Comment on the HIV and AIDS, STIs National Strategic Plan for South Africa 2007-2011 (draft 2, October 2006)

November 15th 2006

This submission is authored and supported by the following organisations:

- The Treatment Action Campaign (TAC)
- The Reproductive Health and HIV Research Unit (RHRU), Wits University
- The Southern African HIV Clinicians Society (SAHCS)
- The AIDS Law Project

We relied on several individuals who are not linked to these organisations during the drafting of this document, and we would like to thank them for their help at such short notice.

Executive summary

We welcome the opportunity to comment on the draft NSP 5-year plan. Although we are aware that the Chief Director: HIV/AIDS and STDs has requested only short inputs ("not essays") the complexity of the plan, and its importance to South Africa, has required the detailed response below. In addition, whilst working on this submission a further draft (dated 14 November 2006) has been made available. However, most of the points we deal with below remain relevant.

The following are the key areas that we believe need to be addressed:

- The document is the first South African country plan that combines prevention, treatment, nutrition, care and support in a single plan. We welcome the fact that in its preparation thus far, consensus has been achieved on its broad framework through a process of consultation. However the document has reached a stage where it requires careful attention to the detailed programmes and targets it requires, and this in particular needs further expert input.

- Given the complexity of the Plan, and its importance, we feel that delaying the release of the final document (by no more than three months) would allow wider consultation, more scientific input and strengthen it considerably.

- However, we believe that SANAC can achieve consensus on the NSP's key messages, broad programmatic areas, interventions and targets in time for World AIDS day on December 1st 2006.

- At present the draft is not user friendly, neither does it communicate the most urgent and important priorities for our response. In this regard we believe the NSP must set out several key challenges, including:

    - Scaling up voluntary HIV testing dramatically and sustaining consistent visible messages that recommend knowing your status (Attached to this proposal is a suggested new approach to HIV testing);
    - Protecting and promoting the sexual rights of girls and women and ending violence;
    - Encouraging voluntary disclosure and linking this to non-discrimination, treatment literacy and respect for human rights;
    - Encouraging people to seek treatment for HIV and TB and devising a plan to ensure that the treatment need is met by South Africa's private and public health sectors.

- One area where the draft needs extensive discussion relates to target setting. We strongly feel national and provincial targets must be aggregated from district-level targets on key aspects of the plan, that are rapidly calculated, and that district managers are held accountable for these targets. All targets, where possible,

should be district-specific, but in particular, PMTCT and ARV access targets for adults and children must be set at district level.

- The very low projected treatment numbers in the care and treatment section is of huge concern – not least because they contradict the targets in the Operational plan. They suggest that only 20% of people eligible for antiretrovirals will be treated annually.

- Many of the interventions mentioned are often very difficult to measure. We have suggested hard outcomes for the Priorities section that are more practical. There needs to be attention to practical monitoring and evaluation at a local level that acknowledges the problems experienced in the last two years in data collection.

- There are a number of key omissions in the draft including:

    - A critical evaluation of spending on the programme, with strong reference to outputs.
    - Management of HIV in our prison population
    - Management of HIV in the military.
    - the role that the private health sector can play in terms of access to treatment and care, (this is despite reference to the fact that this document should guide all South African sectors).

- There is needless duplication of other state structures' targets. It would be better to explicitly situate this plan as a part of other priority national strategies around poverty reduction, the Millenium Development Goals etc.

- Within the epidemiology section, the description of the epidemic is at times needlessly dramatic, at other points over-optimistic, and at times contradicts the cited data.

- There should be an explicit acknowledgement of the need for local research in the programme, and a plan for regular government-researcher-stakeholder forums to discuss research priorities and results of ongoing projects.

- The document needs significant editing for consistency, accuracy and language. We feel that as this will be a reference document for five years, it should be as polished and professional as possible.

Introduction:

This document was constructed through the work of several organisations with strong histories within the HIV care field. The Treatment Action Campaign (TAC) and AIDS Law Project have been engaged in advocacy for human rights and access to care for HIV affected and infected individuals for many years, and have strong community support programmes. The Reproductive Health and HIV Research Unit (RHRU) has worked with the Department of Health on a range of issues concerning reproductive health, including contraception, termination of pregnancy, STD treatment, HIV prevention, epidemiology and access to HIV care. The Southern African HIV Clinicians Society represents over 10 000 health care workers in the region, has played a major role in HIV training, and was instrumental in assisting in the construction of the Comprehensive Plan with the Department of Health.

We welcome the opportunity to comment on the Plan for 2007-2011, and particularly welcome the strong focus on targets, although the draft's not assigning responsibility for targets to specific provinces and districts is a matter of concern.

We further welcome the commitment to a multi-sectoral approach to the epidemic in Southern Africa. We also firmly believe that the South African Department of Health, which has a constitutional obligation to provide appropriate health care and which allocates the majority of resources to fight the HIV epidemic, should be the major driver in tackling the epidemic.

We have reviewed the draft plan, and have made a large number of suggestions, which we feel are practical and could be implemented over the five year period with appropriate support and resources.

Broad comments:

Wherever appropriate, we believe national targets should be derived from province-specific targets. This holds provincial departments accountable for implementation, and allows analysis of the overall programme, so that weaknesses in the programme can be rapidly evaluated and dealt with.

The private health sector appears to have been ignored in almost every aspect of this document. We have updated several indicators in this regard, but the document should include a discussion on private and workplace HIV care programmes.

HIV is driven by a large array of social factors, and a multi-sectoral approach requires addressing women's empowerment, poverty, youth behaviour, and a large number of other areas. However, many of the indicators used appear to have been assembled in a fairly uncoordinated fashion, and there exists the danger of duplication with other government departments. Several of the indicators related to social upliftment are

covered by other South African government policies, with targets, and we suggest that these be referenced and adhered to, and the specific targets covered therein removed from this document. This will avoid duplication and confusion, and ensure consistency across government departments. We have made specific recommendations per indicator throughout.

