



# **GLOBAL AIDS RESPONSE PROGRESS REPORT 2012**

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**REPUBLIC OF SOUTH AFRICA**

## FOREWORD

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South Africa is signatory to the 2001 UNGASS Declaration of Commitment, the 2006 Political Declaration on Universal Access and 2011 Resolution 65/677: intensifying our Efforts to Eliminate HIV and AIDS. It is my pleasure to submit the Country's Report on Global AIDS Response. The report serves to provide feedback with respect to goals agreed upon and progress made in measuring the South African country's response on HIV and AIDS using global indicators for the period 1 January 2010 to 31 December 2011. The period under review falls within the timeframe of implementation of the 2007- 2011 National Strategic Plan: HIV & AIDS and STI.

During this reporting period, we have implemented new policies to increase universal access to free antiretroviral therapy. These interventions target all pregnant women who are HIV infected, all infants born to mothers who are HIV positive, all persons with CD4 of less or equal to 350 CD4 Cells/mm<sup>3</sup> and all persons with TB who are co-infected with HIV. The measures have resulted in substantial increases in public sector expenditure. The number of persons who started ART in 2010 and 2011 has more than doubled. The national HIV counselling and testing campaign reached about 13 million people against the target of 15 million by June 2011. The campaign was implemented throughout South Africa with the collaboration of government, non-governmental and business sectors. Counselling and testing was done at health facilities, non-health facilities and at nationally and provincially organised mass events.

Our annual HIV surveys among pregnant women and household population surveys continue to show that the prevalence of HIV remains stable in the country and that the total number of persons living with HIV is still very high. This may be attributed to the impact of the ARV treatment programme, the largest in the world. Data are showing a reduction in HIV-related mortality particularly among women. In addition, mother to child transmission of HIV has declined from 8.5% in 2008, to 3.5% in 2010, a direct impact of the accelerated programme for the elimination of vertical transmission. During 2010 and 2011, we conducted various reviews and research on progress made in our national response to HIV and TB; these included for example, the end-term review of the 2007-2011 National Strategic Plan, the National AIDS Spending Assessment and the Know-Your-Epidemic/Know-Your-Response. These reviews and assessments informed the development of the 2012-2016 National Strategic Plan on HIV, STIs and TB. Like its predecessor, the 2012-2016 National Strategic Plan is aligned to international and regional commitments on HIV and AIDS and TB.

This report has been compiled with full participation of government, civil society, business and development partners in accordance with the Guidelines on the Construction of Indicators for 2012 reporting.

We would like to acknowledge the enormous contribution and efforts that went into the preparation of 2012 Country Report. The report benefited from data and information provided by national and provincial governments, civil society organisations including non-governmental organizations, the business sector, and

development partners. Members of the government and civil society also participated in workshops to complete and validate the National Commitments and Policy Instrument. The report drafting process was coordinated by the South African National AIDS Council which ensured multi-sectoral stakeholder participation.

**MR KGALEMA MOTLANTHE**  
**DEPUTY PRESIDENT: REPUBLIC OF SOUTH AFRICA**

## ACKNOWLEDGEMENTS

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The 2012 Global AIDS Report for South Africa was compiled by a team of consultants from Health and Development Africa (Pty) Ltd under the guidance and direction of the National Department of Health and the Research, Monitoring and Evaluation Technical Task Team of the South African National AIDS Council. The Report has benefitted from the wider consultations and data collection processes which took place throughout the country over the past two years. These processes include the Know Your Epidemic and Know Your Response; National AIDS Spending Assessment, Final Review of South Africa's National Strategic Plan on HIV, AIDS and STIs 2007-2011; and new National Strategic Plan on STIs HIV, and TB 2012-2016.

This report would not have been possible without the active participation by many of the HIV and AIDS stakeholders, advocates and representatives from government, civil society, business and development partners. We thank them for their support and active engagement during this process.

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## ABBREVIATIONS AND ACRONYMS

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AEF	AID Effectiveness Framework	ETR	End of Term Review
AIDS	Acquired Immune Deficiency Syndrome	EU	European Union
ASSA	Actuarial Society of South Africa	FBO	Faith Based Organisation
AZT	Azidothymidine	GFATM	Global Fund for HIV, TB and Malaria
CPT	Cotrimoxazole Prophylactic Treatment	HCP	Health Communication Programmes
CSO	Civil Society Organizations	HDA	Health and Development Africa
CSG	Child Support Grant	HCBC	Home and Community Based Care and Support
CSW	Commercial Sex Worker	HCT	HIV Counselling and Testing
CSVV	Centre for the Study of Violence and Reconciliation	HISP	Health Information Systems Programme
CHW	Community Health Worker	HSRC	Human Sciences Research Council
DBE	Department of Basic Education	KYE	Know Your Epidemic
DFID	Department for International Development	KYR	Know Your Response
DOH	Department of Health	LTSM	Learning and Teaching Support Materials
DHIS	District Health Information System	MARPS	Most-at-risk populations
DPSA	Department of Public Service and Administration	MCP	Multiple Concurrent Partners
DSD	Department of Social Development	MDG	Millennium Development Goal
ECD	Early Childhood Development	MRC	Medical Research Council
EH&W	Employee Health and Wellness	MTR	Mid-term Review
EPWP	Expanded Public Works Programme	NASA	National AIDS Spending Assessment
		NCPI	National Commitments and Policy Instrument
		NDOH	National Department of Health

NHI	National Health Insurance	PLHIV	People Living with HIV
NIM-ART	Nurse Initiated Management of ART	RHRU	Reproductive Health Research Unit
NSP	National Strategic Plan	SABCOHA	South African Business Coalition on HIV/AIDS
NSDA	National Service Delivery Agreement	SANAC	South Africa National AIDS Council
NT	National Treasury	STI	Sexual Transmitted Infections
OVC	Orphans and Vulnerable Children	UNGASS	United Nations General Assembly Special Session on HIV/AIDS
PAC	Provincial AIDS Council	UNAIDS	Joint United Nations Programme on HIV/AIDS
PEPFAR	President's Emergency Plan for AIDS Relief	USAID	United States Agency for International Development
PHC	Primary Health Care	VCT	Voluntary Counselling and Testing
PIC	Programme Implementation Committee of SANAC		

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## SECTION ONE: STATUS AT A GLANCE

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### 1.1 INCLUSIVENESS OF STAKEHOLDERS IN THE REPORT WRITING PROCESS

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The Minister of Health granted approval for the process to consult and compile the country's report to meet the submission deadline of the 31 March 2012. The South African National AIDS Council (SANAC) and National Department of Health (DoH) led the participatory and multi-stakeholder process of compiling the South African Global AIDS Response Progress Report 2012. Technical assistance was provided by the UNAIDS South Africa country office and the Research, Monitoring and Evaluation Task Team of the South African National AIDS Council. SANAC, together with members of various SANAC committees also provided technical support and substantive inputs. Both Government and civil society organisations provided data and their own perspectives for this report.

The process of data collection for the 2012 Global AIDS Response Progress (GARP) report was undertaken between November 2011 and March 2012. The Guidelines for the construction of core indicators were circulated among SANAC members and government departments in November 2011. A letter from the Director-General for Health was sent in January 2012 to the Heads of Statistics South Africa, Human Sciences Research Council, Council for Medical Aid Schemes, Department of Basic Education, Department of Social Development and provincial Departments of Health requesting for the 2012 GARP report. This request was followed by targeted requests for specific data sources during the first week of February 2012 which also included a number of individual medical aid schemes.

The National Commitments and Policy Instrument (NCPI) questionnaire was circulated to government and civil society sectors represented in the SANAC Programme Implementation Committee (PIC). Members of the SANAC were encouraged to submit responses canvassed from their constituencies/sectors. In addition, the government's response was coordinated by the Department of Public Service and Administration through the Intergovernmental Committee on HIV/TB. The NCPI questionnaires were completed by government and civil society officials from both national and provincial levels. Part A of the NCPI was administered at a special session of an HIV and AIDS interdepartmental committee meeting held on 29 February 2012. The meeting, which was organized by the Department of Public Service and Administration (DPSA) brought together 93 government representatives from 43 departments. Part B was completed at a special workshop that took place on the 19 February and included 17 participants representing people living with HIV, Women and Men's sectors, Labour, Sports and Entertainment Sector (SES), Business sector and development partners from GIZ and UNAIDS. Thereafter, Part A and B of the NCPI were validated by a broader group of government, civil society and development partner officials at a National Validation Workshop that was attended by over 40 representatives.

## 1.2 STATUS OF THE EPIDEMIC

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South Africa has a generalised HIV epidemic, which has stabilised over the past four years at a national antenatal prevalence of around 30%<sup>1</sup>. South Africa currently ranks the third highest in the world in terms of the TB burden, with an incidence that has increased by 400% over the past 15 years. There is a wide variation in HIV and TB prevalence by age, race, gender, socio-economic status and geographical location. Whereas STIs such as syphilis have significantly decreased in most provinces over the past 10 years, the prevalence of herpes simplex, which is a co-factor in the acquisition of HIV, is still high in many sections of the population.

Data from population-based sero-surveys and sentinel surveillance of pregnant women suggest that the HIV epidemic has reached a plateau in South Africa<sup>2</sup>. In adults aged 15-49 years, the three HSRC surveys estimated HIV prevalence at 15.6% (2002), 16.2% (2005) and 16.9% (2008, increase not statistically significant). In antenatal care (ANC) clients, HIV prevalence has gradually levelled off just below 30%, after steeply increasing for more than 10 years from 7.6% in 1994 to 29.5% in 2004. The ANC prevalence estimates for 2006, 2007, 2008 and 2009 are very similar at around 29.4% (not statistically different with a 95% confidence interval of 28.7% - 30.2%). Although HIV prevalence has plateaued, the absolute number of people living with HIV (PLHIV) is on a steep increase of approximately 100,000 additional PLHIV each year. The estimated number of PLHIV in 2009 was 5.63 million (Spectrum, in line with the ASSA2008 model estimate of 5.5 million for 2010, ASSA2011). There is a substantial downturn in AIDS related mortality in recent years, with the annual number of AIDS deaths reduced from about 257,000 in 2005 to about 194,000 in 2010 (ASSA, 2011).

South Africa has just completed the development of a new National Strategic Plan for STIs, HIV, and TB for 2012-2016. The NSP's goals and strategic objectives are guided by evidence from various reports, including the *Know Your Epidemic* (KYE) report, a situation analysis of TB in the country and other epidemiological studies. These studies identified key populations that are most likely to be exposed to or to transmit HIV and/ or TB. For HIV, key populations include young women between the ages of 15 and 24 years; people living close to national roads and in informal settlements; young people not attending school and girls who drop out of school before matriculating; people from low socio-economic groups; uncircumcised men; people with disabilities and mental disorders; sex workers and their clients; people who abuse alcohol and illegal substances; men who have sex with men and transgender individuals.

It is estimated that 80% of the South African population is infected with the TB. Most people who are infected will not progress to active TB disease. However, certain populations are at higher risk of TB infection and re-infection, including healthcare workers; miners; prisoners; prison officers and household contacts of confirmed TB patients. In addition, certain groups are particularly vulnerable to progressing from TB infection to disease. These include children; people living with HIV; diabetics; smokers; alcohol and substance users; people who are malnourished or have

silicosis; mobile, migrant and refugee populations; and people living and working in poorly ventilated environments. These groups are considered key populations for TB.

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## 1.3 POLICY AND PROGRAMMATIC RESPONSE

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### 1.3.1 POLICY

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South Africa has a number of progressive laws and policies in support of the multi-sectoral response to HIV. The Know Your Response and the Health Policy Initiative reviews in 2011 identified over 40 policy documents across different sectors. Some examples of such policies included:

- In 2010/2011, the Department of Health produced 60 sets of regulations to give effect to various pieces of health legislation. These regulations range from HIV and TB, dealing with the safety of medicines and food quality, strengthening systems in preparation for the NHI, and the national department's improved oversight role. All these serve as building blocks for the National Health Insurance (NHI) and seek to improve the quality and safety of health products and to strengthen health systems performance.
- Department of Basic Education Integrated Strategy on HIV, STIs and TB
- National Framework for the implementation of Comprehensive HIV and AIDS Programmes for Offenders and Personnel
- National Policy on HIV and AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions
- National Integrated Plan for Youth and Children
- National Action Plan for Orphans and Vulnerable Children
- Policy on Disability
- Promotion of Equality and Prevention of Unfair Discrimination
- South African Defence Force HIV Testing Policy

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### 1.3.2 CORE PROGRAMMATIC RESPONSES

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#### 1.3.2.1 OVERVIEW AND KEY STRATEGIES

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In 2010 President Zuma signed performance agreements with his cabinet to enhance service delivery. Negotiated Service Delivery Agreements (NSDA) documents were produced as accountability towards achievement of the 12 key outcomes taking into account departmental mandates. This approach is meant to rid wastage of resources through the silo approach by encouraging integration and collaboration across government departments. The Outcomes are :

- Outcome 1: Improved quality of basic education.
- Outcome 2: A long and healthy life for all South Africans.
- Outcome 3: All people in South Africa are and feel safe.
- Outcome 4: Decent employment through inclusive economic growth.
- Outcome 5: A skilled and capable workforce to support an inclusive growth path.

- Outcome 6: An efficient, competitive and responsive economic infrastructure network.
- Outcome 7: Vibrant, equitable and sustainable rural communities with food security for all.
- Outcome 8: Sustainable human settlements and improved quality of household life.
- Outcome 9: A responsive, accountable, effective and efficient local government system.
- Outcome 10: Environmental assets and natural resources that are well protected and continually enhanced.
- Outcome 11: Create a better South Africa and contribute to a better and safer Africa and World.
- Outcome 12: An efficient, effective and development oriented public service and an empowered, fair and inclusive citizenship.

The NSDAs are also instruments for mobilisation of entire sectors under the leadership of government towards key outcomes.

The response to HIV and TB falls under key Outcome 2: *“A long and healthy life for all South Africans”*. Delivery on this outcome is led by the health sector. Specific focus is placed on four key outputs namely: increasing life expectancy; reducing maternal and child mortality rates; combating HIV and AIDS and TB; and strengthening the effectiveness of the health system. Outcome 2 has effectively brought together government social sector departments (health, basic education, social development, transport and public works and public service and administration) to bring their comparative advantages to bear towards achievements of the key outputs. For example, the department of basic education is facilitating use of the schools to promote access to public health services and poverty reduction interventions targeting over 12 million learners. Social development is focusing on addressing structural determinants (mobility and migration, gender roles and norms, sexual abuse and intimate partner violence) and social safety-nets to address the impacts of the epidemic while Public Service and Administration focuses on the public service workforce and ensures adherence to public service guidelines.

On the other hand, the Department of Health has adopted a new primary health care (PHC) model that places greater emphasis on both the individual and the family, and focuses on health promotion and prevention, and rehabilitative and referral services rather than exclusively on curative services. It avoids fragmentation that results in multiple community health workers visiting families, and ensures that a single integrated team establishes relations with families in the catchment area. It accentuates strong community participation as well as inter-sectoral collaboration. Three pillars of the new PHC model are deployment of PHC outreach teams consisting of professional nurses, enrolled nurses and community health workers in different wards across the country; the establishment of district specialist teams; and strengthening school health services.

Key strategic achievements across the HIV, TB and STI context include:

HCT	ART	TB	PMTCT
<ul style="list-style-type: none"><li>• Implementation of the largest HIV Counselling and Testing (HCT) campaign in the world</li></ul>	<ul style="list-style-type: none"><li>• A 53% reduction in the price of antiretroviral medicines</li></ul>	<ul style="list-style-type: none"><li>• Active case-finding programme to trace all persons diagnosed with TB, screen their family members, and counsel them to be tested for HIV in their homes</li></ul>	<ul style="list-style-type: none"><li>• The emerging successes of the prevention of mother-to-child transmission (PMTCT) programme</li></ul>

### 1.3.2.2 HCT CAMPAIGN

In April 2010, the President of South Africa launched the largest HCT campaign in the world. This campaign intended to provide an opportunity for community members to be tested for HIV, screened for tuberculosis (TB), and chronic diseases such as diabetes and hypertension. The HCT campaign was one of the biggest partnerships between government, civil society and the private sector (mining, automotive and textile sectors) in South Africa. Partners collaborated and mobilised around the President's call to actively participate in the campaign. The campaign has resulted in significantly increased numbers of people coming forward for counselling and testing. The number of people screened and tested through the campaign is three times the number that the public sector is able to screen annually. Available data indicates that by June 2011, over 13 million South Africans had been tested for HIV.

### 1.3.2.3 PROVISION OF ART

During 2010/2011, the department achieved a significant reduction in the price of antiretroviral medicines. The department awarded a tender for the supply of antiretroviral medicines to the value of R4.2 billion over two years, which resulted in savings of R4.4 billion (53%) – when compared with previous tender prices. The lower prices enabled the health sector to re-allocate more resources towards enrolling people on antiretroviral treatment (ART) with its existing budget. Access to ART was expanded to an additional 650 000 people in 2011, which culminated in 1.6 million people living with HIV receiving treatment by the end of that financial year.

#### 1.3.2.4 ADDRESSING THE BURDEN OF TB

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There are several factors, which make TB a priority for the country. Firstly, South Africa is one of the high burden countries globally and, secondly, there is a high proportion of TB-HIV co-morbidity, which is estimated to be as high as 60%. On World TB Day, in 24 March 2011, the Department of Health launched an active case-finding programme to trace all persons diagnosed with TB, screen their family members, and counsel them to be tested for HIV in their homes. By the end of the reporting period, 180000 households had been visited. This social mobilisation approach will assist in reducing levels of TB and HIV infections in households, families and the community at large. Furthermore, the department also acquired the latest technology in the diagnosis of TB, the GeneXpert. This equipment has the capacity to release TB results within two hours. This will massively improve access to treatment for people diagnosed with TB.

#### 1.3.2.5 PMTCT

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Nine years after the start of a national prevention of mother-to-child transmission (PMTCT) programme, South Africa's mother-to-child HIV transmission (MTCT) rate is under 4% at four to eight weeks after birth, according to South Africa's first national PMTCT impact evaluation conducted by the MRC<sup>3</sup>. The dramatic reduction is the result of the implementation of a comprehensive national programme to prevent transmission of HIV from mother to infant, through antenatal HIV testing and provision of antiretroviral prophylaxis or treatment for mothers and infants.

To determine national and provincial MTCT rates at four to eight weeks after birth in 2009 and early 2010, and to identify factors contributing to MTCT, the PMTCT Evaluation undertook a national cross-sectional facility-based survey of 9915 infant-caregiver pairs at their first infant immunisation visit.

The evaluation looked at the effectiveness of the South African 2008 PMTCT guidelines (Option A) in use at the time. Infants were considered HIV-exposed if born to women who had reported their HIV status and /or their DBS test was antibody-positive; their DBS were tested for HIV infection by DNA polymerase chain reaction (PCR). In total, 30.3% (3003) HIV-exposed infants were identified among the infant-caregivers pairs, of whom 98.5% (2958) had a PCR test result. One-third (33.9%) of the HIV-infected mothers received triple-drug ART and 20% reported exclusive breastfeeding. The longer and more comprehensive the treatment, the lower were the risks for transmission. While exclusive breastfeeding and triple-drug antiretroviral treatment were both protective factors, unplanned pregnancies and mixed feeding were risk factors associated with MTCT. Close to two-thirds (62%) of the pregnancies among HIV-infected women were unplanned.

The national MTCT rate at four to eight weeks calculated according to population live births was 3.5% while the proportion of infants nationwide that were exposed to the risk of HIV infection during pregnancy or around the time of delivery was 31.4%. MTCT rates did not differ according to socio-demographic characteristics, medical care during pregnancy and childbirth, PMTCT knowledge or income.



However, this does not preclude the importance of follow-up throughout the breastfeeding period.

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### 1.3.3 ADDITIONAL PROGRAMMATIC RESPONSES

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#### 1.3.3.1 CHILDREN

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The Department of Social Development (DSD) ensures access to essential services by orphans and other children made vulnerable by HIV and AIDS through strengthening existing national and provincial structures and mechanisms. The DSD is responsible to coordinate, monitor and evaluate OVC programmes in South Africa.

The DSD developed a Children's Directory that provides information on all support services available to the poorest households in the country, which was launched in 2011.

As part of its mandate, the DSD provided grants to 11.6 million people in 2011/12 to support children related care (i.e., the Child Support Grant, Foster Care and Care Dependency grants). The DSD mainly supports orphans and vulnerable children (OVC) through a basket of services including food support, home care, drop-in centres and psychosocial support through Home and Community-Based Care (HCBC) workers. In 2011 1,744,573 OVCs were supported through organisations funded by both the DSD and other development partners.

Despite encouraging progress in grant uptake over the past few years, some reports indicate a lag in grant access to infants as compared to older children. The Children's 2011 HIV and AIDS Scorecard reports that only 52% of children under 1 year that were eligible for a grant, were actually accessing it<sup>4</sup>. One of the primary barriers to grant uptake amongst very young children is delayed birth registration; a process that is further complicated by the death of a parent. This is especially important, as early grant access has been shown to have long-term health and education benefits for children.

Another issue that impacts on children is an adequate cadre of trained and deployed social workers. The DSD recommends a ratio of one social worker providing Direct Formal Welfare Services for every 3,889 people. Data from the SA Council for Social Services Professionals Register in March 2011 indicates that nearly half (45%) of registered social workers are estimated to be involved in Direct Formal Welfare Services. Trained social auxiliary workers can be deployed to help address the skills gap. However, in March 2011, there were only 2,057 registered auxiliary workers, and almost 50% of these were based in Gauteng province. The under-supply of critical social service personnel is an important issue in the welfare of children and families.

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#### 1.3.3.2 PERSONS WITH DISABILITIES

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South Africa has a host of policies and legislation in place to support and further the rights of persons with disabilities. The *Constitution of the Republic of South Africa*

2006 is the cornerstone to advancing the principles of dignity, right to freedom, and equality for all. The Constitution specifically mentions the rights of persons with disabilities in the *Bill of Rights*. This recognition in the Constitution paves the way for the disability sector to fight for the prevention of discrimination, unfair treatment and injustice against this people with disabilities. Disability is also given prominence in the *Promotion of Equality and Prevention of Unfair Discrimination Act, 2000*. The Act prohibits unfair discrimination on the grounds of disability and promotes equality for people with disabilities.

In addition, South Africa is a signatory to a number international treaties and conventions on Human Rights. The latest convention signed by South Africa is the United Nations *Convention on the Rights of Persons with Disabilities (2006)*. South Africa also committed to the Africa Decade for the Persons with Disabilities (1999 - 2009).

The Minister of Women, Children and People with Disabilities has recognized that the progressive realisation of the rights of South Africans with disabilities to equality as guaranteed in the South African Constitution has, despite the release of the White Paper on an Integrated National Disability Strategy in 1997, and ratification of the United Nations Convention on the Rights of Persons with Disabilities and its protocol in 2007, not yielded the results intended. The main factors causing the slow progress include amongst others:-

- On-going discriminatory and stereotypical beliefs towards persons with disabilities which detracts from the mainstreaming of disability considerations in planning, service delivery and monitoring processes across all sectors at all levels;
- Hostile built environments and communication systems which continue to exclude persons with disabilities from mainstream society;
- Lack of capacity within the disability sector, and in particular organisations of persons with disabilities, to effectively advocate for the rights of persons with disabilities in a sustained manner, and in particular at provincial and local levels.

The Department of Women, Children and People with Disabilities convened the National Disability Summit in March 2012 for government and its social partners to engage on the National Disability Agenda priorities, to reach consensus on the approach to the implementation of the UN Convention on the Rights of Persons with Disabilities, to further consult on key aspects of the National Disability Policy and to update delegates on the status of the First Country Report on the Convention .

The disability sector in South Africa has responded to this challenge through participation in national HIV and AIDS strategic planning processes and in developing disability specific HIV and AIDS programmes<sup>5</sup>.

The five broad disability categories recognized in South Africa are:

- Physical disability - encompasses among others, amputees, paraplegics, quadriplegics, hemiplegics, those affected by polio;
- Blindness - totally blind and partially sighted;
- Deaf and hard of hearing;
- Intellectual impairment - encompasses among others, Down Syndrome, autism, cerebral palsy;

- Mental illness - anxiety and depression etc.

Cabinet adopted the NSP 2007 - 2011 in April 2007 and for the first time, thanks to the efforts of the Disabled People South Africa (DPSA), persons with disabilities were recognised as a vulnerable group to HIV and AIDS. This established the ground for mobilisation of resources for disability and prioritising persons with disabilities in the AIDS response.

#### 1.3.3.4 HIV PREVENTION MEDIA CAMPAIGNS

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The most recent national survey relating to media campaigns is the Second National HIV Communications Survey of 2009. This survey examined the use of mass media (broadcast, print and outdoor) by HIV communication programmes<sup>6</sup>. It should be noted, however, that in addition to the mass media, most programmes utilise social mobilisation (such as peer education and community dialogues), supported by small media (posters, booklets and utility items).

The 2009 Survey indicates that there have been significant messaging achievements in particular areas of HIV. It found that many of HIV communication programmes have been impressive, with 90% of the population aged 16-55 years exposed to one or more Health Communication Programmes (HCP). Exposure to HCPs was highest in the segments of the population that HCPs intended to reach – segments comprising individuals who are most likely to be HIV-infected or at highest risk of infection. HCPs have shown success in a number of areas related to HIV in terms of building knowledge and developing appropriate attitudes and beliefs. The Survey does point to a number of challenges that need to be addressed to strengthen prevention messaging for behaviour change:

- Delaying sexual debut;
- Intergenerational sex;
- Transactional sex;
- Alcohol use and risky sexual behaviour.

The survey above found low levels of knowledge about the HIV risk-reduction which male circumcision provides, and about exclusive breastfeeding as part of the strategy for reducing the risk of mother-to-child transmission. This indicates some strategic points of entry for future communication around HIV prevention interventions.

The survey generally found that the eleven communication programmes that were evaluated as part of the study were successful in improving knowledge levels, and developing and/or reinforcing beliefs and attitudes conducive to HIV prevention and accessing care and treatment. Exposure to communication interventions was also responsible for a number of positive behaviour changes in relation to preventing and treating HIV. These changes are gradual and in many cases show an uneven pattern across different segments of the population. This means that the impact of communication - in all its complexity – is not discernible to the casual observer and that formal evaluation is essential to the refinement and improved effectiveness of HCPs.

### 1.3.3.5 LIFE SKILLS AND SEXUALITY EDUCATION

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The Department of Education's (DoE) response to HIV and AIDS over the past 10 years has been governed by the *National Policy on HIV/AIDS for Learners and Educators in Public Schools, and Students and Educators in Further Education and Training Institutions*, developed in 1999. The primary intervention instituted by the then DoE in response to the policy has been the HIV and AIDS Life Skills Education Programme funded by National Treasury through a conditional grant. The focus of the life skills programme has been on the prevention of HIV and AIDS among learners through knowledge and skills building, mainly through the Life Orientation Learning Area, and subsequently integrated into other Learning Areas. In 2010 the Department of Basic Education has developed the Integrated HIV, STIs and AIDS Strategy to guide the response among over 12 million learners and their educators.

With South African youth aged 15-24 experiencing among the highest HIV prevalence in the world, the development of effective HIV prevention programmes is a top public health and policy priority. Comprehensive sexuality education is considered an important means of addressing adolescent risk behaviours, although little evidence supports its direct impact on biological measures of prevention success, particularly HIV and other sexually transmitted infections<sup>7</sup>. In South Africa, experience with youth HIV prevention programmes is limited, with evidence regarding effectiveness still emerging. Research undertaken indicates that although the effects of most interventions on reported sexual risk behaviour or biological outcomes were limited, common elements related to their impact on secondary outcomes can be discerned, as well as aspects of intervention delivery. These include:

- A focus on at least one social/structural risk factor, as in the emphasis on gender, poverty and alcohol in these interventions;
- Using group-based delivery to change social norms;
- Within schools, demonstrating the need to use additional personnel, perhaps from outside the school setting, to deliver interventions, thus relieving a burden on teachers; and
- Directing intervention efforts at the levels of both school and the individual.

