REPUBLIC OF SOUTH AFRICA

COUNTRY PROGRESS REPORT ON THE DECLARATION OF COMMITMENT ON HIV/AIDS

2010 REPORT

Reporting Period: January 2008 - December 2009

FINAL REPORT

31 MARCH 2010

FOREWORD

South Africa is one of the signatories to the Declaration of Commitment on HIV/AIDS made in the 2001 United Nations General Assembly Special Session on HIV/AIDS, and other subsequent commitments such as the Political Declaration from the 2006 High Level Meeting on AIDS.

It is my pleasure to submit the 2010 Country Progress Report on the Declaration of Commitment on HIV/AIDS. This report has been compiled with the collaborative participation of government, civil society, the business sector and development partners, in accordance with the UNGASS Guidelines on Construction of Core Indicators for 2010 Reporting.

South Africa is committed, through our multi-sectoral National Strategic Plan for HIV&AIDS and STIs 2007-2011 (NSP), to implementing strategic interventions guided by various international, continental and regional commitments including the Millennium Development Declaration. The stewardship and coordination provided by the South African National AIDS Council, and councils for AIDS at provincial and district levels is contributing enormously towards achieving the country's goal of Universal Access to treatment, prevention, care and support. During the period 2008-2009, government continued to increase the budget allocated for the national response and revised critical policies and guidelines. On December 1 2009, President Zuma made important policy announcements regarding expanding access to antiretroviral treatment to specific groups of patients, namely pregnant women and people with dual HIV and TB infection with CD4 counts of 350 or less. In addition, all HIV-infected infants will be started on treatment, irrespective of CD4 count. The number of persons who are receiving treatment at public health facilities has reached approximately one million by the end of 2009.

We would like to acknowledge the enormous contribution and efforts that went into the preparation and finalization of 2010 Country Progress Report. In particular, we would like to thank all persons and organizations that contributed towards finalization of the country report. The report benefited from data and information provided by national and provincial governments, the civil society formations including non-governmental organizations, the business sector, and development partners. Members of the government and civil society also participated in workshops for the completion of the National Composite Policy Index questionnaires. I would also acknowledge the approval granted by the South African National AIDS Council to submit the report. My sincerest gratitude to USAID for providing the financial resources for the development and production of this report, John Snow Inc./Enhanced Strategic Information, and for the data collection and report writing conducted by Health and Development Africa (Pty) Ltd.

We trust that this report will make a contribution toward monitoring progress at global level and for the pronouncement of the Secretary General during the UN General Assembly Special Session on HIV and AIDS.

Dr. PA Motsoaledi

Minister of Health

ACKNOWLEDGEMENTS

The 2010 UNGASS Country Progress Report was researched and 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 Task Team of the South African National AIDS Council. The information contained herein also benefits from the wider consultation and data collection process that was carried out by an expanded team of consultants for the Midterm Review of South Africa's National Strategic Plan on HIV, AIDS and STIs during the month of November 2009.

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

The data collection and report drafting was made possible by the generous support of the United States Agency for International Development (USAID) through John Snow Inc/Enhanced Strategic Information.

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AZT	Azidothymidine
CHH	Child-Headed Households
CSO	Civil Society Organizations
CSVR	Centre for the Study of Violence and Reconciliation
CHW	Community Health Worker
DFID	Department for International Development
DoBE	Department of Basic Education
DOH	Department of Health
DHIS	District Health Information System
DSD	Department of Social Development
HISP	Health Information Systems Programme
HCBC	Home and Community-Based Care
HDA	Health and Development Africa
HSRC	Human Sciences Research Council
MCP	Multiple Concurrent Partners
MRC	Medical Research Council
MARPS	Most-At-Risk Populations
MTR	Midterm Review
NASA	National AIDS Spending Assessment
NDOH	National Department of Health
NCPI	National Composite Policy Index
NT	National Treasury
NSP	National Strategic Plan
PEPFAR	US President's Emergency Plan for AIDS Relief
PIC	Programme Implementation Committee of SANAC
RHRU	Reproductive Health Research Unit
STI	Sexual Transmitted Infections
SANAC	South Africa National AIDS Council
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing

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I. STATUS AT A GLANCE

a) Inclusiveness of Stakeholders in the Report Writing Process

The process for compiling the UNGASS Country Progress report was led by the National Department of Health. Technical assistance was provided by the South Africa UNAIDS country office and the Research, Monitoring and Evaluation Task Team of the South African National AIDS Council (SANAC). Technical support and substantive inputs were also provided by SANAC, and members of various SANAC committees, both Government and Civil Society, provided data and their own perspectives for this report. A steering committee comprised mainly of SANAC Programme Implementation Committee (PIC) members was established to oversee all the UNGASS report processes.

Data collection for the 2010 UNGASS Country Progress report was done during the Midterm Review (MTR) of the National Strategic Plan for HIV, AIDS and STI 2007-2011, which took place during November-December 2009. The two activities complemented each other in that they cover the same reporting period and many of the same topic areas. The UNGASS indicators are also embedded in the core M&E indicators for the National Strategic Plan. Many of the interviews conducted with national and provincial stakeholders (both government and civil society) have provided rich information that has been used for both the MTR and the UNGASS Progress reports.

The National Policy Composite Index (NCPI) questionnaire was circulated to a full spectrum of government and civil society sectors represented in the SANAC PIC. Individual members of the SANAC PIC were encouraged to submit responses that were canvassed from their constituencies. In addition, the government's response was coordinated by the Department of Public Service Administration through the Intergovernmental Committee on HIV/TB. The NCPI questionnaires were completed by government officials at the national and provincial levels, and civil society representatives. A special national workshop attended by representatives of government and civil society was held to complete the NCPI questionnaire.

The draft versions of the UNGASS report were circulated among key members of the SANAC PIC to solicit comments and input prior to the national validation workshop. The results of the UNGASS progress report were discussed and validated during a national validation workshop which involved civil society, the private sector, a broad range of government departments and international organizations present in South Africa.

The UNGASS Report serves to provide feedback with respect to goals agreed in the UNGASS Declaration of Commitment and progress made in measuring the South African country`s national response on HIV and AIDS for the reporting period (1 January 2008 to 31 December 2009).

b) Status of the Epidemic

Despite having the most advanced economy in Africa, with well-developed mining, manufacturing, an agricultural and financial sector, South Africa is plagued by large socio-economic inequalities that resulted from the apartheid regime. These inequities continue to manifest in the form of high unemployment rates, wide areas of poverty, and increases in crime[1].

South Africa is one of the countries most severely affected by the AIDS epidemic, with the largest number of HIV infections in the world[2]. UNAIDS estimated that in 2009, the total number of persons living with HIV in South Africa was 5.7 million[i]. South Africa's generalised HIV epidemic is defined as being hyper-endemic[ii] due to the high rate of HIV prevalence and the modes and drivers of HIV transmission. Heterosexual sex is recognized as the predominant mode of HIV transmission in the country followed by mother-to-child transmission, and drivers of the epidemic include migration, low perceptions of risk, and multiple concurrent sexual partnerships[3].

The direct measurement of HIV incidence is extremely challenging, and there is currently no consensus in South Africa on the best method for incidence measurement[4], though there are ongoing efforts within the research community to reach consensus on the best tools and methodologies for measuring HIV incidence. HIV epidemic trends are measured through two methodologies in the country, namely: the annual antenatal HIV prevalence survey, and various population or household based surveys.

The Antenatal HIV Sero-prevalence Survey is conducted annually among pregnant women aged 15-49 years. It provides an estimate of the point of prevalence for that year in the antenatal population of South Africa, and the results are then used to estimate prevalence in the general population. South Africa has almost two decades of good antenatal sentinel surveillance data that assists in monitoring the HIV epidemic trends to better understand the dynamics of the epidemic of the country. The survey is done in all nine provinces among women attending public health sector clinics using an accepted standardised unlinked anonymous methodology[5].

South Africa's 2008 Antenatal survey report was released in July 2009. The overall national HIV prevalence among antenatal women aged 15-49 years is 29.3%[6]. In 2006 and 2007, the HIV prevalence was 29.0% and 29.4% respectively. The findings suggest that HIV prevalence over the last three surveys has stabilized around this level. However, there have been some variations in the HIV prevalence rates in the provinces. The Western Cape reported the lowest estimate of 16.1% while KwaZulu-Natal had the highest HIV prevalence in the country at 38.7%. Mpumalanga has shown an increase in HIV infection from 32.1% in 2006 and to 34.6% in 2007 to 35.5% in 2008.

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[i] Estimates of people in South Africa living with HIV vary according to source, for example, STATS SA and HSRC both estimate HIV prevalence at 5.2 million people (Mid-Year population estimates 2009 and SA national prevalence, incidence, behaviour and communication survey 2008, respectively); while the ASSA 2003 model estimates HIV prevalence at 5.7 million.

[ii] According to UNAIDS (2008), hyper endemic scenarios refer to those areas where HIV prevalence exceeds 15% in the adult population driven through extensive heterosexual multiple concurrent partner relations with low and inconsistent condom use.

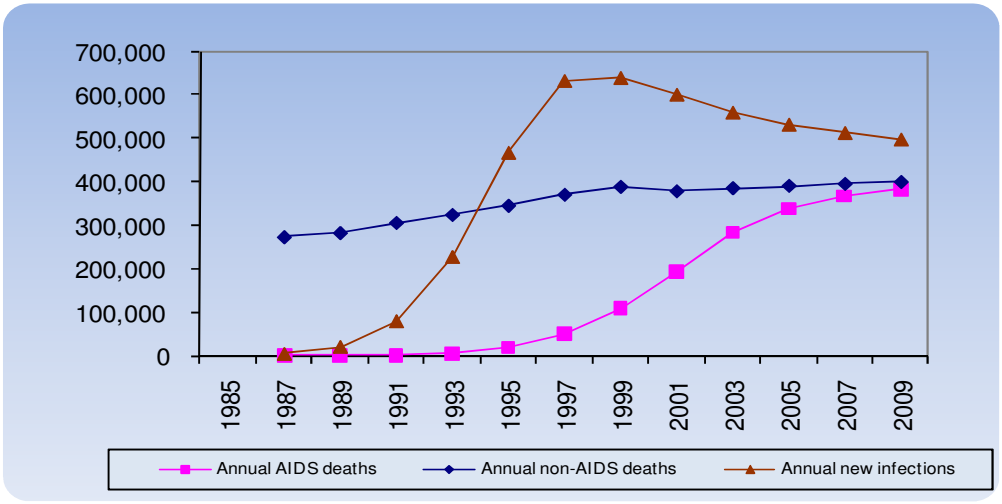
A population-based household survey is conducted every 3 years and is designed to describe the trends in HIV prevalence, HIV incidence and risk behaviour in South Africa. The sample includes individuals of all age groups living in South Africa, including infants less than 2 years of age. People living in hostels, individuals staying in educational institutions, old age homes, hospitals, homeless people, and uniformed-service barracks were excluded from the survey. In the survey, dry blood spot specimens were used to test for HIV antibodies.

The 2005 and 2008 household surveys are comparable for the population aged 2+ and similar prevalence levels were found in all the three surveys[7]. The population survey found the HIV prevalence to have stabilized at around 11% in the population over 2 years of age.

The survey also reported a decline in HIV prevalence among youth 15-24 from 10.3% in 2005 to 8.6% in 2008. However, prevalence remains disproportionately high for females overall in comparison to males. HIV prevalence is highest among the 25-29 years age group, where one in three women were found to be HIV positive. HIV prevalence among males is highest among the 30-34 year age group where 25.8% of men were found to be HIV positive in 2008. Women continue to be worst affected by the HIV epidemic in South Africa[8].

ASSA model estimates (2003) show a steep rise in new HIV infections from 1991, peaking at slightly over 600,000 of the population in 1999, declining slowly from then onwards to rest at just under 500,000 persons in 2009. The steep rise in AIDS deaths starts from 1999 at around 100,000 persons, to level out in 2009 at nearly 400,000 people. The annual numbers of projected AIDS deaths are equal to projected non-AIDS deaths from all other causes, and may be surpassing these.

Figure 1: AIDS deaths, non-AIDS deaths and annual new infections, South Africa, 1985-2009



SOURCE: ASSA model, 2003

c) Policy and Programmatic Response

Policy

In a landmark speech on 29 October 2009 addressing the National Council of Provinces[9], in a culmination of discussions and decisions made since 2007 as per the National Strategic Plan, President Jacob Zuma heralded the beginning of a new movement to accelerate South Africa's universal access to HIV prevention, treatment, care and support.

On World Aids Day 2009, under the theme "I am responsible, we are responsible, South Africa is taking responsibility", the President announced new policies and measures to tackle HIV/AIDS; he also announced a new national HIV counselling and testing (HCT) campaign to be undertaken in April 2010. The new policy on HIV and AIDS will include:

- Treatment for all HIV-positive infants under the age of one, regardless of their CD4 count
- AIDS treatment to be initiated at a CD4 count of 350 or below for pregnant women and TB-HIV co-infected patients
- Mobilize testing for HIV through a Mass National VCT Campaign
- HIV positive pregnant women with a CD4 count above 350 to start ARVs at 14 weeks as part of the prevention of mother to child transmission (PMTCT) of HIV programme

Other critical policies that are in the finalization stages include the HIV Counselling and Testing policy, Stigma Mitigation framework and Medical Male Circumcision document, all developed by the Department of Health in conjunction with relevant stakeholders.

The government has since 2000 developed many policies and programmatic responses to ensure that there is a multisectoral response to HIV/AIDS. This is driven by the five-year National Strategic Plans (the current one is for the period 2007-2011), but supplemented by a variety of complementary policies and guidelines, such as:

- the revised policy and guidelines for the implementation of the PMTCT programme
- the Integrated Nutrition Programme
- Infant and Young Child Feeding Policy (2008)
- A policy on quality health care for South Africa (2008)
- The School Health Policy for South Africa
- Policy guidelines for Youth and Adolescent Health
- Policy Framework for Orphans and other Children made Vulnerable by HIV & AIDS
- National Action Plan for Orphans and other Children made vulnerable by HIV and AIDS
- Home and Community-Based Care Policy Framework

Other policy initiatives include:

Department of Social Development (DSD)

To mitigate the impact of the global economic downturn, and HIV and AIDS, the Department of Social Development advocated an increase in social grants. The child support grant extended children's eligibility until the age of 18 years. The means test for social grants was raised to include wider access to social support. Draft guidelines for Statutory Services to Child-Headed Households (to complement section 137 of the Children's Act of 2005) were drafted to ensure standardised delivery of quality services to children in child-headed households.

The National Action Committee for Children Affected by HIV and AIDS (NACCA), with the Department of Social Development as the Secretariat, was instrumental in engaging stakeholders in the development of a Policy Framework for Orphans and Other Children made Vulnerable by HIV and AIDS and a National Action Plan (2009-2012) during the reporting period.

Years of efforts around child protection culminated in the passing of the Child Justice Bill (25 June 2008), which brings about important changes in giving effect to South Africa's constitutional and international obligations to children in trouble with the law.

Women, Children and Persons with Disabilities

For the first time, the South African government has designated a Ministry dedicated to Women, Children and Persons with Disabilities. This government ministry is spearheading efforts to address policy implementation challenges. The men's sector is also a new addition in the SANAC structure aimed to contribute to the development and emancipation of women and the protection of children.

Department of Public Service and Administration (DPSA)

The Department of Public Service and Administration will amplify mitigation of HIV and AIDS in the workplace through the public sector workplace health and wellness policy for use by all government departments at all levels. The DPSA approved an HIV and AIDS and TB management policy in November 2009, to be launched on the 1st of April 2010.

Department of Higher Education

An HIV and AIDS Policy Framework for Higher Education in South Africa was developed through the Higher Education AIDS (HEAIDS) Programme, a joint initiative of the Department of Education (now Higher Education and Training) and Higher Education South Africa. This framework, adopted in October 2008, embodies the education sector's commitment to HIV and AIDS into every level of operation.

Programmatic response

While implementation of the NSP has been slow in some areas, there has been significant achievements made in the rollout and uptake of ART and PMTCT services, and home and community-based care (HCBC) and support to people infected and affected by HIV and AIDS[10]. Progress made in other sectors has also contributed to the overall response.

Prevention

Central to the response of the government is the prevention programme. This comprehensive public health prevention and care package includes:

- Information, education and mass mobilization
- Detection and management of sexually transmitted infections
- HIV counselling and testing
- Widespread provision of condoms, both male and female
- Medical male circumcision
- Prevention of mother to child transmission (PMTCT)
- Safe blood transfusion
- Post-exposure prophylaxis, and
- Life skills education

Central to prevention activities are media campaigns and related programmes, focused on behaviour change. **Khomanani** is the official government communications campaign; **loveLife** is a prevention programme operating in public schools, clinics and community-based organisations aimed at youth aged 12-17 years as well as out of school children with specific focus on farming communities and informal settlements; **Soul City** is a national prevention campaign through edutainment, offering a television drama series *Soul City*, and *Soul Buddyz,* a radio/television component for 6-12 year olds; and the **Department of Education's life skills** programme. Other media initiatives include local productions such as Siyanqoba Beat it!, 46664 (Nelson Mandela Foundation), Tsha Tsha and Scrutinize (Johns Hopkins University Health and Education South Africa). The challenge is to translate mass media programmes into peer-to-peer initiatives that would have a much wider impact on behaviour change.

HIV counselling and testing (HCT) is a key prevention strategy, that also serves as an entry point for HIV care and treatment services. As such much has been done by government and civil society to test people for HIV, and this has increased from testing around 1 million people per annum, to approximately 2.5 million people in 2009. This will increase even more in 2010 (see below).

There is a large free condom distribution programme, providing approximately 400 million male condoms annually. This will expand to 2.5 billion male condoms in 2010, in response to the President's announcements in December 2009. Although expanding, free female condom distribution is still much smaller[11], mainly due to the very high cost of female condoms.

PMTCT scale up and uptake has increased since initiation of the program in 2004. PMTCT is now almost universally available in public primary health facilities having achieved the NSP target of 95% coverage in public sector antenatal service sites in 2008[12]. Most recently, PMTCT guidelines were revised and adopted to include the introduction of the dual therapy regimen Nevirapine and AZT (Zidovudine). President Zuma announced that the PMTCT regimen would be changed as of 1 April 2010, starting women on the HIV prophylaxis regimen as of 14 weeks (currently 28 weeks). This will have a significant impact on further reducing the transmission of HIV from mother to infant.

Other areas of success include safe blood transfusion, and the scale-up of prevention of mother-to-child transmission of HIV. Though much has been achieved in the last two years, SANAC has broadly acknowledged that more needs to be done to strengthen certain components of the prevention package, and the initiatives embarked upon in 2010 will achieve just that. The 2012 UNGASS report will comprehensively report on these new initiatives, such as:

- The increased provision of male and female condoms
- Medical male circumcision – to be available in all nine provinces by March 2011
- A massive HIV counselling and testing campaign that aims to test 15 million South Africans between April 2010 and June 2011

Treatment

The programmatic response from government in the area of treatment has been significant, primarily in Department of Health public sector facilities, but also in the South African military, and in prisons, through the Department of Correctional Service. In the last five years South Africa has established the largest antiretroviral treatment programme in the world, with around 1 million people on ART by the end of 2009. This has been provided in around 500 public sector health facilities, mainly hospitals, but also some community health centres and clinics. This service has been supplemented by hundreds of private sector and NGO sector service points (e.g. NGO clinics and general practitioners).

As per President Zuma's announcement in December 2009, this treatment programme will expand even further through a decentralised model, and the aim is to initiate patients on treatment through a nurse-driven approach. This will bring services closer to where people live, and the ultimate goal is to progressively enable all 4,000 public sector facilities to provide ART initiation. These changes will allow the country to meet and exceed the treatment goals in the NSP, and will be reported on in the 2012 UNGASS report.

The public ARV treatment programme reported approximately 919,923[iii] people on treatment by the end of November 2009, with the private and non-governmental organisation (NGO) sector supporting an additional estimated 51,633 people. This is a significant increase from the 2008 UNGASS Report. However,

[iii] This figure is current patients on treatment for eight of the nine provinces. Accordingly deregistered patients due to deaths, loss to follow up and transfer out are taken into account submitting monthly summaries.

there are still substantial health system constraints to scaling up ART treatment services, including human resource capacity, infrastructure and drug supply. There are pilot projects testing a task-shifting approach that involves the utilization of professional nurses as well as private sector physicians in ART case management. These models will be implemented in the public sector in 2010 as per President Zuma's announcement of 1 December 2009 regarding the decentralisation of HIV and ART care.

Impact Mitigation

The Department of Cooperative Governance and Traditional Affairs (formerly Provincial and Local Government) published a "*Handbook for Facilitating Development and Governance Responses to HIV and AIDS"* for use by districts and municipalities, intended to guide local government in mitigating the impact of HIV and AIDS in their communities.

The Department of Public Service and Administration is implementing an HIV and AIDS mainstreaming programme, based on a "Train the Trainer" model for the public sector and civil society, which extends to universities, trade unions, and many more. Successes to date include gaining national consensus on HIV and AIDS mainstreaming, institutionalization of the concept, and engagement with a wider variety of partners, especially within civil society.

The Higher Education AIDS (HEAIDS) Programme, a joint initiative of the Department of Higher Education and Training (formerly Education) and Higher Education South Africa with support from the European Union, have achieved some significant outputs in the reporting period. National research around the role of educators with respect to HIV/AIDS was conducted to inform development in teacher education (pre-service and in-service). A teacher education module was piloted in 25 teacher education faculties and schools, which has provided critical lessons in the infusion/integration of HIV into the curricula. A sector-wide sero-prevalence study combined with a Knowledge, Attitude, Behaviour and Perception (KAPB) and risk assessment, provided first-time baseline data of the scale and drivers of the epidemic at institutional and sector levels. A framework for workplace programmes and norms and standards for sustainable funding models and mechanisms at institutional level were developed. In addition to the sector level research, institutions have been directly strengthened through the award of grants (a total of R59.3m) to their institutional programmes.

Since 2008, the South African Business Coalition on HIV/AIDS (SABCOHA) engaged with a variety of sectors (i.e., Children, Traditional Healers, Traditional Leaders, NGOs, and Sex Workers) with the purpose of sensitizing businesses to their needs and providing ways for employers to collaborate with them. SABCOHA also adopted provincial systems strengthening as a means to support the NSP, and is in the process of facilitating business sector representation to Provincial AIDS Councils across the country in an effort to strengthen coordination and cooperation. To date SABCOHA has assisted the Northern and Western Cape provinces in developing business sector strategies and establishing representatives on Provincial AIDS Councils.

d) UNGASS Indicator overview table

Much of the data for the UNGASS Indicator Table are either from government programme data, or the 2008 South African National HIV Prevalence, Incidence, Behaviour and Communication Survey. This survey is only conducted every three years, thus, in those cases where the Survey is the only data source, the 2008 results are indicated, but the 2009 column left blank.