Many of the indicators are written in such a way that measuring success would be very difficult, either because the indicator can not be measured, or because data collection is very difficult or practically not feasible. We have suggested proxy markers and headings in this regard.

In drawing up these indicators, we acknowledge the difficulty experienced in collecting data from sites providing care or responsible for collecting data. Experiences with donor agency indicators, especially the Global Fund and PEPFAR, indicate that simple, routinely collected indicators that have programmatic relevance should be used, rather than vague, difficult-to-assemble areas.

Wherever possible, data should be collected from sentinel sites in representative areas of the programme. This would minimize unnecessary data collection. Furthermore, the country has a rich supply of research organisations, which should be allocated dedicated funding and outputs, regarding evaluating these outputs. The state relies heavily on excellent data collected by the MRC and HSRC, and there are other organisations which could be tasked with expert analysis. For instance, studying the change in sexual behaviours in youth is far better allocated to a research unit to study over the five year cycle, in close consultation with the DoH, than expecting clinics to collect data.

We recommend that each province should be tasked with establishing, by 2008, several sentinel sites in all of the focus areas – this must include sites in the private sector. These sites should sample a variety of rural, urban, economic and social groups, so that as representative sample as possible is obtained.

Integration of services should be directly addressed by the NSP (and be one of its objectives), specifically the integration of TB, STI, family planning/contraception, antenatal and other reproductive health issues. This is complex, but the current vertical approach is acknowledged as a problem in the text but with little idea of how this will be improved.

Comments on referencing

The document is not referenced in many places, and this should be addressed. Furthermore, there are several areas where additional information has been published by provincial governments and academic institutions, and these should be assembled and the information incorporated into the document.

Comments on Introduction and Development of the Strategic Plan (pp 5-9)

The Introduction would benefit from rewriting. While it contextualises the epidemic well, it should be reviewed by an epidemiologist.
Statements such as "*In South Africa, through our efforts, available evidence suggests that rate of increase in prevalence has decreased significantly in the past five years and that HIV incidence has started to decrease*" may be contested, with unproven correlations between complex programmes in the country and changes in incidence and prevalence of HIV.
"The ASSA model suggests that HIV has severely impacted on our society, extracting a terrible human toll, with an estimated 2 million deaths attributed to AIDS-related conditions between 2000 and 2005" is possibly a better opening statement.

There is no mention of TB or STI's in the introduction, which is at odds with the rest of the document.

We suggest you add the following statements to the Introduction:

> "Tuberculosis control continues to prove a challenge for both HIV infected and uninfected populations, with the recent identification of multi-drug resistant (and 'XDR' TB) throughout the country. Treatment and cure rates remain unacceptably low throughout the country."
>
> "Sexually transmitted infection control and treatment remain pivotal to the control of HIV. STIs contribute significantly to population morbidity. While significant progress has been made in decreasing the prevalence of syphilis in South Africa, the ongoing increase in genital ulcer disease, especially herpes, now strongly implicated in HIV-transmission, is of huge concern."

It would be useful, as an appendix, to have a reference list of "documents supplied by lead agencies implementing the strategic plan and secondary data analysis." It would also be useful to list which government departments and civil society sectors were represented in the consultation process, ensuring broad involvement and accountability.

Towards the end of the section, there is mention made of progress made in terms of VCT, PMTCT and access to ART; it is necessary here to acknowledge that these interventions do not cover the necessary number of people requiring these services. In fact, there should be an analysis of the number of people actually accessing these services as a percentage of the estimated need, and targets should be directly linked to this.

Comments on the Situational Analysis (pp 9-17)

The interpretation of the data in this section appears to be correct, but then seems to be rewritten and reinterpreted by other authors, often clumsily. It may need to be reviewed by an epidemiologist. Statements such as "Encouragingly, HIV prevalence among young women (<20 years) has continued to decline, a reasonable indication of decline in incidence in this age group" appear to be overly stating what appears to be a stable rather than improving situation.
Statements that have programmatic implications such as "Projections are that South Africa should begin to see a decline in the prevalence profile" should be referenced.
The section titled 'Major causes and determinants of the epidemic in South Africa' requires significant rewriting simply for clarity. We would suggest statements similar to "The ANC survey estimated that nationally, 30.2% of pregnant women attending public health facilities for antenatal care, were HIV positive in 2005. ANC prevalence has shown a steady linear increase since 1999" as being more accurate.

The section offers no data on the impact of morbidity of HIV on the public and private sector. Similarly, there is no mention of disproportionately affected groups, such as men who have sex with men (MSM), prisoners or intravenous drug users.

There is also no position on sex work or mention of transactional sex.

There is also no mention of the impact of ART on the epidemiology of HIV – specifically with regard to prevalence. This has been modeled in the Operational Plan, and should be updated for this document.

The strong comments on TB and STI's are most welcome. On STIs it should be recognized more clearly that the decline in syphilis is not attributable to behaviour change but to better medical management – a fact that reinforces the need for HIV prevention strategies to being about behaviour change.
Specific targets looking at HIV/TB coinfected patients are appropriate and ensure more coordination between these two vital areas. The comments on MDR (including XDR) TB are appropriately sober. However, there should be some comment on the epidemiology, and acknowledgement of the challenge of using dated diagnostics and treatments, and the challenge that the failure of DOTS-driven programmes have thrown up.

Comments on the Response Analysis (pp 17 – 25)

The review of previous interventions is not critical enough. While there have been many excellent interventions throughout the last 5 years, this section does not acknowledge the many challenges and failures of the programme, especially as the document boasts of a 'coordinated approach' for 14 years. Highlighting the problems allows us to prioritise solutions. Furthermore, detailed analyses by province, as well as a careful examination of the points at which care is provided (rural vs urban, hospital vs clinic, doctor-driven vs nurse driven etc) should be included.

The challenge of ongoing provision of ART, with the poor performance of prevention programmes, should be specifically acknowledged: “It should be noted that because of the average 8-10 year time lag between HIV infection and need for ART, the number of new initiations of ART will remain very high for at least the next decade.” This statement could be reiterated in the section dealing with the ART numbers.