### 1.3.3.6 WORKPLACE WELLNESS PROGRAMMES

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The Department of Public Service Administration (DPSA) developed an Employee Health and Wellness (EH&W) Strategic Framework, and an HIV & AIDS and TB Management Policy which was aligned to all four pillars of the previous NSP 2007-2011. The policy provided for prevention of HIV&AIDS and TB in all government departments in a mainstreamed manner, i.e. internal (workplace) mainstreaming and external (customer service-based) mainstreaming<sup>8</sup>. In the new NSP, this aspect is addressed through implementation of the “*Guidelines on Simultaneous Mainstreaming of HIV&AIDS, Gender and Human Rights in the context of the HIV&AIDS epidemic*” a guide to implementing structural HIV Prevention interventions.

The EH&W took the strategic decision to use the HIV Counselling and Testing Campaign (HCT) as an entry point to treatment, care and support, and integrating it with employee Health and Productivity (HPM), Wellness and Occupational Health and Safety risks identification, removal and mitigation. The DPSA developed a model to intensify and institutionalize HCT in the Public Service, and this will be implemented during the period of the next NSP. Through this model, access will be extended to both Principal Members (employees) and their dependents.

GEMS is the public service medical aid scheme, and the only medical aid which allows for registration of extended family members-- this initiative greatly benefits OVC left in the care of Scheme members. GEMS beneficiaries are referred to Aid for AIDS, an organization that designs, develops and delivers programmes that help businesses care for and medical schemes manage individuals living with HIV/AIDS. GEMS beneficiaries initiated on ARVs through *Aid for AIDS* increased by 28% from 2010 to 2011. This brought the total number of beneficiaries on ARVs to 59 647 by the end of 2011. The majority (76%) of currently registered beneficiaries are principal members. In 2011, females made up 67% of ARV-enrolled patients through GEMS.

As judged by CD4 count at registration, 34% of beneficiaries present very late in the disease with a CD4 count of < 200 and a further 22% present with moderately severe immune-suppression. This pattern has not changed materially since the inception of the programme and DPSA and GEMS are working together with the South African Medical Association SAMA to improve this over the next 5 years<sup>9</sup>.

#### 1.3.3.7 TB/HIV CO-INFECTION

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TB-HIV co-infection is extremely common in South Africa with latest research data placing co-infection rates at 60%. A total of 67% of TB patients were tested for HIV, against a 2010/2011 target of 90%. Additionally, 54% TB/HIV co-infected patients who were eligible for ART started treatment during 2010/2011. This performance was slightly below the 2010/2011 target of 60%. However, it reflected an improvement from the 2009/10 actual performance of 47%. A total of 99% of TB/HIV co-infected patients (86 203 out of 86 504) were initiated on Cotrimoxazole prophylactic treatment (CPT) during 2010/2011, which exceeded the 2010/2011 target of 71%. Provision of Cotrimoxazole has been shown to prevent morbidity and mortality due to invasive bacterial infections in patients with severe compromised immunity. To prevent activation of latent TB infection, 38% (170 311 out of 450 000) HIV-positive patients who were screened and found not to have active TB infection were provided with isoniazid prophylactic treatment (IPT), which was consistent with the target of 40%. The scaling up of the INH was highly successful when compared with the 2009/2010 actual performance, where only 1.8% HIV-positive patients were initiated on IPT.

#### 1.3.3.8 HOME AND COMMUNITY-BASED CARE

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HCBC is a central tenet of the care component of the comprehensive response to HIV and AIDS. This service is provided mainly through non-governmental and community-based organisations. The objective of the HCBC Programme is to ensure:

- Access to care and follow-up through a functional referral system;
- That children and families who are affected and infected by HIV and AIDS access social-welfare services within their communities.

The Department of Health provided stipends to 42,756 community caregivers (CCGs) supporting people living with AIDS and other debilitating conditions. This reflected an improvement of 40% from the 25 278 CCGs who received stipends in 2009/2010. While the actual amount of each stipend is modest, it nevertheless contributes to sustaining the high levels of commitment of these caregivers. An additional intervention for the care and support component is availability of the step-down care (SDF) facilities in various provinces. Ninety-seven SDC facilities were established during 2010/2011, against a target of 98. These facilities have contributed to improving quality of care for sub-acute patients.

#### 1.3.3.9 INTEGRATED FOOD SECURITY AND NUTRITIONAL SUPPORT

The Integrated Food Security and Nutrition Programme is an inter-governmental programme providing relief to households affected by food security, in the form of agricultural help including seedlings, equipment, fertilizers and so on. The aim is to give beneficiaries the equipment they need to produce their own food. The programme assists groups or individuals who want to start a small-scale garden, and subsistence farmers in rural or urban areas.

The Comprehensive Agricultural Support Programme offers support services to previously disadvantaged land-owners to promote and facilitate farming. The programme focuses on

- Information and technology management
- Technical and advisory assistance
- Marketing and business development
- Training and capacity- building
- On/off farm infrastructure and product inputs
- Financial support

The Micro-Agricultural Financial Institutions of South Africa was started to assist emerging farmers to access loans of up to r100 000. It also helps emerging farmers to access a wide range of other financial services, such as savings, credit and insurance. Beneficiaries of loans must show that they will be able to repay loans. To do so, they will have to provide a business plan.

During the reporting period, 79% of primary care level facilities provided nutritional care and support to people living with HIV, AIDS and TB, which exceeded the

2010/2011 target of 65%. A total of 57.4% of PHC facilities had healthcare providers trained on infant and young child feeding in the context of HIV and AIDS, against a target of 60%.

### 1.3.3.10 TRUCK DRIVERS AND OTHER MOBILE POPULATIONS

Under the coordination of the Department of Transport, a Framework for HIV and AIDS was developed for the Transport Sector in line with the old NSP(2007-2011). A Task Team has been established to facilitate revision of the Framework to align with the new NSP (2012-2016). A review of Framework has been completed to inform the new one. In some of the provinces such as KwaZulu Natal and Free State plans are afoot to establish high transmission area (HTA) projects. These projects are aimed at increasing access to HIV, STI and TB services among truck drivers and other mobile populations and their clients. The project sites are on the N3 highway that connects the cities of Johannesburg and Durban.

With respect to migrants, South Africa has made significant progress by implementing World Health Assembly (WHA) Resolution 621.17 that supports access to health services by migrant populations. Training of health service providers on migrant health issues has been implemented in some provinces eg Mpumalanga.

## 1.4 INDICATOR OVERVIEW TABLE

### CORE INDICATORS FOR GLOBAL AIDS RESPONSE PROGRESS REPORTING

TABLE 1: INDICATOR OVERVIEW TABLE, 2012

South African Global AIDS Response Progress Report 2012				
	INDICATOR	DATA RESULTS		DATA SOURCE
		2010	2011	
<b>TARGET 1: REDUCE SEXUAL TRANSMISSION OF HIV BY 50% BY 2015</b>				
<b>General Population</b>				
1.1	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission		No data	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008.  Human Sciences Research Council (HSRC), December 2009
	• Women and men aged 15-24	28.7%		
	• Women and men aged 15-19	28.1%	No data	
	• Women and men aged 20-24	29.5%	No data	
	• Men aged 15-24	30.4%	No data	
	• Men aged 15-19	29.6%	No data	
	• Men aged: 20-24	31.4%	No data	

## South African Global AIDS Response Progress Report 2012

	INDICATOR	DATA RESULTS		DATA SOURCE
		2010	2011	
	<ul style="list-style-type: none"> <li>Women aged 15-24</li> </ul>	27.0%	No data	
	<ul style="list-style-type: none"> <li>Women aged 15-19</li> </ul>	26.3%	No data	
	<ul style="list-style-type: none"> <li>Women aged 20-24</li> </ul>	27.7%	No data	
1.2	Percentage of young women and men aged 15-24 years who have had sexual intercourse before the age of 15 years		No data	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008.
	<ul style="list-style-type: none"> <li>Women and men aged 15-24</li> </ul>	8.5%		Human Sciences Research Council (HSRC), 2009
	<ul style="list-style-type: none"> <li>Women and men aged 15-19</li> </ul>	13.1%	No data	
	<ul style="list-style-type: none"> <li>Women and men aged 20-24</li> </ul>	6.1%	No data	
	<ul style="list-style-type: none"> <li>Men aged 15-24</li> </ul>	11.3%	No data	
	<ul style="list-style-type: none"> <li>Men aged 15-19</li> </ul>	15.1%	No data	
	<ul style="list-style-type: none"> <li>Men aged: 20-24</li> </ul>	8.8%	No data	
	<ul style="list-style-type: none"> <li>Women aged 15-24</li> </ul>	5.9%	No data	
	<ul style="list-style-type: none"> <li>Women aged 15-19</li> </ul>	10.4%	No data	
	<ul style="list-style-type: none"> <li>Women aged 20-24</li> </ul>	3.7%	No data	
1.3	Percentage of adults aged 15-49 years who have had sexual intercourse with more than one partner in the last 12 months		No data	
	<ul style="list-style-type: none"> <li>Women and men aged 15-49</li> </ul>	10.5%		Human Sciences Research Council (HSRC), 2009
	<ul style="list-style-type: none"> <li>Women and men aged 15-19</li> </ul>	20.6%	No data	
	<ul style="list-style-type: none"> <li>Women and men aged 20-24</li> </ul>	16.7%	No data	
	<ul style="list-style-type: none"> <li>Women and men aged 25-49</li> </ul>	8.0%	No data	
	<ul style="list-style-type: none"> <li>Men aged 15-49</li> </ul>	19.3%	No data	
	<ul style="list-style-type: none"> <li>Men aged 15-19</li> </ul>	32.2%	No data	
	<ul style="list-style-type: none"> <li>Men aged: 20-24</li> </ul>	30.1%	No data	
	<ul style="list-style-type: none"> <li>Men aged: 25-49</li> </ul>	14.8%	No data	
	<ul style="list-style-type: none"> <li>Women aged 15-49</li> </ul>	3.7%	No data	



## South African Global AIDS Response Progress Report 2012

	INDICATOR	DATA RESULTS		DATA SOURCE
		2010	2011	
	<ul style="list-style-type: none"> <li>Women aged 15-19</li> </ul>	9.8%	No data	
	<ul style="list-style-type: none"> <li>Women aged 20-24</li> </ul>	4.2%	No data	
	<ul style="list-style-type: none"> <li>Women aged 25-49</li> </ul>	3.0%	No data	
1.4	<p>Percentage of adults aged 15-49 years who had more than one sexual partner in last 12 months reporting the use of a condom at last intercourse.</p> <ul style="list-style-type: none"> <li>Women and men aged 15-49</li> </ul>	No data	No data	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008.  Human Sciences Research Council (HSRC), 2009
	<ul style="list-style-type: none"> <li>Women and men aged 15-19</li> </ul>	No data	No data	
	<ul style="list-style-type: none"> <li>Women and men aged 20-24</li> </ul>	No data	No data	
	<ul style="list-style-type: none"> <li>Women and men aged 25-49</li> </ul>	No data	No data	
	<ul style="list-style-type: none"> <li>Men aged 15-49</li> </ul>	No data	No data	
	<ul style="list-style-type: none"> <li>Men aged 15-19</li> </ul>	No data	No data	
	<ul style="list-style-type: none"> <li>Men aged: 20-24</li> </ul>	75.2%	No data	
	<ul style="list-style-type: none"> <li>Men aged: 25-49</li> </ul>	88.1%	No data	
	<ul style="list-style-type: none"> <li>Women aged 15-49</li> </ul>	86.7%	No data	
	<ul style="list-style-type: none"> <li>Women aged 15-19</li> </ul>	65.4%	No data	
	<ul style="list-style-type: none"> <li>Women aged 20-24</li> </ul>	77.1%	No data	
	<ul style="list-style-type: none"> <li>Women aged 25-49</li> </ul>	93.9%	No data	
1.5	<p>Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results</p> <ul style="list-style-type: none"> <li>Women and men aged 15-49</li> </ul>	24.7%	No data	
	<ul style="list-style-type: none"> <li>Women and men aged 15-19</li> </ul>	11.4%	No data	
	<ul style="list-style-type: none"> <li>Women and men aged 20-24</li> </ul>	24.6%	No data	
	<ul style="list-style-type: none"> <li>Women and men aged 25-49</li> </ul>	29.0%	No data	
	<ul style="list-style-type: none"> <li>Men aged 15-49</li> </ul>	19.8%	No data	
	<ul style="list-style-type: none"> <li>Men aged 15-19</li> </ul>	5.8%	No data	

## South African Global AIDS Response Progress Report 2012

	INDICATOR	DATA RESULTS		DATA SOURCE
		2010	2011	
	<ul style="list-style-type: none"> <li>• Men aged: 20-24</li> </ul>	19.2%	No data	
	<ul style="list-style-type: none"> <li>• Men aged: 25-49</li> </ul>	26.1%	No data	
	<ul style="list-style-type: none"> <li>• Women aged 15-49</li> </ul>	28.7%	No data	
	<ul style="list-style-type: none"> <li>• Women aged 15-19</li> </ul>	18.1%	No data	
	<ul style="list-style-type: none"> <li>• Women aged 20-24</li> </ul>	29.4%	No data	
	<ul style="list-style-type: none"> <li>• Women aged 25-49</li> </ul>	31.1%	No data	
1.6	Percentage of young people aged 15-24 who are living with HIV		No data	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008.  Human Sciences Research Council (HSRC), 2009
	<ul style="list-style-type: none"> <li>• Women and men aged 15-24</li> </ul>	8.7%		
	<ul style="list-style-type: none"> <li>• Women and men aged 15-19</li> </ul>	4.4%	No data	
	<ul style="list-style-type: none"> <li>• Women and men aged 20-24</li> </ul>	13.6%	No data	
	<ul style="list-style-type: none"> <li>• Men aged 15-24</li> </ul>	3.6%	No data	
	<ul style="list-style-type: none"> <li>• Men aged 15-19</li> </ul>	2.5%	No data	
	<ul style="list-style-type: none"> <li>• Men aged: 20-24</li> </ul>	5.1%	No data	
	<ul style="list-style-type: none"> <li>• Women aged 15-24</li> </ul>	13.9%	No data	
	<ul style="list-style-type: none"> <li>• Women aged 15-19</li> </ul>	6.7%	No data	
	<ul style="list-style-type: none"> <li>• Women aged 20-24</li> </ul>	21.1%	No data	
<b>Sex Workers</b>				
1.7	Percentage of sex workers reached with HIV prevention programs	No data	No data	
1.8	Percentage of sex workers reporting the use of a condom with their most recent client	No data	No data	
1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	No data	No data	
1.10	Percentage of sex workers who are living with HIV	No data	No data	
<b>Men who have sex with men</b>				
1.11	Percentage of men who have sex with men reached with HIV prevention programs	No data		

### South African Global AIDS Response Progress Report 2012

	INDICATOR	DATA RESULTS		DATA SOURCE
		2010	2011	
1.12	Percentage of men reporting the use of condom the last time they had sex with a male partner	No data		
1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results Male aged <25 <ul style="list-style-type: none"> <li>• Men aged &lt;25 /Men aged &gt;25</li> </ul>	27.2%.  The data cannot be disaggregated by age		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey,  Human Sciences Research Council (HSRC)
1.14	Percentage of men who have sex with men who are living with HIV <ul style="list-style-type: none"> <li>• Men aged &lt;25</li> <li>• Men aged &gt;25</li> </ul>	9.9%  The data cannot be disaggregated by age		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008.  Human Sciences Research Council (HSRC), 2009

- No data available

### South African Global AIDS Response Progress Report 2012

	INDICATOR	DATA RESULTS		DATA SOURCE
		2010	2011	
<b>TARGET 2: REDUCE TRANSMISSION OF HIV AMONG PEOPLE WHO INJECT DRUGS BY 50 PER CENT BY 2015</b>				
2.1	Number of syringes distributed per person who injects drugs per year by needle and syringes programmes	No data	No data	
2.2	Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	No data	No data	
2.3	Percentage of people who inject drugs who report using sterile injecting equipment the last time they injected	No data	No data	
2.4	Percentage of people who inject drugs that have received an HIV test in the last 12 months and know their results	No data	No data	
2.5	Percentage of people who inject drugs who are living with HIV	No data	No data	
<b>TARGET 3: ELIMINATE MOTHER TO CHILD TRANSMISSION OF HIV BY 2015 AND SUBSTANTIALLY REDUCE</b>				

## South African Global AIDS Response Progress Report 2012

	INDICATOR	DATA RESULTS		DATA SOURCE
		2010	2011	
<b>AIDS RELATED MATERNAL DEATH.</b>				
3.1	Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission	87.3%	87.1%	Numerator: DoH PMTCT Programme, Discovery Health, Aid for AIDS, GEMS  Denominator: ASSA
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	39.2%	54.4%	Numerator: NHLS, Discovery Health, Aids for AIDS, GEMS  Denominator: ASSA
3.3	Mother-to-child transmission of HIV (Modelled) -Estimated percentage of child HIV infections from HIV positive women delivering in the past 12 month	3.5%	No data	MRC, The National South African PMTCT Evaluation, 2010

## South African Global AIDS Response Progress Report 2012

	INDICATOR	DATA RESULTS		DATA SOURCE
		2010	2011	
<b>TARGET 4: HAVE 15 MILLION PEOPLE LIVING WITH HIV ON ANTIRETROVIRAL TREATMENT BY 2015</b>				
14.1	Percentage of eligible adults and children currently receiving Antiretroviral therapy	58.3%	75.2%	NDoH DHIS; 2010 HERO model <sup>a</sup>
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of therapy	No data	No data	
<b>TARGET 5: REDUCE TUBERCULOSIS DEATH IN PEOPLE LIVING WITH HIV BY 50% BY 2015</b>				
5.1	% of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	65%	No data	<u>Numerators:</u> ETR.Net: TB/HIV Collaborative Activities Report 2010 (Using provincial Q4/2011)  <u>Denominator<sup>b</sup>:</u> WHO Report, 2011

<sup>a</sup> Denominator: estimate of persons in need of ART. 2010 calculation: 1,400,377 (includes 1318028 public sector and 82349 private sector) / 2.4 million. 2011 calculation: 1,804,480 (includes 1703907 public sector and 100573 private sector) / 2.4 million. Denominator source: 2010 HERO model's estimate of persons in need of ART: StatsSA estimate of 2.4 million at CD4 count of  $\leq$  350.

<sup>b</sup> Numerator: from NTB Programme. Denominator: Incidence of TB cases in HIV-Positive People, WHO GLOBAL TUBERCULOSIS CONTROL REPORT, 2011.

6.1	Domestic and international AIDS spending by categories and financing sources		National AIDS Spending Assessment (NASA), 2009
	Total	ZAR 18,678,509,395	
	Public/Domestic	ZAR 15,481,920,391	
	International	ZAR 2,126,294,580	

### South African Global AIDS Response Progress Report 2012

	INDICATOR	DATA RESULTS		DATA SOURCE
		2010	2011	
<b>TARGET 7: CRITICAL ENABLERS AND SYNERGIES WITH DEVELOPMENT SECTORS.</b>				
7.1	National Commitment and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programs, stigma and discrimination and monitoring and evaluation)	-See Annex 2-		NCPI Survey
7.2	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	No data	No data	
7.3	Current school attendance among orphans and non-orphans aged 10-14			Statistics South Africa, General Household Survey, 2010
	Part A: Orphan boys and girls aged 10-14	99.6%	No data	
	Part B: Non-orphan boys and girls aged 10-14	99.1%		
7.4	Proportion of poorest households who received external economic support in the last 3 months	No data	No data	

## SECTION TWO: OVERVIEW OF THE EPIDEMIC

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### 2.1 MODES OF HIV TRANSMISSION

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HIV in South Africa is transmitted predominantly heterosexually between couples, with mother-to-child transmission being another main infection route. Drivers of the epidemic in South Africa are intergenerational sex, multiple concurrent partners, low condom use<sup>10</sup>, excessive use of alcohol and low rates of male circumcision.

In relation to intergenerational sex, research has identified younger females having sex with older males as an important factor contributing to the spread of HIV<sup>11</sup>. Subsistence needs and materialism usually motivate such relationships<sup>12</sup>. Shisana and colleagues (2009) found higher HIV prevalence among teenage males and females who reported having sexual partners who are five or more years older than they<sup>13</sup>. Owing to unequal power dynamics in such relationships, vulnerability may be exacerbated for young girls who do not have the skills and power to negotiate condom use<sup>14</sup>.

Research suggests that concurrent sexual partnerships - sexual relationships that overlap in time - are common in South Africa<sup>15</sup>. Modelling studies have illustrated that concurrent sexual partnerships result in sexual networks that have densely clustered pathways that do not occur when people have sequential relationships that do not overlap in time<sup>16</sup>. Consistent condom use among those who have multiple partners appears to be increasing, particularly in the areas most affected by the epidemic.

### 2.2 NATIONAL HIV PREVALENCE TRENDS

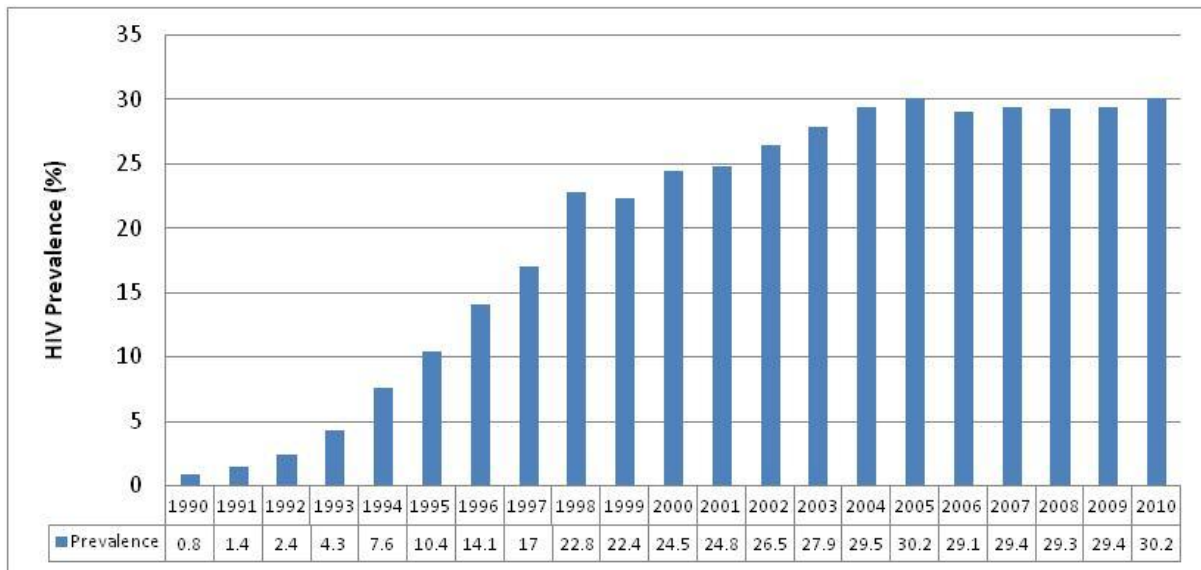
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Population-based sero-surveys and sentinel surveillance of pregnant women suggest that the HIV epidemic in South Africa has reached a plateau. HIV prevalence among surveyed pregnant women was 30.2% in 2010; there has not been a statistically significant increase in prevalence since the early 2000's. The most recent Antenatal Survey (2010) indicates that nationally, the HIV prevalence among women in the age group 30 - 34 years (which constituted 14.5% of those who participated in the survey) remains the highest since 2007.

The 2010 survey provides data on the country's progress on the Millennium Development Goal 6, Target 7, and indicator 18: the goal of which is a reduction of HIV prevalence by 75% by 2015. The baseline prevalence among 15-24 year olds was 23.1% in 2001; in 2010, it was 21.8%; a reduction of 1.3%. With a large ART programme South Africa expects to see an increase in HIV prevalence thereby underscoring the need to refine HIV incidence estimation methodologies. For the future we recommend a revision of this indicator.

The 2010 ANC report produced findings on young adolescents aged 10-14 years old who were HIV positive. Of this small group that participated in the survey (n=121), 11 were HIV positive (9%), an increase from 7.3% in 2008<sup>17</sup>.

FIGURE 1: HIV PREVALENCE AMONG YOUNG WOMEN 15-49 YEARS

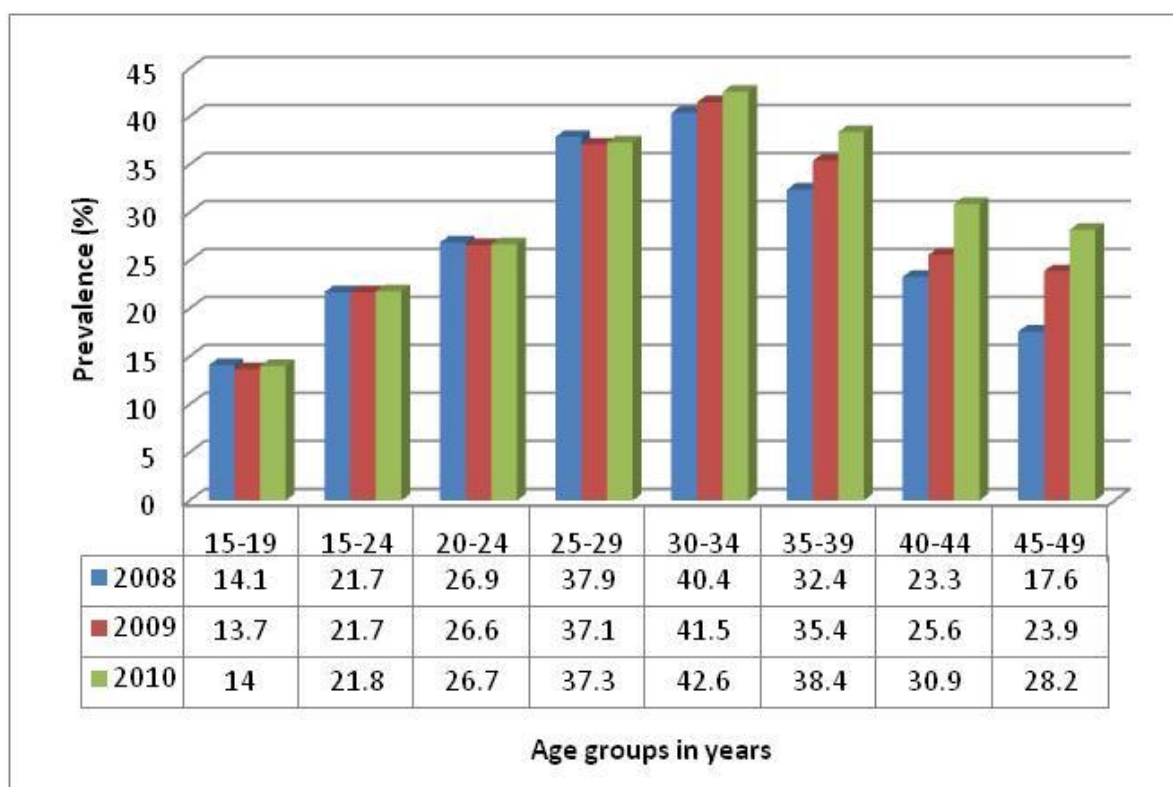


Source: Antenatal Sero-prevalence Survey, 2011

### 2.3 HIV PREVALENCE BY AGE – ANTENATAL SURVEY

Nationally, the HIV prevalence among women in the age group 30 - 34 years remains the highest with a prevalence of 42.6% in 2010. This has increased by 3.3% since 2007. The HIV prevalence among women under 30 years has continued to decline gradually since 2006 while the prevalence of the over 30s continues to increase. However, modelling suggests that most, if not all of the increase in recent years can be attributed to the increase in survival of those on ARVs.

