

# DSD Comprehensive HIV and AIDS, TB and STI strategy

## SUMMARY BOOKLET



social development

Department:  
Social Development  
REPUBLIC OF SOUTH AFRICA



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Health and Welfare Sector  
Education and Training Authority  
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# At a glance

## What is the DSD Comprehensive HIV, TB and STI Strategy?

The Department of Social Development (DSD) has been assigned a specific role in the National Strategic Plan (NSP) for HIV, STIs and TB (2012–2016), namely to contribute towards the prevention of new HIV, STI and TB infections and to lead the country in addressing the social and structural drivers that drive the HIV, TB and STI epidemics.

The DSD Comprehensive Strategy on HIV, TB and STIs (2013–2016) is a framework to guide the activities of all DSD partners whose work is relevant to HIV, TB and STIs in South Africa. It provides goals and strategies for DSD partner responses to these diseases during the period 2013–2016. The strategy will guide the development of national, provincial and district implementation plans.

The strategy does not outline every social and behaviour change programme that is needed in South Africa to address these diseases. It is not an operational plan. The strategy does not replace or duplicate development plans such as the NSP; it will work alongside them.

## What does the DSD Comprehensive HIV, TB and STI Strategy aim to achieve by 2016?

The DSD strategy has four outcomes that are aligned with those of the NSP:

- Decreased risky sexual behaviour in DSD's target population;
- Increased uptake of, and adherence to, HIV and TB treatment in target populations;

- Reduced gender-based and intimate-partner violence; and
- Reduced stigma and discrimination among DSD target populations.

The strategy outlines the relationship between HIV, TB and STI and the susceptibility of those infected with TB and STIs to HIV. It further emphasises the need to adopt a holistic approach towards HIV prevention.

## How was the DSD Comprehensive HIV, TB and STI Strategy developed?

Feedback from a wide range of stakeholders, including national and provincial DSD representatives, other government departments, development partners and civil society organisations was used to develop the strategy.

## How will progress be tracked?

A detailed plan to monitor and evaluate progress towards the goals has been drawn up. Implementation and measurement will be ‘bottom-up’. The DSD monitoring and evaluation (M&E) unit will produce reports based on regular input from provinces. There will be an annual monitoring report, a comprehensive mid-term evaluation report and a final evaluation report.

## What happens next?

The National Implementation Plan outlines how the strategy will be implemented. This results-based plan has been developed and costed. Provinces will prepare provincial implementation plans that are aligned to the national plan. These will describe how the outcomes outlined in this strategy will be met. The DSD strategy will be used as a framework to coordinate and monitor this work.

# Introducing this booklet

## What is the purpose of this booklet?

This booklet introduces you to the DSD Comprehensive Strategy on HIV and AIDS, TB and STI (2013–2016) – ‘The Strategy’. We outline DSD’s strategy for addressing these diseases in South Africa. Stakeholders can use this booklet to ensure that their own social and behaviour change programmes to address HIV, TB and STIs are aligned with DSD’s strategy, and thereby the country level results framework for reducing new HIV infections.

## Who is this booklet for?

This booklet was written for national, provincial and district or local-level stakeholders working towards HIV, STI and TB prevention. The intended audience for this booklet includes:

- DSD
- Other departments, specifically Department of Health, Department of Basic Education, Department of Cooperative Governance and Traditional Affairs, and Department of Transport
- Local municipalities
- Civil society organisations

## How to use this booklet

- The DSD Comprehensive Strategy on HIV, TB and STIs has many chapters and sections, most of which are numbered. This booklet focuses on the sections that facilitate understanding of the strategy and guide development of social and behavioural change programmes.
- Throughout this booklet, difficult words have been explained. These appear in bold in the text.
- At the back of this booklet is a list of useful readings and websites where you can access further information.

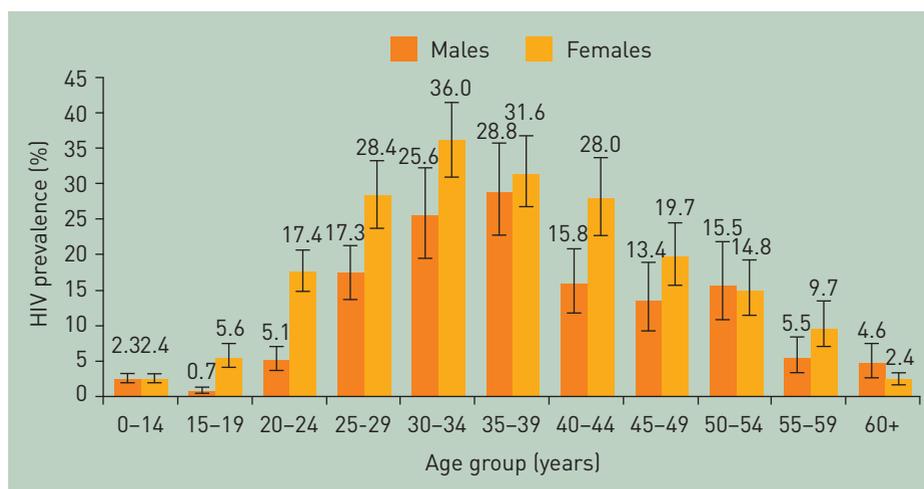
# HIV, TB and STIs in South Africa

Prevalence of HIV and TB is high in South Africa. There is also a high prevalence of STIs, which contribute towards increased risk of HIV transmission. HIV, TB and STIs affect individuals, families, communities and society as a whole.

