HIV AND AIDS AND STI STRATEGIC PLAN FOR SOUTH AFRICA, 2007-2011

12 MARCH 2007

(Draft 9)

Acronyms

ABC	Abstain, Be Faithful, Condomise
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral therapy
ASGI-SA	Accelerated Shared Growth Initiative for South Africa
ASSA	Actuarial Science Society of South Africa
ATIC	AIDS Training and Information Centre
BHF	Board of Healthcare Funders
CBOs	Community-based Organisations
CGE	Commission on Gender Equality
CMA	Civil Military Alliance
DENOSA	Democratic Nursing Organisation of South Africa
DOE	Department of Education
DOF	Department of Finance
DOH	Department of Health
DOHA	Department of Home Affairs
DOJ	Department of Justice
DOL	Department of Labour
DOME	Department of Minerals and Energy
DOT	Department of Transport
DOTS	Direct Observed Therapy Short Course
DOSD	Department of Social Development
EDL	Essential Drug List
GCIS	Government Communication and Information Systems
IDC	Interdepartmental Committee on AIDS
IMC	Inter-Ministerial Committee on AIDS
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HRC	Human Rights Commission
HSRC	Human Sciences Research Council
IEC	Information, Education, and Communication
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MEC	Member of Executive Committee

MOH	Ministry of Health
MRC	Medical Research Council
MTCT	Mother-to-child transmission
MTEF	Medium Term Expenditure Framework
NHA	National Health Act
NHC	National Health Council
NHLS	National Health Laboratory Services
NACOSA	National AIDS Co-ordinating Committee of South Africa
NGOs	Non-Government Organisations
NPPHCN	National Progressive Primary Health Care Network
OVC	Orphaned and vulnerable children
PEP	Post-exposure prophylaxis
PLWHA	People living with HIV infection and/or AIDS
PMTCT	Prevention of mother to child transmission
SALC	South African law Commission
SAMA	South African Medical Association
SANAC	South African National AIDS Council
SAPS	South Africa Police Service
SADC	Southern Africa Development Community
SANDF	South African National Defence Force
SMMEs	Small, Medium Macro enterprises
StatsSA	Statistics South Africa
STIs	Sexually Transmitted Infections
SM	Syndromic Management
TB	Tuberculosis
THP	Traditional Health Practitioner
TL	Traditional Leader
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary HIV Counseling and Testing
WHO	World Health Organisation
XDR-TB	Extensively Drug Resistant Tuberculosis

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1. FOREWORD

2. EXECUTIVE SUMMARY

The HIV & AIDS and STI Strategic Plan for South Africa 2007-2011 flows from the National Strategic Plan of 2000-2005 as well as the Operational Plan for Comprehensive HIV and AIDS Care, Management, and Treatment. It represents the country's multisectoral response to the challenge with HIV infection and the wide-ranging impacts of AIDS.

This NSP seeks to provide continued guidance to all government departments and sectors of civil society, building on work done in the past decade. It is informed by the nature, dynamics, character of the epidemic, as well as developments in medical and scientific knowledge. An assessment of the implementation of the NSP 2000-2005 has been useful in defining the capacities of the implementing agencies.

In May 2006, the South African National AIDS Council (SANAC), under the leadership of its Chairperson, the Deputy President, Mrs. Phumzile Mlambo-Ngcuka, mandated the Health Department to lead a process of developing a new 5-year NSP, for the years 2007-2011.

This process started with a rapid assessment of the implementation of the NSP 2000-2005. In September 2006, a report of the assessment highlighted the following findings:

- All stakeholders embraced the NSP 2000-2005 as a guiding framework.
- It served to broaden the involvement of agencies beyond the Health Department and gave rise to the establishment and expansion key programmes such as health education, voluntary counseling and testing (VCT), prevention of mother to child transmission (PMTCT), and antiretroviral therapy (ART).
- However, stigma and discrimination remain unacceptably high and this has been a deterrent to the utilization of some of the services.
- Also, implementation of programmes tended to be vertical, with some serious capacity deficits especially in the previously disadvantaged rural communities.
- The two major weaknesses of the NSP 2000-2005 were poor coordination at the level of the South African AIDS Council (SANAC) as well as lack of clear targets and a monitoring framework.

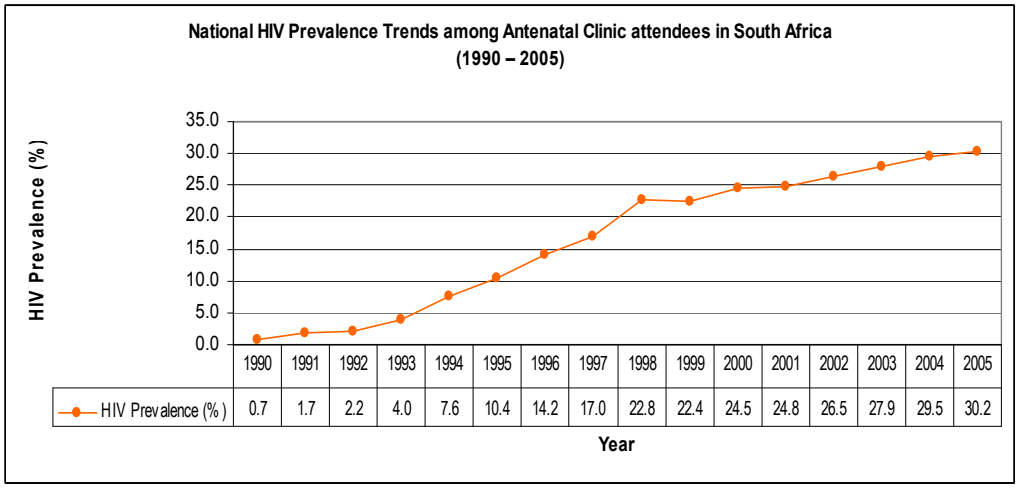
Some key recommendations were:

- A need for a revision of the behaviour change approaches
- Strengthen government implementation
- Consolidate and build existing partnerships
- Strengthen coordination, monitoring and evaluation at the level of SANAC
- Increase the contribution of the business sector, especially with regard to the SMMEs
- Make all interventions accessible to people with disabilities

HIV and AIDS is one of the main challenges facing South Africa today. It is estimated that of the 39.5 million people living with HIV worldwide in 2006, and that more than 63% are from sub-Saharan Africa. About 5.54 million people are estimated to be living with HIV in South Africa in 2005, with 18.8% of the adult population (15-49) affected. Women are disproportionately affected; accounting for approximately 55% of HIV positive people. Women in the age group 25-29 are the worst affected with prevalence rates of up to 40%. For men the peak is reached at older ages, with an estimated 10% prevalence among men older than 50 years. HIV prevalence among younger women (<20 years) seems to be stabilizing, at about 16% for the past three years.

There are geographic variations with some provinces more severely affected. These differences also reflect background socioeconomic conditions as demonstrated by the district level HIV surveillance data in the Western Cape Province. In this province, in 2005, the average was the lowest in the country at 15.7%, but two metropole health areas of Khayelitsha and Gugulethu/Nyanga registered prevalence rates of 33.0% and 29.0% respectively, high above the national average. According to the HSRC Household Survey, people living in rural and urban informal settlements seem to be at highest risk for HIV infection and AIDS.

Figure 1: National HIV prevalence trends among antenatal clinic attendees in South Africa: 1990 –2005



Source: Department of Health, 2006

Although the rate of the increase in HIV prevalence has in past five years slowed down, the country is still to experience reversal of the trends. There are still too many people living with HIV, too many still getting infected. The impact on individuals and households is enormous. AIDS has been cited as the major cause of premature deaths, with mortality rates increasing by about 79% in the period 1997-2004, with a much higher increase in women than in men. Children are a particularly vulnerable group with high rates of mother-to-child- transmission as well as the impacts of ill-health and death of parents, with AIDS contributing about 50% to the problem of orphans in the country. Household level impacts are the most devastating effects of HIV and AIDS in the country. Increases in maternal and childhood mortality are some of the devastating impacts, threatening the country's ability to realise the MDG targets of 2015.

The South African HIV and AIDS epidemic is defined as a generalised one, with ability to propagate on it own in the general population if unchecked. The vulnerable groups and the factors involved have been discussed, but some groups (commercial sex workers, men who have sex with men, commercial migrants, refugees, intravenous drug users, and others), may be at higher risk than the general population.

Whilst the immediate determinant of the spread of HIV relates to behaviours such as unprotected sexual intercourse, multiple sexual partnerships, and some biological factors such as sexually transmitted infections, the fundamental drivers of this epidemic in South

Africa are the more deep rooted institutional problems of poverty, underdevelopment, and the low status of women, including gender-based violence, in society.

Closely linked to HIV and AIDS is the Tuberculosis epidemic. The increase in the past few years of incidence and mortality from TB and recently the emergence of extremely resistant TB (XDR-TB) has been linked to a considerable extent to immune suppression caused by HIV and AIDS. Once more, poverty and an underdeveloped district health system are the other important factors in this regard. Double stigma associated with dual infection with TB and HIV has become a deterrent to health seeking behaviours amongst many South Africans. The effective management of dual infections relies heavily in community-based interventions.

The reversal in the prevalence of syphilis among pregnant women in the past five years is an indication of the gains from the introduction of syndromic management of sexually transmitted infections (STIs) in 1995 as well as the introduction of the primary health care system. The main hurdles with STI control relate to the management of “partners”, emergence of resistant strains of some bacteria, as well as the importance of viral STIs in the spread of HIV.

All of this demands intensification of the multisectoral national response to HIV and AIDS. It calls for a better coordination and monitoring. The NSP will need to recognize and address the special needs of people with disabilities.

The NSP 2007-2011 was developed through an intensive and inclusive process of drafting, collection and collation of inputs from a wide range of stakeholders; through emails, workshops, and meetings. SANAC had opportunity to interrogate the drafts on three occasions.

The national multisectoral response to HIV and AIDS is managed by different structures at all levels. Provinces, local authorities, the private sector and a range of CBOs are the main implementing agencies. Each government department has a focal person and team responsible for planning, budgeting, implementation and monitoring HIV and AIDS interventions. In this plan, communities are targeted to take more responsibility and to play a more meaningful role.

Cabinet is the highest political authority, and the responsibility of dealing with common HIV and AIDS related matters has been deferred to the Inter-Ministerial Committee on AIDS (IMC) composed of eight Ministries. SANAC is the highest national body that provides guidance and political direction as well as support and monitoring of sector programmes. The newly formed SANAC will operate at three levels, viz;

- High level Council – the actual SANAC, chaired by the Deputy President,
- Sector level – with sectors taking responsibility for their own organization, strategic plans, programmes, monitoring, and reporting to SANAC
- Programme level organization- led by the social cluster.

The NSP is based upon a set of key Guiding Principles. These are set out in the document on p.xx. A selection of the key principles is:

- Supportive Leadership
- Effective Communication
- Effective Partnerships
- Promoting social change and cohesion
- Sustainable programmes and funding

The primary aims of the NSP are to:

- reduce the number of new HIV infections by 50%
- reduce the impact of HIV and AIDS on individuals, families, communities and society by expanding access to appropriate treatment, care and support to 80% of all people diagnosed with HIV.

The future course of the HIV and AIDS epidemic hinges in many respects on the behaviours young people adopt or maintain, and the contextual factors that affect those choices. Therefore the NSP aims, particularly, to reduce the number of new infections among people in the 15- 24 age group.

The interventions that are needed to reach the NSP's goals are structured under four key priority areas:

- Prevention;

- Treatment, care and support;
- Human and legal rights; and
- Monitoring, research and surveillance.

Key Priority Area 1: Prevention

Reduce by 50% the rate of new HIV infections by 2011. The intention is to ensure that the large majority of South Africans who are HIV negative remain HIV negative.

1. **Reduce vulnerability to HIV infection and the impacts of AIDS:**
    a. Accelerate poverty reduction strategies and strengthen the safety nets to mitigate the impact of poverty
    b. Accelerate programmes to empower women and educate men and women on women's rights and human rights
    c. Create an enabling environment for HIV testing
    d. Support national efforts to strengthen social cohesion in communities and to support the institution of the family

2. **Reducing sexual transmission of HIV:**
    a. Develop behaviour change curricula for the prevention of sexual transmission of HIV, adapted to different target groups
    b. Implement interventions targeted at reducing HIV in young people, focusing young women
    c. Scale-up positive prevention in HIV positive people
    d. Increase roll out of prevention programmes for higher risk populations
    e. Increase roll out of workplace prevention programmes
    f. Develop a package of reproductive health and HIV prevention services for integration into family planning, ANC, STI, TB and ARV services
    g. Develop a comprehensive package that promotes male sexual health and which addresses gender and gender-based violence
    h. Introduce programmes to mitigate the impact of alcohol and substance abuse
    i. Introduce programmes and strategies to address stereotype gender identities that contribute to gender-based violence

j. Increase accessibility and availability of comprehensive sexual assault care including PEP and psychosocial support

3. **Reduce mother-to-child transmission of HIV**
    a. Expansion of existing mother-to-child transmission services to include: contraception fertility services, reducing unwanted pregnancies and involving men, HIV prevention services in uninfected pregnant women
    b. Scale up coverage of PMTCT to reduce MTCT to less than 5%

4. **Minimize the risk of HIV transmission through blood and blood products**
    a. Minimise the risk of HIV transmission from occupational exposure in health care providers in the formal, informal and traditional settings through the use of infection control procedures
    b. Minimise exposure to infected blood through procedures associated with traditional and complementary practices
    c. Investigate the extent of HIV risk from intravenous drug use and develop policy to minimize risk of HIV transmission through injecting drug use
    d. Ensure safe supplies of blood and blood products (HIV screening tests for measuring both virus and antibodies)

Key Priority Area 2: Treatment, Care, and Support

Reduce HIV and AIDS morbidity and mortality as well as its socioeconomic impacts by providing appropriate packages of treatment, care and support to 80% of HIV positive people and their families by 2011.

1. **Increase coverage to voluntary counseling and testing and promote regular HIV testing**
    a. Increase access to VCT services that recognize diversity of needs
    b. Increase as uptake of VCT

2. **Enable people living with HIV to lead healthy and productive lives**
    a. Scale up coverage of the comprehensive care and treatment package
    b. Increase retention of children and adults on ART
    c. Ensure effective management of TB/HIV co-infection

d. Improve quality of life for children and adults with HIV and AIDS requiring terminal care
e. Strengthen the health system and remove barriers to access

3. **Address the special needs of women and children**
   a. Decrease HIV and AIDS related maternal mortality through women-specific programmes
   b. Provide an appropriate package of services that includes wellness, Opportunistic Infections management, ART and nutrition to children and adolescents who are HIV positive and/or exposed

4. **Mitigate the impacts of HIV and AIDS and create an enabling social environment for care, treatment and support**
   a. Strengthen the implementation of OVC policy and programmes
   b. Expand and implement CHBC as part of EPWP
   c. Strengthen the implementation of policies and services for older people affected by HIV and AIDS
   d. Mainstream the provision of appropriate care and support services to HIV positive people with disabilities and their families

Key Priority Area 3: Research, Monitoring, and Surveillance

The NSP 2207-2011 recognises monitoring and evaluation (M&E) as an important policy and management tool.

1. **Implement the monitoring and evaluation (M&E) framework of the NSP 2007-2011**
   a. Establish and implement a functional M & E system

2. **Support the development of prevention technologies**
   a. Support and monitor efforts to develop effective microbicide products in South Africa
   b. Support efforts to implement an appropriate AIDS vaccine
   c. Support and monitor research on male circumcision and HIV prevention

4. **Conduct operational research**
    a. Conduct research on the cost-effectiveness of other forms of treatment and prophylaxis
    b. Conduct research in support of the implementation of the comprehensive plan
    c. Conduct research on the effectiveness of traditional medicines

5. **Conduct policy research**
    a. Conduct HIV and AIDS studies in selected departments and provinces

6. **Conduct regular surveillance**
    a. Conduct national surveillance on HIV and STI risk behaviours, especially among the youth

Key Priority Area 4: Human and Legal Rights

Stigma and discrimination continue to present challenges in the management of HIV and AIDS. This priority area seeks to mainstream these in order to ensure conscious implementation programmes to address them.

1. **Ensure knowledge of and adherence to the existing legal and policy framework**
    a. Adherence to existing legislation and policy relating to HIV and AIDS
    b. Ensure non-discrimination in access to HIV prevention, treatment and support of marginalized groups.
    c. Monitor HIV-related human rights violations and develop enforcement mechanisms for redress

2. **Mobilise society, and build leadership of HIV positive people, to protect and promote human rights**
    a. HIV positive people are organized, empowered and mobilized to protect human rights at national, provincial and district levels
    b. Respect for the rights of PLWHAs in employment, housing, education, insurance and financial services and other sectors
    c. Greater openness and acceptance of PLWHAs

3. **Identify and remove legal, policy and cultural barriers to effective HIV prevention, treatment and support**
    a. Identify and finalise current relevant legislative and policy processes
    b. Identify, amend or repeal discriminatory laws and/or laws that undermine HIV treatment and prevention programmes
    c. Identify cultural beliefs and practices that violate human rights and undermine HIV prevention
    d. Identify and address gaps in existing anti-discrimination legislation

4. **Focus on the human rights of women and girls, including those with disabilities, and mobilize society to stop gender-based violence and advanced equality in sexual relationships**
    a. Reduce women and girls' vulnerability to HIV infection by reducing poverty amongst women
    b. Ensure that existing laws and policies that protect women and girls from gender-based violence are implemented
    c. Respond adequately to the needs of women in abusive relationships
    d. Ensure that laws, policies and customs do not discriminate against women and girls

This NSP sets out a clear framework for ongoing monitoring and evaluation. It includes a preliminary costing of its main elements and a commitment to raising the very substantial funds that will be needed for its effective implementation.

In conclusion, the NSP must be seen as a dynamic living document that will be subject to regular critical review. It is believed that when all partners, led by SANAC, and with technical support from the Health Ministry, pull together and rally around the identified interventions, the two main aims; that of reducing new infections and mitigating the impact of AIDS on millions of people's lives will be realized.

Many individuals and organization have participated in the development of the NSP 2007-2011. A list of all those involved is provided in Annexure XX. However, our thanks go to all who took time and effort to ensure that South Africa has a National Strategic Plan that

seeks to guide the national response to one of the most important challenges facing our new democracy.

3. INTRODUCTION

HIV and AIDS is one of the major challenges facing South Africa today. Some two decades since the introduction of this disease in the general population, the epidemiological situation is still characterized by very large numbers of people living with HIV and a disproportionate effect on particular sectors of society, viz.; young women, the poor, as well as those living in underdeveloped areas in the country. HIV infection and AIDS disease however, affects the lives of all South Africans in many different ways.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organisation (WHO), estimated the number of people living with HIV at the end of 2006 to be 39.5. million worldwide. While approximately 10% of the world's population lives in sub-Saharan Africa, an enormous 64% of all people living with HIV live in this region - including 77% of all women living with HIV. Levels of infection vary throughout the region with countries north and west having adult (15-49) prevalence levels of between 1% and 5%, while southern Africa have prevalence levels of between 10-20%, with some countries (Botswana, Zimbabwe, Lesotho, and Swaziland) even higher. HIV prevalence has declined in some countries, Uganda in the early 1990s, and recently Zimbabwe, Kenya and urban areas of Burkina Faso. These declines seem to be linked to changes in key sexual behaviours. Overall, HIV prevalence in this region appears to be levelling off, albeit at high levels.

The severity of the epidemic is closely linked to the region's poverty, low status of women, and other socio-economic factors. Even with the knowledge of how to protect oneself from infection, such information may not always be usable in daily situations of economic and social disadvantage that characterize the lives of many young people in poor countries.

In 1992, the National AIDS Coordinating Committee of South Africa (NACOSA) was launched with a mandate to develop a national strategy on HIV and AIDS. Cabinet endorsed this strategy in 1994. A review conducted in 1997, in line with the goals of the NACOSA plan indicated the strengths and weaknesses of a health sector only, disease-specific approach to HIV and AIDS. Some of the recommendations related to capacity building for implementing agencies, increasing political commitment, increase involvement of PLWH, and strengthen integration.

Much was done to implement the recommendations of the NACOSA Plan review. These include the appointment of provincial AIDS coordinators, the establishment of the Inter-Ministerial Committee on AIDS, launch of Partnerships against AIDS by the Deputy President in 1998, development of the Department of Education HIV and AIDS policy for learners and educators, development of other national policies, including the Syndromic management of STDs, the establishment of the South African AIDS Vaccine Initiative (SAAVI)in 1998, the establishment of SANAC, the establishment of the national interdepartmental committee on HIV and AIDS, as well as the development of a Strategic Framework for a South African AIDS Youth Programme.

In 1999, through a consultative process with stakeholders, a National Strategic Plan (NSP 2000-2005) was developed and has been the cornerstone of our response in mitigating against HIV and AIDS. Its aim was to strengthen the implementation of the recommendations of the NACOSA Plan review as well as to enhance the national response to HIV and AIDS and STIs. This plan was lauded by the previous Secretary-General of the United Nations Organisation, Mr Kofi Anan, as one of the best in the world. An assessment of the NSP 2000-2005 has been done and its findings and recommendations are outlined in Section 2.