Table 1: UNGASS indicator overview table, 2008/09

UNGASS INDICATOR TABLE, 2008/09				
#	INDICATOR	DATA RESULTS		DATA SOURCE
		2008	2009	
NATIONAL COMMITMENT AND ACTION				
1	Domestic and international AIDS spending by categories and financing sources	R13,972 mil	R17,579 mil	National Treasury Department
POLICY DEVELOPMENT AND IMPLEMENTATION STATUS				
2	National Composite Policy Index	--	--	NCPI survey
NATIONAL PROGRAMMES				
3	Percentage of donated blood units screened for HIV in a quality secured manner	100%	100%	SANBS
4	Percentage of adults and children with advanced HIV infection receiving ART	45%	56%	NDOH programme data 2008 and 2009; STATS SA Estimate of number of people in need of Treatment
5	Proportion of HIV+ pregnant women receiving antiretroviral medicines to reduce the risk of mother-to-child transmission	87%	83%	Department of Health Annual Report 2008/09; DHIS 2009
6	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	18%	42%	NDOH TB Programme data 2009
7	Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results	25%	37%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008; National Communication Survey 2009
8	Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results • African Females aged 20-34 • African Males aged 25-49 • Males aged 50 Plus (50-55) • Men who have sex with Men • High risk drinkers • Recreational drug users • People with disabilities	• 36% • 25% • 18% • 27% • 23% • 23% • 20%	• 48% • 52% • 3%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008; National Communication Survey 2009

UNGASS INDICATOR TABLE, 2008/09				
#	INDICATOR	DATA RESULTS		DATA SOURCE
		2008	2009	
9	Percentage of most at risk populations reached with HIV prevention programmes	Data not routinely collected	Data not routinely collected	Special survey required
10	Percentage of orphaned and vulnerable children aged 0-17 years whose household received free basic external support in caring for the child	75%	75%	DSD Annual Report 2008/09; Children's Institute, 2009[13]
11	Percentage of schools that provide life skills based HIV education within the last academic year	100%	100%	EMIS: School Realities 2008 and 2009, NDoE
KNOWLEDGE AND BEHAVIOUR				
12	Current school attendance among orphans aged 10-14	98%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008
12	Current school attendance among non-orphans aged 10-14	99%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008
13	Percentage of young women age 15-24 who both correctly identify ways of sexually transmitting HIV and reject major misconceptions about HIV transmission	27%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008
13	Percentage of young men age 15-24 who both correctly identify ways of sexually transmitting HIV and reject major misconceptions about HIV transmission	30%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008
14	Percentage of most at risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission • African Females aged 20-34 • African Males aged 25-49 • Males aged 50 Plus (50-55) • High risk drinkers • Recreational drug users • People with disabilities	• 26% • 28% • 28% • 31% • 36% • 21%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008
15	Percentage of young women and men who have had sexual intercourse before the age of 15	9%	10%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008; National Communication Survey, 2009 (16-49 years)
16	Percentage of women aged 15-49 years who had sexual intercourse with more than one partner in last 12 months	4%	7%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008; National Communication Survey, 2009 (16-49 years)
16	Percentage of men aged 15-49 years who had sexual intercourse with more than one partner in last 12	19%	34%	South African National HIV Prevalence, Incidence, Behaviour

UNGASS INDICATOR TABLE, 2008/09				
#	INDICATOR	DATA RESULTS		DATA SOURCE
		2008	2009	
	months			and Communication Survey 2008; National Communication Survey, 2009 (16-49 years)
17	Percentage of women aged 15-49 years who had more than one sexual partner in last 12 months reporting the use of a condom during last intercourse	68%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008
17	Percentage of men aged 15-49 years who had more than one sexual partner in last 12 months reporting the use of a condom during last intercourse	77%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008
18	Percentage of female and male sex workers reporting the use of a condom with their most recent client	Data not routinely collected	Data not routinely collected	Special survey required
19	Percentage of men reporting the use of condom the last time they had sex with a male partner	Data not routinely collected	Data not routinely collected	Special survey required
20	Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	Data not routinely collected	Data not routinely collected	Special survey required
21	Percentage of injecting drug users reporting the use of a condom during last sexual intercourse	Data not collected	Data not collected	Special survey required
IMPACT				
22	Percentage of young women aged 15-24 who are HIV infected	14%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008
22	Percentage of young men aged 15-24 who are HIV infected	4%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008
23	Percentage of most at risk populations who are HIV infected: • African Females aged 20-34 • African Males aged 25-49 • Males aged 50 Plus (aged 50-55) • Men who have sex with men • High risk drinkers • Recreational drug users • People with disabilities	 • 33% • 24% • 6% • 10% • 14% • 11% • 14%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008
24	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Data not routinely collected	Data not routinely collected	Cohort study
25	Percentage of infants born to HIV positive mothers who are infected	16%	16%	Spectrum modelling

II. OVERVIEW OF THE EPIDEMIC

Sub-Saharan Africa remains the region most heavily affected by HIV worldwide, accounting for over two thirds of all people living with HIV and for nearly three quarters of AIDS-related deaths worldwide in 2008[14].

With a hyper-endemic HIV epidemic, South Africa has more than 15% of the population aged 15-49 living with HIV. UNAIDS estimates that there are 5.7 million people living with HIV in the country; more than 3 million of these are women aged 15 and up, and 280,000 are children ages 0-14 years[15] - making it the world's largest population of people living with HIV.

a) Modes of HIV transmission

HIV in South Africa is transmitted predominantly heterosexually between couples, with mother-to-child transmission being the other main infection route. Drivers of the epidemic in South Africa are intergenerational sex, multiple concurrent partners, low condom use[16], excessive use of alcohol and low rates of male circumcision.

In relation to intergenerational sex, research has indentified younger females having sex with older males as an important factor contributing to the spread of HIV[17]. It has been noted that such relationships are usually motivated by subsistence needs as well as being linked to materialism[18]. 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 themselves[19]. 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[20].

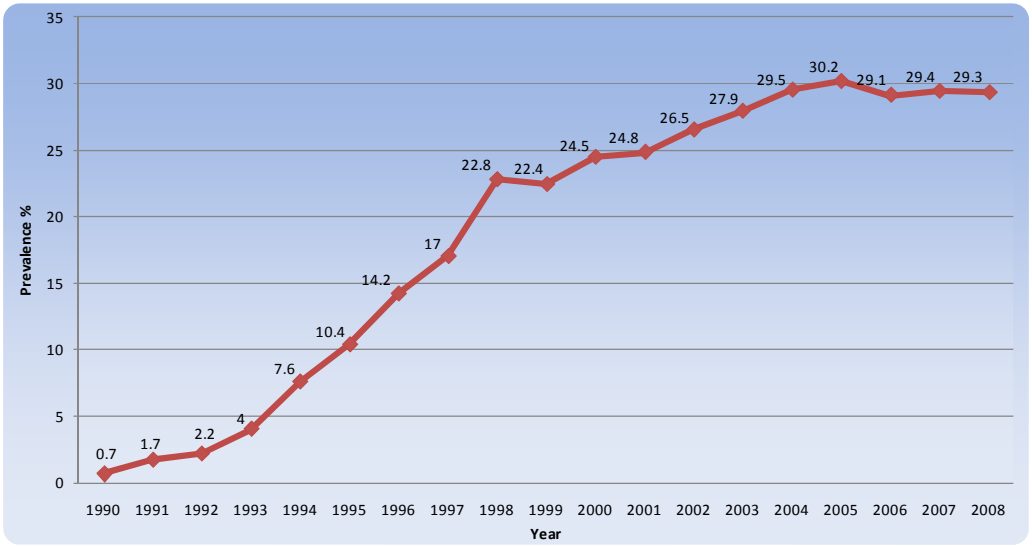
Research suggests that concurrent sexual partnerships – sexual relationships that overlap in time – are common in South Africa[21]. Modelling studies have illustrated that concurrent sexual partnerships result in sexual networks that have densely clustered pathways that do not occur when people have sequential relationships that do not overlap in time[22]. Consistent condom use among those who have multiple partners appears to be increasing, particularly in the areas most affected by the epidemic. UNAIDS reports that in 21 countries where this information has been collected over at least two time points, condom use by women increased in 16 countries, and condom use by men increased in 12 countries. However, advances in condom use cannot be taken for granted, because condom use has declined in a number of countries[23].

b) National HIV prevalence trends

The 2008 antenatal HIV sero-prevalence survey reported that the national overall HIV prevalence amongst 15–49 year old pregnant women served in public health clinics was 29.3%. The estimated national HIV prevalence amongst the women surveyed has remained stable over the past three years, at a rate of 29.1%

in 2006, 29.4% in 2007 and 29.3% in 2008. This agrees with the recent projections by UNAIDS that the HIV epidemic curve is reaching a plateau (Figure 2).

Figure 2: HIV prevalence epidemic curve among antenatal women, South Africa, 1990-2008

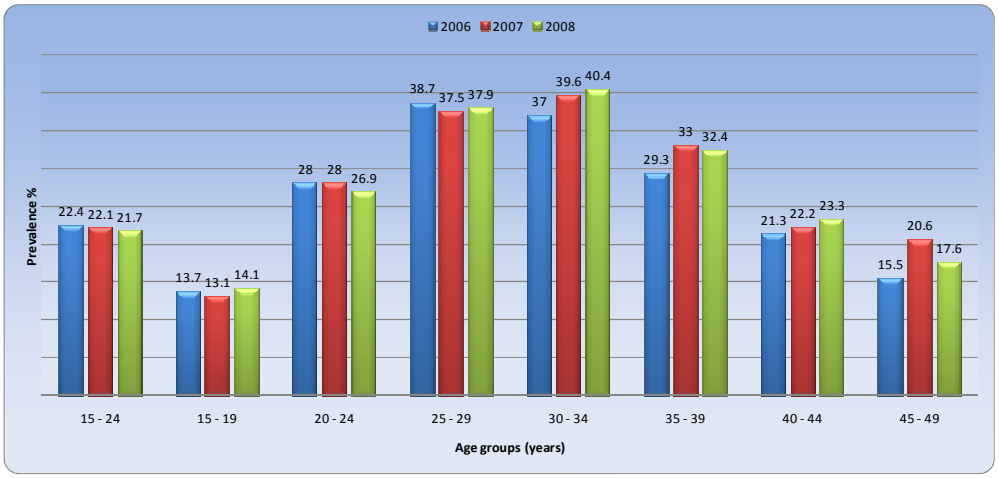


Source: Antenatal HIV sero-prevalence survey 2008

HIV Prevalence by Age – Antenatal survey

HIV prevalence among antenatal women under the age of 25 years has remained stable over the past three years (2006-2008); however, trend data shows that HIV prevalence is increasing among antenatal women aged 30 years and older (Figure 3).

Figure 3: HIV prevalence among antenatal women by age group, South Africa, 2006 to 2008



Source: Antenatal HIV sero-prevalence survey 2008

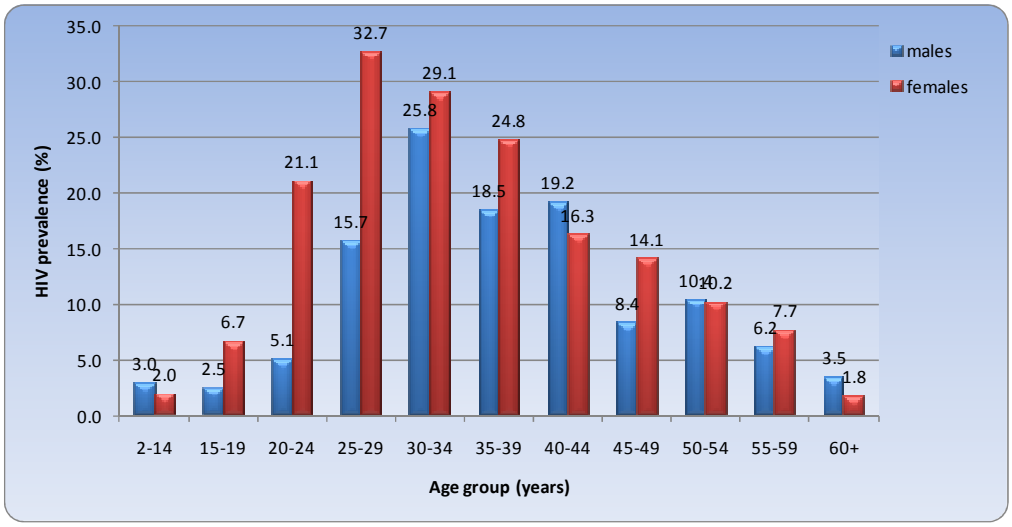
The increase in prevalence among older women could be attributed to the effect that ARV treatment is having on AIDS-related mortality. Triangulation of AIDS mortality data, prevalence estimates and other data is necessary for further extrapolation of prevalence trends.

HIV Prevalence by Age – Population survey

The 2008 South African National Prevalence, Incidence, Behaviour and Communication Survey, referred to as the household survey, shows national HIV prevalence amongst all age groups at 10.6% (

Figure 4). Prevalence amongst the population aged between 15-49 years remains high at 16.9%, showing a slight increase from the 2005 result of 16.2%.

Figure 4: HIV prevalence, by sex and age, South Africa 2008



Source: South African National Prevalence, Incidence, Behaviour and Communication Survey 2008

Women have a higher HIV prevalence overall compared to men, with the exception of the 40-44, 50-54 and 60+ year age groups. This may represent the underlying pattern of sexual dynamics in South Africa where intergenerational sex is common, and a high risk for HIV infection[24].

c) HIV prevalence in youth ages 15-24

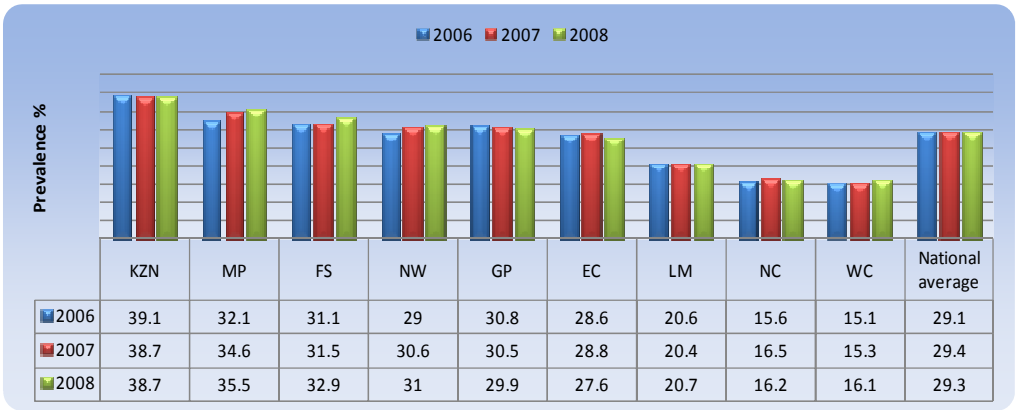
Impact Indicator	2008	2009	Source
Percentage of young women aged 15-24 who are HIV infected	13.9%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008
Percentage of young men aged 15-24 who are HIV infected	3.6%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008
Percentage of young men and women aged 15-24 who are HIV infected	8.7%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008

South Africa measures HIV prevalence in youth as a proxy indicator of HIV incidence and as a marker for prevention programmes. The 2008 household survey showed a low HIV prevalence amongst 15-24 year old males at 4%, while prevalence is higher for young women of the same age group at 14%.

HIV prevalence by province

There is significant variation in HIV antenatal prevalence by province, ranging from a high of 38.7% (KwaZulu-Natal) to a low of 16.1% (Western Cape). The Free State, Gauteng, Mpumalanga, North West and KwaZulu-Natal provinces all recorded higher prevalence than the national average of 29.3%. HIV prevalence in the Eastern Cape (27.6%), Limpopo (20.7%), Northern Cape (16.2%) and Western Cape (16.1%) fell into a range below that of the national average.

Figure 5: HIV prevalence distribution among antenatal women by province, South Africa



	KZN	MP	FS	NW	GP	EC	LM	NC	WC	National average
2006	39.1	32.1	31.1	29	30.8	28.6	20.6	15.6	15.1	29.1
2007	38.7	34.6	31.5	30.6	30.5	28.8	20.4	16.5	15.3	29.4
2008	38.7	35.5	32.9	31	29.9	27.6	20.7	16.2	16.1	29.3

Source: Antenatal HIV sero-prevalence survey 2008

d) HIV Prevalence among most-at-risk populations

Most at risk populations (MARPs) are defined as those populations that are found to have a higher than average HIV prevalence when compared to the general population. According to UNAIDS, MARPs engage in behaviours that put them at higher risk for HIV infection[25]. At-risk populations are among the most marginalized and most likely to be stigmatized. In addition, resources and national HIV-prevention campaigns do not address their specific HIV prevention, treatment and care needs. Unfortunately, research in South Africa has tended to neglect typical MARPs, and thus up-to-date information is largely unavailable, with the exception of some recent studies with MSM.

While the NSP identifies traditional MARPS such as men having sex with men (MSM), intravenous drug users (IDU) and commercial sex workers (CSW), these groups are not typically surveyed. For example, data collected in 1996 and 1998 on all female CSW in the Hillbrow area of Johannesburg showed 45% HIV prevalence among this group (Rees et al, 2000); however, no further data has been gathered on CSW since then[26].

There is growing evidence that HIV prevalence amongst MSM in South Africa is higher than that of the general population. A series of studies were conducted to determine the magnitude of HIV prevalence amongst MSM in South Africa. The results of three recent studies conducted in Johannesburg and Durban (Rispel et al 2009), Soweto (Dladla et al 2009), and Cape Town (Burrell et al 2009) found that MSM are represented in all race groups in South Africa. The Soweto study found an HIV prevalence of 33.9% among gay-identified men, 6.4% among bisexual-identified men, compared to 10.1% among heterosexual-identified men[27]. The Johannesburg and Durban study found an overall HIV prevalence rate of 38.3%[28]. The overall rate for MSM is estimated as 10% of the general population. Greater attention and focus needs to be paid to this population.

The incidence of HIV transmission through intravenous drug use is not known, although prevalence among drug users may be higher than the general population, from 5-20% (Parry & Pithy 2008). The HSRC survey 2008 found a prevalence of 10.8% among the 490 people who self-identified as using drugs for recreational purposes (Shisana et al, 2008). This estimate may be biased by under-reporting of illegal practices. As IDU is thought to be relatively low in South Africa, its contribution to total incidence would likely be very small relative to other modes of transmission[29].

The 2008 household survey identified other MARPs particular to the South African context as follows[30]:

- African Females aged 20-34
- African Males aged 25-49
- Males aged 50 and older
- Men who have sex with men
- High-risk drinkers
- Recreational drug users
- People with disabilities

This study showed that amongst these MARPS, African females aged 20–34 had the highest HIV prevalence followed by African males aged 25–49 years. Prevalence was lowest for both males 50+ years and for MSM (Table 2).

Table 2: HIV prevalence among the most-at-risk populations, South Africa 2008

Indicator	2008	2009	Source
HIV prevalence of African females 20-34 years	33%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008
HIV prevalence of African males 25-49 years	24%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008
HIV prevalence of males 50+ years	6%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008
HIV prevalence of MSM	10%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008

Indicator	2008	2009	Source
HIV prevalence of high-risk drinkers	14%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008
HIV prevalence of recreational drug users	11%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008
HIV prevalence of people with disabilities	14%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008

The results mark HIV prevalence as highest in the African females group aged 20–34 years at 32.7%. African males followed second at 23.7% in the 25–49 age range. The next highest category of MARPs was people with disabilities (14.1%) followed by high-risk drinkers (13.9%). One of the most frequent complaints among people with disabilities was that HIV and AIDS interventions and services are not tailored to the specific needs of this group, particularly in relation to access to services, in both physical convenience and the availability of materials in alternative formats. Recreational drug users, MSM and males aged 50+ years fell into the low end of the prevalence range at 10.8%, 9.9% and 6.0% respectively. However, as discussed above, surveys that focused exclusively on MSM probably provide a more reliable estimate of the HIV prevalence in this population.

Prevention and service initiatives for the South African epidemic remains complex due to the geographical evolution of the many sub-epidemics at the provincial or sub-district levels, and the variety of sub-groups affected. The challenge remains for policy makers to identify the most effective ways to decrease HIV transmission by influencing the circumstances around most-at-risk groups into specific tangible interventions. This would also require more sub-level data collection and analysis to tailor interventions appropriately.

e) Other impact indicators

Survival after 12 months on antiretroviral therapy

Impact Indicator	2008	2009	Source
Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	--	82%	Western Cape Provincial reports, Jan-Jun 2009
	--	72%	Northern Cape Provincial reports, Jan-Sept 2009

Survival data is critical in determining the quality of ART service provision. While South Africa does not yet have one uniform patient monitoring system in place that allows for cohort reporting, some ART sites do have cohort-reporting capacity. The table indicates the percentage of adults on treatment 12 months after initiation of ART.

Provincial cohort survival data is cumulative instead of tracking survival of those initiated in the last 12 months; however, cases where survival data are tracked demonstrates a relatively high survival rate. 82% of ART patients remained in treatment in the Western Cape and 72% were in treatment in the Northern

Cape in 2009. This is similar to the survival rate of 75% of patients enrolled in the Right to Care programme (2008), with selected sites over five provinces.

Reduction in mother-to-child transmission

Impact Indicator	2008	2009	Source
Percentage of infants born to HIV positive mothers who are infected	16%	16%	Spectrum modelling

The Spectrum software package Version 3.37 was used to estimate the number of infants born to HIV-positive mothers, using the number of infants under age 1 year needing cotrimoxazole out of the number of births for the time period. The estimate above does not reflect new policy information. The modelling exercise projected very little difference in the percentage of HIV-positive births from 2005-2016 (ranging from 16.15% to a high of 16.87%) as the number of births also decreases over time.

PCR data collected from the PMTCT programme may be a more sensitive measure of the South African reality, and indicates that the number of HIV-infected babies is likely declining, most likely due to the success of the PMTCT programme. The data show an estimated overall national transmission rate of HIV to babies born to HIV-infected mothers at about 11% (Table 3).

Table 3: PCR data and estimated transmission rates of mother-to-child, South Africa, 2009

PCR category	Not Available	Positive	Negative	Equivocal	Invalid	Total	HIV Transmission Rate
EC	115	2,885	25,422	37	190	28,649	10.2%
FS	281	1,260	8,993	30	0	10,564	12.3%
GP	517	6,533	53,683	117	115	60,965	10.9%
KZN	1,579	7,190	64,288	1,381	0	74,438	10.1%
LP	51	2,095	13,922	255	145	16,468	13.1%
MP	6	2,164	14,919	286	133	17,508	12.7%
NC	43	401	3,031	3	2	3,480	11.7%
NW	105	1,970	14,449	117	107	16,748	12.0%
WC	156	1,350	15,318	9	1	16,834	8.1%
National	2,853	25,848	214,025	2,235	693	245,654	10.8%

SOURCE: National Health Laboratory Services, 2009

III. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

a) National commitment and action

Indicator	2008	2009	Source
Domestic and international AIDS spending by categories and financing source	R13,972 mil	R17,579 mil	National Treasury Department

South Africa is currently conducting a National AIDS Spending Assessment (NASA) exercise, which is the ideal data source to inform this indicator. Unfortunately, the report will only be finalized sometime in 2010 after the UNGASS deadline of 31 March. Thus, a calculation of AIDS spending has been conducted with data from the National Treasury Department.

The data[iv] show that overall spending on HIV and AIDS, domestic and foreign combined had increased by 21% from 2008 to 2009.

[iv] For public spending the medium term budget policy statement (MTBPS) was used. The MTBPS outlines the government's revenue projections, spending priorities, the division of resources between national and provincial as well reporting on major conditional grants. Government department budgets were used to report on AIDS spending, as well as an analysis of quarterly reports on the HIV/AIDS conditional grants. It should be noted that the information reported is in no way conclusive of all assistance provided.

Table 4 details the breakdown of financial support according to source. Domestically, HIV and AIDS is primarily financed through the national health budget, and the HIV and AIDS conditional grant of the budget has grown from R4.3 billion in 2008 to an estimated R5.3 billion in 2009. The national health budget is augmented by spending in social development and education, which addresses impact mitigation on families, particularly orphans and vulnerable children. AIDS prevention research is supported through the Department of Science and Technology. A fair amount of resources are devoted to the National Health Laboratory Service which conducts PCR and other HIV-related testing and monitoring.

A number of bilateral and multilateral donors support the National Strategic Plan; the most notable being the US President's Emergency Plan for AIDS Relief (PEPFAR). While PEPFAR does provide detailed country operational plans, very little is provided by way of final expenditure, as funding is awarded typically over a five year period. Significant support was also provided by the UK, EU and UN agencies.

South Africa was awarded funds from Round 6 of the Global Fund grant and the final tranches of this grant is reflected; however, final Global Fund Round 3 disbursements are not included. Private sector information and response are under-reported.

