A long and healthy life for all South Africans
Health Sector HIV Prevention

2016
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The national Department of Health extends its sincere appreciation to everyone who directly or indirectly contributed to the development and finalisation of the *Health Sector HIV Prevention Strategy*. We especially wish to thank officials from the national and provincial departments of health and other government departments, the South African National AIDS Council (SANAC), development and implementing partners and civil society.

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MP MATSOSO
DIRECTOR-GENERAL: HEALTH
The publication of the Health Sector HIV Prevention Strategy is a sign that we are serious about climbing the highest mountain in the terrain of HIV and AIDS: preventing new HIV infections. Implementation of prevention programmes for HIV is complex because it demands carefully thought-out strategies to get the right combination of packages to the right people at the right time.

Combination prevention not only requires that we strengthen the biomedical elements of prevention – the aspects that we know most about – but also requires that we engage fully with changing the attitudes, beliefs and cultural practices of individuals, couples, families and communities, and addressing other barriers that prevent people from protecting themselves against HIV infection.

The complexity of combination prevention makes it difficult to summarize the role that awaits you. Furthermore, it will require decisive and creative management to answer questions like: “How do we assist residents of informal settlements – who are most prone to infection?” As well, it will require great empathy to put ourselves in the shoes of a migrant worker, a young girl or woman, a gay man and a 13-year-old orphan and imagine what our health facilities can do to empower them to put their health first.

To encourage you in this new challenge, I want to ask you to cast your minds back. When we proposed a mass HIV testing campaign for millions of people, many observers said: “Never! It can’t be done.” When we set out to build the biggest HIV treatment programme in the world, even some of our friends doubted we could do it. In both cases, we proved that we could do what others thought impossible. It took courage and ambition. It took dedication, resources, trusted partners and organization. It demanded flexibility and innovation – a willingness to change how we define our scope of work and responsibility. In addition, it gave us the satisfaction of a job well done, however the epidemic is not beaten and our work is not done.

We must find a way to live without HIV, to be HIV free. Zero new infections among adults and children. Zero deaths from HIV. These are not empty slogans. They must be the burning commitment of every healthcare professional and manager.

The aim of the National Health Sector HIV Prevention Strategy is to provide guidance on the implementation of the combination HIV prevention strategies. Furthermore this document is developed in alignment with the National Development Plan 2030 and the UNAIDS 90,90,90 strategy. This is an important step for South Africa in keeping pace with the global guidance and recommendations.
ABBREVIATIONS AND ACRONYMS

AIDS  Acquired Immunodeficiency Syndrome
ART   Antiretroviral therapy
AYWG  Adolescent Young Women and Girls
DoH   Department of Health
GBV   Gender-based violence
HCT   HIV Counselling and Testing
HCW   Health Care Worker
HIV   Human Immunodeficiency Virus
HPV   Human Papillomavirus
HSRC  Human Sciences Research Council
HTA   High Transmission Area
HTS   HIV Testing Services
IEC   Information, Education and Communication
IPV   Intimate Partner Violence
KP    Key Population
KYE   Know Your Epidemic
KPR   Know your Response
LGBTI Lesbian, Gay, Bisexual, Transgender and Intersex
M and E Monitoring and Evaluation
MMC   Medical Male Circumcision
MSM   Men who have Sex with Men
NDoH  National Department of Health
NDP   National Development Plan 2030
NGO   Non-Government Organisation
NSP   National Strategic Plan on HIV, STIs and TB, 2012-2016
OVC   Orphaned and Vulnerable Children
PEP   Post-exposure Prophylaxis
PMTCT Prevention of Mother-to-Child Transmission
PrEP   Pre-Exposure Prophylaxis
PWD   Persons with Disabilities
PHDP  Positive Health, Dignity and Prevention
PLHIV People Living with HIV
PWID  People who Inject Drugs
SANAC South African National AIDS Council
SBCC  Social and Behaviour Change Communication
SDG   Sustainable Development Goal
SHIPP Sexual HIV Prevention Program
SRH   Sexual and Reproductive Health
STI   Sexually Transmitted Infection
SW    Sex Worker
TB    Tuberculosis
UN    United Nations
USAID United States Agency for International Development
WHO   World Health Organization
GLOSSARY AND DEFINITIONS

**Age-disparate relationships** refer to relationships where the age gap between sexual partners is five years or more. The terms “intergenerational relationships” and “cross-generation relationships” generally refer to a ten-year or greater age disparity between sexual partners.

**Behaviour change communication** refers to communication that promotes changes in behaviours and attitudes by providing tailored messages, personal risk assessment, greater dialogue, and an increased sense of ownership.

**Biomedical** refers to medical and biological interventions. These include medical male circumcision and prevention of mother-to-child transmission.

**Combination HIV prevention** is an approach that seeks to achieve maximum impact on preventing new HIV infections by combining biomedical, socio-behavioural and structural interventions that are human-rights based and evidence informed, in the context of a well-researched and understood local epidemic.

**Eligible for antiretroviral therapy** refers to people living with HIV for whom antiretroviral therapy is indicated according to clinical guidelines.

**Gender-based violence** refers to violence that is directed against a person on the basis of gender. It constitutes a breach of the fundamental rights to life, liberty, security, dignity, equality between men and women, non-discrimination, and physical and mental integrity.

**Gender equality** means that both men and women are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles, and prejudices. Gender equality means that the different behaviours, aspirations, and needs of women and men are considered, valued, and favoured equally. It signifies that there is no discrimination on the grounds of a person’s gender in the allocation of resources or benefits, or in access to services.

**General population** refers to all residents of South Africa, irrespective of their gender, sexual orientation, geographical location or age.

**HIV prevention** refers to interventions and strategies designed to prevent the spread of the human immunodeficiency virus in South Africa. These are carried out at health facilities, in communities and by individuals.

**Injecting drug users** – illegal substances may be injected through subcutaneous, intramuscular, and intravenous routes.

**Key populations** are populations that are at a higher risk of HIV exposure or onward transmission. These include men who have sex with men, transgender people, injecting drug users, people who abuse alcohol, sex workers and their clients, and detained populations. At-risk populations are among the most marginalised and most likely to be stigmatised. In addition, resources and national human immunodeficiency virus prevention campaigns are not necessarily geared to their specific prevention, treatment and care needs concerning the virus. The engagement of key populations is critical to a successful response to the virus. In all countries, key populations include people living with HIV.

**Men who have sex with men** refers to males who have sex with males regardless of whether they have sex with women or have a personal or social gay or bisexual identity. This concept is inclusive of men who self-identify as heterosexual but have sex with other men.

**Migrant populations** refer to both internal (South African) and cross-border migrants. Migrants are people who move in search of better economic opportunities. In South Africa, internal migrants constitute the largest proportion of the migrants in the country.

**Mobile populations** refer to transient workers such as truckers or miners.

**Opportunistic infections** refer to infections that take advantage of a weakened immune system. In people living with HIV, these are often tuberculosis, pneumonia, candidiasis, and the herpes simplex virus.

**Pre-exposure prophylaxis** refers to antiretroviral medicines that are prescribed before exposure or possible exposure to HIV. Pre-exposure prophylaxis strategies under evaluation increasingly involve the addition of a post-exposure dosage.

**Post-exposure prophylaxis** refers to antiretroviral medicines that are taken after exposure or possible exposure to HIV. The exposure may be occupational, as in a needle-stick injury, or non-occupational, as in unprotected sex with a person living with the virus.
Prevention of mother-to-child transmission refers to the four-pronged strategy to prevent new HIV infections in infants and keep mothers alive and families healthy. The four prongs are: halving HIV incidence in women; reducing the unmet need for family planning; providing antiretroviral prophylaxis to prevent HIV transmission during pregnancy, labour and delivery, and breastfeeding; and providing care, treatment, and support to mothers and their families.

