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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.

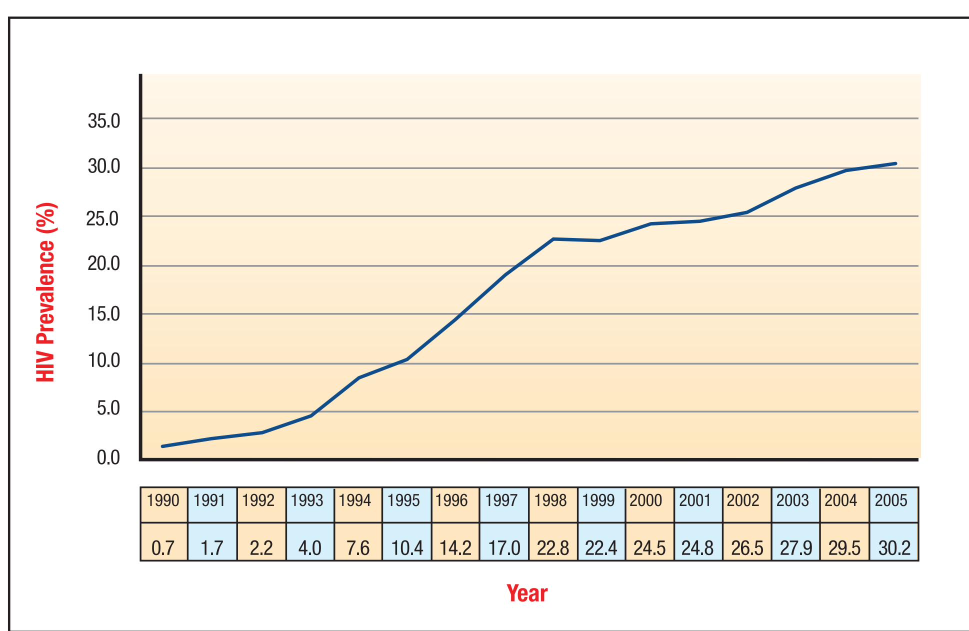
In May 2006, the South African National AIDS Council (SANAC), under the leadership of its Chairperson, the Deputy President, Mrs. Phumzile Mlambo-Ngcuka, mandated the Health Department to lead a process of developing a new 5-year NSP, for the years 2007-2011.

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



Source: Department of Health, 2006

Although the rate of the increase in HIV prevalence has slowed down in the past five years, the country is still to experience a reversal 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[i]. 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[ii].

On the other hand, the reversal in the prevalence of syphilis among pregnant women in the past five years is an indication of the gains from the introduction of syndromic 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 2207-2011 recognises monitoring and evaluation (M&E) as an important policy and management tool. National, provincial and district level indicators to monitor inputs, process, outputs, outcomes and impact will be used to assess collective effort. It is recommended that in line with international trends, a sustainable budget of between 4% – 7% is dedicated for the Monitoring and Evaluation of the NSP.

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

9.1 Establish and implement a functional M&E system.

10. Support research in the development of new prevention technologies

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

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

11.1 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 contraints to access to Social Security Services for woman and children.
    - 19.2 Ensure implementation of existing laws and policies that protect woman and children from gender based violence.
    - 19.3 Address the needs of woman in abusive relationships.
    - 19.4 Ensure that laws, policies and customs do not discriminate against woman and children.

This NSP sets out a clear framework for ongoing monitoring and evaluation. Ambitious but 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.

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