HIV & AIDS and STI Strategic Plan for South Africa

2007-2011
An initiative by the
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<tbody>
<tr>
<td>ABC</td>
<td>Abstain, Be Faithful, Condomise</td>
<td>DPLG</td>
<td>Department of Provincial and local Government</td>
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
<td>DSD</td>
<td>Department of Social Development</td>
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<td>ANC</td>
<td>Antenatal Care</td>
<td>DTI</td>
<td>Department of Trade and Industry</td>
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<td>ART</td>
<td>Antiretroviral therapy</td>
<td>EDL</td>
<td>Essential Drug List</td>
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<td>ASGI-SA</td>
<td>Accelerated Shared Growth Initiative for South Africa</td>
<td>EPWP</td>
<td>Expanded Public Works Programme</td>
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<td>ASSA</td>
<td>Actuarial Science Society of South Africa</td>
<td>FBOs</td>
<td>Faith Based Organisation</td>
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<td>ATIC</td>
<td>AIDS Training and Information Centre</td>
<td>GCIS</td>
<td>Government Communication and Information Systems</td>
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<td>BHF</td>
<td>Board of Healthcare Funders</td>
<td>HCW</td>
<td>Health Care Worker</td>
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<td>CBOs</td>
<td>Community based Organisations</td>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>CCMT</td>
<td>Comprehensive HIV &amp; AIDS Care, Management and Treatment</td>
<td>HRC</td>
<td>Human Rights Commission</td>
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<td>CGE</td>
<td>Commission on Gender Equality</td>
<td>HSRC</td>
<td>Human Sciences Research Council</td>
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<td>CHBC</td>
<td>Community Home Based Care</td>
<td>HTA</td>
<td>High Transmission Areas</td>
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<td>DENOSA</td>
<td>Democratic Nursing Organisation of South Africa</td>
<td>IDC</td>
<td>Interdepartmental Committee on AIDS</td>
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<td>DOE</td>
<td>Department of Education</td>
<td>IDU</td>
<td>Injecting Drug Use</td>
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<td>DOF</td>
<td>Department of Finance</td>
<td>IEC</td>
<td>Information Education and Counselling</td>
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<td>DOH</td>
<td>Department of Health</td>
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<td>Information, Education, and Communication</td>
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<td>IMC</td>
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<td>Department of Justice</td>
<td>JIPSA</td>
<td>Joint Initiative on Priority Skills Acquisition</td>
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<td>DOL</td>
<td>Department of Labour</td>
<td>MDG</td>
<td>Millennium Development Goals</td>
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<td>DOME</td>
<td>Department of Minerals and Energy</td>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>DOT</td>
<td>Department of Transport</td>
<td>MEC</td>
<td>Member of Executive Committee</td>
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<td>DOTS</td>
<td>Direct Observed Therapy Short Course</td>
<td>MOH</td>
<td>Ministry of Health</td>
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<td>Acronym</td>
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<tr>
<td>MRC</td>
<td>Medical Research Council</td>
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<td>MSM</td>
<td>Men who have Sex with Men</td>
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<td>MTCT</td>
<td>Mother-to-child transmission</td>
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<td>MTEF</td>
<td>Medium Term Expenditure Framework</td>
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<td>NHA</td>
<td>National Health Act</td>
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<td>NHC</td>
<td>National Health Council</td>
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<td>NHLS</td>
<td>National Health Laboratory Services</td>
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<td>NACOSA</td>
<td>National AIDS Co-ordinating Committee of South Africa</td>
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<td>NGOs</td>
<td>Non-Government Organisations</td>
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<td>NPA</td>
<td>National Prosecuting Authority</td>
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<td>OI</td>
<td>Opportunistic Infection</td>
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<td>OVC</td>
<td>Orphaned and vulnerable children</td>
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<td>PCR</td>
<td>Polymerase Chain Reaction</td>
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<td>PEP</td>
<td>Post-exposure prophylaxis</td>
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<td>PLHIV</td>
<td>People living with HIV</td>
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<td>PMTCT</td>
<td>Prevention of mother to child transmission</td>
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<td>RHRU</td>
<td>Reproductive Health Research Unit</td>
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<td>SAAVI</td>
<td>South African AIDS Vaccine Initiative</td>
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<td>SALC</td>
<td>South African Law</td>
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<td>SALGA</td>
<td>South African Local Government Association</td>
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<td>SAMA</td>
<td>South African Medical Association</td>
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<td>SANAC</td>
<td>South African National AIDS Council</td>
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<td>SAPS</td>
<td>South Africa Police Service</td>
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<td>SADC</td>
<td>Southern Africa Development Community</td>
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<td>SANDF</td>
<td>South African National Defence Force</td>
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<td>SMMEs</td>
<td>Small, Medium Macro enterprises</td>
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<td>StatsSA</td>
<td>Statistics South Africa</td>
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<td>STIs</td>
<td>Sexually Transmitted Infections</td>
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<td>SM</td>
<td>Syndromic Management</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>THP</td>
<td>Traditional Health Practitioner</td>
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<td>TL</td>
<td>Traditional Leader</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>VCT</td>
<td>Voluntary HIV Counselling and Testing</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<td>XDR-TB</td>
<td>Extensively Drug Resistant Tuberculosis</td>
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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
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 socio-economic 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