## The HIV epidemic in South Africa

Some 12.2% of South Africans of all ages were HIV positive in 2012. Overall, more females were HIV positive than males. Among youth aged 15–19, HIV prevalence was eight times higher in young women than in young men.<sup>1</sup>

Figure 1: HIV prevalence by age and sex, South Africa 2012



Shisana et al., 2014

- 1 Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Zungu N, et al. South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town: 2014.

HIV prevalence was higher than the national average in the following 'key populations':

- Black African females aged 20–34 years (31.6%)
- People who live together but are not married (30.9%)
- Black African males aged 25–49 years (25.7%)
- Disabled persons 15 years and older (16.7%)
- High-risk alcohol drinkers 15 years and older (14.3%)
- Recreational drug users (12.7%).

*Shisana et al., 2014*

**Key populations:** these are groups of people who are disproportionately affected by HIV.

## The TB epidemic in South Africa

South Africa currently has the third-highest burden of TB in the world. TB is the most common opportunistic infection in people living with HIV (PLHIVs). Prevalence of **latent TB** infection is highest (around 88%) in people aged 30–39 years in townships and informal settlements.

**Latent TB:** this means that a person is infected with the TB bacteria but does not have active TB disease.

**Key populations at high risk for TB infection and reinfection:** healthcare workers; miners; prisoners; prison officers; and household contacts of people with active TB.

**Key populations who are vulnerable to progressing to active TB:** children; people living with HIV; diabetics; smokers; alcohol and substance users; people who are malnourished or have silicosis; mobile, migrant and refugee populations; and people living and working in poorly ventilated environments.

## STIs in South Africa

STIs increase the risk of getting HIV in HIV-negative people and in transmitting HIV in PLHIVs. **Herpes simplex II** is a risk factor for HIV transmission and prevalence of this STI remains high in South Africa.

**Herpes simplex II:** this is a type of virus that causes genital ulcers, making it easier for HIV to enter the body.

## Addressing risks and vulnerabilities for HIV, TB and STIs

A variety of factors, operating at different levels, place individuals at risk for contracting HIV:

- Biomedical risk factors are biological factors that influence infectiousness and susceptibility to HIV infection.
- Behavioural and social determinants are factors that influence risk-taking behaviour of people and communities.
- Structural determinants are the social and economic conditions, such as gender, race and poverty as well as physical, organisational, community, legal or policy aspects that create pathways or barriers to good health and that ultimately impact on health.

In order to be successful in reducing new HIV infections, interventions should address risk factors at all three levels – this is called **combination prevention**.

**Combination prevention:** UNAIDS defines combination prevention programmes as “rights-based, evidence-informed, and community-owned programmes that use a mix of biomedical, behavioural, and structural interventions, prioritised to meet the current HIV-prevention needs of particular individuals and communities, so as to have the greatest sustained impact on reducing new infections.”

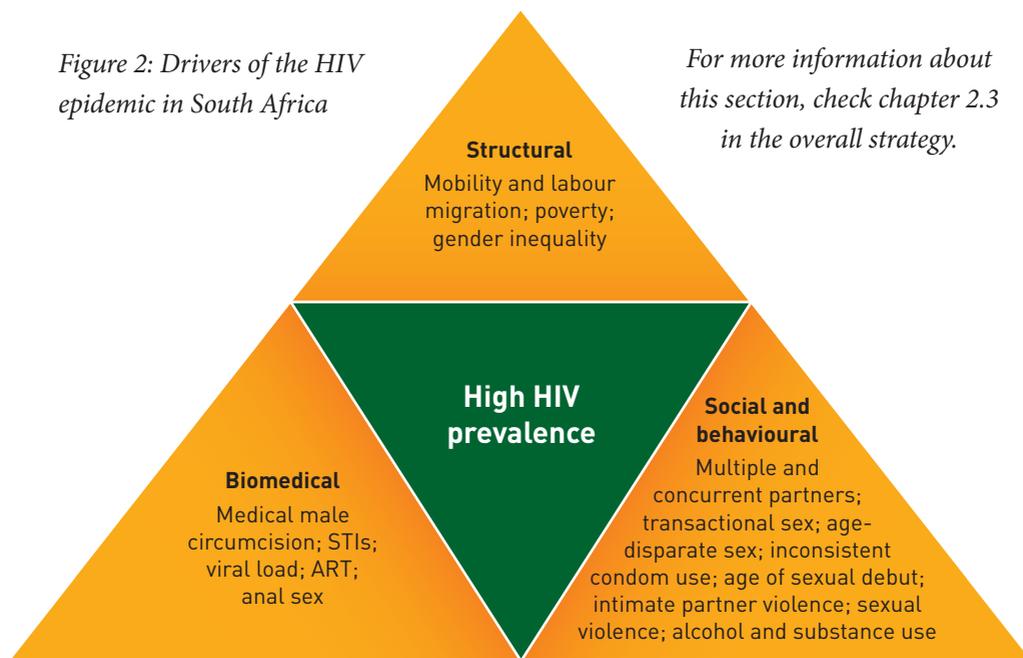
Biomedical approaches to HIV prevention place emphasis on reducing the likelihood of transmission – for example, antiretroviral therapy (ART) reduces viral load among PLHIVs and also reduces risk of infection when taken following exposure to HIV; and medical male circumcision reduces transmission of HIV to men.

