Western Cape Government

Health

Provincial Strategic Plan on HIV/AIDS, STIs and TB

2012 - 2016

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FOREWORD

"Better, Together. Beter Tesame. Kungcono xa sikunye. Ningadinwa nangomso. Maz'enethole"

In developing the Western Cape Provincial Strategic Plan (PSP) for HIV, STIs and TB 2012-2016 we are more than aware that the scourge of HIV and TB continues to have a negative impact on health and wellness in our province. It also continues to serve as a significant social and economic drag on the province's developmental trajectory. We are pleased, therefore, that at national level a comprehensive strategy has been developed to address the structural, bio-medical and human rights dimensions of these epidemics. In developing the Western Cape PSP we have ensured full alignment with the national strategy while at the same time responding to the very specific circumstances and needs of our province. As outlined by the Premier in her State of the Province address this year the Western Cape's developmental vision is guided by the understanding that government cannot, by itself, guarantee a better life for its people. Progress can only be realised as the product of partnerships - between government, citizens, civil society and business.

This applies in a very significant way to our efforts as a province to confront and overcome the mutually reinforcing epidemics of HIV and TB. The PSP is, therefore, a multi-sectoral plan that requires joint understanding, effective dialogue and operational collaboration between all relevant stakeholders to achieve the objectives that have been set for the province, and that are required to be achieved by 2015. Each stakeholder has a role to play and specific responsibilities to meet. That is why we have adopted the slogan "Better Together" to capture and convey our message to the people of the Western Cape that as government we are fully geared to working with all relevant stakeholders to achieve the objectives of this plan.

As a province we are cognizant of the fact that approximately 80% of our health budget is being spent each year on diseases and injuries that could have been prevented if people had acted more responsibly. While our government recognizes that structural impediments create vulnerabilities, we are also committed to challenging and encouraging individuals to take a greater degree of responsibility for their health. This perspective underpins the Healthcare 2020 strategy that I recently had the pleasure of launching, and this new PSP is in full alignment with a shift to the prevention of disease and creating a state of wellness in the province, rather than an exclusive focus on treating illness. The implementation of the PSP, through a joint operational planning process, will cut across a number of provincial government departments including Health, Education, Social Development, Justice, Correctional Services, Community Safety, Agriculture, Human Settlements and Transport. It also focuses on building strategic partnerships with the private sector and civil society in order to place people infected and affected by HIV, STIs and TB at the centre of the healthcare system and treating them according to their individual needs and circumstances.

As a province we must therefore ensure that our new PSP serves as a platform for making further gains in efforts to significantly reduce HIV and TB incidence. Through multi-sectoral partnerships we must also ensure that on-going and new initiatives operationalised through the PSP serve as catalysts for change. As a province our over-riding concern must be to ensure that all the people of the province are able to live long and healthy lives free of the burden and stigma of these debilitating epidemics. Together we can make the change – together we can make things better.

Theuns Botha
Western Cape Minister of Health

ACRONYMS, ABBREVIATIONS AND GLOSSARY

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal care
ART	Antiretroviral Therapy
ARV	Antiretroviral
BAS	Basic Accounting System
BCG	Bacillus Calmette-Guerin
CBO	Community-Based Organisation
DCS	Department of Correctional Services
DAC	District AIDS Council
DHIS	District Health and Information System
DHS	Demographic and Health Survey
DBE	Department of Basic Education
DOH	Department of Health
DOTS	Directly Observed Therapy Short Course
DPSA	Department of Public Service and Administration
DSD	Department of Social Development
EID	Early Infant Diagnosis
FBO	Faith-Based Organisation
GBV	Gender-based Violence
HAST	HIV and AIDS, STI and TB
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HSRC	Human Sciences Research Council
IDU	Injecting Drug Use/User
IPT	Isoniazid Preventive Therapy
KYE	Know Your Epidemic
KYR	Know Your Response
LGBT	Lesbian, Gay, Bisexual and Transgender
M&E	Monitoring and Evaluation
MMC	Medical Male Circumcision
MCP	Multiple or Concurrent Partner
MCWH	Maternal, Child and Women's Health
MDG	Millennium Development Goal
MDR-TB	Multidrug-resistant tuberculosis
MRC	Medical Research Council
MSM	Men who have Sex with Men
MTR	Midterm Review
NGO	Non-Governmental Organisation
NSP	National Strategic Plan for HIV and AIDS, STIs and TB
PAC	Provincial AIDS Council
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PH	Public Health
PLHIV	Persons Living with HIV
PIC	Programme Implementation Committee of SANAC
PICT	Provider Initiated Counselling and Testing
PMTCT	Prevention of Mother to Child HIV Transmission
PrEP	Pre-Exposure Prophylaxis
PSIP	Provincial Strategic Implementation Plan
PSP	Provincial Strategic Plan
OVC	Orphans and Vulnerable Children
SACEMA	South African Centre for Epidemiological Modelling and Analysis
SADC	Southern African Development Community
SAHRC	South African Human Rights Commission
SANAC	South Africa National AIDS Council
SAPS	South African Police Services
SBCC	Social and Behaviour Change Communication
SMS	Short Messaging System
SO	Strategic Objective
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SW	Sex Worker
SWEAT	Sex Workers Education and Advocacy Taskforce
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
WC	Western Cape
WCPG	Western Cape Provincial Government
WHO	World Health Organization

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GLOSSARY OF TERMS

Adherence: Taking medications exactly as prescribed. Poor adherence to an HIV treatment regimen increases the risk for developing drug-resistant HIV and virologic failure.

CD4 Count (also known as CD4 Cell Count, CD4 T Lymphocyte Count): A laboratory test that measures the number of CD4 T lymphocytes (CD4 cells) in a sample of blood. In people with HIV, the CD4 count is the most important laboratory indicator of immune function and the strongest predictor of HIV progression. The CD4 count is one factor used to determine when to start antiretroviral therapy (ART). The CD4 count is also used to monitor response to ART.

Cervical Cancer: A type of cancer that develops in the cervix. Cervical cancer is almost always caused by the human papillomavirus (HPV), which is spread through sexual contact. In women with HIV, invasive cervical cancer is an AIDS-defining cancer.

Cryptococcal Meningitis: A life-threatening infection caused by the fungus *Cryptococcus neoformans*, which infects the membranes surrounding the brain and spinal cord. Symptoms include fever, malaise, and headache. Cryptococcal meningitis most often affects people with weakened immune systems, including people with HIV. In people with HIV, cryptococcal meningitis is an AIDS-defining condition.

Eligibility Criteria: Factors used to determine whether a person is eligible (inclusion criteria) or not eligible (exclusion criteria) to participate in a clinical trial. Eligibility criteria may include disease type and stage, other medical conditions, previous treatment history, age, and gender.

Extensively Drug Resistant Tuberculosis (XDR-TB) A relatively rare type of multiple drug resistant tuberculosis (MDR-TB). Extensively drug resistant tuberculosis (XDR-TB) occurs when a *Mycobacterium tuberculosis* strain becomes resistant to drugs used to treat TB, including the two most effective first-line antibiotics (isoniazid and rifampin) and most of the second-line drugs. XDR-TB progresses more rapidly and is more severe in people coinfected with HIV than in people infected with XDR-TB alone.

Fixed-Dose Combination: Two or more drugs contained in a single dosage form, such as a capsule or tablet. An example of a fixed-dose combination HIV drug is Atripla (a combination of efavirenz, emtricitabine & tenofovir). By reducing the number of pills a person must take each day, fixed dose combination drugs can improve adherence to HIV treatment regimens.

Incidence: The number of new cases of a disease in a specific area during a specific time period.

Injection Drug Use: A method of illicit drug use. The drugs are injected directly into the body—into a vein, into a muscle, or under the skin—with a needle and syringe. Blood-borne viruses, including HIV and hepatitis, can be transmitted via shared needles or other drug injection equipment.

Key populations: Refers to those most likely to be exposed to or to transmit HIV and/or TB –

their engagement is critical to a successful HIV and TB response. Key populations include those whose lack of access to services and risk of HIV infection and TB infection is also driven by inadequate protection for human rights, and prejudice.

Mother-to-Child Transmission (MTCT): When an HIV-infected mother passes HIV to her infant during pregnancy, labor and delivery, or breastfeeding (through breast milk). Antiretroviral (ARV) drugs are given to HIV-infected women during pregnancy and to their infants after birth to reduce the risk of mother-to-child transmission (MTCT) of HIV.

Multiple Drug Resistant Tuberculosis (MDR-TB): A form of tuberculosis (TB) that is resistant to the two most effective antibiotics commonly used to cure TB infection (isoniazid and rifampin). People infected with multiple drug resistant-TB (MDR-TB) are at high risk for treatment failure. They are also at risk for further drug resistance, which can lead to life-threatening disease—extensively drug resistant tuberculosis (XDR-TB).

Opportunistic Infection (OI): An infection that occurs more frequently or is more severe in people with weakened immune systems, such as people with HIV or people receiving chemotherapy, than in people with healthy immune systems.

Post-Exposure Prophylaxis (PEP): Short-term treatment started as soon as possible after high-risk exposure to an infectious agent, such as HIV, hepatitis B virus (HBV), or hepatitis C virus (HCV). The purpose of post-exposure prophylaxis (PEP) is to reduce the risk of infection. An example of a high-risk exposure is exposure to an infectious agent as the result of unprotected sex.

Pre-ART Package: Package of services for people living with HIV, but not yet on treatment. Includes: screening and treatment for opportunistic infections, counselling and psychosocial support (e.g. support groups), and nutritional assessments

Prevention of Mother-to-Child Transmission (PMTCT): Strategies used to prevent the transmission of HIV from an HIV-infected mother to her child during pregnancy, during labor and delivery, or by breastfeeding (through breast milk). Strategies include antiretroviral (ARV) prophylaxis for the mother during pregnancy and labor and delivery, scheduled cesarean delivery, ARV prophylaxis for the newborn infant, and avoidance of breastfeeding.

Reverse Transcriptase-Polymerase Chain Reaction (RT-PCR): A type of viral load test. Viral load tests are used to diagnose acute HIV infection, guide treatment choices, and monitor response to antiretroviral therapy (ART).

Seroconversion: When an HIV-infected person converts from HIV negative to HIV positive by blood testing. Shortly after infection with HIV, the body begins to produce HIV antibodies. It takes the body a while to produce enough antibodies to be detected by an HIV antibody test—usually 10 to 14 days but sometimes up to 6 months. When HIV antibodies in the blood reach a detectable level, the HIV-infected person seroconverts. In other words, the person's antibody test goes from HIV negative to HIV positive.

Sexually Transmitted Infection (STI): An infectious disease that spreads from person to person during sexual contact. Sexually transmitted infections, such as syphilis, HIV infection, and gonorrhea, are caused by bacteria, parasites, and viruses.

Structural interventions: Interventions that change conditions beyond individual control, such as the social and physical environments

Transgender persons: Transgender persons express a gender identity that is different from their birth sex.

CHAPTER 1 – EXECUTIVE SUMMARY

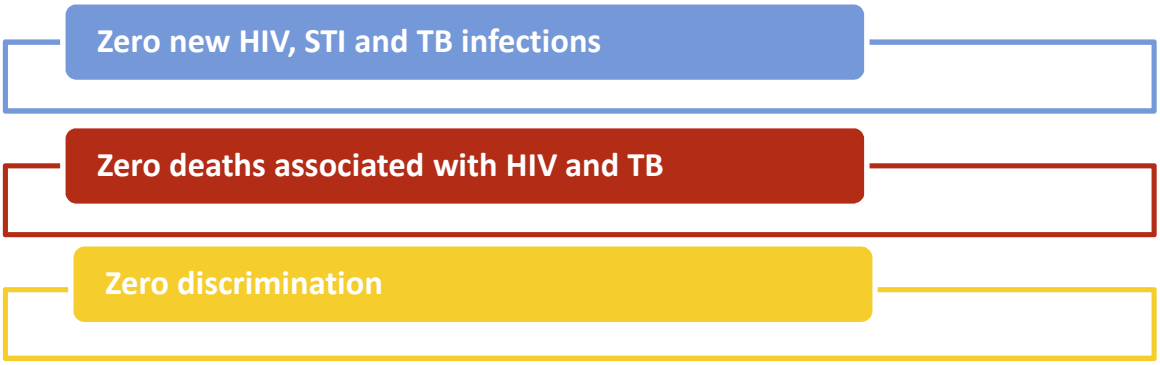
1.1 INTRODUCTION

The HIV, STI and TB National Strategic Plan (NSP) 2012-2016 is the product of extensive research as well as consultation and discussion with a wide range of stakeholders. The South African National AIDS Council (SANAC) has led this process and provided the overall guidance and framework for the plan. One of the key decisions of the consultations was to develop a single integrated strategy for HIV, STIs and TB for 2012-2016. This is primarily due to the high co-infection rate between HIV and TB.

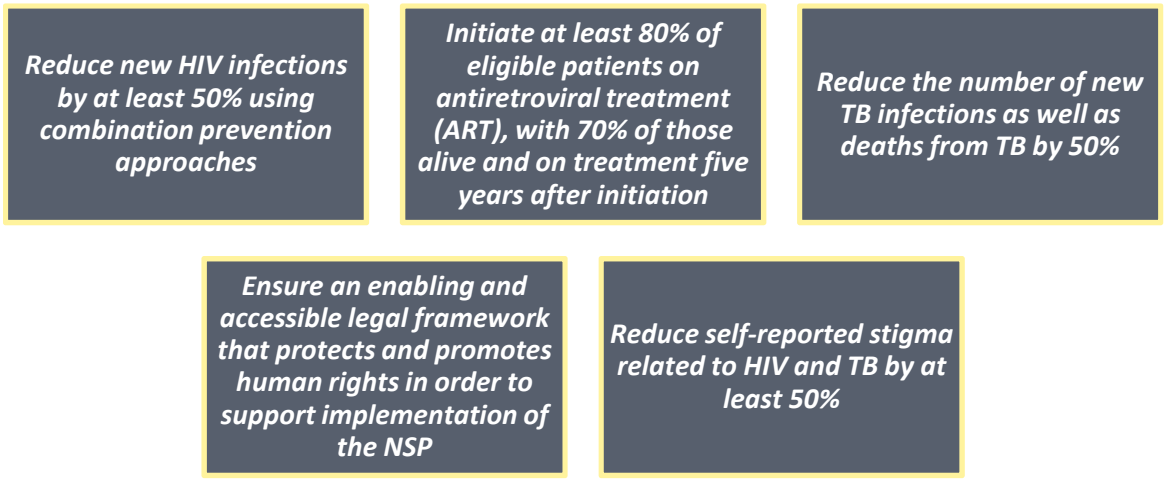
The NSP is the strategic guide for HIV, STI and TB initiatives for the next five years. The plan is results-based and focused on the drivers of the epidemics, building on the achievements in previous NSPs to achieve its goals. Interventions that have worked will be scaled up and the quality of service delivery will be improved, while at the same time proven new interventions will be implemented. Because it is intended to respond to the changes in the twin epidemics the NSP will be reviewed periodically for relevance and effectiveness and the necessary adjustments made.
The NSP aims to inform national, provincial, district and community-level stakeholders on *strategic directions* to be taken into consideration when developing strategies and implementation plans. It will also be used by SANAC as the framework by which they will coordinate and monitor implementation by sectors, provinces, and municipalities. The NSP is firmly located within the Constitutional framework of South Africa and strives towards its ideals of human dignity, non-racialism, non-sexism and the rule of law. The NSP is also aligned with the broader development plans of the government. These include the Medium Term Strategic Framework and Programme of Action, which commit to ensuring "A long and healthy life for all South Africans". The National Planning Commission is currently developing a government framework for addressing major developmental challenges, which will both inform the implementation of the NSP and be strengthened by it. The NSP is aligned with international and regional obligations, commitments and targets related to HIV, STIs and TB.

Vision and Goals

The NSP 2012-2016 is driven by a long-term vision for the country with respect to the two epidemics. It has adopted, as a twenty-year vision, the Three Zeros that have been advocated for by UNAIDS. These are:

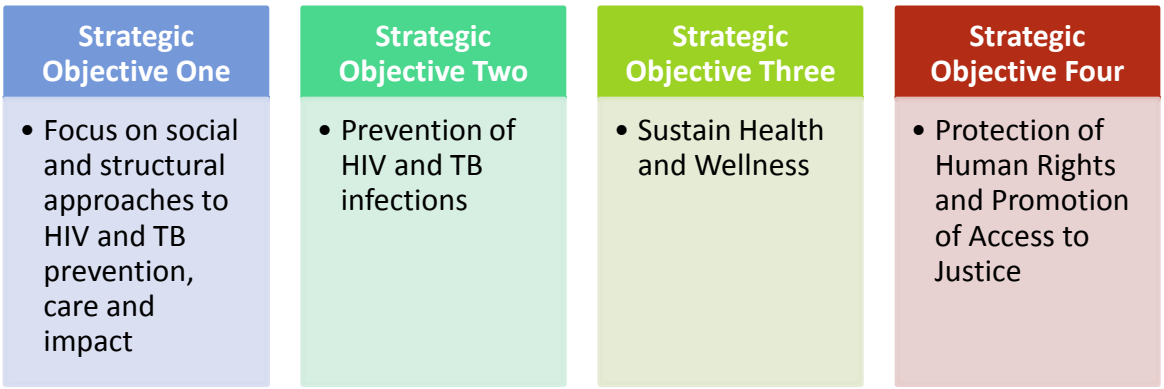


In line with this twenty-year vision, the NSP 2012-2016 has the following broad goals. To:



Strategic Objectives

The plan has four strategic objectives that will form the basis of the HIV, STI and TB response. These are:



Under the leadership and coordination of SANAC, the NSP has guided the Western Cape in the development of suitably aligned implementation plan that reflects the specific contributions to the achievement of the NSP goals. This plan is being costed and resources will be mobilised to support implementation. The NSP was launched on World AIDS Day, 1 December 2011 and the provincial strategic implementation plan was launched on World TB day, 24 March 2012 for implementation to commence on 1 April 2012.

1.2 STRATEGIC OBJECTIVES OF THE PSP 2012-2016

1.2.1 THE NATIONAL EPIDEMICS OF HIV AND TB

South Africa has a generalised HIV epidemic, which has stabilised over the last four years at a national antenatal prevalence of around 30%. There is a wide variation in prevalence across age, race, gender, socio-economic status and geographical location.

The NSP's goals and strategic objectives are guided by evidence from various reports, including the 'Know Your Epidemic' (KYE) report, a situation analysis of TB in the country and other epidemiological studies. These studies identified key populations that are most likely to be exposed to or to transmit HIV and/or TB. These include young women between the ages of 15 and 24 years; people living close to national roads and in informal settlements; young people not attending school and girls who drop out of school before matriculating; people from low socio-economic groups; uncircumcised men; persons with disabilities and mental disorders; sex workers and their clients; people who abuse alcohol and illegal substances; men who have sex with men and transgender persons.

South Africa currently ranks the third highest in the world in terms of TB burden, with an incidence that has increased by 400% in the past 15 years. It is estimated that 80% of the South African population is infected with the TB bacillus, however not everyone is infected with TB[1]. Certain populations are at higher risk of TB infection, including: healthcare workers, miners, prisoners, prison officers and household contacts of confirmed TB patients. In addition, certain groups are particularly vulnerable to progressing from TB infection to TB disease. These include infants, young children, people living with HIV, diabetics, smokers, alcohol and substance users and people who are malnourished, or have silicosis, mobile, migrant and refugee populations and people living and working in poorly ventilated environments. These groups are considered 'key populations' for TB.

1.2.2 THE PROVINCIAL EPIDEMICS OF HIV AND TB

The province is divided into five rural district municipalities – Cape Winelands, Eden, Overberg, West Coast and Central Karoo, and the metropolitan district of the City of Cape Town. The Cape Town Metro district accommodates approximately 66% of the population of the province and has higher density ratios, which is significant for planning and implementation purposes. The Central Karoo district, on the other hand, is sparsely populated.The DoH Strategic Plan notes that the impact of these observed demographic trends in the Western Cape might result in a smaller decline in the fertility rate, a drop in life expectancy as well as an increase in the levels of poverty[2].

The provincial response to HIV and AIDS, STIs and TB is shaped by the particular risk factors and the drivers of these diseases. The burden of disease in the Western Cape comprises the following[3]:

- For men and women aged 15-44 years, HIV and AIDS, tuberculosis, homicide and road traffic accidents were the leading cause of death;
- For adults aged 45-59 years more non-communicable diseases feature among the leading causes of death, including TB, ischaemic heart disease and diabetes.
  The Department of Health notes that diseases are caused and influenced by a range of factors that traverse biological, behavioural, societal and structural domains[4].
- Biological factors include age, gender and genetic make-up;
- Behavioural factors include having multiple sexual partners or life style habits such as smoking, poor diet and lack of exercise;

[1] Not all individuals will developed active TB (also called TB disease). The risk of developing active for HIV-negative individuals is 10% lifetime, and 10% annually for HIV-positive individuals
[2] DoH Strategic Plan 2010/11 – 2014/15, pg. 12.
[3] South African National Burden of Disease Study: Estimates of Provincial Mortality – Western Cape Province, pg 11.
[4] Department of Health Western Cape, HCT Campaign Report, pg. 1.

- Societal factors include gender inequality, as well as cultural and religious norms;
- Structural factors include poverty, unemployment, migration and urbanisation.
  A critical factor that is being increasingly integrated into the strategic planning of the DoH is the inequitable nature of the burden of disease, and the way in which the burden falls more heavily on the poorer and more marginalised sections of the population. The following graph indicates the spread of the burden of disease across the 9 Metro sub-districts:

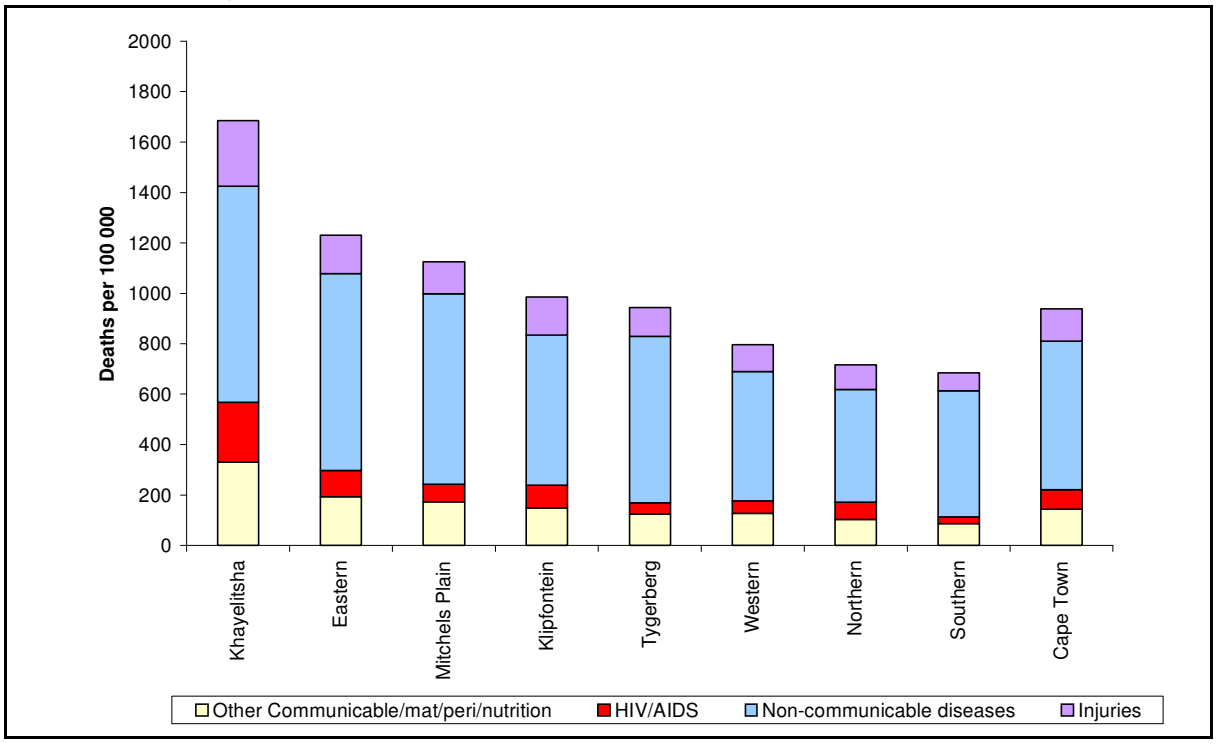


FIGURE 1: WESTERN CAPE BURDEN OF DISEASE PER DISTRICT

Infant mortality rates in the Western Cape are slightly better than in the rest of South Africa. Children in the age group 0-15 years constitute more than twenty five percent (25%) of the total population of the Western Cape. Trends in mortality indicators show that the national figure for infant deaths in their first year is forty eight (48) per one thousand (1000) live births, while the Western Cape figure is twenty six (26). The national figure for child deaths before five (5) years is seventy three (73) per one thousand (1000), while the Western Cape figure is thirty nine (39). HIV and AIDS and social and health service related factors have the greatest impact on these figures.

The population based measurement of maternal mortality remains a challenge and in the absence of complete vital registration reporting for births and deaths, developing countries have adopted various strategies to monitor these trends and in many areas, the data from the health facilities or institutions is the only source of continuous information[5]. According to the first triennial Saving Mothers (SM) report (1999 – 2001) the MMR for the Western Cape was reported as 56.4 per 100 000 live births. However, there was an increase in the SM 2002 – 2004 report, the MMR being 86,2/100 000 live births. The follow up triennial report, SM 2005 – 2007 the Western Cape had an MMR of 67.6/100 000 live births. The 2008 – 2010 triennial report is currently being completed. It is anticipated that there will be an increase in the latter because of the impact of the H1N1 pandemic. This indicates that despite being the lowest in the country, the provincial MMR still fluctuates between

[5] Western Cape Department of Health, Annual Performance Plan 2011/2012, pg. 17.

triennia. When calculating a district MMR, an annual and even triennial comparison could be misleading, as the numbers of maternal deaths in some districts are very small. Therefore in the Fourth Saving Mothers Report (2005 – 2007) it was decided to calculate the district MMR over a six-year period i.e. over two triennia namely, 2002 – 2007.

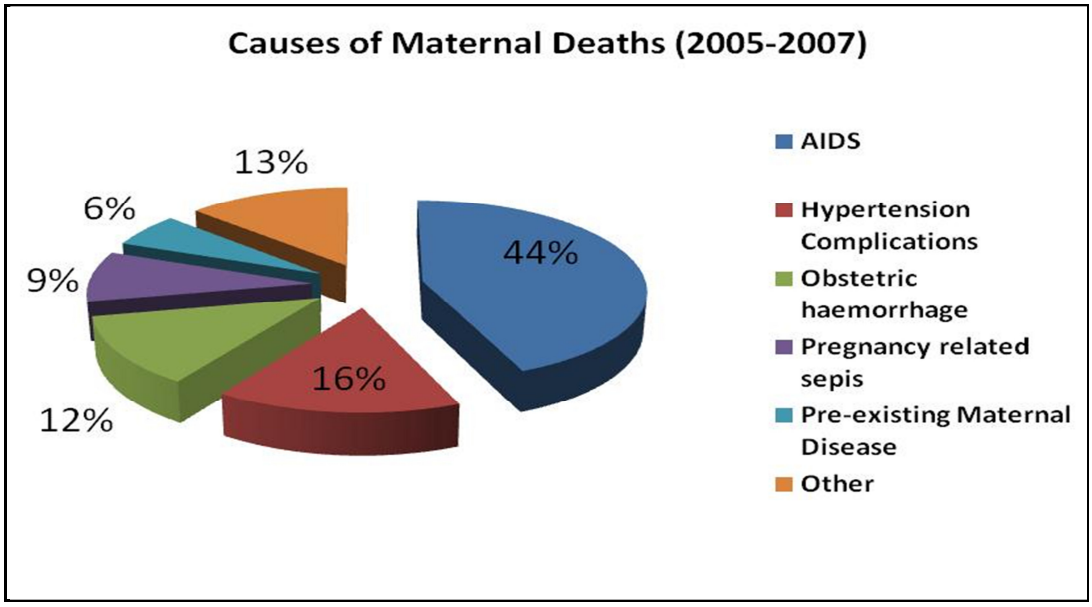


FIGURE 2: CAUSES OF MATERNAL DEATH 2005-2007

While better than other parts of the country, the Western Cape infant mortality figures remain a cause for concern. The major causes of childhood deaths are diarrhoeal disease, lower respiratory tract infections and peri-natal conditions with HIV/AIDS and malnutrition contributing as both primary and underlying causes of child mortality.

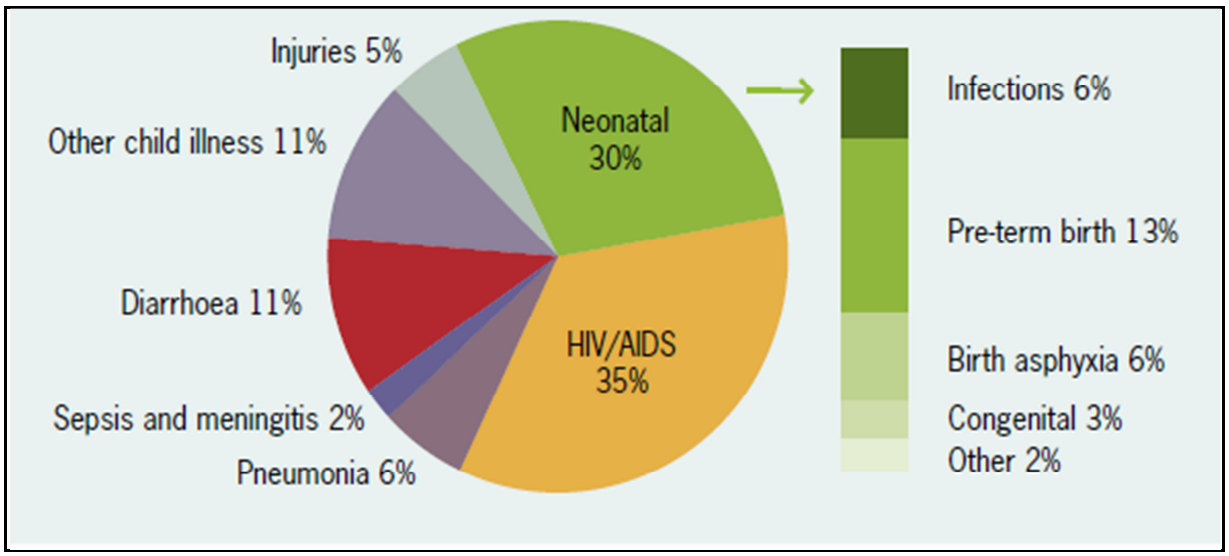


FIGURE 3: CAUSES OF DEATH IN NEWBORN AND CHILDREN UNDER 5 YEARS, 2000-2005

The Western Cape's implementation plan focuses on saving children by reducing the Peri-natal Mortality Rate (PNMR) and Early Neonatal Death Rate (ENNDR). Actions include Vitamin A supplementation to babies in their first year. Strategies to address maternal mortality causes are, implementation of the PMTCT programme; provide antiretroviral therapy to those in need thereof and improving clinical skills of staff in managing obstetric emergencies. In addition to national guidelines developed by the National Committee on Confidential Enquiry into Maternal Deaths

(NCCEMD) the Western Cape has also developed guidelines on managing the five main causes of maternal deaths.

1.2.2.1 HIV AND AIDS

The estimated HIV prevalence in the age group 15-49 years for the Western Cape is 5.3%, which makes it the province with the lowest prevalence rate in the country[6]. The highest HIV prevalence estimates are found amongst the 25-29 and 30-34 year age group. There are also significant variations at district and sub-district level. Apart from mother to child transmission, the risk of acquiring HIV primarily involves the practice of unsafe sex, which is further exacerbated by patterns of high partner turnover and partner concurrency. Further drivers include gender inequalities and the coercive nature of some sexual transactions. According to the Western Cape Burden of Disease Study other contributing factors include poor levels of education, transactional sex, mobility, migration and the socio-economic clustering of poverty, unemployment and overcrowding.

1.2.2.2 TB

The HIV epidemic has led to an enormous increase in the number of TB cases. TB, an opportunistic infection, is responsible for a third of all deaths in HIV-infected people, and people with HIV are far more susceptible to TB infection and less able to fight it off. The reported incidence of tuberculosis (TB) in the Western Cape, particularly in Cape Town, continues to be amongst the highest in the world, complicated and exacerbated by the HIV/AIDS pandemic. Effective management of TB remains one of the key principles of Provincial and Local Government health services. The increasing recognition that HIV is fuelling the TB epidemic in high HIV prevalence populations and that TB is a leading cause of HIV-related morbidity and mortality, has led to broad multi-sectoral strategic plans to guide the response to both pandemics[7]. The Western Cape Department of Health is in the process of adopting an integrated TB and HIV/AIDS strategy[8]. Currently voluntary counselling and testing (VCT) is offered to TB clients with the aim of reducing early death and illness. Cotrimoxazole prophylaxis (drugs to treat pneumonia) is given for dually infected individuals. There has been a dramatic increase in the number of TB cases registered over the past 13 years although there may be a slowing down in TB case-finding as from 2007. The incidence of TB is also declining as from 2008.

TB case finding and incidence rates in the Western Cape 1997-2010		
Year	**All Newly Registered TB Cases**	**Incidence Rate/100 000 All TB**
1997	27509	689
1998	28843	709

[6] National HIV Survey 2008, pg. 36.

[7] http://www.hst.org.za/publications/cape-town-tb-control-progress-report-1997-2003
[8] http://www.capegateway.gov.za/eng/directories/services/11520/6531

1999	31536	761
2000	33665	797
2001	40144	933
2002	42123	960
2003	44414	993
2004	46256	967
2005	47603	989
2006	49105	1033
2007	48911	1008
2008	50177	947
2009	50111	909
2010	49819	885

Figure 4: Case Finding and Incidence Rates

1.2.3 STRATEGIC ENABLERS

Within each of the provincial strategic objectives the key populations infected and affected by HIV and AIDS, STIs and TB will be targeted with different, but specific interventions, to achieve maximum health outcomes. Strategic enablers are factors that are critical to the successful implementation of the PSP, within the broader context of NSP 2012-2016 implementation. Key strategic enablers that underpin the PSP and that will determine the success of its implementation include: governance and institutional arrangements; effective communication; monitoring and evaluation; and research. Separate chapters are dedicated to all of the strategic enablers and will not be detailed here. However, issues related to communication relate to all aspects of the PSP and is therefore highlighted here.

At the request of the Premier, province has established a Provincial AIDS Council Secretariat to strengthen **governance and institutional** obligations. The Secretariat is comprised of the Provincial Head who will spearhead provincial and sectoral strategic planning and implementation as well as liaison functions between the PAC and SANAC. An Assistant Manager's position has been created to assume responsibilities for sectors' M & E functions while a position of an Administrative Officer will provide general administrative support to the Secretariat. The provincial head's position has been filled and the two vacant secretariat posts will be filled during 2012 as part of year one of the PSP implementation.

Effective **communication** is critical for the implementation of the PSP. Communication across the provincial and national response needs to be strengthened, through amongst others a communication strategy for the media. Social and behaviour change communication is also critical to changing risk behaviour and the social conditions that drive the HIV, STI and TB epidemics in the Western Cape. A challenge for communication in a hyper-endemic country is to reach key populations while still ensuring that the general population is well informed and able to prevent and mitigate the effects of HIV, STIs and TB. Each of the PSP strategic objectives will require major communication efforts at all levels of implementation of the PSP.

Strategic Objective 1: Focus on Social and Structural Approaches to HIV and TB Prevention, Care and Impact

Social and structural approaches address the social, economic, political, cultural and environmental factors that lead to increased vulnerability to HIV, TB and STI infections.
Strategic Objective 1 (SO 1) is focused specifically on structural factors that are amenable to change. Eight sub-objectives, and lead agencies for their implementation, have been identified.

These are:

- Mainstream HIV and TB and its gender and rights-based dimensions into the core mandates of all government departments;
- Address social, economic and behavioural drivers of HIV, STIs and TB. This includes addressing challenges posed by: living in informal settlements as well as rural and hard-to-reach areas; migration and mobility; and alcohol and substance abuse;
- Implement interventions to address gender norms and gender-based violence;
- Mitigate the impact of HIV, STIs and TB on orphans, vulnerable children and youth;
- Reduce the vulnerability of young people to HIV infection by retaining them in schools as well as increasing access to post-school education and work opportunities;
- Reduce HIV-related stigma;
- Strengthen community systems to expand access to services; and
- Poverty alleviation and strengthen food security.

Strategic Objective 2: Prevention of HIV, STI and TB Infections

Combination prevention uses a mix of biomedical, behavioural, social and structural interventions that will have the greatest impact on reducing transmission and mitigating susceptibility and vulnerability to HIV, STI and TB. Combination prevention efforts will be focused in high transmission areas and on key populations, whilst sustaining and expanding efforts in the general population.
SO 2 is focused on primary strategies to prevent sexual and vertical transmission of HIV, STIs and to prevent TB infection and disease.

