Western Cape Government
Health and Wellness
FOR YOU

Provincial Implementation Plan for the National Strategic Plan on HIV, TB and STI's

2023 - 2028

Table of Contents

LIST OF TABLES

LIST OF FIGURES

ABBREVIATIONS AND ACRONYMS

ABT	Area Based Team
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
AGYW	Adolescent Girls and Young Women
AYP	Adolescents and Young People
CBO	Community-based Organisation
CDC	Community Day Centre
CHC	Community Health Centre
COPC	Community Oriented Primary Care
CSE	Comprehensive Sexuality Education
CSSS	Clinical Sentinel Surveillance System
DHIS	District Health information System
DMOC	Differentiated Model of Care
DoH&W	Department of Health & Wellness
DSD	Department of Social Development
eHealth	Electronic Health
FET	Further Education and Training
HBV	Hepatitis-B Virus
HCV	Hepatitis-C Virus
HCW	Healthcare Worker
HEI	Higher Education Institution
HIV	Human immunodeficiency Virus
HPV	Human Papillomavirus
GBV	Gender-based Violence
GDPR	Gross Domestic Product Rate
GUS	Genital ulcer syndrome
GW	Genital warts
IEC	Information and Education Communication
IPC	Infection Prevention and Control

LAP	Lower abdominal pain
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer
LTF	Lost to follow-up
MDR-TB	Multi-Drug Resistant Tuberculosis
mHealth	Mobile Health
MSM	Men who have sex with men
MTEF	Medium-Term Expenditure Framework
M&E	Monitoring and Evaluation
NCD	Non-Communicable Disease
NGO	Non-Governmental Organisation
NHLS	National Health Laboratory System
NPA	National Prosecuting Authority
NPO	Non-Profit Organisation
NSP	National Strategic Plan
PCAT	Provincial Council on AIDS & TB
PEP	Post-Exposure Prophylaxis
PEPFAR	United States President's Emergency Plan For AIDS Relief
PHC	Primary Health Care
PIP	Provincial Implementation Plan
PLHIV	Persons Living with HIV
POCS	Department of Police Oversight and Community Safety
PPE	Personal Protective Equipment
PrEP	Pre-Exposure Prophylaxis
PWTB	Persons with Tuberculosis
PWUD	Persons Who Use Drugs
RMC	Resource Mobilization Committee
SALGA	South African Local Government Association
SANAC	South African National AIDS Council
SAPS	South African Police Service
SASSA	South African Social Security Agency
SGBV	Sexual and Gender-based Violence

SPV	Single Patient Viewer
STI	Sexually Transmitted Infection
TB	Tuberculosis
THP	Traditional Health Practitioner
TPT	TB Preventive Therapy
TUTT	Targeted Universal TB Testing
TVET	Technical and Vocational Education and Training
UBPL	Upper Bound Poverty Line
ULAM	Urine Lipoarabinomannan
UHC	Universal Health Coverage
UNAIDS	The Joint United Nations Programme on HIV and ADIS
VDS	Vaginal discharge syndrome
VL	Viral Load
VMMC	Voluntary Medical Male Circumcision
WCED	Western Cape Education Department
WOGA	Whole of Government Approach
WOSA	Whole of Society Approach
XDR-TB	Extremely Drug Resistant Tuberculosis

ACKNOWLEDGEMENTS

The Provincial Council on AIDS & TB is mandated to bring together government, civil society and other stakeholders to provide a comprehensive response to the public health challenges of HIV, TB and STIs. In alignment with the NSP for HIV, TB and STIs 2023 – 2028, this Provincial Implementation Plan positions people and communities at the centre of the response effort and was developed through multiple consultations and engagements at various levels with a range of stakeholders.

This plan has benefited from the commitment and rich contributions of several partners, government departments and civil society groups and organisations. Special appreciation goes to the following groups for their contributions and dedication to the process:

- All participants in the consultations and engagement sessions.
- The members of the Provincial Council on AIDS & TB (PCAT), including the Western Cape Civil Society Forum.
- The members of the Western Cape Programme Review Committee and the Western Cape Resource Mobilisation Committee.
- The Western Cape PCAT Secretariat.

EXECUTIVE SUMMARY

This Provincial Implementation Plan (PIP) aims to give effect to the strategic goals and objectives as outlined in the National Strategic Plan for HIV, TB and STIs 2023 – 2028. HIV, TB and STIs remain public health threats and as such requires a comprehensive and timely response that is multi-sectoral in nature and includes addressing the upstream determinants that continue to drive these diseases.

The NSP identifies four interlinked strategic goals that aims to place the country on track to eliminate HIV, TB and STIs as public health threats by 2023:

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

This PIP places a bigger emphasis on prevention interventions and the urgent need to reduce new infections as well as focussing on improving the quality of life beyond HIV suppression. As a result of increased access to quality treatment, people living with HIV can expect to live a normal lifespan. It therefore becomes critical to include integration of HIV care with Non-Communicable Diseases (NCDs) such as diabetes, hypertension, cervical cancer and mental health concerns.

In keeping with a data-drive response, the PIP advocates for the intentional use of localised data to inform context-specific responses at the local level. An extensive list of interventions is identified in the PIP across the four strategic goals, but this does not imply that all interventions are appropriate in all contexts. It is imperative to determine the most appropriate and optimal mix of interventions that takes the local context into account.

Key populations are groups who, because of specific higher-risk behaviour of HIV, TB and STIs, irrespective of the epidemic-type or local context. They may also have legal and social barriers related to their behaviours that increase their vulnerability to infection. The PIP, in alignment with the NSP, differentiates between key and priority population groups and calls for special considerations to be made in respect of the identified groups.

The PIP promotes the utilisation and expansion of technology and innovations in the response to HIV, TB and STIs. Technological advances and developments have opened the door for the utilisation of novel interventions such as telehealth initiatives, digital technology and social media platforms.

There is a greater emphasis on multi-sectoral partnerships, commitment and accountability. This includes the greater involvement of community-based and community-led interventions as well as strengthening public-private partnerships. For the first time the NSP and PIP explicitly focusses on the sustainability of the HIV, TB and STI response and outlines the need for accountable leadership at all levels.

CHAPTER 1: INTRODUCTION

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1.1 Background

The Western Cape Government Provincial Strategic Plan 2019 – 2024, which sets out the vision and strategic priorities for the province, articulates the vision of residents who are empowered to access and seize the opportunities available to them.[1] This vision includes the aim of strengthening families, developing young people with the hard and soft skills, knowledge and social capital they need to thrive and ensuring access to excellent health services that meet the health needs of a growing population.

The South African National AIDS Council (SANAC) launched the National Strategic Plan for HIV, TB and STIs (NSP) 2023 – 2028 in March 2023. The NSP 2023 – 2028 highlights the broad strategic objectives that aim to reduce barriers to accessing health and social services. It builds on lessons from previous NSP implementation and promotes a new and urgent focus on reducing inequalities for all people living with Human Immunodeficiency Virus (HIV), Tuberculosis (TB) and Sexually Transmitted Infections (STIs) who are not benefitting from treatment and care services.

These strategic documents provide the guidance for the development of the Western Cape Provincial Implementation Plan (PIP) for HIV, TB and STIs. The PIP is the guiding framework for operationalising the multi-sector response to HIV, TB and STIs in the Western Cape. It has been developed in line with the NSP 2023 – 2028 and reflects the commitment of the province to ending HIV, TB and STIs as public health threats by 2030.

This implementation plan aims to highlight the importance of addressing upstream determinants of HIV, STIs and TB including poverty, gender inequity and inequalities in access to services and resources required to live healthy and productive lives. This plan is embedded within existing provincial implementation frameworks such as Community-Oriented Primary Care (COPC) and Whole-of-Government, Whole-of-Society approaches to service delivery. At a programmatic level, priority interventions are identified for HIV, TB and STIs that may accelerate progress towards fully achieving the "95-95-95" targets.

[1] Western Cape Strategic Plan 2019 – 2014. https://www.westerncape.gov.za/text/2020/February/western_cape_strategic_plan_2019-2024.pdf

1.2 Guiding Principles

In alignment with the NSP 2023 – 2028, several key principles guided the development of this plan and should form the basis for implementation:

People centred	Interventions must be designed and implemented in a manner that places people, including healthcare workers and the communities they serve, at its centre.
Universal Health Coverage (UHC)	Ensuring that people have access to the health care they need without suffering undue financial hardship.
Multi-sectoral response	The response to HIV, TB and STIs must be multi-sectoral in nature and must be aimed at addressing the inequalities and socio-economic factors that drive the epidemics.
Human Rights	The response must always promote and protect human rights, including the promotion of gender equality.
Evidence-based and data-driven	Interventions must be informed by objective evidence and reliable, accurate and timeous data.
Participatory and Inclusive	Affected communities, healthcare workers and social services workers must be engaged in decision-making processes that will affect them and must be encouraged to be active participants in the change process.

1.3 The process of developing the Provincial Implementation Plan

The PIP was developed under the leadership and direction of the Provincial Council on AIDS & TB (PCAT). PCAT is a multi-sector advisory body with representation from government, civil society, development partners and private sector. The processes followed in developing the PIP comprised a review of the epidemics in the Western Cape, evidence-based interventions in literature and international guidelines as well as global and national strategies related to HIV, TB and STIs.

Several multi-stakeholder consultations were conducted with representatives from government, civil society sectors, implementing partners, non-governmental organisations (NGOs), Community-Based Organisations (CBOs) and development partners to inform the objectives and priority actions, initiatives and interventions that have been included in the plan.

The PIP has been endorsed by the relevant provincial governance structures, including the Civil Society Forum, the Programme Review Committee, Resource Mobilisation Committee (RMC) and PCAT.

1.4 What is new about this plan?

- **Prevention:** The PIP places a bigger emphasis on prevention interventions and the urgent need to reduce new infections.
- **Integration:** Interventions are geared towards the integration of HIV and TB care with non-communicable diseases (NCDs), cervical cancer, mental health and other required services aimed at providing a comprehensive package of care.
- **Data-driven:** Intentional use of localised data to inform context-specific responses at the local level.
- **Innovations:** The PIP promotes the utilisation and expansion of technology and innovations in the response to HIV, TB and STIs.
- **Multi-sectoral partnerships:** There is a greater emphasis on multi-sectoral partnerships, commitment and accountability. This includes the greater involvement of community-based and community-led interventions as well as strengthening public-private partnerships.

1.5 Theory of Change

Initiatives to significantly reduce the incidence of HIV, TB and STIs will be strengthened through a comprehensive approach that includes meaningful responses to the social, political, economic and environmental factors that affect the risk and vulnerability of individuals and communities. Such an integrated prevention response that includes biomedical, behavioural, social and structural strategies and interventions has been termed by The Joint United Nations Programme on HIV and AIDS (UNAIDS) as *Combination Prevention.*[2] Combination prevention entails the implementation of a package of primary and secondary prevention interventions that are tailored to the specific context and needs of the affected population.

The Western Cape Government (WCG) has adopted a Whole of Society Approach (WoSA) to service delivery with the aim of achieving safe, socially connected, resilient and empowered citizens and communities, with equitable access to services and opportunities. This approach calls for collaborative action across all spheres of government (whole of government) and all sectors (whole of society), guided by a shared purpose to impact meaningfully on the lives of citizens.

The adoption of WoSA provides an opportunity for the Western Cape Province to mitigate HIV, TB and STI risks and vulnerabilities through using the PCAT to drive a more focussed multi-sectoral, integrated approach to HIV, TB and STI prevention that also addresses the broader social determinants of health and encourages positive social transformation.

Given that the PCAT is an existing multi-sectoral structure, with leadership support from the Provincial Cabinet, it is ideally placed to follow a Whole-of-Society Approach in overseeing the implementation of the PIP. The PCAT provides a platform to focus efforts on addressing the social determinants that drive the HIV and TB epidemics and emphasise the need to shift from a strictly biomedical model on addressing these challenges.

The emphasis and focus on the prevention of new HIV, TB and STI infections does not negate the need to continue efforts to strengthen the treatment care pathway for those infected with HIV, TB and/or STIs. Concerted efforts must be made at continuing to improve the proportion of HIV-positive persons on sustained treatment and achieving viral suppression. Similarly, TB clients must be supported to achieve higher levels of TB treatment success and cure.

[2] Combination HIV Prevention: Tailoring and Coordinating Biomedical, Behavioural and Structural Strategies to reduce HIV Infections. Available: http://www.unaids.org/sites/default/files/media_asset/JC2007_Combination_Prevention_paper_en_0.pdf

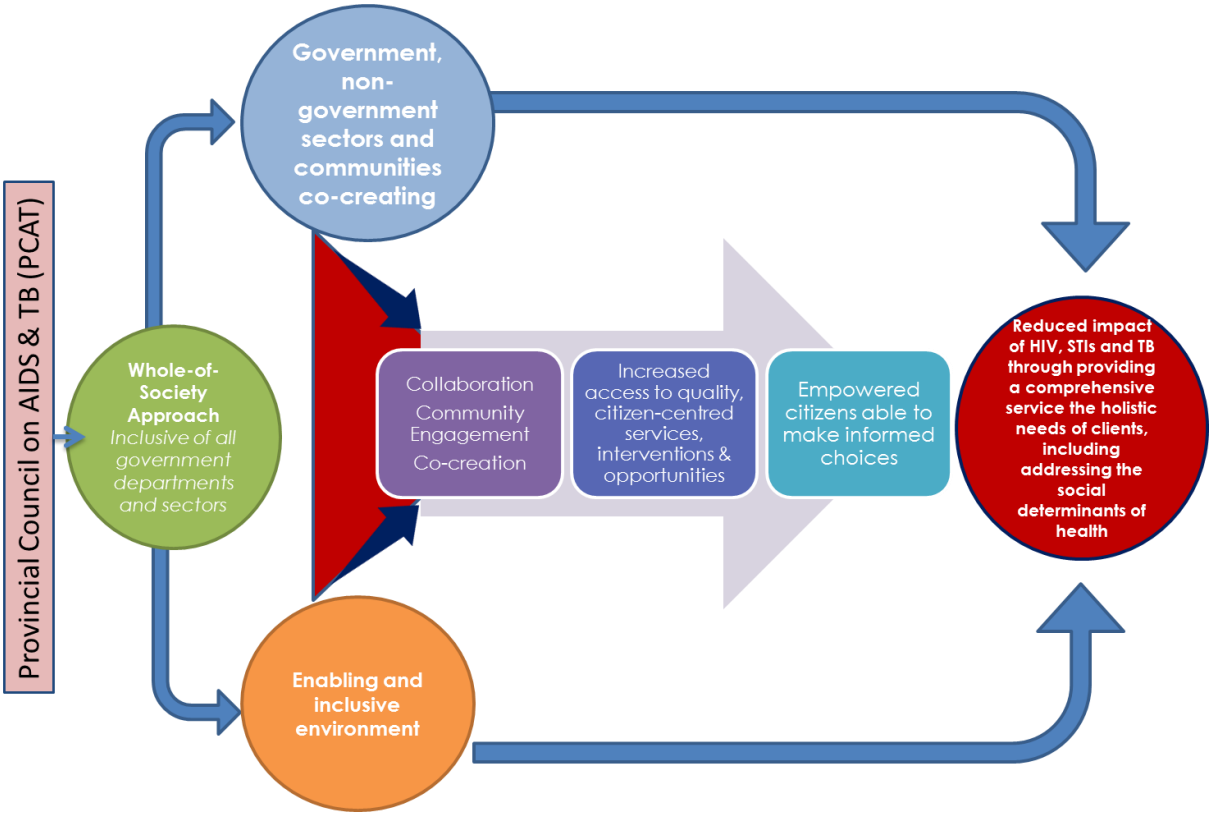

Figure 1: Theory of Change Diagram

The Western Cape aims to achieve the goals contained in the NSP 2023 - 2028 through:

a) Adopting a **Whole-of-Society Approach** to achieve the goals of the NSP 2023 – 2028 and utilise the Provincial Council on AIDS & TB as a platform for driving **this approach in response to HIV, TB and STIs** within the Western Cape;
b) **Focusing on geographic areas that are most affected by HIV, TB and STIs** to tailor interventions to context-specific needs, e.g., focus on violence prevention amongst young men, focus on empowerment initiatives amongst young women, focus on improving access to nutritional support, etc.;
c) Prioritising comprehensive prevention intervention packages, with a focus on **addressing the social determinants** of health in a tangible manner;
d) Adopting a **people-centred, multi-sector** approach (whereby sectors and stakeholders, including health and social service workers, can meaningfully contribute to the design, development and implementation of interventions).

CHAPTER 2: ENVIRONMENTAL ANALYSIS

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2.1. Socio-Economic and Demographic Data[3]

In 2022, the population for the Western Cape province was estimated to be 7.2 million persons with approximately 49.4% and 50.6% of the population being female and male respectively. Over the last ten years, since 2013, the province's total population has increased by 18.7% and presently accounts for 11.8% of the national population, which makes the Western Cape the third largest province after Gauteng and KwaZulu-Natal. 65.8% of the provincial population is concentrated in the metro (City of Cape Town) with a further 13.4% in the neighbouring Cape Winelands district.

The 2022 Quarter 3 results of the Quarterly Labour Force Survey indicates that the Western Cape's number of unemployed persons is an estimated 789 000 people, translating into an unemployment rate of 24.5%. From Quarter 3 2021 to Quarter 3 2022, the Western Cape saw an increase of 203 000 persons being employed. However, the number of employed persons in the Western Cape remains below the number experienced before COVID-19.

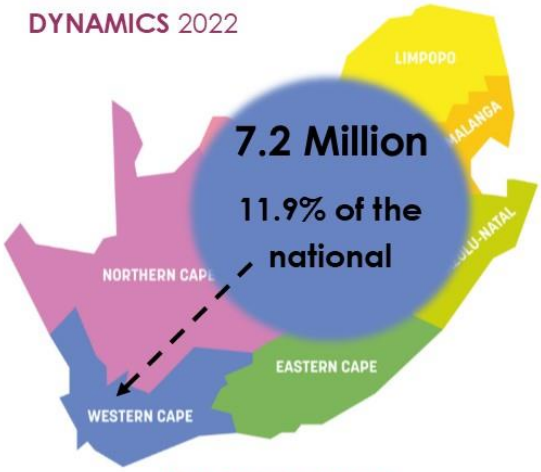
In 2022, 42.7% (25 761) of grade 12 learners in the Western Cape attained the appropriate pass rates to be eligible for university admission. The bachelor pass rates for the Western Cape continues to exceed that of the national average (38.4% in 2022). Although Matric results give an indication of learner performance, education remains a key challenge in addressing inequality. In the Western Cape, it is estimated that 7.7% of children aged 5 to 18 were not attending an educational institution during 2021.

Gender-based violence is still showing worrying signs of increase post the COVID-19 pandemic with 2 518 victims of gender-based violence seeking social development support services between 1 April 2020 and June 2020, compared to 5 960 victims accessing the same services between 1 April 2022 to 30 June 2022.