Table 4: Domestic and international HIV and AIDS expenditure by source, 2008-2009

FINANCING SOURCE	2008		2009	
	ZAR (millions)	USD (millions)[a]	ZAR (millions)	USD (millions)
National Department of Health	474	57	502[b]	60
Provincial Department of Health	3753	455	5433[c]	645
Department of Social Development	607	74	678[d]	81
Department of Social Development (National)	58	7	61	7
Department of Education	171	21	181[e]	21
Department of Science and Technology	55	7	68[f]	8
Defence	58	7	61	7
Transfers to NGO (HIV)	110	13	150[g]	18
National Laboratory Service	357	43	525[h]	62
South African Aids Vaccine Initiative	12	1.5	11[i]	1.3
Medical Research Council	112	14	110[j]	13
Treatment of Opportunistic infections	5000	606	5000	594
Subtotal domestic spending	**10767**	**1305**	**12780**	**1518**
% domestic spending	**77%**	**77%**	**73%**	**73%**
PEPFAR	2978	361	4425[k]	526
Global Fund	100	12	30[l]	4
DfID			200[m]	24
Kaiser Foundation	50	6	50[n]	6
Canada	3	0.33		
Belgium	3	0.33		
UN agencies	25	3	51	6
EU (14)	47	6	43[o]	5
Subtotal development partner spending	**3205**	**389**	**4799**	**570**
% development partner spending	**23%**	**23%**	**27%**	**27%**
TOTAL EXPENDITURE (domestic & foreign)	**13972**	**1694**	**17579**	**2088**

[a] Based on average exchange rate of: 1 ZAR to 8.25 USD for 2008 and 1 ZAR to 8.42 USD for 2009, SOURCE: Foreign Exchange Average Converter tool, ONANDA website, http://www.oanda.com/currency/average
[b] Medium Term Budget State Health Appropriations Vote 2009
[c] Department of Health HIV Conditional Grant Quarterly Report 2009
[d] Medium Term Budget State DSD Appropriations Vote 2009
[e] Medium Term Budget Statement Education Vote 2009
[f] Medium Term Budget Statement Science and Technology Vote 2009
[g] Medium Term Budget Statement Health Vote 2009
[h] NHLS Annual Report 2008/09
[i] Medium Term Budget Statement Health Vote 2009
[j] Medium Term Budget Statement Health Vote 2009
[k] South African National Treasury
[l] South African National Treasury
[m] UK Department of Foreign International Development programme reports
[n] South African National Treasury
[o] EU funding appropriated to the Higher Education HIV/AIDS Programme (HEAIDS)

b) Policy / strategy development and implementation

The existing policy environment is measured using the National Composite Policy Index (NCPI). This is a composite of policy indicators intending to measure the extent to which countries have developed policies and strategies on HIV/AIDS in the broad areas of: strategic planning; political support; HIV prevention, treatment, care and support; human rights; and civil society involvement.

The NCPI questionnaire was administered to SANAC PIC members in a working session held on 19 January 2010. It incorporated government representatives, a range of representatives from civil society and one development partner (for a full list of persons consulted, 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 17 February 2010.

A trend analysis is impossible to determine, as NCPI scores for previous UNGASS Country reports are unavailable. However, a summary of the 2009 NCPI (Annex 2) shows that the national strategic plan was developed through wide multi-sectoral consultation. An HIV socio-economic impact study has informed resource allocation decisions. Political and policy support, and efforts in implementation of HIV programmes (including meeting the needs of OVC) all rated highly for 2009. It was agreed that research data was used to revise the national strategy, but that it was poorly used for resource allocation and programme improvement. M&E efforts of the HIV programme overall were rated low (4 out of 10). The development of a national M&E framework is a key focus for the newly reconstituted SANAC and SANAC Secretariat.

Civil society agreed that South Africa has progressive non-discrimination laws and regulations to promote and protect human rights, acknowledging that most at risk populations are included, excepting IDU and commercial sex workers (CSW). The level of civil society contributions to strengthening political commitment was felt to be high (4 out of 5), but lower in its involvement in planning and budgeting processes. While civil society services are included in the national strategy, it was felt that the efforts are not included in national reports. This group reports contributions to over 75% of the services available for MSM, CSW, HCBC and OVC, and over half of the efforts in reducing stigma and discrimination. It also contributes from one quarter to one-half of the services available to youth, and testing and counselling.

Promoting an enabling environment

A major objective of the NSP is to create a social environment that encourages more people to test voluntarily for HIV and, when necessary, to seek and receive medical treatment and social support. Human rights are integral to all of the priority preventions, as well as active campaigning and monitoring to promote human rights. While data systems are not in place to collect and monitor information on human rights, South Africa has made some huge strides forward.

Human rights and access to justice

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, prisons, and in health care (both public and through medical schemes). These specifically include provisions for vulnerable sub-populations such as women, young people, MSM, prison inmates and migrant populations.

A number of institutions are able to monitor the implementation of laws, such as:

- the **Commission for Gender Equality**, with the responsibility to promote and protect gender equality;
- the **Council for Medical Schemes**, to guarantee minimum standards of health care;
- the **Judicial Inspectorate of Prisons**, to uphold the standards of prisons;
- the **Medicines Control Council**, which approves clinical trials;

- the **SA Human Rights Commission**, to promote and protect human rights;
- the **SA National AIDS Council**, to maintain policy, strategy and implementation of the national response to the disease;
- various **Parliamentary Committees**, to monitor implementation of laws and policies; and
- **Legal AID South Africa and Probono.org, and other** civil society organisations, which enable people to access legal support to enforce their rights and provide critical oversight on implementation of laws.

There are systems of redress in place to ensure that laws are having their desired effect, for example:

- 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):** 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
- the **National Health Research Ethics council**: with the authority to grant or deny permission to carry out research with human participants

Challenges

Certain laws and regulations exist that present obstacles to vulnerable sub-populations receiving the prevention, treatment, care or support that they require, such as those for women, young people, IDU, MSM, CSW, prison inmates, migrants and other mobile populations and people with disabilities. For example, despite the recognition of concurrent sexual partnerships as driver of HIV in South Africa, the Recognition of Customary Marriages Act, 1998 condones polygamy – potentially undermining women's sexual and reproductive health. Oversight bodies lack independence and sufficient resources to act in accordance with their regulatory responsibilities, and problems with financing and appointment procedures have undermined their efficacy. Non-evidence based budgeting processes, by both national and provincial governments can be prohibitive in resourcing public services.

There are policies that promote stigmatization and discrimination, such as exclusions of certain government branches to the Employment Equity Act; likewise, continued criminalisation of sex work creates barriers for HIV prevention and treatment.

While individual councils and commissions work with discrimination cases or record human rights abuses, South Africa does not have one overarching body that gathers and centralises the information. 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; however, the country has been slow to implement the monitoring and evaluation system for HIV and AIDS.

Legal aid services are available on a limited basis, and although government funds some, capacities and resources are stretched and insufficient to address the need. The average person thus does not have access to legal recourse when their rights are infringed upon.

The country's approach to its HIV epidemic fails to address the concentrated epidemics within it, i.e., MSM, CSW, mobile populations, etc; there lacks a policy initiative to address different strategies for targeting most-at-risk populations.

Vulnerable populations

While data is not easily available on each sub-population identified in the NSP, recent reports by the SANAC Women's Sector, SANAC Disability Sector, and Children Rights Centre[31] highlight some of the critical issues for these groups.

Women

Reproductive laws and policies in South Africa are among the most progressive in the world[32], although translating sexual and reproductive health (SRH) into programming and implementation strategies presents a challenge. In the reporting period, South Africa saw some chief legislative and policy advances related to reproductive health, such as:

- **2008**: Criminal Law (Sexual Offences and related matters) Amendment Act , No 32 of 2007
- **2009**: Accelerated PMTCT Guidelines and Implementation Plan, Draft framework for Male Circumcision, and signing of the Addis Call to Urgent Action for Maternal Health

The "One in Nine" campaign is an Oxfam partner organisation that began in South Africa to ensure the expression of solidarity with women who speak out about rape and sexual violence. It takes its name from a Medical Research Council study on sexual violence which found that only one out of every nine rape survivors report the attack to the police. Research shows that even when cases do reach the courts, less than 5% of the rapists are convicted.

Political will and commitment to keeping women's issues high on the national agenda does exist. South Africa is a leader in the area of researching new HIV prevention technologies, such as vaccines and microbicides. However, a clear link between HIV activities (from messaging to services) and women's sexual reproductive health rights is unclear. The Women's Sector report notes that SRH is a neglected area of health provision; for example, funding for SRH has suffered since the health targets were set fifteen years ago, largely due to HIV/AIDS – and that health budgets are not allocated to SRH specifically.[33] A SRH and HIV&AIDS Integration Task Team was formed by the Department of Health to develop integration strategies and activity plans but the progress is slow.

The principal windows of opportunity for prevention of the epidemic among women are efficient, accountable, universal access to female condoms, and microbicide and vaccine development, according to the report. While the South Africa is highly active in researching preventative technologies, female

condoms continue to be inaccessible to women across the country. Fragmented health systems and service delivery – especially from the increased burden of HIV on human resources – creates implementation difficulties and affects quality of care. However it is acknowledged that commitment from sectors beyond those of health only is needed to address mainstreaming of women's health issues.

The sector notes that the strongest allies in women's health issues are academics in health, gender and legal rights and the NGO sector. Some of the obstacles to effective integration of actions designed to promote SRH, prevent HIV/AIDS and confront violence against women include limited funding for civil society, competition between NGOs, and burnout of staff. Limited support and leadership from overarching entities also plays a role.

Children

There is an urgent need for more and better information on the service delivery and child outcomes related to HIV and AIDS in South Africa. This includes ensuring wide access to HIV treatment for HIV-positive pregnant women and HIV treatment for the entire population in need. Substantial increases in the capacity of care and support systems is required; including grant uptake for vulnerable children, proper nutrition, educational and psychosocial support, especially to those families with an ill parent or child-headed households.

For example, the 2009 Child Scorecard found that only about 22% of the required social workers out of those needed to serve the entire population of South Africa were registered with the SA Council for Social Service Professions – which has a negative impact on the ability to implement the Children's Act[34]. In other words, just to help children, the country needs about 5 times as many social workers as it has at the moment. However, a cadre of other community level workers are active in supporting children. These include Child and Youth Care Workers, Social Auxiliary Workers, and Caregivers with home and community-based organisations.

The absence of reliable annual data on infant mortality is a critical gap, and inequalities in provincial services (related to access and child outcomes) need special attention.

In partnership with non-governmental organisation, the private sector as well as communities, the Department of Basic Education implements a number of projects under the umbrella programme *"Care and Support for Teaching and Learning"* ***(CSTL)*** that aim to ensure early identification and services to manage barriers to learning (including HIV). This programme is yet to be taken to scale.

People with disabilities

A 2008 survey suggests that people with disabilities in South Africa may be at more risk to HIV infection than the general population. The findings propose that they tend to have less access to services compared to the general population, and imply that:

- HIV knowledge is lower among people with disabilities; however, awareness of condom use to avoid HIV infection is the same for the disabled and non-disabled sectors of the population
- A lower percentage of people with disabilities had tried to access HIV counselling and testing services compared to the general population
- A lower percentage of people with disabilities reported having been tested for HIV (36.9%) compared to the general population (50.8%, HSRC survey 2008)
- People with disabilities have more positive attitudes towards people who are HIV infected[35]

The SANAC Disability Sector report documented the many limitations in access, such as in physicality of service centres (both in geographic location and in the construction of the service site itself), attitudes of health workers and unavailability of IEC materials in alternative formats. The qualitative component of the study noted vulnerability to violence and sexual aggression, which could lead to a reduced ability to negotiate condom use with sex partners. These challenges contribute to the barriers that disabled South Africans face in fair access to HIV prevention, treatment, and care and support services.

c) National programme implementation

Prevention

South Africa's primary prevention goal is to reduce the national HIV incidence rate by 50% by 2011. A rather ambitious target, government maintains prevention as the mainstay and the most sustainable response to HIV and AIDS. As such, there has been a marked injection of resources and a concerted effort made by government, development partners and civil society in this area. This effort is realized by some of the achievements noted in this chapter.

Blood and blood product safety

Indicator	2008	2009	Source
Percentage of donated blood units screened for HIV with an external quality assured scheme	100%	100%	SANBS

The SANBS continues to supply blood to eight of the nine provinces, whilst the Western Province Blood Transfusion Service provides for the Western Cape. HIV transmission through blood has been virtually eliminated from an average of 2 persons per year to zero since nucleic acid amplification testing (NAT) was introduced in 2005. In line with 2008/09 targets, 100% of donated blood units were screened for HIV in a quality assured manner and adhered to strict quality control measures that are supervised by the South African National Accreditation Service (SANAS). In addition, external quality control proficiency tests are conducted periodically. The safety of blood products in South Africa is currently on par with international standards and transfusion-associated infections are rare.

Prevention of mother-to-child transmission

Indicator	2008	2009	Source
Proportion of HIV+ pregnant women receiving antiretroviral medicines to reduce the risk of mother-to-child transmission	86%	83%	NDOH Annual report 2008/09, DHIS 2009

Prevention of Mother-To-Child Transmission of HIV (PMTCT) is now almost universally available in public primary health facilities, and South Africa achieved the NSP target of >95% coverage in public sector antenatal service sites in 2008. A dual therapy regimen of Nevirapine and AZT was adopted in 2008, with additional improvements in the programme to be implemented as of 1 April 2010.

To calculate PMTCT ART coverage, the DHIS data for Nevirapine coverage for 2008 and 2009 was divided by an estimate of the number of HIV positive pregnant women. This estimate was derived from applying antenatal HIV prevalence to the estimated number of births in South Africa contained in the ASSA 2003 model outputs. The figures for total number of births are similar in both the ASSA outputs, and in Statistics South Africa publications. The number of HIV positive pregnant women was adjusted to account for differential HIV prevalence across the different race groups in South Africa.

The estimate for 2008 is that 86% of HIV positive pregnant women received ART to prevent MTCT of HIV. In 2009 this figure declined to 83%. However, the data for 2009 is incomplete, and in Gauteng province the introduction of dual therapy was not well recorded in the antenatal service. For this reason it is likely that the figure for 2009 is an under-estimate of PMTCT coverage.

The overall goal of the PMTCT programme is 100% coverage of all pregnant women who need PMTCT. Given UNAIDS estimates, this can range from 110,000 to 280,000 women[36]. Given prevention goals, however, it may be beneficial to update this target in the NSP to “raise the bar” for PMTCT reach.

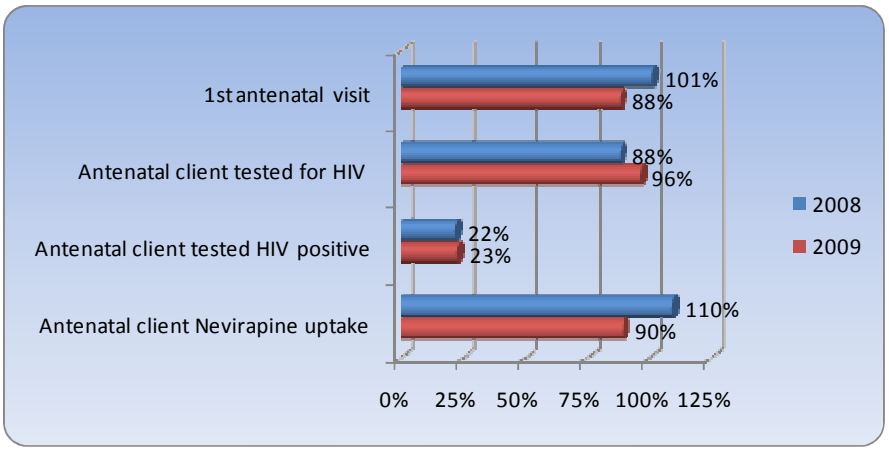
The PMTCT cascade of indicators (

Figure 6) monitors the various stages that ANC clients undergo during PMTCT service delivery. It begins with a rate of those women attending a first antenatal visit out of all women anticipated to need ANC services in the catchment area. The chart shows a slight drop from 2008 to 2009; however, it is unclear as to how first antenatal visits can exceed 100% - the rate for 2009 is more likely to be closer to reality.

Out of all ANC clients presenting for services, the rate of those agreeing to an HIV test increased from 88% to 96% in the last two years[v]. Only around a quarter of those tested were HIV positive, which is not too far from the results of the 2008 Antenatal Sero-Prevalence survey. According to the data, around 90% of those testing HIV positive received a Nevirapine dose either in ANC services or during labour.

[v] DHIS 2009 data for this indicator are missing for Gauteng, KwaZulu-Natal, Mpumalanga, Northern and Western Cape provinces; therefore reliability of the data should be taken with care.

Figure 6: PMTCT cascade of indicators, South Africa, 2008 – 2009



SOURCE: DHIS, 2009

Tuberculosis and HIV collaboration

Indicator	2008	2009	Source
Percentage of estimated HIV+ incident TB cases that received treatment for TB and HIV	18%	42%	NDOH TB Programme data

TB remains the leading cause of death among people living with HIV in the country, thus the government of South Africa's commitment to improve tuberculosis prevention, treatment and cure. Successful TB and HIV collaboration is complicated by the implementation of TB and HIV as separate and parallel programmes, affecting the full integration of both staff and services. Needless to say, accurate recordkeeping of treatment for both diseases has not been universally implemented.

Reports indicate an increase of over 100% in TB patients put on both TB and HIV treatment from 2008 to 2009 (from 18% to 42%, respectively). This is attributed to improved monitoring by the TB programme.

In 2008/09, 45% of HIV positive clients were screened for TB against the NSP target of 60%. About 3% (against a national target of 60%) of HIV infected patients were put onto TB prophylactic preventive treatment. The slow implementation of this programme was mainly due to lack of consensus and normative guidance on dose and duration of prophylaxis. This has now been resolved, and it is expected that this number will rise rapidly in the future. There was considerable improvement in the proportion of TB patients (73.8%) who were screened for HIV. Reports from some of the provinces indicate that some sites enjoy universal HIV screening amongst TB patients.

Prevention and other services for most-at-risk groups

Risk groups are generally targets of most prevention interventions. While the Government of South Africa is committed to reducing the burden of the disease, overall HIV prevention strategies have not sufficiently

targeted all of the MARP categories as defined by the NSP (i.e., commercial sex workers and their clients, girls in transactional or cross-generational sex, IV drug users, mobile populations, etc).

Commercial sex workers

It is unclear how many new HIV infections in South Africa occur as a result of commercial sex work, as recent research on this group is lacking. There are few programmes targeting sex workers; however, one of the key organisations in South Africa is the Sex Workers Education and Advocacy Taskforce (SWEAT), a non-profit organization situated in Cape Town. It works with sex workers on health and human rights and advocates for the decriminalisation of adult sex work in South Africa. There are selected programmes in Gauteng, especially in the inner city of Johannesburg, which also provide services for CSWs.

Recent developments include a Consultation on Sex Work, initiated by the SANAC Women's Sector and the SANAC Inter-sectoral Working Group on Sex Work in November 2009 to discuss human rights and health issues for sex workers, in anticipation of the 2010 FIFA World Cup. The South African Law Commission is writing an analysis for government on decriminalization of sex work and the different options available.

Men who have sex with men

In South Africa, there are not many NGOs in existence that are dedicated in providing services for the lesbian, gay, bisexual and transgender communities. *OUT-LGBT Well-being* is a dedicated and designated NGO that was formed 14 years ago to build healthy empowered lesbian, gay, bisexual, transgender and intersex (LGBTI) communities in South Africa. Their goal is to reduce heterosexist and homophobic attitudes in society and work towards LGBTI's physical and mental health and rights. Amongst many other services that OUT offers, they also provide direct health (including mental health) services to LGBTI clients, which includes targeted HIV/AIDS prevention. OUT runs a full functioning clinic that provides holistic ARV treatment and care, nutrition and PAP smears for women. The organization also distributes barrier methods for gay men and women with PEPFAR support. They offer monthly sessions at the centre to assess the impact of HIV prevention knowledge.

Voluntary counselling and testing

Indicator	2008	2009	Source
Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	25%	37%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008; National Communication Survey 2009

Voluntary counselling and testing is considered an important entry point to treatment, care and support programmes. About 96% of public health facilities offer VCT services. The HSRC household survey found that 25% of people had tested in the last 12 months, notably reaching the 2011 target in the NSP. The NCS survey of 2009 showed that this number had increased further, with 37% of the sexually active population testing in the last 12 months.

Voluntary counselling and testing for most-at-risk populations

The 2008 household survey did include what they termed most-at-risk populations in the South African context, namely: African women aged 20-34 years, African men aged 25-49 years, males aged 50+, men who have sex with men, high-risk drinkers, recreational drug users and people with disabilities. Some data is available on these groups for the UNGASS indicators. The data on HIV testing and counselling is presented in Table 5. There is no recent HIV data available on commercial sex workers and intravenous drug users.

Table 5: HIV testing and counselling for selected MARPs, South Africa, 2008

Indicator	2008	2009	Source
Percentage of **African females 20-34** years who received an HIV test in the last 12 months and who know their results	36%	48%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008; National Communication Survey 2009
Percentage of **African males 25-49** years who received an HIV test in the last 12 months and who know their results	25%	52%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008; National Communication Survey 2009
Percentage of **males 50-55** years who received an HIV test in the last 12 months and who know their results	18%	3%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008; National Communication Survey 2009
Percentage of **MSM** who received an HIV test in the last 12 months and who know their results	27%	--	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008; National Communication Survey 2009
Percentage of **high-risk drinkers** who received an HIV test in the last 12 months and who know their results	23%	--	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008; National Communication Survey 2009
Percentage of **recreational drug users** who received an HIV test in the last 12 months and who know their results	23%	--	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008; National Communication Survey 2009
Percentage of **people with disabilities** who received an HIV test in the last 12 months and who know their results	20%	--	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008; National Communication Survey 2009

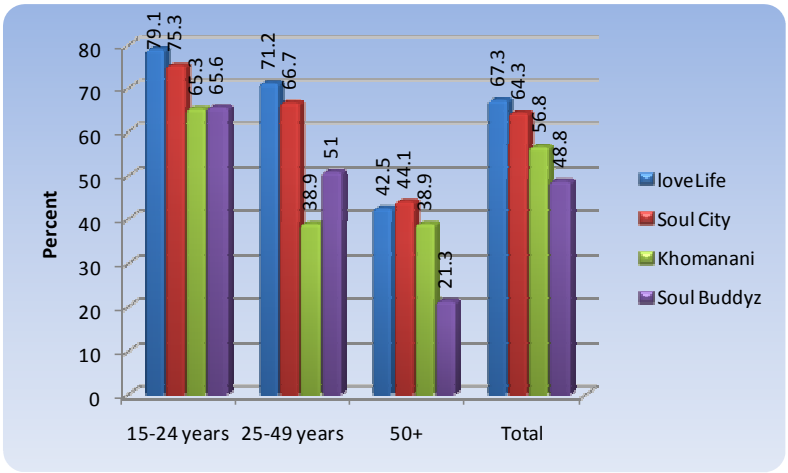
Data collected by the household survey indicates that over a third of African females were tested in 2008; closely followed by nearly a third of MSM. These two groups outweigh the testing ratio of the general population at 25%. A quarter of African males were tested in the same period. High-risk drinkers (23.1%) and recreational drug users (22.5%) follow. Only slightly over 20% of people with disabilities had tested, and the lowest group to seek testing and counselling were males aged 50-55 years.

Recent studies conducted on men who have sex with men found that 47% of respondents in Johannesburg and Durban had ever been tested for HIV, and 38% of men surveyed in Soweto had ever been tested[37]. While this may appear deceptively high compared to what is reported for the general population, it must be kept in mind that the number of people ever tested for HIV tends to be higher than those who were tested in the last 12 months.

HIV prevention media campaigns

Exposure to South Africa's HIV prevention communication through media campaigns is high, with 80% of those surveyed knowing at least one[38]. Not surprisingly, it is highest among 15-24 year olds who are most tuned into media and have been intensively targeted by HIV prevention programmes. Exposure to the population aged 50 and older still remains low (Figure 7).

