2009-2013 HIV AND AIDS RESPONSE:

BRIEFING ON ANOVA HSS SYMPOSIUM

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HIV Cluster NDoH

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Overview of Presentation

• History – governance and programme
• Burden of disease
• Response pre-2009
• Progress 2009 to date
• Challenges
• Addressing the challenges: District plans
• Progress on District Plans
• DHPs & DIPs
• Recommendations
History of the response in SA

• First AIDS death in South Africa- 1982
• First National Plan drafted by civil society
• Adopted by government in 1994
• 1998-2004 marred by political debates
• DOES HIV CAUSE AIDS??
• Treatment Action Campaign wins case against government.
HIV prevalence epidemic curve among antenatal women
South Africa, 1990 to 2011

2003 ART
Provision of Prophylaxis

- Court orders government to provide PMPTC
- Pilot programmes 1 in each province, slow rollout
- Gauteng, KZN, NW begin massive roll out of PMTCT
- Cabinet adopts ART plan in 2003
## ROLL-OUT OF ART PROGRAMME

<table>
<thead>
<tr>
<th>Month</th>
<th>YEAR</th>
<th>ART Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>March</td>
<td>2003</td>
<td>53</td>
</tr>
<tr>
<td>September</td>
<td>2005</td>
<td>199</td>
</tr>
<tr>
<td></td>
<td>2009</td>
<td>490</td>
</tr>
<tr>
<td></td>
<td>2013</td>
<td>3540</td>
</tr>
<tr>
<td></td>
<td>2014</td>
<td>3809</td>
</tr>
</tbody>
</table>
Figure 3.2: HIV prevalence by sex and age, South Africa 2012

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td>2.32</td>
<td>0.7</td>
</tr>
<tr>
<td>15-19</td>
<td>5.1</td>
<td>5.6</td>
</tr>
<tr>
<td>20-24</td>
<td>17.4</td>
<td>17.3</td>
</tr>
<tr>
<td>25-29</td>
<td>28.4</td>
<td>25.6</td>
</tr>
<tr>
<td>30-34</td>
<td>28.8</td>
<td>31.6</td>
</tr>
<tr>
<td>35-39</td>
<td>28.0</td>
<td>36.0</td>
</tr>
<tr>
<td>40-44</td>
<td>19.7</td>
<td>15.5</td>
</tr>
<tr>
<td>45-49</td>
<td>13.4</td>
<td>14.8</td>
</tr>
<tr>
<td>50-54</td>
<td>5.5</td>
<td>9.7</td>
</tr>
<tr>
<td>55-59</td>
<td>4.6</td>
<td>2.4</td>
</tr>
<tr>
<td>60+</td>
<td>2.4</td>
<td>4.6</td>
</tr>
</tbody>
</table>
Problem statement

• TB is the main cause of death of people with HIV

• 22,071 people died of TB in 1997

• 73,903 people died of TB in 2005. (334.8% increase)

• Estimated number of South Africans with TB (2007) 481,584 (1%)

• SA population as a % of world population - 0.7%

• SA population as a % of world population with dual HIV & TB - 28%
Comparison among BRICS & selected SADC countries / 100,000 population (except where indicated)

<table>
<thead>
<tr>
<th>Country</th>
<th>Incidence</th>
<th>Prevalence</th>
<th>% HIV+ Incident Cases</th>
<th>Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Africa</td>
<td>1,000</td>
<td>857</td>
<td>63</td>
<td>59</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>562</td>
<td>433</td>
<td>71</td>
<td>33</td>
</tr>
<tr>
<td>Mozambique</td>
<td>552</td>
<td>553</td>
<td>60</td>
<td>53</td>
</tr>
<tr>
<td>DR Congo</td>
<td>327</td>
<td>576</td>
<td>8</td>
<td>54</td>
</tr>
<tr>
<td>India</td>
<td>176</td>
<td>230</td>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td>Tanzania</td>
<td>165</td>
<td>176</td>
<td>41</td>
<td>13</td>
</tr>
<tr>
<td>Russia</td>
<td>91</td>
<td>121</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>China</td>
<td>73</td>
<td>99</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Brazil</td>
<td>46</td>
<td>59</td>
<td>17</td>
<td>3</td>
</tr>
</tbody>
</table>