FIGURE 2: HIV PREVALENCE AMONG WOMEN BY AGE, 2008-2010



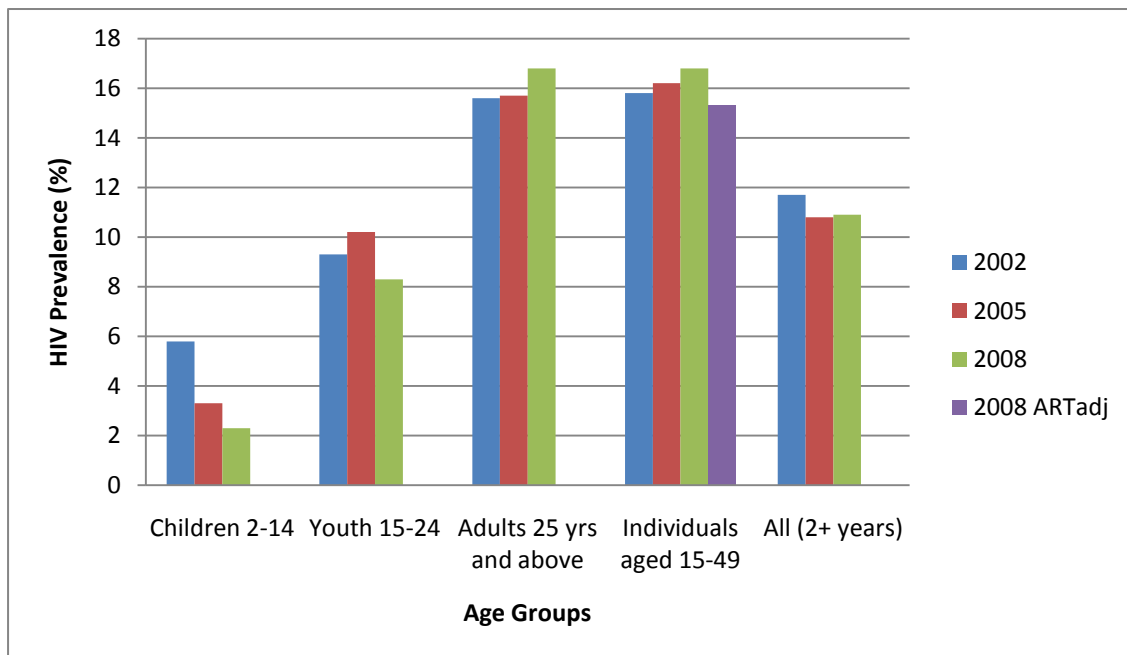
Source: Antenatal Sero-prevalence Survey, 2011

## 2.4 HIV PREVALENCE BY AGE – POPULATION SURVEY

National HIV prevalence in the general population has shown a general downward trend in children and a slight upward trend in adults<sup>18</sup>. Since the first survey in 2002, HIV prevalence levels in children aged 2-14 years have gradually decreased, primarily as a result of the scaled-up national PMTCT programme. Among youth aged 15-24 years HIV prevalence declined from 10.3% in 2005 to 8.7% in 2008, but a further data point is now required to assess whether this represents a statistically significant downward trend. In adults aged 25 years and above, a rise in HIV prevalence is attributed to the availability of ARV treatment<sup>19</sup>.



FIGURE 3: HIV PREVALENCE IN THE GENERAL POPULATION BY AGE, 2002-2008

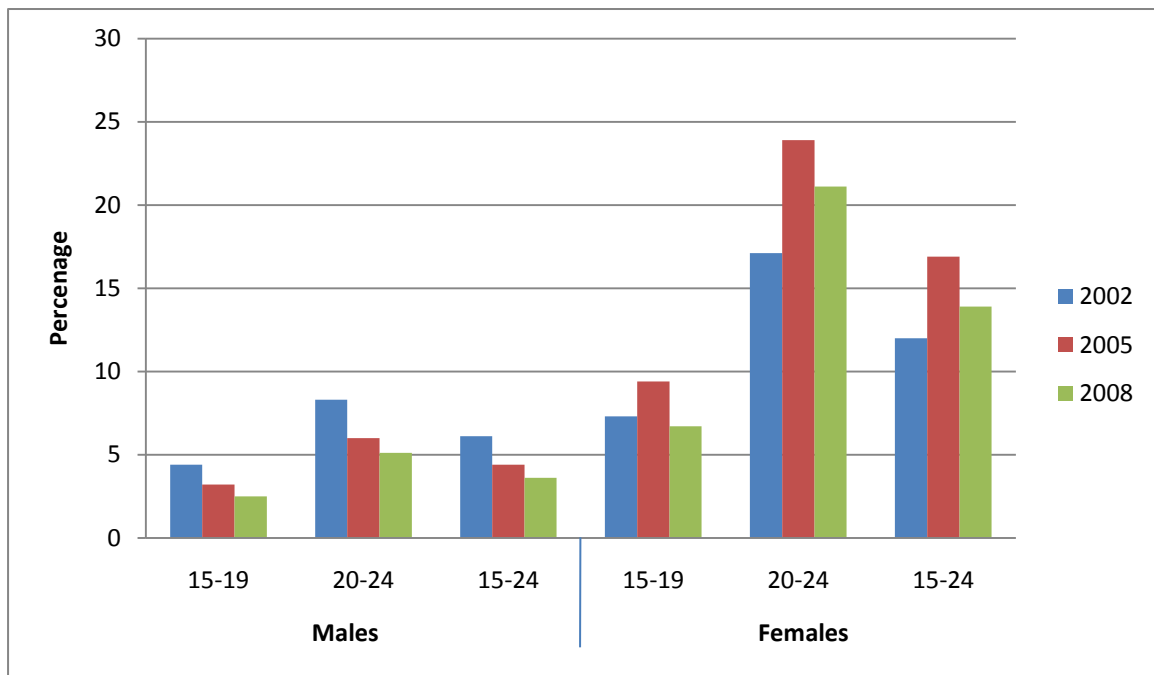


Sources: Shisana & Simbayi (2002), Shisana *et al.* (2005, 2009). ART adjusted data from Rehle *et al.*, 2010

### 2.5 HIV PREVALENCE IN YOUTH AGE 15-24

HIV prevalence in young women is much higher than in young men, particularly in the 20-24 age group. In 2008, HIV prevalence in women aged 20-24 was 21.1% compared to 5.15% in men aged 20-24 years. The *Review of the South African Epidemic* (2011) notes that there is evidence of a downturn in HIV prevalence in youth aged 15-19 years and 20-24 years between 2005 and 2008.

FIGURE 4: HIV PREVALENCE IN YOUTH (15-24 YRS) BY SEX AND AGE, 2002-2008

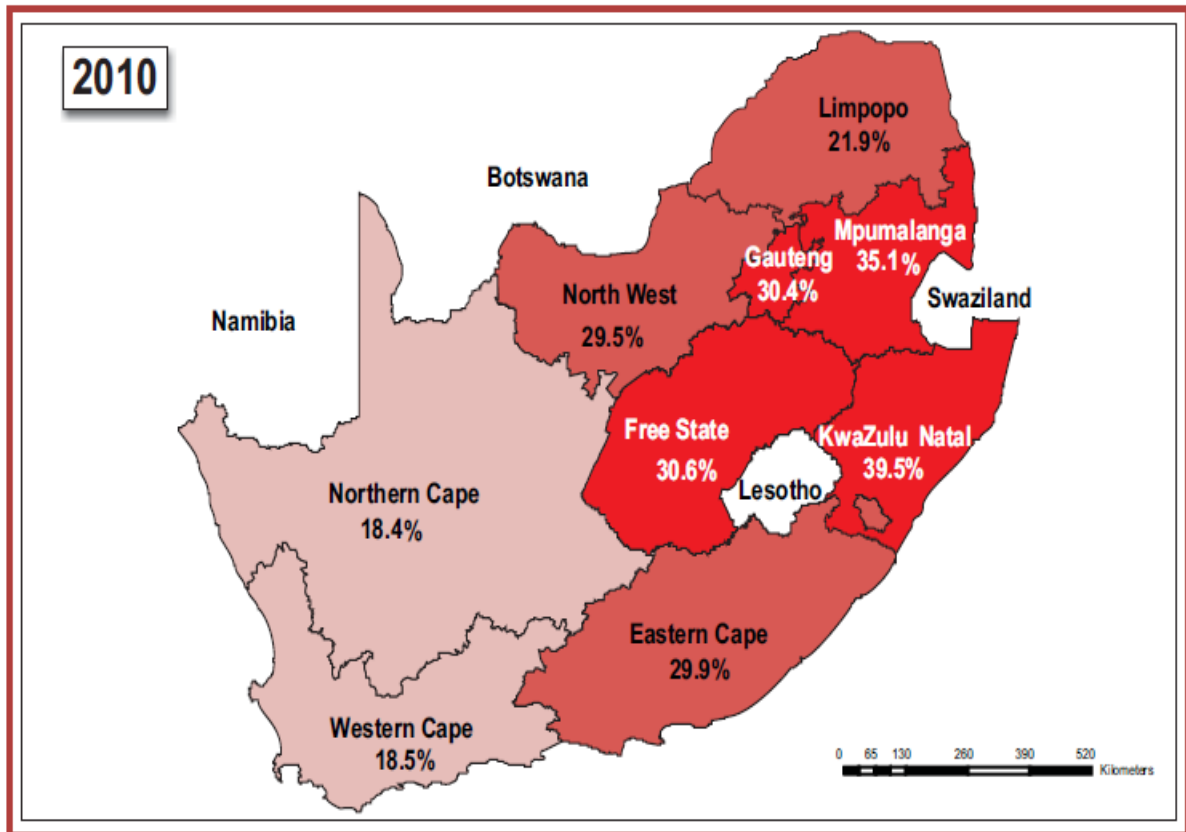


Sources: Shisana & Simbayi (2002), Shisana *et al.* (2005, 2009).

## 2.6 HIV PREVALENCE BY PROVINCE

The prevalence of HIV in South Africa shows considerable variance across its nine provinces. In the past twenty years, the highest HIV prevalence among the 15-49 year olds has been recorded in KwaZulu-Natal, which remained stable at 39.5% on 2009 and 2010. Provinces with 'higher' HIV prevalence after KZN were Mpumalanga (35.1%), Free State (30.6%) and Gauteng (30.4%). HIV prevalence in the Western Cape increased significantly from 16.9% to 18.5% in 2010, due to the larger sample size.

FIGURE 5: HIV PREVALENCE AMONG PREGNANT WOMEN BY PROVINCE, 2010



Source: Antenatal Sero-prevalence Survey, 2011

## SECTION 3: NATIONAL RESPONSE TO THE AIDS EPIDEMIC

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### 3.1 NATIONAL COMMITMENT AND ACTION

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South Africa continues to make progress in addressing its severe HIV/AIDS and TB epidemics. Political leadership on HIV/AIDS is provided by the Presidency, and the Deputy President is the chairperson of the South African National AIDS Council. SANAC is the multi-sectoral coordinating body with representatives from all government departments and 19 civil society sectors<sup>20</sup>. Three organisations representing people living with HIV are also members of SANAC namely the Treatment Action Campaign (TAC), the National Association of People with AIDS (NAPWA) and the Positives Convention.

The work of the Presidency is supported at the provincial level through the nine Offices of Premiers. At the departmental level, most major government departments – including Health, Basic Education, Social Development, Labour, Justice, Police Services, and Correctional Services – have dedicated budgets for sector specific HIV and TB interventions.

Political leadership has resulted in the reduction of ARV costs by 53% and TB treatment costs by 15%, , and support for South Africa to move towards the manufacture of ARVs.

During the period of the NSP 2007-2011 a number of significant developments took place that reflected a high level of political commitment to the principle of universal access. Key developments included the changing of the CD4 threshold to expand the number of people on treatment, the integration of HIV and TB, strengthened capacity for HIV responses at municipal level, the mainstreaming of HIV across all sectors, and the shift from VCT to provider initiated HCT.

Over the review period, the Department of Health has taken a leading role in health systems strengthening for the HIV, STI and TB response, including the following key initiatives:

- To strengthen the human resources base a new unit for capacity development was established;
- Increasing the quantity and quality of health facilities;
- Re-engineering Primary Health Care.

The most significant action on the part of national HIV leadership, under the direction of SANAC, has been the participatory, multi-sectoral development of the new NSP 2012-2016 and operational plan, alongside the development of nine provincial strategic implementation plans.

Major Achievements	Key Challenges
<ul style="list-style-type: none"> <li>• Reduced levels of Mother to Child Transmission (MTCT)</li> <li>• Increase in the number of people tested for HIV</li> <li>• Increased coverage of ART</li> <li>• Enhanced political leadership around</li> <li>• Roll-out of the Male Medical Circumcision programme</li> <li>• Strengthening of provider initiated counselling and testing</li> </ul>	<ul style="list-style-type: none"> <li>• Prevention efforts to lower new infections through combination treatment</li> <li>• Moderate buy-in at the political level in some provinces</li> <li>• Availability of female condoms</li> <li>• MTCT has not (yet) been reduced to zero</li> <li>• Poor monitoring and evaluation of interventions and programmes</li> <li>• Multi-sectoral coordination remains a challenge</li> <li>• Lack of effective implementation in some rural areas</li> </ul>

### 3.2 POLICY / STRATEGY DEVELOPMENT AND IMPLEMENTATION

The current policy environment was measured for the 2012 Global AIDS Report using the National Commitments and Policy Instrument (NCPI), see Annex 2. This mixed qualitative and quantitative survey measures the extent to which countries have developed and implemented HIV/ADS policies and strategies in the following broad areas:

- Strategic planning;
- Political support;
- HIV prevention, treatment, care and support;
- Human rights; and
- Civil society engagement.

The NCPI questionnaire was administered to SANAC PIC members in a working session held on the 29<sup>th</sup> February 2012. The group included government representatives, a range of representatives from civil society and development partners (for a full list of participants see Annex 2). Following the working session, the NCPI was circulated among a larger group of stakeholders for further review and comment, and the final version was vetted in the National Consultation Workshop on 9 March 2012.

In addition to the NCPI exercise, part of the KYR report (2011) included a detailed review of the over 40 policies, laws, guidelines, and strategies guiding HIV prevention in South Africa. The documents were assessed to determine whether they collectively address the minimum package of HIV prevention recommended by international guidelines. The review concluded that although South Africa does not have a single policy on prevention, collectively, the various policies and draft policies do cover the key elements of HIV prevention.

However, the KYR and other reviews have pointed out that simply having policies in place does not constitute an effective programme –implementation is the key issue. The KYR report concurred with the MTR in identifying the main gap as being the lack of a national, unified prevention strategy that is adequately resourced and that flows down operationally and programmatically to provinces and districts. In particular, without a national strategy, the multi-sectoral response was difficult to conceptualise, implement and report on. Other gaps in the policy environment identified by the KYR report included:

- The lack of male engagement in prevention of mother-to-child transmission (PMTCT);
- The need for better communication of the post-exposure prophylaxis (PEP) guidelines;
- The need to better target key populations including out-of-school youth, people with disabilities, mobile and migrant populations, commercial sex workers, and men who have sex with men (MSM);
- The need for policies on female condom distribution, sero-discordant couples, and on regulating the provision of health services across international and regional borders.

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### 3.2.1 PROMOTING AN ENABLING ENVIRONMENT

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A major focus of the national AIDS response has been to create a social environment that encourages more people to test voluntarily for HIV and, when necessary, to seek and receive treatment and related social services support. There has also been significant efforts to ensure that stigma and discrimination related to AIDS, and in particular to key populations and other vulnerable groups, is addressed in a comprehensive manner. For example, the National Department of Health has developed a Stigma Mitigation Framework while SANAC in collaboration with PLHIV groups is implementing the Stigma Index. Human rights and access to justice has been a central theme in both the previous and current NSPs. While there are few data systems in place to collect and monitor information on human rights, South Africa has made significant progress in realising the rights of the population in the context of HIV.

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#### 3.2.1.1 HUMAN RIGHTS AND ACCESS TO JUSTICE

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South Africa has a variety of provisions in the Constitution, as well as laws and other regulations that provide for the security of human rights and protects individuals against discrimination in education, employment, correctional facilities and in health care (both public and private). These specifically include provisions for vulnerable sub-populations such as women and girls, young people, MSM, sex workers, prison inmates and migrant populations. Specific legislation protection the rights and entitlements include:

- **Promotion of Equality and the Prevention of Unfair Discrimination Act 4 of 2000** provides for the further amplification of the constitutional principles of equality and elimination of unfair discrimination;

- **Employment Equity Act 55 of 1998** provides for the measures that must be put into operation in the workplace in order to eliminate discrimination and promote affirmative action;
- **Child Care Act 74 of 1983** provides for the protection of the rights and wellbeing of children
- **Choice on Termination of Pregnancy Act 92 of 1996** provides a legal framework for termination of pregnancies based on choice under certain circumstances
- **Older Persons Act, 2006 (Act No. 13 of 2006)**
- **Children’s Amendment Act 2007 (Act No. 41 of 2007)**
- **Social Assistance Amendment Act, 2010 (Act No. 5 of 2010)**

A number of mechanisms are in place to ensure the implementation of laws, such as:

- The **Commission for Gender Equality**, with the responsibility to promote and protect gender equality;
- The **Judicial Inspectorate of Prisons**, to uphold the standards of prisons;
- The **Medicines Control Council**, which approves medicines and clinical trials;
- The **SA Human Rights Commission**, to promote and protect human rights;
- Various **Parliamentary Committees**, to monitor the implementation of laws and policies; and

There are systems of redress in place to ensure that laws are upheld and that they are having the desired effect:

- The **Commission for Conciliation, Mediation and Arbitration (CCMA)**: arbitrates disputes between workers and employers, including cases of discrimination
- The **Health Professions Council of SA (HPCSA)**: sets ethical rules and hears complaints regarding the conduct of health professionals, and has authority to suspend, fine or revoke licenses to practice
- The **Judicial Inspectorate of Prisons**: as mentioned, to uphold the standards of prisons. Various government departments are currently working together to develop a Prison Health Strategy in response to a number of challenges to the provision of health care services within the prisons.
- The **National Health Research Ethics Council**: with the authority to grant or deny permission to carry out research with human participants.

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### 3.2.3 Challenges

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The South African Law Commission has been reviewing the legal barriers to sex work for the past seven years.

Current policy that does not explicitly allow for the provision of needle syringe exchange (NSE) and opioid substitution therapy (OST) programmes as part of a holistic prevention package for injecting drug users (IDU). Laws should be aligned with the nine injecting drug

users (IDU) interventions recommended by the World Health Organization (WHO) and the United Nations Office on Drugs and Crime (UNODC).

The country’s approach to its HIV epidemic has not effectively addressed any potential concentrated epidemics within it, such as MSM, CSW and mobile populations.

Legal aid services are available on a limited basis, and although government funds some, capacities and resources are insufficient to address the need. While individual councils, commissions, etc work with discrimination cases or record human rights abuses, oversight bodies lack sufficient resources to act in accordance with their regulatory responsibilities, and problems with financing and appointment procedures have undermined their efficacy. The NSP does explicitly provide for the promotion and protection of human rights and attempts to create benchmarks for compliance with human rights standards and the reduction of stigma. Unfortunately, South Africa lacks one overarching body that gathers and centralises the information around human rights, including that pertaining to HIV and AIDS.

### 3.3 NATIONAL TARGETS AND ASSOCIATED PROGRAMME RESPONSES

#### TARGET ONE: REDUCE SEXUAL TRANSMISSION OF HIV BY 50% BY 2015

##### 3.3.1 GENERAL POPULATION - KNOWLEDGE OF HIV AND AIDS

**Indicator 1.1: Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (Disaggregated by sex and age)**

INDICATOR	DATA SOURCE	
	2010	
Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission		
• Women and men aged 15-24	28.7%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008.  Human Sciences Research Council (HSRC) , 2009
• Women and men aged 15-19	28.1%	
• Women and men aged 20-24	29.5%	
• Men aged 15-24	30.4%	
• Men aged 15-19	29.6%	
• Men aged: 20-24	31.4%	

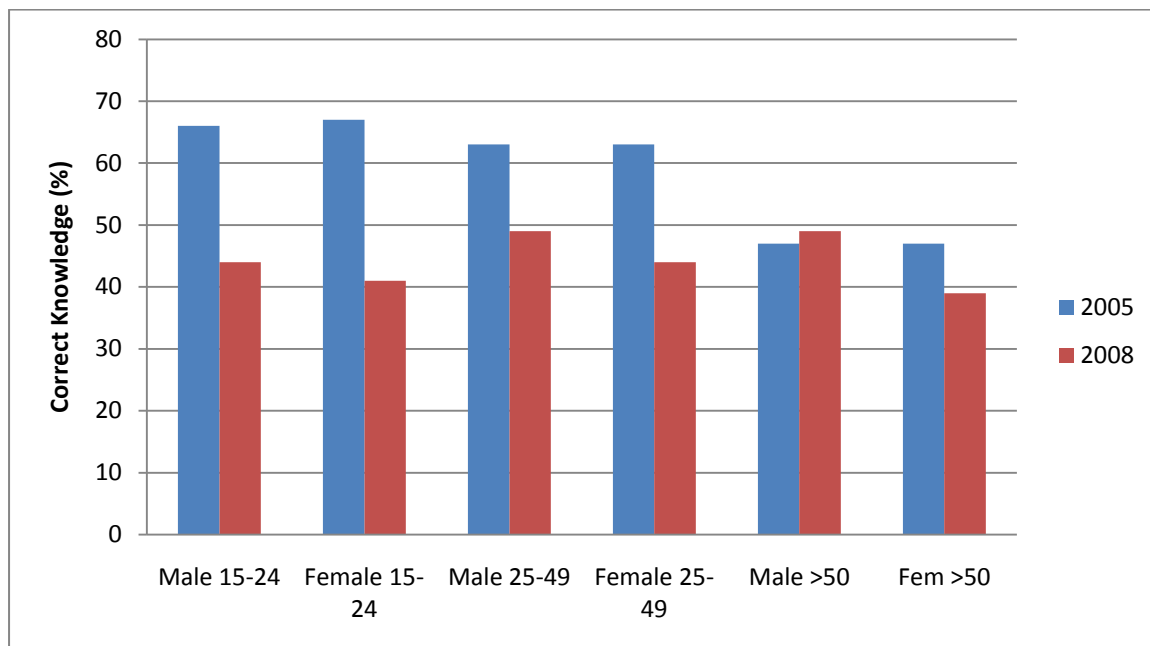


• Women aged 15-24	27.0%		
• Women aged 15-19	26.3%		
• Women aged 20-24	27.7%		

In South Africa, the wide delivery of effective behaviour change strategies has been central to reversing the global HIV epidemic, and has formed a key element of the national prevention pillar. The national approach to prevention recognizes that human behaviour is complex; widespread behaviour changes are challenging to achieve; and that there are important gaps in knowledge about the effectiveness of HIV prevention. In a country like South Africa there is a clear recognition on the part of both government and civil society that nothing short of countrywide mobilization will sufficiently address the epidemic's threat. Where HIV is generalized, every workplace, school, and community setting should be identified for intensive HIV prevention activities. Efforts continue to be made, through a broad range of education and information sharing initiatives, to ensure that HIV becomes a natural and central topic of discussion, and that new societal norms are forged regarding gender relations and sexual behaviour.

According to the *Review of the South African AIDS Epidemic*(date) correct knowledge about preventing sexual transmission decreased significantly between 2005 and 2008. In adults, it decreased significantly from 60.7% in 2005 to 44.4% in 2008 ( $p < 0.0001$ ) (Shisana et al., 2009). It should be noted that there has not been a follow-up to the 2008 *South Africa National HIV Prevalence, Incidence, Behaviour and Communication Survey*. This means that this report is not able to provide more recent data for this indicator, and that the data contained in the previous UNGASS Report for South Africa remains the same. The figure below shows the level of correct responses to two questions about the prevention of infection (consistent condom use, partner reduction).

FIGURE 6: CORRECT KNOWLEDGE ABOUT PREVENTION OF SEXUAL TRANSMISSION OF HIV, SOUTH AFRICA, 2005 - 2008



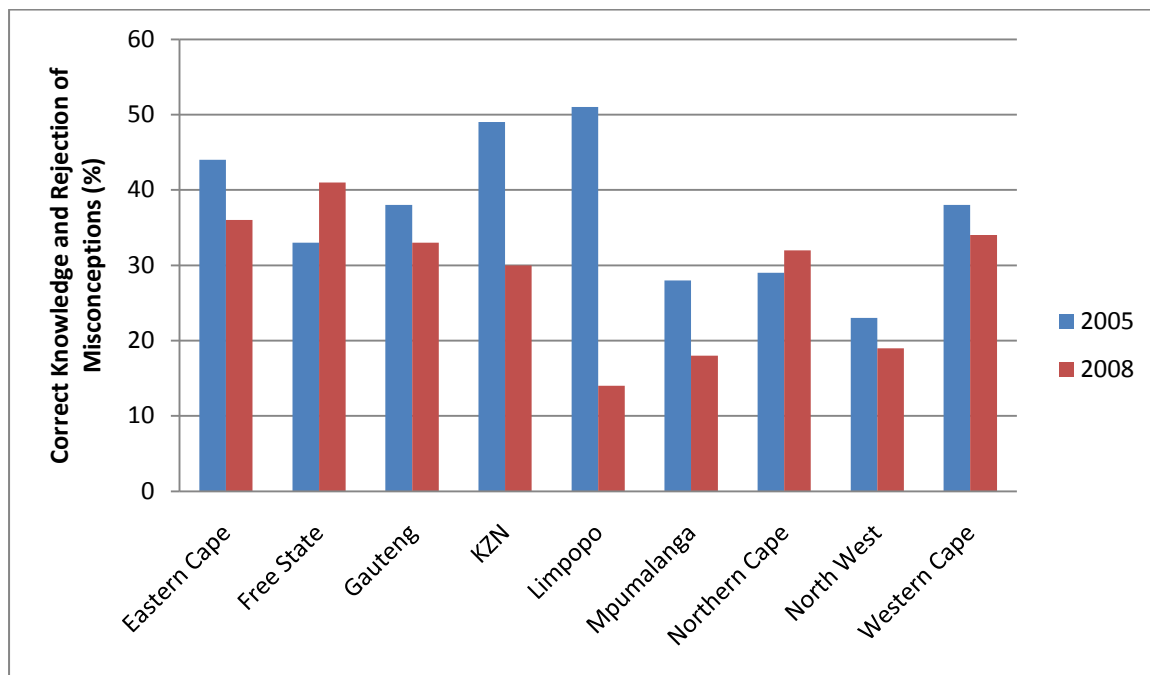
Source: Shisana *et al.* 2009

In all age and sex strata, the decrease was significant except for men aged 50+ years. Correct knowledge on the prevention of sexual transmission of HIV was lower in 2008 than in 2005 in all age and sex strata except in males aged 50 or above. Correct knowledge on prevention and the rejection of misconceptions about HIV transmission has decreased, especially in Limpopo, KwaZulu-Natal, Mpumalanga, and Eastern Cape. Given the unusual provincial pattern of responses to the knowledge questions in this survey, it is highly likely that the decrease in knowledge shown in the survey was an artefact of survey methodology as opposed to real decrease in actual knowledge of HIV risk.

