HIV & AIDS and STI
STRATEGIC PLAN FOR SOUTH AFRICA
2007-2011

AIDS HELPLINE
☎ 0800-012-322

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
CHBC	Community Home Based Care
DCS	Department of Correctional Services
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
DPSA	Department of Public Service and Administration
DPWE	Department of Public Works and Energy
DPLG	Department of Provincial and Local Government
DSD	Department of Social Development

DTI	Department of Trade and Industry
EDL	Essential Drug List
EPWP	Expanded Public Works Programme
FBOs	Faith–Based Organisation
GCIS	Government Communication and Information Systems
HCW	Health Care Worker
HEAIDS	Higher Education AIDS Proramme
HIV	Human Immunodeficiency Virus
HRC	Human Rights Commission
HSRC	Human Sciences Research Council
HTA	High Transmission Areas
IDC	Interdepartmental Committee on AIDS
IDU	Injecting Drug Use
IEC	Information Education and Counselling
IEC	Information, Education, and Communication
IMC	Inter-Ministerial Committee on AIDS
JIPSA	Joint Initiative on Priority Skills Acquisition
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MEC	Member of Executive Committee
MOH	Ministry of Health
MRC	Medical Research Council
MSM	Men who have Sex with Men
MTCT	Mother-to-child transmission
MTEF	Medium Term Expenditure Framework
NBTS	National Blood Transfusion Service
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
NPA	National Prosecuting Authority
OVC	Orphaned and vulnerable children
PEP	Post-exposure prophylaxis
PLHIV	People living with HIV
PMTCT	Prevention of mother to child transmission
RHRU	Reproductive Health Research Unit
SAAVI	South African AIDS Vaccine Initiative
SALC	South African Law Commission
SALGA	South African Local Government Association
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 Counselling and Testing
WHO	World Health Organisation
XDR-TB	Extensively Drug Resistant Tuberculosis

TABLE OF CONTENTS

1. FOREWORD

In 2000, the Minister of Health, Dr Manto Tshabalala-Msimang challenged the country to break the AIDS chain. The 2000-2005 National Strategic Plan outlined some key interventions to bring the country close to the realisation of this vision. Five years later, much has been done, much achieved. We could have done better in some areas. There is no reason to doubt the commitment demonstrated by government and its partners in the fight against HIV and AIDS.

The indications are that we are indeed on course towards breaking the AIDS chain. The rate of the increase in prevalence of HIV has slowed down in the past five years, with a tendency to stabilisation. The down side is that these stabilisation rates are high, with many devastating impacts to the South African society in general. Realising this reality, the Cabinet approved the National Operational Plan for Comprehensive HIV and AIDS management, treatment, care and support in 2003. It is through the Comprehensive Plan that interventions to reduce the morbidity and mortality of HIV and AIDS were outlined and implemented with great enthusiasm by all partners.

We can now say that South Africans are mobilised to fight the HIV and AIDS epidemic, government leading with relevant policies, programmes, and commitment of resources. More can still be done by civil society to improve the manner in which they are organised for better efficiency. Individuals and communities need to take charge.

These achievements should inspire all of us to work for even better results. This Strategic Plan defines clearly the nature of the South African HIV and AIDS problem. It identifies relevant key interventions to be carried out in order to reduce, by an ambitious but realistic magnitude, the rate of new HIV infections. It also recognises the plight of the many people that are living with HIV and AIDS and outlines relevant interventions to mitigate the impact of this disease on individuals, families, and communities. All of these things have to be done simultaneously.

However, a sustainable and effective national response to this epidemic is one that has HIV prevention as its fulcrum. The success of prevention interventions depends largely on collective societal commitments that support individual behaviour change, a responsibility of all South Africans.

This NSP represents a broad consensus position with a detailed outline of national interventions and targets. Lead agencies have been identified that should take responsibility for the execution of and the attainment of the different elements of the Plan. It is a document that seeks to guide the national response and should be used by all government departments, the private sector, civil society and development partners to assist the country reach the desired goals of halving new infections and reducing the impact of HIV and AIDS on individuals, families and society.

The country is on course towards breaking the chain of AIDS; let us, in the next five years, guided by this NSP, be the country that has, in a sustainable manner, won the fight against HIV and AIDS.

Mrs Phumzile Mlambo-Ngcuka
Deputy President and Chairperson of SANAC

2. EXECUTIVE SUMMARY

The HIV & AIDS and STI Strategic Plan for South Africa 2007-2011 (NSP) flows from the National Strategic Plan of 2000-2005, the Operational Plan for Comprehensive HIV and AIDS Care, Management, and Treatment (CCMT) as well as other HIV and AIDS strategic frameworks developed for government and sectors of civil society in the past five years. It represents the country's multi-sectoral response to the challenge with HIV infection and the wide-ranging impacts of AIDS.

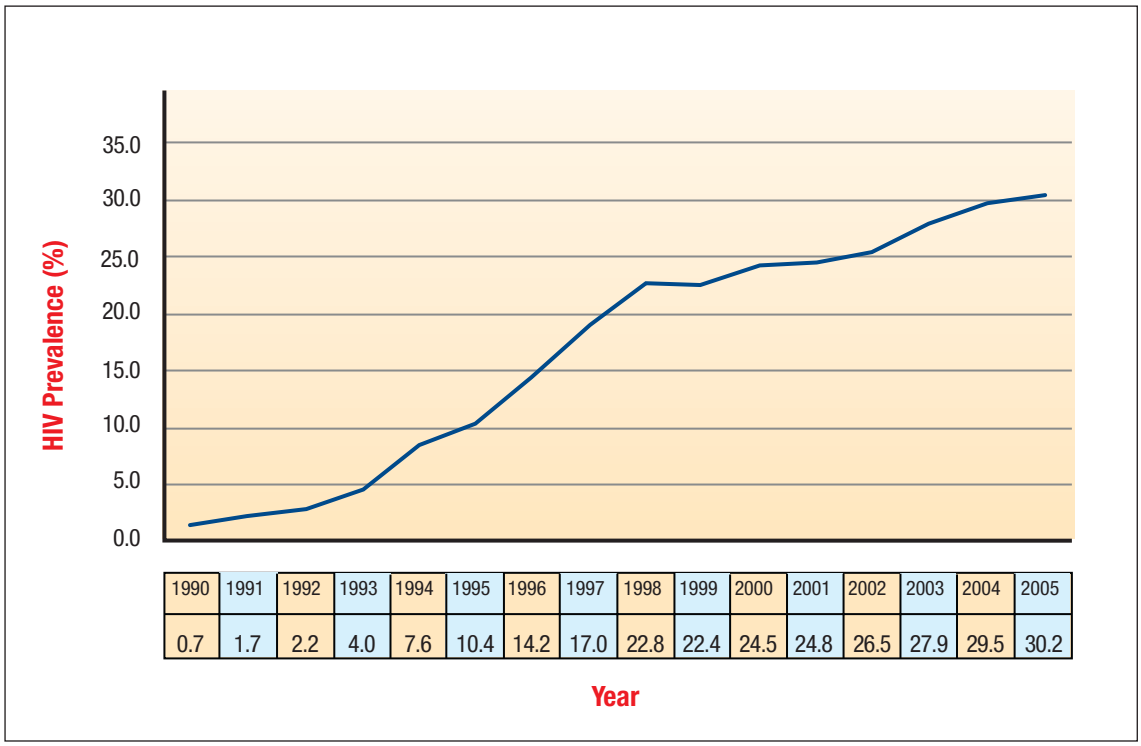
In May 2006, the South African National AIDS Council (SANAC), under the leadership of its Chairperson, the Deputy President, Mrs. Phumzile Mlambo-Ngcuka, mandated the Health Department to lead a process of developing a new 5-year NSP, for the years 2007-2011.

This 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 was useful in defining the challenges and the capacities of the various implementing agencies.

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, more than 63% were from sub-Saharan Africa. In 2005 about 5.54 million people were estimated to be living with HIV in South Africa, with 18.8% of the adult population (15-49 years) and about 12% of the general population 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 than others. 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, overall HIV prevalence was the lowest in the country at 15.7%, but two metropolitan health areas of Khayelitsha and Gugulethu/Nyanga registered prevalence rates of 33% and 29% respectively. According to the HSRC Household Survey, people living in rural and urban informal settlements seem to be at highest risk for HIV.

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 slowed down in the past five years, the country is still to experience a reversal in the trends. There are also still too many people being newly infected with HIV.

The epidemics of HIV and tuberculosis (TB) are interlinked. In southern Africa, between 50% and 80% of TB patients are HIV positive. Whilst a primary risk factor for TB infection is overcrowding, the development of TB disease is significantly more likely where there is co-infection with HIV as a product of immunosuppression[i]. TB is the commonest infectious disease associated with HIV infection in sub-Saharan Africa. A high overall prevalence of HIV in South Africa thus contributes to increasing incidence of active TB disease. Based on the overall number of TB cases reported to the Ministry of Health, the incidence rate of TB has increased from 169 per 100 000 people in 1998 to 645 per 100 000 people in 2005 although reporting rates in many parts of the country are far from complete. In the presence of HIV, TB is associated with substantially higher case fatality rates regardless of initiation, or in the presence, of effective TB chemotherapy[ii].

On the other hand, 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", asymptomatic infections, the emergence of resistant strains of some bacteria, as well as the importance of viral STIs in the spread of HIV.

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, meetings, and a national consultative conference. SANAC had opportunity to interrogate drafts on three occasions.

The national multisectoral response to HIV and AIDS is managed by organized structures at different levels in government and nongovernmental sectors. 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. Responsibility for dealing with ongoing 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 strategic and political guidance as well as support and monitoring of sector programmes.

The newly strengthened SANAC will operate at three levels through:

- A high level council, meeting twice per annum, chaired by the Deputy President,
- Sector level co-ordination – with sectors taking responsibility for their own organisation, strategic plans, programmes, monitoring, and reporting to SANAC
- Programme level organization - led by the social cluster of government.

The NSP is based upon a set of key Guiding Principles. A selection of the key principles includes:

- Supportive Leadership
- Effective Communication
- Effective partnerships, including meaningful involvement of people living with HIV and AIDS
- Promoting social change and cohesion
- Sustainable programmes and funding

The primary aims of the NSP are to:

- Reduce the rate of new HIV infections by 50% by 2011.
- 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 HIV positive people and their families by 2011.

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

- Prevention;
- Treatment, care and support;
- Research, monitoring, and surveillance;
- Human rights and access to justice

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:

1.1 Accelerate poverty reduction strategies and strengthen safety nets to mitigate the impact of poverty.

1.2 Accelerate programmes to empower women and educate men and women, (including the boy and girl child), on human rights in general and women's rights in particular.

1.3 Develop and implement strategies to address gender based violence.

1.4 Create an enabling environment for HIV testing.

1.5 Build and maintain leadership from all sectors of society to promote and support the NSP goals.

1.6 Support national efforts to strengthen social cohesion in communities and to support the institution of the family.

1.7 Build AIDS competent communities through tailored competency processes.

2. Reduce sexual transmission of HIV:

2.1 Strengthen behaviour change programmes, interventions and curricula for the prevention of sexual transmission of HIV customised for different groups with a focus on those more vulnerable to and at higher risk of HIV infection.

2.2 Implement interventions targeted at reducing HIV infection in young people, focusing on young women.

2.3 Increase open discussion of HIV and sexuality between parents and children.

2.4 Increase roll out of workplace prevention programmes.

2.5 Increase roll out of prevention programmes for higher risk populations.

2.6 Develop and integrate a package of sexual and reproductive health and HIV prevention services into all relevant health services.

2.7 Develop a comprehensive package that promotes male sexual health.

2.8 Develop and integrate interventions for reducing recreational drug use in young people with HIV prevention efforts.

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

2.10 Scale up prevention programmes for HIV positive people.

3. Reduce mother-to-child transmission of HIV

3.1 Broaden existing mother to child transmission services to include other related services and target groups.

3.2 Scale up coverage and improve quality of PMTCT to reduce MTCT to less than 5%.

4. Minimize the risk of HIV transmission through blood and blood products

4.1 Minimise the risk of HIV transmission from occupational exposure among health care providers in the formal, informal and traditional settings through the use of infection control procedures.

4.2 Minimise exposure to infected blood through procedures associated with traditional and complementary practices.

4.3 Investigate the extent of HIV risk from Intravenous Drug Use (IDU's) and develop policy to minimise risk of HIV transmission through injecting drug use and unsafe sexual practices.

4.4 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 infection 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.

5. Increase coverage to voluntary counselling and testing and promote regular HIV testing

5.1 Increase access to VCT services that recognise diversity of needs.

5.2 Increase uptake of VCT.

6. Enable people living with HIV and AIDS to lead healthy and productive lives

6.1 Scale up coverage of the comprehensive care and treatment package.

6.2 Increase retention of children and adults on ART.

6.3 Ensure effective management of TB/HIV co-infection.

6.4 Improve quality of life for people with HIV and AIDS requiring terminal care.

6.5 Strengthen the health system and remove barriers to access.

7. Address the special needs of pregnant women and children

7.1 Decrease HIV and AIDS related maternal mortality through women-specific programmes.

7.2 Determine the HIV status of infants, children and adolescents as early as possible.

7.3 Provide a comprehensive package of services that includes wellness care and ART to HIV-affected, -infected -and exposed children and adolescents.

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

8.1 Strengthen the implementation of OVC policy and programmes.

8.2 Expand and implement CHBC as part of EPWP.

8.3 Strengthen the implementation of policies and services for marginalised communities affected by HIV and AIDS.

8.4 Ensure community AIDS competence in order to facilitate utilization of good quality services.

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. National, provincial and district level indicators to monitor inputs, process, outputs, outcomes and impact will be used to assess collective effort. It is recommended that in line with international trends, a sustainable budget of between 4% – 7% is dedicated for the Monitoring and Evaluation of the NSP.

9. Develop and Implement a monitoring and evaluation framework for appropriate indicators

9.1 Establish and implement a functional M&E system.

10. Support research in the development of new prevention technologies

10.1 Develop and support a research agenda on HIV prevention technologies.

11. Create an enabling environment for research in support of the NSP

11.1 Strenghten the research and development environment in order to support research in the area of HIV & AIDS and STDs.

12. Development and promotion of research on behaviour change

12.1 Support the evaluation of existing interventions and the development of new innovative programmes or interventions aimed at behaviour change for HIV prevention.

13. Develop and support a comprehensive research agenda including operations research, behavioural research, epidemiological trials and other research for new technologies for prevention and care

13.1 Support research on the efficacy of orthodox medicines for HIV treatment and OI prophylaxis.

13.2 Support research on the efficacy of traditional and complementary medicines for HIV treatment and OI prophylaxis.

13.3 Support research on nutritional interventions for those infected or at higher risk of HIV infection.

13.4 Conduct operations research in support of the implementation of the NSP.

13.5 Support research to develop best practice models for community care and support.

13.6 Conduct research on human resource requirements for the effective implementation of the NSP.

13.7 Monitoring funding for the NSP and its cost effectiveness.

13.8 Enhance efforts to develop post-graduate research skills by tertiary institutions.

13.9 Support capacity building in research, surveillance and monitoring among black and women professionals such that the appropriate demographics are achieved.

14. Conduct policy research

14.1 Ensure that policy is evidence informed and regularly updated.

15. Conduct regular surveillance

15.1 Coordinate and strengthen surveillance systems on HIV, AIDS and STIs.

KEY PRIORITY AREA 4: Human Rights and Access to Justice

Stigma and discrimination continue to present challenges in the management of HIV and AIDS. This priority area seeks to mainstream programmes to mitigate these fundamental human rights challenges.

16. Ensure public knowledge of and adherence to the existing legal and policy framework

16.1 Ensure adherence to existing legislation and policy relating to HIV and AIDS, particularly in employment and education.

16.2 Ensure adherence to human rights by service providers.

16.3 Ensure a supportive legal environment for the provision of HIV and AIDS services to marginalized groups.

16.4 Monitor and address HIV-related human rights violations.

16.5 Improve affordability and accessibility of legal services for people with HIV.

17. Mobilise society, and build leadership of people living HIV in order to mitigate against stigma and discrimination

17.1 Empower PLHIV to recognise and deal with human rights violations.

17.2 Ensure respect for the rights of PLHIVs in employment, housing, education, insurance and financial services and other sectors.

17.3 Promote greater openness and acceptance of PLHIVs.

18. Identify and remove legal, policy, religious and cultural barriers to effective HIV prevention, treatment and support

18. 1 Minimise the risk of human rights violations from cultural, religious and traditional practices.

19. Focus on the human rights of women and girls, including people with disabilities, and mobilize society to promote gender and sexual equality to address gender-based violence

19.1 Reduce legal contraints to access to Social Security Services for woman and children.

19.2 Ensure implementation of existing laws and policies that protect woman and children from gender based violence.

19.3 Address the needs of woman in abusive relationships.

19.4 Ensure that laws, policies and customs do not discriminate against woman and children.

This NSP sets out a clear framework for ongoing monitoring and evaluation. Ambitious but reaistic targets have been set for each of the identified interventions. It identifies critical research and surveillance activities to be carried out during the five year period. Whilst implementation of this NSP is a collective responsibility of the South African "community", effective implementation depends largely on the quality of information that is collected and reported from all sectors and by all implementing agencies. Preliminary costing of the main elements is included and a commitment is made to raise funding from government, business, and the various development partners.

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 Department of Health, 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 realised.

Many individuals and organisations have participated in the development of the NSP 2007-2011. A list of all those involved is provided in Annexure A. However, our thanks go to all who committed 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. BACKGROUND

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 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 and AIDS, however, affects the lives of all people who live in South Africa in 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 live 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 countries of southern Africa have prevalence levels of between 10-20%, with some (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.

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 highlighted 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 PLHIV, 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; the 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. An assessment of the NSP 2000-2005 was carried out and its findings and recommendations have been used to inform the NSP 2007-2011.

Several 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 Programme document, from which most of other policies flowed. Some examples are; workplace policies in all government departments, the Integrated Nutrition Programme, Maternal, Child and Women's health, development of the District Health System, Patients' Rights Charter, the White Paper on Transformation of the Health System in South Africa, the Health Charter, as well as many other relevant policy guidelines. 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. This plan was lauded by the previous Secretary-General of the United Nations Organisation, Mr Kofi Annan, as one of the best in the world.

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, reduction of poverty, the empowerment of women, and the provision of basic services such as shelter, clean water, and sanitation. The government views 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), both 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. In addition, the most disadvantaged areas such as informal settlements and rural areas are disproportionately affected by shortages in human resources. There is an equal challenge with shortages of social workers in South Africa. Government developmental programmes like JIPSA need to be implemented with more vigour. Innovative and efficient ways of leveraging 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 HIV 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. This NSP seeks to provide such guidance.

4. SITUATION ANALYSIS

HIV in sub-Saharan Africa constitutes some 64% of the global total of 39.5 million people living with HIV[1]. 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 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[2]. 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 number of sexual partners 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[3]. HIV prevalence is relatively low in neighbouring Mozambique, although increasing rapidly along transport routes[4] and there is some evidence that prevalence may have peaked in Botswana[5].

The severity of the epidemic is closely linked to the region's political economy including poverty, women's relative lack of empowerment, high rates of male worker migration, and other social and cultural factors. Knowledge of how to protect oneself from infection is not providing protection against the background of economic and social deprivation that characterise the lives of many young people and women in poor countries.

4.1 The epidemiology of HIV and AIDS in South Africa

A clear understanding of the nature, dynamics, and character of an epidemic is critical in informing strategies that are relevant and adapted to local conditions.