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 of 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. TB is the most common 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.

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 executive summary 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 (IDUs) 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 socio-economic 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 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 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 Facilitate development in the research environment.

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 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 challenges.

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

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 with 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 PLHIV in employment, housing, education, insurance and financial services and other sectors.
   17.3 Promote greater openness and acceptance of PLHIV.

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 constraints 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 realistic 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.
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 southern Africa have prevalence levels of between 10-20%, with some countries (Botswana, Zimbabwe, Lesotho, and Swaziland) even higher. HIV prevalence has declined in some countries, Uganda in the early 1990s, and recently Zimbabwe, Kenya and urban areas of Burkina Faso. These declines seem to be linked to changes in key sexual behaviours. Overall, HIV prevalence in this region appears to be levelling off, albeit at high levels.

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, 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 STIs, the establishment of the South African AIDS Vaccine Initiative (SAAVI) in 1998, the establishment of SANAC, the establishment of the national interdepartmental committee on HIV and AIDS, as well as the development of a Strategic Framework for a South African AIDS Youth Programme.

In 1999, through a consultative process with stakeholders, a National Strategic Plan (NSP 2000-2005) was developed and has been the cornerstone of our response in mitigating against HIV and AIDS. Its aim was to strengthen the implementation of the recommendations of the NACOSA Plan review as well as to enhance the national response to HIV and AIDS and STIs. This plan was lauded by the previous Secretary-General of the United Nations Organisation, Mr Kofi Annan, as one of the best in the world. An assessment of the NSP 2000-2005 was carried out and its findings and recommendations have been used to inform the NSP 2007-2011.

A number of policies and guidelines have been developed in order to support the implementation of HIV and AIDS strategies in South Africa. This work began in 1994 with the finalisation of the Reconstruction and Development 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.

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 on the private sector need to be developed and introduced.

The challenge of HIV and AIDS in South Africa 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. This NSP seeks to provide such guidance.
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 partner turnover and increased condom use with casual sexual partners.

Southern Africa remains the most affected region, and the HIV epidemic in South Africa is interlinked with epidemics occurring in neighbouring countries. South Africa, Swaziland, Lesotho and Botswana reported the highest antenatal HIV prevalence levels in the world in 2006\(^3\). 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 poverty, women’s relative lack of empowerment, high rates of male worker migration, and other social and cultural factors. Even with knowledge of how to protect oneself from infection, such information may not always be usable in daily situations of economic and social disadvantage that characterise the lives of many young people and women in poor countries.
3.1 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 should be reviewed and adapted to fit local conditions.

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

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

HIV prevalence has been consistently monitored in South Africa including through antenatal HIV and syphilis prevalence surveys, which have been conducted since 1990, and two national population-based surveys which were conducted in 2002 and 2005. A national prevalence survey of youth was also conducted in 2003/4. Figure 1 illustrates antenatal HIV trends from 1990 to 2005, and Figure 2 illustrates HIV prevalence by sex and age group in 2005 in the general population.

*Figure 1: National HIV prevalence trends among antenatal clinic attendees: 1990 – 2005*
A number of other national and sub-national studies have been conducted including employees, the military, health workers, educators, health care workers and hospital patients, amongst children attending health care facilities, 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 is available has allowed HIV prevalence, incidence and AIDS mortality to be estimated using demographic modelling as shown in Table 1 (page 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. 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. 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. 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 has been, however, a discernable increase in HIV prevalence in older age groups.
Figure 3: HIV prevalence of antenatal clinic attendees by age group: 1991 – 2005