A relatively small proportion of the population regard themselves to be at any significant risk for HIV, but significantly, more HIV-positive respondents perceived themselves to be at high risk of HIV compared to HIV negative respondents.

The percentage of people who correctly identify ways of preventing HIV and reject misconceptions about HIV transmission also decreased between 2005 and 2008 - in all adults combined, it decreased significantly from 40.2% in 2005 to 29.0% in 2008 ( $p < 0.0001$ ) (Shisana *et al.*, 2009). Figure 51 shows the results for each province. Two provinces had a small improvement in the indicator (FS, NC), three provinces had a non-significant decrease (GP, NW, WC), and four provinces had a significant decrease (EC, KZN, LP, MP). The figure below shows a composite measure of two questions on prevention knowledge (consistent condom use, partner reduction) and four myths and misconceptions (AIDS cure, witchcraft, link between HIV and AIDS, and sex with a virgin).

FIGURE 7: CORRECT KNOWLEDGE ABOUT PREVENTION OF SEXUAL TRANSMISSION OF HIV AND REJECTION OF MAJOR MISCONCEPTIONS ABOUT HIV, SOUTH AFRICA, 2005 - 2008



Source: Shisana *et al*, 2009

Research supports this perception among South Africans, for example, the 2009 NCS found that 78% of respondents aged 16-55 years said that they would not get infected (21% said they will get infected); among both groups, it is not clear what proportion already know their HIV status (HDA 2010 secondary data analysis). Young people aged 16-24 had slightly lower risk perception with 84% saying they would not get infected compared to the 25-55 year group (76%), and males had lower risk perception than females (85% vs. 72%). There were also racial differences in risk perception (95% of Indians, 88% of whites, 85% of coloureds and 76% of Africans believed they would not be infected).

The school system is an important intervention area for disseminating information and creating awareness around issues related to HIV. The Department of Basic Education (DBE) has been strengthening the HIV and AIDS life skills education programme. Activities included:

- a review of the sexuality education curriculum against the UNESCO International Guidelines on Sexuality Education;
- classroom observations of lessons;
- Development of scripted lesson plans for educators;
- Conducting qualitative research to better understand factors that facilitate and inhibit the teaching of Life Orientation in schools .

There has also been a focus on capacity development, with 3 545 teachers trained as Master Trainers, and 24 275 teachers capacitated from January 2010 to December 2011 to deliver life skills through the curriculum. In total, 1 920 693 sets of Learning and Teaching Support Material (LTSM) were distributed to 24 628 schools. Life Skills Teacher Guides and

Learner Activity books were reviewed for compliance with the National Curriculum Statement. LTSM distributed to schools included a range of materials on sexuality education, drugs and substance use, stigma, discrimination, peer pressure and HIV and AIDS. Functional peer education programmes have been established in 16 505 primary and secondary schools.

### 3.3.2 AGE OF SEXUAL DEBUT (AGE AT FIRST SEX)

**Indicator 1.2: Percentage of young women and men aged 15-24 years who have had sexual intercourse before the age of 15 years (Disaggregated by sex and age)**

INDICATOR	DATA SOURCE	
	2010	
Percentage of young women and men aged 15-24 years who have had sexual intercourse before the age of 15 years		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008.  Human Sciences Research Council (HSRC), 2009
• Women and men aged 15-24	8.5%	
• Women and men aged 15-19	13.1%	
• Women and men aged 20-24	6.1%	
• Men aged 15-24	11.3%	
• Men aged 15-19	15.1%	
• Men aged: 20-24	8.8%	
• Women aged 15-24	5.9%	
• Women aged 15-19	10.4%	
• Women aged 20-24	3.7%	

*(Data for 2011 was not available)*

The *Review of the South African HIV Epidemic* (2011) notes that there is a trend towards earlier sexual debut amongst youth - median age at first sex was 20 years for men and women born before 1950 and 18 years for those born in the 1980s. Sex before 15 years of age increased significantly in Free State, North West and Mpumalanga between 2002 and 2008. Young Africans report higher levels of sexual experience than coloured, Indian and white youth. The Cape Area Panel Study found that girls in lower income households tended to have earlier sexual debut, and that community poverty rates were associated with early sexual debut and higher rates of unprotected sex. In the Africa Centre study area, the most important and highly significant factor protecting females against first sex before the 17<sup>th</sup> birthday was school attendance.

### 3.3.3 MULTIPLE SEXUAL PARTNERS

**Indicator 1.3: Percentage of adults aged 15-49 years who have had sexual intercourse with more than one partner in the last 12 months (Disaggregated by sex and age)**

INDICATOR	DATA SOURCE		
	2010		
Percentage of adults aged 15-49 years who have had sexual intercourse with more than one partner in the last 12 months			South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008. Human Sciences Research Council (HSRC), 2009
• Women and men aged 15-49	10.5%		
• Women and men aged 15-19	20.6%		
• Women and men aged 20-24	16.7%		
• Women and men aged 25-49	8.0%		
• Men aged 15-49	19.3%		
• Men aged 15-19	32.2%		
• Men aged: 20-24	30.1%		
• Men aged: 25-49	14.8%		
• Women aged 15-49	3.7%		
• Women aged 15-19	9.8%		
• Women aged 20-24	4.2%		
• Women aged 25-49	3.0%		

○ *Data for 2011 are not available*

The frequency of reported multiple partners varies by race and is highest in African men. In the 2009 NCS, 16.7% of men and 2.3% of women aged 16-55 years reported two or more partners (among those who had ever had sex). Multiple partner frequency peaks in people in their twenties, but there may be underreporting in older age groups where marriage is more common. Comparing multiple partner data across the five national surveys, there is some indication of an increase over time in the proportion of 16-55 year old men who reported MSPs in the past 12 months. HIV prevalence was higher in respondents reporting more sexual partners. Women reporting more than one partner at the time of survey were 4.3

times more likely to be HIV positive ( $p=0.0001$ ). The sexual concurrency analysis of the NCS 2009 data confirmed the relatively higher concurrency prevalence for African men compared to coloured, Indian and white men. Both females and males see sexual relationships as a path to a number of distinct benefits.

### 3.3.4 CONDOM USAGE

**Indicator 1.4: Percentage of adults aged 15-49 years who had more than one sexual partner in last 12 months reporting the use of a condom at last intercourse (disaggregated by sex and age)**

INDICATOR	DATA SOURCE	
	2010	
Percentage of adults aged 15-49 years who had more than one sexual partner in last 12 months reporting the use of a condom at last intercourse.		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008.  Human Sciences Research Council (HSRC), 2009
• Women and men aged 15-49	75.2%	
• Women and men aged 15-19	88.1%	
• Women and men aged 20-24	86.7%	
• Women and men aged 25-49	65.4%	
• Men aged 15-49	77.1%	
• Men aged 15-19	93.9%	
• Men aged: 20-24	87.8%	
• Men aged: 25-49	65.3%	
• Women aged 15-49	67.5%	
• Women aged 15-19	67.7%	
• Women aged 20-24	78.2%	
• Women aged 25-49	64.5%	

(Data for 2011 were not available)

Young single people (who are not married or cohabiting) and young people reporting multiple sexual partners are most likely to report using condoms. People above 50 and married people are least likely to report condom use. Young females reporting once-off

partners also report low condom use. Regarding short-term trends, overall reported condom use increased between 2002 and 2008, but not among people reporting multiple sexual partners. PLHIV who knew that they were HIV-positive were significantly more likely to use a condom than PLHIV who did not know their HIV status. Available data indicated that condoms were least likely to be used consistently in partnerships characterised by long-term concurrency. In provinces with higher HIV levels, sexually active women are more likely to choose condoms as contraceptives than in provinces with less HIV. Increased condom use among the youth may have contributed to the recent decline in HIV incidence in this age group (note that this is self-reported condom use data with known problems of validity).

### 3.3.5 HIV AND TB TESTING BEHAVIOUR

**Indicator 1.5: Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results (disaggregated by sex and age)**

INDICATOR	DATA SOURCE	
	2010	
Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008 . Human Sciences Research Council (HSRC) 2009
• Women and men aged 15-49	24.7%	
• Women and men aged 15-19	11.4%	
• Women and men aged 20-24	24.6%	
• Women and men aged 25-49	29.0%	
• Men aged 15-49	19.8%	
• Men aged 15-19	5.8%	
• Men aged: 20-24	19.2%	
• Men aged: 25-49	26.1%	
• Women aged 15-49	28.7%	
• Women aged 15-19	18.1%	
• Women aged 20-24	29.4%	
• Women aged 25-49	31.1%	

- ( Data for 2011 were not available)



Coverage of HIV counselling and testing (HCT) increased substantially from 2005 to 2010. In April 2010, South Africa launched a national HCT campaign with the goal of promoting HIV counselling and testing and screening for TB. With a target of testing 15 million people, this was the largest testing campaign ever undertaken. By the end of June 2011, 13.3 million people were tested for HIV out of a targeted 15 million nationwide. In addition, South Africa is currently scaling-up its Provider Initiated Counselling and Testing model to extend access to HCT at health facilities.

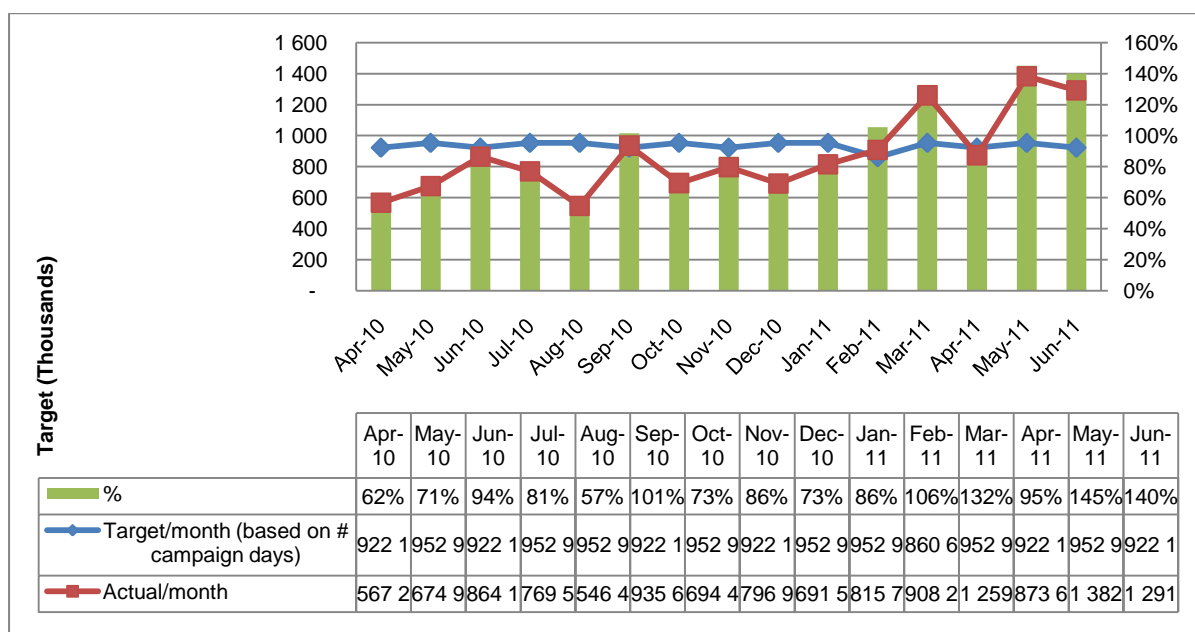
TABLE 2: HCT CAMPAIGN UPDATED TESTING DATA, JUNE 2011

<i>Province</i>	<i>15 Month Target</i>	<i>Pre-Test</i>	<i>Testing Rate</i>	<i>Tested</i>	<i>Target Achieved</i>	<i>Positive</i>	<i>Positivity</i>
<b>Eastern Cape</b>	2,017,693	1,784,091	85%	1,511,670	75%	177,481	12%
<b>Free State</b>	957,889	1,160,997	84%	980,936	102%	157,667	16%
<b>Gauteng</b>	3,349,084	3,174,900	98%	3,119,145	93%	598,741	19%
<b>KwaZulu-Natal</b>	3,059,234	3,686,267	79%	2,920,433	95%	561,057	19%
<b>Limpopo</b>	1,540,604	1,498,031	89%	1,332,651	87%	154,328	12%
<b>Mpumalanga</b>	1,095,823	1,123,017	94%	1,055,899	96%	224,785	21%
<b>North West</b>	998,859	1,291,355	83%	1,066,832	107%	174,113	16%
<b>Northern Cape</b>	337,941	332,935	98%	324,741	96%	28,389	9%
<b>Western Cape</b>	1,607,594	1,089,721	98%	1,063,038	66%	91,364	9%
<b>SA (Total)</b>	<b>14,964,721</b>	<b>15,141,314</b>	<b>88%</b>	<b>13,375,345</b>	<b>89%</b>	<b>2,167,925</b>	<b>16%</b>

Source: NDOH, 2011

Private sector data<sup>21</sup> indicates a further 291 230 individuals were tested for HIV and received their results in 2011. Medical Schemes only offer data for 40% of employees in the formal business sector and employers often directly fund workplace testing. The Bizwell system was launched in October 2010 to enable reporting of private sector data in support of the South African government's national HCT campaign. Bizwell provides a strategic platform for sharing sensitive company information confidentially. The system is designed to safeguard individual confidentiality and limit duplicate reporting. During this reporting period just below 100 companies and 45 service providers rendering HIV Counselling and testing services within the workplace had registered on Bizwell. Summary data is available to the public on the homepage and monthly reports are disseminated to government and stakeholders at provincial and national levels.

FIGURE 8: HIV TESTING ACHIEVEMENTS BY CAMPAIGN MONTH, 2010-2011



Source: NDOH, 2011

The HCT Programme has incorporated symptom screening for TB for all clients who present for HIV testing. Clients who have signs and symptoms of TB are tested for TB or referred to a TB health facility. Government policy is to initiate on ART clients presenting with both TB and HIV infection at a CD4 count of 350 or less. This represents a significant shift from the previous guidelines where treatment was initiated at a CD4 count of less than 200. Progress is being made on scaling-up of TB screening, but further work needs to be done to ensure a more comprehensive integration of HIV testing and TB screening.

TABLE 3: TBSCREENING DATA, 2011

Province	Screened TB	Screening Rate	Referred	Referral Rate
Eastern Cape	790,016	44%	102,300	13%
Free State	997,367	86%	113,974	11%
Gauteng	857,585	27%	182,776	21%
KwaZulu-Natal	2,292,234	62%	360,055	16%
Limpopo	321,863	21%	25,187	8%
Mpumalanga	600,122	53%	82,197	14%
North West	1,192,123	92%	117,613	10%
Northern Cape	113,081	34%	11,492	10%
Western Cape	722,815	66%	58,029	8%
<b>South Africa</b>	<b>7,887,206</b>	<b>52%</b>	<b>1,053,623</b>	<b>13%</b>

Source: NDOH, 2011

Within government departments, an enabling environment has been created within the MPSA and Public Service in general, to increase the number of employees counselled and tested for HIV, screened for TB and other non-communicable diseases. A total of 86 324 employees had participated in the HCT Campaign by 30 June 2011. However, this number is well below the intended target (14%) coverage of 675 000 employees. Testing behaviour varied by province, and the three high prevalence provinces KwaZulu-Natal, Mpumalanga and Free State had comparatively fewer people tested for HIV. Among adults, a quarter have had an HIV test and received their results.

### 3.3.6 PEOPLE LIVING WITH HIV (PLWH)

**Indicator 1.6: Percentage of young people aged 15-24 who are living with HIV (disaggregated by sex and age)**

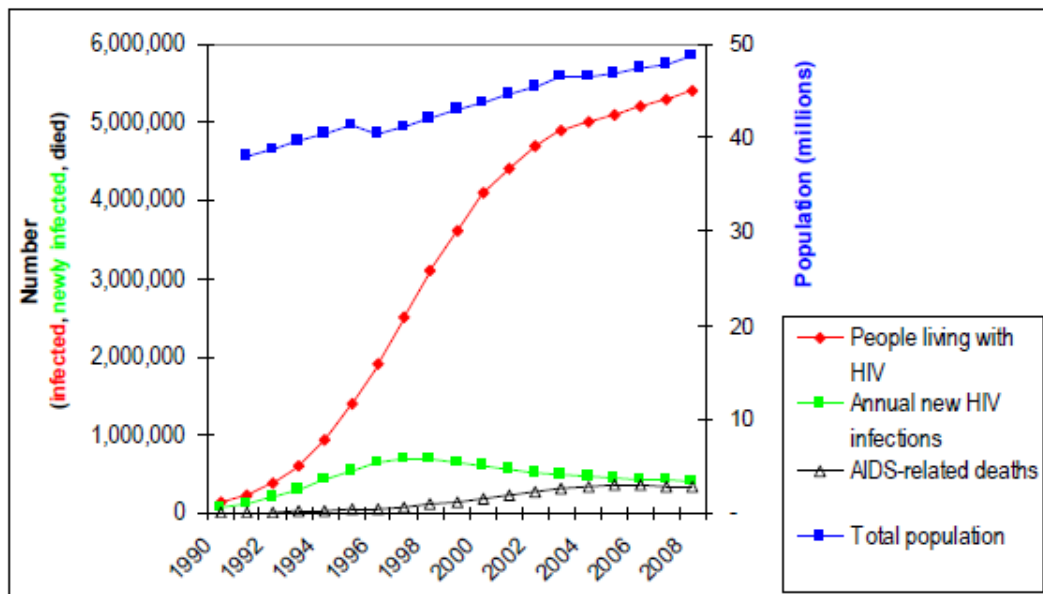
INDICATOR	DATA SOURCE	
	2010	
Percentage of young people aged 15-24 who are living with HIV		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008.  Human Sciences Research Council (HSRC) 2009
• Women and men aged 15-24	8.7%	
• Women and men aged 15-19	4.4%	
• Women and men aged 20-24	13.6%	
• Men aged 15-24	3.6%	
• Men aged 15-19	2.5%	
• Men aged: 20-24	5.1%	
• Women aged 15-24	13.9%	
• Women aged 15-19	6.7%	
• Women aged 20-24	21.1%	

(Data for 2011 were not available)

The ASSA2008 model estimated that in 2010, about 10.9% of the South African population was HIV-infected or an estimated 5.5 million HIV-positive people (ASSA, 2011 - in line with the 2009 Spectrum estimate of 5.63 million PLHIV). Although adult HIV prevalence has stabilised at about 17%, the absolute number of PLHIV is increasing by approximately 100,000 additional PLHIV each year (Spectrum estimate). This is due to the number of

annual new infections exceeding annual AIDS-related deaths, with ARV treatment prolonging the lives of PLHIV, and the denominator of HIV prevalence - population size - increasing each year. According to the new ASSA2008 model estimates, there is a substantial downturn in AIDS related mortality in recent years, with annual number of AIDS deaths reduced from about 257,000 in 2005 to about 194,000 in 2010 (ASSA, 2011). This is largely due to the expansion of the ART programme.

FIGURE 9: MODELLED ABSOLUTE NUMBERS OF PLHIV, ANNUAL NEW INFECTIONS, AIDS-RELATED DEATHS AND TOTAL POPULATION SIZE; ADULTS AGED 15-49 YEARS IN SOUTH AFRICA (1990-2008)



Source: Review of SA HIV Epidemic

There are tremendous differences in provincial HIV prevalence levels (3.8% in Western Cape to 15.8% in KwaZulu-Natal). In 2008, compared to men in Western Cape, men in KwaZulu-Natal, Mpumalanga and North West were significantly more likely to be HIV-positive. Women in Mpumalanga and KwaZulu-Natal were also significantly more likely to be HIV-positive. Provincial HIV prevalence levels appear to have stabilised between 2005 and 2009, which is in line with the trends in national HIV prevalence. There is an even greater range of HIV prevalence levels among South African districts; for example, evidence exists of localised high HIV transmission in areas such as close to national roads<sup>22</sup>.

### 3.4 KEY POPULATIONS

South Africa's HIV epidemic is generalized among the population, but the subset of groups referred to as key populations is at particularly higher risk for HIV transmission. The Human Sciences Research Council (HSRC) defines most-at-risk populations (MARPs) as those groups that have higher than average HIV prevalence when compared to the general population.

Their vulnerability to HIV infection is due to a variety of factors such as more frequent exposure to the virus; involvement in risky behaviours; potentially weak family and social support systems; marginalization; lack of resources; inadequate access to health-care services (quote source). Globally, men who have sex with men (MSM), transgender people (TG), commercial sex workers (CSW), injecting drug users (IDU), prisoners, and migrant populations are shown to be at disproportionate risk for HIV infection<sup>23</sup>. Because they are often marginalized by society and greatly affected by discrimination and stigma, these groups have become some of the most at-risk populations for HIV infection. These groups are collectively labelled “key populations”.

The definition of MARPS, however, varies from country to country, and in South Africa the new National Strategic Plan 2012-2016 has identified a very comprehensive list of key populations that are at higher risk for HIV Infection:

- Young women between the ages of 15 and 24 years are four times more likely to have HIV than males of the same age. On average, young females become HIV-positive about five years earlier than males;
- People living or working along national roads and highways;
- People living in informal settlements in urban areas have the highest prevalence of the four residential types;
- Migrant populations: The conditions associated with migration increases the risk of acquiring HIV;
- Young people who are not attending school. Completing secondary schooling is protective against HIV, especially for young girls;
- People with the lowest socio-economic status are associated with HIV infection;
- Uncircumcised men;
- People with disabilities have higher rates of HIV;
- Men who have sex with men (MSM) are at higher risk of acquiring HIV than heterosexual males of the same age;
- Sex workers and their clients have a high HIV prevalence;
- People who use illegal substances, especially those who inject drugs are at higher risk of acquiring and transmitting HIV;
- Alcohol abuse is a major risk factor for HIV acquisition and transmission;
- Transgender persons are at higher risk of being HIV-positive;
- Orphans and other vulnerable children and youth.

A lack of adequate services, in addition to several social and structural barriers that include stigma and discrimination, have significantly contributed to the disproportionate HIV prevalence present among key populations in South Africa<sup>24</sup>. By investing in the specific sexual and reproductive health needs of key populations at increased risk of HIV acquisition, the number of new infections would be reduced enormously.

Although current data from the reporting period is lacking, evidence exists that supports higher vulnerability to HIV infection among key populations, such as:

- 9.2% of all new HIV infections are related to MSM, as estimated by the South African Centre for Epidemiological Modelling and Analysis (SACEMA)

- With increased heroin trafficking in the last decade, heroin treatment demand rose from less than 1% to 7% of all treatment demand (including alcohol) between 1996 and 2006 (SACEDU 2007)
- 11% HIV prevalence among people who inject drugs was reported in the 2008 household survey (Shisana 2009)
- 19.8% of all new HIV infections are related to commercial sex work (SACEMA).

FIGURE 10: PERCENT OF NEW INFECTIONS ATTRIBUTED TO CSW, IDU, MSM AND THEIR SEX PARTNERS

	<b>Percentage of new HIV infections, group only</b>	<b>Percent of new infections, group and their partners / clients</b>
<b>CSW</b>	5.5%	19.8%
<b>IDU</b>	1.1%	1.3%
<b>MSM</b>	7.9%	9.2%
<b>Total</b>	14.5%	30.3%

Source: SACEMA

The government, together with development partners, is working to develop, support, and strengthen HIV prevention and treatment interventions aimed at some of these populations. For example, CDC South Africa is conducting a systematic review of activities targeting MARPs. National priorities for the prevention of HIV transmission among key populations include:

- Implementing community-based approaches to behaviour change, including peer education and outreach targeted at hard-to-reach groups;
- Distributing condoms and promoting correct and consistent condom use;
- Supporting innovative initiatives to promote counselling and testing and HIV rapid testing in non-clinical settings;
- Promoting sexually transmitted infection (STI) screening and treatment for all persons at high risk for HIV and STIs as part of HIV prevention, treatment and care;
- Promoting and supporting substance abuse prevention and treatment programs that target HIV-infected individuals;
- Strengthening linkages between HIV prevention and HIV treatment, care and support services.

### 3.2.1 SEX WORKERS

#### *Indicators 1.7 – 1.10: Reduce transmission of HIV in sex workers indicators*

INDICATOR	DATA SOURCE		
	2010		
Percentage of sex workers reached with HIV prevention programs	No data		
Percentage of sex workers reporting the use of a condom with their most recent client	No data		
Percentage of sex workers who have received an HIV test in the past 12 months and know their results	No data		
Percentage of sex workers who are living with HIV	No data		

- *Data for 2011 are not available*

In South Africa, there is compelling evidence that most HIV is transmitted between heterosexual partners in the general population. Survey information and qualitative research suggest that most sexual relationships are heterosexual and not same-sex relationships. Within this context is a continuum between transactional sex and commercial sex (sex in exchange for money). Women, men and transgendered persons are involved in the sex industry and in most instances; the provider is a woman and the buyer a man (Gardner, 2009). The same author writes, “Despite the industry’s criminal status, sex work has proliferated in South Africa over the last decade. Street-based sex workers are visible on major roads of every South African city, mainstream magazines feature articles on the sex industry, and newspapers generate income through advertising the services of sex workers”.

Despite this, it is difficult to find reliable statistics on sex work or the population size of sex workers in the country. This has much to do with the hidden nature of the industry and difficulties related to the definition of sex work. In Cape Town, there are just over 1,200 sex workers, according to Gould & Fick (2008), with about 250 sex workers on the streets and some 964 in brothels or working from houses or apartments. Clients of the Cape Town sex workers are a very mixed group of all ages and income groups; many of them married and over 30 years of age.

Available data indicate that sex workers have high HIV prevalence levels. In the study published by Leggett (2009), HIV levels are especially high in African FSW. The author emphasizes that information on race composition of study samples and race-specific HIV

prevalence levels is often missing in data sources, although ethnicity may be a stronger predictor of HIV prevalence than risk behaviours such as drug use or sex work per se.

In turn, men who report visiting sex workers are at increased HIV risk. The multivariate analysis of 2008 HSRC survey data showed that men who reported sex with a sex worker were 2.9 times more likely to be HIV-positive (n =13)– having had sex with a CSW almost tripled men’s odds for HIV infection. HIV prevalence estimates among sex workers in varying South African locales range from 34% to 69% (Leggett 2008, Parry 2008, Van Loggerenberg 2008, Dunkle 2005, Williams 2003, Rees 2000)<sup>25</sup>.

### 3.2.2 MEN WHO HAVE SEX WITH MEN

#### *Indicators 1.11 – 1.14: Reduce transmission of HIV in men who have sex with men indicators*

INDICATOR	DATA SOURCE	
	2010	
Percentage of men who have sex with men reached with HIV prevention programs	No data	
Percentage of men reporting the use of condom the last time they had sex with a male partner	No data	
Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results Male aged <25	27.2%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008 . Human Sciences Research Council (HSRC), 2009
Percentage of men who have sex with men who are living with HIV	9.9%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008. Human Sciences Research Council (HSRC), 2009.

(Data for 2011 were not available)

Whilst HIV infection among MSM was a focus in the early phases of the epidemic in South Africa, there is very little known about the HIV epidemic amongst MSM in the country. MSM has also not been considered largely in national HIV and AIDS interventions. Biologically, MSM who practice receptive anal intercourse have an elevated risk for HIV infection. MSM practices are also 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. In spite of inclusion with the NSP, towards the end of 2009, there had been no Government initiative to achieve goals, and there are no comprehensive surveillance studies for MSM in South Africa. There has been no Government initiative to develop a programme for customized prevention packages, promotion of VCT, provision of appropriate barrier methods, and for the integration in care/treatment and support programmes. Furthermore, there has been no significant (if any) Government funding to put in place such initiatives.

Table 4 shows the most recent data about HIV prevalence among MSM in South Africa, from the 2011 *Know your Epidemic Report*.