Behavioural and social change programmes aim to influence people’s attitudes, norms, beliefs and behaviours around health outcomes. They also link people to services through increasing their knowledge of available services, their rights in relation to accessing those services and to advocate with policy and decision makers to ensure that quality services and commodities (e.g. condoms) are available.

Structural interventions address structural factors to reduce HIV risk at the individual / group level. Structural factors can either be barriers or facilitators of HIV-prevention behaviour. They can include the following factors: social (e.g. stigma, gender inequality), legal-political (e.g. laws and regulations) and economic (e.g. lack of livelihood opportunity). An example of a structural intervention is a cash transfer.

*Figure 2: Drivers of the HIV epidemic in South Africa*

*For more information about this section, check chapter 2.3 in the overall strategy.*



# The DSD Comprehensive Strategy on HIV, TB and STIs

## Background

The National Strategic Plan (NSP) for HIV, STIs and TB (2012–2016) is a comprehensive plan that has been developed to guide South Africa's response to all three diseases. The NSP aims to:

- Reduce new HIV infections by at least 50% using combination prevention approaches;
- Initiate at least 80% of eligible patients on ART, with 70% alive on treatment five years after initiation;
- Reduce the number of new TB infections as well as deaths from TB by 50%;
- Ensure an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the NSP; and
- Reduce self-reported stigma related to HIV and TB by at least 50%.

The role of DSD in the NSP:

- To contribute towards the prevention of new HIV, TB and STI infections; and
- To lead the country in addressing the social and structural drivers of the epidemics.

This strategy outlines DSD's comprehensive response to guide its contributions to the goals of the NSP.

## The purpose of the strategy

The purpose of this strategy is two-fold:

- To guide stakeholders in developing their own social and behaviour-change programmes to address HIV, TB and STIs; and
- To identify roles and responsibilities of different stakeholders.

## Vision and mission

In line with the NSP, this strategy aims to achieve progress towards the vision of creating: A society that promotes individual and community health through comprehensively addressing HIV, TB and STIs.

Its mission is: To provide and support a comprehensive response to HIV, TB and STIs through fostering individual, interpersonal, community and societal level engagement and service provision.

## Guiding principles

### Principle 1: HIV, AIDS and TB are a developmental issue

*What does this mean for DSD's response?*

DSD recognises that these diseases impact on the development of individuals and society as a whole. As such, DSD places emphasis on addressing all levels of society, including the individual, interpersonal relationships, the family, communities, relevant leaders, stakeholders and sectors.

### Principle 2: An integrated, holistic and comprehensive response

*What does this mean for DSD's response?*

DSD recognises that a multi-disciplinary approach, drawing on the complementary strengths of other sectors, is needed. The strategy focuses on holistic and integrated services that include prevention, care and mitigation strategies in combination with advocacy, active community engagement and political leadership.

### Principle 3: Fostering an enabling environment

*What does this mean for DSD's response?*

DSD's role is to create an enabling social environment for the uptake of HIV testing and other biomedical services. DSD works with other departments to create an enabling environment for HIV prevention, care and support through advocacy and mobilisation of communities, promotion of services, and engagement with community leaders and sectoral stakeholders.

### Principle 4: Communities are active agents in the response to HIV, AIDS and TB and broader development

*What does this mean for DSD's response?*

DSD focuses on providing poor and vulnerable people, particularly young people and women, with support towards sustainable livelihoods. This, in turn, encourages community members to be active champions of their own development. When individuals, households and communities are empowered, work together and have access to basic resources, services and infrastructure, they are in a stronger position to minimise the spread of HIV, AIDS and TB and are less vulnerable to the negative economic and social impacts of these diseases.

### Principle 5: Multi-sectoral partnerships are key

*What does this mean for DSD's response?*

DSD acknowledges that close collaboration between government and civil society partners and leadership at all levels is needed for a sustainable response. DSD has involved a variety of stakeholders in the development of the DSD strategy. These partnerships are critical in ensuring that policies and strategies are translated into action. The DSD strategy is implemented in partnership with state-funded institutions, the business sector, community and sectoral leaders, non-governmental organisations (NGOs), community-based organisations (CBOs), faith-based organisations (FBOs), PLHIV networks, women's networks and disability networks, among other stakeholders.