The effectiveness of the PMTCT programme in terms of reducing transmission rates, with the exception of the Western Cape Province, has been very limited. Intensification of the PMTCT programme is expected to sharply reduce the number of newly infected infants with consequent reduction in the need for new initiations of pediatric HAART. This must be acknowledged and we have strengthened the indicators in this regard.

The issue of VCT and adherence counselors, their payments, training and the lack of professional representation and accountability needs to be tackled within the text, even if the solutions are not currently agreed upon.

The issue of human resources is not addressed at all. This is a problem because neither is HIV properly addressed in the DoH’s Human Resources Plan. If this omission is not dealt with, and human resource needs are not calculated, the plan will run aground on a lack of capacity to implement it.

As an emergency short-term measure we suggest firm targets on the recruitment of foreign doctors, nurses and other professionals are put in place at a provincial level, so that immediate relief is accorded to health care facilities. We suggest that 20% of all vacant HIV posts should be filled by foreign medical staff (we respect and support the embargo on the use of staff from resource poor countries) in 2008, increasing to 50% by 2011. Setting this as a percentage rather than an absolute number would not compromise using local staff in any way.

The discussion on the status of women is very rosy, considering the rape statistics not changing over a decade, even if flawed, suggesting that this remains a very real problem. Furthermore, murder of women is still predominantly by intimate male partners. South African research has clearly linked violence against women to HIV risk.

Prevention:

This section needs to be significantly expanded. We recommend that different prevention interventions need to be listed under each of the prevention headings, and each discussed separately. For example:

Behavioural
Underlying education availability to youth (education directly impacts on HIV status) Youth programmes in schools. Youth programmes in health services. Microfinance Targeted programmes at ‘high risk’ groups such as sex work, truckers, migrant workers.

Medical
Male circumcision
STI management
PMTCT
Avoidance of pregnancy as a risk factor for HIV and availability of contraception

Technologies
Condoms: male and female
Microbicides
PrEP
PEP and rape services

Additionally:
There is a need to acknowledge at the start of this section that the impact of prevention programmes thus far has been very disappointing, and that behaviour change has not evolved from broad 'awareness'.
Statements that are inaccurate such as "*The commitment to the prevention of HIV and AIDS has also been present in all government departments. They have developed and implemented the relevant policies and plans. There are suggestions however that implementation capacity of specific activities within government departments is inadequate*" decrease the integrity of the document. Similarly, boasts about life skills programmes reaching all schools, without consideration of the quality or sustainability of these programmes is unhelpful and misleading.

The sudden discussion on truckers and the Maputo corridor (on p 18) does not seem appropriate, especially when next discussing the WHO AFRO prevention initiatives. These should either be tackled in a consistent way (which would be preferable), and their context explained, or left out. Similarly, the discussion of condoms and PMTCT in the same paragraph seems peculiar.

There is a welcome acknowledgement of the challenges experienced by the sexual assault programme. Our comments on the programme targets are contained in the targets sections.

The comments on VCT suggest that the private sector contribution to this is low, and we have inserted this in to our targets. It should be acknowledged that the take-up of VCT in the public sector also remains very low. Aggressive promotion of VCT should be a key plank of the NSP and linked to specific targets and outcomes.

We also recommend that there should a reference to the role that acute HIV infectiousness - it is associated with an amplification of transmission of HIV, is difficult to diagnose and may hamper current preventative strategies - may have in the complex epidemiology of the epidemic, and the need for research in this area, especially amongst pregnant women, STD clients and family planning attendees.

While it is likely to be modest, the possible impact of ART on reducing the infectiousness of people with HIV should be mentioned.

* Treatment, Care and Support

This section, despite acknowledging the huge resource allocation, is very short and lacks any detail. It would be useful to tease out more sections of the programme, dividing it in to sections based on the continuum of care. We have tried to do this within the targets, and this section would benefit from a similar approach. However, it would be useful to have a more detailed discussion on the challenges and resource consumption (by province) of each aspect of the programme. There needs to be a rigourous assessment and explanation of why certain provinces are lagging far behind others, despite similar resource allocation.

"Many accredited service points are already functioning beyond capacity" – this needs to be explained in more detail. Service points providing non-ART care, especially hospital services, can claim this, but we are unaware of this for ART services.

The drive to put ART services in the hands of nurses needs to be explicitly acknowledged and supported in the document, and we have put targets against these in the treatment section. Furthermore, there should be discussion on changing the scope of practice of nurses, counselors and other support staff (as recommended through the experience of treatment programmes in under-resourced rural areas of South Africa).

To ensure clear accountability we recommend that there needs to be very specific role definition of the ARV coordinators and clinic managers at HIV care sites, with clear and measurable parameters for success and failure,.

The issue of home based care and stipends needs to acknowledge many of the challenges encountered in this regard, including the poor administration of stipends, the complexity and lack of capacity of NGOs, and the lack of accountability among counselors and carers.

In addition it is a matter of concern that is very little mention of palliative care: in fact even less then the previous NSP. This is despite a recognition that the number of deaths is on the increase. Palliative care is listed as the second last item on page 39 (under prevention?) and on page 60 there is some mention of improving quality if life for homebound clients using the home-based care worker. But generally, there is no mention of palliative care services and access to pain management, including morphine.

It is essential to have a discussion on the costs of the programme, before the NSP is finalised. At present, the draft contains no situation analysis of the pricing, availability and accessibility of prevention and treatment commodities, specifically there is no discussion on the relative cost of individual ART drugs, or opportunistic infection drugs.

Diagnostics and female condom prices must also be addressed. These costs have a direct impact on the achievement and sustainability of targets and their outcomes.

There is no mention of the issue of drug access, registration and tendering processes, and the challenges and solutions that avail themselves here.

* Research, Monitoring and Evaluation

We recommend that this section start with a discussion on the challenges of routine data collection and analysis, an area widely acknowledged by the Department as being a huge challenge. We still are unsure of the number of people on ART, let alone having reasonable ideas of the percentage who access care and support, the incidence of side effects, or the defaulter rate during the continuum of care.