A number of policies and guidelines have been developed in order to support the implementation of HIV and AIDS strategies in South Africa. This work began in 1994 with the finalisation of the Reconstruction and Development document, from which most of other policies flowed. Some examples are; workplace policies in all government departments, the Integrated Nutrition Programme, Maternal, Child and Woman's health, Development of the District Health System, Patient's Right Charter, the White Paper on Transformation of the Health System in South Africa, the Health Charter, as well as many other relevant policy guidelines. This has been uniform throughout government and sectors of civil society. Another important milestone was the approval by Cabinet of the National Operational Plan for Comprehensive HIV and AIDS Management, Treatment, Care, and Support (The Comprehensive Plan), in November 2003.

The process of redressing the imbalances of the past commenced in 1994 and is progressing with great vigour. Several programmes form the thrust of government

interventions and ensure greater access to education, health services, the reduction of poverty, the empowerment of women, and the provision of basic services such as shelter, clean water, and sanitation. The government sees growing a job -creating economy and good governance as imperatives in ensuring sustained development, and has recently embarked upon an Accelerated Shared Growth Initiative for South Africa (ASGI-SA), to which is linked the Joint Initiative on Priority Skills Acquisition (JIPSA) initiative, all led by the Deputy President.

In spite of these improvements and commitments, the systemic challenge of human resources particularly in the health sector, attenuates the expected benefits of these commitments. The provision of health services is labour intensive and a range of both clinical and management skills are required to deliver quality health services in an affordable and equitable manner. There is currently an imbalance in the distribution of health professionals between the public and the private health care sectors, with the majority of doctors, pharmacists, and dentists in particular placed in the private sector. In addition, the migration of health professionals to developed countries has contributed to the problem of recruiting and retaining health professionals in the public health sector. The introduction of a scarce and rural allowance, the improvement of conditions of work in the public sector and the signing of memoranda of understanding with such countries as the UK are designed to manage the trends towards migration and contribute to retention of personnel. Other sectors are also affected by the dearth of the necessary skills to ensure acceleration of development in the country.

The most needy areas such as informal settlements and rural areas are disproportionately affected by shortages in human resources. Government developmental programmes like JIPSA need to be implemented with more vigour. Innovative and efficient ways of leveraging on the private sector need to be developed and introduced.

The challenge of HIV and AIDS in South African requires an intensified comprehensive, multi-sectoral national response. This response should:

- address the social and economic realities that make certain segments of society most vulnerable
- provide tools for prevention of infection
- provide services designed to mitigate the wide-ranging impacts of the epidemic.

To achieve this there is a continuing need to guide policy and programmes at all levels and in all sectors and to inspire renewed commitment from all South Africans.

4. SITUATION ANALYSIS

4.1 HIV and AIDS epidemiology in South Africa

A clear understanding of the nature, dynamics, and characteristics of an epidemic is critical in informing strategies that can be reviewed and adapted to fit local conditions.

UNAIDS and WHO description of the HIV and AIDS epidemics is based on prevalence rates and population affected. These organisations assert that HIV and AIDS is not the same everywhere given the dynamic nature of an epidemic so one country may move from one category to another.

Even within a country there may be a series of multiple, changing and overlapping micro-epidemics, each with its own nature (the populations most affected), dynamics (patterns of change over time) and characteristics (severity of impact). By this definition, the South African HIV and AIDS epidemic is generalised. It is firmly established in the general population and sexual networking in the population is sufficient to sustain the epidemic independent of sub-populations at higher risk of infection. A numerical proxy of HIV prevalence consistently >1% in pregnant women has been used to qualify a generalised epidemic (World Bank and WHO use >5%). By this definition alone therefore, South Africa has a generalised epidemic.

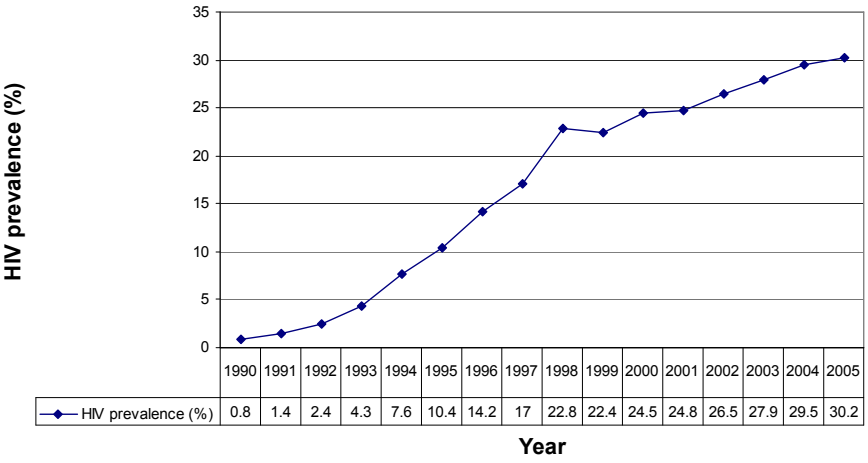
HIV prevalence has been consistently monitored in South Africa including through antenatal HIV and syphilis prevalence surveys, which have been conducted since 1990, and two national population-based surveys which were conducted in 2002 and 2005.[1] A national prevalence survey of youth was also conducted in 2003/4.[2] Figure 1 illustrates

[1] Department of Health. (2006). National HIV and syphilis antenatal sero-prevalence survey in South Africa 2005. Pretoria: Department of Health. Shisana et al Shisana O. 2002. Nelson Mandela / HSRC study of HIV/AIDS: South African national HIV prevalence behavioural risks and mass media. Cape Town: HSRC; Shisana O, Rehle T, Simbayi LC, Parker W, Zuma K, Bhana A, Connolly C, Jooste, S, Pillay V. 2005. South African national HIV prevalence, HIV incidence, behaviour and communications survey. Cape Town: HSRC Press.

[2] Pettifor, A., Rees, H., Steffenson, A., Hlongwa-Madikizela, L., MacPhall, C., Vermaak, K., et al. (2004). *HIV and sexual behavior among South Africans: A national survey of 15-24 year olds*. Johannesburg: Reproductive Health Research Unit, University of Witwatersrand.

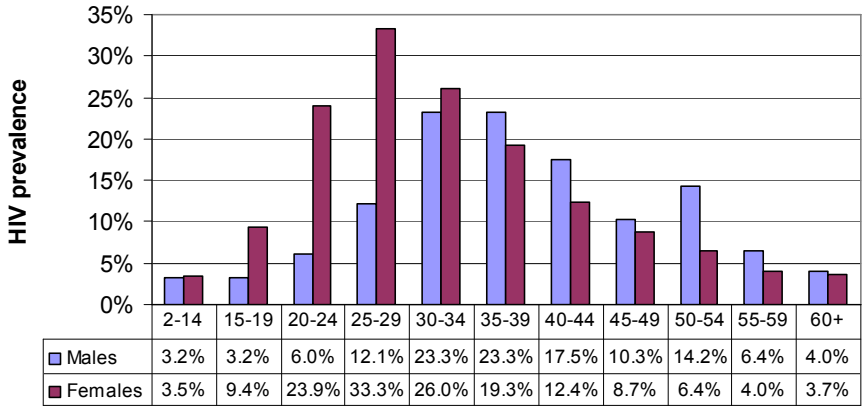
antenatal HIV trends from 1990 to 2005, and Figure 2 illustrates HIV prevalence by sex and age group in 2005 in the general population.

Figure 1: National HIV prevalence trends among antenatal clinic attendees: 1990 – 2005[3]



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
HIV prevalence (%)	0.8	1.4	2.4	4.3	7.6	10.4	14.2	17	22.8	22.4	24.5	24.8	26.5	27.9	29.5	30.2

Figure 2: National prevalence by age and sex: 2005[4]



	2-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+
Males	3.2%	3.2%	6.0%	12.1%	23.3%	23.3%	17.5%	10.3%	14.2%	6.4%	4.0%
Females	3.5%	9.4%	23.9%	33.3%	26.0%	19.3%	12.4%	8.7%	6.4%	4.0%	3.7%

A number of other national and sub-national studies have been conducted including employees, the military, health workers, educators, [5] health care workers and hospital

[3] Department of Health, 2006

[4] Shisana, et al (2005)

[5] Shisana, O., Peltzer, K., Zungu-Dirwayi, N. & Louw, J. (Eds). (2005). The health of our educators: A focus on HIV/AIDS in South African public schools, 2004/5 survey. Cape Town: HSRC Press.

patients[6], amongst children attending health care facilities,[7] and in various other communities and sectors.

Not all, of these data are available in the public domain, and thus it has not been possible to paint a comprehensive picture of the epidemic in different sectors in South Africa.

However, the reasonably comprehensive data that are available have allowed HIV prevalence, incidence and AIDS mortality to be estimated using demographic modelling as shown in Table 1, showing an estimated 5.4 million people living with HIV or AIDS in South Africa in 2006, of which a total of 294 000 were children aged 0-14[8]. These estimates are consistent with those of the Department of Health and UNAIDS of 5.5 million people living with HIV or AIDS of which 235 000 are children for 2005. The annual number of new HIV infections in South Africa peaked in the late 1990s.[8,9] National antenatal HIV prevalence has continued to increase in females over 20, although prevalence levels have remained relatively stable amongst young females aged 15-19 and begun to stabilise in the 20-24 age group over the 2001 to 2005 period.[10] Figure 3 illustrates antenatal HIV prevalence patterns by age group since 1991. There was a sharp increase in HIV prevalence in most age groups until about 2000 when the increase slows down. In recent years there has been a discernable increase in HIV prevalence in older age groups.

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6 Shisana, O., Hall, E., Maluleke, K.R., Stoker, D.J., Schwabe, C., Colvin, M., et al (2002). The impact of HIV/AIDS on the health sector: National survey of health personnel, ambulatory and hospitalised patients and health facilities 2002. Cape Town: HSRC Press

7 Shisana, O., Mehtar, S., Mosala, T., Zungu-Dirwayi, N., Rehle, T., Dana, P. et al. (2004). HIV risk exposure among young children: A study of 2–9 year olds served by public health facilities in the Free State, South Africa. Cape Town: HSRC.

8 Dorrington, R. E., Bradshaw, D., Johnson, L. and Daniel, T. 2006. *The Demographic Impact of HIV/AIDS in South Africa. National and Provincial Indicators 2006.* Cape Town: Centre for Actuarial Research, South African Medical Research Council, Actuarial Society of South Africa. www.commerce.uct.ac.za/Research_Units/CARE/RESEARCH/PAPERS/ASSA2003Indicators.pdf.

9 Rehle, T. & Shisana, O. (2003). Epidemiological and demographic HIV/AIDS projections: South Africa. African Journal of AIDS Research, 2(1). 1–8.

10 Department of Health. (2006). National HIV and syphilis antenatal sero-prevalence survey in South Africa 2005. Pretoria: Department of Health.

Figure 3: HIV prevalence of antenatal clinic attendees by age group: 1991 – 2005

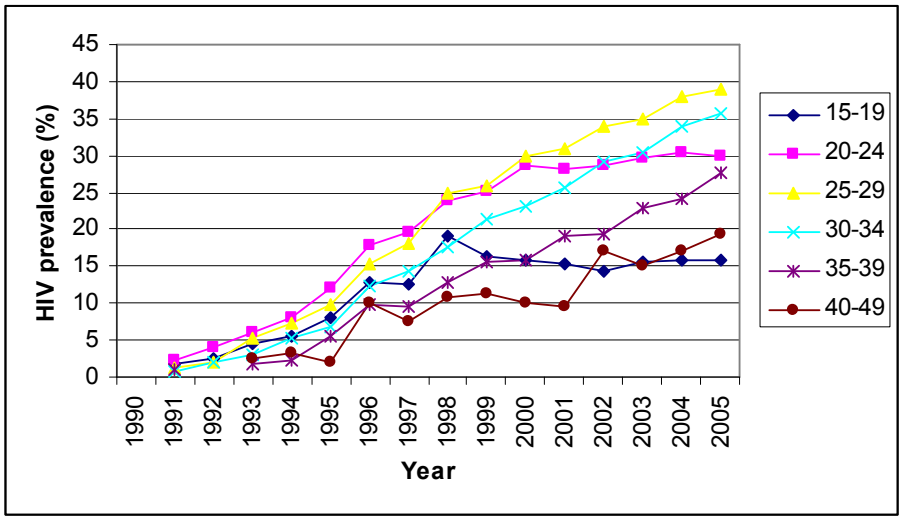


Table 1: HIV and AIDS Indicators at mid-2006[11]

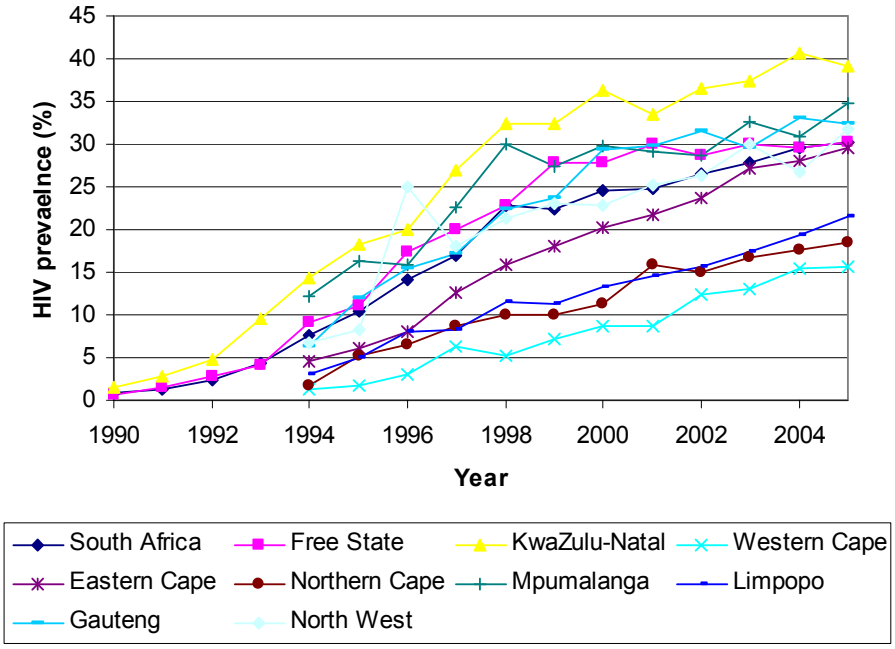
Births	
Uninfected births (over calendar year)	1 057 000
HIV+ births (over calendar year)	38 000
Infected through breastfeeding	26 000
People living with HIV/AIDS	
Total HIV infected	5 372 000
Adults (20-64)	4 880 000
Adult men (20-64)	2 179 000
Adult women (20-64)	2 702 000
Adults (15-49)	4 756 000
Adult men (15-49)	1 946 000
Adult women (15-49)	2 810 000
Youth (15-24)	1 012 000
Male youth (15-24)	181 000
Female youth (15-24)	831 000
Children (0-14)	294 000
New infections	527 000
Prevalence	
Total HIV infected	11.2%
Adults (20-64)	19.2%
Adult men (20-64)	17.8%
Adult women (20-64)	20.4%
Adults (15-49)	18.3%
Adult men (15-49)	15.4%
Adult women (15-49)	21.2%
Youth (15-24)	10.4%
Male youth (15-24)	3.7%
Female youth (15-24)	16.9%
Children (0-14)	1.9%
Incidence	
Total population	1.3%
Adults (20-64)	1.7%
Adult men (20-64)	1.9%
Adult women (20-64)	1.5%
At or before birth (of births)	3.5%
Breastfeeding (no. infected through breastfeeding in year/uninfected births in that year)	2.4%
Number adults (14+) infected by stage	
Stage 1	1 451 000
Stage 2	1 084 000
Stage 3	1 813 000
Stage 4 (not on treatment)	511 000
Receiving antiretroviral treatment	200 000
Discontinued antiretroviral treatment	18 900
Number children (<14) infected by stage	
Pre-AIDS	240 000
Stage 4 (not on treatment)	27 000
Receiving antiretroviral treatment	25 300
Discontinued antiretroviral treatment	1 500
AIDS sick	
New AIDS sick during 2006	479 000
Total AIDS sick mid-year	599 000

[11] Note: Numbers rounded to nearest thousand to avoid spurious accuracy. Source: Dorrington, Bradshaw, Johnson and Daniel (2006)

Heterogeneity of the South African epidemic

HIV prevalence varies considerably throughout South Africa. Some provinces are more severely affected than others, with the highest antenatal prevalence in 2005 being in KwaZulu-Natal (39.1%) and the lowest in the Western Cape (15.7%).

Figure 4: HIV prevalence of antenatal attendees by province: 1990 – 2005

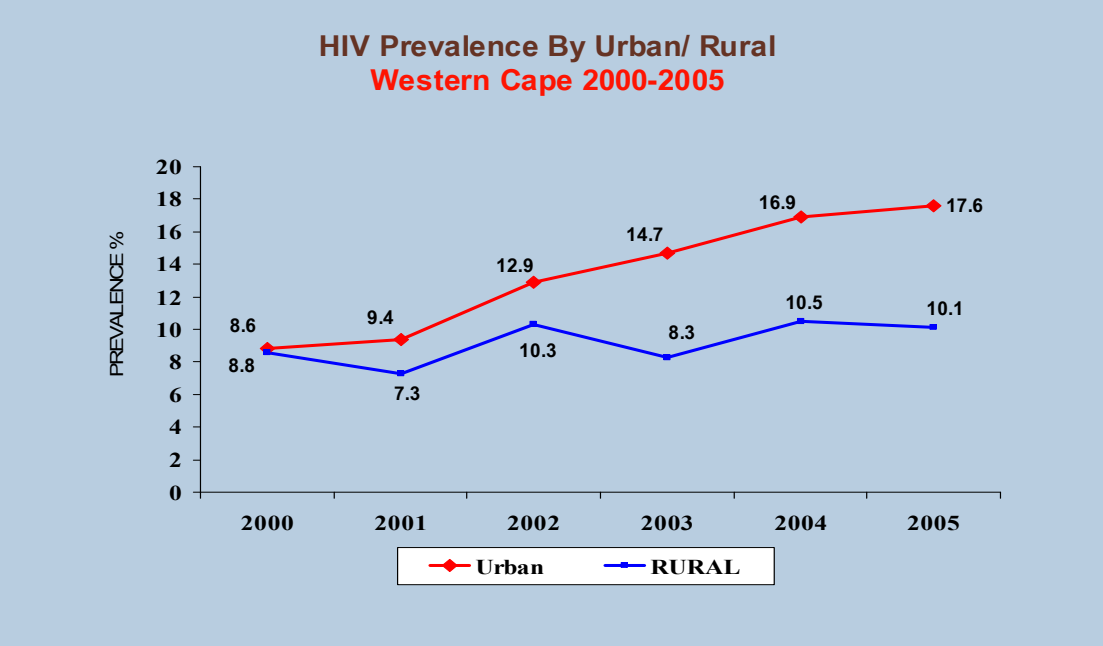


Prevalence also varies sub-provincially by geotype of residence with population-level HIV prevalence (for persons two years and older) in informal urban areas being nearly twice as high as in formal urban areas (17.6% vs 9.1%) in 2005. Levels in informal rural areas were 11.6% and in formal rural areas, 9.9%.[12]

An analysis of sub-provincial antenatal data in the Western Cape has illustrated a high degree of heterogeneity within the province, but also varying growth patterns in the various districts. Districts comprising predominantly informal urban areas have highest overall prevalence.[13]

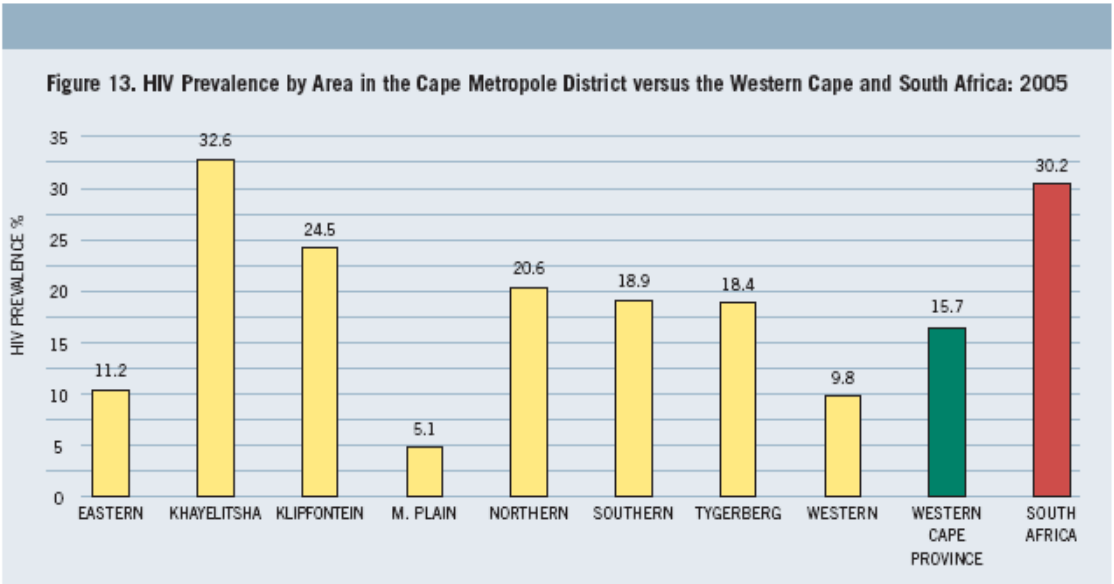
[12] Shisana et al, 2005

[13] Shaikh N, Abdullah F, Lombard CJ, Smit L, Bradshaw D, Makubalo L Masking through averages--intraprovincial heterogeneity in HIV prevalence within the Western Cape, 2006. S Afr Med J. 2006 Jun;96(6):538-43



The reasons for the variable growth of the epidemic are not clear and a combination of factors are attributed to the variation. It is argued that geographical heterogeneity in HIV tends to reflect the degree of urbanization, in addition to other factors such as sexual risk behaviours, sexual networks, population demographics, unemployment, social deprivation, migration, high population density, unemployment and unstable communities (2, 9, 10).

