction compared to 2015, which is below the 35% reduction in the number of TB deaths by 2020 END TB strategy target.[25] Based on 2021 data, 56% of PWTB face catastrophic costs, which is substantially higher than the 0% target by 2020.[25]

Figure 3: *Drug-sensitive TB treatment outcomes, 2015 to 2018*



Source: WHO Global TB Report 2021[26]

STIs Disease Burden

STIs prevalence: In the South African public health sector and other low- and middle-income countries (LMICs) STIs are treated using the syndromic management approach, which is associated with significant overtreatment of people with symptoms and undertreatment of asymptomatic infections.[32] As diagnostic testing is not routinely performed, there is limited STI surveillance, resulting in a lack of population-level prevalence and incidence data. In the absence of this data, the World Health Organisation (WHO) Spectrum STIs model is used to estimate the prevalence and incidence of syphilis, gonorrhoea and chlamydia, as summarised in Box 1.[33] The existing data confirms that there has been no significant decline in chlamydia and gonorrhoea cases over almost 30 years, despite large investments in HIV/STI-prevention programmes.

Syphilis trends: A trend analysis of data from the general adult population from 1985 to 2017 shows that there has been a significant decrease in syphilis cases over the years, following the introduction of syndromic management in the late 1990s and the implementation of routine syphilis screening in the antenatal-care programme.[33] The number of newborns with congenital syphilis was stable between 2010 and 2018, ranging from 89 to 127 per 100 000 live births but sharply increased to 165 per 100 000 live births in 2019.[33,34] South Africa has therefore moved further away from the WHO targets for eliminating MTCT of syphilis.

STI programme: Data on STI syndromes in South Africa is collected in the national clinical sentinel surveillance system for STI syndromes, with male urethritis syndrome (MUS) being the main indicator. Over the past five years, the number of MUS cases reported has been stable. There is a degree of seasonality in the number of cases reported, and a brief drop was reported during the first COVID lockdown period.[35] When comparing the MUS cases reported through the District Health Information System (DHIS), less than 40% of all cases of chlamydia and gonorrhoea were treated, highlighting challenges with programme implementation for symptomatic individuals and the need for diagnostic testing to close the gap on the treatment of asymptomatic infections.

Microbial resistance: Surveillance data from the National Institute for Communicable Diseases (NICD) shows that there is currently little to no resistance of gonorrhoea to ceftriaxone, the drug-used in first-line treatment.[36] However, resistance to drugs previously used to treat gonorrhoea, such as ciprofloxacin, is widespread. The surveillance programme is currently limited and may miss key populations where antimicrobial resistance is most likely to emerge first. Scale up and expansion of antimicrobial surveillance of gonorrhoea are therefore warranted to close this data gap.

Human Papillomavirus: South Africa's cervical cancer incidence is 35.6 per 100 000 compared to the global average of 15.8 per 100 000. It is the leading cause of cancer-related mortality in women (19.5 per 100 000).[37] Infection by high-risk HPV-types that cause cancer is common, with a reported prevalence of 54%, while precancerous lesions were detected in about 10% of all women.[38] HIV is associated with an increased risk of persistent HPV infection and rapid progression to invasive cervical cancer.[39] Although most HPV-types are vaccine-preventable many PLHIV have not been vaccinated.[39-41] In addition, full HPV-vaccination coverage in school-going girls is suboptimal. Coverage in 2017 was 69% for the first dose and 56% for the second dose, which reduced significantly to 37% and 34%, respectively, in 2021.[40]

Viral Hepatitis: Hepatitis B virus surface antigen (HBsAg) test positivity was 6.8% in the general population over the past 5 years, indicating a large burden of hepatitis B virus (HBV) infection in the country.[42] The positivity rate of 3.8% among children under 4-years old is of concern. Women of childbearing age (15-49 years old) had an HBsAg test positivity rate of 4.9%, and of these, 24% were Hb viral protein positive, indicating high infectivity.

Box 1. Spectrum-estimated STI-prevalence incidence rates and incident case numbers in South African women and men between 15 and 49 years in 2017.

STI	METRIC	WOMEN		MEN	
		Point Estimate	95% CI	Point Estimate	95% CI
Gonorrhoea	Prevalence	6.6%	3.8% to 10.8%	3.5%	1.7% to 6.1%
	Incidence rate per 100 000 adult person-years	16 100	7 700 to 38 900	14 200	6 900 to 24 700
	New incident cases	2.3 million	1.1 to 5.0 million	2.2 million	1.1 to 3.8 million
Chlamydia	Prevalence	14.7%	9.9% to 21%	6.0%	3.8% to 10.4%
	Incidence rate per 100 000 adult person-years	14 400	8 000 to 33 100	24 900	14 100 to 40 800
	New incident cases	1.9 million	1.1 to 3.8 million	3.9 million	2.2 to 6.3 million
Active syphilis	Prevalence	0.5%	0.32% to 0.80%	0.97%	0.19% to 2.38%
	Incidence rate per 100 000 adult person-years	153	65 to 414	316	34 to 1.162
	New incident cases	23 175	9 900 to 62 500	47 500	5 100 to 173 000

95% CI = 95% confidence interval.

The 2017 Spectrum STI estimates based on surveillance and monitoring data for STIs, confirmed the high burden of STIs in South Africa.

- The combined adult prevalence estimates for gonorrhoea (5.1%) and chlamydia (10.3%) in women and men are among the highest in the world.
- It was estimated that a combined total of 4.5 million new gonorrhoea infections occurred, with no significant difference in incident rates among both sexes.
- Approximately 5.8 million new chlamydia infections in women and men were estimated, with men almost twice as likely to present with a new infection (2:1), despite the prevalence of both gonorrhoea (6.6%) and chlamydia (14.7%) being higher in women.
- The estimated prevalence of active syphilis of above 0.5% in both sexes remains high. The total number of new syphilis infections in men and women was estimated to be 498 175, with men being twice as likely to develop a new infection.

Source: Kularatne R. S. et al - PLoS One 2018[33]
https://doi.org/10.1371/journal.pone.0205863.t001

Despite this, HBV-vaccination coverage among infants receiving three doses is 84%.[43] South Africa recently adopted the policy to vaccinate babies at birth to prevent HBV infection. There is no data available to determine coverage of this approach in practice. There is limited data on Hepatitis C virus (HCV) prevalence, but one surveillance study identified people who inject drugs as the most important key population.[44]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Key and other priority populations

Key populations are groups who, because of specific higher-risk behaviour, are at increased risk of HIV, TB and STIs, irrespective of the epidemic-type or local context. Also, they often have legal and social barriers related to their behaviours that increase their vulnerability to infection. NSP 2023-2028 focuses on five key populations:

I) Sex workers and their clients;

ii) Trans and gender-diverse people;

iii) Gay men and other men who have sex with men (MSM);

iv) PWUD; and

v) People in prisons and other closed settings (Table 2).

Other priority populations are groups of people particularly vulnerable to HIV, TB and STI infections in certain contexts and might have reduced access to healthcare and social services. These include adolescents (particularly adolescent girls); orphans; homeless children; people with disabilities; people with mental health conditions; migrants and mobile workers; survivors of SGBV; lesbian, gay, bisexual, transgender/transsexual, intersex queer and questioning (LGBTIQ+) groups; and people living in rural areas, informal settlements, and inner cities.[45]

HIV Key and other priority populations: HIV epidemic control hinges on how well we include key and other priority populations in the national response. Modelling shows key populations and their sexual partners will contribute over 40% of new infections in the next five years.[46] Key populations have the highest prevalence and incidence of HIV in the country for multiple reasons, including inadequate efforts to reach these populations, stigma and discrimination and punitive laws. The Thembisa model 4.5 reports 57.9% HIV prevalence in female sex workers, followed by transgender women with 51.9%, and MSM with a prevalence of 29.9%.[21] People who inject drugs (PWID) and people in prisons report prevalence of 21.8% and 17.5% HIV, respectively.

Addressing the HIV-prevention and treatment needs of key and other priority populations in South Africa is central to a comprehensive HIV response.

TB Key and other priority populations: People have different levels of risk of acquiring TB disease (exposure) based on where they live (informal settlements, people in prisons) and work (health workers, miners).[47] Other people are at higher risk of developing active TB disease because of biological (PLHIV and children) and behavioural (tobacco and drug-use) factors or limited access to quality services (people with disabilities or mental health conditions)[47]. TB prevalence is highest among migrants (36%), followed by household contacts (4%), people in prisons (3.9%) and PLHIV (3.0%).[48] TB prevalence is slightly over 1% in health workers (1.4%), mineworkers (1.3%) and people with diabetes (1.2%).[48]

STIs Key and other priority populations: The prevalence of all STIs was higher in women than in men. A particularly high burden was found in AGYW (15-24 years old), PLHIV and pregnant women.[49] From other data, key populations such as MSM and sex workers also have higher rates of STIs than the general population.[50-54] Many of these populations are also at higher risk of hepatitis B and C infections. A particular focus is on reducing hepatitis B among pregnant women and healthcare workers.

Social and structural barriers: Key and other priority populations are particularly affected by social and

structural barriers. These groups experience stigma, discrimination, and other rights violations in many settings. Intersectionality, or the combined influence of multiple overlapping stigmatised identities within a person, influences social relations and individual experiences in everyday life. Reducing social and structural barriers, such as poverty, violence, homelessness, and mental health conditions, are critical in enabling key and other priority populations to access health and social services to reduce new HIV, TB and STI infections.[55,56]

Table 2: *Key and other priority populations*

	KEY POPULATIONS	OTHER PRIORITY POPULATIONS
HIV	**Increased risk of acquiring HIV, TB and STIs and suffering from punitive laws, stigma and discrimination.** • Sex workers and their clients • Trans and gender-diverse people • Men who have sex with men (MSM) • People who use drugs (PWUD) • People in prisons and other closed settings • People living with HIV (PLHIV)	**Increased risk of acquiring HIV, TB and STIs because of biological, behavioural or structural factors.** • Adolescents and young people, especially AGYW • Survivors of SGBV **Face distinct barriers to accessing healthcare services** • Children, including orphans and vulnerable children • Migrants, mobile populations, and undocumented individuals • People with disabilities • People with mental health conditions • LGBTIQ+ persons • People living in rural areas, informal settlements, and inner cities
TB	• PLHIV • Children < 5-years old • Health workers • People in prisons and other closed settings • People living in informal settlements • Mineworkers and peri-mining communities • Sex workers • Migrants, mobile populations, and undocumented individuals	• Contacts of PWTB • People with prior TB • Smokers • People with harmful alcohol- use • The elderly • Adolescents and young people • People with diabetes • Pregnant women • Men • People with disabilities • People with mental health conditions

	KEY POPULATIONS	OTHER PRIORITY POPULATIONS
STIs	• Sex workers and their clients • Transgender persons • MSM	• Adolescents and young people, especially AGYW • Survivors of SGBV • Pregnant women
Viral hepatitis	**For HBV:** • People in prisons • PWUD • MSM • Sex workers **For HCV:** • PWUD • MSM • People in prisons	• Health workers • Pregnant women


HIV
NEGATIVE

4

The Goals of the NSP 2023-2028

The NSP for HIV, TB and STIs 2023-2028 is devised into four interlinked goals that place people and communities at the centre of the response. The four goals are further broken down into objectives and priorities for action. The objectives for some of the goals are disease-focused, but the implementation of screening, prevention, treatment and support for HIV, TB and STIs is to be integrated.

Goal 1: Break down barriers to achieving outcomes for HIV, TB and STIs

The objectives in Goal 1 describe priority actions to reduce inequalities and barriers that prevent people from accessing essential services to reduce HIV, TB and STIs. Therefore, some strategies include empowering communities to be at the forefront of the response with community-led interventions. In addition, this goal addresses poverty reduction and promoting and protecting human rights and gender equality. Integrated and standardised mental health services access, and delivery is recognised as an important enabler to equitable access to services for HIV, TB and STIs.

Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs

The focus of Goal 2 is access to biomedical, social and psychological support interventions for the prevention, treatment and care of HIV, TB and STIs. The HIV objectives include increasing knowledge and attitudes that promote the uptake of HIV-prevention interventions, optimising the implementation of high-impact HIV-prevention interventions and ensuring that South Africa meets the 95-95-95 targets for HIV. The TB objectives emphasise prevention with TB-preventive therapy (TPT) and the implementation of high-impact HIV-prevention interventions. Furthermore, strategies for increasing TB detection and support for PWTB through existing and new innovative processes, tools and regimens are outlined. The STIs objectives also describe ways to increase the prevention, detection, and treatment of STIs, including HPV to reduce morbidity and mortality associated with untreated infections. The viral hepatitis objective is to reduce the impact of the burden of disease and scaling up prevention, diagnosis, and treatment.

Goal 3: Build resilient systems for HIV, TB and STIs that are integrated into systems for health and social protection, and pandemic response

The COVID-19 pandemic has demonstrated the importance of robust, resilient, and adaptive systems in provision of health services, including HIV, TB and STIs programmes. The objectives under Goal 3 include adequate human resources, the latest technology, better infrastructure and improved supply chain management.

Goal 4: Fully resource and sustain an efficient NSP led by revitalised, inclusive and accountable institutions

The objectives of Goal 4 address leadership, governance, and financing of the NSP priority activities and the sustainability of these initiatives.

The next four sections describe in detail the goals and objectives, and the interventions, target populations and accountable parties as outlined in Appendix B: Logical framework.

GOAL 1:

Break down barriers to achieving outcomes for HIV, TB and STIs

GOAL 1:
Break down barriers to achieving outcomes for HIV, TB, and STIs

Goal 1: Strategic context

There is a direct link between inequalities and vulnerability to HIV, TB and STIs, mental health conditions and-related rights abuses. While inequalities do not directly cause HIV, TB and STIs, inequalities increase unsafe behaviours, mental distress, SGBV and harm. Inequalities could be caused by stigma, discrimination, violence, uneven power relations, harmful gender beliefs and norms, poverty, migration, disability and poor service-delivery.

The COVID-19 pandemic widened inequalities that directly affect health and added strain on already overburdened health, social, economic and legal systems. Despite protective laws and policies and the many gains made over the past five years, violence, femicide, mental health conditions and teen pregnancies are on the increase, human rights are not cemented in all the responses and barriers impeding access to services are not adequately addressed.

Social and structural drivers: The social and structural drivers show clear linkages between gender inequalities, SGBV, poverty, xenophobia, harmful religious and cultural practices, power differences in intergenerational relationships, and other socio-economic factors. Social and structural drivers also negatively affect health behaviours, mental health, sexual and reproductive health and rights (SRHR), and increased risk for HIV, TB and STI exposure.[57-59]

Stigma and discrimination: Persistent and overlapping stigma and discrimination undermine efforts to end HIV, TB and STIs and compromise the effectiveness of prevention, testing, diagnosis, treatment, care and support services, particularly for key and other priority populations.[60-63] Evidence also shows that internalised stigma among PLHIV is associated with lower levels of viral suppression.[64]

Discriminatory laws and practices: Despite South Africa's enabling legal and policy framework, restrictive social and structural factors reduce people's ability and agency to realise rights and access HIV, TB, STI, mental healthcare and other essential services. Specific challenges include inconsistent implementation of protective laws and policies and discriminatory attitudes and practices within law enforcement and healthcare provision, further limiting access to human rights protections.[65-67]

Access to health and social care (including SRHR care, SGBV response services, and mental health services) remains limited for key and other priority populations. Evidence indicates that of 125 surveyed health facilities offering "tailored" services for sex workers, only 69% provided information on SRHR services, around three out of five are offered access to male condoms (57%) and access to post-exposure prophylaxis (PEP) (67%).[68] For trans and gender-diverse people, less than half of health facilities (48%) provided information packages on sexual health services and about a third (35%) provided SGBV services or referrals, while only 14 out of 73 facilities provided hormone therapy.[68]

The criminalisation of certain activities or behaviours – such as sex work, drug-use and drug possession for personal use – further exposes people to stigma, discrimination and other rights violations and limits (and/or denies) access to health and other essential services. Entry into the criminal justice system through arrests and detentions contributes to negative mental health outcomes and increases potential exposure to TB and interruption in services and treatment (e.g., the continuation of opioid substitution therapy (OST)). Criminalisation contradicts human rights-based approaches to providing accessible, acceptable, and available HIV, TB and STI services.[69-71]

Gendered inequalities and violence: Persistent gender inequalities and violence are major barriers to uptake and adherence to HIV-treatment.[71-73] Gender-based inequalities and violence are both causes and consequences of HIV. Intimate partner SGBV increases the risk of HIV exposure and transmission while living with HIV increases the risk of SGBV. Traditional gender norms also inhibit health-seeking among men, contributing to suboptimal outcomes among men across the HIV cascade. Studies have found that men are often expected to be fearless, self-sufficient, and naturally strong and healthy, preventing them from seeking care and support and exacerbating external and internalised stigma.

Despite human rights protections against all forms of violence in private and public spheres [Section 12 of the South African Constitution] and the adoption of the NSP on Gender-Based Violence and Femicide,[74] high levels of SGBV prevail in all spheres of society.[73] Crime statistics for the first quarter of 2022 indicated that 105 women were raped daily; and a woman was killed every four hours in South Africa.[75]

The NSP on Gender-Based Violence and Femicide provides a cohesive strategic framework to guide the national response to SGBV, with specific focus on violence against all women (across age, physical location, disability, sexual orientation, sexual and gender identity, gender expression, nationality and other diversities) and violence against children.[74] Notwithstanding the progress made in implementing the NSP on Gender-Based Violence and Femicide between 1 May 2020 and 30 September 2022, sexual offences continue to increase while widespread discrimination, political, economic and social structural dynamics, and intersectional power inequalities continue to drive SGBV in South Africa. Persistent challenges to effective responses to SGBV include lack of coordination resulting in a fragmented response, duplication of efforts, wastage of resources and impact evaluation; lack of gender-responsive budgeting; rampant impunity; lack of accountability and consequence management.[76] Evidence shows that HIV infection increases up to 60% over the next one to two years for women who have been raped.[29,77] Youth living with HIV experiencing interpersonal violence are nine times more likely to engage in unsafe sexual behaviour, which increases the likelihood of pregnancies seven-fold and decreases adherence to treatment.[78]

Gender and gender inequalities are intrinsically linked to the risk of TB transmission and barriers to TB services. Gender influences the risk of infection and disease, diagnosis and treatment access, the likelihood of adherence and treatment completion, and social and monetary consequences of TB disease. In South Africa, TB is more prevalent in men than women, and access to TB services and health outcomes differ between women and men. Masculine identities negatively affect health-seeking behaviour, which may lead to late or missed TB diagnosis and lower rates of TB treatment access and completion. Lack of male-friendly healthcare services further limits men's access to TB services. For women, access to TB diagnosis, treatment and care is often delayed because of increased stigma, lack of adequate TB and sexual and reproductive healthcare integration, and prevailing harmful gender norms and inequalities limiting women's access to health and rights.[16,18-20]

Mental health: Data from 2018 indicates that 15.9% of South Africans suffer from a mental health condition or substance-use disorder, the most common of which is depression (3.9%), anxiety disorder (3.8%) and substance-use disorders (2.3%).[79] Though prevalence is high in the general population, mental health conditions are substantially higher in PLHIV and PWTB. For example, across surveys of PLHIV in sub-Saharan Africa, 24% were found to have depression compared with 3% in the general population.[80] South African studies have found the prevalence of mental conditions among PLHIV to be as high as 43%.[81]

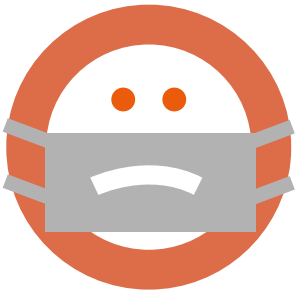
PLHIV are more likely to have suicidal thoughts and to die by suicide compared with the general population[82] and have a 100-fold higher suicide death rate than the general population.[83] Adolescent

mothers have high rates of mental health conditions, but adolescent mothers with HIV have been found to have even higher rates of mental health conditions.[84]

The prevalence of mental health conditions, including depression and anxiety disorders, among PWTB, is estimated to be between 40% and 70%. Moreover, people with mental health conditions also carry other risk factors for TB, including smoking, poor nutrition, and comorbidities such as diabetes and HIV infection and are less likely to access health services.

Mental health conditions increased substantially during COVID-19. It has been estimated that there was a 25-27% global rise in the prevalence of depression and anxiety in the first year of the pandemic.[85]

The two-way link between HIV and TB and mental, neurological and substance-use disorders is well established.[86,87] Mental health conditions are a risk factor for HIV and TB. They complicate disease course and treatment and are associated with reduced prevention and treatment uptake, testing, retention in care and viral load suppression.[87]



Mental health conditions increased by 16-32% during COVID-19

Goal 1: Strategic approach

Effective responses to HIV, TB, STIs and viral hepatitis require deliberate actions to "reduce the underlying inequalities and intersecting forms of discrimination that hold back progress" alongside scaling up high-impact approaches.[71] Reducing inequalities through human rights-based, people- and community-centred approaches is the basis for achieving the 10-10-10 targets for 2025: less than 10% of people experience stigma and discrimination, gender-based inequalities and punitive laws. Achieving these targets demands drastic changes to remove all societal and legal barriers and create an enabling environment for effective responses to achieve the 95-95-95 targets for HIV, TB and STIs and the 90-65-80 elimination targets for hepatitis B and C.[58]

Likewise, the global goal of ending TB as a public health challenge by 2030 underscores the need for rights-based, people-centred approaches and interventions that are gender-sensitive and gender-transformative and that prioritise, reach and involve key and other priority populations.[47]

Effective responses require recognition that medical interventions are necessary but not sufficient and that other interventions extending beyond the health sector are equally needed, specifically for key and other priority populations.[88]

Goal 1: Objectives and Sub-objectives

Objective 1.1:
Strengthen community-led responses to HIV, TB and STIs

- **Subobjective 1.1.1** Build an enabling environment for cohesive and inclusive communities focusing on key and other priority populations.

  Support the development and implementation of multi-sectoral and integrated community and district plans to build resilient individuals, parents, families, and communities. This will be achieved through mapping and building on community assets, engaging communities in the development and implementation of local development plans, developing integrated service-delivery models across communities, scaling up community-based prevention and early intervention programmes (e.g., parent support programmes), and strengthening holistic support programmes for key and other priority populations in communities.

- **Subobjective 1.1.2.** Strengthen the capacity of community-led responses to implement and report on HIV, TB, STIs and viral hepatitis.

  Intensify the implementation of comprehensive, community-led programmes, enhance meaningful engagement of all key and other priority populations in communities, and strengthen decentralised service-delivery. To achieve this, the capacity of local community-based organisations and programmes will be built, and the availability of decentralised diagnostic and prevention services and self-care options in communities will be increased. Virtual options for self-screening and consultation will also be considered, where appropriate.

- **Subobjective 1.1.3.** Resource and support community-based organisations to implement and monitor responses to HIV, TB, STIs and viral hepatitis.

  Capacitate and support community-based organisations to implement and monitor responses to HIV, TB, STIs and viral hepatitis. Community-based organisations will be trained, and funding will be increased to monitor programme quality.

- **Subobjective 1.1.4.** Improve safety, health and well-being in communities to strengthen the capacity of families to protect and support members affected and infected by HIV, TB, STIs and viral hepatitis.

  Scale up the availability of safe spaces and recreational opportunities in communities. This will be achieved by expanding the availability of shelters for survivors of SGBV and abuse to accommodate homeless individuals. Local infrastructure and maintenance will be monitored to ensure streetlights work, safe drinking water is available and safe parks and other spaces are accessible to users.

- **Subobjective 1.1.5.** Improve integration of HIV, TB, STI and viral hepatitis services into community systems and cultural practices.

  Enhance the integration of proven high-impact approaches and traditional and cultural practices. This will be achieved by engaging traditional leaders and traditional health practitioners (THPs) to ensure the safety and health of all community members.

Objective 1.2:
Contribute to poverty reduction through the creation of sustainable economic opportunities

- **Sub-objective 1.2.1.** Increase access to economic strengthening opportunities.

  Scale up the protection against the consequences of vulnerabilities in communities. Inequities are addressed through skills development and income-generating opportunities specifically for people in the informal sector, women, youth and people with disabilities. Health outcomes and access to tailored services for all people in and out of employment in communities are improved.

  Address and reduce the high job losses experienced as a result of acquiring TB. To facilitate this, employers should have workplace policies that address TB to ensure protection from job losses. For the informal sector, strategies will be implemented to provide interim relief while unable to work.

  Address the high catastrophic costs of TB and the impoverishing effect that TB has on patients and their families. To ensure this, strategies to link TB-affected households to appropriate social protection packages and support will be strengthened.

- **Subobjective 1.2.2.** Scale up and advocate for access to social protection interventions to facilitate equitable access to services.

  Improve access to social protection for people who qualify and employ adequate human resources, such as social workers to facilitate the process. People who are not employed and people with specific needs are supported through different public and private sources, including the basic income grant to protect health and well-being.

- **Subobjective 1.2.3.** Accelerate access to food and nutritional support programmes.

  Strengthen the provision of nutritional support to all eligible people with a focus on key and other priority populations. Multiple sectors are collectively responsible for improving access to adequate nutrition, specifically for more vulnerable individuals, children and families. Production and distribution of food are coordinated and planned.

  Nutritional supplements are the highest driver of non-medical costs for TB patients, contributing significantly to the TB catastrophic costs in the country. Specific interventions need to be implemented to reduce these costs, such as the provision of appropriate nutritional supplements for people on TB treatment.

- **Subobjective 1.2.4.** Scale up programmes that support adolescents and young people (AYP) to remain in and return to school.

  Scale up multi-sectoral support for AYP. Teen pregnancies are reduced, and teen parents are supported to return to and finish school without compromising the interests of the children. To ensure continuity of education, all vulnerable learners should be supported to return to school. Tutoring should be provided for those admitted or absent from school for longer durations.

Objective 1.3:
Reduce stigma and discrimination to advance rights and access to services.

- **Subobjective 1.3.1.** Increase literacy on rights and the impact of intersecting stigma and discrimination.

  Scale up community mobilisation and capacity strengthening on human and legal rights and impact of intersecting stigma and discrimination. This will be achieved through awareness-raising on causes and consequences of stigma and discrimination for HIV, TB, STIs and viral hepatitis risks and access to services; incorporation of human rights and diversity into all tailored programmes for key and other priority populations; and training on human rights, the law and diversity in communities, with a focus on key and other priority populations.

- **Subobjective 1.3.2.** Scale up community-led stigma-reduction interventions and advocacy.

  Advocate for people-centred approaches to enhance access to inclusive, non-judgemental and non-discriminatory community-based services of high quality. This will be achieved through the support of community-based and community-led organisations and networks that implement proven stigma-reduction approaches in community, workplace, education, healthcare, justice and emergency settings using non-stigmatising and empowering language and messaging; and the facilitation of community dialogues on causes, impacts and community-based solutions to reduce stigma and discrimination. Focus on including the voices of PLHIV, PWTB and TB survivors in community-led interventions.

- **Subobjective 1.3.3.** Increase access to redress mechanisms in communities experiencing stigma, discrimination, and other rights violations.

  Strengthen the support and promotion of community-based and community-led redress and rapid-response mechanisms to ensure enhanced access to legal and other services. This will be achieved through establishing community-based ambassadors at health facilities and police stations, scale up community-based and community-led crises response teams and mechanisms to increase linkage to services (e.g., community-led WhatsApp groups) and awareness-raising to enhance access to and use of established helplines (i.e., AIDS Helpline, GBV Helpline, LifeLine, Childline, Mental Health Helpline).

- **Subobjective 1.3.4.** Strengthen social support networks and structures for people most affected by external and internal stigma.

  Strengthen community- and facility-based social support networks and structures, particularly those led by PLHIV, and scale up the capacitation of community-based social support networks and structures on stigma and discrimination. This will be achieved through mapping of community-based social support networks and structures, strengthening existing and establishing additional community-based social support structures based on identified gaps, and training community-based social support structures to identify and respond to stigma and discrimination.

- **Subobjective 1.3.5.** Assess stigma to inform decision-making and accurate data for future programming and track progress.

  Advocate for and support the implementation of regular community-based stigma assessments and ongoing monitoring of incidences. This will be achieved through conducting and

dissemination of results of the Human Rights Accountability Scorecard (annually), supporting the implementation of the Stigma Index 2 with the training of community-led organisations to support data-collection, developing and implementing a TB stigma assessment tool to inform TB-related stigma-reduction interventions, support of community-led monitoring of human rights violations, and advocating for regular rapid assessments to inform stigma-reduction initiatives.

Objective 1.4:

Address gender inequalities that increase vulnerabilities through gender-transformative approaches.

- **Subobjective 1.4.1.** Enhance gender-transformative community-led actions for HIV, TB, and STIs to change harmful social, cultural and gender norms.

  Strengthen community mobilisation efforts to reduce the consequences of gender inequality that are harmful to all genders; engage men and their organisations to promote gender equality; scale up the integration of gender-transformative and diversity-responsive approaches in all community-led actions for HIV, TB and STIs; and support social justice organisations to advocate for and implement gender-transformative community-led responses. This will be achieved through the development and implementation of community-led awareness-raising campaigns to reduce harmful consequences of gender inequality and gender-related stigma and discrimination; engage men and boys in households and communities to promote gender equality; and capacity strengthening of communities to promote shared responsibility for the prevention of HIV, TB, STIs and pregnancy.

- **Subobjective 1.4.2.** Strengthen capacity of leaders at all levels of decision-making to advance gender equality and promote diversity.

  Sensitise decision-makers on harmful consequences of gender inequality, norms and practices and advocate for and support capacity strengthening of leaders across all sectors (e.g., political leaders, religious leaders, traditional leaders and educators) to promote gender equality and diversity and change harmful gender norms. This will be achieved through engaging and training political leaders to advance gender equality and promote diversity; religious leaders on gender inequality and its harmful consequences; traditional leaders on the impact of gender inequality, harmful gender norms and related practices (such as widow inheritance, cultural practices); strengthening training on human rights, gender equality, SRHR and diversity for educators; and monitoring reduction in gender inequality and promotion of diversity through the Human Rights Scorecard.

- **Subobjective 1.4.3.** Enhance capacity in communities to prevent and respond to SGBV.

  Scale up capacity to prevent and respond to SGBV and improve linkage to services for survivors of SGBV through community-led structures. This will be achieved through sensitisation of communities on causes, forms and consequences of SGBV (including diversity) and its links to HIV, TB, STIs and viral hepatitis-risks and service access; awareness-raising on prevalence and impact of specific forms of SGBV against women living with HIV in all their diversity (including obstetric violence); enhancement of legal literacy in communities relating to rights of survivors of SGBV (including access to services); scale up training and support of peer educators in communities to recognise and respond to SGBV; and support of community-led structures (including Community Policing Forums) to respond to SGBV and facilitate timely linkage to services.

- **Subobjective 1.4.4.** Increase access to services for all survivors of SGBV.

  Strengthen support for all survivors of SGBV and improve access to comprehensive, people-centred and inclusive SGBV response services. This will be achieved through the training of health workers to provide comprehensive responses to all persons experiencing SGBV, including tailored age-appropriate services and care for children and adolescents experiencing SGBV; enhanced access to a comprehensive package for all survivors of sexual assault (including ongoing psychosocial support) and provide people-centred services responding to support needs of survivors in all their diversity; advocacy for the expansion of Thuthuzela Care Centres; support for community-based organisations that provide services to survivors of SGBV in areas without access to Thuthuzela Care Centres; advocacy for increased support for places of safety; and promote inclusive access to places of safety for survivors of SGBV.

Objective 1.5:
Enhance non-discriminatory legislative frameworks through law and policy review and reform.

- **Subobjective 1.5.1.** Amend laws to decriminalise sex work.

  Finalise law reform processes to decriminalise sex work. This will be achieved through expediting the drafting of law amendments to the Sexual Offences Act and related laws and policies to decriminalise sex work, facilitation of broad and inclusive public participation with draft legislation, enactment of law amendments by 2026, and scale up of community-and peer-led advocacy for the decriminalisation of sex work.

- **Subobjective 1.5.2.** Advocate for the decriminalisation of drug-use and drug possession for personal use.

  Advance efforts to decriminalise drug-use and drug possession for personal use. This will be achieved through engaging the Law Commission to review drug policies, provide recommendations and draft law amendments to decriminalise drug-use and drug possession for personal use, advocate and support de facto decriminalisation of drug-use and drug possession for personal use, enact the Cannabis for Private Purposes Bill of 2020 and amend relevant sections in the Drug-use and Trafficking Act, engagement with all relevant departments and civil society sectors to support and promote law reform relating to the decriminalisation of drug-use and drug possession for personal use, and capacity strengthening of community-based and peer-led organisations and networks to effectively advocate for the decriminalisation of drug-use and drug possession for personal use.

- **Subobjective 1.5.3.** Enhance legal protection against hate crimes based on sexual orientation, gender identity and expression, and migrancy.

  Enhance legal protection against hate crimes based on sexual orientation, gender identity and expression, and migrancy. This will be achieved through expediting the finalisation and enactment of the Hate Crimes Bill (i.e., Prevention and Combating of Hate Crimes and Hate Speech Bill of 2018) and the scale up of and support to LGBTQI+-led organisations and networks to advocate for the enactment of the Hate Crimes Bill.

- **Subobjective 1.5.4.** Reform law and policy provisions to enhance access to gender-affirming healthcare and other essential services.

  Support inclusive gender-affirming health and other services by amending Section 2.1 of the

Alteration of Sex Description and Sex Status Act, 2003 (Act 49 of 2003), scale up and support trans- and gender-diverse-people-led organisations and networks to advocate for implementation and enactment of laws and policies that enhance access to gender-affirming services.

- **Subobjective 1.5.5.** Advocate for policy alignment pertaining to the age of consent and access to SRHR and other services.

  Harmonise policies to align the age of consent and access to SRHR and other services and ensure enhanced service access for young people (12 and older). This will be achieved through the review of conflicting laws and policies to identify gaps, engagement with all relevant departments and civil society sectors to support policy alignment relating to the age of consent and access to SRHR and other essential services, drafting of policy and law provision amendments to harmonise the age of consent and access to SRHR and other essential services, and support for community-based and community-led organisations and structures to advocate for harmonisation of laws and policies.

- **Subobjective 1.5.6.** Strengthen policy frameworks to include THPs in existing healthcare structures.

  Review laws and policies to identify gaps relating to the integration of THPs into existing healthcare structures, support for drafting law amendments to respond to the identified gaps, intensified engagement towards integration between THPs and the National Department of Health (NDOH) to concretise mechanisms of integration, and support to the THP sector to advocate for the integration of healthcare services provision.

Objective 1.6:

Protect and promote human rights and advance access to justice.

- **Subobjective 1.6.1.** Strengthen human rights and legal literacy relating to HIV, TB and STIs in communities and service provision.

  Scale up community mobilisation to advocate for human rights protection in all aspects of the response to HIV, TB, STIs and viral hepatitis and raise awareness of human and legal rights. This will be achieved through intensified sensitisation in communities on human rights, diversity, risks of and access to HIV, TB, STIs and viral hepatitis services; scale up legal literacy training in communities with a focus on redress mechanisms and access to justice; and advocacy for the enhanced availability of and inclusive access to redress mechanisms.

- **Subobjective 1.6.2.** Strengthen the capacity of communities to monitor and document rights violations related to HIV, TB and STIs and ensure human rights violations are consolidated into the national Human Rights portal.

  Enhance capacity to monitor and document human rights violations and consolidate documented human rights violations. This will be achieved through enhanced support to community-based and community-led organisations that monitor and document rights violations; scale up training of community members (e.g., REActors) to identify, monitor and document HIV, TB, STIs and viral hepatitis-related human rights violations; development of standardised tools to monitor and document rights violations across sectors; support for ongoing consolidation of human rights violations into the national Human Rights portal and dissemination of quarterly reports.

- **Subobjective 1.6.3.** Strengthen the

capacity of communities to respond to human rights violations related to HIV, TB and STIs to facilitate access to justice.

Improve referral and community-based response mechanisms and improve access to justice. This will be achieved through support to community-based and community-led organisations that respond to human rights violations; review and strengthening of community-based referral systems and improvement in referral and case follow-ups; capacity strengthening of Legal Advice Offices to respond to HIV, TB, STIs and viral hepatitis-related human rights violations; enhancement of access to community-based paralegals, particularly in rural areas; and advocacy for increased access to legal services and affordable legal advice.

- **Subobjective 1.6.4.** Scale up sensitisation and strengthen capacity of all service providers through ongoing in-service training and reviewing and amending preservice curricula.

Enhance capacity and sensitisation of all service providers on human rights, diversity, and inclusive service provision. This will be achieved through the scaling up of in-service training and sensitisation of health workers (HWs), social workers, law enforcement agents and members of the judiciary on human rights, diversity and provision of inclusive services; capacity strengthening and sensitisation of healthcare providers on gender, diversity, TB and provision of gender-responsive care, including through the provision of information, education and communication (IEC) material and job aids; capacity strengthening of all duty bearers to protect human rights, promote diversity and respond timeously and effectively to human rights violations in in-service provisions across sectors; review and amendment of preservice curricula for healthcare, social workers and law enforcement agents to integrate human rights, diversity and gender equality; evaluation and strengthening capacity-enhancement efforts through the meaningful involvement of key and other priority populations; and monitoring rights protections in public sector service provisions.

THPs treat people with HIV, TB and STIs. While this may be delaying access to biomedical treatment, it also holds possibilities for productive collaboration with the public sector because THPs show a clear willingness and desire to work more closely with the public healthcare system in relation to HIV, TB and STIs. THPs should be provided with accessible and relatable education information and information on patient rights and responsibilities for HIV, TB and STI care and treatment.

- **Subobjective 1.6.5.** Address impunity and ensure accountability of duty bearers at all levels.

Mobilise communities and support advocacy to increase accountability of all duty bearers who fail to promote and protect human rights, including access to redress at all levels. This will be achieved through awareness-raising in communities on the prevalence and impact of lack of accountability of duty bearers across the public sector, review and improvement of accountability mechanisms across all public sector service provisions, and capacity strengthening in communities to monitor enforcement of accountability mechanisms.

- **Subobjective 1.6.6.** Strengthen the implementation of restorative justice programmes to decrease stigma and discrimination, and enhance access to rights.

Scale up restorative justice programmes to decrease stigma and discrimination, and enhance access to rights. This will be achieved through awareness campaigns to support access to and implementation of restorative justice programmes through community sensitisation on the availability and impact of restorative justice programmes; enhanced linkage to and support of family members to improve the outcome of resocialisation

and reparative programmes; scale up training on social inclusion and promotion of equal rights protections in communities to reduce stigma, discrimination, and other rights violations.

Objective 1.7:
Integrate mental health and standardise delivery and access to mental health services.

- **Subobjective 1.7.1.** Expand integrated literacy, detection and treatment or referral of common mental health and substance-use disorders by ward-based primary healthcare outreach teams (WBOT) in communities, and health and social care workers at facilities.

  Provide comprehensive psychosocial support services in communities, health facilities, schools, and institutions of higher learning. This will be achieved through the rolling out of guidelines that integrate mental health into HIV and TB programming, ensuring that HCWs in the HIV and TB programmes can recognise, manage and/or refer people with mental health conditions. Provide training to community HCWs (CHCWs) on mental health, mental health conditions, screening and support, standardising and implementing evidence-based screening tools for anxiety, depression, and alcohol and drug-use disorders in communities; training social workers and auxiliary social workers to offer adequate psychosocial support to persons with mental health conditions; and training professional nurses on mental health, screening for mental health conditions, treatment and support.

  Social workers and auxiliary social workers will be trained to re-integrate and support people with HIV and TB into the communities, promoting their mental well-being and preventing and addressing mental health conditions.

  Scale up community mental health services to match recommended national norms and include community residential care (including assisted living and group homes), day care services, and outpatient services (including general health outpatient services in primary healthcare (PHC) facilities and specialist mental health support).