Table 1: HIV and AIDS Indicators at mid-2006

<table>
<thead>
<tr>
<th>Births</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninfected births (over calendar year)</td>
<td>1 057 000</td>
</tr>
<tr>
<td>HIV+ births (over calendar year)</td>
<td>38 000</td>
</tr>
<tr>
<td>Infected through breastfeeding</td>
<td>26 000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>People living with HIV/AIDS</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total HIV infected</td>
<td>5 372 000</td>
</tr>
<tr>
<td>Adults (20-64)</td>
<td>4 880 000</td>
</tr>
<tr>
<td>Adult men (20-64)</td>
<td>2 179 000</td>
</tr>
<tr>
<td>Adult women (20-64)</td>
<td>2 702 000</td>
</tr>
<tr>
<td>Adults (15-49)</td>
<td>4 756 000</td>
</tr>
<tr>
<td>Adult men (15-49)</td>
<td>1 946 000</td>
</tr>
<tr>
<td>Adult women (15-49)</td>
<td>2 810 000</td>
</tr>
<tr>
<td>Youth (15-24)</td>
<td>1 012 000</td>
</tr>
<tr>
<td>Male youth (15-24)</td>
<td>181 000</td>
</tr>
<tr>
<td>Female youth (15-24)</td>
<td>831 000</td>
</tr>
<tr>
<td>Children (0-14)</td>
<td>294 000</td>
</tr>
<tr>
<td>New infections</td>
<td>527 000</td>
</tr>
</tbody>
</table>
### SITUATION ANALYSIS

#### Prevalence

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total HIV infected</td>
<td>11.2%</td>
</tr>
<tr>
<td>Adults (20-64)</td>
<td>19.2%</td>
</tr>
<tr>
<td>Adult men (20-64)</td>
<td>17.8%</td>
</tr>
<tr>
<td>Adult women (20-64)</td>
<td>20.4%</td>
</tr>
<tr>
<td>Adults (15-49)</td>
<td>18.3%</td>
</tr>
<tr>
<td>Adult men (15-49)</td>
<td>15.4%</td>
</tr>
<tr>
<td>Adult women (15-49)</td>
<td>21.2%</td>
</tr>
<tr>
<td>Youth (15-24)</td>
<td>10.4%</td>
</tr>
<tr>
<td>Male youth (15-24)</td>
<td>3.7%</td>
</tr>
<tr>
<td>Female youth (15-24)</td>
<td>16.9%</td>
</tr>
<tr>
<td>Children (0-14)</td>
<td>1.9%</td>
</tr>
</tbody>
</table>

#### Incidence

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>1.3%</td>
</tr>
<tr>
<td>Adults (20-64)</td>
<td>1.7%</td>
</tr>
<tr>
<td>Adult men (20-64)</td>
<td>1.9%</td>
</tr>
<tr>
<td>Adult women (20-64)</td>
<td>1.5%</td>
</tr>
<tr>
<td>At or before birth (of births)</td>
<td>3.5%</td>
</tr>
<tr>
<td>Breastfeeding (no. infected through breastfeeding in year/uninfected births in that year)</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

#### Number adults (14+) infected by stage

<table>
<thead>
<tr>
<th>Stage</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>1 451 000</td>
</tr>
<tr>
<td>Stage 2</td>
<td>1 084 000</td>
</tr>
<tr>
<td>Stage 3</td>
<td>1 813 000</td>
</tr>
<tr>
<td>Stage 4 (not on treatment)</td>
<td>511 000</td>
</tr>
<tr>
<td>Receiving antiretroviral treatment</td>
<td>200 000</td>
</tr>
<tr>
<td>Discontinued antiretroviral treatment</td>
<td>18 900</td>
</tr>
</tbody>
</table>

#### Number children (<14) infected by stage

<table>
<thead>
<tr>
<th>Stage</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-AIDS</td>
<td>240 000</td>
</tr>
<tr>
<td>Stage 4 (not on treatment)</td>
<td>27 000</td>
</tr>
<tr>
<td>Receiving antiretroviral treatment</td>
<td>25 300</td>
</tr>
<tr>
<td>Discontinued antiretroviral treatment</td>
<td>1 500</td>
</tr>
</tbody>
</table>

#### AIDS sick

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>New AIDS sick during 2006</td>
<td>479 000</td>
</tr>
<tr>
<td>Total AIDS sick mid-year</td>
<td>599 000</td>
</tr>
</tbody>
</table>

*Source: Dorrington, Bradshaw, Johnson and Daniel (2006)*
Heterogeneity of the South African epidemic

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

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

Prevalence also varies sub-provincially by genotype 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%.

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

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

Women bear the brunt of the epidemic of HIV and AIDS. Women account for 55%. 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. 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 HRSC data also show that children have a high HIV prevalence. In the 2-4 age group, 4.9% of boys and 5.3% of girls are HIV positive, translating into an estimated 129,621 children. In the slightly older age group of 5-9, 4.2% of boys and 4.8% of girls have HIV - an estimated 214,102 children, and in the 10-14 age group, this figure drops to 1.6% among boys and 1.8% among girls.