In the case of the Western Cape, there has been rapid urbanization and migration from rural areas to towns or from other provinces.



National-level HIV prevalence also varies markedly by population group, sex and age group. In 2005, Black Africans were found to be most affected (of the order of six to seven times higher than non-Africans), whilst females aged 15-29 were three to four times more likely to be HIV positive than males in the same age group. HIV was around 3% amongst children aged 2-14, much higher in those aged 15-59 and nearly 4% for people in their sixties.[14]

Women bear the brunt of the epidemic of HIV and AIDS. Women account for 55% of people living with HIV and AIDS in South Africa. This phenomenon is more pronounced in the age groups 20-24 years and 25-29 where the HIV prevalence rates are 23.9% for women to 6.0% for men and 33.3% for women to 12.1% for men, respectively.[15] The peak age for HIV infection in women is 25-29 years while for men it is the 30-35 years age group.

There is no single HIV and AIDS epidemic in South Africa. In addition to the pronounced gender dimension, there are other wide variations. These relate to the different new infection, illness and death epidemics. There is clear correlation between poverty and high HIV prevalence, with communities in informal settlements who often are the poor being

[14] Shisana et al, 2005

most vulnerable. These communities are often also the most underdeveloped, with poor access to social services including HIV and AIDS prevention, treatment, nutrition and care programmes. The vast majority of the population in informal rural and urban settlements are Black African.

Race has recently been identified as a significant risk factor for HIV and AIDS, with black Africans being the most affected. The 2005 HRC survey shows that Black Africans have HIV prevalence more than ten times higher than their White, Coloured and Indian compatriots.

The HRSC data also show that children have a high HIV prevalence. In the 2-4 age group, 4.9% of boys and 5.3% of girls are HIV positive, translating into an estimated 129 621 children. In the slightly older age group of 5-9, 4.2% of boys and 4.8% of girls have HIV - an estimated 214 102 children, and in the 10-14 age group, this figure drops to 1.6% among boys and 1.8% among girls. Work done by the Medical Research Council (MRC) to a large degree corroborates these findings.

4.2 Major causes and determinants of the epidemic in South Africa

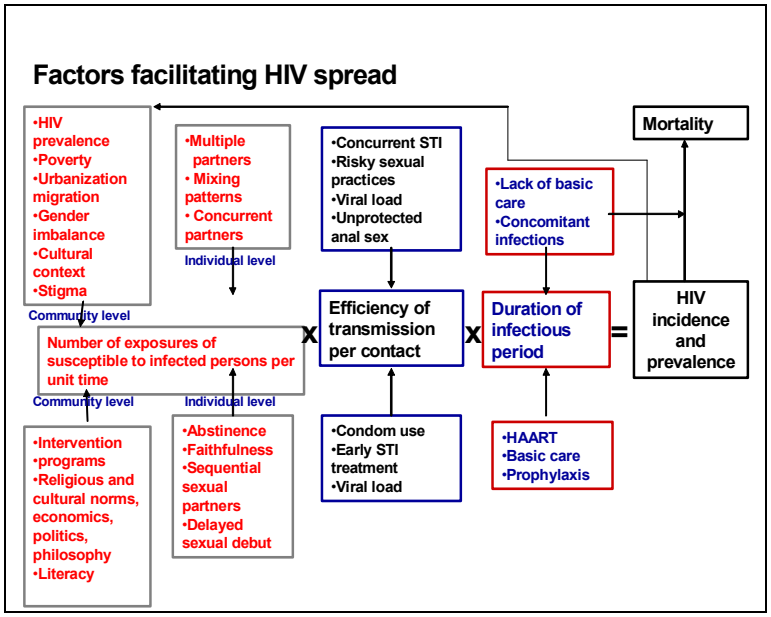
The context for these social and sexual networks is that of a newly democratic society emerging from a history of social disruption and racial and gender discrimination associated with inequitable distribution of resources as a result of Apartheid. The inequitable distribution of resources massively disadvantaged the majority of the population. This has resulted in a bimodal society, which is also reflected in the spread of disease within the population. Poverty related diseases including HIV and AIDS, TB and malaria affect mainly the previously disadvantaged sections of the population.

Many factors influence the heterogeneity and overall high levels of HIV prevalence in South Africa as illustrated in Figure 6[16]. These include biological, individual and social/contextual factors.

[15] Human Science Research Council, 2005

[16] Rehle, T., Lazzari, S., Dallabetta, G., & Asamoah-Odei, E. (2004). Second generation HIV surveillance: better data for decision making. *Bulletin of the World Health Organization*, 82, 121-127.

Figure 5: Factors influencing the reproductive rate of HIV transmission



Source: adapted from Rehle et al, 2004

Whilst HIV is spread predominantly through unprotected sexual intercourse, other modes of infection remain important and are summarised below.

- Mother to child HIV transmission: HIV is transmitted to approximately one third of babies of HIV positive mothers if there is no medical intervention. Use of antiretroviral drugs, obstetric practices including caesarean delivery, and safe infant feeding practices can reduce transmission to very low levels.[17]

- Blood transfusion: The risk of HIV transmission via infected donor blood is high. However, donor and biological screening procedures allow for risk of HIV transmission through blood donation to be contained. Such procedures are followed rigorously in South Africa and risk is estimated to be very low – 1:400 000.[18]

[17] Brocklehurst P, Volmink J. (2002). Antiretrovirals for reducing the risk of mother-to-child transmission of HIV infection. Cochrane Database Syst Rev 2: CD003510.

[18] Heyns, A. & Swanevelder, J. (2005). Safe blood supplies. In S. Abdool Karim & Q. Abdool Karim (Eds.), HIV/AIDS in South Africa. Cambridge: Cambridge University Press.

- Exposure to blood: In healthcare settings HIV can be transmitted between patients and health care workers in both directions via blood on sharp instruments, and may also be transmitted between patients through re-use of contaminated instruments. A number of studies have highlighted the importance of infection control measures in such settings as well as post-exposure prophylaxis in the case of sharp instrument injuries.[19] Exposure to blood can also occur in a wide range of institutional settings and in emergency situations where people are injured. Universal precaution practices including use of gloves and other protective measures are recommended.

- Intravenous drug use (IDU): IDU has long been recognised as a high risk practice for HIV transmission, as needles and syringes may be shared between users. The extent of intravenous drug use in South Africa is under-researched, mainly because of the legal environment and stigma associated with this behaviour. In regions where HIV occurs amongst intravenous drug users, prevalence is very high.[20]

Contextual Factors

(a) Poverty

Poverty does not operate on its own as a risk factor for infection with HIV. Its effect needs to be understood within a socio-epidemiological context. It works through a myriad of interrelations, including unequal income distribution[21], economic inequalities between men and women which promote transactional sex[22], relatively poor public health education and inadequate public health system[23]. Poverty-related stressors arising from aspects of poverty in townships such as poor and dense housing, and inadequate transportation, sanitation and food, unemployment, poor education, violence, and crime, have also been shown to be associated with increased risk of HIV transmission[24].

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[19] Colvin, M. (2005). Impact of AIDS – the healthcare burden. In S. Abdool Karim & Q. Abdool Karim (Eds.), HIV/AIDS in South Africa. Cambridge: Cambridge University Press. 336-350.; Shisana, O., Mehtar, S., Mosala, T., Zungu-Dirwayi, N., Rehle, T., Dana, P. et al. (2004).

[20] UNAIDS, 2006a

[21] Gie, R. et al. (1993). The socio-economic determinants of the HIV/AIDS epidemic in South Africa: A cycle of poverty. *South African Medical Journal*, 83, 223-224.

[22] Halperin, D. & Allen, A. (2001). Is poverty the root cause of African AIDS? *AIDS Analysis in Africa*, 11(4), 1, 3, 15.

[23] Mitton, J. (2000). The sociological spread of HIV/AIDS in South Africa. Journal of the Association of Nurses in AIDS Care, 11(4), 17-26.

[24] Kalichman, S.C., Simbayi, L.C., Kagee, A., Toefy, Y. & Jooste, S. (2006). Association of Poverty, Substance Use, and HIV Transmission Risk Behaviors in Three South African Communities. *Social Science & Medicine,* 62, 1641-1649.

(b) Gender and Gender-based violence

HIV in sub-Saharan Africa constitutes some 64% of the global total of 24.5 million people living with HIV.[25] Levels of infection vary throughout the region with countries in the north and west having adult (15-49) prevalence levels of between 1% and 5%, while those in the southern Africa have prevalence in the region of 10% to 20%, with some countries (Botswana, Zimbabwe, Lesotho and Swaziland) even higher. HIV prevalence has declined in some African countries, starting with Uganda in the early and late 1990s followed by Zimbabwe and urban areas of Ethiopia, Kenya and Malawi. [26] These declines appear to be linked to a combination of factors including changes in key sexual behaviour: delayed sexual debut amongst young people, declines in partner turnover and increased condom use with casual sexual partners.

Southern Africa remains the most affected region, and the HIV epidemic in South Africa is interlinked with epidemics occurring in neighbouring countries. South Africa, Swaziland, Lesotho and Botswana reported the highest antenatal HIV prevalence levels in the world in 2006.[27] HIV prevalence is relatively low in neighbouring Mozambique, although is increasing rapidly along transport routes[28] and there is some evidence that prevalence may have peaked in Botswana[29].

The severity of the epidemic is closely linked to the region's poverty, women's relative lack of empowerment amongst women, high rates of male worker migration, and other social and cultural factors. Even with knowledge of how to protect oneself from infection, such information may not always be usable in daily situations of economic and social disadvantage that characterise the lives of many young people and women in poor countries.

(c) Cultural Attitudes and Practices

The relationship between culture and HIV is under-researched. There is some evidence that cultural attitudes and practices expose South Africans to HIV infections. First, gender inequalities inherent in most patriarchal cultures where women are accorded a lower status than men impact significantly on the choices that women can make in their lives especially with regards to when, with whom and how sexual intercourse takes place[30]. Such decisions are frequently constrained by coercion and violence in the

[25] UNAIDS. (2006a). 2006 report on the global AIDS epidemic. Geneva: UNAIDS
[26] UNAIDS, 2006a; Hallet et al, 2006; Cheluget et al, 2006; Bello et al, 2006; Kirungi et al, 2006; Mahomva et al, 2006
[27] UNAIDS, 2006a
[28] UNAIDS. (2006b). December 06: AIDS epidemic update. Geneva: UNAIDS
[29] Dorrington, R. E., Moultrie, T. A. and Daniel, T. 2006. *Modelling the impact of HIV/AIDS in Botswana.* Gaborone: UNDP and NACA, Botswana.
[30] Meyer-Weitz, A., Reddy, P., Weijts, W., van den Borne, B. & Kok, G. (1998). The socio-cultural contexts of sexually transmitted diseases in South Africa: Implications for health education programmes. *AIDS Care,* 10, 539-555.

women's relationships with men. In particular, male partners either have sex with sex workers or engage in multiple relationships, and their female partners or spouses are unable to insist on the use of condoms during sexual intercourse for fear of losing their main source of livelihood.

Second, there are several sex-related cultural beliefs and behavioural practices such as rites of passage to adulthood especially among male youth, rites of marriage such as premarital sex, virginity testing, fertility and virility testing, early or arranged marriages, fertility obligations, polygamy, and prohibition of post-partum sex and also during breastfeeding, and rites related to death such as levirate (or spouse inheritance) and sororate (a widower or sometimes a husband of a barren woman marries his wife's sister) are also believed to spread HIV infection[31].

HIV infection is also believed to occur during some of the traditional health practices conducted by traditional healers when they use unsterilised sharp instruments such as knives, blades, spears, animal horns and thorns during some of the healing practices and/or recommend sex with a virgin as part of their treatment of patients.

(d) Stigma, denial, exclusion and discrimination

HIV and AIDS is perhaps one of the most stigmatised medical conditions in the world. Stigma interferes with HIV prevention, diagnosis, and treatment and can become internalized by people living with HIV and AIDS.[32] In the UNGASS declaration, governments committed themselves to, among other things, confront stigma, denial and eliminate discrimination by 2003. Although still prevalent, AIDS stigma appear to be declining in South Africa as shown by the findings of the 2005 national HIV and AIDS household survey, when compared to the 2002 survey.[33]

A recent large survey conducted among 1 054 people living with HIV and AIDS (PLWHA) in Cape Town found high levels of internalised stigma.[34] This is mostly due to the fact

[31] Simbayi, L. (2002). Psychosocial and cultural determinants of HIV/AIDS in the SADC region. (Chapter 3). *HIV/AIDS in Southern Africa: A review paper.* Cape Town: HSRC Press.
[32] UNAIDS (2006). Report on the global AIDS epidemic. Geneva: UNAIDS.
[33] Shisana, O., Rehle, T., Simbayi, L.C., Parker, W., Zuma, K., Bhana, A., et al. (2005a). *South African national HIV prevalence, HIV incidence, behaviour and communication survey*. Cape Town: HSRC Press

that HIV infection, as with other STIs, is widely perceived as an outcome of sexual excess and low moral character, with a consequent strong culture of silence by PLWHA because of fear of rejection and isolation by close relatives and the community at large. Stigma appears to be more severe for women than for men.[35]

One of the consequences of the problem of stigma, exclusion and discrimination of people living with HIV and AIDS is that it forces people who are infected to hide their condition and to continue engaging in high-risk behaviour.[36] Another consequence is denial. Both silence and denial about HIV and AIDS are lethal because they prevent people from accurately assessing their own personal infection risk.

(e) Mobility and labour migration

Poverty and unemployment are linked to economic disempowerment and this affects sexual choice-making and exposure to wider sexual networks. Over and above gender vulnerability that flows from economic disempowerment, individuals who engage in work-seeking, mobile forms of work or migrant labour are at increased vulnerability to HIV as a product of higher likelihood to have multiple sexual partners, higher exposure to sex for exchange of money, amongst other risk factors.[37] Mobile individuals include informal traders, sex workers, domestic workers, cross-border mobility, seasonal agriculture workers, migrant workers (e.g. mine-workers, construction workers, and soldiers), long-distance truck, bus and taxi drivers, travelling sales persons and business travellers.[38] These forms of mobility are pervasive in southern Africa. Various studies have illustrated the higher likelihood of mobile groups to be HIV positive. [39] Migration patterns in South Africa have shifted from being predominantly male migration, to a trend towards increasing mobility and migration by women. Mobility and migration not only increase vulnerability to HIV of mobile individuals, but also sending and receiving communities.[40]

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[34] Simbayi, L.C., Strebel, A., Cloete, A., Henda, N., Mqeketo, A., Magome, K., & Kalichman, S.C. (In press). Internalized AIDS Stigma, AIDS Discrimination, and Depression among Men and Women Living with HIV/AIDS, Cape Town, South Africa. *Social Science & Medicine*

[35] Achmat, Z. (2001). (Untitled). Verbatim transcript of the address to the AIDS in Context Conference held at the University of the Witwatersrand on 7th April 2001. [Available from: http://www.tac.org.za]

[36] Qwana E, Mkaya M, Dladla N & Lurie M (2000). An analysis of reasons for wanting and not wanting to disclose HIV status Paper presented at the International AIDS Conference held in Durban.

[37] International Organisation for Migration. (2006). HIV/AIDS, population mobility and migration in Southern Africa: Defining a research and policy agenda. Pretoria: IOM

[38] International Organisation for Migration and UNAIDS. (2003). Mobile Populations and HIV/AIDS in the Southern African Region: Desk Review and Bibliography on HIV/AIDS and Mobile Populations. Pretoria: IOM

[39] International Organisation for Migration. (2006). HIV/AIDS, population mobility and migration in Southern Africa: Defining a research and policy agenda. Pretoria: IOM

(f) Informal settlement

Informal settlement is associated with higher levels of HIV prevalence in South Africa, with HIV prevalence for people aged 15-49 in urban informal areas being nearly twice that of prevalence in urban formal areas (25.8% vs 13.9%). Informal settlements include social fragmentation that may increase the likelihood of exposure to unsafe sex, but there is also a greater likelihood that individuals at higher risk of HIV including work-seekers, temporary workers, and labour migrants are resident in these areas. Diminished resources of informal settlements including inadequate housing, sanitation and health service access, and these exacerbate overall health risks and reforms in housing policy have been recommended.[41]

4.3 Specific Vulnerable Groups

(a) Women

Women, especially black women, have been on the bottom rung of the ladder in terms of participation in the economic, social, and political life of the country. For many years black women have experienced triple oppression - discriminated against on the basis of their class, race and gender. Some practical challenges facing women because of these three forms of oppression relate to violence against and abuse of women, poverty and poor health status in general.

Acknowledging the fact that gender inequality hinders social and economic development, the current government has made great strides towards empowerment of women and gender equality is one of the critical elements of the transformation agenda in the country. Women are beginning to regain their appropriate place in society and are taking responsibility for their lives. Patriarchal attitudes are changing, with men participating in efforts to address challenges such as violence against women. Gender transformation is part of a broader transformation agenda that also seeks to reduce the gap between rich and poor and between historically disadvantaged black communities and white communities with many more resources. However, the high levels of gender-based violence in the country indicate that a lot still needs to be done in this area.

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[40] International Organisation for Migration. (2006). HIV/AIDS, population mobility and migration in Southern Africa: Defining a research and policy agenda. Pretoria: IOM

Notwithstanding the abovementioned achievements, women remain one of the most important vulnerable groups in the country. The difference between men and women is more pronounced in the age groups 20-29 years but particularly striking in the age group 25-29 where the HIV prevalence in the same survey were 33.3% for women compared to 12.2% men.[42] A youth study by the Reproductive Health Research Unit (RHRU, 2002) found that among the 10% of youth who HIV positive, 77% are women are. In additional to biological, economic, social and other cultural vulnerabilities, women are more likely to experience sexual abuse, violence in particular domestic violence including rape.

They take the brunt of caring for sick family members and are the soldiers at the forefront of community-based HIV and AIDS activities. The HIV and AIDS epidemic is clearly feminized, pointing to gender vulnerability that demands urgent attention as part of the broader women empowerment and protection. In view of the high prevalence and incidence of HIV amongst women, it is critical that their strong involvement in and benefiting from the HIV and AIDS response becomes a priority. Teenage females have been underemphasized as a target group, even though pregnancy levels are high in this age group. The fact that the burden of the epidemic falls more on women and girls than on men and boys remains a central challenge to the national response.

(b) Adolescents and young adults (15-24 years):

The United Nations General Assembly Special Session on HIV and AIDS (UNGASS) identified young people aged 15-24 years as a priority group in reducing new HIV infections and set a global target *of reducing incidence of HIV in this group by 20% by 2015*[43]. Data from a decade or more of extensive national antenatal surveys in South Africa show that HIV prevalence among adolescent girls and young women in this age group may be stabilizing, albeit at very high rates. Prevalence in the age group 15-19 has remained at around 16% for the past five year, while in the 20-24 years it has risen only slightly (28%-30%) over the same period. Although current HIV prevention programmes in South Africa have invested significantly in this age group, they are yet to demonstrate the desired impact. Continued investment and expansion of carefully

[41] Thomas, E.P. & Twala, S. (The HIV health challenge for people living in informal settlements – are environmental risks and exacerbating factor. Epidemiology: 6(5):S162
[42] Health Science Research Council , 2005
[43] United Nations (2002) United Nations Special Session on HIV/AIDS, United nations New York

targeted evidence-based programmes and services focusing on this age group remain as critical as ever. Young people represent the main focus for altering the course of this epidemic. UNAIDS data on the experience of several countries including South Africa, confirm that positive behaviour change is more likely in this group than in older ages.

The greatest increase in pregnancy and HIV infection is associated with school leaving. School-leaving is a time of insecurity for young people, the aspirations that existed in school of getting a job and earning an income are often dashed and personal motivation to achieve and the psychological rewards of school achievement are no longer there and there are family pressures to contribute to household income or to leave. In the absence of career opportunities, many young women find fulfilment and affirmation in being a mother – by definition requiring unprotected sex.