The issues around research such as vaccines and microbicides should rather be tackled separately, and government support for these initiatives detailed accordingly. Direct encouragement to these projects by provinces, as well as relevant research and incentives to researchers to make data available to provincial programmes, should be a formal target.

Noting the lack of encouragement for research programmes shown in some sectors of government, it is important to have a separate section on research. We should encourage local researchers and governments to develop joint research priorities and to jointly plan and support research processes and to plan proactively for the release of research findings and to identify the impact that these might have on programmes and policies.

* Human and Legal Rights

The section on the legal and human rights is incorrect in a number of respects. For example, although a praiseworthy (but still incomplete) legal framework has been created around HIV/AIDS, the rights of people with HIV have not been widely safeguarded by the legal and judicial system. Instead a small number of important and high profile cases have masked a general failure by lower levels of the legal system, and statutory human rights institutions, to protect people's rights. The main challenge therefore is to

(a) systematically educate people about human rights and HIV
(b) to encourage more people to contest violations and
(c) ensure that poor communities have access to the legal system.

A paper setting out the degree to which South Africa has carried out recommendations made by UNAIDS on human rights is attached. It contains the following specific recommendations:

1. Government and Civil Society should work together to increase access to justice for PWAs by building the capacity of, and supporting paralegals and community justice workers. It should raise awareness and educate people about human rights, the

workings of Equality Courts (established in terms of the Equality Act) as well as the Human Rights Commission and the Commission on Gender Equality as an effective way of advancing substantive equality and challenging unfair discrimination;
2. Government should ensure the on-going implementation and monitoring of women's rights, and invest substantially more resources and political will into the reduction and mitigation of gender based violence;
3. Government should ensure that the Sexual Offences Bill, as well as any other future law or policy, do not create HIV-specific crimes as these will be ineffective and stigmatise and criminalise people with HIV;
4. Sex work should be decriminalised;
5. Government should expedite the process of proposed amendments to the Equality Act to include the specific prohibition of AIDS discrimination;
6. The SANDF's policy of mandatory HIV-testing of recruits and members and of unfair discrimination against those with HIV should be challenged and struck down;
7. The South African Human Rights Commission should be mandated to monitor human rights in relation to HIV/AIDS. Particular attention should be paid to the implementation of new HIV-testing models and potential human rights violations that may become associated with it.

* Civil Society Sector's response

We welcome the acknowledgement of the importance and impact of this group, and the failure of SANAC to adequately fulfill its mandated role towards civil society. However, the section is generally superficial and sometimes wrong. For example, it is misleading to claim that the business sector's contribution has been "considerable" or that higher education institution's response has been "comprehensive." Both sector's responses have been fragmented, uncoordinated and could be much more focused. Linked to the reorganization of SANAC, the key for the NSP is to define the specific responsibilities that sectors have in particular programmes, and to contribute to achieving nationally agreed targets.

Comments on Current Structures in South Africa to address HIV and AIDS (pp 25-26)

This is a useful overview of the structures. It would be useful to expand in this section more on the overall role of SANAC, as well as mechanisms by which provincial and local government engage on the issues of HIV – in particular the envisaged role of Provincial AIDS councils.
It is also important to include structures which could, but have not so far, play a major role in the NSP, including the Human Rights Commission, Commission on Gender Equality.

Guiding principles (pp 27-28)

Most of the guiding principles that are listed here are relevant. However, the comment that "The national movement on moral regeneration and values promotion shall be utilised to support sustainable behaviour change" will need further discussion. Presently, as it lacks content and is open to very broad interpretation, we would omit it. For example, there is no scientific evidence that abstinence programmes work, and while this should be encouraged as a lifestyle choice, linking it to a moral choice is not supported. We also urge that controversial 'moral regeneration' programmes such as virginity testing be strongly opposed, especially as many of these are likely to be unconstitutional and a violation of the dignity of women and girls.

The goals of the NSP 2007-2011 (pp 28-29)

We recommend that the two primary aims be given both targets and timeframes.

Within the section on 'thrusts of approaches':

> – there needs to be acknowledgement of the need to expand the continuum of care to include addressing those issues which prevent people with HIV from entering care programmes, including substance abuse, poverty, mobility and access to good information.
> - there is a need to clarify the issue of disability grants and other support grants for people with HIV
> - it is unclear why the age group 20-39 has been selected as a 'priority' group. While this group carries the burden of care, infection rates below this age amongst women are very high, and infection rates above this age group amongst both genders remain high.

The National M&E Framework for the NSP 2007-2011 (p 29)

We welcome the strong commitment to a timeline enclosed in this paragraph.

National set of primary indicators and surveillance data for the country (pp 29-31)

This section needs amendment. It is unclear how these indicators differ from the indicators listed under 'Priority areas' and we have expanded that section to include these indicators. Later, the document says that the two are linked, but the linkages are inconsistent and clumsy. It may be practically more useful to have the M&E framework with extensive footnotes, rather than two sections talking to each other.

With regard to the following sub-headings we propose the following additions:

General trend of the epidemic

Add: Use of additional epidemiological data from other relevant HIV surveys, such as the HSRC surveys, the RHRU Youth Survey and recognised mathematical modelling studies, as well as data from agencies such as UNAIDS and WHO.

Youth

Add: Use of additional epidemiological data from other relevant HIV surveys, such as the HSRC surveys and the RHRU Youth Survey.

Abuse of women

It is not clear what is meant by "The number of cases of workplace legislation abuse related to employees contracting HIV"

Social values, human rights and acceptance in the community

This is not an appropriate title for the listed indicators, which deal with VCT, disclosure and children.

Number 1: The number of VCT clients – the term 'counselling and testing" is now generally accepted, although we strongly affirm that consent is important. We cover this under priority areas in more detail.

Number 2: Simply: Number of orphans, and then, proportion estimated to be due to HIV.