- **Subobjective 1.7.2.** Enable professional nurses to prescribe and dispense medication to treat common mental health conditions.

  Advocate for policies to allow trained nurses to support and treat persons with common mental health and substance-use disorders, with the support of a doctor – including methadone for OST. This will be achieved through standardising and implementing screening tools for anxiety, depression and harmful alcohol and drug-use in primary healthcare facilities; and training and accrediting nurses to treat common mental health conditions.

- **Subobjective 1.7.3** Identify persons with mental health conditions who are vulnerable to HIV, TB and STIs and/or living with comorbid conditions and ensure they receive appropriate care and support services.

  Integrate mental health into PHC clinics and general hospitals as part of the minimum package of care. Improve and plan the delivery of mental health services at all levels of the health service and integrate them into HIV, TB and STI services.

PRIORITY ACTIONS

Table 3: *Goal 1 Priority Populations*

PRIORITY ACTION	SETTING	ACCOUNTABLE PARTNERS
> Children 0-9 years		
• Accelerated nutritional and social grant support • Protection against all forms of abuse • Intensified mental health services and access to psychosocial support • Support for school initiation and retention • Ensure access to EPI programmes	• All communities in 52 districts • Schools • Higher education institutions	• Department of Social Development (DSD) • Department of Basic Education (DBE) • NDOH
> Adolescents and young people 10-24 years		
• Empower youth leaders and involve youth in community-led responses • Gender norms education, including risk-reduction in relation to age-disparate relationships • Programmes to keep learners in schools until completion, including support for pregnant and other learners who drop out of school • Information and awareness on harmful drug and alcohol use and integrated screening, brief interventions and referral to treatment for harmful substance-use • Access to parenting programmes • Access to peer groups and clubs to build resilience and empower AGYW and ABYM in all their diversity to contribute to positive change in their families and communities • Access to further education and skills development opportunities • Economic empowerment programmes, including youth employment • Increased access to mentorship and internships • Reasonable accommodation and access for young people with disabilities • Intensified mental health services and access to psychosocial support • Dignity packs • Protection against SGBV and exploitation • Interventions to reduce stigma, discrimination, and other human rights barriers to services, specifically for young key and other priority populations	• All communities in 52 districts • Schools • Higher education institutions	• DSD • DBE • Department of Women, Youth and Persons with Disabilities (DWYPD) • Department of Economic Development (DED)

PRIORITY ACTION	SETTING	ACCOUNTABLE PARTNERS
> Migrants, mobile populations and undocumented individuals		
• Social inclusion and community integration • Intensified mental health services and access to psychosocial support • Protection against xenophobia and violence	• All communities in 52 districts	• DSD • Department of Home Affairs (DOA) • South African Police Service (SAPS)
> People with mental health conditions		
• Screening and treatment for mental health conditions and mental disorders in communities and primary care facilities • Intensified mental health services and access to psychosocial support • Protection against stigma and discrimination, and sexual violence	• All communities in 52 districts	• NDOH • DSD • DWYPD • SAPS
> People with physical disabilities and mental health conditions		
• Protection against stigma and discrimination, and sexual violence, especially AGYW with mental disabilities • Disability-accessible and inclusive healthcare services at all facilities • Intensified mental health services and access to psychosocial support	• All communities in 52 districts	• NDOH • DSD • DWYPD • SAPS
> LGBTIQ+ persons		
• Protection against hate crimes, stigma and discrimination, homophobia, transphobia, and other SGBV • Support with redress of human rights violations • Community systems strengthening and stigma and discrimination reduction	• All communities in 52 districts	• NDOH • DBE • SAPS • DWYPD

Table 4: *Goal 1 Key Population HIV*

SERVICES / INTERVENTIONS / APPROACHES	SETTING	ACCOUNTABLE PARTNERS
> Transgender persons		
• Update the Alteration of Sex Description and Sex Status Act, 2003 (Act 49 of 2003) • Intensify mental health services and access to psychosocial support • Support school retention and completion for transgender youth • Provide transgender-friendly facilities in all settings (bathrooms, inpatient facilities and shelters) • Develop transgender peer-led interventions that support skills building and income generation • Develop sensitisation packages on transgender persons for traditional, spiritual leadership • Provide legal literacy and legal aid for transgender persons • Intensify interventions to decrease primary, secondary and internalised stigma through sensitisation of service providers such as healthcare providers, social service providers, educators, law enforcement agents and policymakers • Involve transgender people in reviewing and developing preservice and in-service curricula of service providers (i.e., HWs, social workers, the judiciary and law enforcement services)	• Department of Justice (DOJ) • Higher education institutions • Health facilities • All service points and settings • Community settings	• DOJ • DBE • NDOH • DOH • National House of Traditional Leaders (NHTL) • National Interfaith Council of South Africa (NILC) • Department of Higher Education and Training (DHET)
> Sex workers and their clients		
• Decriminalise sex work • Develop and support peer-led economic empowerment programmes to support skills development and income generation • Protection against SGBV and exploitation by responding to violence perpetuated against sex workers, fostering police accountability, and promoting safety and security • Responses to immediate and long-term needs of sex workers who are survivors of violence – including sensitisation of law enforcement and justice agents and safe houses • Provide legal literacy and legal aid services • Interventions to decrease secondary stigma by sensitisation of service providers in healthcare social services, justice and law and policymakers • Provide mental health and psychosocial services for sex workers • Involve sex workers in reviewing and developing preservice and in-service curricula of service providers (i.e., HWs, social workers, the judiciary and law enforcement services)	• All communities in 52 districts • Law enforcement and protection services • Social development services • Health services	• DOJ • DED • DOH • SAPS • DHET

> People who use drugs		
• Decriminalise drug-use and drug possession for personal use • Intensify mental health services and access to psychosocial support • Develop non-criminal justice strategies because all criminal justice responses may result in a criminal record, thus limiting future economic involvement and related-risks • Provide a comprehensive package of harm-reduction services in the facility and community-based setting • Develop community-based and peer-led empowerment interventions to build capacity and self-efficacy • Prevent and respond to violence by fostering police accountability, promote safety and security for PWUD, including sensitisation of law enforcement agencies • Provide legal literacy and legal aid • Link to social support and rehabilitation services • Involve PWUD in the review and development of preservice and in-service curricula of service providers (i.e., HWs, social workers, the judiciary and law enforcement services)	• Judiciary and protection services • All communities in 52 districts • Academic institutions • Social development	• DSD • SAPS • NDOH • DHET • DOJ • PAC, DAC and LAC
> People in correctional services		
• Develop non-custodial strategies for reducing prison overcrowding • Develop and support economic empowerment programmes to support skills development and income generation capabilities • Link to social support on discharge from correctional services, including halfway houses and sheltered employment • Provide access to a comprehensive package of HIV, TB, STI and viral hepatitis services, including a comprehensive package of harm-reduction and linkage to care post discharged from correctional services • Provide behaviour modification to prevent reoffending, promoting the safety and security of people in prison • Provide mental health and psychosocial services for people in correctional facilities • Provide screening for drug-use and offer brief intervention • Support for school retention and completion for youth in correctional facilities • Involve people in correctional services in the review and development of the preservice and in-service curricula of the service providers (i.e., HWs, social workers, the judiciary and law enforcement services)	• All communities in 52 districts • Correctional services	• NDOH • DSD • SAPS • Department of correctional services (DOCS) • DOE • DHET

> Men who have sex with men		
• Protect against hate crimes, stigma and discrimination, homophobia, transphobia, and other SGBV • Prevent and respond to violence by fostering police accountability, promoting safety and security • Sensitise law enforcement agents and policymakers • Community-based and network empowerment interventions led by MSM individuals and organisations • Develop and strengthen electronic communication platforms to improve access to IEC while retaining privacy to decrease stigma (including internalised stigma) and discrimination – this should always include sensitisation of healthcare providers and law and policymakers • Strengthen mental health and psychosocial services • Involve MSM in the review and development of preservice and in-service curricula of the service providers (i.e., HWs, social workers, the judiciary and law enforcement services) • Intensify mental health services and psychological support	• All communities in 52 districts • All government service providers	• NDOH • DBE • SAPS • DWYPD • State Information Technology Agency (SITA) • DHET

Table 5: *Goal 1 Key populations and people with increased risk to TB priority actions*

> People living with HIV		
• Develop peer-led, community-based TB health promotion, education and screening packages • Provide nutritional support and food production skills for PLHIV to support the immune system • Provide social support against financial catastrophe for PLHIV through social grants and linkage to skills development activities • Offer mental health and psychological support for adherence and resilience in multi-morbidity (HIV and TB) • Education of religious leaders and public transport owners (related areas where large numbers of people congregate in closed settings) and in non-pharmaceutical TB-prevention strategies	• All communities in 52 districts • Civil Society	• NDOH • Department of Agriculture (DOA) • DSD • PAC, DAC and LAC
> Healthcare workers		
• Strengthen occupational policies and guidelines that support TB-prevention, control and support for HCWs • Develop peer-led support groups for HCWs infected and affected by TB • Offer focused mental health and psychological support for HCWs affected and infected with TB • Develop support packages (financial, additional time off, child care) for families of HCWs who are infected with TB	• All health facilities • DOH settings	• NDOH • DPSA • Professional councils

> People in correctional facilities and other closed settings		
• Develop peer-led, community-based TB health promotion, education and screening packages • Provide nutritional support and food production skills for PLHIV to support the immune system • Provide social support against financial catastrophe for PLHIV through social grants and linkage to skills development activities • Offer mental health and psychological support for adherence and resilience in multi-morbidity (HIV and TB) • Education of religious leaders and public transport owners (related areas where large numbers of people congregate in closed settings) and in non-pharmaceutical TB-prevention strategies	• All communities in 52 districts	• Correctional services • SAPS • NDOH
> Mineworkers and peri-mining communities		
• Strengthen occupational policies and frameworks to support health promotion and occupational safety towards TB • Peer-led health promotion, screening and linkage to appropriate care • Routine screening at living quarters and hostels • Offer a package of social and financial support for employees infected with TB and their families	• Mining companies	• NDOH • Department of trade and industry (dti)
> Refugee/Migrant populations, mobile populations and undocumented individuals		
• Develop peer-led TB health promotion and non-pharmaceutical TB-prevention strategies • Integrate TB screening in the enrolment procedure into the migration centres and linkage to care • Include WBOT visits in the migration waiting centres	• All Home Affairs facilities • All migration and deportation centres	• NDOH • DHA

GOAL 2:

Maximise equitable and equal access to services and solutions for HIV, TB and STIs

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6

Goal 2: Strategic context

HIV: South Africa has the largest HIV-treatment programme in the world. Remarkable progress has been made in PLHIV and ensuring those affected access HIV-testing and treatment services and are virologically suppressed. This was made possible by the massive scale up of HIV-treatment through the adoption of the HIV Universal Test and Treat approach in 2016. [21]

Using innovative differentiated models of HIV care and the UTT policy, South Africa adopted the WHO's recommended tenofovir disoproxil fumarate lamivudine-dolutegravir (TLD) as first-line antiretroviral therapy (ART) for both ART-naive and some ART-experienced individuals. This has resulted in over 5 million people on ART, many of whom are doing well and living a normal lifespan on treatment. However, South Africa is still facing challenges across the HIV-treatment cascade aggravated by human resource shortages and disruptions caused by the COVID-19 pandemic. But across all provinces many are being left behind. For example, although TB is preventable and treatable, it is the leading cause of death among people living with HIV. Similarly, women living with HIV are six times more likely to experience invasive cervical cancer and are more likely than HIV-negative women to die of cervical cancer, even when receiving ART. Yet services for prevention, screening, and treatment of cervical cancer are insufficiently integrated with HIV services, and typically are not available at scale. However, building on lessons learned and progress made in implementing the last NSP, we can end the HIV epidemic. This opportunity ensures all PLHIV, especially key populations and other priority populations, access lifesaving HIV services, and are immediately offered and retained in quality, integrated HIV care, and treatment that improves health and well-being.

TB: In South Africa, TB treatment programme challenges remain in TB-prevention, diagnosis and treatment completion. Only 63% of PLHIV started on ART are on TPT.[25] Approximately a third of TB patients are neither diagnosed nor started on TB treatment.[89] The estimated number of patients falling ill with TB in 2021 was 304 000 cases (95% CI: 207-421).[25] But, only 172 200 cases were reported in 2021.[25] The treatment success rate for new and relapsed cases in 2020 was 78%, and 66% for MDR-/RR-TB cases.[25] The focus in the next few years and according to the TB recovery plan is to enhance TB-prevention, increase the case-detection rate and support PWTB to complete TB treatment.

Furthermore, a multi-sectoral approach has been adopted with mechanisms in place to ensure optimal coordination of the activities, reporting and review of the TB response.

STIs: Key issues remain in the syndromic management of STIs with regard to programme implementation and the need for diagnostic testing to close the gap in treating asymptomatic infections. Less than 40% of all cases of chlamydia and gonorrhoea are treated. There has been a significant decrease in syphilis cases over the years.[33] However, of concern is the increase of syphilis seroprevalence among pregnant women, and increasing cases of newborns with congenital syphilis.[34,90,91] Data on the effectiveness of partner notification for STIs treatment of sexual contacts in South Africa is lacking, but most partners remain untreated. Full HPV-vaccination programmes must be strengthened among school-going girls/learners and expanded to girls not at school.

Viral hepatitis: HBV-vaccination coverage is suboptimal, with only 84% of infants receiving three doses, and the birth dose administration to prevent vertical transmission has not been implemented.[92]

Vaccination of newborns and testing/vaccination of pregnant women is therefore essential to address the burden of HBV among infants. Access to rapid serological HBV testing and HBV DNA testing is required at all care-levels to improve the detection and treatment of HBV. There is limited data on HCV prevalence in South Africa.[44] Additional data is essential to strengthen and focus the HCV programme and efforts to improve testing in key populations and ensure access to direct-acting antiviral agents.

Goal 2: Strategic approach

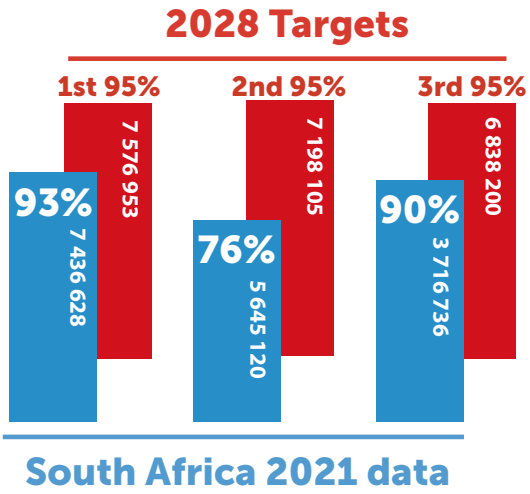
NSP 2023-2028 adopts a people- and community-centred approach to HIV, TB, STIs and viral hepatitis prevention, treatment, and care programming. Working with the affected people is an important element of the NSP to attain greater impact. Adopting high-impact interventions and blending them with a people-and community-centred approach will help to meaningfully address the social determinants of health that affect people with HIV, TB, STIs and viral hepatitis. Although objectives for this goal are very disease-focused, the implementation of screening, prevention, treatment and support for HIV, TB and STIs is to be integrated by all service providers.

HIV-prevention

The NSP 2023-2028 strategic approach focuses on key and other priority populations with a combination of high-impact HIV-prevention interventions to reduce HIV infections. Tailoring HIV-prevention for each group or individual helps to correctly reach people with relevant HIV-prevention tools for high impact. In addition, NSP 2023-2028 does not only focus on biomedical approaches but also on social and community approaches synergistically.

HIV-treatment and care: NSP 2023-2028 builds on lessons from the previous NSP and promotes a new and urgent focus to reduce inequalities for all PLHIV, who are not benefitting from treatment and care services. To this end, an urgent, strategic course correction is needed to get the South African HIV-treatment response back on track. NSP 2023-2028 focuses on improving linkage to care for all PLHIV **(first 95%)**. Next, it will aim to identify, engage or re-engage PLHIV who are not in care or not virally suppressed **(second 95%)**. Increasing retention in care and adherence to HIV-treatment to achieve and maintain long-term viral suppression **(third 95%)** will also be prioritised. A reduction in AIDS-related mortality and improving the quality of life among all PLHIV will be emphasised.

South Africa is transitioning to the 95-95-95 UN targets like the rest of the world, as follows:



TB: In this NSP, the TB strategic focus is on accelerating innovative resource allocation and scale up of TB interventions such as i) testing and treatment for TB, ii) TB quality screening and active systematic case finding, iii) employing new screening and diagnostic tools such as digital chest X-rays and iv) adoption of new regimens for the prevention, diagnosis, treatment, and care for PWTB will be a focus of NSP 2023-2028 for TB. Updating, disseminating, communicating, and engaging all stakeholders (patients, communities, leadership, workers in their diversity, the private sector, government departments, civil society, NGOs, etc) on the policies and guidelines on TB-prevention and management that are all crucial in the control of TB.

STIs: To successfully address the burden of STIs in South Africa, the STI section of 2023-2028 has three comprehensive prongs for the continuum of patient-centred care and services: i) addressing the social determinants of health; ii) biomedical interventions with a strong emphasis on vaccines and diagnostics; and iii) health systems strengthening for high-quality and integrated service-delivery, strong supply chain, and appropriate monitoring and evaluation systems and surveillance and research infrastructure.

Goal 2: Objectives and subobjectives

Objective 2.1:

Increase knowledge, attitudes and behaviours that promote HIV-prevention.

- **Subobjective 2.1.1.** Strengthen social and behaviour change communication (SBCC) through IEC services on HIV-prevention.

  Less than half the young people (18-34 years) in South Africa have correct knowledge of HIV-prevention, and many no longer view HIV as a priority issue. There is, therefore, a need to strengthen education and awareness of HIV-prevention, with a particular focus on the relevance of HIV-prevention to young people's goals and priorities. There is also a need to reach all people with effective prevention messages. Review targeted messages for individual, community- and society-wide campaigns using relevant IEC material for all key and other priority populations, with the focus on providing a comprehensive package of harm-reduction services inclusive of diverse sexual orientation and gender identities. Reach key populations with key messages at least three times a year. Blend electronic social media-use with traditional IEC platforms.

- **Subobjective 2.1.2.** Strengthen age-appropriate comprehensive sexuality education and SRHR education.

  The NSP 2017-2022 provided for the development of scripted lesson plans for Comprehensive Sexuality Education (CSE) delivery. CSE, which teaches and promotes learning about the cognitive, emotional, physical and social aspects of sexuality should include gender identity, sexual orientation and gender expression. To strengthen the provision of CSE in schools, ensure adequate and trained educators are in place and deliver the CSE programme in full annually to all learners.

Out-of-school youth need to be reached with CSE. Regular monitoring of fidelity to curricula must be done in schools. The DBE must retain all learners through education-assistance modalities, teenage pregnancy support, grants, etc., to enable them to receive CSE and SRHR education.

Objective 2.2:

Reduce new HIV infections by optimising the implementation of high-impact HIV-prevention interventions.

- **Subobjective 2.2.1.** Increase the availability and use of male and female condoms and lubricants.

Condom use remains below optimal-levels. Community mobilisation, condom promotion and education approaches must be strengthened for all key and other priority populations. Recruiting and training more peer-led condom promotors would enhance condom use. To make condoms available to all who need them, condoms and lubricants will be distributed through the facility, community, and non-traditional distribution points. There is a need to identify new non-traditional distribution points in key populations and AYP-frequented locations nationwide.

- **Subobjective 2.2.2.** Scale up tailored HIV counselling and testing, including for key and other priority populations.

Although the 90% HIV-testing target was reached, most HIV tests were not tailored to target populations as the yield was low in community testing. The 2025 goal to have 95% of all PLHIV know their status requires comprehensive community-wide (priority population) and tailored HIV-testing (key population) programmes, including index testing and HIV self-screening. Interventions must recruit PLHIV and peer educators to increase the reach of key and other priority populations in their networks with HIV-testing. Prioritise linking tested individuals to prevention and care services. The HIV-testing programme will integrate HIV-testing with testing for STIs and TB.

- **Subobjective 2.2.3.** Promote uptake of voluntary medical male circumcision (VMMC) through targeted demand-generation strategies.

There is a need to increase the provision of circumcision services by opening more facilities for circumcision. NDOH/SANAC must integrate a database for VMMC programmes with the private sector and traditional sector circumcision records. Increasing training of medical circumcision practitioners in traditional circumcision schools and increasing demand for services frequented by young men and men in key population groups could help close the gaps. Such collaboration between the government and traditional sector circumcisions will help to increase the safety of circumcisions.

- **Subobjective 2.2.4.** Promote the availability of PrEP to all who need it and uptake by key and other priority populations.

When PrEP was first introduced in South Africa in the NSP 2017-2022, it was prioritised for population groups with a substantial risk of HIV infection. NSP 2023-2028 proposes to provide PrEP to all individuals who need it. The expansion of the PrEP programme includes new long-acting prevention technology as approved by regulators and adopted by the NDOH . It is therefore important to provide an adequate stock of PrEP and offer PrEP according to individual needs and not only the population group. The following interventions could help to increase coverage and uptake of PrEP: i) consistently make PrEP available in all health facilities and community centres through community-based organisations (CBOs) and in approved places where key and other priority populations can easily access it; ii) strengthen

PrEP marketing to all who need it to increase new PrEP-users annually; iii) rapidly roll out new PrEP products as they become available; iv) promote the correct use of PrEP, including PrEP on demand for appropriate groups.

- **Subobjective 2.2.5.** Improve the availability of PEP and timely access for survivors of sexual violence, those exposed to condomless sex and individuals who require it.

Access to PEP as an emergency preventive tool is hampered by its unavailability at many health facilities. While PEP has largely been provided to survivors of sexual violence and in occupational exposure settings, the NSP 2023-2028 will provide it to anyone exposed to HIV in occupations, sexual violence and condomless sex exposures. To achieve this, training of HWs to offer PEP as an emergency preventive tool and providing PEP within 72 hours at all health facilities and community centres to all people exposed to HIV will be done. Educating people about the importance and timely access to PEP must be promoted. There is a need to sustain the availability and timely provision of PEP to all people exposed to HIV by 2028.

- **Subobjective 2.2.6.** Scale up comprehensive harm-reduction package to PWUD.

It is important to strengthen mapping PWUD in all communities, using peer-led networks of PWUD. Interventions to scale up the provision of a comprehensive package of harm-reduction services among PWUD include: i) a needle and syringe programme; and ii) OST to promote safer behaviours, recruit and deploy people who use(ed) drugs for screening and provide services for mental health, TB and STIs. This helps to deal with stigma and discrimination and thereby increases the acceptability of interventions. Promote PEP to those exposed to HIV, including those sharing needles and syringes.

Include messaging designed to inform PWUD about the dangers of drug-use, especially injecting.

- **Subobjective 2.2.7.** Integrate HIV-prevention with SRHR, SGBV, mental health, STI and TB services.

Ensure all health services, including private facilities, integrate HIV-prevention services and provide a comprehensive package of harm-reduction services at all health facilities and sustain integration by 2028. Integrate private sector data in the national database. Approaches to be taken include linking information on SGBV to HIV-prevention programmes, integrating prevention of vertical transmission programmes with mental health, TB and STIs programmes and integrating HIV-prevention with NCDs health-promoting programmes. Lastly, integrating HIV-prevention into social and community interventions could yield greater results.

- **Subobjective 2.2.8.** Promote innovation and research in HIV-prevention tools, community approaches and service delivery.

Fast-track rollout of proven innovations to scale, e.g., new vaccines and service-delivery approaches. Conduct implementation research to improve national standards, and increase collaboration between researchers, HWs, facilities and communities, including key and other priority populations. Implement research through local researchers for local solutions to the pandemic, while collaborating with international institutions, funders, and researchers.

Objective 2.3:
Eliminate vertical transmission of HIV.

- **Subobjective 2.3.1.** Scale up screening of pregnant and breastfeeding women for HIV and link them to HIV-prevention services, including PrEP.

  All antenatal facilities must test all pregnant women and breastfeeding mothers, and promote PrEP-use to all HIV-negative women and sustain services by 2028. Promote and facilitate early antenatal care bookings for pregnant women, strengthen and promote partner involvement in the prevention of vertical transmission, provide tailored HIV-prevention interventions for HIV-negative pregnant and breastfeeding mothers and promote risk-benefit counselling for pregnant women for HIV-prevention.

- **Subobjective 2.3.2.** Scale up universal uptake of ART among pregnant and breastfeeding HIV-positive mothers.

  All antenatal facilities must test and offer treatment to all HIV-exposed women. Strengthen regular testing of babies and infants at all health facilities and through immunisation programmes. Promote ART retention and viral suppression uptake through support groups, improve growth-monitoring and infant-feeding support services, and encourage consistent and correct condom use.

That **95%** of all people living with HIV know their status

Objective 2.4:
Ensure that 95% of PLHIV, especially key and other priority populations, know their status and 95% of them are on treatment, and 95% of those on treatment are retained in care and achieve long-term viral suppression.

- **Subobjective 2.4.1.** Improve HIV linkage to care for all PLHIV (first 95%).

  Achieving improved health outcomes for all PLHIV begins with ensuring that they are promptly linked to effective HIV care and treatment after diagnosis. To reach our targets, each district must ensure linkage to HIV care and treatment immediately or as early as possible following HIV diagnosis leading to faster viral suppression, increased rates of retention in care, and reduction in transmission risk. In NSP 2023-2028, we must continue to accelerate HIV case finding through the index and network testing, HIV self-screening and other differentiated HIV-testing models and accelerate same-day or rapid initiation of ART for all PLHIV not on treatment. This is especially true for key and other priority populations less likely to be linked to HIV care. This effort requires clinics and community actors to reduce barriers to initiating treatment and care. In combination with efforts, NSP 2023-2028 advocates for facilitated linkage (e.g., clinic staff actively scheduling a referral visit or accompanying the patient to that visit) to achieve higher linkages to ART initiation than passive referral (e.g., providing clients with phone numbers and referral information). Efforts to strengthen client-centred linkage services using innovative, differentiated models of HIV care will also be needed, especially for key and other priority populations, including children, adolescents, men, pregnant and breastfeeding women, and clients with disabilities. Inclusion of self-testing and passive referrals for key populations to aid linkage to care while averting stigma and discrimination.

- **Subobjective 2.4.2.** Identify, engage or re-engage PLHIV who are not in care or not virally suppressed (second 95%).

Although progress has been made over time, only 78% of people with diagnosed HIV are on ART. Men and children living with HIV face additional barriers to staying on ART, and priority activities are needed to ensure they are supported to stay on treatment. The South African Welcome Back Campaign Strategy provides guidance on how to successfully welcome back and retain treatment-naive patients and those returning to care after interrupting ART. Innovative solutions must be strengthened to retain populations that, to date, our systems have been unsuccessful in reaching and retaining in care. Strategies needed include improving diagnosis of children outside of early infant diagnosis, identifying and re-engaging patients with AHD, equipping staff to manage re-engagement of patients in a non-judgemental approach, strengthening tracking-and-tracing services, providing access to peer support from other PLHIV, and implementing patient-centred practices to empower clients and improve retention in care.

- **Subobjective 2.4.3.** Increase retention in care and adherence to HIV-treatment to achieve and maintain long-term viral suppression (third 95%).

PLHIV need ongoing support to stay in care and adhere to ART to achieve and maintain viral suppression. For PLHIV with mental health conditions, where appropriate should be offered counselling services to help retain them in ART care. Differentiated models of care to ensure long-term retention will be prioritised and supported. Transitioning stable clients onto the safer and more potent dolutegravir-based regimen, especially children, enrolling clients into the central chronic medicines-dispensing and distribution (CCMDD) programmes and supporting community ART pick-up. Additional support is required for clients with less-than-optimal outcomes, such as men, pregnant women, children, adolescents, key populations and young people, including collaboration with funded NGOs and support partners who offer services to these groups. Districts should establish systems and related electronic tools such as the NICD's viral load Results for Action reports, TIER.Net to timeously identify clients (particularly pregnant women and children) with elevated viral loads, and facilitate assessment by a clinician and referral to enhanced adherence counselling. Management of side-effects at a client-level, pharmacovigilance at national-level, and high-impact interventions to prevent and respond to HIV drug resistance are vital to ensure a durable treatment programme. Additionally, efforts will be made to extend person-centred monitoring through routine health data systems to support surveillance of the safety of new antiretrovirals in all populations .

Objective 2.5:

Improving the quality of life beyond HIV suppression by reducing HIV-related deaths and comorbidities, coinfections and complications.

- **Subobjective 2.5.1.** Reduce HIV-related deaths from HIV/TB-associated comorbidities, coinfections and complications.

HIV-related deaths have reduced dramatically over the past two decades, largely because of the success of our HIV-treatment programme. To prevent further deaths from preventable HIV/TB-associated infections such as TB and cryptococcal meningitis in patients with AHDs, NSP 2023-2028 prioritises the adoption and implementation of the AHD package of services by i) strengthening screening; ii) prophylaxis; iii) rapid ART initiation; and iv) intensified adherence interventions. The risk of NCDs, including type 2 diabetes mellitus, cardiovascular disease, and some cancers, increases as people age on ART. Integrating priority NCDs

prevention (diabetes, hypertension and cervical cancer, and mental health), assessment and treatment into HIV-treatment services is crucial to ensure a healthy ageing population.

- **Subobjective 2.5.2.** Improve the quality of life for all PLHIV.

Optimising the quality of life and well-being across the lifetime of all PLHIV through integrated, people-centred services and approaches should be prioritised. NSP 2023-2028 makes efforts to strengthen the integration of patient-friendly services (HIV, SRHR, mental health, diabetes, cervical cancer and hypertension); enhance tailored messaging to improve HIV, TB, and STIs treatment literacy; and strengthen the undetectable = untransmissable (U=U) message to increase awareness and improve suppression on ART; identify, implement, and evaluate models of care that meet the needs and ensure the quality of care across services and identify and implement best practices related to addressing psychosocial and behavioural health needs, including providing a comprehensive package of harm-reduction and mental health services. Implement differential client-friendly services for HIV-exposed children and adolescents and their caregivers to ensure continuum of care.

- **Subobjective 2.5.3.** Strengthen strategies to engage men in accessing services.

Employ gender-sensitive approaches to engage men through peer-led interventions to encourage them to enrol in health programmes to reduce premature mortality; inequalities in physical and mental health and well-being; and improve gender equality by engaging men to break harmful gender norms inclusive of self-care.

Objective 2.6:

Strengthen TB-prevention interventions for key and other priority populations and implement airborne infection-prevention and control in health facilities and high-risk indoor places where people congregate.

The objective of the TB-prevention strategy is to reduce TB transmission by implementing airborne infection-prevention control measures and to reduce the progression of TB infection to TB disease by increasing the uptake of TPT to those that are eligible. The guidelines on TPT to be updated and disseminated taking into consideration algorithms for children and those exposed MDR-/XDR-TB, emerging data on new regimens and recommendations. In addition, it emphasises the importance of addressing TB-risk factors and social determinants through a multi-sectoral approach.

- **Subobjective 2.6.1.** Strengthen TB-prevention interventions for key and other priority populations.

Provide TPT and adherence support (with family-centred approaches) and accelerate the scale up of TPT with shorter regimens (80% of those on TPT) to all eligible. Train all HCWs on the new TPT guidelines soon after release. Facilities and all TPT service providers need to ensure the availability of TPT and monitor, prevent and report TPT stockouts. Trace all contacts of PWTB using contact-tracing cards and technologies. Train HCWs, including ward-based outreach teams WBOT and CHCW, on contact-tracing and support community-based contact-tracing programmes. Review emerging evidence on new diagnostic tools for TB infection and consider translation into guidelines

- **Subobjective 2.6.2.** Strengthen the implementation and monitoring of airborne infection-prevention and control measures in health facilities.

  Review, update and disseminate policies and guidelines on airborne infection control at health facilities. Develop and implement an infection control plan according to the National Infection-prevention and Control Strategic Framework and the ideal clinic and hospital frameworks by 2024, and ensure each health facility has a designated staff member responsible for infection control. As part of building resilient health systems, procure adequate quantities and provide personal protective equipment (PPE) such as N95 masks for staff, according to the National Infection-prevention and Control Strategic Framework. Hospitals and clinics must follow the principles and guidelines outlined in the ideal clinic realisation and maintenance (ICR-M) guide and hospital frameworks, and the integrated clinical services management manual on facility re-organisation, fast-tracking of patients, CCMDD and multi-monthly dispensing (MMD) to reduce congestion at their premises.

- **Subobjective 2.6.3.** Strengthen the implementation of airborne infection-prevention in high-risk indoor places where people congregate.

  Review, update and disseminate ventilation standards, taking lessons from COVID-19 for high-risk indoor places, including workplaces, prisons, and education facilities to maximise natural ventilation and in collaboration with other departments and sectors. Educate community members on infection control measures, including maximising natural ventilation, masking, cough etiquette and isolation. Provide IEC material on infection control in the community as part of the communication and engagement plan and in collaboration with other sectors and departments. The appropriate departments must ensure the availability of policies on screening for diseases, including TB, in workplaces and institutions, including the training of personnel to conduct the screening and monitor the implementation of screening for diseases.

- **Subobjective 2.6.4.** Address TB-risk factors and social determinants/barriers through a multi-sectoral approach.

  Provide combination prevention, treatment, and support services for PLHIV and those affected by undernutrition, diabetes, smoking, alcohol, and substance-use disorders in collaboration with other departments and sectors. This will be facilitated through a multisectoral approach that extends beyond the health sector and encompasses a broader development agenda that includes other government departments and stakeholders across civil society, the private sector, academia, professional associations and affected communities. The multisectoral collaboration will be guided by the 2017 Moscow Declaration on the multisectoral accountability framework for TB. Each facility or TB-prevention service provider to develop a database of stakeholders and service providers for contextualised referral pathways.

- **Subobjective 2.6.5.** Support the development, uptake and scale up of new TB vaccines.

  In addition to ensuring optimal coverage with the Bacille Calmette-Guérin (BCG) vaccine, support the development, uptake and scale up of new TB vaccines. This would be achieved by advocating for TB vaccine research funding and participation in TB vaccine research by the affected communities. Support and resource research for new TB vaccines and work with partners on TB vaccine research to expedite approvals so that at least one new TB vaccine is available. Evaluate evidence of new TB vaccines as they become available and recommend guidelines. Prepare to invest in TB vaccine rollout and scale up, and work with partners to support the scale up of TB vaccines. In developing the TB vaccine, roll-out plans apply lessons from the COVID-19 vaccination rollout, such as private-public partnerships.

> “Accelerate the scale up of **innovative processes such as test and treat and point of care testing** to strengthen TB diagnosis.”

Objective 2.7:

Strengthen TB diagnosis and support for PWTB and accelerate scale up of innovative processes, diagnostic tools and regimens for the diagnosis, treatment and care for PWTB.

This objective aims to increase access to quality TB screening services and provide testing for those at high risk or who are symptomatic following innovative processes and newer diagnostic tools to increase the case-detection rate to 95%. Second, 95% of PWTB linked into care provided with adequate adherence support, social support, and mental health support to achieve a 95% TB treatment success rate.

These objectives will be achieved through the following strategic subobjectives.

- **Subobjective 2.7.1.** Strengthen TB diagnosis and increase the TB detection rate.

  Implement and monitor innovative and quality screening processes at clinics and hospitals. These must include screening and risk categorisation of persons who access health services, and persons at high risk or with symptoms referred or provided with TB testing. Strengthen quality systematic and universal testing for TB to increase early diagnosis of TB, including subclinical/asymptomatic TB and extra-pulmonary TB with multiple diagnostic tools such as chest X-rays, sputum tests, and other tests as evidence is established. Provide regular, systematic testing for TB of people at high risk of TB disease such as PLHIV, contacts, HCWs, children and other key and priority populations. Eliminate barriers such as stigma and costs of accessing TB tests. Develop and disseminate guidelines on subclinical TB diagnosis and management based on emerging evidence and recommendations. Accelerate the scale up of innovative processes such as test and treat and point-of-care testing to strengthen TB diagnosis. Accelerate scale up of innovative screening and diagnostic tools such as

digital chest X-rays and urine LAM to increase the TB detection rate. Consider using other samples for TB diagnosis, such as stools in children. Resource and implement TB screening and testing campaigns tailored to key and other priority populations and TB hotspots. These campaigns must include community-based and community-led campaigns of TB screening and testing. Strengthen strategies to engage men in accessing TB screening and diagnosis services.

- **Subobjective 2.7.2.** Strengthen linkage into care for PWTB.

  Strengthen referral systems of PWTB who have recently been diagnosed, especially those diagnosed through community campaigns and in hospitals and ensure that 95% are linked into care. Provide results to people tested for TB by short text messages from the laboratory. Notify 100% of new PWTB diagnosed and started on TB treatment to the national TB Programme (NTP). Disseminate pre- and post-TB testing and guidelines counselling, and invest in capacity building for HCWs, including WBOTs and CHCWs to provide pre- and post-TB testing counselling. Strengthen the interoperability of the electronic TB information systems (Tier. Net and EDRWeb) with the laboratory information system for early identification of patients lost to follow-up. Establish linkages with private laboratories to enable reporting of TB results to the NICD, building on systems developed during the COVID-19 pandemic.

- **Subobjective 2.7.3.** Strengthen access to treatment and care for PWTB.

  Strengthen supply chain management and good medicine/pharmacy stock management of TB treatment medication at health facilities. Update and disseminate the TB treatment guidelines to include new shorter TB regimens for DS-TB and MDR/XDR-TB as new evidence becomes available. Train HCWs on new TB treatment regimens soon after release. Scale up the existing pharmacovigilance monitoring system (PViMS) to effectively manage clients and improve safety. Support the research of new TB treatment regimens, especially formulations for children and MDR/XDR-TB treatment and work with partners on the research of new TB treatment regimens. Provide medical reviews for all PWTB that have completed treatment for one year at six-month intervals. Identify PWTB that completed treatment that needs pulmonary rehabilitation and refer accordingly.

- **Subobjective 2.7.4.** Strengthen support and increase treatment completion for PWTB.

  Provide support to PWTB, such as adherence counselling, family-centred approaches, and treatment buddy during and after treatment. Provide ongoing adherence counselling during treatment and strengthen existing support groups to address comorbidities. Adherence support should also include sending reminders, appointment schedules and other people-centred interventions such as medication monitors. Provide and train on screening tools for mental health, substance and alcohol use disorders. Provide social and mental health services support during and after treatment for PWTB, prioritising those at high the risk of poor adherence (substance and alcohol abuse) and people with MDR/XDR-TB. Establish clear referral pathways to access social support and mental health services at all facilities. Train HCWs on TB stigma prevention and management of patients with mental health conditions and drug and alcohol use disorders. Minimise barriers (travel costs, missing work) to access TB treatment and care. Develop and implement track-and-trace strategies for PWTB who are no longer in care. Adopt and scale up evidence-based digital adherence support technologies for PWTB on treatment.

- **Subobjective 2.7.5.** Provide advanced quality care for people with severe or complicated TB disease.

  Provide multi-disciplinary advanced quality care and support for clients with special needs or complicated TB disease such as children, MDR/XDR-TB and extra-pulmonary TB that may include, and not be limited to special investigations, different regimens, referrals to various specialists and hospital admission. Strengthen referral systems and feedback mechanisms for specialist care.

  Provide palliative care for PWTB. Enhance client support by fostering partnerships with community organisations, hospices, and health facilities. Train HCWs on palliative care for PWTB.

Objective 2.8:

Increase detection and treatment of four curable STIs through systems strengthening, service integration and diagnostic testing; achieve elimination targets for neonatal syphilis; and scale up HPV-vaccination and cervical cancer screening.

- **Subobjective 2.8.1.** Reduce the annual number of new cases of four curable STIs (Chlamydia, gonorrhoea, trichomoniasis and syphilis).