(c) Children 0 – 14 years

Children under the age of 18 comprise 40% of the population of South Africa. In 2004, it was estimated that there are 2.2 million orphaned children (meaning 13% of all children under 18 have lost either a mother or father); nearly half of all orphans were estimated to have lost parents as a result of AIDS[44]. Some of the worst affected children – those in deeply impoverished households – may experience various forms of physical, material and psychosocial deprivation and assaults on their health as a result of poverty and/or a lack of parental care and nurturing environment. Often these children are separated from caregivers and siblings and sent to stay with other relatives or other carers or social networks.

A significant number of children in South Africa are living with HIV and AIDS. According to the 2005 HSRC survey, there is an estimated 129 621 children aged 2-4 years and 214 102 children aged 5-9 in 2005 living with HIV or AIDS[45]. HIV is thought to have contributed to an increase of 42% in under-five mortality in this country in 2004.[46] Also, there is evidence to suggest that 60% of hospital deaths were HIV-related in 2005. Children usually do not have sufficient access to AIDS treatment and care because available services are mostly designed for adults. Serious challenges around the skills of

[44] UNAIDS, UNICEF, USAID (2004) Children on the Brink 2004, Geneva
[45] Shisana, et al (2005) South Africa National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, HRSC, Cape Town
[46] Statistics South Africa (2006). Mortality and causes of death in South Africa, 2003 and 2004: findings from death notification. Pretoria: Statistics South Africa.

health workers and capacity to manage and treat children with AIDS including lack of appropriate ART formulations for treating children remain.

Children are vulnerable to HIV infection through child sexual abuse. Whilst little is known as to the extent of child sexual abuse in South Africa anecdotal estimates suggest that it is quite extensive and thus that it is a risk that needs to be monitored. [47]

(d) People with disabilities

People with disabilities, constitute a significant part of the population (12%). Yet, this group has been particularly neglected in the AIDS response. There are often erroneous perceptions that people with disability are asexual. To date the national response has not addressed the special needs of the various categories of people with disability in terms of prevention, treatment, care and support programmes. People with disability suffer double stigma arising from discrimination as result of their disability status and their HIV status.

Increasingly AIDS is a cause of disabilities and the more people's lives are prolonged while infected so this will become a significant issue and it will be necessary to provide for care, support and treatment. This sector is actively involved in ensuring that people with disabilities respond to the HIV and AIDS challenges that facing the often with little support. The special needs of people with disabilities demand conscious efforts to ensure equitable access to information and services.

(e) Incarceration and HIV

Incarceration is a risk factor for HIV and is correlated with unprotected sex and injecting drug use in correctional facilities, but may also include risk of blood exposure as a product of violence and other factors. Interventions for risk reduction include provision of voluntary testing and counselling, condom provision, addressing rape, and addressing intravenous drug use.[48] Male prisoners are predominantly vulnerable but risks extend to female prisoners. Little is known about the extent of HIV in South African correctional services, nor the relationship between known risk factors and HIV acquisition in South

[47] Kistner, U., Fox, S., & Parker, W. (2004) Child sexual abuse and HIV/AIDS in South Africa: A review. Johannesburg: CADRE/DOH
[48] Jürgens, R. (2006) HIV/AIDS and HIV/AIDS an HCV in prisions: A select annotate bibliography. International Journal of Prisoner Health, 2(2):131-149

Africa. However, a small study in Westville medium security prison near Durban in 2002 found an HIV prevalence of 29.6% amongst male prisoners.[49]

(f) Men who have sex with men (MSM)

Whilst HIV infection amongst MSM was a focus in the early phases of the epidemic in South Africa, there is very little currently known about the HIV epidemic amongst MSM in the country. MSM have also not been considered to any great extent in national HIV and AIDS interventions. Biologically, MSM who practice receptive anal intercourse have an elevated risk for HIV infection. MSM practices are also more likely to occur in particular institutional settings such as prisons, often underpinned by coercion and violence. MSM behaviours and sexualities are wide-ranging and include bisexuality, and the HIV epidemic amongst MSM and the heterosexual HIV epidemic are thus interconnected. [50]

(g) Commercial Sex Workers (CSW)

Sex work is not readily defined but includes a wide range of informal and formal activities that relate to the exchange of sex for material benefit. Key characteristics include frequent and repeated exchange of sex with multiple sexual partners usually for monetary gain. Sex workers are predominantly female. Sex workers are at high risk of HIV infection and are vulnerable as a product of high partner turnover and a limited capacity to ensure safe sex during each and every sexual encounter. Very little is known about HIV prevalence amongst sex workers or their clients in South Africa, but both groups are linked to sexual networks that overlap with the broader epidemic.

(h) Mobile, casual and atypical forms of work

Truck driving, military service and other uniformed services such as security service provision may require regular and sustained travel and may in turn increase the likelihood of multiple sexual partnerships. Such activities have been linked to increased risk of HIV infection. [51] Whilst very little is known about prevalence in these sectors in South Africa, it is likely that risk of infection is higher, and these groups also overlap with the broader epidemic as a product of linked sexual networks.

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[49] Gow, J, Smith, G., Goyer, K., & Colvin, M. (2004). The socio - economic characteristics of HIV in a South African prison. Int Conf AIDS. Abstract no. WePeD6529.

[50] UNAIDS, 1998

[51] Kistner, U., Fox, S., & Parker, W. (2004) Child sexual abuse and HIV/AIDS in South Africa: A review. Johannesburg: CADRE/DOH

(i) Refugees

The disruption of services and support systems caused by conflict or unrest in their home countries means that many refugees have limited information about HIV and AIDS, and they are often not familiar with local services or systems in South Africa. In addition, while their legal status guarantees the right to access HIV-related information and services on the same level as South Africans, barriers such as language, cultural traditions and xenophobia often preclude their ability to access these services. Therefore targeted programmes are necessary to ensure that refugees and asylum seekers have access to information and services- including prevention, care, support and treatment- as an integrated component of the national response to HIV and AIDS.

(j) Injecting drug use

South Africa is a conduit country and market for drugs including injecting drugs such as heroin. Needle and syringe sharing is a common practice amongst injecting drug users, and is a highly efficient mechanism for transferring HIV. Intravenous heroin use in South Africa is presently very low, but has the potential to escalate. There are heroin detoxification programmes available in the country, but no formal needle exchange programmes exist.[52]

4.4 Impacts

Demographic

The demographic impact of HIV and AIDS on the South African population is also apparent in statistics such as the under-5 mortality rate, which has increased from 65 deaths per 1000 births in 1990 to 75 deaths per 1000 births in 2006. Mortality rates in 1990 suggested that a 15-year old had a 29% chance of dying before the age of 60, but mortality rates in 2006 suggest that 15-year olds have a 56% chance of dying before they reach 60. Other estimates provided by the Actuarial Society of South Africa for 2006 include:

- 1.8 million AIDS deaths had occurred in South Africa, since the start of the epidemic.
- Around 740 000 deaths occurred in 2006, of which 350 000 were due to AIDS (approximately 950 AIDS-related deaths per day).

[52] Leggett, T. (2005). Intravenous drug use in South Africa. In S. Abdool Karim & Q. Abdool Karim (Eds.), *HIV/AIDS in South Africa*. Cambridge: Cambridge University Press.

- 71% of all deaths in the 15–49 age group were due to AIDS.
- Approximately 230 000 HIV-infected individuals were receiving antiretroviral treatment, and a further 540 000 were sick with AIDS but not receiving antiretroviral treatment.
- 300 000 children under the age of 18 experienced the death of their mother.
- 1.5 million children under the age of 18 were maternal or double orphans (i.e. had lost a mother or both parents), and 66% of these children had been orphaned as a result of HIV and AIDS.

The economy

The ILO demonstrated in 2004, and again with more recent data in 2006, that the rate of economic growth in countries heavily affected by HIV and AIDS has been reduced by the epidemic's effects on labour supply, productivity and investment over the last decade or more. According to this assessment, 3.7 million labour force participants aged 15 to 64 years were living with HIV or with AIDS in South Africa[53]. However, there is currently no clear evidence on the actual economic impact of HIV and AIDS in South Africa.

Families and communities

Households experience the immediate impact of HIV and AIDS, because families are the main caregivers for the sick and suffer AIDS-related financial hardships. During the long period of illness caused by AIDS, the loss of income and cost of caring for a dying family member can impoverish households[54].

The problem of orphans and vulnerable children will persist for years, even with the expansion of prevention and treatment programmes. Studies in several districts in South Africa found that the majority of orphans are being cared by grandparents, family members or through self-care in child-headed households[55]. Orphans and vulnerable children are at higher risk for HIV infection, as they face numerous material, emotional and social problems[56]. They also face:

[53] (ILO, 2006)
[54] (Ashford, 2006)
[55] (Letlape et al., 2006; Jooste et al., 2006)
[56] (Skinner, 2006)

- Discrimination and stigma, as they are often shunned by society, lack affection and are left with few resources;
- Many of them drop out of school due to inability to pay school fees;
- They also often suffer from malnutrition and ill health and are in danger of exploitation and abuse[57].

Psychosocial impacts, mental health and HIV

Interventions to address HIV and AIDS have tended to focus on biomedical interventions including, for example, condoms for HIV prevention, and ART and PMTCT, for people living with HIV. Psychological distress and psychological disorders are also more prevalent amongst PLHA, and the importance of mental health programming in relation to HIV/AIDS has long been overlooked.[58] Less emphasis has been given to the psychosocial impacts of the disease which are related to illness and death of parents, children and other family members; caring for people who are ill and dying of AIDS; and living with and coping with an HIV positive diagnosis. A recent study in South Africa found a higher prevalence of mental disorders amongst PLHA including depression, anxiety, increased anxiety amongst PLHA with children, and alcohol related problems.

The health care system

HIV and AIDS affect both the supply and demand of health care systems. On the 'supply' side of health systems, the human resource effects of HIV are two-fold: the stress and morale impacts of rapidly changing epidemiological, demand and mortality profiles in patients caused by HIV and AIDS, and HIV infection in providers themselves. In a survey of 512 public sector workers in four provinces, 16.3% were HIV infected[59]. An HIV prevalence study at Helen Joseph and Coronation Hospitals with a 91% response rate, found that 13.7 % of 644 nurses were HIV infected and 19% had AIDS defining CD4 cell counts[60].

Education system

[57] (UNICEF)
[58] Baingana, F., Thomas, R., & Comblain, C. (2004). HIV/AIDS and mental health. Washington: World Bank; Freeman, M., Nkomo, N., Kafaar, Z. and Kelly, K. (2007). Mental disorder in people living with HIV/AIDS in a high prevalence developing country context. Forthcoming in The Lancet.
[59] (Shisana et al, 2003)
[60] (Connelly et al, 2007)

The epidemic affects the supply and demand for primary and secondary schooling. On the supply side, infected teachers will eventually become chronically ill, with increased absenteeism, lower morale and productivity.

A South African education sector study found a sero-prevalence of 12.7% among teachers and significant gender, racial and geographical differences[61].

The challenge of HIV and AIDS in South African requires an intensified comprehensive, multi-sectoral national response. This response should:

- address the social and economic realities that make certain segments of society most vulnerable
- provide tools for prevention of infection
- provide services designed to mitigate the wide-ranging impacts of the epidemic.

To achieve this there is a continuing need to guide policy and programmes at all levels and in all sectors and to inspire renewed commitment from all South Africans.

The South African National Aids Council (SANAC) recommended a rapid assessment of the NSP 2000-2005 as a first step toward developing the NSP 2007-2011. A task team was duly formed to coordinate the assessment, which was done between August and September 2006. This evaluation enabled stakeholders to identify the strengths and weaknesses of the NSP 2000-2005. The NSP 2007-2011 thus partly builds on the findings of this assessment.

5. RESPONSE ANALYSIS

A detailed description of the country's response to the HIV and AIDS epidemic is beyond the scope of this plan. However, this section offers a brief overview of progress made by various agencies in implementing the NSP 2000-2005 as well as some of the gains for the NACOSA period.

The NSP 2000-2005 articulated four priority areas - prevention; treatment, care and support; legal and human rights; and research, monitoring and surveillance.

The final report of the assessment of the NSP 2000-2005 concluded that:

1. All stakeholders in government and civil society embraced the NSP 2000-2005 as a guiding framework during the time of its implementation. Sectoral HIV and AIDS policies and operational plans in South Africa are designed according to the principles and structures charted in the NSP 2000-2005.
2. Participation in the fight against HIV and AIDS has broadened to involve agencies other than the Department of Health and government departments during the time of the NSP 2000-2005.
3. There has been an increase in the levels of HIV and AIDS awareness and in the acceptance of people living with HIV and AIDS. However, behaviour has not changed proportionately to levels of awareness and availability of prevention methods such as condoms.
4. Stigma and discrimination remain unacceptably high.
5. The NSP 2000-2005 gave rise to the establishment and expansion of key programmes such as health education, voluntary HIV counselling and testing (VCT), prevention of mother to child transmission (PMTCT) and antiretroviral therapy (ART). There has been significant growth in input to and uptake of these programmes over the period of the NSP 2000-2005.
6. The implementation of these programmes tended to be vertical, with capacity deficits evident in their implementation. This is reflective of the health system or lead agency's weaknesses rather than a weakness in the strategic framework.
7. The lack of a clear monitoring and evaluation framework and clear targets and responsibilities was a major weakness of the NSP 2000-2005.
8. The overall co-ordination of activities at SANAC level and within civil society was another major weakness.

Key recommendations for government departments included:

1. Review the approach and content of the Abstain, Be faithful, Condomise (ABC) strategy behind the design of Information, Education and Communication materials (IEC). There should be greater emphasis on strategies that are designed to influence behaviour rather than simply to raise awareness. Also, there should be emphasis on positive messaging - sending a clear message that it is possible to live a happy, fulfilled life with HIV.

[61] (Shisana et al., 2005b)

2. Strengthen the implementation of government departments' HIV and AIDS plans. Establish an interdepartmental framework to record the experiences of the various departments.
3. Consolidate and build existing partnerships, especially concentrating on increasing the contribution of the private sector.
4. Strengthen co-operative agreements among SADC member states and promote implementation of these agreements to create a regional framework.
5. Strengthen the co-ordination and monitoring and evaluation of the sector within the framework of SANAC.

The key recommendations identified the following needs within civil society:

1. Develop strategies to enable SANAC representatives to fulfil their mandate of co-ordinating activities in civil society.
2. Develop strategies to increase business sector contribution in all aspects of the response to HIV and AIDS, especially small, medium and micro enterprises (SMMEs). Formalise structures in the trained health professional (THP) sector.
3. Establish a monitoring and evaluation plan for all civil society structures. Strengthen co-ordination among all sectors of civil society involved in treatment, care and support activities.
4. Make prevention education and other HIV and AIDS related interventions accessible to people with special needs.

The findings of the assessment on the extent of implementation of the NSP 2000-2005 are summarized as follows:

Prevention:

Information Education and Counselling (IEC) materials in South Africa are of sound technical quality and widely available. All stakeholders disseminate similar messages, articulated around ABC, stigma-mitigation and human and legal rights. The DOH has invested a great deal in the production and dissemination of IEC materials through the existing and popular mass media.

A recent report on the status of HIV and AIDS communication campaigns reported that the government AIDS Communication Programme, Khomanani is the best of all in the

country, achieving excellent reach and is well known and recognised by the general population. The target of reaching all schools in South Africa through the Life Skills program has also been achieved and significant progress has been made in building capacity among educators. Behavioural change, however, remains a problem. Reports indicate that consistent condom use among the youth is still not optimal.

All government departments are committed to the prevention of HIV and AIDS. Departments have developed and implemented appropriate policies and plans. There are suggestions, however, that implementation capacity for specific activities within government departments is inadequate.

In August 2005, South Africa joined the WHO Afro Regional Resolution to declare 2006 a year of accelerated HIV prevention and a five-year strategy for accelerated HIV prevention was developed. HIV prevention is one of the key priority programmes articulated in the Strategic Plan of the DOH for 2006/2007.

Some programmes have been implemented in high transmission areas (HTA) and have grown rapidly due to high demand. These include several regional initiatives such as the Corridors of Hope service on the major trucking routes in South Africa.

Male Condom accessibility, judged according to the quantity of condoms procured and distributed, has significantly improved during the NSP 2000-2005. Condoms are being distributed increasingly via non-traditional outlets, but the number of condoms handed out at these venues remains low compared to overall distribution.

The number of PMTCT sites has increased during the NSP 2000-2005 period. DOH has provided some skilled personnel, medicines and other commodities to ensure that access to PMTCT increased. The training of health care providers on PMTCT may, however, be lagging behind the expansion of the PMTCT services. Fertility options for women known to be HIV-positive are still lacking. The effectiveness of this programme is still to be established.

The availability of post exposure prophylaxis (PEP) services has also improved during the NSP 2000-2005. Policies are available; and the number of sites and drug availability

has improved since 2000. But the percentage of people who have been raped who actually receive PEP is low. This could be due to weak human resource capacity or failings of other support systems (for example, data/information management) for the programme.

Significant investment has been made in infrastructure since 2000 including recruitment of staff, training of staff, and procurement of equipment and supplies for VCT. The proportion of people counselled to those who are tested has improved during the NSP 2000-2005 period, as has the proportion of health care workers being trained to provide the service. The contribution of the private health sector to VCT is minimal, too low in proportion to the resources in that sector.

Treatment, Care and Support:

Standard treatment guidelines for the management of HIV and AIDS related conditions in the public health sector were developed and distributed with training of health care workers. An important milestone in this regards was the development and approval by Cabinet of the National Operational Plan for Comprehensive HIV and AIDS Management, Treatment, Care and Support (The Comprehensive Plan). This plan united the country in ensuring that a comprehensive package of good quality services is equitably provided to those in need whilst strengthening the health system.

Since the launch of this plan, a lot of resources have been allocated to treatment, care and support within facilities. Policy and guidelines for all aspects of HIV and AIDS were updated to include the use of Antiretroviral drugs and nutrition interventions. Staff training has increased, laboratory services are more accessible, physical infrastructure has improved. In the first year of the implementation of the Comprehensive Plan, accredited service points covered all health districts. Today many accredited service points are already functioning beyond capacity.

South Africa now has the largest number of people enrolled on antiretroviral therapy in the world. There are however many more people in need of this and other related interventions to reduce morbidity and mortality from HIV and AIDS. In particular more eligible adults than children have accessed these services. There is a need to develop more innovative strategies to improve access for children as well. The management of

TB poses a specific challenge as the cure rate remains low and resistance increases despite the efforts that have been put into the programme.

Community and home-based care have grown rapidly in South Africa in the last five years. Guidelines have been developed and training is available for home-based carers. In general, communities are responding positively to the need to care for PLWHA. Collaboration between the government and some CBOs is well established, with many receiving funding from the government. The provision of a stipend for home-based carers is an important incentive that also contributes to poverty alleviation. This programme is seen as the department of health's contribution to the national Expanded Public Works Programme (EPWP). Policies for the management of community care givers as well as career path programmes have been developed whilst good quality services are provided to home-bound clients and children in early childhood centres.

The burden of HIV and AIDS on children has increased greatly. The number of Orphans and Vulnerable Children (OVC) has more than doubled in the past three years. The government response to this reality is multi-sectoral, comprehensive and developmental. There is significant inter-sectoral collaboration between relevant government departments and civil society to address the needs of these children.

Research, Monitoring and Evaluation:

South Africa's efforts to develop a vaccine have met with international acclaim. Support from government and other research institutions is very valuable to the initiative. The various scientific teams involved have observed all ethical requirements. HIV vaccine development has strengthened the level of community participation in scientific research and capacity to do research has increased considerably in the country. The challenge is to ensure equitable spread of this development. It is however still a long way before an effective vaccine is available for use.

A number of HIV and AIDS research projects have been commissioned during the NSP 2000-2005 to investigate various treatment options in South Africa. Great emphasis has been placed on ensuring that new drugs are safe - both in the mainstream and traditional health sectors. Studies have been conducted to establish the incidence of HIV. There are still some methodological discussions yet to be concluded in this domain.

Several behavioural surveys of varying methodological strength have been carried out. Some of these were aimed at establishing a baseline against which future surveys could be assessed. The antenatal care survey for the prevalence of HIV among pregnant women was conducted once a year during the time of the NSP 2000-2005.

Human and Legal Rights:

Between 1994 and 2007 South Africa developed a sophisticated legal framework dealing with health, which has respect for human rights at its centre. There are also a number of laws, policies, guidelines and judgments that specifically protect the rights of people living with HIV and AIDS in South Africa. However, information on these rights has not been widely enough disseminated. Linked to this is the failure to allocate resources for human rights education and protection, leading to the human rights-based response being limited and fragmented and largely driven by NGOs. As a result, poor, marginalised and disabled people face the problem of being unable to afford or have easy access to the legal and judicial system.

During the NSP of 2000-2005 some research has reported a lessening of stigma and the latest evidence suggests the majority of South Africans are willing to care for PLWHA. In addition there have been a number of successful cases challenging unfair discrimination. But despite this the combination of stigmas against HIV, disability and sexual orientation, together with other forms of discrimination, remain a challenge. This continues to deter people, particularly from vulnerable groups, from seeking HIV testing, treatment and support. In addition, much greater openness about HIV remains elusive.

