

PROGRAMME COORDINATING BOARD FIELD VISIT | 15-18 October 2018

UNAIDS PCB Field Visit to South Africa

I) Summary:

As part of UNAIDS' efforts to link Board discussions with programme implementation, a delegation of the UNAIDS Programme Coordinating Board (PCB) undertook a field visit to South Africa on 15-18 October 2018 in advance of the forty-third PCB meeting.

The delegation included members from Algeria, Belarus, China, Ecuador, Finland, Madagascar and the United Kingdom, as well as the PCB NGO Delegation represented by the All-Ukrainian Network of People Living with HIV and UNAIDS Cosponsors participating from the global, regional and national levels. The delegation met with a range of stakeholders engaged in the response to HIV in South Africa.

In particular, the delegation met with senior officials from the Ministry of Health, the Premier of KwaZulu-Natal, CAPRISA representatives, the South African National AIDS Council (SANAC), the Higher Education and Training Health, Wellness and Development Centre (HEAIDS), as well as development partners, the UN country team, UN Joint Team on AIDS and the acting Resident Coordinator. The delegation also met with civil society organisations working in the province of Kwa-Zulu Natal, and with civil society representatives of SANAC. In addition, it met with sex workers as part of the University of Witwatersrand project "HIV prevention among Sex Workers and their clients" and the representatives of the major mining companies within the Minerals Council South Africa.

The visit was a valuable opportunity for Board representatives to observe the AIDS epidemic and the HIV response of a country with an important epidemic and an adult (15+) HIV prevalence rate of some 19.2%. The visit also served to demonstrate the value of the integrated multisectoral support provided by the Joint Programme through the Joint Team to the national AIDS response, in the context of support for overall development efforts from the UN Country Team (UNCT) led by the UN Resident Coordinator.

Key issues addressed during the visit:

- South Africa has the largest HIV epidemic in the world, with 20% of the global number of people living with HIV (7.4 million people), 15% of new infections (270,000) and 12% of AIDS related deaths (110,000).
- Since 2010, new HIV infections have decreased by 31% and AIDS-related deaths have decreased by 45%.

- Results from the 5th National HIV Prevalence, Incidence, Behaviour and Communication Survey 2017 (led by the South Africa Human Sciences Research Council - HSRC) show that incidence among adolescent girls and young women 15–24 years old is 15.1 per thousand which is three times more than their male peers at that age group.
- Direct comparison with the 2012 Survey shows a 44% reduction in incidence among 15–49 years old and a 17% reduction among 15–24-year olds.
- Progress against the 90-90-90 targets as measured through the survey was 84.9%, 70.6% and 87.5%, translating into 84.9% of People Living with HIV (PLHIV) knowing their status, 59.9% of PLHIV on antiretroviral treatment (ART) and 52.4% of PLHIV virally suppressed.
- Behavioural indicators show progress in some areas and stagnation or even regression in some other areas:
 - 30.8% of males 15 and above were medically circumcised, a considerable increase from 18.6% in the 2012 survey.
 - Proportions of adolescent boys and young men aged 15–24 having their sexual debut before 15 have increased.
 - The number of people who have more than one sexual partner in the past 12 months increased among girls and women and decreased among boys and men from 2012 to 2017.
 - Condom use at last sex has remained stable among both males and females.
- The decline in incidence in all groups can be attributable most likely to progress on HIV testing and treatment.
- There is lower testing coverage and lower initiation onto treatment for men than for women.
- There is large drop out from treatment: in 2017, almost 770,000 people started treatment and about 270,000 people dropped out.
- The new single-pill HIV treatment regimen containing dolutegravir (DTG) has not been registered by the Medicines Control Council. According to the National HIV Think Tank the country will not reach <88,000 new HIV infections by 2020 with the scale-up of UTT (universal test and treat) alone, even with DTG.
- South Africa has the largest treatment programme in the world, accounting for 20% of people on antiretroviral therapy globally (4.4 million).
- The country also has one of the largest domestically funded programmes, with about 75% of the AIDS response funded by the government (a total of US \$2.07 billion was spent from domestic public and international sources in 2017).

- Challenges for sustainability: the Investment Case conducted in 2016 projected a funding gap of ZAR 7,000,000,000 (almost US\$ 460,000,000) for 2019.

II) Background

“The story of the AIDS response in South Africa can be characterised as a journey from denial to acceptance, dependency to ownership, despair to hope, and impressive results” said Michel Sidibe, UNAIDS Executive Director and Under-Secretary General of the United Nations from 2009 to 2019.

Indeed, the history of the South African AIDS response is the most well-known of any country in the world. It is a history of a well-publicized struggle against AIDS denialism in the early days and a turn-around that laid the foundation of the remarkable progress of recent years. As the epidemic established a foothold in South Africa in the 1980s, the response was slowed down by denialism that ignited a political and policy conflict between the government and civil society. Vibrant civil society activism with people living with HIV at its core fought for universal access to HIV treatment and the rights of people living with HIV. These struggles led to the establishment, among other, of a national programme for the prevention of mother-to-child transmission of HIV in 2002 and an operational treatment plan in 2003, but the pace of implementation was very slow.

A major turning point in the national AIDS response occurred in the year 2009 with a change of political leadership to President Jacob Zuma and Dr Aaron Motsoaledi as Minister of Health. New momentum emerged in the AIDS response, underpinned by a bold and visionary political leadership partnering with a world class and often ground-breaking scientific community as well as a vibrant civil society.