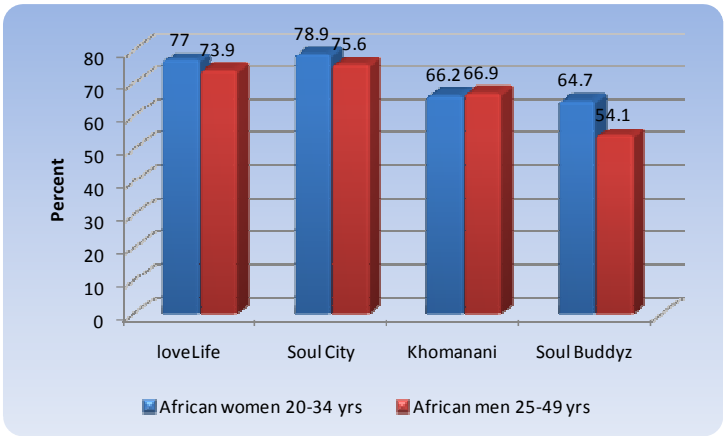
Figure 7: Exposure to HIV prevention media campaigns by age group, 2008



SOURCE: South African National Prevalence, Incidence, Behaviour and Communication Survey 2008

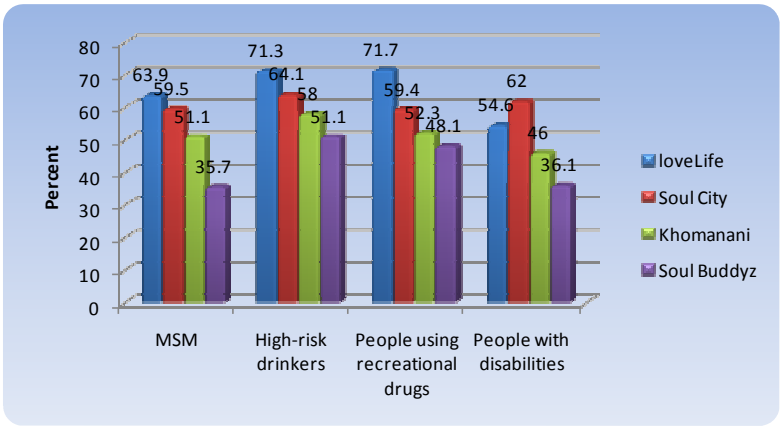
LoveLife and Soul City enjoy good media coverage among sectors of the general population at higher risk, namely 20-34 year old women and 25-49 year old men (Figure 8). Given that these age groups are not the primary target of loveLife, it implies a positive spill over effect into the general population. LoveLife also has highest reach among MSM, heavy drinkers and people who use recreational drugs, while Soul City has highest reach among people with disabilities (Figure 9).

Figure 8: Proportion of high-risk groups (by age) exposed to HIV prevention media campaigns, 2008



SOURCE: South African National Prevalence, Incidence, Behaviour and Communication Survey 2008

Figure 9: Proportion of high-risk groups exposed to HIV prevention media campaigns, 2008



SOURCE: South African National Prevalence, Incidence, Behaviour and Communication Survey 2008

Data systems are not established in South Africa to collect information on the reach of HIV prevention programmes among MARPs, as defined by UNGASS.

Life Skills HIV Education

Indicator	2008	2009	Source
Percentage of schools that provide life skills based HIV education within the last academic year	100%	100%	EMIS: School Realities 2008 and 2009, NDOE

Since the last UNGASS reporting period there have been some significant changes in the approach to HIV and AIDS in education, namely the full integration of the Life Skills programme in all learning areas. This change in curriculum has taken time, however, it ensures that the HIV Life Skills programme is an integral part of the curriculum for every learner. Materials are being developed for learners within special schools and are being progressively made available wherever they are needed.

The full integration of life skills across learning areas has involved a variety of directorates (i.e., GET Curriculum, FET Curriculum, EMGD, Values in Education and Inclusive Education). Life skills are infused with the natural sciences curricula, and HIV and AIDS is mainstreamed into other daily lessons such as mathematics and economics.

Training of school principals and heads of department played a critical role in mainstreaming HIV and AIDs throughout the overall curricula, as well as to prepare them to identify and support learners experiencing challenges such as children from child-headed households. An additional 1,500 teachers were trained as master trainers in the last financial year to ensure quality programming and for sustainability purposes. 25,000 other educators (beyond Life Orientation teachers) were trained in the new approach. The DOE and DOH developed learning and teaching support materials for the revised Life Skills curriculum. 270,000 learner activity books and 10,800 teacher guides (for Grades R-3) were printed and distributed to 450 Quintile 1 schools across provinces between April 2008 and March 2009.

Other important programmes to note include the peer education programme and Soul Buddyz clubs (in primary schools), which are programmes to equip learners with skills that enable them to face challenges and support others that experience similar problems. 47,605 learners were trained in peer education in primary and secondary schools, with 4,760 educators trained as peer mentors to support and guide implementation.

School-Based Support Teams (also called Health Advisory Committees) have been successful in supporting and relieving the workload of teachers to attend to vulnerable learners' needs. These include registration of birth, application for social grants, assisting with cleanliness of learners coming from homes that cannot afford to do so, etc. through an integrated service delivery approach with other government departments, funders, as well as NGOs and the private sector.

This approach is being institutionalised through the Care and Support for Teaching and Learning (CSTL) programme. A CSTL framework and implementation guidelines will be finalised by 31 March 2010.

Condom availability

While male condoms are generally accessible, they are not sufficiently available to the groups that need them the most. Female condoms are expensive and available primarily in family planning settings. While research has found that the 'overwhelming majority of South Africans believe that condoms are easily accessible'[39], this is not the case among high-risk groups and in certain parts of the country.

Local studies among MSM report that condom availability is inadequate (Rispel and Metcalf 2009); condom distribution in prisons is limited; and availability of female condoms is very limited, with the DOH distributing over 3 million free female condoms per year, despite acknowledgement of a greater need[40].

However, great strides have been met with public-private partnerships in increasing condom availability in the workplace. Between January 2008 and December 2009, SABCOHA in partnership with the Department of Health distributed 14,612,000 condoms to workplaces.

Workplace programmes

The private sector has witnessed the expansion of workplace programs in most corporate companies and many large and medium size companies, with the minimum requirement of a prevention strategy. NSP objectives are addressed though workplace prevention programmes and most large companies offer IEC, HCT, STI management and TB screening. In addition to this, specific programs have been implemented over the last two years, namely:

- The implementation of supply chain development programs in the auto component manufacturing and energy sectors, and the road freight industry;
- Development of sector strategies in the contract cleaning, automotive manufacturing, and mining sectors

- Extensive behaviour change programs have been implemented in most banks as part of their wellness programs.

There are vulnerable sectors that have initiated programs, such as the agricultural sector (AgriAids) and the Road Freight Industry (Trucking Wellness) aimed at HIV prevention.

In the reporting period, SABCOHA has trained approximately 4,835 micro-enterprises operating in the informal sector, with a focus on women-owned businesses. The training focused on health and HIV, and ensuring the business remains open.

In 2008 SABCOHA held a series of Peer Educator Forums in Rustenburg, Durban, Port Elizabeth, East London, Cape Town and Johannesburg. The purpose of these forums was to provide the latest information on peer education, offer a learning exchange and to source information for a national database of peer educators, which has been finalised.

Treatment, care and support

STI management

STI management is an important complementary treatment service that can help reduce transmission of HIV. STI treatment and management in South Africa provides a mixed picture. On the positive side the incidence of sexually transmitted infections among adults 15 years and above (as calculated from district health information system statistics) was 4.4% for 2007. The prevalence of syphilis has shown a steady decline from 1997 (11.2%) to 1.9% in 2008. The latter may be attributed to the widespread implementation of syndromic management for STIs, and possibly due to a shift to safer sexual behaviour owing to the HIV epidemic. The point estimate for 2006 was a bit lower (1.8%), and the possibility of a renewed increase in prevalence must be watched carefully.

In general, appropriate management of STIs continues to receive priority. Adequately trained staff using syndromic management guidelines offered one hundred percent (100%) of STI services in the public sector; this succeeds the NSP target of 60%. While national STI partner notification rate achieved 100%, the national STI partner-tracing rate was much lower at 21%, against a target of 40%.

Antiretroviral therapy

Indicator	2008	2009	Source
Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	45%	56%	NDOH programme data, 2008 and 2009

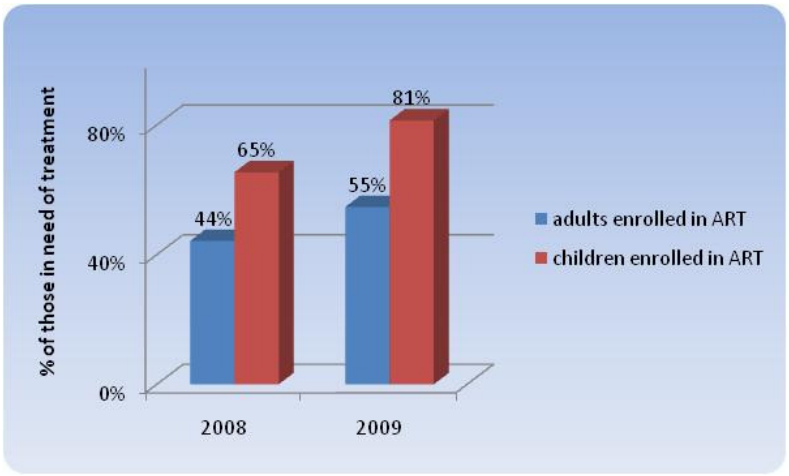
South Africa has made remarkable progress in rolling out antiretroviral treatment, with the largest number of people enrolled on ARVs in the world[41]. ART is provided in all nine provinces through the public sector health system, as well as through NGOs and private sector physicians. The NSP goal is to provide an

appropriate package of treatment, care and support services to 80% of people living with HIV and their families by 2011.

This clearly reflects an ambitious target as the data show that about 56% of adults and children in need are on treatment through the public sector as of 30 November 2009. By end of November 2009, programme data showed that 833,653 adults and 86,270 children (under age 15) were on treatment[vi]. This is an increase of about 30% of children enrolled in ART and an increase of about 26% in adult treatment from 2008 to 2009.

The South African ART programme reached 81% of children in need of ARVs in 2009 and 55% of adults in need, using STATS SA estimates (Figure 10).

Figure 10: Percentage of adults and children in need receiving ART, South Africa, 2008-2009



SOURCE: NDOH programme data, 2008-2009

PEPFAR is by far one of the largest donors supporting ART provision in South Africa. As of September 2009, PEPFAR-supported site level service delivery totalled 589,808 of the public sector patients (this is a sub-set of the number reported above), and an additional 57,164 patients at NGO and private sector sites.

While exact figures are unknown, an additional 51,633 adults and children were reported on ART in the private sector in 2009[vii]; although this number may be misleading as 86,000 people were estimated to be on treatment through workplace treatment programmes and Disease Management Providers in 2008[42].

[vi] All provinces (except NW) are able to report on all actual patients in care and have subtracted the deregistered due to loss to follow-up, stop, transfer out, death and any reason. The proportion of deregistered patients that are children has not been confirmed by the EC, FS, GP, KZN, LP and NW provinces. These numbers reflect government data which exclude people on treatment through medical aid schemes, workplace treatment programmes, donor-funded non-profit organizations and the private sector.

[vii] Statistics from Aid for AIDS, data from 2008 unavailable.

Although figures for people currently on treatment remain a challenge, South Africa clearly leads ART provision in the world.

Estimating the need for ART treatment and calculating the exact number enrolled in treatment programmes can be difficult, even with the best systems in place. South Africa's ART programme lacks one unified patient monitoring system, making it extremely difficult to collate an accurate figure of persons currently receiving treatment, or to assess survival rates. The Department of Health is conducting a review of the different ART data collection systems implemented in the country, in order to determine the best suited patient monitoring system for rollout to ART sites.

The number of accredited ART sites at public facilities has increased in the reporting period and more sites are in the process of accreditation to expand ART even further. Task-shifting is a new policy that is being piloted in some provinces, whereby professional nurses and in some cases, doctors from the private sector take over ART case management after initiation of treatment by a public health physician. These pilots have shown positive results in addressing resource constraints while enabling better access to services.

Home and community-based care

Community caregivers, under the auspices of NGOs, CBOs and faith-based organizations (FBOs) offer home/community-based care and support (HCBC) services largely at community and household level. Many of these organizations are supported directly through the Department of Social Development and the Department of Health's Directorate of HIV, AIDS and STI Care and Support Programme, or directly through development partners. HCBC organizations reported to the DSD a total of 411,867 orphans and vulnerable children supported in the 2008/2009 financial year, and 449,732 children in the first three quarters of 2009 (up to December 2009).

In the reporting period, the DSD in collaboration with the DOH developed a comprehensive monitoring and evaluation system for HCBC at all levels of governance and service delivery in South Africa with support from the Japanese International Cooperation Agency (JICA). The project was rolled out full scale in three provinces, i.e. North West (two districts), KwaZulu-Natal (all districts) and Northern Cape (all districts). The system involves data collection on beneficiaries' profiles and services offered by NGOs from the lowest level of care, to district, provinces and national level.

Through the DSD, 41,908 community caregivers received accredited training in 2008/09[43]. Training on psychosocial care and support was conducted to strengthen the DSD response to the epidemic.

Professionals and para-professionals were trained on succession planning to ensure protection of the rights of orphans and vulnerable children, in particular, their inheritance rights. Training on the establishment and strengthening of Child Care Forums at local level was conducted in provinces.

Nutritional support

The Department of Social Development provides food parcels and supplements to families affected by HIV and AIDS through HCBC organizations. The number of people living with HIV receiving nutritional support (734,900) surpassed the NSP target of 500,000 for 2008/09. There is a need to mobilize more resources to explore opportunities for nutritional care and support for HIV and AIDS affected individuals and households to ensure that nutrition is accessible and adequate.

Through funding from the National Treasury, the Department of Basic Education implements a National School Nutrition Programme (NSNP) in primary schools, progressively expanding it to secondary schools over 3 years starting in 2009. The programme has three objectives, namely providing daily nutritious meals, strengthening nutrition education as well as promoting food production through school gardens. The total budget of the programme is R2.4 billion (2009/10 financial year). A total of 7,215,743 learners in 18,334 primary and 1,725 secondary schools are currently on the programme.

Orphans and vulnerable children

Indicator	2008	2009	Source
Percentage of orphaned and vulnerable children aged 0-17 years whose household received free basic external support in caring for the child	75%	75%	DSD Annual Report 2008/09; Children's Institute, 2009[44]

The most recent estimates of children with one or both parents deceased reached ranges from 1.5 to 3 million[45]. While the majority of these orphans are receiving support from a family member, the impact on families and communities is enormous. The childcare system experiences severe backlogs because of the significant administrative burden of obtaining court orders and applying for foster care grants.

The Department of Social Development institutionalized the national surveillance system of maternal orphans in the country. Vital registration data on childbirth and maternal deaths is matched retrospectively to track maternal orphans. The said data can be further utilized to determine the maternal orphans' access to government services.

Without a functional multi-sectoral monitoring system in place, it is difficult to calculate the exact number of OVC that receive support. In absence of this, a calculation was made of the total number of child support grants, foster care grants and care dependency grants compared against a proxy figure for the number of children in need (those of which were living in households that are income-poor). This results in an estimated 75% of South Africa's OVC receiving support in the last year. While caution should be taken with the interpretation of this indicator[viii], it does form an important benchmark against which support to OVC can be monitored.

[viii] Data collected for this indicator does not include all possible services provided to OVC according to UNGASS indicator guidelines, and the most recent data for the denominator is from 2006.

There is a growing movement to support children through partnerships between government and communities. Examples of these are "Schools as Nodes of Care and Support" initiatives and the Child Care Forums. Both were initiated within civil society and have been integrated into various government policies.

Financial support

In response to the global financial shocks and rising fuel and food prices, the DSD advocated an increase in social grants in the reporting period. In order to effectively respond to the impact of the crisis on food security caused by the global economic meltdown, the Social Relief of Distress budget was increased from R124 million to R624 million to shield the poor from undue hardships. By March 2009, child support grants, foster care grants and care dependency grants all grew an average of about 6%[46].

Extension of the child support grant became effective on 1 January 2009, when the DSD ensured that children are eligible until the age of 18 years for the Child Support Grant. The means test for social grants (i.e., child support grant and care dependency grant) was raised significantly to allow people with slightly higher incomes to apply for social support.

The DSD finalised important research that looks at how to improve income support to vulnerable groups such as children aged 15 to 18 years, caregivers of children in receipt of the child support grant, unemployed youth aged 19 to 25 years and unemployed adults aged 26 to 59 years.

In 2008, services to child-headed households (CHH) included the development of draft guidelines for Statutory Services to Child-Headed Households (which complement the implementation of section 137 of the Children's Act of 2005). The purpose of the guidelines is to enable stakeholders and service providers to understand the situation of children in CHH, ensure delivery of quality services to children in CHH and provide guidance and allow uniformity and standardisation of services to children in CHH.

Food security

The Department of Education's National Schools Nutrition Programme (NSNP) allocated R2.4 billion in 2009/10, with 18,334 primary and 1,725 secondary schools in the programme. A total of 7,215,743 learners (6,265,065 in primary schools and 950,679 in secondary schools) benefitted from the NSNP in 2009[47]. The programme aims to alleviate poverty amongst poor communities in general, and at enhancing learning capacity via good nutrition and the strengthening of food production initiatives in schools. The programme is implemented in primary schools and is being progressively expanded to secondary schools over a three-year period, which started in 2009.

All schools that participated in the NSNP were encouraged to plant vegetable gardens, with 6,226 gardens reported during the period under review. The programme also aims to promote skills development, the reviving of indigenous knowledge and values, the provision of additional nourishing fresh produce, as well as at encouraging parental participation in school activities and income-generating activities.

Knowledge and behaviour change

School attendance

Indicator	2008	2009	Source
Current school attendance among orphans aged 10-14	98%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008
Current school attendance among non-orphans aged 10-14	99%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008

School attendance amongst orphans is significantly high at 97.9%, closely matching school attendance of non-orphans at 99.3%. Many support services for orphans and other vulnerable children take place in and around the educational system. There are no data available for support or other services reaching out-of-school youth.

HIV knowledge

Indicator	2008	2009	Source
Percentage of young women age 15-24 who both correctly identify ways of sexually transmitting HIV and reject major misconceptions about HIV transmission	27%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008
Percentage of young men age 15-24 who both correctly identify ways of sexually transmitting HIV and reject major misconceptions about HIV transmission	30%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008

The 2008 household survey showed a disturbingly low result, with 27% of young women and 30% of young men positively answering the standard HIV knowledge indicator. However, when examining the results across provinces, it is noticeable that strange patterns emerge in a few provinces, which are skewing the overall results. This could be due to an error in the survey procedures, problems with interpretation of the questions or with the calculations of results. It is difficult to interpret this indicator, as historically, HIV knowledge has been high throughout South Africa. For these reasons, this indicator should be interpreted with caution.

HIV knowledge among most-at-risk groups

Indicator	2008	2009	Source
Percentage of **African females 20-34** years who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	26%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008
Percentage of **African males 25-49** years who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions	28%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008

Indicator	2008	2009	Source
about HIV transmission			
Percentage of **males 50-55** years who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	28%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008
Percentage of **MSM** who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	24%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008
Percentage of **high-risk drinkers** who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	31%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008
Percentage of **recreational drug users** who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	36%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008
Percentage of **people with disabilities** who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	21%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008

The same concerns relating to data apply to the data for MARPS on HIV knowledge. Again, for this reason these data should be interpreted with caution. Data from the 2008 household survey shows the percentages of MARPs that correctly identified two ways of preventing the sexual transmission of HIV and rejection of four misconceptions about HIV transmission among all the MARPs studied. Participants had to answer all six questions correctly. Recreational drug users, followed by high-risk drinkers scored the highest in this area at 35.5% and 30.6% respectively. African males and Males aged 50-55 scored in the second highest quintile, at 28%, followed by African females scoring at 26.1%. Both MSM and people with disabilities who were evaluated for the first time in 2008 had the lowest percentages of groups with accurate knowledge of HIV, at 24% and 21% respectively.

Sexual debut

Indicator	2008	2009	Source
Percentage of young women and men who have had sexual intercourse before the age of 15	9%	10%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008; National Communication Survey, 2009 (16-49 years)

The 2008 household study found that generally a small proportion of young people (8.5%) had started having sex before the age of 15 years, which was similar to the previous three surveys. Data from the 2009 National Communication survey seems to corroborate this finding at around 9.5%.

Multiple sexual partners

Indicator	2008	2009	Source
Percentage of women aged 15-49 years who had sexual intercourse with more than one partner in the last 12 months	4%	7%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008; National Communication Survey, 2009 (16-49 years)
Percentage of men aged 15-49 years who had sexual intercourse with more than one partner in the last 12 months	19%	34%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008; National Communication Survey, 2009 (16-49 years)

Among all 15-49 year olds, multiple partnerships have doubled since 2002 (from 5.5% to 10.6% in 2008)[48]. Women demonstrate a lower tendency towards multiple concurrent partners as compared to men. However, there has been a significant increase in both males and females who reported having more than one sexual partner since 2002; from 9.4% to 19.5% (2008) among males and 1.6% to 3.7% (2008) among females. There was no change found from the 2005 household survey to the one conducted in 2008. The National Communication Survey found that multiple partners had nearly doubled for women (to 7%) and had risen by 15% for men.

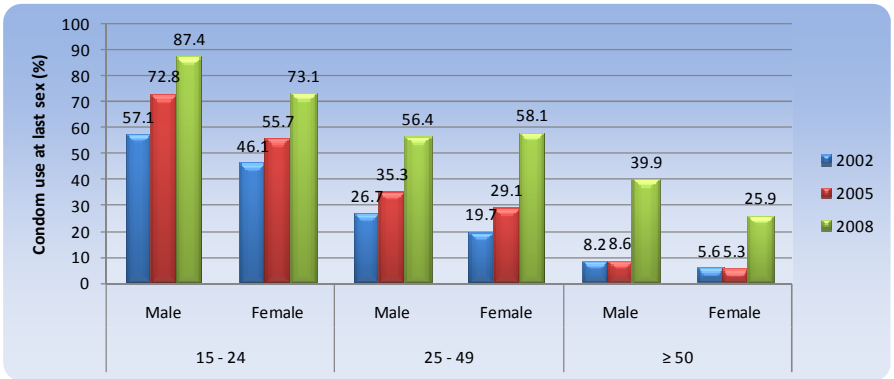
Condom use

Younger people show the highest rates of condom use which bodes well for the future of HIV prevention, and could be linked to the decline in HIV prevalence and incidence among teenagers and younger adults[49]. The government still has a free condom distribution programme whereby 283 million male condoms were distributed in 2008 and 4.3 million female condoms were distributed in the same period.

Condom use among South Africans in general has been on the rise since 2002 (

Figure 11). The 15-24 age groups show the highest percentage using condoms, at 73.1% for females and 87.4% for males. Interestingly, a sharp increase was noticed in condom use among 25-49 year olds when comparing 2005 to 2008. Males of this age range increased their condom use by 21% and females by 29%. Again, sharp increases in condom use were noted in both males and females in the 50+ age range, increasing by 31% and 20% respectively.

Figure 11: Condom use at last sex by age and sex, South Africa 2002, 2005 and 2008



SOURCE: South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008

Multiple sexual partners and condom use

Indicator	2008	2009	Source
Percentage of women aged 15-49 years who had more than one sexual partner in the last 12 months reporting the use of a condom during last intercourse	68%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008
Percentage of men aged 15-49 years who had more than one sexual partner in the last 12 months reporting the use of a condom during last intercourse	77%		South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008

HIV prevention communication has been successful in promoting condom use and HIV testing with upward trends in both practices over the past few years. According to the household survey, there was a substantive increase in condom use at last sex among females with multiple partners, from 52.5% in 2005 to 67.5% in 2008. At the same time, condom use for males in the same category showed a slight downward shift, from 81.1% in 2005 to 77.1% in 2008.

Most-at-risk groups and condom use

A recent study by Lane et al, (2009) looked at condom use among men who have sex with men in a sample of 378 men in Soweto, Johannesburg. The study found that with their last 5 partners, about 35% of men had unprotected receptive anal sex and 15% had unprotected insertive anal sex[50]. While this implies that a large percentage of MSM do have protected sex (65% and 85%, respectively), 100% condom use should be advocated as studies indicate very high levels of HIV (ranging from 33% to 38%) among this group.

There is no current data available on condom use among commercial sex workers or intravenous drug users in South Africa.