The following eight sub-objectives are included for HIV, STI and TB prevention:

- Maximise opportunities to ensure everyone in South Africa is tested for HIV and screened for TB, at least annually, and enrolled in wellness and treatment, care and support programmes;
- Make accessible a package of sexual and reproductive health (SRH) services, including integrating SRH services into PHC and conducting prevention activities in non-traditional outlets. The package includes medical male circumcision, emphasis on dual protection; and provision of both male and female condoms;
- Prevent HIV, STIs and TB in adolescents and youth through a comprehensive package of services in schools, and for out-of-school youth;
- Reduce transmission of HIV from mother to child to less than 2% at six weeks after birth and less than 5% at 18 months of age by 2016. This includes strengthening the management, leadership and coordination of the prevention of mother to child HIV transmission (PMTCT) programme and ensuring its integration with maternal and child health programmes. TB screening will be integrated into the PMTCT programme.
- Implement a comprehensive national social and behavioural change communication strategy with a focus on key populations. This aims to increase demand and uptake of services, to promote healthy behaviours, and to challenge norms and behaviours that put people at risk of HIV and TB;

- Prepare for the potential implementation of future innovative, scientifically proven HIV, STI and TB prevention strategies, such as pre-exposure prophylaxis and microbicides;
- Preventing TB infection and disease. This includes intensified TB case finding, TB infection control, workplace/occupational health policies on TB and HIV, Isoniazid preventive therapy (IPT), immunisation, prevention of multidrug-resistant TB (MDR-TB) and reducing TB-related stigma, alcohol consumption and smoking; and
- Implement 'treatment for prevention' strategies that ensure early ARV initiation as per national policy guidelines and early treatment of TB and improved TB cure rate.

Strategic Objective 3: Sustain Health and Wellness

The primary focus of this strategic objective is on achieving significant reduction in deaths and disability as a result of HIV and TB. This will be accomplished by universal access to affordable and good quality diagnosis, treatment and care.
The four sub-objective of SO 3 are:

- Reduce disability and death resulting from HIV and TB. This includes: annual testing/screening for HIV, TB and STIs; improved contact tracing; increased access to high-quality drugs; early diagnosis and rapid enrolment into treatment; improved access to treatment for children, adolescents and youth; initiation of all HIV positive TB patients and pregnant women on ART; design of a patient-centred pre-ART package; early referral of all complicated cases; and appropriate screening and treatment for cryptococcal infection;
- Ensure universal access to treatment, care and support for HIV, TB and STIs. This includes programmes targeted at key populations and implementation of innovative technologies;
- Ensure that people living with HIV, TB and STIs remain within the healthcare system, are adherent to treatment and maintain optimal health. This includes the establishment of ward-based PHC teams; and regular communication using all appropriate media;
- Ensure that systems and services remain responsive to the needs of people living with HIV, TB and STIs. This includes integrating HIV and TB care with an efficient chronic care delivery system; expanding operating hours of service delivery points; ensuring continuum of care across service delivery points, strengthening quality standards; and adequate monitoring of drug resistance.

Strategic Objective 4: Protection of Human Rights and Promotion of Access to Justice

South Africa's response to HIV, STIs and TB is based on the understanding that the public interest is best served when the rights of those living with HIV and/or TB are respected, protected and promoted.

The four sub-objectives of SO 4 focus on a set of interventions to ensure that the current legal framework for human rights in the context of HIV and TB is applied. They are:

- Identify and remove laws that undermine implementation of all NSP interventions and/or increase vulnerability to HIV and/or TB infection. This includes audits of primary and secondary legislation and the criminal law and implementing a law reform agenda and process;
- Ensuring rights are not violated when interventions are implemented and establishing mechanisms for monitoring abuses and vindicating rights. This includes auditing interventions to identify potential for human rights abuses; guarding against rights violations as part of policy development and programme planning; using existing bodies to monitor human rights abuses and increasing access to justice; and building capacity within civil society to increase

access to justice;

- Reduce HIV and TB discrimination in the workplace. This includes campaigns against unfair discrimination and empowerment of employees especially those in small and non-traditional workplaces; and
- Reduce unfair discrimination in access to services. This includes ensuring that oversight bodies receive and address complaints, and training service providers to prevent unfair discrimination.

1.3 MONITORING AND EVALUATION

The NSP highlights the key aspects towards building and operationalisation of a comprehensive monitoring and evaluation (M&E) system for monitoring the NSP. The framework takes into account existing monitoring and evaluation sub-systems being implemented by different stakeholders, as well as planning and monitoring frameworks and policies in government.

Objectives of the M&E framework are to:

- Monitor the HIV and TB epidemics, focusing on incidence, prevalence, morbidity and mortality;
- Build a M&E system for the NSP that strengthens existing systems, and incorporates new systems for community-based monitoring and reporting;
- Monitor implementation of the NSP; and
- Develop and implement an evaluation agenda for the NSP.

A strengthened M&E Unit in the SANAC Secretariat (with technical support from task teams) will be responsible for implementing the monitoring and evaluation framework at national level. The M&E component of the Provincial AIDS Councils Secretariat will assume the same responsibility at provincial and sectoral levels in the province.

A midterm and end-of-PSP evaluation will be conducted. The Midterm Review will focus on achievements, challenges, emerging issues and recommendations for the remaining term of the PSP, and will take place in 2014. To complement the midterm evaluation, annual programme reviews will be conducted.

1.4 RESEARCH

The main goal of research on HIV, STIs and TB in South Africa is to provide scientific evidence to guide and enhance the country's response to the three diseases. The NSP provides an overall approach to the research agenda, rather than listing individual research topics. Four main streams of research are presented as the basis for generating the knowledge needed to support the goals of the NSP. These are:

- Surveillance and vital statistics;
- Health systems and operations research;
- Research for innovation; and
- Policy, social and public health research.

South African research on HIV, STIs and TB is widely recognised as being world class, however most of the current research done by South African researchers is skewed towards global issues, largely dictated by their dependence on international funding. Therefore a new approach and the following four steps are proposed:

- Researchers and policy makers must commit jointly to an evidence-based approach to the country's HIV, STI and TB response;
- Regular interaction must occur between researchers, policy makers and the leaders of public health programmes to ensure that the HIV, STI and TB policies and programmes take account of the latest science;

- A national research agenda needs to be developed on the basis of detailed knowledge of the burden of disease; and
- Local funding of HIV, STI and TB research must increase substantially.

1.5 COSTING AND FINANCING THE PSP 2012-2016

The NSP has been designed to indicate broad goals and objectives for the country's response. However, without detailed activities and implementation plans, any costing undertaken at this stage can only provide an estimate of the likely magnitude of the costs.

An updated and adjusted version of the Resource Needs Model from the "AIDS 2031" costing, and the National AIDS Cost Model will be used to provide broad estimates of the cost of the NSP. This model will be calibrated to the latest Actuarial Society of South Africa (ASSA) epidemiological indicators. A gap analysis, comparing projected costs to current expenditure will also be undertaken. Recommendations on the financing of the NSP will also be made.

Once the province has developed a measurable implementation plan, the costing of this plan will be undertaken and completed. A results-based costing tool will link the resource needs estimates to their intended outputs and results. This will enable provinces to track their expenditure and to ultimately ensure that their spending achieves their overall goals.

1.6 COMMUNICATING THE PSP

The PSP is a critical document to enable the Western Cape to coordinate and build efforts to control HIV, STIs and TB. To gain buy-in and for accountability, the PSP must be available as widely as possible. The PSP document will be widely distributed to all stakeholders. A simplified, accessible version of the PSP will also be published in the Western Cape official languages (English, Afrikaans and IsiXhosa), for distribution to the general public.

CHAPTER 2 – THE PROVINCIAL RESPONSE

2.1 NATIONAL OVERVIEW

The HIV, STI and TB National Strategic Plan (NSP) 2012-2016 is the culmination of extensive review of achievements against the goals and objectives set out in the NSP 2007-2011 using reports, documentation, consultation and deliberation over several months with a wide range of stakeholders. These processes were key to determine the strategic priorities in dealing with the dual epidemics of HIV and TB in South Africa. The South African National AIDS Council (SANAC), and more specifically its Programme Implementation Committee (PIC), and the Plenary Committee of SANAC provided the overall guidance and framework for the NSP. One of the key decisions included the development of a single integrated strategy for HIV, STIs and TB for 2012-2016. This is primarily due to the high HIV and TB co-infection rate.

The NSP 2012-2016 is the strategic guide for HIV, STI and TB initiatives for the next five years. It is results-based and focuses on the drivers of the epidemics to achieve the goals defined below. It builds on the achievements of the previous NSPs, scaling up what has been done well, and improving the quality of services, while at the same time integrating new and proven strategies. The NSP is intended to respond to the rapid changes in the epidemic and will therefore be reviewed regularly for relevance and effectiveness. It is located within the broader development plan of government. The NSP is a multisectoral, overarching guide that aims to inform national, provincial, municipal and community-level stakeholders on the *strategic directions* to be considered when developing strategies and implementation plans. It will also be used by SANAC as the framework by which it will coordinate and monitor implementation. Every government department, sector and provincial authority will need to develop implementation plans by March 2012 in line with the NSP. Provincial strategic and operational plans are derived from a number of core documents, including:

- The NSP – 2012 -2016;
- Western Cape DoH Strategic Plan;
- The HIV/AIDS Conditional Grant Business Plans.
- The Provincial Strategic Objective 4: Improving Wellness
- Vision 2020 for the health sector
- Government sector departments' strategic and annual performance plans (APPs);
- Sectors' strategic plans.

2.2 WESTERN CAPE DEMOGRAPHIC OVERVIEW

The Western Cape province is situated in the south west of the Republic of South Africa and covers a land surface of 129,307km^2 which is 10.6% of the country's total land surface. The population of the Western Cape is 5,223,900, which represents approximately 10.4% of South Africa's total population[9]. The Western Cape population growth is estimated at 2.1% per annum. Migration

[9] StatsSA, Mid-year Population Estimates 2010, pg. 4.

stream is a factor in the province's population growth with an out-migration of 111,500 and an in-migration of 206,100, with a total population gain of 94,600 for the period 2006-2011[10]. The Western Cape and Gauteng are the only two provinces that have a significant positive net migration stream. The province is divided into five rural district municipalities – Cape Winelands, Eden, Overberg, West Coast and Central Karoo, and the metropolitan district of the City of Cape Town. The Cape Town Metro district accommodates approximately 66% of the population of the province and has higher density ratios, which is significant for planning and implementation purposes. The Central Karoo district, on the other hand, is sparsely populated.

While the Provincial Department of Health is responsible for the delivery of health care in the rural district municipalities, in the Cape Metro District both the Cape Town Municipality and the Metro District Health Services are involved.

FIGURE 5: WESTERN CAPE DISTRICT MUNICIPALITIES

The DoH Strategic Plan notes that the impact of these observed demographic trends in the Western Cape might result in a smaller decline in the fertility rate, a drop in life expectancy as well as an increase in the levels of poverty[11]. Over the past decade the estimated Western Cape maternal mortality ratio has increased from 62.4 (2002) to 98.9 (2004) per 100,000 live births. This indicates that despite being the lowest in the country, the provincial MMR has increased steadily over time and is attributed mainly to non-pregnancy related sepsis, primarily as a result of HIV and AIDS[12]. When considered together in the Western Cape, HIV/AIDS and Tuberculosis (TB) constitute

[10] StatsSA, Mid-year Population Estimates 2010, pg. 13.
[11] DoH Strategic Plan 2010/11 – 2014/15, pg. 12.
[12] DoH Strategic Plan 2010/11 – 2014/15, pg. 15.

the largest burden of premature mortality (22% of years of life lost), and rank among the three major causes of years of life lost in the province[13].

2.3 PSP VISION

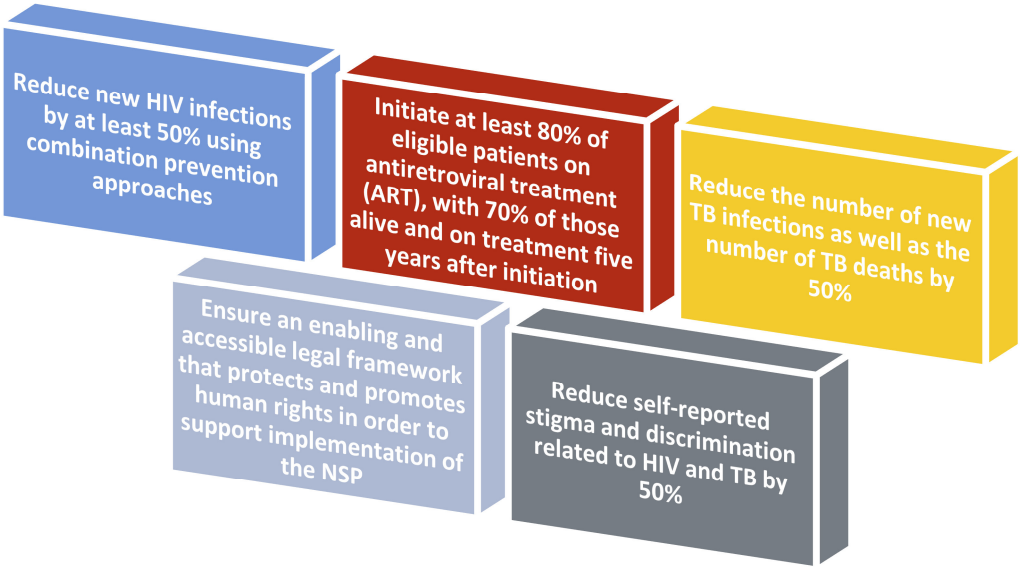
The PSP 2012-2016 is driven by the national long-term vision for health – "a long and healthy life for all South Africans", as well as the provincial vision with respect to the two epidemics. In alignment with the national vision the province will gear its response to the twenty-year vision of the Three Zeros that have been advocated for by UNAIDS. These are:

- Zero new HIV, STI and TB infections;
- Zero deaths associated with HIV and TB;
- Zero discrimination.

Its vision is also linked to the provincial vision of "delivering the open opportunity society for all" and the provincial health vision of "quality health for all".

2.4 PSP GOALS

In line with this twenty-year vision (the Three Zeros), and Provincial Strategic Objective 4 – "Increasing Wellness" - the Western Cape PSP 2012-2016 has the following broad goals:



[13] Burden of Disease

2.5 PSP PRINCIPLES

The PSP recognizes that the HIV, TB and STI response requires a whole-of-society approach that mobilizes the resources, knowledge, creativity and commitment of all role-players – including provincial and local government, civil society, business, partner donor agencies and individual citizens. The principles that underpin the Western Cape PSP as well as the national, provincial and sectoral implementation plans are as follows:

- ***Long-term focused and vision led*** – all provincial PSP initiatives will be clearly linked to the vision of the NSP (national response) and will demonstrate how they contribute to the achievement of that vision at the provincial level;
- ***High impact and scalability*** – in line with international trends, preference will be given in planning and implementation to high-value, high-impact and scalable initiatives
- ***Cost effectiveness*** – recognising that the implementation of the PSP takes place in an increasingly resource constrained environment priority will be given to cost-effectiveness within provincial planning processes and delivery of good returns on investment;
- ***Evidence based*** – PSP initiatives within the Western Cape will be based on epidemiological and programmatic evidence and implementation will focus on the achievement of well-formulated objectives and targets.
- ***Rights based*** – PSP initiatives within the Western Cape will be rights based, with a focus on ensuring that the rights of key populations and marginalised groups are protected, and that stigma and discrimination is combated at all levels;
- ***Flexible and responsive*** – the PSP will be flexible and responsive so as to ensure that changes and adaptations can be made quickly when context and evidence demands;
- ***Multi-sectoral*** – the PSP will promote the integration of the human and financial resources of all sectors of society so that the PSP goals and objectives can be achieved, especially at local level where a community-centred integrated approach is critical;
- ***Engaged with communities*** – to deepen the impact of the PSP communities will be strengthened and enabled to own and drive HIV and TB prevention, treatment, care and support initiatives that have relevance for them;
- ***Partnership*** – the PSP will promote constructive, sustainable partnerships at all levels and provincial ownership through empowerment, communication and coordination.

2.6 EPIDEMIOLOGY OF HIV AND TB

2.6.1 THE NATIONAL HIV EPIDEMIC

An understanding of the epidemics and the key drivers thereof are fundamental in guiding the NSP as well as the provincial strategic and operational plans. A review of the evidence shows that the HIV prevalence in pregnant women attending public sector clinics is stabilizing at a very high level of around 30%.

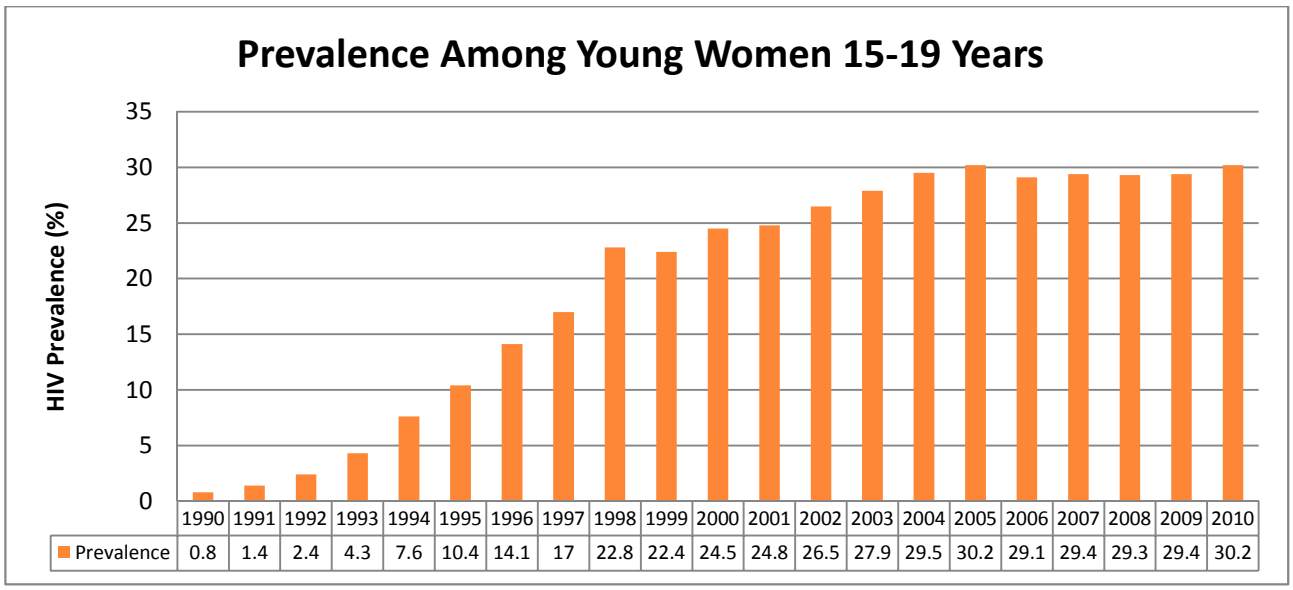


FIGURE 6: ANTENATAL SEROPREVALENCE RATES, SOUTH AFRICA1990-2010 (2010 NATIONAL ANTENATAL SENTINEL HIV AND SYPHILIS PREVALENCE SURVEY IN SOUTH AFRICA)

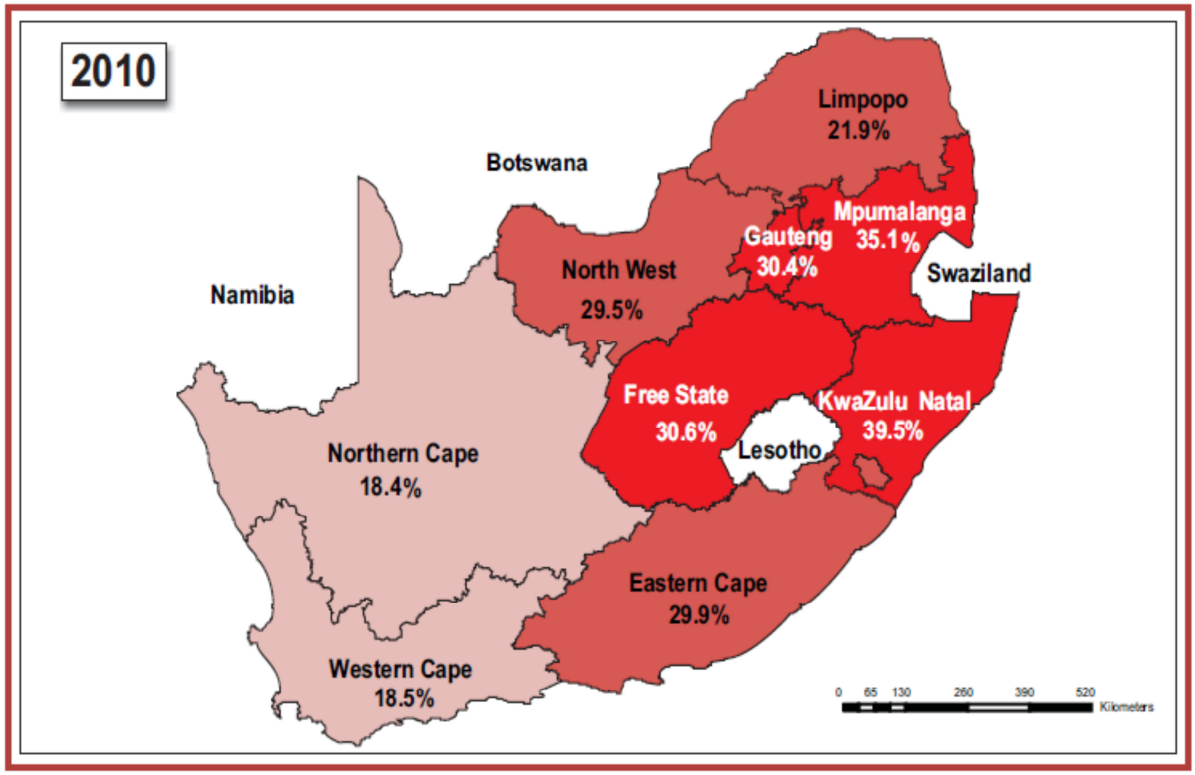
However, there is marked heterogeneity in HIV prevalence by key epidemiological variables such as age, race, gender, geographical location and social economic status reflecting differentials in exposure to risk of infection. The HIV interventions proposed in the NSP are guided by the findings of the "Know Your Epidemic" report and other analyses that identified the key proximate determinants of the HIV epidemic in South Africa. These include behavioural, social and biological factors – as well as underlying structural and societal factors such as poverty, gender inequalities, human rights abuses, and migrant labour. South Africa has a generalised HIV epidemic driven largely by sexual transmission. Using the Spectrum model, the 2009 the HIV prevalence in the adult population (aged 15-49) was estimated at 17.8%. An estimated 5.63 million adults and children were living with HIV. Of these, 5.3 million were adults aged 15 years and older, 3.3 million were females and 334,000 were children.[14]

2.6.2 THE PROVINCIAL HIV EPIDEMIC

The prevalence of HIV in South Africa shows considerable variance across its nine provinces.

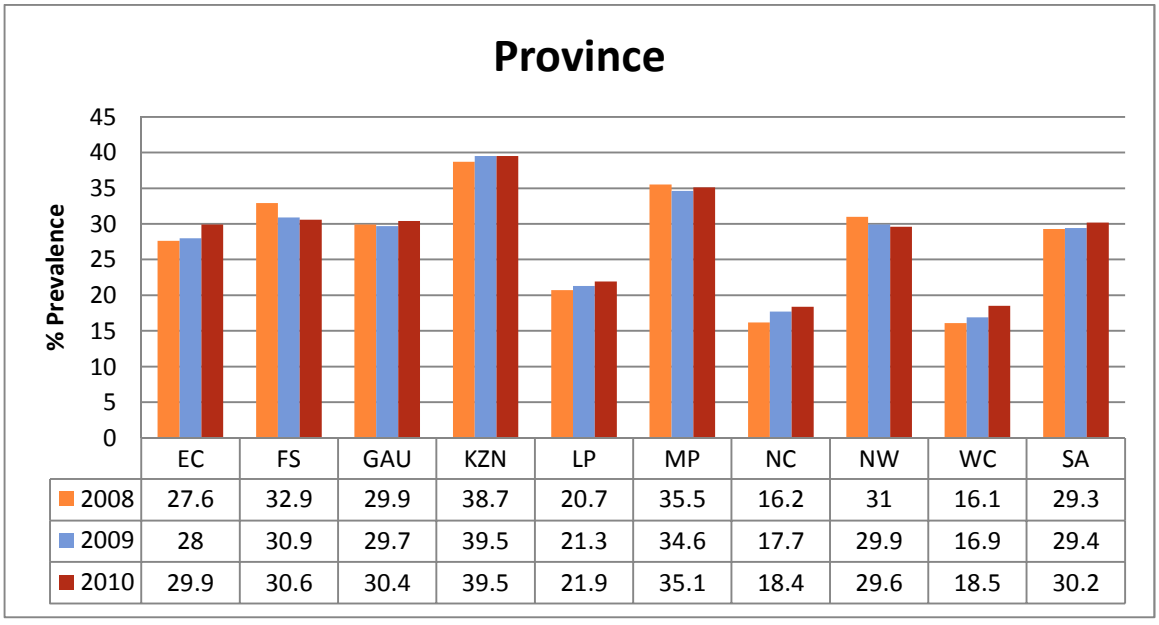
FIGURE 7: HIV PREVALENCE AMONG PREGNANT WOMEN BY PROVINCE, 2010

[14] Department of Health programme data, 2010



Source: Antenatal Sero-prevalence Survey 2010

Results from the 2010 *National Antenatal Sentinel HIV and Syphilis Prevalence Survey* indicate that the highest HIV prevalence rates are located in the Central and Eastern parts of the country, and the lowest prevalences in the Western Cape, Northern Cape and Limpopo. KwaZulu-Natal has the highest HIV prevalence followed by Mpumalanga and Free State with overall prevalence rates greater than 30.0%. North West, Limpopo, Gauteng and the Eastern Cape have prevalence rates between 20.0% and 30.0%. The Northern Cape and the Western Cape are the only provinces that have HIV prevalence rates of below 20.0%.



	EC	FS	GAU	KZN	LP	MP	NC	NW	WC	SA
2008	27.6	32.9	29.9	38.7	20.7	35.5	16.2	31	16.1	29.3
2009	28	30.9	29.7	39.5	21.3	34.6	17.7	29.9	16.9	29.4
2010	29.9	30.6	30.4	39.5	21.9	35.1	18.4	29.6	18.5	30.2

FIGURE 8: HIV PREVALENCE AMONG ANTENATAL WOMEN BY PROVINCE, SOUTH AFRICA 2008

The estimated HIV prevalence in the age group 15-49 years for the Western Cape is 5.3%, which makes it the province with the lowest prevalence rate in the country. The highest HIV prevalence estimates are found amongst the 25-29 and 30-34 year age group. In 2009, the Western Cape provincial HIV prevalence amongst 15 - 49 antenatal women was 16.9% (95% CI: 13.8% – 20.5%). The overall HIV prevalence increased from 15.3% in 2007 to 16.9% in 2009[15].There are also significant variations at district and sub-district level.

YEAR	2008			2009			2010		
	N	*%HIV+*	*95%CI*	*N*	*%HIV+*	*95%CI*	*N*	*%HIV+*	*95%CI*
Provincial (comp)	3,828	**16.1**	12.6-20.3	3,679	**16.9**	13.8-20.5	3,981	**18.5**	15.1-22.5
Cape Winelands	539	**16.1**	8.2-17.3	499	**13.2**	9.0-19.1	557	**14.9**	10.4-20.9
Central Karoo	54	**12.0**	7.5-27.1	51	**11.8**	6.8-19.6	59	**8.5**	3.1-20.9
Eden	338	**14.8**	8.8-18.8	39	**18.2**	12.9-25.0	353	**18.7**	13.6-25.2
Cape Metropole	2,536	**13.0**	13.2-23.9	2,481	**18.0**	13.8-23.1	2,656	**20.2**	15.7-25.6
Overberg	157	**17.9**	10.3-23.8	130	**20.8**	14.1-29.5	156	**17.3**	11.9-24.5
West Coast	204	**15.9**	6.2-13.6	199	**9.5**	6.1-14.6	200	**10.0**	6.6-14.9

FIGURE 9: HIV PREVALENCE AMONG ANTENATAL WOMEN BY DISTRICT, WESTERN CAPE, 2008 TO 2010 (SOURCE: EPIDEMIOLOGY & SURVEILLANCE NDOH).

The Cape Metropole carries the heaviest burden of HIV in the Western Cape, with more than 70% of the HIV infected pregnant women in the province. Prevalence in the West Coast has remained at or below 10% for the past three years. The Central Karoo district has shown a decrease by 3.3% from 11.8% in 2009 to 8.5% in 2010. However, in the Cape Winelands and Overberg districts there has been a slight increase of 1.7% and 3.5% respectively from 2009 to 2010.

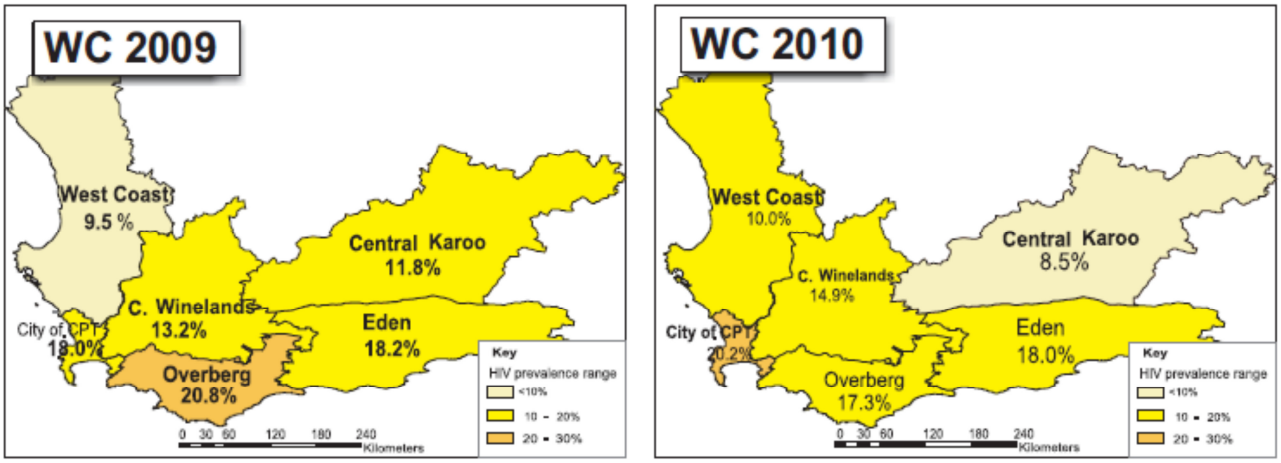


FIGURE 10: HIV PREVALENCE DISTRIBUTION AMONG ANTENATAL WOMEN BY DISTRICT, WESTERN CAPE, 2009-2010

[15] South Africa National HIV and Syphilis Antenatal Sero-Prevalence Survey 2010, pg. 54

Using modeled estimates from Spectrum (UNAIDS) and ASSA, the total number of people living with HIV (2009) is estimated at 5,62 million. Fewer new infections among adults (344 000) and children (42 700) were estimated for 2009 compared to 2008 estimates. Approximately 214 000 mothers were in need PMTCT services. Table 15b shows the provincial HIV prevalence estimates in the general population Provincial distribution of the estimated number of new infections for adults aged 15-49 and children younger than 15 years.

	Estimated number of new infections (adults 15-49)		Estimated incidence (adults 15-49) % per annum		Estimated number of new infections (children 0-14)	
	UNAIDS	ASSA[5]	UNAIDS	ASSA	UNAIDS	ASSA
South Africa	335 700	302 000	1.5	1.3	48 481	50 000
Kwazulu-Natal	98 600	78 000	2.3	1.7	14 235	15 000
Mpumalanga	28 200	27 000	1.9	1.6	4 069	5 000
Free State	22 600	19 000	1.7	1.4	3 263	3 000
Gauteng	67 100	68 000	1.4	0.9	9 692	9 000
Northwest	28 500	22 000	1.6	1.5	4 111	4 000
Eastern Cape	46 400	47 000	1.6	1.6	6 704	7 000
Limpopo	29 000	28 000	1.1	1.0	4 181	4 000
Northern Cape	3 100	3 500	0.7	0.7	449	500
Western Cape	12 300	14 000	0.5	0.5	1 778	2 000

FIGURE 11: PROVINCIAL ESTIMATES OF NEW INFECTIONS, 2009; UNAIDS/ASSA MODELS

The incidence for the South African population as a whole for 2009 was estimated at 1.5% of the uninfected per year. The Spectrum model showed considerable variation in the estimates of adult (15-49) incidence by province. The lowest incidence estimates were obtained for the Northern Cape (0.7%) and Western Cape (0.5%).

Apart from mother to child transmission, the risk of acquiring HIV primarily involves the practice of unsafe sex, which is further exacerbated by patterns of high partner turnover and partner concurrency. Further drivers include gender inequalities and the coercive nature of some sexual transactions. According to the Western Cape Burden of Disease Study other contributing factors include poor levels of education, transactional sex, mobility, migration and the socio-economic clustering of poverty, unemployment and overcrowding. Table 2 highlights key determinants of the HIV epidemic in the Western Cape based on *Know your Epidemic* and *Burden of Disease Report* as well as other analyses and highlights actions that will mitigate the impact of the epidemic.

TABLE 12: KEY DETERMINANTS OF THE HIV AND TB EPIDEMICS IN THE WESTERN CAPE

Behavioural and Social Determinants	
Sexual debut	Tailored prevention interventions for the youth to facilitate delay of sexual debut and sustain protective behaviours
Multiple sexual partners	Multi-level interventions focusing on sexual, social and cultural norms and values
Condom use	Increase consistent use, especially among key populations, including those involved in sex work
Age-disparate sexual (intergenerational)	Target prevention strategies at those men and women who have partners much younger/older than themselves given they are more likely to be HIV-

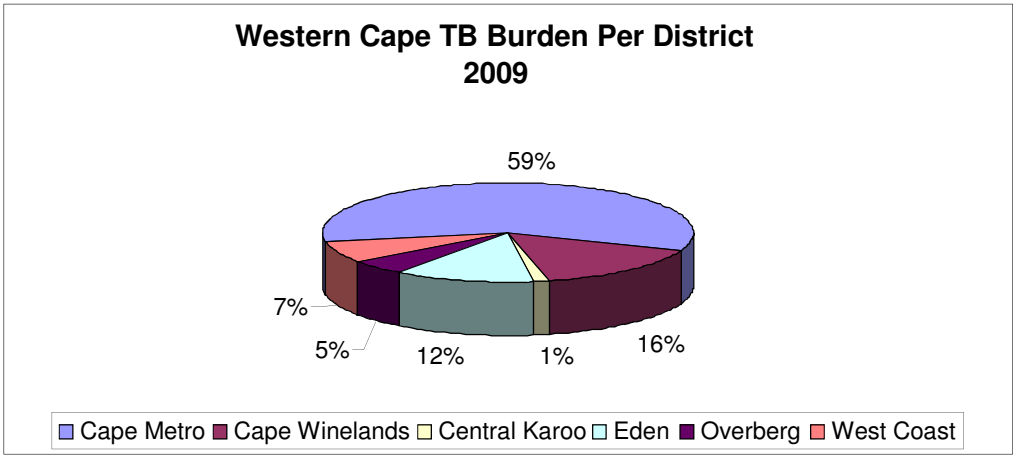
relationships	positive than people who reported partners of similar age only
Alcohol and substance abuse	Interventions to decrease alcohol abuse and other substance abuse (including illegal substances)
Prevention knowledge and risk perception	Prevention strategies for people who continuously expose themselves to the risk of HIV infection because of incorrect perceptions of personal risk
Stigma and discrimination	Initiatives that directly address the factors that facilitate the stigmatization of HIV and AIDS and TB, and that drive discrimination against infected and affected people
Biological Determinants	
Mother to Child Transmission	Strengthen the implementing the four prongs of the PMTCT programme, and work towards MTCT elimination
Male Medical Circumcision	Continue with aggressive rollout of a national medical male circumcision programme
Other Sexually Transmitted Infections	Prevention and early treatment of STIs
Treatment as Prevention	Initiating all eligible people living with HIV to treatment according to national guidelines to improve their health outcomes and to reduce transmission
Structural Determinants	
Mobility and Migration	The risk of HIV infection is higher among individuals who either have personal migration experience or have sexual partners who are migrants and therefore appropriately targeted interventions are required
Gender Roles and Norms	Address the position of women in society, particularly their economic standing
Sexual Abuse and Intimate Partner Violence	Interventions on gender-based violence and intimate partner violence

2.6.3 THE PROVINCIAL TB EPIDEMIC

The World Health Organization (WHO) estimates[16] shows that South Africa currently ranks the third highest in the world in terms of TB burden, behind India and China with an incidence that has increased by 400% in the past 15 years, reaching 970 new infections per 100,000 population in 2009[17]. This increase in incidence is compounded by multidrug-resistant tuberculosis (MDR-TB), with almost 7,386 confirmed MDR-TB cases in 2010 and 741 confirmed cases of extensively drug-resistant TB (XDR-TB) during the same period. The HIV epidemic is currently driving the TB epidemic with more than 70% of TB patients also living with HIV. Approximately 1% of the South African population develops TB disease every year. Case detection for all forms of TB has steadily increased from 279,260 in 2004 to 401,608 in 2010. The number of new smear positive cases has remained stable during the same period. The highest prevalence of latent TB infection, estimated at 88% occurred among people in age group 30-39 years in township situations and informal settlements. This underscores the fact that TB is a disease of the poor. Township and informal settlement conditions are characterized by overcrowding and low social economic status all of which provide fertile ground for TB infection and disease.