Some countries prefer to use the term ‘vertical transmission’ to acknowledge the role of the father/male sexual partner in transmitting HIV to the woman and infant. This may encourage male involvement in the prevention efforts.

Priority populations are groups of people who are susceptible to HIV infection because of their medical conditions. These include people with tuberculosis, pregnant women and people living with HIV.

Serodiscordant couples are couples where one partner is living with HIV while the other partner does not carry the virus. A couple refers to two people that have a sexual relationship.

Sex work refers to sex between consenting adults older than 18 years, either regularly or occasionally, formally or informally, for cash; a service where the person selling may or may not self-identify as selling sexual services.

Sex worker refers to consenting female, male and transgender adults, and young people older than 18 years who receive money or goods in exchange for sexual services, either regularly or occasionally.

Sexual and reproductive health services refer to services for family planning, infertility services, prevention of unsafe abortion and post-abortion care, diagnosis and treatment of sexually transmitted infections, including HIV infection, reproductive tract infections, cervical cancer and other gynecological morbidities, and the promotion of sexual health, including sexuality counselling.

Sexually transmitted infection refers to infections that are spread by the transfer of organisms from person to person during sexual contact. These include HIV, chlamydia trachomatis, and the human papillomavirus, which can cause cervical, penile, or anal cancer, genital herpes, cancroid, syphilis, and gonorrhea.

Transgender refers to a person with a gender identity that is different from his or her sex at birth; they may be male to female or female to male. They may also prefer not to conform to any gender binary, or to rather use gender-neutral references.

Vulnerable populations are groups of people that are particularly vulnerable to HIV infection under certain circumstances. These include young women and girls, orphaned and vulnerable children, people in prisons and detention centres, persons with disabilities, migrant and mobile workers, and seronegative partners in serodiscordant couples.

Young women refer to girls between the ages of 15 and 19 years and young women between the ages of 20 and 29 years.
SECTION A: STRATEGIC APPROACH TO HIV COMBINATION PREVENTION

1. INTRODUCTION

South Africa has a generalised human immunodeficiency virus (HIV) epidemic with prevalence estimated at 18% among adults aged 15–49 years, 30% among men having sex with men (MSM), 60% among sex workers (SWs), 12% among people who inject drugs (PWID) and 44% among detained persons. An estimated 25% of new infections are linked to MSM, and SWs and their partners.

In response to the large HIV epidemic, the National Department of Health (NDoH) has embarked on a combination prevention approach to achieve universal access to HIV prevention, treatment, care, and support for both the general and the key populations (KPs) in line with the National Strategic Plan on HIV, STIs, and TB, 2012–2016 (NSP). The Health Sector HIV Prevention Strategy provides a framework to implementers for the planning and implementation of prevention interventions tailored to the needs and local context. The internationally accepted approach of ‘combination prevention’ is the cornerstone of this strategy. The approach offers the best prospects for addressing documented weaknesses in HIV prevention programming and for generating significant and sustained reductions in HIV incidence in diverse settings.

1.1. DEVELOPMENT OF THE STRATEGY

The Health Sector HIV Prevention Strategy is aligned to several South African and international guidelines and strategies including the NSP, National Development Plan 2030 (NDP), UNAIDS 90-90-90 Strategy, Know your Epidemic Report (KYE), and Know your Response Report (KYR) (2009). Finally, this strategy is closely aligned with the United Nations’ (UN) sustainable development goal (SDG) #3 that states that all governments should “ensure healthy lives and promote well-being for all at all ages”.

1.2. STAKEHOLDER ENGAGEMENT

The Department of Health (DoH) recognises that the NSP mandate for HIV prevention is shared by several government departments at national, provincial and local levels, by a range of civil society sectors and organisations, and by funding partners. In planning and implementing the prevention packages, health services have a responsibility to co-ordinate and work collaboratively with these structures.

1.3. AIMS AND OBJECTIVES

The aims of the strategy are to provide:

- a framework for a comprehensive package of HIV prevention services provided by the DoH, specifically to reduce the number of new HIV infections; a coordinated HIV prevention response at all levels
- prioritise HIV prevention interventions, geography and per population for optimised reduction of new infection
- scale up implementation of combination (biomedical, behavioural and structural) HIV prevention interventions
- monitor and track progress

1.4. PRINCIPLES

Several principles underpin the NSP, and provincial and sectoral implementation plans. These should be applied equally to the Health Sector HIV Prevention Strategy. Key principles are as follows:

- **Rights-based** – Strategies must be rooted firmly in the protection and promotion of human and legal rights, including prioritising gender equality and gender rights
- **Evidence-based** – Initiatives should be based upon evidence and implementation should focus on the achievement of well-formulated objectives and targets
- **Flexible** – This is a living document that should be flexible and adaptable based on emerging evidence
- **Multi-sectoral** – All implementers should leverage the comparative advantage of various sectors and forge strategic partnerships for synergy
- **Leadership and accountability** – True engagement at all levels can only be achieved through advocacy, ownership, empowerment, communication, and co-ordination
2. ELEMENTS OF COMBINATION PREVENTION

2.1. DEFINING COMBINATION PREVENTION

Combination prevention refers to the strategic simultaneous use of different classes of prevention interventions (biomedical, behavioural and structural) that operate on multiple levels (individual, couple, community and societal) to respond to the specific needs of particular audiences and modes of HIV transmission, and to make efficient use of resources through prioritising partnerships and engagement of affected communities.

We need to ensure that we know our target populations and epidemics and design unique combinations or packages of prevention services and activities to suit the varied context and target populations. For example, the NDoH has identified adolescents, young women and girls (AYWG) as a priority population that must be prioritised with combination prevention interventions. Sex workers, PWID and MSM have also been identified as key populations that should urgently be targeted with combination prevention interventions.

This approach is based on the following realities:

• increasingly compelling evidence\(^1\) suggests that a combination of interventions can successfully reduce HIV infection. No single intervention is fully effective in preventing HIV infection, tuberculosis (TB) and sexually transmitted infections (STIs).

• geographic regions (provinces, districts and sub-districts), and communities are not homogenous; there is not a ‘one-size-fits-all’ approach to effective combination prevention, as sections of the population are exposed to different HIV infection risks

The key features of the Health Sector HIV Prevention Strategy are as follows:

• it is tailored to districts and local needs and contexts
• it is a combination of biomedical, socio-behavioural and structural interventions
• it aims at full engagement of affected communities, promoting human rights and gender equality
• it operates synergistically, consistently over time, and at multiple levels (individual, family, community, and society).
• it invests in decentralised and community responses and enhances co-ordination and management
• it is flexible and easily adapted to changing epidemic patterns
• its effectiveness is based on the correct dosage of interventions

2.2. SOCIAL ECOLOGY MODEL

While acknowledging the role of individuals in HIV prevention, the DoH acknowledges the impact that interpersonal relationships, communities and social factors have on an individual’s health-seeking behaviour. The Social Ecology Model identifies a wide range of factors that affect the health and wellness of an individual, and the social drivers of ill health and structural factors that increase risk and vulnerability to HIV infection. As a result, this strategy is aligned to the Social Ecology Model, depicted in Figure 1.