Impact alleviation

South Africa does not have data collection systems in place to adequately monitor progress on activities in the National Strategic Plan that aim to alleviate the impact of the epidemic on individuals, families and communities. Both the government of South Africa and civil society contributes to the policy development and direct service provision in mitigating the impact of HIV and AIDS. The achievements gained in impact alleviation by South Africa during the reporting period have been integrated into this chapter under Treatment, Care and Support.

IV. BEST PRACTICES

BEST PRACTICE: Country-driven donor support

The Department of Health's EU and donor-funded project in the Free State Province employs a model system that can be emulated by other agencies. This programme uses the National Strategic Plan and the Province's Annual Performance Plan to guide donor support of the country's specific needs. An appointed Project Manager serves as a liaison between the donor and the DOH, which allows seamless follow-up, reporting and action. The M&E system of this project tracks millions of Rand that supports a total of 74 NGOs.

Funds vary in amount and are dispersed in a series of three tranches, with continued funding based on programme performance. Project Managers (placed at each of the 5 districts) support the organisations and programme reporting requirements. Not only do the Project Managers manage the programme, they also manage NPO Forums in each district!

Data is shared regularly among the district teams and each district takes turns hosting the quarterly meetings. Reports are filtered up through the Department of Health via the relevant Cluster.

The support from the provincial level certainly adds to the programme's success. The Senior Manager, Donor Funded Projects attends the district meetings regularly. This programme demonstrates that even small organisations can manage sophisticated M&E systems and that, with proper support, coordination is possible down to the district level. Hands together for the DOH!

Best Practice: AIDS Coordination mainstreamed

Ugu District in KwaZulu-Natal Province has one of the highest HIV prevalence rates in South Africa. Under an initiative from the Premier's office, all districts were encouraged to launch their District AIDS Councils (DAC) in 2006. Ugu District opted to create a management position with responsibility for HIV/AIDS coordination within the mayor's team. But this post has more responsibility than simply inviting DAC members to meetings – the District HIV/AIDS Coordinator implemented a system whereby HIV/AIDS is flagged in all municipality managers' performance contracts. This means that all items raised in the DAC will be implemented by the relevant department, as HIV/AIDS is part of the manager's employment mandate.

The District HIV/AIDS Coordinator also facilitated the development of a district AIDS plan that is in line with the district's Integrated Development Plan and the NSP. It has six priority areas, as opposed to the NSP's four (additional points include care for vulnerable groups and policy development and administration). The plan was developed through a bottom-up approach, starting with local municipality planning.

All departments and sectors have to report on their activities using a standardised format, with reporting separated into employee wellness initiatives and how the department is delivering on its HIV/AIDS objectives. If there are any problems with delivery on agreed services, the coordinator can raise issues with the District Executive Committee, which meets weekly. Congratulations on a great example of mainstreaming HIV/AIDS into your daily business!

Best Practice: Local takes the lead

The Department of Cooperative Governance and Traditional Affairs (formerly Provincial and Local Government) published a "*Handbook for Facilitating Development and Governance Responses to HIV and AIDS"* for use by districts and municipalities.

This handbook, supported by the INCA Capacity Building Fund and the Medical Research Council of South Africa, is a set of instruments designed for step-by-step mainstreaming of HIV and AIDS into local planning. It includes a model HIV/AIDS strategy for a city; a model workplace HIV/AIDS policy; guidelines for networking; guidelines for multi-sectoral planning; and a model advocacy presentation.

Piloting of the project in KwaZulu-Natal Province resulted in an overwhelming response for rollout of the training programme. Two participatory workshops were held for Councillors and officials, one of which included trainers from a second province to expand the project throughout South Africa. The Handbook and training of local staff has shown to meet a real need of a practical, step-by-step guide to mainstreaming HIV and AIDS at the local level, with potential for neighbouring countries as well. Congratulations to our local government!

BEST PRACTICE: A good business model

The Department of Social Development (DSD) in North West Province employs a model M&E system to be emulated by other agencies. Guided by the Provincial OVC Support Plan, this comprehensive M&E system tracks the R35 mil expenditure to over 75 organisations that ultimately served 58,000 beneficiaries by the end of 2009.

Funds are dispersed in a lump sum of R800,000 to each qualifying NGO and they must fulfil stringent M&E reporting requirements. NGOs are guided in which data to collect and how and when to report to the DSD. Internal capacity building is part and parcel of this programme, as the goal is for organisations to become self-sufficient and thus less reliant on government support. NGOs who participate are encouraged to seek other ways to generate income, or to solicit funds from other sources.

Organisations are trained to operate like any other business (such as to get three quotations for services rendered), and funds are even provided by the DSD to cover the cost of audit by an external accounting firm!

The support from the provincial level certainly adds to the programme's success. The Director of HIV Programmes travels across the province to lend support and recently visited those sites that benefitted from a boost in new infrastructure.

This programme demonstrates that even small organisations can manage sophisticated M&E systems and that, given the ways and means; they can build internal capacity at the same time. Way to go DSD!

Best Practice: Brothers for Life

Brothers for Life is a national men's campaign aiming to create a movement of men that draws on the spirit of brotherhood that exists among South African men. It aims to encourage men to positively influence each other as men, partners, parents and as leaders.

The campaign is a collaborative effort led by SANAC, the Department of Health, USAID/PEPFAR, Johns Hopkins Health and Education in South Africa (JHHSEA), Sonke Gender Justice, the UN and twenty other civil society partners working in HIV prevention and health.

Along with positive self-identification, the campaign aims to address some of the risks driving the South African epidemic such as multiple concurrent partnerships, and to increase HIV awareness, testing and disclosure. Its scope also extends to other general areas, such as positive health seeking behavior, and parenting and family relationships.

Brothers for Life is a call to men across South Africa who know that the choices they make today will determine their future tomorrow. Kudos for our South African men!

Best Practice: A Man Knows!

In 2008, more than 20,000 men stepped forward to learn their HIV status during South Africa's first provincial testing week. The campaign was organized and implemented by PEPFAR-funded partners, Right to Care, and the Society for Family Health's social marketing franchise, New Start, with the support of the South African government. According to the Human Sciences Research Council's National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, South African men are well-informed about HIV and AIDS and understand that testing early can lead to a longer and healthier life. However, only a third of South Africans – and a quarter of all South African men – have ever been tested for HIV. Men are particularly hard to reach, because of social and cultural roles; women are usually the primary caregivers who visit clinics with children.

However, the main reason for men not testing is emotional: fear of stigmatization, denial, and fear of losing jobs or relationships. Thus the campaign took an emotionally charged angle, using a hard hitting theme – A MAN KNOWS! The theme called on men to be brave, to get tested, and to know their status. Being a man is an inherent notion that resonates with South African men and the campaign thus called on men to be proud, take a stand and get tested. South African celebrities supported the campaign, including the popular South African musician Johnny Clegg, legendary cricketer, Makhaya Ntini, swimming superstar, Natalie Du Toit, and football hero, Lucas Radebe.

The campaign was a phenomenal success. Nearly 35,000 people were tested, of those, 60% were men. Work is already underway to conduct the next testing week – this time, a national event. The theme, focusing on men will remain the same in 2010, but testing will take place throughout South Africa. The campaign is coordinated by the National Department of Health and the Society for Family Health, but other PEPFAR-funded partners will be asked to provide counselling and testing support during the testing week, which will be held in April of 2010.

Best Practice: Integrating TB and HIV

In 2009, the US Centers for Disease Control and Prevention, Global AIDS Program, South Africa (CDC/GAP South Africa), together with CDC-funded partners (including the Council for Industrial and Scientific Research and the Medical Research Council's "that's it") provided technical assistance to improve TB/HIV integration in the Cacadu district of the Eastern Cape, South Africa. The TB Directorate of the provincial and national Departments of Health were involved with the intervention every step of the way. One of the sub-districts, Camdeboo, was selected for an intensive, all-stops intervention, which consisted of implementing activities designed to improve infection control, TB/HIV recording and reporting (ETR.Net), patient management information systems (SmartCare), TB/HIV integration, and health promotion. All activities were preceded by hands-on training sessions for health-care workers, and several culturally and language appropriate information, education, and communication (IEC) materials were developed and distributed to participating clinics only after training was conducted. These IEC materials are also appropriate for creating awareness among the community and particularly among youth.

Through interventions and better collaboration, strong partnerships between clinics and laboratories were established. The turnaround-time for specimens decreased from more than 7 days to between 24 and 72 hours. Specimen collection has improved and contamination decreased. As a direct result of the interventions, every municipal facility in Camdeboo has facility specific infection control policies. Relevant and adequate tools are readily available, and the sub-district has taken ownership of infection control; today, CDC/GAP South Africa only provides support the district on request.

This model has worked so well, that it will be rolled out to additional sub-districts in the Eastern Cape, and in other South African provinces. CDC/GAP South Africa is already rolling out training in the Free State.

V. MAJOR CHALLENGES AND REMEDIAL ACTIONS

a) Progress on key challenges

A number of challenges were identified in the 2008 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 were implemented since then that address these challenges. Progress that South Africa has achieved is noted as follows.

2006/2007 KEY CHALLENGES	PROGRESS IN 2008/2009
National Commitment and Policy	
Mainstreaming the harmonization of HIV AIDS, STI and TB activities across all spheres of government	Recommendations of the 2009 Midterm Review (MTR) that involve development of Provincial Strategic Plans and active M&E by SANAC are designed to increase mainstreaming of HIV/AIDS across sectors
Human resource constraints, particularly in the public health sector (though mitigated to some extent by community participation) poses a significant threat to the achievement of national targets.	There are some successful examples of ART initiatives that addressed human resource constraints: • Task shifting ART case management from doctors to nurses; also referrals of ART case management to private sector physicians • The Step Down system of referring ART patient management from initiation site to a local clinic
A need to develop sector plans that feed into the national plan that in turn needs to be cascaded down to provincial and district plan with clear objectives and targets.	• The 2009 MTR recommends bottom-up development of Provincial Strategic Plans that will feed up into the NSP; three of the 9 provinces have been drafted thus far • The MTR also recommends streamlining indicators and targets and breaking targets down to provincial level
A need for the South African National AIDS Council to develop structures at all levels including national, provincial and district.	The MTR recommends using existing PCAs, DAC and LAC to implement the NSP, overseen by SANAC. With the newly established independent SANAC Secretariat in September 2009, significant progress has been made
Programme implementation	
Coverage in informal settlements and rural areas limited largely as a result inefficient resource allocation.	Some civil society initiatives have focused on rural and informal areas, such as mobile VCT clinics
Lack of testing campaigns targeted at specific groups attending health care facilities	• In 2009 the President announced a mass testing campaign effective April 2010; • Efforts are underway to make HIV/AIDS materials available in alternative formats for people with disabilities
Effectiveness of new initiatives such as male circumcision need to be tested	Male circumcision has been adopted as national prevention strategy policy, to be implemented as of April 2010
Expansion of VCT outside of health facilities need to be tested.	The mass testing campaign starting in April 2010 will expand HIV counselling and testing beyond health facilities

2006/2007 KEY CHALLENGES	PROGRESS IN 2008/2009
Monitoring & Evaluation	
Lack of a uniform data collection system across all provinces and national government. Poor data collection and management across government departments and different spheres of government Lack of inter departmental data sharing within government particularly around reporting on orphans and vulnerable children.	The MTR recommends one data collection tool to be developed to collect multi-sector data and a national database to collate, store and report on the national response; to be managed by SANAC M&E Unit. The SANAC Secretariat has already started to review the National M&E Framework.
A need for more comprehensive reporting on sources and uses of donor funding Difficulties in calculated total spend on HIV AIDS including government spend, donor funding and HIV related spending across government departments.	South Africa is currently conducting a National AIDS Spending Assessment that will clearly identify AIDS spending by domestic and foreign sources, as well as funding of HIV and AIDS according to area. This will inform future resource allocation and programme planning.
Survival rates of patients who receive ARV medicines and are still alive after 12 months not collected.	The NDOH is conducting a review of all patient monitoring systems that are in place in order to select a model system for rollout across the country. The system will also provide cohort reporting.
Data on traditional Most at Risk Populations (MSM, IDU.CSW) not routinely collected.	SANAC M&E TTT to review the national prioritized research agenda which should include special studies such as those required to assess MARPs.

b) Challenges in the current reporting period

While South Africa has demonstrated progress in addressing the challenges that were identified in the 2006-2007 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 review of the 2008 South Africa National HIV Prevalence, Incidence, Behaviour and Communication Survey and the 2009 Midterm Review of the National Strategic Plan for HIV, AIDS and STIS, 2007-2011 has provided a wealth of information. For purposes of this section, a list was compiled of the most critical challenges that either may hinder the national response and/or South Africa's ability to report on UNGASS targets.

National Commitment and Policy, and Monitoring and Evaluation

1. ***The lack of <u>two out of three</u> of the UNAIDS "Three Ones"[ix]:***

    - "One National AIDS Coordinating Authority, with a broad-based multi-sectoral mandate"

        — The ambiguity of SANAC's legal status harms its effectiveness to manage the overall response

        — SANAC Secretariat is unable to function as coordinator and leader of the response without a full complement of staff and the proper positioning within SANAC

    - "One agreed country-level Monitoring and Evaluation System"

        — Collating and reporting on the multi-sector response is impossible without a fully staffed M&E Unit, one data collection system and one national database

2. ***Weak management and coordination efforts across sectors***

    - Limits the cooperation among implementers, and between implementers and SANAC
    - Neglects implementers who are "outside of the loop" (i.e., private sector, organizations not funded by government or donors)

3. ***The lack of streamlined and clear indicators supported by appropriate data management systems***

    - Data on ART and the PMTCT programme is largely unreliable; data and reporting from other programme areas is inconsistent

Programme implementation

1. ***Lack of a unified, national prevention strategy***

    - Inhibits multi-sector contributions to prevention and any resulting achievements to be captured and widely disseminated

2. ***Uncoordinated implementation among agencies involved in Impact Mitigation, Human Rights and Access to Justice***

    - 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

3. ***Health system constraints***

[ix] 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.

- Scale up of critical programmes such as ART and PMTCT can exacerbate an already over-burdened health system
- Parallel services inhibit necessary integration (i.e., TB and HIV collaboration)

4. Limited programming for "traditional" MARPs

- Programme development for MARPs requires evidence-based information to guide it

c) Planned remedial actions

Efforts to rectify many of the challenges named above are already in the planning and implementation stages. However, some of the top recommendations coming out of the 2009 Midterm Review of the NSP merit further consideration. They have been included in this list, although at the writing of this report the MTR has not yet been finalised.

1. Increase the functionality of the SANAC Secretariat

Formalise the Secretariat's legal status, determine alternative fund-holding arrangements, and contract the needed staff. Adapt and reorganize the other SANAC structures as necessary with an emphasis on accountability and governance.

2. Transform HIV/AIDS information into HIV/AIDS intelligence

Set up the SANAC M&E Unit, finalise priority indicators and implement one national reporting system and database. Employ regular information dissemination for stakeholders.

3. Apply as much effort to prevention as has been applied to treatment to date

Implement the mass testing campaign in 2010, and employ follow-up with prevention campaigning, counselling and support to those who test.

Develop an evidence-based multi-sectoral prevention strategy (building on the current draft strategy). Set prevention targets at all levels (i.e., ward, district and province) that feed into national targets.

Prevent as many babies as possible from being born infected with HIV.

Scale up best practice interventions in education institutions across South Africa, resourcing both the Departments of Education and the DSD and municipalities that support OVCs and other youth.

4. Integrate ART with related health services into primary health care delivery

Formally adopt, and invest sufficient resources in, task-shifting and down-referral policies so that patients on ART can be seen at the lowest appropriate level in the health system. This will allow people with more than one illness, e.g. HIV infection plus TB or diabetes etc., to access their health care in one place, close to where they live.

VI. SUPPORT FROM DEVELOPMENT PARTNERS

a) Key support received from development partners

While the government of South Africa is the primary investor in the response to HIV and AIDS, a number of bilateral, multilateral and donor organizations also provide significant funding and other types of support. These entities work through public health facilities, government departments and existing civil society organizations. They support not only the costs of medicines, general healthcare and other types of support, but also help to ensure the sustainability of these programmes.

Development Partners 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 is room for better integration of development partner and South African government collaboration, which will increase the effectiveness of such partnerships.

Support from bilateral development partners

The United States government, through support from five agencies (USAID, Centers for Disease Control and Prevention (CDC), Department of Defense (DOD), Peace Corps and the Department of State), collaboratively implement the President's Emergency Plan for AIDS Relief (PEPFAR) which is by far the largest supporter of AIDS programmes in South Africa. PEPFAR supports over 300 diverse partners including government, civil society, faith-based organisations and research institutions, in the areas of prevention, treatment, care and support, and capacity building.

To date, PEPFAR has supported the SA government to initiate over 600,000 persons on ART and provided training through partners to 28,000 health care workers who deliver ART. Care and support in collaboration with DOH, DSD, and DOE has been provided to 2.1 million persons including over 486,000 orphans and vulnerable children. PEPFAR supports the NDOH in various other areas such as Monitoring and Evaluation of critical health indicators, the Accelerated Plan for PMTCT, and ART costing.

Other bilateral donors include the UK, the Netherlands, Australia, Germany and the European Union. They support programmes, provide technical assistance and direct funding. Some far-reaching support has been provided by DFID, which facilitated the establishment of the Rapid Response for Health Fund (RRHF). This fund assists the Minister of Health in achieving the goal of revitalizing and reorientation of the country's health sector by providing quick financial and technical support. Some of the initiatives of the fund include:

- **Ministerial Advisory Council on Health (MACH**), is a multidisciplinary committee that provides technical assistance and advice to the Minister of Health. This committee and its various

subcommittees (i.e., technical task teams) are committed to strengthening the South African health system.

- **Strengthening of South Africa National AIDS Council (SANAC)** has been supported through the recruitment of key staff; it also contributed to both of the 2008 and 2009 World AIDS Day campaigns and the Midterm Review of the NSP in 2009.

Support from multilateral development partners

The UNAIDS South Africa office coordinates and delivers technical assistance to the national HIV and AIDS response. Through UNAIDS, the UN collectively supported the development of the National Strategic Plan on HIV, AIDS and STIs 2007-2011, including the costing of the plan and development of an M&E Framework. It also provided technical assistance for the country in applications for Rounds 6, 7, 8 and 9 of the Global Fund. UNAIDS supports the strengthening of civil society and makes funding available to a number of organizations.

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is an international financing institution that invests the world's money to save lives. To date, South Africa has been awarded GF grants for Rounds 1, 2, 3, 6 and 9 for HIV/AIDS and HIV/TB, with all grants totalling over $291 million.

b) Action to be taken by development partners

A critical component of achieving progress against national targets (which includes the UNGASS indicators) is a well coordinated response. To this end, there are a number of key actions to be taken by development partners to ensure the success of the national response.

1. As South Africa is committed to the "Three Ones" principles advocated by UNAIDS, *all partners must align their contributions with the national strategic plan* in order to achieve success. This includes that development partners should ensure that their own plans collectively align and complement each other.
2. As a key measure, development partners should *support existing structures that are in place*; namely, the SANAC, Provincial, District and Local-level AIDS councils.
3. Development partners should *support the health system as a whole, and incorporate innovative ways of building capacity and infrastructure* to enable scale-up of national HIV and AIDS programming.
4. To ensure equitable and appropriate allocation of resources, development partners should *align their data collection systems with the national monitoring and evaluation system*.
5. In support of elevating HIV/AIDS information to HIV/AIDS intelligence, development partners should *support wide national dissemination of research, surveys and routine data among stakeholders*.

VII. MONITORING AND EVALUATION ENVIRONMENT

A review of South Africa's current M&E system has been based on the UNAIDS Organising Framework for a Functional National HIV Monitoring and Evaluation System. This document introduces the "12 Components" of a functional national M&E system, for the purpose of establishing some benchmarks against which national M&E systems could be assessed. It is designed around three core areas:

- Area 1: People, partnerships and planning
- Area 2: Collecting, verifying, and analysing data
- Area 3: Using data for decision-making

While this chapter is not intended to include a full evaluation of the national M&E framework, many of the relevant components from the UNAIDS document were taken into account and used as an analysis framework against which to assess the strength of the monitoring and evaluation environment for the UNGASS reporting period.

a) Overview of current M&E system

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.

A framework for ongoing M&E of the goals, objectives and interventions of the National Strategic Plan for HIV & AIDS and STI, 2007-2011 was available in early 2009, which details M&E responsibilities, indicators, definitions, and data collection and information flow. This also includes UNGASS indicators as part of the national set. Implementation of the national M&E framework has been slow.

Routine surveillance, household and communication surveys and key health information systems such as the DHIS and Electronic TB Register produce strategic information on a regular basis. South Africa also has extensive research capacity within its academic and research institutions, government, donors and the private sector. Information is generally made publicly available and is posted on a number of websites and other domains.

Substantial investment is devoted to improving the quality of M&E systems across the country, from donor-funded capacity building throughout the health services, to the current review of patient monitoring programmes in advance of developing one unified ART system. Unfortunately, capacity building is not led by one cohesive plan of action.

Data quality audits remain a missed opportunity within routine supervision and data which is collected by programmes and organisations is still not routinely used for programme improvement; a 'culture of M&E' is still under development.

b) Implementation challenges and progress

Challenges

While SANAC does have provision for an M&E Unit, it has been unstaffed for the last two years and does not have M&E capacity. Thus, there has been no routine collation and reporting on the national HIV and AIDS response during the reporting period. Two narrative reports were produced by government for SANAC plenary meetings on national progress during 2008. Most of the established M&E units do not have the authority to ensure or enforce regular reporting. Civil society represents the least-supported sector in terms of M&E capacity.

Despite having a national Strategic Plan and M&E Framework, South Africa lacks a costed M&E workplan that clearly identifies activities, actors, costs and timeframes of data collection and use for reporting and management of the national response. In addition, the lack of a coordinated capacity building plan around M&E has led to difficulty in applying uniform implementation according to prioritised need.

Patient monitoring of ART receives extensive support from government and development partners alike; however, there are many ART patient monitoring systems currently employed mainly by development partners, while at some sites, nothing at all in place to monitor treatment outcomes or patient survival rates. The Department of Health took a decision during 2009 to subject all the ART patient monitoring systems to an independent evaluation which is being conducted by the Medical Research Council. 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 practice of data use for programme improvement is not consistent across organisations or all cadres of appropriate staff — there is need to build up a 'culture of M&E' within all sectors. This seems to be a result of overburdening of staff in resource-constrained settings, and in other instances, due to a lack of skills, knowledge and experience in translating data into strategic information and using it for programme management. Even organisations in the same sector that routinely collect and produce data outputs do not participate in regular data-sharing among themselves.

Progress

In 2009 the Ministry for Performance Management Monitoring and Evaluation was established in the Presidency and it released a policy document on "Improving Government Performance: Our Approach" which proposed for a very clear set of outcomes and a few crucial measures for all sectors.

During 2008-2009, commitment to reporting on HIV and AIDS continued as a requirement of the Division of Revenue Act (DORA) and mandatory programme reporting by government departments to National Treasury. This reporting is linked to monitoring of the use of conditional grants for HIV and AIDS including ARVs in the public health sector. The Department of Public Service and Administration is spearheading a focus on M&E of the government's response to HIV and AIDS; this commitment is further evident in the establishment of a new M&E Department in the Office of the President. A change in government personnel has lead to a revived interest in HIV and AIDS; the President himself expressed public support during the 2009 World AIDS Day Campaign.

M&E is recognized as an important management tool in the country and interest is generally keen to improve this area. Significant capacity does exist to move the M&E agenda forward. SANAC is already in the process of staffing the M&E Unit and capacity exists in other sectors. The 2009 Midterm Review of the National Strategic Plan on HIV, AIDS and STIs recommended the use of district and sub-district structures that are already in place for coordinating M&E and research efforts, through the Provincial, District and Local AIDS Councils.

South Africa provides some very valuable and rich information regarding the drivers of the epidemic and possible prevention technologies, as seen with recent microbicide clinical trials, the introduction of dual therapy in the prevention of mother-to-child transmission and in the adoption of male circumcision as a prevention method.