Number 3: Wording should be: "The number of people publicly disclosing their HIV status". There may need to be some discussion on this as it appears it would be very difficult to measure – it could take the form of a research project in sentinel site looking at changing disclosure patterns, or rather be a profiling exercise looking at 'big names' that disclose, measured by media profiling. We recommend that both are important – the research project may show trends in disclosure in the general population, while disclosure by prominent South Africans may decrease stigma, encourage testing, and facilitate access to care.

Prevention

This is an excellent section with a large amount of detail. However, it is not congruent with the indicators above, which lack detail, and hence this section feels very inconsistent.

The focus on 20-39 year olds (as already mentioned above) is not supported, especially as there are other age groups (>17 years and 15-49 year olds) mentioned. The surveys from the HSRC indicate that there is significant risk of HIV in the age group over 40. Furthermore, 20-39 years often encompasses a huge range of life experiences (higher education, entry into the job market, marriage, children, etc) and it is unclear why having

this age band helps the programme, as different interventions are required within this and other age brackets.

Finally, it is unclear why the headings: - HIV and AIDS prevention, care, treatment and support, ART, nutrition, palliative care – are used in this section. HIV prevention is unlikely to have a link with nutrition and palliative care, and the link to ART and HIV care is speculative and unlikely to be strong. We suggest leaving this out.

Comments on Priority areas (pp 32- END)

This section would be much clearer if there was an introduction to each priority area, and explanations next to the indicators, in one assembled section.
The headings: Goals and interventions are inconsistently tackled – sometimes the intervention text reads as a target, and goals and interventions occasionally are mixed up.
This is obviously the most important part of the NSP and yet the way the draft attempts to set targets for every intervention is unrealistic. Instead, we believe that the NSP should define a basket of crucial targets around prevention, treatment and care and link these targets to:

(a) key messages and

(b) key sectors or institutions to whom responsibility for driving and monitoring targets must be devolved. These sectors would then be accountable to SANAC for reporting back.

Not all targets can be the responsibility of the Health Department. For example, targets for ensuring access to PEP for occupational exposure should be made the responsibility of the NEDLAC constituencies; targets for sex education and access to condoms, etc., for children should be made the responsibility of Education Department and Human Rights Commission; DoH should only have direct responsibility for targets in areas that it controls, for example, numbers of people on ART, etc.
When it comes to interventions such as VCT, we propose that targets should be set for different stakeholders, i.e. targets on numbers of people being tested in private health care facilities; numbers accessing VCT (government/NGO); numbers routinely accepting testing at public health facilities, etc.
However, finally under this section we believe it is necessary that key targets be discussed, agreed and owned by key sectors. This is further justification for extending by several months the process for finalizing the NSP.

Priority area 1: Prevention

1.1 Reduce poverty

The reduction of poverty is critical in controlling and informing our approach to the epidemic. However, we believe that the NSP should be aligned with poverty targets and indicators generated by central government.

However, we propose that two new HIV-specific indicators be added. These are:

1. the development of Provincial guidelines on access to disability and other HIV-related grants during 2007
2. Measurement of the number of eligible individuals and families accessing HIV-related grants" to be measured from 2008 onwards, with a starting percentage of 30% per province.

The motivation for this is that social support grants are a major source of support for poorer communities, and have been a major focus of government social upliftment expenditure. HIV has major economic consequences for those infected and their families, and this should be a priority area. Furthermore, there has been extensive confusion regarding access to disability grants. This reinforces the need to widely publicize the Guidelines to the relevant health care workers and implementing agencies.

1.2 Improve the status of women in society

The listed intervention: "Mainstream HIV and AIDS activities in all programmes for gender" is potentially meaningless and unmeasurable. We suggest removing this.

We recommend that responsibility for monitoring this section and it's relationship to HIV risk be given to the Commission on Gender Equality and that it be linked to specific indicators such as: an increase the percentage of women living above the poverty line, an increased number of women who are employed, an increased number of women who have access to microfinance.

Other aspects of the NSP that directly affect women are covered elsewhere – for example, access to PEP, access to female condoms, grants access, etc.

1.3 Accelerate the rate of development particularly of rural poor and urban informal settlements

This section too is exceedingly broad. We recommend that it refer to existing governmental targets and plans, but link these with a requirement that they integrate concrete and measurable HIV-prevention programmes into service delivery. On this basis it would be possible to set targets for, and measure the percentage of communities with:

- Faith-based HIV education and support programmes
- Non-faith based HIV education and support programmes
- HIV testing programmes that have ensured 20% voluntary testing annually of untested and uninfected of community
- Home based care provision for all eligible infected people
- Peer education programmes
- Access to HIV information and condoms in schools, workplace and churches

3.1 Promote improved health seeking behaviour and adoption of safe sex practices

"Produce and disseminate IEC material and messages to different stakeholders" – We believe that the interventions listed here should be far more detailed, and also measure the outcomes and quality of the interventions . For example, "Implement life skills education in all primary and secondary schools" –is already said to be 100% – but this does not assess the quality of the intervention. Thus, we suggest: "Knowledge of risks of HIV infection assessed to be good to excellent amongst 15-year olds" – and aim for 80% at 2011.

Change the indicators regarding trade unions to a percentage, and aim for 100% by 2011.

"Facilitate and support the trucking industry's AIDS prevention programme" – this intervention lacks content. Instead we suggest:

- Percentage of truckers testing for HIV (aim for 80% by 2011):
- Percentage of truckers treated for STIs (aim for 80% by 2011)
- Number of condoms distributed to truckers

As we do not have data on this sector, we would need to be guided as to the targets, but clearly they are key to the control of the epidemic.

"Expand services in High Transmission Areas" – this intervention is without content. We suggest:

- Increase number of provincial programmes that treat STIs, distribute condoms and provide VCT to sex workers;
- Increase number of provincial programmes to treat STIs, distribute condoms and provide VCT to hostel dwellers;

Where other high transmission areas are identified, similar indicators could be applied. For example, the trucker indicators (above) would be more appropriate under this intervention.