![Social Ecology Model Diagram]

Figure 1: Social Ecology Model


### 2.3. DETERMINANTS OF HIV

The strategy considers social determinants of HIV as most HIV infections are sexually transmitted. Fewer than 3% of all new infections occur in mother-to-child during pregnancy, childbirth or through breastfeeding, and approximately 5% through occupational exposure and accidents. In South Africa, a very small percentage (<1%) of HIV transmission occurs through intravenous drug use. In the past five years, there has not been a single reported case of HIV transmission through blood transfusion.

In support of the NSP (2012-2016), the strategy highlights key determinants of the HIV epidemic in South Africa based on the report and other analyses, and highlights actions that will mitigate the impact of the epidemic and improve HIV outcomes, as tabulated in Table 1.

| Table 1. Determinants of HIV, proposed activities, and HIV outcomes |
|--------------------------------------------------------|--------------------------------------------------------|--------------------------------------------------------|
| HIV testing services (HTS) | HTS is the entry point to prevention, care, and treatment, and it should be expanded to reach more people | Reduction of HIV transmission and new infections |
| Prevention of mother-to-Child transmission (PMTCT) | Strengthen the implementation of the PMTCT programme | |
| Medical male circumcision (MMC) | Continue with large-scale rollout of a national MMC programme as part of a package of sexual and reproductive health (SRH) | |
| Other STIs | Prevent, screen, diagnose, and provide early treatment for STIs | |
| Post-exposure prophylaxis (PEP) | Increase knowledge, capacity building among healthcare workers and clients to increase access to and strengthen the implementation of PEP at district level | Increase access to HIV related services (prevention, care, treatment, and support to reduce morbidity and mortality) |
| Expansion of treatment coverage | Initiate all eligible people living with HIV to treatment according to national guidelines to improve their health outcomes and to reduce transmission | |
| Future prevention tools microbicides, pre-exposure prophylaxis (PrEP) | • conduct clinical trials with other potential prevention tools (e.g. microbicides) introduce PrEP to help at risk HIV-negative people reduce their risk of HIV infection by taking a daily pill. Pilot this intervention with selected priority and key populations. PrEP strategies under evaluation in South Africa include daily treatment or intermittent dosing related to risk of HIV exposure, which usually involves the addition of a post-exposure dosage | |
| Behaviour change | Conduct interventions that increase HIV knowledge, change attitudes, and risk perception including education and addressing perceptions of personal risk | Reduce risk behaviour that increase transition to HIV |
| Delayed sexual debut | Develop and conduct tailored prevention interventions for the youth (especially young girls) to facilitate the delay of sexual debut and sustain protective behaviours | |
| Intergenerational relationships | Target prevention strategies at those men and women who have partners much younger/older than themselves, given that significant age discrepancy increases HIV-exposure risk compared to people who reported partners of similar age | |
| Multiple sexual partners | Conduct multi-level interventions that focus on sexual, social, cultural and gender norms and values | |
| Consistence and promotion of condom use | Increase consistent condom use, especially among key populations | |
| Prevention with positives | Ensure that many people know their HIV status, are staged for HIV, and enrolled to treatment and care | |
| Alcohol and substance abuse | Implement interventions to decrease alcohol and other substance abuse, including illegal substances | |
| Heavy burdened health and social systems | • establish systems to link people to care immediately after diagnosis, and support adherence and retention in carebuild capacity of systems and health care providers of clinical care and related services for people affected and infected with HIV | To achieve viral suppression that maximises the benefits of early treatment and reduces transmission risk |
| Stigma and discrimination that increase disparities and inequities | • conduct interventions that address stigma and eliminate discrimination associated with HIV status • provide targeted interventions to priority and key populations that decrease their vulnerability to HIV transmission and eliminate barriers to accessing HIV services | Elimination and reduction of stigma and discrimination |
| Gender roles and norms | Challenge the gender roles, norms and inequities that increase women’s vulnerability to HIV and compromise men’s and women’s health; address the position of women in society, particularly their economic standing; and engage with men on changing socialisation practices | Increasingly co-ordinated national, provincial, district HIV response to reduce disparities and inequities to access and utilisation of HIV related services |
| Sexual abuse and intimate partner violence (IPV) | Implement interventions to prevent gender-based violence (GBV), as well as IPV, and educate men about women’s rights | |
| Mobility and migration | Conduct appropriately targeted interventions for individuals who either have personal migration experience or have sexual partners who are migrants | |
3. THE CONCEPTUAL FRAMEWORK

3.1. THE APPROACH

HIV prevention is central to address the determinants highlighted in Table 1. South Africa is adopting the combination HIV prevention approach, as it is central to achieve the three prevention objectives:

- reduction of direct HIV transmission
- behaviour change
- reduction of morbidity and mortality

This approach uses the social-ecological framework to tailor interventions and to encourage health-seeking behaviour and a collective response towards HIV prevention. Through this strategy, district managers and their teams must ensure active participation and engagement of communities through targeted community dialogues to create an environment that is conducive to reduce HIV transmission and increase access to HIV prevention services to improve HIV outcomes.

3.2. TARGET POPULATIONS

HIV affects all people at a general population level thus the strategy targets the general population in South Africa. However, in line with the stipulations of the NSP and recent evidence, the strategy proposed interventions for specific key, vulnerable, and priority populations as shown in Figure 2.

3.2.1. Girls and young women

By far the highest rate of new HIV infections occurs among AYWG. According to published studies, the incidence of HIV in the population group 15-24 has increased and this can be attributed to several factors such as decreased condom use, increased concurrent multiple partners, low risk perceptions and age disparate relationships (Human Sciences Research Council (HSRC) 2014). The WHO joint review report for HIV, TB, and PMTCT identified increased teenage pregnancy and low integration between TB and HIV.

Therefore, prevention interventions for girls and young women aged 15-24 years must become the highest priority among health authorities and services at every level. Girls and young women include in- and out-of-school youth and are also part of the broader community. Emphasis must be put on those in informal settlements. HIV prevention among girls and young women demands special and innovative attention in terms of national social and behaviour change communication (SBCC) strategies.
3.2.2. Young people who are not attending school

School attendance provides a protective shield against HIV infection; national surveys have shown lower prevalence among learners than their out-of-school peers. Not only do young people lose the protection of the school when they drop out, but the factors causing them to leave school -- poverty, family problems, psychological problems, learning difficulties -- may make them more vulnerable to HIV infection and place them beyond the reach of many health promotion programmes.

3.2.3. People working along national roads and highways (Mobile populations)

The employment conditions in the long-distance road transport sector increases the likelihood of having multiple and concurrent sexual partners in different places and restricts access to healthcare. A package of interventions should be provided at dedicated, accessible HIV and sexual health services for truckers. Health workers should mobilise support from a range of stakeholders, across national borders, to sustain and coordinate such services.

3.2.4. People living in informal settlements in rural and urban areas

HIV prevalence is higher in urban informal settlements than in any other type of residential area, with rural informal areas having the next highest prevalence. Informal settlements usually have poor service provision, few community facilities, and may be quite weakly linked into the economic, cultural, and social mainstream of society. The aim of this package of prevention interventions is to see that access to HIV services is as good as in formal residential areas, that there is effective engagement with whatever community networks exist to promote health, and that there is commitment by leadership to an affirmative HIV prevention agenda for residents of informal settlements.

3.2.5. Migrant populations

Migration is a major feature of our society: migrant labour, migration from rural areas to towns and cities, and migration from beyond our borders. A large number of migrants are single or travel alone (the wives or partners are not accompanying them) and these circumstances often lead to risky sexual practices. The thrust of the package of interventions is providing access to non-discriminatory HIV services and utilising partnerships with migrant networks and relevant Non-government organisations (NGOs) for relevant SBCC activities.