  To achieve a reduction of the four curable STIs (*chlamydia, gonorrhoeae, trichomoniasis, syphilis*), prioritise and implement the following interventions i) scale up of STI prevention by providing high-quality health information; targeted biomedical prevention options and timely health services; ii) implementation of STIs diagnostic testing of key and other priority populations to detect and treat asymptomatic infections; iii) optimisation of STIs treatment outcomes by implementation of STIs diagnostic testing of symptomatic individuals; and iv) the development and implementation of effective STIs partner notification and treatment strategies.

  To prevent the four curable STIs, implement the following interventions: i) provide information and education together with effective STIs prevention tools, for example, condom distribution and medical male circumcision services, and train/retrain HCWs in primary healthcare settings on the detection and treatment of STIs, including priority populations; ii) integrate STI care with primary healthcare, reproductive healthcare and HIV services and rapid specialist referral systems with access to advanced diagnostics to manage cases of treatment failure; iii) improve surveillance of STIs and antibiotic resistance and implement strategies to strengthen partner notification and contact-tracing, especially for key populations. The target populations for these interventions include AGYW, pregnant women, PLHIV, MSM, transgender persons, sex workers and PrEP-users.

- **Subobjective 2.8.2.** Achieve elimination of neonatal syphilis.

  To achieve elimination of neonatal syphilis; i) implement syphilis rapid diagnostic testing and same-day treatment of pregnant women during antenatal care; ii) provide comprehensive follow-up post-treatment, including serological monitoring and provision of partner treatment; and iii) ensure sustained access to benzathine benzylpenicillin (BPG) for all cases of syphilis and alternative treatment options when these become available. The approach is to screen all pregnant women for syphilis at the first antenatal clinic visit. The target is to screen and treat > 95% of pregnant women, resulting in less than 50 cases of congenital syphilis per 100 000 live births. A second approach will be to screen all infants born to syphilis-positive mothers at birth, as well as infants born to women who were unbooked or untested. The final approach is to link all children diagnosed with congenital syphilis to care and ensure they receive treatment.

- **Subobjective 2.8.3.** Scale up HPV-vaccination and cervical cancer screening.

Interventions to achieve this goal include i) scale up of age-based school HPV-vaccination programme including independent schools and options for out-of-school girls; ii) expanding the HPV-vaccination programme to other population groups at high risk of HPV-associated disease; iii) transition from high-quality cytology to HPV DNA as a primary test for cervical cancer screening; and iv) implementation of and monitoring the cervical cancer care cascade, including rapid management of women with high-risk cervical lesions. The first approach is to achieve high coverage of full HPV-vaccination of schoolgirls and out-of-school girls younger than 15 years of age to receive at least one dose of the HPV vaccine, and vaccination of populations eligible for catch-up vaccination. Second, implementation of awareness-raising for HPV-vaccination and strengthening primary and high school curricula on HPV and encourage HPV-vaccination in key populations. The final approach is to strengthen access to HPV testing and colposcopy services. Considering the high risk of cervical cancer, women with high-risk lesions must have a colposcopy within a maximum of six weeks of a cervical smear test, and continue the cervical cancer screening for women 30 years and older, and women living with HIV of 25 years and older.

Objective 2.9:

Reduce viral hepatitis morbidity through scale up of prevention, diagnostic testing and treatment.

Prevention of viral hepatitis shall be increased by i) scale up of the HBV birth dose-vaccination of newborns; ii) HBV diagnostic testing and vaccination of HCWs; and iii) scaling up of providing comprehensive package of harm-reduction services for PWUD. The most important approach to prevention is to ensure HBV-vaccination within 24 hours at all birth facilities as part of the existing vaccination schedule. Second, all HCWs that work at public and private health facilities to be offered HBV-vaccination. Lastly, harm-reduction services should increase needle and syringe programmes, opioid-substitution therapy and HCV education.

- **Subobjective 2.9.1.** Scale up diagnostic testing and treatment of viral hepatitis.

Diagnostic testing and treatment of viral hepatitis will be increased by i) implementation of HBV diagnostic testing and treatment of key populations and pregnant women, and scaling up testing coverage of PLHIV; and ii) by implementing targeted HCV diagnostic testing and treatment strategies for key populations. The first approach to scale up diagnostic testing and treatment is to implement HBV diagnostic testing and treatment of key populations and pregnant women, and scale up testing coverage of PLHIV. Second, all PWUD should be offered screening for HCV. Furthermore, ensuring that effective HCV treatment is available and 100% of those diagnosed are offered treatment is crucial.

PRIORITY ACTIONS

Table 6: *Goal 2 Priority Populations*

SERVICES / INTERVENTIONS / APPROACHES	SETTING	ACCOUNTABLE PARTNERS
Children 0-9 years		
• Index testing for HIV-positive mothers • Health education, with particular focus on sexual exploitation in the absence of primary caregivers • Age-appropriate CSE in residential, school and non-school and youth-friendly settings • Child and youth-friendly health and social services in schools and community settings, which include: - Choice and access to safe abortion - Additional support and protection for orphans, children in child-headed households and homeless children • Access to HIV, TB and STI services for prevention, screening, testing, and treatment: - Early testing and optimised comprehensive, high-quality treatment and care for infants, children, and adolescents living with HIV to achieve universal coverage of ART and viral suppression - Prioritise rapid introduction and scale up of access to optimised child-friendly HIV-treatment, including DTG fixed-dose combination and achieve sustained viral load suppression - Strengthen viral load monitoring and adherence in children living with HIV, as indicated in the ART guidelines • Implement differential client-friendly services for HIV-exposed children and adolescents and their caregivers to ensure continuum of care • Protection against all forms of abuse • Intensified mental health services and access to psychosocial support to support adherence • Strengthen treatment literacy campaigns and psychosocial support for caregivers and adolescents	• All communities in 52 districts • Early childhood development (ECD) centres • Schools • Higher education institutions	• Households • NDOH • DBE • DHET • DSD

Adolescents and young people 10-24 years

• Age-specific support to adolescents and young key populations with HIV and TB and young LGBTIQ+ (support for disclosure, adherence) • Adolescent- and youth-friendly SRHR services in schools and community settings, which include: - Two-dose HPV-vaccination - Contraceptives including condoms - Choice and access to safe abortion - Appropriate support for pregnant children • Access to HIV, TB and STI services for prevention, screening, testing and treatment • Intensified mental health services and access to psychosocial support to support adherence • Access to screening for HBV and HCV and access to HBV-vaccination as an adolescent or adult • Adolescents on ART should be virally suppressed given the best treatment option and adherence support • Improving adolescent-friendly services to increase retention and virally suppressed rates; and prepare and plan for transition adult ART care and treatment services • Promote U = U campaign to reduce HIV transmission by promoting treatment adherence and decreasing loss to follow-up, increasing viral suppression and improving data management	• All health facilities • Schools • Higher education institutions	• NDOH • DBE

Pregnant and breastfeeding adolescents and women (PBAW)

- Scale up initiation of DTG-based regimen to PBAW as per revised guidelines
- Improve viral load-monitoring in PBAW to ensure viral suppression
- Improve data management for pregnant women
- Establishment of psychosocial support services for pregnant and breastfeeding women living with HIV
- Explore implementation of multi-month dispensing for post-natal mothers
- Establishment of psychosocial support services for HIV-positive pregnant and breastfeeding women
- Closing the treatment gap for pregnant and breastfeeding women living with HIV and optimising continuity of treatment towards the goal of elimination of vertical transmission
- Strengthen integration of ART services in all Maternal and Child Health services

Migrants, mobile populations and undocumented individuals		
• Create demand to promote the uptake of SRH services by migrants • Sensitise service providers to the needs, rights and responsibilities of migrant and mobile populations, as well as related protective policies • Increase the availability of migrant-friendly facilities for prevention, screening, testing and treatment of HIV, TB and STIs • Intensified mental health services and access to psychosocial support to support adherence • Offer a comprehensive package of HIV-prevention services, including harm-reduction in prisons, such as OST	• Communities	• NDOH • DSD • DHA • SAPS
People with mental health conditions		
• Offer counselling services to persons with a mental health condition as a means to retain them in treatment • Tailored communication materials and tools • Access to tailored SRHR and other services • Access to assistive devices	• Facilities	• NDOH
LGBTQI+ persons		
• Sensitised health, education and social services	• Facilities	• NDOH • DBE • DSD
Survivors of SGBV		
• PEP, PrEP • Sensitive and supportive services • Appropriate psychosocial support	• Facilities	• NDOH • DSD • SAPS

Table 7: *Goal 2 Key populations priority actions inclusive of HIV, TB, STIs*

SERVICES / INTERVENTIONS / APPROACHES	SETTING	ACCOUNTABLE PARTIES
Sex workers and their clients		
• Access to PEP and PrEP on request • Access to a comprehensive basket of HIV-prevention resources, (i.e., vaginal rings, internal and external condoms with compatible lubricants) • Access to IEC materials SRHR • Access to SRHR services, including termination of pregnancy • Access to TB screening, testing and linkage to care • Intensify cervical cancer screening for HIV-positive sex workers and include the HIV-negative in the HPV-vaccination • Promote U = U campaign to reduce HIV transmission by promoting treatment adherence and decreasing loss to follow-up, increasing viral suppression and improving data management	• Health Facilities • High Transmission Areas program	• NDOH • NGOs • DSD
Transgender people		
• Inclusion of gender-affirmation package of services at all levels of care • Transgender-friendly facilities in all service settings • Access to comprehensive mental health and psychosocial support • Tailored sexual health screening • Access to internal and external condoms • Access to targeted SRHR package of services • Peer-led support groups to support testing, linkage to care and retention in care (95;95;95) for HIV, TB and STIs • Provide community-based testing and appropriate linkage to care • Amplify the package of care by inclusion of eHealth and mHealth services to improve access and retention in care	• All Facilities	• NDOH • NGOs • DSD • Higher education • DBE
Men who have sex with men		
• Access to internal and external condoms with compatible lubricants • Offer VMMC for MSM with female partners • Tailored sexual health screening, inclusive of anal health • Provide mental health and psychosocial support • Access to PEP and PrEP on request • Peer-led support to aid testing, initiation of treatment and retention in care (95;95;95) • Enhanced package of care by inclusion of eHealth and mHealth services to improve access and retention in care	• All communities in 52 districts	• NDOH

People who use drugs		
• Access to sterile needles and syringes, including community-based access points • Offer OST • Offer a comprehensive package of HIV-prevention services, including harm-reduction • Access to TB screening and testing services and linkage to care for PWTB	• All communities in 52 districts	• DSD • NDOH • NGOs • Provincial AIDS Councils
People in prisons		
• Access to HIV, TB and STI package of care and linkage to care during and post-incarceration • TB non-pharmaceutical intervention • Infection control standards in correctional facilities • Access to internal and external condoms with compatible lubricants • Offer a comprehensive package of prevention services for HIV, TB and STIs, including harm-reduction in prisons – including OST	• Correctional facilities	• DO Correctional Services • SAP • NDOH
Migrant and mobile populations		
• WBOT catchment areas to include migrant and mobile communities • TB screening, testing and linkage to care	• All 52 Districts	• NDOH • DHA
People living with HIV		
• Strengthen cervical cancer screening and HPV-vaccination for women • Strengthen access to TB screening and prophylaxis • Empower peer-led support groups for adherence and linkage to care • Integrate mental health services in the package of care • Promote U = U campaign is to reduce HIV transmission by promoting treatment adherence and decreasing loss to follow-up, increasing viral suppression and improving data management	• All health facilities	• NDOH


BOYS

GOAL 3:

Build resilient systems for HIV, TB and STIs that are integrated into systems for health, social protection, and pandemic response

GOAL 3:

7

Build resilient systems for HIV, TB and STIs that are integrated into systems for health, social protection, and pandemic response.

Goal 3: Strategic context

Robust and resilient health systems are essential to effectively respond to HIV, TB and STIs and other health outcomes. In the past decade, resilience has emerged as a key concept for health and social systems globally. System resilience ensures sufficient capacity to manage, absorb or mitigate risks. The COVID-19 pandemic exposed ongoing low-resource availability and difficulty in accessing services due to major vulnerabilities in our health and social systems. This highlights the importance of ensuring that systems are built to be resilient and adaptable to change, while maintaining the provision of essential services. Therefore, establishing resilient systems and strengthening them is a priority in NSP 2023-2028.

Additionally, the country is poised for big health system reform through the National Health Insurance (NHI). The NHI Bill was introduced to Parliament in July 2019, aiming to revolutionise the health system in South Africa and be at the heart of sector reforms to address the gross distortions and ensure equitable access to quality health services for all South Africans through UHC. The NDP 2030 underpins the NHI and has the potential to address major social determinants of health, including poverty, inequality, and unemployment. Hence, over and above the gains following the COVID-19 pandemic, which entirely transformed the outlook of healthcare, the NHI will drastically change South Africa's healthcare landscape.

Goal 3: Strategic approach

The need to address systems vulnerabilities and provide resilient health and social systems will intensify in the coming years with future emergencies of many kinds. These include, but are not limited to the impacts of climate change and extreme weather, natural and man-made disasters as well as cyberthreats and the structural ageing of infrastructures. Resilient systems need to integrate operational robustness as part of their design. This includes considering human resources, technology, strategic information, supply chain management, pharmacovigilance, laboratory management, humanitarian settings, emergency preparedness, research and knowledge management.[93] This will minimise service disruption when similar disasters and pandemics occur.

To build resilient health systems, securing community buy-in is vital. In South Africa, the unique challenges of the COVID-19 pandemic improved how community organisations worked. Organisations that worked in silos during other emergencies had to pool their expertise and resources to form collaborative networks, with positive results.[94] The NSP 2023-2028 will strengthen local organisations and institutions by identifying policies, institutions and technologies that enable the locally-driven design of resilient systems. This will also include a strong focus on humanitarian-oriented approaches aimed at quick recovery, sustainability and perseverance of the systems following emergencies. Priority should be given to community-led initiatives, employing adequate workers (who are appropriately trained is critical for the delivery of HIV, TB and STI services), fostering evidence-based practices, including infrastructure development, and ensuring reliable medical and diagnostic supplies as well as establish policies and mechanisms for exchanging knowledge and experiences between provinces, institutions and sectors.

GOAL 3:

Build resilient systems for HIV, TB and STIs that are integrated into systems for health, social protection, and pandemic response.

Objectives and Subobjectives

Objective 3.1:

Engage adequate human resources to ensure equitable access to services for HIV, TB, STIs, and other conditions that contribute to these diseases.

- **Subobjective 3.1.1.** Deploy adequately trained workforce in prevention, treatment and care programmes for HIV, TB and STIs.

  South Africa needs workers of different categories to provide Health promotion on disease-prevention and curative, therapeutic, rehabilitative and palliative services. Increasing service demand requires additional staff and training, and education reforms are needed in educational institutions to supply adequate numbers of all cadres of the workforce, from community workers to specialists. NSP 2023-2028 advocates for recruitment, training, capacity development and deployment of adequate numbers of various staff cadres across different levels of care and service provision.

- **Subobjective 3.1.2.** Capacitate and facilitate ongoing professional development, training and mentoring of different categories of staff to address skills and knowledge gaps.

  Capacity building and development of staff across all cadres of service provision to strengthen the capacity of individuals to implement evidence-driven programmes and systems to perform core functions. Professional development needs to be an ongoing focus at all levels of care and across all cadres of the workforce in South Africa to enable the health and social workforce to perform their duties, with regular updates on new matters related to diagnosis, care and management of HIV, TB and STIs.

- **Subobjective 3.1.3.** Fast-track wellness and psychosocial support programmes in workplaces.

  The WHO calls for effective interventions to prevent occupational hazards and to protect and promote health in the workplace and access to occupational health services. South Africa's wellness management programme is largely preventive in nature, focusing on primary (avoid the risk or condition) and secondary (minimise the effects of the condition) prevention.

- **Subobjective 3.1.4.** Revise and revitalise evidence-based methods to estimate the workforce needed for service provision, implementation, and emergency responses to disasters or pandemics for HIV, TB and STIs.

  Functioning health systems require a health workforce that is qualified, available, equitably distributed and accessible to the entire population as the basis for guaranteeing access to services (health, social or humanitarian). The country will adopt a phased scale-up approach, prioritising the poorest communities as new funding becomes available. When recruiting a new cadre for the support of HIV, TB, and STI responses, organisations or institutions should seek to also engage people from key and other priority populations. As much as possible, services for HIV, TB and STIs should be delivered by organisations or staff that reflect the community being served, including people from the local community.

Objective 3.2:
Use timely and relevant strategic information for data-driven decision-making.

An effective national response to the HIV, TB and STI epidemics requires strategic information that is systematically collected, consolidated, analysed and applied. There are three components of strategic information (SI) for the NSP: monitoring and evaluation (M&E), surveillance and surveys, and research. A functional and effective M&E system is the engine that generates, analyses and uses SI. This objective on strategic information management covers M&E and routine surveillance and surveys to generate and use timely SI to enhance the response to the three epidemics. This will be implemented through more efficient and effective M&E and better surveillance activities. This NSP recognises public health data as a national public good and develops models for data-sharing. In addition, this NSP emphasises the interpretation and use of available data for planning and decision-making to improve programmes.

- **Subobjective 3.2.1**. Build a national framework and scorecard (specifying processes, data sources, human resources, stakeholders, and other items) for NSP SI.

  A detailed SI framework specifying data sources, processes, human resources, stakeholders and other items will be developed to ensure that NSP 2023-2028 has the necessary systems for an efficient and effective routine SI. The framework and associated scorecard will strengthen governance and accountability for NSP implementation, and tracking progress. Specifically, the SI framework will include the following:

  M&E Framework: The SI framework builds on the existing NSP M&E framework, maintaining relevant indicators and adding needed indicators for a more comprehensive M&E. In addition, it prioritises indicators so that efforts can be tailored towards needed disaggregation, data quality, data analysis and reporting for action.

  Data sources: The SI framework will use the comprehensive list of indicators in the NSP M&E framework to map all needed and available data, data sources and frequency of data-collection for all indicators. The mapping exercise will highlight current and potential data gaps and specify mitigating strategies. This activity will ensure there are data sources for all NSP indicators.

  Data disaggregation: The SI framework will pursue data disaggregation specified in the M&E framework for improved granularity in tracking performance. Appropriate data disaggregation at the sources of data-collection will be important in this regard. First, NSP 2023-2028 will ensure the usual disaggregation by basic demographic characteristics for more indicators. Second, disaggregation by additional variables, for example, disability and key population will be specified. While the NSP recognises the hurdles in collecting more data for disaggregation, it also notes that improved data disaggregation is needed for a more effective response. Thus, this NSP highlights the need for continuous engagement with relevant departments and stakeholders for disaggregation data on disability.

  Regular surveillance surveys in key populations: It is a central activity in this NSP to regularly conduct nationally representative population-size estimations (PSEs) and integrated bio-behavioural surveys (IBBS) among key populations using standardised methodology. The SANAC SI Unit will work with key stakeholders to determine the frequency and standardisation of surveillance surveys for PSEs and IBBS. While a number of PSEs and IBBS were conducted during the last NSPs, they often focused on large metros. Nationally representative PSEs that can be disaggregated by district will be pursued. For IBBS, the frequency of data-collection will be more predictable so that the data becomes available at key times during the NSP cycle.

Surveillance surveys in the general population: This NSP also emphasises surveys that contribute to monitoring and surveillance activities in the general population, such as the South African National Prevalence, Incidence, Behaviour and Communication Survey and the Stigma Index surveys. The possibility of measuring the STIs burden using these surveys will be explored.

Data quality: As data quality is a critical component of SI, SANAC will provide a data governance framework for the NSP data quality. It will support data quality interventions for key NSP data sources, including the use of new technologies. It will ensure that data quality assessments for key data sources are regularly conducted and reported at national and subnational-levels. This activity will include data quality assessments conducted by NDOH, SANAC and community organisations.

Strengthen analysis: The SI framework for this NSP 2023-2028 specifies the human resources and technical skills needed to analyse and present data in formats useful for planning and management from national to district-levels.

Human resources and a costed M&E plan: A well-resourced SI system is the backbone of an efficient and effective M&E system. The NSP ensures that the SI information system has sufficient human resources at national, provincial and district-levels to carry out the routine activities of collecting, analysing and reporting data at specified times. To strengthen accountability and governance, the framework will specify persons responsible for activities in the SI cascade. More broadly, the M&E plan will be costed so that other resources for the SI activities in the NSP are provided for.

SI reports: The SI framework for this NSP will specify SI reports to be released at national and subnational-levels and the reporting frequency for each report. Furthermore, the framework will specify the audience and methods of dissemination for each report and who should take action for the findings (government and non-government participants).

Create a simple SI scorecard: Using the list of activities and deliverables in the SI framework, a simple checklist and scorecard will be created and reported periodically on the performance of the NSP SI. SANAC will report on this scorecard at the national and subnational-levels.

- **Subobjective 3.2.2.** Enhance integration of data systems, including data-sharing between sectors for a more coordinated response.

The multisectoral nature of the NSP should be reflected in the coordination of data from the different sectors. However, the NSP data ecosystem remains fragmented. Also, some services are challenging to implement or track because of the lack of unique identifiers and communication between different data systems. For example, while HIV birth testing results can be interpreted as unique-person records, the same interpretation will not be correct after a few weeks because of duplication of persons, which is difficult to identify as infants do not have a unique identifier. Thus, the rapid production and availability of SI for the NSP will remain suboptimal without a coherent and harmonised country data system. The following priority actions will be implemented to improve communication between key data systems for enhanced data products for end-users.

Implement interoperability of data systems: This NSP will pursue the development of a harmonised national data system to support the NSP. A health information system that uses a unique identifier will allow for better patient care and make SI more efficient, with a more effective public health response. This will be achieved by building interoperability between the different existing public data systems through a unique identifier or by building an entirely new information system that unifies the functions of health and non-health data systems.

This work will require collaboration between the main NSP data custodians, including, but not limited to the NDOH, NICD and many others.

The exercise will identify key public sector data management systems that should be considered for interoperability, for example, NHLS/NICD systems, DHIS, TIER.Net, EDRWeb, DSD system, Home Affairs data, social protection database and HPRS, among others. The need for a unique identifier in public data systems, for example, the HPRS and newly proposed Home Affairs identification system, and its potential role in the NSP will be tabled. The country will also identify and learn from case studies where relevant. After the review of the different data management systems, existing opportunities for interoperability will be implemented in the context of the country's current legislation and policies.

Enhance the role of SANAC's Situation Room in the NSP: SANAC's ongoing development of the Situation Room is a success for the national response. The Situation Room will be central to this NSP's objective of more rapid and real-time data analysis, and reporting. SANAC will spend the first two years of NSP 2023-2028 showcasing and rolling out the Situation Room for more stakeholders across all sectors to access. This will include capacity building of stakeholders to use the Situation Room and, more broadly, data interpretation and evidence-based decision-making. SANAC will encourage collaboration among stakeholders to use data emanating from the Situation Room.

Strengthen data-sharing between sectors: Guided by current legislation and building on SANAC's multisectoral structures, this NSP will strengthen existing data-sharing collaboration between sectors. This will involve the development of a framework for data-sharing between public, private and community sectors to unlock the potential benefits of data across these sectors. The framework will identify emerging issues in data-sharing, data needs from different sectors, comparability of data-collection tools, format and frequency of data-sharing, etc.

- **Subobjective 3.2.3.** Strengthen and expand data and surveillance structures for STIs and viral hepatitis.

  Data and surveillance systems for the STIs programme are currently limited to MUS reporting in DHIS, clinical sentinel surveillance and microbiological aetiological surveillance at a few facilities. This NSP will strengthen and expand the current systems to provide more comprehensive data for M&E and patient care. This will include population-level surveys and age- and gender-disaggregated STIs programme data for the burden of disease estimations, expanded antimicrobial resistance surveillance, viral hepatitis surveillance that includes key population data, and STI testing coverage in antenatal care.

  This NSP includes additional STI indicators and will pursue adding an STI module to TIER.Net for better longitudinal patient care, improved M&E and integration with key prevention and treatment programmes such as VMMC, PrEP and ART programmes. The prevalence and incidence of STIs in key populations will be monitored using surveillance surveys. This NSP uses HIV population-based surveys, such as the SABSSM and the ANC sentinel surveillance surveys to monitor the prevalence and incidence of STIs in the general population.

- **Subobjective 3.2.4.** Implement rapid data analysis of routine HIV, TB and STI data at national and local-levels for more effective action.

  Lessons from the COVID-19 pandemic showed that rapid analysis and reporting of routine monitoring data leads to improved public health action. Therefore, a novel feature of this NSP SI is the rapid analysis of routine data at national and local-levels. This NSP will promote the culture of data-use for the national response, especially at subnational-levels. This strategic approach is premised on the notion that there is no need for continuous data-collection without continuous data analysis.

The NSP implements a system to rapidly analyse routine surveillance and M&E data, and watches out for geographical clusters with excess infections for early public health action and probable better patient care. A few key indicators for analysis and the data source will be agreed upon, and analysis will be conducted frequently (monthly or weekly). Using a defined alert threshold per indicator, geographical clusters with an excess number of infections will be flagged for action. Findings will be reported in SI products. These surveillance activities leading to early detection of potential outbreaks will strengthen the preventability of infections.

Data analysis at district and subdistrict-levels for rapid local action will be strengthened. This NSP will also increase support for community and community-led monitoring and the release of public-facing M&E data, ensuring that SI is not a one-way street. This subobjective will be achieved through three main strategies.

Allocate data analysts for routine data analysis at national and local-levels: This strategy, though simple requires the allocation of epidemiologists and/or other data analysts for rapid and frequent data analysis by geographic area (district-level at the minimum). Epidemiologists at national and provincial- levels will be assigned and capacitated to conduct needed analysis. NICD provincial epidemiologists will play important roles in this regard.

Capacitate local staff to use data for action: Local staff at subdistrict-levels, including facilities will be capacitated to analyse their own data and take appropriate actions more rapidly. The goal is to promote data-use at all levels, including at the level of service-delivery, strengthen data reporting and improve the quality of care and health outcomes. This will also include giving feedback to higher structures for action so that SI flows in both directions.

Support community-led monitoring: This NSP also enhances community participation in monitoring these triple epidemics. To achieve this, SANAC will support community-led monitoring and research and ensure that community-generated data contributes to tailoring the national response. In addition, SANAC will work with existing government structures to enhance the availability of public-facing data, as was done during the COVID-19 pandemic. Such data will be presented in easily digestible formats and published on public-facing platforms. Making data on HIV, TB and STIs more readily available to the public will improve awareness, openness and trust and enhance community participation in the national response.

> “This NSP will also increase support for **community and community-led monitoring and the release of public-facing M&E data**, ensuring that SI is not a one-way street.”

Objective 3.3:
Expand the research agenda for HIV, TB and STIs to strengthen the national response.

- **Subobjective 3.3.1.** Strengthen research for the NSP and invest in South Africa-initiated research while supporting collaboration with international counterparts.

The implementation of the NSP raises many research questions from diverse stakeholders in different focal areas. Answering these research questions will strengthen the national response. The fundamental research questions are whether the national response is achieving set targets, causing desired changes, and producing the desired impacts. Thus, using research studies for evaluations is central to the NSP implementation. In addition to evaluation research, other NSP-related research questions in diverse focal areas should be tackled to drive an efficient and effective national response. To this end, local researchers should be funded to conduct research projects that answer locally relevant questions.

Conduct surveys for the timely evaluations of the NSP interventions: Implement surveys in the general and key populations for the evaluation of NSP interventions. SANAC will timeously conduct the mid-term and end-term evaluations for this NSP and ensure proper timing of surveillance surveys.

Accelerate NSP-related research, including operations and translational research: The SANAC SI Unit will engage with, relevant stakeholders and collate priority NSP research questions in line with other national research agendas, for example, the NDOH *National Health Research Strategy: Research Priorities for South Africa 2021-2024*. The process will also include a channel for submitting community-generated research questions. SANAC will maintain a curated repository of these research questions and address them through commissioned projects and strategic partnerships with academic researchers who may assign such research questions to postgraduate students. NSP-related research will include secondary research, such as systematic reviews to inform the national response.

Furthermore, structures will be created for sharing research evidence and emerging best practices to strengthen policy and practice. And key stakeholders will be capacitated on evidence-based practice, while addressing structural barriers to translating important research findings into practice and policy.

Adopt a model for funding South Africa-initiated research: To strengthen the research agenda for HIV, TB and STIs, a system is needed for funding researchers undertaking locally-generated research. This NSP will adopt a system in collaboration with South African institutions of research and knowledge management, for funding South Africa-initiated research. SANAC and NDOH will work with the National Research Foundation (NRF), the Council for Scientific and Industrial Research (CSIR), the NICD and similar institutions to infuse NSP-related research into research agendas that are funded by these organisations. SANAC, collaborating with other stakeholders, will equally initiate and strengthen collaborations with academic institutions to undertake such research projects.

> “...Structures will be created for sharing research evidence and **emerging best practices** to strengthen policy and practice.”

Objective 3.4:
Harness technology and innovation to fight the epidemics with the latest available tools.

- **Subobjective 3.4.1.** Harness technology and innovation to fight epidemics with the latest available tools.

  The COVID-19 crisis has changed how the world functions, bringing to light many limitations of existing systems and showing the need to reimagine the role of information technology (IT) and innovation as a tool for increasing access to HIV, TB and STI service provision. The NSP also aims to embrace new partnerships with the IT community to use the potential of digital and social innovations to connect people, share experiences through social media, access information, deliver services and support social movements to respond to HIV, TB and STIs, and related inequalities. Continued innovation will be needed to develop new and more effective service-delivery strategies, biomedical technologies and even accelerate progress towards ending the epidemics. Greater investments are needed in the development of vaccines and a cure. Artificial intelligence and data science breakthroughs can improve diagnostics and personalise HIV-prevention and treatment options and services in ways that uphold human rights.

- **Subobjective 3.4.2**. Increase investment in knowledge production and technology outputs from South African institutions to generate more home-grown solutions in response to HIV, TB and STIs.

  The country has been found to be lagging behind its emerging peers and global technology and knowledge leaders. Harnessing South Africa's untapped potential for innovation could help create new solutions that can be used to improve service-delivery and outcomes. Innovation in technology includes establishing an integrated digital health ecosystem of people, processes and technology that supports the strengthening of health systems to enable efficient service-delivery and effective patient care. Other existing systems such as telehealth to be strengthened and also facilitate adoption and use of eHealth and mHealth in the prevention, treatment and care services.

Objective 3.5:
Leverage the infrastructure of HIV, TB and STIs for broader preparedness and response to pandemics and various emergencies.

Emerging diseases, such as COVID-19, disrupt people's health and have negative social, political and economic impacts. As a result of these health emergencies, weak health and social systems not only cost lives, but pose risks to the economy and the security of the country. Hence, it is imperative to adopt and adapt proven strategies that have been learnt and proven effective in the responses to HIV, TB and STI epidemics.

- **Subobjective 3.5.1:** Apply lessons learnt from the response to HIV, TB and STIs to support emerging pandemics and other health and development threats.

  Government departments, health facilities, foundations, NGOs and research centres to collaborate and share lessons learned and how best to prepare for the next pandemic. Adoption of existing epidemiological modelling systems to support the response to pandemics, if relevant. In addition, strengthen community-based care delivery infrastructure for healthcare and related services delivery.

- **Subobjective 3.5.2.** Scale up effective COVID-19 adaptations for responses to HIV, TB and STIs and other future emergencies.

  Strengthen collaboration between different departments and other stakeholders working

on HIV, TB, STIs, mental health, hepatitis, cervical cancer, COVID-19, human rights, social justice and identify opportunities and synergies that will enhance the response to the pandemics.

- **Subobjective 3.5.3:** Support integration and linkages and formalise clear referral pathways for management of communicable, non-communicable and opportunistic infections for people with HIV, TB and STIs.

  The implementation of the services and support for HIV, TB and STIs to be integrated with the management of other acute and chronic diseases as outlined in the Integrated Clinical Services Manual. This would include the expansion of community-based referrals for comprehensive health and social services and offering flexible appointments for patients.

Subobjective 3.5.4: Engage a range of medical role-players working on HIV, TB, STIs, mental health, hepatitis, cervical cancer, COVID-19, human rights, social justice and other sectors and identify opportunities for collaboration.

Develop multi-sectoral strategies for prevention, treatment and care programmes on HIV, TB, STIs mental health, hepatitis, cervical cancer, COVID-19, human rights, social justice locally and internationally. This would include strengthening public-private partnerships.

> “Harnessing South Africa’s **untapped potential for innovation** could help create new solutions that can be used to improve service-delivery and outcomes.”

Objective 3.6:
Build a stronger public health supply chain management.

A wide range of pharmaceutical products are needed to diagnose, treat, and prevent HIV, TB and STIs. Uninterrupted availability of quality commodities and supplies including vaccines, diagnostics, and medication are necessary for effective service-delivery. This NSP, therefore, needs to ensure that capacity for the supply chain, with emphasis on the quantification, procurement, storage and distribution of health commodities, cold chain infrastructures and waste management are optimal. Continuous strengthening of systems that support the supply chain is crucial to ending the epidemics and should always be linked to the availability of human resources to support the system.

Subobjective 3.6.1: Ensure adequate availability of quality HIV, TB and STI commodities and supplies that include both prevention and therapeutic interventions.

Review and monitor supplies of essential medication for HIV, TB and STI prevention and treatment, and other commodities required to provide quality care. Train staff on monitoring of items and lead times for ordering. Ensure that the storage conditions of the supplies are appropriate at facility and community-level.

Subobjective 3.6.2: Continued efforts to work towards optimising access at the lowest possible prices to drugs that people with HIV, TB or STIs need.

As part of efforts to optimise access to the lowest possible prices of drugs, there is a need to adjust structural and policy factors that influence drug-pricing and curtail distribution markups to lower prices. Most importantly, foster continued innovation in drug development within the country and promote widespread use of generics.

Objective 3.7:
Strengthen access to comprehensive laboratory testing of HIV, TB and STIs including molecular diagnostics, serology, and culture.

Strengthening appropriate diagnosis is crucial in preventing onwards transmission and sequelae of untreated infection, which may occur acutely or in the long term.

The current syndromic management approach for STIs is associated with substantial under- and overtreatment with poor antimicrobial stewardship. Asymptomatic infections are left untreated under this approach. In line with the WHO STIs strategy, diagnostic testing will be implemented in targeted populations to overcome these limitations and improve health outcomes. This requires access to laboratory and point-of-care access to STI diagnostic tests, and the development of effective implementation approaches.

- **Subobjective 3.7.1.** Ensure access to comprehensive laboratory testing for HIV, TB and STIs including molecular diagnostics, serology, and culture.

  Strengthen training and support for laboratory services. Moreover, expedite development of laboratory information systems. Strengthen access to comprehensive quality laboratory testing for HIV, TB and STIs including molecular diagnostics, serology, and culture.

  Laboratory diagnostic tests to be accessible at community-level through the community-based programmes, as well as at facility-level.

- **Subobjective 3.7.2:** Improve facility- and laboratory-based surveillance activities to monitor effective prevention and treatment modalities of HIV, TB and STIs.

  Some of the essential surveillance for HIV programme include HIV viral resistance as South Africa has one of the largest ARVs programmes. Invest in monitoring of genotypes and the dynamics of transmission in TB infection. The STI programme needs enhanced surveillance on routinely collected data.

- **Subobjective 3.7.3:** Increase and enhance access to self-screening and testing modalities for HIV, TB and STIs.

  Because of structural barriers, stigma and discrimination, uptake of HIV, TB, and STI testing remains suboptimal. Hence, testing modalities other than provider-initiated testing should ideally be scaled up. Diversifying testing approaches and services to include community-based testing and self-screening, and testing will go a long way in reaching underserved and marginalised populations, such as key and other priority populations.

> “The development of **innovative medicines and health products is essential** for making progress in preventing, detecting, and treating diseases.”

Objective 3.8:
Support the acceleration of the approval of new health product.

- **Subobjective 3.8.1.** Support efforts to overcome regulatory barriers that delay market entry of new biomedical technologies, including medicines.

  The development of innovative medicines and health products is essential for making progress in preventing, detecting, and treating diseases. However, it can take a while to pass through regulatory bodies such as the South African Health Products Regulatory Authority (SAHPRA). SAHPRA has had to drastically reduce review timelines to align with global averages. As was evident during the COVID-19 pandemic, biomedical interventions that could potentially take a long time to approve were approved within a few months. This NSP capitalises on the gains of the COVID-19 pandemic to ensure swift assessment of new drugs.

- **Subobjective 3.8.2.** Employ new guidelines and policies to enhance quick and easy access to new biomedical commodities.

  A comprehensive approach that combines initiatives to guarantee funding, optimise evidence generation and align regulatory requirements can effectively tackle innovation deficits. Hence, an overall vision with greater policy coherence backed by strong political commitment and transparency is critical. The inclusion of civil society structures is important to advocate for the changes needed. Transparency is needed to ensure easy and prompt access to biomedical interventions.

> “Strengthen collaboration between different departments and other stakeholders working in **HIV, TB, STIs, mental health, hepatitis, cervical cancer, COVID-19, human rights, and social justice,** and identify opportunities and synergies that will enhance the response to pandemics.”

Box 2. Cross-cutting catalytic priority actions for key populations

Context

Often implementing partners have more liberty to test innovations in implementation sites to learn first-hand what is feasible and best practice in the real-world setting. An effort should be made to harness private sector innovations for scale up and spread nationally.

The NSP is driven by a strategy of harm-reduction principles and person-centeredness.

1. Review the essential drug list to include key population-specific drugs (gender-affirming hormones for transgender persons).
2. Integrate and mainstream mental health package of services and inclusion of psychotropic medications in the essential drug list.
3. Offer methadone for OST (for PWUD) in community-based and peer-led structures.
4. Provide OST and gender-affirming hormone therapy is aligned with the principle of tailored interventions, mitigating structural barriers that expose and increase the risk of exposure to infection.
5. OST supports the PWUD to save lives.
6. Evidence supports that gender-affirming care improves the mental health and well-being of transgender persons.[95]

Application of evidence-based practice as part of ethical care for key populations.

- Develop and review key population guidelines (professional tools) and data-collection tools with the latest evidence to guide standardised and integrated service-delivery.
- Implement policies and strategies that rely on the translation of the guiding documents into standard operating procedures (SOPs) and guidelines to operationalise the interventions.

Integration of key population package of services into programme/package of services.

- Develop and implement accreditation of key population facilities in the Ideal Clinics Dashboard to standardise the delivery of key population services.
- Develop guidelines and standardise criteria for integrating key population services into all public health facilities.
- Include the care of key populations into the strategic documents for integration into the primary healthcare-level (inclusive of WBPHCOTs) of care as that is the entry point to health services.
- Develop district service-level agreements (SLA) with implementing and district support partners to test and share innovative packages of care for scale up.

Strengthen the use of digital service-delivery approaches.

Include eHealth and mHealth in the package of services for key populations. eHealth and mHealth encompass a vast spectrum of healthcare services, from electronic prescribing and preparing medical records to text message prompts to remind clients to take their medicines. These interventions offer privacy and empowerment to key populations by allowing the use of smart or portable devices for health services and information. Further, these technologies offer the opportunity to deliver tailored interventions to key populations and can address health inequities by enabling the delivery of sophisticated public health services to communities that find traditional forms of healthcare inaccessible because of stigma and discrimination. Lastly, these approaches can support adherence and, thus, retention in care.

Universal coverage.

Develop central coordination and map government departments that offer services to key populations to develop one-stop service points and/or linkage to healthcare and coverage according to the universal coverage principles, thus ensuring that there is coverage geographically and with regard to programming. This could be done by mapping where communities are located and then allocating services and programmes, using data and evidence to support the interventions.

Knowledge production to support evidence-based interventions for key and other priority populations.

- Advocate for research funding to support the key population agenda to facilitate contextual intervention development.
- Advocate for research on key and other priority populations: there is a lack of studies and evidence on these populations because of limited publications emerging from South Africa.
- Include sensitisation and clinical competence for key populations as part of the curriculum in academic institutions. This will allow exposure of students to the topic and hopefully improve the production of research rooted in the South African context.
- Strengthen strategies to estimate key population sizes to support programme implementation, planning and funding.