3.2: Broaden responsibility for the prevention of HIV to all sectors of government and civil society

This section is too broad and requires the development of objective measures. The indicators under this section should be tied to the performance of SANAC. On this basis indicators could be:

- Quarterly meetings of SANAC attended by 80% of members.
- Regular reports by sectors to SANAC on implementation of the NSP.

3.3 Implement HIV and AIDS prevention for mobile populations

This objective too might be better placed under the 'high transmission areas' above. Again, this intervention appears to not have much substance. We suggest that more concrete interventions would be:

- Establish formal MOUs with each SADC country concerning the treatment of cross-border migrants, refugees and asylum seekers in terms of local health service provision.
- Establish national/SADC guidelines for the provision of health care to displaced, migrant and refugee communities.
- Publicise guidelines advising health care worker of heir responsibilities to these communities in all areas providing care.

These interventions could take place during 2007. While they cover more than HIV, the clear articulation of policy on these vulnerable groups is needed.

3.4 Strengthen the implementation of HIV and AIDS workplace programes

We recommend making the targets clearer as follows:

- Percentage of workplaces with open and ready access to condoms
- Percentage of workplaces with HIV education programmes
- Percentage of workplaces with VCT programmes

Responsibility to monitoring these aspects on the NSP should be devolved to NEDLAC.

3.5 Improve access to and use of male and female condoms (15 – 49 years)

It is unclear why this age bracket was selected, particularly as it complicates data collection.

The first indicator: The 'traditional and non-traditional' distribution of condoms should be explained, and a % set to each. We suggest that 30% of condoms should be distributed by non-traditional means by 2011.

We recommend adding targets for the following:

- % of prisons offering condoms, and the numbers of condoms used per prison
- % of schools offering condoms
- % of government buildings offering condoms

We also draw attention to the fact that measuring consistent and correct condom use would require the type of sentinel surveillance system and collaboration with the research community already discussed above.

3.6 Promote mutual faithfulness among sexually active population

While important, this objective lacks measurable content. We propose:

- Decrease concurrency among men by 10% per year
- Decrease concurrency among women by 10% per year
- Increase VCT uptake by men by 10% per year

The last indicator is important because it has proved very difficult to include men in education and care programmes.

3.7 Decrease populations of youth less than 14 years initiating sex

There is an inconsistency here with the main text, which mentions age <17 years.

4.1 Increase coverage for VCT (15 – 49 years)

The following indicators are more specific, easier to collect, and guide programmes:

- Percentage of clinics at a PHC level offering HIV testing
- ✓ percentage of TB clients accepting HIV testing
- ✓ percentage of STI clients accepting testing
- ✓ percentage of family planning clients accepting HIV testing
- ✓ percentage of inpatient clients accepting HIV testing
- ✓ percentage of casualty clients accepting HIV testing
- ✓ percentage of antenatal clients accepting HIV testing
- ✓ percentage of male partners of antenatal clients accepting HIV testing
- Percentage of workplaces offering HIV testing (see 3.4 above)
- Percentage of pharmacies offering HIV testing
- Percentage of schools offering HIV testing
- Percentage of total population testing annually

Each of the proposed interventions should be monitored by province as well as by health district.

If stigma and discrimination is substantially decreased within the period of the NSP consideration should be made of partner/ family notification after HIV diagnosis – this could follow the model of the STD programme.

5.1 Increase PMTCT coverage

In relation to this goal we draw attention to the submission made by the SANAC Children's sector and Wits Paediatric HIV clinics which we endorse. However, some issues and indicators that we think would need to be addressed include:

- Percentage of pregnant women testing for HIV in:

- The public sector
- The private sector
- Percentage of positive women receiving PMTCT treatment as per the relevant protocol
- Percentage of women receiving PMTCT services who subsequently access family planning/contraception services

6.1 Minimise the risk of occupational exposure to HIV and other blood borne pathogens

There is a need to develop new, practical occupational PEP guidelines for the pubic and private sector. In addition paragraph (b) should be amended to read: 'Provide all aspects of care required for post exposure prophylaxis guidelines at all health services.'

7.1 Increase access to the comprehensive package for management of victims of sexual assault

Despite being a part of the comprehensive package of care since 2002 access to PEP and other care services for rape survivors is extremely limited, unmonitored and unmanaged. It is also important to be aware that this service forms part of the package of care that the State is planning to make available in the current draft of the Criminal Law (Sexual Offences and Related matters) Amendment Bill.
In respect of both the state's duty of care to victims of violence the target in the draft NSP (50% of primary health facilities by 2008) is far too conservative. It should be increased and linked to interventions that:

a. Encourage women to report rape to both the police and health services
b. Integrate medical and legal services for rape survivors
c. Promote knowledge about risks of HIV infection as a result of rape and PEP as a way of reducing that risk;

9.1 Ensure effective syndromic management of STIs in the public and private sector

This is a crucial intervention the success of which has implications for HIV prevention and behaviour change more broadly. It is another example of a programmatic intervention that needs wide consultation with the health profession as well as active community mobilization. The interventions listed in the draft are insufficient. We propose the addition of harder interventions including:

- Setting targets for the number of nurses trained in syndromic management in public sector
- Targets for facilities receiving uninterrupted supplies of STI drugs
- Partner notification returns
- Prevalence, resistance and programme implementation overview survey bi-annually
- Publication of new genital ulcer guidelines
- Provision of drugs for treatment of genital ulcer disease

10.1 Delay progression of disease and reduce the spread of HIV

We believe that 'reduce the spread of HIV' is the same as prevention, and should be removed from this section. Strengthened HIV prevention and care messages for people already living with HIV is however crucial -- as people with HIV have been left out of much HIV prevention thus far.

In addition it must be recognized that most people with HIV do not access chronic care until they are sick (and even then many still avoid health services), and measuring attendance is difficult. The CD4 count test, done regularly, is a proxy marker for access to chronic care, hence we suggest setting targets for and monitoring:

- The number of HIV positive patients tested who return for CD4 count testing after diagnosis
- The number of HIV positive people who return for a second CD4 count within 1 year of receiving the first.