3.2.6. People in the lowest socio-economic groups

This population includes a range of sub-groups who differ in terms of gender, age, physical location and other variables. Many of the poorest South Africans are also members of other key populations for HIV prevention – for example, residents of informal settlements, youth out-of-school, and some migrants. There are great problems in terms of targeting interventions for the lowest socio-economic groups and therefore no specific table is provided in this strategy, because these people fall under different categories.

3.2.7. Uncircumcised men

The proportion of uncircumcised youths and men varies considerably from province to province. The key element in the package of interventions outlined below is the provision of good quality medical services for circumcision. Other vital aspects of the prevention package – such as promoting uptake – depend on this intervention.

3.2.8. People with disabilities

The package focuses on special provisions that are necessary to ensure access to HIV services and information for people with disabilities (PWD), recognising vulnerability to HIV infection often increases where disability creates social and economic dependence.

3.2.9. Men who have sex with men

Men who have sex with men (MSM) is a term that refers to all men who have sex with other men regardless of whether they also have sex with women or define themselves as gay, bisexual or heterosexual. Several studies have shown a combination of high HIV infection risk and poor access to services, largely due to real or perceived discrimination and services being poorly prepared to meet their specific needs. The package of services seeks to address these factors. The evidence for efficacy of PrEP in MSM is strong and there are existing platforms for health care delivery specifically targeted to these high-risk, hard-to-reach populations. For these reasons, roll out of PrEP should be considered in these groups first. Routine HIV counselling and testing should be strongly encouraged in these groups and PrEP or antiretroviral treatment (ART) offered dependent on HIV status.

3.2.10. Sex workers and their clients

Studies have shown that sex workers are at increased risk of HIV infection, and sex work contributes significantly to the onward transmission of HIV. The package centres on ensuring that sex workers have access to HIV prevention services, taking account of the barriers to healthcare, including stigma attached to sex work and the clandestine lifestyle that often accompanies sex work. The evidence for efficacy of PrEP in sex workers is strong and there are existing platforms for healthcare delivery
specifically targeted to these high-risk, hard to reach populations. For these reasons, roll out of PrEP should be considered in these groups first. Routine HIV counselling and testing should be strongly encouraged in these groups and PrEP or ART offered dependent on HIV status.

3.2.11. People who use illegal substances

This prevention package focuses on people who inject drugs (PWID). Injecting drug users often contract HIV through needle-sharing but are also at high risk of contracting HIV because of the link between sex work and injecting drug use and the prevalence of unsafe sex among drug users. The package focuses on comprehensive prevention of HIV, hepatitis and other STIs as well as the management of all these infections.

3.2.12. People who abuse alcohol

Heavy alcohol use is associated with sexual risk-taking, including casual sexual encounters and multiple partnerships. Heavy drinkers and binge drinkers have higher HIV prevalence than those who refrain from such patterns of drinking. The package of services focuses on raising awareness of how alcohol misuse exposes individuals to HIV infection, taking prevention outreach to bars and clubs, and providing services for HIV prevention and management of excessive drinking.

3.2.13. Transgender persons

The HIV prevention and SRH needs of transgender persons are not widely understood in the health services. The package focuses on increasing access to services for transgender individuals and enabling the services to respond more sensitively and effectively to their needs.

3.2.14. Orphans and other vulnerable children and youth

This sub-population represents a targeting challenge. Programmes focused on the overall psycho-social care of orphans and vulnerable children (OVC) present the strongest opportunity to reach and counsel them on HIV prevention measures. The utilisation of social protection measures is essential to break the cycle of vulnerability and infection.

3.2.15. Pregnant women and infants

Given the high rate of HIV in women of childbearing age, improvements to prevention of mother-to-child transmission (PMTCT) services must be sustained and extended. In addition, PMTCT services need to be aligned with the implementation of the new Contraception and Fertility Planning Policy and Guidelines (Department of Health, unpublished) to ensure that women living with HIV can avoid unwanted pregnancies, plan their families and safeguard their health.

3.2.16. People living with HIV

The package rests on people living with HIV (PLHIV) knowing their status, accessing ART where eligible (because ART is both an effective treatment for AIDS and it provides effective protection for HIV-negative sex partners), and accessing the psycho-social support that enables them to avoid re-infection and prevent the onward transmission of HIV to their partners and children.

3.2.17. Serodiscordant couples

Central to this package of services is the creation of an enabling environment for disclosure of HIV status within steady relationships and counselling services to support disclosure. These are combined with standard HIV prevention services as well as access to ART for the positive partner, where eligible.

3.2.18. People with tuberculosis

The HIV and tuberculosis (TB) epidemics feed off each other. Each lowers the immune response of infected individuals and makes them more susceptible to the other infection. Therefore, better control of TB is in itself a measure to reduce new HIV infections.

3.2.19. Survivors of sexual abuse and gender-based violence

The incidence of sexual assault and gender-based violence (GBV) in South Africa is among the highest in the world and exacerbates the HIV epidemic. The package of services combines strengthening healthcare for survivors – including PEP – with advocacy to increase reporting of sexual and gender-based violence, improve uptake of PEP and mobilise community opinion against GBV in particular, but also against all discriminatory treatment of women.

3.2.20. Detainees

The package rests on the recognition that sexual activity, including coercive sex, is a reality of prison life. It seeks to ensure that essential HIV prevention services and interventions are available in prison environments and that there is managerial and political commitment to safeguarding the health of prisoners.
3.2.21. Young people in school or tertiary education institutions

Keeping young people in high school or tertiary education is in itself a strategic HIV prevention intervention. In addition, the package seeks to leverage the learning environment to increase HIV awareness and risk-reduction behaviours among young people, and provide access to health services through schools and educational institutions.

3.3. MOST-AT-RISK OR KEY POPULATIONS

The UNAIDS Investment Framework (2011, p. 5) has defined the role of social and program enablers, and synergies with development sectors to enhance effectiveness of the proposed interventions by target population. Programme enablers include community-centred planned, designed and delivered interventions; programme communication; management and incentives; procurement and distribution; and research and innovation. The social enablers include political commitment and advocacy; laws, legal policies and practices; community mobilisation; stigma reduction; mass media and local responses to change risk environment. The synergies with other sectors include social protection; education; legal reform for gender equality; prevention of GBV; poverty reduction; and strengthened health and community systems and employer practices.

Although South Africa has a generalised HIV epidemic, some sub-populations are at a higher risk of being HIV infected or transmitting HIV and the burden of disease is not the same in all areas. It is therefore, important to make sure that HIV prevention services in each district are tailored to the specific needs of these groups based on a comprehensive package of appropriate interventions. This strategy aims to educate healthcare workers (HCWs) not only on the needs of the general population, but also on the HIV prevention needs of these sub-populations.

As articulated in the NSP 2012-16, it is crucial to include key populations in the HIV prevention intervention programmes in order to make an impact. Throughout the world, the HIV prevalence is substantially higher among key populations as compared to the general population. In South Africa, evidence shows that key populations are greatly affected by HIV and that they account for a disproportionate number of new HIV infections, thereby indicating that HIV prevention interventions to date have not reached and benefited these individuals. HIV prevalence in these groups has been measured to be much higher than the general South African population as demonstrated in Table 2.