[16] 2011. WHO Report. Global Tuberculosis Control
[17] WHO Global TB Control Report, 2010

The HIV epidemic has had negative impacts on the outcome of TB case management as those co-infected with HIV experience a higher mortality. Among HIV-positive patients who acquire extensively drug resistant TB (XDR-TB) mortality is high. TB screening among people living with HIV is around 40% with a very low rate (about 38%) on isoniazid preventive therapy (IPT). There is late initiation of ART in TB patients, contributing to mortality. Treatment success rate of new infectious TB cases is around 74% compared to the global target of >85%. The combination of TB and HIV continues to pose a serious public health challenge in the Western Cape and is a leading cause of premature death[18].



In response to the challenge of HIV / TB co-infection, including the growing epidemic of drug-resistant tuberculosis (DR-TB), the Western Cape has demonstrated significant progress in TB control with the implementation of the global TB DOTS Strategy and the provincial Enhanced TB Response Strategy. The Western Cape response is also aligned to the Tuberculosis Strategic Plan for South Africa 2007-2011 and has integrated the same vision, mission and strategic objectives into the provincial response. The Western Cape TB response was reviewed in 2009, as part of the provincial reviews of the *Joint Review of the National TB Control Programme South Africa*[19]. The provincial SO4 notes that the biggest risk factor for TB is concurrent HIV infection. It also points to the fact that TB is described as a social disease as it is closely linked to the upstream issues of poverty, unemployment and overcrowding. The Western Cape is reported to have one of the highest incidences for all smear positive cases of TB in South Africa (885 per 100,000). 90% of patients with TB fall into the economically active group[20].

TB Cure Rate			
	Current Estimate	**Target 2014**	**Source**
Western Cape	79.4% in 2009/2010	80% is the target for 2012/13 in 2010/11 APP	Annual Report: 2009/10 Annual Performance Plan: 2010/11
South Africa	65%	85%	Negotiated Service

[18] Department of Health Media Pack World TB Day 2010

[19] The review was jointly conducted under the auspices of the National Department of Health and the World Health Organisation.

[20] National ETR.Net 2010

FIGURE 15: TB CURE RATES WESTERN CAPE

Over the past few years there has been an increase in the TB cure rate, but the DoH recognises the need for urgent intervention, with a focus on high-burden areas in order to halt the rise in prevalence. A significant challenge for the DoH's prevention efforts to mitigate the burden of co-infection is the emergence of multi-drug resistant (MDR) and extreme drug resistant (XDR) forms of TB. Patients who contract XDR-TB, and in particular those TB patients who are also HIV+, are virtually untreatable using currently available ant-TB drugs[21]. There is a concern in the province that the percentage of HIV+ MDR patients on ART has been declining since 2007, as shown in the following graph[22]:

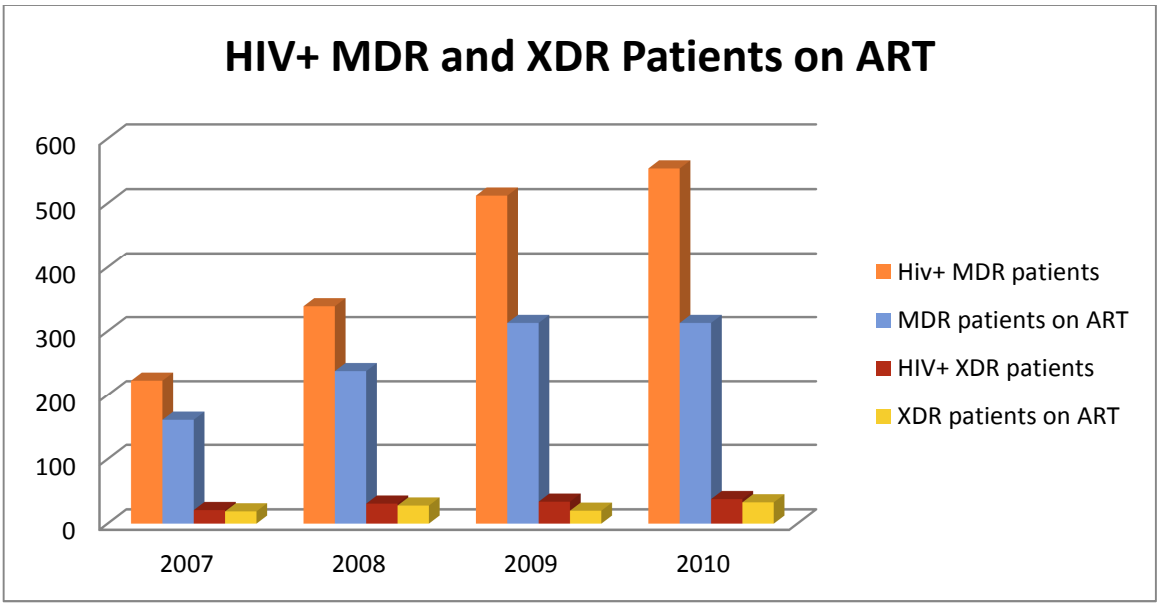


FIGURE 16: HIV+ MDR AND XDR PATIENTS ON ART

All drug resistant patients are eligible for ART, whatever their CD4 count happens to be. Despite this there has been a steady decline in the initiation of HIV+ MDR and XDR patients onto ART. 72% of MDR patients were on ART in 2007, but this declined to 56% of patients on ART in 2010. Poor recording and reporting contributed to these low numbers and monitoring and evaluation will be strengthened. The provincial HCT Programme has incorporated symptom screening for TB for all clients who present for HIV testing. Clients who have signs and symptoms of TB are tested for TB or referred to a TB health facility to be tested. Intensified TB case finding promotes early start of tuberculosis treatment, which reduces HIV related TB disease and death, and at the same time contributes to infection control by reducing transmission of TB in communities and health facilities. Under the ongoing HCT programme clients presenting with both TB and HIV infection will be initiated on ART where their CD4 count is 350 or less. This represents a significant shift from the previous guidelines where treatment was initiated only where the CD4 count was less than 200. Figure 16 compares the districts in terms of positivity load as well as performance. On average there is a good CPT coverage of 90.3%.

[21] Overview of TB Programme 2007-2011, pg. 12.
[22] Source: Western Cape Department of Health - Overview of TB Programme 2007-2011

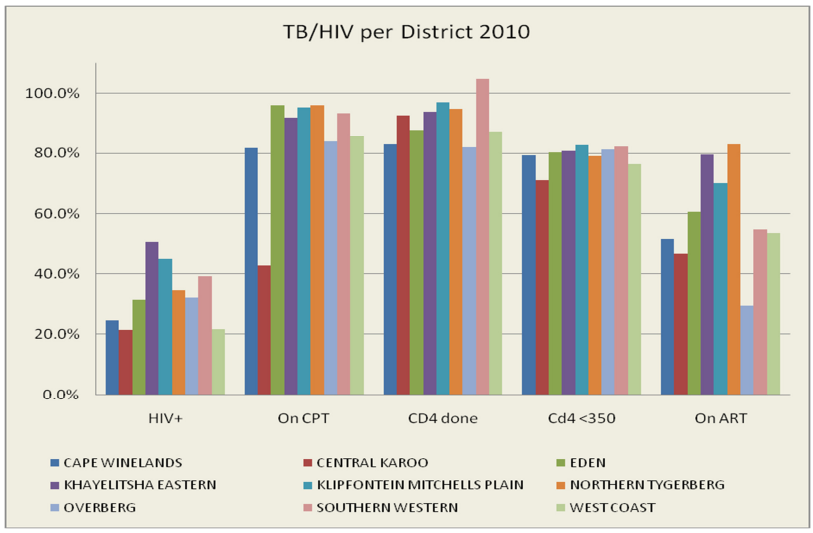


FIGURE 16: TB/HIV PER DISTRICT 2010

The eligibility for ART is high, with 73% of cases having a CD4 count of <350. The province managed to initiate 67.5% of eligible cases on ART. There are huge variations between districts in the proportions of people initiated on ART. The TB/HIV elements illustrate remarkable progress but also identify clearly the challenges in both service delivery and information management. Incidence rates in the Western Cape have shown a downward trend since 2008 consistent with the case numbers with no increase the EPTB as was expected with the HIV epidemic. The smear negative rate and smear negative as a percentage of PTB, however, increased constantly over the past 6 years as predicted in a growing HIV epidemic.

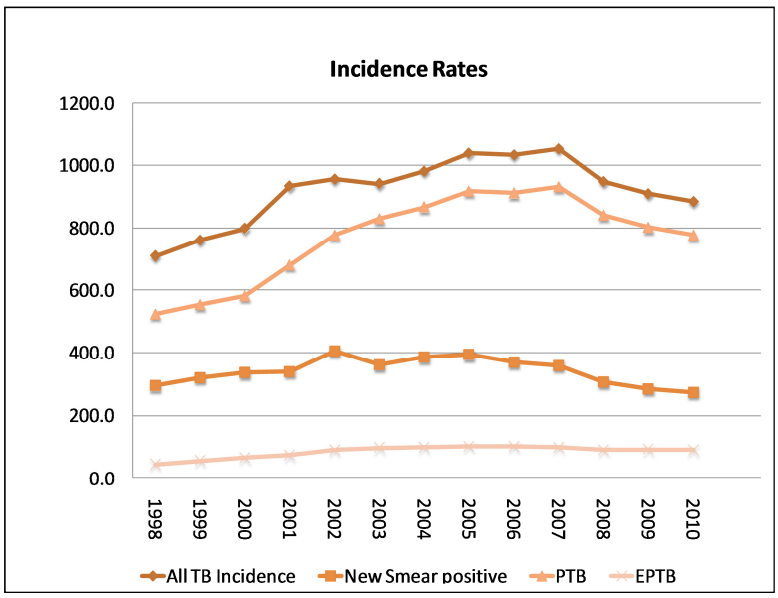


FIGURE 17: TB INCIDENCE RATES 2001-2010

2.7 KEY POPULATIONS FOR THE HIV AND TB RESPONSE

Even though the Western Cape HIV prevalence is well below the national figure, it is impacted by the national generalised HIV epidemic, and has some of the highest rates of TB infection and disease burden in the world. In the Western Cape there are still higher levels of infection and

transmission within certain geographic areas, as well as among some key populations. Though the PSP promotes a broad framework for addressing HIV, STIs and TB at a general population level, it also identifies certain sub-populations that should be targeted for specific prevention, care, treatment and support interventions based on risk and need. The identification of key populations for targeted interventions should be included in all implementation plans.

The Western Cape KYE report highlights the areas where the epidemic seems to be concentrated, and some of the major risk factors for HIV infection. Many of these groups are among the most marginalized and most likely to be stigmatized as many resources and provincial HIV-prevention campaigns do not necessarily address their specific HIV and TB prevention, treatment and care needs[23]. In the context of the PSP, key populations that are at higher risk for HIV infection include:

- **Young women between the ages of 15 and 24** years are four times more likely to have HIV than males of the same age. (This risk is especially high among pregnant women between 15 and 24). On average young females become HIV-positive about five years earlier than males;
- **People living or working along national roads and highways;**
- **People living in informal settlements** in urban areas have the highest prevalence of the four residential types[24];
- **Young people who are not attending school.** Completing secondary schooling is protective against HIV, especially for young girls, in addition men and women with tertiary education are significantly less likely to be HIV positive than those without tertiary education;
- **People with the lowest socio-economic status** are associated with HIV infection. Those who work in the informal sector have the highest HIV prevalence with almost a third of African informal workers being HIV positive. Among women, those with less disposable income have a higher risk of being HIV positive;
- **Uncircumcised men.** Men who reported having been circumcised *before* their first sexual encounter were significantly less likely to be HIV positive.
- **Persons with disabilities** have higher rates of HIV. Attention should be paid to the different types of disabilities, as the vulnerabilities of different groups and the associated interventions required will be different.
- **Men who have sex with men (MSM)** are at higher risk of acquiring HIV than heterosexual males of the same age, with older men (>30 years) having the highest prevalence.[25],[26]. The South African Centre for Epidemiological Modelling and Analysis (SACEMA) estimates that 9.2% of new HIV infections are related to MSM.[27]
- **Sex workers and their male clients** have high HIV prevalence with estimates varying from 34-69%.[28] SACEMA estimates that 19.8% of all new HIV infections are related to sex work.
- **People who use illegal substances** are at higher risk of acquiring and transmitting HIV. There is a large and growing problem with crack cocaine and Tik, especially among young people

[23] Know Your HIV Prevention Response Western Cape Provincial Report, pg, 35
[24] Urban formal, urban informal, rural formal, and rural informal
[25] Burrell, Mark, Grant, Wood and Bekker. 2010. Sexual risk behaviours and HIV-1 prevalence among urban men who have sex with men in Cape Town, South Africa, and Rispel, L. & Metcalf, C. (2009) Are South African HIV policies and programmes meeting the needs of same-sex practising individuals?
[26] Shisana, 2009
[27] Welte, 2010. SACEMA Quarterly (22 March 2010)
[28] Leggett 2008, Parry 2008, Van Loggerenberg 2008, Dunkle 2005, Williams 2003, Rees 2000

and sex workers, highlighting the need to consider scaling up substance abuse reduction programmes. Research shows that of injecting drug users, 65% practice unsafe sex.[29]

- **Alcohol abuse** is a major risk factor for HIV acquisition and transmission. Heavy drinking is associated with decreased condom use, and an increase in multiple and concurrent sexual partners. Data [30] indicates that people who drink alcohol are 57% more likely to be HIV positive. This figure is higher amongst heavy drinkers. It is also a major impediment to treatment adherence.
- **Transgender persons** are at higher risk of being HIV-positive. Due to a fundamental misunderstanding of this community and because of stigma, this population is often at risk for sexual abuse and marginalised from accessing prevention, care and services.
- **Orphans and other vulnerable children and youth** are another key population for whom specific interventions will be implemented as primary prevention for HIV, as well as to mitigate impact and break down the cycle of ongoing vulnerability and infection.

Up to 80% of the population of the Western Cape is infected with the TB bacillus[31], but certain populations are at higher risk of TB infection. These high-risk groups include: healthcare workers, mine workers, prisoners, prison officers and household contacts of confirmed TB cases. In addition, certain groups are particularly vulnerable to progressing from TB infection to TB disease. These include infants, young children, people living with HIV, diabetics, smokers, people with silicosis, alcohol and substance users and people who are malnourished, or have silicosis. However, little research has been done to quantify the contribution of the various risk factors to the TB burden in South Africa in the same way as the KYE studies have done for HIV. This will be addressed in this NSP (KYE for TB).

In addition, and similar to HIV, certain groups are considered key populations for TB. Taking risk of TB infection, risk of progression from infection to TB disease and poor access to services into account, the following groups should be prioritised for TB services:

- **Household contacts** of confirmed TB cases, including infants and young children;
- **Healthcare workers, mine workers, correctional services staff and inmates;**
- **Children and adults living with HIV;**
- **Diabetics** and people who are malnourished;
- **Smokers, drug users and alcohol abusers;**
- **Mobile, migrant and refugee populations**; and
- People living and working in **poorly ventilated** and **overcrowded** environments, including those that live in informal settlements.

Within each strategic objective these populations will need to be targeted with different, but specific interventions, to achieve maximum impact.

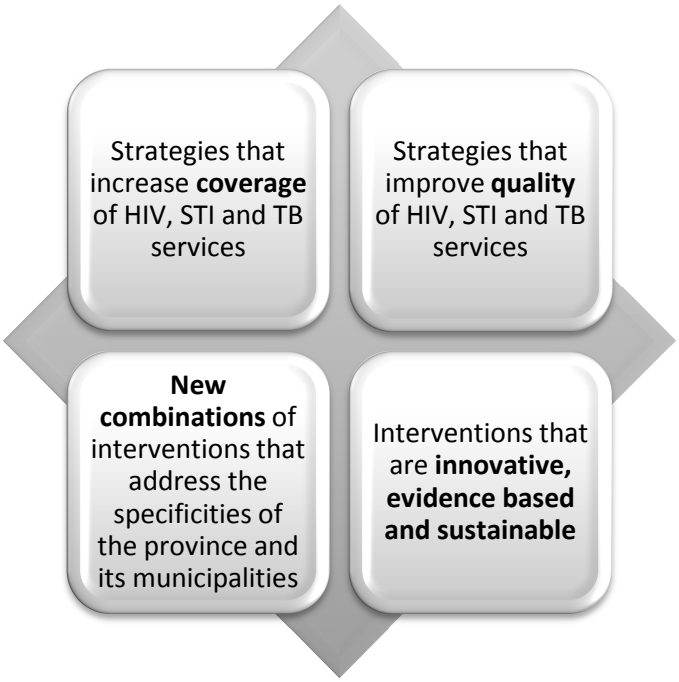
2.8 PSP STRATEGIC OBJECTIVES

[29] Parry, 2008. Medical Research Council
[30] Fisher, LB et. al. 2007. Predictors of Initiation of Alcohol Use Among US Adolescents. Findings From a Prospective Cohort Study
[31] Latent infection. Not everyone infected with the TB bacillus will develop TB disease

For the next five years, the following four strategic objectives will form the basis of the Western Cape's HIV, STI and TB response that will in turn provide the impetus towards achieving the twenty-year Three Zeros vision and the province's health and wellness vision:

- ***Focus on social and Structural Approaches to HIV and TB Prevention, Care and Impact*** – the primary objective being to address societal norms and behaviours that fuel the twin epidemics of HIV and TB, as well as structural interventions to reduce vulnerability to and to mitigate the impacts of HIV and TB;
- ***Prevention of new HIV, STI and TB Infections*** – the primary objective being to ensure a multi-pronged approach to HIV, STI and TB prevention that includes all biomedical, behavioural, social and structural approaches in order to reduce new HIV, STI and TB infections;
- ***Sustain Health and Wellness*** – the primary objective being to ensure access to quality treatment, care and support services for those with HIV and/or TB and to develop programmes to focus on wellness; and
- ***Protection of Human Rights and Promotion of Access to Justice*** – the primary objective being to address issues of stigma, discrimination, human rights violations, and gender inequality.

The following chapters provide more detail on how each of these objectives will be achieved over the 2012-2016 period. The PSP provides strategic direction and proposes several strategies to scale up the response to HIV and TB. In summary these can be categorised as:



2.9 PSP AND INTERNATIONAL OBLIGATIONS

The PSP 2012-2016 aims to align and be consistent with national, international and regional obligations, commitments and targets, including:

- The Constitution of the Republic of South Africa;
- Universal Access to Comprehensive Prevention Programmes, Treatment, Care and Support;
- The Millennium Declaration and the Millennium Development Goals;
- UNGASS Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS, June 2011;

- UNAIDS 2011-2015 Strategy: Getting to Zero;
- WHO Health Strategy for HIV and AIDS 2011-2015;
- World Health Assembly (WHA) Resolutions on TB Control (WHA 60.19; WHA 58.14. and WHA 62.15)
- The Stop TB Strategy and the Stop TB Partnership's Global Plan to Stop TB 2006-2015;
- Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV 2010-14;
- African Union commitments;
- Southern African Development Community commitments;
- International human rights agreements that South Africa has ratified;
- International trade agreements;
- International Labour Organisation Recommendation on HIV and AIDS and the World of Work, 2010;
- Joint WHO-ILO-UNAIDS policy guidelines on Improving Health Workers' Access to HIV and TB Prevention, Treatment, Care and Support Services; and
- UN Convention on Persons with Disabilities

2.10 PSP IMPLEMENTATION

The PSP will guide all provincial stakeholders in the development of implementation plans that will reflect their specific contributions to the achievement of the PSP. These plans will be costed and resources will be mobilized where possible to support implementation. All implementation plans will be multi-sectoral in their orientation and clearly demonstrate accountability and responsibility for all interventions across all stakeholders (for example, the role of civil society stakeholders in the implementation of interventions in the province), and driven by the provincial and district AIDS or health councils. In terms of achieving the provincial goal of "increasing wellness" relevant provincial government departments have undertaken the following strategic interventions towards reducing the incidence of HIV and AIDS, TB and STIs:

2.10.1 DEPARTMENT OF HEALTH

The Government of the Western Cape is committed to increasing the wellness of the people of the Province. This will be achieved by coordinating measures to address the upstream factors that contribute to the burden of disease and through the provision of comprehensive quality health care services, from primary health care to highly specialized services. Under the new PSP 2012-2016 the Department of Health will continue, through its mandate and leadership role, to strengthen and expand its good network of partners working in the areas of HIV and TB and will continue to use existing structures to focus on the following critical areas:

1. Promote HIV Testing through the HIV counseling and testing campaign (HCT).
2. Promote the use of condoms in males and females.
3. Male medical circumcision.
4. Behaviour change to:
    - Reduce early sexual debut, concurrency, multiple partners, alcohol misuse and drug abuse and increase condom use
    - Social mobilisation to encourage:
        - Male Medical Circumcision
        - HIV testing and counseling

5. Active TB case finding and promoting adherence to treatment until completion.

The initiatives that will be undertaken through the PSP 2012-2016 will be informed by the development of a new health and wellness strategy towards 2020. The Western Cape Department of Health is in the process of developing the 2020 strategy document that will outline the long-term strategy of the Department of Health in its efforts to increase wellness in the province. The strategy includes seven key principles based on patient centred quality of care, which should also inform and guide provincial efforts to address the burden of disease and challenges posed by HIV, STIs and TB: The Western Cape District Health Councils Act, 5 of 2010 came into operation on 24 August 2011, by proclamation which was signed on 22 August 2011 (Provincial Government Gazette Extraordinary 6901). According to section 7(8) of the Act, the Minister or his representative must convene the first meeting of a district health council within ninety days of the commencement of the Act.

Health outcomes approach:	Health service interventions will focus on improving the health outcomes of the population. This includes increasing life expectancy and reducing maternal and child mortality. The focus areas are: HIV/AIDS and TB Homicide/ violence/ road traffic accidents Chronic diseases of lifestyle Child health Women's health
Primary health care philosophy:	Provides a comprehensive service that includes preventive, promotive, curative and rehabilitative care Primary health care is usually the first point of patient contact and is supported by all levels of the service, including Emergency Medical Services and Planned Patient Transport. Health and wellness are directly affected by social, economic and political factors. There is inter-sectoral collaboration to address the upstream factors that contribute to the burden of disease. There is community involvement in health: The community is involved in the decision making and oversight process regarding the provision of their health services.' This also implies that on a personal level people take ownership and responsibility for their own health care, within their means.
Strengthening of the district health system model:	The District Management Team (DMT) is responsible for the health outcomes of a defined population within a particular geographic area The DMT is the custodian and accountable for services delivered and the health outcomes within the area. The DMT ensures access to specialized services and support for the area. The DMT co-ordinates the provision of all health services, both public and private, within the area. Provincialisation of PHC services within the Metro.
Equity:	This is an important social justice principle. There must be equity in terms of: ➢ Access to services ➢ Allocation of resources ➢ Outcomes Patients receive the service that they require according to their need.
Affordable health service	The health service must function within its allocated budget. Health services planning must project required need for services and quantify what services will sustainably be provided within the projected budget.

	There will be advocacy to address funding gaps between the projected funding allocation and the projected need for services. Alternative sources of funding of health services must be pursued. There must be optimal efficiency at all levels of the service to maximize the value of the health rand.
Strategic partnerships	Strong relationships must be forged with strategic partners to facilitate the delivery of quality health services and improved health outcomes. Strategic partners include: Organized labour Universities Non-profit organisations/ community-based organisations Other government departments, e.g.: Department of Transport and Public Works, Centre for e-Innovation Other spheres of government Private sector

CHAPTER 3 – THE PROVINCIAL GOVERNMENT'S DEVELOPMENT AGENDA AND HIV, STIS AND TB

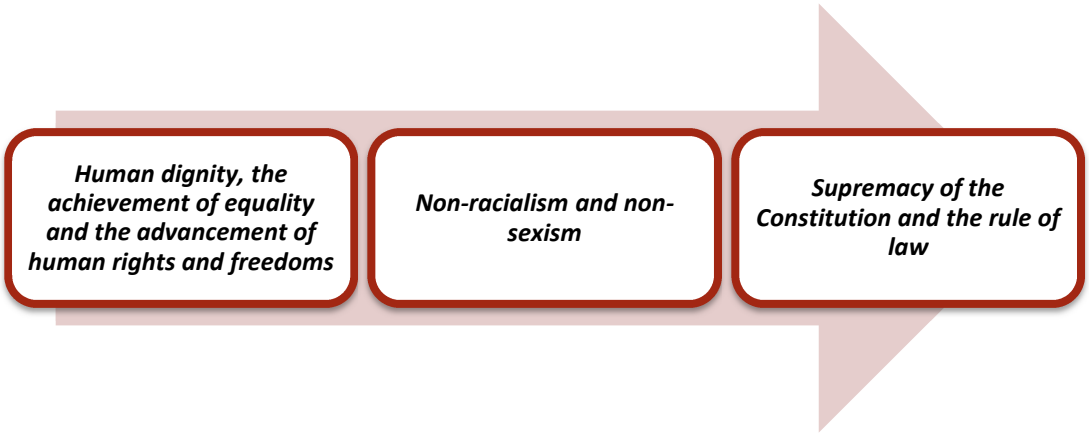
3.1 OVERVIEW

The need to respond to HIV has been a priority for almost three decades. Over time, various conceptual shifts have influenced the characteristics of the response. Initially, the primary interventions were driven through mass information and communication campaigns backed up by a narrow biomedical focus. This was soon followed by a focus on behavioural aspects including cultural issues that were identified as risks for HIV acquisition. Interventions shifted to behavioural change with a strong focus on placing the onus on individuals to adopt healthy practices supported by available biomedical interventions. Recognition of the limitations of the biomedical and anthropological / behavioural paradigms emerged when the concept of the social determinants of ill health became better understood, leading to the established and accepted paradigm of also conceptualising HIV and TB as a development issue. Such a concept recognises the socio-economic context in which these epidemics occur and the inter-relatedness of HIV and TB with other development concerns such as poverty and associated challenges, e.g. nutrition, unemployment, inequity, lack of access to basic amenities, lack of social cohesion and many other aspects.

A strategic approach to the development of a provincial plan for HIV, STIs and TB invariably requires a broad understanding of provincial planning frameworks and priorities. This is not only because HIV is a chronic, lifelong condition requiring lifelong interventions; but also because economic growth and stability, eradication of poverty, access to education, the building of a developmental state and nation building require long-term planning. Moreover, the magnitude of the HIV and TB epidemics and the cost of the associated burden of disease may undermine some of the objectives that are articulated in the various planning frameworks. Conversely some of the planning frameworks present unique opportunities to address the social drivers of the epidemic thus lessening the burden on the overstretched health system and making it possible for the province to achieve its development goals.

3.2 DEVELOPMENT AND THE CONSTITUTIONAL FRAMEWORK

The founding provisions of the Constitution provide the framework within which the PSP 2012-2016 is located, namely:



Considered in its broadest terms, the Constitution lays down a set of ideals that the PSP 2012-2016 must strive towards, such as the commitment to heal the divisions of the past and to improve the quality of life of all South Africans. It also establishes a set of values that must be advanced and promoted, for example, non-sexism and non-racism, the achievement of equality, and the right to human dignity and freedoms.

Since 1994, government policies and programmes have firmly endorsed the imperatives of equity, quality and access. To a large degree, these imperatives guide the NSP in terms of its implementation and performance. At a macro level, the 2009 – 2014 **Medium Term Strategic Framework (MTSF)** sets out the strategic mandate of government. The MTSF identifies strategic priorities and targets that serve as the basis for determining the government's implementation plans for the period to 2014. The second of the twelve key targets relates to health outcomes - *A long and healthy life for all South Africans.* This outcome has in turn been translated into a National Service Delivery Agreements signed by the Minister of Health that commits to specific outputs. The PSP goals, vision and targets are aligned with the Negotiated Service Delivery Agreement for health.

The four outputs that relate to Outcome 2 (long and healthy life) which are the health NSDA but also signed onto by all relevant national Ministers as well as the MECs for Health are:

- Increasing life expectancy;
- Decreasing maternal and child mortality;
- Combating HIV and AIDS, and reducing the burden of disease from TB; and
- Strengthening health systems effectiveness.

Beyond the 2014 timeframe, the National Planning Commission has articulated a long-term vision for South Africa, to be released in November 2011 as the National Development Plan. In addition, the National Planning Commission is currently developing a broad government framework for addressing the major developmental challenges in South Africa, including:

- High rates of unemployment;
- Poor quality education;
- Poorly located and inadequate infrastructure;
- Weak economic growth;
- Spatial challenges marginalising the poor;
- High burden of disease;
- Uneven public service delivery;
- Corruption and its impact on service delivery; and
- Lack of social cohesion.

At the international level, the Millennium Development Goals (MDG) Framework has identified 8 MDG goals with specific targets that all countries are striving to achieve by 2015. By situating the response to HIV, STIs and TB within the broader development agenda and integrating the human rights and gender dimensions, countries are in a better position to accelerate progress across an array of MDGs.

3.3 PROVINCIAL HEALTH AND DEVELOPMENT AGENDA

The Provincial Government of the Western Cape recognizes that ill health remains as a significant drag on provincial growth and development. In this context ill health has two components:

- "Upstream causes" of ill health that drive the burden of disease;
- The quality of care and support provided by public health and social services.

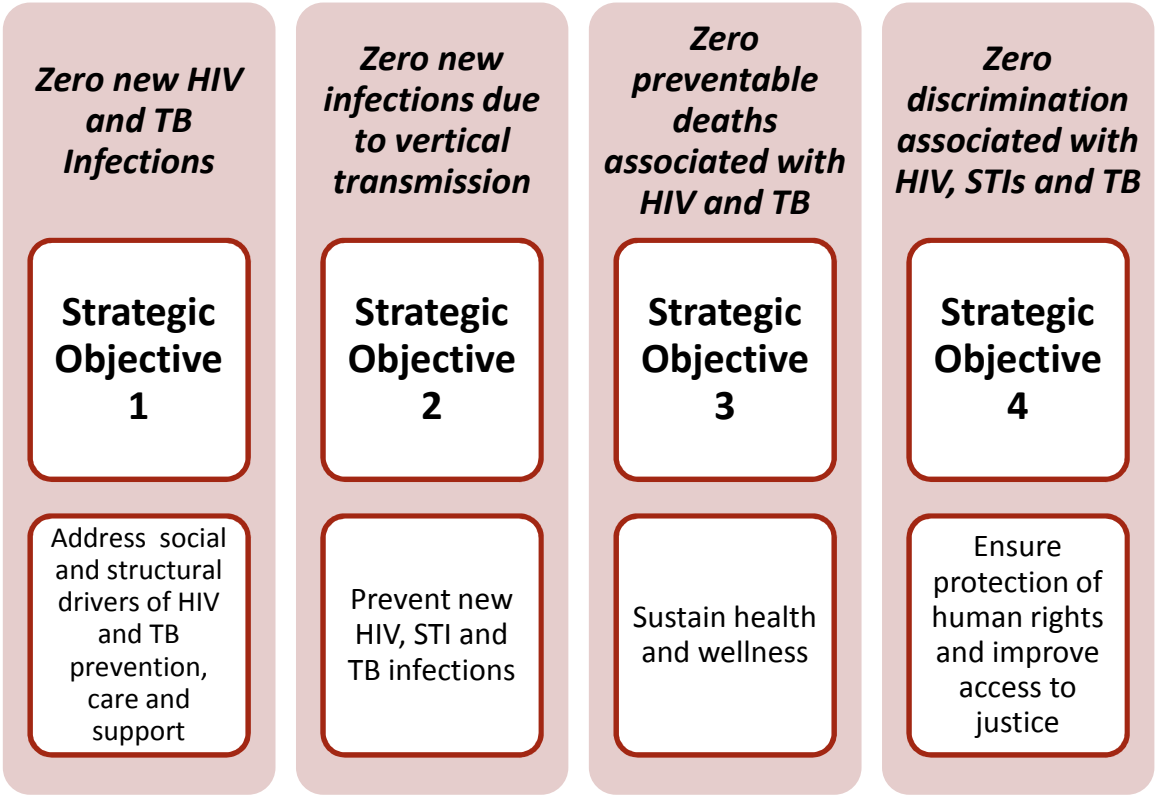
The quality, efficiency and effectiveness of the province's response to managing the burden of disease in the province is critical to increasing wellness and improving the quality of life for people living in the Western Cape. It is evident that HIV/AIDS and TB pose a significant challenge to this aspiration. Although the Western Cape has an HIV prevalence rate that is well below the national figure, the burden of HIV and TB continues to undermine and threaten gains that have been made in reducing infant and maternal mortality. Investing strategically to address HIV and TB and the other MDG goals will maximise efficiencies and enhance sustainability.

The implementation of the PSP 2012-2016 is underpinned by an understanding of the broader national high-level planning frameworks to enable rational and appropriate evidence-informed strategies to be prioritised during planning. An appreciation of the above enables the PSP to focus strategically on interventions that will move the province closer to the achievement of both the five-year vision and the twenty-year vision. Given the profound impact of HIV and TB on progress towards the MDGs, the PSP 2012-2016 is crucial to the national vision of "a long and healthy life for all South Africans", and the provincial vision of "quality health for all".

CHAPTER 4 – STRATEGIC OBJECTIVES OF THE PSP 2012-2016

4.1 INTRODUCTION

On the basis of an extensive consultative process, it was agreed that the NSP 2012-2016 vision and goals would be achieved through sets of interventions that have been organized under four national strategic objectives:



PSP GOALS:

- Reduce new HIV infections by at least 50% using combination prevention approaches
- Initiate at least 80% of eligible patients on antiretroviral treatment, with 70% alive and on treatment five years after initiation;
- Reduce the number of new TB infections, as well as the number of TB deaths by 50%;
- Ensure an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the PSP;
- Reduce self-reported stigma and discrimination related to HIV & TB by 50%

4.2 STRATEGIC OBJECTIVE 1: FOCUS ON SOCIAL AND STRUCTURAL APPROACHES TO HIV AND TB PREVENTION, CARE AND IMPACT

4.2.1 INTRODUCTION

The impact of infection and disease on people living with HIV, TB and STIs, as well as their families and communities in the Western Cape is complex and multi-dimensional. The people of the Western Cape suffer a quadruple burden of disease, with the largest share of the burden being caused by infectious diseases, in particular Tuberculosis, HIV and AIDS. The burden of disease affects the poor more significantly as they are generally the hardest hit by illness and death caused by HIV and TB. Understanding and responding to the nature and drivers of this aspect of the burden is the foundation of the provincial strategy to sustain health and increase wellness in the Western Cape. Social and structural approaches address the social, economic, political, cultural and environmental factors that lead to increased vulnerability.

Some of the structural approaches seek to address deeply entrenched and long-established cultural, socio-economic and behavioural factors such as economic inequality, gender inequality, marginalisation and lack of access to basic services that are difficult to resolve in the short-term. For this reason they commonly require long-term strategies and interventions that are largely addressed by national socio-economic and development strategies and policies. It is thus important to mainstream HIV and TB management into the core strategies of provincial government departments in order to ensure a comprehensive and sustainable approach to the dual epidemics.

Specific interventions to mitigate the impact of the epidemics are critical in order to support affected communities and to break down the vicious cycle of ongoing vulnerability and infection from generation to generation. Strategic Objective (SO) 1 will focus on key structural factors that are amenable to change over the next five years. These deal with the factors that facilitate the spread and impact of HIV and TB, as well as those that are protective and should be harnessed and promoted.