### 3.2 Major causes and determinants of the epidemic in South Africa

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. These include biological, individual and social/contextual factors.
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.\(^\text{23}\)

- **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.\(^\text{24}\)

- **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\textsuperscript{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\textsuperscript{36}.

**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\textsuperscript{27}, economic inequalities between men and women which promote transactional sex\textsuperscript{28}, relatively poor public health education and inadequate public health system\textsuperscript{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\textsuperscript{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\textsuperscript{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\textsuperscript{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\textsuperscript{33}. In South Africa, the gender system fosters power imbalances that facilitate women’s risks for sexual assault and sexually transmitted infections (STIs)\textsuperscript{34}. South African men, like men in most societies, possess greater control and power in their sexual relationships\textsuperscript{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\textsuperscript{36}. Men who have limited resources and lack the opportunity for social advancement often resort to exerting power and control over women\textsuperscript{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. 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’.

(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. 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, 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.

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. In the UNGASS declaration, governments committed themselves, among other things, to 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.
A recent large survey conducted among 1 054 people living with HIV (PLHIV) in Cape Town found high levels of internalised stigma44. 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 men45.

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 behaviour46. Another consequence is denial. Both silence and denial about HIV and AIDS are lethal because they prevent people from accurately assessing their own personal infection risk 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 factors47. 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 travellers48. These forms of mobility are pervasive in southern Africa. Various studies have illustrated the higher likelihood of mobile groups to be HIV positive49. 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 communities50.

(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 risks51.
3.3 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, and gender equality is one of the critical elements of the transformation agenda in the country. Women are beginning to regain their appropriate place in society and are taking responsibility for their lives. Patriarchal attitudes are changing, with men participating in efforts to address challenges such as violence against women. Gender transformation is part of a broader transformation agenda that also seeks to reduce the gap between rich and poor and between historically disadvantaged black communities and white communities with many more resources. However, the high levels of gender-based violence in the country indicate that a lot still needs to be done in this area.

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. A youth study by the Reproductive Health Research Unit (RHRU, 2002) found that among the 10% of youth who HIV positive, 77% are women. In addition to biological, economic, social and other cultural vulnerabilities, women are more likely to experience sexual abuse, violence (in particular domestic violence) and rape.

They take the brunt of caring for sick family members and are the soldiers at the forefront of community-based HIV and AIDS activities. The HIV 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.
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 years it has risen only slightly (28%-30%) over the same period. Although current HIV prevention programmes in South Africa have invested significantly in this age group, they are yet to demonstrate the desired impact. Continued investment 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, the aspirations that existed in school of getting a job and earning an income are often dashed and personal motivation to achieve and the psychological rewards of school achievement are no longer there, and there are family pressures to contribute to household income or to leave. In the absence of career opportunities, many young women find fulfilment and affirmation in being a mother – by definition requiring unprotected sex.

(c) Children 0 – 14 years

Children under the age of 18 comprise 40% of the population of South Africa. In 2004, it was estimated that there were 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. 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. HIV is thought to have contributed to an increase of 42% in under-five mortality in this country in 2004. 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 is a risk that needs to be monitored.
(d) People with disabilities
People with disabilities constitute a significant part of the population (12%). Yet, this group has been particularly neglected in the AIDS response. There are often erroneous perceptions that people with disability are asexual. To date, the national response has not addressed the special needs of the various categories of people with disability in terms of prevention, treatment, care, and support programmes. People with disability suffer double stigma arising from discrimination as result of their disability status and their HIV status.

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

(e) 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. 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.

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

(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\(^6\). 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 formal needle exchange programmes exist\(^6\).

(k) 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\(^6\). 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, coinfection 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\(^6\). High viral load in the late phases of HIV is reduced through antiretroviral therapy\(^6\).
(l) Sexual HIV transmission and individual risk factors

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. Orphanhood, which increases as a result of deaths of parents from AIDS, has been found to increase the likelihood of earlier sexual debut. Shifts towards later sexual debut have been correlated with prevalence declines in a number of African countries.

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.

Transactional sex
Transactional sex involves the exchange of sex for material gain. Transactional sex involves disempowerment which may include a reduced ability to negotiate safer sex – particularly condom use. 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.

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. 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, and declines in HIV prevalence have been associated with declines in number of sexual partners in the past year. 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%. Higher proportions of having multiple partners amongst youth aged 15-24 were also reported in a national survey in 2004 – 44% for males and 12% for females.

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, whilst inconsistent use is not significantly protective. 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.