Table 2. HIV prevalence of key populations in South Africa

<table>
<thead>
<tr>
<th>POPULATION GROUP</th>
<th>HIV PREVALENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>General population (men and women, 15-29 years)</td>
<td>17%</td>
</tr>
<tr>
<td>Men who have sex with men</td>
<td>10% - 50%</td>
</tr>
<tr>
<td>Sex workers</td>
<td>40% - 69%</td>
</tr>
<tr>
<td>People who inject drugs</td>
<td>3% - 35%</td>
</tr>
<tr>
<td>Inmates</td>
<td>19% - 41%</td>
</tr>
</tbody>
</table>

It has been demonstrated that national efforts to reach zero new HIV infections, zero stigma and zero AIDS related deaths may be achieved through the explicit commitment to addressing the HIV prevalence among key populations as part of South Africa’s response to HIV.

3.3.1. Sex workers’ programme

Sex worker (SW) community mobilisation and engagement should be achieved through the establishment of local (community-based) sex worker-led organisations. Peer-led engagement activities should be used to mobilise SWs and link them with SW organisations, engagement platforms, and relevant services. Support for the establishment and maintenance of sex work-focused organisations should be established to facilitate knowledge and skill sharing, as well as capacity building.

Service provision should include a minimum package of comprehensive sex worker-focused services, inclusive of HIV/TB/STI and condom distribution, sexual and reproductive health, psychosocial and justice-related services and peer education. The composition of the package of services, and mode of delivery should be contextually determined according to characterisation of the sex work, including street-based or brothel-based SWs, hotel escorts, and other high transmission areas (HTAs).

Sensitisation of service providers - all implementers should be sensitised (including health workers, security and justice service providers) around sex work, SW vulnerability and the role service providers can play in assisting people to realize their Constitutional Rights and justice. All commodities should be made easily available.

Advocacy efforts should be focused on deepening society’s awareness of sex work and the effects of marginalisation and prejudice through a combination of communication and advocacy methods, including human rights awareness.
campaigns, activities in support of defending human rights violations and a decriminalisation campaign.

**Health systems strengthening** should occur through human resource capacity development, commodity procurement, and quality assurance activities.

**Strategic information** should inform programme development and adjustments. These data should be obtained from monitoring and evaluation, surveillance, research and quality assurance activities.

South Africa has also committed to act upon international declarations that refer to addressing the needs of the key populations, specifically the UN Declaration of Commitment to HIV/AIDS (UNGASS) and the recent Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS.

### 3.4. THE DRIVERS OF THE STRATEGY

To succeed with the implementation of the Strategy several drivers are required as reflected in Figure 2.

**Figure 2. Key Drivers for Accelerated HIV Prevention**

### 3.5. REQUIREMENTS FOR IMPLEMENTATION

Although health sector managers will be the primary implementers of the Strategy, they will work with other sectors to deliver the biomedical, socio-behavioural and structural Figure 3 describes the responsibilities of district managers.

**Figure 3. Responsibilities of District Managers**

1. Understanding the nature of their districts’ or subdistricts’ HIV epidemic to prioritize the delivery of HIV prevention packages that match local patterns of HIV and TB transmission.

2. Knowledge of guidelines and policies that support an enabling environment for implementation of different interventions (e.g. HCT, VMMC, TB screening and treatment).

3. Awareness that not all priority or key populations feature strongly in every district. Therefore, they need to exercise judgment about where to invest their efforts.

4. Preparedness to work with all stakeholders (community leaders, government departments, the private sector, non-governmental organizations [NGOs], community-based organizations [CBOs], the religious sector, local media and KPs).
3.6. CAPACITY BUILDING

In order to have a workforce that is fully equipped to provide a comprehensive package of HIV prevention and high-quality services, staff should receive training as needed to improve their ability to provide such services to their communities. This should be done by knowledgeable staff who maintains confidentiality, who avoid discrimination, and who are responsive to the needs of local KPs.

A capacity building approach will enhance and contribute to the delivery of sustainable quality services, which, in turn, will ensure that the set goals are achieved.

At operational level, the following must be addressed:

- Ensure that all workers have job descriptions and that a performance management system is in place
- Implement infrastructural and operational plans that support programme management and accountability
- Establish systems that function across different organisations and departments
- Implement and support use of policies and guidelines

Capacity building should ensure that HCWs have the skills to:

- conduct risk assessments of the key drivers in communities
- conduct risk assessments on individual users of health services
- advise on HIV prevention, screening, and treatment
- advise on TB screening, diagnosis and treatment
- advise on STI prevention, screening, and treatment

In addition, HCWs should be able to combine elements of the biomedical, socio-behavioural, and structural interventions to create effective HIV prevention packages:

- conducting targeted HTS, using the right modality in the right place and for the right population
- educating and encouraging consistent and correct condom use
- developing health-seeking behaviour among clients, including regular testing
- developing protective changes in behaviour, including non-concurrent sexual partnerships and safe injecting practices
- encouraging uptake of MMC
- preventing mother-to-child transmission
- using treatment as prevention

3.7. COMMUNITY PARTICIPATION AND COLLABORATION

Through the strategy, communities should be educated on the availability of HIV prevention services. The DoH will work with its partners, including communities, to increase the reach and utilisation of HIV prevention services.

The DoH will collaborate with other sectors to address structural enablers of HIV acquisition. Collaboration with other sectors will also ensure that rights are not violated when interventions are implemented and that discrimination based on HIV and TB is reduced and, ultimately, eliminated.
SECTION B: IMPLEMENTATION GUIDE

The strategy has drawn on priorities and evidence-based interventions identified in the National Strategic Plan for HIV 2012 - 2016. It has selected from these and "mixed" them together to form different combination prevention packages for addressing the specific needs of different key populations. The strategy acknowledges that addressing micro-epidemics including hotspots is critical for the success of the programme.

1 COMBINATION PREVENTION INTERVENTIONS

1.1 INTERVENTIONS FOR THE GENERAL POPULATION

The outcomes expected from a package of prevention interventions for the general population include:

- reduction of HIV transmission and risky behaviours
- strengthened treatment cascade
- reduction of HIV morbidity and mortality
- reduction of stigma and discrimination.

A minimum core package of combination prevention interventions for adult male and females of reproductive age should include:

- PMTCT
- MMC
- HTS and linkages to care and treatment
- ART, adherence, and viral load monitoring
- Condom promotion
- STI and TB screening and management
- PEP

Additional combination prevention interventions for adults in the general population are depicted in Figure 4.

FIGURE 4. COMBINATION PREVENTION PACKAGES FOR ADULTS
1.2 INTERVENTIONS FOR PRIORITY POPULATIONS

Interventions for specific priority key populations are shown on the following pages.