### Principle 6: Mitigating vulnerability

*What does this mean for DSD's response?*

DSD acknowledges that living in poorer socio-economic circumstances increases vulnerability to HIV, AIDS and TB. DSD thus focuses on social development. DSD's approach emphasises the following: accelerating

poverty reduction strategies and strengthening the safety nets to mitigate the impact of poverty; ensuring effective food-security safety nets; ensuring efficient and accessible social services; and creating cohesive communities and robust social networks that can advocate for services and provide support.

### Principle 7: Support throughout life-stages

*What does this mean for DSD's response?*

DSD recognises the beneficiaries of social assistance – primarily children, youth and older people – go through different stages in life that require a distinctive yet integrated policy response. DSD is committed to a multi-pronged life-stage approach aimed at providing interventions to assist all vulnerable South Africans, from childhood through to old age.

### Principle 8: HIV, STI and TB prevention responses should be evidence informed, complementary and comprehensive

*What does this mean for DSD's response?*

DSD recognises that behavioural and social responses that aim to reduce risks at individual, family, community and sectoral levels are part of a comprehensive approach to HIV prevention. This also includes biomedical and structural approaches. The DSD strategy emphasises the importance of ensuring a balanced response, which not only focuses on individual risk factors but also addresses socio-cultural, economic, political, legal and other contextual factors that increase vulnerability to HIV, TB and STIs.

### Principle 9: A rights-based approach is necessary to prevent and mitigate inequality, stigma and discrimination

*What does this mean for DSD's response?*

DSD recognises that marginalised, disempowered and vulnerable people and subgroups are also more likely to be affected by HIV, STIs and TB. DSD therefore focuses on rights-oriented advocacy and mobilisation to prevent and mitigate inequality, stigma and discrimination. DSD emphasises the protection and promotion of human and legal rights, including the rights of PLHIVs, gender rights and principles of gender equity.

*For more information about this section, check chapter 1.4 in the overall strategy.*

*Figure 3: Socio-ecological Model for Prevention, Treatment, Care and Support*

**INDIVIDUAL (HIV-)**

- Risk and vulnerability

**INDIVIDUAL (HIV+)**

- Treatment, care and support
- Transmission and co-infection

**SOCIAL NETWORKS**

- Sexual partner
- Children
- Family members
- Friends
- Associates
- Colleagues

## **COMMUNITY**

- Leaders
- Resources
- Organisation
- Services
- Connectedness
- Dialogue
- Mobilisation
- Risk exacerbating factors  
(high HIV prevalence,  
alcohol, drugs, crime,  
violence, poverty,  
mobile  
populations)

## **SOCIETY**

- Economic system
- Infrastructure
- Policies and laws
- Values and norms
- Political / social /  
cultural leadership

## The strategy and other development plans

The strategy takes into account the broader development agenda of the South African constitution and its international, regional and national obligations. For a full list of legislation, policies and frameworks that were consulted to develop the strategy, see the back page of this booklet.

## Approach to the strategy

The figure below shows that individuals do not exist in isolation. Rather it shows that there are interwoven relationships between individuals, their social networks, their communities and the broader society. This model is called the socio-ecological model.

DSD understands that the response to HIV, TB and STIs requires a holistic approach and that addressing individual level factors only is unlikely to be effective. The DSD uses this model to show the different spheres that need to be addressed to bring about transformation.

### DSD's key approaches to supporting individuals and their social networks

- The needs of both HIV-negative and HIV-positive people should be addressed.
- PLHIVs should be integrated into the HIV, TB and STI prevention response.
- Social networks are important both in terms of HIV risk and vulnerability and in relation to treatment, care and support.

#### **DSD has identified key populations to work with the individual level:**

- Orphans and vulnerable children (OVCs)
- Young women aged 15–24 receiving child support grants
- Out-of-school youth aged 15–24
- Families
- Older persons

- Sex workers and their clients
- People who abuse alcohol and/or drugs
- Farming communities
- Persons with disabilities

## DSD's key approaches to supporting communities and society

- At a societal level, communication and dialogue is a key approach.
- **Mainstreaming** of HIV, TB and STIs is another key approach.

**Mainstreaming:** this refers to the process of adopting policies and procedures to reduce an organisation's vulnerability to infection with HIV, TB and STIs and to their impacts. This programming should also reduce susceptibility and vulnerability of the communities supported by the organisation.

- **Internal mainstreaming** is achieved through considering these health issues in relation to internal staffing and human resource policies, as well as through planning, implementation, budgeting, monitoring and evaluation processes. Internal mainstreaming includes a health and wellness programme for all DSD staff.
- **External mainstreaming**, or the adaption of programmes to reduce individual and community vulnerability to these three diseases, is discussed in more detail in the next section.