TABLE 4: RECENT HIV PREVALENCE DATA FROM MEN HAVING SEX WITH MEN IN SOUTH AFRICA (2008-2009)

HIV Prevalence (95% CI)	Characteristics of Sample	Source
<b>47%</b>	Men with anal experience, aged 18-58 years, in Soweto, Gauteng	Lane et al, 2009
<b>43.6% (37.6-49.6)</b>	MSM from Johannesburg and Durban, (n=285)	Rispel et al, 2009
<b>35%</b>	MSM in Cape Town, Durban, Pretoria, (n=37)	Parry et al, 2008
<b>34%</b>	Self-identified MSM from peri-urban townships in Cape Town, (n=200)	Burrell et al, 2009
<b>13.9%</b>	MSM in Gauteng, KwaZulu-Natal and Western Cape, (n=1021). Self-reported sero-prevalence among the 732 MSM who reported having been tested	Sandfort et al, 2008
<b>10%</b>	Self-identified MSM from urban areas in Western Cape, (n=542)	Burrell et al, 2009
<b>9.9% (4.6-20.2)</b>	National sample, (n=86)	Shisana et al, 2008

Source: KYE, 2011

Local non-governmental organisations conduct the bulk of HIV Prevention work, which tends to be limited in scope and number. The following LGBT service organizations are involved in HIV prevention and service delivery, research and advocacy:

- OUT Lesbian/Gay/Bisexual/Transgender (LGBT) Well-being services Pretoria and includes medical, advocacy, prevention and research programmes;
- The Triangle Project services Cape Town and includes medical, advocacy, prevention and research programmes;
- Health4Men services is based in Cape Town and includes medical, advocacy, prevention and research programmes;
- The Desmond Tutu HIV Foundation services Cape Town and include medical and research services;
- The Durban Gay and Lesbian Centre services Durban and include prevention, research and advocacy programmes.

These five organisations also do limited mainstreaming of LGBT/MSM/WSW issues in an attempt to sensitise relevant service providers to the need for responsive and appropriate public health services for MSM. Because many mainstream health service providers assume

that everyone is heterosexual, it is difficult for MSM/WSW to openly discuss their same-sex sexual encounters and specific reproductive health needs.

Many of the LGBT groups operate on small budgets and have restricted resources to achieve needed delivery, advocacy, mainstreaming and research (source?). The recent addition of a LGBT Sector to the South African National AIDS Council is hoped to further these priorities and make available resources.

**TARGET 2: REDUCE TRANSMISSION OF HIV AMONG PEOPLE WHO INJECT DRUGS BY 50% BY 2015**

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**3.5 INJECTING DRUG USERS**

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***Indicators 2.1 – 2.5: Reduce transmission of HIV in among people who inject drugs indicators***

INDICATOR	DATA SOURCE
Number of syringes distributed per person who injects drugs per year by needle and syringes programmes	
Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	
Percentage of people who inject drugs who report using sterile injecting equipment the last time they injected	
Percentage of people who inject drugs that have received an HIV test in the last 12 months and know their results	
Percentage of people who inject drugs who are living with HIV	

*(Data for 2010 and 2011 are not available)*

South Africa currently addresses the inter-linkage between IDU and HIV as a component within a broader substance abuse strategy. Regulations under the Prevention of and Treatment for Substance Abuse Act (No 70 of 2008) were drafted and submitted for consultation with stakeholders in all nine provinces<sup>26</sup>. A substance abuse prevention model for adults was approved, and development of the treatment model continued. The International Day against Drug Abuse and Illicit Trafficking was observed in the Eastern Cape and community mobilisation programmes were launched in the Northern Cape in October 2010.

The second Biennial Summit on Substance Abuse was held in KwaZulu-Natal in March 2011. It produced resolutions guiding the development of a national drug master plan and the Programme of Action for combating substance abuse.

Despite the recent efforts above, very little data is available in South Africa on IDU, and HIV prevalence among IDU is unknown. The most recent data, based on small sample sizes, show HIV prevalence among IDUs ranging from 11%<sup>27</sup> to 20%<sup>28</sup>. These studies also reported 86% of South Africans who do inject drugs, share injection equipment, not only syringes but also other drug paraphernalia needed for preparing the drug for injection -- and 65% of them practice unsafe sex<sup>29</sup>.

The use of contaminated drug injecting equipment bears a high risk for transmitting HIV; and as the research above shows, IDU are often linked to other risky practices such as sex work or unsafe sexual practices. Injecting equipment is sometimes shared, re-used, inadequately cleaned and poorly disposed of<sup>30</sup>; the re-use of needles and syringes by IDUs is common, with some re-using equipment at least 2 or 3 times and up to 15 times. These sharing and needle disposal practices put IDUs and others at risk for contracting HIV. The IRARE study also showed a strong relationship between drug use and risky sexual practices<sup>31</sup>, for example:

- Informants reported that with the exception of heroin, drugs generally increased sexual desire and improved sex, but led to impotence if too much was consumed. Heroin was not often used with sex. High-risk sexual behaviour was generally linked to drug use and people were less cautious when on drugs;
- Many interviewees reported having sexual relations with a number of partners, such as strangers, sex workers, clients, drug dealers, friends, girlfriends/boyfriends and spouses, and having group sex. Sexual mixing across sub-populations and into the wider community was highly prevalent.

Among IDUs assessed in the IRARE, there was a widespread lack of awareness about where to access HIV treatment and preventive services, and numerous barriers to accessing appropriate HIV and drug-intervention services were reported.

**TARGET 3: ELIMINATE MOTHER-TO-CHILD TRANSMISSION OF HIV BY 2015  
AND SUBSTANTIALLY REDUCE AIDS-RELATED MATERNAL DEATHS**

**3.6 PREVENTION OF MOTHER-TO-CHILD TRANSMISSION**

**Indicator 3.1: Eliminate mother-to child transmission of HIV indicators**

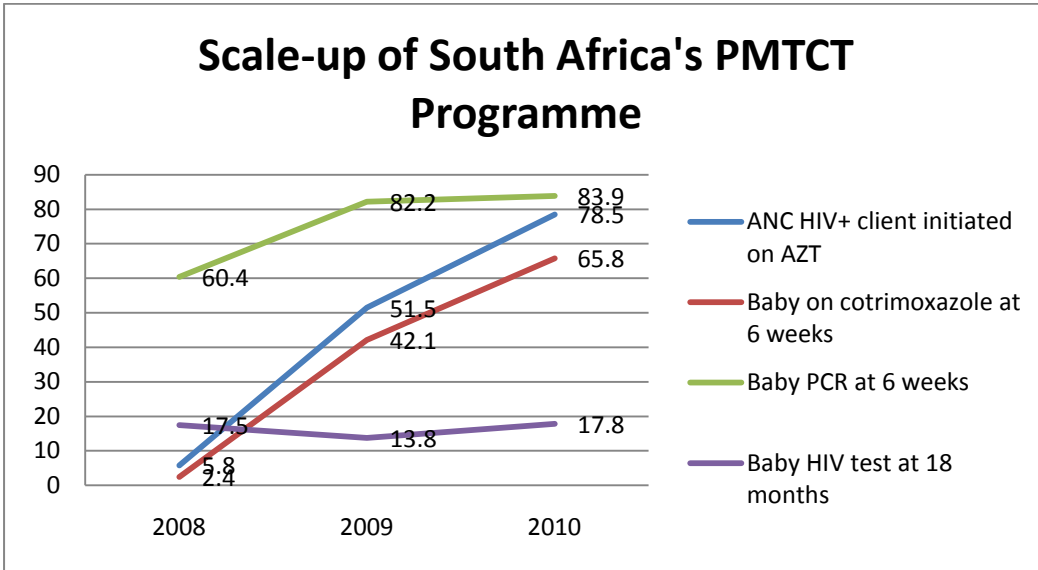
INDICATOR	DATA SOURCE		
	2010	2011	
Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission	87.3%	87.1%	Numerator: DoH PMTCT Programme, Discovery Health, Aid for AIDS, GEMS <sup>32</sup>  Denominator: ASSA

Since 2008, South Africa has rapidly scaled-up its PMTCT and Early Infant Diagnosis (EID) programmes. By 2010, PMTCT was offered at 98% of health facilities. The national HCT Campaign also played a strong role in engaging pregnant women for HIV testing --about 274,000 pregnant women were tested at ANC facilities by June 2011. In 2010 the South African government revised the PMTCT guidelines to include AZT from 14 weeks, HAART for all pregnant women with CD4 cell counts less than or equal to 350, and infant nevirapine prophylaxis for six weeks (if the mother is on HAART or not breastfeeding) or throughout the breastfeeding period. Furthermore, the PMTCT guidelines promote the integration of PMTCT services into routine maternal, newborn, and child health services<sup>33</sup>.

The available data from both public and private sources show that around 87% of women are receiving ART, up from 83% in 2009. South Africa's PMTCT Acceleration Plan (A-Plan) has contributed to this achievement. The A-Plan – an intensive health systems improvement plan coordinated between Government, donors, NGOs and health workers – has used a two-pronged approach of raising the quality and coverage of PMTCT services and implementation of social mobilisation strategies to promote better understanding, demand and uptake of services by pregnant women.

Figure 11 shows that among infants exposed to HIV, 84% received a PCR test at 6 weeks, 66% were given cotrimoxazole at 6 weeks, and 18% had an HIV antibody test at approximately 18 months.

FIGURE 11: PERCENT COVERAGE OF NATIONAL PMTCT AND EARLY INFANT DIAGNOSIS PROGRAMMES, 2008-2010



Source: DHIS, March 2011

**Indicator 3.2: Eliminate mother-to child transmission of HIV indicators**

INDICATOR	DATA SOURCE		
	2010	2011	
Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	39.2%	54.4%	Numerator: NHLS, Discovery Health, Aids for AIDS, GEMS Denominator: ASSA

The PMTCT programme in South Africa involves a series of interventions at various stages of pregnancy and during and after birth. The proportion of infants born to HIV-positive mothers who test HIV-positive within 2 months of birth is an important indicator of the success of comprehensive PMTCT programmes, as effective PMTCT programmes will reduce the proportion of babies who become HIV-infected. Data from the National Health Laboratory Service (NHLS) show a 15% increase from 2010 (39.2%) to 2011 (54.4%) in the percentage of infants testing for HIV within 2 months of birth.

**Indicator 3.3: Eliminate mother-to child transmission of HIV indicators**

INDICATOR	DATA SOURCE		
	2010	2011	
Mother-to-child transmission of HIV (Modelled) -Estimated percentage of child HIV infections from HIV positive women delivering in the past 12 months	3.5%	No data	MRC, The National South African PMTCT Evaluation, 2010

Indicator 3.3 is designed to be modelled from Spectrum; however, data collected from the 2010 National South African PMTCT Evaluation was used. This was a cross-sectional facility based survey conducted at immunisation points at public Primary Health Care/Community Health Centres (PHC/CHC) in all nine provinces. Since this was a randomised study and immunisation uptake at 6 weeks is >99% in South Africa, this is probably the most current and reliable data available on Mother-to-Child Transmission. The study found a national HIV transmission rate of 3.5%. Table 5 shows the varying transmission rates among provinces

The 2010 evaluation will serve as a baseline to monitor the effectiveness of the antenatal and intrapartum aspects of the National PMTCT Programme (i.e., early Mother-to-Child Transmission (MTCT) rates). The survey will be repeated in 2011 and 2012 during which postnatal transmission will also be measured.<sup>34</sup>

TABLE 5: WEIGHTED INFANT HIV EXPOSURE AND 4-8 WEEK (EARLY) MOTHER TO CHILD TRANSMISSION OF HIV (MTCT) RESULTS BY PROVINCE, 2010

Province	Infant HIV exposure %	MTCT (%)
Eastern Cape	30.5	4.7
Free State	31.3	5.9
Gauteng	30.4	2.5
KwaZulu Natal	44.3	2.9
Limpopo	23.9	3.6
Mpumalanga	37	5.7
Northern Cape	16	1.4
Northwest	31.3	4.4
Western Cape	21	3.9
<b>South Africa</b>	<b>32</b>	<b>3.5</b>

Source: SAPMTCTE, 2011

Another data source considered was data from the HIV PCR report for monitoring early infant diagnosis within the PMTCT programme from the NHLS. To achieve this result, the number of infants testing PCR positive was calculated out of the total number of infants tested for PCR at  $\leq 2$  months of age. These data show a decrease in transmission rates from 4.3% in 2010 to 2.8% in 2011. Despite whichever figure is used, all indications are that MTCT is significantly decreasing in the country. The 2010 country report for South Africa had

reported a 16% transmission rate (modelled by Spectrum) and available PCR data at that time showed a transmission rate of around 11%.

**TARGET 4: HAVE 15 MILLION PEOPLE LIVING WITH HIV ON ANTI-RETROVIRAL TREATMENT BY 2015**

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**3.7ART TREATMENT**

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**Indicators 4.1: Percentage of eligible adults and children currently receiving Antiretroviral therapy (disaggregated by sex and age)**

INDICATOR	DATA SOURCE		
	2010	2011	
Percentage of eligible adults and children currently receiving Antiretroviral therapy	58.3%	75.2%	NDoH DHIS; 2010 HERO model's estimate of persons in need of ART <sup>3</sup>

Rollout of antiretroviral therapy (ART) continues to be successful, with 1.8 million persons ever started on ART since the commencement of the treatment programme. Treatment initiation rates have reached 30,000 per month on average. This can be attributed to the revision of the treatment guidelines in 2009 which increased the threshold for ART treatment in pregnant women and patients co-infected with TB and HIV to CD4+ count 350, and the provision of safer and effective antiretroviral therapy regimens for adults and children.

Health systems strengthening efforts that supported the expansion of access to treatment was the implementation of Nurse Initiated Management of ART (NIMART). Over 10,000 professional nurses have since been trained to imitate and managed ART.

The rapid expansion of access to ART in South Africa -- the largest HIV treatment programme in the world -- is not without its challenges. Some of these include multiple monitoring systems that vary from province to province. The NDoH has developed a new 3-tiered patient-based monitoring system for ART, which is being implemented throughout the country in phases. This will enable certain health facilities with larger numbers of ART patients the use of an electronic monitoring system.

**Indicator 4.1: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of therapy. (No national data available except from one province)**

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<sup>3</sup> 2010 calculation: 1,400,377 (includes 1318028 public sector and 82349 private sector) / 2.4 million. 2011 calculation: 1,804,480 (includes 1703907 public sector and 100573 private sector) / 2.4 million. Denominator used is the 2010 HERO model's estimate of persons in need of ART: StatsSA estimate of 2.4 million at CD4 count of </=350.



Private sector data indicates around 86% survival rate of adults and children who are on ART, following 12 months of the initiation of therapy. Discovery Health reported an increase in survival rates among its patients by 8% in the last two years, from 76% in 2010 to 84% in 2011.

**TARGET 5: REDUCE TUBERCULOSIS DEATHS IN PEOPLE LIVING WITH HIV  
BY 50% BY 2015**

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***Indicator 5.1: Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV***

INDICATOR	DATA SOURCE		
	2010	2011	
% of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	65%	No data	<u>Numerators:</u> ETR.Net: TB/HIV Collaborative Activities Report 2010 (Using provincial Q4/2011)  <u>Denominator:</u> WHO Report, 2011

Tuberculosis (TB) is a major public health problem and South Africa is one of the twelve TB high burden countries globally. The high proportion of TB-HIV co-morbidity in this country, which is currently estimated to be 73%, exacerbates this. Managing TB needs multi-pronged strategies that deal with personal health services and public health to prevent the spread. The TB strategies include: health education to raise awareness on how the disease is spread; social mobilisation and case finding to track those who might be defaulting on treatment and those exposed due to contact with an TB infected person; and treatment through the directly observed treatment strategy (DOTS) which is a WHO and NDoH health policy.

For social mobilisation, one of the key areas of success was in improving the TB treatment completion rate and decreasing the proportion of TB patients that default from treatment. During 2010/2011, 74% of patients successfully completed their treatment, against a target of 75%. Furthermore, only 7.9% TB patients defaulted from treatment, which was consistent with the 2010/2011 target.

Drug resistant TB in the form of MDR and XDR TB is becoming more prevalent. The strategy for this public health problem in South Africa is through designating facilities specifically for the management of these types of TB. To this end, nineteen facilities (over the target of 15 facilities) were designated for drug resistant TB in 2010/2011.

TB detection is currently based on microscopy (for drug susceptible TB) and culture (for drug-resistant TB). diagnose TB with simultaneous detection of Rifampicin resistance (a good indicator of drug-resistant TB). This technology, called, has high sensitivity in both smear-positive as well as smear-negative, culture positive individuals. TB culture results are available on average 35 days after the sputum is taken. The TB Programme acquired thirty GeneXpert MTB/Rif machines, and an additional 17 will be procured over the next few months in order to achieve a target of at least one GeneXpert machine in each of the 52 health districts. This new technology, endorsed by the World Health Organisation (WHO), can diagnose TB with simultaneous detection of Rifampicin resistance (a good indicator of drug-resistant TB). The high sensitivity of this new technology can detect in both smear-positive as well as smear-negative, culture positive individuals, and should increase TB case notification as it is rolled out..

**TARGET 6: REACH A SIGNIFICANT LEVEL OF ANNUAL GLOBAL EXPENDITURE (BETWEEN \$22 BILLION AND \$24 BILLION) IN LOW AND MIDDLE INCOME COUNTRIES**

***Indicator 6.1: Domestic and international AIDS spending by categories and financing sources***

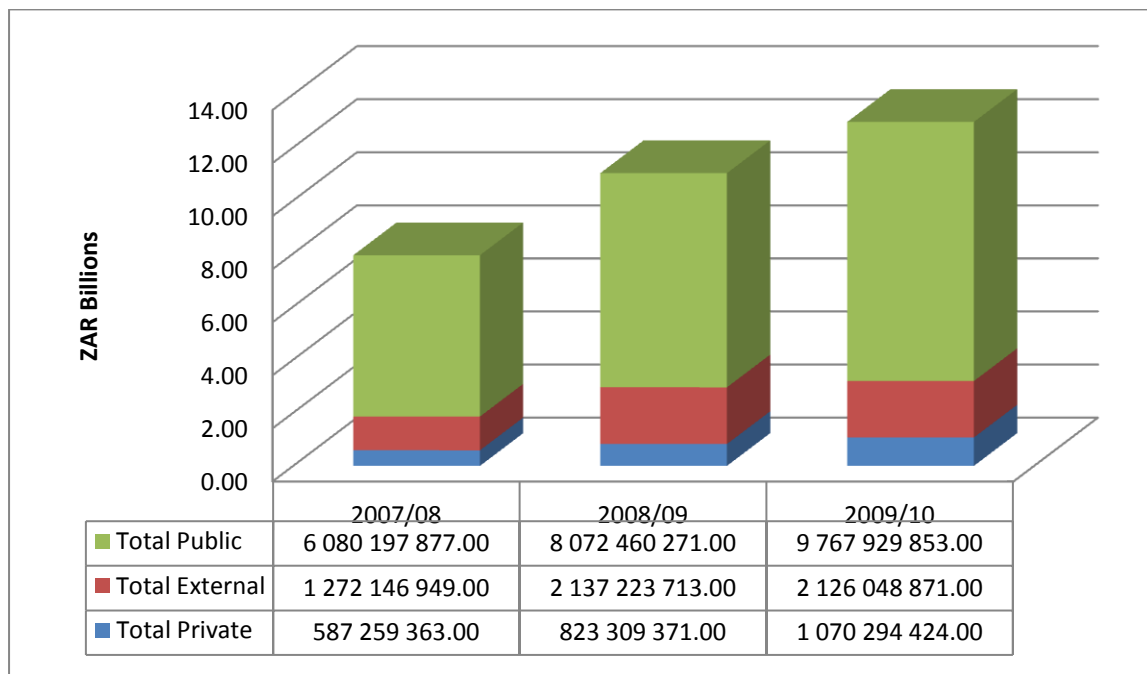
INDICATOR	DATA RESULTS	DATA SOURCE
Domestic and international AIDS spending by categories and financing sources		2009 National AIDS Spending Assessment (NASA)
Total	ZAR 18,678,509,395	
Public/Domestic	ZAR 15,481,920,391	
International	ZAR 2,126,294,580	

South Africa is facing a major and mounting financial challenge as it strives to respond to the HIV/AIDS epidemic in the country<sup>35</sup>. The funding needed to respond to HIV/AIDS on three critical fronts—for prevention, treatment, and care of orphans and others affected by AIDS—is continuing to escalate rapidly, especially as hundreds of thousands of additional South Africans enter ART programmes. This situation poses huge financial dangers and risks for the country, particularly at a time when South Africa is feeling the negative effects of the global economic recession and is struggling to maintain its government budget for a wide range of pressing needs, beyond HIV and AIDS.

On the financial front, there are some positive signs. The South African government has progressively allocated new resources to fund the response to HIV and AIDS in the 2009/10–2011/12 medium term period through conditional grants and equitable share allocations. SA has sourced an additional R900 million from PEPFAR for the AIDS Treatment programme, to cover a budget shortfall expected in 2009/10. In 2007/08, South Africa spent almost R8 billion on HIV/AIDS and TB, which increased by 39% to R11 billion in

2008/09<sup>36</sup>. In 2009/10, the amount increased again by 18% to reach R13 billion (US\$1.6 billion).

FIGURE 12: TOTAL FUNDING & SOURCES FOR HIV/AIDS/TB IN SA (ZAR, 2007/08-2009/10)



Source: Draft NASA Report, 2012

Survey challenges have resulted in some loss of data and the NASA has estimated that approximately 85% of the total country's spending has been captured. In addition, the costs of in-patient and outpatient treatment of opportunistic infections (OIs) delivered by the Department of Health (DOH) could not be included, since the cost components (tests, drugs, salaries etc.) were not labelled as HIV-specific. This was particularly true for out-patient TB treatment and in-patient TB treatment in general hospitals (although TB treatment in TB hospitals was captured and included). It is estimated that an additional R5.1 billion, R5.4 billion and R5.7 billion were spent in 2007/08, 2008/09 and 2009/10 respectively by the Department of Health in the treatment of Opportunistic Infections (OIs) related to HIV-infection. These OI expenditure figures have not yet been validated, but they suggest that total HIV and AIDS spending, and particularly public sector expenditure, may have been substantially higher than NASA estimates.<sup>37</sup>

TABLE 6: SOURCES OF ALL HIV AND TB SPENDING IN SOUTH AFRICA (ZAR, 2007/08 - 2009/10)

SA HIV Sources	2007/08 (ZAR)	2008/09 (ZAR)	2009/10 (ZAR)	2009/10 (US\$)	2009/10 %
Total Public	6,080,197,877.00	8,072,460,271.00	9,767,929,853.00	\$ 1,217,976,739	75.3%
Total External	1,272,146,949.00	2,137,223,713.00	2,126,048,871.00	\$ 265,099,986	16.4%
Total Private	587,259,363.00	823,309,371.00	1,070,294,424.00	\$ 133,456,498	8.3%
<b>Total SA Sources</b>	<b>7,939,604,189.00</b>	<b>11,032,993,355.00</b>	<b>12,964,273,148.00</b>	<b>\$ 1,616,533,224</b>	

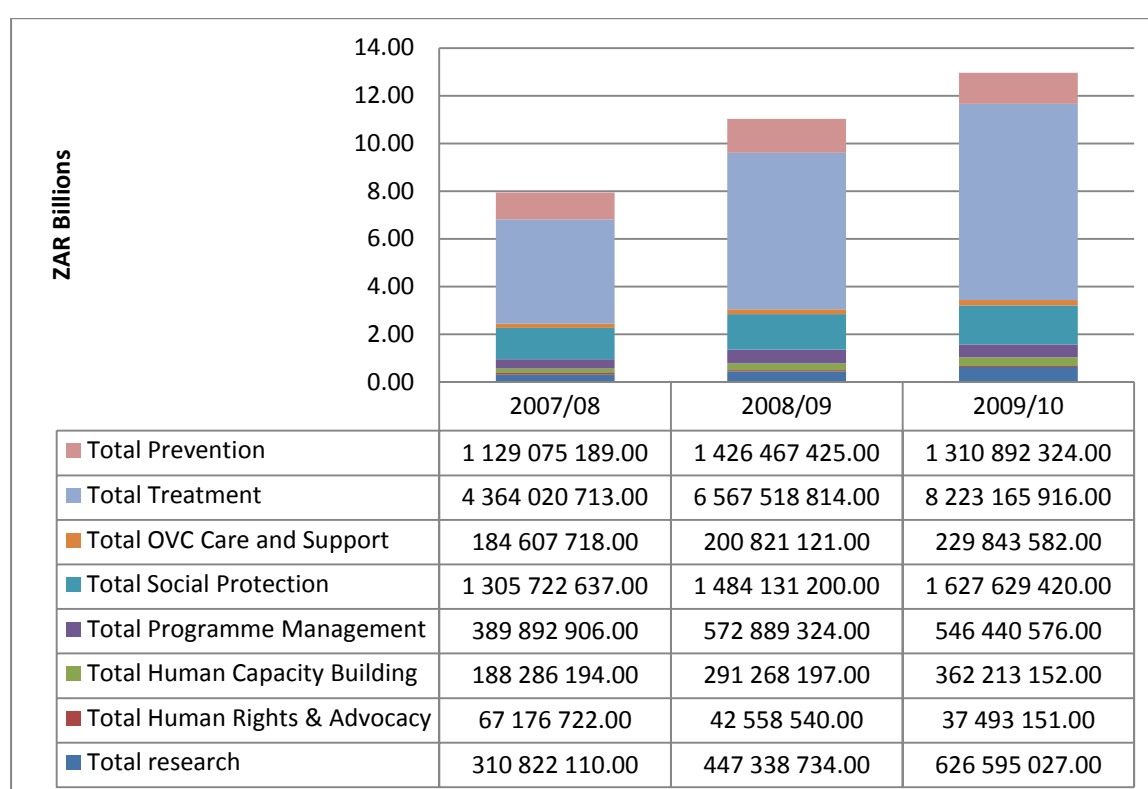
Source: Draft NASA Report, 2012

In 2009/10, public sources contributed on average 75.3% of total HIV/AIDS funds, while external and private sources contributed 16.4% and 8.3% respectively. The contribution from public funds averaged 74% throughout the three-year period, but varied significantly within

the provinces, with the highest contribution being in Free State at 90% in 2009/10, and the lowest at the national level where external partners contributed 65% of the total, the public 26%, and the private sector only 9%. Over the three-year period, public funding increased by 27% on average, from R6 billion in 2007/08 to R8 billion in 2008/09, and reaching R9.8 billion (US\$1.2 billion) in 2009/10. The external aid rose dramatically, by 68% between 2007/08 and 2008/09 from R1.3 billion to R2.14 billion. However, in 2009/10, external aid actually declined slightly by 1% to R2.13 billion (US\$ 265 million).

Most of the HIV/AIDS and TB funds in SA were spent on treatment activities in all three years. In 2009/10, 63.4% of total funds went to treatment – including antiretroviral treatment (ART), home-based care (HBC), palliative care, sexually transmitted illnesses (STIs) and TB treatment, etc. – followed by social protection, which included a proportion of the Child Support Grant (12.6%), prevention interventions (10.1%), research (4.8%), and programme management and co-ordination (4.2%). The remaining categories were: care for orphans and vulnerable children (OVC) receiving only 1.8% (in addition to the Foster Care Grant and the Child Support Grant), enabling environment (human rights protection, advocacy, etc.) receiving 0.3%, and human resource capacity-building (training, etc.) receiving only 2.8% of the total HIV/AIDS and TB spending in 2009/10 in South Africa.