Undircumcised men

**Objective:** Provision of good quality medical services for circumcision

**Characteristics:**
- Men reporting not to be circumcised

**Predisposing factor:**
- Being uncircumcised is associated with higher HIV-infection risk

**Important to note:**
- Men who reported having been circumcised were significantly less likely to be HIV positive

**Intervention**

**Actions**
- Increase access to VMMC services at public health facilities and include capacity building
- Partner with competent organisations that offer VMMC services to increase access
- Educate men undergoing circumcision and their partners to continue using condoms
- Incorporate VMMC messages in general health messages
- Engage and involve traditional male circumcision schools and traditional leaders

**Responsible agencies**
- DOH
- DOH
- CBCs
- DOH
- VMMC partners

FIGURE 5. INTERVENTIONS FOR UNCIRCUMCISED MEN
**Figure 6. PHDP Interventions**

- **Biomedical**
  - Screen for TB and STIs and provide treatment according to guidelines
  - Offer vaccination against hepatitis B and the human papilloma virus (HPV) in women who are eligible
  - Provide support for disclosure
  - Provide care and treatment services in a manner that is responsive to the needs of PHDP, e.g., multi-month scripts and later clinic hours
  - Keep registers of PHDP on and not on ART
  - Provide HIV services in a non-discriminatory manner

- **Social-Behavioural**
  - Raise awareness among PHDP about risks of re-infection
  - Promote awareness about options for safe pregnancy to women living with HIV
  - Include information about serodiscordancy in community-level HIV education campaigns
  - Integrate efforts to re-educate stigma attached to PHDP
  - Educate PHDP about their rights and promote access to HIV prevention and treatment services

- **Structural**
  - Engage national and local organisations servicing the interest of PHDP in developing or implementing a strategy for positive health, dignity, and prevention at facility level
  - Involve PHDP in programme formulation and implementation
  - Support the running and establishment of various types of support

**Responsible agencies**

- **DOH**
- **CBOs**
Figure 7. Interventions for Pregnant Women/New Mothers and Their Unborn/Newborn Babies

**Biomedical**
- Screen for TB and STIs and provide treatment according to guidelines
- Offer vaccination against hepatitis B and the human papilloma virus (HPV) in women who are eligible
- Provide support for disclosure
- Provide care and treatment services in a manner that is responsive to the needs of PHDP e.g. multi-month scripts and later clinic hours
- Keep registers of PHDP on and not on ART
- Provide HIV services in a non-discriminatory manner

**Socio-Behavioral**
- Raise awareness among PHDP about risks of re-infection
- Promote awareness about options for safe pregnancy to women living with HIV
- Include information about sero-discordancy in community-level HIV education campaign
- Integrate efforts to re-educate stigma attached to PHDP
- Educate PHDP about their rights and promote access to HIV prevention and treatment services
- Provide information, education and communication (IEC) materials on how to live positively with HIV. The IEC materials must be of appropriate literacy level

**Structural**
- Engage national and local organisations servicing the interest of PHDP in developing or implementing a strategy for positive health, dignity and prevention at facility level
- Involve PHDP in programme formulation and implementation
- Support the running and establishment of various types of support
FIGURE 8. INTERVENTIONS FOR OUT-OF-SCHOOL YOUTH
FIGURE 9. INTERVENTIONS FOR IN-SCHOOL OR TERTIARY YOUTH
FIGURE 11. INTERVENTIONS FOR PEOPLE WITH TB
1.3 INTERVENTIONS FOR VULNERABLE POPULATIONS

Vulnerable populations are groups of people who are vulnerable to HIV infection at certain times. These populations need honed interventions to address their risk.

FIGURE 12. SPECIFIC INTERVENTIONS FOR VULNERABLE POPULATIONS
FIGURE 13. INTERVENTIONS FOR AYWG
FIGURE 14. INTERVENTIONS FOR OVC
FIGURE 15. INTERVENTIONS FOR PWD
FIGURE 16. INTERVENTIONS FOR SURVIVORS OF SEXUAL ABUSE AND GBV
Figure 17. Interventions for Mobile Populations

Vulnerable Populations

Mobile Populations

Objective: Dedicated, accessible HIV and sexual health services for truckers and other transient workers

Characteristics: Usually truckers and other transient workers

Predisposing factor: Employment conditions in the long-distance road transport sector increase the risk of multiple and concurrent sexual partners and restrict opportunities to accessing health care

Important to note: A percentage of long-distance truckers is sex worker (SW) clients

Intervention

Biomedical
- Ensure that all mobile populations and SWs are aware of their nearest high-transmission area (HTA) sites for the provision of HIV prevention and treatment services

Socio-Behavioural
- Facilitate community engagement on the risks of living in an HTA
- Orientate communities about available services for KPs

Structural
- HTA sites should provide education on HIV prevention and treatment services
- Form health-promotion and HIV-prevention partnerships with the road freight industry and other relevant industries

Actions

Responsible agencies

- DOH

Department of Transport
- DOH
- Unions
- Employers
- Department of Transport

FIGURE 17. INTERVENTIONS FOR MOBILE POPULATIONS
Figure 18. Interventions for Migrant Populations

**Vulnerable Populations**

**Migrant populations**

**Objective:** Access to non-discriminatory HIV prevention and treatment services

**Characteristics:**
- Includes internal migrant populations (people that have moved from one part of South Africa to another) and cross-border migrant populations (people that have moved to South Africa from another country)

**Predisposing factor:**
- The conditions associated with migration increase the risk of acquiring HIV

**Important to note:**
- Approximately 3% of people living in South Africa are estimated to be cross-border migrants

### Intervention

**Biomedical**
- Refer to Figure 4: Combination HIV Prevention Interventions
- DOH

**Socio-Behavioural**
- Utilize informal networks to spread messages on HIV prevention and care
- Empower migrant communities to liaise with health service providers and health services
- Undertake behaviour change communication to promote health-seeking behaviour and HIV risk-reduction behaviours
- Educate communities and HIV prevention service providers on the rights of migrant populations
- Have available IEC material and mobilization activities targeted at migrant populations in appropriate languages respecting cultural nuances
- Department of Home Affairs (DHA)
  - Community leaders
  - Community radio stations

**Structural**
- Ensure provision of non-discriminatory services to migrant populations
- Ensure that the rights of migrant populations are respected in the provision of HIV prevention and care services
- Establish networks with stakeholders (CBOs, employers, schools) that engage with migrant populations to ensure coordinated provision of HIV services
- Ensure that South Africa’s policy on migrants is upheld
- Ensure engagement of CBOs in working as partners in the provision of efficient, rights-based HIV services to migrant populations
- Ensure that the migrants are aware of health care facilities near them
- Department of Labour (DOL)
- DHA
- SAPS
- Department of Transport
FIGURE 19. INTERVENTIONS FOR PEOPLE LIVING IN INFORMAL SETTLEMENTS AND PEOPLE OF LOW SOCIO-ECONOMIC STATUS
Figure 20. Interventions for Serodiscordant Couples

- **Biomedical**
  - Provide competent screening services for HIV, TB and STIs to couples
  - Provide treatment services to couples
  - Strengthen couple counselling
- **Socio-behavioural**
  - Include information on serodiscordancy in community-level HIV education campaigns
  - Provide IEC material on serodiscordancy
  - Educate communities at large on HIV in serodiscordant couples
  - Educate serodiscordant couples on HIV prevention
  - Educate couples on the availability of PEP and the impact of viral load
  - Educate positive partners on the serious risks of HIV infection to their partners
  - Provide information on options for safe pregnancy
- **Structural**
  - Design programmes for supporting partner disclosure
  - Provide psychosocial support and referral to additional support services

**Responsible agencies**
- DOH
- DOH
- CBOs
- DOH
Figure 21. Interventions for Detained Populations

VULNERABLE POPULATIONS

Detained populations

Objective: Access to critical HIV prevention services

Characteristics: Inmates in correctional settings, deportees in detention centres, people in police holding cells, juveniles in juvenile detention centres

Predisposing factor: Violence, particularly sexual violence, commonly affects detainees and increases the risk of HIV acquisition and transmission

Important to note: Research has identified disproportionately higher levels of HIV and TB among prisoners compared with the general population

Intervention

BIOMEDICAL

• Provide ART services in correctional centres
• Provide MMC services
• Provide lubricants
• Promote consistent screening of TB and STIs and other opportunistic infections in correctional centres