### **DSD encourages community-level programmes to incorporate the following communication for social change principles:**

- Moving away from people as objects for change, towards people and communities as agents for change;
- Moving away from delivering messages, towards supporting dialogue and debate on key issues;
- Moving away from a focus on individual behaviour, towards a focus on social norms, policies, culture and supportive environments;
- Moving away from persuasion, towards negotiation and partnership; and
- Moving away from external technical expertise, towards integrating communities in assessing issues of concern at local level.

# DSD's response to HIV, TB and STIs

DSD's response to HIV, TB and STIs follows the socio-ecological model and aims to address factors at different levels. The table below summarises DSD's targeted response for each key population DSD has identified.

*For more information about this section, check chapter 4 in the overall strategy.*

Target group	Policy / policies (or guidelines)	Programme	Partners
<b>Children</b>			
<b>Orphans and other vulnerable children</b>	National Policy Framework for Orphans and Children Made Vulnerable by HIV & AIDS; National Action Plan for OVCs; Guidelines on Psychosocial Support for Children Living with HIV and AIDS and Other Chronic Diseases; Conceptual Framework on Psychosocial Support for Orphans and Other Children made Vulnerable by HIV and AIDS	<ul style="list-style-type: none"> <li>• Child support grant</li> <li>• Isibindi Model</li> <li>• Orphans and vulnerable children and youth project</li> <li>• Maternal orphan surveillance system</li> </ul>	<ul style="list-style-type: none"> <li>• DSD Orphans and Vulnerable Groups Unit</li> <li>• German Development Bank (KfW)</li> <li>• UNICEF</li> </ul>
<p>Studies have shown that orphaned youth are at higher risk of getting HIV and STIs due to increased risky sexual behaviour. Around 4% or 900 000 children are maternal orphans in South Africa. The two core components of the comprehensive DSD strategy are the child support grant (CSG) and the Isibindi Model. The CSG aims to reduce child poverty, and child and youth care workers provide direct support to children using the Isibindi Model. The orphans and vulnerable children project is new in KwaZulu-Natal, Limpopo and North West. This project aims to build and renovate Community Care Centres and to improve skills development programmes. Finally, a maternal orphan surveillance system has been developed to identify maternal orphans in the country. This system allows DSD to determine whether children are benefitting from any social grant and it also links children to comprehensive protective services.</p>			

Target group	Policy / policies (or guidelines)	Programme	Partners
<b>Young people aged 15–24 years</b>	National Policy Framework for Women’s Empowerment and Gender Equality; DSD Strategy for Women 2010–2014; The National Policy Guidelines for Victim Empowerment; Zero Draft GBV Prevention Strategy; DSD Gender-Based Violence Action Plan	<ul style="list-style-type: none"> <li>Programmes aimed at reducing the incidence of social crime and providing victim empowerment services</li> </ul>	<ul style="list-style-type: none"> <li>DSD Social Crime Prevention and Victim Empowerment Unit</li> </ul>

Violence against women and children is a driver of the HIV epidemic. The DSD gender-based violence programme focuses on building and maintaining partnerships between government, NGOs and academic institutions. This programme follows a victim-centred approach and aims to reduce social crime. It also provides services including the following: shelters for abused women and their children; victim empowerment; counselling to abused women and their children; skills training and development; referrals to legal and medical services; HIV and AIDS counselling and personal development.

<b>Youth out of school</b>	National Youth Development Strategy	<ul style="list-style-type: none"> <li>Masupatsela Youth Pioneer programme</li> <li>loveLife groundBREAKER peer education programme</li> </ul>	<ul style="list-style-type: none"> <li>DSD Youth Development Unit</li> <li>DSD HIV and AIDS unit</li> </ul>
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Children who drop out of school are more vulnerable to HIV. Not only is staying in school protective against HIV but it improves children’s life opportunities and their resilience. For those who remain out of school, mentoring and employment opportunities are needed. DSD’s HIV-prevention response for this vulnerable group is fourfold:

- DSD provides oversight and supports implementation of the National Youth Development Strategy.
- To reduce youth unemployment, DSD promotes youth leadership through the Masupatsela Youth Pioneer programme.
- DSD is to fund NGOs and FBOs delivering services such as treatment of substance abuse, life skills and personal development training, and HIV and AIDS counselling.
- DSD works with the loveLife groundBREAKER peer education programme. Peer educators promote healthy lifestyles and HIV prevention at schools and in the community. Going forward, the DSD-loveLife partnership will focus particularly on young people in farming and deep rural areas.