On World AIDS Day, in the presence of the visiting UNAIDS Executive Director, the President announced far reaching policies that would lead the current largest treatment programme in the world. These policy declarations were given effect by the launch of a massive HIV Counselling and Testing Campaign and Treatment Expansion.

Since 2009, UNAIDS backed a sustained advocacy push in South Africa to support the national leadership in keeping HIV high in the political agenda. The Executive Director conducted over 30 high level missions to South Africa to support the national leadership and position South Africa at the apex of the global and regional AIDS response. South Africa has always largely funded its own AIDS response from its national treasury – just over US\$ 2 billion in 2017 (over 75% of the response) up from US\$ 1 billion in 2011/12.

III) Objectives of the Programme Coordinating Board visit to South Africa

The goals and objectives for this field visit were to:

1. Provide an opportunity for PCB participants to see the context of the HIV epidemic in South Africa and engage directly with various stakeholders involved in the national AIDS response.
2. Enable delegates to consider the value of an integrated, multi-sectoral response and the role of UNAIDS-led UN Joint Team in support of the nationally owned response and the work of other International Development Partners supporting the national response.
3. Offer an opportunity for the PCB delegation to inform discussions at the forthcoming PCB and report back on the work of the Joint Programme at country level.

IV) The HIV epidemic and response in South Africa

Progress in the response has been remarkable in recent years:

- 4.4 Million People living with HIV are accessing life-saving treatment – representing 20% of people on treatment in the world.
- Number of AIDS deaths: 47% reduction in AIDS deaths from 2010 to 2017 (from 168,000 to 89,000).
- Life expectancy: 8% increase in life expectancy at birth (59.9 to 65.2) from 2010 to 2017.
- Number of new child infections: 56% reduction in number of mother to child HIV transmitted infections (from 28,000 to 12,500) from 2010 to 2017.
- More than 95% of pregnant women access HIV treatment.
- HIV incidence declined by 44% between 2012 and 2017 (HSRC Estimates).

Some challenges:

- South Africa accounts for 0.7% of the Global Population but 20 % of the number of people living with HIV in the world.
- There are 7.4 million people living with HIV.
- Almost 3 million people living with HIV are not yet on treatment.
- Per year, there are 110 000 new infections among young people aged 15-24 years; 2100 per week and almost 300 per day.
- Infections among adolescent girls and young women are 88,000 per year, almost 1700 per week; 240 per day.

90-90-90 Strategy

National figures as of mid-2017:

- 90% of those living with HIV know their status
- 58% of people knowing their status are on ART (56% of PLHIV)
- **78%** of people on ART were virally suppressed (43% of PLHIV)
- The 2018 GAM data reports a total of 4.4 million people on ART: **South Africa has reached the first 90.**

Sustainability of the response

Total AIDS spending in 2017 amounted to more than US\$ 2 billion with:

- **US\$ 1,546 billion** from domestic public resources
- **US\$ 473 million** from PEPFAR
- **US\$ 55 million** from GFATM

TB/HIV in South Africa

- South Africa is part of 14 countries with a very large burden of Drug Sensitive-TB, MDR-TB and HIV-associated TB. TB is the largest killer of PLHIV contributing up to one third of the deaths. HIV, through suppressing the immune system, predisposes PLHIV to much higher risks of TB compared to the general population.
- In 2016, South Africa notified 244,053 TB patients to WHO which was significantly lower than the 438,000 patients estimated by WHO in the same year. There are almost 200,000 missing TB patients.¹
- Despite more screening and testing, fewer TB patients have been detected year on year, since the peak of 406,000 registered in 2009. The South Africa National TB Prevalence Survey has been initiated and will provide clarity on the burden of TB and the declining trend.
- The National Strategic Plan for HIV, TB and STIs (NSP 2017-2022) aims to achieve the National 90-90-90 targets for TB: to **find 90% of all TB patients** and place them on appropriate treatment; to **find at least 90% of the TB patients in key populations (including PLHIV)** and place them on appropriate treatment; to

¹ It should be noted that, subsequently to the Field Visit, WHO made a significant revision in the estimated burden of TB in South Africa between 2017 and 2018 (estimated for 2016 and 2017). The estimated number of new TB cases in South Africa in 2017 was 322,000 [230,000 – 428,000] and the number of registered cases in that year was 227,224 making the gap less than 100,000.

achieve 90% treatment success for drug-susceptible TB, and 75% for drug resistant TB.

- South Africa showed strong political commitment in the lead up to and during the **UNGA High Level Meeting (HLM) on TB** and the outcome Political Declaration contains global targets and strategies that lay the foundation for Ending TB by 2030.

V) PCB Field Visit activities

Monday 15 October

Meeting with Dr Yogan Pillay, Deputy Director-General at the South African National Department of Health

The meeting of the PCB delegation with Dr Yogan Pillay was an opportunity for the delegation to discuss the importance of political leadership in the HIV response, cross-ministerial engagement, the benefits of having a UN Joint Programme to ensure ongoing political commitment, as well as collaboration with civil society partners. It was also an opportunity to understand the history of the HIV response in South Africa since the change of political leadership to President Jacob Zuma with Dr Aaron Motsoaledi as Minister of Health. Dr Yogan Pillay is the Deputy Director-General at the South African National Department of Health and is responsible for the following health programmes: HIV & AIDS, TB and Maternal, Child and Women's Health (MCWH).