GOAL 4:

Fully resource and sustain an efficient NSP-led by revitalised, inclusive and accountable institutions

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Fully resource and sustain an efficient NSP led by revitalised, inclusive and accountable institutions.

Goal 4: Strategic context

HIV, TB and STIs continue to be a major public health challenge but also an increasingly developmental one. This explains why leaders at all levels of AIDS Councils must always strive to find the best fit between these two vital elements. Over the years, SANAC has observed with interest that remarkable gains in the fight against the three epidemics are often realised in provinces, districts and wards where leaders deliberately and repeatedly place issues of HIV, TB and STIs at the apex of their developmental risk agendas. By demonstrating political will and resolute commitment to eradicate HIV, TB and STIs, political heads of departments and their directors-general, premiers, members of the executive council, district and municipal mayors (including members of mayoral committees) will be playing catalytic roles in translating the aspirations and goals of this NSP into concrete action and results.

South Africa's economy has been exposed to a slowing global economy and volatile markets. The domestic economy contracted severely from the effects of the COVID-19 pandemic, exacerbated by low economic growth, extreme unemployment, high debt servicing costs, the national energy crisis, and unexpected shocks, such as unrest and floods in some parts of the country in 2021.

The government is expecting economic growth in the medium-term as the economy recovers and due to implementation of stimulus measures and structural reforms, but fiscal space for health is expected to remain constrained over the NSP period, despite better-than-expected revenue-collection estimates in 2022.

The government's austerity approach to spending in the past few years has resulted in cuts to the baseline budgets of all government programmes that do not have special protection and the introduction of measures to realise efficiencies, including through centralised procurement, more effective contract negotiations and strengthened in-year monitoring of budget execution and improving human resource efficiency.

Between 2019-20 and 2022-23, the annual value of the health budget declined by approximately R3.2 billion. According to analysis by McLaren et al, the government will spend about R332.80 less per health user in 2023 in real terms than it did in 2019[96].

Domestic HIV and TB programmes drove approximately 13% of total public health spending in 2019-2020. The South African government spent R29 billion on HIV and TB in 2019-2020, comprising 71% of total expenditure on these diseases (a decrease in share from 2017-2018 of 73%). Budget allocations to the HIV/ AIDS and TB conditional grants for the 3-year 2022 MTEF period show a small decrease in real terms. The conditional grant components for HIV/ AIDS, Tuberculosis, Community Outreach Services and HPV immunisation were restructured under the District Health Programmes grant in 2022. A total of R81.8 billion for these components for the 3-year MTEF period is more than R6 billion less than what was allocated under the 2019 MTEF.

The Department of Basic Education's HIV/ AIDS and Life Skills programme as well as the Department of Social Development's HIV/ AIDS programme also reflect similar baseline reductions to the NDOH, both showing declines in funding in real terms over the medium-term.

Although recent allocations to South Africa from both PEPFAR and the Global Fund have increased, as they support South Africa to intensify efforts to reach the

three 95s for HIV and TB, policies and actions from both development partners strongly encourage upper middle-income countries such as South Africa to increase domestic funding in key areas and to systematically plan for the transition of selected externally-funded functions to the public sector.

Of particular concern is that development partners are a major source of funding for South Africa's key and vulnerable population interventions, human rights interventions, VMMC and that they also invest significant funds in health systems strengthening, including health information management systems, quality improvement, CHCWs and contracting of NGOs for community outreach services.

Despite increasing resource needs for this ambitious NSP, fiscal space for increased spending on health over the period will remain constrained. South Africa and its external and private sector partners will need to invest smarter, and in harmony, based on economic evidence; and just as importantly spend efficiently to ensure that the NSP's outcomes are achieved.

Available funding for the NSP

Estimating available funding for the next 5-year period of the NSP is required to enable resource needs to be compared with available resources, and to allow sustainable financing strategies to be defined and put in motion. This analysis considers medium-term budget commitments from all government programmes relevant to the NSP's objectives, as well as funding commitments and forecasts from South Africa's main development partners and the private sector.

It is estimated that South Africa will have approximately R249 billion available to finance the NSP 2023-2028, increasing annually from R45 billion in year 1 to R53 billion in year 5.

The South Africa Government is expected to contribute 77% of total available funding over the NSP period. Development partners are expected to fund approximately 21% of the available funding, and the private sector just under 3%.

Table 8: *Total projected funding available for the NSP (2023/24-2027/8, ZAR billion)*

Source of Funds (ZAR billion)	2023/24	2024/25	2025/26	2026/27	2027/28	% share over period
Govt of SA	33.57	36.82	38.44	40.13	41.90	77%
USG (PEPFAR+USAID)	7.45	7.54	7.46	7.08	6.73	14.5%
Global Fund	3.10	3.16	3.09	3.09	3.09	6%
Estimated private sector	1.24	1.24	1.29	1.35	1.41	2.5%
Total Available NSP Funds (ZAR bill)	45.36	48.76	50.29	51.66	53.13	100%

Sources: Estimates of National Expenditure 2022, National Treasury and estimated 4.48% inflationary growth for 2025/26 to 2027/28. NDOH conditional grant allocations include HIV, TB, Community Outreach Services, HPV immunisation and COVID-19 PEPFAR: COP22 direct investment for USG FY23 and assumed to decline by 20% over the following 4-year period. USAID TB funding estimated based on NASA 2019/20 findings. GF: final approved budget for current grant (2022/23-2024/25) and based on their allocation letter amounts for the next funding cycle, plus 50% of potential catalytic funding. Private Sector: estimated spending on private ART patients (as per Thembisa Optimise).

Table 9 shows the funding contribution from government programme budgets across multiple sectors. The NDOH contributes 89% of expected public funding for the NSP, mostly via the District Health Programmes Conditional Grant. The national and provincial departments of social development have the potential to contribute over R3.5 billion per annum from various sub-programme budgets to the NSP implementation (10% of total estimated public funding). The DBE also funds critical interventions in schools (approximately 1% of estimated available funding).

Public sector funding predominates HIV and STI service-delivery, while development partners invest funds at a greater proportion in social enablers and programme enablers (that include health systems strengthening and programme management). Development partners also are major funders of combination prevention programmes for key and priority populations, as well as interventions that address human rights-related barriers to service-delivery to key populations. It should be noted that actual funding allocations during the NSP period are subject to change as a result of more harmonised investment planning and prioritisation between all funding partners, informed by evidence and the strategic thrusts of this new NSP.

Financial resource needs for the NSP

The NSP has been developed as a strategic document to guide the country's response to HIV, TB and STIs and to set guideposts for the development of provincial and sector strategies and plans. The cost estimates for the NSP should similarly be viewed as a high-level estimate of financial resource needs, driven by the goals and targets that have been set. When sectors and spheres of government and development partners cost their implementation plans and formulate budgets, they should refer to the NSP costing outputs as benchmarks.

The cost estimates of the NSP reflect the strategic thrust of the new NSP, in that there are increased allocations to community-based and community-led service-delivery and responses to social and

Table 9: *Total available funding for the NSP 2023-2028 by government programme (ZAR million)*

Public Allocations for HIV and TB (ZAR millions)	2023/24	2024/25	2025/26	% share over MTEF
Department of Health	29 534	32 710	34 131	89%
Department of Social Development	3 464	3 586	3 743	10%
Department of Basic Education HIV/AIDS (Life Skills grant)	242	253	264	1%
Other Departments	104	109	114	0.3%
Total Public funds for HIV and TB	**33 343**	**36 657**	**38 252**	**100%**

Sources: Estimates of National Expenditure 2022, National Treasury and estimated 4.48% inflationary growth for 2025/26 to 2027/28. Other DSD sub-programme contributions include services to people with disabilities, community-based care for children, care and services to families, community mobilisation, institutional capacity building for NPOs, youth development, women development, victim empowerment, substance-abuse prevention and rehabilitation.

structural drivers of HIV, TB and STIs, in addition to the continued investments in effective prevention, treatment and health systems strengthening interventions. Approximately 30% of resource needs for the NSP are categorised as community-based services (62% for facility-based services and 8% for above site functions).

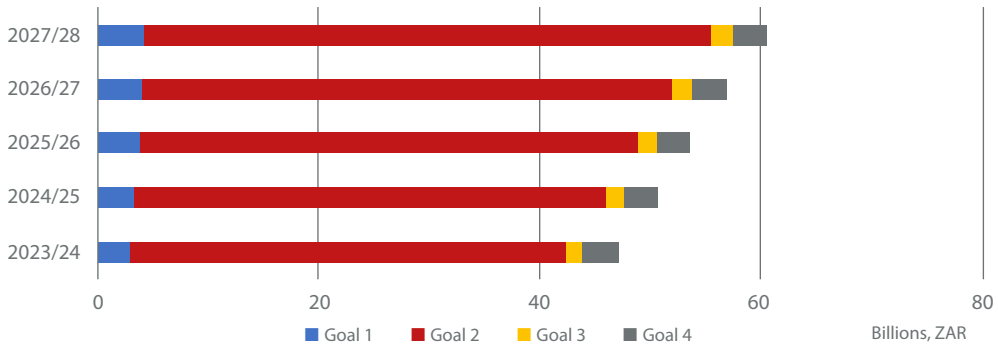
The total cost of implementing this NSP is estimated at R268 billion over 5 years. The annual nominal cost in year 1 is R47 billion in 2023/24 and increases to R60 billion in 2027/28 (average annual increase of 6.4% per annum or 3.2% increase per annum in real terms). In comparison, the most recent National AIDS Spending Assessment (Figure 4) calculated total expenditure on HIV and TB programmes in 2019/20 as R37.5 billion (R42.7 billion at 2023/24 prices).

Table 11 (overleaf) provides further detail of the estimated costs by goal and per NSP subprogramme.

Goal 1, which seeks to break down barriers to HIV, TB and STI services and solutions, and which also builds capacity for community-led delivery, drives 7% of the total costs of the NSP (at an average of R3.7 billion per year over 5 years).

Goal 2, which maximises equitable access to HIV, TB and STI solutions drives most of the costs of the NSP, at 84% of the total costs, and this goal includes HIV-prevention at 18% of total NSP costs, HIV-treatment and care (54% of total costs), Tuberculosis-prevention, diagnosis and treatment at 9% of total costs (averaging R5 billion per year) and STI service-delivery at 3.3% of total NSP costs (averaging R1.8 billion per year). Goal 2 includes both facility-

Figure 4: *Total annual cost estimates by NSP Goal 2023/24-2027/28 (ZAR billions)*



Total annual cost estimates by NSP Goal 2023/24-2027/28 (ZAR billions)
Sources: The NSP costing exercise drew from a number of sources, including national costing models, published and unpublished costing literature and national government plans. 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 RSA NSP 2023-2028 Costing Model. Main sources include:

- *Thembisa Optimise*
- *Thembisa TB model and National TB Cost Model, NDOH, HERO and TB Think-Tank outputs (2022)*
- *South African HIV Investment Case Update. SANAC. 2021*
- *The Costs of Managing Cervical Cancer in South Africa, DOH, HE²RO et al, 2017*
- *RSA NSP Unit Cost Workbook, 2023*

and community-based interventions, including combination prevention outreach programmes to key and priority populations.

Goal 3: Building resilient systems for health and social welfare comprises 3.4% of total costs and Goal 4 is directed at good governance, financial sustainability, and multi-sectoral coordination, drives 5.45% of total NSP costs (which includes both government and development partner costs).

The NSP investment in prevention illustrate prioritised investments in HIV-prevention, with a focus on the 5 pillars of the UNAIDS prevention roadmap. The graph below shows that most of the resources required under the HIV-prevention (Figure 5) spend is for community-based and community-led outreach which offers combination prevention services in communities to key and other priority populations drive 45% of total HIV-prevention costs. Included in the prevention response are plans to medically circumcise 600 000 males per annum, enrol over 400 000 people on ARV-based prevention per annum by year 2; distribution over 725 million male and female condoms each year, implement activities to reduce vertical transmission, and implement a range of interventions under harm-reduction and social and behaviour change programmes. Comprehensive sexuality education and integrated HIV-prevention/ SRHR services in and out of schools is also included in the HIV-prevention programme.

Table 10: *Total cost estimates by NSP subprogramme 2023 to 2028 (ZAR millions)*

Goal	NSP sub-programme	2023/24	2025/26	2027/28
Goal 1	Community mobilisation	216	247	275
	Community-led monitoring and advocacy	237	259	282
	Organisational capacity building	135	147	161
	Structural interventions	2 286	3 231	3 556
	Economic empowerment	246	555	630
	Families and parenting	157	252	275
	GBV and gender inequality	250	377	414
	Human rights, stigma and discrimination	107	129	141
	Mental Health	427	585	641
	Nutrition Support	263	287	313
Goal 2	Community-based and community-led outreach	3 360	4 259	4 883
	SBCC	635	744	843
	Condom programming	929	1 014	1 119
	ARV-based prevention	625	754	829
	PMTCT	250	252	247
	VMMC	874	948	1 032
	Harm-reduction	55	119	176
	Integrated HIV/SRH clinical outreach service	171	224	286
	Integrated HIV/school health services	967	1 139	1 279
	HIV-testing services	1 389	1 445	1 578
	HIV-treatment	24 337	27 218	30 987
	HIV community and palliative care	150	149	151
	TB-prevention	245	285	304
	TB case finding	1 069	1 248	1 504
	DS TB diagnosis treatment and care	2 486	2 630	2 888
	MDR/XDR diagnosis, treatment and care	810	775	757
	STI prevention, treatment and care	318	519	822
	Viral hepatitis prevention, treatment and care	111	248	363
	Cervical cancer	813	1 034	1 139
Goal 3	HSS: Human resources for health	240	262	286
	HSS: Laboratory systems	458	525	593
	HSS: Pandemic, emergencies preparedness	23	39	44
	HSS: Regulatory access	16	18	20
	HSS: Strategic info, research and M&E	596	739	783
	HSS: Supply chain management	70	76	83
	HSS: Technology and innovation	92	105	119
Goal 4	Governance, leadership and co-ordination	570	623	680
	Sustainability and transition planning	3	11	12
	Programme management and donor support	2 510	2 331	2 259
	Grand Total	**47 047**	**53 617**	**60 340**

Review of significant cost-drivers in the NSP and their assumptions.

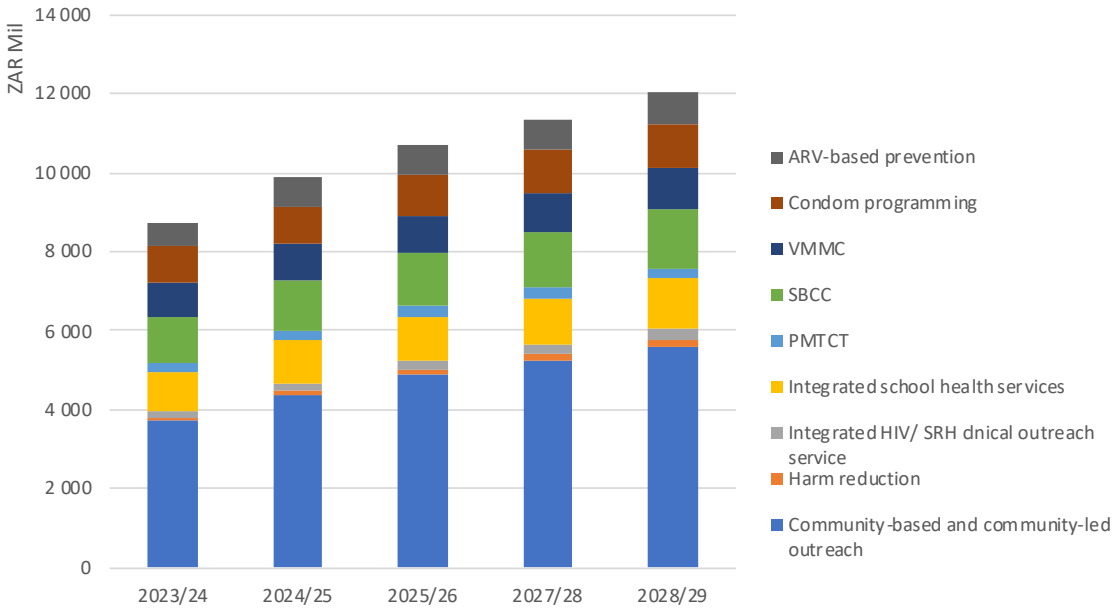
Breaking down barriers to achieving HIV, TB and STI solutions

Interventions under Goal 1: Breaking down barriers to achieving HIV, TB and STI solutions, reflects the emphasis of the new NSP on pivoting to a more community-led and community-centred response (average costs of R3.7 billion per annum). Cost estimates for community systems, which include community mobilisation, community-led monitoring and civil society organisation-capacity strengthening were derived from ingredients-based unit costing and relevant in-country budget and expenditure reports, and drive 17% of Goal 1 costs.

HIV-prevention, treatment and care

Interventions and coverage-levels under Goal 2, the NSP (equitable access to HIV, TB and STI solutions)

Figure 5: *HIV-prevention Programme: Total costs by subprogramme (ZAR millions)*



have been selected and prioritised to maximise health outcomes and returns from investments, while seeking to minimise long-term costs. This strategic approach used evidence and guidance from the South African HIV Investment Case (2021) . The investment case methodology used the model Thembisa Optimise which incorporates an HIV transmission model, a custom-made cost model as well as an allocative optimisation routine. For the development of the new NSP, the Investment Case scenario for achieving 95% ART coverage and delivering a package of effective prevention interventions within a constrained funding envelope was selected. In addition to ART at maximal-levels of linkage and retention, this package includes PrEP for key and priority populations, VMMC, EIMC, condom distribution and differentiated HTS, including self-testing at optimised coverage-levels.

Achieving the 95% ART coverage by 2024 will avert 186 000 deaths, avert 2.1 million HIV infections, and save 7.1 million life years.

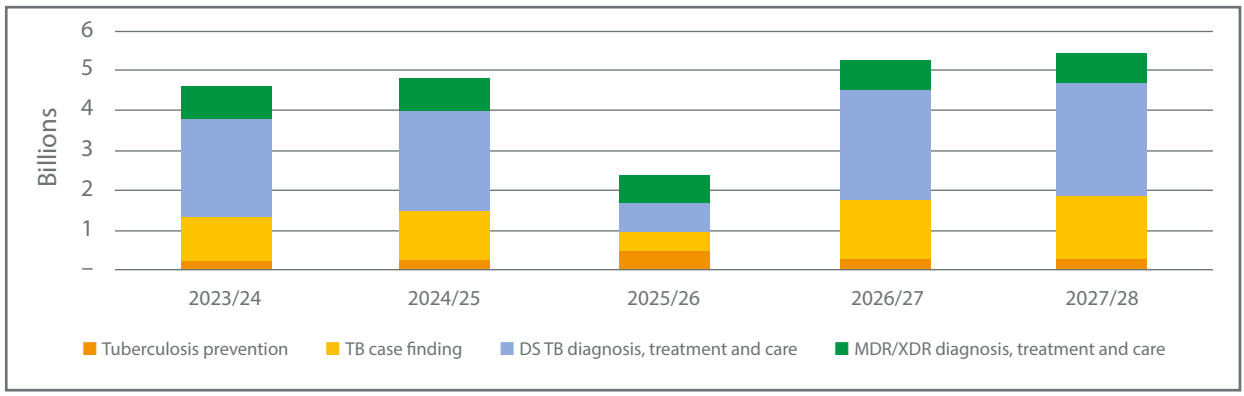
TB-prevention, case finding, diagnosis and treatment

The TB cost component of the NSP made use of the newly developed Thembisa TB model as well as unit costs summarised in the National TB Cost Model (NTCM). Novel interventions, including targeted universal testing for TB and digital chest X-rays were included in the cost estimates.

The total cost of TB interventions in the NSP is R25 billion over 5 years (Figure 6), which is just under 5 billion rand per year. TB preventative therapy interventions which consist of 3HP and IPT for people with HIV and household contacts contributes 6% to total costs.

Finding patients with TB, accounts for 32% of total cost. These interventions include TB symptom-screening, testing and intensified case finding through targeted universal testing for household contacts, people living with HIV and individuals with a history of previous TB. The largest budget driver is diagnostics, treatment and care for TB patients, contributing 53% of total cost. These costs include TB diagnosis through Gene Xpert, inpatient and outpatient costs for DS adult patients, and paediatric TB treatment. Treatment for multi-drug resistant TB patients contributes 16% of total TB costs, which remains a significant cost-driver despite recent

Figure 6: *Total cost estimates for Tuberculosis by intervention and by year (ZAR billions)*



treatment cost reductions from the introduction of the effective short-course regimen for MDR-TB.

STI prevention, diagnosis and treatment

Data on STI prevalence and costs of diagnosis and treatment remains limited, and therefore setting the STI targets and estimating the costs of STI-screening, diagnosis and treatment remain particularly challenging. This highlights the need to improve costing and programme data on STIs and develop mathematical models to assist the rollout and expansion of new strategies and technologies for STI diagnosis and treatment.

The following interventions have been costed as part of the STI resource needs estimate:

- Syphilis-screening and treatment of pregnant women attending antenatal care at first visit and again at 32 weeks, if not positive at first visit and treatment of exposed newborns with symptomatic syphilis.
- Syndromic management females and males presenting with vaginal discharge syndrome (VDS) and male urethritis syndrome (MUS), respectively. Scale up diagnostic tests for chlamydia and gonorrhoea in pregnant women as well as females and males presenting with VDS and MUS respectively, followed by treatment.
- Viral hepatitis: hepatitis B vaccination for all newborn babies and public sector HCWs and screen all pregnant women for hepatis B. Administer diagnostic tests for hepatitis C for all PWID, followed by treatment.
- Cervical cancer: administer full HPV-vaccination to Grade 5 females and AGYW who missed immunisation. Annual cervical cancer screening with cervical smear testing and/or HPV DNA testing of women living with HIV.

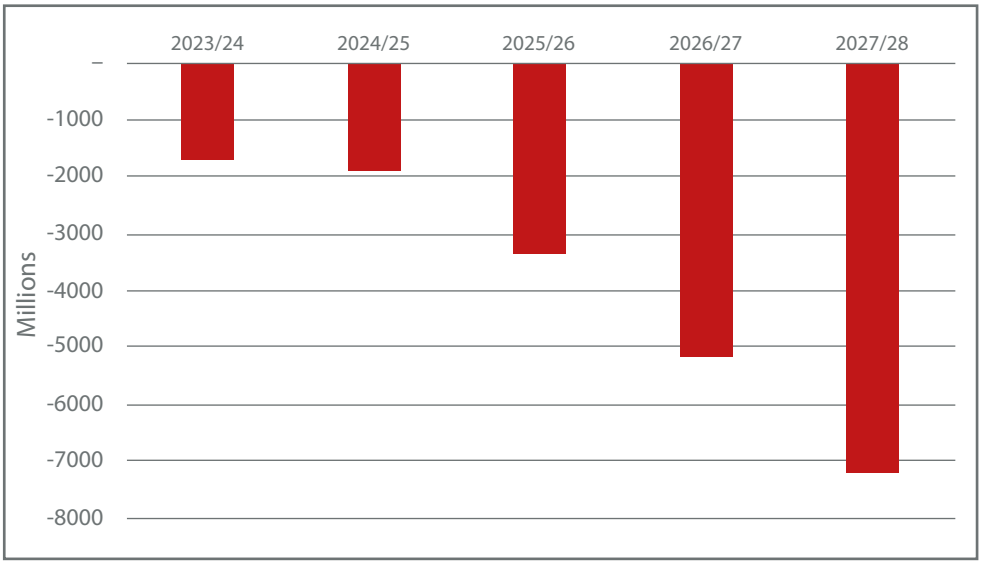
Scaling up diagnostic for two of the main curable STIs (chlamydia and gonorrhoea) for high-risk AGYW and symptomatic adult males and females form by far the greatest share of total STI costs (62%), followed by cervical cancer screening in pregnant women (16%); and expanding HPV-vaccination to out-of-school AGYW (6%).

Funding gaps

A comparison of the annual costs of the NSP and expected available funding, shows a funding gap that increases each year from approximately R1.7 billion in year 1 to R7.2 billion in year 5. (Figure 7).

The financial gaps are driven by the bold Goals of the NSP, the annual growth of people retained on ART (increasing by over 1 million people over the 5 years) and rapidly scaling up finding, diagnosing and treating people with TB. If the ambitious coverage targets in the NSP are to be achieved, strategies to realise efficiency-savings and mobilise additional resources for priority gaps will be required.

Figure 7: *Projected annual funding gap for the NSP 2023-2028 (ZAR millions)*



Leadership and Governance of the NSP

The National Strategic Plan on HIV, TB, and STIs 2023-2028 (NSP) recognises the critical importance of governance, leadership, coordination, and accountability in achieving its goals and objectives. Effective governance and leadership are vital for guiding the implementation of the NSP and ensuring it is carried out efficiently, transparently, and with a focus on accountability. Accountability mechanisms are necessary to ensure that all stakeholders are responsible and answerable for their roles and responsibilities in the implementation of the NSP.

An effective HIV, TB, and STIs response starts with political intent and leadership accountability. Sustained political, civic, traditional, community and corporate leadership commitment at all levels, national, provincial, district and community is essential to ensuring an effective and focused multi-sectoral response. Political will is required for HIV, TB, and STIs response to be taken out of the "health" box, to be considered a developmental issue that affects all South Africans. HIV, TB, and STIs responses need to be more assertively mainstreamed into planning and policy development processes. This calls for HIV, TB and STIs to become a standard agenda item in the integrated development planning processes; from planning to financing.

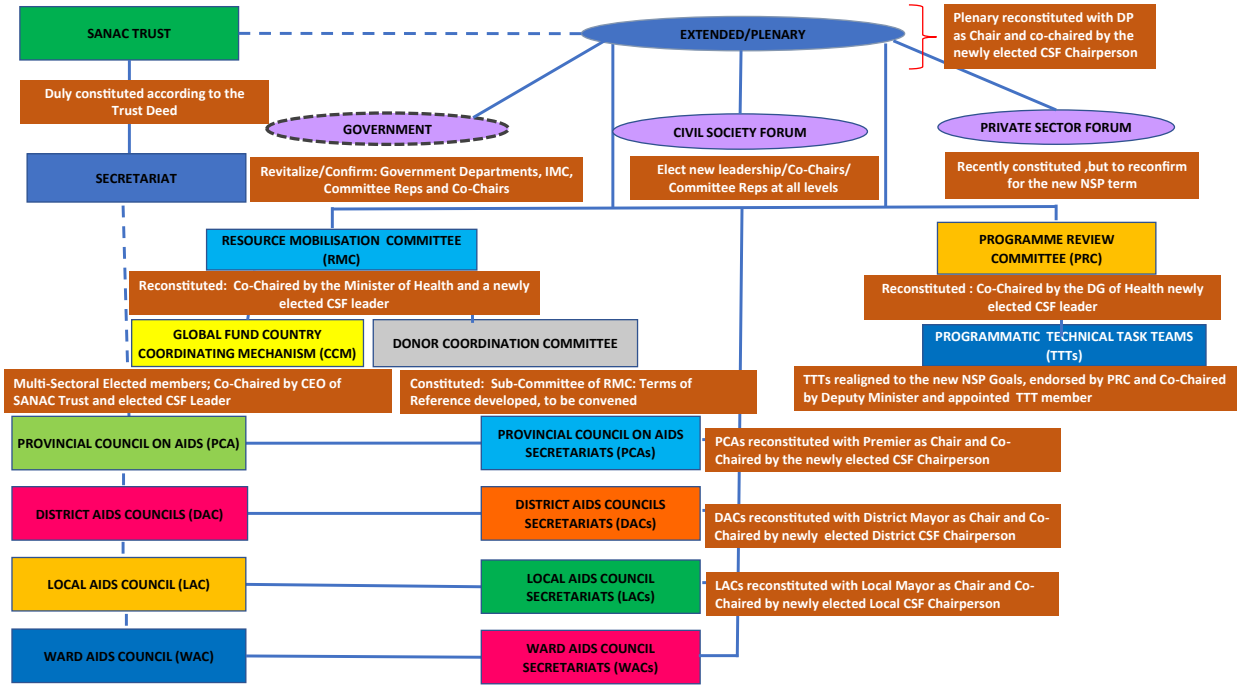
National, provincial, and local leaders have an advocacy role to play in engaging with community members and community leaders on issues of HIV,

TB, and STIs. This includes active participation in community HIV, TB and STIs events and public statements that promote and help reduce new infections including stigma and discrimination.

Coordination, management, and institutional arrangements

South African National AIDS council is mandated to coordinate the response of HIV, TB and STIs. The coordination of the multi-sectoral response takes place at four different levels namely, national, provincial, district and community. The coordinating structures are multi-sectoral and have representation from different structures, government, civil society organisations, development partners and the private sector. Coordination among various stakeholders is essential to harness synergies, optimise resources, and avoid duplication of efforts. It is through coordination of these structures that quality and comprehensiveness of services, accountability, harmonisation, and alignment can be achieved. However, as observed in some areas the greatest challenge to improved coordination, and management of the provincial, district and local structures has been the lack of participation of management authority.

Figure 8: *The institutional arrangements for the coordination structures of HIV, TB and STIs response at national, provincial, district and local-levels*



Objectives and subobjectives

Objective 4.1:

Sufficient domestic and external funds are mobilised and allocated to facilitate the efficient implementation of HIV, TB, and STIs programmes and to address the underlying associated risk factors that have direct consequences for these conditions.

- **Subobjective 4.1.1.** Secure adequate and predictable funding for an efficient response from public, private and external funding sources.

South Africa's main development partners are signalling their intention to reduce funding as South Africa gets closer to achieving epidemic control, while macro-economic factors have severely constrained public sector funding needed for upfront investments in preventing new infections and controlling the epidemics. At the same time, domestic health financing reforms are under way, with the implementation of the National Health Insurance planned for implementation in 2026.

Relevant multi-sector structures that include the SANAC Sustainability Technical Working Group (TWG), Donor Coordination Committee, Resource Mobilisation Committee and senior budget planning structures led by the National Treasury, must fulfil their mandates in ensuring that health financing transitions are optimised and that there is sufficient fiscal space to attain and maintain control of the HIV and TB epidemics.

Priority actions:

- Coordinate sufficient and complementary investments from government departments, development partners and the private sector to achieve the NSP goals, guided by a national resource mobilisation strategy for the NSP (which will be formulated in year 1).
- Protect baseline allocations and, where necessary, raise public allocations for HIV, TB and STIs in the MTEF, through relevant MTEF budget structures, supported by economic evidence and analysis, including costing studies, investment cases, budget impact assessments and budget re-prioritisation exercises.
- Create additional budget space for HIV and TB priorities through systematically pursuing activities at national and provincial-levels that result in measurable efficiency savings that can be re-invested in under-resourced priority areas.
- Raise additional funds for HIV and TB through innovative financing mechanisms, including blended finance structures, outcomes based contracting and public-private partnerships. Document best practice and build on the progress and learnings from the Imagine Social Impact Bond (SIB) for adolescent learners and the Solidarity Fund for COVID-19.
- Strengthen private sector engagement activities that are aligned with the NHI programme, including strategic purchasing of priority services and establishment of mechanisms for public-private co-investment in shared priorities, such as youth health.
- As part of the roadmap towards NHI, and expected reduced funding from development partners, the primary health financing mechanisms for HIV and TB, namely conditional grants and off-budget bilateral grants should be reviewed and refined to better coordinate and integrate investments from multiple funding sources within the changing health financing policy environment.

- **Subobjective 4.1.2**. Evidence-based prioritisation ensures that the right mix of interventions are implemented in the right places, with precision to maximise impact.

National- and provincial-level decision support tools should be refined and applied widely to support role players in prioritising the right interventions in the right places, based on multiple criteria that consider epidemiological factors as well as social and structural drivers.

Priority actions:

- Support the continued application of disease transmission, cost, and impact-assessment models to guide more precise programming, optimisation and budget planning (using models such as Thembisa Optimise and Thembisa TB model), and the widen application of models to provincial-level.
- Under the guidance of the health financing, economics, and sustainability TWG undertake cost analyses and economic evaluations to drive value for money in HIV, TB and social enabler programmes and inform the transition of effective service-delivery models from vertical programmes to efficient, integrated district programmes.

- **Subobjective 4.1.3**. Health financing and financial management systems and capacities are optimised to support sustainable financing, budget monitoring and accountability.

Modern and well-functioning health financing and public financial management (PFM) systems are essential enablers for effective resource mobilisation, resource allocation, good budget execution and financial accountability.

Priority actions:

- Revitalise health economics and resource mobilisation structures for improving the use of economic data and evidence for resource mobilisation, planning and decision-making.
- Strengthen government financial information systems and their integration with programme, procurement, and human resources information systems to generate routine financial data for management, decision-making and accountability monitoring. This should include a repository for publicly available in-country input costs and unit costs.
- Further routinise expenditure surveys such as the National AIDS Spending Assessment, and strengthen tracking of TB, STI and social programme expenditure to comparable levels of HIV-expenditure tracking through a centrally-coordinated exercise that achieves simplification, harmonisation, and routine reporting.

Objective 4.2:

Sustainability and transition plans and actions are routinely developed and implemented to ensure that interventions remain on-track to achieve NSP goals.

In the context of constrained domestic fiscal space, changing donor priorities, and the need to transition towards integrated service-delivery and financing, as the country moves towards epidemic control sustainability planning and management have become an essential discipline for managers and budget holders. This process requires well-equipped senior officials to plan, negotiate and prioritise, supported by strong communication and coordination. Due to the complexity and time taken to adapt programmes and financing arrangements, it is recommended that measurable milestones towards sustainability goals are articulated with responsibilities in stakeholder-driven roadmap plans.

South Africa is pursuing a sustainability planning agenda which is most recently guided by the National Sustainability Framework for HIV/AIDS and TB 2021-23 (SANAC, 2021). The framework, which is accompanied by sustainability assessment and planning tools, presents sustainability goals and progress measures across six sustainability domains. The framework also provides guidance to national and provincial departments and multi-sectoral bodies to institutionalise and mainstream sustainability plans and performance metrics into their annual planning cycles.

Sustainability in the context of this NSP is defined as the ability to maintain or increase progress towards NSP goals, with a reduction in support from international development partners or other emergency domestic support. This requires the ability for public sector platforms to deliver uninterrupted, effective, and equitable services through a modern and resilient health system that is responsive to shocks.

A broad sustainability assessment completed by SANAC in 2021, revealed several HIV and TB sub-programmes are vulnerable to disruption including key and other priority population programmes, community-led service-delivery and civil society representative, and oversight groups.

- **Subobjective 4.2.1.** Proactive multi-sectoral sustainability and transition planning leads to an integrated domestic response that is resilient to external shocks.

South Africa is expected to show global leadership in sustaining self-determined HIV and TB and socially enabling responses that are affordable and effective as well as integrated into provincial public health programmes.

Priority actions:

- Resource and empower relevant entities to lead sustainability planning and management at national and provincial levels, including SANAC and Provincial Councils of AIDS (PCA) secretariats and TWGs, and through the creation of specific job descriptions and accountability mechanisms, under the guidance of the National Sustainability Framework for HIV/ AIDS and TB.
- Undertake regular sustainability assessments and transition planning exercises for priority subprogrammes and systems at national and provincial-levels, using available tools such as sustainability scorecards, sustainability dashboards and provincial sustainability roadmaps, under the auspices of a nationally coordinated sustainability planning agenda.
- Develop appropriate indicators for integration and sustainability, and incorporate them into the national and provincial accountability framework as well as sector strategic and annual plans. Track sustainability progress through SANAC/PCA reporting mechanisms and support to community-led monitoring.

- Scale up and strengthen social contracting mechanisms and co-financing for sustainable delivery of services through community-based and community-led organisations, including those representing key and vulnerable populations.
- Undertake long-term planning and design sustainable financing pathways for vulnerable programmes, especially for services that are heavily reliant on development partners, including combination prevention outreach programmes for key and vulnerable populations.

> “Sustainability in the context of this NSP is defined as the **ability to maintain or increase progress towards NSP goals with a reduction in support from international development partners** or other emergency domestic support.”

Objective 4.3:

Reset and reposition SANAC, all AIDS Councils and Civil Society organisations for an optimal, efficient, and impactful 2023-28 NSP execution experience.

- **Subobjective 4.3.1.** Build execution capability of existing AIDS Council structures while accelerating the establishment and institutionalisation of new ones across the board.

  The institutional capacity gaps of all AIDS Councils to be established through independently-led capacity audits. This will inform planning and roll-out of focused capacity building targeting the various levels of leadership. The overall aim is to enhance governance and financial management according to best practices and achieve a greater localisation and decentralisation of response support and coordination.

- **Subobjective 4.3.2.** Drive a multi-stakeholder-driven response operation.

  Based on the feedback from nation-wide stakeholder perception and satisfaction surveys, improve the implementation of the NSP.

- **Subobjective 4.3.3.** Foster the greater participation of the private sector and civil society in the affairs and operations of all AIDS Councils.

  This NSP places people and communities at the centre of the response, and we would like to ensure that the private sector, labour, and civil society are part of the multi-sectoral response.

- **Subobjective 4.3.4.** Ensure this NSP is an integral and central part of the planning and budgeting culture of all state organs.

  As part of the development and implementation of the NSP, the leadership needs to ensure that the HIV, TB and STIs response forms an integral mainstay of all ministers, premiers, mayors and mayoral Committee members, directors-general, heads of department and municipal managers' performance appraisal scorecards.

> "When the government, business and civil society leaders form a **united front and take a firm stance** against the scourge of HIV, TB and STIs as observed at the height of the COVID-19 pandemic, the level of human suffering and economic costs imposed by these epidemics can be drastically minimised."

Objective 4.4:

Optimisation of synergies through forging mutually rewarding partnerships and alliances across the entire response value chain.

- **Subobjective 4.4.1:** Rally key multi-sectoral partners behind a single and integrated response strategy and vision.

  The leadership needs to prioritise amplifying the South African Government's voice regarding HIV, TB and STI issues on regional and international platforms. In addition, build a community-wide alliance and guiding coalition against the epidemics. Some of the interventions will be to organise dialogue sessions with the Civil Society Forum for continuous and proactive engagement to discuss mutual interests and concerns.

A strong and committed leadership and governance system in driving the implementation of the multi-sectoral response against HIV, TB and STIs during the NSP 2023-28 period is critical. That commitment must be evident at national, provincial, district and municipal-levels and remains a potent force and impactful weapon in the hands of SANAC. The dominant view within SANAC is that when the government, business and civil society leaders form a united front and take a firm stance against the scourge of HIV, TB and STIs as observed at the height of the COVID-19 pandemic, the level of human suffering and economic costs imposed by these epidemics can be drastically minimised. Leaders at all levels of AIDS Councils as well as in the political, business, labour and civil society spheres have the moral duty to remain vigilant, resilient and resolute not only to protect past gains but also to continuously and relentlessly place HIV, TB and STIs at the top of the country's health agenda.