Civil Society Sectors response:

Various sectors of civil society were identified as lead agencies in the implementation of the NSP 2000-2005. Challenges with lack of indicators and , poor coordination make it difficult to provide an accurate account on the performance of these sectors. However, during 2000-2005 many sectors expanded their involvement in HIV Prevention, Treatment, Care and Support. For example, the PLWHA, the business, higher education, traditional health practitioners, people with disabilities, children, and religious sectors are some of the sectors that have made meaningful contributions.

The main challenge is now for the sectors to coordinate and monitor their activities more effectively. There is also a need for sectors to ensure that campaigns on HIV reach to all of their members.

6. DEVELOPMENT OF THE STRATEGIC PLAN 2007-2011:

During 2006 SANAC, under the leadership of the Deputy President, Mrs. Phumzile Mlambo-Ngcuka, mandated the Department of Health (DOH) to lead the development of a national strategic plan to ensure continued guidance strengthening of the national, mullti-sectoral response to HIV and AIDS.

This plan would build onto what has been done, take into account the current state of the epidemic and developments in scientific knowledge, and will establish national targets and monitoring frameworks. Guided by the Minister of Health, Dr Manto Tshabalala-Msimang, SANAC concluded that the National Strategic Plan (NSP) 200-2005 is fundamentally still relevant. This work began in August and September with an assessment of progress in the implementation of the NSP 2000-2005.

The methods used were a review of documents supplied by lead agencies implementing the NSP and secondary data analysis. These initial findings were presented to government and civil society for validation. Stakeholders were afforded an opportunity to provide additional information. About two hundred people represented a wide range of different government departments and organisations across various sectors in these workshops in August and September 2006. There were representatives of fifteen different government departments, organisations representing PLWH, faith-based organisations (FBOs), non-governmental organisations (NGOs), community based organisations (CBOs) traditional healers, legal and human rights organisations, organisations representing people with special needs, youth organisations, organised labour, business, the hospitality industry, organised sport and academic institutions.

The first draft of the NSP 2007-2011 was presented at a consultation with all sectors on the 20th October 2006. Inputs from this consultation were incorporated and a second draft was circulated to all stakeholders for further comments. Civil society structures also had an opportunity to consult among themselves at a congress held on 27 and 28

October 2006. Some of the resolutions of this congress were considered. The draft NSP was then presented to SANAC on 31 October 2006. Further consultations with NGOs, PLWHA, women's groups, the youth troika, labour, and the children's sector yielded additional inputs, which were considered. Inputs from other government departments, expert clinicians, researchers and professional organisations were also included.

The DOH and the National Health Council (NHC) interrogated and endorsed the final draft, which was then presented to the civil society section of SANAC on 20 November 2006, where it was decided that more work to enhance the document was to be done by a task team of experts. A national expert task team was appointed (Annexure A) and the team presented the final draft to a national consultation on the 14-15 March 2007 for endorsement. The NSP 2007-2011 was then adopted by SANAC as the document expressing the national commitment and approach to HIV & AIDS and STIs.

7. PURPOSE OF THE STRATEGIC PLAN 2007-2011

The National Strategic Plan 2007-2011 is designed to guide South Africa's response to HIV & AIDS & STIs control in the next five years. This strategy document draws on lessons learned in responding to HIV and AIDS in the last decade. The NSP builds on existing strengths and successes, considers the policy and legal environment, developments in scientific evidence, international practices, estimated need and current coverage rates demonstrable capacities, projects potential achievements by 2011, is informed by resources available, and looks at innovative ways to address areas of weakness, and sets ambitious targets to meet the broad aims the national response to HIV and AIDS and STIs. Linked to this plan is a Framework for Monitoring and Evaluation.

Practically speaking, the new NSP seeks to strengthen and improve the efficiency of existing services and infrastructure and introduce additional interventions based on recent advances in knowledge.

Whilst the two main goals of the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa are to provide comprehensive care and treatment for people living with HIV and AIDS as well as to facilitate the

strengthening of the national health system, the NSP 2007-2011 is not a plan for the health sector alone. Instead, it seeks to be relevant to all agencies working on HIV and AIDS in South Africa, within and outside the government. The underlying basic premise is the recognition that no single sector, ministry, department or organisation can by itself be held responsible for the control of HIV and AIDS.

It is envisaged that all government departments and sectors of civil society will use this document as a basis to develop their own HIV and AIDS strategic and operational plans to achieve a focussed, coherent, country-wide approach to fighting HIV and AIDS. It will be used as a basis for engagement with national and international partners on matter that pertain to HIV and AIDS. Where there are policy gaps, these will be addressed and financial and other resources will be mobilised accordingly. This alignment and harmonisation of efforts will also enable consistent and effective monitoring and evaluation of the national response to HIV and AIDS, which will enable further revision and improvement of interventions.

8. GUIDING PRINCIPLES

The principles guiding the implementation of the NSP 2007-2011 confirm those articulated in the Constitution, the NACOSA Plan, the Department of Health *White Paper for the Transformation of the Health System in South Africa, 1997*, the Comprehensive Plan, and Batho Pele. These Principles are summarised below:

- **Supportive Leadership:** The NSP should be driven by South Africa's political leadership with the support of leaders from all sectors.
- **Effective Communication:** Clear and ongoing communication is an essential tool for the attainment of the aims of the plan.
- **Effective Partnerships:** All sectors of government and all stakeholders of civil society shall be involved in the fight against HIV and AIDS.
- **Promoting social change and cohesion:** The national movement on moral regeneration and values promotion shall be enhanced to support sustainable behavioural change.

- **Tackling Inequality and poverty**: the NSP affirms government's constitutional duty to take reasonable legislative and other measures to ensure progressive realisation of rights to education, health care services and social security to all people of South

Africa. HIV and AIDS interventions will be implemented in a way that complements and strengthens other developmental programmes.

- **Promoting Equality for Women and girls**: The NSP recognises the particularly vulnerable position of women and girls to HIV, AIDS and its social impact. It commits to prioritising interventions focussing on the causes of gender inequality, and the horrific impact that HIV has on many women and girls.
- **Protecting and Respecting Children:** The impact of HIV on the rights of children is enormous. Respect for the best interests of the child dictates that children's rights and needs must be at the forefront of all interventions for HIV prevention, treatment and support.
- **Recognising Diversity:** The NSP recognises the special needs and diversity of disability rights as human rights and recognises disability as a social and developmental issue.
- **Ensuring Equality and non-discrimination:** The NSP is committed to challenging discrimination against groups of people who are marginalised, including people with disabilities, orphans, refugees, asylum seekers, foreign migrants, sex workers, men-who-have-sex-with-men, intravenous drug users, and older persons. All these groups have a right to equal access to interventions for HIV prevention, treatment and support.
  - **Personal Responsibility:** Every person in South Africa has a responsibility to protect themselves and others from HIV infection and to know their HIV status and seek appropriate care and support,
  - **Building Community Leadership:** Programmes shall be informed and owned by communities and their leaders.
  - **Using scientific evidence:** The interventions outlined in the NSP shall, wherever possible, be evidence-based.
  - **Strengthening care systems:** Strengthening of health and social systems, and organisational capacity of NGOs, FBOs and CBOs, is central to effective implementation.
  - **Accessibility:** All essential commodities including prevention technologies, medicines, diagnostics tools, nutritional and food supplements, shall be made affordable and accessible.
  - **Monitoring Progress**: All interventions shall be subject to monitoring and evaluation.

- **Financial sustainability:** No credible, evidence-based, costed HIV and AIDS and STI sector plan should go unfunded. There should be predictable and sustainable financial resources for the implementation of all interventions. Additional resources from donor agencies shall be harmonised to align with policies, priorities and to fund programme and financial gaps

9. GOALS OF THE NSP 2007-2011

The primary aims of the NSP are to:

- reduce the number of new HIV infections by 50%.
- reduce the impact of HIV and AIDS on individuals, families, communities and society. by expanding access to appropriate treatment, care and support to 80% of all people diagnosed with HIV

In particular young people in the age group 15-24 should be a focus of all the interventions, especially for behaviour change based prevention.

The interventions that are needed to reach the aims of the NSP are structured according to the following four key priority areas:

- Prevention;
- Treatment, care and support;
- Human and legal rights; and
- Monitoring, research and surveillance.

The section that follows focuses in more detail on the interventions that will be pursued in the next 5 years. However it needs to be understood that these priority areas are a continuum in the response to HIV and AIDS.

PRIORITY AREA 1: PREVENTION

The target is to reduce the national HIV incidence rate by 50% by 2011. Identifying and keeping HIV negative people negative is the most effective and sustainable intervention in the AIDS response.

(The unavailability of incidence measures is a cause for uncertainty regarding the reliability of monitoring targets in this regard. Monitoring incidence will be informed by modeling work for quite some time in the NSP period.)

It is thought that as much as 85% of the South African HIV epidemic is caused by heterosexual spread. Vertical transmission from mother to child and less frequently , transmission associated with blood products account for the rest of the infections. The HIV epidemic is complex and diverse that although not fully understood, is known to be driven by many behavioural, social, and biological factors that both exacerbate and/or facilitate the spread of HIV. It is unlikely that the society will be able to keep up with the demand for health and social services unless there is a significant slowing down in the incidence of newly infected individuals. This situation underscores the central role and importance of HIV prevention.

Goal 1: Reduce vulnerability to HIV infection and the impact of AIDS
Goal 2: Reduce sexual transmission of HIV
Goal 3: Reduce mother-to-child transmission of HIV
Goal 4: Minimise the risk of HIV transmission through blood and blood products

PRIORITY AREA 2: TREATMENT, CARE AND SUPPORT

The target is to provide an appropriate package of treatment, care and support services to 80% of HIV positive people and their families by 2011 in order to reduce morbidity and mortality as well as other impacts of HIV and AIDS.

Key to meeting these targets are:

- Establishing a national culture in which all people in South Africa regularly seek voluntary testing and counselling for HIV. This will necessitate a paradigm shift in health care provision where HIV testing is routinely offered to people attending health services, as well as the identification of new strategies for the provision of counselling and testing outside of health facilities.
- Strengthening the health system so as to create the conditions for universal access to a comprehensive package of treatment for HIV, including antiretroviral therapy, and the integration of HIV and tuberculosis care. The complexity of maintaining more than one million people on antiretroviral therapy at high levels of adherence will emerge as a key medium term challenge and will require systems and resources. This underscores the

critical need to ensure that investments in treatment build the capacity of the health system more generally and also contribute to strengthening prevention.

- Draw on and disseminate the growing body of experience and innovation in care, treatment and support strategies across the country, in both public and private sectors.
- Focus on specific issues and groups: the prevention-of-mother-to-child transmission, the care of children and HIV infected pregnant women, and wellness management of people before they become eligible for ART.
- Ensure the effective implementation of policies and strategies to mitigate the impacts of HIV, in particular orphans and vulnerable children, youth headed households, and on the health and educational system as well as support to older people.

The goals for treatment, care and support are structured principally around these key challenges as follows:

Goal 5: Increase coverage of voluntary counselling and testing and promote regular HIV testing

Goal 6: Enable people living with HIV to lead healthy and productive lives

Goal 7: Address the special needs of women and children

Goal 8: Mitigate impacts of HIV and AIDS and create an enabling social environment for care, treatment and support

PRIORITY AREA 3: RESEARCH, MONITORING AND SURVEILLANCE

Goal 9: Implement the monitoring and evaluation framework of the NSP

Goal 10: Support the development of prevention technologies

Goal 11: Support AIDS vaccine development

Goal 12: Conduct operational research

Goal 13: Conduct policy research

Goal 14: Conduct regular surveillance

PRIORITY AREA 4: HUMAN RIGHTS, ACCESS TO JUSTICE AND LAW REFORM

HIV and AIDS is a human rights issue. A major objective of the NSP is to create a social environment that encourages many more people to test voluntarily for HIV and, when necessary, to seek and receive medical treatment and social support. Respect for and the promotion of human rights must be integral to all the priority interventions of the NSP. But in addition, active and ongoing campaigns that promote, protect, enforce and monitor

human rights must be linked to every intervention and mounted at district, provincial and national level. The NSP identifies a range of activities to improve access to justice, in order that people can challenge human rights violations immediately and directly. It sets out issues for law reform in order to create a legal framework that uniformly assists HIV prevention, treatment, research and surveillance.

GOAL 15: Ensure knowledge of and adherence to the existing legal and policy frameworks

GOAL 16: Mobilise society and build leadership of people living with HIV to protect and promote human rights

GOAL 17: Identify and remove legal, policy, and cultural barriers to effective HIV prevention, treatment and support

GOAL 18: Mobilise society to respect and protect human rights of women and girls, including those with disabilities, to eradicate gender-based violence and advance equality in sexual relationshipPRIORITY AREAS FOR STRATEGIC PLAN 2007-2011

PRIORITY AREA 1: PREVENTION: 50% reduction in HIV incidence rate by 2011

GOAL 1: REDUCE VULNERABILITY TO HIV INFECTION AND THE IMPACT OF AIDS							
Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
Accelerate poverty reduction strategies and strengthen safety nets to mitigate the impact of poverty	Scale up government poverty alleviation programmes	30%	40%	60%	80%	90%	DSD; DTI; Business; ETC; Presidency
	Monitor poverty reduction and report on MDG target one	annual	Annual	annual	Annual	Annual	DSD; DTI; Private sector; Presidency; NPA
	Advocate for the equitable provision of basic social services such as water, sanitation, roads, transport, health services, education especially in rural and urban informal settlements	quarterly campaigns	quarterly campaigns	quarterly campaigns	quarterly campaigns		DSD; DTI; DPLG; SALGA; Business; Spatial development programmes

Accelerate programmes to empower women and educate men and women on women rights and human rights	Implement all national policies and legislation aimed at improving the status of women	annual monitoring					
	Develop and implement a communication strategy to educate men and women on women's rights and human rights	develop and implement	quarterly campaigns	quarterly campaigns	quarterly campaigns	quarterly campaigns	
Create an enabling environment for HIV testing	Develop high profile campaigns utlising well-known figures to promote HIV testing and disclosure	develop and implement	monthly	monthly	monthly	monthly	
Support national efforts to strengthen social cohesion in communities and to support the institution of the family	Support progammes that aim to develop HIV and AIDS knowledgeable and competent communities and families	develop and implement	30%	50%	70%	90%	

GOAL 2: Reduce sexual transmission of HIV							
Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
Develop behavior change curricula for the prevention of sexual transmission of HIV, adapted to different target groups	Develop curricula for the sexual prevention of HIV which include: safer sex counselling including information about different sexual practices, decrease partner number, Gender, gender based violence, concurrency, intergenerational sex, male and female condom use, STI recognition and treatment, VCT, contraception, pregnancy testing, appropriate referral	Guidelines and curricula developed	Implement	Implement	Implement	Implement	DoH, DoE, Academics, NGOs
	Adapt curricula for different target groups including: Young people out of school, primary school children, secondary school children, higher education institutions, pregnant women, older men and women, higher risk groups (see below)						

Implement interventions targeted at reducing HIV infection in young people, focusing on young women	Review policies that might impact on high rates of teenage pregnancy and related school dropout, and HIV, among schoolchildren.	Review and formulate new policies and guidelines	Implement	Implement	Implement	Implement	DoH, DoE, NGOs
	Reduce the % of teenage pregnancies	Reduce by 10%	Reduce by 20%	Reduce by 30%	Reduce by 40%	Reduce by 50%	
	Utilising revised curricula, strengthen life skills education in all primary and secondary schools, and improve training of teachers to implement the curricula	70% institutions	80%	90%	100%	100%	DoH, DoE, NGOs
	Evaluate, revise and implement parenting programmes that promote positive engagement and communication with children.	Review and formulate new policies and guidelines	Implement	Implement	Implement	Implement	DoH, DoE, NGOs (including loveLife, Soul City, Khomanani), religious institutions

	Strengthen HIV prevention programmes including VCT and STI and contraceptive services in higher education institutions	100%	100%	100%	100%	100%	HEAIDS, Higher education institutions, DoE
	Increase targeted behaviour change programmes for out of school youth in different setting e.g. rural areas, periurban areas, and farms.	20% of districts	50% of districts	70% of districts	85% of districts	100% of districts	DoE, DoH, DoSD, NGOs, Religious institutions
	Increase and coordinate multi-media strategies aimed at youth that enhance knowledge around HIV, Gender sensitivity and that promote communication about HIV and sexuality	quarterly campaigns	quarterly campaigns	quarterly campaigns	quarterly campaigns	quarterly campaigns	Youth programmes argeting youth (loveLife, Soul City, Khomanani)
	Increase access to youth friendly health services in the public sector– including STI management, VCT and rapid HIV testing facilities, contraception, TOP referral, mental health, reducing substance use, IEC, peer support	20% of districts	50% of districts	70% of districts	85% of districts	100% of districts	DoH, NGOs

Scale-up positive prevention interventions in HIV infected persons	Develop a comprehensive programme for wellness and HIV prevention for people living with HIV, including discordant couples	Develop and implement	70	80%	90%	90%	DoH, PWA sector and NGOs
	Integrate HIV wellness and prevention services for people living with HIV into treatment and care services, including palliative and home-based care	40%	60%	80%	90%	90%	DoH, PWA sector, NGOs
	Enhance and support wellness and positive prevention services offered by NGOs, CBOs and community support groups	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	DoH, PWA sector, NGOs
Increase roll out of prevention programmes for higher risk populations	Incremental roll-out of comprehensive customised prevention package to higher risk occupational groups including uniformed services, mining industry, long distance transport services, agriculture industry and the hospitality industry, including access to VCT and provision of male and female condoms, STI symptom recognition and STI services	50% of services	60% of services	70% of services	80% of services	100% of services	Relevant employee institutions, DoH, DoL

	Incremental roll-out of comprehensive customised prevention package in prisons, including access to VCT and access to male condoms, lubricantsSTI symptom recognition and access to PEP and STI treatment	50% of services	80% of services	90% of services	100% of services	100% of services	DoCS, NGOs,DoH
	Incremental roll-out of comprehensive customised prevention package for MSM and transsexuals including promotion of VCT and access to male and female condoms, and STI symptom recognition	50% of services	60% of services	70% of services	80% of services	100% of services	DoH, NGOs
	Incremental roll-out of comprehensive customised prevention package for sex workers and their clients, including promotion of VCT and access to male and female condoms, STI symptom recognition	50% of services	80% of services	90% of services	100% of services	100% of services	DoH, DoSD, DoL, NGOs
Increase roll out of workplace prevention programmes	Incremental roll-out of comprehensive prevention package in workplaces, includingaccess to VCT, and provision of male and female condoms	40%	60%	80%	90%	100%	DoCS, NGOs,DoH

Develop a package of reproductive health and HIV prevention for integration into family planning, ANC, STI, TB, ARV services	Integrate reproductive health services into HIV prevention activities and vice versa in public sector	30% of services	40% of services	60% of services	80% of services	100% of services	DoH
	Increase access to male and female condoms through distribution in formal and informal outlets including the hospitality and entertainment venues	30%	50%	60%	80%	90%	DoH, NGO, organisations representing private sector practitioners, medical aids
	Increase access to quality STI services in the public and private sector in which updated yndromic management guidelines are utilised	40%	60%	80%	100%	100%	DoH, NGO, organisations representing private sector practitioners, medical aids

Develop a comprehensive package that promotes male sexual health and which addresses gender and gender based violence	Identify, evaluate and roll out effective gender sensitive male intervention programmes in the workplace and in communities	Evaluate and increase coverage	implement	implement	implement	Implement	NGOs, Mens sector
	Development of policy and guidelines for safe male circumcision as part of a comprehensive HIV prevention package, addressing formal and traditional sector	Develop and implement	implement	implement	implement	Implement	NGOs, Mens sector
Introduce programmes to mitigate the impact of alcohol and substance use	Introduce a comprehensive package of HIV prevention services in beerhalls, brothels, clubs, traditional ceremonies, and shebeens	Develop and Implement	40%	60% of facilities	80% of facilities	90% of facilities	NGOs, Mens sector, the alcohol industry, traditional leaders
	Campaigns that promote responsible alcohol consumption	quarterly campaigns	quarterly campaigns	quarterly campaigns	quarterly campaigns	quarterly campaigns	NGOs,mens sector, the alcohol industry, traditional leaders

Introduce programmes and strategies to address stereotype gender identities that contribute to gender based violence	Develop and implement evidence based programmes including a communication strategy that provides clear messages on the non-acceptability of coercive sex, addresses gender stereotypes and addresses the stigmatisation of rape survivors	Programmes evaluated and implemented	quarterly campaigns	quarterly campaigns	quarterly campaigns	quarterly campaigns	NGOs, DoSD, academics
	Private sector and government support to roll-out integrated microfinance and gender education interventions starting in the poorest areas	Develop and implement at least 1 per province	4 per province	8 per province	16 per province	32 per province	NGOs, DoSD, academics
Increase the accessibility and availability of comprehensive sexual assault care including PEP and psychosocial support	Increase the proportion of facilities offering the comprehensive package of sexual assault care in accordance with the National Policy on Sexual Assault Care of NDOH	40%	60%	80%	100%	100%	DoH
	Increase the proportion of facilities providing post-sexual assault care that offer PEP to all survivors testing HIV negative	30%	50%	60%	70%	90%	DoH
	Increase the number of districts with accessible social and mental health services able to support child and adult victims of gender-based violence	20%	40%	60%	80%	100%	DoH, DoSD, NGOs