FIGURE 13: TOTAL SA HIV/AIDS & TB SPENDING ACTIVITIES – ALL SOURCES (2007/08-2009/10)

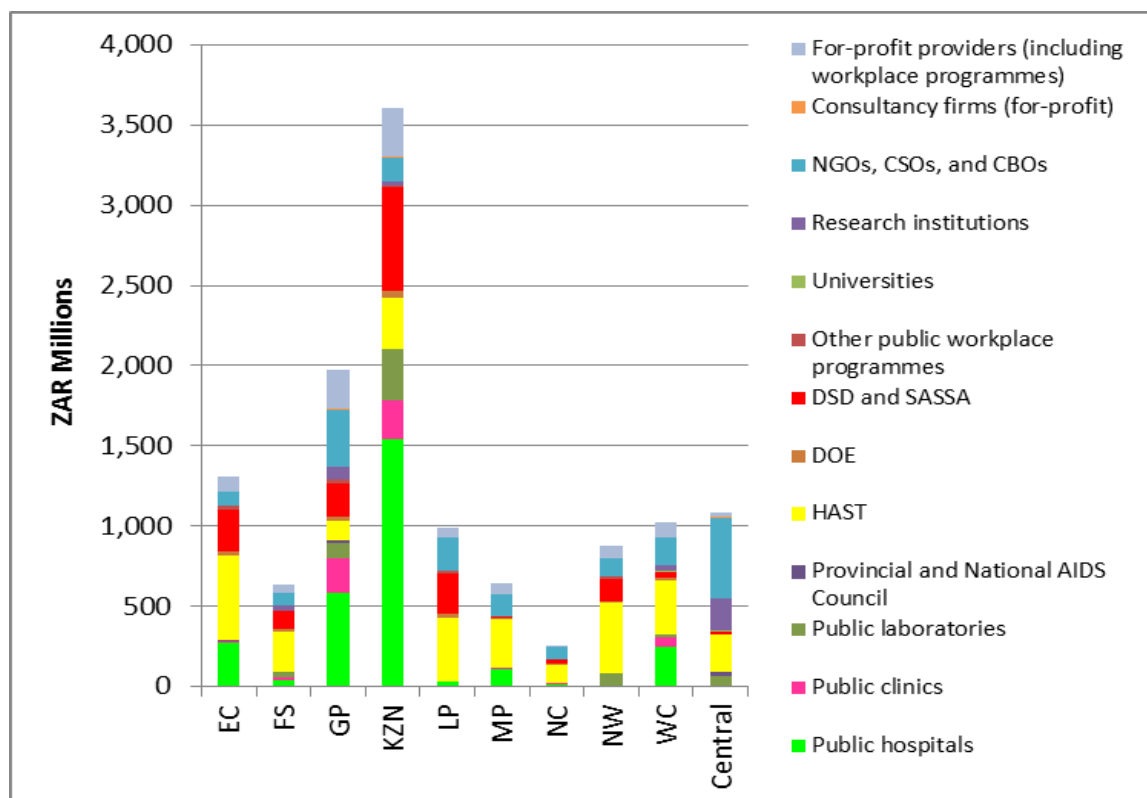


Source: Draft NASA Report, 2012

The bulk of HIV/AIDS and TB services in SA was provided by public entities, spending R9.2 billion (US\$1.1 billion), or 70.6% of the total expenditure in 2009/10. Private service providers (including NGOs and the private health services) spent R3.7 billion (US\$ 467 million), or 28.9% of the total in 2009/10, and external entities spent only 0.5%, or R64

million (US\$8 million), in 2009/10. The largest providers were the provincial Departments of Health, mainly the HIV and AIDS/STI/TB (HAST) Units at 23.5%, the hospitals at 22.1%, with NGOs, CBOs and CSOs also at 15.9%, followed by the Department of Social Development (DSD), and the South African Social Security Agency (SASSA) lumped together at 13% of the total in 2009/10<sup>38</sup>.

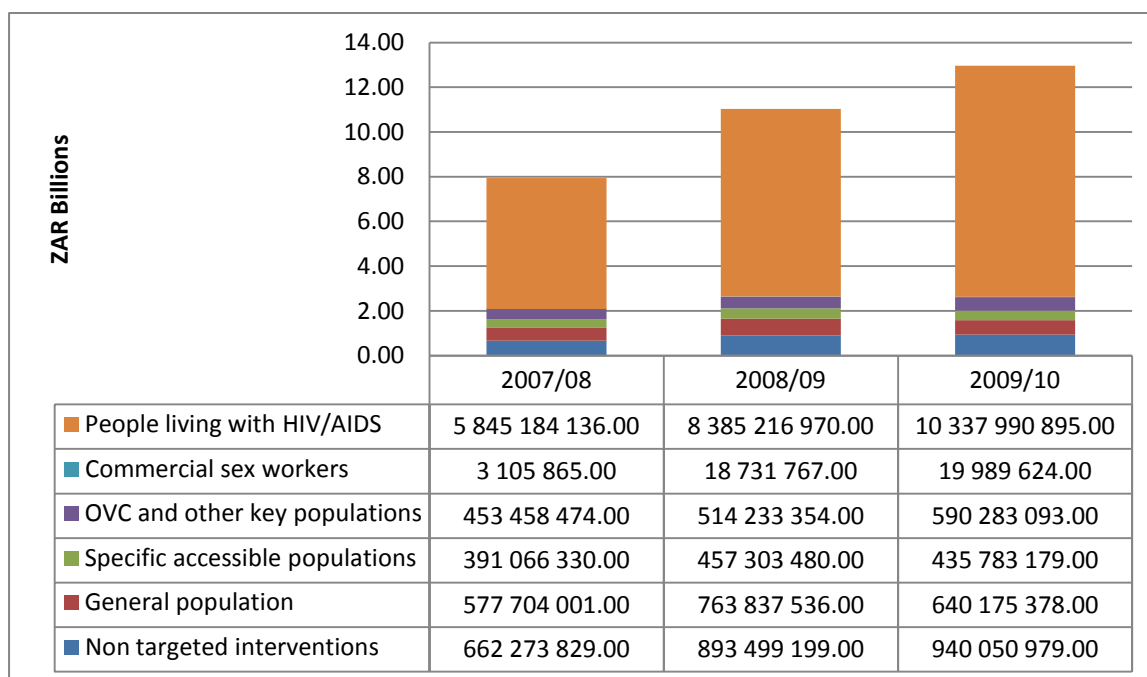
FIGURE 14: PROVINCIAL & CENTRAL HIV/AIDS & TB SERVICE PROVIDERS (RM, 2009/10)



Source: Draft NASA Report, 2012

According to the NASA Report (2012) people living with HIV/AIDS (PLWHA) were the primary beneficiaries of HIV/AIDS and TB expenditure in South Africa. This is as a result of the significant spending on antiretroviral therapy (ART) and other treatment and care activities. In 2009/10, R10.3 billion (US\$1.3 billion) or 79.7% of total HIV/AIDS and TB spending was on programmes targeted to PLWHA. Key vulnerable groups, such as OVC, truck drivers, prisoners and children born (or to be born) of women living with HIV, benefited from R590 million (US\$ 74 million), only 4.6% of the total spending in 2009/10. Accessible populations, such as youth-in-school – through the Department of Education (DOE) Life-Skills programme – and healthcare workers – through post-exposure prophylaxis (PEP) services – benefited from 3.4% (R436 million or US\$54 million) in 2009/10. Interventions targeting commercial sex workers (CSW) had only R20 million (US\$ 2.5 million), or 0.2%, of total spending in 2009/10. Spending on interventions targeting men-who-have-sex-with-men (MSM) and intravenous drug users (IDU) could not be found. Spending on non-targeted interventions formed 7.3% of the total (R940 million, US\$117 million), and general population interventions amounted to 4.9% (R640 million or US\$80 million).

FIGURE 15: BENEFICIARIES OF HIV/AIDS SPENDING IN SA (EXCLUDING PLWHA)



Source: Draft NASA Report, 2012

One of the key recommendations made in the NASA Report is the need for South Africa to increase the priority given to prevention: The NASA Report notes that spending on prevention in South Africa actually decreased in 2009/10 by 8%. In order to reduce the number of persons needing treatment, it is vital that budgets are increased for those key prevention interventions that have been shown to have the greatest impact. Medical male circumcision, and, potentially, the microbicides currently under development, could reduce HIV transmission rates significantly. Prevention of mother-to-child transmission (PMTCT), condoms and post-exposure prophylaxis (PEP) remain effective interventions to be expanded, and while it may be difficult to prove the effectiveness of social mobilisation, advocacy and behaviour change campaigns, they are nevertheless “critical enablers”, without which the impact of biomedical interventions is reduced. At the same time (according to recent research findings), expanding access to ART will also reduce the levels of infectivity of HIV-positive patients.

## TARGET 7: CRITICAL ENABLERS AND SYNERGIES WITH DEVELOPMENT SECTORS

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### 3.8 NATIONAL POLICY ENVIRONMENT

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South Africa's National Strategic Plan 2007-2011 was reviewed during the reporting period and detailed findings and recommendations were outlined in the End of Term Review. This Review provided the platform for the development of the new National Strategic Plan (NSP) for the period 2012-2016. The new NSP was developed through wide multi-sector consultation. The NSP 2012-2016 included some modifications and incorporated key populations. The multi-sectoral Operational Plan includes formal programme goals, clear targets, detailed costs for programmatic areas, as well as an indication of funding sources to support programme implementation and a Monitoring and Evaluation framework. The civil society was actively involved in the development of the multi-sectoral strategy.

There is strong political support for the national HIV response led by the Presidency, Ministry of Health and other government Ministries. . The country has mechanisms to promote interaction between government, civil society organizations, and the private sector for the implementation of HIV strategies/programmes. Between 5 and 10% of the national HIV budget in 2011 was channelled through activities undertaken by civil society organisations. The country reviewed national policies and some examples of amendments are included in the completed NCPI (annex). Government officials ranked very high (9 out of 10) in terms of the political support for the HIV programme in 2011. The civil society representatives consider that the Government does involve people living with HIV, key populations and other vulnerable sub-populations in governmental HIV policy design and programme implementation through political and financial support.

### 3.9 GENDER-BASED VIOLENCE

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No data was available for the indicator 7.1: Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months.

The principle of gender equality is enshrined as a fundamental right in the Constitution of South Africa(1996) and since 1994 there have been major advances for women in certain areas, most notably in the political and legal spheres (ICRW, 2008). In South Africa, the gender hierarchy and dominant constructions of South African masculinities legitimate the control of women (Jewkes et al., 2009).

It is increasingly recognised that intimate partner violence has significant impact on women's physical, reproductive and sexual, and mental health (Campbell, 2002; Garcia-Moreno et al., 2006). Refusing sex, inquiring about other partners, or suggesting condom use have all been described as triggers for intimate partner violence; yet all are intimately connected to the behavioural cornerstones of HIV prevention (e.g. Maman et al., 2000). Perpetrators of

violence themselves are an unlikely but crucially vulnerable group, many of whom live in wider contexts of risk, such as substance abuse (Jewkes et al., 2006).

Due to prevalent violence, young people in South Africa are exposed to a culture of sexual violence. The number of HIV infections transmitted during rape per annum in South Africa has been estimated at 100-300 (Jewkes et al., 2009). This estimate assumes an annual number of rape cases of 28 228 adults and 17 597 children (extrapolated figure from case report register), and an HIV transmission probability of 0.003 in the absence of genital injury, and 0.1-0.03 in the presence of a genital injury). The number appears small in an epidemic of about 400 000 new infections (2008 estimate by Spectrum), but the South African Police Service estimates that only one in every 35 raped women actually report the rape and that most report to clinics or hospitals, not police. At the individual level, a positive relationship has been identified between perpetration of violence and HIV infection(Dunkle et al. 2004).

The Victims of Crime Survey (2011) contains questions about victims' of assault and sexual offences knowing their perpetrators<sup>39</sup>. The data shows that a large proportion (29.9%) of the victims (from selected individuals) of assault was attacked by a known community member(s) from the area, followed by those attacked by their spouse or partner (20.9%), while only 10.5% stated that the perpetrators were an unknown community member. 9.4% were assaulted by a relative. When it comes to sexual offences, 38.4% of victims were victimised by a known community member.

The South Africa Police Services (SAPS) Crime Report (2011) covers data on sexual offences, but the figures not disaggregated further and therefore do not provide a clear picture of intimate partner violence<sup>40</sup>. The Report notes a ratio decrease of -4.4%, from 138.5 sexual offences per 100 000 of the RSA population in 2009/2010 to 132.4 per 100 000 in 2010/2011. This represents a decrease of 2 136 cases, from 68 332 to 66 196. This is an exact repeat of the -4.4%ratio decrease recorded in 2009/2010<sup>41</sup>.

The number of social contact or violent crimes committed against adult women and children of both genders under the age of 18 (meaning up to the age of 17 years, 364 days, 23 hours and 59 minutes) are provided in Table 7. With the exception of the murder of adult women and sexual offences against children (younger than 18 years) all the other social contact crimes against women and children decreased. This is in quite sharp contrast to 2009/2010, when in most cases significant increases in social contact crimes against women and children were recorded.

TABLE 7: CRIMES AGAINST WOMEN OF 18 YEARS AND OLDER: 2006/7 – 2010/11

Crime Category	2006/7	2007/9	2008/9	2009/10	2010/11	Differences 2010/2011 vs. 2009/2010	% Increase/ decrease
<b>Murder</b>	2 602	2 544	2 436	2 457	2 594	137	5.6%
<b>Attempted murder</b>	3 362	3 016	2 996	3 008	2 842	-166	-5.5%
<b>All sexual offences</b>	34 816	31 328	30 124	36 093	35 820	-273	-0.8%
<b>Common assault</b>	100 390	94 286	91 390	94 176	89 956	-4 220	-4.5%
<b>Assault GBH</b>	66 132	64 084	6 150-	62 143	60 630	-1 513	--2.4%
<b>Total</b>	210 302	195 258	188 425	197 877	191 842	-6 035	-3.0%



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### 3.10 ORPHANS AND VULNERABLE CHILDREN

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**Indicator 7.3: Current school attendance among orphans and non-orphans (10-14 years old, disaggregated by age)**

INDICATOR	DATA SOURCE	
	2010	
Current school attendance among orphans and non-orphans aged 10-14	99.6%	Statistics South Africa, General Household Survey, 2010
<u>Part A</u>		
• Orphan boys and girls aged 10-14		
• Orphan <b>boys</b> aged 10-14	99.6%	
• Orphan <b>girls</b> aged 10-14	100%	
<u>Part B</u>		
• Non-orphan boys and girls aged 10-14	99.1%	
• Non-orphan boys aged 10-14	99.0%	
• Non-orphan girls aged 10-14	99.1%	

(No data available for 2011)

The education system in South Africa has contributed significantly to the achievement of objectives within the second pillar of the NSP, *Treatment, Care and Support*. Accordingly, the education system has worked to increase care and support for OVC through strengthening the implementation of OVC policy and programmes. The Department of Basic Education has also been playing a lead role in addressing barriers to retention and achievement in school for learners who are HIV affected or infected and ensuring that constraining factors are mitigated by implementation of pro-poor policies<sup>42</sup>.

Home and Community Based Care and Support, which falls under the DSD, is one of the programmes selected to contribute to the social sector plan for the Extended Public Works Programme (EPWP). Community caregivers in HCBC organisations provide services to individuals, families and communities. A total of 19,895 community members were trained on issues such as succession planning, childcare forums, the *Children's Act*, psychosocial

support, and monitoring and evaluation. This helped to give them career paths and to create jobs. Besides this, more than 1 000 community caregivers were trained in psychosocial wellbeing. A monitoring and evaluation system for HCBC (manual and computerised) was developed and implemented in 341 districts. A computerised HCBC data capturing system was developed and rolled out in North West, KwaZulu-Natal, Limpopo and Northern Cape. Guidelines for support groups and psychosocial support for children and adults with HIV and other chronic conditions have also been developed.

The Department of Social Development has facilitated and monitored implementation of a national action plan for orphans and other children made vulnerable by HIV and AIDS. The Minister for Social Development launched a Report on Surveillance System for Maternal Orphans during the World AIDS Day 2010 event in KwaZulu-Natal. This system is now enabling the Department of Social Development to update information on orphan hood, and review and plan relevant interventions.

Between the Departments of Social Development and Basic Education there is clearly an effective network of surveillance and support to ensure that orphaned children are retained within the education system. School attendance amongst orphans is significantly high at 99.6%, which is marginally higher than the school attendance of non-orphans at 99.1%. Many support services for orphans and other vulnerable children take place in and around the social welfare and educational system. There are no data available for support or other services reaching out-of-school youth.

### 3.11 SOCIAL SUPPORT TO PEOPLE IN NEED

No data were available for indicator 7.4: Proportion of poorest households who received external economic support in the last 3 months.

South Africa has very high levels of inequality in wealth and income, and this remains a significant factor in South Africa's HIV response. The UNDP's multidimensional poverty index ranks South Africa at 0.057 with 22.2% regarded as vulnerable to poverty<sup>43</sup>. South Africa's income inequality is more severe than in Mozambique (47.1), Zimbabwe (50.1), Swaziland (50.7), Zambia (50.7) and Lesotho (52.5) but less severe than income inequality in Botswana (61.0) and Namibia(74.3). Wealth continues to be stratified along gender and racial lines. Female-headed households are, on average, poorer than those headed by men, and the white minority dominate the upper income strata.

Social Assistance is an income transfer in the form of grants or financial award provided by the government. It is provided in the form of an Old Age grant, Disability grant, War Veteran grant, Care Dependency grant, Foster Child grant, Child Support grant and Grant-in-Aid. The Social Assistance programme is the government's most successful poverty alleviation programme targeting the poor and vulnerable people.

The National Treasury approved the universalisation (removal of the means test) of the older person's grant, to be phased in by gradually by raising the means test ceiling up to the lowest tax threshold. Recipients of the disability grant declined by 5.60%, from 1 291 264 to 1 218 916 in 2010. The decline largely involves recipients of the temporary disability grant<sup>44</sup>. The South Africa MDG Report notes that in 2010 14.1 million South Africans were beneficiaries of income support (goal 1 indicator)<sup>45</sup>. SASSA data indicates that by the end of April 2011 10,175,388 people were beneficiaries of grants.

TABLE 8: NUMBER OF GRANT RECIPIENTS BY GRANT TYPE APRIL 2011

<b>Grant Type</b>	<b>National Totals</b>
Care Dependency	110, 593
Child Support	5,761,332
Foster Children	355,851
Grant-in Aid	59,395
Old Age	2,686,838
Permanent Disability	989,446
Temporary Disability	210,985
War Veteran	948
<b>Grand Total</b>	<b>10,175,388</b>

Source: SASSA, 2011

## SECTION FOUR: BEST PRACTICE

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South Africa has documented best practices. Best practices in combating HIV&AIDS in South Africa have included the following:

- Combination therapy;
- Provider initiated HCT;
- PMTCT accelerated plan;
- Introduction of Gene-Xpert technology;
- SAAVI; and
- NIMART

## ***Combination Prevention in South Africa***

In recent years, there has been international recognition for the concept of combination prevention – understanding that no single intervention will address HIV and TB infection at a population level. Combination prevention programmes are rights-based, evidence-informed, and community-owned programmes that use a mix of biomedical, behavioural, and structural interventions, prioritized to meet the HIV prevention needs of particular individuals and communities, to have the greatest sustained impact on reducing new infections. Combination prevention implemented in South Africa includes:

- easily accessible and available male and female condoms in sufficient quantities to enable consistent use (in multiple settings including health facilities, malls, taxi ranks, shebeens, prisons and sex worker settings);
- medical male circumcision for men on demand;
- PMTCT;
- treatment for STIs
- regular testing and counselling.
- Prophylactic Exposure Prophylaxis (PEP)
- Microbicides
- Test and treat - using antiretroviral treatment as prevention

The CAPRISA 007 RHIVA trial (Reducing HIV in Adolescents), a cluster randomized trial underway in a very high incidence area of Kwa-Zulu-Natal, is assessing the impact of enhancing educational quality and providing conditional cash transfers to high school learners to reduce HIV incidence. Testing a structural approach at the individual level, much as did the IMAGE microfinance project among women in Limpopo, South Africa, the RHIVA trial secondary end-points include individual academic performance, participation in activities to build confidence in the future, and knowledge of HIV status (Q.A. Karim, personal communication). Addressing the extremely complex, interwoven cultural, social, and economic vulnerability of girls and young women in hyper endemic areas of southern Africa will continue to preoccupy a broad array of researchers and partners long into the future

### ***Provider Initiated Counselling and Testing***

With the introduction of new guidelines in February 2010, South Africa's policy on voluntary counselling and testing was expanded to include a number of new components. These components include a revision of counselling protocols as well as a shift for HIV Counselling and Testing (HCT) to be offered by health providers on any patient's visit to any health facility for any ailment. Provider-initiated HIV counselling and testing remains voluntary but it places an obligation on the health care worker to explain to patients the importance of knowing one's HIV status and of testing habitually for HIV as part of a normal health seeking behaviour.

The shift towards provider-initiated HCT comes as one of the measures derived from the 10-point plan of the National Department of Health – particularly the intention of point 1: 'Providing Strategic Leadership for better health outcomes' and of point 7: 'Accelerating implementation of the HIV & AIDS and Sexually Transmitted Infections National Strategic Plan 2007-11'. The imperative of expanding the number of clients counselled and tested for HIV comes as a result of the magnitude of South Africa's epidemic. Over 1200 people become infected with HIV every day in South Africa. Five pillars, two of which pertained to media and communication and social mobilization, have supported the successful HCT campaign. The impacts of these interventions are key to driving people to present at public health facilities and other sites. As indicated earlier, over 13,2 million South Africans accepted HIV testing as part of the HCT campaign. SANAC has supported districts with a number of interventions at the national level, which have been complemented by the activities that have been rolled-out at district level as per the district HCT strategy. The success of the HCT campaign has been a result of the strength of planning and interventions at the district level, by civil society and the private sector.

## ***Addressing Gender Based Violence in the Context of HIV***

As part of a broader SADC initiative in support of the regional *Protocol on Gender and Development* Gender Links undertook a pilot GBV Indicator Project in Gauteng. The purpose has been to develop reliable baseline data, targets and indicators for measuring progress on addressing GBV in a context where most violence is under-reported or not reported at all, leaving administrative data as an unreliable source of information for policy and planning purposes. Following the completion of the Gauteng study, the GBV Indicators study was rolled-out in the KwaZulu-Natal, Western Cape and Limpopo provinces of South Africa in 2011. By 2012, Gender Links will have completed the study in four provinces in South Africa and two SADC countries.

## ***PMTCT Acceleration Plan***

South Africa has scaled up its national Prevention of Mother to Child Transmission (PMTCT) programme and has achieved its ambitious target to reduce Mother to Child Transmission (MTCT) from 12 percent in 2007 to less than 5 percent by 2011 after significant policy changes in the PMTCT protocol within the same period. According to a review of progress documented in the *draft* National Strategic Plan (NSP) 2012-2016, as of 2010, PMTCT services are now available at 98 percent of health facilities and MTCT at six weeks has been reduced to 3.5 percent.

South Africa's PMTCT Acceleration Plan (A-Plan) has contributed to this achievement. The A-Plan – an intensive health systems improvement plan coordinated between Government, donors, NGOs and health workers - used a two-pronged approach of raising the quality and coverage of PMTCT services and implementation of social mobilisation strategies to promote better understanding, demand and uptake of services by pregnant women.

The Strengthening South Africa's Response to HIV and Health (SARRAH), managed by HLSP and funded by DFID, supported the pilot implementation of the A-Plan in six districts in 2009, the lessons from which were expected to inform the scale up of the A-Plan to eighteen further districts, and eventually nationwide. This case study explains the approach of the A-Plan in those districts, its critical success factors and broader lessons learned for strengthening nationwide PMTCT services.

## ***Introduction of GeneXpert for TB Diagnosis***

Recently, the WHO endorsed new technology to diagnose TB with simultaneous detection of Rifampicin resistance (a good indicator of drug-resistant TB). This technology, called GeneXpert MTB/Rif, has high sensitivity in both smear-positive as well as smear-negative, culture positive individuals. When compared with microscopy and culture, a single GeneXpert test detects 98% of smear-positive TB, whilst microscopy has sensitivity of around 72%. In addition to high levels of sensitivity, a GeneXpert test result can be available within two hours. The department has acquired 30 of these machines and an additional 17 will be procured over the next few months in order to achieve a target of at least one GeneXpert machine in each of the 52 health districts. A full roll out will be carried out over the next 18 months until current technology, mainly microscopy, will be fully replaced by the GeneXpert throughout the country. Already, 20 400 tests have been run on these machines, with TB detected in about 18% of suspected cases. This far exceeds detection rates of between 2% and 10%, using current technology, again demonstrating that we have been under detecting TB using current technology. In addition, the tests that have been run show a 6.49% detection of resistance to Rifampicin (a good indicator of MDR-TB), well above current levels of just under 2%.

## ***The South African AIDS Vaccine Initiative (SAAVI)***

The South African AIDS Vaccine Initiative (SAAVI) was established to coordinate the research, development and testing of AIDS vaccines in South Africa<sup>46</sup>. The programme forms an integrated part of the worldwide drive to develop an HIV/AIDS vaccine. This collaboration involves many other global players in the field, including organizations such as the US National Institutes of Health (NIH), the NIH-funded HIV Vaccine Trials Network, the International AIDS Vaccine Initiative (IAVI), the European Union (EU), the African AIDS Vaccine Programme, the European and Developing Countries Clinical Trials Platform (EDCTP), the Ethiopian AIDS Vaccine Initiative, the Nigerian AIDS Vaccine Programme, and the Botswana Harvard AIDS Institute, as well as international biotechnology companies. Although SAAVI closely collaborates with these and other organisations, it operates 24 *Annual Report 2010/2011* independently, allowing it to pursue its own specific goals and maintain its focus on the needs of southern Africa.



## ***Nurse initiated management of patients on ART (NIM-ART)***

The government's policy decision (2010) to scale up provision of ART across South Africa has been a welcome development. The limited capacity of the public health sector to achieve this scale of increase, however, has presented a number of key implementation challenges. The main challenge is the reality that there are insufficient numbers of doctors in the public sector to initiate and follow up on such a rapid increase in patient load. The task-shifting policy approach to nurse-initiated management of patients on ART (NIM-ART) has become a key strategy for expanding treatment access. Provinces are moving rapidly to prioritise this service delivery model through an extensive capacity development programme for clinicians and nurses. As part of the HCT Campaign clinicians have been trained as mentors and increasing numbers of nurses have been authorized to prescribe ART. To facilitate the process of training nurse managers of ART clients (including medication prescription), a pilot NIM-ART Course was developed in the Western Cape. The course includes modules in HIV/ART management, the PALSA+ course, an assessment of competency by an experienced clinician (mentor), and an authorization process determined by the District Director. The NIM-ART initiative in the provinces is being strengthened by the active involvement of civil society partners. The work being done by MSF in ART clinics in Khayelitsha to reduce saturated enrolment capacity through nurse based ART services is illustrative of the progress being made.

## ***ANOVA Health4Men and Play Nice Projects for Men who have Sex with Men***

The project has developed substantial expertise in responsible sex messaging and marketing to diverse MSM groupings, largely through research. Messaging is inclusive of MSM who are HIV positive and HIV negative, as well as men who do not know their status. It also caters to gay as well as straight-identifying MSM. While it continues to build knowledge of this under-researched sector, Health4Men has shifted towards disseminating expertise by producing guidelines and manuals and through various training initiatives aimed at making public sector health services more competent to address MSM sexual health needs. The project also trains peer educators, and deploys voluntary ambassadors in township areas to promote responsible sex and HIV screenings.