Packages of care

9

Table 11: *Minimum package of services: general population*

SERVICES	SETTING	ACCOUNTABLE PARTIES
• Tailored IEC • Accessible, friendly, comprehensive service-delivery and health promotion customised to client needs • Condom and lubricant promotion and provision • Prevention of vertical transmission, PrEP, VMMC and other high-impact prevention options to prevent HIV • HIV screening, testing, treatment, and support to stay in care • TB-prevention, screening, testing, treatment-and-contact-tracing • STIs prevention, screening, testing and treatment • Comprehensive SRHR services (including cervical cancer screening, Pap smears, access to emergency contraception and safe abortion services) • Mental health screening, treatment and psychosocial support (anxiety, depression, and harmful drug and alcohol-use) • Violence screening, treatment or referral, support and access to justice • Access to PEP and post-sexual assault support • Prevention, support and redress for human rights violations • Access to social protection for persons who qualify	• In communities, and at facilities	• All implementing agencies • NDOH • DSD • DBE • DHET • Private Sector • National Prosecuting Authority (NPA) • Correctional Services

Table 12: *Minimum package of services: Key and other priority populations*

SERVICES / INTERVENTIONS / APPROACHES	SETTING	ACCOUNTABLE PARTIES
Inclusive package of services for all key and vulnerable populations that will be customised to the age and population served		
• Health information customised to client needs • Tailored SBCC • Decentralised service-delivery in non-traditional settings, including after hours and weekends • Sensitised health and social-care providers to render culturally competent, gender-sensitive, age-responsive and friendly SRHR services for key and vulnerable populations • PrEP, PEP and other high-impact options tailored to needs • Condom and lubricant promotion, provision, negotiation skills • Intensified HIV-prevention, screening, testing and treatment • Intensified TB-prevention, screening, testing, treatment and contact-tracing • Intensified STIs prevention, screening and treatment • Viral hepatitis prevention, screening, testing and treatment • Tailored SRHR services • Intensified mental health screening and psychosocial support and referral to harm-reduction services • Integrating screening, brief intervention and referral for drug-use treatment at primary care-level • Violence screening and referral to psychosocial and other support services and redress for human rights violations • Access to PEP, safe abortion and post-sexual assault support	• Peer-led outreach in communities • Health promotion and demand creation on social media • Sensitised facilities • Virtual / services	• Implementing partners • NDOH • DSD • DBE • DHET • NPA • SAPS • Home Affairs and Border management agency • DWYPD • Department of Transport • SANAC Secretariat • Private Sector
Core rights-based programme components: • Human rights and constitutional protection • Health empowerment • Economic empowerment • Gender norms and equality • Justice • Principles of universal design and reasonable accommodation that enables access for persons with disabilities		

Table 13: *Minimum package of services: Children*

SERVICES / INTERVENTIONS / APPROACHES	SETTING	ACCOUNTABLE PARTIES
• Health education, with a particular focus on sexual exploitation in the absence of primary caregivers • Gender norms education, including risk-reduction in relation to age-disparate relationships • Accelerated nutritional and social grant support • Access to comprehensive HIV, TB, STI and viral hepatitis detection, care and treatment services • Child and youth-friendly SRHR services in schools and community settings which include: - HPV-vaccination - Contraceptives including condoms - Choice and access to safe abortion - Protection against all forms of abuse • Age-appropriate CSE in residential, school and non-school and youth-friendly settings • Intensified mental health services and access to psychosocial support • School initiation, retention and completion	• Households • ECD facilities • Schools • Communities	• DSD • DBE • NDOH • Private Sector

Table 14: *Minimum package of services: Adolescents and young people*

SERVICES / INTERVENTIONS / APPROACHES	SETTING	ACCOUNTABLE PARTIES
• Peer-led outreach • Youth-friendly SRHR services in schools and community settings, which include: - PrEP - STI screening and treatment services - Access to screening for mental health and harmful alcohol and drug-use disorders, psychosocial support and mental healthcare services. Complete two-dose HPV vaccine - Complete two-dose HPV vaccine - Prevention of vertical transmission - Choice and access to safe abortion - Contraceptive services - Male and female condom provision in schools and tertiary institutions - Sanitary towels/dignity packs • Programmes to keep girls in schools, including support for pregnant learners • Access to parenting programmes • Access to peer groups and clubs • Economic empowerment programmes • Increased access to further education opportunities • Increased access to mentorship and internships • Reasonable accommodation and access for young people with disabilities • Age-specific support to HIV-positive adolescents and young key populations (support for disclosure, adherence) • Youth-friendly services in line with the national policy to reduce the vulnerability of young vulnerable populations, and improve their confidence in seeking SRHR services • Create demand at community-level and promote the uptake of SRHR services by migrants, sex workers, and young key and other priority populations	• School health services • Out of school adolescents and young people	• DBE • DHET • NDOH • DSD • NGOs • Department of Labour (DOL) • Private Sector

Table 15: *Minimum package of services: People with mental health conditions*

SERVICES / INTERVENTIONS / APPROACHES	SETTING	ACCOUNTABLE PARTIES
• Mental healthcare integrated into general healthcare • People with mental conditions are treated in primary healthcare clinics and general hospitals in most cases • Mental health services are available at all levels of the health service	• Communities • Primary care facilities • Hospitals	• NGOs • NDOH • DSD • Private Sector

Table 16: *Minimum package of services: People with physical and mental disabilities*

SERVICES / INTERVENTIONS / APPROACHES	SETTING	ACCOUNTABLE PARTIES
• Peer-led or peer-supported outreach • Specialised health education regarding risk and vulnerability to HIV, TB, STIs and viral hepatitis, particularly regarding sexual exploitation of people with disabilities • Accelerated nutritional and social grant support for people with disabilities who qualify • CSE inclusive of and accessible to learners with disabilities • Intensified psychosocial support and access to mental healthcare services • Intensified TB screening, treatment and care for people with disabilities in confined living conditions • Advocacy for mainstreaming of the policy that 7% of all programmes include people with disabilities • Ensure universal design and reasonable accommodation for people with disabilities	• Schools • Communities • Workplaces • Health facilities • Policy making	• NGOs • NDOH • DSD • DBE • Policymakers • Private Sector

Table 17: *Minimum package of services: Migrants, mobile populations and undocumented individuals*

SERVICES / INTERVENTIONS / APPROACHES	SETTING	ACCOUNTABLE PARTIES
• 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, seafarers, long-distance taxi drivers, pilots and cabin attendants • Provision of health services along 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., SGBV, drug and alcohol-use • Intensified psychosocial support • Cross-border collaboration on HIV, TB and STIs policy and programming • Use informal networks to raise awareness about available 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 • Sensitise healthcare providers and law enforcement authorities on the rights of non-nationals is essential. In addition, equipping service providers with migrant-sensitive job aids and instruments to enhance implementation that will strengthen service provision to migrants • Sensitise migrants, sex workers, and young vulnerable populations living in migration-affected communities about their rights and responsibilities to improve their access to SRHR services	• Truckers • Seasonal workers • Mineworkers • Taxi drivers	• Southern African Development Community (SADC) • The Department of International Relations and Cooperation (DIRCO) • Multilaterals • NGOs • DSD • SAPS • DHA • DOA • DOT • NDOH • Private Sector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Appendixes

Appendix A: Glossary of terms

Active case finding for TB	Health system proactive TB screening, conducted within facilities and in the community.
Advanced HIV disease	WHO defines advanced HIV disease (AHD) as CD4 cell count <200cells/mm3 or WHO Stage 3 or 4 in adults and adolescents. All children younger than 5-years old are considered to have advanced HIV disease. This includes individuals presenting to care who are antiretroviral therapy (ART) naive, and those returning to care after interrupted treatment.
Biomedical factors	Biomedical factors relate to human physiology and its interaction with medicine.
Cisgender (SANAC, 2020)	Denoting or relating to a person whose sense of personal identity and gender corresponds with their sex assigned at birth.
Community-led organisations (WHO, 2022)	Groups and networks that are led by the constituencies they serve. They are self-determining and autonomous entities where the majority of governance, leadership, staff, spokespeople, membership and volunteers reflect and represent the experiences, perspectives and voices of their constituencies.
Community-led responses (WHO, 2022)	Actions and strategies undertaken by these groups to improve the health and human rights of their constituencies. These responses are informed and implemented by and for communities themselves and the organisations, groups and networks that represent them.
Comprehensive sexuality education (CSE)	CSE is a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. CSE is offered in formal setting, scientifically accurate, culturally relevant, based on human rights approach, age and developmentally-appropriate (UNESCO, 2018). CSE aims to equip children and young people with knowledge, skills, attitudes, and values that will empower them to realise their health, well-being and dignity, develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others and understand and ensure the protection of their rights throughout their lives.
Comprehensive social protection (UNAIDS, 2015)	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 and other priority populations. It also includes economic empowerment programmes, referrals, and linkages to maximise the impact of investments in (and across) sectors.

Appendix A:

Criminalisation	Refers to the process by which behaviours and persons are turned into crimes and criminals through laws and policies that make certain behaviours illegal, for example sex work, drug-use or possession of certain drugs. Criminalisation includes 'de facto' and 'de jure' criminalisation. De facto criminalisation refers to changes "in reality" (without a change in law) while there are efforts under way to change the law, and de jure criminalisation refers to what is "stated in law".
Differentiated service-delivery (WHO, 2022)	An approach that simplifies and adapts services to better serve the needs of people living with HIV, TB or sexually-transmitted infections (STIs), and to optimise the available resources in health systems. Differentiated service-delivery (DSD) is an approach used to provide people-centered HIV, TB and STIs care. UNAIDS defines DSD as "a client-centered approach that simplifies and adapts HIV services across the cascade, in ways that both serve the needs of people living with HIV better and reduce unnecessary burdens on the health system".
Diversity (AFSA Human Rights Toolkit, 2019)	Refers to the various characteristics (identities) of people within a group, and the various characteristics (identities) of an individual.
Drug-resistant TB Disease	B disease caused by a strain of TB bacteria that is resistant to the most commonly used anti-tuberculosis drugs.
Duty bearers (AFSA Human Rights Toolkit, 2019)	Are people or institutions who are legally obligated to respect, protect, promote, and fulfil the entitlements of rights holders (e.g., government officials, including law enforcement officials, health and social care providers).
Extensively drug-resistant TB disease	TB illness caused by a strain of TB bacteria that is resistant to isoniazid and rifampicin, as well as fluoroquinolone, and at least one of the three injectable second-line drugs.
Gender-affirming healthcare (Reisner et al, 2016).	Healthcare that holistically attends to transgender people's physical, mental, and social health needs and well-being while respectfully affirming their gender identity.
Gender-based violence (UNAIDS, 2015)	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. It includes violence perpetrated against some boys, men and transgender persons because they challenge (or don't conform to) prevailing gender norms and expectations (e.g. they may have a feminine appearance) or to heterosexual norms".

Gender equality (UNAIDS, 2015)	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 people in all their diversity 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 identity (SANAC, 2020)	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.
Gender-transformative (UNAIDS, 2015)	Gender-transformative programmes not only recognise and address gender differences, but they also seek to transform gender norms and stereotypes that increase the vulnerability of people who do not conform to gender norms (including transgender people and gay men, and other men who have sex with men). They attempt to examine the damaging aspects of gender norms, experimenting with new behaviours to create more equitable roles and relationships. In addition, gender-transformative HIV response seeks not only to address the gender-specific aspects of HIV, but also to change existing structures, institutions and gender relations into ones that are based on gender equality.
Harmful gender norms (UNAIDS, 2015)	Harmful gender norms are social and cultural norms of gender that cause direct or indirect harm to women and men. Some examples are norms that contribute to women's risk and vulnerability to HIV or those that hinder men from assuming their share of the burden of care or from seeking information, treatment, and support.
Human rights (AFSA Human Rights Toolkit, 2019)	These are basic entitlements that everyone has, because they are human. Human rights are universal; they apply to everyone and are based on the idea that all people are equal and should be treated with respect and dignity, regardless of who they are or where they live.
Integrated service-delivery **(ND0H, 2022)**	Integrated health services are health services that are managed and delivered in a way that ensures that people receive a continuum of health promotion, disease-prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services at the different levels and sites of care within the health system, and according to their needs throughout their life-course.

Appendix A:

Intersectionality[1]	Refers to "the complex, cumulative manner in which the effects of different forms of discrimination combine, overlap or intersect". It means that different forms of discrimination don't exist in a vacuum – for those who embody different marginalised identities, these often overlap and amplify each other to create a unique experience of discrimination that is more than just the sum of its parts.
Key populations	Key populations are groups of people who, due to specific higher-risk behaviours, are at increased risk of HIV, TB, STIs or viral hepatitis irrespective of the epidemic type or context. Also, they often have legal and social issues related to their behaviours that increase vulnerability to these diseases. They also are essential partners in an effective response to HIV, TB, STIs and viral hepatitis transmission (World Health Organization, 2022).
Legal literacy (SANAC, 2020)	Initiatives to build the capacity of people living with HIV, people with TB and other key and priority populations to know their legal and human rights and to take action when these are violated.
Men who have sex with men **(UNAIDS, 2015)**	Refers to males who have sex with males regardless of whether they also have sex with women or have a personal or social gay or bisexual identity. This term is inclusive of men who self-identify as heterosexual but have sex with other men (Department of Health, 2014; SANAC, 2017; UNAIDS, 2015).
Mental health	A state of mental well-being that enables people to cope with the stressors of life, to realise their abilities, to learn well and work well, and to contribute to their communities. Mental health is an integral component of health and well-being and is more than the absence of mental disorder
Mental disorder	As defined by the International Classification of Diseases 11th Revision (ICD-11), a mental disorder is a syndrome characterised by clinically significant disturbance in an individual's cognition, emotional regulation or behaviour that reflects a dysfunction in the psychological, biological or developmental processes that underlie mental and behavioural functioning. These disturbances are usually associated with distress or impairment in personal, family, social, educational, occupational or other important areas of functioning.
Migrant	An umbrella term, not defined under international law, reflecting the common lay understanding of a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons. The term includes a number of well-defined legal categories of people, such as migrant workers; persons whose particular types of movements are legally defined, such as smuggled migrants; as well as those whose status or means of movement are not specifically defined under international law, such as international students (IOM terminology guidelines 2019).

National Scorecard (SANAC, 2020)	The National Scorecard is a data-collection tool to gather information on human rights and gender-related violations of national concern, in order to monitor human rights- and gender-related barriers (and the impact of programmes to address barriers) in the national response.
People in prisons (Male and Female) (WHO, 2022)	The term "prisons" refers to all places of detention within a country, and the term "prisoners" refer to all those detained in criminal justice and prison facilities, including adult and juvenile males, females, trans and gender-diverse individuals, during the investigation of a crime, while awaiting trial, after conviction, before sentencing and after sentencing.
Point-of-care testing (NDoH, 2020)	Tests conducted at the site at which clinical care is being provided, with the results being returned to the person being tested or caregiver on the same day as sample collection and testing to enable clinical decisions to be made in a timely manner.
Other priority population	Other priority populations describe groups of people who in a specific geographical context (country or location) are important for the HIV, TB and STI response, because they are at increased risk of acquiring HIV, TB and/or STIs or disadvantaged when living with these diseases due to a range of societal, structural or personal circumstances that create distinct barriers to accessing services.
Redress mechanisms (AFSA Human Rights Toolkit, 2019)	Refers to any action that assists a person who has experienced rights violations. This can range from accessing psychosocial support and seeking advice to lodging a complaint, documenting what happened and/or seeking legal recourse. Seeking legal recourse refers to actions that use the law and, if required court structure to find a solution to the situation. Seeking legal recourse is just one of a number of ways people whose rights have been violated can access redress mechanisms.
Screening	Screening is a population-based intervention offered to an identified key population that attempts to detect medical conditions in individuals and groups that are not experiencing signs and symptoms of illness. It is a key strategy of preventative medicine and should be distinguished from diagnosis and active case finding.
Self-screening (NDoH, 2020)	A process in which a person collects their own specimen (oral fluid or blood) and then performs a screening test and interprets the results, often in a private setting, either alone or with someone they trust.
Sexual violence (SANAC, 2022. Human Rights Toolkit. Training of Trainers Manual: Sexual and Gender-based Violence)	Sexual violence is an extreme form of gender-based violence. It includes any act, conduct or threat of a sexual nature committed against a person without their consent. Forms of sexual violence include sexual assault, rape, and sexual harassment.

Appendix A:

Social services (social protection)	Is concerned with preventing, managing, and overcoming situations that adversely affect people's physical and mental well-being. Social protection consists of policies and programmes designed to reduce poverty and vulnerability by promoting efficient labour markets, diminishing people's exposure to risks, and enhancing their capacity to manage economic and social risks, such as unemployment, exclusion, sickness, disability, mental health conditions, homelessness, and old age (United Nations Research Institute for Social Development (UNRISD), 2010).
Social and structural drivers (Baral et al., 2013)	Those social, economic, organisational, and political power and domination factors which act as determinants of HIV, TB and STIs vulnerabilities. These factors facilitate or impede an individual or group's ability to access services and/or adhere to treatment.
Social protection (NSP 2017 – 2022)	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 and vulnerable and marginalised groups. 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.
Stigma and discrimination (SANAC, 2020)	Stigma 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. 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 or TB, this can be a person's confirmed or evaluated HIV-positive status or infection with TB, irrespective of whether or not there is any justification for differential treatment.
Subclinical TB	TB disease that is confirmed by presence of TB bacilli following investigations such as culture/Xpert/chest X-ray, but the person with TB has no observable symptoms.
Systematic screening for TB	Systematic screening for active TB entails health system-initiated TB screening for large numbers of people to identify clients with symptoms suggestive of TB.
TB contact	A person who has spent time with a person with infectious or active TB disease.
TB-preventive therapy	The use of medicines to prevent TB infection from progressing to active TB disease.

Transgender persons (SANAC, 2020)	Transgender is an umbrella term to describe people whose gender identity and expression does not conform to the norms and expectations traditionally associated with the sex they were assigned at birth by default of their primary sexual characteristics. It is also used to refer to people who challenge society's view of gender as fixed, unmoving, dichotomous and inextricably linked to one's biological sex. Gender is more accurately viewed as a spectrum, rather than a polarised, dichotomous construct. 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.
Transphobia	Dislike of or prejudice against transsexual or transgender people.
Vaccination	Administration of a vaccine to prevent and protect from specific infections and diseases.
Vulnerability (IOM, 2019)	Vulnerability is defined as the limited capacity to avoid, resist, cope with or recover from harm. This limited capacity is the result of the unique interaction of individual, social, community, and political characteristics and conditions, mostly outside the person's control.


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Logic Framework for the NSP Goals

Appendix B: Goals, Objectives and Priority Actions

Table 8

Logical framework **Goal 1:** Break down barriers to achieving outcomes for HIV, TB and STIs

In some cases, examples have been provided for illustration purposes, which does not exclude the implementation of other implementations that have not been specified as examples. As more data is reviewed, other new innovative interventions should be considered.

OBJECTIVE 1.1: Strengthen community-led HIV, TB and STI responses

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS BE SPECIFIC AND PRIORITISE	ACCOUNTABLE PARTNERS
Subobjective 1.1.1: *Build an enabling environment for cohesive and inclusive communities focusing on key and other priority populations*	• Map community assets and determinants of health profiles in communities • Engage communities, with a focus on key and other priority populations, in the development and implementation of local development plans and allocation of resources. • Scale up community-based prevention and early intervention programmes, e.g., parent support programmes • Strengthen holistic care and support programmes for key and other priority populations • Conduct national awareness campaigns • Educate affected communities about migration • Empower youth leaders and Involve youth in community-led responses.	• **Strengthen the development and implementation of multi-sectoral and integrated development plans (IDPs) to build resilient individuals, parents, families and communities** • **Strengthen the development and implementation of multi-sectoral district development plans (MDIPs)**	• Key populations • AYP • Migrants, mobile populations and undocumented individuals • People with disabilities • People with mental health conditions • Communities in all 52 districts	NDOH DSD DBE DHA Civil Society, including non-governmental organisations (NGOs) and CBOs Private Sector
Subobjective 1.1.2: *Strengthen the capacity of community-led responses to implement and report on HIV, TB, STIs and viral hepatitis*	• Build the capacity of programmes to offer a broad range of tailored services in communities • Strengthen the capacity of local NGOs and other CBOs to implement and report on HIV, TB, STIs and viral hepatitis • Conduct social mobilisation through community dialogues	• **Intensify implementation of comprehensive, community-led and peer-led programmes**	• Key populations • Children • AYP • Women in rural areas, informal settlements and inner cities • People with disabilities • Migrant and mobile populations	DSD NDOH Private Sector
	• Employ and train members of key populations and other priority populations as peer educators	• **Enhance meaningful engagement of all key and other priority populations in communities**	• Key and priority populations	NDOH DSD NGOs and CBOs Private Sector

OBJECTIVE 1.1: Strengthen community-led HIV, TB and STI responses *(cont.)*

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS BE SPECIFIC AND PRIORITISE	ACCOUNTABLE PARTNERS
	• Expand the availability of self-testing and screening and point-of-care tests for HIV, STIs and pregnancy • Make self-care options available at Central Chronic Medicines Dispensing and Distribution (CCMDD points, e.g., pregnancy tests, HIV self-screening, STI testing) • Offer virtual consultations and counselling, especially in rural communities • Offer online screening tools for HIV, STIs, TB and common mental health conditions	• **Strengthen decentralised service-delivery in communities**	• Communities in all 52 districts • Key and priority populations	DoH at every level especially key populations programme, Goals, Objectives and Priority Actions, DCS, DBE, Private Sector, Department of Transport, DSD, NGOs
Subobjective 1.1.3: *Resource and support CBOs to implement and monitor responses to HIV, TB, STIs and viral hepatitis*	• Allocate 30% of available funding to local CBOs • Identify and train eligible community-based and community-led organisations. • Build capacity for community-led monitoring of HIV, TB and STIs	• **Capacitate and support CBOs to implement and monitor responses to HIV, TB and STIs**	• Key and other priority populations • Communities in all 52 districts	NDOH DSD
Subobjective 1.1.4: *Improve safety, health and well-being in communities to strengthen the capacity of families to protect and support members affected and infected by HIV, TB, STIs and viral hepatitis*	• Increase the number of shelters and safe houses available in communities • Revive street committees and crisis response teams to create safety nets in communities. • Ensure adequate street lighting and safety after dark • Prioritise availability of clean water and sanitation to all communities • Allocate areas for safe playgrounds and parks to promote physical activity • Enforce age-related regulations to reduce access to alcohol for minors • Implement families matter programmes • Strengthen availability of psychosocial support services in communities	• **Scale up availability of safe spaces and recreational opportunities in communities**	• AYP • Children • Survivors of SGBV • People living in rural areas, informal settlements and inner cities • People with disabilities • People with mental health conditions • Migrants, mobile populations and undocumented individuals	DSD NDOH Public Works SAPS Human Settlements Arts, Sport and Culture Department of Cooperative Governance and Traditional Affairs (COGTA)

Table 8

Logical framework **Goal 1:** Break down barriers to achieving outcomes for HIV, TB and STIs

OBJECTIVE 1.1: Strengthen community-led HIV, TB and STI responses *(cont.)*

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS BE SPECIFIC AND PRIORITISE	ACCOUNTABLE PARTNERS
Subobjective 1.1.5: *Improve the integration of HIV, TB, STI and viral hepatitis services into community systems and cultural practices*	• Involve traditional leaders and capacitate them on HIV, TB and STIs • Engage THPs in the detection and delivery of community-led HIV, TB and STI services • Integrate with the medical male circumcision (MMC) programme • Monitor and improve the safety of initiation schools and initiates • Messaging to prevent harmful cultural practices • Capacity building of community-based HWs and social service practitioners on integrating community systems and cultural practices into health services	• **Enhance integration of proven high-impact approaches and traditional and cultural practices**	• All 52 districts, specifically districts in rural areas • THPs	SANAC AIDS Councils at all levels COGTA Local municipalities NDOH DSD

OBJECTIVE 1.2: Contribute to poverty reduction through the creation of sustainable economic opportunities

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS BE SPECIFIC AND PRIORITISE	ACCOUNTABLE PARTNERS
Subobjective 1.2.1: *Increase access to economic strengthening opportunities*	• Ensure equitable access to skills development and income-generating opportunities, e.g., equal pay • Reduce unemployment of AYP by linking AYP with expanded public works programme (EPWP) • Engage the private sector to scale up and support AYP and women-led community-based enterprises	**Scale up protection against the consequences of vulnerability in communities**	• Waste pickers • Informal traders • Homeless and street-based persons • Children • AYP • Women in all their diversity • Survivors of SGBV • People with disabilities • Migrants, mobile populations and undocumented individuals	DSD DPSA Private Sector DHET Civil Society, including implementing partners Department of Small Business Development (DSBD) National Development Agency (NDA)
Subobjective 1.2.2: *Scale up and advocate for access to social protection interventions to facilitate equitable access to services*	• Micro-financing for women trading in the informal sector • Scale up application and payment of social grants to all who are eligible • Enhance access to tailored social protection for key and other priority populations • Increase access to social protection for those who qualify • Increase access to dignity packs to reduce impact of period poverty • Raise awareness of social protection interventions	**Improve access to social protection for those who qualify**	• Adolescent and young parents • People with mental health conditions • People with disabilities • Adolescent girls and women in all their diversity • Migrants, mobile populations and undocumented individuals	DSD Civil Society, including implementing partners Private Sector
Subobjective 1.2.3: *Accelerate access to food and nutritional support programmes*	• Promote and support food gardens at schools and in communities • Revitalise proven food production solutions • Increase access to nutritional support at schools and in communities • Integrate best practices across government departments for inclusive access to nutrition • Expand drop-in centres, especially in rural areas, informal settlements and inner cities	**Strengthen the provision of nutritional support to all eligible people with a particular focus on key and other priority populations**	• People and communities in all 52 districts • Children • People with mental health conditions • People with disabilities	DOA DSD NGOs SANAC sectors Private Sector

Table 8

Logical framework **Goal 1:** Break down barriers to achieving outcomes for HIV, TB and STIs

OBJECTIVE 1.2: Contribute to poverty reduction through the creation of sustainable economic opportunities *(cont.)*

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS BE SPECIFIC AND PRIORITISE	ACCOUNTABLE PARTNERS
Subobjective 1.2.4: *Scale up programmes that support AYP to remain in and return to school*	• Offer parenting programmes for teen mothers and fathers • Access to childcare and ECD • Provide psychosocial support to pregnant teens and teen mothers • Advocate for tailored community-based health and social services • Decrease care-taking responsibilities of girls and young women with strengthened community-based care structures • Upscale supporting programmes for adolescent girls/boys and young women/men to remain in and return to school (programmes such as Summer Boarding Course (SBC), SRH dialogues, Families Matter, Let's talk, youth camps, holiday programmes)	**Scale up multi-sectoral support for AGYW**	• Adolescent and young parents • Children, specifically orphans and other priority children • AYP not in employment, education or training • Learners with disabilities • Migrant learners • LGBTIQ+ learners • Children and adolescents living with HIV and TB	DWYPD NDOH DBE DSD DHET Civil Society, including NGOs and CBOs

OBJECTIVE 1.3: Reduce stigma and discrimination to advance rights and access to services

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS BE SPECIFIC AND PRIORITISE	ACCOUNTABLE PARTNERS
Subobjective 1.3.1: *Increase literacy on rights and the impact of intersecting stigma and discrimination*	• Raise awareness of causes and consequences of stigma and discrimination against HIV, TB, STIs and viral hepatitis risks and access to services • Incorporate human rights and diversity into all tailored programmes for key and other priority populations • Facilitate training on human rights, the law and diversity in communities, with a focus on key and other priority populations • Strengthen partnerships with HIV and TB sectors to raise awareness in communities of human rights, stigma and discrimination	**Scale up community mobilisation and capacity strengthening on human and legal rights and impact of intersecting stigma and discrimination**	• People and communities in all 52 districts • Key populations • People with disabilities • Migrants, mobile populations and undocumented individuals • People with mental health conditions • LGBTIQ+ persons • People living with HBV and HCV	SANAC DOH DSD DBE Civil Society Sectors Implementing partners Private Sector
Subobjective 1.3.2: *Scale up community-led stigma-reduction interventions and advocacy*	• Identify community-based and community- and peer-led organisations and networks to support proven stigma-reduction approaches • Facilitate community dialogues on causes, impacts and community-based solutions to reduce stigma and discrimination • Increase support for interventions focusing on reducing internalised stigma • Scale up the involvement of young members of key and other priority populations • Advocate for people-centred approaches to enhance access to inclusive, non-judgemental and non-discriminatory quality community-based services	**Advocate for people-centred approaches to enhance access to inclusive, non-judgemental and non-discriminatory community-based services of high quality**	• People and communities in all 52 districts • Key and other priority populations • Young members of key and other priority populations	SANAC DoH DSD DBE Civil Society Sectors, including NGOs Implementing partners Private Sector
Subobjective 1.3.3: *Increase access to redress mechanisms in communities experiencing stigma, discrimination and other rights violations*	• Establish and support community-based ambassadors at health facilities and police stations to mitigate access to services • Strengthen and scale up community-based, community-led crisis response teams and mechanisms to increase linkage to services (e.g., community- and peer-led WhatsApp groups) • Support access and utilisation of established helplines (AIDS Helpline, SGBV Helpline, LifeLine, Childline, Mental Health Helpline) with community-based awareness campaigns	**Strengthen the support and promotion of community-based and community-led redress and rapid-response mechanisms**	• Key populations • People with disabilities • Migrants, mobile populations and undocumented individuals • People with mental health conditions • Survivors of gender-based discrimination and violence in all their diversity	SANAC DoH DSD DBE SAPS DCS Civil Society Sectors Implementing partners Private Sector

Table 8

Logical framework **Goal 1:** Break down barriers to achieving outcomes for HIV, TB and STIs

OBJECTIVE 1.3: Reduce stigma and discrimination to advance rights and access to services *(cont.)*

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS BE SPECIFIC AND PRIORITISE	ACCOUNTABLE PARTNERS
Subobjective 1.3.4: *Strengthen social support networks and structures for people most affected by external and internal stigma*	• Map community-based social support networks and structures • Strengthen and integrate existing community-based social support structures • Establish additional community-based social support structures	**Prioritise the revitalisation of community- and facility-based social support networks and structures**	• People and communities in all 52 districts • Key and other priority populations	NDOH key populations programme DSD Civil Society sectors, including NGOs
	• Train members of CBOs on social support structures to identify and respond to stigma and discrimination	**Scale up the capacitation of community-based social support networks and structures on stigma and discrimination**	• PLHIV • PWTB • Key populations • LGBTIQ+ persons	NDOH key populations programme DSD Civil Society sectors, including NGOs
Subobjective 1.3.5: *Assess stigma to inform decision-making and accurate data for future programming and track progress*	• Conduct and disseminate results annually of Human Rights Accountability Scorecard • Support the implementation of the Stigma Index 2 with training of community-led organisations to support data-collection • Develop and implement a TB stigma assessment tool to inform TB-related stigma-reduction interventions • Support community-led monitoring of human rights violations • Advocate and support rapid assessments to inform stigma-reduction initiatives	**Advocate for and support the implementation of regular community-based stigma assessments and ongoing monitoring of incidences**	• PLHIV • PWTB • Key populations • People with disability • Migrants, mobile populations and undocumented individuals • LGBTIQ+ persons	Human Sciences Research Council (HSRC) and other researchers SANAC Secretariat Civil Society sectors

OBJECTIVE 1.4: Address gender inequalities that increase vulnerabilities through gender-transformative approaches

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS BE SPECIFIC AND PRIORITISE	ACCOUNTABLE PARTNERS
Subobjective 1.4.1: *Enhance gender-transformative community-led actions for HIV, TB, and STIs to change harmful social, cultural and gender norms*	• Review and monitor community-led actions and programmes to enhance integration of gender-transformative and diversity-responsive approaches	**Strengthen community mobilisation efforts to reduce the consequences of gender inequality that are harmful to all genders**	• People and communities in all 52 districts	DWYPD, DSD, NDOH, Civil Society sectors. Implementing partners Communities Private Sector
	• Engage and sensitise men and boys in households and communities to champion gender equality and change harmful gender norms	**Prioritise engagement of men and their organisations to promote gender equality**	• Men and boys in communities and households	
	• Develop and implement community-led awareness-raising campaigns to reduce harmful consequences of gender inequality and gender-related stigma and discrimination	**Scale up the integration of gender-transformative and diversity-responsive approaches in all community-led actions for HIV, TB and STIs**	• People and communities in all 52 districts	
	• Capacitate communities to promote shared responsibility for prevention of HIV, TB, STIs, viral hepatitis and unintended pregnancy	**Support social justice organisations to advocate for and implement gender-transformative community-led responses**	• People and communities in all 52 districts • Key and other priority populations	
Subobjective 1.4.2: *Strengthen capacity of leaders at all levels of decision-making to advance gender equality and promote diversity*	• Engage and train political leaders to advance gender equality and promote diversity • Engage and train religious leaders on gender inequality and its harmful consequences • Engage and sensitise traditional leaders on the impact of gender inequality, harmful gender norms and practices (including widow inheritance)	**Prioritise the sensitisation of decision-makers on harmful consequences of gender inequality, norms and practices**	• People and communities in all 52 districts • LGBTQI+ persons • People with disabilities • Migrants • Adolescent girls and women in all their diversity	SANAC, DWYPD, DSD, Congress of Traditional Leaders of South Africa (CONTRALESA), Civil Society sectors, Implementing partners Private Sector
	• Strengthen implementation of training on human rights, gender equality, SRHR health and diversity for educators • Monitor reduction in gender inequality and promotion of diversity through the Human Rights Scorecard	**Advocate for and support the capacity strengthening of leaders across all sectors to promote gender equality and diversity and change harmful gender norms**	• People and communities in all 52 districts	SANAC, DWYPD, DSD CONTRALESA, Civil Society Sectors, Implementing partners Private Sector

Table 8

Logical framework **Goal 1:** Break down barriers to achieving outcomes for HIV, TB and STIs

OBJECTIVE 1.4: Address gender inequalities that increase vulnerabilities through gender-transformative approaches *(cont.)*

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS BE SPECIFIC AND PRIORITISE	ACCOUNTABLE PARTNERS
Subobjective 1.4.3: *Enhance capacity in communities to prevent and respond to SGBV*	• Sensitise communities on causes, forms and consequences of SGBV (including diversity) and its links to HIV, TB and STI risks and service access • Raise awareness on the prevalence and impact of specific forms of sexual and gender violence against women living with HIV in all their diversity (including obstetric violence) • Increase legal literacy in communities relating to rights of survivors of SGBV (including access to services)	**Scale up capacity strengthening to prevent and respond to SGBV**	• People and communities in all 52 districts • Survivors of SGBV, in all their diversity • Key populations • LGBTIQ+ persons • People with disabilities • Migrants, mobile populations and undocumented individuals	SANAC, DWYPD, DSD NDOH SAPS, Civil Society sectors, including NGOs, Implementing partners
	• Scale up training and support of peer educators in communities to recognise and respond to SGBV • Strengthen and support community-led structures (including Community Police Forums) to respond to SGBV and facilitate timely linkage to services	**Improve linkage to services for survivors of SGBV through community-led structures**	• Survivors of SGBV, in all their diversity	
Subobjective 1.4.4: *Increase access to services for all survivors of SGBV*	• Scale up and intensify training of HWs to provide comprehensive responses to all persons experiencing SGBV • Enhance access to a comprehensive package for all survivors of sexual assault (including ongoing psychosocial support) and provide people-centred services responding to support needs of survivors in all their diversity	**Strengthen the support for all survivors of SGBV (e.g., comprehensive package for all survivors), including tailored age-appropriate services and care for children and adolescents**	• People and communities in all 52 districts • Survivors of SGBV, in all their diversity • Key and other priority populations • People with mental health conditions	SAPS, NDOH, DSD, DBE, DHET, Civil Society Sectors, Implementing partners

OBJECTIVE 1.4: Address gender inequalities that increase vulnerabilities through gender-transformative approaches *(cont.)*

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS BE SPECIFIC AND PRIORITISE	ACCOUNTABLE PARTNERS
Subobjective 1.4.4: *Increase access to services for all survivors of SGBV*	• Advocate for the expansion of Thuthuzela Care Centres • Strengthen and support CBOs that provide services to survivors of SGBV in areas without access to Thuthuzela Care Centres • Advocate for increased support for places of safety and promote inclusive access to places of safety for survivors of SGBV • Capacitate GBV and femicide hotspot districts on the provision of psychosocial services policy and Intersectoral Policy on Sheltering Services in implementing the NSP for GBV and femicide • Strengthen victim empowerment project (VEP)	**Prioritise the improvement in access to comprehensive people-centred and inclusive SGBV response services (e.g., Thuthuzela Care Centres, places of safety)**	• People and communities in all 52 districts • Survivors of SGBV, in all their diversity • Key and other priority populations • People with mental health conditions	

Appendix B

Table 8

Logical framework **Goal 1:** Break down barriers to achieving outcomes for HIV, TB and STIs

OBJECTIVE 1.5: Enhance non-discriminatory legislative frameworks through law and policy review and reform

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS BE SPECIFIC AND PRIORITISE	ACCOUNTABLE PARTNERS
Subobjective 1.5.1: *Amend laws to decriminalise sex work*	• Expedite drafting of law amendments to the Sexual Offences Act and related laws and policies to decriminalise sex work • Facilitate broad and inclusive public participation with draft legislation • Revise draft amendments to incorporate public comments and submissions • Enact law amendments by 2026 • Scale up and support community-and peer-led advocacy for decriminalisation of sex work	**Finalise law reform processes to decriminalise sex work**	• Sex workers and their families • Clients of sex workers	DOJ DCS SANAC Civil Society sectors Private Sector
Subobjective 1.5.2: *Advocate for the decriminalisation of drug-use and drug possession for personal use*	• Advocate Law Reform Commission to prioritise review of drug policies, provide recommendations and draft law amendments for the decriminalisation of all drug possession for personal use • Promote and support de facto decriminalisation of drug-use and drug possession for personal use • Enact the Cannabis for Private Purposes Bill of 2020 and amend relevant sections in the Drug-use and Trafficking Act • Engage with all relevant departments and civil society sectors to support and promote law reform relating to decriminalisation of drug-use and drug possession for personal use • Capacitate community-led organisations and networks to effectively advocate for decriminalisation of drug-use and drug possession for personal use	**Advance efforts to decriminalise drug-use and drug possession for personal use**	• PWUD and their families • Communities in all 52 districts	DJ & CS SANAC South African Law Reform Commission (SALRC) South African Network of People Who Use Drugs (SANPUD) Civil Society sectors Private Sector

OBJECTIVE 1.5: Enhance non-discriminatory legislative frameworks through law and policy review and reform *(cont.)*

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS BE SPECIFIC AND PRIORITISE	ACCOUNTABLE PARTNERS
Subobjective 1.5.3: *Enhance legal protection against hate crimes based on sexual orientation, gender identity and expression, and migrancy*	• Expedite finalisation and enactment of the Hate Crime Bill (i.e., Prevention and Combating of Hate Crimes and Hate Speech Bill of 2018) • Scale up and support LGBTIQ+ led organisations and networks to advocate for the enactment of the Hate Crime Bill • Scale up and support migrants against xenophobia	**Enhance legal protection against hate crimes based on sexual orientation, gender identity and expression, and migrancy**	• MSM • Transgender persons • Sex workers • Women who have sex with women • LGBTQI+ persons • People with disabilities • Learners	DJ & CD SANAC Civil Society sectors Private Sector
Subobjective 1.5.4: *Reform law and policy provisions to enhance access to gender-affirming healthcare and other essential services*	• Promote and support implementation of Gender-Affirming Healthcare Guidelines for South Africa • Support and advocate for the amendment of Section 2.1 of Act 49 (Alteration of Sex Description and Sex Status Act of 2003) and related legislation, i.e., Home Affairs, as it relates to identification	**Strengthen policy implementation relating to gender-affirming healthcare**	• Transgender persons and their families	DJ & CD NDOH SANAC Civil Society sectors Private Sector
	• Scale up and support trans and gender-diverse people-led organisations and networks to advocate for implementation and enactment of laws and policies that enhance access to gender-affirming services	**Support law and policy reform to enhance access to gender-affirming services**	• Transgender persons and their families	Civil Society sectors DJ & CD DHA SANAC Private Sector
Subobjective 1.5.5: *Advocate for policy alignment pertaining to the age of consent and access to SRHR and other services*	• Review and identify de-harmonised laws and policies. • Engage with all relevant departments and civil society sectors to support policy alignment relating to age of consent and access to SRHR and other essential services. • Draft policy and law provision amendments to harmonise age of consent and access to SRHR and other essential services. • Strengthen and support community-based and-led organisations and structures to advocate for harmonisation of laws and policies	**Harmonise policies to align age of consent and access to SRHR and other services and ensure enhanced service access for young people (12 and above)**	• Children • AYP • People with disabilities • Migrants, mobile populations and undocumented individuals • Communities in all 52 districts	DJ & CD, NDOH, DSD, SALRC, SANAC, Civil Society sectors Private Sector