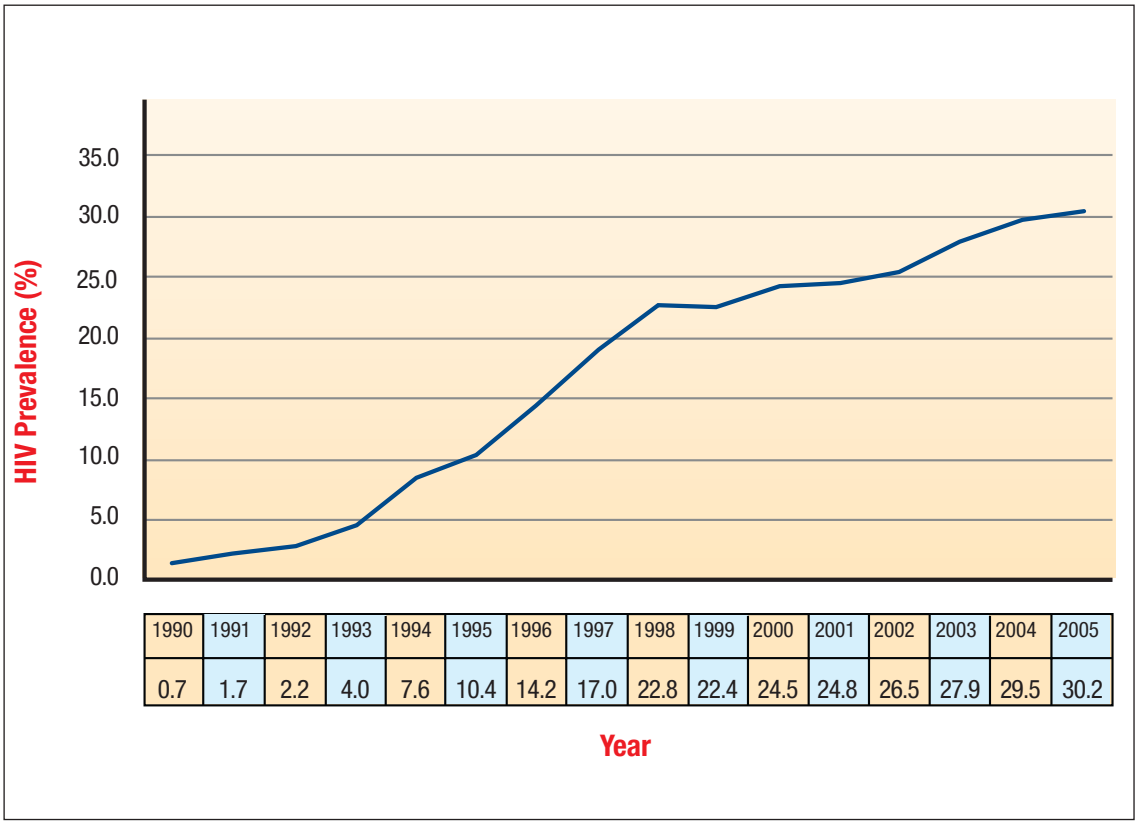
UNAIDS and WHO description of the HIV and AIDS epidemics is based on prevalence rates and population affected. In some countries the epidemic is concentrated in particular groups. In others it is 'generalised' accross the population. However, given the dynamic nature of an epidemic, one country may move 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 character (the populations most affected), dynamics

(patterns of change over time) and characteristics (severity of impact). 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 who are at higher risk of infection. A numerical proxy of HIV prevalence consistently more than 1% in pregnant women has been used to qualify a generalised epidemic (World Bank and WHO use more than 5%) and by this definition alone South Africa has a generalised epidemic.

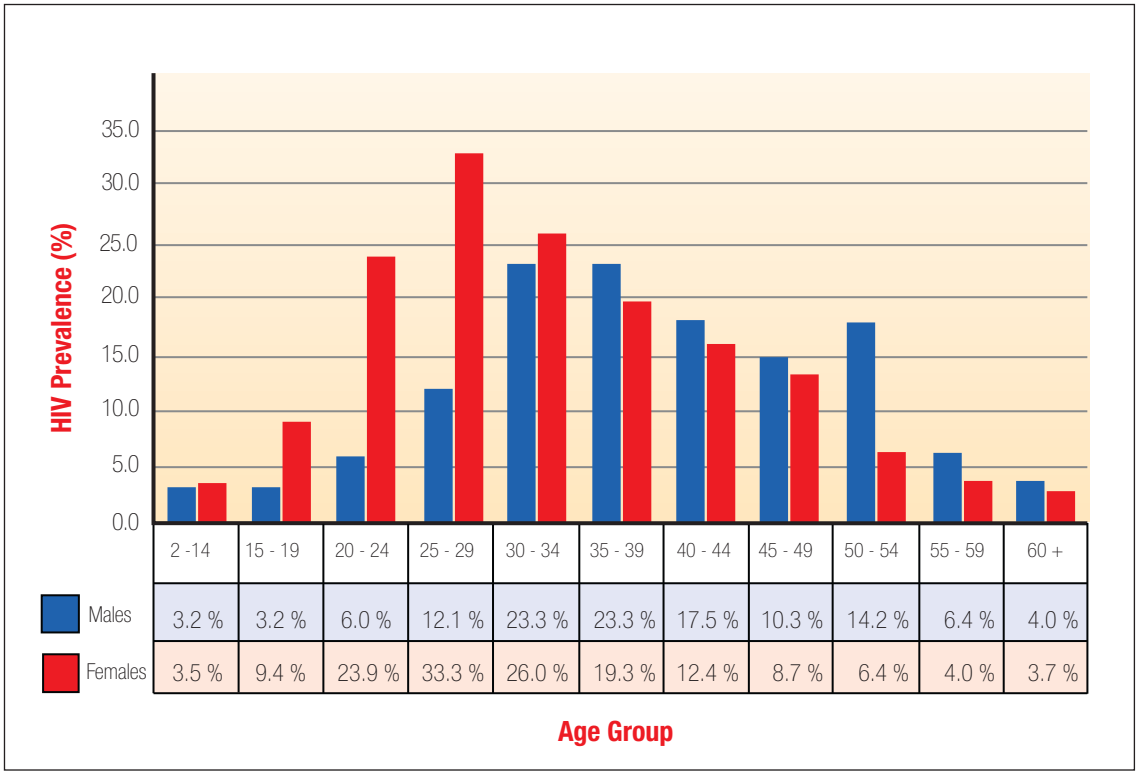
HIV prevalence has been consistently monitored in South Africa including through antenatal HIV and syphilis prevalence surveys, which have been conducted since 1990, and two national population-based surveys which were conducted in 2002 and 2005 [6]. A national prevalence survey of youth was also conducted in 2003/4. Figure 1 illustrates antenatal HIV trends from 1990 to 2005 [7], 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 [8]



[8] Department of Health, 2006

Figure 2: National prevalence by age and sex: 2005 [9]



[9] Shisana, et al (2005)

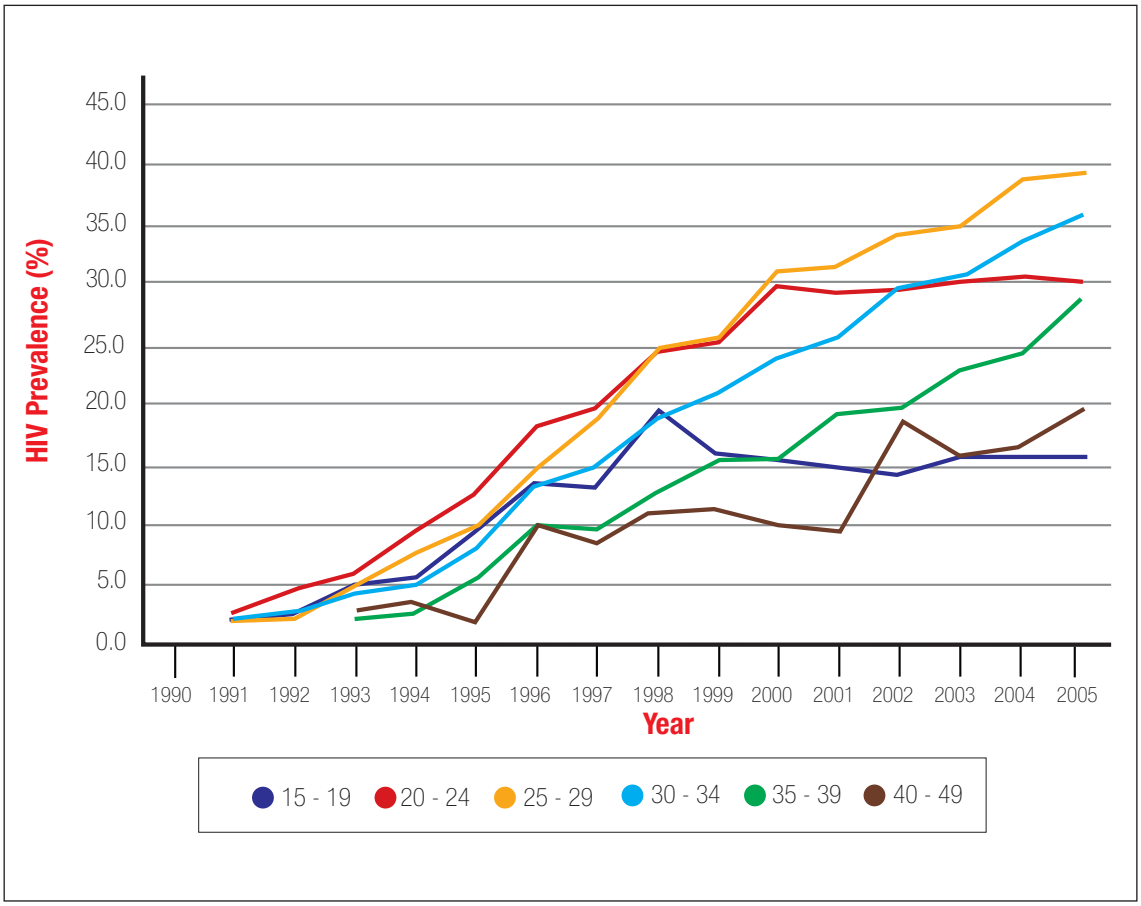
A number of other national and sub-national studies have been conducted including amongst groups of employees, the military, health workers, educators[10], health care workers and hospital patients[11], amongst children attending health care facilities[12], and in various other communities and sectors.

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 (p.24), showing an estimated 5.4 million people living with HIV in South Africa in 2006, of which a total of 294 000 were children aged 0-14[13] . 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[13,14]. 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[15]. 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 slowed down. In recent years there, however, has been a discernable increase in HIV prevalence in older age groups.

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



Source: Department of Health, 2006

Table 1: HIV and AIDS Indicators at mid-2006 [16]

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

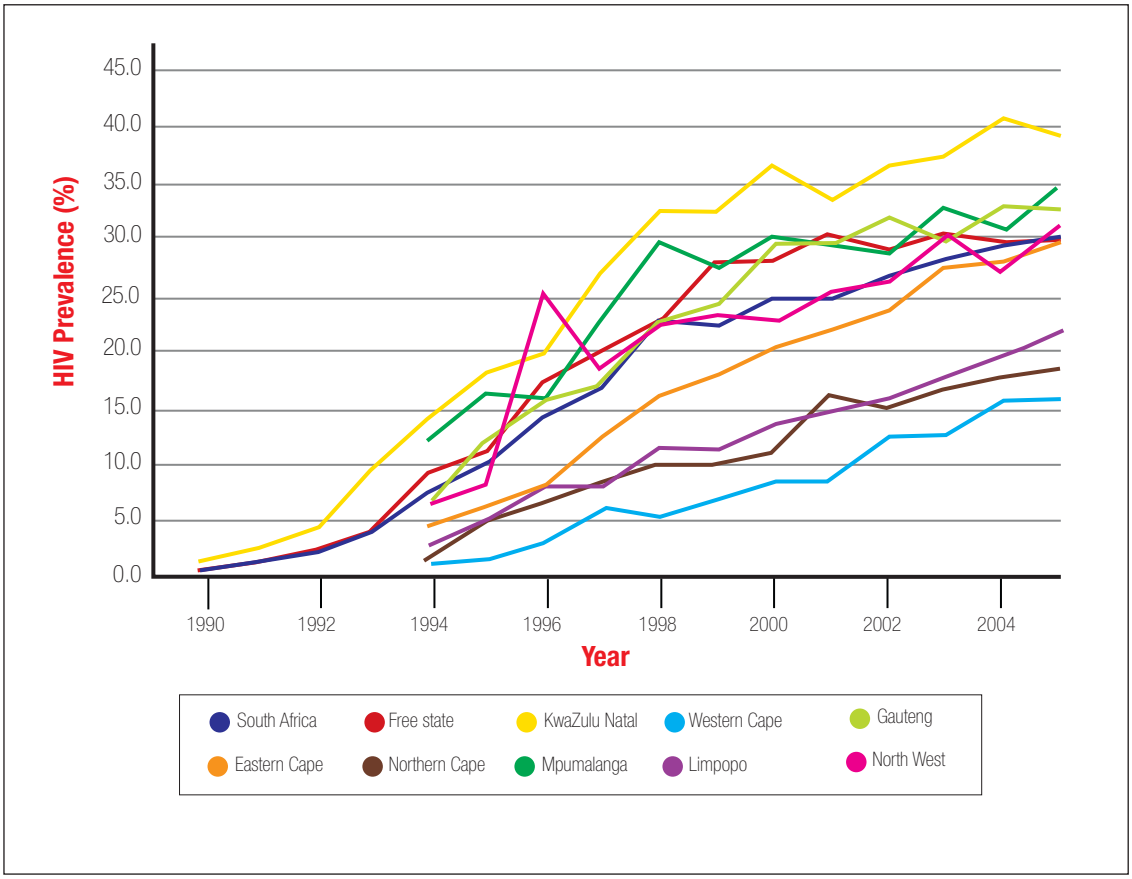
[16] Note: Numbers rounded to nearest thousand to avoid spurious accuracy.

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

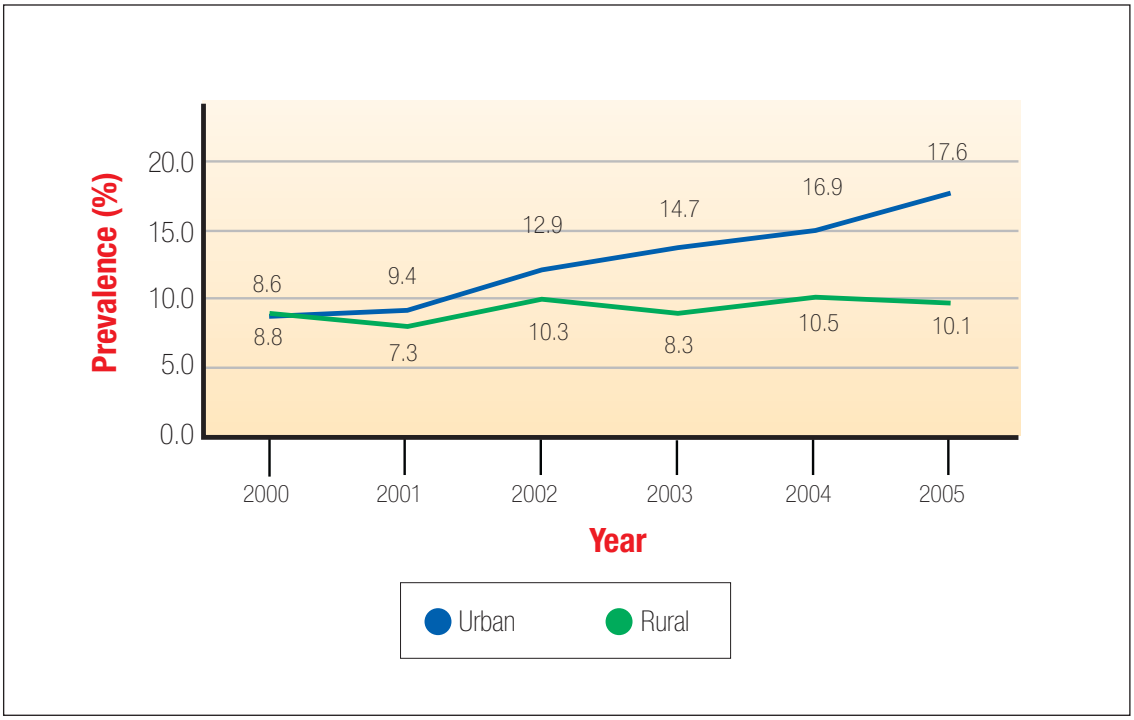


Source: Department of Health, 2006

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%[17].

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[18].

Figure 5: HIV Prevalence By Urban/Rural: Western Cape 2000 – 2005.

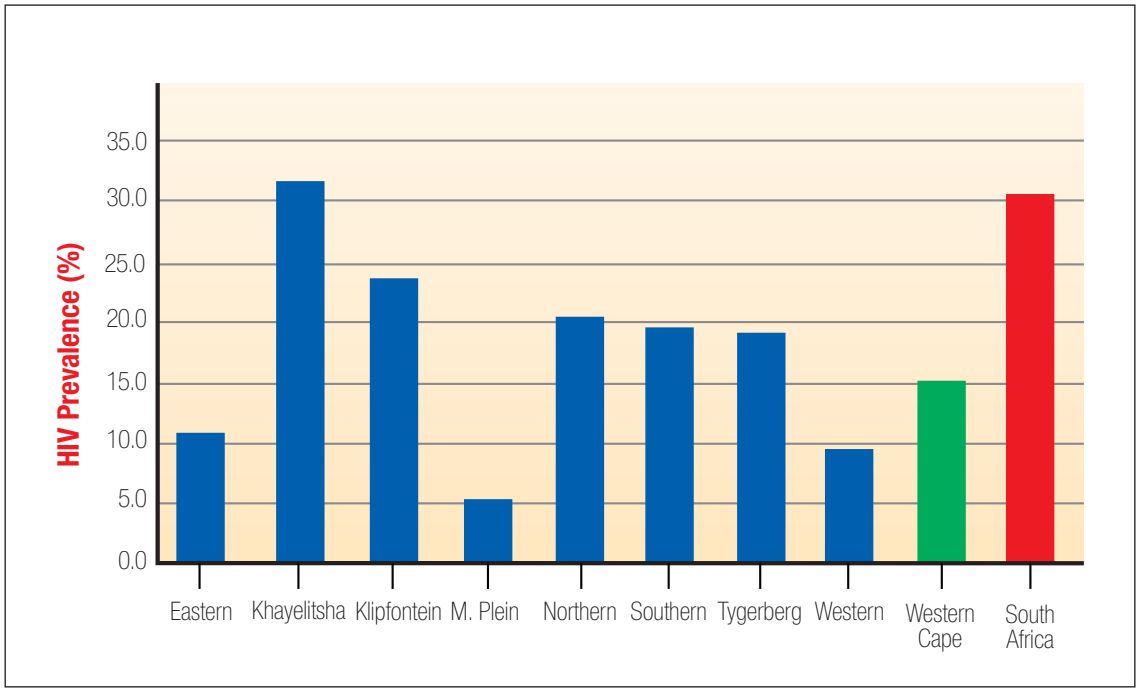


Source: HIV antenatal province and area survey, Western Cape Department of Health, 2005

The reasons for the variable growth of the epidemic are not clear and a combination of factors is attributed to the variation. It is argued that geographical heterogeneity in HIV trends 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.

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

Figure 6: HIV Prevalence by Area in the Cape Metropole District versus the Western Cape and South Africa: 2005



Source: HIV antenatal province and area survey, Western Cape Department of Health, 2005

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[19].

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 and 25-29 years 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[20]. 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 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 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.