SOCIO-BEHAVIOURAL

• Ensure provision of HIV prevention and education, including care and support to detainees
• Educate correctional centre populations about the risks of HIV acquisition and transmission in correctional centres
• Undertake behaviour change communication to increase sexual risk-reduction behaviour among detainees
• Ensure peer-based activities

STRUCTURAL

• Support NGOs that provide health services to provide comprehensive HIV prevention education in detention centres, particularly correctional services
• Advocate for programmes that eradicate stigma, discrimination and violence in detention settings
• Ensure availability of HIV prevention, care, treatment and support programmes for PHDP in correctional services
• Advocate for the establishment of support services for victims of sexual assault and PHDP in correctional services
• Advocate for the health and welfare of populations in different correctional services

Actions

Responsible agencies

• DOH
• Department of Correctional Services (DCS)

• DOH
• CBOs
• DHA
• DCS

Refer to the figure for more detailed information on interventions and responsible agencies.
1.4. INTERVENTIONS FOR MOST-AT-RISK POPULATIONS

**Figure 22. Interventions for Most-At-Risk Populations**

**Figure 23. Interventions for MSM**
FIGURE 24. INTERVENTIONS FOR TRANSGENDER PEOPLE
FIGURE 25. INTERVENTIONS FOR SEX WORKERS AND THEIR CLIENTS
FIGURE 26. INTERVENTIONS FOR PEOPLE WHO USE ILLEGAL SUBSTANCES
Figure 27. People Who Abuse Alcohol

**Objective:** Access to HIV services

**Characteristics:** People who consume excessive alcohol

**Predisposing factor:** Heavy alcohol use is associated with risky sexual behaviour

**Important to note:** Heavy drinkers and binge drinkers have higher HIV prevalence than people who refrain from such patterns of drinking

**Intervention**
- Biomedical
  - Promote appropriate biomedical interventions
  - Refer to Figure 4: Combination HIV Prevention Interventions

- Socio-behavioural
  - Create demand for HIV prevention services among people that abuse alcohol
  - Empower people that abuse alcohol to access and utilize health services
  - Create awareness about the dangers of alcohol abuse and the associated risks of HIV infection
  - Design community awareness programmes that promote behaviour change

- Structural
  - Ensure availability of programmes targeting alcohol abusers
  - Link alcohol abusers to drug abuse centres/programmes
  - Strengthen linkages to counselling and referral

**Actions**
- Responsible agencies
  - DOH
  - CSOs
  - Taverns and other businesses that provide alcohol
  - DOH
  - DSD
2. MONITORING, EVALUATION, RESEARCH, AND INNOVATION

2.1. INDICATORS

Monitoring and evaluation are essential components of programme implementation. A plan would not be complete without a set of core indicators that could be used to determine progress towards goals. Below is a set of core indicators meant to assess the reach of HIV prevention programmes among general and targeted sub-populations. Some of the indicators are routine, while some can only be collected through special structural and socio-behavioural surveys conducted periodically among the general or special populations.

The indicators below are adapted from the NSP, provincial business plans and from the Global AIDS Response Progress Report (2013). The main aim of designing indicators is to ensure that decision makers, key stakeholders, and key implementers have useful, feasible, and relevant information to help them manage and implement their sectors’ responses to the HIV epidemic effectively. District managers are encouraged to monitor data from routine and non-routine indicators closely and give feedback to relevant stakeholders, including the targeted populations, as a way of generating demand for services and for strengthening advocacy with leaders and other stakeholders.

**TABLE 3. CORE INDICATORS FOR HIV PREVENTION PROGRESS REPORTING**

![Table 3. Core Indicators for HIV Prevention Progress Reporting](image-url)
5. BUDGETING

Costs for HIV prevention should be built into provincial and district business plans. The HIV conditional grant will be the primary source of funding for the Health Sector HIV Prevention Strategy. Costing our strategies is an important part of programme implementation. This allows the manager to establish what resources are available and how to best utilise them for maximum effect. In the same way, the costing of prevention activities, prioritising and allocating sufficient resources for their implementation, is a critical component of HIV prevention programming. Within HIV prevention, cost analysis has the potential to help managers at district level decide on the most appropriate way to deliver a particular strategy.

The following figures provide guidance on how to budget for HIV prevention interventions.

TABLE 4. COSTING (TO BE INCORPORATED INTO BUSINESS PLANS)

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Factors that need to be budgeted for</th>
<th>Tips to district managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HTS</td>
<td>• Facility targets for HTS</td>
<td>• Inform the number of test kits to procure</td>
</tr>
<tr>
<td>2. MMG</td>
<td>• Targets for facilities rendering the service</td>
<td>• Consider different key populations when developing targets</td>
</tr>
<tr>
<td>3. Condoms</td>
<td>• See the condom distribution plan for male and female targets for districts</td>
<td>• Determine primary and secondary distribution points in line with priority groups</td>
</tr>
<tr>
<td>4. Meetings</td>
<td>• Identify local leaders (leaders from different sectors)</td>
<td>• Determine social marketing of male and female condoms</td>
</tr>
<tr>
<td>5. Community</td>
<td>• List the groups to target and topics to discuss</td>
<td>• Brainstorm innovative ways of promoting condom use in districts</td>
</tr>
</tbody>
</table>

TABLE 5. COSTING (CONTINUED)

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Factors that need to be budgeted for</th>
<th>Tips to district managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. IEC</td>
<td>• Decide on the most effective types of IEC material in districts</td>
<td>• Ensure all groups are targeted when developing IEC material</td>
</tr>
<tr>
<td>7. Mass media</td>
<td>• Determine the type of mass media to be used (newspaper, TV, radio)</td>
<td>• Use appropriate language and literacy levels</td>
</tr>
<tr>
<td>8. Staff</td>
<td>• Determine category of staff to be trained</td>
<td>• Use the most effective types of IEC material</td>
</tr>
<tr>
<td>9. Staff</td>
<td>• Determine number of staff to be trained</td>
<td>• Ensure that all groups are targeted when developing IEC material</td>
</tr>
</tbody>
</table>

...
6. QUALITY ASSURANCE

Quality assurance (QA) has to be viewed as a process of assessing the extent to which HIV prevention services are responsive to the needs and priorities of the community and key populations.

The following are the general national standards operating procedures for QA of HIV prevention that must be followed by all service providers:

- train all HCWs in all aspects of HIV prevention
- ensure that training is provided by accredited service providers and certificates are issued
- conduct on-going and regular training to ensure that quality services are provided
- assess staff performance to ensure high-quality prevention services
- conduct QA on all commodities according to the national standards
- adhere to national policies, regulations, guidelines, and statutes
- ensure effective coordination and collaboration between stakeholders and the DOH and formal memoranda of agreement must be in place
- assess HIV rapid test kits for validity and reliability according to national protocol
- ensure that quality counselling is provided
- ensure that clients have signed consent forms
- maintain and adhere to clients' confidentiality and privacy
- be considerate and respect clients' cultures, language, gender, sexual orientation, and ages
- always make risk-reduction material available to clients
- initiate client satisfaction assessments to get feedback for the improvement of services
- ensure that IEC material and messaging is appropriate for clients. These must be reviewed and approved for distribution and use
- offer HIV services in settings that are acceptable and accessible to target populations
- establish a proper referral system to ensure continuity of care
- ensure sound information and data management to assist in programme evaluation.
- procure supplies regularly to ensure an uninterrupted supply of equipment
- adhere to infection prevention and control protocols at all times to ensure that universal precautions are in place and disposal of medical waste is managed properly
REFERENCES


APPENDIX 1: PREP AS A PREVENTION INTERVENTION

PrEP refers to antiretroviral medicines that are taken by an HIV-negative person before exposure or possible exposure to HIV in order to prevent HIV infection. PrEP strategies under evaluation include daily treatment or intermittent dosing related to risk of HIV exposure which usually involves the addition of a post-exposure dosage.