Tuberculosis and HIV

• 22,071 people died of TB in 1997

• 73,903 people died of TB in 2005. (334.8% increase)

• Estimated number of South Africans with TB (2007) 481,584 (1%)

• SA population as a % of world population - 0.7%

• SA population as a % of world population with dual HIV & TB - 28%
<table>
<thead>
<tr>
<th>2007-2011</th>
<th>2012-2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Reduce number of infections by 50%</td>
<td>▪ Includes reduction of TB, and reduce vulnerability to mitigate impacts of HIV and TB</td>
</tr>
<tr>
<td>▪ Reduce impact of HIV and AIDS in communities and expanding access to treatment</td>
<td>▪ Preventing new HIV, STI and TB</td>
</tr>
<tr>
<td></td>
<td>▪ Sustain Health and wellness</td>
</tr>
<tr>
<td></td>
<td>▪ Ensuring protection of human rights and increase access to justice</td>
</tr>
</tbody>
</table>
Government takes action

- October 2009: Cabinet is briefed on available evidence showing extent of HIV and AIDS in the country
- November 2009: NCOP is briefed on HIV epidemic in SA
- December 2009: policy changes are announced
1. All TB-HIV co-infected people (co-infection rate 73%) be put on ARV’s with CD4 count of 350 instead of the current 200

2. All pregnant women be put on ARV’s immediately upon diagnosis (presently at CD4 count of 200 – too late) (approximately 1 million pregnancies, 300 000 of them are HIV+. Presently 60 000 CD4 count of 200 on ARV’s, hence adding another 240 000)

3. All children under 1 year who are HIV+ be on ARV’s immediately on diagnosis
4. All pregnant HIV positive women to start PMTCT at 14 weeks instead of 28 weeks.

5. All HIV positive people with a CD-4 count of 350 or less, be put on ARVs – i.e Universal Coverage.
The Action (24 April 2010)

• President launches the biggest HIV Counselling and Testing Campaign in the World at Natalspruit Hospital

• New Campaign called HCT (HIV Counselling and Testing) instead of VCT (Voluntary Counselling and Testing)

• HCT is provider initiated whereas VCT is individual initiated
Further Action (1 December 2013)

• Deputy President to re-launch the HCT Campaign and massify it more than ever before

• Deputy President to launch a massive MMC (Medical Male Circumcision) Campaign

  - Venue: Gert Sibande District
Progress after the President Launched the HCT Campaign

- **People on ARVs:**
  - 3 100 000 (February 2010)
  - 2,4 million (November 2013)

- **Facilities providing ARVs:**
  - 490 (February 2010)
  - 3 540 (November 2013)

- **Nurses trained and certified to provide ARVs:**
  - 250 (February 2010)
  - 23 000 (November 2013)

March 2015: 3 103 902 people on ART
Progress after the President Launched the HCT Campaign Contd.

- Mother to child transmission (MTCT)
  8% (2008)

- After acceleration of Prevention of Mother to child transmission (PMTCT)
  3.5% (2010)
  2.7% (2011)
  1.5% (2014)

- FDC (Fixed Dose Combination)
  700 000 (September 2013)

- MMC
  0 (2009)
  1,345,390 (2013)
• Due to the scale up of the ART and PMTCT programmes, annual AIDS deaths in all age groups have dropped by about 30% between 2004 and 2012
Record access to HIV-treatment, record drop in AIDS-related deaths

Annual AIDS death, Provincial (2014 – 2016)
Strengthened Prevention of Mother-to-Child Transmission services is bringing South Africa closer to its goal of ‘Zero new HIV infections among children’

Number of new HIV infections children 0-14 years, National (2004-2016)
• Population living with HIV/AIDS 2004-2016 is increasing
• Population living with HIV by province – 2004-2016
• Number of new infections are declining - 2004-2016
New HIV Guidelines

• In January 2015 new guidelines with changes in eligibility for ART initiation
  – Adolescent & Adults: CD4 count ≤ 500
  – Pregnant & breastfeeding women: to be initiated on ART irrespective of CD4 cell count

• Introduced birth PCR and 10 weeks
Governance

• The South African National AIDS Council was established through Cabinet decision in 2000
• SANAC acts as a multisectoral, coordination structure to monitor the implementation of the National Strategic Plan
• Serves as a platform which brings together the highest level of government and civil society leadership to review the country’s strategy and to monitor performance of the implementation of the National Strategic Plan for HIV, STI’s and TB, 2012-2016.
Fit for purpose (SANAC)