4.2.2 PSP SUB-OBJECTIVES

Sub-Objective 1.1: Mainstream HIV and TB and its gender and rights-based dimensions into the core mandate of all Western Cape provincial government departments and SANAC sectors (including people with disabilities and other vulnerable groups)

The Western Cape provincial government as a collective has the responsibility for defining the development agenda of the province and for ensuring the achievement of the province's aspiration of "delivering the open opportunity society for all"[32]. Given the profound impact of HIV and TB and the huge burden of disease attributable to these epidemics, every provincial

[32] Western Cape Draft Strategic Plan 2010.

government department has a critical role to play in addressing the complex interplay of macro, community-level and individual-level factors that underpin the social drivers of the dual epidemics. This includes a recognition and understanding of the gender and human rights dimensions of the epidemics, and the critical importance of ensuring that policies, strategies and programmes are developed in a gender and human rights-responsive way. The province will engage proactively with the Department of Public Service and Administration's (DPSA) *Guidelines on Gender Sensitive and Rights Based HIV&AIDS, STI's and TB Mainstreaming Into Public Administration and Public Service 2012-2016,* and ensure that these are integrated into the work of provincial departments. Within the context of the PSP provincial departments that have a responsibility for specific HIV, TB and STI programming will ensure that their policies and programmes are in alignment with national requirements as set out in the DPSA guidelines:

"Basic human rights principles are core elements for effective strategies to address the intersection of gender and HIV. Rights based programming principles stress the universality, inalienability, interdependence and indivisibility of rights. Commonly, rights based approaches are understood to be based on human rights principles on non-discrimination, participation, inclusion, empowerment, transparency, accountability, obligation and interconnectivity (i.e. assuring the conditions for enjoyment of rights.) Thus, the HIV programmes targeting women, and girls must have as their fundamental basis the promotion, protection and realization of human rights in general and gender equality in particular."[33]

Intervention 1.1.1 Mainstream HIV and its gender and rights-based dimensions into the core mandate of all Western Cape provincial government departments and SANAC sectors (including people with disabilities and other vulnerable groups)

The Western Cape will move to ensure that all provincial government departments integrate gender and human rights into their departmental strategic and operational plans. This will require provincial departments to review and implement gender mainstreaming plans and other departmental policy instruments to ensure that they adequately address HIV, STIs and TB along with their gender and rights-based dimensions. This approach, including a move to ensuring the standardization of a rights-based approach to HIV planning and implementation, will be underpinned by the Employee Health and Wellness Programmes within the public sector in the Western Cape. These processes will be supported by civil society partners through their advocacy, lobbying, training and capacity development interventions.

Sub-Objective 1.2: Address socio-economic factors that are drivers of the epidemics as identified in the KYE Report for the Western Cape Province

Intervention 1.2.1 Identify and address structural barriers to access to HIV, STI and TB services to residents in informal settlements

[33] Department of Public Service and Administration, Guidelines on Gender Sensitive and Rights Based HIV&AIDS, STI's and TB Mainstreaming Into Public Administration and Public Service 2012-2016 Draft 5: December 2011

Lack of access to adequate housing and the poor living conditions in informal settlements provide fertile ground for HIV, STI and TB transmission, as well as spread of many other communicable diseases, especially among children. Housing as a factor linked to risk for HIV and TB infection, or affecting AIDS care should be viewed from the perspective of these various forms of lack of access to housing. The hot, dry summers and winter rainfall experienced in the Western Cape further exacerbate risks to people living in informal settlements – particularly with regard to the hazards of fires in densely populated communities and the health risks posed by poor drainage and damp living circumstances. The use of inadequate building materials in informal settlements, together with the lack of access to basic services such as sewerage, electricity and running water pose additional health challenges. Lack of housing and the consequent living conditions of individuals are integrally linked with other upstream factors such as poverty, unemployment and lack of education that are, in themselves, risk factors for HIV and TB infection. Areas of informal housing and shelters are, therefore, being considered as high risk factors and will be given priority.

The Provincial Government is committed to developing integrated and sustainable human settlements, in part as a means to achieving improved health outcomes for the poorer sections of the province's communities. The Provincial Government is aiming to accelerate the provision of housing opportunities, including prioritizing the on-site upgrading of informal settlements and the provision of serviced sites. These initiatives are geared to assisting greater numbers of people and to helping more of those people who have limited or no access to basic services[34].

HIV prevalence is increasing rapidly in rural, formal settlements. A big challenge in rural areas is access to appropriate services. A large proportion of the rural population has no sustainable livelihood, which contributes to deprivation and ill health. The Provincial Government is committed to developing and implementing a comprehensive strategy to address the social, economic, infrastructural and governance challenges that have been identified in rural areas. Access to health services, including HIV and TB interventions, has also been prioritised. Primary agriculture is the biggest source of growth in the districts outside of the City of Cape Town, and accounts for 25% of the economy of the Central Karoo, 23.7% of the Overberg, 23% of the West Coast and 16.3% of the Cape Winelands[35]. The sector has the advantage of being able to employ high numbers of people who have not completed school, and services such as banking and retail in small towns depend on the agricultural sector to make a profit.

Intervention 1.2.2 Address vulnerability associated with mobility and migration, with a focus on seasonal workers, refugees and immigrants to the Western Cape

Since the early stages of the epidemic, infections in rural areas have been traced to those who had been in urban areas (Jochelson et al., 1991); HIV prevalence levels have been higher along roads (Tanser et al. 2000; Tanser et al., 2009); and truckers have been found to be at higher risk because of their greater mobility (Ramjee & Gouws, 2002). According to Hargrove (2007), oscillating migration is an essential component for an epidemic to be as severe as the one witnessed in South Africa[36]. The increasing volume of movement into, out of and across the Western Cape has implications for the spread of infectious disease. Border-crossings, truck stops and shack

[34] The Western Cape's Draft Strategic Plan, pg. 40
[35] The Western Cape's Draft Strategic Plan, pg. 68
[36] The HIV epidemic in South Africa: What do we know and how has it changed? 2011, pg. 132

settlements on main roads are becoming known as HIV 'hotspots'. Another associated risk factor is the feminisation of migration, whereby impoverished women move to or between towns and engage in informal income generating activities such as hawking, and may resort to commercial sex work as a means of income.

Within the context of the Western Cape, the dynamics of migration include movement from rural to urban areas within the region and from other regions, as well as people in search of employment migrating from other provinces to do seasonal farm work in the rural regions[37]. Truck drivers and migrant labourers are particularly vulnerable to HIV and TB transmission. Both internal mobility within and cross-border mobility to the Western Cape increase the prevalence of HIV and TB as indicated by the geographical dispersion of these diseases. Migration for the purpose of finding work takes place in many sectors of the labour force, and vulnerable groups should be identified that are at high risk for HIV/AIDS. Border-crossings, truck stops and shack settlements are high risk areas and would benefit from targeted interventions in the province. In addition, bi-directional transmission has been shown to exist, and partners of migrant workers are also at high risk. Migration that is accompanied by poverty, overcrowding and marginalisation increases the risk for HIV. Under these conditions, difficulty with case finding and early detection of cases increases the risk for TB.

Intervention 1.2.3 Reduce alcohol and substance abuse related vulnerabilities in high burden areas of the Western Cape

Evidence from the KYE has highlighted the national impact of alcohol abuse and substance use on HIV transmission and vulnerability to TB. Alcohol has been and remains a problem in the Western Cape, with findings from household surveys reflecting higher prevalence rates for risky drinking in the Western Cape relative to the other provinces. The Western Cape also has the highest national prevalence of risky drinking (16%)[38]. Alcohol and substance abuse in the Western Cape is the result of a complex set of dynamics that have arisen from historical socio-economic dynamics that are very specific to the province. The Western Cape, for example, has the highest proportion of binge drinkers in high school - 34% versus 23% for the national average. A third of adolescents aged 11 to 17 from nine districts in Cape Town report having been drunk at least once in their lifetime. According to the MRC, the number of people seeking treatment for methamphetamine (commonly known as 'tik') has now overtaken those with alcohol problems. Among patients under 20 years, six out of ten use tik as a primary or secondary substance of abuse. Recent statistics also show that Cape Town has one of the highest number of heroin users in the country - in excess of 15 000[39]. Besides the devastating effects of drug and alcohol abuse on the individual and families, associated risks include an increase in TB, HIV and Aids, Hepatitis B (HBV) and Hepatitis C (HCV) risk and infection. It is also well known that this type of abuse also encourages risky sexual behaviour, criminality and violent behaviour. Under SO4 – *decreasing the incidence of injury groups* - the Western Cape will implement an alcohol prevention model in the high 5 areas and also develop a comprehensive package of care for IDUs. Civil Society organizations such as *SANCA* will support these processes through capacity building and training of individuals and communities to assist with the implementation of primary prevention programmes, secondary prevention initiatives focused

[37] Recommendations for Policy in the Western Cape Province for the prevention of Major Infectious Diseases, including HIV/AIDS and Tuberculosis, 2007, pg. 58
[38] Harker, N., Kader, R., Myers, B. et al. Substance Abuse Trends in the Western Cape: A review of Studies conducted since 2000, pg. 8.
[39] http://www.capetown.gov.za/en/drugs/Pages/default.aspx

on high-risk groups such as youth and abused women, and tertiary prevention initiatives directed at providing a treatment programme to substance abusers, their families and collaterals. Cape Town Municipality has developed a substance abuse policy, which includes the provision of substance abuse outpatient treatment and rehabilitation services at a number of sites in the Metro.

Sub-Objective 1.3: Implement interventions to address gender inequities and gender-based violence that function as drivers of HIV and STIs

Intervention 1.3.1 Implement targeted interventions to address gender-based violence

South Africa is grappling with high levels of violence against women with sexual assault and intimate partner violence contributing to increased risks for HIV infection[40]. Women who experience sexual assault in South Africa, like women in other parts of the world, are at higher risk of HIV/AIDS. In addition, the rate of rape in the Western Cape is among the highest in South Africa[41]. National crime statistics from the South African Police Services (SAPS) for 2010/2011 indicate that the highest incidence of all reported sexual offences was recorded in the Western Cape, followed by the Free State and Northern Cape, while Limpopo featured at the bottom of the list[42].

Province	2009/2010	2010/2011	Increase/Decrease
RSA	138.5	132.4	-4.4%
Gauteng	148.6	125.0	-15.9%
KwaZulu-Natal	127.0	120.2	-5.4%
Limpopo	93.8	89.8	-4.3%
Mpumalanga	127.6	122.8	-3.8%
Western Cape	***180.7***	***178.0***	***-1.5%***
Eastern Cape	136.1	139.1	2.2%
Northern Cape	160.8	169.2	5.2%
North West	137.9	147.0	6.6%
Free State	157.8	171.3	8.6%

FIGURE 18: TRENDS IN SEXUAL OFFENCES (SAPS)

Culturally sanctioned gender roles are intimately connected with both gender-based violence (GBV) and HIV risk, with the links between gender roles, GBV, and HIV risk remain complex and culturally specific. The gender hierarchy leads to expectations of female obedience, women assuming a passive role in sex, and male sexual dominance and entitlement[43]. Gender inequality also operates as a barrier to social and economic development, and the achievement of gender equality remains one of the critical components of the transformation agenda. It is clear that in the Western Cape there is a need for a concerted effort to deal with gender based violence broadly

[40] Jewkes R, Dunkle K. Nduna M, Shai N. Intimate partner violence, relationship gender power inequity, and incidence of HIV infection in young women in South Africa: a cohort study. The Lancet 2010; 367:41-48
[41] A Strebel, M Crawford, T Shefer,A Cloete, N Henda, M Kaufman, L Simbayi, K Magome, S Kalichman. Social constructions of gender roles, gender-based violence and HIV/AIDS in two communities of the Western Cape, South Africa. Journal of Social Aspects of HIV/AIDS Vol. 3 No. 3 November 2006
[42] SAPS. National Crime Statistics 2011, pg. 28.
[43] The HIV Epidemic in South Africa: What do we know and how has it changed?, April 2011, pg. 116.

to address HIV transmission. Departments in the social and security clusters of government at the provincial level will continue to strengthen initiatives based on a comprehensive multi-sectoral approach to reducing gender-violence in the Western Cape through integrated programmes and services to support, care and empower victims of violence and crime in particular women and children.

The Western Cape Department of Social Development has a Victim Empowerment sub-programme that aims to design and implement integrated programmes and services to support, care and empower victims of violence and crime in particular women and children. The focus of the programme is on the following key areas:

- All victims of violence and crime including their families have a right to access services. Historically this programme focused on victims of human trafficking, domestic violence, sexual assault and rape. Although the need for services is bigger and broader than these afore-mentioned categories, within this financial year the programme will progressively integrate in supporting all victims.
- The programme aims to sustain existing shelters and enhance quality of services to victims of crime, hence focus will be to capacitate shelters to comply with the applicable minimum norms and standards.
- Through the use of (mainly) internal social work professional resources, gender based prevention programme will be expanded to reach out to youth in community- based structures.
- The department will enhance and strengthen the 6 regional forums by providing capacity building, technical support and monitor implementation of services and compliance with policy guidelines for VEP.
- The Human Trafficking Bill, once enacted, will have significant implications for the department as it requires social workers to provide counseling services to victims of human trafficking. The focus will be to deepen and expand internal capacity through training of social workers to ensure that, once the bill is enacted, they are well equipped to provide services to victims of human trafficking and victims of violence.
- Furthermore the department, in collaboration with various stakeholders, will raise awareness about issue of domestic violence, sexual violence and human trafficking as a proactive preventative strategy.
- As work regarding victim empowerment deepened, the need for segregated data on the various categories of victims of violence became apparent, hence the categorization within the various performance indicators. This data will assist with the development of targeted and appropriate services/interventions consistent with the nature of abuse.
- Expand services to rural areas by providing shelters in Vredendal and Beaufort West.
- Provide specialist training for social workers on trauma counseling and debriefing.

The programme is run through a series of strategic partnerships with other government departments, NGOs, FBOs and UN agencies to ensure that all possible areas of collaboration are covered. The services provided include the oversight role regarding the roll-out VEP services by SAPS, school safety, gender programmes, parole board and restorative justice approach, victim charter and witness support services, Thuthuzela services for victims of sexual offences, victim support services at police service centres, protection services to families and family preservation services, crime prevention strategies, and restorative justice and prevention services.

Sub-Objective 1.4: Mitigate the impact of HIV and TB on orphans, vulnerable children and youth

Intervention 1.4.1 Scale up a comprehensive package of services that will remove structural barriers to access to HIV, STI and TB services for OVCs and their support structures

The numbers of orphans and children made vulnerable by HIV has increased over the years. In the Western Cape the Department of Social Development has been leading activities to protect the rights of orphans, vulnerable children and youth and to reduce their vulnerability and impact of HIV and TB. A key focus of the Western Cape HIV response will be the provision of supportive developmental programmes and services to children and families at risk, including reported cases of child abandonment, child neglect and abused children inclusive of assessment of children and families, counseling services and temporary safe care. There is a need to scale up these interventions and strengthen initiatives at community level for the protection of the rights of orphans and in particular child and youth-headed households. Care and support services must also be part of the package of services provided to support orphans and vulnerable children, in order to focus on the psycho-social aspects of children affected and infected by HIV/Aids through quality care and support services that promote positive lifestyles. In South Africa approximately 40% of the population are children under the age of 18 years – 18.7 million in total. In the Western Cape the total population of children 0-18 years is 1,770,850, sex disaggregated as male (885,561) and female (885,289). In the Western Cape the HIV prevalence rate in this age group is as follows:

2-14 Years		15-24 Years	
2002	**2008**	**2002**	**2008**
7.1%	1.1%	11.2%	3.0%

TABLE 19: HIV PREVALENCE RATES FOR CHILDREN 2002 AND 2008

The Department of Social Development is responsible for the care and support of children infected and affected by HIV and AIDS. The DoSD *Annual Report 2010* outlines the Department's key responsibilities in this area[44]:

Strategic Goal	Strategic Objectives
To facilitate the provision of appropriate services that promotes optimal quality of life to those infected and affected by **HIV and AIDS**.	**Awareness and Prevention** To ensure access to reliable up to date information on HIV/AIDS as well as awareness on social development programmes and services for people infected and affected by HIV/AIDS. **Early Intervention** To facilitate the early identification of children and families at risk of HIV/AIDS and ensure the provision of a range of developmental and therapeutic programmes to them.

[44] Department of Social Development Western Cape Annual Report 2009/2010, pg. 13 – document sourced at http://www.capegateway.gov.za/Text/2010/11/ eng_dsd_ar_2010_final.pdf

	Statutory To ensure that all AIDS infected individuals and Orphans and Vulnerable Children (OVCs) receive services that comply with statutory requirements. **Reintegration** To ensure the provision of a range of community based support services that sustain children and families.

TABLE 3: DEPARTMENT OF SOCIAL DEVELOPMENT GOALS AND OBJECTIVES FOR CHILDREN

In the Western Cape the number of children under 15 who have been initiated on ART has shown an upward trend from 86% of those requiring treatment (2006/2007) to 97% (2007/2008). The South African National HIV Prevalence, Incidence, Behaviour and Communication Survey found that there has been a dramatic increase in the number of people reporting using condoms at last sex. The greatest improvement was seen among youth (15–24 years), adult males, and even among females who have traditionally had low rates of reported condom use. The survey notes, however, that this pattern of improvement in reported condom use at last sex is evident in all provinces except in the Western Cape. The Western Cape condom use at last sex for people 15 years and older has shown an increase[45] from 21.3% in 2002 to 49% in 2008.

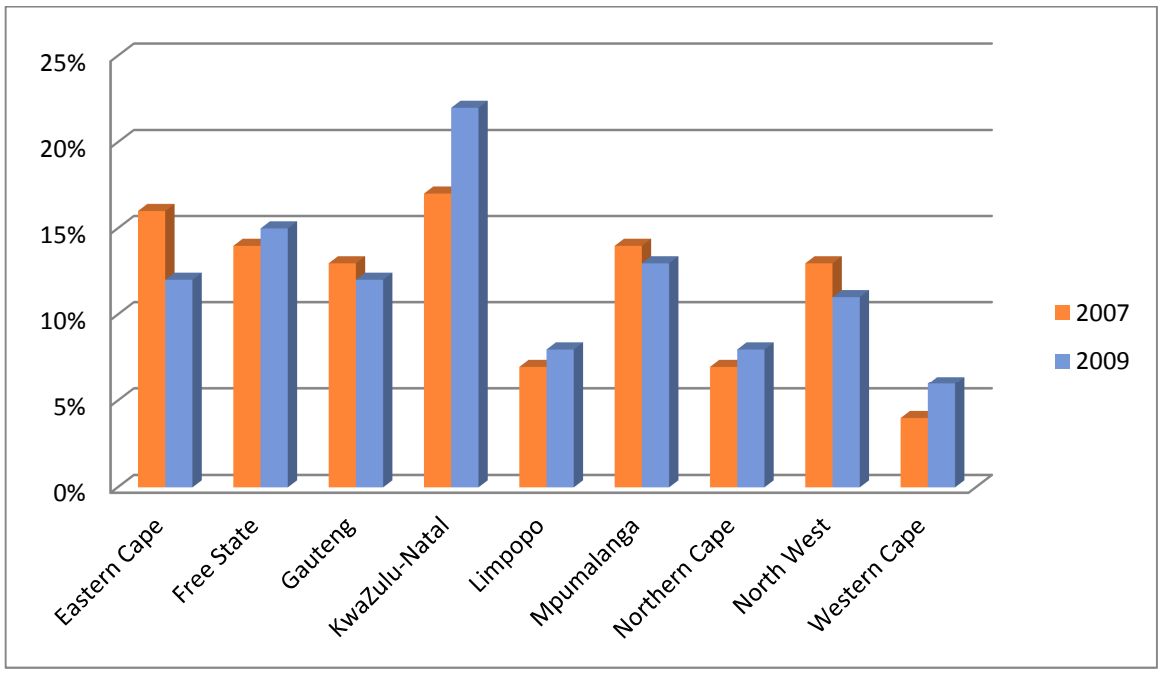


FIGURE 20 PROPORTION OF ADOLESCENT GIRLS AGED 15-19 YEARS VISITING ANTENATAL CLINICS WHO TESTED HIV-POSITIVE IN 2007 AND 2009 (SOURCE: CHILDREN'S HIV AND AIDS SCORECARD 2011)

Through the Western Cape Department of Social Development a broad framework is in place to ensure that an integrated programme of services is provided for the development, care and protection of the rights of children. The following key area for intervention, as guided by the Children's Act and influenced by the situational analysis, have been prioritised by this programme:

[45] HSRC South African National HIV Prevalence, Incidence, Behaviour and Communications Survey, pg.

- Provision of 4 awareness and prevention programmes are implemented in each of the six regions targeting children, parents, families and communities so that they are aware of their rights and responsibilities as well as government services and where to access them. Public awareness will particularly focus on the identified trend of child abandonment in the Province and available alternative care options
- Provision of supportive and developmental programmes targeting children at risk between 12 – 18 years and their care givers e.g.
    - Adolescent development programmes
    - Child witness support programmes
    - Programmes for children exiting alternative care (Independent Living Programmes)
    - Mediation programmes
    - Parenting programmes
    - After hour child protection programmes
    - Behaviour Management programmes.
- Early childhood development opportunities as a departmental priority for children in the ECD age cohort, focusing on services for babies and toddlers. The following projects are envisaged:
    - To systematically increase the number of children having access to Early Childhood Development (ECD) programmes. This includes children in centres as well as home and community based services to children that do not have access to formal centres.
    - A drive to register all unregistered centres to ensure compliance with norms and standards as per Children's Act. This will imply that at least 2 179 unregistered facilities will have to be supported and assessed and potentially increased numbers of children qualifying for subsidy.
    - The registration of ECD programmes in registered Partial Care facilities (ECD centres) with training and capacity building on implementation of programmes as per the Children's Act becomes critical.
    - The ECD Assistant project in partnership with EPWP.
- Protection services to children found to be in need of care targeting:
    - Children found to be in need of care and protection by the Children's Courts will be placed in new foster care placements.
    - Children are placed in lifelong family relationships through the provision of adoption services.
    - Strengthen residential care services to children in Child and Youth Care Centres by increasing funding levels.
    - Transformation of Shelters into Child and Youth Care Centres.
    -

Sub-Objective 1.5: Reduce the vulnerability of young people to HIV infection by retaining them in schools as well as providing post-school education and work opportunities (with a special focus on children out of school, OVC, young girls 15-19 years)

Intervention 1.5.1 Implement interventions that will keep young people and children in school and ensure school completion

The NSP highlights the fact that education remains a critical strategy in addressing the vulnerability of children and young people to HIV infection. A number of studies suggest that higher levels of education equate with lower levels of HIV prevalence[46]. School-going children and young people are less likely to become HIV-positive than those who do not attend school, even if HIV is not included in the curriculum[47]. The Western Cape's Draft Strategic Plan notes that one of the contributing factors to HIV infection is the poor level of education, particularly in communities that experience high levels of poverty, unemployment and overcrowding[48]. Higher levels of education also tend to reduce the vulnerability of girls, and each year of schooling offers greater protective benefits. Improved quality of SRH services are also beneficial to young women in and out of school. Furthermore, educating parents and caregivers to encourage inter-generational conversations with young people on sex and sexuality increases levels of awareness, understanding and practice of HIV prevention modalities. The province is already providing holistic support through extending HIV/AIDS awareness interventions, providing food for identified poor and hungry learners so that they can learn effectively, and promoting a safe school environment.

Intervention 1.5.2 Implement a comprehensive package of services for youth (including out of school youth) that also promotes youth leadership to mitigate the impact of HIV and TB among the youth

Youth-specific interventions are also critical, both for in school youth and for learners who have transitioned out of school. The Western Cape understands that it is crucial to implement targeted programmes for young people who are at risk of harmful lifestyles that will increase the likelihood of HIV infection including alcohol and substance abuse. A range of peer education programmes have been undertaken in the Western Cape that are generally focused on behaviour change as a prevention strategy, but there have been few comprehensive evaluations of impact. A University of Cape Town-led study conducted in 2007/2008 evaluated a government-led peer education programme on the self-reported sexual health behaviour and related psychosocial outcomes of adolescent students in 30 urban, semi-rural and rural public high schools in the Western Cape. The study found that the peer education programme had limited effect on the age of sexual debut, use of condom at last sex, goal orientation, decision-making or future orientation on students. The study concluded that programmes that did not also engage with local communities or tackle wider social issues which are relevant to sexual debut and condom use and psychosocial factors such as goal orientation, decision-making and future orientation and which take into account gendered power relations and poverty are destined to fail[49]. Through the new PSP the Western Cape will strengthen peer education programmes so that they function as critical education and behaviour change interventions. In secondary schools the peer education programmes are being aligned with the HCT Campaign, and in primary schools they are being delivered through the Soul Buddies clubs.

Sub-Objective 1.6: Reduce HIV and TB related stigma and discrimination

[46] The KZN HIV Impact Study, HSRC Survey, Jewkes et al.
[47] Department of Basic Education Draft Integrated Strategy on HIV and AIDS, 2012-2016
[48] WC Draft Strategic Plan, pg. 27.
[49] "Can Peer Education Make a Difference?", pg. 6.

Intervention 1.6.1 Roll out the Stigma Mitigation Framework and the People living with HIV Stigma Index, together with associated interventions, to decrease HIV and TB related stigma

TB and HIV infection both generate significant stigma due a variety of factors, such as lack of understanding of the illness, inadequate access to knowledge, fear, prejudice and socially sensitive issues such as sexuality and gender identity. The WC Provincial Report (Know Your HIV Prevention Response Analysis 2010) notes that most-at-risk populations (MARPs) are among the most marginalized and most likely to be stigmatized as many resources and national HIV-prevention campaigns do not address their specific HIV treatment, care and support needs[50].

A clear programme of action that covers innovative and established methods of stigma reduction will be rolled out in the Western Cape. This is part of the province's commitment to expand and upscale interventions that address HIV and AIDS, TB and STIs, including in the area of human rights and access to justice[51]. The greater involvement of people living with HIV and TB is key in such programmes to empower and educate communities and individuals. A Stigma Mitigation Framework will be implemented and efforts to reduce stigma will be monitored by a Stigma Index. The departments in the security cluster must play a role in monitoring the impact of stigma together with the South African Human Rights Commission.

Sub-Objective 1.7: Strengthen community systems for more effective HIV and TB programmes at community level

Intervention 1.7.1 District Health Councils to develop plans, including MSATS and Community Action Plans, for community system strengthening, which should also be integrated into the Integrated Development Plans

In line with the National Health Systems priorities for 2009-2014: the Ten Point Plan the Western Cape will continue to develop and strengthen its decentralised operational model, including new governance arrangements (Priority 4, Activity 16). A key part of this process will be the ongoing strengthening of the capacity of community systems. This will increasingly enable the province to expand access to critical HIV and AIDS, STIs and TB services at the district health level. Under this PSP the Western Cape will continue to strengthen and streamline current strategies to address capacity, referral networks, coordination and feedback mechanisms. This will reduce overlaps in implementation, improve coordination and increase the reach and quality of services.
The Western Cape Department of Health will continue to place increasing emphasis on strategic health planning that is focused on a "patient-centred experience of quality". As part of its effort to overcome the fragmentation of health services and existing coordination challenges, the DoH has established Geographic Service Areas as the preferred functional management arrangement. The purpose is to build cohesive district health services and strengthen collaboration between health facilities under the leadership of district management teams (DMTs).

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[50] KYR Western Cape Provincial Report 2010, pg. 35.
[51] Western Cape Department of Health, Strategic Plan 2010/11-2014/15, pg. 7.

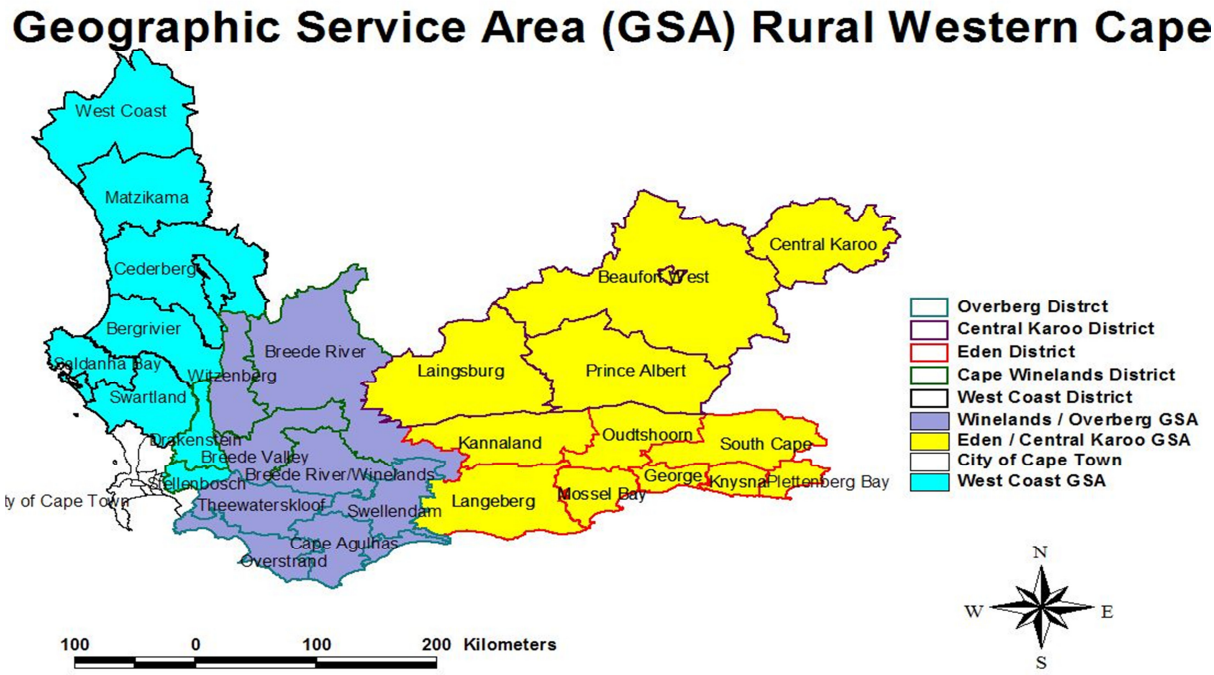


FIGURE 21: GEOGRAPHIC SERVICE AREAS - RURAL WESTERN CAPE

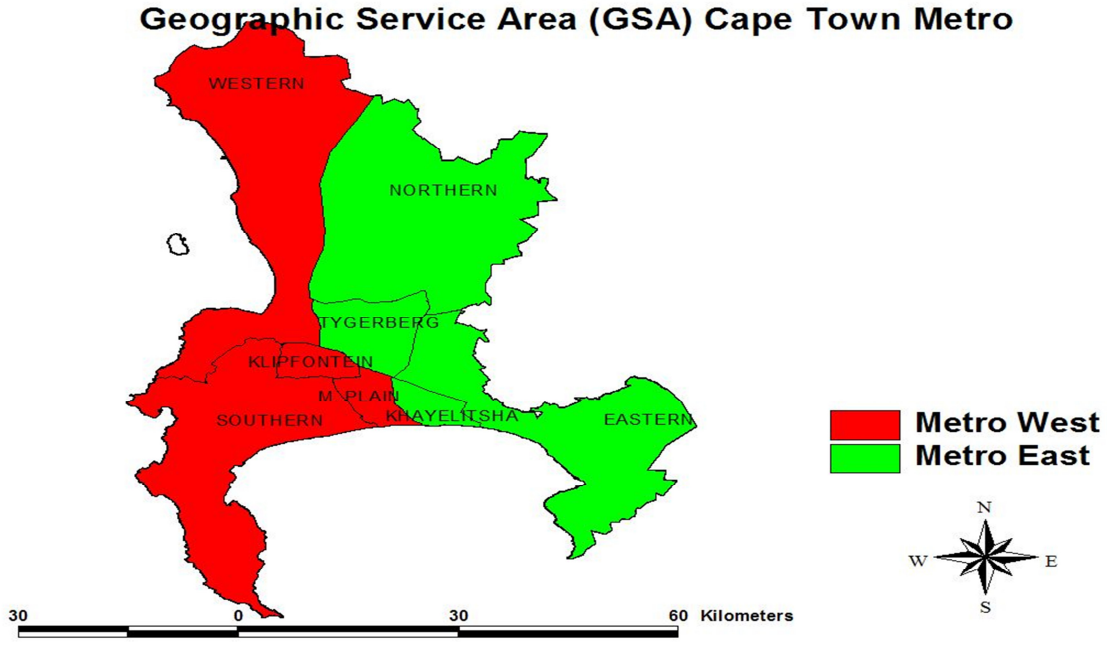


FIGURE 22: GEOGRAPHIC SERVICE AREAS - CAPE TOWN METRO

This approach enables the province to implement strategies to support municipalities and local communities to address challenges and strengthen community systems. The province will continue to prioritise working partnerships with an extensive network of civil society organisations, institutions and individuals in communities across the Western Cape. This enables the province to tap into the skills, commitments and infrastructure that these partnerships provide so that they can be optimally utilised to enhance existing programmes and to create new programme opportunities and services.

The Department of Health with its partners will be implementing a comprehensive advocacy communication and social mobilization plan to facilitate mobilization of key populations of the Western Cape to empower people to overcome stigma and discrimination and their risk of HIV and TB infection. A strategic communication plan and ACSM package will be rolled out which will include the following:

- Conducting a variety of community outreach activities and community dialogues to key and vulnerable populations to create a demand for services and improve access to services by providing sexuality and TB education and engaging networks of people living with HIV;
- Funding of HTA projects in all districts targeting key populations with the focus on interventions that redress harmful social norms and lead to positive behaviour change;
- Conducting specific community and door-to-door campaigns to increase knowledge on HIV and TB and promote services and provide services such as condom distribution, HIV counseling and testing, TB screening ,TB case finding, cervical screening, treatment of STIs etc.;
- Development of a variety of health education material and tools to support above projects and interventions;
- Implement a communication strategy utilizing the various forms of the media to achieve the overall goals of the PSP;
- Creation of effective partnerships to give voice to people who are infected and affected.

Sub-Objective 1.8: Scale up efforts geared to poverty alleviation and food security programmes

1.8.1 Comprehensive food security strategy strengthened and expanded, prioritising vulnerable individuals in households

Conditions of poverty, inequality and deprivation exacerbate the socio-economic conditions that favour increased HIV and TB prevalence, and lower socio-economic status is frequently associated with higher risk behaviours. Findings from the Cape Area Panel Study indicated that girls in lower income households tended to have earlier sexual debut, and economic hardships were associated with girls having multiple sexual partners as a result of transactional sex patterns. Community poverty rates also predict earlier sexual debut and higher rates of unprotected recent sex for boys[52]. In seeking to reduce poverty in the Western Cape the Provincial Government is following a "capability deprivation" approach that aligns with its vision of an open opportunity society for all. Although the Western Cape is one of the wealthiest provinces, poverty remains a challenge. The Western Cape's Draft Strategic Plan notes that 26.2% of total households have a household income of less than R1,500 per month, and 10.9% of children under five are underweight. Poverty is one of the major contributors to poor health through food insecurity, which in turn is linked to HIV acquisition and poor adherence risk, and every effort will be made by the provincial government and its partners to ensure food security for all, especially those with chronic diseases. Child-headed and youth-headed households will be prioritised to ensure that needs such as food, shelter and access to health, and social services are fast-tracked. The Western Cape will implement a Nutrition Programme (with supplementation and education) in health facilities for patients who meet set criteria, including the provision of food to patients who cannot take their medication because they

[52] Data from Dinkelman et al, *Cape Area Panel Study* (2007, 2008) as referenced in *The HIV Epidemic in South Africa*, 2011, pg. 133.

have no food. Other initiatives will support this, such as those run by business through their CSI programmes and by civil society organizations.