Health4Men has expanded to Gauteng and North West provinces. Health4Men in Soweto opened in July 2009 and works closely with OUT — an NGO with years of experience working in LGBTI issues. The Simon Nkoli Centre in Soweto is based at Chris Hani Baragwanath Hospital and sees on average 25 patients a day. This includes men who collect medication, HIV screening, additional blood work or STI -related cases. Since the centre opened its doors, the outreach workers in particular have adapted their hours of work. They visit clubs popular with MSM, distributing water-based lubricant, appointment cards for the centre, condoms and pamphlets. The centre has also focused on MSM sensitisation training for healthcare workers and partners in the area as well as collaborating with organisations that specialise in addressing problems of addiction and substance abuse.

The Play Nice HIV prevention programme is designed specifically for gay-identifying and other MSM. Addressing men's sexual health issues and HIV in a frank manner, using language that men can relate to, Play Nice pushes the proverbial envelope. Play Nice distributes its own free branded condoms (slightly larger than standard, who said one size fits all?) and free sachets of water-based lubrication. "One of our biggest challenges is educating men about using water-based lubrication with condoms for anal sex. Many men continue to use products like butter, cooking oil and petroleum jelly, which often cause condom failure. Prevention initiatives are currently focused on MSM living in township areas around Cape Town and in the Paarl area<sup>47</sup>.

## ***Engaging with men as a Key component of the Gender Response***

During 2010 – 2011 Sonke Gender Justice Network began to strengthen the policy and advocacy work they had already been involved in by establishing a Policy, Advocacy and Research Unit and expanding their International Programmes and Networking Unit. During 2010 – 2011, these units were able to conduct various pieces of work, which focused on HIV and AIDS National Strategic Plans (NSPs), and the importance of engaging with men as a key component of the gender response in order to affect broad and large-scale societal impacts.

An analysis of NSPs from sixteen countries across five global regions was conducted at the end of 2010. This assessed the extent to which plans acknowledge the importance of engaging men and boys in reducing gender-related vulnerabilities and of promoting gender transformation. It also included a look at the degree to which they have planned and outlined specific work to address these issues. The findings of this policy scan were presented and discussed at a global meeting in Nairobi in 2010. Representatives of the UN Joint Teams, Men Engage (represented by Sonke Gender Justice Network) and the Athena Network committed to providing ongoing technical support to seven priority countries to support them to integrate GBV and male involvement strategies into their NSPs.

During 2011, a scan of NSPs from thirteen African countries was conducted, resulting in a set of policy reports for six of those countries. These reports highlight the strengths and gaps within the NSPs in terms of whether they commit to engage with men to increase their uptake of VCT and treatment; support their partners to access VCT and treatment; use condoms; and become involved in PMTCT processes, the care economy and GBV prevention. The analysis also determined the extent to which NSPs acknowledge the importance of gender norms transformation work; address the needs of marginalised men and boys; and their commitment to the rollout of medical male circumcision services, which should incorporate gender equality training. The reports make recommendations for future policy and advocacy areas to guide collaborative work between Sonke and partner organisations in those countries to advocate for the strengthened engagement of men and boys within HIV and AIDS NSPs.

Within South Africa Sonke was able to support the SANAC Men's Sector, functioning as its secretariat, to make submissions to the various drafts of the 2012 – 2016 South African NSP on HIV, STIs and TB, which was developed during 2011. Due to these and other submissions, the South African NSP (launched 1 December 2011) contains language that addresses the following issues: harmful gender norms and socialization processes, men's health-seeking behaviour, masculine gender norms around alcohol abuse, MMC rollout that incorporates gender sensitization, the engagement of fathers in PMTCT, and the provision of services and condoms to marginalised groups.

## ***HIV-911 Programme: Bringing you hope and connection***

The HIV-911 database consists of over 12 000 organisations involved in HIV, TB and STI-related prevention, treatment and support. In addition, it encompasses organisations providing socio-economic, legal and psychosocial support programmes. The database includes all provinces, with service provider information categorised by municipality and service type. The database is constantly maintained, updated and expanded.

HIV-911 has developed a variety of products that draw on this database. These products are designed to help individuals and families to connect with a range of service providers in their area. Similarly, service providers use the database products to recommend supplementary support services to their clients and to facilitate networking between themselves and likeminded organisations. As a result, HIV-911's tag line is "*Bringing you hope and connection.*"

HIV-911's database products include an annually updated set of provincial hard copy directories for the service provider community as well as a variety of online, landline and mobile phone products that facilitate individual access to the database, 24-hours a day. For example, they recently introduced a mobile phone directory that provides clients with immediate referral support information. Called "*Impilo – Health in my Hands*" this service is available 24-hours a day on any mobile phone. The service is free on all networks except Vodacom.

HIV-911 is the flagship programme of the Centre for HIV/AIDS Networking (HIVAN), a self-funded Centre of the University of KwaZulu-Natal. They are situated within the Faculty of Applied Human Sciences. The HIV-911 Programme aims to:

- Connect individuals seeking information on where to locate HIV, AIDS and TB-related services to organisations who provide these services;
- Assist HIV, AIDS and TB-related service organisations with locating like-minded services within any area of South Africa;
- Develop a stable of services that will enable access to reliable HIV, AIDS and TB-related referral information in a cost-effective and time efficient way, while ensuring confidentiality and sensitivity for HIV or TB infected and affected individuals; and
- Continually seek and establish collaborative relationships with organisations that have access to data on HIV, AIDS and TB-related support services to facilitate the integration of this data into the HIV-911 database.

## ***Building Partnerships for Health***

Columbia University's ICAP activities in South Africa have been funded by PEPFAR through the U.S. Centers for Disease Control and Prevention (CDC). The ending of the cooperative agreement between CDC and ICAP marked the beginning of programme sustainability under the South African government and local partners. The strong relationship among CDC, ICAP, and the Eastern Cape Department of Health began in 2003 with CDC providing support through President Clinton's LIFE Initiative, and was quickly followed by CDC/PEPFAR funding in 2004. With the launch of PEPFAR, there was a rush to provide emergency care and treatment to underserved populations, and established international organizations were enlisted to help with the scale-up. ICAP was one of four such "Track 1" program partners recruited to jump-start programs in South Africa. Today all these programs are transitioning their services to local governments – and all, like ICAP, have left solid foundations on which the South African facilities can build and grow. In collaboration with the Government of South Africa ICAP's program has been successful in providing life-saving care and treatment to thousands of adults and children living with HIV,

ICAP cemented their legacy in the Eastern Cape by officially handing over five newly renovated clinics in Mdantsane to the government. Since the program's inception, ICAP has helped nearly 100,000 adults and almost 8,000 children start antiretroviral therapy. In addition, ICAP started strengthening the health system early on by developing reporting and monitoring systems, providing skilled staff, and training and mentoring existing staff. These programs will be handed over to two local district support partners, Health Systems Trust and Aurum Research Foundation.

With CDC funding, ICAP will continue to strengthen facilities in the OR Tambo district in the Eastern Cape. CDC has also funded ICAP to lead several evaluations in South Africa, including one on paediatric HIV treatment and another on populations at higher risk of HIV infection. In addition, ICAP will conduct a multi-country study on medical male circumcision in several southern African countries. Finally, in collaboration with the University of Cape Town, ICAP will investigate and develop TB/HIV training courses for clinicians and infection control diplomas for clinic staff.

## SECTION FIVE: MAJOR CHALLENGES AND REMEDIAL ACTIONS

### 5.1 PROGRESS ON KEY CHALLENGES

A number of challenges were identified in the 2010 UNGASS Country Progress Report, which can be categorized around three broad thematic areas: a) National Commitment and Policy, b) Programme Implementation and c) Monitoring and Evaluation. Some specific measures have been implemented since then to address these challenges. South Africa has made significant progress in a number of these critical areas, and these are outlined in the table below:

TABLE 9: PROGRESS ON KEY CHALLENGES, 2012-2011

2008/2009 KEY CHALLENGES	PROGRESS IN 2010/2011
<b><i>National Commitment and Policy</i></b>	
<p><b><i>The lack of two out of three of the UNAIDS "Three Ones"<sup>4</sup>:</i></b></p> <ul style="list-style-type: none"> <li>• "One National AIDS Coordinating Authority, with a broad-based multi-sectoral mandate" <ul style="list-style-type: none"> <li>○ The ambiguity of SANAC's legal status harms its effectiveness to manage the overall response</li> <li>○ SANAC Secretariat unable to function as coordinator and leader of the response without a full complement of staff and the proper positioning within SANAC</li> </ul> </li> <li>• "One agreed country-level Monitoring and Evaluation System" <ul style="list-style-type: none"> <li>○ Collating and reporting on the multi-sector response is impossible without a fully staffed M&amp;E Unit, one data collection system and one national database</li> </ul> </li> </ul>	<p>Under its new CEO SANAC is currently engaged in a process to strengthen its structures and capacity to coordinate and oversee programme delivery under the new NSP 2012-2016.</p> <p>SANAC is currently working on the development of a national M&amp;E Plan that will be fully aligned with the new NSP 2012-2016 and that will more effectively underpin programming and impact evaluation.</p> <p>Still silent on SANAC legal status – perhaps emphasize its high political profile – and the fact that it is chaired by the Deputy President</p> <p>The NSP 2012-2016 produced under the leadership of SANAC was endorsed by Cabinet and launched by the President of the country on World AIDS Day, 01 December 2012.</p>
<p><b><i>Weak management and coordination efforts across sectors</i></b></p> <ul style="list-style-type: none"> <li>• Limits the cooperation among implementers, and between implementers and SANAC</li> </ul>	<p>Through SANAC and the PICs greater efforts are being made to coordinate sectors through more effective management of multi-stakeholder processes</p>

<sup>4</sup>The UNAIDS "Three Ones" principles, endorsed by key donors and led by affected countries in 2004, are designed to achieve the most effective and efficient use of resources, and to ensure rapid action and results-based management. They include: a) **One** agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; b) **One** National AIDS Coordinating Authority, with a broad-based multi-sectoral mandate; and c) **One** agreed country-level Monitoring and Evaluation System.

2008/2009 KEY CHALLENGES	PROGRESS IN 2010/2011
<ul style="list-style-type: none"> <li>Neglects implementers who are “outside of the loop” (i.e., private sector, organizations not funded by government or donors)</li> </ul>	
<p><b><i>The lack of streamlined and clear indicators supported by appropriate data management systems</i></b></p> <ul style="list-style-type: none"> <li>Data on ART and the PMTCT programme is largely unreliable; data and reporting from other programme areas is inconsistent</li> </ul>	<p>Work continues across all sectors to strengthen data management systems and to standardise and harmonise departmental and sectoral M&amp;E processes. This process includes the development of a set of standardised indicators in a national M&amp;E system that will enable all stakeholders in the HIV, STI and TB sectors to harmonise data collection, data analysis and data synthesis more effectively.</p> <p>Be specific about the three-tiered M&amp;E system for ART</p>
<b><i>Programme implementation</i></b>	
<p><b><i>Lack of a unified, national prevention strategy</i></b></p> <ul style="list-style-type: none"> <li>Inhibits multi-sector contributions to prevention and any resulting achievements to be captured and widely disseminated</li> </ul>	<p>The Department of Education is currently strengthening the HIV and AIDS life skills education programme. Activities included a review of the sexuality education curriculum against the UNESCO International Guidelines on Sexuality Education; classroom observations of lessons; hosting a satellite session at the 5<sup>TH</sup> SA AIDS Conference in June 2011; the appointment of a consultation to develop scripted lesson plans for educators; and qualitative research to better understand factors that facilitate and inhibit the teaching of Life Orientation in schools (report expected April 2012).</p> <p>Prevention is one of the core pillars of the NSP for 2012-2016</p>
<p><b><i>Uncoordinated implementation among agencies involved in Impact Mitigation, Human Rights and Access to Justice</i></b></p> <ul style="list-style-type: none"> <li>Hinders an accurate gauge of the scale of need required by individuals, families and children that are infected and affected, and the achievements that have been made</li> </ul>	<p>Amongst its four pillars, the new NSP 2010-2016 includes the strategic objective “Ensuring protection of human rights and improving access to justice”.</p> <p>While the focus of this strategic objective is forward-looking, largely containing a set of interventions to be implemented over the course of the NSP, considerations of human rights and access to justice is ever-present. Recognising that the legal framework for respecting, protecting, promoting and fulfilling Rights in the context of HIV and TB are largely</p>

2008/2009 KEY CHALLENGES	PROGRESS IN 2010/2011
	<p>in place; SANAC must give special attention to groups that are at higher risk. SANAC will work with all institutions to address human rights and any form of discrimination with respect to HIV, STI and TB.</p>
<p><b>Health system constraints</b></p> <ul style="list-style-type: none"> <li>▪ Scale up of critical programmes such as ART and PMTCT can exacerbate an already over-burdened health system</li> <li>▪ Parallel services inhibit necessary integration (i.e., TB and HIV collaboration)</li> </ul>	<p>South Africa has embarked on a comprehensive programme to integrated HIV and TB services and combined testing/screening for HIV, TB and STIs.</p> <p>The National Department of Health has focused on a comprehensive approach that is patient-centred and fully integrates TB and HIV services within both curative services. This is aligned with one of the key UNAIDS treatment, care and support objectives for the “sharing of best practice in controlling TB, HIV, malaria, hepatitis B and C, congenital syphilis and other diseases, as well as integrating the prevention and treatment services for these diseases, which is critical to improve the coverage, quality and cost-effectiveness of services”<sup>48</sup>. This strategic approach has been factored into the framework for the new NSP – “integrating TB and HIV care”.</p>
<p><b>Limited programming for “traditional” MARPs</b></p> <ul style="list-style-type: none"> <li>• Programme development for MARPs requires evidence-based information to guide it</li> <li>• The promotion and protection of the rights of key populations needs to be strengthened</li> </ul>	<p>Strong inclusion of key populations in the NSP 2012-2016. South Africa has committed to act upon international declarations that refer to addressing the needs of MARPs, specifically the 2011 Political Declaration on HIV/AIDS in which countries are encouraged to define the specific populations that are key to their epidemic and response based on the epidemiological and social context.</p> <p>A comprehensive situational analysis of HIV in South Africa among men who have sex with men, transgender people, injection drug users, sex workers, prisoners and migrants was published in 2011. Commissioned by the South African National AIDS Council (SANAC), and the South African UN Joint Team on HIV and AIDS, this analysis included a review of the literature, current service provision, gaps and recommendations for key populations and was used to inform the inclusion of key populations in the NSP 2012-2016.</p> <p>In 2011, the National and Kwa-Zulu Departments of Health participated in learning</p>



2008/2009 KEY CHALLENGES	PROGRESS IN 2010/2011
	exchanges with the Avahan Project in India to learn from the Indian experience of addressing the prevention care and treatment needs of Key Populations in South Africa. .
<b>Monitoring &amp; Evaluation</b>	
<ul style="list-style-type: none"> <li>• A need for more comprehensive reporting on sources and uses of donor funding</li> <li>• Difficulties in calculated total spend on HIV AIDS including Government Spend, Donor Funding and HIV related spending across government departments.</li> </ul>	The National AIDS Spending Assessment (NASA) for South Africa has been completed (2012) and seeks to capture all public, external (donor) and business sector contributions to the HIV/AIDS and TB response in the country, in 2007/08, 2008/09 and 2009/10. The NASA report consolidates and compares the results from the nine provinces and spending at the national level to provide a picture of the entire country's spending on HIV/AIDS and TB.
South Africa lacks a costed M&E work plan that clearly identifies activities, actors, costs and timeframes of data collection and use for reporting and management of the national response.	With the recent development of the new NSP 20102-2016 SANAC is currently developing a national M&E framework that will strengthen national capacity to more effectively monitor progress on national HIV, STI and TB outcomes, targets and indicators
The lack of one unified countrywide system impedes South Africa's ability to gauge the extent of its AIDS treatment programme. Data is not regularly collected in a number of other critical areas due to a lack of systems, namely for: men having sex with men, commercial sex workers, IV drug users, mobile populations, support to PLWHA and those affected (including OVC) and human rights issues.	The document <i>Key Populations, Key Recommendations</i> (2011) will provide invaluable guidance on data for sectors involved in HIV programming for key populations

## 5.2 CHALLENGES IN THE CURRENT REPORTING PERIOD

While South Africa has demonstrated progress in addressing the challenges that were identified in the 2008-2009 reporting period, a few key challenges remain. Fortunately, the country has implemented national research studies and assessments that help to clarify and inform the way forward in the national response to HIV and AIDS.

- A culture of reporting against uniform indicators does not exist within the South African business sector. The number of records and rate of reporting falls far below the number actually tested by the business sector during the reporting period. The National Health Act of 2003 provides the legal framework for mandatory reporting by the private health sector to the Minister of Health on key health indicators. Future plans of the Department include the development of specific regulations to guide the

reporting system and processes. Furthermore, the global financial crisis has resulted in reduced spending on employee health and wellness – fewer services means less data. Despite compelling economic reasons for risk mitigation, no incentives exist to secure participation. The conversion from advocacy to registration and registration to reporting takes time, and requires resources and guarantees of company level confidentiality. Accessing comprehensive data from companies is a long-term investment in workplace systems strengthening, and skills and capacity development.

- The Department of Basic Education has faced a number of challenges in its prevention efforts in the reporting period. These include the lack of prioritization of the basic education sector in the HIV and TB national discourse, and a delay in the finalisation of the peer education guidelines for distribution to schools. This has affected negatively on the training of provincial teams in their use.
- The Government Employees Medical Scheme (GEMS) has been experiencing a number of challenges in the reporting period. Late registration is a challenge. During 2009, 39.4% of GEMS patients who registered on Aid for AIDS had a CD4 count below 200 at registration. During 2011, this percentage had decreased to 35.5%. The percentage claims for resistance tests was 0.05% in 2010 and has remained at the same percentage in 2011. The percentage patients on first line ART was 86% at the beginning of 2010 and 85% at the end of 2011, which reflects a stable trend.
- Previous years showed progress with paediatric treatment rollout. Approximately 17,000 new children started treatment from mid- 2006 to mid-2007. In 2010/11, 37,160 new child patients were initiated on ART, against a set target of 40,000 which reflected a 92,9% performance. This was lower than the performance during 2009/10, where 45,044 children were placed on ART. This is attributed largely to a protracted industrial action by public sector workers in August 2010, which affected service delivery.
- A major constraint in the reporting of UNGASS indicators is the redefinition of MARPs in South Africa, which prevents adequate reporting on indicators related to sex workers, IDUs, and to a lesser extent MSM). As quoted in *HSRC Prevalence, Incidence, Behaviour and Communication Survey (2008)* “In this report the definition of most-at-risk populations (MARPs) is expanded to include (a) African females aged 20–34; (b) African males aged 25–49; (c) Males older than 50; (d) Men who have sex with men (MSM), (e) Persons who are high-risk drinkers; (f) Persons who use drugs for recreational purposes, and (g) people with disabilities.” Apart from specialized MSM health services in three metropolitan areas, no national MSM programming exists and none of the NSP targets relating to MSM have been reached. The decriminalization of sex work, and sex worker targets were not achieved during the NSP 2007-2011 period, despite their specific recommendations. Programmes for treating drug users, including IDUs, are limited and most are provided through the private sector. South African health facilities do not provide access to clean needles and syringes, and discrimination by health care workers and fear of arrest prevention IDU from accessing health services, leading to needle reuse and needle sharing.
- There is a need to expand the HIV/AIDS response beyond the health sector. The massive investment of the Department of Health in the response to HIV/AIDS should be balanced with increased spending on integrated HIV/AIDS services in all the other departments, particularly the DSD and DOE. Spending on OVC support, community

development, enabling environment, and human and legal rights activities should be increased in South Africa and would be best provided through NGO services.

- There needs to be an increased priority given to prevention efforts. Spending on prevention in South Africa actually decreased in 2009/10 by 8%. In order to reduce the number of persons needing treatment, it is vital that budgets are increased for those key prevention interventions that have been shown to have the greatest impact. Medical male circumcision, and, potentially, the microbicides currently under development, could reduce HIV transmission rates significantly. Prevention of mother-to-child transmission (PMTCT), condoms and post-exposure prophylaxis (PEP) remain effective interventions to be expanded, and while it may be difficult to prove the effectiveness of social mobilisation, advocacy and behaviour change campaigns, they are nevertheless “critical enablers”, without which the impact of biomedical interventions is reduced.

## SECTION SIX: SUPPORT FROM DEVELOPMENT PARTNERS

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### 6.1 KEY SUPPORT RECEIVED FROM DEVELOPMENT PARTNERS

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The government of South Africa is the primary investor in its own national and provincial response to the HIV/AIDS and TB epidemics. A range of bi-lateral, multi-lateral and donor organizations also provide significant funding and other types of support to initiatives undertaken by the government. These entities work through public health facilities, government departments and existing civil society organizations. They support not only the costs of medicines, infrastructure upgrade, general healthcare and other types of support, but also help to ensure the sustainability of these programmes. Donors collect their own data regarding their own programmes; in most instances, results indicate excellent outcomes particularly on treatment, care and support for both adults and children receiving ART. There remains room for improved integration of development partner and South African government interventions and strengthened collaboration to achieve more effective and sustainable partnerships. It is anticipated that under the new NSP SANAC will work to strengthen the M&E system so that there is improved collection, consolidation and synthesis of data by all relevant stakeholders in the HIV and TB response.

In the 2010/2011 period, the Department of Health signed six agreements with development partners to leverage technical and financial assistance for the implementation of national health systems priorities such as the *10-Point Plan 2009-2014*, and the *Negotiated Service Delivery Agreement (NSDA) 2010-2014*. The 2010/2011 target was to sign seven agreements with international development partners. The following agreements were signed: the USAID Mega Assistance Agreement (September 2010); Memorandum of Understanding with Operation Smile South Africa (December 2010); PEPFAR/SA Partnership Framework; European Union (EU)/SA Financing Agreement; Belgium/NDOH Agreement and the Aid Effectiveness Framework for Health<sup>49</sup>.

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#### 6.1.1 SUPPORT FROM BILATERAL DEVELOPMENT PARTNERS

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Bilateral support comes from a range of different donors. Bilateral organisations were responsible for the largest portion of externally sourced HIV/AIDS and TB funding, totalling R1.5 billion, or 71% of total external funds, in 2009/10. Over the period 2008-2010, the Government of the United States of America (USG) was the largest contributor, with R2.5 billion sourced through the President's Emergency Plan for AIDS Relief (PEPFAR), making up 67.2% of total bilateral aid, 46% of all external aid and 8% of the total HIV/AIDS and TB spending in the country. The next largest bilateral contribution was from the Government of the Netherlands (16.2% of bilateral aid at R637 million) followed by the United Kingdom (UK) through the Department for International Development (DfID) with 10.3% of bilateral aid (R406 million). Several other countries contributed bilateral aid, but these were around 2% each, or less, of total bilateral aid.

The NASA Report 20102 has calculated bilateral donor contributions for the period 2007/2008 to 2009/2010.

TABLE 10: BILATERAL CONTRIBUTIONS TO SOUTH AFRICA'S HIV/AIDS AND TB PROGRAMME (ZAR 2008 – 2010)

<b>Bilateral Sources (ZAR)</b>	<b>2007/08</b>	<b>2008/09</b>	<b>2009/10</b>
Government of Australia	1,715,368	1,843,186	2,528,158
Government of Austria	349,293	536,182	1,573,204
Government of Belgium	1,034,256	2,604,502	1,562,307
Government of Canada	1,860,233	4,868,205	7,750,789
Government of Finland	-	2,085,197	3,216,800
Government of France	16,046,515	7,732,617	16,129,612
Government of German	18,852,956	22,239,399	25,194,769
Government of Ireland	11,678,657	29,390,233	15,587,837
Government of Italy		1,043,845	3,811,384
Government of Japan	11,650,000	13,512,000	15,118,000
Government of Netherlands	155,229,257	280,916,899	87,927,166
Government of Norway	570,636	-	871,053
Government of Spain	-	189,328	-
Governemnt of Sweden	18,050,838	32,307,897	8,487,619
Government of Switzerland			2,236,241
Government of United Kingdom	101,535,240	163,985,541	118,459,737
Government of United States	523,714,721	817,307,712	1,198,723,830
Other bilateral agencies n.e.c.	140,000	2,360,666	1,920,000
<b>Total SA Bilateral Sources</b>	<b>R 862,427,970</b>	<b>R 1,382,923,409</b>	<b>R 1,511,098,506</b>

Source: Draft NASA Report 2012

The United States Government (USG) supports the Government of South Africa largely through the PEPFAR programme. PEPFAR's South African programme aims to build sustainability through health and social system strengthening, with a strong focus on M&E systems and training health teams to use data to improve quality, performance, accountability, and health services. Major achievements of the reporting period include:

- Through the government's HIV Counselling and Testing (HCT) campaign that tested 14.8 million people over 15 months (2010-11), 6.9 million were tested through PEPFAR;
- PEPFAR supported the government's Accelerated Plan for Prevention of MTCT (PMTCT) programme, which effectively reduced infant infections from 8% to 4%;
- Antiretroviral treatment (ART) has been scaled up to reach 1.4 million (21% of those on ART globally), and out of these 1.1 million received support from PEPFAR SA implementing partners.

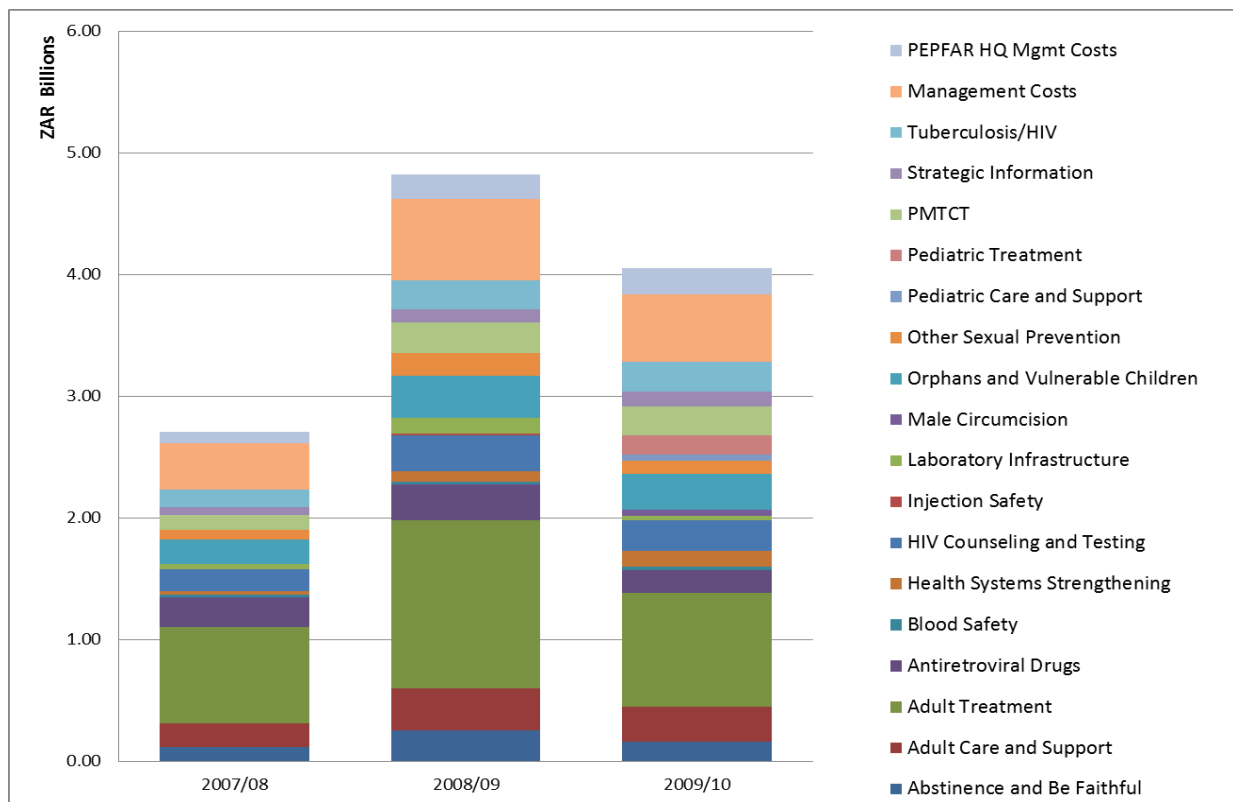
As indicated in the NASA Report 20102 the PEPFAR agencies in South Africa indicated that it was not possible for them to provide actual expenditure broken down by province and by the activities. They could, however, estimate the total USG spending for 2008-2010. However, since most of this estimated data from PEPFAR could not be verified with the recipient partner organisations, these total figures have not been included in all the above figures, except for the portion that was verified with partners. The information provided here reflects the *estimated* data from PEPFAR, which were based on the *intended* spending of partner organisations in 2010/11. PEPFAR asked partner organisations to submit their budget estimates. Partners provided their estimated budgets for the period April 2010 to March 2011; PEPFAR then applied these proportions to the 2007, 2008 and 2009 budgets of these organisations to arrive at an estimate of the total spending for each of these years<sup>50</sup>. It should be noted; therefore, that the figures in this section are modelled estimates of amounts

spent, and not reported actual expenditure, but *also include* the verified amounts indicated above. The figure below shows the activities on which the PEPFAR funds were spent in South Africa for each of the three years. Activities supporting orphans and vulnerable children (OVC) took up the largest single share of expenditure in each year – 19% in 2009. Some of the other major spending activities in 2009 were:

- Adult Treatment and Adult Care and Support (each consuming 14% of total PEPFAR funds);
- ARV drugs (7%); and Health Systems Strengthening (5%); and
- TB/HIV (5%).