• Reviewing the impact of the response and particular how SANAC performed its mandate highlighted significant weaknesses and opportunities (Mid-Term Review of previous NSP and reflecting on the lessons learnt from analysing the work of various sectors as partners in the response)

• Development of 2012-2016 NSP informed by evidence-based indicators and research
SANAC

• A number of reviews recommended a fit for purpose alignment between the work of SANAC and NSP deliverables to deal specifically with challenges experienced at both the programmatic and governance (institutional arrangement) level

• Deputy President in September 2011 tasked an ad-hoc committee to make recommendations on streamlining the work of SANAC
Ad-Hoc Team requested to make recommendations on following:

- Alignment of SANAC structures with the 2012-2016 NSP – policy to implementation
- Streamline structures yet continue multi-sectoral governance at all levels
- Structure must span national provincial, district and local levels the national AIDS and TB response
Accelerating the response

• Multi-sectoral HIV prevention
• Scaling-up evidence-based HIV prevention
• Launch a ‘social movement’ for HIV prevention
• HIV testing
• Targeting HIV prevention interventions
• Rollout of VMMC
• Strengthening ART treatment programme
• Focus on structural prevention
• Financing (PEPFAR and domestic resourcing)
• Strengthening coordination and management
SANAC Secretariat – modus operandi recommendations

• SANAC secretariat must change its modus operandi
  – Senior managers in the secretariat should attend plenary meetings
  – SANAC structures should develop action plans similar to KZN to effectively respond to HIV and AIDS
  – SANAC should develop a prevention and social mobilisation programme focusing on information education and communication
  – SANAC secretariat should draw up clear action plan with timelines for the HCT campaign
  – It is recommended that the SANAC chairperson should request the premiers to instruct MECs to attend plenary
CHALLENGES

- Low HIV and TB treatment coverage among children and adolescents
- Numbers of males circumcised falling short of national targets
- Key populations not yet being adequately reached with HIV and TB services
- Condom use appears to be declining in some population groups
- Multiple sexual partners
- Loss of patients to follow-up
- Age-disparate sexual relationships (younger girls, older males)
ADDRESSING CHALLENGES

• Developing district HIV and TB plans
Rationale for District Plans

- Determine areas of new HIV and TB infections & current burden of disease in each district
- Determining 90,90,90 targets for HIV and TB per district
- Determining what districts need to do to achieve their targets
- Aligning provincial conditional grant allocations to district priorities
- Determining support required per district to meet targets

Allocating technical resources to districts in need
Why The DIP?

- Support attainment of strategic goals for a “long & healthy life of South Africans as expressed in:
  - National Development Plan (NDP): Progressively reduce the burden of TB, HIV/AIDS and other diseases
  - Key recommendations from the Joint HIV, TB & PMTCT review – Improve outcomes through cascade analysis
  - Achieve 90-90-90 targets – Attain impact as outlined through the TB & HIV/AIDS Investment Case

- To align:
  - Planning for programmes with District Health Planning
  - Provincial resource allocations from Equitable Share, Conditional Grant and Donor funding to district priorities
  - Technical resources, especially within DSPs, to district needs
The South African Investment Case

• To improve the **allocative efficiency** of the South African HIV and TB programmes
  
  – what is the best mix (allocation) of effective TB & HIV interventions to get us to our targets?

• Reviewed all available data/studies to find **the most cost effective mix of interventions** against HIV and TB over next 20 years

• Aims to inform & *if necessary change* SA HIV & TB policy

• And **inform programme planning**, including domestic and donor budgets
Conclusions of the Investment Case

- National and global incidence & mortality targets in 2025 are obtainable with current interventions available
- TB targets will not be reached by HIV prevention & treatment alone
- A comprehensive combination package of TB and HIV prevention, intensified case finding, diagnosis & high quality treatment is required
- Costs will go up for HIV no matter what, requiring additional funding. BUT front loading for TB will save money in 5 years!
  - Spend more now or spend more later? If spend more now, impact will be greater

We cannot continue business as usual...
What informs the development of DIPs?