Table 8

Logical framework **Goal 1:** Break down barriers to achieving outcomes for HIV, TB and STIs

OBJECTIVE 1.5: Enhance non-discriminatory legislative frameworks through law and policy review and reform *(cont.)*

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS BE SPECIFIC AND PRIORITISE	ACCOUNTABLE PARTNERS
Subobjective 1.5.6: *Strengthen policy frameworks to include THPs in existing healthcare structures*	• Review laws and policies to identify gaps relating to the integration of THPs in existing healthcare structures • Initiate and support law amendments to respond to the identified gaps towards integration • Scale up engagement between THPs and NDOH to concretise mechanisms of integration • Strengthen and support the THP sector to advocate for the integration of healthcare services provision	**Enhance policy framework to integrate THPs in the provision of healthcare**	• THPs • Communities in all 52 districts	DJ&CD, DOH, SALRC, SANAC, THPCSA (Traditional Health Practitioner Council of South Africa) Private Sector

OBJECTIVE 1.6: Protect and promote human rights and advance access to justice

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS BE SPECIFIC AND PRIORITISE	ACCOUNTABLE PARTNERS
Subobjective 1.6.1: *Strengthen human rights and legal literacy relating to HIV, TB and STIs in communities and service provision*	• Sensitise communities on human rights, diversity and HIV, TB and STI risks and service access	**Scale up community mobilisation to advocate for human rights protection in all aspects of the HIV, TB and STI response**	• PLHIV • PWTB • Key populations • People with disabilities • Migrants • Communities in all 52 districts	DoH key populations programmes, DoH regional training centres. SAPS, Home Affairs, SANAC, Civil Society Sectors, Implementing partners Private Sector
	• Scale up legal literacy training in communities with a focus on redress mechanisms and access to justice. • Advocate for improvement in availability of and inclusive access to redress mechanisms	**Intensify awareness-raising on human and legal rights (Know your rights campaigns)**	• PLHIV • PWTB • Key populations • People with disabilities • Migrants • Communities in all 52 districts	DoH key populations programmes, DoH regional training centres, SAPS, Home Affairs, SANAC, Civil Society Sectors, Implementing partners Private Sector
Subobjective 1.6.2: *Strengthen the capacity of communities to monitor and document rights violations related to HIV, TB and STIs and ensure human rights violations are consolidated into the national Human Rights Portal*	• Identify and support community-based and-led organisations to monitor and document rights violations • Identify and support community-based and community-led organisations to monitor and document rights violations • Scale up and strengthen the training of community members (e.g., REActors) to identify, monitor and document HIV, TB and STIs-related human rights violations • Review and develop standardised tools to monitor and document rights violations across sectors • Dissemination of quarterly reports	**Enhance capacity to monitor and document human rights violations**	• PLHIV • PWTB • Key populations • People with disabilities • Migrants • Communities in all 52 districts	SANAC, DSD, DoH, SAPS, SAHRC, CGE, Civil Society Sectors, Implementing partners Private Sector
	• Support ongoing consolidation of human rights violations into the national Human Rights Portal	**Consolidate documented human rights violations**	• PLHIV • PWTB • Key populations • Priority populations • Communities in all 52 districts	

Table 8

Logical framework **Goal 1:** Break down barriers to achieving outcomes for HIV, TB and STIs

OBJECTIVE 1.6: Protect and promote human rights and advance access to justice *(cont.)*

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS BE SPECIFIC AND PRIORITISE	ACCOUNTABLE PARTNERS
Subobjective 1.6.3: *Strengthen the capacity of communities to respond to human rights violations related to HIV, TB and STIs to facilitate access to justice*	• Identify and support community-based and community-led organisations that respond to human rights violations • Review and strengthen community-based referral systems and improve referral and case follow-up • Strengthen capacity of Legal Advice Offices to respond to HIV, TB and STIs-related human rights violations	**Strengthen referral and community-based response mechanisms (e.g., referral systems, community-based paralegals)**	• PLHIV • PWTB • Key populations • Priority populations • Communities in all 52 districts	Civil Society Sectors including NGOs, Implementing partners
	• Enhance access to community-based paralegals, particularly in rural areas • Advocate for increased access to legal services and affordable legal advice	**Improve access to justice**		

OBJECTIVE 1.6: Protect and promote human rights and advance access to justice *(cont.)*

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS BE SPECIFIC AND PRIORITISE	ACCOUNTABLE PARTNERS
Subobjective 1.6.4: *Scale up sensitisation and strengthen capacity of all service providers through ongoing in-service training and reviewing and amending preservice curricula*	• Scale up in-service training and sensitisation of healthcare providers on human rights and medical ethics related to HIV, TB, STIs and viral hepatitis • Enhance capacity strengthening and sensitisation of healthcare providers on gender, diversity, TB and provision of gender-responsive care, including through the provision of IEC material and job aids • Strengthen in-service training of social workers on human rights, diversity and provision of inclusive social services • Enhance in-service training of law enforcement agents on rights provisions, diversity and provision of inclusive police services • Promote and support training of members of the judiciary on human rights, gender equality (including SGBV) and diversity related to HIV, TB, STIs and viral hepatitis • Evaluate and strengthen capacity-enhancement efforts through the meaningful involvement of key and other priority populations • Provide THP with accessible and relatable education and information as well as with information on patient rights and responsibilities for HIV, TB and STI care and treatment.	**Enhance capacity and sensitisation of all service providers on human rights, diversity and inclusive service provision across all sectors (e.g., health, social, law enforcement, justice, duty bearers)**	• PLHIV • PWTB • Key populations • People with disabilities • Migrants • Communities in all 52 districts	DSD, DBE, DHET, SAPS, Civil Society Sectors, including NGOs
Subobjective 1.6.5: *Address impunity and ensure accountability of duty bearers at all levels*	• Raise awareness in communities on prevalence and impact of lack of accountability of duty bearers across the public sector • Review and strengthen accountability mechanisms across all public sector service provision • Capacitate communities to monitor enforcement of accountability mechanisms • Enhance engagement with Independent Police Investigative Directorate and the police ombudsman for human rights violations committed by SAPS	**Mobilise communities and support advocacy to increase accountability of all duty bearers who failed to promote and protect human rights, including access to redress levels (e.g., strengthen accountability mechanisms)**	• PLHIV • PWTB • Key populations • Priority populations • Communities in all 52 districts	DoH, DSD, DBE, DHET, SAPS, Civil Society Sectors, SAHRC, CGE

Table 8

Logical framework **Goal 1:** Break down barriers to achieving outcomes for HIV, TB and STIs

OBJECTIVE 1.6: Protect and promote human rights and advance access to justice *(cont.)*

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS BE SPECIFIC AND PRIORITISE	ACCOUNTABLE PARTNERS
Subobjective 1.6.6: *Strengthen the implementation of restorative justice programmes to decrease stigma and discrimination and enhance access to rights*	• Sensitise communities on availability and impact of restorative justice programmes • Enhance linkage to and support of family members to improve outcomes of resocialisation and reparative programmes	**Scale up restorative justice programmes to decrease stigma and discrimination and enhance access to rights (e.g., re-socialisation, reparative programmes)**	• People in prisons • PWUD • People treated for harmful alcohol use • Communities in all 52 districts • LGBTQI+ persons	DoH key populations programme, DCS, DSD, Civil Society Sectors, including NGOs, Implementing partners

OBJECTIVE 1.7: Integrate mental health and standardise delivery and access to mental health services

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS BE SPECIFIC AND PRIORITISE	ACCOUNTABLE PARTNERS
Subobjective 1.7.1: *Expand integrated literacy, detection and treatment or referral of common mental health conditions and substance-abuse disorders by WBOT in communities and by health and social care workers at facilities*	• Train community HWs and social service practitioners on mental health conditions, screening and support • Standardise and implement screening tools for anxiety, depression and alcohol and drug-use disorders in communities • Train social workers and auxiliary social workers to offer appropriate psychosocial support to persons with mental health conditions • Train professional nurses on mental health conditions, screening and support • Scale up HIV, TB and STI counselling, treatment adherence and referral for treatment for mental health and substance-use disorders • Facilitate early identification, and referrals for mental health and treatment services for mental health conditions and drug and alcohol use disorders • Scale up community mental health services to match recommended national norms	**Increased availability of comprehensive mental health and psychosocial support services in communities, health facilities, schools and institutions of higher learning**	• PLHIV • PWTB • People with mental health conditions • People with prior and current TB • PWUD • Persons with diverse gender identities • Persons in prisons • Sex workers • AYP • Migrants, mobile populations and undocumented individuals • People with disabilities • Survivors of SGBV • Children, specifically orphans and other priority children	NDOH DSD DBE DHET Private Sector
Subobjective 1.7.2: *Enable professional nurses to prescribe and dispense medication to treat common mental health conditions*	• Standardise and implement screening tools for anxiety, depression and harmful alcohol and drug-use in primary care facilities • Train and accredit nurses to treat common mental health conditions prescribe	**Advocate for policies to allow trained nurses to support and treat persons with common mental health disorders**	• Key and other priority populations • Communities in all 52 districts	South African Nursing Council (SANC) SAHPRA Private Sector
Subobjective 1.7.3: *Identify persons with mental health conditions who are vulnerable to HIV, TB and STIs and/ or living with comorbid conditions and ensure they receive appropriate care and support services*	• Integrate mental health into primary healthcare clinics and in general hospitals as part of the minimum package of care • Improve and plan delivery of mental health services at all levels of the health service and integrate them into HIV, TB and STI services	**Provision of comprehensive mental health and psychosocial support services in communities, health facilities, schools and institutions of higher learning**	• Key and other priority populations • People with mental health conditions • Communities in all 52 districts	NDOH DSD DBE DHET Private Sector

Table 9

Logical framework **Goal 2:** Maximise equitable and equal access to services and solutions for HIV, TB and STIs

OBJECTIVE 2.1: Increase knowledge, attitudes and behaviours that promote HIV-prevention

	PRIORITY ACTIONS	PACKAGES/ APPROACHES/ EXPECTED ACHIEVEMENT/ MEANS OF VERIFICATION	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 2.1.1: *Strengthen SBCC through IEC services on HIV-prevention*	• Provide targeted IEC messages for uptake of HIV-prevention services • Strengthen existing IEC to improve knowledge, attitudes and practices to access HIV-prevention services • Promote continuous behaviour change interventions at individual level, social mobilisation at community-level and advocacy at societal level • Strengthen targeted social media communicati on and messaging • Strengthen SBCC to address stigma and discrimination in key populations • Strengthen youth-friendly centres	• **Align and support health promotion across public and private sectors** • **Promotion of peer-led approaches to SBCC** • **Distribution of IEC material through interpersonal communication and social media**	• AGYW, ABYM, school children, Key population, priority population	NDOH , DBE, DSD, CBOs, DHET, DOT, NGOs, Private healthcare providers, Private schools, Health Insurance Schemes Private Sector

OBJECTIVE 2.1: Increase knowledge, attitudes and behaviours that promote HIV-prevention *(cont.)*

	PRIORITY ACTIONS	PACKAGES/ APPROACHES/ EXPECTED ACHIEVEMENT/ MEANS OF VERIFICATION	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 2.1.2: *Strengthen age-appropriate comprehensive sexuality education and SRHR education*	• Strengthening the scripted lesson plans implementation • Building the knowledge, attitudes, values, skills and behaviours for healthy, respectful and gender-equitable relationships • Supporting children in their transition to adolescence, including through puberty education and social-emotional learning • Strengthening the quality of CSE curricula and delivery, including through support for teacher training and development • HIV and STI prevention and the promotion of HIV-testing, knowing one's status and HIV-treatment. • Preventing and addressing early and unintended pregnancy and child marriage • Promoting gender equality and preventing gender-based discrimination and violence • Expanding knowledge and evidence on CSE	• **CSE curricula and its delivery** • **School retention of teenage pregnant mothers** • **Promotion of HIV-prevention** • **Promotion of gender and sexuality education**	• School and out-of-school children AGYW • ABYM	NDOH DBE DSD CBOs NGOs SANAC Health Insurance Schemes Private healthcare Private Sector

Appendix B

Table 9

Logical framework **Goal 2:** Maximise equitable and equal access to services and solutions for HIV, TB and STIs

OBJECTIVE 2.2: Reduce new HIV infections by optimising the implementation of high-impact HIV-prevention interventions

	PRIORITY ACTIONS	PACKAGES/ APPROACHES/ EXPECTED ACHIEVEMENT/ MEANS OF VERIFICATION	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 2.2.1: *Increase the availability and use of male and female condoms and lubricants*	• Community mobilisation • Condom and lubricants promotion and education • Intensify condom distribution in traditional and non-traditional distribution points, including private health facilities, schools, pharmacies, hotspots, taverns, hair salons, malls, community halls	• **Condom distribution through non-traditional outlets: hair salons, petrol stations, spaza shops, hotels, toll plazas, truck stops, brothels, soccer stadia** • **Implementation of National Condom Communication Plan and youth prevention campaign** • **Strong branding nationally (e.g., billboards, T-shirts, ad space (TV and radio), digital media presence, etc.)**	• Key and other priority populations	NDOH, 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, Informal traders
Subobjec-tive 2.2.2: *Scale up targeted HIV counselling and testing, including for key and other priority populations*	• Targeted counselling and testing of key and other priority populations and linkage to care • Scale up index client testing and network testing • Promote HIV self-testing • Provider-Initiated Counselling and Testing (PITC) at all facilities and pharmacies • Promote the 5Cs approach to HIV-testing (consent, confidentiality, counselling, correct and connection) • Integrate STI and TB counselling and testing into the HIV-testing and counselling programme • Strengthen linkage to care for children and adolescents testing for HIV	• **To increase yield in HCT, target key populations and high burden communities** • **Accelerating distribution of HIV test kits at all places key populations frequent including taverns, brothels, street corners, downtown places, hotels, pubs, and others** • **Promoting index client testing**	• Key and other priority populations	NDOH, DBE, DCS, DSD, DoT, CBOs, NGOs, Retail pharmacies, Private employers, Private healthcare providers, Health Insurance Schemes, Organised labour, Workplaces, SANAC sectors, Hospitality industry, Informal traders

OBJECTIVE 2.2: Reduce new HIV infections by optimising the implementation of high-impact HIV-prevention interventions *(cont.)*

	PRIORITY ACTIONS	PACKAGES/ APPROACHES/ EXPECTED ACHIEVEMENT/ MEANS OF VERIFICATION	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 2.2.3: *Promote uptake of VMMC through targeted demand generation strategies*	• Promote safe circumcision through strengthened collaboration between NDOH's VMMC and traditional circumcision programme • Create demand among key populations • Integrate VMMC services into primary healthcare services • Increase the uptake of VMMC and integrate HIV-prevention in initiation schools • WBPHCOT to create demand VMMC demand at ward/household level	• **Accelerating HTS at or before entering traditional circumcision centres** • **Creating demand at places young men frequent** • **Demand creation among key populations** • **Accelerating VMMC services in outreach facilities and middle-level health providers**	• Boys & men aged 15 or older	NDOH, DCS, DSD, DBE, CBOs, NGOs, Private healthcare providers, Health Insurance Schemes, Private and public institutions, Workplaces, SANAC sectors
Subobjective 2.2.4: *Promote the availability of PrEP to all who need it and uptake by key and other priority populations*	• Provide PrEP in all health facilities • Promote PrEP access for pregnant and breastfeeding adolescents and women • Rapid roll-out of new PrEP products for HIV-prevention • Promote continued use of PrEP while potential for exposure to HIV continues and support easy access to effectively starting and stopping PrEP as needed	• **Run campaigns on PrEP importance, availability, and use** • **Every health facility to provide PrEP to all who need it** • **Create demand among key populations for PrEP** • **Distribute PrEP at community-based centres** • **Promote and offer on-demand PrEP for MSM and other men at risk of HIV exposure**	• Key and other priority populations	NDOH, DBE, DCS, DSD, DoT, CBOs, NGOs, Retail pharmacies, Private employers, Private healthcare providers, Health Insurance Schemes, Organised labour, Workplaces, SANAC sectors, Hospitality industry, Informal traders, DHET
Subobjective 2.2.5: ***Improve the availability of PEP and timely access for survivors of sexual violence, those exposed to condomless sex and individuals who require it***	• Strengthen the delivery of PEP in all health facilities • Increase access to PEP as an emergency service within 72 hours by promoting availability during weekends, public holidays and in pharmacies • Promote timely access to PEP for survivors of sexual violence, people who had condomless sex and HWs exposed to HIV at work as an emergency service	• **Provision of information on PEP importance, availability, and use** • **Every health facility to provide timely PEP to all who need it** • **Creating demand among key populations for PEP** • **Distributing PEP through community-led and community-based centres**	• Key and priority populations	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, Informal traders

Table 9

Logical framework **Goal 2:** Maximise equitable and equal access to services and solutions for HIV, TB and STIs

OBJECTIVE 2.2: Reduce new HIV infections by optimising the implementation of high-impact HIV-prevention interventions *(cont.)*

	PRIORITY ACTIONS	PACKAGES/ APPROACHES/ EXPECTED ACHIEVEMENT/ MEANS OF VERIFICATION	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 2.2.6: *Scale up comprehensive harm-reduction package to PWUD*	• Promote needle and syringe programmes involving the distribution of sterile injecting equipment, collection and safe destruction of used equipment, and information on safer injecting • Support provision of opioid agonist medication by a trained health professional, at an appropriate dose, for as long as a person requires it • Screen for and provide services for mental health, TB, HCV and STIs as part of a harm-reduction programme	• **Screen and offer brief intervention for people living with or at risk for HIV for drug-use** • **Brief advice session on drug-use** • **Brief interviewing, including motivational interviewing and problem-solving therapy combination** • **Development of an effective referral system for treatment and care** • **Involving PWUD in developing messages of prevention**	• PWUD and their partners	NDOH, DSD, CBOs, NGOs, Retail pharmacies, Health Insurance Schemes, Organised labour, Private and public institutions, Workplaces, SANAC sectors, Hospitality industry, Informal traders
Subobjective 2.2.7: *Integrate HIV-prevention with SRHR, SGBV, mental health, STI and TB services*	• Link information on SGBV into HIV-prevention and SRHR programmes • Integration of PMTCT programmes into mental, TB and STIs and hepatitis B programmes • Integrate HIV-prevention into NCDs health promotion services • Integrate HIV-prevention in social and community services	• **Provision of HTS where TB, STIs, hepatitis B, mental health and SRH services are provided** • **Monitoring and evaluating health facilities for provision of integrated services** • **Ensuring friendly services for key populations**	• Pregnant and postnatal women, key and other priority population	NDOH, DBE, DCS, DSD, DoT, CBOs, NGOs, Retail pharmacies, Private employers, Private healthcare, providers, Health Insurance Schemes, Organised labour, SANAC sectors

OBJECTIVE 2.2: Reduce new HIV infections by optimising the implementation of high-impact HIV-prevention interventions *(cont.)*

	PRIORITY ACTIONS	PACKAGES/ APPROACHES/ EXPECTED ACHIEVEMENT/ MEANS OF VERIFICATION	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 2.2.8: *Promote innovation and research in HIV-prevention tools, community approaches and service-delivery*	• Fast-track rollout of proven innovations to scale, e.g., vaccines and service-delivery approaches • Implementation of research to improve national standards • Increase collaboration between researchers, communities and service providers for HIV-prevention	• **Fund research at national, provincial and district-levels** • **Implement research at provincial and district-levels** • **Collaborate on research activities between public and private organisations** • **Strengthen and expand WBOT**	• Researchers and lecturers	NDOH, DBE, DCS, DSD, CBOs, NGOs, Academics, Private Sector, Private and Public Higher Education, and Research Institutions

Table 9

Logical framework **Goal 2:** Maximise equitable and equal access to services and solutions for HIV, TB and STIs

OBJECTIVE 2.3: Eliminate vertical transmission of HIV

	PRIORITY ACTIONS	PACKAGES/ APPROACHES/ EXPECTED ACHIEVEMENT/ MEANS OF VERIFICATION	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 2.3.1: *Scale up screening of pregnant and breastfeeding women for HIV and link them to HIV-prevention services, including PrEP*	• Promote and facilitate early antenatal care bookings for pregnant adolescents and women • Strengthen and promote partner involvement in PMTCT, postnatal programmes • Provide tailored HIV-prevention interventions for HIV-negative pregnant and breastfeeding mothers • Promote risk-benefit counselling for pregnant women for HIV-prevention • Promote access to retesting among PBAW	• **Screening for prevention** • **Partner involvement programmes** • **Implement viral load testing in pregnant and breastfeeding**	Pregnant women Postnatal women Newborn babies and infants Partners of pregnant and postnatal women	NDOH, DBE, DCS, DSD, CBOs, NGOs, Retail pharmacies, Private healthcare providers, Health Insurance Schemes, SANAC, Private Sector
Subobjective 2.3.2: *Scale up universal uptake of ART among pregnant and breastfeeding HIV-positive mothers*	• Promote regular testing of the woman, partner and family, and rapid community/ facility initiation of ART • Promote ART retention and viral suppression uptake through support groups • Improve growth-monitoring and infant-feeding support services • Encourage consistent and correct condom use • Develop and implement guidelines and support for the disclosure conversation among AYP 10-24 years	• **Treatment as prevention** • **Partner involvement programmes**	Pregnant women Postnatal women Breastfeeding women Newborn babies and infants Partners of pregnant and postnatal women	NDOH, DBE, DCS, DSD, CBOs, NGOs, Retail pharmacies, Private healthcare providers, Health Insurance Schemes, SANAC , Private Sector

Table 9

Logical framework **Goal 2:** Maximise equitable and equal access to services and solutions for HIV, TB and STIs

OBJECTIVE 2.4: To ensure that 95% of PLHIV, especially in key and other priority populations, know their status and 95% of them are on treatment and 95% of those on treatment are retained in care and achieve long-term viral suppression

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS BE SPECIFIC AND PRIORITISE	ACCOUNTABLE PARTIES
Subobjective 2.4.1: *Improve HIV linkage to care for all PLHIV (first 95%)*	• Accelerate same-day or rapid initiation of ART • Strengthen client-centred linkage services using innovative differentiated model of HIV care • Support identifying children and adolescents living with HIV to accelerate linkage to HIV care and support	• **Strengthen 2020 use of NDOH SOPs for the minimum package of interventions to support linkage to care, adherence and retention in care** • **Provide active referral support for newly diagnosed patients** • **Fast-track initiation counselling, including a focus on adaptation for same-day initiation and post-initiation counselling aligned with treatment supply return dates** • **Provide a list of supporting organisations, such as CBOs and FBOs, to assist with psychosocial support**	• AGYW • ABYM • Men living with HIV • Children living with HIV • All PLHIV • Key populations and priority populations including children < 5 years old, co-infected with TB • Pregnant women with mental health conditions or hypertensive and diabetic patients	NDOH, DBE, DMOC, CBOs, FBOs, DHET, DoT, NGOs, Private healthcare providers, Pharmacies, NHLS and private laboratories SANAC Private Sector Civil Society Sectors Implementing Partners
Subobjective 2.4.2: *Identify, engage, or re-engage PLHIV who are not in care or not virally suppressed (second 95%)*	• Decentralise and simplify HIV-treatment services • Support viral load monitoring and adherence support for pregnant and breastfeeding women • Prioritise rapid introduction and scale up of access to optimised, child-friendly HIV-treatment and achieve sustained viral load suppression	• **Facilitate linkage to care immediately after diagnosis and provide low-barrier access to HIV-treatment** • **Enhance ongoing counselling services within health, community and workplace settings** • **Enhance capacity and sensitisation of service providers on friendly and appropriate provision of care** • **Regularly review NICD/NHLS Results for Action reports to identify people that are not virologically suppressed**	• Key populations • Men living with HIV • Adolescent girls and boys	CCMDD pick-up points, NDOH, CBOs, FBOs , NGOs, Private healthcare providers (pharmacies)

Table 9

Logical framework **Goal 2:** Maximise equitable and equal access to services and solutions for HIV, TB and STIs

OBJECTIVE 2.4: To ensure that 95% of PLHIV, especially in key and other priority populations, know their status and 95% of them are on treatment and 95% of those on treatment are retained in care and achieve long-term viral suppression *(cont.)*

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS BE SPECIFIC AND PRIORITISE	ACCOUNTABLE PARTIES
Subobjective 2.4.3: *Increase retention in care and adherence to HIV-treatment to achieve and maintain long-term viral suppression (third 95%)*	• Prioritise differentiated model of care strategies for long-term retention • Provide a package of post-test services to improve male clients' uptake of HIV adherence and retention • Strengthen monitoring and management of ART side-effects and pharmacovigilance and ARV toxicity monitoring through routinely collected data • Implement high-impact interventions to prevent and respond to HIV drug resistance	**• Scale up differentiated model of care such as MMD3, adherence clubs and home delivery to support innovative retention strategies for PLHIV and key/priority populations** **• Strengthen mechanisms for linking and ensuring retention of key populations on ART, such as peer-led case-based tracking system** **• Expand the role of expert clients and community linkage and retention facilitators** **• Build the capacity of health and community caregivers by standardising training and mentoring** **• Scale up delivery appropriate use of rehabilitative and palliative care** **• Strengthen community-led initiatives to improve the quality of care and retention** **• Strengthen implementation of tracing interventions through enhanced data-use for timely identification of individuals who interrupt treatment for re-engagement in care** **• Support men-targeted initiatives that promote adherence, retention and improved health outcomes** **• Tailor training and mentorship to improve male-friendly health and social services**	Children <15 years, adolescents, and young people 15–24, pregnant and breastfeeding women and their partners, men in general and key and priority populations.	DOH, DBE, DSD, DHET, Expanded Programme for Immunisation (EPI) Health Insurance Schemes Child health clinics Inpatient wards ICR School health teams Adolescent and Youth Friendly Services (AYFS) facilities and communities ECD Forums, and Child Protection Forums Implementing Partners Civil Society Sectors Private Sector Development Partners

OBJECTIVE 2.4: To ensure that 95% of PLHIV, especially in key and other priority populations, know their status and 95% of them are on treatment and 95% of those on treatment are retained in care and achieve long-term viral suppression *(cont.)*

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS BE SPECIFIC AND PRIORITISE	ACCOUNTABLE PARTIES
Subobjective 2.4.3: *Increase retention in care and adherence to HIV-treatment to achieve and maintain long-term viral suppression (third 95%)*	• Prioritise differentiated model of care strategies for long-term retention • Provide a package of post-test services to improve male clients' uptake of HIV adherence and retention • Strengthen monitoring and management of ART side-effects and pharmacovigilance and ARV toxicity monitoring through routinely collected data • Implement high-impact interventions to prevent and respond to HIV drug resistance	• **Improve the detection management of side-effects** • **Strengthen reporting of adverse reactions to drugs and utilisation of pharmacovigilance reports** • **Review essential drug list to include opioid agonist medications, methadone and buprenorphine and provide a comprehensive package of harm-reduction services specific to key populations (OST)** • **Gender-affirming care for transgender persons**	Children <15 years, adolescents, and young people 15–24, pregnant and breastfeeding women and their partners, men in general and key and priority populations.	DOH, DBE, DSD, DHET, Expanded Programme for Immunisation (EPI) Health Insurance Schemes Child health clinics Inpatient wards ICR School health teams Adolescent and Youth Friendly Services (AYFS) facilities and communities ECD Forums, and Child Protection Forums Implementing Partners Civil Society Sectors Private Sector Development Partners

Appendix B

Table 9

Logical framework **Goal 2:** Maximise equitable and equal access to services and solutions for HIV, TB and STIs

OBJECTIVE 2.5: Improving the quality of life beyond HIV suppression by reducing HIV-related deaths and comorbidities, coinfections, and complications

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 2.5.1: *Reduce HIV-related deaths from HIV/ TB-associated comorbidities, coinfections and complications*	• Prevent, diagnose and treat major OIs in PLHIV with AHD • Scale up availability of short-course TPT regimens for PLHIV who have AHD • Integrate priority NCD prevention (diabetes, hypertension, cervical cancer and mental health), assessment and treatment in HIV care and treatment services • Implement differential client-friendly services for HIV-exposed children and adolescents and their care givers to ensure continuum of care	• **Prioritise country adoption and implementation of the AHD package of services by strengthening screening, prophylaxis, rapid ART initiation and intensified adherence interventions** • **Increase procurement commitments for AHD commodities** • **Strengthen patient/community knowledge and demand for essential commodities** • **Scale up access to point-of-care CD4 testing, urine LAM TB testing and cryptococcal antigen for PLHIV with AHD** • **Prioritise access to short-course TPT for people with AHD** • **Minimise stockouts of equipment needed for assessing clients' eligibility for ART and scale up short-course TPT and co-trimoxazole** • **Update and roll out guidelines and tools for screening and diagnosis of NCDs among PLHIV** • **Integrate literacy on HIV and NCDs among PLHIV in health education and psychosocial support initiatives at health facilities and community-level** • **Strengthen the referral mechanisms for PLHIV to NCDs services for management and treatment** • **Strengthen data systems to collect and utilise data on NCDs among PLHIV for programming**	PLHIV and co-infected with TB People with AHD Men living with HIV (target age group 25-34 years) People with hypertension, diabetes and cervical cancer Children < 5 years Pregnant women	NDOH CBOs NGOs Private healthcare providers and NHLS

OBJECTIVE 2.5: Improving the quality of life beyond HIV suppression by reducing HIV-related deaths and comorbidities, coinfections, and complications *(cont.)*

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 2.5.2: *Improve the quality of life for all PLHIV*	• Develop guidelines and tools for screening and provision of mental health and psychosocial support • Scale up the provision of integrated HIV, SRHR services, and nutrition services to community actors in the community • Scale up HIV and TB treatment literacy among PLHIV • Increase awareness and support models of care that meet the needs of underserved PLHIV (ageing and people with disabilities)	• **Improve and expand counselling services for newly diagnosed HIV-positive and other pre-ART clients to offer comprehensive psychosocial support** • **Strengthen the integration of patient-friendly services (HIV, SRHR, diabetes, cervical cancer and hypertension)** • **Enhance targeted messaging to improve HIV, TB, and STI treatment literacy** • **Strengthen the U=U message to increase awareness and improve suppression of ART** • **Identify, implement, and evaluate models of care that meet the needs and ensure the quality of care across services.** • **Identify and implement best practices related to addressing psychosocial and behavioural health needs, including providing a comprehensive package of harm-reduction services and mental health**	All PLHIV, key popula-tions and priority populations Adolescents, PLHIV who are ageing and people with disabili-ties.	CCMDD NDOH DBE DSD CBOs FBOs DHET DoT NGOs Private healthcare providers Implementing Partners Civil Society Sectors Private Sector Development Partners
Subobjective 2.5.3: *Strengthen strategies to engage men in accessing services.*	• Working men friendly operation hours • Support groups for men • Peer educators and treatment buddies for men	• **Strengthen the integration on HIV, TB and STIs services with other men friendly services**	Men affected by HIV, TB and STIs.	CCMDD NDOH DBE CBOs FBOs Implementing Partners Civil Society Sectors Private Sector Development Partners

Table 9

Logical framework **Goal 2:** Maximise equitable and equal access to services and solutions for HIV, TB and STIs

OBJECTIVE 2.6: Strengthen TB-prevention interventions for key and other priority populations and the implementation of airborne infection-prevention and control in health facilities and high-risk indoor places where people congregate

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 2.6.1: *Strengthen TB-prevention interventions for key and other priority populations*	• Provide TPT and adherence support, and accelerate the scale up of TPT with shorter regimens to people who are eligible • Enhance contact-tracing and testing and utilise technology for screening • Review emerging evidence on new diagnostic tools (skin tests) for TB infection and consider translation into guidelines	• **Update and disseminate TPT guidelines, considering algorithms for children and those exposed to MDR-/XDR- TB** • **Provide adherence support for people on TPT and ensure availability of TPT at health facilities** • **Incorporate new shorter regimens in TPT guidelines** • **Provide contact-tracing cards to PWTB** • **Train HCWs, including WBOT and CHCW, in contact-tracing** • **Support community-led and community-based TB contact-tracing initiatives** • **Utilise technology such as the TB Health Check app** • **Consider translation of the new diagnostic tools, such as antigen-based skin tests for TB infection in guidelines**	Those who have had significant exposure to TB and a high risk of developing active TB disease	NDOH DBE DSD CBOs DHET Department of Transport NGOs Private healthcare providers Private schools Health Insurance Schemes Implementing Partners Civil Society Sectors Private Sector Development Partners

OBJECTIVE 2.6: **Strengthen TB-prevention interventions for key and other priority populations and the implementation of airborne infection-prevention and control in health facilities and high-risk indoor places where people congregate** *(cont.)*

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 2.6.2: *Strengthen the implementation and monitoring of airborne infection-prevention and control measures in health facilities*	• Strengthen the implementation of airborne infection-prevention and control measures in health facilities • Develop and implement monitoring plans for airborne infection-prevention and control measures in health facilities • Support adherence to policy on occupational health for HCWs on airborne infection control and prevention • Ensure availability of PPE such as respirators for HCWs and masks for patients • Decongest health facilities (CCMDD, MMD, etc.) to reduce the risk of airborne disease transmission	• **Review, update and dissemnate policies and guidelines on airborne infection control** • **Develop and implement an infection control plan according to the National Infection-prevention and Control Strategic Framework and the ICR and hospital frameworks** • **Each health facility must have a designated staff member responsible for infection control** • **Resource, procure and provide masks, respirators, and PPE for staff according to the National Infection-prevention and Control Strategic Framework and the ideal clinic and hospital frameworks** • **Follow the principles and guidelines outlined in the Ideal clinic and hospital frameworks, and the Integrated clinical services management manual on facility reorganisation, fast-tracking of patients, CCMDD and MMD**	All people accessing health facilities, including patients and staff members	NDOH DSD Private healthcare providers Implementing Partners Private Sector Development Partners
Subobjective 2.6.3: *Strengthen the implementation of airborne infection-prevention in high-risk indoor places where people congregate*	• Review and update ventilation standards for high-risk indoor places where people congregate, such as schools, prisons and places of worship • Educate community to maximise natural ventilation, masking, self-isolation for PWTB and cough etiquette • Incorporate TB screening within workplace and education institutions under health and safety policies and	• **Review, update and disseminate ventilation standards for high-risk indoor places considering lessons learnt from COVID-19** • **Maximise natural ventilation** • **Partnerships with other sectors to review new building plans or infrastructure to be compliant with the ventilation standards** • **Educate and empower the community members on infection control, how to maximise natural ventilation, masking and its benefits, cough etiquette and isolation for those that are ill** • **Provide IEC material on infection control in the community** • **Ensure availability of policies on screening for diseases, including TB, in workplaces and institutions** • **Train staff to conduct screening** • **Monitor the implementation of screening for diseases**	All community members	NDOH DBE DSD CBOs DHET DoT NGOs Private healthcare providers Private schools Implementing Partners Private Sector Development Partners

Appendix B

Table 9

Logical framework **Goal 2:** Maximise equitable and equal access to services and solutions for HIV, TB and STIs

OBJECTIVE 2.6: **Strengthen TB-prevention interventions for key and other priority populations and the implementation of airborne infection-prevention and control in health facilities and high-risk indoor places where people congregate** *(cont.)*

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 2.6.4: *Address TB-risk factors and social determinants/barriers through a multi-sectoral approach*	• Provide package of interventions for health-related TB-risk factors such as HIV/ AIDS, undernutrition, diabetes, smoking and alcohol • Strengthen the implementation of Multisectoral accountability framework for TB through engaging other sectors to ensure meaningful contribution to the TB response	• **Provide combination prevention, treatment, and support services for PLHIV and those affected by undernutrition, diabetes, smoking and alcohol** • **Increase funding to support collaborative initiatives with key stakeholders** • **Facilitate engagement of other key stakeholders such as departments of labour, education, social services etc.** • **Develop a database of stakeholders and service providers for each facility** • **Support and promote development of contextualised referral pathways for each facility** • **Include TB-prevention (incorporating awareness and advocacy), support or treatment activities in sector specific strategic plans**	• Key and other priority populations for TB • General population • PWUD	NDOH DBE DSD NDOH DBE DSD DCS, CSF, Private Sector, SAPS, DoJ and Correctional services, Mineral resources and energy, GCIS, Department of women, children and persons with disabilities, labour, environment, home affairs, Department of public service and administration, department of finance, public works and infrastructure, COGTA, Human settlement, agriculture, land reform and rural development, DIRCO

OBJECTIVE 2.6: **Strengthen TB-prevention interventions for key and other priority populations and the implementation of airborne infection-prevention and control in health facilities and high-risk indoor places where people congregate** *(cont.)*

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 2.6.5: *Support the development, uptake and scale up of new TB vaccines*	• Advocate for resource mobilisation and allocation of the development of new TB vaccines • Evaluate evidence of new TB vaccines as it becomes available. • Develop a strategy for the roll-out of new TB vaccines	• **Advocate for TB vaccine research funding and for participation in TB vaccine research** • **Support, and resource research for new TB vaccines and work with partners on TB vaccine research** • **Literature review on new TB vaccines as it becomes available** • **Prepare to invest in TB vaccine roll-out and scale up** • **Apply lessons from the COVID-19 vaccination roll-out**	• Key and other priority populations for TB • General population	NDOH DSD DBE Department of Correctional Service NGOs Private healthcare providers Implementing Partners Civil Society Private Sector Researchers Developemnt Partners UN Joint Teams

Table 9

Logical framework **Goal 2:** Maximise equitable and equal access to services and solutions for HIV, TB and STIs

OBJECTIVE 2.7: Strengthen TB diagnosis and support for PWTB, and accelerate the scale-up of innovative processes, diagnostic tools and regimens for the diagnosis, treatment, and care for PWTB

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 2.7.1: *Strengthen TB diagnosis and increase the TB detection rate*	• Strengthen implementation of quality TB systematic screening • Strengthen quality systematic and universal testing for TB, especially in key and other priority populations, to increase early diagnosis of TB, including subclinical/asymptomatic TB and extra-pulmonary TB • Accelerate the scale up of innovative processes such as test and treat and point-of-care testing to strengthen TB diagnosis • Accelerate the scale up of innovative screening and diagnostic tools such as digital chest X-rays and uLAM to increase the TB detection rate • Develop and implement targeted campaigns for TB screening and testing	• **Find, implement and monitor innovative, quality screening processes at clinics and hosptals** • **Provide systematic testing for TB for people at high risk of TB diseases such as PLHIV, contacts, HCWs and other key and priority populations** • **Eliminate barriers to accessing health services, such as stigma and costs** • **Include more than one diagnostic tool for the first test in the TB diagnosis algorithm** • **Increase uptake of molecular WHO-approved rapid diagnostic (mWRD) tools** • **Accelerate the adoption and scale up of point-of-care tests and the test and treat strategy for TB** • **Consider utilising other samples for TB diagnosis, such as stools in children** • **Support research on TB diagnostic tools** • **Evaluate evidence on new innovative diagnostic tools for TB as it becomes available and consider their inclusion in the NTP** • **Update and disseminate guidelines on subclinical TB diagnosis** • **Resource and implement TB screening and testing campaigns targeting key and other priority populations** • **Invest in community-based and community-led campaigns on TB screening and testing**	• Key and other priority populations for TB • All people accessing health services • General population	NDOH DBE DSD DALRRD NHLS/NICD NGOs and CBOs Private healthcare providers Health Insurance Schemes Implementing Partners Civil Society Private Sector Developmet Partners Correctional Service

OBJECTIVE 2.7: **Strengthen TB diagnosis and support for PWTB, and accelerate the scale-up of innovative processes, diagnostic tools and regimens for the diagnosis, treatment, and care for PWTB** *(cont.)*