10.2 Increase access to youth friendly reproductive health services – including STI management, VCT and rapid HIV testing facilities (special focus on youth, women and migrant workers

We suggest the following indicators:

- Number of clinics with accredited 'youth friendly' status
- Number of people < 20 having voluntary HIV counseling and testing
- Number of schools offering life skills education
- Number of schools offering condoms

However, these targets are largely meaningless unless there are qualitative indicators attached to them, and unless those primarily responsible for their implementation agree on a system for ongoing monitoring and evaluation.

11.1 Improve treatment, care and support for people living with and affected by HIV and AIDS

In the resolutions of the Civil Society Congress on HIV prevention and treatment there is a call for standardized national guidelines on various aspects of treatment and care, as well as for the updating of a number of guidelines. We recommend that the NSP, or an annex to it, list relevant guidelines including:

- Sexual (including assault) and occupational post exposure prevention.
- Adult and paediatric pre-ARV guidelines, including the diagnosis, prevention and treatment of opportunistic infections and TB.
- Adult ARV guidelines.
- Paediatric ARV guidelines.
- Guidelines specifically dealing with the care of adults and children who are stable on ARVs.
- Updated PMTCT guidelines.
- Fertility guidelines for family planning for people with HIV - this is increasingly becoming an issue, and is not adequately addressed in the Comprehensive Plan.
- Guidelines for migrants and refugees.

It is regrettable that HIV clinicians and health professionals are left out of the agencies responsible for this aspect of the NSP. Further, if these guidelines are to be updated annually, the NSP needs to suggest a forum for their evaluation, and link it to a system for M & E.

The section titled "Build capacity of health professionals to provide comprehensive HIV and AIDS, STI & TB treatment, care and support" once again leaves out the private health sector. It requires more specific targets, and should also acknowledge the importance of ongoing education. More appropriate targets would be:

Health care workers trained in HIV care:

- number for the first time
- percentage previously trained that attend a refresher course.

The section reading "Establish strong links between health facilities and community-based support programmes" should rather read "Number of support NGOs linked to each HIV care provision site".

We are concerned that community based treatment literacy programmes, such as those pioneered by TAC, are entirely absent from this part of the NSP. Such programmes however are vital to access and adherence and if promoted officially would assist the health department by creating better health understanding and health seeking behaviour among people.

11.2 Ensure effective management of TB & HIV

This section is a priority intervention and is critical to monitoring access to HIV care from high prevalence areas. It, should have far more specific indicators and bolder targets. It must also be linked directly to the section of the NSP that aims to increase the uptake of HIV testing. A 2011 target of 80% for each is suggested.
In addition to what is proposed we recommend a policy of active case detection in:

- STD clinics (% screened)
- ANC facilities (% screened)
- Family planning clinics (% screened)
- % of patients with TB tested for HIV in the TB clinic
- % of TB patients tested HIV positive who receive CD4 staging in the TB clinic
- % referred for ARVs from the TB clinic
- % referred to general HIV care from the TB clinic
- Percentage of HIV positive patients NOT on ARVs receiving IPT

11.3 Reduce morbidity and mortality from HIV and AIDS

In order to be more specific, and **ensure that access is equitable**, we recommend that the intervention titled "Provide ART to eligible HIV positive adult clients" be subdivided in to the following sections:

- Number of adults >18 provided with ART for the first time
- % of adults >18 that have been on ART for >1 year
- % of adults commenced on ART in non-hospital-based clinics
- % of adults initiated on ART exclusively by nurses
- % of pregnant HIV positive women qualifying for ART initiated on ART

This will allow clearer identification of new sites making rapid gains, or of experienced sites slowing down.

We are also concerned that the targets listed in this section represent approximately 20% of those requiring treatment, and should be revised upwards. All epidemiologic data suggests that there are approximately 800 000 people who need ARV's at the moment, because of the backlog of access, and that **an additional** 500 000 people will require treatment annually going forward. This is why we believe that the critical measures should be:

1. The numbers of people who have been on treatment for more than one year
2. The numbers of people newly initiated on treatment in the last year.

In addition, a target for 2007 should be to ensure that waiting lists are ended at all sites.

However, to arrive at realistic targets and strategies to achieve them a special meeting including provincial health departments, health workers associations and NGOs is urgently required.

But in the absence of such a meeting we propose that a starting number would be to cover 50% of new cases in 2007 (an additional 250 000 people) and aiming for 100% (500 000) people by 2011. This can be revised as updated epidemiology is given.

Our paediatric colleagues have suggested new indicators for children. We strongly feel that paediatric targets calculated on the same basis as adult targets – and not simply listed as a percentage of adults.

The focus on pregnant women above focuses ANC services on the rapid assessment and referral/initiation of pregnant women on ART, minimizing the significant consequences of illness in pregnancy (HIV, according to the Confidential Enquiry, is the commonest cause of death during pregnancy) and maximizes PMTCT. Furthermore, there needs to be an urgent programmatic discussion concerning offering all pregnant women ART or expanded PMTCT. At present, there is often a significant delay in pregnant women who qualify for ART getting access to the treatment sites and subsequently being initiated. Loss to follow up is high, and at times, women have delivered by the time initiation is complete. This approach would ensure that the PMTCT intervention is strongest in a group most at risk of transmission AND ensures that the immunologically most vulnerable women are rapidly placed on treatment.

We propose that both references to nutrition in this section should be given as a percentage of those in care (rather than as an absolute number) . This should be 80% by 2011.

We support the proposal that the number of PCR tests done on infants at 6 weeks must be added as an indicator.

An additional indicator should be “Standards of service for ART, TB and STD facilities developed and distributed” with a target date for 2008. This allows evaluation of HIV care sites on an objective level. In addition, “Evaluation against standards of service in HIV care sites with feedback to the site and manager” must have occurred at least once in all sites by 2011.