• NDOH Strategic Plan 2015/16-2019/20 & APP 2015/16 – 2017/18
• 90 90 90 targets
• South African Investment Case
• HIV & TB priority intervention targets
  – District Health Plans
  – Provincial Conditional Grant Business Plans
  – Development Partners plans e.g. PEPFAR COP
• Key recommendations from Joint HIV, TB & PMTCT Review 2013
• NDOH existing indicators and M&E System
• Experience of the PMTCT Stocktaking and 3 Feet Approach pilot in Nelson Mandela Metro
Update: Key DIP Elements

- Endorsement by key stakeholders: SANAC, National Health Council (NHC), National Treasury & District Health Systems & Primary Health Care Branch
- ALL 9 Provincial Remedial Actions have now been submitted to NDoH for review
- The cascades have been revised and improved in response to provincial & district needs
- Tracer indicators adjusted from 26 to 30 through the increase of cascades from 3 to 5 as well as streamlining
- Targets based on the 90-90-90 approach have been set
Update: Lessons Learnt from Phase 1 (First Milestone)

- Strong leadership at both Provincial and District is key to success
- Good collaboration with District Support Partners promotes successful implementation
- The bottleneck analysis stimulates deep discussions which lead to game changing actions
Progress so far

- Following approval of remedial actions:
- Districts have started the process of convening Implementation meetings to develop 90 day Action Dashboards at all levels: Facility, Sub/District & Province
- They have Implemented Facility Run Charts
- They are currently tracking progress through cascade analysis:
  - Facility level:
    - 2 weekly monitoring of the Action Dashboard
    - Monthly monitoring of indicator performance
  - District Level:
    - Monthly monitoring of Action Dashboard & Indicator performance
  - Province Level:
    - Quarterly monitoring of Action Dashboard & Indicator performance
  - National level:
    - Quarterly monitoring of Indicator performance
Districts have started a process of identifying 12 poorly performing indicators from the tracer indicator list at provincial level for analysis & planning at district & facility levels

Have started: Conducting Bottleneck analysis of selected indicators using the facility level 3 x 4 Matrix in all facilities regardless of current performance

District meetings with all facility managers to share outcomes of bottleneck analysis have been convened & implementation plans developed with action dashboards for facility performance monitoring at district, provincial & national levels

Districts are in a process of aggregating all implementation plans from facility, sub/district & provincial levels
FOCUSED TARGETING
The right places and the right people for HIV

<table>
<thead>
<tr>
<th>Locality</th>
<th>HIV Prevalence %</th>
<th>HIV Incidence %</th>
<th>New Infections/ year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urban</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formal</td>
<td>10.1 [8.8 – 11.7]</td>
<td>1.06 [8.84-1.28]</td>
<td>227 000 [180 000 - 274 000]</td>
</tr>
<tr>
<td>Informal</td>
<td><strong>19.9 [17.4 - 22.7]</strong></td>
<td><strong>2.46 [1.98-2.94]</strong></td>
<td>80 000 [64 000 - 96 000]</td>
</tr>
<tr>
<td><strong>Rural</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formal</td>
<td>10.4 [7.4 - 14.4]</td>
<td>0.84 [0.65-1.03]</td>
<td>19 000 [15 000 - 23 000]</td>
</tr>
<tr>
<td>Informal</td>
<td><strong>13.4 [12.2 - 14.7]</strong></td>
<td><strong>0.87 [0.69-1.05]</strong></td>
<td><strong>143 000 [113 000 - 173 000]</strong></td>
</tr>
<tr>
<td><strong>National</strong></td>
<td><strong>12.2 [11.4 – 13.1]</strong></td>
<td><strong>1.07 [0.87 – 1.27]</strong></td>
<td><strong>469 000 [381 000 – 557 000]</strong></td>
</tr>
</tbody>
</table>

Figure II: HIV prevalence by sex and age, South Africa 2012

No one is left behind:

Urban informal settlements have the highest prevalence and incidence rates (2.5%) compared to urban formal areas.