GOAL 3: Reduce mother-to-child transmission of HIV

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
Expansion of existing mother to child transmission services to include: Contraception Fertility services, reducing unwanted pregnancies and involving men, HIV prevention services in uninfected pregnant women	Implement programmes to reduce the percentage of all unwanted pregnancies through scaling up contraceptive services in public sector facilities increasing access to TOP services in public sector facilities and develop policy on medical abortion	20% increase	40%	60%	80%	90%	DoH
	Expand PMTCT guidelines to include fertility guidelines for HIV infected women and discordant couples	Develop and implement guidelines	Annual	Annual	Annual	Annual	DoH, Academics
	Implement HIV prevention programmes for uninfected pregnant women	20% increase in public	40%	60%	80%	90%	DoH, NGOs

		sector ANC services					
	Implement responsible fatherhood programmes in health districts and in the community	Evaluate and develop progammes	Introduce into 20% health districts	40%	60%	80%	NGOs, DoH, DoL
	Expand PMTCT guidelines to include postnatal services and services for mothers and infants beyond six weeks	Develop and implement guidelines	Annual	Annual	Annual	Annual	DoH, academics
Scale up coverage of PMTCT to reduce MTCT to less than 5%	Increase the proportion of public sector antenatal services providing PMTCT	85%	95%	100%	100%	100%	DoH
	Review of guidelines for PMTCT and treatment of pregnant women to ensure optimal prophylaxis regimen and interventions	Annual	Annual	Annual	Annual	Annual	DoH, academics
	Increase proportion of pregnant women tested through implementation of routine provider-initiated VCT for all pregnant women	70%	85%	90%	95%	95%	DoH
	Develop a policy and guidelines about VCT in pregnancy including consideration of provider initiated testing, and frequency of testing	Develop and implement	Annual review	Annual review	Annual review	Annual review	DoH
	Increase the proportion of the estimated population of HIV-infected	6O%	7O%	80%	90%	95%	DoH, NGOs, DoE

	pregnant women in need who receive PMTCT prophylaxis						
	Increase the proportion of facilities that meet quality standards for infant feeding counselling	60%	75%	85%	90%	95%	DoH

	Implement community based strategies to support HIV positive women during and after pregnancy	10% (sub-districts)	30%	50%	70%	80%	DoH, NGOs, DoSD
	Provide nutritional support to HIV-infected women choosing to exclusively breast feed	5%	10%	30%	40%	40%	DoH, DoSD, NGOs
	Provide formula milk to children of HIV positive women choosing not to breast feed	50%	45%	45%	42%	40%	DoH

GOAL 4: Minimise the risk of HIV transmission through blood and blood products							
Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
Minimise the risk of HIV transmission from occupational exposure in health care providers in the formal, informal and	Continuously update guidelines for infection control procedures	Annual	Annual	Annual	Annual	Annual	DoH, academics

traditional settings through the use of infection control procedures							
	Enforce the implementation of infection control in all formal health care facilities	80%	100%	100%	100%	100%	DoH
	Promote the implementation of infection control in informal settings	Develop and disseminate promotional strategy and materials	Annual	Annual	Annual	Annual	DoH, NGOs
	Provide training for all HCWs on infection control	70%	80%	90%	100%	100%	DoH, traditional health care sector
	Ensure continuous supplies of PEP drugs in public and private sector facilities	80%	90%	100%	100%	100%	DoH, private health care sector
	Ensure availability of barrier nursing supplies, equipment and biohazard disposal systems at all formal health care facilities	80%	90%	100%	100%	100%	DoH, private health care sector
	Ensure rapid and easy access to post occupational exposure services, including testing and PEP, and ongoing support during and after treatment, for all health care workers	80%	90%	100%	100%	100%	DoH, private health care sector

	Ensure all formal health care facilities maintain a register of occupational exposure	100%	100%	100%	100%	100%	DoH, private health care sector
Minimise Exposure to infected blood through procedures associated with traditional and complementary practices	Continuously update Guidelines for infection control	Annual	Annual	Annual	Annual	Annual	DoH, academics
	Provide adequate training of traditional healers/practitioners on universal precautions	30%	50%	70%	80%	100%	Traditional practitioners organisations
	Provide information to public raising awareness of HIV risk through unsafe traditional practices	70%	90%	100%	100%	100%	DoH, NGOs
	Provision of supplies to practice safe traditional practices	30%	50%	70%	80%	100%	Traditional practitioners organisations
	Develop and continuously update guidelines on minimising HIV risk in injecting drug use	Develop and implement guidelines	Annual	Annual	Annual	Annual	DoH, NGOs

Investigate the extent of HIV risk from Intra venous drug use (IDUs) and develop policy to minimise risk of HIV transmission through injecting drug use	Research the extent of IDU use and the relationship with HIV infection	20%	60%	80%	100%	100%	DoH, Academic organisations
	Develop policy for HIV prevention in IDUs and review annually	Policy developed and introduced	Annual review	Annual review	Annual review	Annual review	DoH, DoSD, DoSS, NGOs

Ensure safe supplies of blood and blood products (HIV screening tests for measuring both virus and antibodies)	Continuously update guidelines for ensuring safe blood and blood supplies	Annual	Annual	Annual	Annual	Annual	DoH, Blood Bank, academics
	Screening of all blood supplies with best available technology including viral detection	100%	100%	100%	100%	100%	DoH, Blood Bank, academics
	Awareness of risk of HIV transmission in donors and recipients	100%	100%	100%	100%	100%	DoH, Blood Bank, academics

PRIORITY AREA 2: Treatment, Care and Support

The target is to provide an appropriate package of treatment, care and support services to 80% of HIV positive adults and children as well as their families by 2011 in order to reduce morbidity and mortality as well as other impacts of HIV and AIDS.

GOAL 6: INCREASE COVERAGE OF VOLUNTARY COUNSELLING AND TESTING AND PROMOTE REGULAR HIV TESTING

Objective	Intervention	5 year target					Lead Agencies
		2007	2008	2009	2010	2011	
6.1 Increase access to VCT services that recognise diversity of needs	Implement provider-initiated VCT in all health settings, with a special focus on STI, TB, antenatal, familiy planning and general curative services	50% of all health facilities in country (public, private, NGO, FBO)	60% of all health facilities in country (public, private, NGO, FBO)	70% of all health facilities in country (public, private, NGO, FBO)	80% of all health facilities in country (public, private, NGO, FBO)	80% of all health facilities in country (public, private, NGO, FBO)	DOH, All sectors
	Develop standards and career pathways for counsellors as mid-level workers according to the National Qualifications Framework	Draft Policy developed	Final Policy ratified and approved by relevant decision making bodies	20% of VCT counsellors received accredited training	50% of VCT counsellors received accredited training	80% of VCT counsellors received accredited training	DOH, DSD, DPW, JIPSA SETA
	Increase the number of adults who have ever had an HIV test, with a focus on men	25%	35%	50%	60%	70%	DOH, Youth sector & other All sectors
6.2 Increase uptake of VCT	Increase the proportion of adults tested in the last 12	6%	11%	18%	22%	24%	DOH, Youth sector &

	months						other All sectors
	Increase the proportion of newly diagnosed HIV positive adults accessing wellness services	20%	35%	50%	65%	75%	DOH,DPLG, communities, All sectors

GOAL 7: ENABLE PEOPLE LIVING WITH HIV TO LEAD HEALTHY AND PRODUCTIVE LIVES

Objective	Intervention	5 year target					Lead Agencies
		2007	2008	2009	2010	2011	
7.1 Scale up coverage of the comprehensive care and treatment package	Review and update clinical and programmatic guidelines for the management of HIV and AIDS	Annually	Annually	Annually	Annually	Annually	DOH, communities, NGOs, All sectors
	Improve enrolment in and quality of positive living interventions through wellness programmes	**30% eligible clients enrolled in wellness porgrammes**	40%	50%	60%	75%	
	Increase the proportion of adults started on ART who are still on ART after completing one year treatment	85%	85%	85%	85%	85%	
	Increase the number of adults starting ART	120,000 (24% new AIDS cases)	180,000 (35%)	285,000 (55%)	370,000 (70%)	420,000 (80%)	
	Increase the proportion of adults started on ART outside hospital setting	30%	40%	50%	60%	70%	
	Increase the proportion of adults started on ART by nurses	10%	20%	40%	50%	60%	
7.2 Increase retention of children and adults on ART	Increase proportion of adults on ART monitored by nurses	20%	40%	50%	60%	70%	

	Maintain the percentage of people on ART with undetectable viral loads after completing one year of treatment	80%	80%	80%	80%	80%	

Objective	**Intervention**	**5 year target**					**Lead Agencies**
		2007	**2008**	**2009**	**2010**	**2011**	
	Actively trace people on ART who are more than a month late for a clinic/pharmacy appointment	60% of defaulters	70% of defaulters	80% of defaulters	85% of defaulters	85% of defaulters	DOH; communities, NGOs, All sectors
	Implement facility and community based adherence support strategies and programmes	100% sub-districts	100% sub-districts	100% sub-districts	100% sub-districts	100% sub-districts	
	Ensure effective linkage and successful referral between ART facilities and social welfare services	30% of facilities	40% of facilities	60% of facilities	80% of facilities	90% facilities	

7.3 Ensure effective management of TB / HIV co-infection	Screen adult TB patients for HIV and HIV positive adults for TB	40%	60%	80%	90%	90%	DOH; communities, private sector; NGOs; CBOs
	Improve CD4 monitoring of TB/HIV co-infected patients	25%	60%	75%	90%	100%	
	Increase percentage of TB/HIV co-infected adults receiving cotrimoxazole	10%	15%	25%	35%	40%	
	Increase the proportion of eligible clients started on INH prophylaxis	10%	15%	25%	35%	40%	

7.4 Improve quality of life for children and adults with HIV and AIDS requiring terminal care	Provide a comprehensive package of a palliative care to eligible children and adults	200,000	250,000	250,000	250,000	225,000	DOH; DSD; private sector; communities NGOs; CBOs
7.5 Strengthen the health system and remove barriers to access	Build the capacity of health workers to provide comprehensive care, treatment and support	45% of PHC staff	55%	70%	80%	90%	DOH; other departments; private sector; NGOs; CBOs
	Improve drug supply management to decrease the number of facilities experiencing drug stock-outs	<5%	<2%	0%	0%	0%	DOH, private sector
	Increase the proportion of facilities with acceptable turn around times for essential laboratory tests	70% of facilities	80% of facilities	90% of facilities	100% of facilities	100% of facilities	DOH, NHLS

GOAL 8: ADDRESS THE SPECIAL NEEDS OF WOMEN AND CHILDREN

Objective	Intervention	5 year target					Lead Agencies
		2007	2008	2009	2010	2011	
8.1 Decrease HIV and AIDS related maternal mortality through women-specific programmes	Implement community-based strategies to support HIV positive women during and after pregnancy	10% of sub-districts	**30%**	**50%**	**70%**	**80%**	DOH, DSD, NHLS, communities
	Provide nutritional support to HIV positive women choosing to exclusively breast feed	5%	**25%**	**40%**	**50%**	**70%**	
	Increase the proportion of HIV positive pregnant women receiving a CD4 count test prior to 28 weeks	50%	**65%**	**70%**	**80%**	**90%**	
	Increase the number of HIV positive pregnant women starting a comprehensive package of AIDS care including ART	18 408	**29 033**	**58 212**	**91 671**	**110 598**	
	Implement provider-initiated testing of children of HIV positive adults accessing services	30% of facilities	**50% of facilities**	**80% of facilities**	**90% of facilities**	**95% of facilities**	

	Implement integrated contraceptive, cervical screening and fertility services for non pregnant women in treatment and care services	30%	50%	75%	90%	100%	DoH

8.2 Provide an appropriate package of services that includes wellness, OI management, ART and nutrition to children and adolescents who are HIV positive and/or exposed	Implement provider-initiated VCT for children attending TB services	10%	**20%**	**40%**	**50%**	**65%**	
	Implement CD4 count testing for HIV positive children attending TB services	5%	**10%**	**30%**	**60%**	**80%**	
	Review clinical guidelines for the management of infants, children and adolescents with HIV and AIDS	Annually	**Annually**	**Annually**	**Annually**	**Annually**	
	Increase the proportion of children with growth faltering identified and referred for appropriate management	50%	65%	80%	90%	90%	
	Provide food support to children exposed to and/or are HIV positive	30 000	45 000	65 000	100 000	150 000	
	f) Ensure food security to eligible HIV positive adults and children						

	Increase the proportion of HIV positive and exposed children	60%	**75%**	**80%**	**85%**	**90%**	

	receiving cotrimoxazole						
	Increase the number of children starting ART	17 000	**27 000**	**33 000**	**42 000**	**45 000**	
	Increase the proportion of children started on ART who are still on ART after completing one year of treatment	85%	**85%**	**85%**	**85%**	**85%**	
	Increase the proportion of children starting ART in non-hospital based settings	20%	**25%**	**35%**	**40%**	**45%**	
	Provide psychosocial support for children and adolescents including counselling for bereavement, disclosure, adherence and aspirations	10% of sub-districts	20% of sub-districts	60% of sub-districts	80% of sub-districts	100 of sub-districts	

GOAL 9: MITIGATE THE IMPACT OF HIV AND AIDS AND CREATE AN ENABLING SOCIAL ENVIRONMENT FOR CARE, TREATMENT AND SUPPORT

Objective	Intervention	5 year target					Lead Agencies
		2007	2008	2009	2010	2011	
9.1 Strengthen the implementation of OVC policy and programmes	Develop and operationalise mechanisms to identify, track and link OVC and child-headed households to services	Develop concensus of need and set targets	**Targets to be set in 2007**	**Targets to be set in 2007**	**Targets to be set in 2007**	**Targets to be set in 2007**	DSD, DOE communities, NGOs, CBOs
	Increase the proportion of vulnerable children accessing child support grants	55%	**65%**	**80%**	**90%**	**90%**	DSD, DHA, DOE communities, NGOs, CBOs
	Review and implement policy guidelines defining core services for OVC to inform service delivery (exemption from school and health service fees, child support grants, birth registration)	Guidelines reviewed and implemented in 20% of districts	40% of districts	60% of districts	80% of districts	100% of districts	DSD, DOE, NGOs
	Increase the proportion of children obtaining vital documents such as birth and death registration	Design and conduct survey to establish baseline and set targets	Targets to be set in 2007	Targets to be set in 2007	Targets to be set in 2007	Targets to be set in 2007	DSD, DHA, NGOs, communities
	Increase the proportion of not-for-profit registered civil societies supporting OVC receiving organisational, programme support and mentoring services	20%	30%	40%	45%	45%	DSD, NGOs, communities

	Increase the proportion of child-headed households receiving social grants and the services of a caregiver	Design and conduct survey to establish baseline and set targets	Targets to be set in 2007	Targets to be set in 2007	Targets to be set in 2007	Targets to be set in 2007	DSD, NGOs, communities

9.2 Expand and Implement CHBC as part of the EPWP							DOH; DOPW; NGOs
	Recruit and train new community care givers, with emphasis on men	10 000 (10% men)	15 000 (10% men)	20 000 (15% men)	25 000 (20% men)	25 000 (20% men)	
	All community caregivers to receive nationally determined stipends	23 394	30 000	45 000	60 000	75 000	
	Develop standards and career pathways for community care givers as mid-level workers according to the National Qualifications Framework	Draft policy developed	20% community caregivers received accredited training	40% community caregivers received accredited training	60% community caregivers received accredited training	80% community caregivers received accredited training	

Objective	Interventions	5 year Target					Lead Agencies
		2007	2008	2009	2010	2011	
9.3 Strengthen the implementation of policies and services for older people affected by HIV and AIDS	Promote older persons related policies to create awareness about the impact of HIV and AIDS to older persons	High levels of awareness about policies that guide services to older persons					Intersectoral, including Council for the Care of the Aged led by the DSD
	Promote integration and equitable representation of older persons in HCBC programmes		Older persons constitute 20% of people working on HCBC				DSD, NGOs, communities

9.4 Mainstream the provision of appropriate care and support services to HIV positive to HIV positive people with disabilities and their families	Promote integration and equitable representation of people with disabilities in care, treatment and support programmes						DSD, All sectors
	Develop and render targeted care and support programmes for people with disabilities				90% district coverage for programmes and number of people with disability who have been catered for by the targeted programmes		DSD, Disability sector, All sectors

Objective	**Intervention**	**5 year Target**					**Lead Agencies**
		2007	**2008**	**2009**	**2010**	**2011**	
9.5 Mainstream the provision of appropriate care and support services to HIV positive people with disabilities and their families	a) Promote integration and equitable representation of people with disabilities in care, treatment and support programmes.						Intersectoral, lead by the department of social development.
	b) Develop and render targeted care and support programmes for people with disability.				90% district coverage for programmes and number of people with disability who have been catered for by the targeted programmes		Intersectoral + people with disability organizations lead by the Department of Social Development

PRIORITY AREA 3: RESEARCH, MONITORING AND SURVEILLANCE

GOAL 10: DEVELOP AND IMPLEMENT A MONITORING AND EVALUTION FRAMEWORK FOR PROCESS AND OUTCOME INDICATORS

Objective	Intervention	5 year target					Lead Agencies
		2007	2008	2009	2010	2011	
10.1 Establish and implement a functional M&E system	Develop and implement a functional M&E framework	March 2007	Annual report	Annual report	Annual report	Annual report	Government Departments and Research Institutions

GOAL 11: SUPPORT THE DEVELOPMENT OF MICROBICIDES AND OTHER PREVENTION TECHNOLOGIES

Objective	Intervention	5 year target					Lead Agencies
		2007	2008	2009	2010	2011	
11.1 Support and monitor efforts to develop effective microbicide products in South Africa	Review reports on progress with research	Annually					Government Departments and Research Institutions

GOAL 12: SUPPORT AIDS VACCINE DEVELOPMENT

Objective	Intervention	5 year target					Lead Agencies
		2007	2008	2009	2010	2011	
12.1 Support efforts to develop an appropriate AIDS vaccine	Review reports on progress with research	Annually					Government Departments and Research Institutions

GOAL 13: SUPPORT RESEARCH ON EFFICACY OF MALE CIRCUMCISION AS A PREVENTION TOOL

Objective	Intervention	5 year target					Lead Agencies
		2007	2008	2009	2010	2011	
13.1 Support and monitor research on male circumcision and HIV prevention	Review reports on progress with research	Annually					Government Departments and Research Institutions

GOAL 14: CONDUCT OPERATIONAL RESEARCH

Objective	Intervention	5 year target					Lead Agencies
		2007	2008	2009	2010	2011	
14.1 Conduct research on the cost-effectiveness of other forms of treatment and prophylaxis	a) Review international research b) Facilitate local research	Annually					Government Departments and Research Institutions
14.2 Conduct research in support of the implementation of the comprehensive plan	Identify relevant research questions and support relevant research proposals						Government Departments and Research Institutions
14.3 Conduct research on the effectiveness of traditional medicines	a) Support clinical trials b) Review international research c) Collaborate with traditional healers	Annually					Government Departments and Research Institutions

GOAL 15: CONDUCT POLICY RESEARCH

Objective	Intervention	5 year target					Lead Agencies
		2007	2008	2009	2010	2011	
15.1 Conduct HIV and AIDS studies in selected departments and provinces	a) Facilitate policy review and research in order to keep up with scientific developments		Periodic policy reviews: after every 3 years and as necessary.				Government departments and research institutions

GOAL 16: CONDUCT REGULAR SURVEILLANCE

Objective	Intervention	5 year target					Lead Agencies
		2007	2008	2009	2010	2011	
16.1 Conduct national surveillance on HIV and STI risk behaviours, especially among youth	a) Conduct: ○ behavioural sentinel surveys, with a focus on youth ○ routine clinical and microbiological STI surveillance ○ surveillance of AIDS morbidity and mortality ○ national HIV infections surveillance in selected populations and groups, including STI and TB clients, hospitalised patients, men and youth ○ Conduct 3rd and 4th generation surveillance and impact evaluation						Government Departments and Research Institutions

Objective	Intervention	5 year target					Lead Agencies
		2007	2008	2009	2010	2011	
16.1 Conduct national surveillance on HIV and STI risk behaviours, especially among	a) Conduct: ○ behavioural sentinel surveys, with a focus on youth ○ routine clinical and						Government Departments and Research Institutions

youth	microbiological STI surveillance ○ surveillance of AIDS morbidity and mortality ○ national HIV infections surveillance in selected populations and groups, including STI and TB clients, hospitalised patients, men and youth ○ Conduct 3rd and 4th generation surveillance and impact evaluation						

PRIORITY AREA 4: HUMAN RIGHTS, ACCESS TO JUSTICE AND LAW REFORM

GOAL 15: Ensure knowledge of and adherence to the legal and policy environment

Objective	Intervention	5-year target					Lead Agency
		2007	2008	2009	2010	2011	
Adherence to existing legislation and policy relating to HIV and AIDS	Develop a national framework on HIV and AIDS in the Workplace.	X					NEDLAC, DOH, DOL, all sectors
	Revise the DOL Code of Good Practice on HIV and AIDS and Employment	X					SANAC Business sector
	Assist SMEs to implement workplace policies.	X	X	X	X	X	
	Ensure protection of rights of casual, contract and/or poorly organised (such as domestic workers).	X	X	X	X	X	Employment Equity Commission
	Ensure protection of rights of employees expressly excluded from the ambit of labour legislation.	X					
	Develop and distribute human rights guidelines and information on: * Voluntary HIV testing and disclosure;	X					DOH Health professions sector

Ensure non-discrimination in access to HIV prevention, treatment and support of marginalised groups	Develop and disseminate information on HIV prevention, treatment and support that responds to the special needs of: • sex workers • children and adults with disabilities • Drug users • Prisoners • MSM, gay and lesbian people • Orphans and vulnerable children (including children in self-care) • Refugees, undocumented migrants and immigrants • Older persons		All by 2008 X X X X X X X X X X				DOH and SANAC sectors

Monitor HIV-related human rights violations and develop enforcement mechanisms for redress	Statutory bodies to introduce and publicise systems to monitor AIDS related human rights violations and the steps taken to address them.		X				DOJ; SAHRC; CGE; Legal Aid Board; Council for Medical Schemes; HPCSA; SANC
	Create a network of legal service providers	X					
	Promote and fulfil the right of access to justice by increasing the availability, affordability and accessibility of legal services.	X	X	X	X	X	
	Train community-based development workers to identify and address HIV and AIDS human rights issues	X	X				
	Facilitate training of the legal profession, including the judiciary, on the human rights-related issues of HIV and AIDS.	X	X	X	X	X	
	Ensure effective, accountable, timeous and transparent consultative reporting to international bodies on commitments including UNGASS, UN Committee on the Rights of the Child and UN on MDG	X	X	X	X	X	

GOAL 16: Mobilise society, and build leadership of people living with HIV, to protect and promote human rights

Objective	Intervention	5-year target[62]					Lead Agencies
		2007	2008	2009	2010	2011	
People living with HIV are organised, empowered and mobilised to protect human rights at national, provincial and district levels	Develop a nationally relevant human rights package setting out key rights and responsibilities for PLWHA, including for children and people with disabilities	By 2007	X	X	X	X	SANAC PWA sector; SANAC Justice sector DPLG
	Establish and offer training programmes to PLWHAs in all districts on HIV treatment and prevention literacy, and on human rights and the law.	X					
	Provide PLWHAs with information regarding access to legal support.						