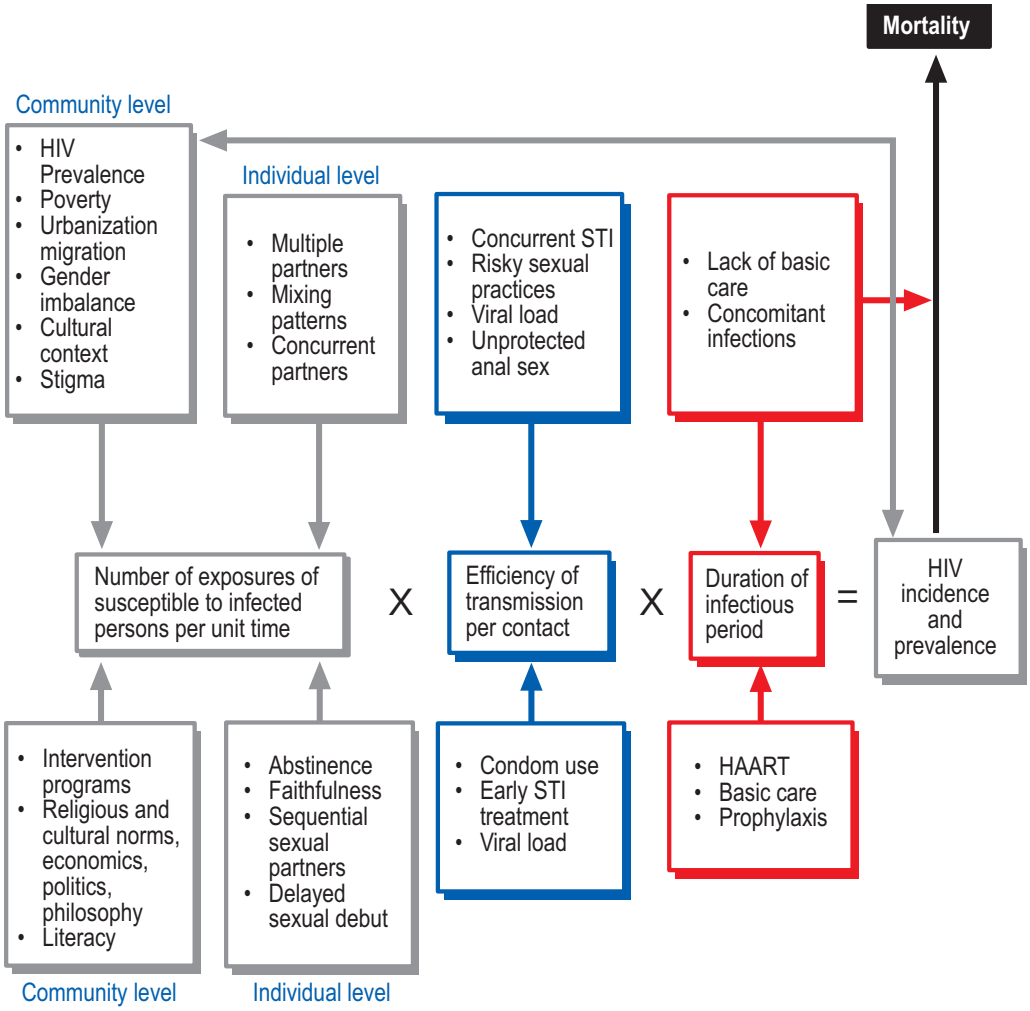
The HSRC data also show that children have a high HIV prevalence. In the 2-4 age group, 4.9% of boys and 5.3% of girls are HIV positive, translating into an estimated 129 621 children. In the slightly older age group of 5-9, 4.2% of boys and 4.8% of girls have HIV - an estimated 214 102 children, and in the 10-14 age group, this figure drops to 1.6% among boys and 1.8% among girls[21].

4.2 Major causes and determinants of the epidemic in South Africa

It is important to be aware that the context of the national 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. 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 7[22]. These include biological, individual and social/contextual factors.

Figure 7: 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[23].
- 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[24].

- 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[25]. Exposure to blood can also occur in a wide range of institutional settings and in emergency situations where people are injured. Not much is known about the extent of the risk in informal health care settings and with traditional practices. Universal precaution practices including use of gloves and other protective measures are recommended.

- Injecting 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 injecting drug users, prevalence is very high[26].

Contextual Factors

(a) *Poverty*

Poverty operates through a variety of mechanisms as a risk factor for infection with HIV and AIDS. Its effect needs to be understood within a socio-epidemiological context. It works through a myriad of interrelations, including unequal income distribution[27], economic inequalities between men and women which promote trans-actional sex[28], relatively poor public health education and inadequate public health system[29]. 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[30].

(b) *Gender and Gender-based violence*

South Africa has one of the highest rates of violence against women, with over 53 000 rapes reported to police in 2000, translating into a rape reporting rate of 123 women per 100 000 population[31]. Sexual violence is linked with a culture of violence involving negative attitudes (e.g. deliberate intention to spread HIV) and reduced capacity to make positive decisions or to respond appropriately to HIV prevention campaigns. More significantly, the experience of sexual assault has also been linked to risks for HIV infection[32].

Equally interesting, two recent studies conducted among men in a township community and in an STI clinic both showed that men with a history of sexual assault were also at significantly higher risk for HIV transmission than their counterparts without such a history [33]. In South Africa, the gender system fosters power imbalances that facilitate women's risks for sexual assault and sexually transmitted infections (STIs)[34]. South African men, like men in most societies, possess greater control and power in their sexual relationships [35].

Women with the least power in their relationships are at the highest risk for both sexual assault and HIV infection, both stemming from the inability of women to control the actions of their sex partners [36]. Men who have limited resources and lack the opportunity for social advancement often resort to exerting power and control over women [37]. Importantly, sexist beliefs and negative attitudes toward women are held by men who have not been sexually violent as well as men who have a history of sexual violence. In fact, negative attitudes toward women are so pervasive there is evidence that they are often held by women themselves [38]. Power and control disparities in relationships create a context for men to have multiple concurrent partners and fuel their reluctance to use condoms. Unfortunately, men's attitudes toward women impede HIV preventive actions and can culminate in the acceptance of violence against women. Qualitative studies in South Africa consistently show that men believe they are more powerful than women and that men are expected to control women in their relationships. There is also evidence that men often hold attitudes that accept violence against women including beliefs that women should be held responsible for being raped. One in three men receiving STI clinic services endorsed the belief that women are raped because of things that they say and do and half of men believed that rape mainly happens when a woman sends a man 'sexual signals'[39].

(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 [40]. Such decisions are frequently constrained by coercion and violence in the 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 [41].

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 [42]. In the UNGASS declaration, governments committed themselves to, among other things, confront stigma, denial and eliminate discrimination by 2003. Although still prevalent, AIDS stigma appears 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 [43].

A recent large survey conducted among 1 054 people living with HIV (PLHIV) in Cape Town found high levels of internalised stigma [44]. This is mostly due to the fact 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 PLHIV 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 [45].

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 [46]. Another consequence is denial. Both silence and denial about HIV and AIDS are lethal because they prevent people from accurately assessing their own personal risk of infection as well as accessing the broad range of available services in this regard.

(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[47]. 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[48]. These forms of mobility are pervasive in southern Africa. Various studies have illustrated the higher likelihood of mobile groups being HIV positive[49]. 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[50].

(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%). There is often social fragmentation within informal settlements that may increase the likelihood of exposure to unsafe sex. In addition there is a greater likelihood that individuals at higher risk of HIV including work-seekers, temporary workers, and labour migrants are resident in these areas. Informal settlements frequently lack adequate housing, sanitation and health service access, and these exacerbate overall health risks[51].

4.3 Populations at higher risk

(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. 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.

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[52]. A youth study by the Reproductive Health Research Unit (RHRU, 2002) found that among the 10% of youth who are 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 bear the brunt of caring for sick family members and are the soldiers at the forefront of community-based HIV and AIDS activities. The HIV epidemic and AIDS 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 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[53].

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 years, while in the 20-24 age group 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 in and expansion of carefully 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. Often the aspirations that existed in school of getting a job and earning an income are dashed. Personal motivation to achieve and the psychological rewards of school achievement are no longer there. In addition there are family pressures to contribute to household income or to leave. In the absence of career opportunities, many young women find fulfillment 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[54]. 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[55]. HIV is thought to have contributed to an increase of 42% in under-five mortality in this country in 2004[56]. 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 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[57].

(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 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. The disabilities sector is actively involved in ensuring that people with disabilities respond to the challenges of HIV and AIDS that are facing them often with little support. The special needs of people with disabilities demand conscious efforts to ensure equitable access to information and services.

(e) *People in prisons*

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[58]. 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 Africa. However, a small study in Westville medium security prison near Durban in 2002 found an HIV prevalence of 29.6% amongst male prisoners[59].

(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, receptive anal intercourse carries 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 [60].

(g) *Sex Workers*

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 [61]. 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.

(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[62].

4.4 Sexual HIV transmission and biological risk

The likelihood that an individual will become infected with HIV through sexual contact depends on the mechanism of sexual contact, the viral load of the HIV positive person and the susceptibility of the individual[63]. Whilst the probability of HIV transmission through a single coital act is relatively low, risk increases through repeat exposure and higher risk is strongly associated with higher viral load in the infected partner, co-infection with sexually transmitted infection(s), genital ulceration, genital maturity, and anal sex, amongst other factors.

Prevalence data and various studies have illustrated the higher biological vulnerability of women and younger women and girls in particular. Biological factors include underdevelopment of the genital tract in young women and girls, a greater surface contact area within the vagina, retention of fluids for a longer period, and the higher possibility of undetected STIs. Both males and females are biologically more vulnerable in the case of receptive anal intercourse, and uncircumcised males are also more vulnerable.

Concurrent sexual partnerships increase the likelihood of exposure of sexual partners to high viral load and consequently, higher likelihood of infection[64]. High viral load in the late phases of HIV is reduced through antiretroviral therapy[65].

4.4.1 Sexual HIV transmission and individual risk factors

(a) *Early sexual debut*

Earlier sexual debut is significantly associated with increased risk of HIV infection. Risks of earlier sexual debut also include higher likelihood of having multiple partners, lower likelihood of condom use at first sex and higher overall numbers of sexual partners, not to mention higher biological susceptibility to infection of adolescent and young girls[66]. Orphanhood, which increases as a result of deaths of parents from AIDS, has been found to increase the likelihood of earlier sexual debut[67]. Shifts towards later sexual debut have been correlated with declines in HIV prevalence in a number of African countries[68].

(b) *Older sexual partners amongst youth*

For young people, particularly girls under 20, having older partners is a significant risk factor for HIV infection as it exposes them to a pool of higher HIV prevalence. Both young males and females are more likely to be HIV positive if they have sexual partners five or more years older than themselves[69].

(c) *Transactional sex*

Transactional sex involves the exchange of sex for material gain. Transactional sex further disempowers woman and may include a reduced ability to negotiate safer sex – particularly condom use[70]. In a study in South Africa, transactional sex amongst females with a non-primary male partner was associated with lifetime experience of partner violence, problematic alcohol and drug use, and substandard housing, amongst other factors[71].

(d) *Partner turnover and concurrent sexual partnerships*

Having a higher overall number of sexual partners, having a high turnover of sexual partners and having concurrent sexual partners (or having a partner who has concurrent sexual partners) are all risk factors for HIV infection[72]. People settle into permanent sexual relationships and marry at relatively older ages in South Africa. This results in a higher likelihood of having numerous life-time sexual partners. The length of the period of risky sexual activity prior to marriage has been shown to be closely correlated with HIV prevalence in a country[73] and declines in HIV prevalence have been associated with declines in number of sexual partners in the past year[74]. In

South Africa, 27.5% of males and 6.0% of females aged 15-24 had two or more partners in the past year. In older age groups the proportions were 14.4% for males and 1.8% for females aged 25-49, and also high for males aged 50 years and older at 9.8%[75]. Amongst youth aged 15-24 higher proportions of having multiple partners were also reported in a national survey in 2004 – 44% for males and 12% for females[76].

(e) *Condom use*

When used consistently and correctly, male and female condoms prevent HIV infection and other STIs. Consistent, but not necessarily correct condom use is estimated to provide 80% protection in comparison to non-use[77], whilst inconsistent use is not significantly protective[78]. Male latex condoms are widely distributed in South Africa including via the public sector, social marketing programmes and commercial sales. Quality control and related logistics for public sector condoms is managed by the Department of Health and over 350-million condoms annually have been distributed on a demand basis in recent years. Public sector distribution includes hospitals and clinics as primary distribution sites, with secondary distribution extending to non-governmental organisations, workplaces, and other locations. Female condoms are distributed to selected sites. Access to male condoms is perceived to be high[79].

Reported levels of male condom use at last sex are high in South Africa, particularly amongst youth at 72.8% for males and 55.7% for females aged 15-24, and over 30% for males and females aged 25-49. However, high levels of reported use have not translated into reductions in antenatal HIV prevalence over the past five years[80]. Increases in condom use with non-regular partners have however been associated with prevalence declines in other African countries[81].

(f) *Male Circumcision*

Epidemiological analyses have demonstrated correlations between circumcision and HIV prevalence[82], and protective effects have been shown in a randomised controlled trial in South Africa[83] and elsewhere[84]. Male circumcision reduces the risk of HIV infection of males through female-to-male transmission[85]. However it is not yet clear whether it reduces male-to-female transmission, although there are likely to be long-term epidemiological benefits[86]. Even after circumcision it remains necessary for men to practice consistent condom use, as well as adopting or maintaining other

HIV prevention strategies such as limiting numbers of sexual partners, whether or not they are circumcised.

(g) *Substance Use*

Alcohol and drug use have a disinhibiting effect on safer sex as a product of diminishing rational decision-making. Alcohol use has been associated with higher risk of HIV infection, with heavy alcohol consumption being linked to higher likelihoods of having unprotected sex with a non-monogamous partner, having multiple sexual partners, and paying for or selling sex[87].

(h) *Knowledge of HIV status*

Knowledge of HIV status appears not to lead to increased adoption of HIV prevention practices amongst people who tested HIV negative, but has been linked to increased prevention behaviours amongst those who test HIV positive[88]. Interventions focusing on people living with HIV who know their status – sometimes referred to as positive prevention – have also shown increases in the adoption of preventive practices[89].

Around 30% of those aged 15 years and older report ever having tested for HIV in 2005, with a significant proportion having tested for HIV in the past year (eg. 49.5% of 15-24 year olds)[90].

4.5 Impacts

Demographic

The demographic impact of HIV and AIDS on the South African population is 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).

- 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[91]. However, there is currently no clear evidence of 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[92].

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[93]. Orphans and vulnerable children are at higher risk for HIV infection, as they face numerous material, emotional and social problems[94]. They also face:

- 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[95].

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 PLHIV, and the importance of mental health programming in relation to HIV has long been overlooked [96]. 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 PLHIV including depression, anxiety, increased anxiety amongst PLHIV 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 the human resource are two-fold: the impact on stress and morale 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 [97]. 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 [98].

Education system

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 [99].

In conclusion 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 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 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.

Recent reports on the status of HIV and AIDS communication campaigns have found that a variety of AIDS communication programmes, including Khomanani, Soul City and loveLife are achieving significant reach and are becoming well known and recognised by the general population. The Life Skills program has been extended to many schools in South Africa 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.

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.

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.

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. Also various projects are underway, funded through the Comprehensive Plan. 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, 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, 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 all of their members.

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.
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.

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 the NSP to ensure continued guidance and strengthening of the national, mullti-sectoral response to HIV and AIDS.

This plan would build on 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 NSP 2000-2005 is fundamentally still relevant. This work earnestly began in August and September 2006 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. The initial findings were presented to government and civil society for validation. Thereafter 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 PLHIV, 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 by the DOH 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, PLHIV, women's groups, the youth troika (the National Youth Commission, National Youth Council and Umsobomvu), 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. In addition, the Deputy President held bilateral meetings with several important sectors – including organised labour, media groupings, business, children's sector – in order to obtain their views and to discuss ways to facilitate their meaningful participation.

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). During February and March 2007, this team (led by the DoH) met to further develop an evidence-informed description of the HIV epidemic in South Africa, review targets, develop a M&E framework and to cost the NSP. The team presented the final draft to a national consultation on the 14-15 March 2007 for endorsement. Inputs from the more five hundred people present at the two-day national conference were incorporated. The NSP 2007-2011 was then adopted by the new SANAC at its inaugural meeting as the document expressing the national commitment and approach to HIV & AIDS and STIs.

7. PURPOSE OF THE STRATEGIC PLAN 2007-2011

The NSP 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 needs for treatment 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 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.

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 and to facilitate the strengthening of the national health system. The NSP 2007-2011, however, 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 plan 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 matters 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 are in keeping with the imperatives of the Constitution, those outlined in the Comprehensive Plan, and *Batho Pele*. These Principles are:

- **Supportive Leadership:** The NSP should be driven by South Africa's political leadership with the support of leaders from all sectors.
- **Leadership role of government:** The effective implementation of the NSP and the attainment of its goals depends on government leadership in resource allocation, policy development, and effective coordination of all programmes and interventions.
- **Greater Involvement of People Living with HIV:** There must be meaningful involvement of people living with HIV in all aspects of the national response.
- **Young People (aged 15-24) as a Priority Group for HIV prevention:** The trend of the HIV epidemic can be reversed if young people are informed and empowered to change their behaviour and reduce their risk. In all interventions there must be a special plan on reaching young people and consciously involving them in activities.
- **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 AIDS response.
- **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 programmes and measures to ensure progressive realisation of rights to education, health care services and social security 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.
- **Challenging Stigma:** The stigma against people with HIV undermines dignity and hinders an effective response to HIV and AIDS. The NSP is committed to ending all stigma by creating knowledge and competence about HIV especially within our communities.
- **Ensuring Equality and Non-discrimination against marginalised groups:** 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 protect themselves and others from HIV infection, 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-informed.
- **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. A budget of between 4% and 7% of the total HIV and AIDS budget should be dedicated to M&E.

- **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 development partners shall be harmonised to align with policies, priorities and fund programme and financial gaps.

9. THE HIV & AIDS and STI STRATEGIC PLAN FOR SOUTH AFRICA: (NSP 2007-2011)

The primary aims of the NSP are to:

- Reduce the rate of new HIV infections by 50%.
- Reduce the impact of HIV and AIDS on individuals, families, communities and society by expanding access to an appropriate package of 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;
- Monitoring, research and surveillance; and
- Human and rights and access to justice.

The executive summary section outlines the key priority areas, the goals and the identified specific objectives. The section that follows focuses in more detail on the interventions that will be pursued in the next 5 years towards the attainment of these objectives. 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 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.

PRIORITY AREA 2: TREATMENT, CARE AND SUPPORT

The target is to provide an appropriate package of treatment, care and support services to 80% of people living with HIV 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.
- Strengthening the health and other systems 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 TB care.
- Drawing 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.
- Focussing 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.

PRIORITY AREA 3: RESEARCH, MONITORING AND SURVEILLANCE

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 inputs, process, outputs, outcomes and impact will be used to assess collective effort. It is

recommended that a sustainable budget of between 4% – 7% of the total HIV and AIDS budget is dedicated for the Monitoring and Evaluation of the NSP in line with international trends.

PRIORITY AREA 4: HUMAN RIGHTS AND ACCESS TO JUSTICE

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. 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.

Youth as a specific target group

Young people are not only the key to South Africa's future, but also the key to whether we meet the goals of the NSP. A key message of the NSP is that one of our greatest challenges is to influence and change the behaviour of young people, particularly those under 24, in order to try to reduce HIV infection in the age group that is most at risk. If this strategy is successful, behaviour change will need to be sustained and monitored as people get older. Also, access to youth-friendly services in clinics and multipurpose centres is key to getting young people involved in HIV and AIDS prevention treatment care and support programmes. The NSP outlines some critical youth specific interventions.