Routine surveillance such as annual antenatal prevalence surveys, the HSRC behavioural survey and a LoveLife prevention survey produced in the last two years has added to the robust variety of strategic information available. This information helps to track HIV prevalence, incidence in pregnant women and HIV knowledge, attitudes and practices among the general population. Many key outcome, output and impact indicators are collected via routine surveillance and behavioural studies, as well as some from the long-standing monitoring systems (i.e., the DHIS and ETR).

Following the 2007 UNGASS Report, the private sector began remedial action in the area of M&E. A Private Sector M&E Seminar was hosted in March 2009, and a business plan was drafted with a budget and donor commitment to funding by August 2009. On behalf of the private sector, the M&E Steering Committee has begun a process of working with the South African National AIDS Council in establishing the M&E Unit.

c) Remedial actions planned for M&E

Key remedial actions for M&E that are in the planning or execution stage are:

1. Intense capacity building and support to SANAC in the development of their M&E Unit and overall national system starts in 2010. The donor funding for this initiative runs until 2013.

2. The NDOH has begun a review of different ART patient monitoring systems that are in use. This will help to determine the best system for adoption of one national electronic patient monitoring system for the ART programme.
3. Implementation of one ART monitoring system will: a) establish standardised data collection tools and procedures; b) eliminate contradictory methods of calculating numerators and denominators; c) provide an accurate measurement of current patients on treatment; d) provide ART patient survival data.

Relevant recommendations of the 2009 MTR include:

4. Prioritise the national indicator set to a maximum of around 20 indicators and direct efforts towards collecting and using the available data
5. Develop a costed M&E workplan to identify roles and responsibilities and to help allocate resources towards M&E
6. Develop one data collection tool and one central database to collect, aggregate and store information on the national response
7. Utilise the Provincial, District and Local AIDS Councils to collect, verify and disseminate data on national indicators
8. Finalise one national prioritised research agenda to guide resource allocation and to inform the overall response with evidence-based strategic information

d) Technical assistance and capacity building needs

As part of the National Composite Policy Index, Part A the section on Monitoring and Evaluation helped to identify the gaps which 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. These are:

1. The development of monitoring expenditures to guide the allocation of resources (if this is not achieved through the National AIDS Spending Assessment).
2. Establishing and supporting an operational M&E Unit within SANAC to monitor the overall national response.
3. The development of all related elements of a functional national M&E system, to include:

    - A costed national M&E implementation plan to measure the achievements of the national strategic plan
    - A data collection system (including data collection tools) for routine monitoring of the response
    - A national (central) database to house data from all sectors and to report on progress against the national strategic plan
    - A dissemination and communication strategy to regularly inform all stakeholders of the progress in the national response

4. Finalization of a national prioritized research agenda to include a focus on MARPs
5. The development and implementation of a capacity building plan for M&E for all sectors, to include data use and to help foster a “culture of M&E”

ANNEXES

Annex 1: Consultation/preparation process for the country report

Annex 2: National Composite Policy Index questionnaire

Annex 3: Table of indicator definitions

Annex 4: SANAC Women's Sector report on UNGASS HIV and AIDS Declaration Goals

Annex 1: Consultation/preparation process for the country report

1) Which institutions/entities were responsible for filling out the indicator forms?

a) NAC or equivalent	Yes	No
b) NAP	Yes	No
c) Others (Please specify):	Yes	No

2) With inputs from

Ministries:

Education	Yes	No
Health	Yes	No
Labour	Yes	No
Foreign Affairs	Yes	No
Others (Please specify): Public Services and Administration, Social Development, Department of Justice, National Treasury)	Yes	No

Civil society organizations	Yes	No
People living with HIV	Yes	No
Private sector	Yes	No
United Nations organizations	Yes	No
Bilaterals	Yes	No
International NGOs	Yes	No
Others (Please specify): World Health Organization	Yes	No

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: Mr. Nhlanhla Ntuli, Director, M&E Directorate, Department of Health

Date: _____

Signature: _____

Please provide full contact information:

Address: Department of Health, Private Bag X828, Pretoria, 0001

Email: ntulinh@health.gov.za

Telephone: (012) 312-0000

Annex 2: National Composite Policy Index questionnaire

NATIONAL COMPOSITE POLICY INDEX (NCPI) 2010

NCPI Data Gathering and Validation Process

Describe the process used for NCPI data gathering and validation

The NCPI questionnaire was first circulated electronically for completion before December 2009 to members of the South African National AIDS Council (SANAC) Programme Implementation Committee (PIC) which includes all 17 sectors and as a government sector in SANAC. It was also circulated to Inter-Departmental Committee on HIV (IDC) which is a governmental structure representing all government departments at national level and offices of the Premiers from the nine provinces.

In December 2009 invitations were all circulated to all members of the SANAC Programme Implementation Committee and members of the Inter-Departmental Committee on HIV (IDC) to a workshop to finalise the completion of the NCPI questionnaire. This workshop was attended by 12 civil society representatives representing people living with HIV/AIDS, women, children, gays and lesbians, research and people living with disability sectors and 14 government officials from health, education, social development, transport, public service and administration, justice and constitutional affairs. There were also two representatives from WHO and UNICEF offices. NCPI questionnaires were sent to all invitee's to ensure that consultation took place within their respective sectors. This was done to ensure that sector representatives where mandated to present a consensus position at the workshop. In addition, detail narrative comments were received from individual sectors including women, human rights and children sectors. These comments have been used in various sections of the NCPI and Country Progress Report. Lastly, the some questions of Section A of NCPI was also discussed by a select group of government officials at the National Validation Workshop.

***Describe the process used for resolving disagreements, if any, with respect to responses to specific questions**:*

Terms of references where discussed and agreed amongst delegates. A chair was elected for each session and was assisted by a facilitator. When unable to reach a unanimous response, consensus was reached by voting. If further deadlock continued the issue would be parked for further consultation.

Highlight concerns – if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like

Not applicable

NCPI Respondents

NCPI – PART A (to be administered to government officials)

Organization	Name /Position	Respondents to Part A				
		A.I	A.II	A.III	A.IV	A.V
Department of Health	Nhlanhla Ntuli, Director, M&E Directorate	✓	✓	✓	✓	✓
Department of Social Development	Dr. Connie Kganakga, HIV/AIDS Director	✓	✓	✓	✓	✓
Department of Public Service & Administration (DPSA)	Modiagi Masthaphuna, Health & Wellness	✓	✓	✓	✓	✓
Department of Public Service & Administration	Dr. Sipho Senabe, Chief Director	✓	✓	✓	✓	✓
Department of Education	Dr. Panday, Director	✓	✓	✓	✓	✓
Department of Social Development	Ruth Powe	✓	✓	✓	✓	✓
National Prosecuting Authority	Phuti Semenya, Deputy	✓	✓	✓	✓	✓
Department of Justice	Isaac Koto	✓	✓	✓	✓	✓
Department of Public Service & Administration	Morero Leseka	✓	✓	✓	✓	✓
Premier's Office, Eastern Cape province	Nondyebo Tyapolwana, Senior Manager	✓	✓	✓	✓	✓
Premier's Office, Limpopo province	Connie Raphahlelo	✓	✓	✓	✓	✓
Department of Transport	Mr. Moss Maswanganye	✓	✓	✓	✓	✓
Department of Agriculture	Ms. Maria Sekgobela	✓	✓	✓	✓	✓
Premier's Office, Free State	Emily Khuzwayo	✓	✓	✓	✓	✓
Premier's Office, KwaZulu-Natal	Fikile Ndlovu	✓	✓	✓	✓	✓
SANAC Secretariat	Ms. Bonakele Dlamini , Director	✓	✓	✓	✓	✓

NCPI –PART B (to be administered to civil society organizations, bilateral agencies, and UN organizations)

Organization	Name /Position	Respondents to Part B			
		B.I	B.II	B.III	B.IV
OUT	Dawie Nel, Director	✓	✓	✓	✓
ECRC	Sibusiso Mhlaugi, Manager	✓	✓	✓	✓
CRC	Meera Levine, HIV Manager	✓	✓	✓	✓
OSISA	Kgobathi Magone	✓	✓	✓	✓
WHO	Dr. Patrick Abok	✓	✓	✓	✓

Organization	Name /Position	Respondents to Part B			
		B.I	B.II	B.III	B.IV
Mosaic	Marieta De Vos, Director	✓	✓	✓	✓
SAMA	Dr. Dumisani Bomela	✓	✓	✓	✓
HSRC	Dr. Geoff Setswe, Acting Research Director	✓	✓	✓	✓
Traditional Leader	Veronica Motlofeloa	✓	✓	✓	✓
SANAC Women's Sector	Marlise Richter, Representative	✓	✓	✓	✓
Tshwaranang Legal Advocacy Centre	Anneke Meerkotter, Director	✓	✓	✓	✓
National People Living With HIV/AIDS	Kenny Sebeti	✓	✓	✓	✓
UNICEF	Dr. David Kalombo	✓	✓	✓	✓
DPSA / Disability Sector	Glilian Burrons	✓	✓	✓	✓

NATIONAL COMPOSITE POLICY INDEX (NCPI) QUESTIONNAIRE

Part A

(to be administered to government officials)

I. STRATEGIC

1.	**Has the country developed a national multi sectoral strategy to respond to HIV** *(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)*	Yes	No	Not Applicable (NA)

Period Covered (Write in): 2007-2011

***IF NO** or **NOT APPLICABLE**, briefly explain why:*

IF YES, complete question 1.1 through 1.10; IF NO, go to question 2

1.1 How long has the country had a multisectoral strategy?
Number of Years: ***Has been established since 2002. It is reviewed every 5 years and was therefore reviewed in 2007 and will again be reviewed in 2011.***

1.2 Which sectors are included in the multisectoral strategy with as specific HIV budget for their activities?

Sectors	**Included in strategy**		**Earmarked budget**	
Health	Yes	No	Yes	No
Education	Yes	No	Yes	No
Labour	Yes	No	Yes	No
Transportation	Yes	No	Yes	No
Military/Police	Yes	No	Yes	No
Women	Yes	No	Yes	No
Women	Yes	No	Yes	No
Young people	Yes	No	Yes	No
Others (Write in) Women Children Agriculture DPSA Justice Social Development Correctional Services Disability sector	Yes to all	No	Yes	No to some
COMMENTS: *Women: uncertainty of the budget, but there is a budget for PMTCT.* *The budget for HIV and AIDS in DSD is for people infected and affected by HIV and AIDS. The programme has prevention, care and support components.*				

***IF NO earmarked budget for some or all of the above sectors**, explain what finding is used to ensure implementation of their HIV-specific activities*

1.3 Does the multisectoral strategy address the following target populations, settings and cross cutting issues?

Target Populations		
a. Women and girls	Yes	No
b. Young women/young men	Yes	No
c. Injecting drug users	Yes	No
d. Men who have sex with men	Yes	No
e. Sex workers	Yes	No

f.	Orphans and other vulnerable children	Yes	No
g.	Other specific vulnerable subpopulations (Disabled and elderly)	Yes	No
Settings			
h.	Workplace	Yes	No
i.	Schools	Yes	No
j.	Prisons	Yes	No
Cross-Cutting issues			
k.	HIV and poverty	Yes	No
l.	Human Rights protection	Yes	No
m.	Involvement of people living with HIV	Yes	No
n.	Addressing stigma and discrimination	Yes	No
o.	Gender empowerment and/or gender equality	Yes	No

1.4	*Were target populations identified through a needs assessment*	*Yes*	*No*

IF YES, *when was this needs assessment conducted?*
Needs assessment was done in 2006 after the review of the multisectoral strategy in 2005

Year: ***2006***

IF NO, *explain how the target populations identified?*

1.5 What are the identified target populations for HIV programme in the country? (Write in)
Women and girls, young people, IDU's, MSM, sex workers, OVC's

1.6	*Were target populations identified through a needs assessment*	*Yes*	*No*

1.7 Does the multisectoral strategy of operational plan include:

a.	Formal programme goals?	Yes	No
b.	Clear targets or milestones	Yes	No
c.	Detailed costs for each programme area? **Estimates**	Yes	No
d.	An indication of funding sources to support programme implementation?	Yes	No
e.	A monitoring and evaluation framework	Yes	No

1.8. Has the country ensured "full involvement and participation" of civil society in the development of the multisectoral strategy?

Active Involvement	Moderate Involvement	No Involvement

If active involvement, *briefly explain how this was organized"* ***Organized through consultations, association with faith based organizations and civil society and government***

IF NO or MODERATE involvement, *briefly explain how this was organized"*

1.9	*Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?*	*Yes*	*No*

1.10 Have external development partners aligned and harmonized their HIV related programmes to the national multisectoral strategy?
All multilateral partners have accepted but only some bi-lateral.

Yes, all partners	Yes, some partners	No

IF SOME or NO, *briefly explain for which areas there is no alignment/harmonization and why.*

2. **Has the country integrated HIV into its general development plans such as in:**

(a) National Development Plan: b) Common Country Assessment/UN Development Assistance Framework; c) Poverty Reduction Strategy; and d) sector-wide approach

Yes	No	N/A

2.1 ***IF YES,*** *in which specific development plan (s) is support for HIV integrated?*

a. National Development Plan IDP	Yes	No	N/A
b. Common Country Assessment/UN Development Assistance Framework	Yes	No	N/A
c. Poverty Reduction Strategy	Yes	No	N/A
d. Sector-wide approach	Yes	No	N/A
e. Other: Local government	Yes	No	N/A

2.2 ***IF YES****, which specific HIV related areas are included in one or more of the development plan?*

HIV-related area included in development plan (s)		
HIV prevention	Yes	No
Treatment for opportunistic infections	Yes	No
Antiretroviral treatment	Yes	No
Care and support (including social security or other schemes)	Yes	No
HIV impact alleviation	Yes	No
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	Yes	No
Reduction of income inequalities as they relate to HIV prevention/treatment, care and/or support	Yes	No
Reduction of stigma and discrimination	Yes	No
Women's economic empowerment (e.g. access to credit, access to land, training)	Yes	No
Other: M&E and Research *(Write in)*	Yes	No

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

Yes	No	N/A

3.1 ***IF YES,*** *to what extent has it formed resource allocation decisions?*

High					**Low**
0	1	***[2]***	**3**	4	5

4.	**Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)**	Yes	No

4.1 ***IF YES,*** *which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of the uniformed services?*

Behavioural change communication	Yes	No
Condom provision	Yes	No

HIV testing and counselling	Yes	No
Sexually transmitted infection services	Yes	No
Antiretroviral treatment	Yes	No
Care and support	Yes	No
Others: Human Rights *(Write in)*	Yes	No

***If HIV testing and counselling is provided to uniformed services**, briefly describe the approach taken to HIV testing and counselling (e.g. indicate if HIV testing is voluntary or mandatory etc)*
Military – Mandatory for outside operations & entry (not accepted on basis of status)
Police – Voluntary
Civil Services – Voluntary
ART is supplied by some private medical aids.
Police and civil services – voluntary; military – mandatory before acceptance into military and before being posted somewhere – although the results do not affect whether or not they will be accepted or affect their posting in anyway.

5.	**Does the country have non-discrimination laws or regulations, which specify protection for most at risk populations or other vulnerable sub-population?**	Yes	No

5.1 ***IF YES,*** *for which subpopulations?*

Women	Yes	No
Young people	Yes	No
Injecting drug users	Yes	No
Men who have sex with men	Yes	No
Sex workers	Yes	No
Prison inmates	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
Other: **Refugees**	Yes	No

IF YES, *briefly explain what mechanisms are in place to ensure these laws are implemented:*

Constitution/Equality Courts

Briefly comment on the degree to which these laws are currently implemented:
Degree to which laws are currently implemented – Don't always have the resources to implement laws. Officials are not always aware of sub-populations rights. While the laws are there – the prosecution may be lagging behind. The problem is the speed and efficiency of implementation, not the implementation itself.

6.	**Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most at risk populations or other vulnerable sub-population?**	Yes	No

6.1 ***IF YES,*** *for which subpopulations?*

Women	Yes	No
Young people	Yes	No
Injecting drug users	Yes	No
Men who have sex with men	Yes	No
Sex workers	Yes	No
Prison inmates	Yes	No
Migrants/mobile populations	Yes	No

Other: **Refugees**	Yes	No

IF YES, *briefly describe the content of these laws, regulations or policies:*

Briefly comment on how they pose barriers:
Women – possibly the polygamy law which applies for certain cultures
Young people – while it is allowed that condoms are distributed within schools – it is the decision of the governing body of a particular school which decides whether this happens or not. IDU's and sex workers – both illegal therefore may struggle to gain access to services

7.	**Has the country followed up on commitments towards universal access made during the high-level AIDS Review in June 2006**	Yes	No

7.1	*Have the national strategy and national HIV budget been revised accordingly?*		*Yes*	*No*
7.2	*Have the estimates of the size of the main target populations been updates*		*Yes*	*No*
7.3	*Are there reliable estimates of current needs and of future needs of the number of adults and children requiring ARVs* ***CEGA @ UCT has estimated what it will take to deal with HIV up until 2031***	*Estimates of current and future needs*	*Estimates of current needs only*	*No*
7.4	*Is HIV programme coverage being monitored?*		*Yes*	*No*
	a) IF YES, is coverage monitored by sex (male/female)?		*Yes*	
	b) IF YES, is coverage monitored by sex (male/female)?		*Yes*	

IF YES, *for which population groups?*
Young and old- groups which are difficult to get to females and males, plus pregnant women

Briefly explain how this information is used:
Reporting purposes

7.4	*Is coverage monitored by geographical area?*	Yes	No

IF YES*, at which geographical levels (provincial, district, others:*

Provincial – how many people on ART, # of women on PMTCT

Briefly explain how the information is used:

7.5	*Has the country developed a plan to strengthen the health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs:* ***It is agreed that the planning is good – it is the implementation which is a problem***	Yes	No

Overall, how would you rate the *strategy planning efforts* in the HIV programmes in 2009

2009 Very Poor Excellent

0 1 2 3 4 5 6 7 ***[8]*** 9 10

Since 2007, what have been key achievements in this area:

- ***More than ½ million on ARV***
- ***More sites for ART provision***
- ***Expanded care for TB***

What are the remaining challenges in this area:

- ***Implementation, Human Resources, infrastructure***

NATIONAL COMPOSITE POLICY INDEX (NCPI) QUESTIONNAIRE

Part A

(to be administered to government officials)

II. POLITICAL SUPPORT

1. Do high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?

President/Head of government	Yes	No
Other high officials	Yes	No
Other officials in regions and/or districts	Yes	No

2.	**Does the country have an officially recognized national multisectoral AIDS coordination body (i.e., National AIDS Council or equivalent)**	Yes	No

***IF NO**, briefly explain why not and how AIDS programmes are being managed:*

2.1 ***IF YES**, when was it created?*
Year: ***Was developed in 1999 and re-launched in 2007***

2.2 ***IF YES,** who is the Chair?*
Name: ***Kgalema Motlanthe*** Position/Title: ***Deputy President***

2.3 ***IF YES,** does the national multisectoral AIDS coordination body*

Have terms of reference?	Yes	No
Have active government leadership and participation?	Yes	No
Have a defined membership?	Yes	
IF YES, how many members? 145		
Include civil society representatives?		
IF YES, how many? **100**		
Include people with HIV?	Yes	
IF YES, how many? **8**		
Include the private sector **10**		No
	Yes	
	Yes	
Have an action plan	Yes	No
Have a functional Secretariat	Yes	No
Meet at least quarterly?	Yes	No
Review actions on policy decisions regularly?	Yes	No
Active promote policy decisions	Yes	No
Provide opportunity for civil society to influence decision-making?	Yes	No
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting	Yes	No

***IF YES**, briefly describe the main achievements:*
Review of the treatment guidelines
Review epidemic
Agreement to male circumcision policy and the increased risk of MSM, CSW

Briefly describe the main challenges:
Governance and legal status not yet defined

M&E

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?

Percentage***: Not available***

5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV related activities?

Information on priority needs?	Yes	No
Technical guidance	Yes	No
Procurement and distribution of drugs or other supplies	Yes	No
Coordination with other implementing partners	Yes	No
Capacity Building **(*some sectors of SANAC)***	Yes	No
Other: *(Write in)*	Yes	No

6. Has the country reviewed national policies and laws to determine which, if any, are consistent with the National AIDS Control policies?	Yes	No

6.1	***IF YES,*** *were policies and laws amended to be consistent with the National AIDS Control policies?*	Yes	No

IF YES, *name and describe how the policies/laws were amended:*

Development of male medical circumcision policy and guidelines followed extensive advocacy and analysis of published evidence on male medical circumcision. Then there were extensive consultation with various stakeholder groups including organised structures of traditional leaders .

The change in the ART Treatment Guidelines was also informed by evidence from published research and then followed by advocacy, discussion in existing structures, cost estimations and finally approval by Cabinet.