[62] Unlike with interventions to prevent and treat HIV infection it is difficult to set quantifiable targets for this section of the NSP. Instead a series of dates, bench-marks and 'must dos' are proposed together with ongoing monitoring of human rights violations and the legal and policy environment.

Respect for the rights of PLWHAs in employment, housing, education, insurance and financial services and other sectors.	Launch sectoral and community-based campaigns promoting human rights, openness and acceptance of people living with HIV and AIDS	X	X	X	X	X	SANAC PWA sector; DOH; DOJ; Education department
	Develop plans in all Ministries and Departments that protect the rights of PLWHAs		X				
	Engage with the insurance and financial services industries and their regulators to end unfair exclusions of PLWHA.	X	X				
Greater openness and acceptance of PLWHA	Build capacity and understanding of human rights in key sectors, including: * the religious sector * traditional healers and leaders * the private sector * the media * people with disabilities * the legal sector (including criminal justice), particularly the judiciary and the police	X	X	X	X	X	SANAC; Government departments; NGOs; all sectors; SABC; SAHRC

Goal 17: Identify and remove legal, policy and cultural barriers to effective HIV prevention, treatment and support

Objective	Intervention	2007	2008	2009	2010	2011	Lead agencies
Identify and finalise current relevant legislative and policy processes	Pass and implement the Criminal Laws (Sexual Offences and Related Matters) Amendment Bill Ensure legislation does not contain provisions harmful to HIV prevention efforts	X					Parliament; DoJ&CD
	Prioritise the promulgation of the Children's Act	X					Parliament; DSD; DoH
	Prioritise the promulgation of the Child Justice Bill Finalise, implement and report on National child abuse, neglect and exploitation protocol Harmonise child age and developmental stages and abilities across legislation	X					
	Ensure that the Prevention of and Treatment for Substance Abuse Bill incorporates HIV harm reduction measures and fast-track its enactment and promulgation	X					Parliament; DSD; DoJ&CD

	Finalise regulations dealing with the international benchmarking of medicine prices	X					DoH
	Finalise regulations dealing with the appropriate regulation of traditional and complementary medicines		X				DoH
Identify, amend or repeal discriminatory laws and/or laws that undermine HIV treatment and prevention programmes	Amend the Sexual Offences Act to decriminalise commercial sex work		X				Parliament; DoJ&CD
Identify cultural beliefs and practices that violate human rights and undermine HIV prevention	Facilitate and sustain dialogue with cultural, religious and traditional leaders to encourage understanding, respect and promotion of human rights	X	X	X	X	X	SAHRC; Traditional leaders; religious leaders;
Identify and address gaps in existing anti-discrimination legislation	Amend the Equality Act to ensure non-discrimination in access to financial services, particularly insurance.		X				Parliament; DoJ&CD; treasury
	Amend the Equality Act to include 'HIV Status' as an express ground of non-discrimination.		X				Parliament; DoJ&CD

Goal 18: Focus on the human rights of women and girls, including those with disabilities, and mobilize society to stop gender-based violence and advanced equality in sexual relationships

Objective	Intervention	2007	2008	2009	2010	2011	Lead agencies
Reduce women and girls' vulnerability to HIV infection by reducing poverty amongst women	For rural women: • Improve literacy levels • Develop and implement a skills development strategy • Improve access to human rights education and information. • Implement micro-finance programmes.	X X	X x	X x	X x	X x	DTI, DSD, DoJ&CD, DSS; DoE;DTI
	Address difficulties in obtaining identity documents which limit access to government services.						DHA

Ensure that existing laws and policies that protect women and girls from gender based violence are implemented **Respond adequately to the needs of women in abusive relationships.**	Ensure that the National Sexual Assault and Management Guidelines are implemented.	X X					DoJ&CD DSS
	Cost and provide adequate resources for the implementation of the Domestic Violence Act.						
	Distribute information to women on how to enforce their legal rights.						
	Train the SAPS on their responsibilities in terms of the National Sexual Assault Policy.	X X					All sectors, DoJ&CD DoH
	Train VCT and adherence counsellors to identify barriers that prevent women from accessing HIV prevention, treatment and car services.						

Ensure that laws, policies and customs do not discriminate against women and girls	Ensure that Master's Office service points administer small estates without discriminating against women and girls.	X					DoJ&CD, traditional leaders
	Finalise the Domestic Partnerships Bill to address discrimination against women who cohabit.	X					DHA, Parliament

10. YOUTH AS A TARGET GROUP (15-24 Years)

The United Nations General Assembly Special Session on HIV and AIDS (UNGASS) identified young people aged 15-24 years as a priority group in reducing new HIV infections and *set a global target of reducing incidence of HIV in this group by 20% by 2015*.

As indicated earlier in this document, youth is a specific focus area in the fight against HIV and AIDS as people in the 15–24 age group are the most vulnerable to HIV infection. In addition, the youth is an important target group to protect against future HIV infection, as today's youth is critical to South Africa's present and future economy.

In this section strategy relating to the youth will be restated so as to emphasise the need for all sectors of society to focus significant resources and energies on this age group.

Objective: Promote improved health-seeking behaviour and adoption of safe sex practices.

1. Produce and disseminate IEC material and messages to different stakeholders
2. Implement Life Skills education in all primary and secondary schools

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

1. Develop sector-specific policies and plans for the prevention of HIV and AIDS and STIs, focusing specially on the youth

Objective: Improve access to and use of male and female condoms, especially amongst 15–24 year olds

1. Expand condom distribution through non-traditional outlets
2. Improve access to condoms in high transmission areas (for example, truck stops, borders, mines and brothels)
3. Increase acceptance, attitudes, perceptions, and efficacy and use of condoms as a form of contraception among the youth

Objective: Increase access to youth-friendly reproductive health services including STI management, VCT and rapid HIV testing facilities, and family planning.

1. Make clinics and HCWs youth friendly
2. Make schools places where youth can access friendly and supportive counselling services

Objective: Increase the number of persons seeking VCT services

1. Increase coverage of VCT among adolescents and the youth.

Objective: Develop and implement programmes to support the health and social needs of children affected by HIV and AIDS

1. Promote advocacy around all issues that affect children
2. Mobilise financial and material resources for orphans and child-headed households
3. Investigate the legal protection of child-headed households
4. Provide social welfare, legal and human rights support to protect educational and constitutional rights

Objective: Implement measures to facilitate adoption of AIDS orphans

1. Investigate the use of welfare benefits to assist children and families living with HIV and AIDS
2. Subsidise adoption of AIDS orphans

Objective: Conduct national surveys on HIV and STI risk behaviours, especially among youth

1. Conduct behavioural sentinel surveys, with a focus on youth
2. Conduct national surveys on HIV-infection in selected populations and groups, including youth

11. STRUCTURAL ARRANGEMENTS

The multi-sectoral national response is managed by different structures at different levels. Each government ministry has a focal person and team responsible for planning, budgeting, implementation and monitoring HIV and AIDS and STI

interventions. The implementing agencies are the provinces, local authorities, the private sector and a range of CBOs. Structures in the various other sectors vary according size of organisation, degree of organisation of the sector, as well as the profile of HIV and AIDS programmes in the organisation.

The following presents a brief overview of some of the important structures at national and provincial levels and their specific role and functions relating to HIV and AIDS.

11.1 CABINET

The Cabinet is the highest political authority in the country. HIV and AIDS issues are not regularly discussed at the weekly cabinet meetings as this responsibility has been deferred to the Inter-Ministerial Committee on AIDS (IMC) and SANAC.

11.2 SOUTH AFRICAN NATIONAL AIDS COUNCIL

SANAC is the highest body that provides strategic and political direction as well as support and monitoring for sector programmes for HIV and AIDS and STIs in South Africa. In 2006, a process of restructuring SANAC was undertaken and consensus on the broad structural arrangements was reached as follows:

- A National AIDS Council - The high-level overall coordinating body
- Sector level coordination
- Programme level coordination

The Deputy President shall be the Chairperson of the Council and sector representation shall be at highest level (President/Chairperson). The Health Ministry shall be an ex officio member at all levels.

11.3 THE INTERMINISTRIAL COMMITTEE ON AIDS

The Inter-Ministerial Committee on AIDS (IMC) has recently been appointed by Cabinet in order to support and monitor the work that is done by SANAC. It is chaired by the Deputy President and is composed of the Ministers of Health, Social Development, Education, Agriculture and Land Affairs, Mining, Public Service and

Administration. The IMC serves at the interface between Cabinet and SANAC, providing leadership on urgent matters that may arise between SANAC meetings.

11.4 THE POLICY COMMITTEE OF THE NATIONAL HEALTH COUNCIL (NHC)

The Policy Committee of the NHC consists of the Minister of Health, the Deputy Minister of Health, the Director General of Health, all the Deputy Directors General in the DOH, all provincial health MECs and their Heads of Department. The committee meets every six weeks, and is the body that approves national policies and guidelines. HIV and AIDS related matters are discussed as it becomes necessary and relevant policy decisions are made. The role of the National Health Consultative Forum (a structure of the National Health Act) in this regard is being defined.

11.5 THE SOCIAL SECTOR CLUSTER

Government has clustered departments at national and provincial level to ensure greater collaboration around cross cutting policy and implementation issues. Clusters meet at both Ministerial and official (DG) levels and are repeated at provincial level. The Social Sector Cluster is one such cluster and is the main cluster that deals with health matters. HIV and AIDS is one of the programmes on Government's Programme of Action for which the Social Cluster is responsible. To ensure maximum discussion and government-wide programming on HIV and AIDS. The Social Cluster is well placed to perform this function at both national and provincial government levels.

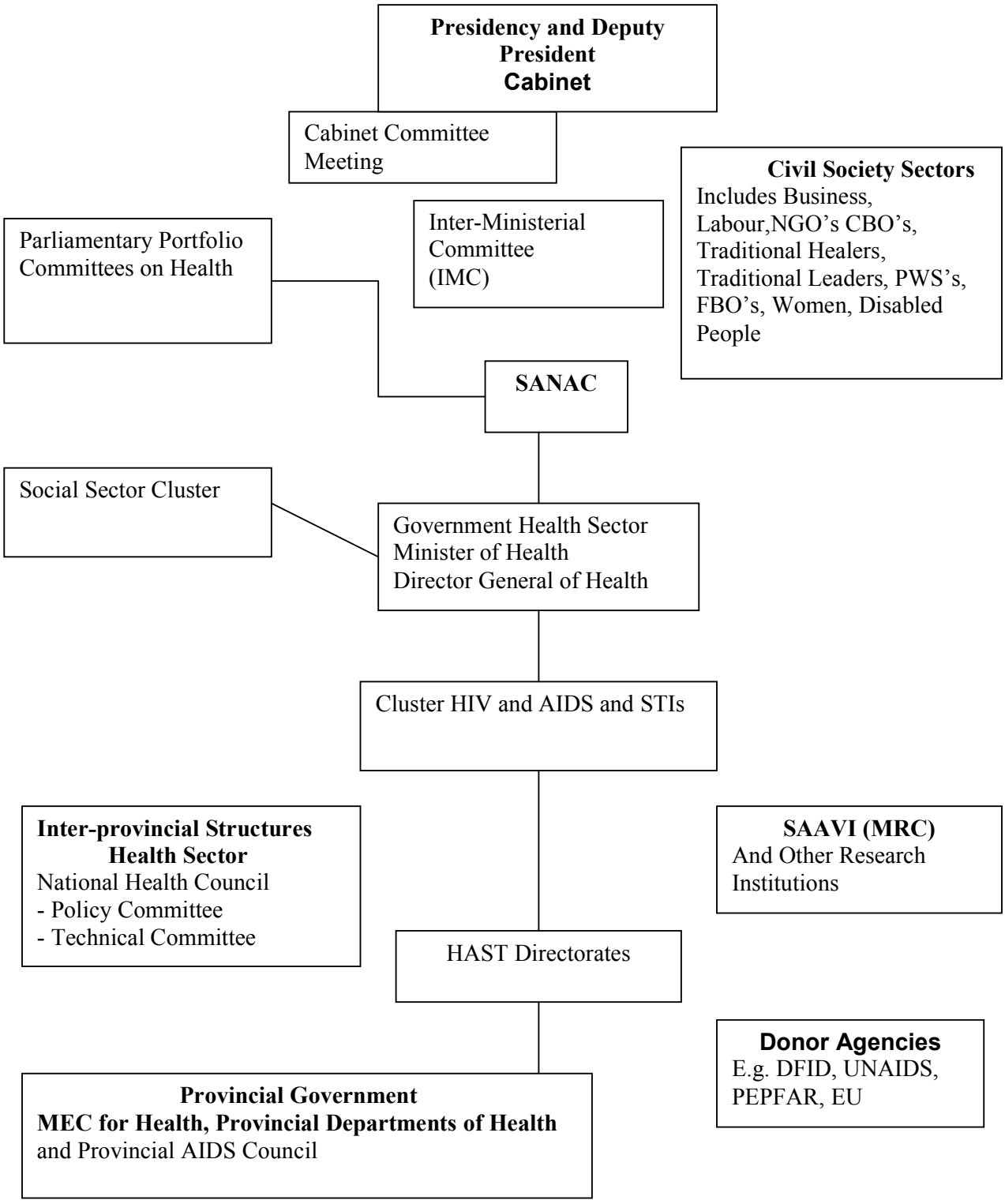
11.6 HIV and AIDS UNITS IN GOVERNMENT DEPARTMENTS:

Each government department has a focal person to manage the implementation of relevant HIV and AIDS programmes. HIV and AIDS issues are brought to the attention of the above national bodies by the HIV & AIDS Units. It is the responsibility of these units to prepare briefing documents for the national forums, and attend meetings to provide further information to aid decision-making in national committees and bodies. They are also responsible for development of relevant strategies, policies and programmes; ensuring availability of finance and other resources; and for providing support to implementing agencies in their departments. This cluster HIV and AIDS in

the DOH also provides secretariat support to SANAC. Government departments as well as sectors of civil society report regularly to SANAC.

11.7 IMPLEMENTING AGENCIES

These are mainly provinces, districts, and local authorities. The private sector and NGOs augment the services that are provided by government. The structures for different government departments are designed to suite the specific needs of the departments, but the principle of intergovernmental relations are the same. It is envisaged that at provincial and district level, the same national level structures will be replicated so that the critical mass of human resources for effective programme implementation is in place


Presidency and Deputy President
Cabinet
Cabinet Committee Meeting
Civil Society Sectors
Includes Business, Labour,NGO's CBO's, Traditional Healers, Traditional Leaders, PWS's, FBO's, Women, Disabled People
Inter-Ministerial Committee (IMC)
Parliamentary Portfolio Committees on Health
SANAC
Social Sector Cluster
Government Health Sector
Minister of Health
Director General of Health
Cluster HIV and AIDS and STIs
Inter-provincial Structures
Health Sector
National Health Council
- Policy Committee
- Technical Committee
SAAVI (MRC)
And Other Research Institutions
HAST Directorates
Donor Agencies
E.g. DFID, UNAIDS, PEPFAR, EU
Provincial Government
MEC for Health, Provincial Departments of Health
and Provincial AIDS Council

12. THE NATIONAL M&E FRAMEWORK FOR THE NSP 2007-2011

The NSP 2007-2011 recognises monitoring and evaluation (M&E) as an important policy and management tool. National, provincial and district level indicators to monitor process, outcomes and impact will be used to assess collective effort.

Research, Monitoring and Surveillance Framework

The Monitoring and Evaluation Framework for the National Strategic Plan consists of two interlinked set of indicators. The first set of indicators is **primary or core list of indicators** that will be used to measure the outcomes of the NSP as a whole (Table 1). The primary indicators are a minimum set covering all priority areas of the NSP.

The second set of M&E framework indicators will comprise a **comprehensive set of indicators** covering all objectives and interventions of the NSP for detailed ongoing monitoring. This set will be defined in detail in three months after the finalization of the NSP as annexure 1 of the NSP. The comprehensive set will be presented in terms of inputs (resources invested), processes (activities), outputs (services provided) and outcomes (actual results) using the results based approach.

Monitoring Oversight

SANAC's Monitoring and Evaluation focal point will establish a mechanism for coordinating inputs from the various sectors. This mechanism may work in close collaboration with the Government wide Monitoring & Evaluation system.

Each sector will be required to develop a monitoring schedule that ensure that common definitions and standards are developed and that the necessary capacity are available for the M&E monitoring of the sector. At the outset, it will be necessary to assess the **state of readiness of existing various M&E mechanisms** in all sectors and gather the baseline for all indicators before the end of 2007. Both the Core and Comprehensive indicator sets will include standard tools (prescribed reporting templates, data collection mechanisms and schedules etc) to ensure that sectors have a systematic mechanism for monitoring sector specific indicators. Each sector will report to SANAC twice a year on sector specific indicators in the form of midyear and end of the year reports.

The Health Sector aspects of the National Strategic Plan will be integrated into the existing HIV and AIDS monitoring and evaluation system coordinated by The Monitoring & Evaluation Directorate of the Department of Health, which is currently responsible for HIV and AIDS Monitoring – *"Monitoring & Evaluation Framework for the Comprehensive HIV and AIDS Care, Management and Treatment for South Africa*" (2004). A focal unit for coordinating the monitoring the National Strategic Plan would be created in that directorate.

The data collection plan will take into account ongoing surveillance, surveys and other sources of data systems. Other relevant data systems and mechanisms will be built into existing information systems and new systems developed to ensure that relevant information is available. In addition reporting mechanism will continue to support ongoing monitoring of other international, regional and national indicators such as those of the United Nations General Assembly on HIV & AIDS (UNGASS), Millennium Development Goals, Abuja framework for Action, NEPAD and SADC indicators, which tend to be aligned with the indicators identified for the NSP.

Reporting Schedule

With regard to Core indicator monitoring, A **mid-term review** of the National Strategic Plan will be conducted during 2009 and the five-year review should be conducted during 2011. The midterm review will be focused on how the available inputs have been used and what outputs and short terms outcomes have been produced. This review should also focus on challenges, role players and interactions between various role players and lead agencies. The reviews would focus on the following questions adapted from UNAIDS document.

- What coverage of services for prevention, treatment, care and support has already been achieved?
- Which affected populations are not being sufficiently reached?
- What are the major obstacles to reaching these populations?
- What are the strategies to overcome these obstacles?
- What financial, technical and human resources are currently available?