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	
1.1: **Accelerate poverty reduction strategies and strengthen safety nets to mitigate the impact of poverty**	Scale up access to government poverty alleviation programmes	30%	40%	60%	80%	90%	**Presidency**; SALGA, DPLG, Govt. Treasury, DSD, DTI, Business
	Monitor poverty reduction programmes and report on MDG target one	Annual	Annual	Annual	Annual	Annual	**Presidency**, DSD, DTI, Private Sector, NPA
	Ensure equitable provision of basic social services such as housing, water, sanitation, roads, transport, health services, upgrading of informal settlements, education especially in rural and urban informal settlements	Quarterly campaigns	Quarterly campaigns	Quarterly campaigns	Quarterly campaigns	Quarterly campaigns	**DPLG**, DSD, DTI, SALGA, Local authorities, Business, Spatial development partners
	Introduce sustainable income transfer system to poor families including child-headed households	20%	30%	40%	50%	60%	**Treasury**, Social Development, Civil Society

GOAL 1: REDUCE VULNERABILITY TO HIV INFECTION AND THE IMPACT OF AIDS continued

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
1.2: **Accelerate programmes to empower women and educate men, and women (including the boy and girl child) on human rights in general and women rights in particular**	Implement all national policies and legislation aimed at improving the status of women	Annual monitoring	Annual	Annual	Annual	Annual	**Presidency**, Men's sector, Women's sector, DOH, DPLG, NPA
	Develop and implement a communication strategy including leadership messages, to educate men and women, boys and girls, on women's rights and human rights	Communi-cation Strategy developed	Quarterly campaigns	Quarterly campaigns	Quarterly campaigns	Quarterly campaigns	**Presidency,** NPA, All
	Roll-out integrated microfinance and gender education interventions starting in the poorest and highest HIV burden areas	Develop & implement at least 1/province	4/province	8/province	16/province	32/province	**DSD**, Private sector, Treasury; NGOs, Presidency
1.3: **Develop and implement strategies to address gender based violence**	Develop communication strategies including leadership messages, which addresses the unacceptability of coercive sex, gender power stereotypes and the stigmatisation of rape survivors	Communi-cation Strategy developed	Quarterly campaigns and ongoing	Quarterly campaigns and ongoing	Quarterly campaigns and ongoing	Quarterly campaigns and ongoing	**NPA**, DOE, DOH, DOSD, DOJ, Presidency, NGOs

1.4: **Create an enabling environment for HIV testing**	Develop high profile campaigns utilising peer influence to promote HIV testing and disclosure	Develop & implement	Monthly	Monthly	Monthly	Monthly	**DOH**, Social Development Cluster, Civil Society Structures, Private sector
	Expand access to HIV testing beyond formal health care settings such as community and non-health care settings	At least 1 non-health care facility point per district	5/district	10/district	20/district	30/district	**DOH**, Social Development Cluster, Civil Society Structures, Private sector
	Develop clear, consistent HIV prevention messages to be delivered by leadership from all sectors at all available opportunities	Prevention key mes-sages for leadership developed	Update quarterly	Update quarterly	Update quarterly	Update quarterly	**DOH**,Govt., Civil Society, Private sector
1.5 **Build and maintain leadership from all sectors of society to promote and support the NSP goals**	Ensure regular updates in sectors on priority activities and messages	Quarterly reports on sector indicators	Quarterly reports on sector indicators	Quarterly reports on sector indicators	Quarterly reports on sector indicators	Quarterly reports on sector indicators	**SANAC**
	Mobilise and engage custodians of culture and cultural practices through debates, seminars and workshops on cultural practices that fuel the spread of HIV as well as those that are desirable	Program for tradition-al leaders developed	Quarterly forum	Quarterly forum	Quarterly forum	Quarterly forum	**Traditional Leaders Sector**, DACST, DOH, tradi-tional structures, Civil Society, Private sector

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
1.6: **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 communities and families	Develop & implement	Ongoing	Ongoing	Ongoing	Ongoing	**DOH**, Social Development Cluster, Civil Society Structures, Private sector, DPLG, SALGA, Local authorities
1.7: **Build AIDS competent communities through tailored competency processes.**	Design and implement ward-based community competency programmes in most vulnerable communities	Community competency programmes developed and piloted in 9 provinces	30% ward-based vulnerable communities covered	50%	60%	70%	**DOH**, DPLG, SALGA, DSD, Local authorities, Private sector CBO's

GOAL 2: REDUCE SEXUAL TRANSMISSION OF HIV

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
2.1: **Strengthen behaviour change programmes, interventions and curricula for the prevention of sexual transmission of HIV, customised for different target groups with a focus on those more vulnerable to and at higher risk of HIV infection**	Introduce, evaluate and customise curricula and interventions for different target groups including: Young people out of school, primary school children, secondary school children, higher education institutions, young women and pregnant women, older men and women, higher risk groups and vulnerable populations (informal settlements, rural areas) (see below)	Evaluation, improve-ment & introduction	Ongoing	Ongoing	Ongoing	Ongoing	**DOE**, DOH, All government departments, All sectors of Civil Society
2.2: **Implement interventions targeted at reducing HIV infection in young people, focusing on young women**	Identify and prioritise interventions in schools reporting high rates of teenage pregnancies per year through a gender sensitive package that addresses sexual & reproductive health and rights, HIV, alcohol and substance abuse.	Create spatial map and database and start implementa tion in priority schools	Implemen-tation in 50% of priority schools	Implemen-tation in 70% of priority schools	Implemen-tation in 80% of priority schools	Implemen-tation in 90% of priority schools	**DOE**, DSD, DOH, PLHIV, Professional organisations, Civil Society, Traditional structures

GOAL 2: REDUCE SEXUAL TRANSMISSION OF HIV

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
	Implement legislation and policies and programs aimed at keeping young people in schools, (particularly orphans and vulnerable children)	Identify and implement	Ongoing	Ongoing	Ongoing	Ongoing	**DOE**, Social cluster, DOH, Civil Society, Traditional structures, Private sector, DTI, Treasury
	Introduce, strengthen and evaluate life skills, SRH education and HIV prevention programmes in all primary and secondary schools	70% institutions	80%	90%	95%	98%	**DOE**, DOH, NGOs, DSD, Academic institutions
	Enhance training of teachers and NGOs to ensure quality delivery of life skills, SRH and HIV prevention programmes in schools	Review and start implemen-tation	30% training completed per district	50% training completed per district	60% training completed per district	80% training completed per district	**DOE**, Social cluster, Private sector, Academic institutions, NGO sector
2.3: Increase open discussion of HIV and sexuality between parents and children	Evaluate, adapt and implement parenting programmes that promote positive engagement and communication with children on sexuality and HIV	Implement in each province	30% of districts covered	50%	70%	90%	**Social Cluster**, NGOs and Civil Society Structures, DAC, DPLG, Local authorities

	Strengthen SRH and HIV prevention programmes including VCT, STI, contraceptive services and psychosocial support in higher education institutions	80% of institutions covered	90%	95%	95%	98%	**HEAIDS**, Higher education institutions, D0E, D0H
	Develop and implement guidelines for educational institutions (schools and Higher education institutions) to be sites of safety, protection and care for children and young people	10%	30%	50%	70%	90%	**DoE**, Social Cluster, NGOs
	Increase targeted HIV prevention and SRH programmes and initiatives for out of school youth in different setting focusing on informal settlements and, rural areas, and considering the needs of street children and child headed households	20% of districts	50% of districts	70% of districts	85% of districts	100% of districts	**DSD**, DOH, DOSD, NGOs, DOE, Religious institutions, Traditional sector
	Increase and coordinate multi-media strategies aimed at youth that promote communication about HIV including HIV prevention, gender and sexuality	quarterly campaigns	quarterly campaigns	quarterly campaigns	quarterly campaigns	quarterly campaigns	**DOH**, Communi-cation sector, Social development cluster, Youth sector, Tradi-tional structures, Civil Society
	Increase access to youth friendly health services in the public sector.	20% of districts	50% of districts	70% of districts	85% of districts	100% of districts	**DOH**

GOAL 2: REDUCE SEXUAL TRANSMISSION OF HIV continued

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
2.4: Increase roll out of workplace prevention programmes (Cross reference with ILO, NEDLAC and SADC Code) for workplace based interventions	Incremental roll-out of comprehensive prevention package in workplaces, including access to IEC, VCT, provision of male and female condoms, STI management and TB screening	40% of workplaces	60%	80%	90%	100%	**DPSA**, NGOs, all government departments, Business NEDLAC
	Incremental roll-out of comprehensive customised HIV prevention package to higher risk occupational groups including uniformed services, mining industry, long distance transport services, agriculture industry and the hospitality industry,	50% of services	60% of services	70% of services	80% of services	100% of services	**DPSA**, Relevant employee institutions, DoH, DoL
	Develop targeted HIV prevention programmes for domestic workers and gardeners and other employees who are hard to reach	Targeted programs developed	30% of districts covered	40%	50%	70%	**DoL**, NGOs DoH, DoSD, DoH, NGOs

2.5: **Increase roll out of prevention programmes for higher risk populations**	Incremental roll-out of comprehensive customised HIV prevention package in prisons, including access to VCT and access to male condoms, lubricants, STI symptom recognition and access to PEP and STI treatment	50% of services	70% of services	80% of services	90% of services	95% of services	**DOH,** DCS, NGOs
	Incremental roll-out of comprehensive customised HIV prevention package for MSM, lesbians and transsexuals including promotion of VCT and access to male and female condoms, and STI symptom recognition	Program developed with relevant groups	40% of groups covered	50%	60%	70%	**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 organised groups covered	70%	80%	90%	95%	**DOH**, DSD, DOL, NGOs, NPA

GOAL 2: REDUCE SEXUAL TRANSMISSION OF HIV continued

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
2.6: **Develop and integrate a package of sexual and reproductive health and HIV prevention services into all relevant health services**	Integrate sexual & reproductive health services and HIV prevention guidelines and programmes into family planning, ANC, STI, TB, ARV treatment services and vise versa in the public and private sector	30% of services	40% of services	60% of services	70% of services	80% of services	**DOH**, Private sector
	Increase access to quality STI services in the public and private sector offered by adequately trained staff utilising the updated syndromic management guidelines	40% of services	50% of services	60% of services	80% of services	90% of services	**DOH**, NGO, Organisations representing private sector practitioners, Medical aids
2.7: **Develop a comprehensive package that promotes male sexual health**	Identify, evaluate and roll out effective gender sensitive male intervention programmes in the workplace, and in communities, that address HIV prevention, gender issues and responsible parenting.	Male sexual health program developed	20%	40%	50%	60%	**DOH**, NGOs, Men's sector

	Convene a multidisciplinary expert working group, including traditional leaders and private practitioners to review the WHO/ UNAIDS male circumcision policy and make policy and programme recommendations	Policy recommendation from expert group adopted by the NHC and implemented	20% of districts	40%	60%	80%	**DOH,** Traditional leaders, Private Sector, NGO's
2.8: **Develop and integrate interventions for reducing recreational drug use in young people with HIV prevention efforts**	Develop and implement policy and programmes for an integrated and comprehensive package of HIV prevention services, including access to male condoms, with responsible alcohol consumption targeted at clients in beerhalls, clubs, pubs, brothels, shebeens and traditional ceremonies, including information on how to access to HIV testing and treatment of STIs	Policy and program developed	40% of districts covered	60% of	80% of	90% of	**DOH**, NGOs, DSD, DTI, Men's sector, the alcohol industry, Traditional leaders
	Integrate HIV prevention messages into existing campaigns to promote responsible alcohol consumption	HIV prevention messages mainstreamed into relevant campaigns	Quarterly campaigns	Quarterly campaigns	Quarterly campaigns	Quarterly campaigns	**DOH**, Social cluster, Communication sector, Civil Society, Private sector, DOH

GOAL 2: REDUCE SEXUAL TRANSMISSION OF HIV continued

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
	Support the introduction of polices and programmes aimed at reducing recreational drug use among young people and ensure that HIV prevention messages are integrated into these programmes	Develop & strat imple-mentation	Ongoing	Ongoing	Ongoing	Ongoing	**DOH**, Social cluster, Academic institutions, Civil Society, Private sector
	Establish public sector drug rehabilitation programmes in all provinces	20 facilities	40 facilities	60 facilities	80 facilities	100 facilities	**DSD**, DOH, NPA, DOJ, DCS, NGO, Social cluster, Private sector
2.9: Increase the accessi-bility 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%	90%	95%	**DOH**, DOJ, NPA, DSD, DCS

	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**
	Evaluate, improve and roll out training programmes on the management of gender violence and rape for the police	Training program updated	30% of police force trained	40%	50%	60%	**DSD**, NPA, DOJ, DCS
	Increase the number of districts with accessible social and mental health services to support child and adult victims of gender-based violence	20% of districts covered	40%	60%	80%	90%	**DOSD**, DOH, NGOs
2.10: **Scale up prevention programmes for HIV positive people.**	Develop and implement programmes that support voluntary disclosure of HIV positive status	Program and policy for voluntary disclosure developed	40% of support groups covered	60% of	80% of	90% of	**DOH**, DSD, PWA sector, Civil Society structures, Private sector
	Develop and implement HIV prevention programmes and interventions to reduce HIV transmission and acquisition by HIV positive persons	Develop & start imple-mentation	20% of known HIV persons covered	40%	60%	80%	**DOH**, DSD, PWA sector, Civil Society structures, Private sector

GOAL 2: REDUCE SEXUAL TRANSMISSION OF HIV continued

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
	Integrate safer sex practices, male and female condoms, STI management, into all ARV treatment programmes including palliative and home based care	40%	60%	80%	90%	90%	**DOH**, PWA sector, Civil Society structures, Private sector
	Enhance and support integrated positive prevention and care services provided by NGOs, CBOs and community support groups	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	**DOH**, PWA sector, Civil Society structures, Private sector

GOAL 3: REDUCE MOTHER-TO-CHILD TRANSMISSION OF HIV

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
3.1 : **Broaden existing mother to child transmission services to include other related services and target groups**	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% of increase	40%	60%	80%	90%	**DOH**
	Expand PMTCT guidelines to include fertility guidelines for HIV infected women, men and discordant couples aimed at supporting informed pregnancy choices	Develop & implement guidelines	Annual	Annual	Annual	Annual	**DOH**, Professional organisations
	Implement HIV prevention programmes for uninfected pregnant women	20% increase in public sector ANC services	40%	60%	80%	90%	**DOH**, NGOs
	Implement responsible fatherhood programmes in health districts and in the community	Evaluate & develop programme	Introduce into 20% health districts	40%	60%	80%	**DOH**, NGOs, D0L, DSD

GOAL 3: REDUCE MOTHER-TO-CHILD TRANSMISSION OF HIV continued

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
	Expand PMTCT guidelines to cover postnatal services including contraception, and services for mothers and infants beyond six weeks	Develop & implement guidelines	Annual	Annual	Annual	Annual	**DOH**, Professional organisations
3.2 : **Scale up coverage and improve quality 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**
	Increase proportion of pregnant women tested through implementation of provider-initiated VCT for all pregnant women	70%	85%	90%	95%	95%	**DOH**
	Develop a policy and guidelines on VCT in pregnancy including consideration of provider initiated testing, and frequency of testing	Develop & implement	Annual review	Annual review	Annual review	Annual review	**DOH**, NGOs, DOE
	Increase the proportion of the estimated population of HIV-infected pregnant women in need who receive PMTCT services	60%	70%	80%	90%	95%	**DOH**

	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**, DOSD, NGOs
	Undertake CD4 testing of all positive pregnant women and prioritise those with CD4 counts <200 for accelerated access to ARV treatment	Start implement ation at all tertiary facilities per province	20% of primary care facilities	40% of primary care facilities	60% of primary care facilities	80% of primary care facilities	**DOH**
	Provide nutritional support to HIV-infected women choosing to exclusively breast feed	Develop policy and program	20% of woman covered	40%	60%	80%	**DOH**, DOSD, NGOs
	Provide formula milk to children of HIV positive women choosing and are eligible to practice replacement feeding	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	
4.1 : **Minimise the risk of HIV transmission from occupational exposure among health care providers in the formal, informal and traditional settings through the use of infection control procedures**	Continuously update guidelines for infection control procedures	Annual	Annual	Annual	Annual	Annual	**DOH**, Professional organisations
	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 home based care and palliative care settings	Develop and disseminate promotional and educational materials	Annual	Annual	Annual	Annual	**DOH**, NGOs,
	Provide training for all HCWs, including home based care workers, on infection control	70%	80%	90%	100%	100%	**DOH**, Private health care sector
	Ensure continuous supplies of PEP drugs in public and private sector facilities as well as in community-based settings	80%	90%	100%	100%	100%	**DOH**, Private health care sector

	Ensure all formal health care facilities maintain a register of occupational exposure	80%	85%	90%	95%	95%	**DOH**, Private health care sector
4.2: **Minimise exposure to infected blood through procedures associated with traditional and complementary practices**	Continuously update Guidelines for infection control for traditional and complementary practitioners	Annual	Annual	Annual	Annual	Annual	**DOH**, Professional organisations
	Provide adequate training of traditional healers/practitioners on infection control	30%	50%	70%	80%	100%	**DOH**, Traditional practitioners organisations
	Provide information to the public raising awareness of HIV risk through unsafe traditional practices	70%	50%	60%	70%	80%	**DOH**, NGOs
	Provision of supplies to practice safe traditional practices	30%	50%	60%	70%	80%	**DOH**, Traditional practitioners organisations

GOAL 4: MINIMISE THE RISK OF HIV TRANSMISSION THROUGH BLOOD AND BLOOD PRODUCTS continued

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
4.3: **Investigate the extent of HIV risk from Injecting drug use (IDUs) and develop policy to minimise risk of HIV transmission through injecting drug use and unsafe sexual practices**	Continuously research and monitor the extent of IDU use and the relationship with HIV infection	Annual	Annual	Annual	Annual	Annual	**DOH**, Professional organisations, DSD
	Develop policy and guidelines for HIV prevention in IDUs and review annually	Policy developed and introduced	Annual review	Annual review	Annual review	Annual review	**DOSD**, DOH, DOSD, NGOs
	Establish public sector drug rehabilitation programs in all provinces	1 per province	3 per	Adequate provision according to provincial need	Adequate provision according to provincial need	Adequate provision according to provincial need	**DOSD**, DOH, NGOs

GOAL 4: MINIMISE THE RISK OF HIV TRANSMISSION THROUGH BLOOD AND BLOOD PRODUCTS continued

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
4.4: **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**, NBTS
	Screening of all blood supplies with best available technology including viral detection	100%	100%	100%	100%	100%	**DOH**, NBTS
	Promote awareness of risk of HIV transmission in donors and recipients	100%	100%	100%	100%	100%	**DOH**, NBTS
	Develop and implement a research programme to understand HIV transmission dynamics in blood donor populations	Establish resources and a research programme	Implement	Implement	Implement	Implement	**DOH**, NBTS

PRIORITY AREA 2: Treatment, Care, and Support

GOAL 5: INCREASE COVERAGE OF VOLUNTARY COUNSELLING AND TESTING AND PROMOTE REGULAR HIV TESTING

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
5.1: **Increase access to VCT services that recognise diversity of needs**	Implement provider-initiated VCT in all health facilities, with a special focus on STI, TB, antenatal, IMCI, family planning and general curative services	60% of all health facilities in country (public, private, NGO)	75% of all health facilities in country (public, private, NGO)	90% of all health facilities in country (public, private, NGO)	95% of all health facilities in country (public, private, NGO)	95% of all health facilities in country (public, private, NGO)	**DOH**, Private sector, NGOs, Youth sector
	Increase access to VCT through workplaces and trade unions	30%	40%	50%	55%	60%	**SANAC**, Business and labour sectors
	Investigate community based VCT strategies (outside of health facilities) for special and unmet needs	Identify successful community VCT strategies	Pilot strategies in at least 10 additional sub-districts	Expand successful strategies to cover 20% of districts	Expand successful strategies to cover 50% of districts	Expand successful strategies to cover 70% of districts	**DOH**, CBOs, NGOs, FBOs, Traditional healers, Youth sector

GOAL 5: INCREASE COVERAGE OF VOLUNTARY COUNSELLING AND TESTING AND PROMOTE REGULAR HIV TESTING continued

5.2: Increase uptake of VCT	Increase the number of adults who have ever had an HIV test, with a focus on men	25%	35%	50%	60%	70%	**DOH**, Private sector, Youth sector & all other sectors
	Increase the proportion of adults tested in the last 12 months	7%	11%	18%	22%	25%	
	Increase the proportion of newly diagnosed HIV positive adults accessing wellness services	50%	60%	70%	75%	80%	