Name and describe any inconsistencies that remain any policies/laws and the National AIDS control policies:

Overall, how would you rate the *political support for the* HIV programmes in 2009

2009	Very Poor									Excellent
	0	1	2	3	4	5	6	7	***[8]***	9	10

Since 2007, what have been key achievements in this area:

- ***All stakeholders including government, civil society and business rally behind the implementation of the National Strategic Plan***
- ***Increasing allocation of financial resources by government for the provision of ART in public health facilities***

What are the remaining challenges in this area:

Translation into resources and poor record of HIV mainstreaming in many ministries

NATIONAL COMPOSITE POLICY INDEX (NCPI) QUESTIONNAIRE

Part A

(to be administered to government officials)

III. PREVENTION

1.	**Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?**	Yes	No	Not Applicable (NA)

1.1 *IF YES, what key messages are explicitly promoted?*
√ Check for key messages explicitly promoted

a. Be sexually abstinent	*√*
b. Delay sexual debut	*√*
c. Be faithful	*√*
d. Reduce the number of sexual partners	*√*
e. Use condom consistently	*√*
f. Engage in safe(r) sex	*√*
g. Avoid commercial sex	*X*
h. Abstain from injecting drugs	*√*
i. Use clean needles and syringes	*X*
J .Fight against violence against women	*√*
k. Greater acceptance and involvement of people living with HIV	*√*
l. Greater involvement of men in reproductive health programmes	*√*
m. Males to get circumcised under medical supervision	*X*
n. Know your HIV status	*√*
o. Prevent mother to child transmission of HIV	*√*
Other: (Write in)	

1.2	*In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?*	Yes	No

2.	**Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?**	Yes	No	N/A

2.1 Is HIV education part of the curriculum?

Primary schools	Yes	No
Secondary schools	Yes	No
Teacher trainings	Yes	No

2.2	*In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?*	Yes	No
2.3	*Does the country have an HIV education strategy for out-of-school young people?* ***Youth out of school are reached by various communication strategies including love Life, youth commission, Khomanani and , other HIV/AIDS programmes***	Yes	No

3.	**Does the country have a policy or strategy to promote information, education and communication and other preventative health interventions for most at risk or other vulnerable sub-populations?**	Yes	No

IF NO, *briefly explain:* **There is currently no such interventions tailored to target at specific most at risk or vulnerable subpopulations. The current IEC and other preventive health interventions are targeted at general population including most at risk populations or other vulnerable sub-population**

3.1 ***IF YES,*** *which populations and what elements of HIV prevention do the policy/strategy address?*
√ Check which specific populations and elements are included in the policy/strategy

	IDU	**MSM**	**Sex workers**	**Clients of Sex Workers**	**Prisons inmates**	**Other populations**
Targeted information on risk reduction and HIV education	X	X	X	X		
Stigma and discrimination reduction	N/A	N/A	N/A	N/A	N/A	N/A
Condom promotion	N/A	N/A	N/A	N/A	N/A	N/A
HIV testing and counselling	N/A	N/A	N/A	N/A	N/A	N/A
Reproductive health, including sexually transmitted infections prevention and treatment	N/A	N/A	N/A	N/A	N/A	N/A
Vulnerability reduction (e.g. income generation)	N/A	N/A	N/A	N/A	N/A	N/A
Drug substitution therapy	N/A	N/A	N/A	N/A	N/A	N/A
Needle & syringe exchange	N/A	N/A	N.A	N/A	N/A	N/A

Overall, how would you rate the *policy in support of the* HIV programmes in 2009											
2009	Very Poor										Excellent
	0	1	2	3	4	5	6	***[7]***	8	9	10
Since 2007, what have been key achievements in this area: ***A number of policies were revised and approved including counselling and testing policy, ART guidelines and male circumcision policy*** *What are the remaining challenges in this area:* ***Targeted messaging***											

4.	**Has the country identified specific needs for HIV prevention programmes?**	Yes	No

IF YES, *how were these specific needs determined?* ***Needs assessment, consultation, research and surveillance***
IF NO, *how are HIV prevention programmes being scaled-up?*

4.1 To what extent has HIV prevention been implemented?

HIV prevention component	**The majority of people in need have access**		
Blood Safety	Agree	Don't Agree	N/A
Universal precautions in health care settings	Agree	Don't Agree	N/A
Prevention of mother-to-child-transmission of HIV	Agree	Don't Agree	N/A
IEC on risk reduction	Agree	Don't Agree	N/A
IEC on stigma and discrimination reduction	Agree	Don't Agree	N/A
Condom promotion	Agree	Don't Agree	N/A
HIV testing and counselling	Agree	Don't Agree	N/A
Harm reduction for injecting drug users	Agree	Don't Agree	N/A
Risk reduction for men who have sex with men	Agree	Don't Agree	N/A
Risk reduction for sex workers	Agree	Don't Agree	N/A

HIV prevention component	**The majority of people in need have access**		
Reproductive health services including sexually transmitted infections prevention and treatment	Agree	Don't Agree	N/A
School based HIV education for young people	Agree	Don't Agree	N/A
HIV prevention for out of school young people	Agree	Don't Agree	N/A
HIV prevention in the workplace	Agree	Don't Agree	N/A
Other	Agree	Don't Agree	N/A

Overall, how would you rate the *efforts in the implementation of the* HIV programmes in 2009										
2009	Very Poor									Excellent
	0	1	2	3	4	5	6	7	***[8]***	9	10
Since 2007, what have been key achievements in this area: ***Education around STIs and condom distribution*** *What are the remaining challenges in this area:* ***Multiple partnerships***										

NATIONAL COMPOSITE POLICY INDEX (NCPI) QUESTIONNAIRE

Part A

(to be administered to government officials)

IV. TREATMENT, CARE AND SUPPORT

1.	**Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to treatment, HIV testing and counselling, psychosocial care, and home and community-based care)**	Yes	No

1.1	*IF YES, does it address barriers for women?*	Yes	No
1.2	*IF YES, does it address barriers for most-at-risk populations?*	Yes	No

2.	**Has the country indentified the specific needs for HIV treatment, care and support services?**	Yes	No

IF YES, *how were these determined?*

- ***Review of previous strategic plan***
- ***Health review***
- ***Research studies***
- ***Stakeholders' consultation***
- ***Evaluation of cost effectiveness of home and community-based care***
- ***Review of TB strategy***

IF NO, *how are HIV treatment, care and support services being scaled?*

2.1 To what extent have HIV treatment, care and support services been implemented?

HIV prevention component	**The majority of people in need have access**		
Antiretroviral Therapy	Agree	Don't Agree	N/A
Nutritional care	Agree	Don't Agree	N/A
Paediatric AIDS treatment	Agree	Don't Agree	N/A
Sexual transmitted infection management	Agree	Don't Agree	N/A
Psychological support for people living with HIV and their families	Agree	Don't Agree	N/A
Home-based care	Agree	Don't Agree	N/A
Palliative care and treatment of common HIV related infections	Agree	Don't Agree	N/A
HIV testing and counselling for TB patients	Agree	Don't Agree	N/A
TB screening for HIV-infected people	Agree	Don't Agree	N/A
TB preventive therapy for HIV infected people	Agree	Don't Agree	N/A
TB infection control in HIV treatment and care facilities	Agree	Don't Agree	N/A
Cotrimoxazole prophylaxis in HIV-infected people	Agree	Don't Agree	N/A
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree	Don't Agree	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree	Don't Agree	N/A
HIV care and support in the workplace (including alternative working arrangements)	Agree	Don't Agree	N/A
Other programmes (*Write in)* Enabling environment for testing and disclosure	Agree	Don't Agree	N/A

3.	**Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?**	Yes	No

4.	**Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as ARVs, condoms, and substitution drugs?**	Yes	No

IF YES, *for which commodities?* *(Write in)*

Overall, how would you rate the *efforts in the implementation of the* HIV treatment, care and support in 2009

2009 Very Poor Excellent

0 1 2 3 4 5 6 7 ***[8]*** 9 10

Since 2007, what have been key achievements in this area:

- ***Increased numbers of facilities accredited to provide ARTs has increased***
- ***Increased number of people on ART and majority of (98%) of persons on ART estimated to be still on regimen 1***

What are the remaining challenges in this area:

- ***Shortage of human resources in particular clinical staff***
- ***Not all facilities approved-infrastructure***
- ***Monitoring – how many people deregistered and pharmacovigilance***

5.	**Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?**	Yes	No	N/A

5.1	***IF YES,*** *is there an operational definition for orphans and vulnerable children in the country?*	Yes	No

5.2	***IF YES,*** *does the country have a national action plan specifically for orphans and vulnerable children in the country?*	Yes	No

5.3	***IF YES,*** *does the country have an estimate of orphans and vulnerable children being reached by existing interventions?*	Yes	No

IF YES, what percentage of orphans and vulnerable children is being reached? ***%*** *(write in)*

Overall, how would you rate the *efforts to meet the HIV-related needs of orphans and other vulnerable children* in 2009

2009 Very Poor Excellent

0 1 2 3 4 5 6 7 ***[8]*** 9 10

Since 2007, what have been key achievements in this area:

- ***Review election plan-develop new plan in line with NSP***
- ***Coordinated response/commitment-members came to meetings***
- ***Monitor services supplied to children***
- ***Surveillance through home affairs to track orphans through death and birth registration. NGOs and CS-looking after OVCs***

What are the remaining challenges in this area:

Funds specifically

Plans are there, challenge is implementation

NATIONAL COMPOSITE POLICY INDEX (NCPI) QUESTIONNAIRE

Part A

(to be administered to government officials)

V. MONITORING AND EVALUATION

1.	**Does the country have a one national Monitoring and Evaluation (M&E) plan?**	Yes	In Progress	No

IF NO, *briefly describe the challenges:*
With specific sectors-functional M&E plans (not national). Unsure if there is an actual document but definitely there is an M&E framework plan in place to develop a plan.

1.1 IF YES, years covered: 2007-2011

1.2	***IF YES,*** *was the M&E framework endorsed by key partners in M&E?*	Yes	No

1.3	***IF YES,*** *was the M&E framework developed in consultation with civil society, including people living with HIV?*	Yes	No

1.4	*IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E framework?*	*Yes, all partners*	*Yes, most partners*	*Yes, but only some partners*	*No*

IF YES, but only some partners or IF NOT, briefly describe what the issues are:
Weakness in civil society M&E (Check MTR to decide on option 2 or 3)

2. Does the national Monitoring and Evaluation framework include:

a. Data collection strategy IF YES, does it address: Routine programme monitoring Behavioural surveys HIV surveillance Evaluation/research studies	Yes Yes Yes Yes Yes	No
Well-defined standardized set of indicators	Yes	No
Guidelines on tools for data collection	Yes	No
A strategy for assessing data quality (i.e. validity, reliability	Yes	No
A data analysis strategy	Yes	No
A data dissemination and use strategy	Yes	No

3.	**Is there a budget for implementation of the M&E**	Yes	In Progress	No

3.1 *IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities? (Write in)*

3.2	***IF YES,*** *has full funding been secured?*	Yes	No

IF NO, *briefly describe the challenges:*
There is no budget

3.3	*IF YES, are M&E expenditures monitored?*	Yes	No

4.	**Are M&E priorities determined through a national M&E assessment?**	Yes	No

IF YES, *briefly describe how often a national M&E assessment is conducted and what the assessment involves:* ***MTR, another evaluation at the end of the 5 yrs***

IF NO, *briefly describe how priorities for M&E are determined:*

5.	**Is there a functional national M&E unit?**	Yes	In Progress	No

IF NO, *what are the main obstacles to establishing a functional M&E Unit?* ***Need to develop infrastructure and capacity; it is also a systemic issue***

5.1 IF YES, is the national M&E Unit based:

In the National AIDS Commission (or equivalent)	Yes	No
In the Ministry of Health	Yes	No
Elsewhere: ***Presidency*** ***Private sector structure has been established at a provincial level***	Yes	No

5.2 ***IF YES,*** *how many and what type of professional staff are working in the national M&E Unit?*

Number of permanent staff:		
Position: (Write in)	*Full time/Part time?*	*Since when?*
Position: (Write in)	*Full time/Part time?*	*Since when?*
(Add as many as needed)		
Number of permanent staff:		
Position: (Write in)	*Full time/Part time?*	*Since when?*
Position: (Write in)	*Full time/Part time?*	*Since when?*
(Add as many as needed)		

DOH to complete

5.3	IF YES, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/report to the M&E Unit for inclusion in the national M&E system *Government is established but not civil society; private sector is still in progress*	Yes	No

IF YES, briefly describe the data sharing mechanisms: *What are the major challenges?* ***Costing not all org have M&E*** ***Some programmes not aligned to the NSP***

6.	**Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities**	No	Yes, but meets irregularly	Yes, meets regularly

6.1	*Does it include representation from civil society?*	Yes	No

IF YES, briefly describe who the representatives from civil society are and what their role is: ***Women sector*** ***Gay + lesbian group*** ***Private sector***

7.	**Is there a central national database with HIV related data?** ***Not central***	Yes	No

7.1 ***IF YES****, briefly describe the national database and who manages it (Write in)*

7.2 IF YES, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations? (Write in)

a. Yes, all of the above

b. Yes, but only some of the above

c. No, none of the above

7.3 Is there a functional Health Information System?

At national level	Yes	No
At sub-national level *IF YES, at what level?*	Ye	No

8.	**Does the country publish at least once a year an M&E report on HIV and AIDS, including HIV surveillance data?** • **Antenatal survey published annually** • **HSRC Survey published every 2 years**	Yes	No

9.	**To what extent are M&E data used?**	Yes	No

9.1 In developing/revising the national AIDS strategy

Low					**High**
0	1	2	3	***[4]***	5

Provide a specific example:

- ***Male Circumcision***
- ***Expanded access to ARVs***
- ***Lowered CD4+ count for ARV***

What are the main challenges, if any?

- ***Non standardization, no comparability of studies***
- ***No centralized data base***
- ***Readily accessible information***

9.2 For resource allocation

Low					**High**
0	1	***[2]***	3	4	5

Provide a specific example:

- ***Number of MARPS groups- no coherent strategy***
- ***No resources allocated, area needs attention (better targeting)***
- ***Plans are not costed***

What are the main challenges, if any?

9.3 For programme improvement

Low					**High**
0	1	***[2]***	3	4	5

Provide a specific example:

Organisations outside government doing M&E into routine data, monitoring in government departments. Is not up to scratch.

What are the main challenges, if any?
Mainstreaming-weakness

10.	**Is there a plan for increasing capacity in M&E data at national, sub-national and service delivery?**	Yes	No

a. Yes, at all levels
b. Yes, but only addressing some levels
c. No

10.1 In the last year, was training in M&E conducted?

At national level?	*Yes*	*No*
IF YES, Number trained (Write in)		
At sub-national level?	*Yes*	*No*
IF YES, Number trained (Write in)		
At service delivery level including civil society?	*Yes*	*No*
If Yes, Number trained (Write in)		

10.2	*Were other M&E capacity building activities conducted other than training?*	Yes	No

IF YES, describe what types of activities: (Write in)

Overall, how would you rate the M&E *efforts of the HIV programme* in 2009

2009 Very Poor Excellent

0 1 2 3 ***[4]*** 5 6 7 8 9 10

Since 2007, what have been key achievements in this area:

- ***Recognize that a plan is needed***
- ***MTR was done***
- ***External Evaluation (surveys) data is being used to influence direction of HIV education***

What are the remaining challenges in this area:

- ***Not well coordinated data collection***
- ***No dedicated structure***
- ***Capacity around M&E (Human Resource)***
- ***Standardization of indicators***
- ***Increase knowledge of M&E importance***

NATIONAL COMPOSITE POLICY INDEX (NCPI) QUESTIONNAIRE

Part B

(to be administered to civil society organizations, bilateral agencies, and UN organizations)

VI. HUMAN RIGHTS

1.	**Does the country have laws and regulations that protect people living with HIV against discrimination? (Including both general non-discrimination provisions and provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.)**	Yes	No

1.1	*IF YES, specify if HIV is specifically mentioned and how or if this is a general non discrimination provision* There are general provisions under the bill of rights in the constitution of South Africa that protect all people against discrimination. Specific protection for people living with HIV in workplace is provided under the code of good practice of the employment equity act. While no specific provision is made for people living with HIV under the bill of rights it was successfully argued in the constitutional court that the government had an obligation to provide ART to people living with HIV.	Yes	No

EXAMPLES:

Constitution: Bill of Rights

Section 9: Prevents the state from discriminating directly or indirectly on the basis of race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth or related grounds. The Constitutional Court's 2000 judgment of Hoffman v South African Airways, the court held that HIV discrimination would fall within the list of grounds on which discrimination is prohibited in the Constitution.

Section 12(2) (c): Prevents anyone from being subjected to medical or scientific experiments without their informed consent.

Section 26: Provides that everyone has the right to have access to adequate housing and that no legislation may permit arbitrary evictions

Section 28: Provides that every child has the right to basic nutrition, basic health care services and social services.

Section 35(2)(e): Provides that all detained individuals (including sentenced prisoners),are entitled to conditions of detention that are consistent with human dignity, at least exercise and the provision, at state expense, of adequate accommodation, nutrition, reading material and medical treatment.

Laws:

Compensation for Occupational Injuries and Diseases Act: allows for compensation for injuries occurring on the job, including infections and disabilities (both permanent and temporary) including occupationally acquired HIV transmission.

Correctional Services Act s 12: Requires the Department of Correctional Services to provide, within available resources, adequate health care services and access to the medical practitioner of their own choice at their own expense.

Employment Equity Act 6: Prevents discrimination against an employee in any employment policy or practice on the basis of race, gender, sex, pregnancy, marital status, family responsibility, ethnic or social origin, colour, sexual orientation, age, disability, religion, HIV status, conscience, belief, political opinion, culture, language and birth.

Labour Relations Act 186: Prohibits any unfair dismissal based on any arbitrary ground, including, but not limited to race, gender, sex, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, political

opinion, culture, language, marital status or family responsibility.

Medical Schemes Act s 24(2)(e): Prevents registration of a medical scheme if the Medical Schemes Council determines the scheme unfairly discriminates directly or indirectly on an arbitrary ground including race, age, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and state of health.

Promotion of Equality and Prevention of Unfair Discrimination: Prohibits unfair discrimination against any person. This includes expressly on the grounds of race, gender, and disability and, as interpreted by **Hoffman v. SAA**, includes HIV. It should be noted that the National Strategic Plan (NSP) recommends amending this Act to include HIV Status as an express ground.

South African Schools Act (chap 2): Provides that public schools must admit all learners and serve their educational needs without unfairly discriminating in any way.

Regulations:

Code of Good Practice on Key Aspects of HIV/AIDS & Employment - Issued under the Employment Equity Act s 54(1)(a): Prevents unfair discrimination on the basis of HIV status, promotes work policies creating a non-discriminatory workplace environment, and sets the conditions for employer/employee initiated HIV testing, amongst other regulations.

General Regulations under the Correctional Services Act s 7(1)(a): Provides that primary health care must be available in a prison at least on the same level as that rendered by the State to members of the community.

General Regulations under Medical Schemes Act: Provides the minimum standards for a Medical Scheme regarding treatment of persons after HIV+ diagnosis. Includes VCT, Cotrimoxazole as preventive therapy, screening and preventive therapy for TB diagnosis and treatment of sexually transmitted infections, pain management in palliative care, treatment of opportunistic infections, prevention of mother to child transmission of HIV, post-exposure prophylaxis following occupational exposure or sexual assault, medical management and medication, including the provision of antiretroviral therapy, and ongoing monitoring for medicine effectiveness and safety, to the extent provided for in the national guidelines applicable in the public sector (the national guidelines are set out in the operational plan for comprehensive HIV and AIDS care, management and treatment for South Africa; and the national antiretroviral treatment guidelines.

UN Convention on Disability

2.	**Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable populations?**	Yes	No

2.1 IF YES, for which populations?

a.	Women	Yes	No
b.	Young people	Yes	No
c.	Injecting drug users	Yes	No
d.	Men having sex with Men	Yes	No
e.	Sex workers	Yes	No
f.	Prison inmates	Yes	No
g.	Migrants/mobile populations	Yes	No
h.	Other: Children	Yes	No

***IF YES**, briefly explain what mechanisms are in place to ensure these laws are implemented:*

Civil Society Networks / Organizations, Legal Aid South Africa and Probono.org: Civil Society organizations highlight HIV discrimination issues, such as the AIDS Consortium's AIDS Charter. Access to justice mechanisms such as the Legal Aid South Africa, Probono.org and other legal advice centres enable people to enforce their rights and provide critical oversight on the implementation of laws.

South African Human Rights Commission: The SAHRC is established in Chapter 9 of the Constitution with the responsibility to promote and protect human rights. The efficacy and independence of the Chapter 9 commissions has been called into question by the Ad Hoc Committee on the Review of State Institutions Supporting Constitutional Democracy. The report details problems in the financing and appointment procedures which undermine the ability for the commissions to effectively perform their Constitutional functions.

Commission on Gender Equality: The Gender Commission is established in Chapter 9 of the Constitution with the responsibility to promote and protect gender equality. The efficacy and independence of the Chapter 9 commissions has been called into question by the Ad Hoc Committee on the Review of State Institutions Supporting Constitutional Democracy. The report details problems in the financing and appointment procedures which undermine the ability for the commissions to effectively perform their
Constitutional functions.

Council for Medical Schemes: Responsible for registering all medical schemes in the country and guaranteeing minimum standards for care provided by medical schemes.

Judicial Inspectorate of Prisons*:* The Judicial Inspectorate serves both an investigative and an adjudicative role. It has the duty to uphold the standards of all prisons in South Africa and has the authority to initiate inspections of prisons and hold hearings and make rulings based on the complaints it receives.

Medicines Control Council: The MCC is the mechanism from which any medicine to be sold or tested in clinical trials in South Africa must receive approval.

Various Parliamentary Committees: Several parliamentary committees are in existence which monitor implementation of laws and policies (i.e. Portfolio Committee on HIV/AIDS).

PLUS

- Equality Courts
- Some Chapter institutions
- Constitutional Courts

Briefly describe the content of these laws:

There remains a stark divide between the passing of laws, the regulations put in place to give them meaning, and the actual enforcement of laws on the ground. The real measure of the government's and the nation's response to the HIV can be found in information of trends in HIV prevalence, HIV incidence, and levels of access to care and treatment. The trends are significantly more indicative of whether the laws put in place have enabled prevention policies, decreased stigma and discrimination, and made a significant impact on advancing the human rights of people living with HIV and AIDS, and human rights generally.

With the above in mind, we provide the following list of bodies which form part of the system of redress. It is important to recognize these bodies for what they are, a series of individual bodies acting in their own sectors rather than a cohesive system for addressing discrimination or enforcement generally.

Access to Legal Aid services: There are limited legal aid services available, some of which are funded by the government and some of which are funded through other means such as pro bono programmes. However, as legal aid services generally practice in diverse areas of the law and are stretched by the number of people in need of assistance, the capacities and resources of legal aid are insufficient to address the need. Funding allocation is a problem and the vast majority of resources allocated to Legal Aid South Africa is utilized to carry out their constitutional obligation to provide legal services to unrepresented accused in criminal matters.

Commission for Conciliation, Mediation and Arbitration (CCMA): Established by the Labour Relations Act to arbitrate disputes between workers and employers, including any cases of discrimination which may be brought to

their attention.

Health Professions Council of South Africa (HPCSA): The HPCSA was created by the Health Professions Act and hears complaints regarding the conduct of health professionals. The HPCSA has the authority to suspend, fine, and revoke licenses to practice within South Africa.

Judicial Inspectorate of Prisons: See above.

National Health Research Ethics Council: Established in the National Health Act ensures, through the creation of Health Research Ethics Committees, that all health related research is done in an ethical manner. The committees have the authority to grant or deny permission to carry out research with human participants.

PLUS

- *Access to health for mobile populations & refugees*
- *Code of Practice- non discrimination in the workplace*
- *Domestic Violence Act*

Briefly comment on the degree to which they are currently implemented:
i.e. Domestic Violence Act has flaws as far as HIV/AIDS is concerned; Needs a strong CSO presence to ensure its implemented effectively; Loopholes in which they are implemented

3.	**Does the country have laws, regulations or policies that present obstacles that present obstacles to effective HIV prevention, treatment, care and support for most at risk populations and other vulnerable subpopulations**	Yes	No

a.	Women	Yes	No
b.	Young people	Yes	No
c.	Injecting drug users	Yes	No
d.	Men having sex with Men	Yes	No
e.	Sex workers	Yes	No
f.	Prison inmates	Yes	No
g.	Migrants/mobile populations	Yes	No
h.	Other: Disabled Persons	Yes	No

***IF YES**, briefly describe the content of these laws, regulations or policies:*

While no laws explicitly prohibit or provide obstacles to effective HIV prevention, treatment, care amongst young people specific policy directive prohibiting condom distribution at schools is considered as obstacles. As the recreational use of drugs is prohibited no specific policy around intravenous drug use such as distribution of sterile injecting equipment or prevention campaigns targeted at IDUs is difficult. Similarly sex work is also illegal creating barriers to effective surveillance and protection.

Recognition of Polygamy: The Recognition of Customary Marriages Act, 1998 recognizes customary marriages and officially condones polygamous marriages. Studies have shown that concurrent sexual networks increase the rates of HIV transmission in comparison to sequential monogamy sexual encounters. Therefore the legal condoning of polygamous could undermine women's sexual and reproductive health, place them at a greater risk of HIV infection and restrict their ability to insist on partner fidelity and to negotiate condom use.

Lack of Independence and Resources for Oversight Bodies: Many of the mechanisms that have been put in place to oversee the government's enforcement of the laws are compromised by a lack of independence. For instance, the Human Rights Commission, the Gender Equality Commission, and the Public Protector are all established in Chapter 9 of the Constitution but have had their efficacy and independence called into question by the Ad Hoc Committee on the Review of State Institutions Supporting Constitutional Democracy. The report details problems in the financing and appointment procedures which undermine the ability for the commissions to effectively perform their Constitutional functions.

Other institutions such as the Medicines Control Council have had members dismissed when decisions of the MCC

were opposed by the Minister of Health. Oversight institutions are frequently situated within the departments and are appointed by the ministers they are tasked with monitoring.

Budgeting process: In early November 2008, the Free State province experienced a shortage of essential medicines, including ARVs; a four month provincial moratorium barred new patients from getting the life-prolonging medication, resulting in a waiting list of over 15,000 people. The 4-month moratorium also cost over 3000 lives, many more lives have been lost since then.

After the stock-outs, there was an Integrated Support Task Team set up to review the provincial departments of health. Looking at the draft Free State Report there were several issues highlighted where budgeting and funding were problematic.

- The first was a lack of cohesion between policy formulation, budgets and resources to implement the policies and planning.
- The lack of alignment between annual plans and the budget
- Financial management practices, including budgeting at national and provincial level were criticized as overspending was a real problem as well as bad management leading to underfunding of certain areas.
- Drug budgets have not been prioritized and this has led to shortages of medicines (lack of evidence-based budgeting).
- lack of integrated information systems result in deficient budgeting processes
- full budgetary impact of the cost of treatment by patients on ART needs to be better quantified

This is not specific to one province but inconsistent and non-evidence based budgeting is pervasive all over South Africa.

Continuation of Policies which promote stigmatization and discrimination: The Employment Equity Act specifically exempts the SANDF, National Intelligence Agency, and the South African Secret Service from any of its provisions, such as the prohibition of discrimination based on HIV-status. Likewise, the continued criminalization of sex work, which the NSP has recommended be decriminalized, creates barriers to access of HIV prevention and treatment services by sex workers and their clients. These laws and policies undermine efforts to promote equality and fundamental human dignity and hinder prevention and treatment efforts.