The following issues were discussed during the meeting:

- The great leadership of President Zuma on the subject with two remarkable examples: 1) 15 million people tested, put on ART and screened for TB in 15 months and 2) the fact that he disclosed his status which helped the national discussion on stigma;
- The current President's leadership, who will launch a new campaign starting 1 December 2018 to test and treat 2 million people;
- The leadership variations in different regions – KwaZulu-Natal has seen sustained leadership for a long time – where not, civil society is pushing for more political accountability;
- Leadership in the private sector has been less vibrant than hoped for. The large companies have respectable policies on HIV, but it is more difficult to get the smaller ones involved;
- The bulk of prevention programmes is funded by the government but 19 of the 20 billion Rand are currently being spent on treatment;

- 9 billion male condoms are distributed per year versus 40 million female condoms – the difference is the price, female condoms being 24 times more expensive;
- However, condoms of both kinds are not being used enough. Therefore, HIV prevention is doing well on the supply / non-medical interventions side, but more work must be done on behaviour change;
- Security of commodities is a big issue and the UN is considered well placed to support it;
- Trade-Related Aspects of Intellectual Property Rights (TRIPS) are not used today as the volume of generics have significantly reduced the cost of drugs, and this trend will continue as the move to Dolutegravir as first line treatment is complete;
- All hospitals should provide post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PREP) – but implementation is not exemplary;
- There are challenges to move from vertical programmes to integration of HIV with Universal Health Coverage, which could also lead to loss of HIV-specific funding;
- School-based life skills programmes have not had the impact hoped for, and quite a number of teachers are reticent to teaching it. It is also a matter of keeping young people in school, and developing out-of-school programmes for those out of school;
- Gender-based violence is too common, it is “almost an epidemic in-itself”;
- Adolescents do not seek services in health care settings. Western cape, for example, has no services outside of health facilities. It is important to see how to take services to people rather than the opposite – but also how to use new technologies in service delivery;
- There is stigmatisation of migrants and key populations – particularly sex workers and men who have sex with men (MSM). This is a general problem when not having a person-centred approach in all services;
- The TB burden is considerable: 60 percent of People Living with HIV have TB;

Meeting with the UNCT and Joint Team members

The United Nations Joint Team on AIDS is the structure under the UN Country Team which convenes and coordinates UN support to South Africa in its efforts to address the AIDS epidemic. The Joint Team brings together the efforts and resources of the UNAIDS Secretariat and eleven cosponsoring organizations, agencies, funds and programmes of the United Nations system – WHO, UNICEF, UNFPA, UN Women, WFP, UNDP, UNODC, ILO, UNHCR, UNESCO, and WB. In South Africa, the Joint Team comprises of all Cosponsors (except WFP which has no country presence) as well as OHCHR and IOM. The UN Joint Team works under the guidance and overall leadership of the Resident Coordinator.

During the discussion with the UN Joint Team, the following issues were underlined:

- The PCB Chair reiterated its three priorities: 1) HIV prevention, 2) the Independent Expert Panel on the prevention and response to harassment, including sexual harassment, bullying and abuse of power and 3) improving how the Joint Programme functions through the implementation of its refined operating model;
- The Joint Programme was cited as a model, but there was a consensus that there is a need to go beyond it, to show where it is actually making a difference. For example, part of the challenges on HIV prevention are not biomedical but structural and behavioural – the Joint Team will have to show its value add on this level;
- Regarding the HIV Prevention Coalition road map, the Ministry of Health called on an inter-ministerial group to recalibrate South Africa’s targets and take accountability of the international commitment – it is currently being domesticated and the question is being asked what needs to be done to reduce annual new infections to 88,000 from 270,000 people. The UN’s role is to show leadership in supporting the Government to frame its work;
- UNAIDS Unified Budget, Results and Accountability Framework (UBRAF) country envelopes² have been used for rolling out a model that ensures the integration of sexual and reproductive health. Looking at services for young people in the education and health sector – at provincial and national level – KwaZulu-Natal and Eastern Province are the primary targets. For example, country envelopes have been catalytic for UNDP to pilot programmes focused on behavioural change, as there have been no new investments in that field;
- In addition, UBRAF country envelopes are supporting the Joint Programme in being a relevant partner to the government on innovative approaches, not only bringing behaviour change programmes to three provinces but also bridging the data gap and improving the quality of data collected;
- The UNAIDS Secretariat was praised for coordinating the work in an exemplary manner. The Joint Team in East and Southern Africa acts as a platform and emphasis was put on the appreciation for the leadership and technical support from UNAIDS. It was valued that the provinces were being focused on.

² For 2018-19, of the annual US\$ 184 million core budget of the Joint Programme, US\$ 140 million was allocated to the Secretariat and US\$ 44 million to the Cosponsors. Each of the 11 Cosponsors received a core allocation of US\$ 2 million flexible funds per year by way of country envelopes to leverage joint action.

- It was also mentioned that the UBRAF country envelopes had to be used to strengthen partnerships with civil society and the private sector while keeping H6 and UN reform as a general frame for it.

Tuesday 16 October

Site visit to Kwazulu-Natal

Meeting with the Kwazulu-Natal Premier and "Member of the Executive Council" (MEC) for Health



The meeting of the PCB delegation with the Premier of Kwazulu-Natal was an opportunity to understand the dimensions of the HIV response at a provincial level. Kwazulu-Natal is prone to instability. The infrastructure is more challenging than in the rest of the country because of its geography: it is on the border with both Mozambique and Eswatini, hilly, and difficult to access. In addition, Kwazulu-Natal has the highest burden of HIV and TB in the country.