In-migration is the movement of people within the country from one province to another. Net in-migration is an important driver of urbanisation which impacts on service delivery demands within urban areas. Net in-migration is also a determinant of population growth in the Western Cape. Between 2016 and 2021, the Western Cape is estimated to have gained 292 325 citizens. Over the same period, the population of the Western Cape increased by 624 616, meaning that net in-migration contributed 46.8 per cent of total population growth.[4]

[3] Western Cape Department of the Premier Annual Performance Plan 2023/24
[4] Provincial Economic Review and Outlook 2022/23, Western Cape Government Provincial Treasury

POPULATION DYNAMICS 2022



EDUCATION

NCS Pass Rate
2021
81.2%

Bachelor Pass
2021
45%

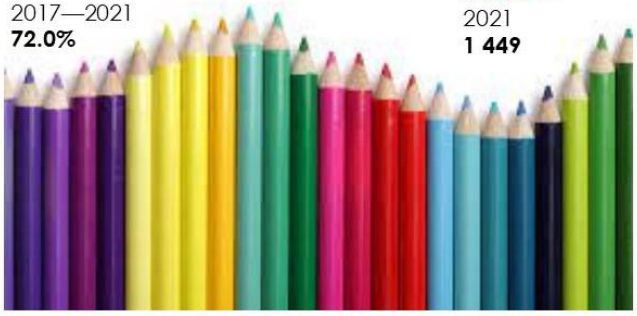
Retention Trends

Grade 1 to 7
2015—2021
90.0%

Grade 8 to 12
2017—2021
72.0%

Teacher/ Learner Ratio
2021
30.4%

Number of Schools
2021
1 449



LIFE EXPECTANCY

2021 — 2026
Female
71.7 Years

2021 — 2026
Male
66.3 Years

Socio-Economic Development in the Western Cape

MUNICIPAL SERVICES

(Share of basic municipal services to total household dwellings in the Western Cape, 2021)

Electricity incl. generator
96.6%

Flush or chemical toilet
95.2%

Refuse removal at least once a week
87.0%

Piped water inside dwelling
75.6%

PRIMARY SUBSTANCE OF USE (Jan to June 2021)

Tik 35%
Cannabis 24%
Alcohol 18%

CRIME (2017/18 to 2021/22)

- ↓ **4.5%** Decrease in robbery at residential premises
- ↓ **2.5%** Decrease in driving under the influence of alcohol or drugs
- ↓ **5.4%** Decrease in drug-related crime
- ↓ **1.6%** Decrease in Sexual Offences
- ↑ **9.2%** Increase in Murders

Source: Provincial Economic Review and Outlook 2022/23, Western Cape Government Provincial Treasury

South Africa suffers among the highest levels of inequality in the world when measured by the commonly used Gini index. Inequality manifests itself through a skewed income distribution, unequal access to opportunities, and regional disparities. Low growth and rising unemployment have contributed to the persistence of inequality.[5]

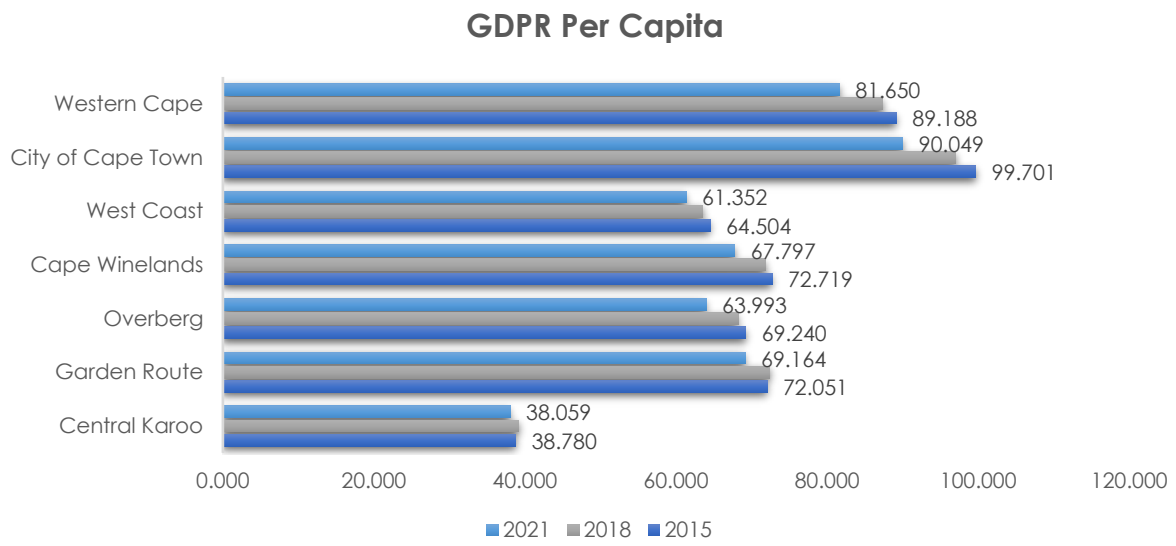


Figure 2: GDPR Per Capita

The Gross Domestic Product Rate (GDPR) per capita is the measure of economic output that accounts for the total number of people. Western Cape GDPR has decreased from R 89 188 in 2015 to R 81 650 in 2021.[6]

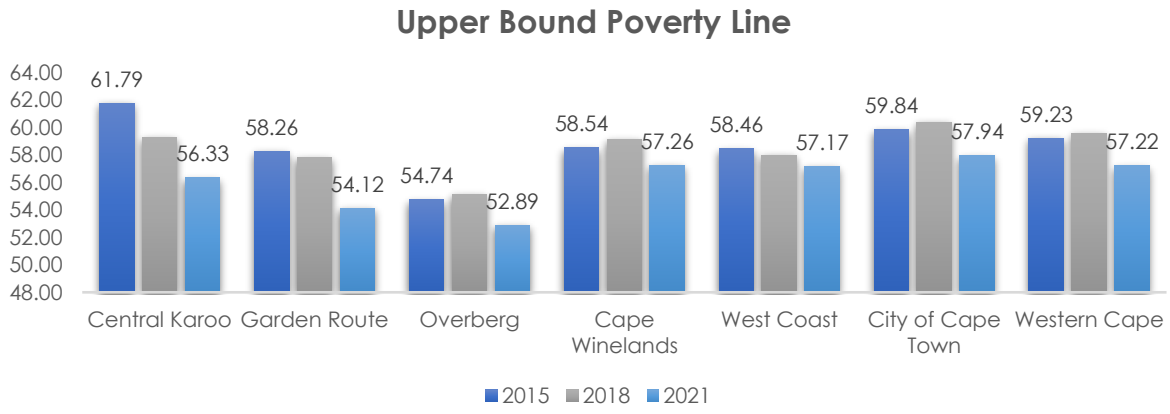


Figure 3: Upper Bound Poverty Line

The Upper Bound Poverty Line (UBPL) head count ratio is the proportion of the population living below the UBPL i.e., that cannot afford to purchase adequate levels of food and non-food items. The UBPL in South Africa is R1 227 (in April 2019 prices) per person per month. In 2021, 57.22 per cent of the Western Cape population fell below the UBPL.[7]

[5] Western Cape Provincial Treasury, 2022. The 2022 Socio-economic profile: City of Cape Town
[6] Ibid.
[7] Ibid.

2.2. HIV Situational Analysis

HIV continues to contribute considerably to the burden of disease in the Western Cape. Although age-standardised HIV mortality rates are declining, HIV accounts for the fourth highest number of deaths in the province (5.7% of all deaths[8]). Amongst the age group 15 – 44 years, HIV ranked as the leading underlying natural cause of death for both males and females, accounting for 15.7% of all deaths in this age group.[9]

The Thembisa Model Provincial Output, Version 4.6 (henceforth referred to as Thembisa Model V4.6) projects that the total number of people living with HIV (PLHIV) in the province increased by 20% in the five-year period between 2016 and 2021. Estimates indicate that there are around 520 000 people living with HIV in the Western Cape.

Table 1: Estimated number of PLHIV in Western Cape by district and age category

District	PLHIV Children <15 yrs	PLHIV 15-24 yrs	PLHIV Adults 25-49 yrs	PLHIV Adults >50 yrs	Total PLHIV
Cape Metro District	7 207	25 889	267 648	57 403	358 146
Cape Winelands District	1 077	4 432	42 035	8 866	56 411
Central Karoo District	99	358	2 207	571	3235
Garden Route District	874	3 984	32 776	8 630	46 264
Overberg District	414	1 894	17 924	4 033	24 266
West Coast District	663	2 861	24 347	5 387	33 259
Grand Total	**10 334**	**39 418**	**386938**	**84891**	**521581**

Source: Naomi Model District Output Sept 2022 (Thembisa 4.6 Calibrated)

The Cape Metro District has the highest estimated burden of PLHIV in total and across all age groups. This is consistent with the population dynamics of this district, which accounts for almost 70% of the total population of the province.

There has been a downward trend in the number of new HIV infections when comparing 2017 estimates to 2022 estimates. The total number of new HIV infections in 2017 were estimated to be 13 408 compared to 11 094 estimated new HIV infections in 2022. This represents a 17% decrease in the number of new HIV infections occurring annually. This rate of decrease was comparable across all districts, with the Overberg District achieving a 20% reduction in new HIV infections when comparing 2017 to 2022 estimates and Central Karoo District achieving a 14% decrease (as depicted in Figure 4).

[8] StatsSA, Mortality and causes of death in South Africa: Findings from death notification 2018 (released in June 2021)
[9] Ibid.

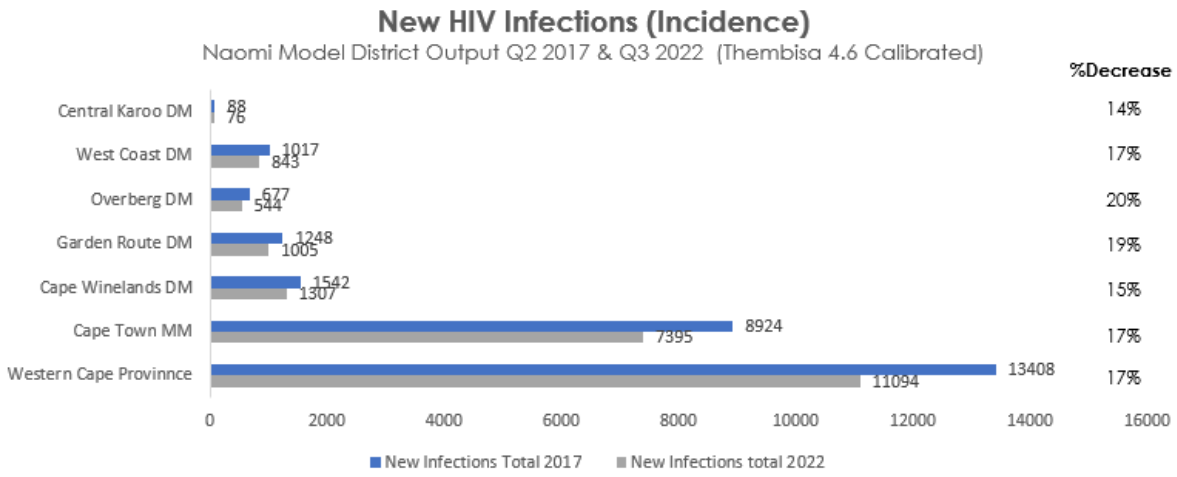


Figure 4: New HIV Infections by District 2017 vs 2022

HIV prevalence refers to the number of persons living with HIV disease at a given time regardless of the time of infection, whether the person has received a diagnosis (aware of infection), or the stage of HIV disease. Although prevalence does not indicate how long a person has had a disease, it can be used to estimate the probability that a person selected at random from a population will have the disease. In Table 2, HIV Prevalence is reported as a proportion of the total population within the geographic area.

Table 2: Estimated HIV prevalence rates in Western Cape by district and age group, 2022

District	Prevalence Total	Prevalence Children <15 yrs	Prevalence Adults 15-24 yrs	Prevalence Adults 25-49 yrs	Prevalence Adults 50+ yrs
Cape Metro	7,7%	0,6%	2,1%	14,6%	6,0%
Cape Winelands	7,4%	0,4%	1,6%	11,4%	5,1%
Central Karoo	4,5%	0,4%	1,7%	9,9%	3,6%
Garden Route	7,6%	0,5%	2,1%	15,8%	6,0%
Overberg	8,1%	0,5%	2,0%	15,7%	6,6%
West Coast	7,3%	0,5%	1,1%	13,6%	6,4%
Source: Naomi Model District Output 2022 (Thembisa 4.6 calibrated)					

Overberg District (8,1%) had the highest estimated total HIV prevalence rate, followed by Cape Metro District (7,7%) and Garden Route District (7,6%). For children under 15 years old, prevalence was relatively consistent across all districts at <1%. Central Karoo had the lowest prevalence rate in total (4,5%) and across all age groups. For all districts, prevalence was highest among adults aged 25-49 years. The 50+ age group showed relatively high prevalence (3,6%-6,6%), especially in comparison to youth aged 15-24 years (1,1%-2,1%).

At the end of March 2023, it was estimated that approximately 531 021 people in the Western Cape are living with HIV, with around 500 263 (94%) knowing their HIV status and approximately 340 058 (68%) currently on treatment.[10] A similar trend is observed across the cascade for children (<15 years) with a notably lower proportion (81%) of this cohort knowing their HIV status. For adult males, the proportion on antiretroviral therapy (ART) is reported to be 64% and for adult females the proportion on ART is reported to be 70%. This reflects a significant treatment gap across the cascade and for each sub-population that has been worsened by the impact of the COVID-19 pandemic.

Figure 5: HIV Care Cascade as at March 2023 (NDoH)

Data available from the private sector suggest that a total of 18 217 clients receive ART through private medical aid schemes in the Western Cape. Proportionally, this equates to less than 6% of all those accessing ART in the province.

[10] DHIS: 31 March 2023

The percentage of people started on ART has increased consistently across all districts until 2019, after which there was a decrease. This coincides with the lockdown restrictions and de-escalation of services due to the COVID-19 pandemic, which resulted in a 35% decrease in ART initiations (from 40 634 patients started on ART in 2019/20 to 26 603 patients started on ART on 2020/21).[11] Whilst 2021/22 saw a 10% improvement in ART initiations (29 261 patients started on ART), this remained well below the target.

District-level performance against the targets within the HIV Care Cascade, correlate with the overall performance at provincial level. All districts have reached the previous target of ensuring that at least 90% of HIV-positive individuals know their status. In terms of HIV-positive persons on ART, this ranges from 65% in the West Coast District to 72% in the Garden Route District and the City of Cape Town (Metro).

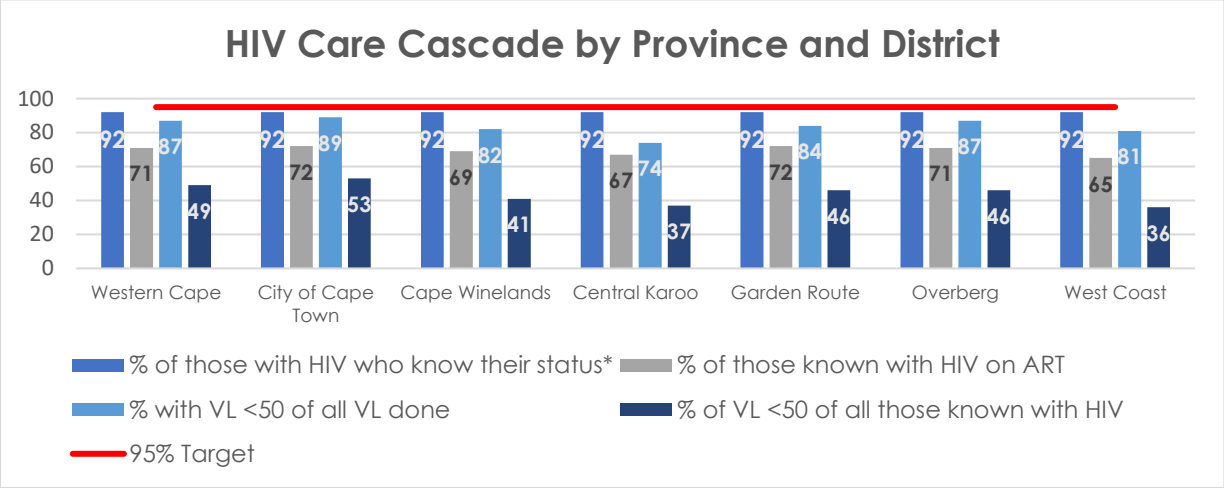


Figure 6: HIV Care Cascade by Province and District (HIV & TB Report July 2023, WCG: Health & Wellness, Provincial Health Data Centre (PHDC))

The linear HIV care cascade masks the complex cycle of engagement, disengagement, temporary disruptions, re-engagement and transitions in care experienced by many people living with HIV.[12] An individual may experience several points of entry and re-entry into care along their treatment journey as they start and stop ART multiple times over the life course. The dynamic cyclical HIV cascade (figure 7) aims to provide a visual illustration of this complex dynamic whereby clients cycle into and out of care and offers some insights into when people are likely to disengage from treatment and/or re-engage treatment along the treatment

[11] Western Cape Department of Health Annual Report 2020/21
[12] Ehrenkranz, et al 2021 PLOS Medicine https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1003651

journey. Further research and analysis are required to understand the underlying factors that drive behaviour along this cascade.

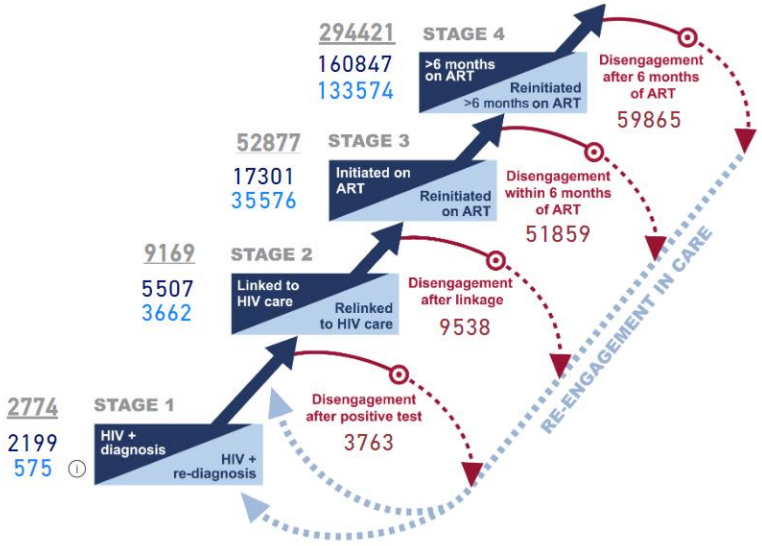


Figure 7: Dynamic cyclical HIV Cascade (Source: SPV as on 31 March 2023)

Retention in care for HIV patients is a challenge and is affected by various factors, including high levels of food insecurity impacting on the nutritional status of patients, high levels of unemployment and poor social support mechanisms. Measures implemented within the Western Cape to improve ART retention in care include the implementation of multi-month dispensing of medication and expanding Differentiated Models of Care (DMOC) to provide clients with options to access medication more conveniently. Further opportunities to improve retention in care are being explored through the use of *Collect and Go E-lockers* and the implementation of telehealth initiatives.

Based on the HIV cascade data available at the end of March 2023, the Western Cape must increase the number of clients on ART with 194 133 individuals to attain the 95-95-95 targets. For adult females the required increase is 115 934, whereas an increase of 72 814 adult males is required.

Based on data extracted from the District Health Information System and the Provincial Health Data System, amongst HIV-positive clients who have had a viral load test done in the last 12 months, between 87% and 93% were virologically suppressed. This helps confirm that those who remain on treatment can achieve virological suppression and live long, healthy lives, without the risk of transmitting HIV to their sexual partners. It remains concerning, though, that less than 34% of patients on ART are having viral load tests conducting regularly. There is thus a need for advocacy efforts in this area and enhancing patients' understanding of the importance of getting viral load tests conducted regularly.

2.3. Tuberculosis Situational Analysis

Despite significant decreases in TB-related deaths, it is still ranked sixth amongst the top causes of premature mortality in the Western Cape, accounting for 4.9% of all deaths in the province in 2018.[13] For the age group 15 – 44 years, TB ranks as the second leading cause of death (after HIV) for both males and females.

The most recent TB prevalence data available is from the national TB prevalence survey published in 2021, which confirmed South Africa's status as a high TB burden country. The survey estimated prevalence in 2018 being 737 per 100 000 population, with the burden found to be 1.6 times higher in males (1094 per 100 000) than in females (675 per 100 000).[14] The survey found that the TB burden was higher among HIV-negative individuals as they were less inclined to seek care compared to their HIV-positive counterparts. Prevalence data at a sub-national level was not available at the time of writing this plan.

The Western Cape public-facing TB dashboard reflects that between 01 April 2022 and 31 March 2023, a total of 54 455 cases of drug-sensitive TB were diagnosed in the Western Cape Province. For the same period, a total of 1 973 cases of drug-resistant TB were diagnosed.

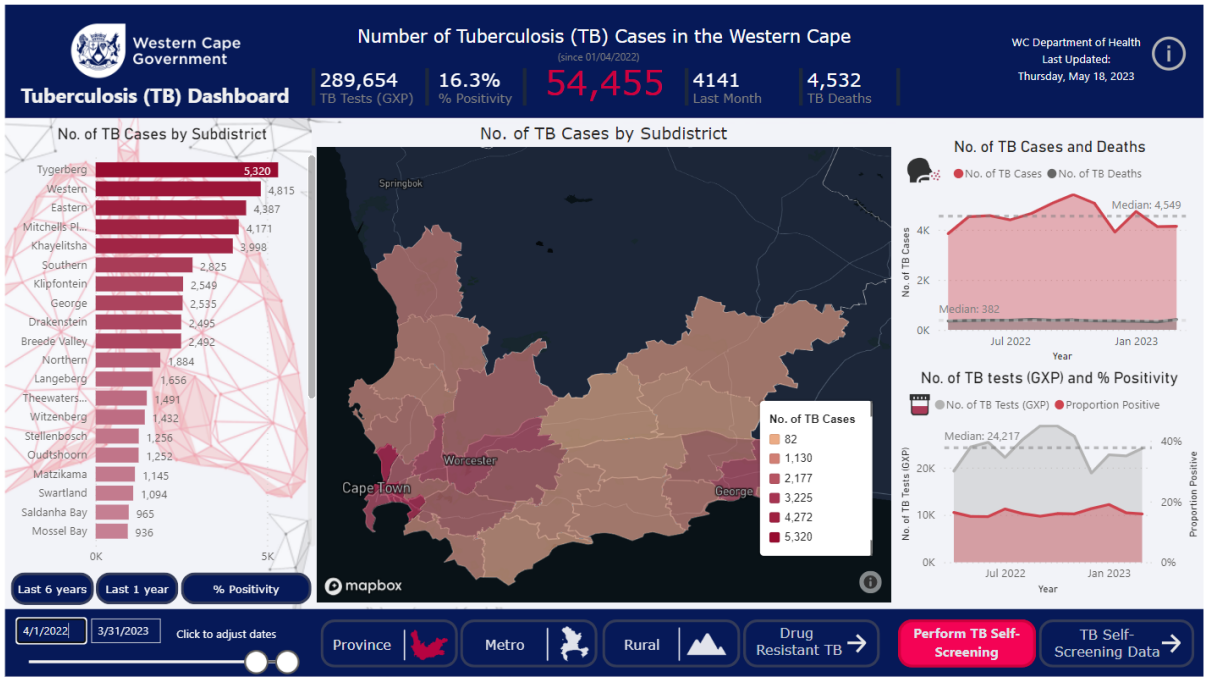


Figure 8: Public-facing TB Dashboard: April 2022 - March 2023

[13] StatsSA, Mortality and causes of death in South Africa: Findings from death notification 2018 (released in June 2021)
[14] The First National TB Prevalence Survey 2018: Short Report https://knowledgehub.health.gov.za/system/files/elibdownloads/2023-04/A4_SA_TPS%2520Short%2520Report_10June20_Final_highres.pdf

The TB treatment success rate declined from 83.5% in 2017[15] to 73% in 2022, despite 92% of clients having been started on treatment[16]. This signifies a high number of clients that are lost-to-follow-up or experiencing treatment interruption.