GOAL 6: ENABLE PEOPLE LIVING WITH HIV AND AIDS TO LEAD HEALTHY AND PRODUCTIVE LIVES

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
6.1: **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**, DSD, Private sector
	Improve enrolment in and quality of positive living interventions through wellness programmes	30% eligible clients enrolled in wellness program-mes	40%	50%	60%	75%	**DOH**, Private sector, NGOs, CBOs, FBOs, Traditional Healers, Communities, Media, Sports and Recreation, All sectors,
	Increase the proportion of HIV-positive adults not on ART who had a CD4 count within the last 12 months	30% positive adults	45%	60%	70%	80%	
	Increase the proportion of eligible adults receiving cotrimoxazole	20%	30%	50%	70%	80%	

GOAL 6: ENABLE PEOPLE LIVING WITH HIV AND AIDS TO LEAD HEALTHY AND PRODUCTIVE LIVES continued

	Implement integrated contraceptive, cervical screening and fertility services for women	30%	50%	75%	90%	100%	
	Provide food support to eligible households	400 000	450 000	500 000	600 000	700 000	
	Provide psychosocial support including counselling for bereavement, disclosure and adherence	10% of sub-districts	20% of sub-districts	60% of sub-districts	80% of sub-districts	100 % of sub-districts	
	Develop and implement community based ART promotion and literacy programmes	50% of sub-districts	60%	70%	80%	80%	
	Increase the number of new adults starting ART	120,000 (24% new AIDS cases)	180,000 (35%)	285,000 (55%)	370,000 (70%)	420,000 (80%)	DOH, Private sector, NGOs
	Increase the proportion of adults started on ART based outside hospital setting	30%	40%	50%	60%	70%	

GOAL 6: ENABLE PEOPLE LIVING WITH HIV AND AIDS TO LEAD HEALTHY AND PRODUCTIVE LIVES continued

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
	Increase the proportion of adults started on ART by nurses	10%	20%	50%	65%	80%	
	Increase proportion of adults on ART managed by nurses	20%	30%	50%	70%	80%	
6.2: Increase retention of children and adults on ART	Increase the proportion of people who are still on ART after completing one year of treatment	85%	85%	85%	85%	85%	**DOH**, Private sector, Communities, NGOs, All sectors
	Maintain the percentage of people on ART with viral loads <400 copies/ml after completing one year of treatment	80%	80%	80%	80%	80%	
	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	
	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	
	Increase the proportion of children receiving cotrimoxazole and a CD4% test at time of diagnosis	30% of facilities	40% of facilities	60% of facilities	80% of facilities	90% facilities	

GOAL 6: ENABLE PEOPLE LIVING WITH HIV AND AIDS TO LEAD HEALTHY AND PRODUCTIVE LIVES continued

6.3: Ensure effective management of TB / HIV co-infection	Ensure implementation of National TB Control Plan	Annual	Annual	Annual	Annual	Annual	**DOH**, NHLS, Communities, Private sector, NGOs, CBOs
	Screen children and adult TB patients for HIV and HIV positive adults for TB	40%	60%	80%	90%	90%	
	Improve CD4 monitoring of TB/HIV co-infected children and adults	25%	60%	75%	90%	100%	
	Increase percentage of TB/HIV co-infected adults receiving cotrimoxazole	20%	25%	40%	65%	80%	
	Review guidelines for and implementation of INH prophylaxis for adults and children	Review guidelines	Implement guidelines	Implement guidelines	Implement guidelines	Implement guidelines	
6.4: Improve quality of life for people with HIV and AIDS requiring terminal care	Provide a comprehensive package of a palliative care to eligible children and adults	200,000 adults and 20,000 children	250,000 adults and 26,000 children	250,000 adults and 25,000 children	250,000 adults and 20,000 children	225,000 adults and 20,000 children	**DOH**, DSD, Private sector, Communities NGOs, CBOs

GOAL 6: ENABLE PEOPLE LIVING WITH HIV AND AIDS TO LEAD HEALTHY AND PRODUCTIVE LIVES continued

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
6.5: **Strengthen the health system and remove barriers to access**	Increase the proportion of health facilities providing comprehensive HIV care including ART	10%	25%	50%	70%	80%	**DOH**, Other departments, Private sector, NGOs, CBOs
	Build the capacity of health workers and managers to provide comprehensive care, treatment and support	45% of PHC staff	55%	70%	80%	90%	**DOH**, Private sector, NGOs
	Expand the human resource pool through increased production, retention strategies and partnerships with private providers	All provinces have a policy in place	Implemen-tation of district pilots in all provinces	60% districts implement	80% districts implement	80% of districts implement	**DOH**, Private sector, Traditional healers, DPSA, DSD, SETA, DPWE, JIPSA
	Strengthen support, mentoring and supervision of health care providers	All districts have plans	All districts have plans	All districts have plans	All districts have plans	All districts have plans	**DOH**, NGOs, Private sector
	Implement policy on occupational exposure to TB in health workers	Develop and finalise policy	Implement policy in 50% of facilities	Implement policy in 50% of facilities	Implement policy in 50% of facilities	Implement policy in 50% of facilities	

GOAL 6: ENABLE PEOPLE LIVING WITH HIV AND AIDS TO LEAD HEALTHY AND PRODUCTIVE LIVES continued

	Develop career pathways for counsellors as mid-level workers according to the National Qualifications Framework	Draft Policy developed	Final Policy ratified and approved	20% of counsellors receive accredited training	50% of counsellors receive accredited training	80% of counsellors receive accredited training	**DOH**, DSD, DPW, JIPSA, SETA
	Streamline drug procurement and supply management to decrease the number of facilities experiencing drug stock-outs	<5%	<2%	0%	0%	0%	**DOH**, Private sector, NGOs
	Decrease the proportion of facilities reporting long turn around times for essential laboratory tests	15% facilities ALT, CD4, TB microscopy >1 week	10% facilities ALT, CD4, TB microscopy >1 week	5% facilities ALT, CD4, TB microscopy >1 week	5% facilities ALT, CD4, TB microscopy >1 week	5% facilities ALT, CD4, TB microscopy >1 week	**DOH,** NHLS, Private sector

GOAL 7: ADDRESS THE SPECIAL NEEDS OF PREGNANT WOMEN AND CHILDREN

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
7.1: **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**, Private sector, DSD, NHLS, DLPG, Communities, NGOs
	Provide food support to HIV positive women choosing to exclusively breast feed	15%	20%	40%	60%	80%	
	Increase the proportion of HIV positive pregnant women receiving a CD4 count at time of positive diagnosis	50%	80%	95%	95%	95%	
	Increase the number of HIV positive pregnant women starting a comprehensive package of AIDS care including ART	25,000	35,000	55,000	80,000	90,000	

GOAL 7: ADDRESS THE SPECIAL NEEDS OF PREGNANT WOMEN AND CHILDREN continued

7.2: Determine the HIV status of infants, children and adolescents as early as possible	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	**DOH**, Private sector, NHLS, NGOs,
	Increase the proportion of facilities with immunisation services offering HIV DNA PCR tests for early infant diagnosis	40%	60%	85%	95%	100%	
	Increase the proportion of exposed children tested with PCR by six months	45%	65%	85%	90%	90%	
	Increase the proportion of symptomatic children attending PHC and hospital facilities tested for HIV	50%	65%	80%	90%	90%	
	Increase the proportion of children receiving cotrimoxazole and a CD4% test at time of diagnosis	35%	45%	60%	80%	90%	

GOAL 7: ADDRESS THE SPECIAL NEEDS OF PREGNANT WOMEN AND CHILDREN continued

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
7.3: **Provide a comprehensive package of services that includes wellness care and ART to HIV-affected, -infected and -exposed children and adolescents**	Review clinical guidelines for the management of infants, children and adolescents with HIV and AIDS	Annually	Annually	Annually	Annually	Annually	**DOH**, DSD, Private sector
	Increase the proportion of children with development delays identified and referred for appropriate management	60%	70%	80%	90%	90%	
	Implement biannual developmental screening for all children <5 years	6% children screened	12%	25%	40%	60%	
	Provide food support to eligible children	30 000	45 000	65 000	100 000	150 000	
	Increase the proportion of HIV positive children not on ART who had a CD4 count according to guidelines	30% positive children	45%	60%	70%	80%	
	Increase the proportion of HIV positive and exposed children receiving cotrimoxazole	65%	75%	90%	95%	100%	

GOAL 7: ADDRESS THE SPECIAL NEEDS OF PREGNANT WOMEN AND CHILDREN continued

	Increase the number of new children starting ART	17 000	24 000	33 000	38 000	40 000	
	Increase the proportion of children starting ART in non-hospital based settings	20%	25%	40%	55%	60%	
	Increase the proportion of children started on ART by nurses in facilities with adequate quality assurance	5%	10%	20%	30%	35%	
	Increase the proportion of stable children on ART managed by nurses	10%	20%	40%	50%	70%	
	Increase the proportion of adolescent friendly ART facilities equipped to provide comprehensive care, treatment and support for HIV positive adolescents	5%	10%	20%	35%	50%	
	Provide psychosocial support for children and adolescents including counselling for bereavement, disclosure, adherence and sexual aspirations	10% of sub-districts	20% of sub-districts	60% of sub-districts	80% of sub-districts	100% of sub-districts	**DOH**, DSD, DPLG

GOAL 8: MITIGATE THE IMPACT OF HIV AND AIDS AND CREATE AN ENABLING SOCIAL ENVIRONMENT FOR CARE, TREATMENT AND SUPPORT

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
8.1: **Strengthen the implementation of OVC policy and programmes**	Monitor implementation of the National Action Plan for OVCs (2006-2008)	Annual	Annual Report	Annual	Annual	Annual	**DSD**, SANAC, DOH, NGOs
	Develop and operationalise mechanisms to identify, track and link OVC and child-headed households to grants, benefits and social services at local level	10%	30%	70%	90%	100%	**DSD**, DOE, DPLG, Communities, NGOs, CBOs
	Increase the number of sub-districts that have OVC response mechanisms (such as CCFs) facilitating access to essential services	30% sub-districts	50%	75%	90%	100%	

GOAL 8: MITIGATE THE IMPACT OF HIV AND AIDS AND CREATE AN ENABLING SOCIAL ENVIRONMENT FOR CARE, TREATMENT AND SUPPORT continued

	Increase the proportion of vulnerable children accessing social grants (child support, foster care and care dependency), benefits and services	CSG 80%	85%	90%	95%	98%	**DSD**, DHA, DOE communities, NGOs, CBOs
		FCG 25%	30%	40%	50%	60%	
		CDG 20,000	30,000	36,000	44,000	50,000	
	Implement service delivery guidelines defining core services at local level for OVC (exemption from school and health service fees, child support grants, birth registration)	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	70%	80%	90%	95%	99%	**DSD**, DOH, NGOs, communities
	Increase the proportion of registered civil society organizations receiving organisational programme support and mentoring	20%	30%	40%	45%	50%	**DSD**, NGOs, communities., Private sector

GOAL 8: MITIGATE THE IMPACT OF HIV AND AIDS AND CREATE AN ENABLING SOCIAL ENVIRONMENT FOR CARE, TREATMENT AND SUPPORT continued

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
	Increase the proportion of child-headed households receiving services of a community caregiver	50%	60%	70%	90%	95%	**DSD**, NGOs, Communities
	Develop the capacity of schools, educators and early childhood development centres to provide psychosocial, educational and adherence support to children in need	15% of schools and centers	30% of schools	50% of schools	60% of schools	80% of schools	**DOE**, DSD, DPLG

GOAL 8: MITIGATE THE IMPACT OF HIV AND AIDS AND CREATE AN ENABLING SOCIAL ENVIRONMENT FOR CARE, TREATMENT AND SUPPORT continued

8.2: Expand and Implement CHBC as part of the EPWP	Recruit and train new community care givers (including CHWs), with emphasis on men	10 000 (10% men)	15 000 (10% men)	20 000 (15% men)	25 000 (20% men)	25 000 (20% men)	**DSD**, DPLG, DOH, DPWE, NGOs
	All community caregivers to receive nationally determined stipends	23 394	30 000	45 000	60 000	75 000	**DSD**, DOH, DPSA, SETA, DPWE
	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 receive accredited training	40% community caregivers receive accredited training	60% community caregivers receive accredited training	80% community caregivers receive accredited training	
	Strengthen support, mentoring and supervision of community caregivers	All districts have plans	All districts have plans	All districts have plans	All districts have plans	All districts have plans	
8.3: Strengthen the implementation of policies and services for marginalised communities affected by HIV and AIDS	Increase proportion of older persons receiving support through HCBC	50%	60%	70%	80%	90%	**DSD**, NGOs, Communities, Council for the Care of the Aged
	Increase proportion of people with disabilities in care, treatment and support programmes	10%	30%	40%	60%	75%	Disability sector, All sectors

GOAL 8: MITIGATE THE IMPACT OF HIV AND AIDS AND CREATE AN ENABLING SOCIAL ENVIRONMENT FOR CARE, TREATMENT AND SUPPORT continued

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
	Develop and implement targeted care and support programmes and material for people with disabilities	10% districts	40% districts	70% districts	90% districts	90% districts	**DSD**, Disability sector, All sectors
	Promote integration and equitable representation of LGBT people in care, treatment and support programmes	100% districts	100% districts	100% districts	100% districts	100% districts	**DSD**, LGBT sector, All sectors
8.4: **Ensure community AIDS competence in order to facilitate utilization of good quality services**	Design and implement ward-based community competency programmes targeting the most vulnerable communities	Community competency programmes developed and piloted in 9 provinces	30% ward-based vulnerable communities covered	50%	60%	70%	**DOH**, DPLG, SALGA, DSD, Local authorities, Private sector, CBOs

Intervention Packages: Definitions

The key priority areas of the NSP refer to a number of intervention packages. For ease of reference the core content of these packages is defined below:

(i) HIV prevention programme, interventions and curricula may include some or all of the following and should be customised to different targeted groups:
Abstinence, especially delaying first sex; safer sex practices; information about HIV risk of different sexual practices; decreasing sexual partner numbers, including risks of more than one partner at a time (concurrency); gender relations and gender- based violence; coercive sex; intergenerational sex; male and female condom use; STI recognition and management; VCT; pregnancy testing; contraception and fertility choices; alcohol and substance use.

(ii) Expanded PMTCT package, includes:
Access to nutritional support for breastfeeding mothers; Contraception and fertility services; reducing unwanted pregnancies; involving men in decision-making; HIV prevention services for uninfected pregnant women.

(iii) Youth friendly sexual and reproductive health services, includes:
Values clarification training aimed at sensitizing health workers; STI management; VCT and rapid HIV testing; contraception; TOP referral; mental health; reducing substance use; IEC, peer education; provision of male and female condoms; appropriate service hours.

(iv) Unwanted pregnancy package, includes:
Scaling up contraceptive services, including promotion of male and female condoms; increasing access to TOP services and developing policy on medical abortion.

(v) Positive prevention package, includes:
Prevention of HIV transmission through safer sex practices; reducing risk of re-exposure to HIV and drug resistant virus; understanding the course of HIV infection; ARV literacy; prophylaxis for opportunistic infections; early detection and treatment of opportunistic infections; adequate nutrition and psychosocial support; precautions for home based care.

(vi) Workplace prevention package, includes:
Access to IEC; VCT; provision of male and female condoms; STI symptoms recognition

and management; TB screening; observance of ILO, SADC and NEDLAC codes of practice.

(vii) Prison prevention package, includes:
Access to VCT; access to male and female condoms; lubricants; STI symptom recognition and access to PEP and STI management; TB screening.

(viii) Prevention package for sex workers and their clients, includes:
Dedicated services including promotion of VCT; access to male and female condoms; STI symptom recognition; information on gender rights.

(x) Wellness care package, includes:
Regular CD4 counts; opportunistic infections prophylaxis and treatment; cervical screening; advice on lifestyle, nutrition, contraceptive use and fertility, positive prevention, social support, and pain and symptom relief.

(xi) Food support package includes:
Food parcels and nutritional supplements, food gardens and guidance on good nutritional practices, enhancing household food security.

(xii) Early Childhood Development Care Package includes:
Social competence, emotional wellbeing, physical and mental health, nutrition, recreation, intellectual development, independence, prevention of child abuse and neglect, identification of child abuse and neglect, psychosocial care and support, referrals.

(xiii) OVC Package includes:
Early identification of OVC, ensuring access to essential services which include: identity, guardianship, succession planning and inheritance rights, social security, education and health services; address basic rights to shelter, food, clothing, parenting and psychosocial care and support, household food security, income-generating and skills development, legal protection issues, establishment of child care forums, protection from abuse, family or alternative care.

(xiv) Incremental roll-out of comprehensive customised HIV prevention package to higher risk occupational groups includes:
Access to VCT and provision of male and female condoms, STI symptom recognition and STI services.