The Premier expressed his gratitude to the Joint Programme, in particular UNAIDS, UNICEF, UNFPA and UNDP for their support and technical assistance. There has been some progress notably on adolescent girls, on Prevention of Mother-to-Child Transmission (PMTCT) – 73 per cent of women are attending antenatal care – and acceleration of Voluntary Medical Male Circumcision (VMMC) which are all key for achieving 90-90-90. Life expectancy has increased to 60 from 42 years old.

Issues that came up during the meeting included:

- The disparity in HIV prevalence by sex is most pronounced among young adults: HIV prevalence among 20 to 24-year-olds is three times higher among females (15.6 percent) than males (4.8 percent).³
- Most programmes look at the biomedical aspect of the response and insufficiently at behaviour change and social sciences. The social aspect of the epidemic is going to be crucial for ending the AIDS epidemic and more investments are needed there;
- Migration and access to treatment for migrants is one of the other key issues in the province. Migration leads to informal settlements – and interim services – rendering follow-up challenging;
- Community care workers have been introduced. They are linked to a health facility and go into the community with which they have close ties and provide services;
- Programmes are developed involving people and through community leadership;
- Lastly it was also stressed that UNAIDS is the critical coordinating structure and is perceived to be needed in the future.

Meeting with civil society and networks of people living with HIV in Kwazulu-Natal



The delegation's meeting with a wide set of civil society actors was an opportunity to see the broad engagement of civil society in the provincial AIDS response in South Africa and to discuss platforms for coordination of civil society interventions and the issues faced in HIV prevention particularly for young people and key populations.

³ The fifth South African national HIV prevalence, incidence, behaviour and communication survey, 2017 (published July 2018).

The civil society organizations participating included: Think SA (HIV and TB), HEAIDS (youth in tertiary institutions), Zoe-Life (children and adolescents living with HIV) and LGBTI Centre (LGBTI advocacy and service delivery).

Issues that were brought up during the discussion included:

- Engagement of civil society was key in the scale up of 2 million additional PLHIV on treatment as well as in the “She conquers” campaign;
- “She conquers” is a national campaign acting as a platform for making all efforts to reduce HIV infections amongst adolescents using PEPFAR Dreams. It aims at tackling poverty as a structural driver as well as social and financial inequality;
- It is important to give students the space to know their health. Services have been brought to campus – for instance services for discordant couples and messaging aiming at reducing stigma. There are some resource challenges as well as the challenge of languages: Kwazulu-Natal is complex as students come from many places;
- Young people do not want to be seen as having health issues in their communities. South Africa needs adolescent-friendly systems within clinics;
- There are also targeted programmes for key populations – for example AIDS Healthcare Foundation (AHF) is a partner on prevention. Civil society and businesses are excited about South Africa’s ambition to not rely on foreign aid;
- Durban is part of the fast track cities, yet still faces challenges in achieving the last 90. Civil society needs to keep government responsible for viral load suppression (currently sitting at 68%).

Meeting with CAPRISA and UNAIDS Special Ambassador for Adolescents and HIV: Quarraisha Abdool Karim

The visit to CAPRISA was an opportunity for the delegation to see the facilities of the world-renowned research centre, as well as to engage with scientists and researchers leading studies on a broad area of HIV-relevant subjects. CAPRISA is the centre for the AIDS programme of research in South Africa. It was established by five partner institutions: University of KwaZulu-Natal, University of Cape Town, University of Western Cape, National Institute for Communicable Diseases, and Columbia University in New York. CAPRISA is a designated UNAIDS Collaborating Centre for HIV Prevention Research. The main goal of CAPRISA is to undertake globally relevant and locally responsive research that contributes to understanding HIV pathogenesis, prevention and epidemiology as well as the links between tuberculosis and AIDS care.



Issues discussed during the visit included:

- There are 5000 new HIV infections every day – 1 of 3 in youth 15-24-year-olds. AIDS is the second leading cause of death among adolescents;
- 70 per cent of the South African population is under 35 – PMTCT and antiretroviral treatment (ART) are changing the country demographics;
- HIV and TB are intertwined and failing to advance HIV prevention and treatment will increase TB mortality;
- It is important to treat HIV and TB simultaneously – some caregivers are not aware that it is possible to delay HIV treatment until after the intense period of TB treatment for those acutely sick of TB;
- CAPRISA’s research agenda is funded primarily through competitive grants submitted to several sponsors (235 million Rand in 2018);
- Research is key for policy influence and accurate programme development;
- The impact of research is tremendous. At the 2016 Durban conference the “Cycle of transmission” research was presented: researchers used genetic analysis of HIV to understand the cycle of transmission of HIV in one part of the country. They were able to conclude that men and women in different age groups have distinct prevention needs, in addition to the standard prevention package including female and male condoms and behaviour change;

- 9 districts out of 12 are high burden in KwaZulu-Natal – young women under 25 are getting infected by men 8 years older. Research is helping to think of new ways of responding to this issue;
- Men who have been recently infected have a high viral load and usually do not know their status yet. This is a time during which they are highly infectious. Therefore, PREP is a necessity for women under 25 in this Province and it is why there is a need to change the focus from facility-based services to service delivery in the communities;
- Men lack role models for gender identity – they need to be reached before 25 for male circumcision as a short-term intervention and new values in society need to be developed and spread as a long-term solution. Studies have shown that girls completing school makes a significant difference.