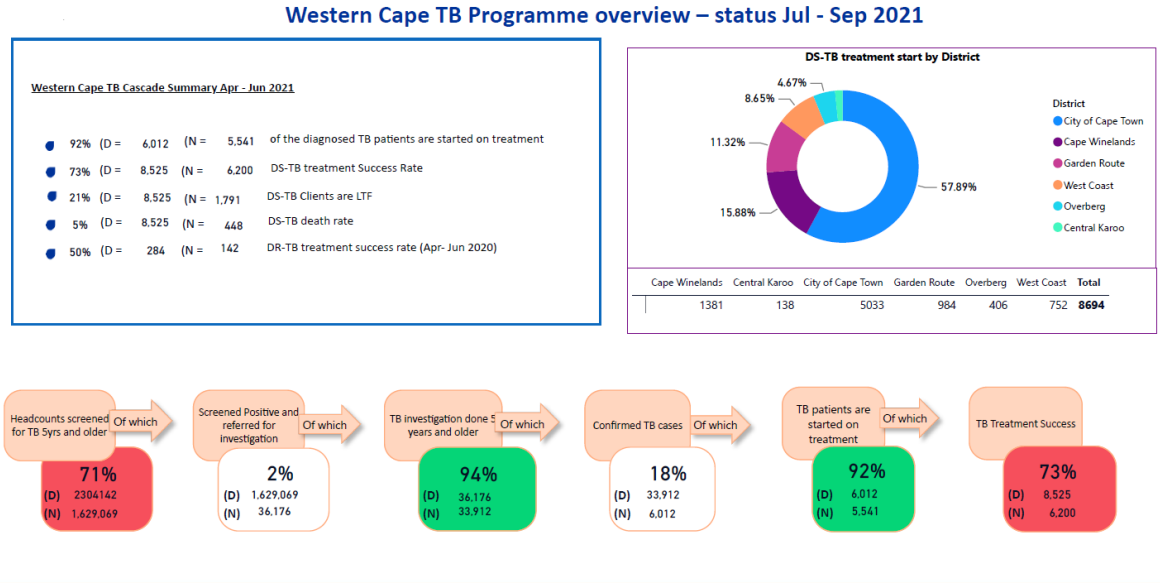


Figure 9: TB Care Cascade (DHIS: 10 Feb 2023)

The number of TB cases diagnosed decreased significantly during 2020 as a direct result of the impact of the COVID-19 pandemic. Significant efforts have been made to ensure that the province is able to increase case detection levels and current data trends show that the 2022/23 TB case finding is approaching pre-COVID-19 levels.

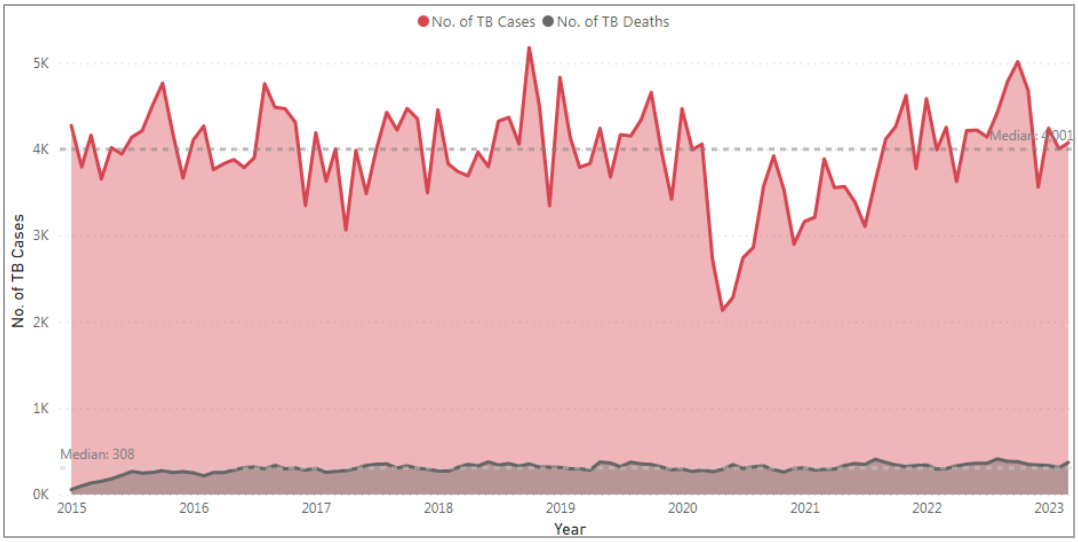


Figure 10:Trend in number of TB Cases detected - 2015 - 2023 (TB Dashboard)

[15] Western Cape Department of Health Annual Report 2016/17
[16] DHIS: 10 February 2023

2.4. Sexually Transmitted Infections Situational Analysis

The burden of sexually transmitted infections (STI) within South Africa is high and several STIs increase the risk of transmission of HIV. Prompt diagnosis and treatment is essential for the control and prevention of STIs and prevention of the spread of HIV.

Although STIs are caused by a variety of microorganisms, the signs and symptoms related to STIs can be grouped into a limited number of 'syndromes'. A syndrome is a set of clinically distinct signs and symptoms that can be easily recognised by the clinician. The most common STI presentations to primary healthcare clinics (PHCs) are the male urethral discharge syndrome (MUDS) and vaginal discharge syndrome (VDS) in men and women, respectively. The main STI pathogens responsible for these two syndromes include Neisseria gonorrhoeae, Chlamydia trachomatis, Trichomonas vaginalis, and Mycoplasma genitalium.

Within South Africa, STI patients are managed using the syndromic management approach in accordance with WHO recommendations. Syndromic management aims to treat the common causes of STI syndromes.[17] . This approach is cost-effective, allowing healthcare professionals to provide treatment that will address most organisms typically associated with an identified syndrome. This also allows for patients to be treated without the need for expensive laboratory-based diagnostics.[18] However, syndromic management is associated with significant overtreatment of people with symptoms and undertreatment of asymptomatic infections. Furthermore, because diagnostic testing is not routinely performed, there is limited STI surveillance and a lack of population-level prevalence and incidence data.

STI surveillance in South Africa currently includes a combination of clinical sentinel syndrome reporting and aetiological testing studies. The STI Clinical Sentinel Surveillance System (CSSS) has a large population coverage and can provide nationally representative data to guide interventions. STI syndromes reported on the CSSS include male urethritis syndrome (MUS) and MUS treatment failure, vaginal discharge syndrome (VDS), genital ulcer syndrome (GUS), genital warts (GW), lower abdominal pain in females (LAP) and "other STIs". Monthly data from 2015-2020 was extracted from the data base and the analysis provides valuable insight into provincial incidence of the most common STI syndromes in adults in the Western Cape.

[17] Mhlongo, S., Magooa, P., Müller, E. E., Nel, N., Radebe, F., Wasserman, E., & Lewis, D. A. (2010). Etiology and STI/HIV coinfections among patients with urethral and vaginal discharge syndromes in South Africa. *Sexually Transmitted Diseases*, *37*(9), 566–570. https://doi.org/10.1097/OLQ.0b013e3181d877b7.

[18] Cassone, M., Batura, N., Li, D., & Smith, E. (2023). *Cost-effectiveness analysis of different screening and diagnostic strategies for sexually transmitted infections and bacterial vaginosis in women attending primary health care facilities in Cape Town*.

Table 3: Estimated STI syndrome incidence (per 100 000 population)

Estimated STI syndrome incidence (per 100 000 population)						
Province	**MUS**	**VDS**	**GUS (Female)**	**GUS (Male)**	**GW (Female)**	**GW (Male**
SA	1913	1569	106	87	47	29
WC	2487	1577	59	55	37	15

Nationally, females have a higher STI incidence than males, but in the Western Cape, the STI incidence in males is 18% higher than in females. The graphs below show the national and district level incidence of the most common STI syndromes.[19]

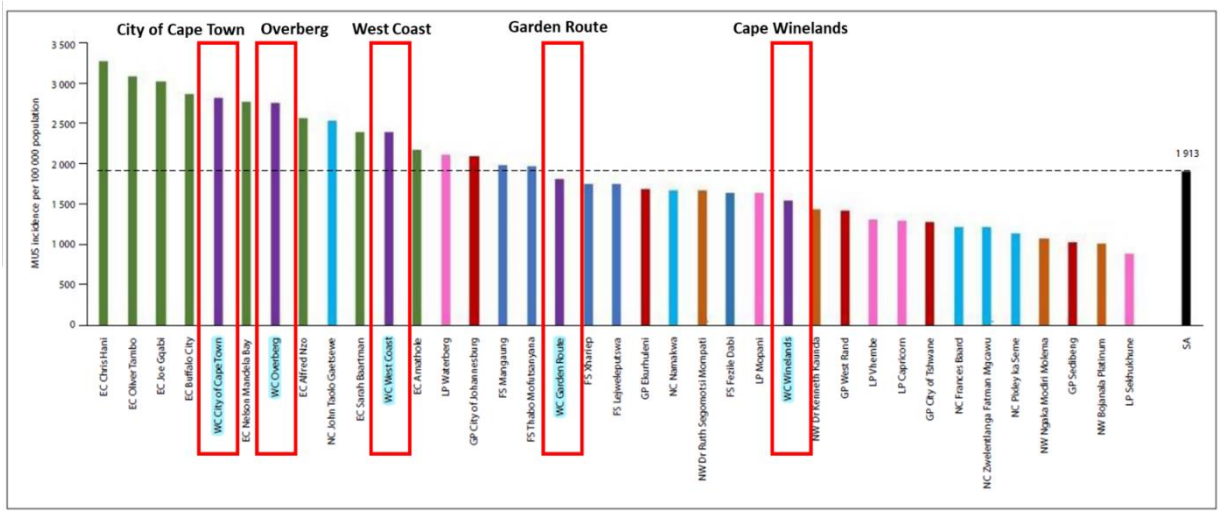


Figure 11: Estimated national and district male urethritis syndrome (MUS) incidences

Available data on Male Urethritis Syndrome indicate an increase in the number of cases treated – from 33 982 in 2016/17 to 48 090 in 2021/22.[20] This is indicative of an increase in case finding and an improved understanding amongst clients and healthcare workers (HCWs) of the need to diagnose and treat STIs.

[19] Frank, D., Kufa, T., ChB, M., Dorrell, P., Hons, B., Kularatne, R., Maithufi, R., Chidarikire, T., Pillay, Y., & Mokgatle, M. (2023). *Evaluation of the national clinical sentinel surveillance system for sexually transmitted infections in South Africa: Analysis of provincial and district-level data*. *113*(7). https://doi.org/10.7196/SAMJ.2023.v113i7.365

[20] Western Cape Department of Health Annual Report 2021/22

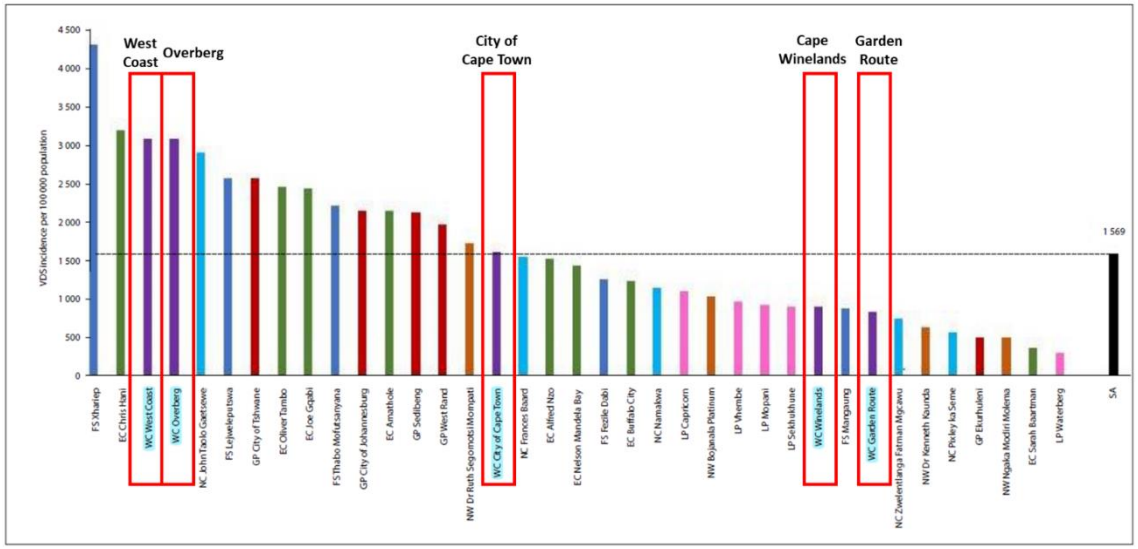


Figure 12: Estimated national and district vaginal discharge syndrome (VDS) incidence

Further to the syndromic management of STIs, key STI programmes in the Western Cape include the Human Papillomavirus (HPV) vaccination campaign, voluntary medical male circumcision (VMMC), syphilis prevention and treatment programs and viral hepatitis prevention and treatment programs.

Human Papillomavirus (HPV) is associated with 99% of cervical cancer cases.[21] If eligible girls are vaccinated against HPV, they have a significantly lower risk of developing cervical cancer in adulthood. It is for this reason that the Western Cape Department of Health & Wellness (DoH&W) and the Western Cape Education Department (WCED) introduced bi-annual HPV vaccination campaigns in schools in 2014 as part of the Integrated School Health Programme. The DoH&W reported that over the period of March – April 2022, health teams visited a total of 1100 schools and achieved a 72% first dose cover of HPV vaccinations.[22] Historical trends reflect a drop-off in coverage for the second dose HPV vaccinations as some learners may drop out, change schools or not attend school on the day that the health team visits to administer the second dose.

Circumcised men compared with uncircumcised men have also been shown in clinical trials to be less likely to acquire new infections with syphilis (by 42%), genital ulcer disease (by 48%), genital herpes (by 28% to 45%), and high-risk strains of human papillomavirus associated with cancer (by 24% to 47% percent).[23] Historically uptake of medical male circumcision has been

[21] https://www.westerncape.gov.za/general-publication/hpv-vaccinations
[22] https://www.westerncape.gov.za/general-publication/hpv-vaccinations
[23] https://www.cdc.gov/nchhstp/newsroom/fact-sheets/hiv/male-circumcision-HIV-prevention-factsheet.html#:~:text=Circumcised%20men%20compared%20with%20uncircumcised,%25%20to%2047%25%20percent)

low in the Western Cape province, with 11 317 males undergoing medical circumcision in the 2021/22 financial year.

Implementation of routine **syphilis** screening in the antenatal program and syndromic syphilis management has shown a significant decrease in cases over the past 30 years. The Antenatal HIV Sentinel Survey key findings published in 2021 indicated that maternal syphilis screening coverage was 97.9% in Western Cape, representing an increase of 2.4% points in syphilis screening coverage from the level in 2017 (95.3%). Syphilis screening coverage increased between 2017 and 2019 in all districts. Of those clients who had syphilis screening, at province level, 2.2% were positive for syphilis, 96.7% were negative, 0.8% were awaiting result and 0.3% results were not in file. Western Cape had the lowest pending results nationally. However, syphilis prevalence increased by 0.5% points from the level in 2015 (1.7%), indicating a need for continued strengthening of the prevention and treatment program in the province.[24]

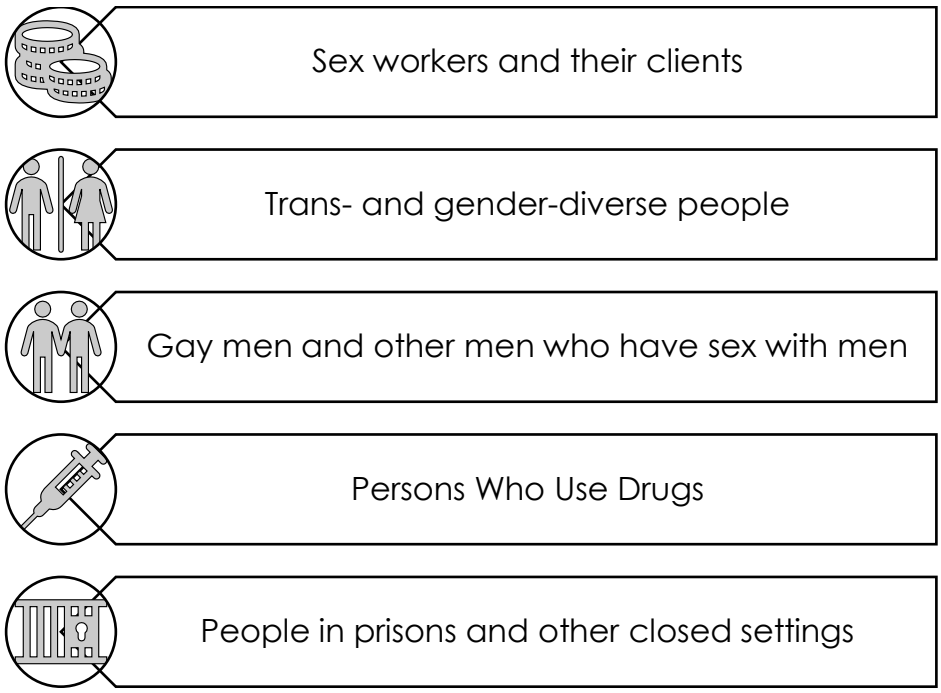
Hepatitis B, a global public health threat, is a potentially life-threatening viral infection of the liver caused by the hepatitis B virus (HBV). Globally, in 2013, there were more deaths due to viral hepatitis (1.4 million) than HIV infection (1.3 million). The HBV vaccine is the backbone of prevention of HBV infection. South Africa introduced the vaccine into the expanded programme on immunisation schedule in April 1995. HepB3 coverage in South Africa averaged 76.6% for the period 2000 to 2018.[25] The Western Cape prioritises testing clients for HBV at ANC visits as well as vaccinating ANC clients with the HepB vaccine. There is limited data available on the Hepatitis C virus (HCV) prevalence, but people who inject drugs have been identified as a key population of concern.

Generally, information on STIs is not regularly recorded or reported on in the Western Cape, and this remains an area for improvement within the timeframe of this Implementation Plan. It is encouraging to note that from April 2023, routine data is being collected on ANC clients tested for and vaccinated against syphilis and ANC clients tested for and vaccinated against HBV. This data can be used to monitor progress over the NSP period 2023-2028.

[24] Woldesenbet, S.A., Lombard, C., Manda, S., Kufa, T., Ayalew, K., Cheyip M., and Puren, A. (2021). The 2019 National Antenatal Sentinel HIV Survey, South Africa, National Department of Health.
[25] Moonsamy, S., Suchard, M., Pillay, P., & Prabdial-Sing, N. (2022). Prevalence and incidence rates of laboratory-confirmed hepatitis B infection in South Africa, 2015 to 2019. *BMC Public Health*, *22*(1). https://doi.org/10.1186/s12889-021-12391-3

2.5 Key and Priority Population Groups

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



Other **priority populations** are groups of people particularly vulnerable to HIV, TB and STIs in certain contexts and might have reduced access to health and social services. These include adolescents (particularly adolescent girls); orphans; homeless children; people with disabilities; people with mental health conditions; migrants and mobile workers; survivors of sexual and gender-based violence (SGBV); lesbian, gay, bisexual, transgender/transsexual, intersex queer and questioning (LGBTIQ+) groups; and people living in rural areas, informal settlements, and inner cities.[26]

Controlling the HIV and TB epidemics is greatly dependent on how well we include key and priority populations in the response. The National Strategic Plan for HIV, TB and STIs 2023 – 2028, identifies the following comprehensive list of key and priority populations for each disease focus area:

[26] National Strategic Plan for HIV, TB and STIs 2023-2028

	Key Populations Increased risk of acquiring HIV, TB and STIs and suffering from punitive laws, stigma and discrimination.	Other Priority Populations Increased risk of acquiring HIV, TB and STIs because of biological, behavioural or structural factors or they face distinct barriers to accessing services
HIV	• Sex workers and their clients • Trans and gender-diverse people • Men who have sex with men (MSM) • People who use drugs (PWUD) • People in prisons and other closed settings • People living with HIV (PLHIV)	• Adolescents and young people, especially adolescent girls and young women (AGYW) • Survivors of SGBV • Children, including orphans and vulnerable children • Migrants, mobile populations, and undocumented individuals • People with disabilities • People with mental health conditions • LGBTIQ+ persons • People living on farms and in informal settlements • Pregnant and breastfeeding women
TB	• PLHIV • Children < 5 years old • Health workers • People in prisons and other closed settings • People living in informal settlements and on farms • Mineworkers and peri-mining communities • Sex workers • Migrants and mobile populations	• Contacts of people with TB (PWTB) • People with prior TB • Smokers • People with harmful alcohol use • The elderly • Adolescents and young people • People with diabetes • Pregnant women • Men • People with disabilities • People with mental health conditions • Undocumented individuals
STIs	• Sex workers and their clients • Transgender persons • MSM	• Adolescents and young people, especially AGYW • Survivors of SGBV • Pregnant women
Viral Hepatitis	**For HBV:** • People in prisons • PWUD • MSM • Sex workers **For HCV:** • PWUD • MSM • People in prisons	• Health workers • Pregnant women

2.6. Reflection on progress in implementing PIP 2017 – 2022

Reflecting on progress towards achievement of the Provincial Implementation Plan for the NSP 2017 – 2022, it is apparent that the Western Cape fell short of several goals. This was exacerbated by the COVID-19 pandemic, which reached South Africa in March 2020. Routine service delivery was disrupted, with health and human resources being diverted to the fight against the disease and focus on COVID-19 vaccination drive. Diagnostic and lab capacity required to support HIV and TB diagnosis were significantly reduced, and because many patients feared contracting COVID-19 at health facilities, there were lower rates of case finding and higher rates of missed appointments and patients lost to follow-up (LTF).