Target group	Policy / policies (or guidelines)	Programme	Partners
<b>Families and older persons</b>			
<b>Families</b>	Green Paper on Families; Integrated Crime Prevention Strategy; Revised Policy Framework for HCBC	<ul style="list-style-type: none"> <li>• Integrated service provision</li> <li>• Home- and community-based care</li> </ul>	<ul style="list-style-type: none"> <li>• DSD Families Unit</li> <li>• Department of Health</li> </ul>
Families provide a safety net for orphans and vulnerable children but are sometimes unable to do so due to limited means. DSD works with families in a number of ways. DSD programmes focus on restoration of family values, preserving families, and on marriage preparation and enrichment. HIV will be mainstreamed into these programmes. DSD works with the Department of Health to address the HIV-related burdens of home- and community-based care (HCBC). DSD provides monthly stipends and incentive grants to community caregivers.			
<b>Older persons</b>	Older Persons Act of 2006, Policy for Older Persons Guidelines on psychosocial support for adults living with HIV and AIDS and other chronic conditions	<ul style="list-style-type: none"> <li>• Mainstreaming of prevention and care and support services to older persons</li> </ul>	<ul style="list-style-type: none"> <li>• DOH</li> </ul>
Older people are vulnerable to HIV infection and often bear the burden of childcare. There have also been reports of sexual abuse and rape of older women. DSD promotes and protects the rights of older persons and ensures that social services adequately address the needs of older persons in relation to HIV prevention, treatment, care and support, as well as the burdens of childcare.			
<b>Most-at-risk populations</b>			
<b>Sex workers and their clients</b>	SANAC Sex Worker Sector Strategy	<ul style="list-style-type: none"> <li>• Support to sex worker NGOs</li> </ul>	<ul style="list-style-type: none"> <li>• Sex worker NGOs</li> </ul>
HIV prevalence is high in sex workers. Due to multiple partnerships, difficulty in negotiating condom use and other factors such as violence, sex workers are at high risk of getting HIV. Clients who have unprotected sex with sex workers are also at risk for HIV. DSD promotes an understanding of the rights of sex workers and works with sex worker NGOs to address the needs of sex workers. DSD is working with sex worker organisations to sensitise DSD's provincial HIV and AIDS coordinators to working with sex workers and including them in the HIV response. The sex worker programme will involve peer educators and will aim to raise awareness of available social security and child protection interventions available from DSD.			

Target group	Policy / policies (or guidelines)	Programme	Partners
<b>People who abuse alcohol and drugs</b>	Anti-Substance Abuse Programme of Action	<ul style="list-style-type: none"> <li>Ke Moja Awareness Programme</li> </ul>	<ul style="list-style-type: none"> <li>DSD Substance Abuse Unit</li> </ul>
<p>Alcohol and drug use decreases inhibitions. This in turn can increase risky sexual behaviour and risk of getting HIV. Contextual factors related to use of illegal drugs also increases vulnerability to HIV. To address this risk, DSD will continue to run the national Ke Moja Awareness Programme in schools and communities. Ke Moja uses an integrated approach, which includes capacity development of facilitators, lobbying for early intervention and integration, increasing awareness of services, increasing community dialogue, providing relevant information to school governing boards and promoting alternative social activities for youth. DSD has also developed a standardised treatment model for people who abuse alcohol or drugs.</p>			
<b>Farmworkers</b>	AGRIAIDS SA Workplan COP14	<ul style="list-style-type: none"> <li>Package of services for farmworkers</li> </ul>	<ul style="list-style-type: none"> <li>AGRIAIDS</li> </ul>
<p>Farmworkers are vulnerable to HIV due to the migratory nature of their work and difficulty in accessing health care services. DSD will work with partners to develop a strategy to reach farming communities and to develop a comprehensive package of services for farmworkers. This will largely be achieved through community dialogues and awareness campaigns.</p>			
<b>People with disabilities</b>	Development Policy on Disability; Integrated National Disability Strategy	<ul style="list-style-type: none"> <li>Mainstreaming of HIV and AIDS into disability programmes</li> </ul>	<ul style="list-style-type: none"> <li>DSD Disability Unit</li> </ul>
<p>People with disabilities may have lower access to HIV-prevention information and services and may be at increased risk of sexual exploitation and violence. DSD will ensure that officials at national and provincial level are trained on disability mainstreaming.</p>			

In addition to working with specific key populations, DSD will continue to provide a set of core services for all vulnerable groups. These are:

- **Social protection**
- Food security
- Comprehensive social security

**Social protection:** this refers to “all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance the social status and rights of the marginalised; with the overall objective of reducing the economic and social vulnerability of poor, vulnerable and marginalised groups.”

*(Devereux & Sabates-Wheeler 2004)*

### **Strategic focus for the next three years**

Over the next three years, DSD’s strategic focus will be two-fold:

- Direct HIV and AIDS programming addressing four key areas: children, youth, alcohol and substance abuse, and gender; and
- HIV and AIDS will be mainstreamed throughout all DSD units and sub-directorates working with the key populations identified above.

# Coordination and implementation of the strategy

## Coordination

Different types of HIV, STI and TB prevention programmes, operating at the different levels shown in Figure 3 on page 16 and 17, are developed and implemented by a variety of stakeholders. To ensure that the prevention response is coordinated, various forums that bring together the different stakeholders are held. These forums exist at national, provincial and local levels.

The purpose of these forums is to:

- Bring together implementing stakeholders including different government departments, civil society organisations and development partners;
- Discuss and debate programmatic issues;
- Share and disseminate information;
- Ensure programmatic synergies to avoid duplication; and
- Promote community empowerment and participation.