12.1 Implement CHBC as part of the EPWP

The intervention “Expand HCBC services to cover all municipal wards” is very vague. We propose:

- Standards of care Guidelines developed for community care givers – aim for 2007.
- Standardised training provided to community care givers for the first time – suggest aim for 100% of all accredited home based carers by 2009.
- Update training provided to % of previously trained group – suggest this is 20% per year
- A policy decision on a system for registration of carers

The draft NSP also proposes "To increase the number of care givers receiving stipends". However, there is a debate as to whether stipends are a good idea or not. We propose the need for a policy decision on formal employment of care givers by the state as part of the EPWP.

12.2 Improve quality of life for homebound clients

The numbers here seem very specific. It is unclear how they are calculated? **In this context a commitment to the roll-out of palliative care services, to alleviate the pain of the large numbers of people who will continue to die of AIDS, is urgent.**

13.1 Strengthen support services to not for profit NGO and CBOs

The proposed interventions are very vague. We suggest:

- An improved system of independent monitoring and evaluation of NGOs
- A system for skills building and training to ensure NGOs provide a proper service
- Discussion of better funding mechanisms to ensure that legitimate NGOs are able to plan to meet essential needs.

13.2 Strengthen social development services to children at risk

"Develop and update policy guidelines that inform service delivery to children" and "Develop competency of practitioners involved in service delivery to children" should rather be:

- Training provided to x HCW's; and then:
- x% of previously trained updated

"Facilitate access of HIV positive children to the comprehensive, integrated social development services" is also nebulous, but the Paediatric Working Group will provide input in to this process.

KEY FOCUS AREA 2 B: Social Development Services to youth, women, the elderly, the disabled and people and their families living with HIV.

This section clearly was developed independently of the main document – it does not follow the same format, it does not focus on the primary area of this document, and does not have similar targets. Many of the outputs date back to 2004, suggesting a 'cut and paste' job (this is acknowledged in the lower part of the text, and an apology extended). Many of the sentiments are important, but it should have the original document included as an annexure. We suggest removing this entire section. Many of the relevant targets are covered in the other interventions.

14.1 Establish and implement a functional M&E system

This area is acknowledged as an area of weakness, and we suggest very specific support structures and targets are required to make this function correctly. For example:

- Number of managers allocated to this specific responsibility per health facility
- Number of data capturers employed per 1000 patients
- Number of data capture points functional (eg fax, computer) consistently for 1 year with <3 days downtime
- Number of facility specific reports issued back to facility managers

15.1 Support and monitor the efforts to develop effective microbicides products in South Africa AND *16.1 Support efforts to develop an appropriate AIDS vaccine*

As a general comment, provinces frequently play a hampering rather than a facilitative process with regard to many research interventions. If there is a serious commitment to support, this needs to be demonstrated. To ensure that these large scale research protocols occur as quickly and amongst the widest population possible, we suggest that assistance with the implementation of these is made an output of all provinces, who should actively solicit participation of their populations.

We suggest indicators for the following:

- Number of provinces supporting this form of research
- Time taken to return comment on submitted research proposals < 1 month (note that we do not support unquestioned research, simply that comment must be speedy and clarification rapid).
- Funding support

General comments on research:

South Africa has a research capacity that is almost without parallel in developing countries. However, this capacity is unacknowledged and largely uncoordinated when it come to research on HIV and health systems broadly.
We propose that under the auspicies of the National Health Research Council a meeting of research institutes, faculties of health science etc be hosted early in 2007, with a view to a better identification of research needs; capacity for monitoring and evaluation (particularly through sentinel surveillance sites in provinces) and dissemination.
At this stage there is little use in coming up with a 'wish list' of research areas, as they change rapidly and need to be attuned with the priorities of the NSP. However, a series of possible indicators could be:

- Number of research projects per province that are:

i) Operational
ii) Basic sciences
iii) Clinical
iv) Other

- Time taken to respond to research protocols < 1month
- Funding made available for research on implementation of the HIV, STD and TB programmes
- Quarterly national meetings held to discuss research results and define priorities

19.1 Develop mechanisms for long and short-term training to improve the capacities of provincial and district staff to conduct HIV and AIDS, STI and TB related operations research and surveillance

While this is laudable, staff often misunderstand the role of evaluation rather than research, and we would argue that this is a far more important skill than the kind of focused research that many academic institutions perform. Evaluation of clinic outcomes is a far easier, faster, cheaper and often more meaningful process than research in this scenario.

19.2 Conduct national surveillance on HIV and STI risk behaviours, especially among youth

This is an excellent section. However, we would include each province, as well as the private sector, in a plan on surveillance.

PRIORITY AREA 4: Human and Legal Rights

This section has already been addressed above.

Additional targets:

In addition to what is already contained in the draft NSP, we would recommend a set of further indicators. These are:

Standards of service for ART, TB and STI facilities developed and distributed" - target date for 2008

Evaluation of Standards of services – at least one evaluation by 2011

Establishment of sentinel monitoring sites in each province by 2008, in both the public and private sector, with regular annual reports from each:

- TB
- STI
- Family planning

- General primary care
- Hospital
- ART
- Home based care

Within each there should be nested analyses of the incidence of genital ulcer disease, STD (with specific reference to gonnococcal disease), TB and ARV drug resistance, opportunistic illness incidence off and on ART, and default rates from care (off and on ART).

Number of foreign graduates as a percentage of vacant posts (with targets of each of 20% by 2008 and 50% by 2011).

Doctors
Nurses
Pharmacists
Social Workers
Dieticians

Policy document on Changes to the Scope of Practice for nursing, counselor and support staff – for 2007

Role definition of ARV coordinators and clinic managers at HIV care sites – for 2007

Prevention for positives programmes in HIV care facilities – aim for 30% by 2008

Finally, it would be appropriate to add a facility based target for correctional facilities and the military, in terms of TB and HIV screening, and treatment. We propose that targets be set for:

TB screening and prevention programmes
HIV testing coverage >60%
ART programmes in facility
Time to ART < 2 months from assessment of requiring ARV's.

ENDS