Data trends in early 2023 are showing promising signs of the health system rebounding to pre-COVID-19 levels, with the improvements in the TB positivity rate, increased uptake of HIV testing services and a return to pre-COVID-19 levels of facility headcounts and community outreach interventions.

HIV prevention interventions need to be urgently ramped up, especially condom distribution which has decreased significantly over the 2017 – 2022 period. Urgent attention must be given to the rapid implementation of scale-up of TB prevention intervention, including Targeted Universal TB Testing (TUTT) and TB Preventive Therapy (TPT). Overall, prevention efforts need to be significantly increased (for HIV, TB and STIs) if we are to turn the tide and reduce the rate of new infections.

During the 2017 – 2022 the Western Cape performed poorly in relation to retaining HIV-positive and TB-diagnosed clients in care. Low retention care rates must be analysed within its socio-economic context and will require a comprehensive, multi-sector approach over the coming years if the province is to see improvement in this area.

Ongoing challenges in relation to ensuring the protection of human rights for key and priority populations persisted throughout the period of 2017 – 2022 with the reported confiscation of HIV prevention commodities (including condoms and needles/syringes) by law enforcement agents. Concerted efforts will be required over the implementation period of this plan to address this and ensure greater access to prevention interventions for those who are most at risk.

Intensified efforts and innovations are required to propel the province towards meeting the goal of ending HIV, TB and STIs as public health threats by 2030.

CHAPTER 3: STRATEGIC APPROACH

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Community Oriented Primary Care Approach (COPC)

The localised trigger response to HIV and TB, which is the key strategic approach to be applied in the response to HIV and TB, must be embedded within the Community Oriented Primary Care Approach, adopted by the Western Cape Government in 2023.

Community-Oriented Primary Care can be defined as: "*a continuous process by which primary care is provided to a defined community on the basis of its assessed health needs through the planned integration of public health practice with the delivery of primary care services*[27]". This approach includes a multidisciplinary approach to the care that includes working with organisations and people in defined communities to identify and response systematically to health and health-related needs in order to improve health outcomes. COPC mobilises resources in places where people live, learn, work and socialise and is designed to enable everyone to contribute to and benefit from health.

The successful implementation of a COPC approach in the Western Cape province will allow for the design of healthcare interventions that remain responsive to the needs of communities in the spaces where they live, learn, work and socialise. It allows for priority setting at a local community level with the appropriate stakeholders and to leverage resources within communities.

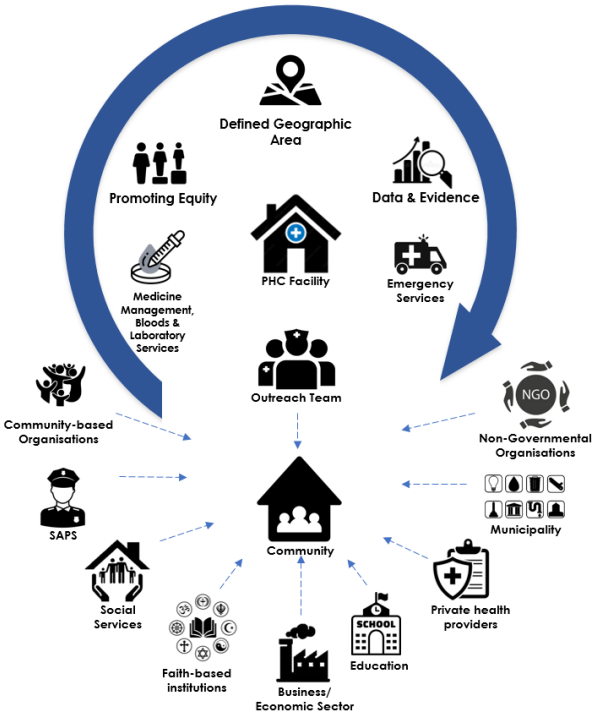


Figure 13: Diagrammatic Illustration of COPC Approach

Critical to the success of COPC is the need to follow a Whole-of-Government and Whole-of-Society approach in the implementation of interventions that stretch beyond a health-focussed approach and also addresses the social determinants that drive the HIV and TB epidemics at local levels.

[27] Fitzhugh Mullan, Leon Epstein, "Community-Oriented Primary Care: New Relevance in a Changing World", *American Journal of Public Health* 92, no. 11 (November 1, 2002): pp. 1748-1755.

Provincial Frameworks Supporting the Implementation of COPC

There provincial policy agenda supports the broader implementation of COPC through the development of key frameworks including the *Differentiated Models of Care and Make Every Contact Count*.

Differentiated Models of Care (DMOC)

Currently most health and wellness services are provided using the standard model of care which requires a patient to physically attend a health facility where the service is provided by one or more HCWs. Differentiated Models of Care differ from the standard model of care in one or more of the following five aspects:

1. The type of service being provided;
2. The location of the service being provided;
3. The target population receiving the service;
4. The individuals who render the service and
5. The time the service is being provided.

The goal of DMOC is to provide good quality health services that are more accessible and comprehensive to citizens in a way that is more responsive to their lived reality while also aiming to be more cost effective than standard model options.

The WCGHW *Framework for the Implementation of Differentiated Models of Care* outlines 13 DMOCS that can be considered:

Out of Facility Models
1. Visiting **patient homes** to deliver medication and provide basic health promotion and disease prevention services. 2. **E-lockers** for collection of chronic medication. 3. **Community Clubs / Adherence Clubs** for issuing of chronic medication and further health promotion and treatment literacy. 4. Use of community venue as **Wellness Centres** where medication is issued, and basic health promotion and disease prevention services are delivered. 5. **Mobiles** can be used for issuing of medication and provision of basic health promotion and disease prevention services. 6. Partnerships with **Private Pharmacies** can be utilised to ensure easier access to chronic medication.

7. Medication issuing and delivery of basic health promotion and disease prevention services can happen at **Workplaces** (including farms). 8. Medication issuing and delivery of basic health promotion and disease prevention services can happen at **Educational Institutions.** 9. Partnerships with **Private GPs** can be utilised.
In Facility Models
10. **QPUP (Quick Pick-up of medication)** at facilities. 11. **Fast lanes** for collection of chronic medication. 12. **E-lockers** for collection of chronic medication. 13. In-facility **Clubs/Adherence Clubs** for issuing of chronic medication and further health promotion and treatment literacy.

DMOCs prioritise the broader management of chronic conditions through innovative models for delivery of medication and provides an opportunity for the provision of other services. These include health promotion and disease prevention, treatment literacy, self-management support and counselling, screening for new conditions, monitoring of existing conditions and clinical activities. The considerations of DMOCs when designing services and service delivery mechanisms, promotes the utilisation and expansion of innovations in the response to HIV, TB and STIs.

Make Every Contact Count (MECC)

MECC is a behaviour change approach that assists all health care providers that are responsible for well-being, care and safety of the public to implement and deliver positive health messages to encourage the population to make more informed health behaviour choices through healthy conversations. The approach focusses on capitalising on the existing opportunities within health facilities, during routine visits, to make a difference to people's health and wellbeing. MECC is embedded in the current health service within the Western Cape and should not be seen as an "add-on" to an already busy environment.

The MECC strategy outlines a proposed paradigm shift for the way in which the Western Cape Government: Health & Wellness employees and partners deliver counselling services. Counselling is not to be limited to mental health conditions nor behavioural or therapeutic counselling. It is a combination of preventive and promotive practice that includes treatment literacy, adherence support, behavioural counselling as well as psychosocial support for all patients receiving healthcare.

Within the strategy for MECC, a tiered counselling model is proposed. This tiered model makes provision for clients and families to be educated on their illness, the signs and symptoms thereof, to be motivated to change their behaviours in a positive manner and to be equipped with the necessary life skills in varying degrees of intensity at different levels of care. The MECC approach supports the emphasis on prevention interventions as a key part of all interactions with clients. The tiered counselling model is illustrated below:

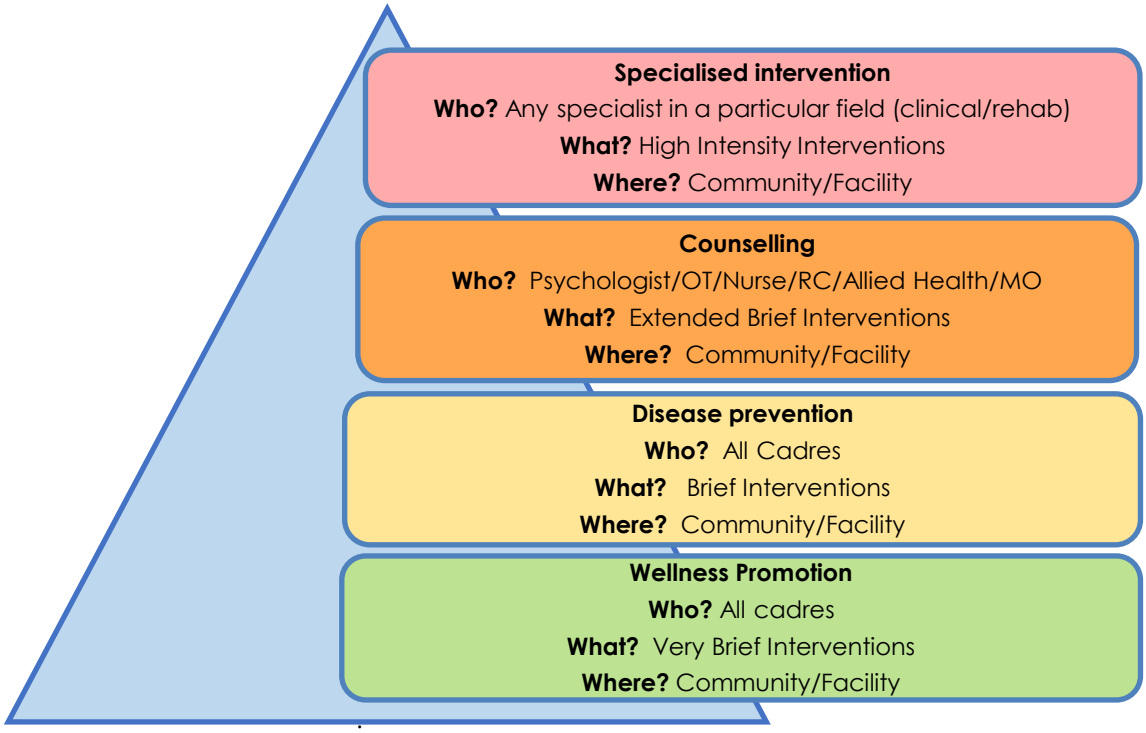


Figure 14: Counselling model for Make Every Contact Count (MECC)

Adopting the MECC approach, will improve person-centred quality of care, enhance positive health seeking behaviour and client experience by providing a supportive environment and creating greater agency among clients for self-management and for seeking appropriate care when necessary. Successful implementation of the MECC strategy can accelerate progress towards achieving the goals articulated in the National Strategic Plan for HIV, TB and STIs and to which this implementation plan is aligned.

A Localised Trigger Response

There are only a limited number of available biomedical interventions that have been shown to reduce transmission of HIV, TB and STIs. These are: condoms, anti-retroviral treatment, TB preventive therapy and medical male circumcision. Each has associated limitations - condoms need to be worn consistently and correctly, treatment needs to be consistently adhered to and circumcision only partially protects the male from acquiring infection but does nothing to prevent transmission to another sexual partner.

The implication is that these 'biomedical' interventions need to be embedded in a context of broader behavioural and social/structural support that encourages their consistent use. Whilst biomedical interventions attempt to block infection or reduce infectiousness, behavioural interventions attempt to motivate behavioural change within communities or individuals and social/structural interventions seek to change the context that contributes to vulnerability or risk.

Current approaches to the prevention and management of HIV, TB and STIs tend to intervene at the biomedical level, the behavioural level and structural level, independently of one another.

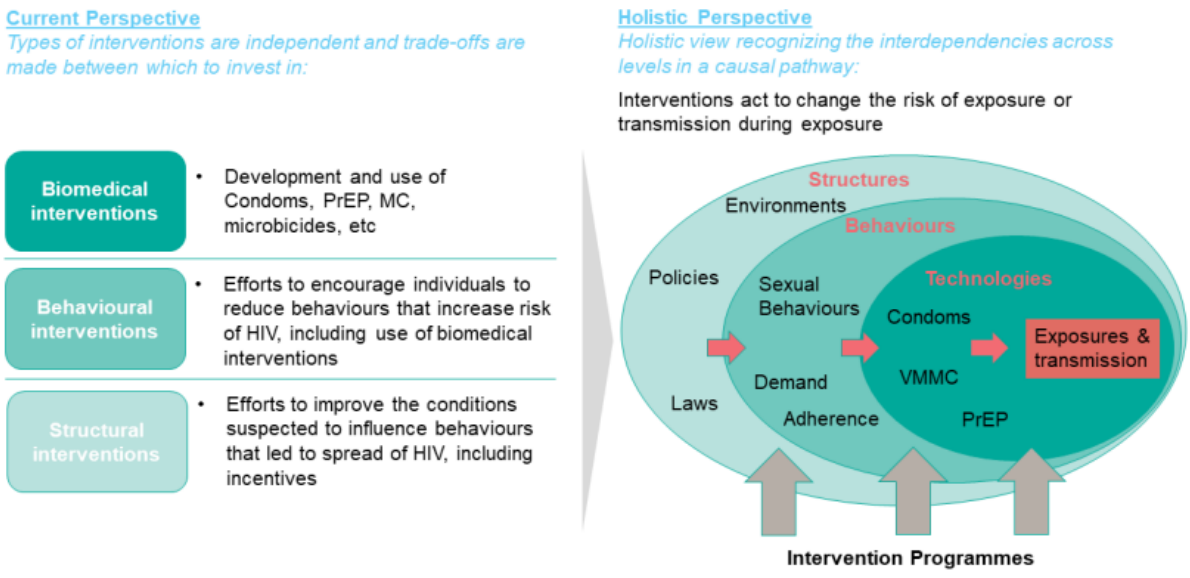


Figure 15: Towards a socio-ecological perspective (Source: Bill & Melinda Gates Foundation)

An effective response to HIV and TB must intervene at the biomedical, behavioural and structural levels in a manner that is coherent, complementary and informed by context.

It is recommended that implementation of programmes aimed at the prevention and management of HIV, TB and STIs follows the "Focus for Impact" methodology. This model was developed by SANAC and uses detailed information, data and insights to identify populations most at risk in areas more severely affected by HIV and TB. This approach aims to ensure implementation of high-impact prevention and treatment services and strengthen efforts to address the social and structural factors that increase vulnerability to infection.

The Focus for Impact approach aims to answer four key questions needed in ensuring a targeted high-impact response to HIV and TB:

1. ***Where*** are the high burden areas?
   Identify geographical areas with a high HIV, TB and STI burden using routine health data.
2. ***Why*** is this a high burden area?
   Profile epidemiology and associated risks using secondary data and community dialogue.
3. ***Who*** is at risk in this high burden area?
   Identify key or priority/vulnerable populations to focus on.
4. ***What*** are we going to do to reduce the burden in this area?
   Multi-sectoral implementation plans and interventions.

Figure 16: Focus for Impact Methodology (P.Russouw)

A. Identification of focus areas (Where)

Various data sources are available to the Department of Health & Wellness via the Provincial Health Data centre that enables it to determine where the HIV and TB epidemic are most concentrated and where additional efforts are required to reach the 95-95-95 targets.

Often these areas can be defined in terms of a single suburb, or single informal settlement or a single clinic's drainage area. Patient line lists can be drawn at the facility level to identify individual clients who are lost to follow up.

The key indicators that will inform the identification of focus areas:

- Headcount screened for TB (%)
- TB Treatment Success Rate
- TB Clients Lost to Follow Up
- PLHIV Who Know their Status
- PLHIV on ART (as proportion of known positives)
- PLHIV Virologically suppressed (as proportion of all viral loads done)

B. Profile the Population (Who)

Determine the population profile, informed by demographic information, deprivation/poverty index, social and economic indicators. The most examined demographics include gender, race, age, economic and social status, number of households and their distribution, poverty levels and amongst others.

This profile may also include a community profile that indicates accessibility of schools, health facilities, recreational areas, public transportation and other community assets such as faith-based organisations, non-profit organisations and commercial/business facilities.

It is important to know and understand the population profile in order to ensure that interventions are population-sensitive and respond to the needs of the population.

C. Explore the social determinants per focus area (Why)

Once the focus areas are identified a process must commence to investigate and explore the social determinants (the non-medical factors that influence health outcomes, inclusive of behavioural and structural factors) that are contributing to HIV and TB in each focus area.

These determinants will help to create a contextual understanding of the factors that drive HIV and TB within the specified geographic area or community. An important part of this process would be to gain a better understanding of the affected community's use of living, working, learning and social spaces.

D. Identify appropriate evidence-based and innovative interventions to implement in a multi-sector response (What)

Successfully implementing a combination of interventions requires engagement and collaboration with other sectors, other government departments and diverse stakeholders. Each identified focus area may require a tailored package of interventions that speaks directly to specific context – informed by the community profile and identified social determinants.

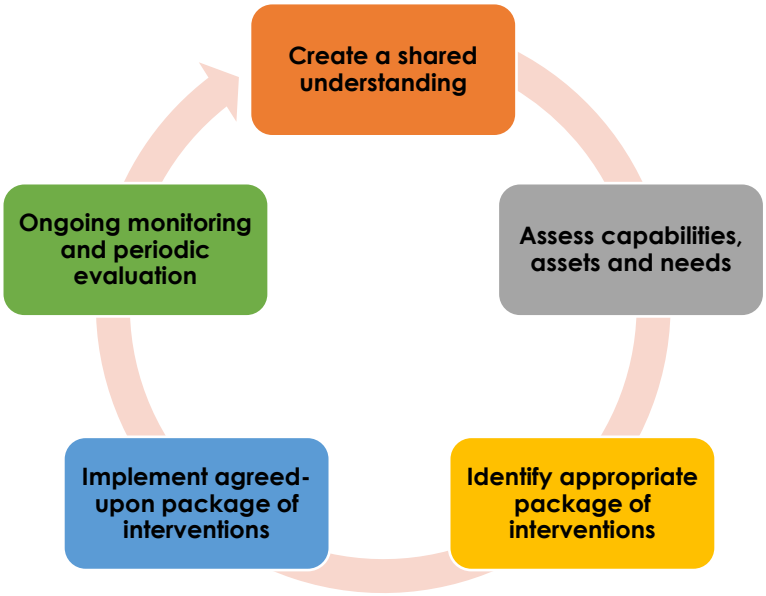


Figure 17: Recursive implementation cycle

Local teams initiate action by first creating a shared understanding of the context-specific challenges that contribute to reduced retention in care (including challenges related to health services, health systems, socio-economic conditions and the social determinants of health). Thereafter they assess the capabilities, assets and needs of the community in order to construct an appropriate package of local interventions. Once the interventions are implemented, the teams evaluate their impact at agreed intervals and re-engage in the recursive cycle of discerning which interventions should be continued, which need to be stopped and which should be added (Figure15).

Model for implementation of localised response

The proposed model for implementing the localised trigger response is derived from work emanating from the Western Cape Programme Review Committee. This model outlines activities that occur at the strategic and operational levels, linked by a coordination mechanism that is responsible for regularly reviewing progress and advising on necessary adjustments to be made at either level.

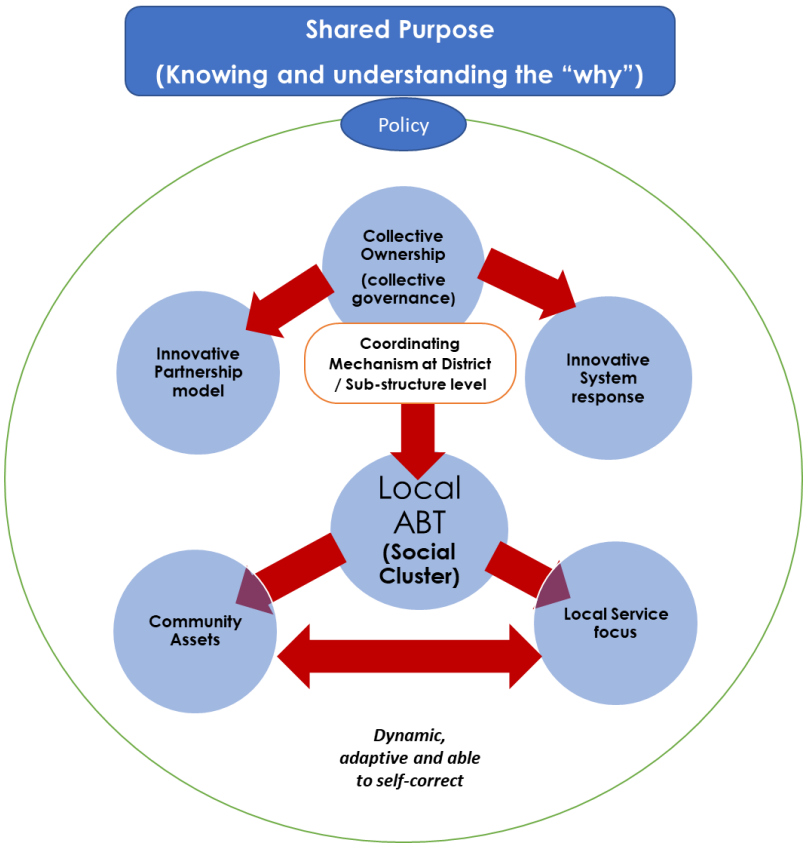


Figure 18: Proposed Implementation Model for the localised response

Implementation of the localised response for HIV and TB requires creating a shared purpose amongst stakeholders and role players. The shared purpose is embedded in a call to serve – understanding why responding to the HIV and TB epidemics are important and acknowledging the impact on people's lives.