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 2.7.2: *Strengthen linkage into care for PWTB*	• Strengthen referrals and linkage into care for PWTB • Provide pre-and post-TB testing counselling to support linkage into care for PWTB • Utilise technological tools to support referrals and linkage into care for PWTB	• **Strengthen referrals of PWTB who were recently diagnosed, especially those diagnosed through community campaigns and in hospitals** • **Provide results to people who tested for TB by short text messages from the laboratory** • **Notify all new PWTB diagnosed and started on TB treatment to the NTP** • **Disseminate guidelines on pre- and post-TB testing counselling** • **Invest in capacity building for HCW, including WBOTs and CHCW, to provide pre- and post-TB testing counselling for PWTB** • **Utilise technological tools such as medical health records, laboratory systems and TB reporting programmes to support the referral and linkage into care for PWTB** • **Strengthen existing in-facility processes and collaborate with sub-district/district support mechanisms to track PWTB and bring them back into care**	• People who received a positive TB test and PWTB • All people affected by TB	NDOH DBE DSD DHET DALRRD NGOs and CBOs NHLS Private Laboratories Private healthcare providers Health Insurance Schemes Implementing Partners Correctional Service Private Sector Civil Society Sectors SANAC Development Partners

Table 9

Logical framework **Goal 2:** Maximise equitable and equal access to services and solutions for HIV, TB and STIs

OBJECTIVE 2.7: **Strengthen TB diagnosis and support for PWTB, and accelerate the scale-up of innovative processes, diagnostic tools and regimens for the diagnosis, treatment, and care for PWTB** *(cont.)*

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 2.7.3: *Strengthen access to treatment and care for PWTB*	• Strengthen supply chain management and good medicine/pharmacy stock management of TB treatment medication at health facilities • Accelerate the scale up of shorter TB regimens • Evaluate evidence of new TB treatment regimens as it becomes available, especially for MDR-/XDR-TB • Support research in the development of new effective TB treatment regimens, especially for MDR-/XDR-TB • Provide care after TB disease • Develop guidelines for the treatment of subclinical TB	• **Support the supply chain management for TB treatment medication and ensure availability of all the required medication, including child-friendly formulations for TB treatment at health facilities, especially those providing decentralised MDR-/XDR-TB treatment** • **Fast-track processes to ensure the availability of child-friendly formulations at health facilities as soon as they become available** • **Update and disseminate the TB treatment guidelines to include new shorter TB regimens and train HCWs on new TB treatment regimens** • **Monitor the implementation of new shorter TB regimens, including pharmacovigilance** • **Evaluate the evidence on new TB treatment regimens as it becomes available and consider incorporating the new TB regimens into South African TB treatment guidelines** • **Support the research of new TB treatment regimens, especially formulations for children and MDR-/XDR-TB treatment** • **Provide medical reviews for all PWTB that have completed treatment for one year, at six-monthly intervals** • **Identify PWTB that completed treatment that needs pulmonary rehabilitation and refer accordingly** • **Evaluate evidence as it becomes available on subclinical TB management and develop guidelines on the management of subclinical TB**	• PWTB • People affected by TB	NDOH DHET DBE DSD NGOs and CBOs Private healthcare providers Health Insurance Schemes Implementing Partners Correctional Service Private Sector Civil Society Sectors SANAC Development Partners

OBJECTIVE 2.7: Strengthen TB diagnosis and support for PWTB, and accelerate the scale-up of innovative processes, diagnostic tools and regimens for the diagnosis, treatment, and care for PWTB *(cont.)*

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 2.7.4: *Strengthen support and increase treatment completion for PWTB*	• Provide support, such as adherence counselling and treatment buddy, during and after treatment for PWTB • Provide social and mental health services support during and post-treatment for PWTB, prioritising high-risk individuals and people with MDR-/XDR-TB • Minimise barriers (travel costs, missing work) to access TB treatment and care • Develop and implement track and trace strategies for PWTB that are no longer in care • Adopt and scale up evidence-based digital adherence support technologies for PWTB on treatment	• **Provide adherence counselling as part of the post-test counselling for people newly diagnosed with TB and promote the treatment buddy model for on-going support** • **Provide adherence support for PWTB on treatment through counselling, sending reminders and appointment schedules that are people-centred** • **Provide social support and mental health support during and after treatment for PWTB, prioritising those at high risk of poor adherence and people with MDR-/XDR-TB** • **Establish clear referral pathways for accessing social support and mental health support services** • **Minimise barriers such as travel costs, missing work for PWTB to access TB treatment and care services and families affected by TB experiencing catastrophic costs** • **Develop and implement track and trace strategies for PWTB that are no longer in care** • **Adopt and scale up evidence-based digital adherence support technologies for PWTB on treatment, such as telephonic reminders, text messages and video calls as appropriate**	• PWTB • People affected by TB	NDOH DBE DHET NGOs and CBOs Private healthcare providers Health Insurance Schemes DSD Implementing Partners Correctional Service Private Sector Civil Society Sectors SANAC Development Partners
Subobjective 2.7.5: *Provide advanced quality care for people with severe or complicated TB disease*	• Provide advanced quality care for patients with special needs or complicated TB diseases such as children, MDR-/XDR-TB and extra-pulmonary TB • Provide palliative care for PWTB who need it, including support for their families	• **Provide advanced quality care for patients with special needs or complicated TB disease, such as children, MDR-/XDR-TB and extra-pulmonary TB that might include, and is not limited to, special investigations, different regimens, referrals to various specialists and hospital admis-sion** • **Establish a palliative care pro-gramme for PWTB who need it** • **Enhance partnerships between the hospice and the facilities that provide TB treatment**	• People with TB • People affected by TB	NDOH NGOs and CBOs Private healthcare providers Health Insurance Schemes Implementing Partners Correctional Service Private Sector Civil Society Sectors Development Partners

Table 9

Logical framework **Goal 2:** Maximise equitable and equal access to services and solutions for HIV, TB and STIs

OBJECTIVE 2.8: Increase detection and treatment of four curable STIs through systems strengthening, service integration and diagnostic testing; achieve elimination targets for neonatal syphilis; and scale-up HPV-vaccination and cervical cancer screening

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 2.8.1: *Reduce the annual number of new cases of four curable STIs*	• Scale up STI prevention by providing high-quality health information targeted biomedical prevention options and timely health services • Implement STI diagnostic testing of key/priority populations to detect and treat asymptomatic infections • Optimise STI treatment outcomes by implementing STI diagnostic testing of symptomatic individuals • Develop and implement effective STIs partner notification and treatment strategies	• **Prevent STIs by providing information and education and effective STI prevention tools, e.g., condom distribution and VMMC services** • **Training/Retraining of HCWs including primary healthcare on detection and treatment of STIs, including priority populations** • **Scale up diagnostic STI testing to improve detection, starting with pregnant women, AGYW, sex workers and other priority populations** • **Integration of STI care with primary healthcare, reproductive healthcare and HIV services** • **Improved surveillance of STIs (including *chlamydia* and *gonorrhoeae*, trichomoniasis and syphilis) and antibiotic resistance** • **Establish effective and rapid specialist referral systems with access to advanced diagnostics to manage cases of treatment failure and complicated STIs** • **Implement strategies to strengthen partner notification and contact-tracing, especially for key populations (such as ex-pedited partner therapy)**	• AGYW • Pregnant women • PLHIV • MSM • TG • Sex workers • PrEP-users	NDOH, DBE, DSD, DHET, DoT, CBOs, TVET, NGOs, Private healthcare providers/ sector, Private schools, Health Insurance Schemes, NICD, NHLS, Civil Society Implementing Partners Correctional Service Private Sector Civil Society Sectors Development Partners

OBJECTIVE 2.8: Increase detection and treatment of four curable STIs through systems strengthening, service integration and diagnostic testing; achieve elimination targets for neonatal syphilis; and scale-up HPV-vaccination and cervical cancer screening *(cont.)*

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 2.8.2: *Achieve elimination of neonatal syphilis.*	• Implement syphilis rapid diagnostic testing and same-day treatment of pregnant women during antenatal care. • Provide comprehensive follow-up after treatment, including serological M&E of partner treatment. • Ensure sustained access to BPG for all cases of syphilis and consider alternative treatment options when these become available.	• **Screening of all pregnant women for syphilis at first antenatal care visit** • **Screening for syphilis at birth for all infants born to syphilis-positive or to unbooked or untested women** • **Linking all children diagnosed with congenital syphilis to care and ensuring they receive treatment**	• Pregnant women • Newborns and infants	NDOH, DSD, CBOs, NGOs, Private healthcare providers, Health Insurance Schemes, NICD, NHLS, Private health sector
Subobjective 2.8.3: *Scale up HPV-vaccination and cervical cancer screening*	• Scale up of age-based school HPV-vaccination programme including independent schools and options for out-of-school girls • Expand HPV-vaccination programme to other population groups at high-risk of HPV-associated disease • Transition from high-quality cytology to HPV DNA as primary test for cervical cancer screening • Implement and monitor the cervical cancer care cascade including rapid management of women with high-risk cervical lesions	• **High coverage of full HPV-vaccination of schoolgirls and out-of-school girls** • **Implement awareness-raising for HPV-vaccination and strengthen curriculum in primary and high schools on HPV** • **Encourage HPV-vaccination in key populations** • **Strengthen access to HPV testing and colposcopy services**	**Vaccination:** All girls 10-12 years of age; populations eligible for catch-up vaccination **Cervical cancer screening:** Women 30+, WLHIV 25+	NDoH, DBE, DCS, DSD, DOT, CBOs, NGOs, Retail pharmacies, Private healthcare providers, Health Insurance Schemes

OBJECTIVE 2.9: Reduce viral hepatitis morbidity through scale up of prevention, diagnostic testing, and treatment

	PRIORITY ACTIONS	INITIATIVES/ INTERVENTIONS	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 2.9.1: *Scale up diagnostic testing and treatment of viral hepatitis*	• Scale up HBV birth dose vaccination of newborns • HBV diagnostic testing and vaccination of HCW • Scale up harm-reduction services for PWUD • Implement HBV diagnostic testing and treatment of key populations and pregnant women and scale up testing coverage of PLHIV • Implement targeted HCV diagnostic testing and treatment strategies for key populations	• **Provide Hep B vaccination within 24 hours at all birth facilities as part of existing vaccination schedule** • **Offer all HCWs Hep B vaccination at public and private health facilities** • **Provide needle exchange programmes, OST and Hep C education** • **Prevention of hepatitis B vertical transmission and provide TDF prophylaxis for highly viraemic pregnant**	• Pregnant women • New-borns • HCW • People with HIV, PWID	NDoH, DCS, DSD, NGOs, Private healthcare providers, Private schools, Health Insurance Schemes, NICD, NHLS, Civil Society, Private Sector, Implementing Partners

Table 10

Logical framework **Goal 3:** Build resilient systems for HIV, TB and STIs that are integrated into systems for health, social protection, and pandemic response.

OBJECTIVE 3.1: Engage adequate human resources to ensure equitable access and leave nobody behind

	PRIORITY ACTIONS	APPROACHES	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 3.1.1: *Deploy adequately-trained workforce in prevention, treatment and care programmes for HIV, TB and STIs*	• Expand the number of inter-professional workers by training more cadres • Allocate adequate financial resources for various cadres of the HIV, TB and STI responses	• Ensure that human resources required are sufficient in number where they are needed	• Medical practitioners • Professional nurses • Lay counsellors • WBOTs • Peer-educators • Community representatives • Social service practitioners • Laboratory personnel	NDoH DSD DBE DPSA Private Sector
Subobjective 3.1.2: *Capacitate and facilitate ongoing professional development, training and mentoring of different categories of staff to address skills and knowledge gaps*	• Train interprofessional workers in the field in new policies and guidelines, integrated services, task-shifting approaches and contact-tracing • Train and capacitate community workers on HIV, TB, STIs, viral hepatitis and mental health prevention, treatment, and care services • Train, sensitise and capacitate workers in their diversity on the specific needs of key and other priority populations	• Ensure that there are appropriately-trained human resources where they are needed and deployed	• Medical practitioners • Professional nurses • Lay counsellors • WBOTs • Peer-navigators • Community representatives • Social service practitioners • Laboratory personnel	NDoH DSD DPSA Private Sector
Subobjective 3.1.3: *Fast-track wellness and psychosocial support programmes in workplaces*	• Establish an appropriate and supportive organisational structure for wellness management • Provide wellness management resources and facilities	• Promote and protect the health and wellbeing of human resource structures	• Medical practitioners • Professional nurses • Lay counsellors • Ward-based outreach teams • Peer-navigators Community reps • Social service practitioners • Laboratory personnel	DPSA NDoH DSD DBE DHET Other Government Departments Private Sector
Subobjective 3.1.4: *Revise and revitalise evidence-based methods to estimate the workforce needed for service provision, implementation and emergency responses to disasters for pandemics for HIV, TB and STIs*	• Advocate for the needs-based approach in calculating workforce needed	• Equitably distribute HWs across the provincial and public-private divides based on the principles of UHC as one of the key lessons South Africa has learnt from its fight against COVID-19	• Medical practitioners • Professional nurses • Lay counsellors • Ward-based outreach teams • Peer-navigators Community reps • Social workers • Laboratory personnel	NDoH DSD DPSA Private Sector

OBJECTIVE 3.2: Use timely and relevant strategic information for data-driven decision-making

	PRIORITY ACTIONS	OUTPUTS	ACCOUNTABLE PARTNERS
Subobjective 3.2.1: *Build a national framework and scorecard (specifying processes, data sources, human resources, stakeholders, and other items) for the NSP strategic information*	• Develop and implement a detailed SI framework for the NSP, including a data quality improvement strategy • Develop and implement a simple scorecard for the framework	• Availability of high-quality data for tracking all NSP indicators, allowing for relevant disaggregation • Well-resourced and costed M&E Plan • Promptly released and actionable SI products	SANAC NDOH DBE DSD NHLS/NICD Private Sector Implementing Partners Development Partners Civil Society Forum
Subobjective 3.2.2: *Enhance integration of data systems, including data-sharing between sectors for a more coordinated response*	• Implement interoperability of data system • Enhance the role of SANAC's Situation Room in the NSP • Strengthen data-sharing between sectors	• Coherent and harmonised country data system • Increased awareness and use of the Situation Room for decision-making by stakeholders across all sectors • A framework for data-sharing between the public and private sector and the community	SANAC NDOH NHLS/NICD DPME Other government departments Private Sector Civil Society Forum Implementing Partners Development Partners
Subobjective 3.2.3: *Strengthen and expand surveillance structures for STIs and viral hepatitis*	• Strengthen and expand routine surveillance of STIs and viral hepatitis	• Increased number of STIs sentinel surveillance sites • STIs module added to TIER.Net • Representative population-based survey estimates of STIs burden	SANAC NDOH NICD/NHLS Private Sector
Subobjective 3.2.4: *Implement rapid data analysis of routine HIV, TB and STI data at national and local-levels for more effective action*	• Allocate data analysts for routine data analysis at national and local-levels • Capacitate local staff to use data for action • Support community-led monitoring	• Analytical capacity at national and local-levels • Actionable monthly SI reports at national and local-levels • Release of public-facing data • Feedback channels for SI	SANAC NDOH NHLS/NICD Partners

OBJECTIVE 3.3: Expand the research agenda for HIV, TB and STIs to strengthen the national response

	PRIORITY ACTIONS	OUTPUTS	ACCOUNTABLE PARTNERS
Subobjective 3.3.1: *Strengthen research for the NSP and invest in South Africa-initiated research while supporting collaboration with international counterparts*	• Conduct surveys for the timely evaluations of the NSP interventions • Accelerate NSP-related research, including operations and translational research • Adopt a model for funding South Africa-initiated research	• **Timely evaluations of the NSP interventions** • **A curated database of priority NSP research questions** • **Capacity building on evidence-based practice** • **Model for funding South Africa-initiated research**	SANAC NDOH Universities and research organ-isations (NRF, HSRC, CSIR, NRF)

OBJECTIVE 3.4: Harness technology and innovation to fight the epidemics with the latest available tools

	PRIORITY ACTIONS	APPROACHES	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 3.4.1: *Harness technology and innovation to fight epidemics with the latest available tools*	• Accelerate technology skills transfer • Accelerate the scale-up of innovative diagnostic tools	• **Expand the use of scientific knowledge in support of innovation**	• Researchers • Technicians	DSIT DHE NICD NHLS Research institutions
Subobjective 3.4.2 *Increase investment in knowledge production and technology outputs from South African institutions to generate more home-grown solutions in response to HIV, TB and STIs*	• Accelerate the use of safe and effective generics • Accelerate market entry of domestic products • Foster competition to ensure the continued affordability of biomedical commodities including vaccines • Accelerate the use of safe and effective generics • Accelerate market entry of domestic products • Foster competition to ensure the continued affordability of biomedical commodities, including vaccines • Establish an integrated digital health ecosystem of people, processes and technology that supports the strengthening of health systems to enable efficient service-delivery and effective patient care • Strengthen telehealth and facilitate adoption and use of eHealth and mHealth in prevention, treatment and care services • Employ digital tools in diagnostics, data-collection and analytics	• **Efficiently deliver effective medicines** • **Ensure that digital health technologies and innovations advance the right to health and access to services**	• General population • Medical practitioners • Key and other priority populations	NDOH Private Sector Medical Schemes DSIT DHET NICD NHLS Private Laboratories
Establish an integrated digital health ecosystem of people, processes and technology that support health systems strengthening to enable efficient service-delivery and effective patient care	• Strengthen telehealth and facilitate adoption and use of eHealth and Health in the prevention, treatment and care services • Employ digital tools in diagnostics, data-collection and analytics	• Ensure that digital health technologies and innovations advance the right to health and access to services	• General population • Medical practitioners • IT specialists • Key and priority populations	DSIT DHET Private Sector SANAC Development Partners

OBJECTIVE 3.5: Leverage the infrastructure of HIV, TB & STIs for broader preparedness and response to pandemics and various emergencies

	PRIORITY ACTIONS	APPROACHES	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 3.5.1: *Apply lessons learnt from the response to HIV, TB and STIs to support emerging pandemics and other health and development threats*	• Collaboration between foundations, NGOs and research centres should be entry points in disseminating best practices • Adoption of existing epidemiological modelling systems to support the response • Multi-sectoral and multi-dimensional global and local mobilisation uniting and synergising a response towards eradicating the epidemics • Community-based care delivery infrastructure • Training of a diverse health workforce able to handle diverse conditions, including infectious diseases	• **Adapt to changing epidemic patterns and rapidly deploy innovations learnt from the care and management of HIV, TB and STIs** • **Leverage the infrastructure employed for HIV, TB and STIs to manage future pandemics**	• General population	DHE DSIT NDoH Private Sector Health Insurance Companies
Subobjective 3.5.2: *Scale-up effective COVID-19 adaptations for responses to HIV, TB and STIs responses and other future emergencies*	• Maintenance of a robust surveillance system • Decentralisation of services to local-level • Evidenced-based decision-making process • Swift application of technology and innovation • Strengthening of private-public partnerships • Enhancement of community engagement • Capacity building • Contact-tracing strategies	• **Lessons learnt during COVID-19 must be leveraged to improve the public health response to HIV, TB and STIs and other future emergencies**	• General population	Government Departments Private Sector
Subobjective 3.5.3: *Support integration and linkages and formalise clear referral pathways for management of communicable, non-communicable and OIs for people with HIV, TB and STIs*	• Reduce loss to follow up across the cascades of care • Expand community-based referrals for comprehensive health and social services • Offer flexible service hours convenient to patients • Expand the range of services, medication and self-care options available at pick-up points	• **Integration for a multi-sectoral response to the three epidemics**	• Medical practitioners • Professional nurses • Lay counsellors • Ward-based outreach teams • Peer-navigators • Community reps • Social workers • Laboratory personnel	NDoH Health Insurance Schemes Medical Aid Schemes
Subobjective 3.5.4: *Engage a range of actors working on HIV, TB, STIs, mental health, hepatitis, cervical cancer, COVID-19, human rights, social justice and other sectors, and identify opportunities for collaboration*	• Develop multi-sectoral strategies for prevention, treatment and care programmes • Strengthen private-public partnerships • Collaborate at international, transnational, regional, national, and local-levels	• **Integration for a multi-sectoral response to the three epidemics**	• General population	Donor Agencies NGOs Civil Society NDoH

OBJECTIVE 3.6: Build a stronger public health supply chain management

	PRIORITY ACTIONS	APPROACHES	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 3.6.1: *Ensure adequate availability of quality HIV, TB and STI commodities and supplies that include both prevention and therapeutic interventions*	• Review and monitor supplies of the essential medication for HIV, TB and STI prevention and treatment, and other commodities required to provide quality care • Train staff on supply chain management principles, such as minimum-levels and lead time for ordering • Ensure that all supplies at facilities and community service points are stored under appropriate conditions • Curtail import taxes for internationally acquired medicines • Limit taxes and regulate supply chain distribution markups • Price regulation to ensure sustainable margins for commercial suppliers	• **Enhance access to quality healthcare** • **Prevent medication and supplies stock-outs**	• PLHIV • PWTB • STI-infected people • Contacts	NDoH Pharmaceutical Companies Civil Society Private Sector Development Partners Other Govermnet Departments
Subobjective 3.6.2: *Continued efforts to work towards optimising access at the lowest possible prices to drugs that people with HIV, TB or STIs need*	• Adjust structural and policy factors that influence drug-pricing • Curtail distribution markups to lower prices • Foster continued innovation in drug development • Promote widespread use of generics	• **Expand access to preventive and therapeutic biomedical commodities for HIV, TN and STIs**	• PLHIV • PWTB • STI-infected people • Contacts	Civil Society NDoH Pharmaceutical Companies Private Sector

OBJECTIVE 3.7: Strengthen access to comprehensive laboratory testing for HIV, TB and STIs including molecular diagnostics, serology, and culture

	PRIORITY ACTIONS	APPROACHES	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 3.7.1: *Ensure access to comprehensive laboratory testing for HIV, TB and STIs including molecular diagnostics, serology, and culture*	• Provide support for laboratory training • Expedite development of laboratory information systems • Strengthen access to comprehensive laboratory testing for HIV, TB and STIs including molecular diagnostics, serology, and culture • Ensure quality systems for instrument verification and external quality assessment	• Ensure adequate and appropriate diagnostic and surveillance aids to prevent, treat and prevent complications	• PLHIV • PWTB • STI-infected people • Contacts	NDOH DSIT NHLS/NICD Private Laboratories Development Partners
Subobjective 3.7.2: *Improve facility- and laboratory-based surveillance activities to monitor effective prevention and treatment modalities of HIV, TB and STIs*	• Ensure access to HIV-testing, including self-testing • Ensure accessibility to viral load and resistance testing in the care of PLHIV • Monitoring of genotypes and the dynamics of transmission in TB infection • Enhanced programmes to routinely collect and analyse local STI surveillance data • Ensure access to HBV DNA quantification to identify highly-viraemic pregnant women, guide initiation of TDF and monitoring of HBV-infected individuals on TDF	• Track magnitude and dynamics of the epidemics	• PLHIV • PWTB • STI-infected people • Contacts of cases of TB and STIs	NDOH NHLS/NICD Private Laboratories Implementing Partners
Subobjective 3.7.3: *Increase and enhance access to self-screening and testing modalities for HIV, TB and STIs*	• Regulate sale, distribution, advertisement, and use of quality-assured self-testing modalities • Employ means of confirming an individual's positive test result • Linkage to counselling and care services for individuals with positive results that used a self-test kit	• Close testing and treatment gaps	• General • Key and other priority populations	NDOH DSIT Implementing Partners

OBJECTIVE 3.8: Objective 3.8 Support acceleration of the approval of new health products

	PRIORITY ACTIONS	APPROACHES	POPULATIONS	ACCOUNTABLE PARTNERS
Subobjective 3.8.1: *Support efforts to overcome regulatory barriers that delay market entry of new biomedical technologies, including medicines*	• Dedicated pathways to review different applications • Additional facilitated pathways for urgent applications • Set review timelines	• Accelerate market entry of new health technologies	• General • Key and other priority populations	NDOH SAHPRA Private Sector Pharmaceutical Companies Health Insurance Schemes
Subobjective 3.8.2: *Employ new guidelines and policies to enhance quick and easy access to new biomedical commodities*	• Accelerated approvals for applications addressing unmet needs • Support prioritisation of applications for medicines serving the therapeutic areas that address the highest public health need in South Africa	• Enforce timely access of safe, quality, and effective medicines to patients	• General • Key and other priority populations	NDOH SAHPRA Private Sector Pharmaceutical Companies Health Insurance Schemes

Table 11

Logical framework **Goal 4:** Fully resource and sustain an efficient NSP-led by revitalised, inclusive and accountable institutions

OBJECTIVE 4.1: Sufficient domestic and external funds are mobilised and allocated to facilitate the efficient implementation and coordination of HIV, TB and STI programmes and address the underlying-associated risk factors that have direct consequences for these conditions.

	PRIORITY ACTIONS	OUTPUTS	ACCOUNTABLE PARTNERS
Subobjective 4.1.1: *Secure adequate and predictable funding for efficient response from public, private and external funding sources*	• Coordinate sufficient and complimentary investments from government departments, development partners and the private sector, guided by a national resource mobilisation strategy	• **National resource mobilisation strategy**	National RMC, HFES TWG, SANAC, National Treasury, CSF, Private Sector, Development Partners
	• Protect and raise public allocations for HIV, TB and STIs in the MTEF, using costing and expenditure data, evidence-based advocacy, investment cases, budget impact assessments, budget bids, and budget reprioritisation exercises	• **Increase in domestic allocations greater than 20% of baseline in real terms**	NDOH All implementing departments. National RMC, HFES TWG
	• Create more budget space for HIV and TB priorities by systematically pursuing activities at national and provincial-levels that result in efficiency savings that can be re-invested in under-resourced priority areas	• **Efficiency saving monitoring report**	NDOH All implementing departments. National RMC, HFES TWG
	• Raise additional funds for HIV and TB through innovative financing mechanisms, including blended finance structures, outcomes-based contracting and public-private partnerships. Build on the progress and learnings from the Imagine SIB for adolescent learners	• **Funding from innovative sources doubles from baseline**	National Treasury, SAMRC, Main implementing departments, Private Sector, Development Partners
	• Innovative funding platforms created during the COVID-19 pandemic period should be adapted to provide additional, complementary funding for HIV, STI and TB interventions	• **New source of funding or co-funding agreement or public/private pooling mechanism in place**	SANAC, NT, NDOH, DBE, DSD
	• Primary health financing mechanisms for HIV and TB, such as conditional grants and off-budget bilateral grants should be reviewed and refined to coordinate and to better integrate investments from different domestic and external sources	• **National resource mobilisation strategy** **Monitoring report on coordinated and harmonised financing**	National RMC, HFES TWG, SANAC, National Treasury, Development Partners

	PRIORITY ACTIONS	OUTPUTS	ACCOUNTABLE PARTNERS
Subobjective 4.1.2: Evidence-based prioritisation ensures that the right mix of interventions is implemented in the right places, with precision to maximise impact	• Support the continued application of disease transmission, cost and impact-assessment models to guide more precise programming, optimisation and budget planning (using models such as Thembisa Optimise) and the wider application of models to the provincial-level	• **Annual outputs from HIV response and optimisation modelling for HIV, TB and STIs**	NDOH National RMC, HFES TWG, SANAC Secretariat
	• Under the guidance of the health financing, economics and sustainability TWG, undertake cost analyses and economic evaluations to drive value for money in HIV and TB programmes and inform the transition of effective service-delivery models from vertical programmes to efficient, integrated district programmes	• **Active HFES TWG** • **Annual VfM research agenda**	National RMC, HFES TWG, SANAC Secretariat
Subobjective 4.1.3: Health financing and financial management systems and capacities are optimised to support sustainable financing, budget monitoring, and accountability	• Revitalise health economics and resource mobilisation structures to improve the use of economic data and evidence for resource mobilisation, planning and decision-making	• **Active National and Provincial Resource Mobilisation Committees** • **Bi-annual RMC - TWG engagements**	National RMC, Provincial PCAs, HFES TWG, SANAC Secretariat
	• Strengthen government financial information systems and integration with programme, procurement and human resource information systems to generate routine data for management decision-making and accountability monitoring. This should include a repository for publicly available in-country input costs and unit costs	• **Reporting solution for integration of DHIS2 and BAS data for management and accountability** • **NSP unit cost repository, updated annually**	National RMC, HFES TWG, SANAC Secretariat, National Treasury
	• Tracking and reporting of all HIV, TB and STI budgets and expenditures should be strengthened through a centrally coordinated exercise that achieves simplification, harmonisation, and routinisation of reporting	• **Bi-annual NASA and TB spending assessments** • **Annual Resource Mapping Report** • **Routine, automated DOH spending reports on HIV and TB sub-programmes**	National RMC, National Treasury, Provincial PCA Secretariat, HFES TWG, SANAC Secretariat and main implementing departments

OBJECTIVE 4.2: Sustainability and transition plans and actions are routinely developed and implemented to ensure that NSP interventions remain on track to achieve short-, medium- and long-term goals.

	PRIORITY ACTIONS	OUTPUTS	ACCOUNTABLE PARTNERS
Subobjective 4.2.1: *Proactive multi-sectoral sustainability and transition planning lead to an integrated domestic response that is resilient to external shocks*	• Resource and empower relevant entities to lead sustainability planning and management at national and provincial-levels, including SANAC and PCA secretariats and TWGs, and through the creation of specific job descriptions and accountability mechanisms under the guidance of the National Sustainability Framework for HIV/AIDS and TB	• **SANAC Secretariat Sustainability Manager** • **Provincial PCA sustainability KPIs**	SANAC Secretariat, PCA Secretariats Private Sector Civil Society SAG
	• Undertake regular sustainability assessments and transition planning exercises for priority subprogrammes and systems at national and provincial-levels using available tools such as sustainability scorecards, sustainability dashboards, and the provincial sustainability roadmaps, under the auspices of a nationally coordinated sustainability planning agenda	• **Transition plans for 2 donor-reliant sub-programmes** • **Annual sustainability assessments and scorecards for selected subprogrammes and provinces**	SANAC Secretariat, PCA Secretariats, relevant departments, HFES TWG, subprogramme multi-sector co-ordination structures
	• Develop appropriate sustainability indicators for integration and incorporate them into the NSP accountability framework, as well as sector-strategic and annual plans. Track progress through SANAC/PCA reporting mechanisms and support to community-led monitoring	• **Performance reporting for at least 4 core sustainability KPIs at national and provincial-level**	SANAC Secretariat, PCA Secretariats, relevant departments, HFES TWG
	• Scale-up and strengthen social contracting mechanisms and co-financing of sustainable delivery of services through civil society, communities, and key and vulnerable populations	• **Social contracting guideline for provinces** • **Cost-effective public sector social contracting model for KP combination prevention**	SANAC Secretariat, PCA Secretariats, National Treasury, relevant departments, HFES TWG
	• Undertake long-term planning and sustainable financing pathways for CHW programming, especially for services that rely heavily on development partners	• **Transition plan for donor funded CHWs**	NDOH, Provincial DOHs, SANAC Secretariat, Development Partners

OBJECTIVE 4.3: Reset and reposition SANAC, all AIDS Councils and civil society organisations for an optimal, efficient and impactful NSP 2023-28 execution experience.

	INTERVENTIONS	APPROACHES	ACCOUNTABLE PARTNERS
Subobjective 4.3.1: *Build execution capability of existing AIDS Council structures while accelerating the establishment of new ones across the board*	Identify inherent institutional capacity gaps at all AIDS Councils	**Conduct independently-led institutional capacity audits at all AIDS Councils**	Office of the Premiers SANAC AIDS Councils
	Roll-out focused capacity building programmes targeting all levels of AIDS Councils' leadership	**Provisioning of governance and leadership training and mentoring support**	Office of the Premiers SANAC AIDS Councils
	Enhance the operating and financial leverage of AIDS Councils	**Unlock co-funding opportunities through public-private partnerships and provisioning of donor linkage support**	Office of the Premiers SANAC AIDS Councils
	Promote best practices in response governance and leadership	**Facilitate benchmarking-related exchange visits for all provincial AIDS Councils**	Office of the Premiers SANAC AIDS Councils
	Achieve greater localisation and decentralisation of response, support and coordination	**Ramp-up efforts to establish, formalise and institutionalise new AIDS Councils**	Office of the Premiers SANAC AIDS Councils
Subobjective 4.3.2: *Drive a multi-stakeholder-driven response operation*	Periodically gauge the level of stakeholder satisfaction in the manner in which the NSP is implemented	**Conduct nation-wide stakeholder perception and satisfaction surveys**	AIDS Councils and SANAC
Subobjective 4.3.3: *Foster the greater participation of the private sector and civil society in the affairs and operations of all AIDS Councils*	Placing the private sector, labour and civil society at the centre of the response	**Mainstreaming representatives of the private sector, labour and civil society into key decision-making structures of AIDS Councils**	SANAC AIDS Councils Premiers, Mayors DPME Office of the Presidency

OBJECTIVE 4.3: (continued)	Interventions	Approaches	ACCOUNTABLE PARTNERS
Subobjective 4.3.4: *Ensure this NSP is an integral and central part of the planning and budgeting culture of all state organs*	• Reform the performance-management system governing ministers, premiers, mayors, and mayoral committee members	**Ensure HIV, TB and STI response forms an integral mainstay of performance appraisal scorecards of all ministers, premiers, mayors and mayoral committee members, directors-general, heads of department and municipal managers**	Office of the Presidency Premiers Mayors DPME SANAC
	• Lobby for resetting organisational structures of district and local municipalities to ensure they are response-compliant	**Ensure establishment of fully-fledged HIV, TB and STI desks within district and local municipalities**	Office of the Presidency Premiers Mayors DPME SANAC
	• Mainstreaming the response into the planning culture of all spheres of government	**Ensure HIV, TB and STI response form the backbone of 5-year plans, annual performance plans and annual operational plans of all spheres of government**	Office of the Presidency Premiers Mayors DPME SANAC SAG
	• Mainstreaming the response into the budgeting culture of all spheres of government	**Ensuring all spheres of government allocate a dedicated budget towards the HIV, TB and STI response**	Office of the Presidency Premiers Mayors DPME SANAC SAG
	• Ensure the affairs and operations of SANAC and AIDS Councils are governed by an Act of parliament	**Lobbying and advocating for the promulgation of the SANAC and AIDS Councils Act to give their operations legal effect**	Office of the Presidency Office of the Speaker of Parliament SANAC
	• Strengthen the accountability climate of the response	**Review and reset existing accountability framework to enhance its responsiveness and agility**	AIDS Councils Premiers Mayors DPME Office of the Presidency

OBJECTIVE 4.4: Optimisation of synergies through forging mutually rewarding partnerships and alliances across the entire response value chain.