4.2.3 STRATEGIC OBJECTIVE 1: TABLE OF OBJECTIVES AND INTERVENTIONS

Strategic Objective 1		Address social and structural drivers of HIV and TB prevention, care and support	
High level Indicator		% of sectors with HIV, TB and related gender and rights-based dimensions integrated	
Western Cape Targets 2016		Increase the percentage of provincial government departments implementing operational plans with HIV, STI, TB and related gender and rights- based dimensions integrated to 100%	
Sub-Objective 1.1		Mainstream HIV, STIs and TB into the strategic plans of all provincial government departments and SANAC sectors	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
1.1.1 Mainstream HIV and its gender and rights-based dimensions into the core mandate of all Western Cape provincial government departments and SANAC sectors (including people with disabilities and other vulnerable groups)	% of government departments that have strategic and operational plans with HIV and gender integrated developed	Review and implement gender mainstreaming plans and other departmental policy instruments to ensure that they adequate address HIV and its gender and rights-based dimensions	All Government Departments
		Ensure the mainstreaming of HIV and its gender and rights-based dimensions into Employee Health and Wellness Programmes within the public sector in the Western Cape	PEAP
		Implement life skills programme its gender and rights-based dimensions Procure service provider to translate Grade R-7 Learner Activity Books in braille for the schools of the blind;	WCED
		Strengthen the mainstreaming of HIV into directorate and department plans	Cape Town Municipality
		Convene an annual meeting of Higher Education institutions to coordinate mainstreaming of HIV and its gender and rights-based dimensions	Academia
		Advocate and lobby for the rights of HIV+ people Promote NGO interventions that focus on gender equality projects Undertake policy scans and development, capacity building and advocacy to ensure that issues of men and boys are integrated Train Community Team Leaders/Community Health Worker (CHW) Supervisors on recognising and referring cases of gender based violence and addressing masculinity norms Provide services to key populations including sex workers, men who have sex with men (MSM), prisoners and migrants	Civil Society

		Advocate for HIV, STIs and TB and its gender and rights-based dimensions, and its effects on children	

Sub-Objective 1.2		Address socio-economic factors that are drivers of the epidemics as identified in the KYE report for the Western Cape Province	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
1.2.1 Identify and address structural barriers to access to HIV, STI and TB services to residents in informal settlements (Specifically refer to *BD Study and also refer to the Province Western Cape Strategic Objectives)	Provincial plan to address HIV, STIs and TB in informal settlements	Implement annually Health *Four Seasons Strategy, World AIDS Day and World TB Day celebrations* as well as the *Community Dialogues* Strategy targeting informal settlements, rural settlements and farms Training of Community Team Leaders/CHW Supervisors on conducting community dialogues to identify context-specific HIV prevention challenges and solutions Conduct community dialogues at sub-district and district level with NGOs and CBOs to identify action plans to address HIV and TB challenges and solutions	DoH and service delivery partners
		Life Skills Programme and Peer Education programmes to target informal settlements, rural settlements and farms	WCED
		Implementation of the Western Cape strategy for developing integrated and sustainable human settlements	DoHS
		Implement the Western Cape Strategy of creating opportunities for growth and development in rural areas	DoA
		HIV, STI and TB activities to be included in the Integrated District Development Plans as well as District Health Council Plans Above Plans to identifying structural barriers contributing to the HIV and TB epidemics at local level that need to be addressed Active community participation to be ensured through various forums and jamborees Mobilise active community participation in forming action plans at sub-district and district level to ensure inputs to the IDPs and District Health Plans	DoLG and District Health Councils
		Target farms and rural settlements with HIV/AIDS and TB education through the medium of theatre	Academia

		Implementation of relevant targeted NGO Projects e.g. Campaign against xenophobic violence, and campaigning for access to safe and clean water and sanitation services for residents of informal settlements Provide support to implement etr.net and tier.net systems and to review data to target interventions Support for re-engineering of primary health care (PHC) including outreach teams that will increase access to HIV/STI/TB services for informal/rural settlements and farms, community care workers trained to prevent, find and treat HIV, STIs and TB Support projects for HIV/STI/TB prevention and treatment in informal settlements, farms and to sex workers and correctional services Facilitate consultative forums that ensure participation of civil society in forming action plans to address structural issues that influence HIV/AIDS and TB at sub district and district level Capacity building of CBOs and NGOs that address structural issues	Civil Society
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
1.2.2 Address vulnerability associated with mobility and migration, with a focus on seasonal workers, refugees and immigrants to the Western Cape	Comprehensive package of services for truckers, taxi drivers and migrant workers	Seasonal Workers policies and wellness to be addressed as well as agricultural policies Provide training for HCWs in the rights of these groups Establish health posts on farms (DOH and Department of Agriculture) Implement HTA Projects focusing on truckers, refugees migrant and seasonal workers Development of referral systems to ensure adequate follow up as these people move from place to place. Portable documentation and notes. Development of a comprehensive package of care for these vulnerable target groups Improving access to care and development of more user friendly health facilities, especially with regards attitudes to foreigners and language differences	DoH and partner service providers DOA
		Education and awareness programmes at weigh bridges and truck-stops targeting truckers. Interventions must include male and female condom	DoT&PW

		distribution	
		Education and awareness programmes at entry points to the country, i.e. borders, ports, airports, etc.	DoHA / ACSA
		Businesses/companies with high rate of seasonal workers to ensure the implementation of a comprehensive employee health and wellness programme that includes access to HCT, health education and other health services	Business
		Build the capacity of NGOs to address vulnerability associated with mobility and migration Train CHWs to identify substance abuse during home visits and refer appropriately	Civil Society
		Strengthen UNHCR immigrant and refugee projects	Development Agencies
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
1.2.3 Reduce alcohol and substance abuse related vulnerabilities in high burden areas of the Western Cape	Strategies to reduce alcohol & substance abuse developed and implemented (reducing advertising, reducing availability, age of access) Package of harm reduction services developed	Implement alcohol prevention model in high 5 areas - Strategic Objective 4 *Decreasing the Incidence of Injury Group* Implementing a system whereby communities with a higher incidence of substance abuse are identified. Targeted interventions can then be more specifically directed at these groups. Development of a comprehensive package of care for these groups as it pertains to IDU	DoH / SO4 Group
		Implement the *"Substance Abuse Programme"* aimed at giving those at risk of substance abuse (Drugs and Alcohol) access to prevention, treatment and rehabilitation programmes.	WC DoSD and service delivery partners
		Implement and monitor the Western Cape Substance Abuse Strategy	DoP
		Advocacy, education and awareness raising programmes within the Western Cape Government departments Short-term counselling and support for substance abusers and their families Ensure the provision and implementation of HR practices (special leave) to assist employees to access rehabilitation services	Employee Health and Wellness Programme (EHWP), HRM & Labour Relations
		Advocacy, education and awareness raising programmes within private sector business (workplaces)	Business

		Implement NGO programmes to reduce alcohol and substance abuse e.g. Conduct HIV awareness training on link between substance abuse and HIV Capacity building and training of individuals and communities to assist with the implementation of primary prevention programmes; ***Secondary prevention*** initiatives focus on high-risk groups such as youth and abused women; ***Tertiary prevention*** is directed at providing a treatment programme to the substance abuser, their families and collaterals	Civil Society
Sub-Objective 1.3		Implement interventions to address gender inequities and gender-based violence that function as drivers of HIV and STIs	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
1.3.1 Implement targeted interventions to address gender-based violence	Exposure to physical or sexual intimate partner violence in the last 12 months Number of women who have accessed health or other services for physical or sexual violence in the last 12 months Number of people reached that have access to victim support services Number of victims of crime and violence in VEP service sites managed by government Number of victims of crime and violence in	Implement HTA Projects such as the "Brother's for Life" Project, Intimate Partners Violence Project, Abuse No More Project etc. Learn lessons from pilot project on domestic violence and prioritise possible roll out Increase training and awareness among health care providers and making them more receptive and supportive of victims of domestic violence Training for front-line staff in health facilities in screening for domestic violence and child abuse	DoH and partners service providers
		Scale up the "Abuse no more" programme Explore inclusion into life orientation curriculum	WCED
		Design and implement integrated programmes and services to support, care and empower victims of violence and crime in particular women and children (Victim Empowerment Programme – VEP) Ensure that victims of domestic violence, sexual and physical violence have access to continuum of services Provide on-going counselling and support Ensure further emphasis on child protection services & women shelters	WC DoSD and partners (SAPS, DOH, DoCommunity Safety, WCED, DoJ)
		Implement programmes (e.g. anger management, etc.) to educate offenders and staff Roll out gender empowerment workshops	DCS
		Popular opinion leaders involved in speaking out against violence and being	DCAS

	VEP service sites managed by NPOs Number of reported victims of human trafficking placed in rehabilitation programmes	used as role models in schools, etc	
		Sustain *Thuthuzela* project and Centres, led by the NPA's Sexual Offences and Community Affairs Unit (SOCA), in partnership with various departments and donors as a response to the urgent need for an integrated strategy for prevention, response and support for rape victims	NPA
		Awareness, education and advocacy relating to gender equality in the workplace (including sexual harassment and discrimination)	Business
		General awareness and empowerment of students Support project at UCT to develop a specialization curriculum for Social Workers in dealing with Domestic Violence	Academia
		Implement NGO and partner projects with targeted interventions to address gender-based violence e.g. Provide services to survivors of rape & domestic abuse, lobby against violence against women and provide training Build the capacity of government, civil society organisations and citizens to achieve gender equality, prevent gender-based violence and reduce the spread of HIV and the impact of AIDS, especially through working with men and boys Promote and implement Education and Advocacy programmes for Sex Workers Promote projects that focus on Woman's Health to create a healthcare service that is well positioned as a healthcare access point for victims of Gender Based Violence Provide training in collaboration with relevant stakeholders for Community Team Leaders, CHW Supervisor and CHWs on addressing masculinity norms and preventing gender-based violence Participate in the Shukumisa Campaign and roll-out Shukumisa monitoring of police station and health facility compliance with Sexual Offences Act regulations CHW educated to identify domestic violence and child abuse and refer appropriately	Civil Society

		Train Community Team Leaders/CHW Supervisors and CHWs to identify domestic violence and refer appropriately Implement HTA Projects such as the "Brother's for Life" Project, Intimate Partners Violence Project, Abuse No More Project	
Sub-Objective 1.4		Mitigate the impact of HIV, and TB on orphans, vulnerable children and youth	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
1.4.1 Scale up a comprehensive package of services that will remove structural barriers to access to HIV, STI and TB services for OVCs and their support structures	Comprehensive package of services available and access reported on bi-annually	Policies and strategies to retain learners in school e.g. teenage pregnancy policy positive behaviour strategy, pathways for children who exit in Grade 9, early identification of learning barriers to etc.	WCED
		Making available and accessible the process of assessment and allocation of social grants to orphans and vulnerable children as well as their care-givers e.g. Social relief of distress, Food Security Services, Grant in aid, Family support services and Child support grant Implement a comprehensively approach orphans and vulnerable children with interventions such as promoting the concept of family, encouraging South Africans to adopt orphaned children, to provide a nurturing environment enabling the development of full human capital Provision of institutional care and support and foster care Provide *i*nstitutional capacity building and support to CBOs providing support to OVC and offering a package of services to organisations: nutritional support, material allowance, psychosocial support and care, institutional capacity building support	WC DoSD
		Monitor the prevalence of child labour as indicator of the impact of HIV on adult mortality (in the context of SA being a signatory to ILO conventions on Child Labour)	DoL
		Raise awareness of the importance of early grant uptake for young children who are eligible Awareness raising, intervention recommendations and support for organisations dealing with orphaned, vulnerable children and youth Sharing of best practice models	Civil Society
Sub-Objective 1.5		Reduce the vulnerability of young people to HIV infection by retaining them in schools as well as	

		providing post-school education and opportunities (special focus on children out of school, OVC, young girls 15-19yrs)	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
1.5.1 Implement interventions that will keep young people and children in school and ensure school completion	Learner drop-out rate in Grades 9, 10 and 11 (gender disaggregated)	Implement School Health Strategy and Programme (With DoED) Provision of Schooling for scholars with MDR/XDR-TB at TB hospitals (with DoED)	DoH
		Implement policies to retain learners in school e.g. teenage pregnancy policy positive behaviour strategy, guidelines re pathways for children who exit in Grade 9, early identification of learning barriers and Life-skills programme	DoED
		Implement extra-curricular activities at schools (sports, cultural activities, etc.)	DCAS in partnership with private sector & civil society
		Provide HIV awareness counselling as part of the LO curriculum. To introduce a culture of HIV prevention and HIV testing among the youth. Programmes that address destigmatization Identify activities that address youth leadership through collaboration with the Youth Development Agency Create spaces to enable inter-generational conversations on sex, sexuality and gender equality that reduce the vulnerability of young people to HIV Promote Caring Schools and inclusive education through raising awareness around, and advocating for the school health policy to be implemented and practiced across schools in the Western Cape	Civil Society
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
1.5.2 Implement a comprehensive package of services for youth (including out of school youth) that also promotes youth leadership to mitigate the impact of HIV and TB	Comprehensive package developed and implemented	Implement life skills programme and peer education programme Introduce HCT to the learners and HIV prevention awareness	WCED
		Implement NGO and partner projects with targeted interventions to mitigate the impact of HIV and TB among the youth e.g. Implement peer education programmes using a quality-assured approach to youth leadership in HIV prevention, risk behaviour reduction and school/community-based support for vulnerable youth Facilitate development of leadership, education, and communication skills to transform those most vulnerable into future pillars of their community	Civil Society

among the youth		Use innovative technology on-line to teach teenagers and teachers about HIV/AIDS and encourage them to get tested	
Sub-Objective 1.6		Reduce HIV and TB related stigma and discrimination	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
1.6.1 Roll out the Stigma Mitigation Framework and the People living with HIV Stigma Index, together with associated interventions, to decrease HIV and TB related stigma	Reduction of self-reported stigma (using PLHIV stigma index)	Implement HIV/AIDS/STIs and TB ACSM Strategy	DoH
		Minimise stigmatisation and discrimination in the workplace through education and training that encourage employees to reveal fears/prejudices and promote openness Promote the need for confidentiality in the workplace	PEAP
		Implement life skills programme DOE, Peer Education Programme	WCED
		Align and implement stigma mitigation framework Implement HIV/AIDS/STIs and TB ACSM Strategy	DCS
		Minimise stigmatisation and discrimination in the workplace through education and training that encourage employees to reveal fears/prejudices and promote openness Promote the need for confidentiality in the workplace	Business
		Implement Advocacy, communication and social mobilization campaigns to reduce stigma Scale up peer education and support programmes, including the involvement of PLWH Know your status discussions and living positively education MSM training for health care workers Provide education materials, employ TB/HIV Ambassadors who run support groups, promote disclosure and advocate for workplace policies to decrease stigma Children's Sector contributes to and participates in drafting the stigma mitigation framework, and to make it available in accessible formats to children and members	Civil Society
Sub-Objective 1.7		Strengthen community systems for more effective HIV and TB programmes at community level	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**

1.7.1 District Health Councils to develop plans, including MSATS and Community Action Plans, for community system strengthening, which should also be integrated into the Integrated Development Plans	District Health Council plans developed	Establish and sustain clinic committees, health forums, adherence clubs and support groups Develop 6 district health plans Promote the PHC re-engineering concept of sub-district health agents or CHWs, properly supported by an outreach team Conduct dialogues with community health workers to promote PHC reengineering concept Establish well-functioning referral systems for patients referred down and up the system	DoH / District Health Councils
		District Liaison Officer Care & support do inter-sectoral capacity building in all districts, School Governing bodies	WCED
		Strengthen community systems	DoLG
		Implement capacity building programmes for MSAT structures and NGOs throughout Western Cape Develop action plans with high prevalence sub-districts for community systems strengthening and input to district health plans and IDPs Provide accredited training to CHWs on CHBC in collaboration with training service providers Provide training on quality assurance and monitoring and evaluation of community based services to document impact on TB/HIV case finding and treatment outcomes	Civil Society
Sub-Objective 1.8		Scale up efforts geared to poverty alleviation and food security programmes	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
1.8.1 Comprehensive food security strategy strengthened and expanded, prioritising vulnerable	Comprehensive plan in place and implemented Reduction of number of vulnerable households in relation to food insecurity Number of people	Implement Nutrition Programme (supplementation, education,) in health facility to patients who meet set criteria, including the provision of food to patients who cannot take their medication because they have no food	DoH
		Implement National School Nutrition programme	WCED
		To provide social relief of distress services to those affected by undue hardship and disasters	WC DoSD
		Ensuring food security through providing agriculture infrastructure to qualifying farmers, agricultural training, conservation of natural resources and rural	DoA

individuals in households	accessing the Nutrition Programme at Health Facilities	development projects	
		Business to include funding for food security programmes via their CSI interventions	Business
		Establishment of Food Banks	Civil Society

4.3 STRATEGIC OBJECTIVE 2: PREVENTION OF HIV AND TB INFECTIONS

4.3.1 INTRODUCTION

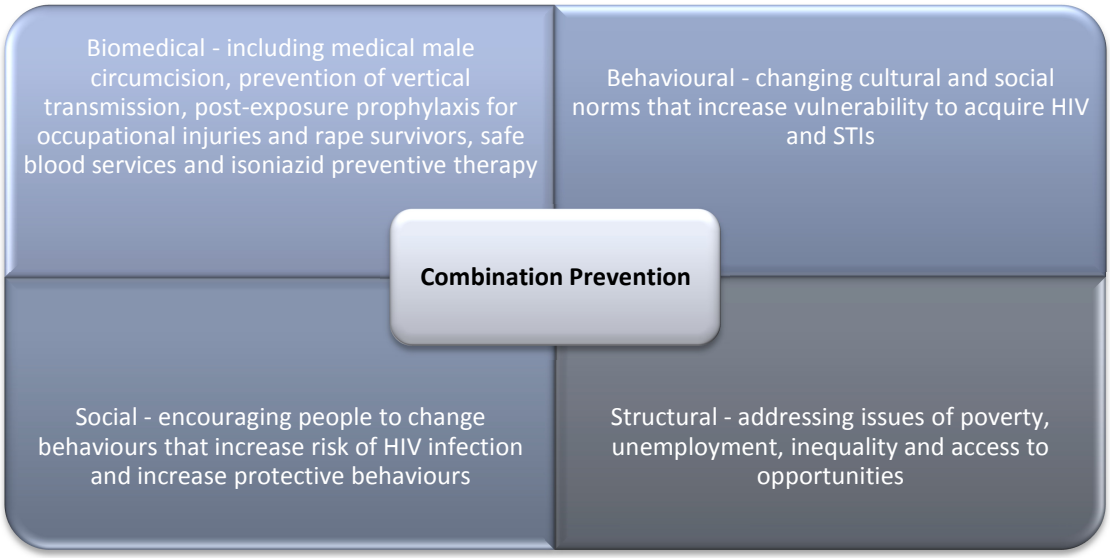
Targeted, evidence-based combination prevention is needed to achieve the long-term goal of zero new HIV, STI and TB infections. Focusing prevention efforts in high transmission areas and on key populations in the Western Cape is likely to have the greatest impact, whilst simultaneously sustaining efforts in the general population are the key strategic challenges of the PSP.

4.3.2 SUB-OBJECTIVES

The primary strategies to prevent new HIV and STI infections relate to preventing sexual transmission and vertical transmission.

Combination Prevention

Preventing new HIV and TB infections requires combination prevention interventions. This approach recognises that no single prevention intervention can adequately address the HIV and TB epidemics at the population and individual levels.



Combination prevention will have the greatest impact on reducing transmission, mitigating individuals' susceptibility and vulnerability to infection, and the infectivity and impact of the infectious agents. Interventions that reduce unsafe sex will also reduce STIs. Prevention of TB requires prevention interventions for both HIV infection and TB, including HIV counseling and testing, disclosure and partner testing, behavior modification, earlier antiretroviral therapy, and the "Three I's for HIV/TB": isoniazid preventive treatment, intensified case finding, and infection control for TB.
There continues to be a gap in access to integrated TB and HIV services in South Africa[53]. TB services have been relatively accessible with drug and treatment points at PHC facilities, while ART has primarily been available through tertiary and more recently secondary healthcare facilities and

[53] This is referenced in A Practical Guide for TB and HIV Service Integration at Primary Health Care Facilities, pg. 8.

hospitals. Since 2010 ART availability at PHC level and integration with TB services has been a National Department of Health priority, focused on a comprehensive approach that is patient-centred and fully integrates TB and HIV services within both curative services. This is aligned with one of the key UNAIDS treatment, care and support objectives for the "sharing of best practice in controlling TB, HIV, malaria, hepatitis B and C, congenital syphilis and other diseases, as well as integrating the prevention and treatment services for these diseases, is critical to improve the coverage, quality and cost-effectiveness of services"[54]. This strategic approach has been factored into the proposed framework for the new NSP – "integrating TB and HIV care".

The Western Cape has already made strides in promoting an integrated approach to HIV & AIDS and TB[55]. In 2003 the Cape Town Metro established a task team to develop an audit tool to evaluate the quality of TB, HIV &AIDS and STI services rendered at primary health care facilities in the district in response to a need expressed by health programme managers. The tool was developed by the Department of Health and the City of Cape Town with the assistance and support of the University of the Western Cape School of Public Health and later with the Desmond Tutu TB Centre of the University of Stellenbosch. The intention of the tool was to build capacity at facility level and sub-district level to improve the performance of the HIV, TB and STI programmes, as well as to encourage the integration of these three programmes.

The purpose of the tool is to evaluate the current performance of the programme components even in situations where they are not integrated. It also serves to re-orientate facility and district staff towards an integrated approach. Whilst facility and sub-district managers are seen as the main beneficiaries of the evaluation process, the information generated is also useful for provincial and national programme managers to identify key implementation successes and challenges. The information provides guidance in the monitoring of the programme and the formulation of policy. The tool includes the evaluation of the following programmes: HCT, HIV General Care, STI, TB, ARV and PMTCT as well as aspects of general health care and systems. The Metro district has now institutionalised the process and is evaluating all facilities on a semi-annual basis. The province has started with capacity building and support in the rural districts to implement annual audits. Overall the auditing process has proved to be extremely valuable in accelerating integration and improving the quality of coordinated service delivery.

Massive progress is noted over the past 4 years in terms of integrated TB/HIV service delivery. Testing rate improved with an increase in the HIV positivity rate. The HIV positivity rates vary amongst districts but are consistent with Antenatal Survey results. Figure 12 clearly illustrates the start of CD4 results being captured and the change in policy with regard to ART eligibility.

[54] UNAIDS, Getting to Zero, pg. 40.
[55] Overview of TB Programme 2007-2011 Western Cape, pg. 10.

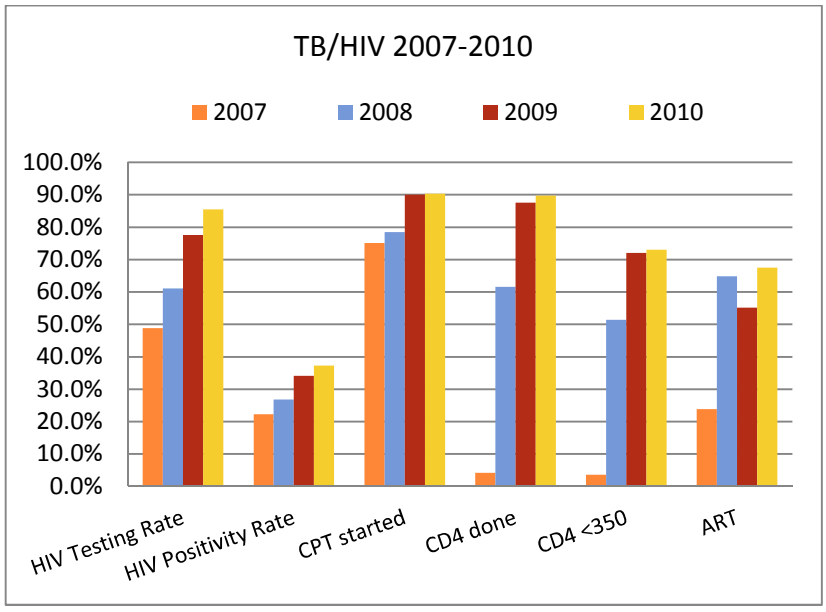


FIGURE 23: TB AND HIV INTEGRATION TREND

The eligibility for ART is high, with 73% of cases having a CD4 count of <350. The province managed to initiate 67.5% of eligible cases on ART. There are huge variations between districts in the proportions of people initiated on ART. The TB/HIV elements illustrate remarkable progress but also identify clearly the challenges in both service delivery and information management. Combination prevention efforts must also consider the prevention needs of people living with HIV and their role in prevention of new HIV infections. A human rights framework that promotes health, empowerment and dignity will guide this.

The following eight sub-objectives are included for HIV, STI and TB prevention:

- Ensure everyone in the Western Cape is tested for HIV and screened for TB, annually and enrolled in wellness and treatment, care and support programmes;
- Make accessible a package of sexual and reproductive health programmes to prevent HIV and STIs, with emphasis on key populations;
- Prevent HIV, STIs and TB in adolescents and youth through a package of sexual and reproductive health and TB education and services for learners, those in institutions of higher learning and for out-of-school youth;
- Prevent vertical transmission of HIV to reduce MTCT to, at least, less than 2% at 6 weeks and less than 5% at 18 months by 2016;
- Implement a national social and behavioural change communication strategy with a focus on key populations to shift attitudes, promote healthy behaviours, increase self-efficacy and increase demand and uptake of services;
- Prepare for the potential implementation of innovative biomedical prevention strategies, such as microbicides and PrEP;
- Prevent new TB infection and disease through IPT, early identification and treatment of TB and an improved TB cure rate;
- Implement treatment for prevention strategies that ensure early ARV initiation in line with national guidelines.

Sub-Objective 2.1: Maximise opportunities to ensure that everyone in the Western Cape is tested for HIV and screened for TB at least once a year and enrolled in wellness and treatment, care and support programmes

Intervention 2.1.1 HIV testing and screening for TB in all health facilities as well as in non-health settings is implemented

Under the new PSP the Western Cape will continue to strengthen its HIV Counselling and Testing Campaign (HCT) to ensure that people know their status. The campaign will continue to give effect to the Presidential and ministerial announcements in terms of a focused and dedicated campaign to support the NSP and PSP objective of reducing new HIV infections by 50% and to commence 80% of eligible clients on ART.

The intention of the Campaign has been to mobilise all people to know their status, by engaging all public and private partners to collaborate to reach set targets. As part of the 15 month campaign to test 15 million South Africans in a 15 month period, the Western Cape Province managed to test by the end of June 2011 more than 1 000 000 people of the agreed target of testing 1 100 000 individuals aged 12 years and older who are sexually active.

The National HIV testing and counselling Policy of implementing Provider Initiated Counselling and Testing (PICT) in all health facilities has been rolled out to all health facilities in the Western Cape with the support of ACTS South Africa. The purpose of PICT is to empower health care workers and providers to expand HCT in clinical settings to reduce the impact of HIV on individuals, families and communities by preventing further HIV transmission by providing early access to treatment services. Provider-initiated HIV counselling and testing remains voluntary but it places an obligation on the health care worker to explain to patients the importance of knowing one's HIV status and of testing habitually for HIV as part of a normal health seeking behaviour. HCT integrates prevention and treatment, which are the two key mutually-reinforcing pillars of the NSP. HCT is widely relevant, focused and action-oriented which makes widespread social mobilisation possible.

Scaling up TB suspect screening is aligned with the HCT campaign. Each person who is counseled and tested for HIV is also screened for TB. Clients who have signs and symptoms of TB are tested for TB or are referred to a TB health facility to be tested. Intensified TB case finding promotes early start of tuberculosis treatment, which reduces HIV related tuberculosis disease and death, and simultaneously contributes to infection control by reducing transmission of tuberculosis in communities and health facilities.

The Western Cape will continue to mobilise communities to test and to raise awareness through a multi-media approach, using radio, the print media, trailer advertising, flyers and Mxit. Non-medical HCT testing within communities, tertiary institutions and the workplace will be expanded through the funding of non-medical HCT sites and teams.

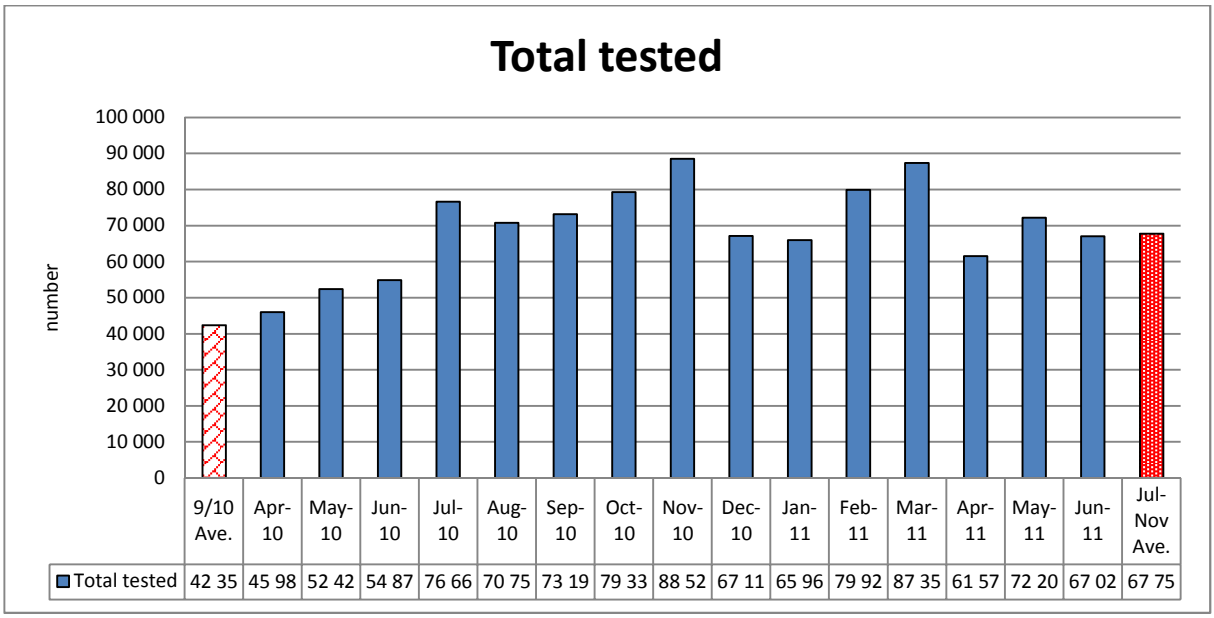


FIGURE 24: TOTAL NUMBER OF PEOPLE TESTED FOR HIV IN THE WESTERN CAPE 2010 - 2011

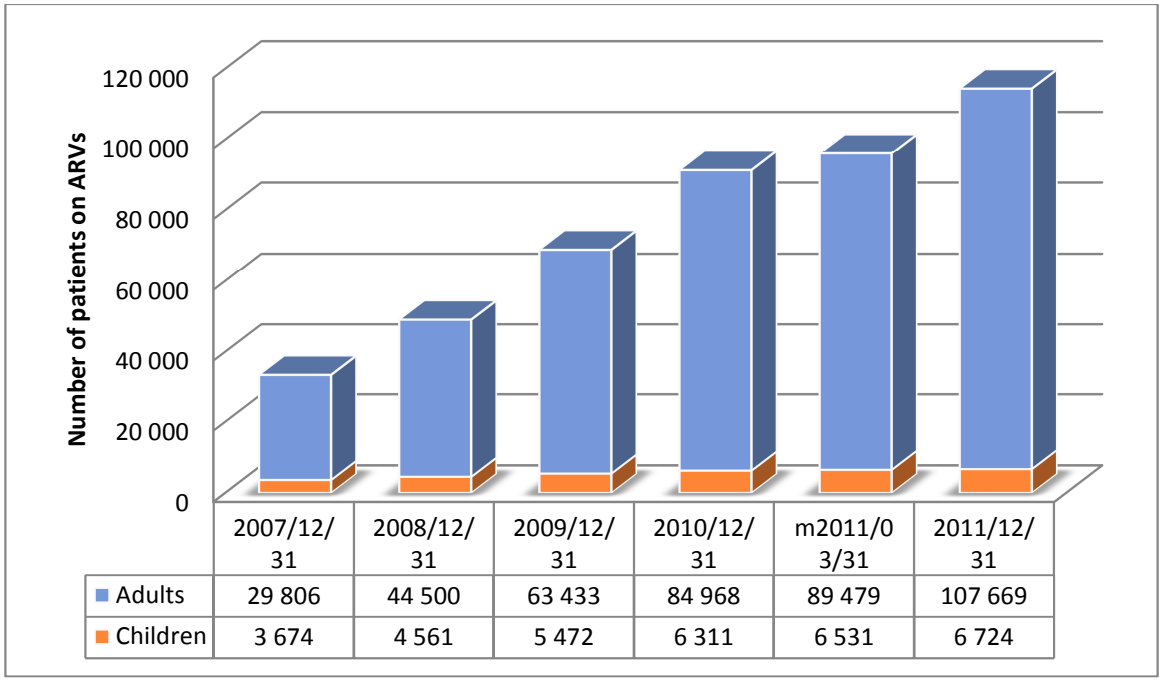
By 2011 the Western Cape Department of Health has registered over 100,000 people for the province's antiretroviral ARV drug programme. These numbers indicate an important achievement for the province and the success is ascribed to the fact that in the past two years the provincial government has made the major shift from testing ill people at certain designated health facilities to a provider-based testing system, which aims to test every person that presents at health facilities. The result of this (primarily through the HCT campaign) is that 1.1 million people in the province have been tested within a period of 18 months. The Western Cape has made global headlines by changing the Prevention of Mother to Child Transmission therapy from mono-therapy to dual therapy. The evidence in PMTCT outcomes as a result of this was later used by National to build on and thus institute triple therapy for the South Africa. As a result the mother-to-child transmission rate has decreased from 8 percent to 3.2 percent. In assessing progress made in initiating HIV+ people on ART it is important to make two clear distinctions:

- Firstly the total number of people who are HIV-infected in the province; and
- Secondly the need for treatment.

330 000 is the total number of people estimated to be living with HIV in the province, not the number who have tested positive. This number is derived from actuarial projections and is based on results from survey data, like the annual antenatal survey, which are then projected onto the whole population.

In an effort to demonstrate the method of HIV testing, approximately 840,000 people were tested for HIV in the last financial 12-month period, of which about 74,000 were HIV-infected (8.7% of those tested). It is not clear whether those people were recently infected or distantly infected or whether they were already aware of their status or not. This kind of data is not used to estimate the total number of HIV-infected people in the province because it is subject to too many biases. In terms of the need for treatment, the most important thing to note is that HIV-infected people do not need ART in the early stages of their infection. Highly active anti-retroviral medication is only medically indicated when a person's immune system has been damaged to such an extent by the HIV virus that either: a) symptoms of illness appear or, b) their immune system is shown to be much depleted, as measured by their CD4 count. This normally happens about 6-7 years after the initial infection occurs. So, of the 330,000 people living with HIV in the province, 100,000 are on HAART and about

180,000-200,000 acquired their infection recently (within the last 6-7 years) and thus do not need ART this year (but will need it in due course). This leaves only about 30,000 unaccounted for, which is the target the Western Cape has set itself as the number of people who need to start ART in the next financial year. The following graph indicates the number of people on ART in the Western Cape for the years 2007 to 2011[56].



	2007/12/31	2008/12/31	2009/12/31	2010/12/31	m2011/03/31	2011/12/31
Adults	29 806	44 500	63 433	84 968	89 479	107 669
Children	3 674	4 561	5 472	6 311	6 531	6 724

FIGURE 25: NUMBER OF PEOPLE ON ART IN THE WESTERN CAPE 2007-2011

The government's policy decision (2010) to scale up provision of ART across South Africa has been a welcome development. The limited capacity of the public health sector to achieve this scale of increase, however, has presented a number of key implementation challenges. The main challenge is the reality that there are insufficient numbers of doctors in the public sector to initiate and follow up on such a rapid increase in patient load. Nurse initiated management of patients on ART (NIM-ART) has, as a result, become a key strategy for expanding access. The Western Cape DoH has moved rapidly to prioritise this service delivery model through an extensive capacity development programme for clinicians and nurses. As part of the HCT Campaign 26 clinicians were trained as mentors and to date 16 nurses have been authorized to prescribe ART. In order to facilitate the process of training nurses to be able to manage an ART client and prescribe the necessary medication a pilot Western Cape NIM-ART Course has been developed, consisting of the following modules:

- A short training course in HIV/ART management;
- PALSA Plus course;
- An assessment of competency by an experienced clinician (mentor);
- An authorization process determined by the District Director.

[56] Information provided by the Western Cape Department of Health

The NIM-ART initiative in the province is being strengthened by the active involvement of civil society partners. The work being done by MSF in ART clinics in Khayelitsha to reduce saturated enrolment capacity through nurse based ART services is illustrative of the progress being made.

Sub-Objective 2.2: Make accessible a package of sexual and reproductive health programmes with emphasis on key populations to prevent HIV and STIs

Intervention 2.2.1: A package of SRH services is provided that includes fertility management services, dual contraception, social services and mental health

The Western Cape strives to deliver an integrated package of SRH services as part of the PHC approach within the district health system. The package includes termination of pregnancy services, contraception counselling and dual contraceptive method use. This is essential to reduce unintended pregnancies (especially teenage pregnancies) and to improve planning for safe and desired pregnancies. Contraception services will be provided at all PHC facilities and contraception will be offered to HIV-positive women at every opportunity. Contraceptive services will be integrated into ART services as these services are expanded to primary health care level. A target for the couple year protection rate has been set for 60% aiming to increase it to 64% over the next 3 years. Termination of pregnancy (TOP) services will continued to be delivered at designated TOP facilities throughout the province.

Intervention 2.2.2: Maximise coverage of readily available and accessible male and female condoms using both health facilities, and non-traditional outlets

A comprehensive condom programme is a key priority for the Western Cape, because condoms, both male and female, are recognized as the only currently available and effective way to prevent HIV – and other sexually transmitted infections – among sexually active people. The goal of condom programming is to reduce the number of unprotected sex acts, which will, in turn, reduce the incidence of unintended pregnancy and sexually transmitted infections.