Wednesday 17 October

Meeting with the South African National AIDS Council

The South African National AIDS Council (SANAC) brings together government, civil society and the private sector to create a collective response to HIV, TB and STIs in South Africa. The Council is chaired by the Deputy President of South Africa. The visit to SANAC was an opportunity to engage with SANAC members and see how the tripartite entity oversees the country's response to HIV, how it coordinates the country's multisectoral response and through which priorities, how it mobilizes the necessary resources to do so and how it monitors the progress made against the targets set in the National Strategic Plan (NSP).

Issues discussed during the visit included:

- The SANAC is a voluntary body established by the Cabinet in 2002 with the primary role of providing advice to the Government;
- The NSP is a critical instrument: it is aligned to a national development plan and the SDGs – then it is tailored to fit the HIV response to fit a particular area. The Premier signs off on every provincial plan;
- The TB caseload has halved since 2009 but it is still three times over the epidemic level at 781 cases/100.000 at national level and three times higher in mines;
- 160,000 people are estimated to have TB without being on treatment;
- In Western Cape, 75% of all new HIV infections are in Cape Town City;
- The Prevention Coalition has set the objective to reduce new HIV infections from 270,000 to 88,000 – with a focus on young women and girls;

- PEPFAR Dreams does impact evaluation where they were able to demonstrate the power of testing: if a person is tested in the last 12 months, they are less likely to have HIV and are 24% less likely to be HIV positive if they experienced condom demonstration and education;
- It is known that teaching about contraception in school reduces the risk of HIV. However, there is resistance to policy from parents, including for the distribution of condoms. It is very different from biomedical interventions which are easy to measure and report on – and more easily funded. The most difficult things to change are the structural drivers – substance use and gender-based violence being the most important.
- South Africa needs changes in policies to provide better services. The country is currently working on decriminalization of sex work. It also needs social scientists and marketers to promote behaviour change and new ways of thinking;
- All provincial plans are developed with UNAIDS, including the multisectoral approach. District profiles are developed with UNAIDS and together they leverage the information that exists on the drivers of the epidemic in each district.

Meeting with the Health Partnership Forum

The meeting with the Health Partnership Forum in the SANAC premises included representation from the European Union, Finland, France, Germany, GIZ, Ireland, Italy, Japan, Netherlands, Norway, the UK, the US, the Gates Foundation, the Global Fund, ILO, MSF and WHO. It was an opportunity for the delegation to engage on the sustainability of the financing of the response, as well as the opportunities for scaling up financing for HIV prevention.

Issues discussed during the meeting included:

- The Health Partnership Forum was established 15 years ago, with the aim to improve the coordination between the department of health and all development partners. It is one of the most functional fora in South Africa in terms of multisectorality. Its work has clear links with the annual ODA Forum chaired by the Minister of Health;
- There is not a lot of foreign aid (less than 1% of the government budget) therefore there are not many donor coordination mechanisms;
- The private sector work on health is not included in this forum, its primary role not being to coordinate the actions of all national entities;
- The most active partners are MSF, JICA, German Cooperation, CHAI, EU, KfW, PEPFAR, CDC and GIZ particularly on Comprehensive Sexuality Education and school health.

- For 2019 PEPFAR is programming an investment of US\$ 650 million with a focus on strategic information and laboratories;
- There is a focus on the prevention portfolio for Adolescent Girls and Young Women (AGYW). The number of new HIV infections is diminishing, but the rate is too slow. There are approximately 500,000 circumcisions per year;
- There is a remarkable viral load capacity in country which is quite unique: all people who are on treatment know their viral load;
- PEPFAR support is in 27 of the districts. The focus at the moment is on the highest burden districts;
- CDC, UNAIDS and WHO are working on a system for modelling - the Thambisa model (more nuanced than Spectrum);
- GIZ is working on HIV prevention in schools with the department of health, education and social development and closely with the GFATM: an AGYW project funded through a primary recipient and supported by the Country Coordinating Mechanism and local staff;
- MSF has been operational in South Africa since 1999. It operates in 4 areas (14 wards) with a focus on prevention – testing and condom education which has had a great impact on halving new HIV infections. Targeting mortality reduction is also important through adherence and welcome back packages as well as other work to reduce stigma and discrimination amongst nurses;
- CHAI has been working on Voluntary Medical Male Circumcision (in South Africa, Zambia and Zimbabwe they represent 50 per cent of all circumcisions). As PEPFAR transitions out they are building on sustainability. They provide access to an initiation setting where men come for Voluntary Medical Circumcision, where otherwise they are not accessing health services. They also provide PREP to sex workers and AGYW.
- What is the role of donors in the future? The forum is a place where it is possible to reflect on these questions of sustainability, support to the government, innovation and risk taking, being more catalytic with regards to people in prisons, migrants, sex workers, injecting drug users;
- There is a consensus that life skills programmes do not seem to be working. In addition, a red flag is being raised by the development partners on the drug use pockets in the country: drug use is increasingly becoming a problem – even regionally. In fact, the entire GFATM proposal is on key populations but there is always a risk that key populations programmes drop out when GFATM transitions out, which is a problem;

- South Africa has a framework in place not to marginalize key populations and they are getting more and more data – 50% of sex workers and 33% of MSM are living with HIV and their 90-90-90 cascade looks very poor;
- PEPFAR considers that South Africa is not yet out of the emergency phase – significant investment on strategic information and supply chain management are still needed and there is no outlook for disengaging in the immediate future;
- It would be important to get additional ministries involved because implementation gaps persist, and not move away from actual service delivery. Funding is used to go into inter-governmental structures, often at district level which is the weakest – and financial flows to this level are not always effective;
- GIZ offers support on how to localize global UN guidance for educators and students;
- There is a very rich NGO network in South Africa. Funding for civil society is a major issue – PEPFAR and the Gates Foundation have been struggling with this.