- How can budgets and programmes be adjusted to address these obstacles?
- What process and outcome targets will help move the response forward and help measure success?
- What additional resources will be required to move significantly towards the goals of the NSP by 2011?

The **5-year review** would mainly be outcomes based assessment using data form multiple sources.

With regard to the comprehensive set of indicators, a detailed schedule of reporting schedules, data sources and data collection mechanisms will be included in the document (Annex. 1).

Table 1 : Primary Set of Indicators

	Indicator	Data Sources	Frequency of reporting	Responsibility
Priority Area 1: Prevention 11 indicators	Budget and expenditure on prevention in private and public sectors	National Treasury, National AIDS Expenditure Accounts	Annual and five yearly	National Treasury
	Proportion of HIV positive women receiving PMTCT regimen	DHIS	Annually	DOH
	Mother-to-child transmission rate is critical, though hard to collect routinely. Suggest surveillance is required			
	Proportion of the infants in national PMTCT programme receiving PCR	DHIS (new)	Annually	DOH
	Number of male and female condoms distributed annually by public and private sector	Condom distribution database	Annual	DoH, SABCOHA, NGOs
	Percentage of men and women who have had sex before age 15 (Age at first sexual debut)	Nelson-Mandela HSRC HIV survey, SADHS, Youth Risk Behavioural Survey	2 yearly, 5 yearly	DOH, HSRC, MRC
	Condom use at last sex among 15-24	Nelson-Mandela HSRC HIV survey, SADHS, Youth Risk Behavioural Survey	2 yearly, 5 yearly	DOH, HSRC, MRC
	Proportion men with concurrent partners	SADHS	2 yearly, 5 yearly	DOH, HSRC
	Median age of partner, among pregnant women 15-19	Annual antenatal HIV, Nelson-Mandela HSRC HIV survey Survey, SADHS	Annual, 2 yearly, 5 yearly	DOH, HSRC
	Percent of primary and secondary school educators trained on lifeskills education	DoE	Annual	DoE
	HIV Prevalence by age group	Annual antenatal HIV Survey	Annual	DOH
	Derived incidence among 15-20	Annual antenatal HIV Survey	Annual	DOH, MRC
	Teenage pregnancy rate	Annual ANC survey	Annual	DOE DOH

Priority Area 2: Care, Treatment and Support (12)	Budget and expenditure on care, treatment and support in private and public sectors {budgets > cost of targets (vs. other way around)}	National Treasury National AIDS Expenditure Accounts	Annual and five yearly	National Treasury
	Percentage of women, men and children with advanced HIV infection who are receiving antiretroviral combination therapy (enrolment compared to need - % of target met)	Cohort Surveillance /M&E data Comprehensive HIV and AIDS Plan	Two yearly	DOH and others
	Proportion of well adults tested in the last twelve months	Annual antenatal HIV, Nelson-Mandela HSRC HIV survey Survey, SADHS	Annual, 2 yearly, 5 yearly	DOH, HSRC
	Proportion of new TB/STI/pregnant women tested for HIV	DHIS (new indicator)	Annual	DOH
	Proportion of HIV-positive TB/STI and pregnant women receiving CD4 testing	DHIS (new indicator)	Annual	DOH
	Proportion of HIV positive pregnant women initiated on ART	DHIS(new indicator)	Annual	DOH
	Percentage of adults and children (by age groups) on ART who are still alive 12 months after initiation of antiretroviral therapy;	Cohort Surveillance /M&E data Comprehensive HIV and AIDS Plan	Two yearly	DOH and others
	Consider including "Deaths pior to initiation of ART in patients attending wellness clinics" – perhaps surveillance?			
		Cohort Surveillance /M&E data Comprehensive HIV and AIDS Plan	Two yearly	DOH and others
	Proportion CD4< 50 on start	Cohort Surveillance /M&E data Comprehensive HIV and AIDS Plan	Two yearly	DOH and others

	Viral load suppression 12months	Cohort Surveillance /M&E data Comprehensive HIV and AIDS Plan	Two yearly	DOH and others
	Cause-specific adult mortality rate	Vital registration data	Two yearly	DOH, DHA StatsSA and MRC
	CD4's done pre-ART	NHLS new form	Two yearly	NHLS
	Percentage of HIV + adults and children on antiretroviral therapy receiving supplement meals and micronutrient supplements	M&E data Comprehensive HIV and AIDS Plan	Annual	DOH
	Percentage of OVC (boy/girl) aged under 18 living in households whose household have received a basic external support package	M&E data	Annual	DSD
Priority Area3: Research Monitoring and Surveillance (3)	Budget and expenditure on research, monitoring and surveillance in private and public sectors	National Treasury Records National AIDS Expenditure Accounts	Annual and five yearly	National Treasury
	Prevalence and behavioural surveys conducted	Research database	Annual and 5 yearly	DOH
	Number of core indicators in plan available and collected	SANAC	Annual	SANAC
	Number of national and community campaigns to reduce HIV stigma and discrimination	DPLG	Annual	DPLG
	Number of legal support services for people living with HIV		Annual	AIDS Law Project and DOJCD
	Number of legal and social support services for women care-givers and victims of sexual Violence		Annual	AIDS Law Project and DOJCD

13. FINANCIAL IMPLICATIONS

Estimates of the costs of providing the following key interventions outlined in the NSP:

- Life skills interventions in the education sector
- Behavioural change programmes
- Condom provision
- Programmatic interventions to strengthen STI management
- Post exposure prophylaxis for survivors of sexual assault
- Post exposure prophylaxis for occupational exposure
- Increasing uptake of HIV-testing (VCT)
- Comprehensive care and support including antiretroviral treatment, community and home based care and food support for HIV-infected adults and children
- Prevention of mother to child transmission of HIV
- HIV-testing for infants
- Policy for orphans and vulnerable children

Estimates of annual and total costs have been based on targets contained in the NSP regarding the coverage of each intervention or programme together with the associated unit costs. While costing covers many of the key programmatic areas, some areas have been omitted because costing can only be done once detailed Operational Plans have been finalized. These areas include the creation of an enabling social, political and regulatory environment and the creation of information systems for monitoring and evaluation. Similarly, the costs of a variety of grants such as the proposed chronic care grant and grants covering social protection for children. Costs will need to be assessed once policy has been finalized. Finally, it will be important to consider the resources required to address the needs of disabled and other special needs groups.

The key driver of costs is adult antiretroviral treatment, at approximately 40% of the total cost. The second most expensive programme (7% of the total) relates to the support of orphans and vulnerable children thus emphasizing the importance of safeguarding families through delaying maternal and paternal mortality.

The cost implications of the NSP are large, in some options exceeding 20% of the health budget without considering the costs arising from the effect of the epidemic on

hospital and primary care services. In attempting to increase the feasibility of this plan, some of the key considerations are:

1. Extending prevention programmes and getting them to work is critical to reduce long term morbidity and costs. A simple example is PMTCT. If this programme was functioning properly, it would radically reduce paediatric aids cases.
2. Innovative financing arrangements such as partnerships with the key donors (Global Fund to Fight AIDS, TB and Malaria and PEPFAR) as well as partnerships with the private health sector, business and a range of other stakeholders is crucial.
3. Attention should be placed on increasing the affordability of medicines.
4. To enhance efficiency, attention must be given to strengthening the primary health care infrastructure so that the location of care can be shifted out of hospitals into quality primary health care services, especially at the community health centre level. This will also improve the accessibility of the service to patients.
5. Improved monitoring and evaluation is essential to show value for money for the large amount of resources being allocated to the programme. In addition, weaknesses in existing monitoring and evaluation systems makes it very difficult to adequately cost the NSP because of uncertainty around baseline performance and outputs.

Attention needs to be given to programmes to improve adherence to treatment; poor compliance and associated rapid development of resistant strains would lead to increasing reliance on more expensive lines of treatment.

Total Costs

Table 1 and **Table 2** outline the costs of the key interventions contained in this report, grouped according to priority areas (e.g. prevention), goals (e.g. reduce HIV transmission) and interventions (e.g. post exposure prophylaxis) contained in the NSP.

In **Table 1**, low cost scenarios are summarized, with the key difference relating to the assumption of only 60% of new AIDS cases receiving ART by 2011. In **Table 2**, high cost scenarios are summarized, where 80% of new AIDS case receive ART by 2010.

When considering these costs, the following points should be borne in mind:

- Home based care and ART treatment will avert the inpatient care costs that would have been incurred for patients in the absence of these interventions
- Some estimates need to be revised once Operational Plans have been developed
- Costs relating to the creation of an enabling political, social and regulatory environment and monitoring and evaluation systems have not been included
- During the Operational Plan, it will also be important to pay attention to the needs of disabled and other special needs groups

The key driver of costs is adult antiretroviral treatment, at approximately 40% of the total cost. The second most expensive programme (7% of the total) relates to the support of orphans and vulnerable children thus emphasizing the importance of safeguarding families through delaying maternal and paternal mortality.

Table 1: Summarized total costs for the low cost scenarios (million Rands, 2005/06 prices)

			Year					
Priority area	Goal	intervention	2007	2008	2009	2010	2011	% Total
Prevention			**643**	**792**	**951**	**1,098**	**1,247**	**12%**
	Reduce sexual transmission		**642**	**790**	**949**	**1,097**	**1,245**	**12%**
		Behavioural change interventions	300	400	500	600	700	6%
		Condom provision	145	152	172	180	188	2%
		Life skills	158	168	177	186	195	2%
		PEP for sexual assault	10	10	11	11	12	0%
		STI management	30	60	90	120	150	1%
	Reduce transmission through occupational exposure		**1**	**1**	**1**	**1**	**1**	**0%**
		PEP for occupational exposure	1	1	1	1	1	0%
Care, support and health system strengthening			**4,042**	**5,612**	**6,960**	**8,474**	**10,012**	**88%**
	Scale-up access to VCT		**260**	**420**	**423**	**426**	**428**	**5%**
		HIV testing	260	420	423	426	428	5%
	Maintain health of HIV-infected adults		**2,495**	**3,365**	**4,250**	**5,301**	**6,360**	**55%**
		Antiretroviral treatment for adults	1,588	2,296	3,115	4,036	5,014	40%
		Food support for adults	521	586	652	782	912	9%
		Home and Community Based Care	386	483	483	483	435	6%
	Address the special needs of mothers and children		**1,007**	**1,267**	**1,447**	**1,627**	**1,823**	**18%**
		Antiretroviral treatment for children	245	359	488	635	791	6%
		OVC	452	561	589	618	649	7%
		PMTCT dual therapy and infant testing	310	348	370	374	383	4%
	Strengthen the health system		**280**	**560**	**840**	**1,120**	**1,400**	**11%**
		Strengthen TB programme management	30	60	90	120	150	1%
		Increase CHC coverage	250	500	750	1,000	1,250	9%
Grand Total			**4,685**	**6,404**	**7,910**	**9,572**	**11,259**	**100%**

Table 2: Summarized total costs for the high cost scenarios (million Rands, 2005/06 prices)

			Year					
Priority area	Goal	intervention	2007	2008	2009	2010	2011	% Total
Prevention			**643**	**775**	**990**	**1,207**	**1,427**	**11%**
	Reduce sexual transmission		**642**	**773**	**989**	**1,206**	**1,426**	**11%**
		Behavioural change interventions	300	400	500	600	700	6%
		Condom provision	145	135	212	289	369	3%
		Life skills	158	168	177	186	195	2%
		PEP for sexual assault	10	10	11	11	12	0%
		STI management	30	60	90	120	150	1%
	Reduce transmission through occupational exposure		**1**	**1**	**1**	**1**	**1**	**0%**
		PEP for occupational exposure	1	1	1	1	1	0%
Care, support and health system strengthening			**4,329**	**6,075**	**7,786**	**9,804**	**11,893**	**89%**
	Scale-up access to VCT		**278**	**364**	**451**	**568**	**714**	**5%**
		HIV testing	278	364	451	568	714	5%
	Maintain health of HIV-infected adults		**2,724**	**3,809**	**4,926**	**6,309**	**7,714**	**57%**
		Antiretroviral treatment for adults	1,816	2,739	3,791	5,044	6,367	44%
		Food support for adults	521	586	652	782	912	8%
		Home and Community Based Care	386	483	483	483	435	5%
	Address the special needs of mothers and children		**1,047**	**1,343**	**1,570**	**1,808**	**2,064**	**17%**
		Antiretroviral treatment for children	285	434	611	816	1,032	7%
		OVC	452	561	589	618	649	6%
		PMTCT dual therapy and infant testing	310	348	370	374	383	4%
	Strengthen the health system		**280**	**560**	**840**	**1,120**	**1,400**	**9%**
		Strengthen TB programme management	30	60	90	120	150	1%
		Increase CHC coverage	250	500	750	1,000	1,250	8%
Grand Total			**4,972**	**6,850**	**8,777**	**11,011**	**13,320**	**100%**

14. EFFECTIVE IMPLEMENTATION OF THE HIV AND AIDS AND STI STRATEGIC PLAN:

To achieve effective implementation, the following practical and policy issues will have to be addressed:

a) Adoption of the HIV & AIDS & STI Strategic Plan by SANAC:

After it has been adopted by SANAC, the HIV & AIDS & STI Strategic Plan 2007-2011 should be used in developing national, provincial and district operational plans as well as sector plans. Yearly operational plans should be based on realistic objectives.

b) Establish and Improve Structures for Delivery:

In a similar fashion to the process undertaken by SANAC there is a need to review and develop structures at all levels, from national to community where necessary. Provinces should consider duplicating appropriate national structures, such as SANAC, at provincial and local level. It is vital to establish appropriate structures at district level and it is recommended that District HIV and AIDS Committees be established. These district structures should include all the role players in the field of HIV and AIDS within relevant communities, particularly local government in order to ensure coherence in dealing with HIV and AIDS, STIs and TB issues and making development plans. It is vital that non-health issues such as transport and poverty alleviation are included in HIV and AIDS and STI planning.

c) Policy and Legal Issues needing attention:

In relation to two of the key priority areas there are a number of policy and legal issues that require urgent attention in order to assist with the implementation of the NSP. These are set out briefly below:

HIV Prevention:

Reduction of new HIV infections by 50% is an ambitious target. A supportive policy framework is critical for programme development in this regard.

- Establishing a national culture in which people regularly seek voluntary testing and counselling for HIV will necessitate a paradigm shift in the traditional approach to VCT. In particular it requires a policy where HIV testing is offered by health providers to specified groups of people attending health services, as well

as the identification of new strategies for the provision of counselling and testing outside of health facilities.

- At the end of 2006 research results confirmed that circumcised males have a significantly lower risk of HIV infection. A mechanism is needed to determine how best to translate such evidence into policy and programmes.
- There is overwhelming evidence that better efficacy is achieved with dual therapy in PMTCT and this regimen is known to be highly cost effective. Policy on the regimen used in PMTCT needs to be updated accordingly.
- A number of higher risk groups, such as sex workers, continue to face legal barriers to accessing HIV prevention and treatment services, because of the criminalisation of their activity. An audit of criminal laws, and their amendment with a view to ensuring non-discrimination and harm reduction, is recommended.

Treatment, Care and Support:

In the section below the cost of medicines is identified as the largest overall component of treatment, care and support. The price of medicines and their cost effectiveness can be impacted upon by (a) adopting polices that will contribute to adherence and (b) lowering prices. In this regard the NSP recommends the introduction of a chronic diseases grant that will promote adherence by supporting people with long term medical needs.

In addition it will be necessary to examine and amend the medicines regulatory framework to ensure access to a sustainable supply of affordable essential prevention and treatment commodities. This can be done by:

- Amending the Patents Act to permit compulsory licensing in accordance with Revised Guideline 6 of the *International Guidelines on HIV/AIDS and Human Rights* and the WTO's *Declaration on the TRIPs Agreement and Public Health* and decision on the *Implementation of paragraph 6 of the Doha Declaration on the TRIPs Agreement and public health*
- Addressing the underlying problems that prevent the Medicines Control Council from registering fast-track medicines timeously

Policy and regulatory frameworks are also needed to support implementation of innovative human resource strategies, for example 'task-shifting' (see section below).

d. Financing the NSP:

Weaknesses in existing monitoring and evaluation systems make it very difficult to adequately cost the NSP because of uncertainty around baseline performance and outputs. Nonetheless, the cost implications of the NSP are extremely large, in some options exceeding 20% of the health budget. This is without considering the costs arising from the effect of the epidemic on hospital and primary care services.

This poses challenges for both the affordability and sustainability of the plan, around what efficiencies might be possible and difficult resource allocation choices within the health sector and between sectors. In ensuring the feasibility of this plan, some of the key considerations are:

- Extending prevention programmes and getting them to work is critical to reduce long term morbidity and costs. A simple example is PMTCT. If this programme was functioning properly, it would radically reduce paediatric AIDS cases.
- Innovative financing arrangements such as partnerships with the key donors (Global Fund to Fight AIDS, TB and Malaria and PEPFAR) as well as partnerships with the private health sector, business and a range of other stakeholders is crucial.
- Attention should be placed on increasing the affordability of medicines.
- Improved monitoring and evaluation is essential to show value for money.
- Attention needs to be given to programmes to improve adherence to treatment; poor compliance and associated rapid development of resistant strains would lead to increasing reliance on more expensive lines of treatment.

It is important to plan to ensure that adequate funding for ensuring delivery is made available at national, provincial and district levels. One method is to establish an agreed percentage of financial resources that all provinces must place directly into HIV and AIDS programmes. The best mechanism of ensuring predictable and sustainable provision of financial resources is the conditional grant that is available through the division of revenue.

d) Human Resources:

A number of important systems level innovations will be necessary to implement and scale up the interventions outlined in this NSP. The biggest threat to the implementation of the NSP is the unavailability of skilled personnel. Human resources shortages, however are not a pretext for paralysis. Innovative ways have been used to mobilise local communities for the provision of services. These strategies have been successful in promoting greater access to services. Some examples include the use of community development workers, community care givers, lay counsellors in health facilities.

Task shifting involves the delegation of activities to less qualified cadres and includes, for example training of primary health care nurses (rather than doctors) to initiate antiretroviral treatment, lay counsellors (rather than nurses) “pricking” patients for rapid HIV tests, lay counsellors (instead of social workers) for orphan support activities. The regulatory and policy barriers to achieving this need to be removed and the process set in motion to provide the necessary training. Such policy decisions would require a supportive systemic environment, in order minimise the risk of compromising quality of services. In this regard, defining roles and responsibilities, targets setting, planning identifying vulnerable groups, removing barriers to access, building integrated networks, and strategies of prevention care and support as well as inter-sectoral collaboration are some of the core responsibilities at district and local level.

In this respect initiatives to develop integrated local government responses to HIV and AIDS through the Department of Provincial and Local Government and to strengthen the managerial capacity and functioning of health districts are central to the implementation of the NSP.

Finally, the ability to engage in and sustain partnerships , formal (contractual) or informal between a range of actors – patients and providers, public and private sectors, governmental and non-governmental players, and various sectors is a major determinant of success of the NSP. This applies as much to national processes in bodies such as SANAC, as to provincial and local interactions. The mobilisation of community institutions such as churches, schools and traditional authorities and coordination between health and social development sectors is at the base of social protection for orphaned and vulnerable children. Similarly, high levels of adherence and

the success of treatment programmes in many places is attributed to effective collaborations between people living with HIV, their organisations and health and social services. Partnerships allow for the rapid diffusion of new ideas and best practises, not only horizontally between local areas and provinces but also vertically between emerging experiences on the ground and policy and decision making spheres.

15. WAY FORWARD

Effective coordination across the sectors is key to the successful implementation of this NSP. The SANAC secretariat will be strengthened to ensure that all sector responsibility for their role as leading agencies in the implementation of the Plan. Government departments, sectors of civil society, provinces and other implementing agencies will be assisted in the development of their strategies and operational plans. Responsible policy-making bodies should ensure that all the identified gaps are address in order to support implementation of the Plan. All the necessary resources will be mobilised.

The HIV & AIDS & STI Strategic Plan provides a broad framework for government, NGOs, business, organised labour, women's and organisations and all sectors of society in responding to HIV and AIDS and STIs. Each sector should develop more specific operational plans based on its role in society, its activities and its specific strengths. Sectors are encouraged to establish technical AIDS committees, guided by and according to the requirements of SANAC structures.

16. CONCLUDING REMARKS

The HIV and AIDS and STI Strategic Plan 2007-2011 is seen as a dynamic document that will be subject to regular critical review. This will be undertaken at the National, Provincial and District levels with inputs from all stakeholders. A mid-term review will be conducted and the Strategic Plan modified in accordance with the findings.

17. ACKNOWLEDGEMENTS

The development of this *"HIV & AIDS & STI Strategic Plan for South Africa: 2007 – 2011"* would not have been possible without the immeasurable assistance from countless individuals, organisations and all those who participated in the various sector summits. Our thanks goes to all who took the time and effort to assist in the development of the document, be it through drafting sections or reading and commenting several times to improve the quality. Special thanks go to the task team members (Annexure A), who worked tirelessly to ensure excellent quality of this very important document.

Annexure A: Map of South Africa

The following map represents the nine provinces that make up South Africa.