The intended outcome of a process of fostering collective ownership of the multi-sector response to HIV, STIs and TB is to:

- Contribute towards the development of an innovative system response that promotes effective coordination and management of services at a local level;

- Promote a culture where clients and beneficiaries work alongside service providers to co-create effective solutions;
- Empower clients to make more positive health choices, including choices that will enable improved adherence to treatment and greater awareness of mental health.

The concept of Social Cluster Area-Based Teams

It is proposed that implementation of the localised trigger response is given effect through social cluster Area Based Teams (ABT) in prioritised geographic areas. The functions, roles and responsibilities of social cluster ABT members will be aligned to the policy directives and mandates of respective identified stakeholders.

The ABT will provide a platform for connecting, collaborating and co-creating to enhance access to services that will promote the prevention of HIV and TB, as well as support sustained adherence to treatment.

The main role of the ABT will be to foster collective ownership of the multi-sector response to HIV, TB and STIs. Core members of the ABT should include Department of Social Development (DSD), DoH&W and WCED, and other relevant stakeholders, including NGOs and community-based organizations.

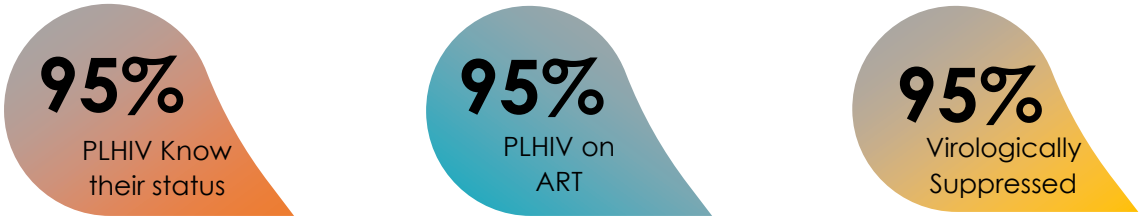
The ABT will be a joint operational structure, that collects, analyses and synthesizes local information to inform the response to service delivery needs at local level. It will be responsible for assessing progress on identified priorities at district/sub-district level and make recommendations for improvements via the relevant and appropriate structures.

The positioning of the ABT should be aligned to the principles of the COPC approach, that advocates for multi-sector collaboration in addressing health challenges at a local level. Within this approach, it is acknowledged that the strategic enablers for effective execution are:

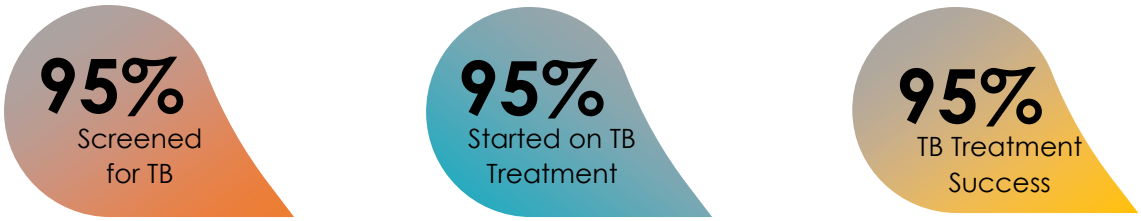
i. Effective communication
ii. Access to accurate, timely and relevant data
iii. Supportive and enabling environment
iv. Identification and application of context-specific interventions

High-level Targets

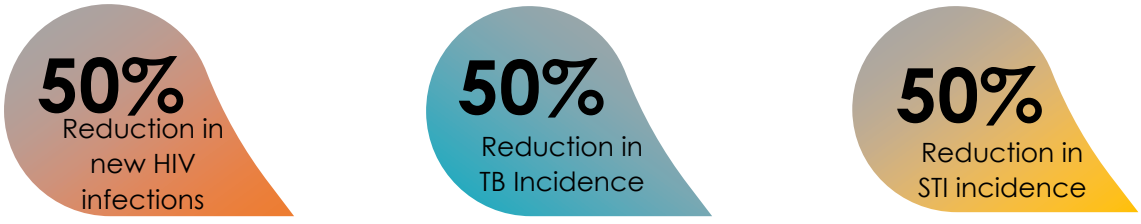
The implementation of the localised trigger response through ABTs aims to achieve the following targets:



In alignment with the global strategy to end HIV as a public health threat, we aim to ensure that at least 95% of persons living with HIV are aware of their status, 95% of persons living with HIV to be on treatment and 95% to be virologically suppressed.



Whilst the cascade for TB care differs from the HIV care cascade, it is possible to align targets for the TB response to the 95-95-95 global strategy for HIV. We aim to ensure that 95% of all clients are screened for TB, that 95% of those diagnosed with TB are started on treatment and that 95% of those who start TB treatment, attain treatment success.



In keeping with the target expressed in the NSP, the Western Cape aims to reduce new HIV infections by at least 50%. Although the NSP articulates a target of 25% reduction in TB incidence, this plan aims to achieve a 50% reduction in TB incidence and 50% reduction in STI incidence.

CHAPTER 4: GOALS, OBJECTIVES AND INTERVENTIONS

CHAPTER 4: GOALS, OBJECTIVES AND INTERVENTIONS

This Western Cape Provincial Implementation Plan aligns to the NSP 2023 – 2028 and therefore has adopted the goals and objectives contained in the national strategy.

GOAL 1: Break down barriers to achieving HIV, TB and STI solutions

The NSP 2023 – 2025 identifies the following critical barriers that impedes access to HIV, TB and STI solutions:

- **Social and structural drivers:** Gender inequalities, gender-based violence, poverty, economic inequalities, xenophobia, harmful religious and cultural practices, disability and other restrictive socio-economic factors reduce people's ability and agency to realise rights and access comprehensive health and social services.
- **Stigma and Discrimination:** Persistent stigma and discrimination continues to undermine efforts to end HIV and TB. Specific challenges include inconsistent implementation and/or application of protective laws and policies and discriminatory attitudes and practices within law enforcement and health care provision, further limiting access to human rights protections.
- **Discriminatory laws and practices:** Criminalisation of certain activities and behaviours such as sex work or drug possession for personal use, further perpetuates discrimination and stigma and can result in rights violation (e.g., confiscation of needles and syringes) and limits access to health and other essential service provision.
- **Gender inequalities and violence:** The intersections between gender inequalities and gender-based violence and increased risk for HIV acquisition are well-documented.
- **Mental Health:** Mental health considerations have become an increasingly important consideration in the design and implementation of programmes and interventions aimed at ending HIV, TB and STIs.

Goal 1: Objectives	
Objective 1.1	Strengthen community-led HIV, TB and STI responses.
Objective 1.2	Contribute to poverty reduction through the creation of sustainable economic opportunities.
Objective 1.3	Reduce stigma and discrimination to advance rights and access to services.
Objective 1.4	Address gender inequalities that increase vulnerabilities through gender-transformative approaches.
Objective 1.5	Enhance non-discriminatory legislative frameworks through law and policy review and reform.
Objective 1.6	Protect and promote human rights and advance access to justice
Objective 1.7	Integrate and standardise delivery and access to mental health services.

Objective 1.1: Strengthen community-led HIV, TB and STI responses			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Build an enabling environment for cohesive and inclusive communities	Develop and maintain a database/ interactive mapping tool of community assets and health profile.	• Update Health Service Provider Platform to accurately reflect NGOs and CBOs delivering health services in communities. • Develop sub-district health profiles to inform the design and implementation of HIV, STI and TB programmes.	Department of Health & Wellness (DoH&W)
	Implementation of Community-Oriented Primary Care as a model of integrated service delivery.	• Engage communities, with a focus on key and priority populations, in the development and implementation of local development plans and allocation of resources.	DoH&W
	Scale-up community-based prevention interventions, that are universally accessible.	• Expand the rollout of Wellness Hubs in communities. • Expansion of community-based substance use interventions. • Rollout of parenting programmes.	DoH&W Department of Social Development (DSD) Western Cape Education Department (WCED)
	Increase knowledge and awareness at community level.	• Conduct regular awareness-raising activities in community settings.	DoH&W DSD WCED
Resource and support community-based organisations to implement and monitor HIV, TB and STI responses	Strengthen the capacity of local NGOs and other community-based organisations to implement and report on HIV, TB, STIs and viral hepatitis.	• Invest in capacity building of NGOs and CBOs to improve organisational capacity in relation to fund-raising, governance, human resource management and data management.	DSD Funded Partners

Objective 1.1: Strengthen community-led HIV, TB and STI responses			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
		• Mentoring of smaller organisations by more established organisations as a means of skills sharing/skills transfer.	
	Allocate funding to local NPOs and CBOs to implement HIV, TB and STI response programmes.	• Appoint local NPOs and CBOs to implement HIV, TB and STI response programmes in all sub-districts via available funding for community-based services and in alignment with fair and transparent processes.	DoH&W DSD
	Build capacity for community-led monitoring of HIV, TB and STIs.	• Advocate for improved access to information for communities. • Training and capacity building of community structures, CBOs and NPOs on using available health data to support decision-making.	Civil society sectors DoH&W Implementing Partners
Improve safety, health and wellbeing in communities to strengthen the capacity of families to protect, support members affected and infected by HIV, TB, STIs and viral hepatitis	Reduce risk through the implementation of programmes that build resilience of individuals, parents and families, including people with disabilities.	• Implementation of Family Matters programme for family strengthening. • Expand and up-scale parenting skills programmes. • Enhance early childhood development programmes.	DSD
	Reduce risk through improvements to urban infrastructure and physical environment in communities.	• Improve availability of clean water and sanitation in all communities. • Increase access to safe spaces for recreation and physical activity. • Ensure adequate street lighting.	Relevant Municipality

Objective 1.1: Strengthen community-led HIV, TB and STI responses			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
	Reduce alcohol-related harms.	• Implement regulatory measures in relation to minimum pricing units. • Implement regulatory measures to standardise trading times for licenced liquor outlets.	Department of Police Oversight and Community Safety (POCS) Department of Trade & Industry
Improve the integration of HIV, TB and STI services into community systems and cultural practices	Strengthen policy frameworks to include Traditional Health Practitioners (THPs) in existing healthcare structures and processes.	• Establish formalised partnerships between DoH&W and THPs to improve access to effective and efficient services for HIV, TB and STIs. • Establish guidelines for health and social service practitioners (including THPs) on integrating community systems and cultural practices into health services.	DoH&W
	Monitor and improve safety of initiation schools and initiates.	• Implement a health screening process for all initiates that includes screening for HIV, TB and NCDs. • Implement measures to prevent the occurrence of adverse events related to initiation procedures. • Monitor and regularly report on adverse events that occur at initiation sites.	Department of Cultural Affairs and Sport (DCAS) Traditional Health Practitioners

Objective 1.2: Contribute to poverty reduction through the creation of sustainable economic opportunities			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Increase access to economic		• Implementation of Presidential Youth Employment Initiative.	Western Cape Government

Objective 1.2: Contribute to poverty reduction through the creation of sustainable economic opportunities			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
strengthening opportunities for young people	Reduce unemployment of young people (aged 18 – 35 years), including young people with disabilities.	• Further rollout and expansion of YearBeyond programme to provide unemployed youth with meaningful work experience. • Provision of work training and work experience for matriculants via the First Work Experience PAY programme. • Increase youth employment via the Expanded Public Works Programme.	
		• Greater investment in skills development and job creation for young people. • Increase opportunities for mentorship, on-the-job-training and paid internships.	Private Sector
Scale up and advocate for access to social protection interventions to facilitate equitable access to services	Improve access to social protection for those who qualify.	• Raise awareness of social protection interventions and qualification criteria. • Sustain community-based access points for social protection. • Provide assistance with completion of application processes.	South African Social Security Agency (SASSA) DSD
	Accelerate access to food and nutritional support programmes.	• Promote and support food gardens at schools and in communities. • Increase access to nutritional support at schools and in communities. • Integrate best practices across government departments for inclusive access to nutrition.	Department of Agriculture DSD WCED

Objective 1.2: Contribute to poverty reduction through the creation of sustainable economic opportunities			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
	Improve school retention rates for primary and high school cohorts.	• Scale up programmes that support Adolescents and Young People (AYP) to remain in and return to school. • Implementing learner tracking mechanisms to follow-up with learners who have dropped out of school or find and place learners who have never attended school. • Expand learning opportunities in technical and vocational streams. • Implementing early intervention processes and increased attention, support and remedial action for learners at risk of drop-out. • Implement context-specific learner retention strategies that motivate learners to go to and stay in school – Perform to Transform Strategy.	WCED

Objective 1.3: Reduce stigma and discrimination to advance rights and access to services			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Increase literacy on rights and the impact of intersecting stigma and discrimination	Scale up community-led stigma-reduction interventions and advocacy.	• Identify community-based and community- and peer-led organisations and networks to support proven stigma-reduction approaches. • Advocate for people-centred approaches to enhance access to inclusive, non-judgemental and non-discriminatory quality community-based services.	DoH&W Civil Society Sectors Development Partners Implementing Partners

Objective 1.3: Reduce stigma and discrimination to advance rights and access to services			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
		• Increase support for interventions focusing on reducing stigma.	
	Raise awareness of causes and consequences of stigma and discrimination.	• Facilitate community dialogues on causes, impacts and community-based solutions to reduce stigma and discrimination. • Advocate and support rapid assessments to inform stigma-reduction initiatives.	Civil Society Sectors
Increase access to redress mechanisms in communities experiencing stigma, discrimination and other rights violations	Strengthen the support and promotion of community-based and community-led redress and rapid-response mechanisms.	• Strengthen and scale up community-based, community-led crisis response teams and mechanisms to increase linkage to services (e.g., community- and peer-led WhatsApp groups). • Support access and utilisation of established helplines (AIDS Helpline, SGBV Helpline, LifeLine, Childline, Mental Health Helpline) with community awareness campaigns.	DSD DoH&W Civil Society Sectors
		• Expand access to redress mechanisms and legal advice in relation to rights violations, especially for key populations.	Department of Justice National Prosecuting Authority (NPA) NPOs DSD
Strengthen social support networks and structures for	Prioritise the revitalisation of community- and facility-based social support networks and structures.	• Map community-based social support networks and structures. • Strengthen and integrate existing community-based social support structures.	DSD Civil Society Sectors NGOs and CBOs

Objective 1.3: Reduce stigma and discrimination to advance rights and access to services			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
people most affected by stigma		• Expand community-based social support structures	

Objective 1.4: Address gender inequalities that increase vulnerabilities through gender-transformative approaches			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Enhance gender transformative community-led actions for HIV, TB, and STIs to change harmful social, cultural and gender norms	Strengthen efforts to reduce the harmful consequences of gender inequality.	• Engage and sensitise men and boys in households and communities to champion gender equality and change harmful gender norms. • Create greater awareness of gender-based violence in different settings, including schools, health facilities, workplaces, recreational spaces, etc.	DSD WCED DoH&W NGOs Private sector
	Enhance capacity in communities to prevent and respond to SGBV.	• Community dialogues • Information and educational material	DSD NPOs Women's Sector
	Strengthened programming that addresses the restoration of human dignity, build caring communities conducive to women's safety.	• Commemoration of Women's Day, 16 Days of Activism. • Communications campaigns on services available to victims of GBV. • Provision of information guides and motivational literature/books for survivors of GBV disseminated to various government and business and civil society settings.	DSD NPA Department of Justice Law & Human Rights Sector Civil Society Forum

Objective 1.4: Address gender inequalities that increase vulnerabilities through gender-transformative approaches			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Strengthen capacity of leaders at all levels of decision-making to advance gender equality and promote diversity	Strengthened leadership and accountability for advancing gender equality and promoting diversity, including greater inclusion of persons with disabilities.	• Mobilisation of leaders and advocates for GBV reduction within government, private sector and civil society. • Capacity building and training interventions for leaders at all levels of decision-making. • Capacitate & raise awareness amongst Municipal Gender Focal Persons on the GBV NSP to inform the development of local GBV Plans.	DSD Municipalities
	Improve co-ordination and collaboration within and across government, private sector and civil society.	• Establish regular platforms for engagement. • Share good practices and lessons learned in the implementation of GBV initiatives.	DSD
Increase access to services for all survivors of SGBV	Ensure access to more a victim-centred criminal justice service that is sensitive to and meets the needs of victims of GBV, including victims who are persons with disabilities or special needs.	• Include specific focus on GBV responsiveness in oversight of police stations. • Monitoring of protection of victims at courts. • Increase access to legal support services. • Legal services including reporting the incidents to the South African Police Service (SAPS), obtain protection orders where needed. • Preparing and supporting victims with court cases. • Provision of paralegal support services to victims of GBV including LGBTQIA+ persons.	SAPS Department of Justice Department of Police Oversight and Community Safety
	Improve access and support to victims and prevent secondary victimization.	• Provide comfort, social relief and referral to other social support services and provide information on coping	DSD DoH&W

Objective 1.4: Address gender inequalities that increase vulnerabilities through gender-transformative approaches			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
		strategies and court preparation and support through Thuthuzela Care Centres. • Sensitisation sessions targeted at addressing GBV and provision of tools and information (LGBTQIA+, Human Trafficking, GBV among others) educating on the role of key role players in supporting and assisting survivors of GBV. • Establishment of referral pathways for victims of GBV. • Provision of effective shelter services to victims of crime and violence.	

Objective 1.5: Enhance non-discriminatory legislative frameworks through law and policy review and reform			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Advocate for the finalisation of law reform processes to decriminalise sex work	Participate in and support efforts that advocate for the amendment of laws to decriminalise sex work.	• Facilitate broad and inclusive public participation processes to raise awareness in relation to law reform for the decriminalisation of sex work.	PCAT Civil Society Forum Sex work Sector
		• Advocate for the finalisation of law reform processes to decriminalise sex work. • Support community-and peer-led advocacy for decriminalisation of sex work.	Department of Justice Sex Work Sector
Advocate for the decriminalisation of drug-use and drug	Participate in and support efforts that advocate for the decriminalisation of	• Facilitate broad and inclusive public participation processes to raise awareness in relation to law reform	PWUD Sector PCAT Civil Society Forum

Objective 1.5: Enhance non-discriminatory legislative frameworks through law and policy review and reform			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
possession for personal use	drug-use and drug possession for personal use.	for the decriminalisation of drug-use and drug possession for personal use. • Engage with all relevant departments and civil society sectors to support and promote law reform relating to decriminalisation of drug-use and drug possession for personal use.	Department of Justice
Enhance legal protection against hate crimes based on sexual orientation, gender identity and expression, and migrancy	Enhance legal protection against hate crimes based on sexual orientation, gender identity and expression, and migrancy.	• Support LGBTIQ+ led organisations and networks to advocate for the enactment of the Hate Crime Bill (Prevention and Combating of Hate Crimes and Hate Speech Bill of 2018). • Support initiatives aimed at addressing xenophobia. • Increase awareness of hate crimes based on sexual orientation, gender identity and expression, and migrancy.	LGBTIQI+ Sector PCAT Civil Society Forum Department of Justice
Reform policy provisions to enhance access to gender affirming healthcare and other essential services	Strengthen policy implementation relating to gender-affirming healthcare.	• Promote and support implementation of Gender Affirming Healthcare Guidelines for South Africa. • Support trans and gender-diverse people-led organisations and networks to advocate for implementation and enactment of laws and policies that enhance access to gender-affirming services.	DoH&W LGBTIQI+ Sector

Objective 1.6: Protect and promote human rights and advance access to justice			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Strengthen human rights and legal literacy relating to HIV, TB and STIs in communities and service provision	Sensitise communities on human rights, diversity and HIV, TB and STI risks and service access.	• Intensify awareness-raising on human and legal rights (Know your rights campaigns). • Scale up legal literacy training in communities with a focus on redress mechanisms and access to justice.	Department of Justice Law & Human Rights Sector Civil Society Forum
Strengthen the capacity of communities to monitor, document and respond to rights violations related to HIV, TB and STIs	Enhance capacity to monitor and document human rights violations	• Identify and support community-based and-led organisations to monitor, document and respond to rights violations. • Enhance access to community-based paralegals, particularly in rural areas. • Training of community members to identify, monitor and document HIV, TB and STIs-related human rights violations. • Support ongoing consolidation of human rights violations into the national Human Rights Portal.	Department of Justice PCAT
	Review and strengthen community-based referral systems and improve referral and case follow-up.	• Strengthen capacity of Legal Advice Offices to respond to HIV, TB and STIs-related human rights violations. • Advocate for increased access to legal services and affordable legal advice.	Civil Society Sectors including NGOs, Implementing partners
Enhance capacity and sensitisation of all service providers	Sensitisation and strengthen capacity of all service providers (healthcare providers, social workers, educators,	• Scale up in-service training and sensitisation of healthcare providers on human rights and medical ethics related to HIV, TB, STIs and viral hepatitis.	DoH&W DSD THP Sector

Objective 1.6: Protect and promote human rights and advance access to justice			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
on human rights, diversity and inclusive service provision across all sectors	law enforcement, etc.) through pre-service and in-service training.	• Strengthen in-service training of social workers on human rights, diversity and provision of inclusive social services. • Provide THP with accessible and relatable education and information as well as with information on patient rights and responsibilities for HIV, TB and STI care and treatment. • Enhance in-service training of law enforcement agents on rights provisions, diversity and provision of inclusive police services. • Strengthen capacity-enhancement efforts through the meaningful involvement of key and other priority populations. • Embedding sensitisation in the basic training of all service providers.	Law Enforcement agencies Higher Education Institutions (HEIs) Employers of Service Providers

Objective 1.7: Integrate and standardise delivery and access to mental health services			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Increase the availability of comprehensive mental health and	Provision of mental health and psycho-social support services across the care continuum of patients.	• Provide appropriate mental health care services at every level of care within the health system, with seamless integration of services between the levels of care.	DoH&W

Objective 1.7: Integrate and standardise delivery and access to mental health services			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
psychosocial support services in communities, health facilities, schools and institutions of higher learning		• Effective management and transfer of in-patients to psychiatric hospitals/psychiatric units. • Improve hospital infrastructure and expand bed capacity for mental health patients. • Strengthen out-patient mental health care services at hospital OPDs, Community Health Centres (CHCs) and Community Day centres (CDCs).	
	Build the capacity of teachers and learners to better respond to and cope with well-being and psycho-social concerns, including disability-related challenges.	• Provide psycho-social check-in tools and training in psychological first aid for teachers. • Implementation of wellness sessions for teachers and learners. • Provision of care and support assistants to high-risk schools. • Support for Grade 12 learners on coping with stress, study techniques, etc. • Implementation of peer education programmes.	WCED
	Expand access points for community-based psycho-social support services	• Improve community-based social support for mental health clients after discharge. • Appropriate provision of mental health services in Child and Youth Care Centres. • Train community healthcare workers and social service practitioners on mental health conditions, screening and support.	DSD DoH&W WCED

Objective 1.7: Integrate and standardise delivery and access to mental health services			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
	Reduce stigma associated with mental health conditions.	• Increase awareness and understanding of mental conditions through the provision of Information and Education Communication (IEC) materials. • Communications campaigns. • Promotion of available resources, e.g. mental health helpline, online resources, etc.	DSD Civil Society sectors NGOs and CBOs Implementing partners

GOAL 2: Maximise equitable and equal access to HIV, TB and STI services and solutions

HIV, TB and STI services are available at all levels of care in the Western Cape and across the life course. Services include the provision of primary prevention interventions, access to screening, testing and treatment as well as care services which include access to counselling and psycho-social support. The aim is to provide an integrated health service, with most clients accessing care at primary health care (PHC) level and having various options to receive their medication.