PRIORITY AREA 3: Research, monitoring and surveillance

GOAL 9: DEVELOP AND IMPLEMENT A MONITORING AND EVALUATION FRAMEWORK FOR APPROPRIATE INDICATORS

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
9.1: Establish and implement a functional M&E system	Develop a functional M&E framework that reports against indicators and which includes an M&E plan for each SANAC sector	M&E framework finalised and adopted- June 2007	Report produced	Report produced	Report produced	Report produced	**SANAC M&E Unit**, DOH, Government Departments and Research Institutions, Private sector and Civil Societies
	Timely produce and submit the 2008 Country UNGASS Report	Draft 2008 UNGASS report compiled by November 2007	Final UNGASS report	Draft 2010 UNGASS report compiled by November 2009	Final UNGASS report	Draft 2012 UNGASS report compiled by November 2009	**DOH**, All Government Departments, Civil Societies
	Strengthen the health information system in the provincial departments, the national department and the private sector focusing on data quality and data flow.	Assess-ment of existing M&E systems completed	Annual Data quality assess-ment completed	Annual Data quality assess-ment completed	Annual Data quality assess-ment completed	Annual Data quality assess-ment completed	**DOH**

GOAL 9: DEVELOP AND IMPLEMENT A MONITORING AND EVALUATION FRAMEWORK FOR APPROPRIATE INDICATORS

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
	Improve capacity, to manage data by all sectors	Annual Data quality assessment completed Review capacity needs and develop and implementation plan	Improved capacity to manage data in 20% of sectors	Improved capacity to manage data 40% of sectors	Improved capacity to manage data 70% of sectors	Improved capacity to manage data in all sectors	**SANAC M&E Unit,** Government Departments and Research Institutions, Private sector and Civil Society
	Develop baseline data on NSP indicators	First set of baseline data available - November 2007	End of year 2007 report on indicators;				**SANAC M&E Unit,** Government Departments and Research Institutions, Private sector and Civil Society

			Finalised baseline indicators - March 2008				**SANAC M&E Unit**, Government Departments and Research Institutions, Private sector and Civil Society
	Use M&E data to identify the barriers to the implementation of the NSP and develop strategies to address these.	Identify areas of weakness in the implementation of the NSP and develop interventions to address these	Ongoing	Ongoing	Ongoing	Ongoing	**SANAC M&E Unit**, Government Departments, Private sector and Civil Society

GOAL 10: SUPPORT RESEARCH IN THE DEVELOPMENT OF NEW PREVENTION TECHNOLOGIES

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
10.1: **Develop and support a research agenda on HIV prevention technologies**	Support and monitor research to develop and implement HIV prevention technologies including microbicides, AIDS vaccine, male circumcision, Pre exposure prophylaxis and other new biomedical technologies	Annual report on status of research on HIV prevention technologies	Annual report on status of the development & research on HIV prevention technologies	Annual report on status of the development & research on HIV prevention technologies	Annual report on status of the development & research on HIV prevention technologies	Annual report on status of the development & research on HIV prevention technologies	**SANAC M&E Unit**, Government Departments, Research Institutions

GOAL 11: CREATE AN ENABLING ENVIRONMENT FOR RESEARCH IN SUPPORT OF THE NSP

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
11.1 **Strenthgen the research and development area in order to support research in the area of HIV & AIDS and STDs**	Strengthen the system for the ethical and regulatory review of research to ensure quality timeous review and follow up of clinical studies	Review the effectiveness of the structures legally mandated to monitor and approve research proposals (MCC, Ethics Committees) Develop plans to strengthen these structures	50% Research submissions approved in < 3 months	60% Research submissions approved in < 3 months	80% Research submissions approved in < 3 months	90% Research submissions approved in < 3 months	**DOH**, Government Departments, MCC, National Health Research Committee, National Health Research Ethics Council,
	Strenghten the research and development environment in order to support research in the area of HIV & AIDS and STDs.	Priority research questions identified and appropriate arrangements made	5 priority research issues per province identified and commis-	5 priority research issues per province identified and commis-	5 priority research issues per province identified and commis-	5 priority research issues per province identified and commis-	**DOH**, Government Departments, Research Institutions, Private sector and Civil Society

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
		for research to be undertaken	sioned or as appropriate Ongoing research & feedback	sioned or as appropriate Ongoing research & feedback	sioned or as appropriate Ongoing research & feedback	sioned or as appropriate Ongoing research & feedback	
	Promote collaboration between researchers and communities Promote collaboration between researchers, and Government to discuss and implement an agreed research agenda	Encourage the formation of community advisory groups to support relevant population based studies	Ongoing	Ongoing	Ongoing	Ongoing	**SANAC**, DOH, HEIs, Research Institutions, Private sector and Civil sector
	Promote collaboration between researchers, and Government to discuss and implement an agreed research agenda	Official senior govern-ment committee established as a forum for discussion about current HIV research priorities and results	Annual meetings	Annual meetings	Annual meetings	Annual meetings	**SANAC**, DOH, HEIs, Research Institutions, Private sector and Civil sector

GOAL 12: DEVELOPMENT AND PROMOTION OF RESEARCH ON BEHAVIOUR CHANGE

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
12.1: **Support the evaluation of existing interventions and the development of new innovative programmes or interventions aimed at behaviour change for HIV prevention**	Evaluate behavioural interventions focusing on young women, men youth and higher risk groups. Conduct randomised control trials evaluated by biological markers and behaviour change indicators to test the efficacy of behaviour change interventions. Evaluate targeted behavioural interventions aimed at HIV prevention for HIV positive individual	DOH identifies significant research funds and efficient mechanisms for allocating funds for priority research questions	Open call for proposal and commissioning	5 studies commissioned or as appropriate. Ongoing feedback	5 studies commissioned or as appropriate. Ongoing feedback	New studies commissioned as required. Ongoing feedback	**SANAC M&E Unit**, Government Departments, Research Institutions, Private sector and Civil Society

GOAL 13: DEVELOP AND SUPPORT A COMPREHENSIVE RESEARCH AGENDA INCLUDING OPERATIONS RESEARCH, BEHAVIOURAL RESEARCH, EPIDEMIOLOGICAL TRIALS AND OTHER RESEARCH FOR NEW TECHNOLOGIES FOR PREVENTION AND CARE

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
13.1: **Support research on the efficacy of orthodox medicines for HIV treatment and OI prophylaxis**	Support selected clinical trials for products with real potential of efficacy	Research review and agreement on research agenda	Open call for proposal and commissioning	10 studies commissioned or as appropriate	10 studies commissionedor as appropriate	Results of all commissioned studies produced	**SANAC M&E Unit**, Government Departments, HEIs and Research Institutions, Private sector and Civil Society
13.2: **Support research on the efficacy of traditional and complementary medicines for HIV treatment and OI prophylaxis**	Support selected clinical trials for products with real potential of efficacy	Research review and agreement on research agenda	Open call for proposal and commissioning	10 studies commissioned or as appropriate	10 studies commissionedor as appropriate	Results of all commissioned studies produced	**SANAC M&E Unit** Government Departments, HEIs and Research Institutions, Private sector and Civil Society, Traditional healers
13.3: **Support research on nutritional interventions for those infected or at higher risk of HIV infection**	Conduct a national consultative workshop on the nutrition and HIV consensus document produced by the SA Academy of Science and adopt a research agenda	Workshop conducted and research agenda identified and Commissioned	Research commissioned and 5 studies commenced	5 studies commenced. Ongoing feedback.	5 studies commenced. Ongoing feedback	as required commenced. Ongoing feedback.	**SANAC M&E Unit,** Government Departments, Research Institutions, Private sector and Civil Society, Traditional healers

GOAL 13: DEVELOP AND SUPPORT A COMPREHENSIVE RESEARCH AGENDA INCLUDING OPERATIONS RESEARCH, BEHAVIOURAL RESEARCH, EPIDEMIOLOGICAL TRIALS AND OTHER RESEARCH FOR NEW TECHNOLOGIES FOR PREVENTION AND CARE continued

13.4: **Conduct operations research in support of the implementation of the NSP**	Identify relevant operations research questions on the implementation of NSP and provide support to research proposals	Research review and agreement on research agenda	5 studies commis-sioned or as appro-priate. Ongoing feedback	5 studies commis-sioned or as appro-priate. Ongoing feedback	5 studies commis-sioned or as appro-priate. Ongoing feedback	New studies commis-sioned as appropriate. Ongoing feedback	**SANAC M&E Unit** Government Departments, Research Institutions, Private sector and Civil Society
13.5: **Support research to develop best practice models for community care and support**	Conduct research on different models of community care and support	Call for proposals advertised and com-missioning	5 studies commis-sioned or as appro-priate	5 studies commis-sioned or as appro-priate	5 studies commis-sioned or as appro-priate	Commis-sion research as required ongoing feedback	**SANAC M&E Unit,** Government Departments, Research Institutions, Private sector and Civil Society

GOAL 13: DEVELOP AND SUPPORT A COMPREHENSIVE RESEARCH AGENDA INCLUDING OPERATIONS RESEARCH, BEHAVIOURAL RESEARCH, EPIDEMIOLOGICAL TRIALS AND OTHER RESEARCH FOR NEW TECHNOLOGIES FOR PREVENTION AND CARE continued

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
13.6: **Conduct research on human resource requirements for the effective implementation of the NSP**	Develop a research agenda to assess human resource needs for the provision of community based care Support research on direct impact of HIV on health care workers in the public health sector Ongoing research to evaluate HR requirements and training requirements within the public sector to respond to HIV	Call for proposals advertised and commissioning	5 studies commissioned or as appropriate	5 studies commissioned or as appropriate	5 studies commissioned as appropriate	Commission research or as required. Ongoing feedback.	**SANAC M&E Unit,** Government Departments, Research Institutions, Private sector and Civil Society
13.7: **Monitoring funding for the NSP and its cost effectiveness**	Support research on the cost effectiveness of different aspects of the NSP	3 studies commissioned or as appropriate Baseline detailed costing study completed	3 studies commissioned or as appropriate	3 studies commissioned or as appropriate	3 studies commissioned or as appropriate	Commission research or as required. Ongoing feedback	**SANAC M&E Unit,** Government Departments, Research Institutions, Private sector and Civil Society

GOAL 13: DEVELOP AND SUPPORT A COMPREHENSIVE RESEARCH AGENDA INCLUDING OPERATIONS RESEARCH, BEHAVIOURAL RESEARCH, EPIDEMIOLOGICAL TRIALS AND OTHER RESEARCH FOR NEW TECHNOLOGIES FOR PREVENTION AND CARE continued

13.8: **Enhance efforts to develop post-graduate research skills by tertiary institutions**	Recruit, train and mentor black researchers and women in particular	Budgets devel-oped and contracts offered to HEIs	10 PhDs students recruited	10 PhDs students recruited		10 PhDs graduated	**SANAC M&E Unit,** Government Departments, Higher Education Institutions, Research Institutions, Private sector
13.9: **Support capacity building in research, surveillance and monitoring among black and women professionals such that the appropriate demographics are achieved**	Create career paths within research organisations and HEIs institutions to retain and support particularly women and black researchers, and identify new funding mechanisms to achieve this	Funds identified Appropriate senior researcher positions created in research and HEIs	Appropriate senior researcher positions created	Appropriate senior researcher positions created	Appropriate senior researcher positions created	Appropriate senior researcher positions created	**SANAC M&E Unit,** Government Departments, Higher Education Institutions, Research Institutions, Private sector

GOAL 14: CONDUCT POLICY RESEARCH

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
14.1: **Ensure that policy is evidence informed and regularly updated**	Government to convene appropriate multisectoral groups including policy makers and researchers to facilitate policy and guideline research reviews in order to base policy on current scientific developments		Periodic policy reviews: after every 3 years and as necessary			Periodic policy reviews: after every 3 years and as necessary	**SANAC M&E Unit,** Government Departments, Research Institutions, Private sector and Civil Society

GOAL 15: CONDUCT REGULAR SURVEILLANCE

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
15.1: **Coordinate and strengthen surveillance systems on HIV, AIDS and STIs**	Build mechanisms to coordinate HIV, AIDS, & STIs surveillance systems	Different surveillance systems in existence and required identified by DoH and commissioned where required	Integrated surveillance systems for HIV, AIDS and STIs established	Report produced	Report produced	Report produced	**SANAC M&E Unit,** Government Departments, Research Institutions, Private sector and Civil Society
	Conduct surveillance of HIV prevalence and AIDS morbidity and mortality	National mortality surveillance National prevalence surveillance implimented in all provinces	National Burden of Disease report	Natural mortality surveillance District level HIV prevalence monitoring Implimented in all provinces		Natural mortality surveillance	**SANAC M&E Unit, DOH,** Government Departments, Research Institutions, Private sector and Civil Society

GOAL 15: CONDUCT REGULAR SURVEILLANCE continued

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
	Conduct surveillance of HIV incidence and utilise best international methodology to obtain this data Participation in international fora on the estimation of HIV incidence	DOH to convene a national consultation on measurement of HIV incidence and HIV-related mortality, and to commission research	Progress report on incidence methodology testing Estimated incidence figures		Estimated incidence figures		**DOH,** Government Departments, Research Institutions, Private sector and Civil Society
	Conduct HIV and sexual, behavioural sentinel surveys, with different target age-groups	Commission National Youth HIV and sexual behavioural surveys Commission National population based HIV and sexual behavioural surveys	Youth risk behavioural surveys conducted 2008 SADHS conducted Behavioural Surveillance Survey for all age-groups			Youth risk behavioural survey conducted Behavioural Surveillance Survey for all age-groups	**SANAC M&E Unit,** Government Departments, Research Institutions, Private sector and Civil Society

GOAL 15: CONDUCT REGULAR SURVEILLANCE continued

	Conduct surveillance of national HIV/TB infections in selected populations.	Annual report produced	Annual report produced	Annual report produced	Annual report produced	Annual report	**DOH,** Government Departments, Research Institutions, Private sector and Civil Society
	Conduct surveillance on drug and ARV resistance	Active surveillance instituted in ARV rollout sites in public facilities identified	Ongoing	Ongoing	Ongoing	Ongoing	**DOH,** Government Departments, Research Institutions, NHLS, Private sector and Civil Society
	Strengthen the active surveillance, reporting and analysis of Adverse Drug Reaction (ADR) in the accredited facilities providing ART and include private sector facilities	Active surveillance instituted in public and private facilities identified	ADR report produced		ADR report produced		**DOH,** Government Departments, Research Institutions, MCC, Private sector and Civil Society

GOAL 15: CONDUCT REGULAR SURVEILLANCE continued

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
	Conduct routine clinical and microbiological STI surveillance	Annual reports produced	Annual reports produced	Annual reports produced	Annual reports produced	Annual report	**DOH**, Government Departments, Research Institutions, NHLS, Private sector and Civil Society

PRIORITY AREA 4: HUMAN RIGHTS AND ACCESS TO JUSTICE

GOAL 16: ENSURE PUBLIC KNOWLEDGE OF AND ADHERENCE TO THE LEGAL AND POLICY PROVISIONS

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
16.1: Ensure adherence to existing legislation and policy relating to HIV and AIDS, particularly in employment and education	Conduct a national analysis of the implementation of AIDS programmes in workplaces	Report produced					**DOL,** NEDLAC, DOH, DPSA, Employment Equity Commission SANAC, Business sector, Trade Union sector
	Finalise and implement a national agreement on a framework for HIV and AIDS policy and programmes in the workplace. Implement the agreement in all workplaces	Agreement finalised	60%	70%	80%	90%	
	Update the DOL/Employment Equity Commission Code of Good Practice on Key Aspects of HIV and AIDS and Employment (2000)	Code Updated			Review & update Code		
	Assist SMMEs to develop and implement workplace policies.	10%	30%	50%	70%	80%	**DOL**, Business sector

GOAL 16: ENSURE PUBLIC KNOWLEDGE OF AND ADHERENCE TO THE LEGAL AND POLICY PROVISIONS continued

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
	Develop and implement tools to and monitor, protect and enforce the rights of: • Casual, contract and/or poorly organised employees (such as domestic workers). • Employees expressly excluded from the ambit of labour legislation.	Tools developed	30% of industry covered	40%	50%	60%	**DOL, SAHRC,** Trade Union sector
	Develop and distribute a national guideline of rights of children in schools to access to information, prevention, treatment, care and support.	Guidelines developed and approved	50% of schools	60%	70%	80%	**DOE, DSD,** SANAC Education sector
	Develop and distribute a national guideline on children and HIV in pre-primary schools	Guidelines developed and approved	70% of pre-primary schools	80%	85%	90%	

GOAL 16: ENSURE PUBLIC KNOWLEDGE OF AND ADHERENCE TO THE LEGAL AND POLICY PROVISIONS continued

16.2: **Ensure adherence to human rights by service providers**	Develop and distribute guidelines for health workers on human rights and: • Voluntary HIV testing and counselling • Confidentiality and disclosure; • Children and HIV	Guidelines developed and approved	60%	70%	80%	90%	**SANAC**, Health professions sector; DOH, DOE, Human Rights sector
16.3: **Ensure a supportive legal environment for the provision of HIV and AIDS services to marginalised groups.**	Develop and distribute information materials on rights to 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) • Children • Refugees, undocumented migrants and immigrants • Older persons	Materials developed and approved	40% of organised groups covered	50%	70%	80%	**DOH, SAHRC,** SANAC sectors

HIV & AIDS and STI STRATEGIC PLAN FOR SOUTH AFRICA

GOAL 16: ENSURE PUBLIC KNOWLEDGE OF AND ADHERENCE TO THE LEGAL AND POLICY PROVISIONS continued

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
16.4: **Monitor and address human rights violations**	Develop monitoring tools for human rights Establish systems for collecting information	Tools developed	Systems establish-ed, impl-mented and reported	Ongoing Annual Report	Ongoing	Ongoing	**SANAC, PLHIVA**, Legal and Human Rights sector
16.5: **Improve affordability and accessibility of legal services for people with HIV**	Implement and monitor the measures taken to protect human rights after violations	Ongoing	Annual Report				**Human Rights sector** and SANAC, Legal sector, SAHRC Statutory bodies: HPCSA, CMA, NEDLAC
	Monitor the insurance and financial services industries and their regulators to end unfair exclusions of PLHIV.	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	
	Develop a database and create a network of legal service providers that assist people with HIV and AIDS	Database on providers developed and updated	10%	20%	50%	70%	**Human Rights sector,** SANAC, Law sector

GOAL 16: ENSURE PUBLIC KNOWLEDGE OF AND ADHERENCE TO THE LEGAL AND POLICY PROVISIONS continued

	Train community-based development workers to identify and address HIV and AIDS human rights issues	Programme developed	20% Districts covered	50%	80%	90%	**DOH,** Human Rights sector
	Train the legal profession, including the judiciary, on the human rights and HIV and AIDS.	Programme developed	50% Districts covered	70%	80%	90%	**DOJ**

GOAL 17: MOBILISE SOCIETY, AND BUILD LEADERSHIP OF PEOPLE WITH HIV IN ORDER TO MITIGATE AGAINST STIGMA AND DISCRIMINATION

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
17.1: **Empower PLHIV to recognise and deal with human rights violations**	Develop a PLHIV manual on human rights, including for children and people with disabilities	Manual developed	50% Manual distributed with training	60%	70%	80%	**DOH**, Private sector, DSD, NHLS, DLPG, Communities, NGOs
	Distribute manual through health facilities, social development offices, courts						
	Training support groups and organisations of PLHIV	10% of sub districts	20%	50%	70%	80%	**DPLG**, Provincial AIDS Councils, SANAC, Media sector
	Conduct national media campaign on rights of PLHIV; integrate rights issues and events into all media campaigns	Quarterely	Quarterly	Quarterly	Quarterly	Quarterly	

GOAL 17: MOBILISE SOCIETY, AND BUILD LEADERSHIP OF PEOPLE WITH HIV IN ORDER TO MITIGATE AGAINST STIGMA AND DISCRIMINATION continued

17.2: Ensure respect for the rights of PLHIV in employment, housing, education, insurance and financial services and other sectors.	Launch and strengthen sectoral and community-based campaigns that promote and protect human rights	Quarterly	Quarterly	Quarterly	Quarterly	Quarterly	**DOH, DPLG**
	Develop and implement policies and programmes in government departments and SANAC sectors that protect the rights of PLHIV	Policies & pro-grammes developed and approved	40% SANAC sectors covered	60%	80%	90%	**SANAC, Government departments**
17.3: Promote greater openness and public acceptance of PLHIV	Provide detailed information on HIV and build understanding and capacity to monitor, protect and promote human rights in key sectors, including: * the religious sector * the health sector * the education sector * traditional healers and leaders * the private sector * the media * people with disabilities * the legal sector (including criminal justice, correctional services), particularly the judiciary and the police	Ongoing Program develop	30% of each sector covered	50%	70%	80%	**SANAC** sectors

GOAL 18: IDENTIFY AND REMOVE LEGAL, POLICY, RELIGIOUS AND CULTURAL BARRIERS TO EFFECTIVE HIV PREVENTION, TREATMENT AND SUPPORT

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
18.1: **Minimise the risk of human rights violations from cultural, religious and traditional practices**	Facilitate and sustain dialogue with cultural, religious and traditional leaders to build consensus on harmful practices	10% of sub-districts	20%	50%	70%	80%	**Traditional leaders**, SAHRC, Religious leaders, SANAC Human Rights sector

GOAL 19: FOCUS ON THE HUMAN RIGHTS OF WOMEN AND CHILDREN, INCLUDING PEOPLE WITH DISABILITIES, AND MOBILIZE SOCIETY TO PROMOTE GENDER AND SEXUAL EQUALITY AND ADDRESS GENDER-BASED VIOLENCE

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
19.1: Reduce legal constraints to access security services for women and children	Improve access to human rights education and information for women in resource limited settings:	30% of identified nodes	50%	70%	80%	90%	DOJ, DCS, DSD
	Educate communities and vulnerable groups about rights and access to ID documents and social security	50% of districts covered	60%	70%	80%	90%	DOHA & DSD
	Ensure easy access for women and children to registration and social grants	Fasttrack program in place	50% districts covered	70%	80%	90%	
19.2: Ensure implementation of existing laws and policies that protect women and children from gender based violence	Ensure that the National Sexual Assault and Management Guidelines are implemented by health care workers in all districts.	40%	60%	70%	80%	90%	DOH

GOAL 19: FOCUS ON THE HUMAN RIGHTS OF WOMEN AND CHILDREN, INCLUDING PEOPLE WITH DISABILITIES, AND MOBILIZE SOCIETY TO PROMOTE GENDER AND SEXUAL EQUALITY AND ADDRESS GENDER-BASED VIOLENCE continued

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
19.3: **Address the needs of women in abusive relationships.**	Distribute Guidelines on SAPS and their responsibilities in terms of the National Sexual Assault Policy	40% of facillities covered	50%	60%	70%	80%	**DOJ**, DCS, Human Rights sector
	Train SAPS on Guidelines	Training Programme developed	50% service providers covered	70%	80%	90%	
	Train VCT and adherence counsellors to identify barriers that prevent women from accessing HIV prevention, treatment and care services.	Training programme developed	50% counsellors developed	70%	80%	90%	**DOT**, DCS, DOH, Human Rights Sector
19.4: **Ensure laws, policies and customs do not discriminate against women and children**	Develop and implement guidelines on the impact of HIV on the Master's Office and running of deceased's estates, with focus on women and children.	Guidelines developed and distributed	60% target group covered	80%	90%	95%	**DOJ, DCS**, Traditional leaders, DOHA, Parliament

10. STRUCTURAL ARRANGEMENTS

The multi-sectoral national response is managed by various 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 different 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 roles and functions relating to HIV and AIDS.