Meeting with the Higher Education and Training HIV/AIDS Programme, Ministries of Education

The Delegation also met with the Higher Education and Training HIV/AIDS Programme (HEAIDS). HEAIDS is a non-profit company under the leadership of the Department of Higher Education and Training. HEAIDS works in partnership with Universities South Africa (USAf) and the South African College Principals Organisation (SACPO).

The key focus of the HEAIDS Programme is to ensure that young people passing through the education sector within more than 400 campuses countrywide, are healthy and competent to take their rightful place in contributing to the economic growth of the country. The HEAIDS Programme components have helped increase life expectancy both in terms of economic and healthy living for hundreds of poor and vulnerable young people, who are now accessing proper care and support in terms of treatment, psychological and social well-being, with the support of HEAIDS' partners.

Issues discussed during the meeting included:

- Higher education starts at 15 years in South Africa, which is the age when new HIV infections start to rise (15-24) in particular for girls;
- HEAIDS was set up in 2011 and UNAIDS supported all the steps to create it. The HEAIDS Model is to be used in Mozambique, Zimbabwe and Eswatini;
- 92 per cent of the labour force has been through higher education;
- The tertiary system in South Africa is over-populated - More than 2 million people start tertiary education every year;

- 32 % of students have unplanned pregnancies;
- 35 % of students use drugs or alcohol every month and 60% on a regular basis;
- 10% of total number of rapes in South Africa happen in higher education;
- 1 in 3 girls is raped before the age of 21 – 150 girls every day. In this respect there is a big issue with cultural norms. A survey has shown that 55% of people in higher education do not think that forcing sex onto someone you know constitutes sexual violence.
- LGBTI do not graduate because of stigma (many of them are HIV-positive) – half of MSM use alcohol and drugs before having sex;
- The First Things First campaign was launched for peer to peer testing and screening. The idea is to destigmatise as 95% of the adult population in South Africa does not want to go to a clinic. “We bring the clinic to them”. This has led to a significant increase in testing and condom distribution within tertiary academic institutions;
- Stigma is very high in education – student to student – it is a difficult environment. In fact, there is more stigma in education than health;
- Inside the education system there is “sex for marks”: men abusing young student girls for higher marks;
- A positive point is that South Africa’s investment in Higher Education has increased fivefold in five years.

Meeting with the SANAC Civil Society Forum

SANAC is a multisectoral entity bringing government, civil society and the private sector together to coordinate the implementation of the National Strategic Plan, led by the Presidency. This meeting was an opportunity to discuss the HIV response with civil society directly involved in SANAC. SANAC’s membership is elected by constituency – LGBTI people elect their own members. SANAC has 18 very diverse civil society sectors and they represent specific sections of society. All the 18 sectors represented have a plan aimed at dealing with these topics in line with the National Strategic Plan for 2012 – 2016.

Issues brought up during the meeting included:

- The relationship with UNAIDS was acknowledged: it is a major support to have country directors who have a good understanding of the epidemic and take interest in civil society;
- There has been direct support from UNAIDS into the national association of PLHIV, the Treatment Action Campaign and Positive Women’s Network;

- The Prevention Coalition requires that new HIV infections fall below 88,000 by 2020, which is in less than two years. Those are considerable expectations on the country and civil society expressed concerns as to whether this timeline can be met;
- There are concerns over stock-outs if 2 million more people simultaneously need access to treatment. UNAIDS has a role to play with manufacturers;
- The issue of social and structural drivers is often taken too lightly, however Sexual and Gender-Based Violence is a key driver of the epidemic in this country;
- With regards to key populations, the labelling may perpetuate stigma and adds to discrimination;
- There was acknowledgement of support from the UNAIDS country office, however UNAIDS must go beyond the current level of support and ensure that the organisations are sustainable. If organisations are not well resourced, they cannot contribute to the HIV response adequately;
- 90-90-90 is a good strategy, but how to talk about the three 90s where there are no ARVs, high loss to follow-up, no contraceptives, and the support groups have vanished?
- There is a shortage of human resources – community care workers are delegated to other functions in clinics and therefore less able to do follow-up work with People Living with HIV;
- With regards to adherence and mental health there is a clear lack of psychological support: people only receive treatment with no further support, often leading to treatment fatigue;
- Nutrition programmes should be integrated into treatment services – there are issues of adherence linked to people being hungry and there is a strong need to integrate the two services;
- There is a shortage of contraceptives and a number of women fall pregnant without wanting to. The civil society groups asked UNAIDS to do public advocacy on the global GAG rule;
- There are PLHIV in the workforce and they need to be kept there. Special programmes for mineworkers are needed (through ILO). Workplace programmes are programmes of the 90s; they have not kept up with science and need to be revamped;
- Community health workers are key and there is a target for UNAIDS to reach 2 million community health workers in Africa. Here the issue is compensation – people usually volunteer but they cannot volunteer forever;
- South Africa also has to address the intersection with tuberculosis. There is a high burden of disease – 1,800 AGYW are infected per week, and there was very recently a High Level Meeting on TB;

- Funding is not reaching people and there is a high rate of corruption in South Africa. This is not a funding crisis but a crisis of how the funding especially from GFATM and PEPFAR is flowing;
- SANAC civil society reiterated the importance of effectively using the PCB NGO Delegation to draw attention to the most critical issues in the UNAIDS Programme Coordinating Board;
- In 2008 there was an outbreak of xenophobia and homophobia – 72 countries still criminalize same sex relationships – of these 32 are in Africa – Mozambique and the Seychelles recently joined;
- It is important to provide papers to undocumented migrants who are living with HIV as this is fundamental for them to access treatment;
- The platforms that UNAIDS has provided have opened doors and allowed for civil society to participate better;
- UNAIDS develops global strategies: women and girls, key populations, etc – these are useful because civil society domesticates them and decision-makers can then be held to account;
- It would be helpful to document the South Africa governance model for other countries to use.