With more than 340 000 people on antiretroviral treatment in 2022, the ART programme is one of the largest treatment programmes in the province. Notwithstanding the relatively large number of people on treatment, challenges persist in ensuring that those diagnosed and initiated on treatment, remain on sustained treatment and achieve viral suppression. This challenge is further compounded by co-morbidities which have resulted in TB being the leading cause of death amongst people living with HIV, women living with HIV being six times more likely to experience invasive cervical cancer and being more likely than HIV-negative women to die of cervical cancer.[28] This underscores the need for strengthening the integration of health services and for the provision of holistic care that is person-centred.

TB remains a priority health concern in the Western Cape with more than 50 000[29] people diagnosed with TB the province between April 2022 and March 2023. The treatment success rate for new and relapsed cases in 2021 was 73%[30] for drug-sensitive TB, an indication that more than one quarter of all TB clients started on treatment are not attaining treatment success. The priority focus areas for the TB response must include the enhancement of TB prevention, increasing TB case finding and supporting persons with TB to complete their treatment.

As articulated in the NSP 2023 – 2028, key challenges remain in syndromic management of STIs with regard to programme implementation and the need for diagnostic testing to close the gap in treating asymptomatic infections. Data on the effectiveness of partner notification for STI treatment of sexual contacts is lacking in South Africa and this is an area where much improvement is required. Rollout of the HPV vaccination programme has been a move in the right direction to prevent infections but efforts are required to expand this programme to reach girls who are not attending school. Hepatitis B testing and vaccination of antenatal clients needs to be strengthened as well as coverage of infants to prevent vertical transmission.

[28] NSP for HIV, TB and STIs 2023 - 2028
[29] Public-facing TB Dashboard accessed at https://www.westerncape.gov.za/site-page/provincial-tb-dashboard on 14 July 2023
[30] DHIS

Integrated health services respond to the needs of individuals and populations and deliver comprehensive good-quality services throughout the life course through multidisciplinary teams who work together across settings and use evidence and feedback loops to continuously improve performance.[31] Services for HIV, TB and STI must therefore be provided as part of an integrated package of care that also includes the provision of services for non-communicable diseases, mental health and sexual and reproductive health.

The implementation of Differentiated Models of Care (DMOCs) is one of the important interventions that seek to address challenges experienced by both clients and the health service providers. Many clients have challenges of access to PHC facilities due to distance to travel to facility, costs involved in attending such facilities – both financially and in terms of time away from work, studies or from the care of children and other dependents. Such factors may result in a decrease in adherence - to visits and treatment- and poorer clinical outcomes.

It is imperative that solutions be explored that can provide better services to more citizens in a way that is more responsive to their lived reality – for example providing services that are more easily accessible e.g. provision of services at more alternative venues, or at more convenient times.

A multi-sectoral approach must be adopted to ensure that optimal coordination of activities that seek to improve outcomes for persons living with HIV and persons diagnosed with STIs and TB.

Goal 2: Objectives	
Objective 2.1	Increase knowledge, attitudes and behaviours that promote HIV-prevention.
Objective 2.2	Reduce new HIV infections by optimising the implementation of high-impact HIV-prevention interventions.
Objective 2.3	Eliminate vertical transmission of HIV.
Objective 2.4	To ensure that 95% of PLHIV know their status and 95% of them are on treatment and 95% of those on treatment are retained in care and achieve long-term viral suppression.
Objective 2.5	Strengthen TB-prevention interventions for key and other priority populations and the implementation of airborne infection-prevention and control in health facilities and high-risk indoor places where people congregate.
Objective 2.6	Strengthen TB diagnosis and support for PWTB, and accelerate the scale-up of innovative processes, diagnostic tools and regimens for the diagnosis, treatment, and care for PWTB.
Objective 2.7	Increase detection and treatment of curable STIs through systems strengthening, service integration and diagnostic testing; achieve elimination targets for neonatal syphilis; and scale-up HPV-vaccination and cervical cancer screening.
Objective 2.8	Reduce viral hepatitis morbidity through scale up of prevention, diagnostic testing, and treatment.

[31] WHO (2018) Technical brief on primary health care: integrating health services.

Objective 2.1: Increase knowledge, attitudes and behaviours that promote HIV-prevention			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Strengthen social and behaviour change communication interventions	Implementation of coordinated communications interventions across government, civil society and private sector, that is universally accessible.	• Provide targeted IEC messages for uptake of HIV-prevention services. • Promote continuous behaviour change interventions at individual level, social mobilisation at community-level and advocacy at societal level. • Strengthen targeted social media communication and messaging. • Improve communications to address stigma and discrimination in key populations.	DoH&W Implementing Partners Civil Society Sectors Private sector
	Promote health and wellbeing through strengthened behaviour change communication	• Distribution of information and communication materials that promote health and wellness and is aimed at prevention of non-communicable disease. • Promotion of healthier lifestyles, healthier diets and increased physical activity. • Increasing awareness of services and/or interventions that can improve general health and wellbeing of individuals and communities.	DoH&W Implementing Partners Civil Society Sectors Private sector
Increase communication and information reach underserved populations	Strengthen age-appropriate comprehensive sexuality education and SRHR education, that also takes into account people with disabilities.	• Strengthening the scripted lesson plans implementation. • Support learners in their transition to adolescence, including through puberty education and social-emotional learning.	WCED

including young people and men		• Strengthening the quality of Comprehensive Sexuality Education (CSE) curricula and delivery, including through support for teacher training and development. • HIV and STI prevention education and the promotion of HIV-testing in schools. • Establish peer groups for men. • Host and facilitate community dialogues around key health and social concerns	

Objective 2.2: Reduce new HIV infections by optimising the implementation of high-impact HIV-prevention interventions			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Scale-up access to available biomedical HIV prevention interventions	Increase the availability, access to and use of male and female condoms and lubricants.	• Intensify distribution of male and female condoms and lubricants at traditional distribution sites (health facilities, pharmacies, etc.). • Scale-up non-traditional distribution sites for male and female condoms and lubricants (e.g. truck stops, public toilets, shebeens, community halls, etc.). • Revitalise condom distribution to institutions of higher learning (universities, Further Education and Training (FET) colleges and Technical and Vocational Education and Training (TVET) colleges). • Promote consistent use of condoms and lubricants through relevant IEC materials and appropriate social media platforms.	DoH&W Civil Society sectors NGOs and CBOS Private Sector

Objective 2.2: Reduce new HIV infections by optimising the implementation of high-impact HIV-prevention interventions			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
	Targeted HIV counselling and testing, including for key and other priority populations.	• Promote and expand access to HIV Self-screening kits, especially for key populations and high burden communities. • Scale up index client testing. • Integrate NCD, STI and TB counselling and testing/screening services into HIV testing services.	DoH&W Implementing Partners Civil Society sectors NGOs and CBOS Private Sector
	Promote uptake of Voluntary Medical Male Circumcision (VMMC) through targeted demand generation strategies.	• Promote safe circumcision through strengthened collaboration between VMMC and traditional circumcision programme. • Strengthen demand creation for VMMC at places that men frequent. • Integrate VMMC services into primary healthcare services, including Men's Clinics.	DoH&W Men's Sector Traditional Health Practitioners Civil Society sectors NGOs and CBOS Private Sector
	Promote the availability of PrEP to all who need it and uptake by key and other priority populations	• Scale-up rollout of PrEP provision to all primary healthcare facilities • Active promotion of PrEP pregnant and breastfeeding women, adolescent women, MSM and other high risk population groups • Rollout Community-based PreP provision	DoH&W Implementing Partners Civil Society sectors
	Improve the availability of PEP and timely access for survivors of sexual violence, those exposed to condom-less sex and individuals who require it	• Increase access to PEP as an emergency service within 72 hours by increasing availability during weekends, public holidays and in pharmacies.	DoH&W Private Sector Civil Society sectors

Objective 2.2: Reduce new HIV infections by optimising the implementation of high-impact HIV-prevention interventions			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
		• Promote timely access to PEP for survivors of sexual violence, people who had unprotected sex and those who experience occupational exposure to HIV.	
Scale-up harm reduction programmes	Provision of comprehensive harm-reduction package to PWUD	• Promote needle and syringe programmes involving the distribution of sterile injecting equipment, collection and safe destruction of used equipment, and information on safer injecting. • Support provision of opioid substitution therapy by an appropriately trained health professional • Screen for and provide services for NCDs, mental health, TB, Hepatitis C and STIs as part of harm reduction programme. • Offer brief interventions, counselling and advice on drug use.	DoH&W PWUD Sector Civil Society sectors DSD

Objective 2.3: Eliminate vertical transmission of HIV			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Intensify prevention of vertical transmission programme (VTP) service provision for	Scale up screening of pregnant and breastfeeding women for HIV and link them to HIV-prevention services, including Pre-Exposure Prophylaxis (PrEP)	• Promote and facilitate early antenatal care bookings for pregnant adolescents and women. • Strengthen and promote partner involvement in prevention of vertical transmission of HIV, postnatal programmes.	DoH&W DSD NPOs and CBOs

all pregnant and breastfeeding women		• Promote access to HIV testing and retesting among pregnant and breastfeeding women. • Strengthen and expand rollout of First 1000 days programme.	
	Scale up universal uptake of ART among pregnant and breastfeeding HIV-positive mothers.	• Promote regular testing of the woman, partner and family, and rapid community/ facility initiation of ART. • Support adherence to ART care through peer support groups for pregnant and breastfeeding HIV-positive women.	DoH&W NPO Partners Women's Sector

Objective 2.4: To ensure that 95% of PLHIV, especially in key and other priority populations, know their status and 95% of them are on treatment and 95% of those on treatment are retained in care and achieve long-term viral suppression			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Improve HIV linkage to care for all PLHIV (first 95%)	Strengthen client-centred linkage services using innovative differentiated model of HIV care.	• Accelerate same-day or rapid initiation of ART. • Provide counselling and referral support for newly diagnosed patients. • Create an enabling environment for HIV-positive clients to access HIV treatment services that are non-judgemental and that are integrated with services for NCDs and mental health. • Provide education and counselling support for HIV-positive clients who are diagnosed with co-morbidities including NCDs and mental health concerns.	DoH&W NPO Partners Civil Society stakeholders

Objective 2.4: To ensure that 95% of PLHIV, especially in key and other priority populations, know their status and 95% of them are on treatment and 95% of those on treatment are retained in care and achieve long-term viral suppression			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Improve sustained ART retention in care for HIV-positive clients (second 95%)	Identify, engage, or reengage PLHIV who are not in care or not virally suppressed.	• Facilitate linkage to care immediately after diagnosis and provide low-barrier access to HIV-treatment. • Enhance ongoing counselling services within health, community and workplace settings. • Enhance capacity and sensitisation of service providers on friendly and appropriate provision of care. • Utilise Treatment Action Lists to actively follow-up clients who disengage from care.	DoH&W NPO Partners Civil Society stakeholders
	Improve uptake of regular viral monitoring.	• Improve viral load monitoring and adherence support for pregnant and breastfeeding women. • Integrate data systems to track and monitor viral load uptake (e.g. National Health Laboratory System (NHLS) data to sync to Sinjani).	DoH&W NHLS

Objective 2.4: To ensure that 95% of PLHIV, especially in key and other priority populations, know their status and 95% of them are on treatment and 95% of those on treatment are retained in care and achieve long-term viral suppression			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Increase retention in care and adherence to HIV-treatment to achieve and maintain long-term viral suppression (third 95%)	Prioritise differentiated models of care (DMOC) strategies for long-term retention.	• Implement context-specific and appropriate models of care to promote long-term retention in care. • Strengthen monitoring and management of ART side-effects through effective pharmacovigilance systems that include causality assessments and ARV toxicity monitoring. • Reinforce the role of patient advocates and peer support for treatment adherence. • Scale-up treatment literacy programmes. • Build social support systems that enable improved adherence to treatment.	DoH&W PLHIV Sector Civil Society Sectors DSD

Objective 2.5: Strengthen TB-prevention interventions for key and other priority populations and the implementation of airborne infection-prevention and control in health facilities and high-risk indoor places where people congregate			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Strengthen TB-prevention interventions for key and other priority populations	Increase awareness of TB as a major infectious disease in the Western Cape.	• Enable public access to TB data and capacitate communities to utilise this information for decision-making. • Implement effective communications campaigns to highlight the need for routine TB screening and	DoH&W Implementing Partners CBOs and NGOs DSD WCED

Objective 2.5: Strengthen TB-prevention interventions for key and other priority populations and the implementation of airborne infection-prevention and control in health facilities and high-risk indoor places where people congregate			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
		testing of high-risk groups (Targeted Universal TB Testing). • Actively promote the TB Health Check App. • Implement TB screening protocols at congregate settings such as shelters, schools, etc., integrated with screening for other health conditions including NCDs.	
	Increase uptake of TB prevention interventions.	• Increase uptake of TB Preventive Therapy (TPT) at all primary health care facilities. • Expand access to 3HP and 3RH (short-course treatment regimens to prevent TB). • Implement new TB regiments as they become available.	DoH&W
	Strengthen the implementation and monitoring of airborne infection-prevention and control measures.	• Improve and maintain infection prevention and control at healthcare facilities, including patient education, staff training, cough etiquette and screening. • Ensure availability of suitable personal protective equipment (PPE) such as N95 respirators for HCWs and surgical masks for patients. • Institute compulsory HCW education and training in TB IPC and on the proper use of protective respirators. • Advocate for IPC measures in public transport and other congregate settings.	DoH&W DSD Department of Mobility Civil Society Sectors

Objective 2.5: Strengthen TB-prevention interventions for key and other priority populations and the implementation of airborne infection-prevention and control in health facilities and high-risk indoor places where people congregate			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
		• Ensure adequate and appropriate ventilation in high-risk settings such as health facilities and congregate settings.	

Objective 2.6: Strengthen TB diagnosis and support for PWTB, and accelerate the scale-up of innovative processes, diagnostic tools and regimens for the diagnosis, treatment, and care for PWTB			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Strengthen TB diagnosis and increase the TB detection rate	Strengthen implementation of targeted strategies for TB screening and testing.	• Implement community-based screening and testing services for TB, integrated with screening for other health conditions including HIV, STIs, NCDs and mental health. • Improve TB screening at health facilities through the compulsory TB screening of all patients. • Accelerate the scale up of innovative screening and diagnostic tools such as digital chest X-rays and Urine Lipoarabinomannan (uLAM) to increase the TB detection rate.	DoH&W NGOs Civil Society Sectors
	Enhance TB contact tracing.	• Support community-led and community-based TB contact tracing initiatives. • Utilisation of telehealth initiatives to improve contact tracing.	DoH&W NGOs Civil Society Sectors

Objective 2.6: Strengthen TB diagnosis and support for PWTB, and accelerate the scale-up of innovative processes, diagnostic tools and regimens for the diagnosis, treatment, and care for PWTB			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Strengthen linkage into care and access to treatment for Persons with TB	Strengthen referrals and linkage into care for PWTB.	• Improve utilisation of SMS notification of results through improving accuracy patient contact details. • Provide counselling to Persons with TB to support linkage to care. • Strengthen referral processes for persons with TB who are diagnosed in hospitals or in community settings. • Accelerate the implementation of shorter TB regiments.	DoH&W
	Implement innovative solutions to track and trace persons with TB who are no longer in care.	• Utilise available Treatment Action Lists to follow-up on clients who are not initiated on treatment or who disengage from treatment. • Utilisation of telehealth initiatives to strengthen linkage to care and adherence to TB treatment.	DoH&W

Objective 2.6: Strengthen TB diagnosis and support for PWTB, and accelerate the scale-up of innovative processes, diagnostic tools and regimens for the diagnosis, treatment, and care for PWTB			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Strengthen support and increase treatment completion for PWTB	Provide comprehensive, person-centred support package to increase TB treatment completion.	• Provide support, such as adherence counselling and treatment buddy, during and after treatment for PWTB. • Provide social support and mental health support during and after treatment for PWTB, prioritising those at high risk of poor adherence and people with multi-drug resistant (MDR)-/ extremely drug resistant (XDR)-TB. • Adopt evidence-based digital adherence support technologies. • Provide nutritional support to persons living to TB to improve chances of treatment completion.	DoH&W

Objective 2.7: Increase detection and treatment of STIs through systems strengthening, service integration and diagnostic testing; achieve elimination targets for neonatal syphilis; and scale-up HPV-vaccination and cervical cancer screening			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Reduce the annual number of new cases of STIs	Accelerate efforts to prevent, find and treat STIs	• Prevent STIs by providing information and education and effective STI prevention tools, e.g., condom distribution and VMMC services. • Training/Retraining of HCWs including primary healthcare on detection and treatment of STIs, including priority populations.	DoH&W Implementing Partners NGOs and CBOs

Objective 2.7: Increase detection and treatment of STIs through systems strengthening, service integration and diagnostic testing; achieve elimination targets for neonatal syphilis; and scale-up HPV-vaccination and cervical cancer screening			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
		• Emphasise integration of STI care with sexual and reproductive health services. • Implement strategies to strengthen partner notification and contact tracing, especially for health and priority populations. • Implement strategies to advocate for the improvement of supply and access to "tracer drugs" used in the treatment of STIs	
Achieve elimination of neonatal syphilis.	Fast-track efforts aimed at the elimination of neonatal syphilis	• Screening of all pregnant women for syphilis at regular intervals as part of antenatal care. • Screening for syphilis at birth for all infants born to syphilis-positive or untested women. • Linking all children diagnosed with congenital syphilis to care and ensuring they receive treatment. • Implement syphilis rapid diagnostic testing and same-day treatment of pregnant women during antenatal care.	DoH&W Implementing Partners NGOs and CBOs
Scale up HPV-vaccination and cervical cancer screening	Scale up of age-based HPV-vaccination programme	• Implement awareness-raising for HPV-vaccination. • Address vaccine hesitancy through implementation of comprehensive education and awareness-raising for HPV-vaccination.	DoH&W Women's Sector WCED NGOs and CBOs

Objective 2.7: Increase detection and treatment of STIs through systems strengthening, service integration and diagnostic testing; achieve elimination targets for neonatal syphilis; and scale-up HPV-vaccination and cervical cancer screening			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
		• Implement and monitor the cervical cancer care cascade including rapid management of women with high-risk cervical lesions	

Objective 2.8: Reduce viral hepatitis morbidity through scale up of prevention, diagnostic testing, and treatment			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Scale up diagnostic testing and treatment of viral hepatitis	Scale up diagnostic testing and treatment of viral hepatitis	• Scale up HBV birth dose vaccination of newborns. • Hepatitis-B Virus diagnostic testing and vaccination of HCWs. • Scale-up access to Hepatitis prevention services for PWUD, including provision of needle exchange programmes and Hepatitis education and awareness. • Implement targeted Hepatitis-C Virus diagnostic testing and treatment strategies for key populations.	DoH&W Private healthcare providers Employers of healthcare workers

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

Establishing and maintaining resilient systems for health and social services is recognised as a priority within the NSP 2023 – 2028. These resilient systems must have sufficient capacity to manage, absorb and mitigate risks whilst also having sufficient agility to enable adaptation to change. This has been starkly highlighted by the recent COVID-19 pandemic which laid bare the vulnerabilities that exist within health and social systems. Resilience is the ability of systems not only to prepare for shocks, but also to minimise the negative consequences of such disruptions, recover as quickly as possible, and adapt by learning lessons from the experience to become better performing and more prepared.