There is increasingly compelling evidence from a number of multi-centre, randomised, controlled trials that antiretroviral therapy taken by HIV negative people who are at high risk of HIV infection can significantly reduce their risk of HIV acquisition.

The strongest evidence of protection against HIV infection is seen among high risk heterosexual men, in men who have sex with men, and in discordant couples. The data from studies on the effectiveness of oral PreP in heterosexual women are inconsistent: some showed protection while others showed no protection. Varying adherence, varying levels of genital inflammation and suboptimal vaginal tenofovir levels were postulated as possible reasons for this inconsistency in protection. The World Health Organization's Consolidated Guidelines On HIV Prevention, Diagnosis, Treatment And Care For Key Populations (July 2014) recommends the use of PrEP ‘as an additional HIV prevention choice within a comprehensive HIV prevention package for men who have sex with men’.

Studies have examined daily, intermittent and pre-coital administration of oral antiretrovirals. The majority of studies have shown a significant protective benefit (44% - 75%) from PrEP against HIV infection. Adherence to PrEP does not need to be perfect to be effective, but the protective effect is greatest in those who are most adherent to the treatment regimen. Adherence to PrEP appears to be highest in people who self-identify as at highest risk. Lack of effectiveness is most commonly associated with evidence of poor adherence. In summary when PrEP is taken, it works effectively to prevent HIV infection even in those at very high risk of infection.

The roll out of PrEP for the generalised population requires further consideration and more evidence of its effectiveness. PrEP is not likely to be for everyone, nor is it likely to be forever rather it will be part of the lifecycle of options for combination HIV prevention and used when an individual is engaged in high risk sexual behaviour.

Other forms of PrEP (topical gels for vaginal or rectal use, depo-injections and intravaginal rings are also in development.

There is no evidence from current trials that PrEP use leads to risk compensation (i.e. more frequent high HIV risk behaviour and reduced condom use), with no increase in self-reported risky behaviour or of unintended pregnancy. However, PrEP should always be included as part of a comprehensive package of combination HIV prevention and repeated advice on reducing number of partners, reducing risky sexual practices, correct and consistent condom use, medical male circumcision and post-exposure prophylaxis should be given to those on PrEP, as well as adherence counselling. Regular HIV tests repeated every one to three months depending on risk profile should be a condition for continued PrEP.

Development of antiretroviral resistance from PrEP is very rare, with only a small number of reports from people who had or developed acute HIV infection at the time they were started on PrEP.

PrEP is well tolerated. In most RCT studies of PrEP, rates of death, serious adverse events, and laboratory abnormalities (including renal dysfunction) were low and not significantly different between those taking PrEP and those taking placebo. There is no evidence in systematic reviews or from pregnancy registers of any problems with tenofovir.

Herpes Simplex Virus 2 (HSV-2) Prevention: A number of studies have also demonstrated the added benefit of reducing HSV-2 infection rates, which may enhance the HIV protective effect of PrEP given that HSV-2 is a risk factor for HIV & also given the limited HSV-2 prevention interventions.

Cost: Currently there is a lack of data on cost and cost-effectiveness of PrEP and of the cost of scaling up national programmes. The population impact of national scale up of PrEP in high risk populations is not yet known. The main cost driver in South Africa will be ongoing monitoring with regular HIV testing and adherence support, provided that drug costs can be minimised if Truvada can be licensed by Gilead to generic manufacturers for this indication. Different models of HIV testing such as household, community and self-testing will need to be researched as a priority.
MSM and Sex workers: The evidence for efficacy of PrEP in sex workers and MSM is strong. Two recent randomised control trials of PrEP in MSM were halted early because of the overwhelming effect of PrEP in preventing HIV and there are existing platforms for health care delivery specifically targeted to these high-risk, hard to reach populations. For these reasons, roll out of PrEP should be considered in these groups first. Routine HIV counselling and testing should be strongly encouraged in these groups and PrEP or ART offered dependent on HIV status. PrEP is an intervention of proven efficacy and as such could be considered an issue of occupational safety for sex workers, like a safety helmet for building site workers.

Girls and young women: The next priority group at high risk of HIV infection is girls and young women but there are still many unanswered questions regarding identification of those at risk (risk profiling or targeting those living in high transmission areas), risk perception of the client, and delivery mechanisms. Roll-out should be planned to carefully evaluate the optimal service delivery platform and adherence support mechanisms, likely to be linked to SRHR services within adolescent and youth friendly clinics. However the ability to deliver services through the school health programme, especially Grade nine to ten, should be examined in order to prevent the high risk of HIV transmission in this vulnerable population.

People who inject drugs (PWID): The extent of intravenous drug use in South Africa is not yet known and harm reduction services for PWID are in their infancy. Currently there are no civil society bodies representing the needs of PWID. This group should be considered for PrEP once services are in place to meet their needs.

Discordant couples: Studies looking at discordant couples in South Africa have been challenging because difficulty in finding discordant couples in long-term relationships (e.g. Partners PrEP study) and bringing partners together for testing, counselling and preparation for PrEP. Testing of partners should be encouraged and PrEP may play an important role in ensuring safer conception and in acting as an added protection for the HIV negative partner until the positive partner is virally suppressed on ART.

Pregnant women: Could be considered as a special subgroup of discordant couples. They are in regular contact with health services and can be closely monitored. There is a potential double benefit from preventing HIV infection for both mother and baby, so may be an appropriate addition to PMTCT services where the mother is found to be HIV negative and in an ongoing sexual relationship with an HIV positive partner.

Other risk groups: There is evidence that prison inmates have a higher risk of HIV than the general population and that some acquisition occurs during incarceration. However, identification of those who would benefit most from PrEP is unknown and requires further study. UNODC are studying the role of PrEP in HIV prevention in prisons. Similarly the evidence for increased risk among certain labour groups such as miners, migrant workers, truck drivers etc is insufficient to recommend targeted PrEP in these groups.
**MSM and Sex workers:** The evidence for efficacy of PrEP in sex workers and MSM is strong. Two recent randomised control trials of PrEP in MSM were halted early because of the overwhelming effect of PrEP in preventing HIV. There are existing platforms for health care delivery specifically targeted to these high-risk, hard to reach populations. For these reasons, roll out of PrEP should be considered in these groups first. Routine HIV counselling and testing should be strongly encouraged in these groups and PrEP or ART offered dependent on HIV status. PrEP is an intervention of proven efficacy and as such could be considered an issue of occupational safety for sex workers, like a safety helmet for building site workers.

**Girls and young women:** The next priority group at high risk of HIV infection is girls and young women but there are still many unanswered questions regarding identification of those at risk (risk profiling or targeting those living in high transmission areas), risk perception of the client, and delivery mechanisms. Roll-out should be planned to carefully evaluate the optimal service delivery platform and adherence support mechanisms, likely to be linked to SRHR services within adolescent and youth friendly clinics. However the ability to deliver services through the school health programme, especially Grade nine to ten, should be examined in order to prevent the high risk of HIV transmission in this vulnerable population.

**People who inject drugs (PWID):** The extent of intravenous drug use in South Africa is not yet known and harm reduction services for PWID are in their infancy. Currently there are no civil society bodies representing the needs of PWID. This group should be considered for PrEP once services are in place to meet their needs.

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