## Implementation

DSD is responsible for the overall implementation of the strategy. However, the successful implementation of this will be the result of the combined effort of all stakeholders working towards the same goals. These include:

- DSD
- Other departments, specifically Department of Health, Department of Basic Education, Department of Cooperative Governance and Traditional Affairs, Department of Transport
- Local municipalities
- Civil society organisations

DSD will oversee implementation by coordinating the work of the various stakeholders at national level. Provincial DSD will oversee implementation at provincial and district levels.

The implementation is governed by the Intergovernmental Relations Act, which requires that local municipalities must support and promote programmes of the national government. DCOGTA guides the development of specific programmes for vulnerable communities where there are high prevalence rates and low responses and impact.

### Civil society organisations and development partners

At grassroots level a network of well-organised civil societies exists. DSD funds civil societies and influences the type of interventions that they develop and implement. DSD also ensures that the programmes are aligned to government priorities, such as the adoption of more men's and boy's organisations to support women and girl child rights, women's groups and networks to drive advocacy and to reduce stigmatisation and discrimination.

### Strong partnerships with communities

Communities have a pivotal role in all prevention programmes and form part of the coordination and implementation structures for the strategy. DSD recognises the partnership with communities as an enabler to community buy-in which is necessary for the strengthening of programmes, especially in rural areas.

# Monitoring and evaluating the strategy

A detailed framework to monitor and evaluate progress towards achieving the results set out in strategy has been drawn up. Progress will be measured using core **indicators** that will be aligned with validated reporting tools and integrated into DSD's existing HCBC M&E system.

**Indicators:** these are quantitative measures that provide information to monitor performance and measure achievement.

The overall impact of the strategy implementation will be measured by collecting indicators to measure the outputs, outcomes and impacts of the strategy over time. These are detailed in the results-based framework on the following pages.

## Interventions

1. Develop a social and behaviour communication mobilisation strategy;
2. Conduct community-level dialogues to scale up HIV and TB response;
3. Profile vulnerable youths in tertiary institutions and link them with the food security programme to reduce their vulnerabilities to HIV;
4. Implement DSD Employee Health and Wellness strategy to prevent new infections and reduce the burden of HIV and TB;
5. Strengthen the psychosocial support programme within the integrated school health programme (ISHP);
6. Develop and implement stigma and discrimination programmes for DSD target populations;
7. Scale up access to social protection system including social grants, psychosocial support for vulnerable households and individuals;
8. Scale up access to food security for vulnerable individuals, (including HIV+ pregnant women as in NDP), groups and households affected by HIV and TB;
9. Implement national Anti-Substance Abuse programme of action;
10. Implement Gender-Based Violence Prevention programmes;
11. Develop and implement programmes for families to enhance communication on sexuality for children and young people;
12. Develop and implement programmes for pregnant teenagers;
13. Strengthen the provision of HIV and TB related legal services; and
14. Strengthen the capacity of service providers to implement HIV&AIDS programmes to vulnerable individuals, households and communities.

**Output 1:** Increased community dialogues on HIV and TB

**Output 2:** Increased HIV and TB knowledge in DSD target populations

**Output 3:** Increased access to standardised basket of services along the continuum of care for HIV and TB services to HIV-affected households and individuals

**Output 4:** Increased access to social grants, sustainable livelihoods and food security programmes by individuals and households affected by HIV and TB