Universal Health Coverage (UHC) means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship.[32] In our collective efforts to attain UHC, we must move towards universal access to health services with social protection; making the health system more equitable with a set of proactive measures to reach the unreached.[33] UHC must be seen as the foundation for an equitable health system and it thus becomes imperative to create the capacity to mobilise around the equity agenda within the spheres of government and with civil society, to progressively realise the right to health care for all people.[34]

Resilient systems for health and social services, and all efforts aimed at achieving UHC, calls for multidisciplinary and multi-sectoral approaches that includes participation from civil society, private sector and government.

Goal 3: Objectives	
Objective 3.1	Engage adequate human resources to ensure equitable access to services for HIV, TB, STIs, and other conditions that contribute to these diseases.
Objective 3.2	Use timely and relevant strategic information for data-driven decision-making.
Objective 3.3	Expand the research agenda for HIV, TB and STIs to strengthen the national response.
Objective 3.4	Harness technology and innovation to fight the epidemics with the latest available tools.
Objective 3.5	Leverage the infrastructure of HIV, TB and STIs for broader preparedness and response to pandemics and various emergencies.
Objective 3.6	Strengthen access to comprehensive laboratory testing of HIV, TB and STIs including molecular diagnostics, serology, and culture.

[32] World Health Organisation. (2023). Universal Health Coverage (UHC) https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)
[33] Health is Everybody's Business
[34] Ibid

Objective 3.1 Engage adequate human resources to ensure equitable access and leave nobody behind			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Ensure that human resources required are sufficient in number where they are needed	Adequately trained workforce in prevention, treatment and care programmes for HIV, TB and STIs.	• Capacitate and facilitate ongoing professional development, training and mentoring of different categories of staff to address skills and knowledge gaps. • Train and capacitate community workers on HIV, TB, STIs, viral hepatitis and mental health prevention, treatment, and care services. • Train, sensitise and capacitate workers in their diversity on the specific needs of key and other priority populations, including people with disabilities to address special needs. • Apply a needs-based approach in calculating workforce needs.	DoH&W Higher Education Institutions (HEIs) Health Professionals Sector
Promote and protect the health and wellbeing of human resource structures	Implement wellness and psychosocial support programmes in workplaces for healthcare and social service workers.	• Provide accessible wellness management resources and facilities to promote mental and physical health and wellbeing of service workers. • Promote optimal utilisation of existing Employee Health and Wellness Programmes. • Create enabling workplace environments that promote healthier behaviours. • Implement whole-system responses for improving the physical and mental health and wellbeing of service workers.	DoH&W DSD Private sector Employers of health and social service workers Health Professionals Sector

Objective 3.2 Use timely and relevant strategic information for data-driven decision-making			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Enhance integration of data systems, including data-sharing between sectors for a more coordinated response	Implement a coherent and harmonised data system for monitoring progress.	• Develop and implement a monitoring and evaluation (M&E) framework for the PIP. • Strengthen data-sharing between sectors through formalised reporting structures and data sharing agreements where required. • Expand capability of the use of Single Patient Viewer to track patients across levels of care within the public health system. • Improve access to private sector data in relation to HIV, TB and STIs.	PCAT Secretariat DoH&W Private Sector
	Strengthen and expand routine surveillance and data collection systems.	• Improve data collection processes and routine surveillance systems for STIs and viral hepatitis. • Capacitate local level programme implementers to utilise data for decision-making. • Ensure provision of up-to-date public facing data and dashboards. • Enhance data systems to disaggregate data to include persons with disabilities and sexual orientation, where applicable.	PCAT Secretariat DoH&W Private Sector
Improve capability across sectors for utilisation of data for decision-support	Increase capacity for utilisation of data for decision-support	• Increased awareness and use of available dashboards and tools for decision-making by stakeholders across all sectors.	PCAT Secretariat

		• Build capacity amongst stakeholders to use data for action. • Support community-led monitoring. • Regular sharing of information and progress reports. • Institute feedback mechanisms for strategic information.	

Objective 3.3 Expand the research agenda for HIV, TB and STIs to strengthen the national response			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Strengthen research related to HIV, TB and STIs and invest in locally initiated research while supporting collaboration with international counterparts	Develop a provincial research agenda for HIV, TB and STIs.	• Develop a curated database of priority research questions for HIV, TB and STIs to advance the response. • Expand collaboration opportunities between government and civil society with academic institutions. • Advocate for and support locally initiated research activities. • Create platforms for sharing research findings (Research Days). • Educate and raise awareness amongst research participants on research ethics and the responsibilities of researchers to the participants and communities in which research is conducted.	DoH&W Academic institutions Research Sector Civil Society Sectors

Objective 3.4 Harness technology and innovation to fight the epidemics with the latest available tools			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Expand the use of innovative solutions that harness the potential of technological developments	Expand access to and the use of innovative solutions	• Increase access to digital tools for diagnostics and data collection. • Accelerate technology skills transfer. • Increase investment in digital health technologies. • Expand the use of electronic health (eHealth) and mobile health (mHealth) in prevention, treatment and care services. • Strengthen telehealth initiatives to support adherence to treatment and improve linkage to care.	Department of Economic Development DoH&W Development partners Private sector

Objective 3.5 Leverage the infrastructure of HIV, TB & STIs for broader preparedness and response to pandemics and various emergencies			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Adapt to changing epidemic patterns and rapidly deploy innovations learnt from the care and management of HIV, TB and STIs	Apply lessons learnt from the response to HIV, TB and STIs to support emerging pandemics and other health and development threats.	• Create platforms for information sharing and dissemination of good practices and evidence-based interventions. • Support the maintenance of robust surveillance systems. • Enhance community engagement strategies to ensure that affected communities are partners in the response. • Leverage existing multi-sectoral platforms at local levels to share lessons and good practices.	DoH&W Partners Stakeholders WOSA/WOGA

Objective 3.6 Strengthen access to comprehensive laboratory testing for HIV, TB and STIs including molecular diagnostics, serology, and culture			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Ensure access to comprehensive laboratory testing for HIV, TB and STIs	Improve surveillance activities to monitor effective prevention and treatment modalities of HIV, TB and STIs.	• Ensure accessibility to viral load and resistance testing in the care of PLHIV. • Monitoring of genotypes and the dynamics of transmission in TB infection. • Improve systems for linkage to care for those who use self-screening kits. • Strengthen access to comprehensive laboratory testing for HIV, TB and STIs including molecular diagnostics, serology, and culture.	DoH&W NHLS

GOAL 4: Fully resource and sustain an efficient HIV, TB and STI response led by revitalised, inclusive and accountable institutions

The Western Cape economy has been exposed to a slowing global and domestic economy and volatile markets. The domestic economy contracted severely from the effects of the COVID-19 pandemic, exacerbated by low economic growth, extreme unemployment, high debt servicing costs, the national energy crisis, and unexpected shocks, such as unrest and floods in some parts of the country in 2021.[35] Within this context of economic austerity, every effort must be made to protect domestic funding provisions for HIV, TB and STIs.

Sustainability can be defined as the ability of a health program or country to both maintain and scale up service coverage to a level, in line with epidemiological context, that will provide for continuing control of a public health problem and support efforts for elimination thereof, even after the removal of external funding.[36] Although recent allocations to South Africa from both United States President's Emergency Plan For AIDS Relief (PEPFAR) and the Global Fund have increased, policies and actions from these development partners strongly encourage upper middle-income countries like South Africa to systematically plan for the transition of selected externally-funded functions to the public sector.[37] One cause for concern is that development partners continue to be a major source of funding for interventions aimed at key and priority populations and also invest significant funding in health systems strengthening and expansion of community-based services.

Adequate financing, an enabling environment and appropriate governance, leadership and accountability are the underlying prerequisites for a sustainable HIV and TB response including its systems and services. It is however, worth highlighting that despite increasing resource needs to ensure that the 95-95-95 goals are achieved, fiscal space for increased spending on health and social services over the period of this implementation plan will remain constrained.

Goal 4: Objectives	
Objective 4.1	Sufficient domestic and external funds are mobilised and allocated to facilitate the efficient implementation and coordination of HIV, TB and STI programmes and address the underlying-associated risk factors that have direct consequences for these conditions.
Objective 4.2	Sustainability and transition plans and actions are routinely developed and implemented to ensure that NSP interventions remain on track to achieve short-, medium- and long-term goals.
Objective 4.3	Strengthen Provincial Council on AIDS & TB and related structures, including civil society organisations for an optimal, efficient and impactful NSP 2023-28 execution experience.

[35] NSP 2023 - 2028
[36] The Global Fund Sustainability, Transition and Co-financing Policy. Accessible at: https://www.theglobalfund.org/media/4221/bm35_04-sustainabilitytransitionandcofinancing_policy_en.pdf
[37] NSP 2023 - 2028

The Western Cape Resource Mobilisation Committee (RMC) has recommended that the following interventions be prioritised in relation to resource mobilisation efforts:

Focus Area	Interventions
Adolescents and Youth	Parenting Programmes Early Childhood Development Mental Health and Psycho-social support
Retention in Care	Addressing the socio-economic drivers of poor retention: - Migrancy - Food insecurity - Substance Abuse - Safety - Unemployment
Biomedical Prevention	Pre-Exposure Prophylaxis Targeted Universal Testing for TB
Differentiated Models of Care (DMOC)	Strengthen DMOC to enhance community-based services Expand to key industries and workplaces to facilitate increased access for hard-to-reach populations
Community-Oriented Primary Care (COPC)	Invest in efforts to intensify the response in identified priority geographic areas Capacity building and enhancing community participation in COPC initiatives
Decision Support	Enabling greater access to data and information Build capacity that enables the use of data for decision-making Development of simplified tools for data analyses
Communication	Mass communication campaign to amplify and increase awareness Targeted messaging Consider media as a stakeholder in the response

Objective 4.1 Sufficient domestic and external funds are mobilised and allocated to facilitate the efficient implementation and coordination of HIV, TB and STI programmes and address the underlying-associated risk factors that have direct consequences for these conditions.			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Mobilise adequate funding for efficient response from public, private and external funding sources	Coordinate sufficient and complimentary investments from government departments, development partners and the private sector.	• Conduct regular reviews of investment and expenditure related to HIV, TB and STIs. • Protect public allocations for HIV, TB and STIs in the MTEF using budget impact assessments and budget reprioritisation exercises. • Re-invest efficiency savings in under-resourced priority areas. • Raise additional funds through innovative funding mechanisms, e.g. outcomes-based contracting, social impact bonds and public-private partnerships. • Undertake cost analyses and economic evaluations to drive value for money in HIV and TB programmes	Provincial Treasury DoH&W Development Partners Private Sector
Optimise health financing and financial management systems and capacities to support sustainable financing, budget monitoring, and accountability	Effectively implement systems and structures to support sustainable financing, budget monitoring and accountability.	• Establish and strengthen resource mobilisation structures to improve the use of economic data and evidence for resource mobilisation, planning and decision-making. • Strengthen integration of financial systems with programme information systems to generate comprehensive data sets to inform decision-making and improve programme and financial management. • Strengthen tracking and reporting of HIV, TB and STI budgets and expenditure.	Provincial Treasury DoH&W Development Partners Private Sector

Objective 4.2 Sustainability and transition plans and actions are routinely developed and implemented to ensure that NSP interventions remain on track to achieve short-, medium- and long-term goals.			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Institute multi-sectoral sustainability and transition planning for HIV and TB programmes	Develop a multi-sectoral sustainability plan for HIV and TB.	• Targeted transitioning of donor-supported health workforce required to sustain the HIV and TB response, ensuring optimised use of available workforce. • Regularly review allocation of resources in line with epidemiological changes, health needs and innovations in prevention and treatment. • Comprehensive assessment of possible health financing options and mechanisms. • Donor support to be strategically coordinated by government to supplement the domestic contributions. • Transitional planning to be an essential component of all donor-funded programmes. • Undertake regular sustainability assessments and transition planning exercises for priority subprogrammes.	PCAT Secretariat Provincial Treasury DoH&W Development Partners Private Sector Civil Society Sectors

Objective 4.3 Strengthen Provincial Council on AIDS & TB and related structures, including civil society organisations for an optimal, efficient and impactful NSP 2023-28 execution experience.			
Sub-Objective	**Priority Action**	**Initiatives and Interventions**	**Accountable Parties**
Strengthen capacity of existing AIDS Council structures	Capacity building of AIDS Council structures	• Roll-out focused capacity building programmes for all PCAT stakeholders (government, civil society and private sector). • Foster the greater participation of the private sector and civil society sectors. • Establish suitable, context-specific multi-sectoral structures to coordinate HIV, TB and STI activities at district and local levels. • Strengthen Programme Review Committee and Resource Mobilisation committee by ensuring adequate and competent representation from government, civil society, private sector and relevant subject-matter experts.	PCAT Secretariat Government Departments Civil Society Sectors
Strengthen the accountability climate of the response	Implementation of measures to ensure greater accountability for the HIV and TB response at all levels.	• Advocate for inclusion of HIV, TB and STI response to form part of performance appraisal scorecards of all mayors and mayoral committee members, heads of department and municipal managers. • Support the work and functions of the Provincial TB Caucus. • Ensure continuous and pro-active engagement with civil society.	PCAT Secretariat Office of the Premier Provincial Top Management SALGA Civil Society Sectors

CHAPTER 5: MONITORING AND EVALUATION FRAMEWORK

CHAPTER 5. MONITORING AND EVALUATION FRAMEWORK

5.1. Reporting structure

The national Monitoring and Evaluation (M&E) Framework for the National Strategic Plan on HIV, TB and STIs 2023 - 2028 (NSP) has been developed by SANAC, and SANAC will assume overall responsibility for monitoring progress against the NSP targets and indicators. The M&E Framework for the Provincial Implementation Plan is aligned to the national framework and considers existing monitoring and evaluation sub-systems being implemented by different stakeholders. At all levels, the province will work to ensure that it harmonises all M&E inputs in full support of the national system.

M&E of the multi-sector response will require coordination of all sectors (government, civil society, private sector and development partners) to ensure optimal use of available resources. In this regard, the PCAT Secretariat will play a central role in ensuring that the province provides accurate and verifiable data on progress made in achieving the goals of the NSP and PIP.

The Western Cape Province is cognisant of the critical importance of ensuring a uniform M&E system. A uniform M&E system will enhance the close monitoring and evaluation of the implementation and progress towards the achievement of the goals of the Provincial Implementation Plan (PIP) for HIV, STIs and TB. This provincial M&E framework is aligned to the national M&E framework and is informed by the National Strategic Plan (NSP). The M&E framework considers existing monitoring and evaluation systems being implemented by the government and other critical stakeholders in the province.

Data on selected indicators will flow from the relevant government, civil society, government and business sectors to the PCAT Secretariat. The Secretariat will then consolidate and synthesise the data so that it is aligned with national requirements and forward this data to the SANAC Strategic Information Unit as per agreed reporting timelines. While government and civil society sectors will report within their established structures at the different levels, they will be required to feed into the Provincial structure at the same time. This will help strengthen the multi sectoral responses at the different levels.

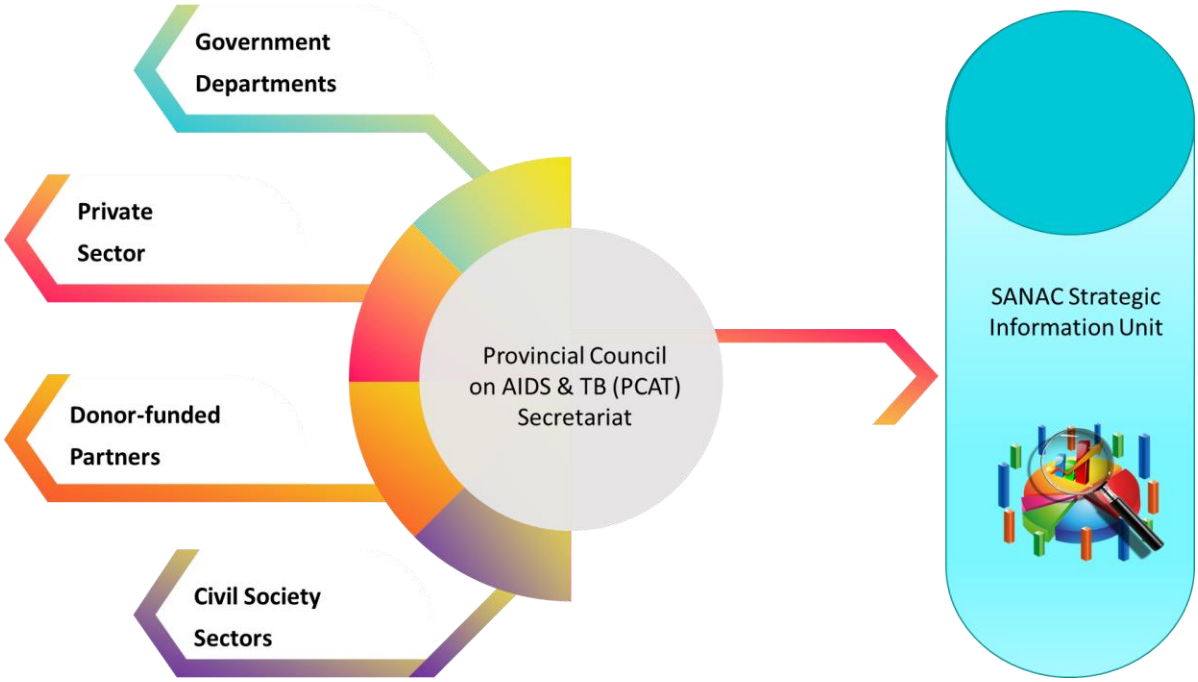


Figure 19: Reporting and data flow

5.2 Definitions

Indicators Indicators are realistic and measurable criteria of progress. They are defined before the project starts and allow us to monitor or evaluate whether a project does what it said it would do. In this PIP, the indicators as outlined in the M&E framework will form the link between theory and practice. They are an integral tool that will enable us to know whether our work is making a difference. Indicators describe observable changes or events which relate to the intervention/s. They provide the evidence that something has happened – whether an output delivered, an immediate effect occurred, or a long-term change observed.

Outcome indicators Outcome Indicators measure whether the programme is achieving the expected effects/changes in the short, intermediate, and long term. Most programmes refer to their longest-term/most distal outcome indicators as **impact** indicators. Because outcome indicators measure the changes that occur over time, indicators should be measured at least at baseline (before the program/project begins) and at the end of the project. Long-term outcomes are often difficult to measure and attribute to a single intervention. However, that does not mean a

program should not try to determine how they are contributing to the impact of interest (e.g., decrease in morbidity related to health issue or social concern).

Input indicators Input indicators measure the contributions necessary to enable the program to be implemented (e.g., funding, staff, key partners, infrastructure).

Process indicators Process indicators measure the programme's activities and outputs (direct products/deliverables of the activities). Together, measures of activities and outputs indicate whether the programme is being implemented as planned. Many people use output indicators as their process indicators; that is, the production of strong outputs is the sign that the programme's activities have been implemented correctly. Others may collect measures of the activities and separate output measures of the products/deliverables produced by those activities.

5.3. Monitoring and evaluation framework

This multi-sectoral M&E framework is aligned to the M&E framework of the NSP 2023 – 2028 to ensure coherence in the reporting frameworks at the different levels and to allow for comparison (where possible) across provinces.