The distribution of male condoms has been a key part of the governments HIV prevention strategy for many years. There has been an increase from 8 million in 1994 to an estimated 376 million in 2006. The Western Cape distributed 102 546 000 condoms in 2011. Effective partnerships remain fundamental to successful and sustainable HIV responses and this is one intervention in which strong partnerships have been built in the province with various government departments, sectors, civil society and business to expand condom distribution. These partnerships will be strengthened in order to reach set targets for the next 5 years.

The comprehensive condom programme in the province will integrate various activities including male and female condom promotion, communication for behaviour change, segmentation of messages and advocacy. Optimized distribution, consistent supply, quality assurance and a coordinated management of supplies through the five decentralised condom stores will be managed by a newly appointed Logistics Manager. Key interventions for this programme include the following:

- Ensure consistent access to both male and female condoms
- Review procurement policies
- Investigate lubricant provision

- Ensure uninterrupted supply to health facilities and partners through strengthening supply chain management
- Develop consistent messaging on the use of male and female condoms
- Ensure a constant supply of male and female condoms to public sector workplaces
- Provide education to increase use of male and female condoms

Intervention 2.2.3: Expansion of MMC as part of male sexual and reproductive health programme using provincial safe circumcision guidelines

WHO and UNAIDS advocate MMC as an important strategy in the prevention of HIV infection, especially in areas where HIV is transmitted primarily via heterosexual intercourse and where there is a high prevalence of HIV along with a low prevalence of male circumcision. Research findings suggest that the effectiveness of MMC in reducing the risk of female-to male transmission occurs when the foreskin is completely removed. There is no evidence that incomplete removal of the foreskin prevents HIV infection. Strong evidence has been provided that failure to abstain 6 weeks from sexual activity post MMC increases the risk of transmission of HIV since the surgical site has not yet completely healed and the skin has not had an opportunity to become keratinized.

In the Western Cape MMC will be provided as an integral component of a comprehensive package of male sexual and reproductive health services and multi-faceted HIV prevention strategies that maximize benefits and reduces risks at both the individual and public health levels. For the Western Cape with its diverse cultural groups and practices the successful implementation of the MMC strategy requires a strong network of partnerships between government, NGOs, traditional providers and the private sector. The Province has embarked on building human capacity, skills and infrastructure to deliver the services. District teams will be established in each district and targets have been set. Men aged 15 – 49 years of age will be prioritised. MMC services will be made available on a voluntary basis with informed consent. HIV-infected men who still want to access circumcision services will be counselled on the specific risks and issues concerned. If their HIV-infection and immunologic status is suppressed (i.e., those with CD4 T cell count < 200 cells/mm^3) they will be advised to defer circumcision and initiate ARV treatment until such time that their CD4 T cell count is > 200 cells/mm^{3}for at least 6 months, but should they still desire services they will not be denied based on their HIV status. All HIV-infected men will be referred to HIV and AIDS care and treatment services.

Intervention 2.2.4 Scale up surveillance and treatment of STIs in key populations and develop appropriate responses, with a strong focus on males

Sexually transmitted infections (STIs) still constitute a major health problem in the Western Cape. The Department of Health in the Western Cape has put in place a strategy which aims to achieve the following:

- Make services accessible and user friendly;
- Ensure regular supply of drugs and consumables, availability of equipment and infrastructure;
- Ensure that staff are competent to manage and treat STIs syndromes;
- Ensure access to and availability of laboratory services and quality control;
- Ensure well-functioning referral systems;
- Monitor the programme through sentinel surveillance sites;
- Ensure strong partnerships with the private sector.

Sub-Objective 2.3: Prevent vertical transmission of HIV to reduce MTCT to, at least, less than 2% at six weeks and less than 5% at 18 months by 2016

Intervention 2.3.1 Adapt and implement the Action Framework for "No child born with HIV by 2015 in South Africa" within the Western Cape context, with a focus on the four prongs

The Action Framework for "No Child Born with HIV by 2015 in South Africa" will be finalised and adopted and its implementation monitored. The Action Framework provides a road map for the elimination of vertical transmission and includes four prongs, namely:

1. Primary prevention of HIV among young women, with specific interventions targeting women who test negative and specific positive prevention interventions;
2. Prevention of unintended pregnancies for teenagers and HIV-positive women. This involves ensuring that PMTCT is integrated into sexual and reproductive health and family planning services and that functional linkages are established to routinely address reproductive health needs of both HIV-negative and HIV-positive women;
3. Prevention of HIV transmission from HIV-positive women to their infants through better implementation of national guidelines on ARVs for treating pregnant women and preventing MTCT and on-going infant feeding counselling and support; and
4. Provision of appropriate treatment, care and support to HIV-positive mothers, their infants and family with a focus on establishing appropriate mechanisms for referral and linkages with long-term HIV care services (including ART, cotrimoxazole prophylaxis, TB screening and treatment, diagnosis of HIV infection in infants), and other child survival services to ensure continuum of care for women and children.

Strengthening the management, leadership and coordination of the PMTCT programme, and its integration with maternal, child and women's health (MCWH) programmes is key to achieving targets. The Western Cape is still the Province with the lowest transmission rate in the Country. Improvement can be made to the extent that close to 0% transmission rate can be achieved, should an integrated approach be put in place and adhered to. The PMTCT Programme is one of the flagship HIV prevention programmes of the Western Cape. The provincial PMTCT programme is implemented at 100% of facilities, including hospitals and midwife obstetric units (MOUs) that provide antenatal care service. The programme is available as a service to all the pregnant women who test positive; the aim should be, no child infected with HIV as MTC transmission is preventable.

The Western Cape took the lead to initiate dual therapy as a regime for PMTCT in the Country, in 2004 and set the trend for the NDoH to apply the strategy to all the Provinces. The transmission rate decreased noticeably in the Province. The Western Cape has been acknowledged as one of the best practices in the Country. In 2009, gaps in PMTCT service delivery were identified at the birthing facilities. As a result a need to employ PMTCT Coordinators in each district was identified to strengthen the PMTCT programme and ensure further improvements. Nine additional posts were created and filled. This intervention will assist the Western Cape to achieve the set targets of the NSP and PSP.

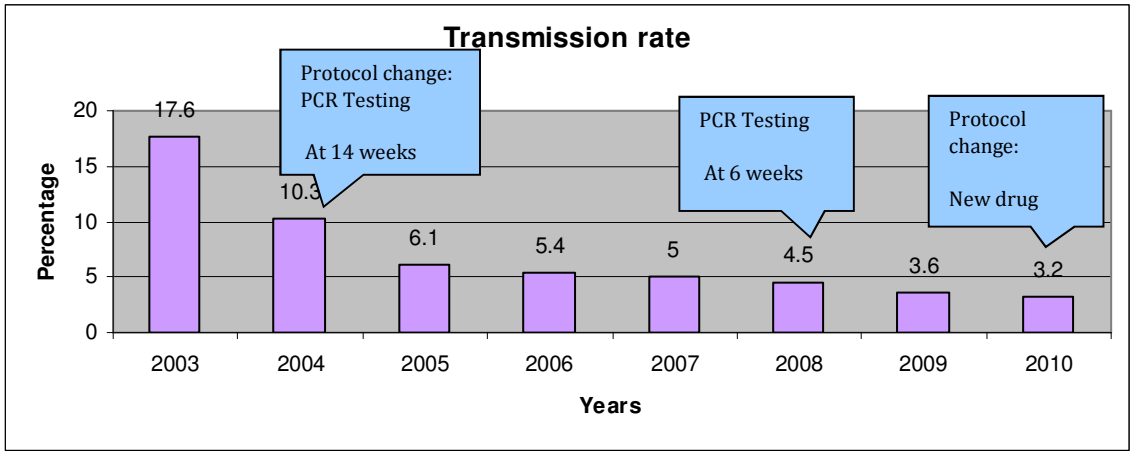


FIGURE26: PMTCT: WESTERN CAPE TRANSMISSION RATES 2003-2010

Focussed interventions for PMTCT will be rolled out in the province through the PMTCT Implementation Plan, which serves as one of the flagship HIV prevention programmes for the Western Cape.

Sub-Objective 2.4: Develop and implement a comprehensive social and behavioural change communication (SBCC) strategy in the Western Cape, including a specific focus on key populations

Intervention 2.4.1 Western Cape SBCC strategy developed and implemented with specific focus on key populations

A comprehensive and multi-sectoral provincial social and behavioural change communication (SBCC) strategy will be developed for the Western Cape as a means to increase demand and uptake of services, to promote positive norms and behaviours and to challenge perceptions, assumptions and practices that place people at risk (including norms around gender and alcohol consumption). An additional focus will be placed on sexuality and reproductive health education as well as TB symptom recognition, cough hygiene and how to access services forms an important component of a comprehensive communication strategy. The strategy will shift attitudes and behaviours related to the reduction of HIV and STI transmission with a focus on consistent and correct condom usage, delaying sexual debut and the reduction of age mixing, and multiple and concurrent partners. This strategy will take into consideration the special communication needs of persons with disabilities in the province.

Intervention 2.4.2 Increase demand and uptake of services and promote positive norms and behaviours

Under the new PSP the Western Cape will ensure that there is an increased level of social mobilization, awareness raising and advocacy around HIV, STI and TB services in the province. These initiatives will be characterized by efforts to promote positive norms and values that will result in improved health outcomes. An "ARVs at CD4 350" media campaign will be run to ensure that people in the Western Cape start ART at 350 and that community members enjoy improved health benefits and that transmission is reduced in the province. It is anticipated that this will also lead to a reduced cost burden in the managing of sick patients only accessing health services when sick or faced with a low CD4 count. These initiatives will be

undertaken in recognition of the fact that while there have been changes to the policy and guidelines, there is a lag in community perceptions.

Adherence related media campaigns, through radio, newspapers, TV, road side advertisements, will be rolled out to remind people on ART to take their treatment. The theme of these messages will be that adherent community members will remain well and that new transmissions will be reduced. These campaigns are aligned with the Wellness objectives of the province. Training will be rolled out to all staff at all healthcare access points - both facility and community based – encouraging them to be receptive and non- judgmental and sensitizing all staff to issues related to appropriate behavior in the context of culture, sex, race, gender and human rights considerations. Additional civil society interventions will be introduced aimed at facilitating community dialogues, community radio interviews, community newspapers, collaboration with Community Media Trust to train community journalists.

Sub-Objective 2.5: Prepare for the potential implementation of future innovative, scientifically proven HIV, STI and TB prevention strategies

Intervention 2.5.1 Review and assess the use of treatment for prevention, PEP, PrEP, whirley bird vents, TB vaccines and microbicides to prevent the spread of new HIV and TB infections

Current prevention strategies, both at global, national and provincial level, are premised on current knowledge and understanding of the HIV, STI and TB epidemics. The field, however, is dynamic and new developments take place all at the time. This means that the Western Cape response needs to be flexible and adaptable, and sufficiently geared to responding to and aligning with alternative or new combination prevention efforts that may emerge over the 2012-2016 period. Innovative strategies to prevent the spread of new HIV infections include microbicides, antiretroviral pre-exposure prophylaxis (PrEP), new vaccines (including a herpes simplex virus type 2 vaccine), post-exposure prophylaxis (PEP) beyond sexual assault and occupational exposure, and antiretroviral treatment for prevention). The province will work on the implementation of prevention strategies work closely with those public, private and civil society organizations that are in the forefront of medical research in these areas.

PrEP using ARVs either orally or topically (microbicides) has been shown to be modestly effective against HIV acquisition. Studies in women in the general population, MSM and discordant couples have shown protection levels varying from 39% to 73%. However, antiretrovirals have not yet been licensed for PrEP, and international guidelines on their use have not yet been issued. In preparation for the potential future implementation of microbicides and PrEP, further work needs to be done on strategies and feasibility of implementing these prevention strategies. The following innovations will be explored by the Western Cape:

- The provision of oral PrEP for MSM;
- The provision of oral PrEP for key populations that would benefit, such as discordant couples;
- The provision of microbicides (topical PrEP) to women at risk (of HIV and HSV-2) in the general population;
- The introduction of whirly bird vents for TB infection control in resource-constrained facilities;
- The provision of a HSV-2 vaccine if current candidate vaccines in testing are shown to be effective; and

- The provision of PEP in circumstances other than occupational exposure and post-sexual assault.

Sub-Objective 2.6: Reduce TB infections and related disease

A combination prevention approach is also necessary for an effective response to TB infection and disease. The following interventions combine behavioural, social, structural and biomedical approaches.

Intervention 2.6.1 Reduce TB Infections and related diseases

Intensified TB Case Finding: This will be achieved through annual TB symptom screening and testing (for those with a positive symptom screen) through testing campaigns that will include intensified TB campaigns and household campaigns. These will take place in communities, schools, universities, workplaces, uniformed forces, places of worship, farms, taxi ranks and shebeens. The focus will be on screening of all health facility attendees and at-risk populations (TB-exposed infants and children, people living with HIV, contacts of people with sensitive and drug resistant TB, pregnant women, healthcare workers, mine workers, prisoners and prison staff). Clients with TB symptoms will be tested for TB.

TB case finding including early detection of drug-resistant TB will be significantly enhanced as South Africa phases in Xpert MTB/RIF as a replacement TB test for sputum microscopy country-wide over the next 2 years to detect TB. The GeneXpert System (Cepheid) using the Xpert MTB RIF assay, a cassette-based cartridge, has provided the possibility of a rapid diagnosis of tuberculosis, while simultaneously providing a rapid screen for rifampicin (RIF) resistance. The assay is highly sensitive and specific for M. tuberculosis (MTB) infection and has received a strong recommendation from the World Health Organization in December 2010 as the initial test in individuals suspected of MDR-TB or those with HIV co-infection. The national rollout of Xpert MTB/RIF will afford South Africa with a unique opportunity to evaluate effectiveness, cost and cost-effectiveness of implementing Xpert MTB/RIF and inform public health policy, locally and internationally. The National Health Laboratory Services in conjunction with the Department of Health is in the process of rolling out above technology in the Western Cape and this will be expanded over the next two years to cover the entire province.

As soon as a person has been diagnosed with tuberculosis, the person will be placed on effective TB treatment. Using GeneXpert technology it is anticipated that the turnaround time from identifying TB symptoms to starting treatment should be less than two working days for sensitive TB and Rifampicin resistant TB, and within five days for MDR-TB. TB adherence support will be also provided for all patients on treatment. Dually infected clients will receive integrated adherence support for both ART and TB treatment.

To further enhance TB case-finding, a policy of using nebulisers in primary health facilities for inducing sputum in symptomatic children and immune-compromised patients, in whom sputum production is a problem, should be considered. Interventions that focus on prompt diagnoses and treatment for smear negative TB and extra-pulmonary TB are particularly important for people living with HIV. There will be active follow-up of TB contacts, especially child contacts. Community based services will be strengthened to support the follow-up of contacts and to conduct intensified TB

campaigns. Civil society organizations will also support the province in the follow-up investigation of case contacts at homes and in the work and social environments.

TB Infection Control: Instilling a culture of cough hygiene is essential to achieve better respiratory infection control in the community. A greater emphasis on TB and respiratory infection control is needed in households, schools, health care facilities, prisons, and other congregate settings to ensure a safe environment. TB infection control requires a combination of administrative, environmental and personal respiratory infection interventions. This should be delivered in the context of broader infection control standards (including hand washing, safe disposal of medical waste, injection and sharps safety). All health facilities providing HIV and TB care must be assessed annually against a set of quality standards for infection control. This also requires each health facility to have an infection control plan and officer.

Respiratory infection control should also be prioritised in prisons, high-risk industries (mines, textiles, construction, and agriculture), single sex hostels, long-distance public transport (such as taxis, buses and trains), schools (including preschool facilities), homeless shelters and repatriation centres. Infection control should be considered as a component of health impact assessment for all new government and private sector projects and programmes, in particular in developing minimum standards for buildings that take into consideration airborne infection control. Annual risk assessments should be carried out and 90% of high-risk institutions (health facilities, schools, prisons, and mines) should achieve a basic infection control standard.

***Workplace/occupational health policies on TB and HIV*:** All high-risk workplaces should have clear management policies on confidentiality, discrimination, routine medical screening and testing of employees, respiratory infection control, treatment, sick leave, psychosocial support, and job modification/alternative placement where necessary. All workplace wellness programmes should address HIV, STI and TB in an integrated manner and aligned with national standards (SANS[57] 16001).

Isoniazid Preventive Therapy (IPT): The implementation, monitoring and evaluation of IPT must be scaled up for adults and children living with HIV, asymptomatic child contacts of people with infectious TB and mine workers.

[57] South African HIV National Standard for workplace programmes (SABS)

Immunisation: Ensure 100% BCG vaccination for all eligible infants at birth. BCG vaccination protects children against serious forms of childhood TB such as TB meningitis, but does not confer protection against TB to adults. A surveillance system for monitoring the incident cases of disseminated BCG disease in HIV exposed infants should be implemented to guide policy in this regard. There is a need to fast-track the development of new TB vaccines that are effective in all children and people living with HIV through advocacy for investment, public-private partnerships, accelerated and novel licensing mechanisms and rapid uptake and implementation of effective candidate TB vaccines.

Intervention 2.6.2 Improve the management of drug resistant TB

The Western Cape will, under the new PSP, strengthen measures to prevent the further development and spread of drug resistant TB include, including improvements in identifying and curing drug susceptible TB and early detection and effective treatment of all MDR-TB cases (reduce time from suspicion to starting standard 2nd line treatment – five working days, 100% of confirmed MDR-TB cases treated as per national guidelines with at least 60% success rate). The management of MDR & XDR TB will be improved as a means to reducing morbidity and mortality among MDR and XDR-TB patients and to improve treatment outcomes. All eligible MDR and XDR-TB patients will be initiated on ART.

The governance structures for addressing drug resistant TB will be further strengthened. The Provincial MDR/XDR-TB Review Committee will meet monthly to review treatment failures and complex patients requiring review, as well as developing, reviewing, updating and implementing protocols for the management of DR-TB. Stronger surveillance mechanisms will be implemented. The Western Cape will implement a decentralised DR-TB diagnosis and management system, and integrate this within a TB and HIV diagnosis and treatment programmes that will include the following components:

- Doctors are appropriately trained and available to diagnose MDR-TB and initiate ambulatory patients on appropriate treatment;
- The time from suspicion of DR-TB and submission of sputum samples to laboratories to starting second line treatment at sub district level (*to achieve 5 working day target in terms of NSP*) will be carefully monitored;
- Clinic TB nursing staff will be trained in DR-TB management (monitoring according to standard protocol), including administration of Capreomycin at primary care level for patients already initiated and stabilised on treatment as inpatients;
- Adequate support will be provided for DR-TB patients to complete 2 year treatment regimens
- DR-TB professional nurses and counselors will be appointed in each sub-district to provide programme and adherence support;
- Counselling will be provided, together with the implementation of weekly support groups at clinic or sub-district level, active defaulter tracing, access to social assistance and provision of hearing screening at sub-district level for patients on injectables;
- Targets for MDR-TB treatment outcomes will be established and monitored;
- The Western Cape provincial plan for managing DR-TB treatment failures will be defined;
- Monitoring and evaluation of the DR-TB programme will be devolved to district and sub-district level and M & E capacity will be strengthened;
- A plan for the management of paediatric contacts (<5 years and HIV positive) of patients with DR-TB at sub-district level will be defined;
- The province will ensure that TB contact tracers include all household and close contacts (any age) of patients with DR-TB.

Sub-objective 2.7: Address sexual abuse and improve services for survivors of sexual assault

Intervention 2.7.1 Ensure that comprehensive post-sexual assault care is available, including PEP, medical care, counseling, and access to justice and protection services for rape survivors

There is strong evidence that ART used in HIV-positive individuals can reduce the risk of sexual transmission of HIV to an HIV-negative partner. Treatment of HIV is now recognised as a critical HIV prevention intervention. Every attempt must be made to initiate treatment in HIV-positive individuals as early as possible, in line with current national guidelines. This approach also provides significant benefits to people living with HIV. The provision of PEP, in a province with a high prevalence of sexual assault, is a critical service together with access to justice. By most reports, the Thuthuzela model in the Western Cape has been effective in improving overall care to victims of sexual assault and increasing the chance of successful prosecution in court. Efforts will be made to expand the provision of PEP to rape survivors, supported by intensified training for HCWs to build their capacity to respond effectively to sexual assault cases. The provincial government will work closely with civil society partners to ensure that all support services are in place to encourage victims to access assistance, and that the awareness and skills of medical staff is enhanced to respond effectively and appropriately.

Sub-objective 2.8: Prevent HIV, STIs and TB in adolescents and youth through a package of SRH and TB education and services at schools and for out-of-school youth

Intervention 2.8.1 Implement sexuality education, inclusive of life skills education, through the curriculum in all schools (in grades 1-12)

The Western Cape Department of Education has prioritized the health, support and safety of learners[58] through the following interventions:

- Streamlining and strengthening HIV AIDS projects in schools;
- Extending school nutrition programme and ensure learning programme is not affected;
- Improving security at schools;
- Investigating models for learners with special needs.

To create a safe and supported environment for education and enrichment to take place optimally (SO 2.4) and to maximise successful academic and social participation of all learners in the culture and curriculum of educational institutions and minimise barriers to learning (SO 4.1). The WC Department of Education currently manages its HIV and AIDS response through five pillars:

- Advocacy: World AIDS day events, advocacy materials, posters;
- Care and support: delivering services to schools in high risk areas, funding of upgraded sick bays (80 schools to date), first aid kits, care and support for teaching and learning;
- Learning support materials: provide activity book and teachers guide, grade 8 and 9 material (life orientation specific), grade 1 to 7 across the curriculum, grade 10 to 12 "Today's

[58] WC DoE Annual Performance Plan 2011/12 – 2013/14, pg. 12.

Choices", library books for schools on HIV related issues, drugs etc. for approximately 1,590 schools in the province;

- Co-curricular activities: peer education, soul buddies, youth conferences;
- Educator Training and Development: these programmes are delivered by contracted service providers to provide training and development in schools as nodes of care and support, basic generic skills, listening and referral skills, bereavement support, facilitating soul buddy clubs, drug abuse and testing in schools, training NGOs and educators involved in peer education, teenage preventative programme, persona doll training for foundation phase.

Each of these pillars is underpinned by a set of activities that will be implemented over the course of the PSP period:

- Distribute guidelines for implementing the HIV Life skills education programme, Sexuality Reproductive Health education in the curriculum and co-curricular activities;
- Facilitate the hosting of events relating to the National Health Calendar, focusing on HIV/AIDS, TB, substance abuse, teenage pregnancy, risky sexual behaviour, gender violence, positive lifestyles and choices;
- Provide advocacy materials/ resources for advocacy events, e.g. badges, brochures, Z-Cards, flyers, key holders, wrist bands, printing of certificates, posters, DVDs, etc. Procure service provider for wall murals;
- Organise capacity and skills development workshops for 300 educators to integrate sexuality reproductive health and HIV programmes into the school curriculum as part of the CAPS training;
- Capacity and skills development workshops for Principals, School Governing Body member representative, School Management Team members and Representative Council of Learners members to develop school implementation/ action plans, school HIV policy that will include the psycho- social and emotional safety plan for learners infected and affected by HIV/AIDS;
- Conducting skills development training for 400 educators in Listening and Referral Skills and Bereavement support to assist learners who are infected and affected by HIV/AIDS. Training to be offered to educators on a voluntary basis only;
- Organise the training of 50 educators to manage and support Soul Buddyz Clubs in primary schools;
- Organise capacity and skills development workshops for the provincial task team, district based support team and the school based support teams to implement the Care and Support for Teaching and Learning (CSTL) in the 25 previously identified WCED schools. Focus on 4 of the 7 CSTL strategies in 25 WCED schools;
- Facilitate capacity and skills development workshops for grade 7 learners in primary schools. Focusing on identifying of risky situations, coping strategies, prevention, positive lifestyle choices, behaviour change and care and support;
- Facilitate capacity and skills development workshops for grade 8-9 learners in secondary schools. Focusing on Teenage Pregnancy Programmes, prevention, behaviour change and care and support;
- Organise capacity and skills development workshops for 800 educators to integrate sexuality reproductive health and HIV programmes into the school curriculum also focusing on reducing stigma and discrimination, dealing with levels of denial evident in society, how to help support and guide learners affected/ infected by HIV socially, emotionally and educationally and how to run successful life skills extra mural activities;
- Organise capacity and skills development workshops for parents that will include the following: dealing with disclosure, discrimination and prejudice, understanding HIV/AIDS, offering emotional support, sympathy and understanding to HIV positive orphans and

vulnerable children, how to talk to their children about sexuality issues, how to support the school;

- Facilitate a provincial camp for 100 Grade 5-7 learners;
- Implement a pilot co-curricular programme at 10 schools;
- Organise provincial gathering (conference) for 100 learners;
- Capacity and skills development workshops for implementing organisations of the new peer education model as developed by the curriculum directorate;
- Implement a district based programme focusing on child headed households, empowering learners with life skills and coping skills;
- Facilitate sick bay upgrades at 200 selected high risk (primary and secondary schools to address Orphans and Vulnerable children's' (OVC) needs within the school community;
- Facilitate Personal Mastery workshops for orphans and vulnerable children from selected schools;
- Facilitate capacity and skills development workshops for 800 female learners in secondary schools. Focusing on Teenage Pregnancy Programmes, prevention, behaviour change and care and support;
- Facilitate the implementation of support groups for vulnerable learners at selected schools.

Intervention 2.8.2 Develop and implement HIV prevention strategies for Further Education & Training Colleges and Institutions of Higher Learning, and for out-of-school youth

Under the PSP the Department of Education, in collaboration with DoH and other civil society partners, will scale up HCT and condom distribution in Further Education and Training (FET) and Institutions of Higher Learning. The majority of people within this group are youth, who can be targeted with behavior change / modification and health promotion messages that are appropriate to this age group. Intensified awareness raising initiatives around counseling and testing will also be scaled up on campuses. Mechanisms will be explored to ensure that students identified with HIV or TB are linked to care and also retained in care. While this group is not a key population it will be targeted for scaled up condom distribution.

4.3.3 STRATEGIC OBJECTIVE 2: OBJECTIVES AND INTERVENTIONS

Strategic Objective 2		Prevention of HIV and TB Infections	
High level Indicators		HIV incidence / prevalence, TB incidence, TB mortality, Patients alive and on treatment	
Western Cape Targets 2016		Reduce HIV prevalence in women aged 15 -24 years to 11,5% Increase the number of clients tested for HIV to 857 822 per annum Increase the number of clients screened for TB to 841 002 per annum Increase the number of male condoms distributed to 130 000 000 per annum Increase the number of males medically circumcised to 70 000 per annum Reduce the percentage infants born to women living with HIV who tested PCR positive within 2 months after birth to 0 % Increase the TB Cure rate to 85% per annum	
Sub-Objective 2.1		Maximise opportunities to ensure that everyone in Western Cape is tested for HIV and screened for TB at least once a year and enrolled in wellness and treatment, care and support programmes	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
2.1.1 HIV testing and screening for TB in all health facilities as well as in non-health settings is implemented	Number of people tested for the first time for HIV and screened for TB annually Number of people doing repeat testing for HIV and screening for TB annually % of referrals presenting at TB clinics	Expand after hours (extended) services for HCT and TB screening Put in place strategies for continuum of care and retention in care Put in place a quality assurance programme for HIV rapid tests	DoH and service delivery partners
		Explore the possibility of removing the barriers to testing in schools Offer a minimum of HIV awareness training in the Life Orientation curriculum	WCED
		Link testing to all-pay points for clients	WC DoSD
		Expansion of HIV testing to bigger events (cultural and sport events)	DCAS
		Routine offer of HIV test and TB screening and linkage to care to offenders and awaiting trial inmates Implement a full package of screening in all correctional facilities which will include HCT, TB, STIs, hypertension, diabetes, anaemia, mental illness and alcohol abuse within 21 days Facilitate the employment of lay counsellors for HCT, TB and STIs screening	DCS
		Strengthen and improve wellness and access to HIV testing and TB screening to government department employees	DoH, DotP, WCED (PEAP)

	% of referrals presenting at TB clinics and testing positive for TB	Mass mobilization and education on HIV and TB prevention HCT and TB testing campaigns Provide disability friendly information on HIV,AIDS ,TB and STIs to persons with disabilities	Disability sector
		SACTWU pilot with SABCOHA to take the pilot into the private sector Encourage the implementation of comprehensive health and wellness programmes at private sector workplaces within the Western Cape that include access to HIV testing and TB screening (in partnership with DoH)	Business
		Scale up of HCT and TB screening programme within tertiary institutions (staff and students)	Academia
		Implement ward based teams doing door to door campaigns Target interventions for specific groups not accessing the routine services e.g. HTA, migrant workers, sex workers and males Continued education on the availability of the service and benefits of early detection Test taxi drivers for TB for their PDPs Provide HCT with TB/STI screening, CD4 testing, STI syndromic management, post-exposure prophylaxis and emergency contraception in non-health settings Scale up community mobilization, with a focus on education and awareness Continue to conduct clinic talks in clinics across the province educating clients about testing, treatment, MMC etc. Education and awareness of health care workers and NGOs for testing MSM Provide HCT and TB screening through mobile teams and through training Community Team Leaders/ CHW Supervisors and CHWs to provide HCT and TB/STI screening at household level Monitor the implementation of the integrated schools health programmes effectiveness at increasing regular TB & HIV screening	Civil Society

Sub-Objective 2.2		Make accessible a package of sexual and reproductive health programmes with emphasis on key populations to prevent HIV and STIs	
Intervention	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**

outputs			
2.2.1 A package of SRH services is provided that includes fertility management services, dual contraception, social services and mental health	% of health facilities providing integrated package of SRH services	Extended hours to improve access to sexual and reproductive health services Finding a mechanism to improve drug (STI, PEP and emergency contraception) supply to partner organisations Improve quality of service providers and service delivery (non-judgmental service) Consider piloting innovative models of youth friendly services Ensure all public health facilities offer SRH Implement IUD insertion services at all primary healthcare facilities (*supports evidence that injectable increases likelihood of contracting HIV*)	DoH and service delivery partners
		Exploring school health policy with the possibility of piloting SRH services in schools Streamline access to schools psychologist and social worker to improve quality of services	WCED
		Implement, STI screening and treatment and provide appropriate SRH services to inmates in Correctional facilities	DCS and Service Partners
		Employment of social workers who deal with supporting clients Redrafting contractibility list	WC DoSD
		Education and awareness-raising on mental health amongst public servants in the Western Cape (workplace) Ensure access to counselling and support services for public servants (employees)	EHWP
		Include in workplace wellness campaigns	DotP
		Consider offering SRH packages at the workplaces	Business
		Consider extending the hours of student health centres Structuring and strengthening placement of 3rd and 4th year student Increase output of relevant professions, including social workers, auxiliary social workers, psychologists	Academia
		Mobile HCT teams provide SRH services to communities, farms, sex workers, MSM, and in correctional services facilities Provide health education and decision making capacity with a focus on male friendly services and SRH service to young males	Civil Society

		Increase awareness to the fact that the children are HIV negative and it is the responsibility of parents, educators and healthcare providers to ensure they are capacitated to remain HIV negative Establishing linkages in referral pathways, community databases Expansion of support groups Care for carer training and support for CHWs and Community Care workers Increase awareness and take measure to minimize the risk of vulnerable people becoming victims of sexual abuse and exploitation Scale up employment of social workers and social auxiliary workers	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
2.2.2 Maximise coverage of readily available and accessible male and female condoms using both health facilities, and non-traditional outlets	Number of male and female condoms distributed % of consistent male condom use Male condoms distribution rate	Ensure consistent access to both male and female condoms Review procurement policies Investigate lubricant provision Ensure uninterrupted supply to health facilities and partners through strengthening supply chain management Develop consistent messaging on the use of male and female condoms Ensure a constant supply of male and female condoms to public sector workplaces Education and awareness raising to advocate for the use of male and female condoms (drama groups, talks, information sharing)	DoH / PEAP and service delivery partners
		Explore strategies to make condoms more accessible to children in school	WCED
		Improve access at all pay points; local and district offices	WC DoSD
		Review access at sports clubs and events	DCAS
		Review optimum access to condoms in all correctional facilities Distribute male and female condoms at all correctional facilities and workplaces	DCS
		Optimize process of usage and supply of condoms	DotP
		Increase HIV prevention activities such as widespread male and female condom distribution	Disability sector
		Investigate prioritization of the need to optimize usage and supply of condoms Address possible resource gap	Business

		Assign responsibility to key personnel	
		Optimize process of supply, distribution and usage of condoms through HCT teams, facility-based counsellors and workplace services Distribution of condoms at key civil society events Explore the possible expansion of the programme to the private sector	Civil Society
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
2.2.3 Expansion of MMC as part of male sexual and reproductive health programme using provincial safe circumcision guidelines	Number of males medically circumcised	Upscale training Traditional healers: linkages / training / support Explore with NDOH GP's provision of service Update website: sites and contact details Explore the possibility of outreach services by HCWs	DoH
		LO curriculum: review - promote the procedure and emphasise the need to still use condoms	WCED
		Facilitate voluntary Male Medical Circumcision (MMC)	DCS
		Communication: scale up	DotP
		Upscale education: campaigns	Business
		Upscale education: campaigns	Academia
		Integration of MMC awareness into other services Streamline referral to MMC sites of all HIV-negative males identified in HCT for circumcision Strengthen participation in provincial MMC task team	Civil Society
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
2.2.4 Scale up surveillance and treatment of STIs in key populations and develop appropriate responses, with a		Run male clinics in high burden areas Desensitization of health care workers around key populations: sex workers / MSM Manage and sustain STI surveillances site and adhere to reporting requirements	DoH and service delivery partners
		Life orientation: ensure covered adequately - upscale	WCED
		Review policy with regard to adequate addressing of key populations Education: specific key population requirements	DCS
		Focus on attracting more men to available services	Academia

strong focus on males		Conduct further research into MSM and STI in prison populations	
		Training around risks in key populations: sex workers / MSM Up scaling and expanding service provision Scale up peer education to access key populations, including the employment of sex worker peers educators Assess the feasibility of HIV prevention using Microbicides and Pre Exposure Prophylaxis using ARVs	Civil Society
Sub-Objective 2.3		Prevent vertical transmission of HIV to reduce MTCT to, at least, less than 2% at 6 weeks and less than 5% at 18 months by 2016	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
2.3.1 Adapt and implement the Action Framework for "No child born with HIV by 2015 in South Africa" within the Western Cape context, with a focus on the four prongs	Percentage infants born to women living with HIV who tested PCR positive within 2 months after birth % of children born to women living with HIV who tested positive at 18 months after birth	Training workshop to strategise and operationalise 4 prongs Finalize provincial action plan Project management of 4 prong implementation Appropriate counselling of women for appropriate infant feeding choices M&E: 18 month data reporting Targets: review 5% target at 18 months (between 2 and 3) Promote early bookings at MOUs Integration of PMTCT services into MOU and baby clinic services. Integration of TB services into antenatal services	DoH and service delivery partners
		Promotion of the concept of delayed sexual debut, Scale up efforts to prevent unwanted pregnancies and STI and HIV prevention	WCED
		Support mother / baby pair tracking from pregnancy(through the PMTCT cascade) up to 18 month after birth Develop visit schedules for CBWs to support pregnant women until 18 months post-partum, including the antenatal period as well to support early initiation of treatment when required Strengthen advocacy of PMTCT policy Ensure pregnancy testing / HIV testing and the early referral of HIV+ pregnant mothers Scale up peer education and support programmes, including the involvement of	Civil Society

		PLWHA Provide clinical mentorship to improve PMTCT including early HCT and early initiation of ART for HIV-positive pregnant women, adherence support for PMTCT/ART, Strengthen the process of PCR testing at 6 weeks, and the provision of post-partum ART Improve Provincial Mobilisation on PMTCT campaign raising awareness to create more widespread coverage of the PMTCT programme (addressing Teen Pregnancy)	
Sub-Objective 2.4		Develop and implement a comprehensive social and behavioural change communication (SBCC) strategy in the Western Cape, including a specific focus on key populations	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
2.4.1 Western Cape SBCC strategy developed and implemented with specific focus on key populations	Provincial SBCC strategy in place or percentage Number of interventions implemented (mass media: percentage of adult population reached)	SO4 to coordinate the development of a SBCC strategy Increase the utilisation of SO4 capacity to identify strategic linkages	DoH and service delivery partners
		Implement a minimum package of behavioural HIV, STI and TB prevention services (peer education, IEC, condoms, lubrication and HCT) Implement an ACSM strategy(dialogues, distribution of IEC material, cell to cell campaign) on HIV, STIs and TB specific to the correctional setting Develop and implement standardized guidelines for health education in correctional facilities	DCS
		Conduct capacity building interventions with key focal persons (as agents of change) in Municipalities on social and behaviour change (attitudinal barriers) and legislative requirements Training for CDWs (as primary agents of change) per district on key messages - social and behaviour change (attitudinal barriers)	DLG
		Train Community Team Leaders/CHW Supervisors and CHWs to identify vulnerable communities, provide education and provide adherence support Target key populations and ensure appropriate and relevant SBCC e.g. signing for a deaf audience and braille for the blind	Civil Society