**Output 5:** OVCY have increased access to education support

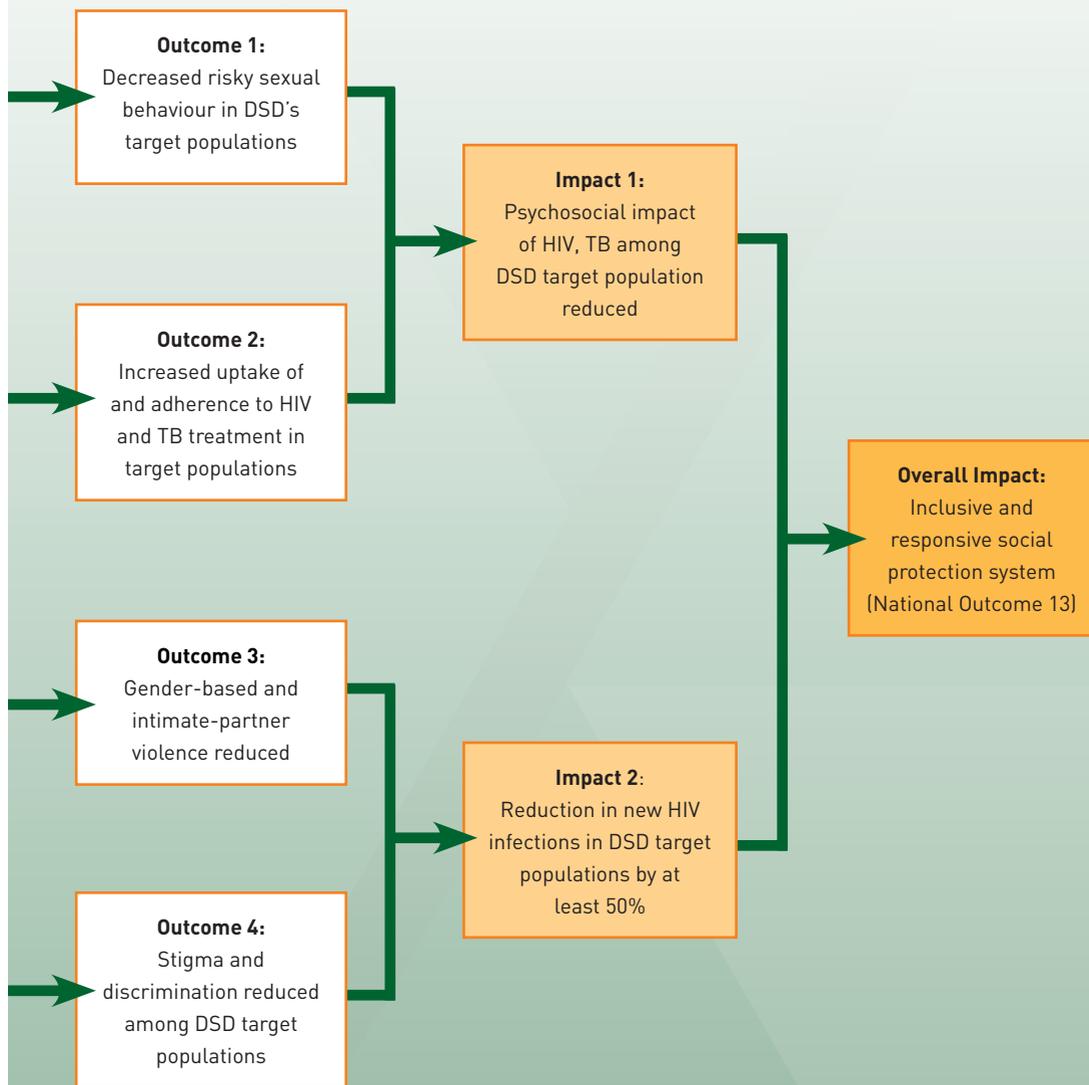
**Output 6:** Increased access to psychosocial support for DSD target populations (including ISHP)

**Output 7:** Access to legal services and legal literacy increased, especially on laws and practices that impede universal access to HIV, STI and TB services for DSD target populations

**Output 8:** DSD employee health and wellness programmes strengthened

**Output 9:** Increased coverage of evidence-based prevention, treatment and care services for people who use alcohol and drugs

**Output 10:** Gender-based violence prevention programmes scaled-up in all provinces



**The M&E system will enable DSD and partners to:**

- Guide the planning, coordination and implementation of the strategy;
- Assess the effectiveness of strategy implementation;
- Identify gaps and challenges in service delivery and areas for programme improvement;
- Ensure accountability to those infected or affected by HIV, TB and STIs, as well as to those providing financial resources; and
- Strengthen inter-sectoral collaboration.

Implementation and measurement will be a ‘bottom-up’ approach. DSD will produce reports based on regular input from provinces. There will be an annual monitoring report, a comprehensive mid-term evaluation report and a final evaluation report.

# Other useful documents

- Anti-Substance Abuse Programme of Action.  
Children's Act 38 of 2005.  
Department of Basic Education, 2010. Integrated Strategy on HIV and AIDS 2011–2015 Full Report. Pretoria: Department of Basic Education.  
Department of Provincial and Local Government, 2007. Framework for an Integrated Local Government Response to HIV and AIDS. Pretoria: South Africa.  
DSD Development Policy on Disability, 2008.  
DSD Gender Based Violence Action Plan.  
DSD National Strategic Plan 2011/12–2013/14.  
DSD Strategy for Women 2010–2014.  
Green Paper on Families, 2011.  
Integrated Crime Prevention Strategy.  
Integrated National Disability Strategy.  
National Action Plan for OVC.  
National DSD Women's Empowerment and Gender Policy, 2010.  
National Evaluation Policy Framework Draft, 2011.  
National Policy Framework for Orphan and Children made Vulnerable by HIV&AIDS.  
National Policy Framework for Women's Empowerment and Gender Equality.  
National Policy Guidelines for Victim Empowerment.  
National Youth Development Strategy.  
Policy Framework for Orphans and other Children made Vulnerable by HIV and AIDS, 2006–2008.  
Republic of South Africa National Department of Health, 2009. The National Tuberculosis Control Programme, National Tuberculosis Policy Guidelines. Pretoria: South Africa.  
SANAC. National Strategic Plan on HIV, STIs and TB, 2012–2016. Pretoria: 2011.  
SANAC Sex Worker Sector Strategy.  
Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Zungu N, et al. South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town: 2014.  
South Africa National Policy Framework for HCBC, July 2010.  
Zero Draft GBV Prevention Strategy.



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