Thursday 18 October

Site Visit to the Minerals Council South Africa (Mineral Resources)



On the last day of the field visit, the PCB delegation visited the Minerals Council South Africa. The Minerals Council is a mining industry employers' organisation that supports and promotes the South African mining industry. It looks for ways to advance the position of the

South African mining industry, and to make improvements, participating in various initiatives and projects in areas relating to health, education, policy and regulations. During the meeting, the following entities made presentations and comments: private companies Anglo American Platinum and Sibanye Stillwater, the Association of Mineworkers and Construction Union (AMCU), the International Labour Organisation (ILO) as well as the South African Department of Health. Anglo American Platinum and Sibanye Stillwater are two of the world's largest mining companies representing more than 120,000 jobs in South Africa.

Issues discussed during the visit included:

- Though the “Masoyise Program on Health”, the mines are achieving better results on TB and HIV compared to the national average;
- There is a trilateral collaboration between the UN (ILO, UNAIDS and WHO), the Department of Health and the Minerals Council;
- Private sector involvement is critical in ensuring healthy lives for all and the potential is considerable. Indeed, the SDG agenda has a focus on engaging the private sector;
- The Department of Health stressed the fact that migration and living away from home has a big impact on workers – mineworkers from Lesotho, Zimbabwe and Mozambique migrate between mines and countries: about 500,000 workers come in annually to work in South Africa;
- The mining industry is also greatly impacted by high levels of dust exposure – in spite of extremely difficult working conditions, there is no official uniform for mineworkers in South Africa;
- TB is still the largest occupational killer in the mining industry;
- The Association of Mineworkers emphasised that confidentiality was always an issue as employees who go to clinics to collect ARVs might be exposed. In addition, companies repeatedly report stigma as a major barrier to service delivery;
- It is a male-dominated sector – and men are the missing population in health: they usually do not get tested;
- The approach to reaching the three 90s is multisectoral. For example, UNAIDS has pushed the Council to pilot HIV self-testing. WHO and ILO have been instrumental in guiding employers based on the ILO decent work agenda and workplace instruments;
- However, there is a fragmented policy framework for occupational health as there are three ministries involved;
- The industry is fully committed to achieving the UNAIDS Fast Track targets including 90-90-90 – also for TB as set out by WHO. It has made financial allocations at the level of the Council and individual companies;

- There are deliberate efforts made to reduce TB incidence in the mining sector to below the national rate by 2024. By 2017, 96 per cent of employees were screened for TB. Now TB incidence is down to 510 per 100,000 from 820 in 2016 and below national average;
- HIV positive employees can enrol into treatment and care in most companies, and some of them have adopted the three 90s targets as part of the Key Performance Indicator in 2017.

Site visit to the University of Witwatersrand project: HIV prevention among Sex Workers and their clients

The site visit to the University of Witwatersrand enabled the delegation to hear about a successful project targeting key populations, namely sex workers, including transgender, and their clients to improve HIV prevention.

Key issues discussed during the visit included:

- This project started in 1996 and a lot has been learned from it. The work of the project has to continue because the HIV epidemic is far from ending;
- The objectives of the project are to improve testing yield, retention in care and viral load suppression;
- The project supports the policy development of the Government as well as its implementation;
- There is a focus on populations in need to deliver accessible HIV services;
- HIV prevalence among sex workers is around 70 per cent in major cities and there is limited access to ART;
- There is late initiation of ART and poor links to treatment;
- Transgender people are 50% more likely to contract HIV – and for those on hormonal therapy the mental health component is particularly important;
- The project uses a decentralised model to reach sex workers: peer outreach with concentration on the hot-spots;
- It is important to try to understand the conditions sex workers operate in in order to tailor services to their specific needs;
- Alcohol and drugs, especially injectable drugs constitute a problem and make sex workers even more vulnerable;
- There is a highly mobile community with migrant sex-workers – they are particularly vulnerable to police abuses – many of them are undocumented and cannot do referral to hospitals;

- Men between 35-50 years old have the highest HIV prevalence, but they are also those who access sex workers the most;
- The project offers HIV Counselling and Testing and same day initiation on ART;
- A mobile van delivers services and sex workers are the ones to say when the van should come – this is also used for ART initiation (learning from models in India);
- Transgender and sex worker programmes run separately – transgender people often do not want to be under the sex workers banner;
- PREP retention is a challenge, people use it occasionally;
- The project is linking sex worker programmes to other economic development opportunities.