		Appropriate education material to be designed and made available for the mentally and physically disabled e.g. sign language on DVD's,	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
2.4.2 Increase demand and uptake of services and promote positive norms and behaviours	Number of interventions implemented (mass media: percentage of adult population reached) Percentage of population reached	Start ARVs at CD4 350 media campaign (*Ensuring people in Western Cape start ART at 350 will keep community members well and reduce transmission in the province and reduce the cost burden of managing sick patients only accessing health services when sick/low CD4 count. Change of policy has not changed community perceptions. Aligned with Wellness objectives of province*) Adherence related media campaigns that remind thousands of people on ART to take their treatment conducted through radio, newspapers, TV, road side advertisements. (*Adherent community members will remain well and reduce new transmissions. Aligned with Wellness objectives of province*). Training of all staff at all healthcare access points both facility and community based, to be receptive and non- judgmental and desensitizing all staff to behaviour, culture, sex, race, gender etc. Facilitate community dialogues, community radio interviews, community newspapers, collaboration with Community Media Trust to train community journalists	Civil Society
Sub-Objective 2.5		Prepare for the potential implementation of future innovative, scientifically proven HIV, STI and TB prevention strategies	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
2.5.1 Review and assess the use of treatment for prevention, PEP, PrEP, whirley bird vents, TB vaccines and microbicides to prevent the	Reports on efficacy and effectiveness of new prevention strategies, with recommendations for implementation (if appropriate)	Call for and support pilots for demonstrating: Treatment as prevention including piloting Option B/B+ PrEP interventions ART initiation in discordant couples irrespective of CD4 count of positive partner Strengthened TB and DR-TB regimens Strengthened 2nd line ART treatment	DoH and service delivery partners
		Work on the implementation of prevention strategies and working closely with those organizations in the forefront of this medical research, with the goal of	Civil Society

spread of new HIV infections		minimising the chances of HIV transmission Participation in PAC and SANAC technical task teams to review evidence and develop new interventions	
Sub-Objective 2.6		Reduce TB infections and related disease	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
2.6.1 Reduce TB infections and related diseases	NSP TB cure rate NSP defaulter rate IPT coverage % facilities complying with IC standards TB infection rates amongst Health Department staff	Conduct intensified TB Campaigns Improve TB treatment outcomes Provide adherence support Active follow-up of TB contacts especially child contacts Up-scaling IPT coverage for eligible HIV +ve patients Ensure complete coverage of all health facilities by GeneXpert Ensure collection and review of data on GeneXpert roll out, with periodic review of GeneXpert algorithm Implement infection control policies and provide training Implement Occupational Health policies on TB and HIV	DoH and service delivery partners
		Develop and implement TB Management and Infection Control Guidelines for correctional settings Participate in the establishment of minimum infrastructure standards for infection control and ventilation in all correctional facilities especially in health facilities Intensified case finding (TB screening and testing of inmate TB contacts) Set up TB surveillance systems amongst inmates and officials Initiate all TB positive inmates on treatment	DCS
		All new health facility infrastructure plans ensure effective maintainable structural TB infection control measures All public facilities to have basic infection control policies with, as minimum, signs stating risk of contracting TB if windows are not open	Dept of Public Works & all Departments
		All public transport, including taxis, to have clear signage stating that there is a risk of contracting TB if windows are not open	Department of Transport
		Follow up with investigating case contacts at home and in the work and social environments	Civil Society

		Awareness raising at key civil society events and consultative meetings, newsletters, website and e- mail networks Train Community Team Leaders/CHW Supervisors and CHWs to screen for symptoms of TB, collect sputum adhering to infection control guidelines Clinical mentorship, provision of IPT registers, community advocacy for IPT Promote the open window campaign Provide clinical mentorship to public health facilities on infection control assessments and the development of infection control plans Train community based services (CBS) on infection control at community level Training and education of employers about the needs and requirements in their work environments for the prevention of HIV and TB	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
2.6.2 Improve the management of drug resistant TB		Improve the management of MDR & XDR TB to reduce morbidity and mortality among MDR and XDR-TB patients and to improve treatment outcomes Initiate all eligible MDR and XDR-TB patients on ART Sustain Provincial MDR/XDR-TB Review Committee to meet monthly to review treatment failures and complex patients requiring review Develop, review, update and implement protocols for the management of DR TB Establish stronger surveillance for TB Implement decentralised DR-TB diagnosis and management, and integrate within TB and HIV diagnosis and treatment programmes including: Ensure doctor trained and available to diagnose MDR-TB and initiate ambulatory patients on appropriate treatment Monitor time from suspicion of DR-TB and submission of sputum sample to lab to starting second line treatment at sub district level (*to achieve 5 working day target in terms of NSP*) Ensure clinic TB nursing staff trained in DR-TB management (monitoring according to standard protocol), including administration of Capreomycin at primary care level for patients already initiated and stabilised on treatment as inpatients Ensure adequate support for DR-TB patients to complete 2 year treatment	DoH and service delivery partners

		regimen Provision of DR-TB PN and counsellor in each sub-district to provide programme and adherence support Counselling, implementation of weekly support groups at clinic or sub-district level, active defaulter tracing, access to social assistance and provision of hearing screening at sub-district level for patients on injectables Set and monitor targets for MDR-TB treatment outcomes Define provincial plan for managing DR-TB treatment failures Decentralise registration of DR-TB patients to sub-district level; allocate dedicated clerk for DR-TB data collection, monitoring and evaluation Define plan for management of paediatric contacts (<5 years and HIV positive) of patients with DR-TB at sub-district level Ensure TB contact tracers include all household and close contacts (any age) of patients with DR-TB	
		Mobilizing everyone in society at all levels to assist in treating those with MDR/XDR TB and to reduce further transmission of the infections Training on decentralized management of drug resistant TB including DR-TB counsellors and employment of PHC/outreach teams	Civil Society
Sub-Objective 2.7		Address sexual abuse and improve services for survivors of sexual assault	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
2.7.1 Ensure that comprehensive post-sexual assault care is available, including PEP, medical care, counselling, access to justice and protection		Implement post exposure prophylaxis (PEP) to rape survivors Build capacity of HCWs through the provision of training programmes Provide comfort packs to rape survivors Provide counselling services	DoH and service delivery partners
		Review and implement Post Exposure Prophylaxis (PEP) guidelines Increase accessibility and availability of PEP care to inmates	DCS
		Ensure that all support services are in place to encourage the victims to seek assistance Improve the awareness and skills of medical staff in order for them to be receptive and supportive of sexual abuse survivors	Civil Society

services for rape survivors		Ensure clinical mentorship for PEP in public health facilities and provision of PEP through mobile HCT teams Advocate for provision and improved integration of PEP, medical care, counselling, access to justice, and protection services for child and youth sexual abuse survivors	
Sub-Objective 2.8		Prevent HIV, STIs and TB in adolescents and youth through a package of SRH and TB education and services at schools and for out-of-school youth	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
2.8.1 Implement sexuality education, inclusive of life skills education, through the curriculum in all schools (in grades 1-12)	Percentage of schools implementing curriculum-based sexuality education	Introduce HIV awareness and prevention at schools and improve access to HCT Support peer education programme	DoH / Service provider partners
		Implement Life Skills Programme in all schools Implement Peer Education Programme	WCED
		Provide support for the 'Kick TB/HIV Campaign' in schools Provide support for the school health program as part of re-engineered PHC	Civil Society
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
2.8.2 Develop and implement HIV prevention strategies for Further Education & Training Colleges and Institutions of Higher Learning, and for out-of-school youth	80% of young people out of school with comprehensive knowledge of HIV, TB and STIs and access to SRH and TB services	Enhance roll-out of One Man Can Campaign with students at all tertiary institutions in the Western Cape in collaboration with the HIV centres on all campuses Provide HCT, TB screening and SRH services at institutions of higher learning through mobile services	Civil Society

4.4 STRATEGIC OBJECTIVE 3: SUSTAIN HEALTH AND WELLNESS

4.4.1 INTRODUCTION

The primary focus of SO 3 is the significant reduction in deaths and disability as a result of HIV and TB infection in the Western Cape through universal access to accessible, affordable and good quality diagnosis, treatment and care.

4.4.2 SUB-OBJECTIVES

The four sub-objectives for SO 3 are to:

- Reduce disability and death resulting from HIV and TB through universal access to HIV and TB screening, diagnosis, care and treatment;
- Ensure that people living with HIV, STIs and/or TB remain within the health care system, are adherent to treatment and maintain optimal health; and
- Ensure that systems and services remain responsive to the needs of people living with HIV, STI and/or TB disease.

The core strategies for this strategic objective relate to early and improved diagnosis of HIV, TB and STI, improved access to speedy, appropriate and user-friendly treatment services (including rehabilitation and palliative care services) and retention in treatment and care. A radical expansion of primary health care is being implemented through the re-engineering of primary health care with a special emphasis on community-based services. Community-based services have a critical role to play in expanding the quality and reach of health and wellness services, and if implemented appropriately, will address much of the concerns regarding the last PSP, in terms of programme reach, early diagnosis, follow-up, support to adherence and retention in care.

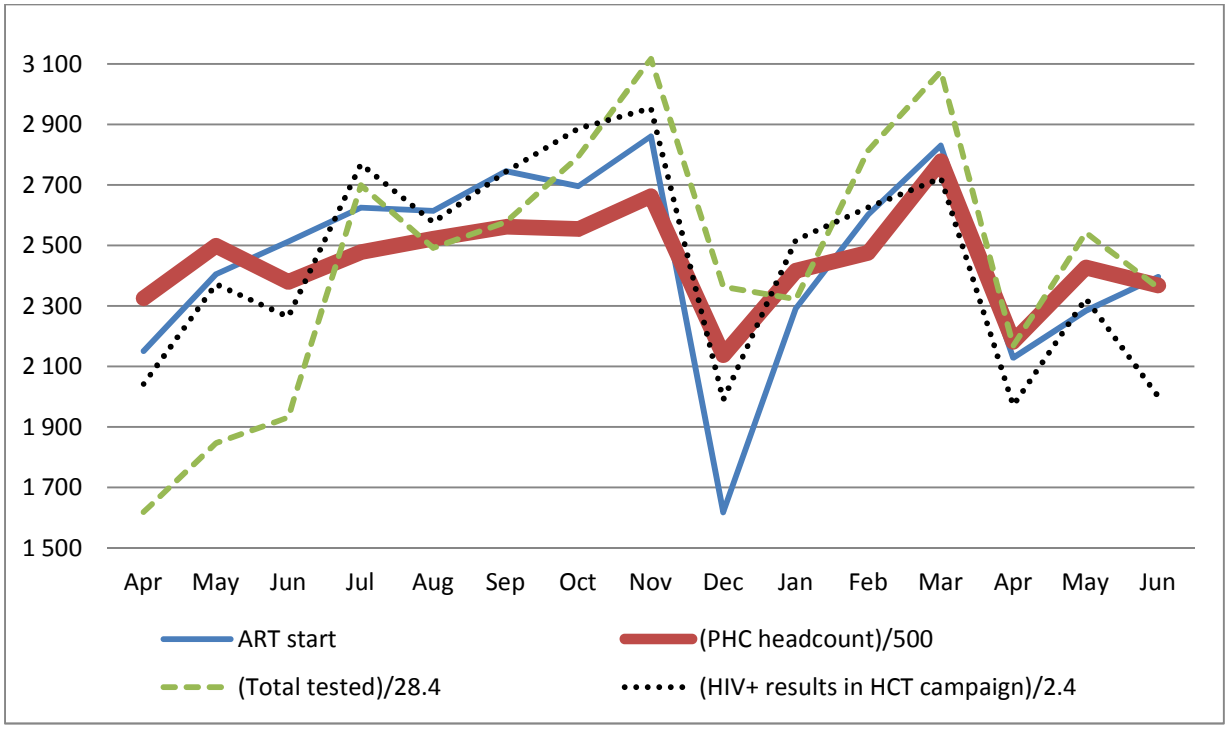


FIGURE 27: ART STARTERS VS: PHC TOTAL HEADCOUNT, TOTAL TESTED AND HIV+ RESULTS 2010/11

The biggest risk factor for TB is concurrent HIV infection. Tuberculosis is described as a social disease as it is closely linked to the upstream issues of poverty, unemployment and overcrowding. The Western Cape's incidence (all cases) of TB is 885 cases per 100 000. This gives the Western Cape the third highest incidence of TB in South Africa after Kwa-Zulu Natal and the Eastern Cape. However, the Department is making significant progress in addressing the epidemic through the implementation of the *Enhanced TB Response Strategy*. The programme achieved a new smear positive TB cure rate of 80.4% in 2010/11. The provincial TB Cure rate is the highest TB cure rate in South Africa. The TB defaulter rate has decreased slowly over the past few years with the implementation of various interventions and stands at 7% in 2010/11, whereas approximately three years ago it was 9.2%. Although this is a significant improvement, more effort will be required to reach the national and global 2011 target of a defaulter rate of below 5%. This is required to decrease the size of the infectious pool in the community and prevent the generation of drug resistant TB, which requires longer stays in hospital, is much more costly to treat, and has significant worse treatment outcomes.

Sub-Objective 3.1: Reduce disability and death resulting from HIV and TB through universal access to HIV and TB screening, diagnosis, care and treatment

Critical to this objective is early accurate diagnosis and initiation of treatment according to national guidelines. There are significant prevention benefits associated with earlier treatment for HIV, TB and STIs, e.g. early treatment of HIV will reduce the risk of TB disease.

Intervention 3.1.1: Implement targeted programmes of HIV, STI and TB screening, care and treatment support for key populations in the Western Cape (including sex workers and their clients, truckers, prisoners, persons with disability, migrants, refugees)

All screening should be done with adequate counseling, including being conscious of persons with communication issues, and cognitive and physical disabilities. Screening must be linked to follow-up clinical and laboratory investigations for those with TB symptoms and appropriate treatment. HIV staging, TB and STI point-of-care diagnosis should be done where possible. This intervention should be commenced as soon as possible, with the primary care revitalisation programme being central, with full coverage by 2016.

Intervention 3.1.2: Ensure access to affordable, high quality drugs to treat HIV, STIs and TB

The Western Cape will ensure that adequate supplies of quality-assured, affordable (lowest cost) first- and second-line TB drugs are provided through increased local production, pooled procurement, negotiated price reductions, improved regulatory approval and better supply chain management. In addition, access to age-appropriate paediatric TB formulations must be assured. Common drug combinations should be available as fixed dose combinations to reduce the pill burden, improve adherence, reduce dosage miss-prescribing, and reduce the dispensing load of pharmacies. New drugs for drug resistant TB need to be made available on compassionate basis for pre-XDR-TB and XDR-TB patients. Expanded access to opportunistic infection medication should be made available at primary care. Systems have been put in place to ensure an uninterrupted supply of TB and ART drugs. A Pharmocovigilence Programme is also in place to monitor adverse ARV/TB drug events.

Intervention 3.1.3: Ensure the earliest possible enrolment and universal access to appropriate care and treatment for HIV and TB, after screening and diagnosis

Loss to follow-up, especially if referral is required, is high within the system. Better links are needed between TB screening sites and strengthened clinical and laboratory services with greater availability of rapid PCR-based tests for TB and drug-resistant TB, liquid culture, and drug susceptibility testing. These and other new diagnostic technologies should be evaluated and validated to improve diagnosis of extra-pulmonary and smear-negative TB.

ART can reduce a person's risk of TB thus early ART for all eligible people living with HIV will have a significant impact on TB incidence, and will reduce mortality in HIV positive TB patients. Basic ART, TB and MDR-TB treatment should be nurse-initiated and available in all PHC facilities. STIs are almost always treated immediately on diagnosis and hence health professionals in the private and public health sectors must follow syndromic management guidelines. Point of care tests for TB and HIV should be available in every health facility (dependent on available appropriate technology). To ensure early treatment, the following must occur:

- ART started within 2 weeks of staging and adherence eligibility being confirmed for "fast track" clients;
- All ART started within 8 weeks of starting TB treatment;
- All TB treatment to be started less than 2 days after confirmation of TB at screening site (<5 days for MDR TB);
- All primary care, antenatal, TB and mobile outreach health facilities to become fully functional nurse-initiated ART and MDR TB initiation sites for adults, children and pregnant women;
- Unless clinically indicated otherwise, all patients started on ART and MDR-TB treatment should be managed at the PHC level;
- Ensure 85% treatment success rate for drug susceptible TB (60% for MDR-TB).
-

Intervention 3.1.4: Ensure HIV treatment of children, adolescents and youth

Child mortality is a good indicator of failing health systems and should trigger urgent action to prevent unnecessary morbidity and mortality. Unfortunately, diagnostic difficulties and poor monitoring systems often mean that this information is not available or is inaccurate. The following interventions are key:

- Notification of all paediatric cases of HIV;
- Specific child indicators to be prioritised in the M&E system, with management interventions if targets are not reached. These include 90% of children initiated and maintained on ART and/or TB treatment, milestone screening and interventions for early identification of nutrition and HIV-related stunting;
- Routine HIV testing and PCR screening, with adequate counselling;
- Strengthened and standardised TB diagnostic approach to children;
- Strengthening specific clinics to offer specific child and adolescent-friendly HIV/TB service packages, including adherence support programmes; and
- Address specific problems related to stigma and adherence in adolescents.
-

Intervention 3.1.5: Implement revised standardized paediatric diagnostic and treatment policy

If tested and treated for HIV early, children born with HIV can survive and stay healthy. The revised standardized paediatric diagnostic and treatment policy will be implemented. ART will be initiated in all eligible HIV-infected infants and children irrespective of the CD4 count or

whether the infant is sick. All HIV-positive children diagnosed with TB start ART as soon as possible after initiation of TB therapy.

Intervention 3.1.6: Initiate all HIV-positive TB patients and pregnant women on lifelong ART, irrespective of CD4 count

In line with WHO recommendations all TB patients and pregnant women should, with immediate effect, be on ART irrespective of CD4 count. This intervention recognises the high mortality associated with HIV/TB co-infection, as well as the benefits for maternal health and PMTCT of having women on treatment.

Intervention 3.1.7: Implement a patient-centred pre-ART package for PLWHIV not requiring ART

Loss to follow-up of people living with HIV with high CD4 counts and not in immediate need of ART is high. This results in many patients returning late to care, when they are ill and past the point when they should have started ART for maximum benefit. Pre-ART packages should be designed around what patients' value, rather than simply what health providers believe they need. Positive health, dignity and prevention[59] interventions, including safe sex, fertility, IPT and health advice, must be considered within the package of care.

Intervention 3.1.8: Ensure that all people in the Western Cape living with low CD4 counts (<100) are screened for cryptococcal infection and given appropriate treatment

Cryptococcal infection, which is the second commonest serious opportunistic infection after TB, produces much morbidity (including blindness and deafness) and mortality. This is complex and expensive to treat, and occurs generally at CD4 counts of less than 100 cells/ul. Screening on all samples where the CD4 counts is less 100 should be routine and reported along with the CD4. Treatment guidelines should be reviewed and implementation monitored.

Intervention 3.1.9: Prevention, screening and treatment for cervical cancer

A Programme for prevention, screening and treatment of cervical cancer is in place in the Western Cape. Campaigns to detect cervical cancer will be conducted and pap screening will be offered. Women who have positive tests will be referred to specialised services for further investigations and treatment.

Sub-Objective 3.2: Ensure that people living with HIV, TB and STIs remain within the health care system, are adherent to treatment and maintain optimal health

Central to this objective is recognition that services, including screening, need to move beyond conventional healthcare provision areas, and that certain groups require specifically tailored interventions.

[59] What used to be referred to as Prevention with Positives

Intervention 3.2.1: Strengthen primary health care with a focus on provision of medication at PHC facilities and support at household level

The KYE report provides good evidence for those at risk for HIV, and suggests communities that would benefit from focused support. In addition, there are key populations that have specific needs. These are:

- Sex workers: Traditionally, this group has been very difficult to reach with clinical services, due to criminalisation, high levels of police harassment, stigma and discrimination. Treatment programmes directed at targeting HIV, TB and STIs as part of a broader mobile health and prevention package should be developed where there are large concentrations of brothel- and street-based sex workers. An enabling legal framework (including decriminalisation), health care worker sensitisation and sex worker involvement, is imperative for the effectiveness of this intervention. In addition, programmes focusing on sex worker clients in identified 'hot spots', focusing on prevention as well as HIV testing and linking to care, must be part of sex worker health programmes.
- Drug and heavy alcohol users: Illegal drug users suffer from similar legal and stigma issues as sex workers; use of drugs and alcohol impede adherence and may enhance medication side effects. A package of interventions should be designed to address HIV, TB and STIs within this community. Drug and alcohol screening in all high-risk patients should be routine and interventions to address the abuse disorder be implemented. Treatment and referral interventions should be routinely available within primary health care clinics.
- Prisons and detention facilities: These facilities have high rates of TB and high rates of HIV. The Department of Correctional Services must commit to annual HIV, TB and STIs screening, and prompt treatment of all prisoners and correctional services staff, ensuring continuum of care through proper referrals.
- Workplaces: All workplaces (including small and medium enterprises) offer opportunities to deliver varying degrees of prevention, diagnostic, treatment and care services for HIV, STIs and TB in the context of wellness programmes. However, certain work environments should be prioritised for prevention, case finding, treatment and care. These include the mining, transport and healthcare sectors. The private sector, all employers and labour unions should collaborate with the health sector to ensure that all formal sector and informal sector employees are tested and screened annually and have equitable access to prevention, treatment and care services.
- Refugees, legal foreigners, undocumented migrants: These individuals should have equitable access to TB screening, HIV testing and appropriate treatment in line with Department of Health policies and guidelines. The Departments of Health, Correctional Services and Home Affairs must jointly develop and implement guidelines and implement these uniformly within the relevant facilities.
- Persons with disabilities: Screening and testing programmes that focus on this group must use tailored interventions according to specific needs of persons with disabilities. Access to health services for persons with disabilities is still often difficult and must be addressed urgently. Universal design of all facilities, and accessible communication (and where not possible, reasonable accommodation for the different communication needs), is imperative and must be designed and implemented in partnership with organisations focusing on the needs of persons with disabilities.

4.4.3 STRATEGIC OBJECTIVE 3: OBJECTIVES, AND INTERVENTIONS

Strategic Objective 3		Sustain health and wellness	
High level Indicator		HIV incidence / prevalence, TB incidence, TB mortality, Mother-to-child transmission rate (6 weeks and 18 months)	
Western Cape Targets for 2016		Reduce HIV prevalence in women aged 15 -24 years to 11% Reduce the percentage infants born to women living with HIV who tested PCR positive within 2 months after birth to 0% Increase the new smear positive TB treatment cure rate of 85% per annum Increase the total number of children and adults on ART to 178 480 per annum Initiate 27 000 new patients on ART in 2016 Ensure to have 90% retention in care of ART clients at 12 month, 75% at 48 months and 65% at 96 months Increase ARV's to eligible HIV positive TB patients to 100%	
Sub-Objective 3.1		Reduce disability and death resulting from HIV, TB and STIs through universal access to HIV and TB screening, diagnosis, care and treatment	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
3.1.1 Implement targeted programmes of HIV, STI and TB screening, care and treatment support for key populations in the Western Cape (including sex workers and their clients, truckers, prisoners, persons with disability, migrants, refugees)	Number of targeted HIV, STI and TB screening and support programmes in place for key populations (disaggregated per category)	Provide suitable platform for men to access care Continue to use workshops, community radio and clinic talks as a way to engage men and increase their utilization of HIV services Ensure that migrants and "refugee" migrants have access to "emergency" care service points at borders of province (patient held cards) Strengthen a centralised data base to access migratory patient treatment history Expand delivery platforms of care Provide HIV, STI and TB screening, care and treatment support for taxi drivers, sex workers and other key populations Health services to be accessible for the disabled to ensure access to HIV, STI and TB services	DoH and service delivery partners
		Provide HIV, STI and TB screening, care and treatment support for awaiting trial prisoners Offer comprehensive screening and male sexual health services	DCS
		Expand access to farm workers in general	DoA

		Expand access to migrant populations in agriculture, with specific / seasonal clinics planned in conjunction with other stakeholders	
		Scale up referral of disabled people to health care facilities to go for HIV and TB testing	Disability sector
		Increase focus of private medical aids dealing with business to facilitate access and coverage of working population currently not members of a medical aid	Business
		Engagement and baseline assessment of HIV and TB services provided by other government departments / NGOs (define responsibilities and accountability / identify who to cover funding gaps to cover services/ identify who, how and monitor changes in service provision (formal external monitoring)) Provide HCT, TB screening and SRH services to key populations including sex workers and their clients, truckers, prisoners, persons with disability, migrants, refugees Know your status events and communication at key civil society consultative meetings, newsletters, websites and social media Strengthen collaboration with organisations providing HIV prevention services to correctional facility inmates Provide a comprehensive package of treatment services for HIV, STI and TB for key populations, including sex workers and their clients, truckers, prisoners, persons with disability, migrants and refugees Advocate and raise awareness around HIV testing and TB screening by contributing to standards for HCT and disclosure for children and adolescents - defining "child friendly services"	Civil Society
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
3.1.2 Ensure access to affordable, high quality drugs to treat HIV, STIs and TB	% smear positive TB cases that are successfully treated % of drug stock-outs for HIV / STI / TB	Ensure an uninterrupted TB and ART drug supply Commission research to examine how to make the system more flexible and fast track high priority conditions Fast track availability of fixed dose ARV combinations in the public sector including exerting pressure on NDOH to ensure registration and availability on	DoH

	programmes	public tender (*essential to improve adherence*)	
		Link up and collaborate with Civil Society groups campaigning for cheaper medicines	Civil Society
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
3.1.3 Ensure the earliest possible enrolment and universal access to appropriate care and treatment for HIV and TB, after screening and diagnosis	% of people becoming eligible who receive ART TB case registration rate Referrals to Community Based Care Services	Ensure all DOH service points, including BANC sites, provide an HIV / TB service package (care and treatment) that includes nutrition support (supplements, access to dietetic services) Ensure infrastructure to allow for service points to provide SP and Nutrition Therapeutic Programme (NTP) to patients who meet set criteria Ensure all staff are capacitated within all DOH services points to provide an HIV / TB service package (care and treatment) Design, development and piloting in consultation with partners a standardized decentralised (community based) service package (SSP) (including improving TB literacy of communities) Strengthen CBS Implement SSP and train: support; motivation and holding accountable those providing the service Expanding delivery platforms of care: general and priority groups. Standardization of care and treatment strategies / standards across health providing sectors (private / defence force / public) Include the aspects of woman's health and cervical cancer screening Training nurses to initiate smear negative TB (using GeneXpert results) Implementing and monitoring nurse initiated TB treatment for smear negative TB. Track nurse led initiation of patients after authorisation to prescribe. Ensure nurses initiating TB treatment or ART are able to initiate both TB treatment and ART in co-infected patient Monitor implementation of ARV initiations at 200-350 to identify facilities with low numbers of initiations at high CD4 counts.	DoH and service delivery partners
		Motivate disabled persons who are on ART to adhere to their treatment	Disability sector
		WC Department of Health consults with private sector to get their buy in to	Business

		quicker initiation of co-treatment in a consultation	
		Training / sharing with DOH in proven treatment literacy and other strategies (education in rights) Engagement and baseline assessment of HIV and TB services provided by other government departments / NGOs (define responsibilities and accountability / identify who to cover funding gaps to cover services/ identify who, how and monitor changes in service provision (formal external monitoring)) Provide training on TB/ART case finding and adherence support	Civil Society
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
3.1.4 Ensure HIV treatment of children, adolescents and youth	Number of paediatric HIV cases recorded Number of paediatric patients retained in care (on ART and retention in care on ART as proxy indicators) – seeing as most children qualify for ART?) Number of paediatric HIV cases	Individualised care appropriate for children with personal folder at primary healthcare level (*PHC level needs to be emphasised*) Pilot and where successful, implement community based child ART adherence clubs in child friendly environments such as crèches including pharmaceutical support for changing dosages Appropriate and effective recording and reporting system for children on an individual basis Pilot and if successful implement linkage and retention in care interventions specific to adolescents and young adults Implement awareness campaigns in clinics, communities and media advocating for child disclosure particularly in young adolescent with a specific focus on the benefits of disclosure and the recommended process for disclosure Ensure availability and access to appropriate child disclosure assistance services for children vertically infected with HIV Support increased availability of paediatric HIV training	DoH and service delivery partners
		Advocate for availability of drugs and supply to clients Clinical mentorship on paediatric and adolescent TB/HIV diagnosis, treatment and care including provision of adolescent friendly services	Civil Society
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
3.1.5 Implement	Treatment completion	Provide training in revised standardized paediatric diagnostic and treatment	

revised standardized paediatric diagnostic and treatment policy	rate for children	policy to relevant HCWs Monitor and audit implementation of revised standardized paediatric diagnostic and treatment policy Monitor and evaluate treatment completion rate for children Implement Nutrition Programme (supplementation, education, rehabilitation of children with severe acute malnutrition as per NTP policy) in health facility to patients who meet set criteria Train professional staff in lactation management (ie. 80 hour lactation management training and 10 day integrated training) Train professional and non-professional staff including CHW to implement the infant feeding guideline (ie. 3 day counseling for infant feeding choices) Capacitate staff to identify at risk patients / clients Supply equipment to support safe and hygienic infant feeding in birthing units when replacement feeding has been chosen appropriately Support the promotion of good health and record keeping in children (ie. plastic sleeves for the RtHB)	DoH and service delivery partners
		Strengthen paediatric HIV social support groups and services Clinical mentorship on paediatric and adolescent TB/HIV diagnosis and treatment policy	Civil Society
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
3.1.6 Initiate all HIV-positive TB patients on lifelong ART, irrespective of CD4 count	Number of newly registered TB patients who are HIV positive and on ARVs as a proportion of all newly registered TB patients who are HIV positive.	Test all TB patients for HIV Conduct WHO Staging and CD 4 counts on all TB patients who are HIV+ Amend Provincial guidelines/circulars to ensure all TB patients can be started on ART irrespective of CD4 count Strengthen capacity to initiate ART in all eligible TB patients immediately on co-infection diagnosis Monitor all co-infected patients who are on both TB treatment and ART	DoH and service delivery partners
		Advocate for availability and supply of ART Clinical mentorship to initiate ART for all TB patients	Civil Society
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
3.1.7 Implement a	Patient-centred pre-	Pilot possible pre-ART packages of care to reduce load on facilities and make	

patient-centred pre-ART package for PLWHIV not requiring ART	ART package for PLWHIV not requiring ART is in place and operational All people in the Western Cape living with HIV/AIDS/TB are screened (weight, height, BMI or MUAC and given appropriate nutrition education and support as per NTP policy	services more accessible. Implementation of standardize pre-ART package of care Monitor and audit standardize pre-ART package of care Monitor TB/HIV integration indicators Conduct annual audit on quality of care	DoH and service delivery partners
		Provide clinical mentorship on pre-ART care including prevention (IPT, CPT) and management of opportunistic infections, support for implementation of tier.net	Civil Society
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
3.1.8 Ensure that all people in the Western Cape living with low CD4 counts (<100) are screened for cryptococcal infection and given appropriate treatment	Number of people in the Western Cape living with low CD4 counts screened for cryptococcal infection	Develop Guidelines on screening for cryptococcal infection and treatment Provide training on these guidelines Audit implementation annually	DoH and service delivery partners
		Strengthen public education and treatment literacy for cryptococcal infection Provide clinical mentorship on prevention of cryptococcal meningitis	Civil Society
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
3.1.9 Prevention, screening and treatment for cervical cancer	Number of women screened for cervical cancer	Implement cervical screening policy Conduct cervical screening campaigns, including campaigns that attempt to educate men about the importance of women accessing such services Provide education and training for the early detection of cervical cancer Investigate HPV vaccine	DoH and service delivery partners
		Conduct annual cervical screening on all incarcerated women	DCS

		Conduct cervical screening on all HIV positive incarcerated women twice a year	
		Conduct awareness campaigns and provide health education Provision of cervical cancer screening in mobile HCT services for HIV-positive clients and key populations (eg, sex workers)	Civil Society
Sub-Objective 3.2		Ensure that people living with HIV, TB and STIs remain within the health care system, are adherent to treatment and maintain optimal health	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
3.2.1 Strengthen primary health care with a focus on provision of medication at PHC facilities and support at household level	% of chronic patients receiving medication at home Number of adherence support clubs	Roll out ART adherence clubs at all primary healthcare facilities with stable ART patients Pilot decentralising ART adherence clubs into accessible community based venues including supporting drug supply, clinical supervision and M&E Plan and phase in implementation of decentralised ART adherence clubs in community based venues including patients' homes Integrate TB and HIV roles and responsibilities of PHC outreach team including CCWs. Include HCT in role of CCWs Roll out after hours ART adherence clubs at clinics	DoH and service delivery partners
		Align civil society programmes to the provincial strategy Provide *t*raining on delivery and monitoring of a comprehensive package of prevention, diagnosis, initiation of treatment Provide adherence support for major causes of morbidity and mortality based on the burden of disease	Civil Society

Sub-Objective 3.3		Ensure that systems and services remain responsive to the needs of people living with HIV, TB and STIs	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
3.3.1 Integration of HIV and TB care with an efficient chronic care delivery system	% of clinics offering integrated chronic care	Provide support for the establishment of chronic dispensing units for HIV, TB and other chronic diseases, including symptom/side effect monitoring and adherence support	Civil Society

4.4 STRATEGIC OBJECTIVE 4: PROTECTION OF HUMAN RIGHTS AND PROMOTION OF ACCESS TO JUSTICE

4.4.1 INTRODUCTION

South Africa's response to HIV, STIs and TB, which recognises the centrality of constitutional values and human rights, is based on the understanding that the public interest is best served when the rights of those living with HIV and/or TB – or at risk of infection – are respected, protected and promoted. Not only is this globally accepted public policy, it is also in line with the rights entrenched in Chapter 2 of the Constitution and the obligations they impose on the state regarding their progressive realisation. Amongst others, these include the rights to equality, dignity, life, freedom and security of the person and privacy.

The PSP takes as a starting point the constitutional recognition that access to health care and other social services – which includes reproductive health care – is itself a fundamental right, with the state taking primary responsibility for ensuring access. In this regard, each strategic objective – where appropriate – addresses the specific access needs of particular groups, including, but not limited to, women (pregnant, with child-bearing potential or post-menopausal), men, adolescents, children, and persons with disabilities. Ensuring access to health care services requires that interventions be planned and implemented in a manner that understands the specific needs of these groups and the social, cultural and other barriers that may stand in their way of accessing services. While the focus of this strategic objective is forward-looking, largely containing a set of interventions to be implemented over the course of the next few years, considerations of human rights and access to justice are ever-present. The Midterm Review of the NSP 2007-2011 recognised that "very little data (either quantitative or qualitative) (was found) to measure progress in … Priority Area (4) of the NSP." In particular, it found that it was "not possible to make accurate comment on coverage, or gaps in coverage". In addition, the Midterm Review raised serious concerns regarding the quantitative nature of the indicators chosen in the previous NSP; in particular, it did not seek to monitor or assess the effectiveness or impact of the goals, objectives and interventions.

Through this strategic objective of the PSP the Western Cape will work to realize the provincial strategy of "increasing social cohesion" through a strengthened focus on human rights and access to justice. A key element of this strategy is to mobilize the resources, knowledge, creativity and concern of all role-players – including all spheres of government, civil society, business and individual citizens – to increase social cohesion on a partnership basis. Through its Strategic Plan the province has made a specific commitment to promoting a culture of human rights – specifically the rights of women and children – and to emphasizing human rights in departmental programmes.

4.4.3 SUB-OBJECTIVES

This strategic objective recognises that the PSP can play a central role in protecting human rights and promoting access to justice in the context of the response to HIV and TB. It has the following four sub-objectives:

- To identify and remove laws that undermine the implementation of all PSP interventions or increase vulnerability to HIV and/or TB infection;
- To ensure that rights are not violated when interventions are implemented, and that credible mechanisms for monitoring abuses and vindicating rights are established;

- To reduce HIV and TB discrimination in the workplace; and
- To reduce unfair discrimination in access to services.

Targeted interventions, which are identified in respect of each of these four sub-objectives will in all likelihood be implemented at a range of different spheres or levels. These are clearly outlined under the priority activities identified by sectors in the Objectives and Interventions table.