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. Increases in condom use with non-regular partners have however been associated with prevalence declines in other African countries.

**Male circumcision**

Epidemiological analyses have demonstrated correlations between circumcision and HIV prevalence, and protective effects have been shown in a randomised controlled trial in South Africa and elsewhere. Although male circumcision reduces the risk of HIV infection of males through female-to-male transmission, it is not clear whether it reduces male-to-female transmission, although there are likely to be long-term epidemiological benefits. It remains necessary for men to practise 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.

**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.

**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. 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.

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).
3.4 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 AIDS in South Africa91. 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 households92.

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 for by grandparents, family members or through self-care in child-headed households93. Orphans and vulnerable children are at higher risk for HIV infection, as they face numerous material, emotional and social problems94. 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 abuse95.
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. 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 of health systems, the human resource effects of HIV are two-fold: the stress and morale impacts of rapidly changing epidemiological, demand and mortality profiles in patients caused by HIV and AIDS, and HIV infection in providers themselves.

In a survey of 512 public sector workers in four provinces, 16.3% were HIV infected. 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.

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.

In conclusion, the challenge of HIV and AIDS in South Africa 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.
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 regard 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 enrolled on antiretroviral therapy in the world. There are however many more who haven’t accessed 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 PLWHAs. 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 (OVCs) 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 PLWHAs. In addition there have been a number of successful cases challenging unfair discrimination. But despite the combined 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 co-ordination 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 PLWHAs, 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 coordinating 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.
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, multi-sectoral response to HIV and AIDS.

This plan will 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 20 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 an 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 than 500 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.
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, 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.
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 for 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 to protect themselves and others from HIV infection, to know their HIV status and to 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.
The primary aims of the NSP are to:

- Reduce the number of new HIV infections by 50%.
- Reduce the impact of HIV and AIDS on individuals, families, communities and society by expanding access to 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 and 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 disseminating 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.
- Ensuring 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 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.
**GOAL 1: REDUCE VULNERABILITY TO HIV INFECTION AND THE IMPACT OF AIDS**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Intervention</th>
<th>5-year target</th>
<th>Lead Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1: Accelerate poverty reduction strategies and strengthen safety nets to mitigate the impact of poverty</td>
<td>Scale up access to government poverty alleviation programmes</td>
<td>2007 30%</td>
<td>2008 40%</td>
</tr>
<tr>
<td></td>
<td>Monitor poverty reduction programmes and report on MDG target one</td>
<td>Annual</td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td>Ensure equitable provision of basic social services such as housing, water, sanitation, roads, transport, health services, education especially in rural and urban informal settlements</td>
<td>Quarterly campaigns</td>
<td>Quarterly campaigns</td>
</tr>
<tr>
<td></td>
<td>Introduce sustainable income transfer system to poor families including child-headed households</td>
<td>2007 20%</td>
<td>2008 30%</td>
</tr>
<tr>
<td>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</td>
<td>Implement all national policies and legislation aimed at improving the status of women</td>
<td>Annual monitoring</td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td>Develop and implement a communication strategy including leadership messages, to educate men and women, boys and girls, on women’s rights and human rights</td>
<td>Communication Strategy developed</td>
<td>Quarterly campaigns</td>
</tr>
<tr>
<td></td>
<td>Roll-out integrated microfinance and gender education interventions starting in the poorest and highest HIV burden areas</td>
<td>Develop &amp; implement at least 1province</td>
<td>4province</td>
</tr>
<tr>
<td>1.3: Develop and implement strategies to address gender based violence</td>
<td>Develop communication strategies including leadership messages, which addresses the unacceptability of coercive sex, gender power stereotypes and the stigmatisation of rape survivors</td>
<td>Communication Strategy developed</td>
<td>Quarterly campaigns and ongoing</td>
</tr>
<tr>
<td>1.4: Create an enabling environment for HIV testing</td>
<td>Develop high profile campaigns utilising peer influence to promote HIV testing and disclosure</td>
<td>Develop &amp; implement</td>
<td>Monthly</td>
</tr>
<tr>
<td>Expand access to HIV testing beyond formal health care settings such as community and non-health care settings</td>
<td>At least 1 non-health care facility point per district</td>
<td>5district</td>
<td>10district</td>
</tr>
<tr>
<td>Develop clear, consistent HIV prevention messages to be delivered by leadership from all sectors at all available opportunities</td>
<td>Prevention key messages for leadership developed</td>
<td>Update quarterly</td>
<td>Update quarterly</td>
</tr>
</tbody>
</table>

| 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 | 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 traditional leaders developed | Quarterly forum | Quarterly forum | Quarterly forum | Quarterly forum | Traditional Leaders Sector, DACST, DoH, traditional structures, civil society, & private sector |

| 1.6: Support national efforts to strengthen social cohesion in communities and to support the institution of the family | Support programmes that aim to develop HIV and AIDS knowledgeable and competent 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