VI) Conclusions from the Field Visit

The PCB Delegation concluded its visit with a debriefing with the Regional Director and Country Director on the key take away messages and lessons learned:

- South Africa has a complex HIV history but has managed to control it thanks to the tremendous efforts of civil society and political commitment.
- There is a very wide range of stakeholders and partnerships collaborating on the HIV response in the country, including with the private sector.
- There has been important progress in the number of AIDS-related deaths, with an almost 50% decrease since 2010, thanks to more people being tested and treated.
- Although the number of new HIV infections has fallen in the same period, the rates have slowed. HIV prevention will need to be stepped up to reverse the epidemic in the near future. The Global HIV Prevention Coalition will play an important role in this matter.
- Adolescent girls and young women continue to be disproportionately affected by HIV because of inter-generational sex, transactional sex and SGBV which is a fundamental problem especially with the high rates of rape in South Africa.
- One of the main questions being posed by HIV experts in South Africa is how to achieve behaviour change, which will be key for the next generation.
- Community engagement needs reinforcing while innovatively involving young people and religious and local leaders.
- Migration is a destabilizing factor for effective service delivery and care givers.
- Key populations are highly stigmatized – particularly sex workers and men who have sex with men, but also transgender people – and have few chances of accessing health services.

- Decentralizing HIV care and health service delivery, using mobile clinics and outreach following the population / location approach is showing results.
- The multisectorality of the response is fundamental and the UNAIDS family has a central role to play in bringing stakeholders together to advance towards a common set of agreed targets.

ANNEX

The National Wellness Campaign – “Cheka iMpilo”

South Africa is planning to launch a national Wellness Campaign to accelerate screening and testing for HIV/TB and NCD. The launch of this campaign was initially scheduled for June 2018 but was postponed. It is still hoped the launch will take place before the end of this year. UNAIDS EXD was and remains invited to launch the campaign with the President when it happens.

Background

- This new campaign builds on the very successful 2010 National HIV Testing Campaign launched by President Zuma and UNAIDS EXD and led to more than 12 million South Africans tested for HIV in 15 months. Over 2 million tested HIV positive but linking people to treatment and care remained a challenge.
- In **2016**, it was estimated that 7.1 million people are living with HIV. 86% of PLHIV are aware of their status, 65% of those who know their status are on treatment, and 80% of those on treatment achieved viral suppression. A rise in hypertension and diabetes morbidity and mortality in the general population as well as among PLHIV is also a major concern.
- To address this, the country developed a new NSP for 2017-2022 that included bold targets and innovative interventions to help the country meet 90-90-90 targets for HIV and TB. However, bold steps to jump start progress were needed.
- In response, President Cyril Ramaphosa in his first State of the Nation Address in February 2018 stated ***“This year, we will take the next critical steps to eliminate HIV from our midst. By scaling up our testing and treatment campaign, we will initiate an additional two million people in antiretroviral treatment by December 2020. We will also need to confront lifestyle diseases such as high blood pressure, diabetes, cancers and cardiovascular diseases.”***

Campaign Strategy

- The National Wellness Campaign, with a local branding of ***“Cheka iMpilo,”*** meaning “Be there tomorrow for the ones you love, Check your health today,” is a national multi-disease campaign. It will run from April 2018 until March 2021 and aims to provide an enabling environment for health seeking behaviour.
- The primary objectives of the campaign are to:
 - o put **two million** people on ART by the end of December 2020
 - o put **80,000 missing TB** patients on treatment in year one
 - o intensify **NCD** case finding by screening 7 million persons
 - o intensify **STIs** screening, diagnosis and treatment
- A strategic mix of innovative game changers will be used to fast-track progress such as:
 - o targeting by population and location to obtain a high yield
 - o prioritize pregnant women and diabetics for TB diagnosis and treatment
 - o implement effective screening, testing and same day treatment initiation for HIV, TB and NCDS in a provider-initiated manner
 - o explore training of EMS staff to test for HIV
 - o intensify TB and HIV index tracing in communities
 - o implement innovative modalities for young people and men for HIV testing such as HIV self-screening, and PrEP for young girls

o collaborate with Private sector: General Practitioners, Pharmacies, Medical Insurance, Laboratories, and Businesses. *PCB Field Visit, South Africa, 15-18 October 2018.*

- HIV Prevention is one of the pillars of the National Wellness Campaign. Prevention will be strengthened through prevention counselling for STIs and NCDs, VMMC, Condom Promotion, PrEP, and referral of high-risk persons to services.
- Although the campaign will run nationwide, intensified efforts will be conducted in the 27 high burden districts with specific focus on 15-24-year-olds particularly AGYW through the existing programmes (She Conquers, Dreams), men 15 years and older, key populations, pregnant women, TB patients, diabetics, older persons, and people with disabilities.
- Services in the community will be intensified with Community Health Workers, NGOs, CSOs providing screening, testing and referral for treatment and prevention services and adherence support.
- A critical aspect for success of the campaign is generating demand for health services. The communications plan will include specific HIV messaging by target population tailored to specific gaps in their continuum of care, including a mix of printed and social media, use of high-profile champions, and community activations.

Partner Support

- Success will depend on engaging partners from all relevant sectors of government, civil society, traditional and faith-based leaders, youth, private sector, organised labour and development partners.
- The South Africa PEPFAR COP 18 is designed to support this plan as agreed by the Minister of Health and Ambassador Birx - the “**Now Now Plan**” to accelerate implementation of the treatment **SURGE Plan**.
- The **SURGE plan** will support: supplemental HR and Facility Improvements, increase in Community Health Workers, Faith-Based and Community Organization Initiatives, mobilizing General Practitioners and the Private Sector, ARVs and Centralised Chronic Medicines Dispensing and Distribution (CCMDD) and improvements to Health Information Systems. The Plan will improve linkage to care and is aligned with the National Wellness Campaign targets.
- A National Nerve Centre has been established led by SANAC and NDoH with multi-stakeholder participation, to monitor and evaluate implementation. Provincial and District nerve centers will also be established.

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