Sub-Objective 4.1: Ensure rights are not violated when interventions are implemented and establish mechanisms for monitoring abuses and exercising rights

In implementing interventions through the PSP the Western Cape will pay particular attention to ensuring that the rights of clients receiving services are not compromised in any way. The Department of Health will develop a tool to track and monitor human right violations (for example patient complaint and compliments questionnaires), and also identify partners who can support them in identifying these tools. Efforts will also be made to build some provision into the HCT campaign to monitor the extent to which participants are not giving proper consent.

Human rights are cross-cutting across all sectors. Government departments have a constitutional mandate to ensure that the rights of citizens are promoted and protected. Civil society organizations will, however, take the lead in supporting provincial initiatives through advocacy and information sharing on key human rights issues, as well as mobilising communities and advocating for rights and access to justice. Provincial government will support civil society efforts to ensure the implementation of the SOA, DVA and DCS laws and regulations. The DoH will facilitate a broad consultation with the business sector and organized labour to clearly establish what the law and the constitutional court have said about the employability of people with HIV and best practice for handling confidential information. Children's Sector members are trained on specific laws and understand them, and therefore are able to monitor the provision of health services for children in order for them to have improved health outcomes.

Intervention 4.1.1: Audit interventions to identify potential for human rights abuses

Each provincial government department will conduct an audit of their legislative frameworks that have the potential to undermine or facilitate implementation of the PSP.

Intervention 4.1.2: Guard against rights violations as part of policy development and programme planning

The Western Cape will ensure that new social policies and programmes will be analysed using a Human Rights lens as part of the formulation and design process. In particular policies and programmes will be required to ensure that key populations are specified within strategic and operational frameworks. A critical element of this approach will be the improved level of integration and collaboration between government departments with regards to policy formulation. Government departments will give priority to ensuring that policies do not contradict each other. The realization of the rights of women and girls will receive priority, and intensive efforts will be made to eliminate the scourge of gender-based violence. This will include improvements in the conviction rate of sexual offences cases and the reduction in secondary victimization within the criminal justice system, specifically through the establishment of multi-disciplinary Thuthuzela care centres and through adopting a victim-centred approach. The province is also committed to

strengthening the skills of all role players in the multi-disciplinary prosecution of sexual offences and reduction in the cycle period for the finalisation of cases.

Intervention 4.1.3: Use existing bodies to track human rights abuses and increase access to justice

Relevant provincial government departments will take the necessary law reform steps once any audits have been completed. The Western Cape will also support ongoing efforts to hold watchdog bodies to account, especially those with immediate bearing on HIV and AIDS, including the Commission for Gender Equality, the Human Rights Commission, the Judicial Inspectorate of Prisons. This will include ensuring that prisoners on ARV treatment receive regular treatment to avoid defaulting and the need for second line treatment and that the rights of inmates to health services are observed. The province will also ensure that migrant communities have access to disability grants.

Intervention 4.1.4: Build capacity within public institutions and civil society to increase access to justice and redress

South Africa has a Constitution that contains a comprehensive Bill of Rights. A major challenge remains, however, in terms of ensuring that these constitutionally enshrined rights are translated into practice, and in particular where they involve health and related rights for key populations. In partnership with civil society organizations the province will strengthen capacity development interventions to ensure that service providers – who are duty bearers – enable citizens – who are rights holders – to access their socio-economic rights in a fair and equitable manner. This will include the provision of sensitivity training to public servants so that they act in a non-judgemental way and provide services to every customer with equal respect and empathy.

Sub-Objective 4.2: Reduce HIV and TB discrimination in the workplace

This sub-objective seeks to ensure that implementing parties – when they conceptualise and plan the interventions contemplated in the PSP – take reasonable measures to guard against rights violations. In addition, it seeks to harness the human and institutional resources of existing constitutional and statutory structures and civil society organisations in the province to advance the PSP's human rights agenda. Further, it seeks to create a coordinated framework for (a) monitoring human rights abuses that have the potential to undermine the interventions set out in the NSP, and (b) ensuring that rights – where violated – may be vindicated efficiently and effectively. While primarily responsibility for implementation of this sub-objective rests in the relevant national government departments, the Western Cape has a key role to play in providing technical support and coordination.

Intervention 4.2.1: Initiate a provincial campaign against unfair discrimination

Public sector, civil society and the private sector in the Western Cape will work collaboratively on a provincial campaign to raise awareness among employees and employers regarding access to information on stigma and unfair discrimination. The campaign will need to be monitored to track the impact of the campaign, which will require the development of a standardised M&E tool to measure stigma (including the number of cases recorded) within communities across the Western Cape. Civil Society in particular will support ongoing efforts to hold watchdog bodies to account,

especially those with immediate bearing on HIV and AIDS, including the Commission for Gender Equality, the Human Rights Commission, the Judicial Inspectorate of Prisons. Other initiatives will include workplace education and provision of HCT with TB/STI screening and adherence support for TB.

Intervention 4.2.2: Empower employees in small and informal workplaces

The Department of Labour in the Western Cape will ensure that there is a programme in place to create awareness around human right violations within the workplace. A concerted effort will be made to engage with business so that there is a common understanding that participation in the health care of the work force is inevitable and absolutely essential for all to be involved. This will create the awareness that every employer is going to be adversely affected by HIV/TB in some way or another if this is not done.

Sub-Objective 4.3: Reduce discrimination in access to services

This sub-objective deals with unfair discrimination, and specifically on HIV or TB status as a basis for differential treatment. While there may be discrimination in all spheres of public and private life, this sub-objective has a particular focus on the workplace. It focuses on those workplaces where unfair discrimination is most likely to remain unchecked and/or where employees are least likely to be able to access legal services. A focus on the workplace enables the PSP to draw attention to, and begin addressing concerns that are common to all types of unfair discrimination for the following reasons:

- An enabling legal framework, whilst essential, is not enough to ensure that unfair discrimination is eliminated;
- People need to have knowledge of and be in a position to claim their rights;
- Those who unfairly discriminate against people with HIV and/or TB often do so in ignorance of the ways in which HIV and TB are prevented, transmitted and treated; and
- Being aware of the law, those who unfairly discriminate against people with HIV and/or TB often try to find others ways in which to give effect to their prejudices.

  This approached is informed by the recognition that the right to work is central to the ability of people with HIV and/or TB to mitigate the impact of HIV and TB on them, their families and society more broadly. Given high levels of unemployment in the Western Cape, denying equal opportunity in employment on the basis of HIV status or TB disease may place an undue burden on the province in the provision of health care services, education, housing, social assistance and basic services, amongst others.

  The sub-objective is to be achieved through the following two interventions:
- Developing and implementing a provincial campaign, as part of a broader national campaign, against unfair HIV and/or TB discrimination in all workplaces; and
- Empowering employees in small and "non-traditional" workplaces in the province to claim their own rights.

Intervention 4.3.1: Ensure that oversight bodies receive and address complaints

Organised labour, business and government in the Western Cape will assume responsibility for conceptualising, developing, resourcing and implementing a provincial, multi-media campaign to address unfair discrimination in the workplace. This campaign will address how HIV and TB are acquired and treated, what services are available to prevent and treat them, and why

discrimination cannot be justified under any circumstances.

Intervention 4.3.2: Provide training to prevent unfair discrimination

Civil society organisations working on access to justice will, in collaboration with key provincial government departments, conceptualise, develop, resource and implement a plan to build the capacity of organisations working with and/or representing employees in small and non-traditional workplaces. These include domestic workers, farm workers and employees working within correctional and other detention facilities. Such a plan will involve materials development and training on HIV and employment law, and be sensitive to provincial needs. Encouragement will be provided to people who are HIV positive to fulfil the role of HIV ambassadors and to show that HIV is a treatable disease and that living with HIV is possible.

Health service providers will be trained on migrant and refugee rights and needs, and the knowledge and capacity of service providers on MSM rights and needs will be enhanced. "Know your status" events will be conducted and communication on living positively will be disseminated at consultative meetings, as well as through newsletters, websites and social media. The provincial government will also work with key role players to support the development of a comprehensive, integrated and age appropriate school health programmes, as well as to provide information to educators and learners about children's rights.

Intervention 4.3.3: Targeted education (information) to key populations

Civil society organisation with specific expertise and experience working with key populations will scale up their information sharing, health education and promotion interventions. The focus under the PSP will be on accessing hard to reach key populations with messaging that has direct relevance and use for their particular circumstances. This will include outreach and HIV education to migrants and refugees and to prisoners and inmates, ensuring access to education for farm workers and MSM, facilitate peer education amongst sex workers, advocating for children with disabilities to have access to services, and educating and raise awareness about LGBT children in schools.

4.4.3 STRATEGIC OBJECTIVE 4: OBJECTIVES AND INTERVENTIONS

Strategic Objective 4		Ensure protection of human rights and increased access to justice	
High level Indicator		Stigma Index	
Sub-Objective 4.1		Ensure rights are not violated when interventions are implemented and establish mechanisms for monitoring abuses and exercising rights	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
4.1.1 Audit interventions to identify potential for human rights abuses	% of primary and secondary legislation audited	Identify human rights champions within the DOH/PHCs Develop a tool to track and monitor human right violations (for example patient complaint and compliments questionnaires) Identify partners who can support the DOH in identifying these tools Build some provision into the HCT campaign to monitor the extent to which participants are not giving proper consent (e.g. sub-samples asked about the consent procedures after the event)	DoH and service delivery partners
		Advocacy on human rights is cross-cutting across all sectors but civil society will take the lead in supporting provincial initiatives	WCED
		DoH facilitates a broad consultation with the business sector and organized labour to confirm what the law and the constitutional court have said about employability of people with HIV and best practice for handling confidential information	Business
		Conduct advocacy and campaigns on human rights Mobilise communities and advocate for rights and access to justice Support civil society efforts to ensure the implementation of the SOA, DVA and DCS laws and regulations Children's Sector members are trained on specific laws and understand them in order to have better health outcomes for children	Civil Society
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
4.1.2 Guard against rights violations as part of policy development and programme	% of Law reform agenda developed % of tabled bills in Parliament and/or promulgated	New policies and programmes should be analysed using a Human Rights lens Key populations will be specified within frameworks and programmes Address language barriers Improved integration and collaboration between government departments with regards to policy formulation	DoH and service delivery partners

planning	amended regulations	Give priority to ensuring that policies do not contradict each other (eg. TOP at 16 (without consent) but for HCT consent forms are needed, sex workers found with condoms are arrested by the police) Consider setting up and piloting a hotline for reports of abuses Provide accessible and high quality services, sensitive to gender and culture and non-discriminatory	
		Develop a policy on HIV prevention in schools that includes respect for human rights	WCED
		CDWs conduct awareness sessions on the intersection of GBV with HATs per district (attitudinal barriers).	DLG
		Design and implement integrated programmes and services that provide for the development, care and protection of the rights of children	WC DoSD
		Improve the conviction rate of sexual offences cases Reduce secondary victimization within the criminal justice system and adopt a victim-centred approach Strengthen skills development of all role players in the multi-disciplinary prosecution of sexual offences Reduce the cycle period for the finalisation of cases	Department of Justice NPA SAPs
		Establish a system in correctional facilities for monitoring rights violations using their own staff or civil society Report rights violations to the SAHRC periodically Review and align policies and guidelines that are discriminatory Strengthen the protection of vulnerable inmates (first offenders, youth/juvenile offenders, mentally ill, physically challenged, sex offenders, drug and substance abusers, children accompanying their mothers, terminally ill the elderly and women offenders)	DCS
		Review and input on new policies to ensure protection of human rights Involve civil society so that they are fully engaged in policy and programme development Increase capacity of civil society to provide services including counselling, representation, and support	Civil Society

		Distribute materials on rights	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
4.1.3 Use existing bodies to track human rights abuses and increase access to justice	% of Law reform agenda developed % of tabled bills in Parliament and/or promulgated amended regulations	Ensure that inmates on ARV treatment receive regular treatment and ensure continuity of care to avoid defaulting and the need for second line treatment Ensure that the rights of inmates to health services are observed	DCS
		Support on-going efforts to hold watchdog bodies to account, especially those with immediate bearing on HIV and AIDS, including the Commission for Gender Equality, the Human Rights Commission, the Judicial Inspectorate of Prisons	Civil Society
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
4.1.4 Build capacity within public institutions and civil society to increase access to justice and redress		Streamline procedures between departments, for example in rape cases Enhance the standardisation of health-related services within all public institutions	DoH
		Capacity building of inmates and officials to understand and claim their human rights	DCS
		Provide sensitivity training for public servants so that they are non-judgemental and provide services to every customer with equal respect and empathy	Civil Society
Sub-Objective 4.2		Reduce HIV and TB discrimination in the workplace	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
4.2.1 Initiate a provincial campaign against unfair discrimination		Joint planning among all stakeholders to develop a provincial campaign against unfair discrimination	DoH together with all relevant stakeholders
		Raise awareness among employees and employers regarding access to health and rights information Monitor the impact of the anti-discrimination campaign Develop a standardised M&E tool to measure stigma (no. of cases recorded) within communities Support ongoing efforts to hold watchdog bodies to account, especially those with immediate bearing on HIV and AIDS, including the Commission for Gender Equality, the Human Rights Commission, and the Judicial Inspectorate of Prisons	Civil Society

		Provide workplace education and provision of HCT with TB/STI screening and adherence support for TB	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
4.2.2 Empower employees in small and informal workplaces		Create awareness around human right violations within the workplace, especially in small and informal workplaces	DoL
		Work with business to facilitate their participation in the health care of the work force Raise awareness amongst employers that proactive responses can reduce the impact of HIV/TB on their workforce and consequently their business	Business
Sub-Objective 4.3		Reduce discrimination in access to services	
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
4.3.1 Ensure that oversight bodies receive and address complaints		Include rights and responsibilities within the school curriculum	WCED
		Raise awareness around the rights of inmates to health care and HIV related programmes	DCS
		Support ongoing efforts to hold watchdog bodies to account, especially those with immediate bearing on HIV and AIDS, including the Commission for Gender Equality, the Human Rights Commission, the Judicial Inspectorate of Prisons	Civil Society
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**
4.3.2 Provide training to prevent unfair discrimination		Encourage people who are HIV positive to fulfil the role of HIV ambassadors and to show that HIV is a treatable disease and that living with HIV is possible Educate health service providers on migrant and refugee rights and needs Strengthen the knowledge and capacity of service providers on MSM rights and needs Facilitate "know your status" events and communication on living positively at consultative meetings, newsletters, websites and social media Work with key role players to support the development of a comprehensive, integrated and age appropriate school health programme Provide information to educators and learners about children's rights	Civil Society
Intervention outputs	**Indicator**	**Priority Activities Per Sector**	**Responsible Sector**

4.3.3 Targeted education (information) to key populations		Implement behaviour modification programmes that reduce stigma and discrimination in all facilities for both inmates and staff	DCS
		Continue outreach and HIV education to migrants and refugees and to prisoners and inmates Ensure access to education for farm workers and MSM Facilitate peer education amongst sex workers Advocate for children with disabilities to have access to services	Civil Society

4.5 STRATEGIC ENABLER – EFFECTIVE COMMUNICATION

The NSP has noted that strategic enablers are critical factors for the successful implementation of both the national and provincial plans for the period 2012-2016. In alignment with the national plan the Western Cape will focus on four strategic enablers that will function as key determinants of the successful implementation of the PSP. These enablers are:

- Governance and institutional arrangements at provincial, metro and district level;
- Effective communication between all relevant PSP stakeholders to ensure effective multi-sectoral collaboration and implementation;
- Monitoring and evaluation to track progress on results; and
- Research on areas that lack critical data for effective planning, programming and implementation.

The PAC Secretariat will take responsibility for first-line communication between the national and provincial efforts and between sectors to ensure that all efforts are coordinated and focus on achieving the goals of the PSP. This is in alignment with the provincial vision of "better, together". The Secretariat will develop a comprehensive communication strategy in consultation with all relevant stakeholders to ensure that continuous two-way communication is in place and that all implementing partners are kept up to speed on all strategic, operational and M&E issues.

The Secretariat will also take responsibility for communicating with provincial media about the PSP and its goals, principles, interventions, achievements and challenges. This approach will seek to establish trust and secure buy-in from people and organisations not directly involved in provincial and district AIDS structures. The Secretariat is also concerned to ensure the widest possible acceptance of the PSP, enabling all relevant stakeholders in the Western Cape to work together towards these goals. As part of its communications mandate the Secretariat will also actively promote social and behaviour change communication around HIV, STI and TB issues. This will encompass the individual, community and socio-political levels and includes advocacy, media, social/community mobilisation and campaigns.

An ongoing challenge for communication in the province is to access and engage with key populations in health education and promotion initiatives. The Secretariat will ensure that there is a particular focus in this area as part of efforts to highlight and reinforce the concerns that are articulated in pillar four of the PSP around issues of stigma, discrimination and access to justice. Communication for human rights, social drivers of the epidemic and prevention has to be mostly outside of the health services, as the majority of people that are HIV-negative live, work and play outside of the health services. In this regard the existing capacity of some sectors, including the religious sector and the local business sector, to mobilise and communicate with its members should be utilised, as they can more effectively promote and facilitate local community-level dialogues and campaigns.

Each of the PSP strategic objectives will require major communication efforts at all levels. These communication efforts must encompass the various platforms for communication, including traditional media (newspapers, television, radio), but also social media platforms accessible on computers and cell phones (Facebook, Twitter, Mxit), SMS, local community dialogues and interpersonal communication. In the Western Cape the Secretariat will, in collaboration with relevant stakeholders, explore local communication efforts to reach particular vulnerable communities and groups, specifically mobile populations, persons with disabilities, sex workers and prisoners.

The communication strategy needs to be informed by evidence and the realities on the ground to ensure that the drivers (including structural and social drivers) of the epidemic are adequately addressed. Coordination is critical to provincial HIV and TB communication efforts. It will also be necessary to explore ways in which adequate funding can be leveraged to enable communication in multiple languages, including Braille and sign language, as well as to ensure repeated communication to reach the necessary scale is needed to change risk behaviour and sustain healthy behaviours.

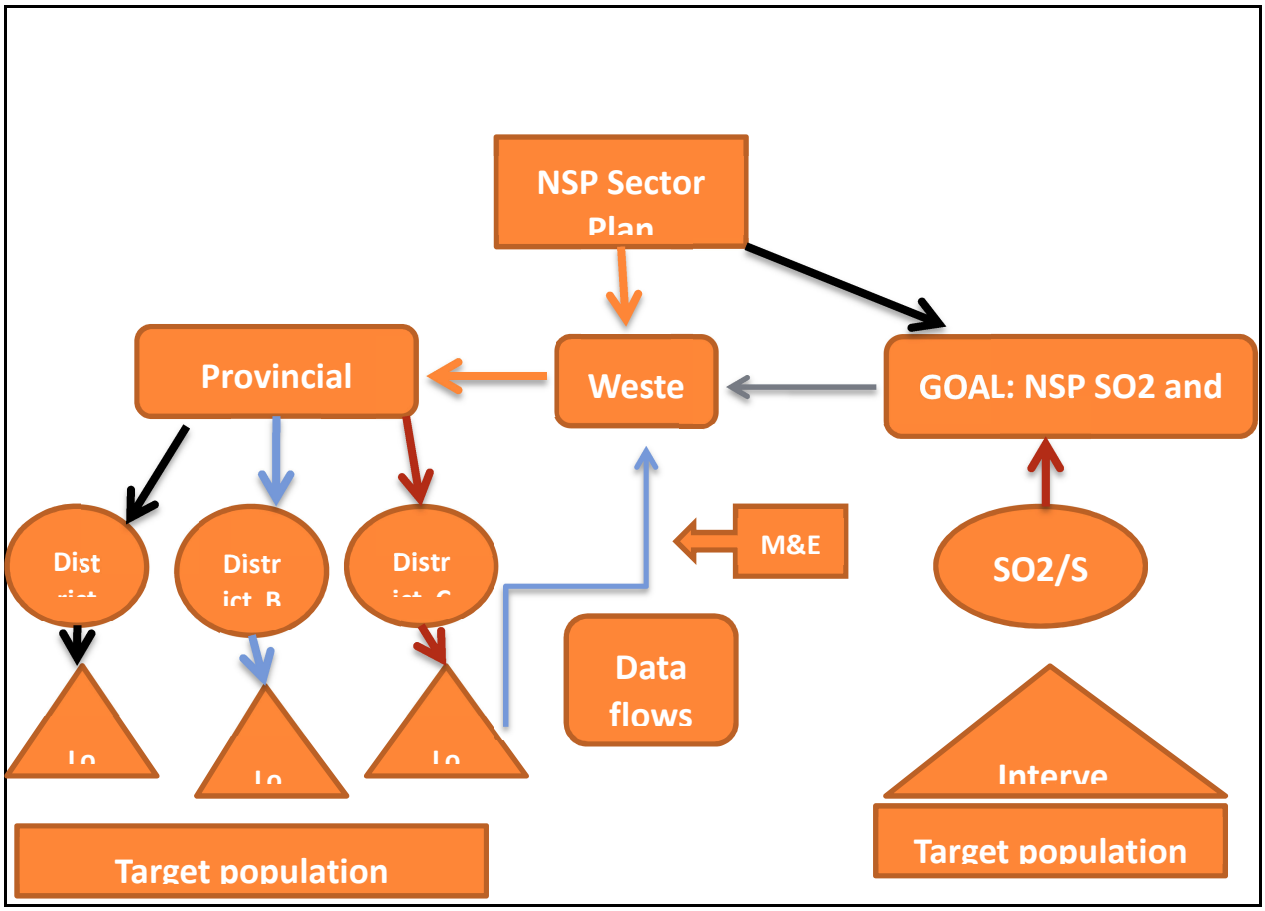
The PSP is a critical document to enable the Western Cape to coordinate and build efforts to control HIV, STIs and TB. To gain buy-in and for accountability, the PSP must be available as widely as possible. The PSP document will be widely distributed to all stakeholders. A simplified, accessible version of the PSP will also be published in the Western Cape official languages (English, Afrikaans and IsiXhosa), for distribution to the general public.

4.6 OPERATIONAL PLANNING

The Provincial Strategic Plan 2012-2016 provides the Western Cape with a framework for further strengthening its ongoing response to HIV, STIs and TB, and enables the province to implement programmes that are fully aligned with the national plan. The Operational Plan, however, provides the province with a more detailed implementation map as it outlines sector-specific activities that will serve as the means to achieving the strategic objectives. The process of developing an Operational Plan for the PSP has involved a consultative process with all stakeholders involved in the HIV, STI and TB response in the Western Cape. Two multi-sectoral stakeholder workshops were held in late 2011 and early 2012, and provided key government, civil society and business sector stakeholders with an opportunity to provide inputs and to identify interventions under each of the PSP strategic objectives. Agreement has also been reached the Operational Plan will serve as a rolling five year implementation that will be updated on an annual basis. This will facilitate the following provincial processes:

- Target setting for each objective;
- Tracking and data collection against the selected PSP indicators;
- Review of interventions on an annual basis;
- Assessment of progress, identification of gaps and challenges, and determination of remedial actions;
- An assessment of each sector performance against the objectives;
- Synthesis of data on an annual basis to facilitate reporting to the PAC and to SANAC as part of ongoing monitoring and evaluation.

The Western Cape will ensure that the operational planning process is informed by the needs and perspectives of people in the province who utilize the services provided. Within the context of "Better, Together" the province will ensure that the multi-sectoral services provided to end users are responsive to their needs, are of a good quality and are focused on achieving improved health and wellness for citizens of the province. To achieve this end the province will continue to strengthen decentralized processes, including decentralized health and social development services, so that the flow of information is from the local level upwards. The province is therefore fully committed to ensuring that local, district, metro and provincial health and wellness systems and processes are as fully integrated as possible so that the provision of services becomes seamless and reaches every person requiring the required service, irrespective of whether they live in the Cape Town metro or in the most remote region of the central Karoo.



The PAC secretariat will work with sectors to ensure that implementation data collected feeds into the consolidated provincial monitoring and evaluation system. This is a critical element of the province's PSP performance and will enable the province to feed into the national M&E framework (described in Chapter 5).

CHAPTER 5 – MONITORING AND EVALUATION OF THE PSP

5.1 INTRODUCTION

The Western Cape will, over the period of the PSP, strengthen its M&E capacity so the province can effectively and efficiently meet national reporting requirements. The province recognizes the critical importance of developing and sustaining a uniform M&E system. The development of the national Monitoring and Evaluation Framework for the NSP will be led by SANAC, and through their M&E function SANAC will monitor progress against the NSP targets and indicators. The framework will take into account existing monitoring and evaluation sub-systems being implemented by different stakeholders, as well as planning and monitoring frameworks and policies in government. At all levels the province will work to ensure that it harmonises all M&E inputs so that the national system is fully supported.

5.2 M&E COORDINATION

Monitoring and evaluation of the multi-sectoral response will require greater coordination of all sectors (public, private, civil society and development partners) to ensure optimal utilisation of the available resources and continuous learning through sharing of experiences. The PAC Secretariat in the Western Cape will take a lead role in ensuring that the province is able to provide accurate and verifiable data on progress made in achieving PSP targets and indicators for all of the strategic objectives.

5.3 BASELINE VALUES

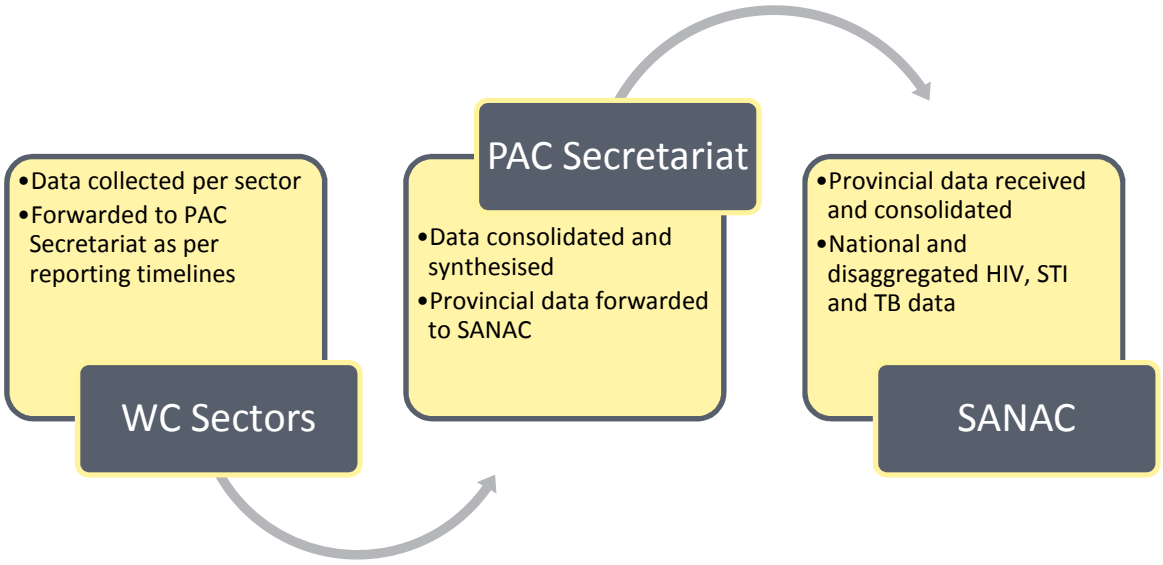
The M&E Unit in the SANAC Secretariat will lead a process to determine consensus baseline values for the core indicators selected at national level. The Western Cape and sectors will follow a similar process to establish baseline values for the indicators of choice at the respective levels with the support of the SANAC Secretariat. Determination of baseline values at national, provincial and sectoral levels will be completed during the course of 2012.

5.4 LEVELS OF MONITORING AND EVALUATION

Using the PSP and the provincial Operational Plan as a common platform the Western Cape PAC together with sectors will develop joint monitoring and evaluation plans that will guide monitoring of their specific implementation plans. The plans will emphasise the need to strengthen existing routine monitoring and evaluation sub-systems to be able to produce good quality data in a timely manner. Additional indicators might be added at the lower level to assist with monitoring of progress of PSP implementation without overburdening the data collection system and compromising on quality. Periodic monitoring reports will give status at a glance on the response at the respective level. The provincial PAC Secretariat will take overall responsibility for the coordination of data inputs as well as the consolidation of data received.

5.5 DATA FLOW

Data on selected indicators for HIV, STIs and TB will flow from the relevant government, civil society and business sectors to the Secretariat of the Provincial Councils on AIDS (PCAs). The Secretariat will then consolidate and synthesize the data so that it is aligned with national M&E requirements, and forward this data to the SANAC M&E Unit as per agreed reporting timelines. While government and civil society sectors will be reporting within their established structures at the different levels, they will be required to feed into the Provincial structure at the corresponding levels at the same time. This will help strengthen the multi-sectoral responses at the different levels.
The SANAC Secretariat will provide a progress report on selected core indicators on a quarterly basis. These progress reports will also be shared with the institutions providing the data as feedback. SANAC Secretariat will also manage international reporting obligations.



5.6 PSP REVIEWS

A midterm and end-of-PSP review will be conducted. The midterm review will focus on achievements, challenges, emerging issues and recommendations for the remaining half of the PSP, and will take place in 2014. In addition to the midterm review, annual programme reviews will be conducted. This will require multi-sectoral stakeholders to come together at the end of each implementation year to review progress and challenges, and set priorities for the following year focusing on results and mutual accountability. The final PSP review will be conducted in 2016 to provide the evidence base for the next PSP. Independent evaluators will carry out the midterm and end-term reviews.

CHAPTER 6 – RESEARCH

The main goal of research on HIV, STIs and TB in South Africa under the umbrella of the new NSP is to provide ongoing scientific evidence to guide policy and enhance the country's response to the three diseases. The NSP notes that the production of new knowledge to impact on these diseases is a critical component of South Africa's strategic response. This includes generating behavioural, sociological, economic and biomedical information to enhance the implementation of existing interventions and programmes as well as the development of innovative new approaches for the prevention, diagnosis, treatment and care, and mitigation of the impact of HIV, STIs and TB, either singly or in combination. The Western Cape will ensure that it contributes to national level research, as well as to its own provincial context where specific research concerns will be addressed.

6.1 INTRODUCTION

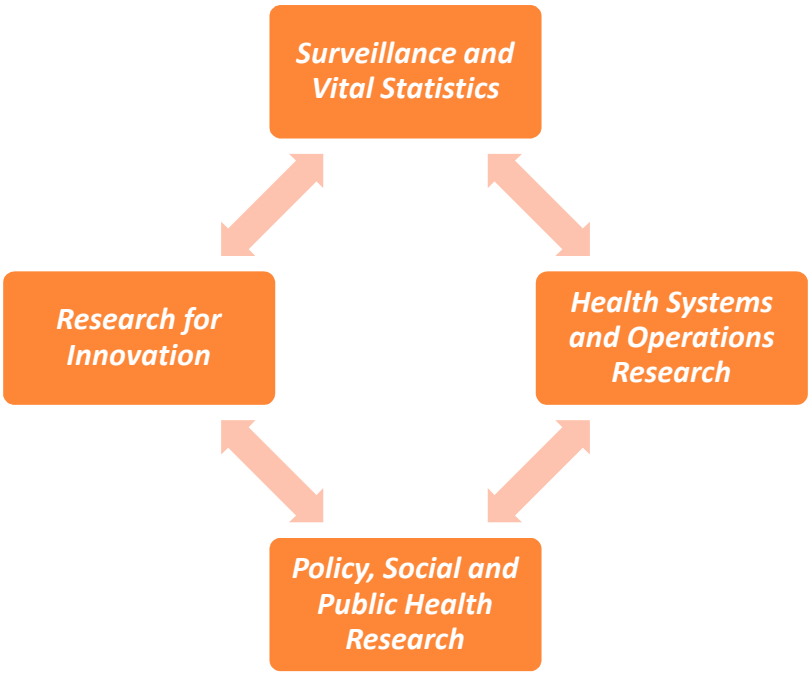
The NSP argues that South African research on HIV, STIs and TB is widely recognised as being world class. Over the past five years South African researchers have made several groundbreaking contributions that have impacted all three diseases. In spite of this excellent reputation, one of the major challenges has been the lack of a strong link between the research conducted in South Africa and the country's local needs. Most of the current research done by South African researchers is skewed towards global issues, largely dictated by their dependence on international funding. To correct this situation, which existed during the last NSP (2007-2011), it is crucial that research, over the next few years, includes a focus on local priorities and that local funding for research in support of the NSP for the period 2012 to 2016 is increased. The establishment of a local research agenda linked much more closely to the country's specific needs related to HIV, STIs and TB and in line with the four strategic objectives, with the necessary funding is an important initial step.

The Western Cape is endowed with three high quality universities – the University of the Western Cape, Stellenbosch University and the University of Cape Town – that already make significant contributions to academic research on both the biomedical and socio-economic (structural) dimensions of HIV, STIs and TB. The Western Cape is also richly endowed with civil society organisations and networks that produce important quantitative and qualitative research around the social determinants of HIV and TB, including research around gender and human rights considerations. The private sector in the Western Cape has also demonstrated a willingness to partner with both national and provincial research agendas. Over the next five years the PSP will provide academia, civil society and the private sector in the province with a framework for potential research projects. This may be focused provincial level academic research, collaborative provincial research agendas, joint research projects with national agencies such as the HSRC, MRC and CSIR or research that is undertaken with regional and international research partners.

6.2 PROPOSED RESEARCH STREAMS FOR THE PSP 2012-2016

Four main streams of research are presented below as the basis for generating the knowledge needed to support the goals of the NSP. An overall approach is provided, rather than listing individual research questions or research topics. The four streams represent the continuum between policy, behavioural, sociological and non-hypothesis driven descriptive studies and

long-range clinical and basic science research. This will inform the development of a new research agenda during the 2012-2016 period. While the priorities ascribed to individual research questions may change over the next five years, this overarching approach provides a framework to locate and organise changing research priorities. Through the PSP the Western Cape will align itself to the four broad inter-related research areas identified in the NSP:



These research areas are sufficiently broad in nature for the Western Cape to identify and develop research agendas that arise out of these, but that also address the specificities of the HIV, STIs and TB challenges in the province.

CHAPTER 7 – COSTING AND FINANCING THE PSP 2012-2016

7.1 INDICATIVE COSTS OF THE PSP

The process of costing will be completed during the course of 2012. Once the NSP has finalised the national targets of each intervention identified as necessary to achieve the national goals, an estimation of the provincial share of each of the targets should guide the Provincial Strategic Implementation Plans (PSPs). A simple results-based costing tool will guide the costing of provincial strategic implementation plans. At SANAC level this model has been developed to assist in costing the nine PSPs during 2012, and the process has been formalized. Provinces will be approached on a needs basis and will be able to access this costing expertise as required.

7.2 GAP ANALYSIS

The AIDS Spending Assessment (NASA) was conducted in the Western Cape in 2011. It sought to capture all public, external (donor) and business sector contributions to the HIV/AIDS and TB response in the province for the years 2007/08, 2008/09 and 2009/10. It identified that in the Western Cape the major service provider was the DOH HIV/AIDS, STI & TB Directorate (HAST), delivering R335 million in services (or 33% of the total) in 2009/10. Public hospitals provided 25%, or R252 million, of services in 2009/10. The third largest provider was constituted by CBOs, CSOs and NGOs, which were responsible for 17% of the total expenditure. The usefulness of the NASA Report has been in its identification of spending trends and how these reflect specific areas where the bulk of funding has been allocated.

The NASA report indicated that the bulk of publicly sourced funding in the Western Cape was on treatment, constituting 57.5% in 2007/08. This amount increased to 64.4% in 2008/09 and 71.4% in 2009/10. This increase in treatment has been primarily driven by the increased spending on ART specifically. However, prevention spending decreased from 22.4% of total spending in 2007/08 to 14.5% in 2009/10. In nominal terms, the public allocation to prevention increased slightly in 2008/09 and then stagnated. Research and human rights and legal services account for very little public expenditure each year. Each year, approximately 7% of public spending was used for impact mitigation activities. The portion spent on Co-ordination of the Multi-sectoral Response and Programme Management decreased over the years from 3.6% in 2008/09 to 1.7% in 2009/10. A possible explanation for this is increased efficiency within the departments. OVC support initially increased in 2008/09 to R16 million from R6.8 million (2007/08) and then decreased in 2009/10 to R10.2 million. This may be attributed to a reduced HIV/AIDS budget for the Department of Social Development in the same period. Overall, the increasing proportion to treatment, without equally increasing proportions to prevention and other activities is concerning. Also of concern has been the rather low spending on the most-at-risk populations, such as commercial sex workers (CSWs), youth out-of-school, men who have sex with men (MSM) and intravenous drug users (IDUs). These trends serve as a pointer to where focused funding may need to be allocated within the framework of the new PSP.

7.4 COSTING OF THE PROVINCIAL STRATEGIC OPERATIONAL PLAN

The Operational Plan will be costed on an annual basis as government departments, civil society organizations and the private sector identify activities for which they have funding.

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Afrikaans and isiXhosa versions of this publication are available on request.