<table>
<thead>
<tr>
<th>Objective</th>
<th>Intervention</th>
<th>5-year target</th>
<th>Lead Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.1:</strong> 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</td>
<td>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)</td>
<td>Evaluation, improvement &amp; introduction</td>
<td>Ongoing</td>
</tr>
<tr>
<td><strong>2.2:</strong> Implement interventions targeted at reducing HIV infection in young people, focusing on young women</td>
<td>Identify and prioritise interventions in schools reporting high rates of teenage pregnancies per year through a gender sensitive package that addresses sexual &amp; reproductive health and rights, HIV, alcohol and substance abuse.</td>
<td>Implement spatial map and database and start implementation in priority schools</td>
<td>Implement in 50% of priority schools</td>
</tr>
<tr>
<td></td>
<td>Implement legislation and policies and programs aimed at keeping young people in schools, (particularly orphans and vulnerable children)</td>
<td>Identify and implement</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Introduce, strengthen and evaluate life skills, SRH education and HIV prevention programmes in all primary and secondary schools</td>
<td>Institutions</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td>Enhance training of teachers and NGOs to ensure quality delivery of life skills, SRH and HIV prevention programmes in schools</td>
<td>Review and start implementation</td>
<td>30% training completed per district</td>
</tr>
<tr>
<td><strong>2.3:</strong> Increase open discussion of HIV and sexuality between parents and children</td>
<td>Evaluate, adapt and implement parenting programmes that promote positive engagement and communication with children on sexuality and HIV</td>
<td>Implement in each province</td>
<td>30% of districts covered</td>
</tr>
<tr>
<td>Objective</td>
<td>80% of institutions covered</td>
<td>90%</td>
<td>95%</td>
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</tr>
</tbody>
</table>
| Strengthen SRH and HIV prevention programmes including VCT, STI, contraceptive services and psychosocial support in higher education institutions | 10%                        | 30%  | 50% | 70% | 90% | HEAIDS, Higher education institutions, DoE, DoH  
| 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 | 20% of districts            | 50%  | 70% | 85% | 100% | DoE, Social Cluster, NGOs  
| Increase targeted HIV prevention and SRH programmes and initiatives for out of school youth in different settings focusing on informal settlements and, rural areas, and considering the needs of street children and child headed households | quarterly campaigns         | quarterly campaigns           | quarterly campaigns | quarterly campaigns | DSID, 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 | 20% of districts            | 50%  | 70% | 85% | 100% | DoH, Communication sector, Social development cluster, youth sector, traditional structures, civil society  
| Increase access to youth friendly health services in the public sector.  | 20% of districts            | 50%  | 70% | 85% | 100% | DoH  

2.4: Increase roll out of workplace prevention programmes (Cross reference with ILO, NEDLAC and SADC Code) for workplace based interventions

| Objective                                                                 | 40% of workplaces | 60%  | 80% | 90% | 100% |
| 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 | 50% of services | 60%  | 70% | 80% | 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 | Targeted programs developed | 30% of districts covered | 40% | 50% | 70% | DPSA, Relevant employee institutions, DoH, DoL  
| Develop targeted HIV prevention programmes for domestic workers and gardeners and other employees who are hard to reach |


GOAL 2: REDUCE SEXUAL TRANSMISSION OF HIV (continued)

<table>
<thead>
<tr>
<th>Objective</th>
<th>Intervention</th>
<th>5-year target</th>
<th>Lead Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.5: Increase roll out of prevention programmes for higher risk populations</td>
<td>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</td>
<td>50% of services</td>
<td>70% of services</td>
</tr>
<tr>
<td></td>
<td>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, STI symptom recognition</td>
<td>Program developed with relevant groups</td>
<td>40% of groups covered</td>
</tr>
<tr>
<td>2.6: Develop and integrate a package of sexual and reproductive health and HIV prevention services into all relevant health services</td>
<td>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</td>
<td>50% of organised groups covered</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td>Integrate sexual &amp; reproductive health services and HIV prevention guidelines and programmes into family planning, ANC, STI, TB, ARV treatment services and vice versa in the public and private sector</td>
<td>30% of services</td>
<td>40% of services</td>
</tr>
<tr>
<td></td>
<td>Increase access to quality STI services in the public and private sector offered by adequately trained staff utilising the updated syndromic management guidelines</td>
<td>40% of services</td>
<td>50% of services</td>
</tr>
<tr>
<td>2.7: Develop a comprehensive package that promotes male sexual health</td>
<td>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</td>
<td>Male sexual health program developed</td>
<td>20%</td>
</tr>
</tbody>
</table>
### 2.8: Develop and integrate interventions for reducing recreational drug use in young people with HIV prevention efforts