10.1 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.

10.2 SOUTH AFRICAN NATIONAL AIDS COUNCIL

SANAC is the highest body that provides strategic and political guidance as well as support and monitoring for sector programmes for HIV and AIDS and STIs. 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 specific objectives of SANAC are to:

a) advise government on HIV, AIDS and Sexually Transmitted Infections (STIs) policy and strategy, and related matters
b) create and strengthen partnerships for an expanded national response to HIV and AIDS in South Africa
c) receive and disseminate all sectorial interventions to HIV and AIDS and consider challenges
d) to oversee continual monitoring and evaluation of all aspects of the NSP.

The Deputy President is the Chairperson of the Council and sector representation is at highest level (President/Chairperson). The Health Ministry is an ex officio member at all levels. The Health Department also serves as the secretariat of SANAC.

10.3 THE INTERMINISTRIAL COMMITTEE ON AIDS

The Inter-Ministerial Committee on AIDS (IMC) has been appointed by Cabinet to support and monitor work on HIV and AIDS, including that 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. It represents government at the high-level Council.

10.4 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.

10.5 GOVERNMENT CLUSTERS

Government departments at national and provincial level are organised around five clusters (economic; social; governance; justice; crime prevention and safety; and international relations), 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 the main cluster that deals with health and social matters. HIV and AIDS is one of the programmes on Government's Programme of Action for which the Social Sector Cluster is responsible. The social cluster is well placed to provide leadership and support to other clusters and public sector departments to ensure maximum discussion and government-wide programming on HIV and AIDS at both national and provincial level. The Social Cluster is well placed to perform this function at both national and provincial government levels.

10.6 HIV and AIDS UNITS IN GOVERNMENT DEPARTMENTS:

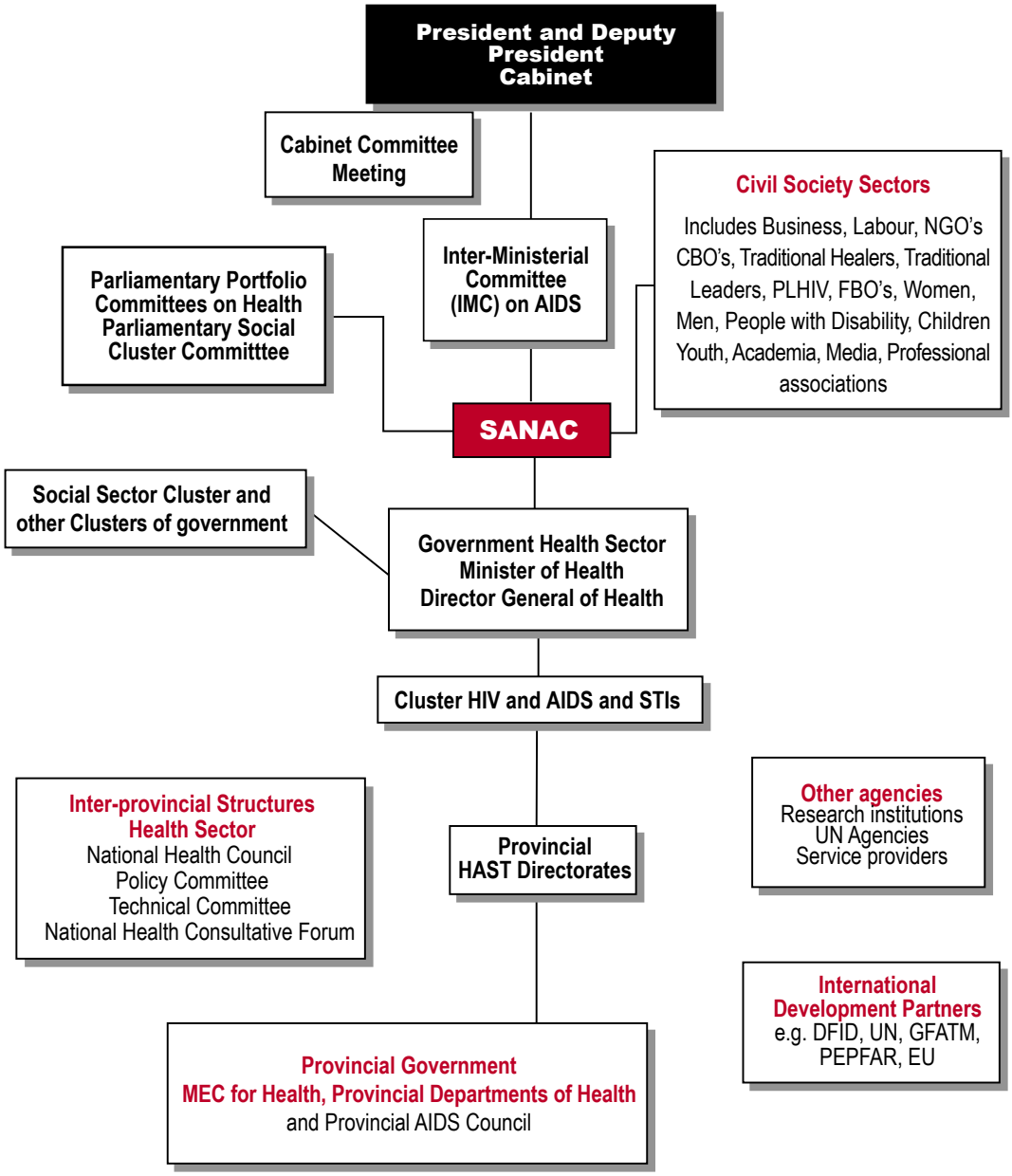
Each government department has a focal person to manage the implementation of relevant HIV and AIDS programmes. HIV and AIDS issues are brought to the attention of the above national bodies by the HIV & AIDS Units. It is the responsibility of these units to prepare briefing documents for the national 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.

10.7 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 suit 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.

Figure 8: Structural Organisation

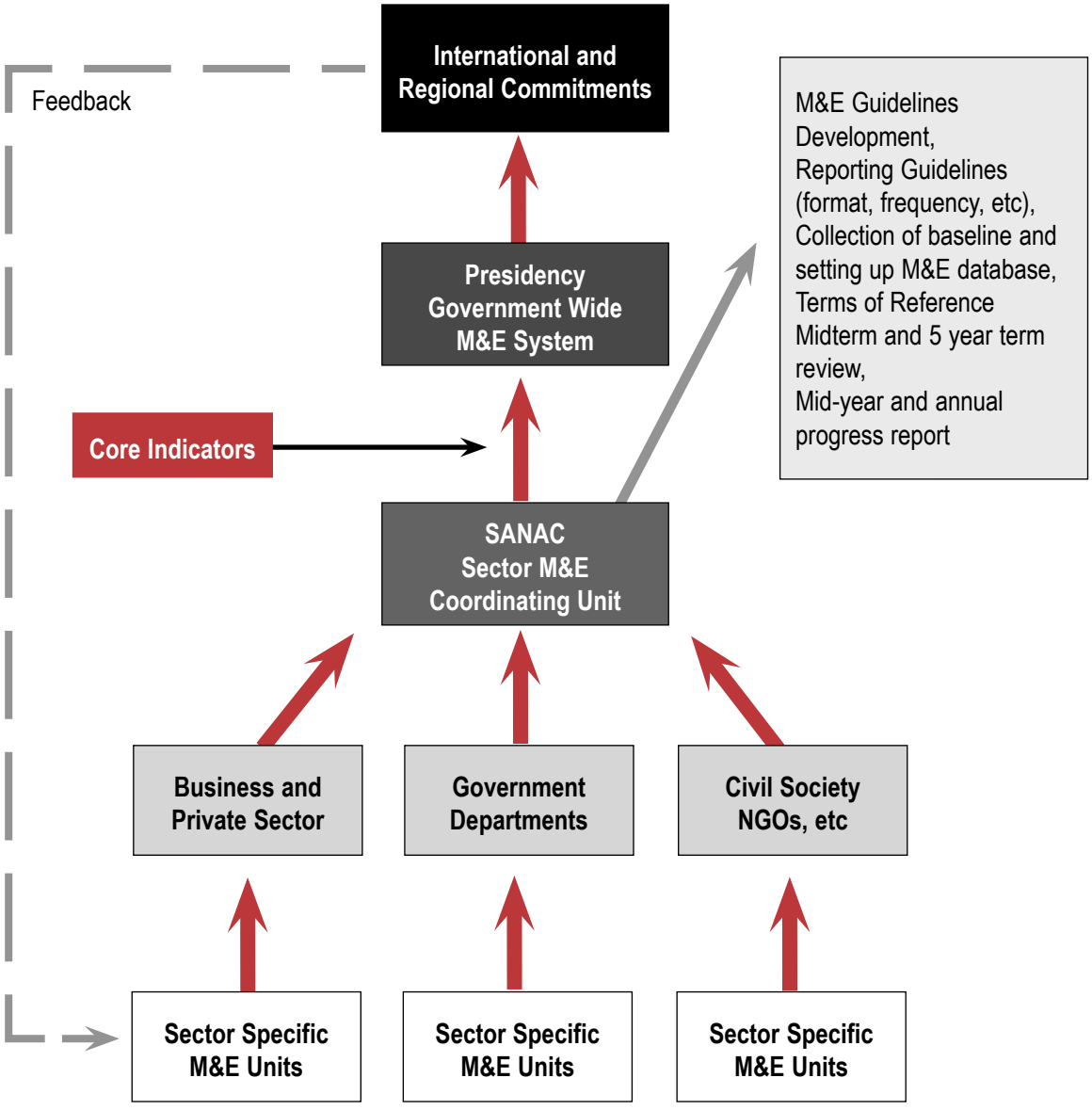


11. THE NATIONAL M&E FRAMEWORK

The NSP recognises that establishing effective systems for monitoring and evaluation (M&E) are a vital management tool. National, provincial and district level indicators to monitor inputs, process, outputs, outcomes and impact will be used to assess collective effort. It is recommended that a sustainable budget of between 4% – 7% is dedicated for the Monitoring and Evaluation of the NSP in line with international trends.

Research, Monitoring and Surveillance Framework:

Figure 8: The organogram below depicts the Framework envisaged by the NSP



Research Coordination:

The SANAC's M&E Sector Coordinating Unit will monitor the NSP research agenda and liase closely with their counterparts within relevant departments to identify and, when necessary commission, priority research.

Line departments should ensure that funded research institutions, such as the National Research Foundation, Medical Research Council, Human Sciences Research Council, Higher Education Institutions, Council for Scientific and Industrial Research and others, integrate the NSP research agenda in their annual research programmes.

Existing research databases will be used and all clinical trials will be registered on the South African National Clinical Trials Register. Systematic reviews will be conducted on emerging evidence on interventions including microbicides, vaccines, male circumcision, post-exposure prophylaxis, herpes simplex suppression, nutritional interventions and traditional medicine. These reviews should inform policy.

Surveillance:

The following activities will be accelerated with regard to surveillance and monitoring:

- Provision of standards for public and private sector facilities to draw from a basic facility based monitoring system that enables both monthly and quarterly cohort reporting in the Comprehensive HIV and AIDS Plan.
- Strengthening of health information systems including the DHIS to incorporate new NSP indicators.
- Collaboration with partners to ensure that a sentinel surveillance system is in place for ART based on individualized patient data.
- Collaboration with provinces to ensure a passive stimulated adverse drug reaction reporting system is implemented in each province, and that reports are transferred to the national pharmacovigilance centre.
- Collaboration with MRC and HSRC to ensure that the DHS and HIV prevalence surveys are adapted or augmented to meet national information requirements.
- Implementation of the WHO Resnet resistance surveillance protocol.
- Consultations on the best possible measures of trends in HIV incidence and HIV-related mortality.

Monitoring and Evaluation, Oversight and Reporting Schedule:

The Monitoring and Evaluation Framework 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 2). 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 goals, objectives and interventions of the NSP for detailed ongoing monitoring and evaluation. This set will be defined in detail after the finalization of the NSP as an annexure of the NSP. The comprehensive set will be developed by persons nominated by the various sectors and finalized by end of July 2007. 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.

Role of SANAC Monitoring and Evaluation Coordinating Unit:

As a central coordinating body of the NSP, the M&E unit of the SANAC will be responsible for the development of M&E Guidelines, Reporting Guidelines, and Terms of Reference for Mid-term and 5 year term reviews. SANAC's Monitoring and Evaluation Coordinating Unit will establish a mechanism for data collection and for coordinating reporting from the various sectors. This mechanism will work in close collaboration with the Government-Wide Monitoring & Evaluation System of the Presidency.

The M&E Unit of the SANAC will assess the state of readiness of existing sector specific M&E mechanisms and collect baseline data for all core indicators during the first phase of the implementation of the NSP. This unit will also will link with the current reporting mechanisms of international and regional indicators. The initiation and conducting of the Mid-term and 5-year reviews on core indicators will be coordinated by the M&E Unit of the SANAC

Each sector/lead agency will develop a monitoring schedule that ensures that common definitions and standards are developed and that the necessary capacity is available for the sector M&E systems. At the outset, it will be necessary to assess the **state of readiness of various existing 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.

Feedback mechanisms for the dissemination of indicator data will be strengthened and be integrated into the quarterly Government Cluster System Reporting and Government Communication and Information Services. Lead agencies will report back to their constituencies using their communication channels including district based AIDS councils.

The Health Sector aspects of the NSP will be integrated into the existing HIV and AIDS monitoring and evaluation system coordinated by 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 NSP 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, the reporting mechanism will continue to support ongoing monitoring of other international, regional and national indicators such as those of the UNGASS, the Millennium Development Goals, Abuja framework for Action, NEPAD and SADC indicators, which are aligned with the indicators identified for the NSP.

Midterm and Five Year Review:

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 will also focus on challenges, role players and interactions between various role players and lead agencies. The reviews will focus on the following questions:

- What coverage of services for prevention, treatment, care and support and legal and human rights 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 an outcomes based assessment using data from multiple sources.

With regard to the comprehensive set of indicators, a detailed schedule of reporting schedules, data sources and data collection mechanisms will be developed as an annex to this document.

Table 2: Primary Set of Indicators

	Indicator	Data Sources	Frequency of reporting	Responsibility
Priority Area 1: Prevention	Budget and expenditure on care, treatment and support in private and public sectors *	National Treasury, National AIDS Expenditure Accounts	Annual and five yearly	National Treasury
	Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother to child transmission*	DHIS	Annually	DOH
	Percentage of infants born to HIV-infected mothers who are infected	Based on programme coverage Treatment protocols and efficacy studies	Annually	DoH
	Proportion of the population living below $ 1 per day**	StatsSA survey	5 yearly	StatsSA
	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 women and men aged 15-49 who had have had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse * **	Population-based survey	Every 4-5 years	DOH, HSRC
	Percentage of young men and women aged 15-24 who have had sexual intercourse 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

	Indicator	Data Sources	Frequency of reporting	Responsibility
Priority Area 1: Prevention *continued*	Percentage of women and men 15-49 who have had sexual intercourse with more that one partners in the last 12 months *	Nelson-Mandela HSRC HIV survey, 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
	Percentage of schools that provided life skills-based HIV education in the last academic year *	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
	Percentage of most-at-risk populations reached with HIV prevention programmes	Behavioral surveys	Every two years	DoH, HSRC
	Teenage pregnancy rate	SADHS, Youth Risk Behavioural Survey,	2 yearly, 5 yearly	DOE,DOH, MRC
	Proportion of population with sustainable access to an improved water source, urban and rural**	StatsSA community survey	Annually	StatSA , DWAF
	Proportion of population with access to improved sanitation, urban and rural**	StatsSA community survey	Annually	StatSA , DWAF
	Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major mis-conceptions about HIV transmission	Behavioral surveys	Every two years	DoH, HSRC

	Indicator	Data Sources	Frequency of reporting	Responsibility
Priority Area 2: Care, Treatment and Support	Budget and expenditure on care, treatment and support in private and public sectors *	National Treasury National AIDS Expenditure Accounts	Annual and five yearly	National Treasury
	Percentage of adult and children with advanced HIV infection receiving antiretroviral therapy*	Cohort Surveillance /M&E data Comprehensive HIV and AIDS Plan	Two yearly	DOH and others
	Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results*	Annual antenatal HIV, Nelson-Mandela HSRC HIV survey Survey, SADHS	Annual, 2 yearly, 5 yearly	DOH, HSRC
	Percentage of most at risk populations that have received an HIV test in the last 12 months and who know their results*	DHIS (new indicator)	Annual	DOH
	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
	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	Programme monitoring	Annual	DoH
	Proportion of HIV positive pregnant women initiated on ART*	DHIS(new indicator) Cohort Surveillance	Annual	DOH

	Indicator	Data Sources	Frequency of reporting	Responsibility
Priority Area 2: Care, Treatment and Support *continued*	Percentage of adults and children (by age groups) with HIV known to be on treatment 12 months after initiation of antiretroviral therapy*	M&E data Comprehensive HIV and AIDS Plan	Two yearly	DOH and others
	Percentage of female and male sex workers reporting the use of a condom with their most recent client	Behavioral surveys	Every two years	DoH, HSRC, MRC
	Percentage of persons attending wellness clinics who died prior to initiation of ART	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 Orphaned and Vulnerable Children (boy/girl) aged 0-17 whose household have received a basic external support in caring for the child*	M&E data	Annual	DSD

	Indicator	Data Sources	Frequency of reporting	Responsibility
	Current school attendance among orphans and among non-orphans aged 10-14* **	Population based surveys	Population based surveys	DoH, HSRC, MRC
Priority Area3: Research Monitoring and Surveil-lance	Budget and expenditure on research, monitoring and surveillance in private and public sectors*	National Treasury Records National AIDS Expenditure Accounts	Annual and 5 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
Priority Area 4: Human Rights, Access to Justice	Budget and expenditure in private and public sectors*	National Treasury Records National AIDS Expenditure Accounts	Annual and 5 yearly	National Treasury
	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	DOJCD, civil society,
	Number of legal and social support services for women, care-givers and victims of sexual violence		Annual	DOJCD, civil society

* UNGASS and ** MDG indicators

12. FINANCIAL IMPLICATIONS

This section estimates 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, PEPFAR and other multilateral and bilateral) 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 which could lead to increasing reliance on more expensive lines of treatment.

Total Costs

Table 3 and *Table 4* 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 3*, 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 4*, high cost scenarios are summarized, where 80% of new AIDS case receive ART by 2011.

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.

Table 3: Summarized total costs for the low cost scenarios (million Rands, 2005/06 prices)

Priority area	Goal	intervention	Year 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	180	2%
		Life skills	158	168	177	186	185	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 4: Summarized total costs for the high cost scenarios (million Rands, 2005/06 prices)

Priority area	Goal	intervention	Year 2007	2008	2009	2010	2011	% Total
Prevention			643	775	990	1,207	1,247	11%
	Reduce sexual transmission		**642**	**773**	**989**	**1,206**	**1.246**	**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%**

HIV & AIDS and STI STRATEGIC PLAN FOR SOUTH AFRICA

13. REQUIREMENTS FOR EFFECTIVE IMPLEMENTATION OF THE NSP:

This section highlights contextual issues relating to systems weaknesses, policy gaps and regulatory requirements to be addressed primarily (but not exclusively) by government.