The graph shows that a large portion was also spent on Partner Management and Overhead costs, at 15% (R25 million) in 2009. The NASA Report 2012 notes, however, that this was a manual estimate: partner management costs were estimated at 15% of their total budget and added on to the figures provided by the partner organisations. It is also important to note that although the financial year of the US Government is October 1 to September 30, partners receive their funds at different times of the year, which affects spending rates and creates challenges for partners in terms of budget planning.

FIGURE 16: PEPFAR HIV/AIDS AND TB ESTIMATED SPENDING ACTIVITIES IN SA (2007/08-2009/10)51



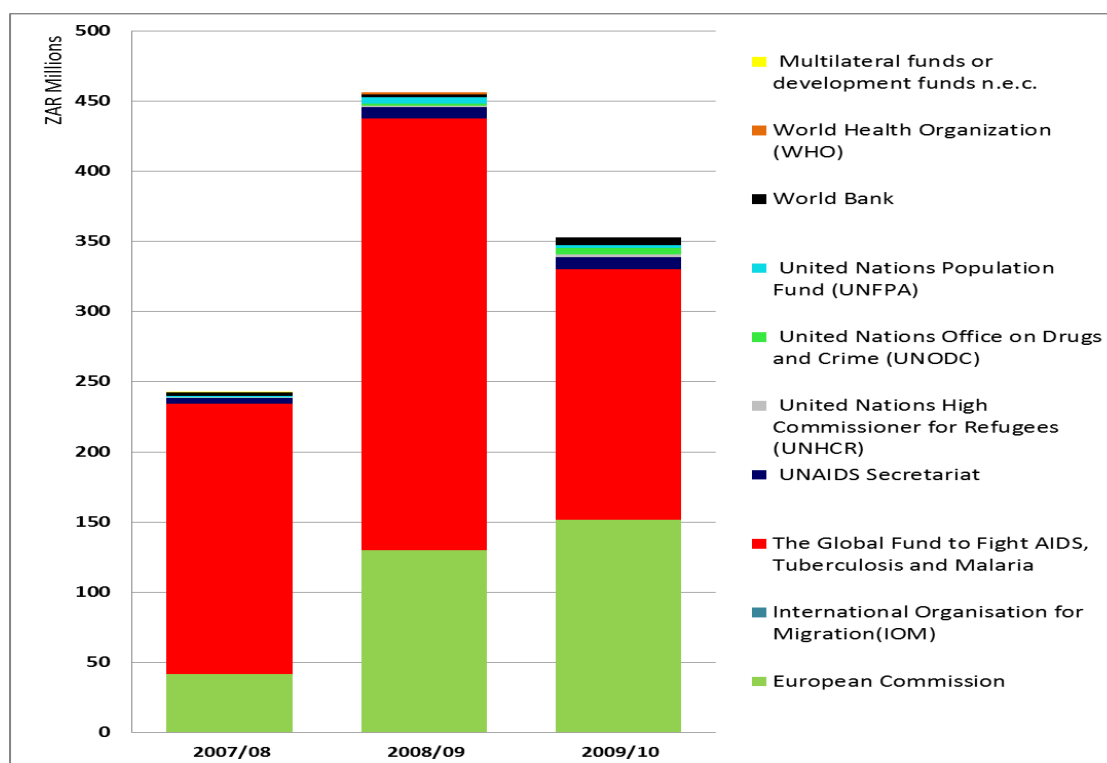
Source: Draft NASA Report 2012

## 6.1.2 SUPPORT FROM MULTILATERAL DEVELOPMENT PARTNERS

Multilateral support comes from a range of different agencies, including the UN, the European Union (EU) and the Global Fund. The draft NASA Report 2012 indicates that multilateral organisations contributed 20% of the total external funding in 2009/10. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) made the largest contribution of R680 million over the three-year period: 65% of total multilateral funds, 12.3% of external aid, and only 2.1% of the total funding. The European Commission (EC) provided contributions totalling R323 million over the period. This included 31% of multilateral aid, 5.8% of external aid, and only 1% of the total spending. There were several other multilateral contributors such as the UN agencies, the World Bank and the World Health Organization (WHO), but these contributed less than 1% of the multilateral aid over the three years, except for UNAIDS which contributed R21 million over the study period, making up 1% of multilateral aid, 0.4% of all external aid, and only 0.1% of the total HIV/AIDS and TB spending in the country.

There were a number of international foundations – such as the Bill and Melinda Gates Foundation – that have been funding various HIV/AIDS and TB activities in South Africa. These were relatively small contributions, but together contributed 13% of the external aid, and 2% of the total HIV/AIDS and TB spending over the three year period. The NASA Report 20102 has calculated multilateral contributions for the period 2007/2008 to 2009/2010.

FIGURE 17: TOTAL MULTILATERAL AID - PROVINCES AND CENTRAL (2007/08-2009/10) (R350M IN 2009/10)



Source: Draft NASA Report 2012

## 6.2 ACTION TO BE TAKEN BY DEVELOPMENT PARTNERS

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Although ODA to South Africa represents less than 1% of GDP, donor support to the national HIV/AIDS and TB programme remains significant. Ongoing predictable and sustainable support remains important as South Africa deals with the challenges of the HIV/AIDS and TB epidemics and their impact on the socio-economic wellbeing of the country. The following issues should be taken into consideration by the donor community:

- The impact of the global economic crisis could well result in increased country demand for International Development Association (IDA) in support of the national HIV/AIDS programme and uncertainty in official development assistance (ODA). The cancellation of the Global Fund (GFATM) Round 11 and requests totalling more than \$20 billion over the next three years amidst increasing funding requests from eligible countries have added to the overall uncertainty and placed doubt on the capacity of governments to scale up prevention and treatment programmes. Donors supporting South Africa will need to carefully assess their ongoing support to HIV/AIDS and TB programmes to ensure that delivery in critical areas such as the provision of ARVs is not compromised.
- South Africa has just completed the drafting of its new National Strategic Plan for 2012-2016, as well as nine provincial plans. Costed operational plans and a supporting M&E Framework are in the process of being finalized. Donors will need to ensure that current and future support is fully aligned with the new NSP, and that donor priority areas are harmonized with key areas outlined in the NSP. Donors will also need to engage with SANAC on funding gaps as identified through the costing process.
- Donors need to work more closely with their national counterparts to improve the accuracy and frequency of data collection on expenditure. The finance managers, together with programme managers, need to stipulate clear guidelines to be followed for financial data capturing and coding, so as to enable more effective budget monitoring and cost-efficient service delivery. The financial data should be linked to output indicators in a single consolidated Monitoring and Evaluation (M&E) system.
- The draft NASA Report 2012 recommends that donors work with the government to centralise and institutionalise HIV/AIDS expenditure data collection. This is a critical step for improving and institutionalizing expenditure tracking systems, with detailed HIV-coding, and for these to be populated by all actors including bilateral and multilateral donors in the HIV/AIDS field in South Africa. The information should be centralised on an ongoing basis and managed by SANAC and HAST to ensure improved co-ordination and alignment of all efforts at national and provincial levels.
- There remains an ongoing need for increased transparency of funding by external sources. The draft NASA Report argues that development partners should be more transparent about what they are funding in South Africa, as well as what they intend to commit to in the longer term, in order to foster a harmonised and integrated response that is guided by the country's priorities. This will enhance the government's ability to measure future funding requirements, and to address funding gaps in a sustained and aligned manner, so as to reduce overlap and gaps in key areas.



## SECTION SEVEN: MONITORING AND EVALUATION ENVIRONMENT

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### 7.1 OVERVIEW OF CURRENT M&E SYSTEM

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South Africa does have a structure in place (the SANAC with allocation for an M&E unit) to collect and aggregate national-level data on HIV and AIDS. Individual government offices also have M&E Units or functions (such as Department of Health, the Office of the President, Department of Education, Department of Social Development, etc); although civil society does not generally have such structures.

- The *Mid-Term Review* of the NSP 2007-2011 identified the following main conclusions on the monitoring, research and surveillance component of the NSP 2007-2011:
- There is not one multisectoral, M&E system to collate, aggregate, analyse and report on the national response; SANAC does not currently have M&E capacity, with the general management of M&E conducted in an ad-hoc manner amongst the various sectors;
- The NSP has too many, non-prioritised and in some cases, un-measurable indicators;
- Without a national NSP implementation plan in place, there has been a missed opportunity to break targets down by priority area and province;
- Regular, public reports on the NSP progress do not exist.
- Monitoring, evaluation and research tends to be an under-capacitated and underappreciated area. Thus, data quality suffers and use of data for programme improvement is not a priority.

The *End of Term Review* of the NSP 2007-2011 concluded that in fact little progress had been made since the MTR findings. The ETR noted that the NSP 2007-2011 targets were not clearly defined, and that monitoring evaluation systems were not well coordinated, with reporting between public and private sector being inconsistent. It found that there were an unwieldy number of indicators, and that there was little differentiation between those that related to outcome and those related to process. Throughout the system, monitoring evaluation and analysis capacity continues to be a challenge, reducing the reliability of data used for budget and planning processes.

Both the MTR and the ETR identify the need for one national agenda to guide efforts around research of HIV and AIDS in South Africa. An inventory of all AIDS research in the country was conducted and a prioritised agenda for AIDS research was developed; however, there appears to be little knowledge among key stakeholders of this agenda. While major stakeholders actively collaborate on some of the routine surveillance it appears that most other research is limited to site-specific endeavours that are not reflective of national collaboration. Civil society are usually the most under resourced and cannot afford extensive capacity around data collection systems, thereby contributing to information gaps. Donor funded programmes and private sector businesses tend to have better resourced data collection systems; however, the lack of one coordinating M&E system means that the information that is collected is often not shared amongst the actors.

## 7.2 IMPLEMENTATION CHALLENGES AND PROGRESS

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### 7.2.1 CHALLENGES

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During the process of administering the National Commitments and Policy Instrument (NCPI) inputs were made on key challenges that have been experienced during the reporting period<sup>52</sup>. It was noted that while an M&E Framework had been developed it was not adequately implemented. Part of the challenge has been the lack of sustainable funding for developing a national HIV, STI and TB M&E plan and an appropriate system to implement it. Another challenge has been the lack of alignment between the M&E systems of the various partners working in the HIV, STIs and TB sector. SANAC has recognised this challenge and is prioritising the development of a national M&E Plan that will be fully aligned with the new NSP 2012-2016. The NCPI highlighted the following issues:

- With no agreed M&E system for HIV and AIDS there has been a lack of standardised reporting;
- Individual government departments and sectors have M&E plans and regular reporting processes, but there is a lack of coordination and collaboration between government departments, and between government and civil society partners;
- Different departments are using their own data, which is often not consistent;
- The private sector through SABCOHA facilitated an M&E forum to harmonise private sector reporting with that of government, but room for improvement still exists;
- Challenges have been experienced with the consistency and quality of civil society reporting;
- There is a general challenge around the quality and consistency of data provided by the various sectors;
- Little is currently being done to build the capacity of M&E officers to ensure more efficient data collection, analysis and reporting;
- While there is a national M&E Working Group there is still no central national database with consolidated HIV-related data;
- South Africa does not publish an annual M&E report on HIV that includes HIV surveillance data;
- There is a challenge around the use of M&E to determine more targeted resource allocation.

There is broad understanding that the public sector should be using the national evidence base and relevant data for programme planning, systems improvement, implementation and for impact evaluation. This is especially important as South Africa rolls out critical national prevention and treatment programmes, including the HCT campaign, the expanded roll-out of ART, and the scaling up of task-shifting to nurse-initiated treatment. Another concern is that there is not a proper monitoring system and no programme in place to educate people about their rights and to help them to protect their rights. This requires much greater involvement by government and the Chapter nine institutions. Given that the new NSP prioritises the human rights and access to justice this M&E area will require focused attention.

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## 7.2.2 PROGRESS

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While South Africa continues to experience challenges in strengthening its overall M&E capacity for HIV, STIs and TB the country has also made some significant progress in ensuring that it has a strong evidence base for effective planning, programming and implementation as it moves into the new NSP phase. Key achievements include the following:

- Development of a results-based M&E Plan on HIV and AIDS for the public sector (2010);
- The establishment of a public sector Technical Working Group on M&E;
- The establishment an RME TTT (technical working group) on M&E at the national level in 2009;
- The release of the *National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa* in 2010;
- The research and development of the *South Africa Know Your Epidemic Report* that was published in 2011;
- The production of the *Mid-Term Review* (2009) and the *End of Term Review* (2011) of the NSP 2007-2011;
- The release of the document *Key Populations, Key Solutions: A Gap Analysis and Recommendations for Key Populations and HIV in South Africa*;
- The development of a results-based Operational Plan for the new *NSP 2012-2016*;
- The development of a draft M&E Plan that is aligned with the new NSP is currently in progress;
- The completion of the *National AIDS Spending Assessment (NASA)*.

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## 7.3 REMEDIAL ACTIONS PLANNED FOR M&E

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The national multi-stakeholder team responsible for developing the new NSP was fully cognisant of this reality, and the planning process has focused on ensuring the centrality of M&E. The NSP 2012-2016 highlights the key aspects towards building and operationalising of a comprehensive M&E system for monitoring the NSP. A detailed M&E framework for monitoring the NSP will be developed by SANAC by April 2012 and will then be made available on the SANAC website [www.sanac.org.za](http://www.sanac.org.za). The framework will take into account existing M&E systems being implemented by different stakeholders, as well as planning and monitoring frameworks and policies in government.

The M&E framework seeks to:

- Monitoring the HIV and TB epidemics, as well as STIs, focusing on incidence, prevalence, morbidity and mortality;
- Building an M&E system for the NSP that strengthens existing systems, and incorporates systems for community-based monitoring and reporting;
- Monitoring implementation of the NSP and report periodically on its implementation;
- Developing and implement an evaluation agenda for the NSP.

A strengthened M&E Unit within the SANAC Secretariat will be responsible for implementing the M&E framework at national level. The M&E units in the provincial AIDS

councils and sectors will assume the same responsibility at provincial and sectoral levels to ensure continuous feedback of relevant and accurate information.

#### 7.4 TECHNICAL ASSISTANCE AND CAPACITY BUILDING NEEDS

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As part of the National Composite Policy Index, Part A the section on Monitoring and Evaluation helped to identify the gaps that exist in South Africa's overall M&E system. Based on the responses to this questionnaire, a set of priority areas for technical assistance and capacity building becomes clear. The main challenges identified in the reporting period include:

- Issues of sustainability and coordination between sectors and departments
- Data quality issues including incomplete data from some sectors; lack of overall M&E capacity to ensure efficient reporting
- Differing data outputs as the various departments use their own data
- Data use does not necessarily translate into effective planning or management for example, with resource allocation

Overall, the lack of a budgeted, multi-sectoral national M&E system for HIV and AIDS makes it difficult to generate coherent, consistent, accurate information to be used on a routine basis to plan and manage the overall national strategy. Without baseline data, it is difficult to set and monitor progress against intervention targets. A Data Use or Dissemination Plan needs to be developed to assist in identifying gaps and making an effort to move forward in real capacity development around M&E.

## ANNEXES

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### ANNEX 1: CONSULTATION/PREPARATION PROCESS FOR THE COUNTRY REPORT

## ANNEX 1: CONSULTATION/PREPARATION PROCESS FOR THE COUNTRY REPORT

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- 1) Which institutions/entities were responsible for filling out the indicator forms?
- |                      |   |  |
|----------------------|---|--|
| a) NAC or equivalent | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No            |
| b) NAP               | Yes                                     | <input checked="" type="checkbox"/> No |
| c) Others            | Yes                                     | <input checked="" type="checkbox"/> No |
- (please specify):

- 2) With inputs from Ministries:

Education	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Health	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Labour	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Foreign Affairs	Yes	<input checked="" type="checkbox"/> No
Others	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No

(please specify): Department of Public Services Administration, Department of Social Development

Civil society organizations	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
People living with HIV	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Private sector	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
United Nations organizations	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Bilaterals	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
International NGOs	Yes	<input checked="" type="checkbox"/> No
Others	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No

(please specify): giz, USAID/PEPFAR, JICA

- 3) Was the report discussed in a large forum?  Yes  No
- 4) Are the survey results stored centrally?  Yes  No
- 5) Are data available for public consultation?  Yes  No

- 6) Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?

Name / title: Dr. Yogan Pillay, Deputy Director-General, HIV and AIDS& MCWH, Department of Health

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Please provide full contact information:

Address: Civitas Building, Pretoria, South Africa

Email: Pillay@health.gov.za

## ENDNOTES

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<sup>1</sup>South Africa National AIDS Council, 2011, National Strategic Plan 2012 – 2016, SANAC.

<sup>2</sup>South Africa National AIDS Council, 2011, The HIV epidemic in South Africa: What do we know and how has it changed?

<sup>3</sup> Study results from a national survey, conducted between June to December 2010 by the MRC, to evaluate the effectiveness of the South African Prevention of Mother to Child Transmission (SA PMTCT) programme at six weeks postpartum show that out of a sample size of 9915 infants, 31, 4% were HIV-exposed. The national HIV transmission rate from mother-to-child, measured in these 9915 infants aged 4-8 weeks attending public sector clinics for their (six week Dap/Pentair) immunization was 3.5%.

<sup>4</sup>Yezingane Network, 2011, The Children's HIV and AIDS Scorecard 2011 – Monitoring South Africa's Response to Children and HIV and AIDS, Children's Rights Centre

<sup>5</sup>SANAC, 2008, HIV, AIDS and Disability in South Africa

<sup>6</sup>Department of Health, 2009, Second National HIV Communications Survey, USAID / HAD / CMT / Soul City / Khomanani

<sup>7</sup> Harrison, O, Newell, M, Imrie, J. and Hoddinott, G., 2010, HIV prevention for South African youth: which interventions work? A systematic review of current evidence, BMC Public Health 2010, 10:102

<sup>8</sup> DPSA, 2011, Public Sector Input on Consolidation and Strengthening the Government Response to the HIV and TB Epidemic

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<sup>10</sup>Shisana O, Rehle T, Simba LC, Zuma K, Jooste S, Pillay-Van Wyk V, Mbelle N, Van Zyl J, Parker W, Zungu NP, Pezi S & the SABBSM III Implementation Team (2009) South African National Prevalence, Incidence, Behaviour and Communication Survey 2008: A turning tide among teenagers? Cape Town: HSRC Press.

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<sup>13</sup> Mercer CH, Copas AJ, Sonneberg P, Johnson AM, McManus S, Erens B, Cassell JA (2009). Who has sex with whom? Characteristics of heterosexual partnerships reported in national probability survey and implications for STI risk. International Journal of Epidemiology 38: 206-214

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<sup>14</sup> Parker W, Makhubhele B, Ntlabathi P, Connolly C. Concurrent Sexual Partnerships amongst young adults in South Africa. Challenges for HIV prevention communication. Challenges for HIV prevention communication. CADRE. 2007

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<sup>16</sup> UNAIDS 2006 Report on the global AIDS epidemic

<sup>17</sup> Department of Health, (2011). The 2010 National Antenatal Sentinel HIV & Syphilis Prevalence Survey in South Africa.

<sup>18</sup> The HIV Epidemic in South Africa: What do we know and how has it changed, 2011, SANAC.

<sup>19</sup> Pettifor AE, Maesham DM, Rees HV & Padian NS (2004). Sexual Power and HIV Risk, South Africa. Emerging Infectious Diseases 10: 1996-2004

<sup>20</sup> This section is informed by responses from government and civil society to the NCPI questionnaires.

<sup>21</sup> The following HIV testing data were reported by the following private sector organizations for 2011: 70,229 from GEMS; 75,798 from BIZWELL, which includes data from 102 registered companies; 44,867 from Aid for AIDS, representing data from 29 companies and medschemes (excluding GEMS); and 100,336 from Discovery Health.

<sup>22</sup> Human Sciences Research Council (HSRC), 2008. South African National HIV Prevalence, Incidence, Behaviour and Communication Survey.

<sup>23</sup> The Global Fund, (2011). Addressing Sex Work, MSM And Transgender People In The Context of the HIV Epidemic , Information Note, July 2011

<sup>24</sup> Desmond Tutu HIV Foundation, 2011, Key Populations, Key Solutions: A Gap Analysis and Recommendations for Key populations in South Africa, and Recommendations for the National Strategic Plan on HIV, STIs and TB 2012-2016, DTHF, UNAIDS, UNFPA, SANAC

<sup>25</sup> SANAC, 2011. Report of the End of Term Review of the NSP 2007-2011

<sup>26</sup> Department of Social Development, 2011, Annual Report 2010/2011.

<sup>27</sup> Shisana O, Rehle T, Simba LC, Zuma K, Jooste S, Pillay-Van Wyk V, Mbelle N, Van Zyl J, Parker W, Zungu NP, Pezi S & the SABBSM III Implementation Team (2009) South African National Prevalence, Incidence, Behaviour and Communication Survey 2008: A turning tide among teenagers? Cape Town: HSRC Press.

<sup>28</sup> Parry CD, Carney T, Petersen P, Dewing S, Needle R. (2010). HIV-risk behavior among injecting or non-injecting drug users in Cape Town, Pretoria, and Durban, South Africa.

<sup>29</sup> Parry CD, Carney T, Petersen P, Dewing S, Needle R. (2010). HIV-risk behavior among injecting or non-injecting drug users in Cape Town, Pretoria, and Durban, South Africa.



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<sup>30</sup>Parry CD, Carney T, Petersen P, Dewing S, Needle R. (2010). HIV-risk behavior among injecting or non-injecting drug users in Cape Town, Pretoria, and Durban, South Africa.

<sup>31</sup>Parry CD, Carney T, Petersen P, Dewing S, Needle R. (2010). HIV-risk behavior among injecting or non-injecting drug users in Cape Town, Pretoria, and Durban, South Africa.

<sup>32</sup>Numerator data source: DHIS, NDOH and Aid for AIDS, GEMS and Discovery. 2010 Numerator is compiled from: Public sector data, including 215,512 on dual therapy; 82,379 on HAART; less 25,861 who switched from AZT to HAART, based on an assumption of 12%. Private sector data, including 3,712 on dual therapy; 3995 on HAART. 2011 Numerator is compiled from: Public sector data, including 184,239 on dual therapy; 108,790 on HAART; less 22,109 who switched from AZT to HAART, based on an assumption of 12%. Private sector data, including 3906 on dual therapy; 3995 on HAART.

<sup>33</sup><http://www.mrc.ac.za/pressreleases/2011/10press2011.htm>

<sup>34</sup>Medical Research Council (MRC), 2010. Evaluation of the Effectiveness of the National Prevention of Mother-to-Child Transmission (PMTCT) Programme on Infant HIV at 6 weeks postpartum in South Africa.

<sup>35</sup>CEGAA / Results for Development Institute, 2011, Costs and Financing of HIV/AIDS In South Africa

<sup>36</sup>SANAC, 2012, National AIDS Spending Assessment (NASA) 2007-2008 to 2009-2010 Fourth Draft Report, CEGAA

<sup>37</sup> NASA only captures those funds that were actually spent by the recipient service providers in the study years. Hence budget allocations and donor commitments are not captured, and only those amounts that can be proven to have been spent in service delivery have been included. Overall the NASA was estimated to capture 98% of public expenditure, 80% of external funding, and 80% of private /non-governmental expenditure. Most donors funding was thought to be captured although some PEPFAR expenditure which could not be validated had to be excluded. Medical insurers account for most of the reported private sector expenditure, but there is thought to be underestimation of expenditure by for-profit businesses and out-of-pocket payments.

<sup>38</sup> Expenditure on outpatient TB care, provided mainly in the public sector, could not be distinguished from other PHC service costs, and are thus not included in the above estimates. As mentioned above, inpatient OI treatment costs are also excluded from the figures.

<sup>39</sup>StatsSA, Victims of Crime Survey, 2011.

<sup>40</sup>South Africa Police Services (SAPS), 2011, Annual Report 2010/2011.

<sup>41</sup>The reason why historical comparisons between the latter figures and the figures for preceding years are extremely difficult and even impossible, is that sexual offences as presently defined differ substantially from those recorded in the past – i.e. prior to December 2007. The definition of rape (formerly understood as referring exclusively to vaginal penetration by a male sexual organ) has been expanded to also include vaginal, oral and anal penetration of a sexual nature by whatever means (and thus male rape) which previously fell under the category of indecent assault. The concept of sexual offences includes a range of transgressions that have never previously formed part of rape or indecent assault – including sex work, pornography, public indecency and human

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trafficking. The consolidation of these various types of sexual offences makes it impossible to compare the present sexual offences figures with those recorded in the past.

<sup>42</sup>Department of Basic Education, 2010, Draft Integrated Strategy on HIV and AIDS 2012-2016, Summary Report.

<sup>43</sup>UNDP, 2011, Human Development Report Statistical Index  
[http://hdr.undp.org/en/media/HDR\\_2011\\_EN\\_Tables.pdf](http://hdr.undp.org/en/media/HDR_2011_EN_Tables.pdf)

<sup>44</sup>Department of Social Development, 2011, Annual Report 2010-2011.

<sup>45</sup>StatsSA, South Africa Millennium Development Goal Report 2010

<sup>46</sup>Medical Research Council, 2011, Annual Report 2010 / 2011.

<sup>47</sup>ANOVA Health Institute, 2010 Annual Report, USAID

<sup>48</sup>UNAIDS, 2010, Getting to Zero.

<sup>49</sup>Department of Health, 2011, Annual Report 2010/2011

<sup>50</sup>This methodology has significant weaknesses: circumstances change quarter-to-quarter and year-to-year, and therefore the percentage of the annual budget spent in one quarter will not necessarily accurately reflect spending rates three years earlier, or later in the same year.

<sup>51</sup>The categories of programme areas changed slightly between these years. For example, in 2007, it was named broadly as "Care and Support", while in 2009 this was split between "Paediatric" and "Adult".

<sup>52</sup>National Commitments and Policy Instrument (NCPI), 2012, Part A and Part B.