<table>
<thead>
<tr>
<th>Action</th>
<th>Completion</th>
<th>20% of districts</th>
<th>60% of districts</th>
<th>80% of districts</th>
<th>90% of districts</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>Policy recommendation from expert group adopted by the NHC and implemented</td>
<td>20% of districts</td>
<td>40% of districts covered</td>
<td>60% of districts</td>
<td>80% of districts</td>
</tr>
<tr>
<td>DoH, Traditional leaders, Private Sector NGOs</td>
<td></td>
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<tr>
<td>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</td>
<td>Policy and program developed</td>
<td>40% of districts covered</td>
<td>60% of districts</td>
<td>80% of districts</td>
<td>90% of districts</td>
</tr>
<tr>
<td>DoH, NGOs, DSD, DTI, Men's sector, the alcohol industry, traditional leaders</td>
<td></td>
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</tr>
<tr>
<td>Integrate HIV prevention messages into existing campaigns to promote responsible alcohol consumption</td>
<td>HIV prevention messages mainstreamed into relevant campaigns</td>
<td>Quarterly campaigns</td>
<td>Quarterly campaigns</td>
<td>Quarterly campaigns</td>
<td>Quarterly campaigns</td>
</tr>
<tr>
<td>DoH, social cluster, communication sector, civil society, private sector</td>
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</tr>
<tr>
<td>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</td>
<td>Develop &amp; stratimplementation</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>Ongoing</td>
</tr>
<tr>
<td>DDH, Social cluster, Academic institutions, civil society, private sector</td>
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<td></td>
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</tr>
<tr>
<td>Establish public sector drug rehabilitation programmes in all provinces</td>
<td>20 facilities</td>
<td>40 facilities</td>
<td>60 facilities</td>
<td>80 facilities</td>
<td>100 facilities</td>
</tr>
<tr>
<td>DSD, DoH, NPA, DoJ, DCS, NGO, Social cluster, Private sector</td>
<td></td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Action</th>
<th>Facilities</th>
<th>40% of facilities</th>
<th>60% of facilities</th>
<th>80% of facilities</th>
<th>90% of facilities</th>
<th>95% of facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>40% of facilities</td>
<td>60% of facilities</td>
<td>80% of facilities</td>
<td>90% of facilities</td>
<td>95% of facilities</td>
<td></td>
</tr>
<tr>
<td>DoH, DoJ, NPA, DSD, DCS</td>
<td></td>
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</tr>
</tbody>
</table>
GOAL 2: REDUCE SEXUAL TRANSMISSION OF HIV (continued)

<table>
<thead>
<tr>
<th>Objective</th>
<th>Intervention</th>
<th>5-year target</th>
<th>Lead Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2007</td>
<td>2008</td>
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</tbody>
</table>

Increase the proportion of facilities providing post-sexual assault care that offer PEP to all survivors testing HIV negative
December 2007: 30%
December 2008: 50%
December 2009: 60%
December 2010: 70%
December 2011: 90%
DOH

Evaluate, improve and roll out training programmes on the management of gender violence and rape for the police
December 2007: 30% of police force trained
December 2008: 40%
December 2009: 50%
December 2010: 60%
DSD, NPA, DOJ, DCS

Increase the number of districts with accessible social and mental health services to support children and adult victims of gender-based violence
December 2007: 20% of districts covered
December 2008: 40%
December 2009: 60%
December 2010: 80%
December 2011: 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
December 2007: Program and policy for voluntary disclosure developed
December 2008: 40% of support groups covered
December 2009: 60% of
December 2010: 80% of
December 2011: 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
December 2007: Develop & start implementation
December 2008: 20% of known HIV persons covered
December 2009: 40%
December 2010: 60%
December 2011: 80%
DOH, DSD, PWA sector, Civil society structures, Private sector

Integrate safer sex practices, male and female condoms, STI management, into all ARV treatment programmes including palliative and home based care
December 2007: 40%
December 2008: 60%
December 2009: 80%
December 2010: 90%
December 2011: 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
DOH, PWA sector, Civil society structures, Private sector
## Goal 3: Reduce Mother-to-Child Transmission of HIV