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

After it has been adopted by SANAC, the NSP will be used in developing sector plans at national, provincial and district level. Yearly operational plans should be based on realistic objectives that are linked to the NSP's objectives, interventions and targets.

b) Establish and Strengthen Structures for Delivery:

In a similar fashion to the review process undertaken by SANAC in 2006, there is a need to review and develop structures at all levels, from national to community where necessary. It is recommended that Provinces replicate appropriate national structures, such as SANAC, at provincial and local level. It is particularly important to establish appropriate structures at district level. It is recommended that District HIV and AIDS Committees be established. These district structures should include all local role players within communities. Local government structures should mainsteam HIV and AIDS, TB and STI activities to harmonise with local integrated development plans: issues such as access to transport and poverty alleviation as intregral to HIV programmes.

c) Addressing Policy and Legal Issues:

In each of the key priority areas there are issues of policy and regulation that require attention from relevant policy makers and the legislature. These are set out briefly below:

Facilitating Effective HIV Prevention:

A reduction of new HIV infections by 50% in five years is an ambitious target. A supportive legal and policy framework is critical for effective implementation of key aspects of the plan.

The NSP proposes focused prevention efforts on groups who are known to have a higher risk of being infected with HIV because of their age, sex, behaviours or social status. It recommends that all policy and law makers be familiarise themselves with and understand the NSP.

In this regard the NSP recommends that:

- Legislation and policy that will protect children's rights be finalised. This includes the Children's Act and Child Justice Bill.
- Existing laws that protect women and girls from gender based violence are effectively implemented. In particular that:
  - Adequate resources are provided for the implementation of the Domestic Violence Act.
  - The Domestic Partnerships Bill is finalised.
  - The Sexual Offences Act is finalised.
- The recommendation of the Equality Review Committee to amend the Equality Act to include 'HIV status' as an express ground of non-discrimination is considered in order to meet the objectives set out in Key Priority Area 4.

The NSP recognises that several higher risk groups, such as sex workers and drug users, face barriers to accessing HIV prevention and treatment services, because their activities are unlawful. The NSP therefore recommends:

- The decriminalisation of sex work.
- The finalisation and implementation of the Prevention and Treatment for Substance Abuse Bill, and its incorporation of HIV harm reduction measures.

Finally, there are a number of policy issues that must be addressed by the Department of Health:

- Whilst the NSP affirms that VCT remains the primary model, Goal 6 expands this model to include HIV testing that is *offered* by health providers to specified groups of people attending health facilities. It also proposes to identify new strategies for the provision of counselling and testing outside of health facilities. These new initiatives require a development of policy.
- In early 2007 the World Health Organisation/ UNAIDS issued recommendations on male circumcision for HIV prevention. It is recommended that the Department of Heath consider the effectiveness of male circumcision as an HIV prevention intervention and develop appropriate policies.
- There is overwhelming evidence that better efficacy is achieved with dual therapy in PMTCT. A dual-therapy regimen is also known to be highly cost effective. Goal 3 requires that policy on the drug regimen used in PMTCT needs to be updated according to the Guidelines of the WHO.

Facilitating Treatment, Care and Support: Affordability of Medicines

It is estimated that, at current prices, the provision of anti-retroviral therapy will account for about 40% of the total cost of the NSP. This much needed service will soon be unaffordable at the current drug prices. The following legal opportunities can be exploited in order to make medicines more affordable.

- Amending the Patents Act (57 of 1978) to permit compulsory licensing of medicines when deemed necessary. This 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*.
- Finalising of regulations establishing international benchmarks for medicine prices.
- Removing obstacles to the timeous registration of essential medicines.

Social Security:

The NSP recommends strengthening systems to provide food support to children and adults on chronic medication and the introduction of a Chronic Diseases Grant, a policy choice currently being considered by the Social Cluster of Government.

Strengthening Human Resources for Health:

A major threat to the implementation of the NSP's interventions to provide prevention treatment, care and support is the unavailability of skilled personnel.

Human resource shortages, however, are not a justification for paralysis. South Africa has already found innovative ways to mobilise local communities for the provision of services. These strategies have been successful in promoting greater access to services. Some examples include defining clear responsibilities for the use of community development workers, community care givers and lay counsellors in health facilities.

A number of important systems level innovations are therefore recommended by the NSP.

- Task shifting: This 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 NSP recommends that regulatory and policy barriers to task shifting be identified; nursing scopes of practice be amended and that processes are set in motion to provide the necessary training to health care workers.

- In order minimise the risk of compromising the quality of services, such policy decisions require a supportive systemic environment. In this regard, defining norms and standards, roles and responsibilities, target setting, 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.

d) Sustainability of Financing:

Weaknesses of existing monitoring and evaluation systems have made 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; for example, if the NSP target of 80% of AIDS cases receiving ART was achieved this would exceed 20% of the health budget (see table 4 on p 144). This is before taking into account 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 NSP. It requires policy makers to consider what efficiencies might be possible and to make difficult resource allocation choices within the health sector and between sectors.

To ensure the financial feasibility of this plan, some of the key considerations are:

- Extending HIV prevention programmes and getting them to work. This 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 development partners (Global Fund to Fight AIDS, TB and Malaria, PEPFAR, other bilateral and multilateral partners) as well as partnerships with the private health sector, business and a range of other stakeholders.
- Increasing the affordability of medicines.
- Improving monitoring and evaluation, which will amongst other things show value for money.

- Sustaining high 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 for the Cabinet and Treasury to continue to ensure that adequate funding for ensuring service delivery is made available at national, provincial and district levels. The best mechanism of ensuring predictable and sustainable provision of financial resources is the conditional grant that is available through the division of revenue.

14. WAY FORWARD

Effective coordination across the sectors is key to the successful implementation of the NSP. The SANAC secretariat will be strengthened to ensure that all sectors are accountable 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 will ensure that all the identified gaps are addressed.

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 and implement more specific operational plans based on its role in society, its activities and its specific strengths.

15. 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.

16. ACKNOWLEDGEMENTS

The development of this “HIV & AIDS and 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.

REFERENCES

i Sharma, S.K., Mohan, A., & Kadhiravan, T. (2005). HIV-TB co-infection: Epidemiology, diagnosis and management. Indian Journal of Medical Research,121:550-567; Sonnenberg, P., Glynn, J.R., Fielding, K., Murray, J., Godfrey-Fausset, P., & Shearer, S. (2005). How soon after infection with HIV does the risk of tuberculosis start to increase? A retrospective cohort study in South African gold miners. Journal of Infectious Disease, 191:150-8

ii Zumla, A., Malon, P., Henderson, J., & Grange, J.M. (2000). Impact of HIV infection on tuberculosis. Postgrad Medical Journal, 76:259-268.

1 UNAIDS. (2006a). 2006 report on the global AIDS epidemic. Geneva: UNAIDS

2 UNAIDS, 2006a; Hallet et al, 2006; Cheluget et al, 2006; Bello et al, 2006; Kirungi et al, 2006; Mahomva et al, 2006

3 UNAIDS, 2006a

4 UNAIDS. (2006b). December 06: AIDS epidemic update. Geneva: UNAIDS

5 Dorrington, R. E., Moultrie, T. A. and Daniel, T. 2006. *Modelling the impact of HIV/AIDS in Botswana. Gaborone: UNDP and NACA, Botswana.*

6 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.

7 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.

8. Department of Health, 2006

9. Shisana, et al (2005)

10 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.

11 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

11 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.

13 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

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

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

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

17 Shisana et al, 2005

18 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

19 Shisana et al, 2005

20 Human Science Research Council, 2005

21 Shisana, et al, 2005

22 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.

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

24 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.

25 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).

26 UNAIDS, 2006a

27 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.

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

29 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.

30 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.

31 Jewkes, R., & Abrahams, N. (2002). The epidemiology of rape and sexual coercion in South Africa: An overview. *Social Science and Medicine*, 55, 1231-1244.

32 CADRE [Centre for AIDS Development, Research and Evaluation]/ DoH [Department of Health, South Africa] (2003). *Gender-based violence and HIV/AIDS in South Africa: A bibliography.* Johannesburg: CADRE.

33 Kalichman, C., Simbayi, L.C., Cain, D., Cherry, C., Henda, N. & Cloete, A. (2007). Sexual assault, sexual risks, and gender attitudes among South African men. *AIDS Care*, 19(1), 20-27.

34 Jewkes, R., Penn-Kekana, L., Levin, J., Ratsaka, M., & Schrieber, M. (2001). Prevalence of emotional, physical, and sexual abuse of women in three South African provinces. *South African Medical Journal*, 91(5):421-428.

35 Jewkes, R., & Abrahams, N. (2002). The epidemiology of rape and sexual coercion in South Africa: An overview. *Social Science and Medicine*, 55, 1231-1244.

36 Kalichman, S.C., & Simbayi, L. (2004c). Sexual assault history and risks for sexually transmitted infections among women in an African township in Cape Town, South Africa. *AIDS Care,* 16, 681-689

37 Boonzaier, F. (2005). Women abuse in South Africa: A brief contextual analysis. *Feminism & Psychology*, 15, 99-103.

38 Kalichman, S.C., & Simbayi, L.C (2005). Genital Bleeding During Sex among Sexually Transmitted Infection Clinic Patients in Cape Town, South Africa. *Sexual Health*, 2, 85-88.

39 Morrell, R. (2002). *Changing men in South Africa*. University of Natal Press, Durban, South AfricaNIMH Multisite Study Group. (1998)

40 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.

41 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.

42 UNAIDS (2006). Report on the global AIDS epidemic. Geneva: UNAIDS.

43 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

44 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*

45 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]

46 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.

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

48 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

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

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

51 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

52 Health Science Research Council , 2005

53 United Nations (2002) United Nations Special Session on HIV/AIDS, United nations New York

54 UNAIDS, UNICEF, USAID (2004) Children on the Brink 2004, Geneva

55 Shisana, et al (2005) South Africa National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, HRSC, Cape Town

56 Statistics South Africa (2006). Mortality and causes of death in South Africa, 2003 and 2004: findings from death notification. Pretoria: Statistics South Africa.

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

58 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

59 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.

60 UNAIDS, 1998

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

62 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.

63 Vernazza PL, Eron JJ, Fiscus SA, Cohen MS. (1999). Sexual transmission of HIV: infectiousness and prevention. AIDS 13:155-166.

64 Pilcher, C.D. et al. (2004). Brief but efficient: Acute HIV infection and the sexual transmission of HIV. Journal of Infectious Diseases. 189:1785-1892

65 Taylor S, Boffito M, Vernazza PL. (2003). Antiretroviral therapy to reduce the sexual transmission of HIV. J HIV Ther 8:55-66.

66 Pettifor, A.E., van der Straten, A., Dunbar, M., Shiboski, S.C., & Padian, N. (2004). Early age of first sex: a risk factor for HIV infection among women in Zimbabwe. AIDS, 18(10):1435-1442; Harrison, A. Cleland, J. Gouws,.Frohlich, . 2006, Early Sexual Debut Among Young Men in Rural South Africa: Heightened Vulnerability to Sexual Risk?, Sexually Transmitted Infections, 81, pp. 259-261; Gregson, S., Nyamukapa, C., Garnett, G.P., Mason, P.R., Zhuwau, T., Carael, M., et al. (2002). Sexual mixing patterns and sex-differentials in teenage exposure to HIV infection in rural Zimbabwe. The Lancet 359:1896-1903; ßPettifor, A. E., Rees, H. V., Steffenson, A., Hlongwa-Madlklzela, L., MacPhall, C., Vermaak, K., Kleinschmidt, I, 2004, HIV and sexual behavior among South Africans: a national survey of 15-24 year olds, Reproductive Health Research Unit, University of Witwatersrand.

67 Thurman, T.R., Brown, L., Richter, L., Maharaj, P., & Magnani, R. (2006). Risk Behavior among South African Adolescents: Is Orphan Status a Factor? AIDS and Behavior 10(6):627-635

68 Kirungi, W.L., Musinguzi, J., Madraa, E., Mulumba, N., Callejja, T., Ghus, P., & Bessinger, R. (2006). Trends in antenatal HIV prevalence in Urban Uganda associated with uptake of preventive sexual behaviour. Sexually Transmitted Infectinons, 82(S1):i36-i41; Hallet, T.B., Aberle-Grasse, J., Bello, G., Boulos, L.M., Cayemittes, M.PA., Cheluget, B. et al. (2006). Declines in HIV prevalence can be associated with changing sexual behaviour in Uganda, urban Kenya, Zimbabwe and urban Haiti. Sexually Transmitted Infections. 82(Suppl 1).:i1-i8

69 Shisana et al, 2005; Kelly, R.J., Gray, R.H., Sewankambo, N.K., Serwadda, D., Wabire-Mangen, F., Lutalo, T. & Wawer, M. (2003). Age Differences in Sexual Partners and Risk of HIV-1 Infection in Rural Uganda. Journal of Acquired Immune Deficiency Syndromes. 32(4):446-451

70 Pettifor, A.E., Measham, D.M., Rees, H.V., & Padian, N.S. (2004). Sexual power and HIV risk in South Africa. Emerging Infectious Diseases, 10:1996-2004.

71 Dunkle, K.L., Jewkes, R.K., Brown, H.C., Gray, G.E., McIntyre, J.A., & Harlow, S.D. (2004). Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. Lancet 363:1415-1421.

72 Morris, M. & Kretzchmar, M. (2000). A microsimulation study of the effect of concurrent partnerships on the spread of HIV in Uganda. Working Paper 00-07. Pennsylvania State University; Wawer, M. J. et al. (2005). Rates of HIV-1 transmission per coital act, by stage of HIV-1 infection, in Rakai, Uganda. Journal of Infectious Diseases. 191(9).:1403-9.

73 Bongaarts J (2006) Late Marriage and the HIV Epidemic in sub-Saharan Africa. Working Paper 216, Population Council.

74 Hallet, T.B., Aberle-Grasse, J., Bello, G., Boulos, L.M., Cayemittes, M.PA., Cheluget, B. et al. (2006). Declines in HIV prevalence can be associated with changing sexual behaviour in Uganda, urban Kenya, Zimbabwe and urban Haiti. Sexually Transmitted Infections. 82 (Suppl 1): i1-i8; Shisana et al, 2005.

74 Shisana et al, 2005.

76 Pettifor AE, Rees HV, Steffenson A, Hlongwa-Madlklzela L, MacPhall C, Vermaak K, Kleinschmidt I. 2004. HIV and sexual behavior among South Africans: A national survey of 15-24 year olds. Johannesburg: Reproductive Health Research Unit, University of Witwatersrand.

77 Weller, S., & Davis, K. (2002). Condom effectiveness in reducing heterosexual HIV transmission. Cochrane Database Syst Rev. 4:2003

78 Ahmed, S., Lutalo, T., Wawer, M., Serwadda, D., Sewankambo, N.K., Nalugoda. F., et al. (2001). HIV incidence and sexually transmitted disease prevalence associated with condom use: a population study in Rakai, Uganda. AIDS 15:2171-2179

79 Shisana et al, 2002

80 Shisana et al, 2005; Pettifor et al, 2004.

81 Hallet et al, 2006

82 Weiss, H.A., Quigley, M.A., & Hayes, R.J. (2000). Male circumcision and risk of HIV infection in sub-Saharan Africa: A systematic review and meta-analysis. AIDS 14:2361-2370

83 Auvert, B., Taljaard, D., Lagarde, E., Sobngwi-Tambekou, J., Sitta, R., & Puren, A. (2005). Randomised, controlled intervention trial of male circumcision for reduction of HIV infection risk: The ANRS 1265 Trial. PLOS Medicine 2(11)e298

84 Bailey, R. C., Moses, S., Parker, C. B., Agot, K. *et al*. 2007. "Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial", *Lancet* 369:643-656; Gray, R. H., Kigozi, G., Serwadda, D., Makumbi, F. et al. 2007. "Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial", Lancet 369(657-66)

85 Bonner, K. (2001). Male circumcision as an HIV control strategy: Not a 'natural condom'. Reproductive Health Matters, 9(18):1-13

86 Williams, B.G., Lloyd-Smith, J.O., Gouws, E., Hankins, C., Getz, W.M., Hargrove, J., et al. (2006). The potential impact of male circumcision on HIV in sub-Saharan Africa. PLOS Medicine 3(7):e262

87 Weiser, S.D., Leiter, K., Heisler, M., McFarland, W,, Percy-de Korte, F., et al. (2006) A population-based study on alcohol and high-risk sexual behaviors in Botswana. PLoS Med 3(10): e392; Zuma K, Gouws E, Williams B, Lurie M. 2003. Risk factors for HIV infection among women in Carletonville, South Africa: Migration, demography and sexually transmitted diseases. Int J STD AIDS 14:814-817.

88 Weinhardt et al, 1999; Coates et al, 2000; Matovu et al, 2004

89 Johnson et al, 2006; Crepaz et al, 2006

90 Shisana et al, 2005

91 (ILO, 2006)

92 (Ashford, 2006)

93 (Letlape et al., 2006; Jooste et al., 2006)

94 (Skinner, 2006)

95 (UNICEF)

96 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.

97 (Shisana et al, 2003)

98 (Connelly et al, 2007)

99 (Shisana et al., 2005b)

ANNEXURE A: CORE TASK TEAM MEMBERS

A Task Team was appointed by the Director-General Health and comprised of:
Dr Nomonde Xundu – Cluster Manager: HIV & AIDS and STIs, National Department of Health – Chairperson

Dr Lindiwe Makubalo – Cluster Manager: Health Information, Evaluation and Research, National Department of Health

Dr Connie Kganakga – Chief Director: HIV and AIDS, Department of Social Development

Prof Quarraisha Abdool–Karim – Associate Scientific Director – CAPRISSA – University of KwaZulu-Natal

Dr Molefi Sefularo – WHIT for ANC strategic meeting – Parliament

Mr Obed Qulo – Project Director, HEARD

Prof Rob Dorrington – Director of the Centre for Actuarial Research – University of Cape Town

Dr Mbulawa Mugabe – Country Coordinator: UNAIDS

Ms Hendrietta Bogopane-Zulu – Member of Parliament

Prof Helen Schneider – Centre for Health Policy, School of Public Health – WITS

Dr Fazel Randera – Health Advisor: Chamber of Mines

Mr Mark Heywood – Executive Director: AIDS Law Project

Mr Sibane Mngadi – Media Liaison, Ministry, National Department of Health

Mr Nkululeko Nxesi – Director, NAPWA

Dr Clarence Mini – NAPWA

Ms Sipho Mthathi – General Secretary: Treatment Action Campaign

Mrs E Grundling – Secretariat to Task Team

Ms Sandra Mabamba – Secretariat to Task Team

Prof Helen Rees – Executive Director: Reproductive Health and HIV Research Unit

Dr Ernest Darkoh – Programme Director: Broadreach Healthcare

Dr Francois Venter – President: HIV Clinicians Society

Dr Andrew Boulle – University of Cape Town

Dr Mark Blecher – Director: Social Services, National Treasury

Ms Susan Cleary – Researcher: Health Economics Unit, University of Cape Town

Mr Allan Liebenberg – Coordinator: National Association of Schools Governing Body Western Cape

Ms Mpumi Matangana – Manager: MSF

Ms Veliswa Labgatala – Professional Nurse: City of Cape Town

Mr Warren Parker – Director: CADRE

Ms Helen Meintjies – Senior Researcher: Children's Institute, University of Cape Town

Dr Harry Moultrie – Director: WITS Pediatric HIV Clinics

Ms Karen Allan – Project Manager: ACEAA

Ms Prudence Mabele – Founder and Executive Director: Positive Women's Network for people Living with HIV & AIDS

ANNEXURE B: MAP OF SOUTH AFRICA

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