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

No	Indicator	Indicator Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsible
							2023/24	2024/25	2025/26	2026/27	2027/28		
OBJECTIVE: Strengthen community-led HIV, TB and STI responses													
1	The number of beneficiaries accessing PSS services	Output	Count: number of beneficiaries accessing PSS services through the DSD	Geographical area, sex, disability	DSD	5396 (2022/23)	3650	3650	4210	4210	4210	Annual	DSD
OBJECTIVE: Contribute to poverty reduction through creation of sustainable economic opportunities with a focus on key and priority populations													
2	Unemployment rate	Outcome	Uses the official definition of unemployment among 15-64-year olds as defined by Statistics South Africa	Geography, age, sex	Statistics South Africa Quarterly Labour Force Survey	21,6% (2022/23)	TBD	TBD	TBD	TBD	TBD	Annual	SANAC, Statistics South Africa
3	Number of beneficiaries receiving social grants	Output	Count - Number of beneficiaries receiving social grants.	Geographic area, type of grant, disability	SASSA annual report	1 661 745 (2022/23)						Annual	DSD

No	Indicator	Indicator Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsible
							2023/24	2024/25	2025/26	2026/27	2027/28		
5	The number of people accessing food through DSD programmes	Output	Count: Cumulated over a five-year period	Geography, programme (drop-in Centres, Community Nutritional Centres, Home and Community-Based organisations)	DSD Annual Report	15922 (2022/23)	9620	9620	9620	9620	9620	Annual	
OBJECTIVE: Address gender inequalities that increase vulnerabilities through gender- transformative approaches													
6	Number of victims of GBVF and crime who accessed sheltering services	Output	Count: Number of GBVF victims supported with shelter services	Province, sex	EQPR	2369 (2022/23)	1900	1900	1950	1980	1980	Annual	DSD
7	Number of sexual offences	Outcome	Count: Total sexual offences as reported by South African Police Service annually	Type of sexual offence: rape, sexual assault, attempted sexual offences and contact sexual offences	SAPS	7294 (2022/23)	TBD	TBD	TBD	TBD	TBD	Annual	SAPS

No	Indicator	Indicator Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsible
							2023/24	2024/25	2025/26	2026/27	2027/28		
8	Percentage of female and male adolescents who experienced bullying during the past 12 months	Outcome		Geographic area, age, grade, sex, disability	General Household Survey							Annual	WCED
OBJECTIVE: Protect and promote human rights and advance access to justice													
9	Percentage of health care providers trained on medical ethics and Human rights	Output		Geographical, sex	DOH&W	(2022/23)						Annual	DOH&W

No	Indicator	Indicator Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsible
							2023/24	2024/25	2025/26	2026/27	2027/28		
10	Percentage of people living with HIV reporting their rights were violated who sought legal redress	Outcome	Numerator: number of people living with HIV who reported their rights were violated who sought legal redress. Denominator: number of people living with HIV reporting their rights were violated in the last 12 months.	Geographical, age, sex, key pops, people living with disabilities	Stigma Index Survey		10%	20%	30%	40%	50%	Every 2 to 3 years	SANAC
OBJECTIVE: Integrate and standardise delivery and access to routine mental health services													
11	PHC client treated for mental disorders	Output	Count - Number of clients treated for mental health disorders. PHC Mental disorders treatment rate	Geographical, age, sex.	DHIS	30 636 (2022/23)						Annual	DOH&W

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

No	Indicator	Indicator Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsible
							2023/24	2024/25	2025/26	2026/27	2027/28		
HIV Prevention and Harm Reduction													
1	Number of new HIV infections	Impact	Modelled	Sex, Age (< 15, 15-25, 25-49 years)	Thembisa model	11741 (2022)	11432	11273	11160	11064	10980	Annual	SANAC, PCAT
2	Mother-to-child transmission rate at 10 weeks	Impact	Numerator: Infant PCR test positive around 10 weeks Denominator: Total Infant PCR test around 10 weeks	Geographic area	DHIS	0.3% (2022/23)	0.8%	0.7%	0.7%	0.6%	0.6%	Annual	DOH&W
3	Mother-to-child transmission rate at 18 months	Impact	Children born to HIV-positive women who tested positive for HIV antibodies around 18 months after birth	Geographic area	Thembisa Model	0,52% (2022/23)	0,50%	0,50%	0.49%	0.49%	0.50%	Annual	DOH&W
OBJECTIVE: Increase knowledge, attitudes and behaviours that promote HIV prevention													
6	Delivery 10 to 19 years in facility rate	Outcome	Numerator: Delivery in facility 10 to 19 years Denominator: Total number of deliveries in facility	Geographic area Age: 10-14 years; 15 -19 years	DHIS	11,5% (2022/23)	11.0%	10.8%	10.6%	10.4%	10.2%	Annual	DOH&W

No	Indicator	Indicator Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsible
							2023/24	2024/25	2025/26	2026/27	2027/28		
7	Number of learners reached through combination prevention interventions	Output	Numerator: Number of learners reached through functional adolescents and young people (AYP) education programmes Denominator: N/A	Geographic area, age	WCED Provincial reports	230,515 (2022/23)	TBD	TBD	TBD	TBD	TBD	Annual	WCED
8	Percentage of schools that are providing age-appropriate comprehensive sexuality education (CSE) through life skills and orientation	Output	Numerator: Number of schools that are providing CSE Denominator: Number of selected schools	Geographic area	WCED Provincial reports	75% (2021/22)						Annual	WCED
10	Number of beneficiaries receiving DSD Social Behaviour Change programmes	Output	Numerator: Number of beneficiaries receiving SBC programmes. Denominator: N/A	Geographic area, Sex, Age, type of programme	DSD Annual Report							Annual	DSD

No	Indicator	Indicator Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsible
							2023/24	2024/25	2025/26	2026/27	2027/28		
OBJECTIVE: Reduce new HIV infections by optimising the implementation of high impact HIV prevention interventions													
12	Number of male condoms distributed	Output	Numerator: Male condoms distributed Denominator: N/A	Geographic area, Sex, Age (15+) --- These sex and age disaggregation?	DOH&W Annual report WCGHW Annual report	55 420 700 (2022/23)	89 956 044	-	-	-	-	Annual	DOH&W, DCS, SAPS, DHET/ HEAIDS, DPSA, SABCOHA
13	Number of female condoms distributed	Output	Numerator: Female condoms distributed Denominator: N/A	Geographic area, Sex, Age (15+)	DOH&W Annual report WCGHW Annual report	1,258,400 (2022/23)	1169660	-	-	-	-	Annual	DOH&W, DCS, SAPS, DHET/ HEAIDS, DPSA, SABCOHA
15	Number of people tested for HIV	Output	Numerator: Number of people tested for HIV. Denominator: N/A	Geographic area, Sex, Age (15+)	DHIS, Thembisa Model	1 555 501 (DHIS, 2022/23	2000 000	-	-	-	-	Annual	DOH&W, DCS, DHET/HEAIDS DOT, DPSA, SAPS

No	Indicator	Indicator Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsible
							2023/24	2024/25	2025/26	2026/27	2027/28		
16	Number of medical male circumcisions performed	Output	Numerator: Number of medical male circumcisions performed Denominator: N/A	Geographic area Age (10-14; 15+)	DOH&W Annual report WCGHW Annual report	13226 (2022/23)	21887	-	-	-	-	Annual	DOH&W, DCS, DHET/ HEAIDS Private sector (Council of Medical AID Schemes), Traditional sector
17	Number of people receiving oral PrEP for the first time during the reporting period	Output	Numerator: Number of people receiving oral PrEP for the first time during the reporting period Denominator: N/A	Geographic area, Sex, Age, key and priority populations	DHIS	16977 (2022/23)	31660	-	-	-	-	Annual	DOH&W
18	New sexual assault case HIV-negative issued with post exposure prophylaxis	Output	Count: number of individuals who experienced sexual assault and were provided with post exposure prophylaxis	Geographic area, Sex, Age (15+)	DHIS	3288 (2022/23)	5548	-	-	-	-	Annual	DOH&W

No	Indicator	Indicator Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsible
							2023/24	2024/25	2025/26	2026/27	2027/28		
19	Percentage of health facilities with post-exposure prophylaxis available	Output	Numerator: Number of health facilities with PEP available for those who are at risk of HIV infection through occupational and/or non-occupational exposure to HIV. Denominator: Total number of public primary healthcare facilities	Geographical area, facility type	DHIS	(2022/23)	-	-	-	-	-	Annual	DOH&W
20	Number of people reached through substance abuse prevention programmes	Output	Numerator: Number of people reached through substance abuse prevention programmes Denominator: N/A	Age: children 18 years and below 19 and above	DSD Annual report	6040 (2022/23)	4042	4042	4092	4092	4092	Annual	DSD

No	Indicator	Indicator Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsible
							2023/24	2024/25	2025/26	2026/27	2027/28		
24	Couple year protection rate	Outcome	Numerator: Women protected against pregnancy by using modern contraceptive methods. Denominator: females 15–49 years	Geographical area	DHIS	50,2% (2022/23)	55.0%	55.6%	56.4%	56.4%	56.4%	Annual	DOH&W
HIV Treatment and Care													
25	Adult AIDS mortality	Impact	Numerator: Adult mortality attributable to HIV (total AIDS deaths).	Geographic area, Age, Sex, ART status	Thembisa Model	4005 (2022/23)	3838	3638	3520	3428	3350	Annual	SANAC
26	Non-AIDS deaths in HIV-positive individuals	Impact	Count – Total number of non-AIDS deaths among PLHIV	Geographic area, Age, Sex	Thembisa Model	3329 (2022)	3410	3483	3548	3754	3971	Annual	SANAC
Objective: To ensure that 95% of people living with HIV, especially key populations, and other priority populations, know their status and are 95% on treatment and 95% are retained in care and achieve long-term viral suppression													
27	Percentage of people living with HIV who know their HIV status	Outcome	Numerator: Number of PLHIV who know their HIV status. Denominator: Total number of PLHIV.	Geographic area, Age, Sex	Thembisa Model HSRC Survey	92% (2022/23)	94.5%	95.1%	95.5%	96.0%	96.5%	Annual	SANAC, PCA

No	Indicator	Indicator Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsible
							2023/24	2024/25	2025/26	2026/27	2027/28		
28	Percentage of infants born to women living with HIV receiving a virological test for HIV within two months of birth	Outcome	Numerator: Number of infants who received an HIV test within seven days: Denominator: Total number of births to HIV-positive mother in the last 12 months	Geographical	Numerator: NHLS Denominator: Thembisa Model	0.8% (2022)	TBD	TBD	TBD	TBD	TBD	Annual	SANAC
29	Number of adults and children living with HIV on ART (TROA)	Outcome	Numerator: Total adults and children remaining on ART	Geographic area, Age, Sex, institution	DHIS, Private sector, Surveys, Thembisa Model	340557 (2022/23)	357 298	372 666	387 001	400484	413128	Annual	DOH&W, DPSA, DHET/HEAIDS, DCS Private Sector (Council of Medical AID Schemes-CMS)

No	Indicator	Indicator Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsible
							2023/24	2024/25	2025/26	2026/27	2027/28		
30	Percentage of adults and children living with HIV known to be on ART 12 months after starting (Retention)	Outcome	Numerator: Number of adults and children who are still alive and receiving ARVs 12 months after initiating treatment. Denominator: Total number of adults and children initiating ART	Geographic area, Age, Sex	DHIS, Private sector	68% Not in ETR. Ask DOH&W (2021/22)	58,3%	59,7%	61,2%	62.8%	64.5%	Annual	DOH&W Private Sector, (CMS)
31	HIV viral load suppressed rate (VLS) at 12 months	Outcome	Numerator: People living with HIV viral load under 1000 copies/mL. Denominator: Total number of PLHIV who know their HIV status and are on ART	Geographic area, Age, Sex	DHIS, Private sector	92% (2022/23)	92,3%	93%	94,3%	95%	97%	Annual	DOH&W Private Sector, (CMS)

No	Indicator	Indicator Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsible
							2023/24	2024/25	2025/26	2026/27	2027/28		
32	Percentage of health facilities received Treatment literacy tool kit (Implementation framework and IEC material)	Output	Numerator: number of health facilities who received Treatment literacy tool kit (National implementation framework and IEC material) Denominator: number of health facilities in the country	Geographic area	SANAC DOH&W	0 (New indicator)	20%	40%	60%	80%	>95 %	Annual	DOH&W SANAC Partners
TB Prevention and Treatment													
33	TB incidence	Impact	Numerator: Number of new and relapse cases of TB (all forms) estimated to occur in a given year. Denominator: Total population per 100 000	Geographic area, age, sex	WHO Global TB report From WHO TB report app (2022 data) Expressed as a rate: no. Per 100 000 population per year	TB incidence: 468						Annual	DOH&W

No	Indicator	Indicator Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsible
							2023/24	2024/25	2025/26	2026/27	2027/28		
34	TB Mortality	Impact	Numerator: Number of deaths caused by TB in HIV-negative people and HIV-positive people. Can be expressed as a rate. Denominator: Total population per 100 000	HIV status	WHO Global TB report From WHO TB report app (2022 data) Expressed as a rate: no. Per 100 000 population per year	4,0% (2022/23) HIV-negative TB mortality: 39 HIV+ TB mortality: 52	4.03%	3.97%	3.91%	3.91%	3.91%	Annual	DOH&W
Objective: Strengthen TB prevention interventions for key and other priority populations and implement airborne infection prevention and control in health facilities and high-risk indoor places where people congregate													
35	Number of people in contact with TB patients who began preventive therapy	Output	Count: Number of people in contact with TB patients who began preventive therapy.	Geographic area, Age (<5, 5+ years	DHIS	7021 (Under 5 2021) (2021/22)						Annual	DOH&W
36	Number of PLHIV on ART who initiated TB preventive therapy	Output	Count: Number of eligible PLHIV on ART started on TPT. TPT is given to PLHIV who are newly diagnosed and those in care.	Geographic area, Age	DHIS	11063 (2022/23)						Annual	DOH&W

No	Indicator	Indicator Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsible
							2023/24	2024/25	2025/26	2026/27	2027/28		
Objective: Strengthen TB diagnosis and support for PWTB, and accelerate the scale-up of innovative processes, diagnostic tools and regimens for the diagnosis, treatment, and care for PWTB													
37	Number of TB tests done	Output	Number of TB tests performed (laboratory)	Geographic area	NHLS	40947 (2022/23)						Annual	DOH&W
38	Number of TB cases diagnosed	Output	Number of laboratory-diagnosed TB cases	Geographic area	NHLS	31577 (2022)						Annual	DOH&W
39	Number of notified cases of all forms of TB (i.e., bacteriologically confirmed + clinically diagnosed). This indicator measures all TB notifications including previously treated cases.	Output	Number of notified cases of all forms of TB (i.e., bacteriologically confirmed + clinically diagnosed). This is the total TB notifications.	Geographic area Sex, age, HIV-status, type of diagnosis (bacteriological and clinical), sector (mines and prisons)	Tier.NET and EDRWeb	53831 DS - 42667 + MDR/RR - 1931 (2022)						Annual	DOH&W

No	Indicator	Indicator Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsible
							2023/24	2024/25	2025/26	2026/27	2027/28		
40	Treatment coverage	Outcome	Numerator: Number of people/clients started on TB treatment (Notified cases). Denominator: Number of incident cases	Geographic area, sex Age: <5, 5 years and older	DHIS/Modelled data	82% (2022)	TBD after incidence estimation	TBD after incidence estimation	TBD after incidence estimation	TBD after incidence estimation	TBD after incidence estimation	Annual	DOH&W
41	Proportion of TB/HIV co-infected patients on ART	Outcome	Numerator: Number of registered HIV+TB co-infected patients on ART. Denominator: Number of registered HIV /TB co-infected patients	Geographic area Sex	Tier.NET and EDRWeb (SPV)	89,4% DS – MDR/RR - 1,9%(2022)	91% DS - 91% MDR/RR - 96%	92% DS - 92% MDR/RR - 96%	93% DS - 93% MDR/RR - 96%	94% DS - 94% MDR/RR - 96%	95% DS - 95% MDR/RR - 96%	Annual	DOH&W
42	TB treatment success rate	Outcome	Numerator: TB people/clients cured and completed treatment. Denominator: Total TB clients initiated on treatment	Geographic area, Drug sensitive, drug resistant TB	WHO Global TB report Annual report	81.0% (2022/23)	76.2%	78.8%	79.3%	79.8%		Annual	DOH&W

No	Indicator	Indicator Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsible
							2023/24	2024/25	2025/26	2026/27	2027/28		
STIs and Viral Hepatitis Prevention and Treatment													
43	Percentage of women accessing antenatal care services who tested positive for syphilis	Impact	Numerator: Number of antenatal care attendees with a positive syphilis serology. Denominator: Number of women attending antenatal care services who were tested for syphilis during the first visit.	Geographic area, Age	DHIS	No Data on Info. systems Estimated (2022/23)						Annual	DOH&W, NICD
44	Congenital syphilis rate	Impact	Numerator: Number of reported congenital syphilis cases (live births and stillbirth) in the past 12 months. Denominator: Number of live births in the past 12 months	Geographic area	NMC/DHIS	No Data on Info Systems Estimated 300/100 000 live births (2021/22)	200/100 000 live births	150 per 100 000 live births	100 per 100 000 live births	50 per 100 000 live births	<50 per 100 000 live births	Annual	DOH&W, NICD

No	Indicator	Indicator Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsible
							2023/24	2024/25	2025/26	2026/27	2027/28		
OBJECTIVE: Increase detection and treatment of four curable STIs through systems strengthening, service integration and diagnostic testing; achieve elimination targets for mother-to- child transmission of syphilis; and scale-up HPV vaccination and cervical cancer screening													
45	New Male Urethritis syndrome episodes treated rate	Output	Numerator: Male Urethritis Syndrome treated – new episodes. Denominator: Male population 15-49 years	Geographic area, Age 15 – 49 years	DHIS	52720 25.8% (2022/23)	400					Annual	DOH&W
46	Number of sex partners notified	Output	Numerator: Number of sex partners notified. Denominator: NA	Geographic area, Age, type of STI (CT and NG)	DHIS	No Data available Estimated 20% (2022)	30%	40.0%	50%	50.0%	50%	Annual	DOH&W
47	Percentage of women accessing antenatal care services who were tested for syphilis	Output	Numerator: Number of women attending antenatal care services who were tested for syphilis during the first prenatal visit (<13 weeks gestation) Denominator: Number of women attending antenatal care services	Geographic area, Age	DHIS, sentinel surveillance surveys (ANCHSS)	ANCHSS – 97.9% (2022/23)	97%	97.5%	98%	98.5%	99%	Annual	DOH&W, NICD

No	Indicator	Indicator Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsible
							2023/24	2024/25	2025/26	2026/27	2027/28		
48	Syphilis treatment rate	Output	Number of women attending antenatal care services who tested positive for syphilis and were treated. Denominator: Number of women attending antenatal care services who tested positive for syphilis	Geographic area, Age	DHIS	97.6% (2022/23)	92%	94.0%	96%	98.0%	98%	Annual	DOH&W, NICD
49	HPV coverage	Output	Numerator: Number of girls 9 years and older that received HPV dose. Denominator: Number of grade 4 learners ≥ 9 years	Geographic area, Age, Type of dose	DHIS	13991- 1st dose 148,036- 2nd dose (2019/20)	80%	80%	90%- 1st dose 80%- 2nd dose		95%- 1st dose 85%- 2nd dose	Annual	DOH&W
50	Proportion of cervical cancer screening with cervical smear testing and or HPV DNA testing, including WLHIV	Output	Number of HPV DNA tests divided by the total number of cervical cancer screening	Geographical area	DHIS	7%	planning	10%	20%	30%	40%	Annual	DOH&W

No	Indicator	Indicator Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsible
							2023/24	2024/25	2025/26	2026/27	2027/28		
51	Proportion of women with a high-risk lesion receiving colposcopy and treatment within 6 weeks of cervical cancer screening	Outcome	Number of women treated for high-risk lesion following colposcopy divided by the number of women with high-risk cervical screening result	Geographical area	DHIS	TBD (TBD)	60%	70%	80%	90%	95%	Annual	DOH&W
OBJECTIVE: Reduce viral hepatitis morbidity through scale-up of prevention, diagnostic testing, and treatment													
52	HBV birth dose vaccination coverage of new-borns	Output	Numerator: Number of new-borns received HBV vaccination within 24 hours of birth. Denominator: total number of new-borns	Geographical area, sex	DHIS	87%(DHIS)	30%	50%	70%	80%	90%	Annual	DOH&W

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

No	Indicator	Indicator Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsible
							2023/24	2024/25	2025/26	2026/27	2027/28		
Objective: Use timely and relevant strategic information for data-driven decision-making													
1	NSP Five-year costed National M&E Plan	Output	NSP Five-year costed National M&E Plan	NA	SANAC Annual Report		M&E plan costed					Once off	SANAC
2	Annual score on SI performance scorecard	Output	Total score based on the summation of performance on different aspects of the SI cascade.	National, Provincial	SANAC SI Scorecard	N/A	80% Scorecard developed	85% of total	90% of total	95% of total	100% of total	Semi-annual	SANAC
OBJECTIVE: Expand the research agenda for HIV, TB and STIs to strengthen the national response													
3	Number of NSP, mid-term and end-term evaluation conducted	Output	Qualitative Yes/No indicator	N/A	NSP reports				Mid-term review conducted		End-term review conducted		SANAC
OBJECTIVE: Leverage the infrastructure of HIV, TB & STIs for broader pandemic and various emergencies' preparedness and response													
4	Proportion of primary healthcare facilities that has attained ideal status	Outcome	Numerator: Number of health facilities that have attained the ideal clinic status. Denominator: Total number of primary healthcare facilities	Geographic area Type of health facilities	Facility Assessment reports	84% (2021/22)	82.3%	88.4%	92.7%	95%	100%	Annual	DOH&W

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

No	Indicator	Indicator Type	Calculation	Disaggregation	Data source	Baseline value	Target					Reporting frequency	Responsible
							2023/24	2024/25	2025/26	2026/27	2027/28		
OBJECTIVE: Sufficient domestic and external funds are mobilised and allocated to facilitate the efficient implementation of HIV, TB and STI programme													
1	Government HIV and TB expenditure (as % of General Government Expenditure)	Outcome	Numerator: Total Government expenditure on HIV and TB Denominator: Total General Government Expenditure	Disease programmatic area, geographical area (national, provincial)	NASA and routine expenditure tracking	TBD	Baseline +5%	Baseline +5%	Baseline +5%	Baseline +5%	Baseline +5%	Annual	SANAC
2	Percentage of functioning District AIDS Councils measured according to functionality assessment, including civil society and community engagement	Output	Numerator: functioning District AIDS Councils measured according to functionality assessment, including civil society and community engagement. Denominator: total number of DACs in the country (52).	NA	SANAC	65%	70%	80%	90%	95%	100%	Annual	SANAC

Western Cape Provincial Council on AIDS & TB

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