<table>
<thead>
<tr>
<th>Objective</th>
<th>Intervention</th>
<th>5-year target</th>
<th>Lead Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1: Broaden existing mother to child transmission services to include other related services and target groups</td>
<td>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</td>
<td>20% increase</td>
<td>DOH</td>
</tr>
<tr>
<td></td>
<td>Expand PMTCT guidelines to include fertility guidelines for HIV infected women, men and discordant couples aimed at supporting informed pregnancy choices</td>
<td>Develop &amp; implement guidelines</td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td>Implement HIV prevention programmes for uninfected pregnant women</td>
<td>20% increase in public sector ANC services</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>Implement responsible fatherhood programmes in health districts and in the community</td>
<td>Evaluate &amp; develop programme</td>
<td>Introduce into 20% health districts</td>
</tr>
<tr>
<td></td>
<td>Expand PMTCT guidelines to cover postnatal services including contraception, and services for mothers and infants beyond six weeks</td>
<td>Develop &amp; implement guidelines</td>
<td>Annual</td>
</tr>
<tr>
<td>3.2: Scale up coverage and improve quality of PMTCT to reduce MTCT to less than 5%</td>
<td>Increase the proportion of public sector antenatal services providing PMTCT</td>
<td>85%</td>
<td>DOH</td>
</tr>
<tr>
<td></td>
<td>Increase proportion of pregnant women tested through implementation of provider-initiated VCT for all pregnant women</td>
<td>70%</td>
<td>DOH</td>
</tr>
<tr>
<td></td>
<td>Develop a policy and guidelines on VCT in pregnancy including consideration of provider initiated testing, and frequency of testing</td>
<td>Develop &amp; implement</td>
<td>Annual review</td>
</tr>
<tr>
<td></td>
<td>Increase the proportion of the estimated population of HIV-infected pregnant women in need who receive PMTCT services</td>
<td>60%</td>
<td>DOH</td>
</tr>
</tbody>
</table>
### GOAL 3: REDUCE MOTHER-TO-CHILD TRANSMISSION OF HIV (continued)

<table>
<thead>
<tr>
<th>Objective</th>
<th>Intervention</th>
<th>5-year target</th>
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<tr>
<td></td>
<td>Increase the proportion of facilities that meet quality standards for infant feeding counselling</td>
<td>2007  60%</td>
<td>2008  75%</td>
</tr>
<tr>
<td></td>
<td>Implement community based strategies to support HIV positive women during and after pregnancy</td>
<td>2007  10% (sub-district)</td>
<td>2008  30%</td>
</tr>
<tr>
<td></td>
<td>Undertake CD4 testing of all positive pregnant women and prioritise those with CD4 counts &lt;200 for accelerated access to ARV treatment</td>
<td>2007  Start implementation at all tertiary facilities per province</td>
<td>2008  20% of primary care facilities</td>
</tr>
<tr>
<td></td>
<td>Provide nutritional support to HIV-infected woman choosing to exclusively breast feed</td>
<td>2007  Develop policy and program</td>
<td>2008  20% of woman covered</td>
</tr>
<tr>
<td></td>
<td>Provide formula milk to children of HIV-positive women choosing and are eligible to practice replacement feeding</td>
<td>2007  50%</td>
<td>2008  45%</td>
</tr>
</tbody>
</table>
### GOAL 4: MINIMISE THE RISK OF HIV TRANSMISSION THROUGH BLOOD AND BLOOD PRODUCTS

<table>
<thead>
<tr>
<th>Objective</th>
<th>Intervention</th>
<th>5-year target</th>
<th>Lead Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>Continuously update guidelines for infection control procedures</td>
<td>Annual</td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td>Enforce the implementation of infection control in all formal health care facilities</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Promote the implementation of infection control in home based care and palliative care settings</td>
<td>Develop and disseminate promotional and educational materials</td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td>Provide training for all HCWs, including home based care workers, on infection control</td>
<td>70%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Ensure continuous supplies of PEP drugs in public and private sector facilities as well as in community-based settings</td>
<td>80%</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>Ensure all formal health care facilities maintain a register of occupational exposure</td>
<td>80%</td>
<td>85%</td>
</tr>
<tr>
<td>4.2: Minimise exposure to infected blood through procedures associated with traditional and complementary practices</td>
<td>Continuously update Guidelines for infection control for traditional and complementary practitioners</td>
<td>Annual</td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td>Provide adequate training of traditional healers/practitioners on infection control</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Provide information to the public raising awareness of HIV risk through unsafe traditional practices</td>
<td>70%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Provision of supplies to practise safe traditional practices</td>
<td>30%</td>
<td>50%</td>
</tr>
</tbody>
</table>