High HIV prevalence and incidence rates among young women and adolescent girls, key populations.
Major cities

Location Specific: District and Cities Fast Track approach

<table>
<thead>
<tr>
<th>Metro</th>
<th>HIV Prevalence % (HSRC 2012)</th>
<th>Estimated number PLHIV (calculation HSRC data)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cape Town</td>
<td>5.2 [3.4–7.8]</td>
<td>177 587</td>
</tr>
<tr>
<td>Mangaung</td>
<td>7.9 [5.3–11.6]</td>
<td>58 645</td>
</tr>
<tr>
<td>Nelson Mandela</td>
<td>8.3 [4.5–14.9]</td>
<td>90 414</td>
</tr>
<tr>
<td>Tshwane</td>
<td>11.7 [8.1–16.6]</td>
<td>352 182</td>
</tr>
<tr>
<td>Buffalo City</td>
<td>13.6 [10.6–17.3]</td>
<td>103 943</td>
</tr>
<tr>
<td>Ekurhuleni</td>
<td>14.3 [10.3–19.5]</td>
<td>468 521</td>
</tr>
<tr>
<td>eThekwini</td>
<td>14.5 [11.2–18.6]</td>
<td>516 167</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>2 301 419</strong></td>
</tr>
<tr>
<td><strong>National</strong></td>
<td></td>
<td><strong>6 400 000</strong></td>
</tr>
</tbody>
</table>

Fast Track Cities: South Africa’s 8 largest metros are home to 36% PLHIV
The right places and the right people for TB

Focusing on screening and treating those who are most vulnerable

- Miners
- Residents of peri-mining communities
- Residents of informal settlements
- Prison inmates
How the DIP 90 90 90 complements and supports existing planning

National
- NDP
- MTSF
- NSP
- NSDA
- NSPs
- National APP
- SA Investment Case

Provincial
- Strategic Plan
- Service Delivery Imp. Plan
- Provincial APP
- Conditional Grant Business Plan (HIV/TB)

District
- Integrated Dev. Plans
- DHERs
- Annual Reports

Annual District Health Plan
- District Operational plans
- 90-90-90 DIP

Annual District Health Plan
- District Operational plans
- 90-90-90 DIP

Annual District Health Plan
- District Operational plans
- 90-90-90 DIP

Annual District Health Plan
- District Operational plans
- 90-90-90 DIP
Medium Term Strategic Framework (MTSF) 2014-2019

Health Strategy: Service Delivery Agreement 2014-2019
(Vision, Mission, Goals, Objectives, policy directions, legislation - includes Tools & guidelines for implementation)

Health System effectiveness - includes Quality Improvement and NHI

National DoH Strategic Plan, Annual Performance Plans & Budgets

Provincial DoH Strategic Plan, Annual Performance Plans & Budgets

District Health Plans & Budgets

Provincial Operational Plans

Key Success Factors (1)

- National DOH leadership – development of technical tools, feedback support of the process
  - LTP, APP, DHP, DIP frameworks and guidelines
  - APP, DHP, DIP Support and Feedback
- Improved planning capacity at Provincial and District level
  - Use of the DHER and NHIRD to improve evidence-based planning
- Move from compliance planning to population demand driven planning processes and tools
  - Training on using evidence for planning
  - Workshops to determine planning priorities
- Allowance for a combination of top down and bottom-up planning processes
  - Ensure budget and planning cycles align
  - Aligned templates and guidelines
- Realistic costing of Plans
  - Improve relationship between services delivery at facilities / District and finance teams in the District DoH.
Key Success Factors (2)

- **Inter-sectoral Collaboration** - address Social Determinants of Health
  - Map trends and relationships between SDoH and Health outcomes
  - Include collaboration with other sectors in Health’s planning
- **Concerted effort from Provincial DOH** in supporting the District to develop and finalize DHP’s
  - Dedicated District planning support persons located within Planning Clusters / Directorates

**Institutionalization** of Provincial and District monitoring and evaluation processes, and operationalising plans
  - **Institutionalizing** planning, internal reporting and monitoring
  - Writing up action plans to achieve goals

- **Improved Data Quality**
  - Dedicate time to quality checking data and improving data input through training, capacity building and improved data collection
- **Accessibility of data and information** to improve planning and decision making
  - Make use of the NHIRD and other information systems: National could assist in how to use the NHIRD for planning
Cruising at 30,000ft

Minister Motsoaledi ‘it is time we zoomed in from cruising altitude at 30,000 feet to 3 feet’ – where the action happens, where the rubber hits the road.

Action on the ground...DIPs!
Zero New HIV Infections
Zero Vertical Transmission
Zero Discrimination
Zero AIDS and TB related Deaths

Thank you