	PRIORITY ACTIONS	OUTPUTS	ACCOUNTABLE PARTNERS
Subobjective 4.4.1: *Rally key multi-sectoral partners behind a single and integrated response strategy and vision*	• Deepen regional collaboration and cooperation by implementing applicable SADC protocols on HIV, TB and STIs	• **Sign, revive and jointly implement cooperation agreements with neighbouring countries to harmonise cross-border-related responses**	All spheres of AIDS Councils, Office of the Presidency, DPME, SAG, Private Sector
	• Amplify the South African Government's voice regarding HIV, TB and STI issues on regional and international platforms	• **Participate at high-level international conferences on HIV, TB and STIs**	SANAC, Office of the Presidency, Private Sector, Civil Society Forum
	• Build a community-wide alliance and guiding coalition against the epidemics	• **Place HIV, TB and STI response at the apex of NEDLAC's business risk agenda**	NEDLAC, SANAC, DPME, Trade Unions and Organised Business
	• Ensure continuous and proactive engagement with Civil Society	• **Organise dialogue sessions with Civil Society Forum**	Civil Society Forum
	• Forum to discuss matters of mutual interests and concerns		AIDS Councils SANAC Private Sector


PREVENT HIV
PREVENT TB
GET TESTED
NO VIOLENCE
OUR ACTIONS COUNT
SOUTH AFRICAN NATIONAL AIDS COUNCIL

Monitoring and Evaluation Framework for the NSP Goals

Appendix C

Appendix C

Goal 1: Break down barriers to achieving outcomes for HIV, TB and STIs

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
Objective 1.1: Strengthen community-led HIV, TB and STI responses												
1) The number of beneficiaries accessing PSS services	Output	Count: number of beneficiaries accessing PSS services through the DSD	Geographical area, sex, disability	DSD	555374 (2021/22)	610,911	672,003	739,203	813,123	894,435	Annual	DSD
Objective 1.2: Contribute to poverty reduction through creation of sustainable economic opportunities witha focus on key and priority populations												
2) Number of township and rural enterprises provided with financial and non-financial support	Output	Count: Number of township and rural enterprises that received financial and non-financial support from the Department of Small Business Development	Type of support: (financial and non-financial), geographical area, groups (women, youth and persons with disabilities)	Department of Small Business Development Annual Report	7038 (2021/22)	20,000	20,000	20,000	20,000	20,000	Annual	DSBD
3) Unemployment rate	Outcome	Uses the official definition of unemployment among 15-64 year olds as defined by Statistics South Africa	Geography, age, sex	Statistics South Africa Quarterly Labour Force Survey	34.3 (2021)	TBD	TBD	TBD	TBD	TBD	Annual	SANAC, Statistics South Africa
4) Number of beneficiaries receiving social grants	Output	Count: Number of beneficiaries receiving social grants.	Geographic area, type of grant, disability	SASSA annual report	11,478,760 (2021/22)	11,942,502	12,181,352	12,424,979	12,673,479	12,926,948	Annual	DSD

Objective 1.2: Contribute to poverty reduction through creation of sustainable economic opportunities with a focus on key and priority populations *(cont.)*												
Indicator	**Type**	**Calculation**	**Disaggregation**	**Data source**	**Baseline value**	**Target**					**Reporting frequency**	**Responsibility**
						2023/24	**2024/25**	**2025/26**	**2026/27**	**2027/28**		
5) The number of people accessing food through DSD programmes	Output	Count: Cumulated over a five-year period	Geography, programme (drop-in Centres, Community Nutritional Centres, Home and Community-Based organisations)	DSD Annual Report	790056 (2021/22)	790,056	869,062	955,968	1,051,565	1,156,721	Annual	DSD
6) The number of vulnerable children aged 0-18 years served through Risiha Programme	Output	Count: Number of children accessing services through drop-in centres	Geographical area, sex	Risiha reporting template and DSD provincial reports	TBD (2021/22)	10% increase from prior year	10% increase from prior year	10% increase from prior year	10% increase from prior year	10% increase from prior year	Annual	DSD
Objective 1.3: Reduce stigma and discrimination to advance access to rights and services												
7) 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, age, sex, TB, HIV status, disability	HSRC Survey	84.5% (2017)		90%			95%	Every 5 years	SANAC
8) 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 in the past 12 months. Denominator: Total number of respondents.	Geographic area, type of stigma, age, sex key population, disability	Stigma Index Survey	External Stigma - 15.4% Internalised Stigma - 40.9% TB-related Stigma - 46.1% (2021)		External Stigma <10% Internalised Stigma - 20% TB-related Stigma - 20%			External Stigma <10% Internalised Stigma - <10% TB-related Stigma - <10%	Every 3 years	SANAC

Appendix C

Goal 1: Break down barriers to achieving outcomes for HIV, TB and STIs

Objective 1.3: Reduce stigma and discrimination to advance access to rights and services *(cont.)*

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
9) ***Percentage of people living with HIV who report experiences of HIV-related discrimination in healthcare settings***	Outcome	Numerator: Number of people living with HIV who report healthcare-related stigma in the past 12 months. Denominator: Total number of respondents.	Geographic area, type of stigma, age, sex key population, disability	Stigma Index, SANAC	5.4% (2021)		< 10%			< 10%	Every 3 years	SANAC

Objective 1.4: Address gender inequalities that increase vulnerabilities through gender-transformative approaches												
Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
10) Proportion of ever-married or partnered girls or women aged 15 to 49 years who experienced physical or sexual violence from a male intimate partner in the past twelve months	Outcome	Numerator: Number of women 15-49 years old who have or have ever had an intimate partner and report experiencing physical or sexual violence from at least one of these partners in the past 12 months. Denominator: Total number of women 15-49 years old surveyed who currently have or have had an intimate partner	Geographic area, type of stigma, age, sex, disability	HSRC Survey	29.1% (2017)	20%				< 10%	Every 5 years	SANAC
11) Number of victims of GBVF and crime who accessed sheltering services	Output	Count: Number of GBVF victims supported with shelter services	Province, sex	EQPR	5309 (2021/22)	10% increase from prior year	10% increase from prior year	10% increase from prior year	10% increase from prior year	10% increase from prior year	Annual	DSD

Goal 1: Break down barriers to achieving outcomes for HIV, TB and STIs

Objective 1.4: Address gender inequalities that increase vulnerabilities through gender-transformative approaches *(cont.)*

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
13) Percentage of men who reported perpetrating physical violence against an intimate partner in the past 12 months	Outcome	Numerator: Number of male respondents responding positively to question of perpetrating physical or sexual violence against an intimate partner in the past twelve months. Denominator: Total number of respondents who responded to the question	Geographic area, type of stigma, age, sex, disability	HSRC survey	TBD (2017)					TBD	Every 5 years	SANAC
14) Percentage of female and male adolescents who experienced bullying during the past 12 months	Outcome	Numerator: Number of female and male adolescents who have experienced bullying in the past twelve months. Denominator: Total number of learners in school	Geographic area, age, grade, sex, disability	General household survey	0.015 (2019)	1.30%	1%	0.90%	0.70%	0.50%		DBE

Objective 1.6: Protect and promote human rights and advance access to justice												
Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
15) ***Percentage of health care providers trained on medical ethics and Human rights***	Output	Numerator: number of health care providers (nurses) trained on medical ethics and human rights. Denominator: number of nursing professionals in SA (registered, enrolled and auxiliaries)	Geographical, sex	NDOH	2% (2021)	TBD	TBD	TBD	TBD	TBD	Annual	NDOH
16) ***Percentage of people living with HIV who know of laws in South Africa to protect people living with HIV from discrimination***	Outcome	Numerator: Percentage of people living with HIV who know any laws in South Africa to protect people living with HIV from discrimination. Denominator: number of people living with HIV who responded to the question.	Geographical, age, sex, key pops, people living with disabilities	Stigma Index Survey	54% (2021)	60%	65%	70%	80%	90%	Every 3 years	SANAC

Goal 1: Break down barriers to achieving outcomes for HIV, TB and STIs

Objective 1.6: Protect and promote human rights and advance access to justice *(cont.)*

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
17) Percentage of people living with HIV reporting their rights were violated who sought legal redress	Outcome	Numerator: number of people living with HIV who reported their rights were violated who sought legal redress. Denominator: number of people living with HIV reporting their rights were violated in the last 12 months.	Geographical, age, sex, key pops, people living with disabilities	Stigma Index Survey	8% (2021)	10%	20%	30%	40%	50%	Every 3 years	SANAC

Objective 1.7: Integrate and standardise delivery and access to routine mental health services

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
18) PHC client treated for mental disorders	Output	Count: Number of clients treated for mental health disorders.	Geographical, age, sex.	DHIS	69139 (2021/22)	89,881	116,845	151898.383	197,468	256,708	Annual	NDOH

Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs

HIV-prevention and Harm-reduction

Impact indicators

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
1) Number of new HIV infections	Impact	Modelled	Sex, Age (< 15, 15-25, 25-49 years)	Thembisa model	198,311 (2021)	172,578	147,030	128,401	104,627	81,467	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	0.91% (2021/22)					0.46%	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	Thembisa Model	2.9% (2022)	2.7%	2.4%	2.1%	1.8%	1.4%	Annual	NDOH

Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs

Impact indicators *(cont.)*

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
4) HIV prevalence among specific key populations	Impact	Numerator: Number of specific key populations who test positive for HIV Denominator: Total number of specific key populations tested for HIV	Geographic area, sex, age, SW, MSM, PWID, People with disabilities, Inmates	IBBS surveys Thembisa Model	FSW - 57.9%, 2022 (Thembisa 4.5) MSM - 29.9%, 2022 (Thembisa 4.5) PWID - 21%, 2017 (TripVal Study) TG - 51.9%, 2021 (Botshelo Ba Trans Study) Inmates - 17.5%, 2020 (DCS annual report, 2021)		FSW - 54.3% MSM - 28.4% PWID - 18% TG - 49% Inmates - 17.5%			FSW - 48.5% MSM - 26.1% PWID - 16% TG - 45% Inmates - 17.5%	Every 3 - 5 years	SANAC

Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs

OBJECTIVE 2.1: Increase knowledge, attitudes and behaviours that promote HIV-prevention

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
5) 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	Output	Numerator: Number of respondents who gave the correct answer to all five questions	Geographical, age, sex.	HSRC Survey	36.1% (2017)	50%	60%	70%	80%	90%	Every 5 years	SANAC
6) Delivery in 10 to 19 years in facility rate	Output	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	14.3% (2020/21)	14.3%	13.3%	12.3%	11.3%	10.3%	Annual	NDOH
7) Number of learners reached through combination prevention interventions	Output	Numerator: Number of learners reached through functional adolescents and young people (AYP) education programmes Denominator: N/A	Geographic area, age	DBE Provincial reports	230,515 (2021/22)	TBD	TBD	TBD	TBD	TBD	Annual	DBE

Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs

OBJECTIVE 2.1: Increase knowledge, attitudes and behaviours that promote HIV-prevention *(cont.)*

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
8) Percentage of schools that are providing age-appropriate comprehensive sexuality education (CSE) through life skills and orientation	Output	Numerator: Number of schools that are providing CSE Denominator: Number of selected schools	Geographic area, age	DBE Provincial reports	12% (2021/22)	22%	42%	62%	82%	90%	Annual	DEB
9) 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 to the question	Geographic area, sex, age, disability	HSRC survey	10.6% (2017)	<10% years			<5%		Every 5 years	SANAC
10) Number of beneficiaries receiving DSD Social Behaviour Change programmes	Output	Numerator: Number of beneficiaries receiving SBC programmes. Denominator: N/A	Geographic area, Sex, Age, type of programme	DSD Annual Report	603,947 (2021/22)	664,342	730,776	803,853	884,239	972,663	Annual	DSD

Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs

Objective 2.2: Reduce new HIV infections by optimising implementation of high-impact HIV-prevention interventions

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
11) 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, disability	HSRC Survey	38.9% (2017)	50% years	SANAC			90%	Every 5 years	SANAC
12) Number of male condoms distributed	Output	Numerator: Male condoms distributed Denominator: N/A	Geographic area, Sex, Age (15+) --- These sex and age disaggregation?	NDOH Annual report	544,534,154 (2021/22)	700,000,000	700,000,000	700,000,000	700,000,000	700,000,000	Annual	NDOH, DCS, SAPS, DHET/ HEAIDS, DPSA, SABCOHA
13) Number of female condoms distributed	Output	Numerator: Female condoms distributed Denominator: N/A	Geographic area, Sex, Age (15+)	NDOH Annual report	17,487,505 (2021/22)	25,000,000	25,000,000	25,000,000	25,000,000	25,000,000	Annual	NDOH, DCS, SAPS, DHET/ HEAIDS, DPSA, SABCOHA

Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs

Objective 2.2: Reduce new HIV infections by optimising implementation of high-impact HIV-prevention interventions *(cont.)*

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
14) Percentage of specific key and priority 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, sex, age, SW, MSM, PWID, People with disabilities, Inmates	IBBS	FSW - 75.6%, 2018 (SAHMS-2) MSM - 72.2%, 2019 (SAMHMS-2) PWID - 52%, 2017 (TripVal Study) TG - 76.6%, 2021 (Botshelo Ba Trans Study) ()		FSW - 90% MSM - 90%, PWID - 90% TG - 90%			FSW - 95% MSM - 95%, PWID - 95% TG - 95%	Every 3 - 5 years	SANAC, NDOH, DCS
15) Number of people tested for HIV	Output	Numerator: Number of people tested for HIV. Denominator: N/A	Geographic area, Sex, Age (15+)	DHIS, Thembisa Model	17,598,704 (DHIS, 2021/22)	17,905,816	17,000,000	17,000,000	17,000,000	17,000,000	Annual	NDOH, DCS, DHET/HEAIDS DOT, DPSA, SAPS
16) Number of medical male circumcisions performed	Output	Numerator: Number of medical male circumcisions performed Denominator: N/A	Geographic area Age (10-14; 15+)	NDOH Annual report	361,216 (2021/22)	600,000	600,000	600,000	600,000	600,000	Annual	NDOH, DCS, DHET/ HEAIDS Private Sector (Council of Medical AID Schemes), Traditional sector
17) Number of people receiving oral PrEP for the first time during the reporting period	Output	Numerator: Number of people receiving oral PrEP for the first time during the reporting period Denominator: N/A	Geographic area, Sex, Age, key and priority populations	DHIS	248,020 (2021/22)	410,827	410,827	410,827	410,827	410,827	Annual	NDOH

Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs

Objective 2.2: Reduce new HIV infections by optimising implementation of high-impact HIV-prevention interventions *(cont.)*

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
18) New sexual assault case HIV-negative issued with post exposure prophylaxis	Output	Count: number of individuals who experienced sexual assault and were provided with post exposure prophylaxis	Geographic area, Sex, Age (15+)	DHIS	30,019 (2021/22)	30,625	33,683	37,046	37,046	37,046	Annual	NDOH
19) Percentage of health facilities with post-exposure prophylaxis available	Output	Numerator: Number of health facilities with PEP available for those who are at risk of HIV infection through occupational and/or non-occupational exposure to HIV. Denominator: Total number of public primary healthcare facilities	Geographical area, facility type	DHIS	33.9% (2021/22)	54%	74%	90%	100%	100%	Annual	NDOH

Appendix C

Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs

Objective 2.2: Reduce new HIV infections by optimising implementation of high-impact HIV-prevention interventions *(cont.)*

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
20) 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	2,436,961 (2021/22)	2,558,809	2,686,750	2,821,087	2,962,141	3,110,248	Annual	DSD
21) Percentage of specific key populations with access to core package of HIV, TB and STI services	Output	Numerator: Number of specific key populations with access to core package of HIV, TB and STI services. Denominator: Estimated number of key populations	SW, MSM, PWID, Transgender, Inmates,	Programme data, IBBS	MSM 35% SW 69% PWID 25% TG 5% Prisons 45% (2021/22)	MSM 45% SW 70% PWID 30% TG 7% Prisons 45	MSM 50% SW 75% PWID 35% TG 10% Prisons 45%	MSM 60% SW 80% PWID 45% TG 20% Prisons 45%	MSM 70% SW 85% PWID 55% TG 30% Prisons 45%	MSM 80% SW 90% PWID 65% TG 40% Prisons 45%	Annual	SANAC, NDOH, DCS, DSD
22) Percentage of specific key and priority populations with access to core package of HIV, TB and STI services	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	Geographical area	Programme data, IBBS	1.6% (2021/22)	1.80%	2.5%	4%	7%	10%	Every 3-years	SANAC

Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs

Objective 2.2: Reduce new HIV infections by optimising implementation of high-impact HIV-prevention interventions *(cont.)*

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
23) Needles and syringes distributed per person who injects drugs	Output	Numerator: Number of needles and syringes distributed in the past 12 months by needle–syringe programmes. Denominator: Number of people who inject drugs in the country	Geographical area	Programme data, IBBS	55 (Programme data, 2022)	80	110	140	170	200	Annual	SANAC
24) Couple year protection rate	Outcome	Numerator: Women protected against pregnancy by using modern contraceptive methods. Denominator: females 15–49 years	Geographical area	DHIS	49.5% (2020/21)	55%	60%	65%	70%	75%	Annual	NDOH

Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs

HIV-treatment and Care												
Impact indicators												
Indicator	**Type**	**Calculation**	**Disaggregation**	**Data source**	**Baseline value**	**Target**					**Reporting frequency**	**Responsibility**
						2023/24	**2024/25**	**2025/26**	**2026/27**	**2027/28**		
1) Adult AIDS mortality	Impact	Numerator: Adult mortality attributable to HIV (total AIDS deaths)	Geographic area, Age, Sex, ART status	Thembisa Model	71,663 (2021)	61,415	58,791	56,485	54,454	52,580	Annual	SANAC
2) Non-AIDS deaths in HIV-positive individuals	Impact	Count – Total number of non-AIDS deaths among PLHIV	Geographic area, Age, Sex	Thembisa Model	88,261 (2022)	83,848	75,022	70,609	66,196	66,196	Annual	SANAC
Objective 2.4: Ensure that 95% of people living with HIV, especially key populations, and other priority populations know their status and are 95% on treatment, and 95% are retained in care, and achieve long-term viral suppression												
3) Percentage of people living with HIV who know their HIV status	Outcome	Numerator: Number of PLHIV who know their HIV status. Denominator: Total number of PLHIV.	Geographic area, Age, Sex	Thembisa Model HSRC Survey	94.2% (2022)	94.5%	95.1%	95.5%	96.0%	96.5%	Annual	SANAC, PCA
4) Percentage of infants born to women living with HIV receiving a virological test for HIV within two months of birth	Outcome	Numerator: Number of infants who received an HIV test within seven days: Denominator: Total number of births to HIV-positive mother in the last 12 months	Geographic area, Age, Sex	Numerator: NHLS Denominator: Thembisa Model	94% (2022)	96%	98%	99%	100%	100%	Annual	SANAC, NDOH

Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs

Objective 2.4: Ensure that 95% of people living with HIV, especially key populations, and other priority populations know their status and 95% are on treatment, and 95% are retained in care, and achieve long-term viral suppression *(cont.)*

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
5) Percentage of specific key populations living with HIV who know their HIV status (1st 95)	Outcome	Numerator: Number of specific key populations living with HIV who know their HIV status Denominator: Total number of respondents living with HIV who answered the question "Do you know your HIV status from an HIV test?"	Geographic area, sex, age, SW, MSM, PWID, People with disabilities, Inmates	IBBS	FSW - 80.1%, 2018 (SAHMS-2) MSM - 65.9%, 2019 (SAMHMS-2) PWID - TBD TG - 90%, 2021 (Botshelo Ba Trans Study) Inmates - TBD		FSW - 95% MSM - 95%%, PWID - 95% TG - 95%			FSW > 95% MSM > 95%%, PWID - 95% TG - 95%%	Every 3-years	SANAC, NDOH, DCS
6) 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	DHIS, Private sector, Surveys, Thembisa Model	75% (2022)	79%	83%	87%	91%	95%	Annual	NDOH, DPSA, DHET/HEAIDS, DCS Private Sector (Council of Medical AID Schemes-CMS)

Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs

Objective 2.4: Ensure that 95% of people living with HIV, especially key populations, and other priority populations know their status and 95% are on treatment, and 95% are retained in care, and achieve long-term viral suppression *(cont.)*

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
7) Percentage of specific key populations living with HIV receiving ART (2nd 95)	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 and know their status	Geographic area, SW, MSM, PWID, Inmates, People with disabilities	IBBS	FSW - 59.4%, 2018 (SAHMS-2) MSM - 72.1%, 2019 (SAMHMS-2) PWID - TBD TG - TBD Inmates - TBD		FSW - 83% MSM - 83%, PWID - 83% TG - 83%%			FSW - 95% MSM - 95%, PWID - 95% TG - 95%		
8) 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, Private sector	TBD (2021/	TBD	TBD	TBD	TBD	TBD	Annual	NDOH Private Sector, (CMS)

Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs

Objective 2.4: Ensure that 95% of people living with HIV, especially key populations, and other priority populations know their status and 95% are on treatment, and 95% are retained in care, and achieve long-term viral suppression *(cont.)*

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
9) HIV viral load suppressed rate (VLS) at 12 months	Outcome	Numerator: People living with HIV viral load under 1000 copies/mL. Denominator: Total number of PLHIV who know their HIV status and are on ART	Geographic area, Age, Sex	DHIS, Private sector, Thembisa Model	92% (2022)	93%	94%	95%	96%	97%	Annual	NDOH Private Sector, (CMS)
10) Percentage of specific key populations living with HIV who have suppressed viral loads (3rd 95))	Outcome	Numerator: Number of specific key populations living with HIV on ART with suppressed viral loads (≤1000 copies/mL). Denominator: Estimated number of key populations living with HIV who know their HIV status and are on ART	Geographic area, SW, MSM, PWID, Inmates, People with disabilities	IBBS	FSW - 81.6%, 2018 (SAHMS-2) MSM - 88.3%, 2019 (SAMHMS-2) PWID - TBD TG - TBD Inmates - TBD		FSW - 95% MSM - 95%, PWID - 95% TG - 95%			FSW > 95% MSM > 95%, PWID >95% TG >95%	Every 3-years	SANAC, NDOH, DCS

Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs

Objective 2.4: Ensure that 95% of people living with HIV, especially key populations, and other priority populations know their status and 95% are on treatment, and 95% are retained in care, and achieve long-term viral suppression *(cont.)*

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
11) ***Percentage of community organisations trained on HIV literacy including U=U science and messaging***	Output	Number of community organisations trained on HIV literacy. Denominator: Number of community organisations registered under the NPO sector national register	Geographical area	SANAC	0 (New indicator)	20%	40%	60%	70%	100%	Annual	Provincial DOH, PCA and Civil Society Forum, NPO sector, Implementing partners, SANAC
12) ***Percentage of health facilities that received Treatment literacy tool kit (Implementation framework and IEC material)***	Output	Numerator: number of health facilities who received Treatment literacy tool kit (National implementation framework and IEC material) Denominator: number of health facilities in the country	Geographic area	SANAC NDOH	0 (New indicator)	20%	40%	60%	80%	>95 %	Annual	NDOH SANAC Partners

Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs

TB-prevention and Treatment

Impact indicators and CHE

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
1) 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 Global TB report	304,000 (2021)	282000	263000	246000	230000	215000	Annual	NDOH
2) TB incidence*	Impact	Numerator: Number of deaths caused by TB in HIV-negative people and HIV-positive people. Can be expressed as a rate. Denominator: Total population per 100 000	HIV status	WHO Global TB report	56,000 (2021)	TBD	TBD	TBD	TBD	TBD	Annual	NDOH

**** TB incidence and mortality target are preliminary and will be reviewed once estimates from the TB Thembisa Model and Investment Case modelling are completed.***

Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs

Impact indicators and CHE *(cont.)*

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
3) 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	DS-TB and DR-TB	South Africa National TB patient costs survey, 2022	56% (2020)					30%	Every 3 to 4 years	NDOH

Objective 2.6: Strengthen TB-prevention interventions for key and other priority populations and implement airborne infection-prevention and control in health facilities and high-risk indoor places where people congregate

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
4) Number of people in contact with TB patients who began preventive therapy	Output	Count: Number of people in contact with TB patients who began preventive therapy.	Geographic area, Age (<5, 5+ years	DHIS	17012 (Under 5 2021) (2021/22)	179,821	221,941	256,157	286,587	290,687	Annual	NDOH
5) Number of PLHIV on ART who initiated TB-preventive therapy	Output	Count: Number of eligible PLHIV on ART started on TPT. TPT is given to PLHIV who are newly diagnosed and those in care.	Geographic area, Age	DHIS	195,581	218,830	259,845	297,064	314,480	Annual	NDOH	NDOH

Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs

Objective 2.7: Strengthen TB diagnosis and support for PWTB, and accelerate scale-up of innovative processes, diagnostic tools and regimens for diagnosis, treatment, and care for PWTB

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
6) Number of TB tests done	Output	Number of TB tests performed (laboratory)	Geographic area	NHLS	1,952,766 (2021)	3,085,166	3,046,254	2,929,901	2,809,682	2,659,883	Annual	NDOH
7) Number of TB cases diagnosed	Output	Number of laboratory-diagnosed TB cases	Geographic area	NHLS	172,865 (2021)	185,110	182,775	175,794	168,581	159,593	Annual	NDOH
8) Number of notified cases of all forms of TB (i.e., bacterio-logically confirmed + clinically diagnosed). This indicator measures all TB notifications including previously treated cases.	Output	Number of notified cases of all forms of TB (i.e., bacteriologically confirmed + clinically diagnosed). This is the total TB notifications	Geographic area Sex, age, HIV-status, type of diagnosis (bacteriological and clinical), sector (mines and prisons)	Tier.NET and EDRWeb	187,719 DS - 180870 + MDR/RR - 6849 (2021)	224,776	221,941	213,464	204,705	193,791	Annual	NDOH
9) Treatment coverage	Output	Numerator: Number of people/clients started on TB treatment (Notified cases). Denominator: Number of incident cases	Geographic area, sex Age: <5, 5 years and older	DHIS/ Modelled data	62% (2021)	TBD after incidence estimation	TBD after incidence estimation	TBD after incidence estimation	TBD after incidence estimation	TBD after incidence estimation	Annual	NDOH

Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs

Objective 2.7: Strengthen TB diagnosis and support for PWTB, and accelerate scale-up of innovative processes, diagnostic tools and regimens for diagnosis, treatment, and care for PWTB *(cont.)*

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
10) Proportion of TB/HIV co-infected patients on ART	Output	Numerator: Number of registered HIV+TB co-infected patients on ART. Denominator: Number of registered HIV / TB co-infected patients	Geographic area Sex	Tier.NET and EDRWeb	90% DS - 90% MDR/RR - 96% (2021)	91% DS - 91% MDR/RR - 96%	92% DS - 92% MDR/RR - 96%	93% DS - 93% MDR/RR - 96%	94% DS - 94% MDR/RR - 96%	95% DS - 95% MDR/RR - 96%	Annual	NDOH
11) TB treatment success rate	Output	Numerator: TB people/ clients cured and completed treatment. Denominator: Total TB clients initiated on treatment	Geographic area, Drug sensitive, drug resistant TB	WHO Global TB report	78% (new and relapse, 2020 cohort) 66% (MDR, 2019 cohort) 2022, WTB Report (2020/2019)	80% - New and Relapse 68% - MDR/ RR-TB	83% - New and Relapse 70% - MDR/ RR-TB	86% - New and Relapse 72% - MDR/ RR-TB	88% - New and Relapse 74% - MDR/RR-TB	90% - New and Relapse 75% - MDR/ RR-TB	Annual	NDOH
12) Number of PWTB reached through PSS services	Output	Count: Number of PWTB reached through PSS services by DSD	Geographic area, sex	DSD HIV and AIDS Quarterly report	0 (New indicator)	Establish programme activities and aim to achieve the target of 22,478	44,388	64,039	81,882	96,896	Annual	DSD

Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs

STIs and Viral Hepatitis Prevention and Treatment

Impact indicators

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
1) Percentage of pregnant women who tested positive for gonorrhoea	Impact	Numerator: Number of pregnant women who tested positive for chlamydia. Denominator: Number of pregnant women tested for gonorrhoea. Pregnant women used for sentinel surveillance	Geographical location, age	NHLS (National Priority Database) DHIS, sentinel surveillance surveys (ANCHSS)	6.6% (2017)	Establish baseline	10% annual decline from baseline	10% annual decline from previous year. Add indicator to NIDS	10% annual decline from previous year	10% annual decline from previous year	Annual	NDOH , NICD
2) Percentage of pregnant women who tested positive for chlamydia	Impact	Numerator: Number of pregnant women who tested positive for chlamydia. Denominator: Number of pregnant women tested for gonorrhoea. Pregnant women used for sentinel surveillance	Geographical location, age	NHLS (National Priority Database) DHIS, sentinel surveillance surveys (ANCHSS)	14.7% (2017)	Establish baseline	10% annual decline from baseline	10% annual decline from previous year. Add indicator to NIDS	10% annual decline from previous year	10% annual decline from previous year	Annual	NDOH, NICD

Appendix C

Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs

Impact indicators *(cont.)*

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
3) Percentage of women accessing antenatal care services who tested positive for syphilis	Impact	Numerator: Number of antenatal care attendees with a positive syphilis serology. Denominator: Number of women attending antenatal care services who were tested for syphilis during the first visit	Geographic area, Age	DHIS	Estimated 2,5 -3,5% (2021/22)	2.00%	1.50%	1.00%	0.50%	<0.5%	Annual	NDOH, NICD
4) Congenital syphilis rate	Impact	Numerator: Number of reported congenital syphilis cases (live births and stillbirth) in the past 12 months. Denominator: Number of live births in the past 12 months	Geographic area	NMC/DHIS	Estimated 300/100 000 live births (2021/22)	200/100 000 live births	150 per 100 000 live births	100 per 100 000 live births	50 per 100 000 live births	<50 per 100 000 live births	Annual	NDOH, NICD

Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs

OBJECTIVE 2.8: Increase detection and treatment of four curable STIs through systems strengthening, service integration and diagnostic testing; achieve elimination targets for mother-to-child transmission of syphilis; and scale-up HPV-vaccination and cervical cancer screening

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
5) 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	358060 (2021/22)	322254	286,448	250,642	214,836	179,030	Annual	NDOH
6) Percentage of women accessing antenatal care services who were tested for gonorrhoea and chlamydia	Output	Numerator: Number of women attending antenatal care services who were tested for gonorrhoea and chlamydia during the first prenatal visit (<13 weeks gestation) Denominator: Number of women attending antenatal care services	Geographic area, Age, type of STI (CT and NG)	DHIS, sentinel surveillance surveys (ANCHSS)	(TBD)	10%	20.0%	40%	60.0%	80%	Annual	NDOH
7) Number of sex partners notified	Output	Numerator: Number of sex partners notified. Denominator: NA	Geographic area, Age, type of STI (CT and NG)	DHIS	Estimated 20% (2022)	30%	40.0%	50%	50.0%	50%	Annual	NDOH

Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs

OBJECTIVE 2.8: Increase detection and treatment of four curable STIs through systems strengthening, service integration and diagnostic testing; achieve elimination targets for mother-to-child transmission of syphilis; and scale-up HPV-vaccination and cervical cancer screening *(cont.)*

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
8) 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	DHIS, sentinel surveillance surveys (ANCHSS)	ANCHSS - 96.4% (2019)	97%	97.5%	98%	98.5%	99%	Annual	NDOH, NICD
9) Syphilis treatment rate	Output	Numerator: Number of women attending antenatal care services who tested positive for syphilis and were treated. Denominator: Number of women attending antenatal care services who tested positive for syphilis	Geographic area, Age	DHIS	90% (2019)	92%	94.0%	96%	98.0%	98%	Annual	NDOH, NICD

Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs

OBJECTIVE 2.8: Increase detection and treatment of four curable STIs through systems strengthening, service integration and diagnostic testing; achieve elimination targets for mother-to-child transmission of syphilis; and scale-up HPV-vaccination and cervical cancer screening *(cont.)*

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
10) 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	87.5%- 1st dose 76.7%- 2nd dose (2019/20)			90%- 1st dose 80%- 2nd dose		95%- 1st dose 85%- 2nd dose	Annual	NDOH
11) Proportion of cervical cancer screening with cervical smear testing and or HPV DNA testing, including WLHIV	Output	Number of HPV DNA tests divided by the total number of cervical cancer screening	Geographical area	DHIS	TBD (TBD)	planning	10%	20%	30%	40%	Annual	NDOH
12) Proportion of women with a high-risk lesion receiving colposcopy and treatment within 6 weeks of cervical cancer screening	Outcome	Number of women treated for high-risk lesion following colposcopy divided by the number of women with high-risk cervical screening result	Geographical area	DHIS	TBD (TBD)	60%	70%	80%	90%	95%	Annual	NDOH

Goal 2: Maximise equitable and equal access to services and solutions for HIV, TB and STIs

Objective 2.9: Reduce viral hepatitis morbidity through scale-up of prevention, diagnostic testing, and treatment

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
13) HBV birth dose vaccination coverage of newborns	Output	Numerator: Number of newborns received HBV-vaccination within 24 hours of birth. Denominator: total number of newborns	Geographical area, sex	DHIS	TBD (TBD)	30%	50%	70%	80%	90%	Annual	NDOH
14) Percentage of healthcare workers protected against HBV	Outcome	Numerator: Number of HCWs with HBV immunity. Denominator: total number of HCWs tested	Geographical area, sex		TBD (TBD)	50%	60%	70%	80%	90%	Annual	NDOH

Goal 3: Build resilient systems for HIV, TB and STIs that are integrated into systems for health, social protection, and pandemic response

Objective 3.1: Engage adequate human resources to ensure equitable access to HIV, TB and STIs services

Indicator	Type	Calculation	Dis-aggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
1) Doctor to patient ratio	Output	Numerator: The number of physicians available. Denominator: country population size. Ratio expressed per every 10,000 inhabitants in a population	Geographical area	TBD	TBD	TBD	TBD	TBD	TBD	TBD	Annual	NDOH
2) Percentage of organizations 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	Government: DPSA Employment Health and Wellness Report, Business: SABCOHA report, Mining: Mining Council	Government: 100% Businesses: Mining: TBD (2021/22)	Government: 100% Businesses: Mining: TBD	Government: 100% Businesses: Mining: TBD	Government: 100% Businesses: Mining: TBD	Government: 100% Businesses: Mining: TBD	Government: 100% Businesses: Mining: TBD	Annual	SANAC

Goal 3: Build resilient systems for HIV, TB and STIs that are integrated into systems for health, social protection, and pandemic response

Objective 3.2: Use timely and relevant strategic information for data-driven decision-making

Indicator	Type	Calculation	Dis-aggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
3) NSP Five-year costed National M&E Plan	Output	NSP Five-year costed National M&E Plan	N/A	SANAC Annual Report		M&E plan costed					Once off	SANAC
4) Annual score on SI performance scorecard	Output	Total score based on the summation of performance on different aspects of the SI cascade	National, Provincial	SANAC SI Scorecard	N/A	80% Scorecard developed	85% of total	90% of total	95% of total	100% of total	Semi-annual	SANAC

Objective 3.3: Expand the research agenda for HIV, TB and STIs to strengthen the national response

5) Number of NSP, mid-term and end-term evaluation conducted	Output	Qualitative Yes/ No indicator	N/A	NSP reports				Mid-term review conducted		End-term review conducted		SANAC
6) Adoption of a functional model for funding SA-initiated research	Output	Qualitative Yes/ No indicator	N/A	SANAC Annual Report		Model developed	Model adopted				Once off	SANAC

Goal 3: Build resilient systems for HIV, TB and STIs that are integrated into systems for health, social protection, and pandemic response

Objective 3.5: Leverage the infrastructure of HIV, TB & STIs for broader pandemic and various emergencies preparedness and response												
7) Proportion of primary healthcare facilities that has attained ideal status	Outcome	Numerator: Number of health facilities that have attained the ideal clinic status. Denominator: Total number of primary healthcare facilities	Geographic area Type of health facilities	Facility Assessment reports	55% (2021/22)	65%	75%	85%	95%	100%	Annual	NDOH

Objective 3.6: Build a stronger public health supply chain management												
Indicator	**Type**	**Calculation**	**Dis-aggregation**	**Data source**	**Baseline value**	**Target**					**Reporting frequency**	**Responsi-bility**
						2023/24	**2024/25**	**2025/26**	**2026/27**	**2027/28**		
8) Percentage of health facilities with tracer medicines for the three diseases available on the day of the visit or day of reporting	Outcome	Numerator is number of health facilities with tracer medicines for HIV, TB and STIs available in the week of reporting (last week of the reporting period). Denominator: all health facilities (hospitals, clinics and depos) submitting data to the National Surveillance Centre. Excludes CCMDD, as STI drugs are not chronic	Type of medicines (ARVs, TB and STIs), Geographic area Type of health facilities	National Surveillance Centre	88.3 2022/23	90%	92%	94%	96%	97%	Annual	NDOH

Goal 4: Fully resource and sustain an efficient NSP-led by revitalised, inclusive and accountable institutions

Objective 4.1: Ensure sufficient domestic and external funds are mobilised and allocated to facilitate efficient implementation of HIV, TB and STI programme

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
1) ***Government HIV and TB expenditure (as % of General Government Expenditure)***	Outcome	Numerator: Total Government expenditure on HIV and TB. Denominator: Total General Government Expenditure	Disease programmatic area, geographical area (national, provincial)	NASA and routine expenditure tracking	TBD	Baseline +5%	Baseline +5%	Baseline +5%	Baseline +5%	Baseline +5%	Annually	SANAC
2) ***Percentage of HIV expenditure through non-government organisations***	Outcome	Numerator: Total HIV expenditure through non-government organisations. Denominator: Total HIV expenditure	Geographical area (national, provincial), Type of NGO	NASA and routine expenditure tracking	35%	37%	40%	40%	40%	40%	Annual	SANAC
3) ***Percentage of total HIV expenditure on key population beneficiary groups from public sources***	Outcome	Numerator: Total public HIV expenditure on key population groups. Denominator: Total public HIV expenditure	Geographic area, SW, MSM, PWID, AGYW	NASA and routine expenditure tracking	TBD	Baseline	Baseline +5%	Baseline +5%	Baseline +10%	Baseline +10%	Annually	SANAC

Goal 4: Fully resource and sustain an efficient NSP-led by revitalised, inclusive and accountable institutions

Objective 4.1: Ensure sufficient domestic and external funds are mobilised and allocated to facilitate efficient implementation of HIV, TB and STI programme *(cont.)*												
Indicator	**Type**	**Calculation**	**Disaggregation**	**Data source**	**Baseline value**	**Target**					**Reporting frequency**	**Responsibility**
						2023/24	**2024/25**	**2025/26**	**2026/27**	**2027/28**		
4) Percentage increase in private sector investment in NSP service-delivery	Outcome	Numerator: Private Sector investments in NSP (expenditure and donated goods). Denominator: Baseline private sector investments in NSP	Disease area, NSP goal, geographical area	NASA and routine expenditure tracking	TBD	Baseline	Baseline +5%	Baseline +5%	Baseline +5%	Baseline +5%	Annually	SANAC
Objective 4.2: Sustainability and transition plans and actions are routinely developed and implemented to ensure that interventions remain on-track to achieve NSP goals												
5) No of HIV sub-programme/ sub-national sustainability assessments completed	Output	Count number of assessments undertaken and submitted using a SANAC-approved template and approved	NSP programmes	Synthesis from multiple sources, including DOH, DSD, DBE and partners	1 Sustainability Synthesis Report (2022)	1	2	2	1	1	Annually	SANAC

Goal 4: Fully resource and sustain an efficient NSP-led by revitalised, inclusive and accountable institutions

Objective 4.2: Sustainability and transition plans and actions are routinely developed and implemented to ensure that interventions remain on-track to achieve NSP goals *(cont.)*

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
6) No of provincial-level sustainability or transition plans for eligible NSP programmes completed and approved by SANAC	Output	Count number of plans prepared and submitted using a SANAC-approved template and approved	Provinces and NSP programmes	Synthesis from multiple sources, including DOH, DSD, DBE and partners	Nil	0	3	3	3	3	Annually	SANAC

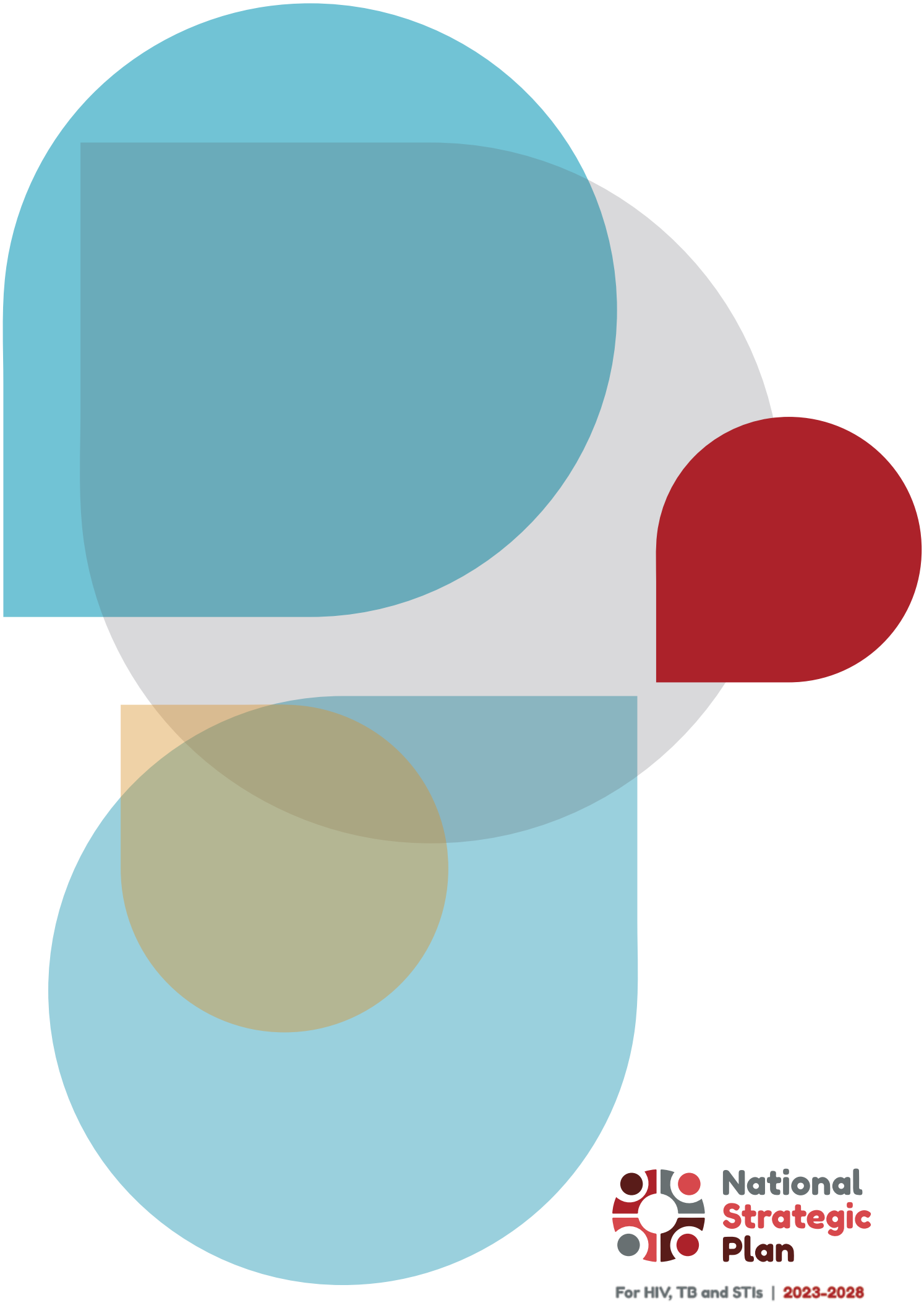
Objective 4.3: Reset and reposition SANAC, all AIDS Councils and Civil Society organisations for an optimal, efficient and impactful 2023-28 NSP execution experience

7) Percentage of functioning District AIDS Councils measured according to functionality assessment, including civil society and community engagement		Numerator: functioning District AIDS Councils measured according to functionality assessment, including civil society and community engagement. Denominator: total number of DACs in the country (52).	NA	SANAC	65%	70%	80%	90%	95%	100%	Annually	SANAC
8) Number of accountability framework reviews conducted	Output	Count	NA	SANAC	New	1	1	1	1	1	Annual	SANAC and PACs

Goal 4: Fully resource and sustain an efficient NSP-led by revitalised, inclusive and accountable institutions

Objective 4.3: Reset and reposition SANAC, all AIDS Councils and Civil Society organisations for an optimal, efficient and impactful 2023-28 NSP execution experience *(cont.)*

Indicator	Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsibility
						2023/24	2024/25	2025/26	2026/27	2027/28		
9) Percentage of performance agreements signed by Ministers, Premiers and Mayors with an HIV, TB and STI component as one of the mainstays of the performance scorecard	Output	To be added	To be added	To be added	New	50	60	80	90	100	Annual	SANAC, PACs, OTP;
10) SANAC and AIDS Councils Act promulgated by parliament	Output	Qualitative Yes/No indicator	NA	SANAC	Not applicable	Lobby	Lobby	Draft Bill	Final Bill	Act signed	Once off	SANAC



National Strategic Plan

For HIV, TB and STIs | 2023-2028