Lack of Harm Reduction Strategies: There is an insufficient level of commitment to harm reduction strategies within South Africa. There are few programs promoting harm reduction amongst drug users. While South Africa's IDU population is relatively limited in comparison to many countries and is not the focal point of domestic HIV transmission, there is still a need for programs which encourage responsible behaviour, promote higher levels of condom usage, needle exchange programs in areas with higher levels of IDUs, and other programs which lessen the risk of HIV transmission amongst higher risk populations.

Failure to Adequately Provide for Disabled Persons: Disabled persons face significant difficulties in accessing information, adequate care, and instruction regarding the taking of medications.

Failure to budget for the needs for children: The Children's Act requires that children's best interests are of paramount importance. Their rights are also enshrined in the Constitution. Unfortunately inadequate resources are allocated to ensure implementation of the Children's Act. For example, social workers who are tasked with implementing many provisions in the Act are in short supply and many areas throughout South Africa seldom see social workers.

Access to services for refugee and migrant women: Although the NDOH formulated policy stating that refugee and migrant populations should have access to clinics and ART, there is still widespread reports of migrant women being turned away from clinics for important SRHR and HIV$AIDS services due to prejudice and/or ignorance of health practitioners at local facilities.

4.	**Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy**	Yes	No

***IF YES**, briefly describe human rights explicitly mentioned in any HIV policy or strategy*

National Strategic Plan: The NSP, in Chapter 8, priority area 4, includes the promotion of Human Rights and Access to Justice. Inclusive in this recognition is acknowledgment of the need for access to justice mechanisms enabling people to enforce their rights.

PLUS

The protection of human rights and access to justice is strongly articulated in the national strategic plan.

5.	**Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most at risk populations and/or other vulnerable subpopulations?**	Yes	No

IF YES, briefly describe this mechanism?

While there are individual councils, commissions, and different enforcement mechanisms which take on discrimination cases or record human rights abuses in individual sectors, there is no overarching body which gathers and centralizes this information. Other than monitoring of cases and decisions out of these various bodies, there is no ability to gain any real sense of the levels of discrimination being experienced or whether discrimination is being targeted at different subpopulations. The NSP discusses the creation of monitoring tools and systems for collecting this information, but since its inception in 2007 they have yet to be implemented.

6.	**Has the government through political and financial support, involved people living with HIV, MARPS and /or other vulnerable subpopulations in government HIV policy design and programme implementation**	Yes	No

IF YES*, briefly describe this mechanism?*
Through the processes which have led to the creation of the South African National AIDS Council (SANAC) and the National Strategic Plan (NSP), the government has created spaces in which most-at-risk populations could participate in HIV-policy design and implementation. However, the problem remains that funding and the ability to access this space is functionally limited to those sectors which have already been mobilized and had strong civil society organizations able to represent their interests on the national level.

The responsibility of the government in the creation of effective HIV-policy design and implementation is not merely in creating an open space to which input from at risk populations may be brought but requires recognition of at-risk sectors which are not currently actively represented and the creation, through funding or otherwise, of independent entities consisting of members of those underrepresented groups who can provide input into the government's plans.

PLUS

While the government has involved people living with HIV and MARPS in design of policy and program implementation by way of the multisectoral South African National AIDS Council. Financial support is provided to people living with HIV organizations, no financial support is provided to either organizations serving MSM or commercial sex workers.

7. Does the country have a policy of free services for the following?

a. HIV prevention services	Yes	No
b. Antiretroviral treatment	Yes	No
c. HIV-related care and support intervention	Yes	No

8.	**Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?**	Yes	No

8.1	*In particular, does the country have a policy to ensure equal access to HIV prevention, treatment, care and support for women outside of pregnancy and child birth*	Yes	No

IF YES, *briefly describe the content of this policy?*
The National Strategic Plan is very strong on access to treatment for all who need it.

However, antenatal and PMTCT programmes with less emphasis on younger and older women and women who are not pregnant. The following HIV-related care services are not free in the public sector:

- Fertility planning guidance for HIV positive women and discordant couples
- Cervical cancer vaccine for girls
- Medical abortion services

9.	**Does the country have a policy to ensure equal access for MARPS and/or other vulnerable subpopulations to HIV prevention, treatment, care and support?** Generally under the bill of rights and specifically in the national strategic plan However, research studies conducted by OUT LGBT Well-being in both KwaZulu-Natal and Gauteng concluded that discrimination and violence experienced by lesbian and gay people in the school environment is widespread. There is also a widely held perception that lesbian women are not at risk of contracting HIV. Given the homophobic socio-cultural attitudes towards lesbian women, they however often adopt a range of survival strategies, including posing as bisexual, thus exposing themselves to HIV. The use of rape to 'cure' or punish lesbians is an extreme and brutal expression of compulsory heterosexuality. While we know of lesbians who are living with HIV and even of lesbians who have died of AIDS, there is an absence of research data on HIV prevalence among lesbian women and Women who have sex with Women (WSW) in South Africa.	Yes	No

IF YES, *briefly explain the different types of approaches to ensure equal access for different populations:*

The National Strategic Plan is clear on access for all including MARPS and this further entrenched under the Bill of Rights in the Constitution.

SANDF – no HIV testing for soldiers

9.1	*If yes, does this policy include different types of approaches to ensure equal access for different MARPS and/or other vulnerable populations?*	Yes	No

Up until the creation of the National Strategic Plan there has been no policy initiative which addresses different strategies for targeting subpopulations. The tendency of the South African response to HIV has been to treat the epidemic as a generalized epidemic to be combated in a generalized manner. What has not been accurately or effectively researched is the differences within the subpopulations. A more accurate and effective approach is to see the South African epidemic as a generalized epidemic with concentrated epidemics within it. While these epidemics certainly interact, they must be approached with different strategies for prevention, treatment, care, and support.

10.	**Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, and termination)?**	Yes	No

11.	**Does the country have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review?**	Yes	No

11.1	*If yes, does the ethical review committee include representatives of civil society, including people living with HIV?*	Yes	No

IF YES, describe the approach and effectiveness of this review committee:

All research proposals must be submitted to an ethics committee before inception. Currently the practice is working well. While provision is made for PLWHA to serve on the committee, currently PPLWHA are not represented. At a

Women's Sector Prevention seminar in August 2009, HIV+ women specifically noted that they want to be included on ethical committees where randomised trials etc. are being discussed.

12. Does the country have the following human rights monitoring and enforcement mechanisms?

Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, ombudspersons which consider HIV-related issues within their work	Yes	No
Focal points within government health and other departments to monitor HIV related human rights abuses and HIV related discrimination in areas such as housing and employment	Yes	No
Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts	Yes	No

Note: The effectiveness of some of these entities has been questioned. In particular, the South African Human Rights Commission is complicated by funding and appointment procedures which potentially undermine its independence.

IF YES on any of the above questions, describe some examples: To the extent that it is possible to create benchmarks for compliance with human rights standards and reduction of stigma the government has attempted to do so in Chapter 8 priority area 4 of the NSP. Also the Department of Health drafted a National Stigma Mitigation Framework which will provide a basis for combating HIV related stigma. PLUS Law Reform Commissions exist, Human Rights Commission active, strong civil society organizations act as watchdogs e.g. Treatment Action Campaign, and AIDS Law Project. The NSP strongly recommends Focal Point persons in all government departments and currently this mechanism does exist. The NSP sets clear targets.

13.	**In the last 2 years, have members of the judiciary (including labour courts/employment tribunals) have been trained/sensitized to HIV and human rights issues that may come up in the context of their work?** ***Note:*** *Such training is provided to magistrate courts, but there is no such training in other areas.*	Yes But to a limited event	No

14. Are the following legal support services available services in the country?

Legal and systems for HIV casework *Note: The capacity and funding of the legal aid system remains limited. Moreover the resources usually concentrate on criminal matters leaving civil matters unfunded*	Yes	No
Private sector law firms or university based centres to provide free or reduced- cost legal services to people living with HIV *Probono.org attempts to leverage pro bono work from private law firms to provide legal services to the poor. The Law Society and Bar Council has set in place rules for the amount of hours pro bono work required per annum by attorneys and advocates. Implementation of these rules has not yet been properly monitored. Community-based advice offices, university law clinics and public interest law institutions are available in some areas but their reach is limited due to funding constraints.*		
Programmes to educate, raise awareness among people living with HIV concerning their rights *Yes, but the only programmes offered are by civil society organizations with limited funding and reach.*		

15.	**Are there programmes in place to reduce HIV-related stigma and discrimination?**	Yes	No

IF YES, what types of programmes?

Media (*but of limited reach*)	Yes	No
School Education	Yes	No
Personalities regularly speaking out	Yes	No
Others: *Support groups*	Yes	No

Overall, how would you rate the *policies, laws and regulations* in place to promote and protect human rights in relation to HIV in 2009

2009	Very Poor									Excellent
	0	1	2	3	4	5	6	***[7]***	8	9	10

Since 2007, what have been key achievements in this area:

The government, especially the National Department of Health, has made a concerted effort to implement and enforce the extensive HIV protective mechanisms mentioned above. Recently, the SANDF sent the first HIV positive soldier to Sudan as a result of legal proceedings brought against them for discrimination.

However, there are major problems of bad management in the provinces, lack of budgets for primary care and basic provision of medicines and dire human resource capacity. These problems are preventing the provision of adequate quality healthcare.

There has been no monitoring or evaluation of the HIV response and no coordinated effort to reach the targets set out in the NSP. Hopefully with the establishment of a new South African National AIDS Council Secretariat, SANAC can provide a forum for both a coordinated response and monitoring of such.

The country has not identified the specific needs for HIV prevention programmes.

Moreover, the treatment, care and support services are inadequate and do not provide for all those in need. Budget targets for those in need of treatment are not in line with how many people are actually on treatment.

Vulnerable groups (as identified in the NSP) are still very much marginalized and this includes orphaned children, sex workers, men who have sex with men and people with disabilities.

PLUS

- The National Policy Framework linked to the Sexual Offences Act, No 32 of 2007 should be finalised as a matter of urgency and the effective provision of PEP should be monitored
- Recognition of LGBTI in the SANAC structures and definite policy formulation on MSM and lesbian health issues

What are the remaining challenges in this area:
- Law reform process remains slow for e.g. decriminalisation of commercial sex workers has been in the pipeline for 10 years.
- The integration of SRH and HIV/AIDS policies, and services should become priority.
- Final framework on medical termination of pregnancy and protocol guidelines for HIV positive women
- Accelerate the movement of draft laws into acts
- Reports of forced sterilisation of HIV+ women needs to be investigated.
- HIV/AIDS implications faced by women who are victims of domestic violence need to be highlighted and linked to the implementation of the Domestic Violence Act.
- Human trafficking act needs to be finalised and implemented

Overall, how would you rate the *efforts to enforce policies, laws and regulations* in 2009

2009	Very Poor									Excellent
	0	1	2	3	4	***[5]***	6	7	8	9	10

Since 2007, what have been key achievements in this area:

Acceleration of PMTCT and ART provision

Collaborative engagement between civil society and government

What are the remaining challenges in this area:

Some groups though recognized under the NSP, such as MSM and CSW remain underserved
Non-implementation of sections of the NSP
Implementation of PEP policy at facility level
Lack of integration of TB/HIV policy and practice
Implementation at facility level of policy that provides health care to foreign migrants

NATIONAL COMPOSITE POLICY INDEX (NCPI) QUESTIONNAIRE

Part B

(To be administered to civil society organizations, bilateral agencies, and UN organizations)

II. CIVIL SOCIETY

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

Low					High
0	1	2	3	***[4]***	5

Comments and examples:

- *SANAC structures include civil society representation and participation*
- *National Strategic Plan directs the outcome of civil society participation*
- *Male circumcision policy direct result of civil society pressure and lobbying*
- *Civil society advocacy influenced research agenda*
- *Policy shift away from denialism towards action as evidenced by 2009 World AIDS Day statement*
- *Civil society in South Africa strongly resisted the AIDS denialism that existed in the country pre-2009*
- *Litigation against Matthias Rath*
- *Civil society participated in the Department of Education summit on teenage pregnancy*
- *Civil society presented extensive submissions at the parliamentary hearings on the Domestic Violence Act in October 2009, linking domestic violence and HIV/AIDS*
- *Civil society provided extensive input for the National Policy Framework of the Sexual Offences Act (draft)*

2. To what extent has civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?

Low					High
0	1	2	***[3]***	4	5

Comments and examples:

- *NSP informs policy which informs budgets*
- *Limited activity in setting operational budgets*
- *Limited involvement in budget allocation*
- *Far more involvement required in costing and budgeting*

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment. care and support included in:

a. The national AIDS strategy?

Low					High
0	1	2	3	***[4]***	5

b. The national AIDS budget?

Low					High
0	1	2	***[3]***	4	5

c. The national AIDS reports?

Low					High
0	1	***[2]***	3	4	5

Comments and examples:

The DSD supports some civil society organizations directly and uses them as partners to perform work such supporting OVC (as per the NSP)
The LGBIT sector provides prevention and treatment services but receive no funding or support from government

4. To what extent is civil society include in the monitoring and evaluation (M&E) of the HIV response?

a. Developing the national M&E plan?

Low					High
0	1	2	3	***[4]***	5

b. Participating in the national M&E committee/working group responsible for coordination of M&E activities?

Low					High
0	1	2	3	***[4]***	5

c. M&E efforts at local level?

Low					High
0	***[1]***	2	3	4	5

Comments and examples:

- *No national or local level M&E coordination system in place*
- *M& E Technical Task Team in SANAC structure*
- *Participation in development of framework does not imply impact*
- *Could be related to communication on the ground district councils and provincial structures*

5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organisations (e.g. networks of people living with HIV, organisations of sex workers, and faith-based organisations)?

Low					High
0	1	2	3	***[4]***	5

Comments and examples:

- *Opportunity to participate good but capacity of reps is still low (MSM, CSW, and PLWHA)*
- *Current participation of MSM, CSW, and PLWHA in current SANAC structures a big improvement on previous council and strategic plan*

6. To what extent is civil society able to access:

a. Adequate financial support to implement its HIV activities?

Low					High
0	1	2	***[3]***	4	5

b. Adequate technical support to implement its HIV activities?

Low					High
0	1	2	***[3]***	4	5

Comments and examples:

- *Ability of large civil society organisations (CSOs) to access funding is much better than smaller ones which lack capacity and often don't meet criteria of DSD to access funding*
- *Many local CBOs and CSOs do the work but get no support.*
- *Large national CSOs participate in structures and get support*
- *Release of government data has improved but can still be improved*
- *Government regular release surveys, such as antenatal sero-prevalence surveys*

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

Prevention of Youth	<25%	25%-50%	51%-75%	>75%
Prevention of MARPS				
Injecting drug users	<25%	25%-50%	51%-75%	>75%
MSM	<25%	25%-50%	51%-75%	>75%
Sex workers	<25%	25%-50%	51%-75%	>75%
HIV Counselling and Testing	<25%	25%-50%	51%-75%	>75%
Reduction of stigma and discrimination	<25%	25%-50%	51%-75%	>75%
Clinical services (antiretroviral therapy / opportunistic infections)	<25%	25%-50%	51%-75%	>75%
Home-based care	<25%	25%-50%	51%-75%	>75%
Programmes for orphans and vulnerable children	<25%	25%-50%	51%-75%	>75%

Overall, how would you rate the *efforts in civil society participation* in 2009											
2009	Very Poor										Excellent
	0	1	2	3	4	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:

- CSOs actively participated in drafting National Strategic Plan
- CSOs participate on SANAC structures, such as PIC, TTT, RMC and the Plenary
- MAPR CSOs represented on SANAC structures
- CSO involvement in Global Fund Round 9 applications

What are the remaining challenges in this area:

- Long processes delay civil society involvement
- Better resourcing of CSOs, especially to convene meetings, perform M&E etc.
- Clarity around role of SANAC as an advisory council; oversight vs. Implementation; and financing

NATIONAL COMPOSITE POLICY INDEX (NCPI) QUESTIONNAIRE

Part B

(to be administered to civil society organizations, bilateral agencies, and UN organizations)

III. PREVENTION

1.	**Has the country identified the specific needs for HIV prevention programmes?**	Yes	No

IF YES, how were the specific needs determined?

- *Extensive consultative process that included all sectors*
- *Process informed by science, research, situational analysis, and global bad practice*

IF NO, how are HIV prevention programmes being scaled-up?

N/A

1.1 To what extent has HIV prevention been implemented?

HIV prevention component	**The majority of people in need have access**		
Blood Safety	Agree	Don't Agree	N/A
Universal precautions in health care settings	Agree	Don't Agree	N/A
Prevention of mother-to-child-transmission of HIV	Agree	Don't Agree	N/A
IEC on risk reduction	Agree	Don't Agree	N/A
IEC on stigma and discrimination reduction	Agree	Don't Agree	N/A
Condom promotion	Agree	Don't Agree	N/A
HIV testing and counselling	Agree	Don't Agree	N/A
Harm reduction for injecting drug users	Agree	Don't Agree	N/A
Risk reduction for men who have sex with men	Agree	Don't Agree	N/A
Risk reduction for sex workers	Agree	Don't Agree	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	Agree	Don't Agree	N/A
School based HIV education for young people	Agree	Don't Agree	N/A
HIV prevention for out of school young people	Agree	Don't Agree	N/A
HIV prevention in the workplace	Agree	Don't Agree	N/A
Other: - All prevention material not available in Braille - Prevention material not available in languages of large pool of foreign migrants - Foreign migrants often excluded from prevention programmes, including PMTCT - Condom distribution among MSM ineffective as it excludes water-based lubricants - Difficult process accessing post-exposure prophylactics for victims of sexual assaults	Agree	Don't Agree	N/A

Overall, how would you rate the *efforts in the implementation of HIV prevention programmes* in 2009

2009 Very Poor Excellent

0 1 2 3 4 5 6 ***[7]*** 8 9 10

Since 2007, what have been key achievements in this area:

- Release of draft guidelines on male circumcision
- Increase in testing rate
- Increase in condom use
- Introduction of dual therapy PMTCT

What are the remaining challenges in this area:

- Prevention campaigns targeting MSM and CSW

NATIONAL COMPOSITE POLICY INDEX (NCPI) QUESTIONNAIRE

Part B

(to be administered to civil society organizations, bilateral agencies, and UN organizations)

IV. TREATMENT, CARE AND SUPPORT

1.	**Has the country identified the specific needs for HIV treatment, care and support services?**	Yes	No

IF YES, how were these specific needs determined?

- *Mass consultations with all stakeholders*
- *Extensive consultative process that included all sectors*
- *Process inform by science, research, situational analysis, and global bad practice*

IF NO, how are HIV treatment, care and support services being scaled-up?

1.1 To what extent have HIV treatment, care and support services been implemented?

HIV prevention component	**The majority of people in need have access**		
Antiretroviral Therapy	Agree	Don't Agree	N/A
Nutritional care	Agree	Don't Agree	N/A
Paediatric AIDS treatment	Agree	Don't Agree	N/A
Sexual transmitted infection management	Agree	Don't Agree	N/A
Psychological support for people living with HIV and their families	Agree	Don't Agree	N/A
Home-based care	Agree	Don't Agree	N/A
Palliative care and treatment of common HIV related infections	Agree	Don't Agree	N/A
HIV testing and counselling for TB patients	Agree	Don't Agree	N/A
TB screening for HIV-infected people	Agree	Don't Agree	N/A
TB preventive therapy for HIV infected people	Agree	Don't Agree	N/A
TB infection control in HIV treatment and care facilities	Agree	Don't Agree	N/A
Cotrimoxazole prophylaxis in HIV-infected people	Agree	Don't Agree	N/A
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree	Don't Agree	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree	Don't Agree	N/A
HIV care and support in the workplace (including alternative working arrangements)	Agree	Don't Agree	N/A
Other programmes (*Write in)*	Agree	Don't Agree	N/A

Overall, how would you rate the *efforts in the implementation of HIV care, treatment and support programmes* in 2009

2009	Very Poor										Excellent
	0	1	2	3	4	5	***[6]***	7	8	9	10

Since 2007, what have been key achievements in this area:

- Rapid expansion of ARV provision
- Introduction of task shifting ,down referral ,etc.

What are the remaining challenges in this area:

- Clarity on task-shifting, especially with regard to testing and ART
- HIV-related services, specifically SRH services such as contraception, cervical screening and Termination of Pregnancy needs to be integrated and scaled up at facilities
- Procedure around accessing PEP in event of sexual assault needs to be reviewed (Police not implementing policy effectively)
- Process around accreditation of sites needs to be improved
- Chronic illness grant process needs to be accelerated and adopted
- Lip-service to youth-friendly services should be translated into real and effective services
- Inadequate nutritional support for PLWHA needs to be addressed
- School feeding schemes stop during holidays putting vulnerable children at risk

2.	**Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?**	Yes	No

2.1	*IF YES,* is there an operational definition for orphans and vulnerable children in the country?	Yes	No
2.2	*IF YES,* does the country have a national plan specifically for orphans and vulnerable children in the country?	Yes	No
2.3	*IF YES,* does the country have an estimate of orphans and vulnerable children being reached by existing interventions?	Yes	No

IF YES, what percentage of orphans and vulnerable children is being reached? ***% (****write in)*

Calculation of reach is difficult as data collection incomplete.

Annex 3: Table of indicator definitions

UNGASS INDICATOR TABLE, 2008/09					
#	INDICATOR	DATA RESULTS		DATA SOURCE	NUMERATOR / DENOMINATOR AND COMMENTS
		2008	2009		
NATIONAL COMMITMENT AND ACTION					
1	Domestic and international AIDS spending by categories and financing sources	R13,972 mil	R17,579 mil	National Treasury Department	See table on Pg. 30
POLICY DEVELOPMENT AND IMPLEMENTATION STATUS					
2	National Composite Policy Index	--	--	NCPI survey	See Annex 2
NATIONAL PROGRAMMES					
3	Percentage of donated blood units screened for HIV in a quality secured manner	100%	100%	SANBS	
4	Percentage of adults and children with advanced HIV infection receiving ART	45%	56%	NDOH programme data 2008 and 2009; STATS SA Estimate of number of people in need of Treatment	678,550 NDOH 2008 / 1,491,000 STATS SA 919,923 NDOH 2009 / 1,630,000 STATS SA; 2009 results are month ending 31 Nov 09
5	Proportion of HIV+ pregnant women receiving antiretroviral medicines to reduce the risk of mother-to-child transmission	79%	90%	Department of Health Annual Report 2008/09; DHIS 2009	Percentages only provided by NDOH, PMTCT programme Some 2009 data are incomplete for the FS, GP, KZN, MP, NC and WC provinces The denominator used by DHIS appears undercounted
6	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	18%	42%	NDOH TB Programme data 2009	15,213 / 86,492, NDOH TB programme, 2008 42,576/101,439, NDOH TB programme, as of June 2009
7	Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results	25%	37%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008; National	

UNGASS INDICATOR TABLE, 2008/09					
#	INDICATOR	DATA RESULTS		DATA SOURCE	NUMERATOR / DENOMINATOR AND COMMENTS
		2008	2009		
				Communication Survey 2009	
8	Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results • African Females aged 20-34 • African Males aged 25-49 • Males aged 50 Plus (50-55) • Men who have sex with Men • High risk drinkers • Recreational drug users • People with disabilities	• 36% • 25% • 18% • 27% • 23% • 23% • 20%	• 48% • 52% • 3%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008; National Communication Survey 2009	
9	Percentage of most at risk populations reached with HIV prevention programmes	Data not collected	Data not collected	Special survey required	Data not collected as per UNGASS; see comparable data in Section IV
10	Percentage of orphaned and vulnerable children aged 0-17 years whose household received free basic external support in caring for the child	75%	75%	DSD Annual Report 2008/09; Children's Institute, 2009[51]	9,347,178 / Numerator: number of child support grants, foster care grants and care dependency grants issued (2009) 12,377,000 / Denominator: 2007 estimated number of children 0-17 years of age living in households that are income-poor (below the poverty level, under R350 per person per month)
11	Percentage of schools that provide life skills based HIV education within the last academic year	58%	58%	EMIS: School Realities 2008 and 2009, NDoE	
KNOWLEDGE AND BEHAVIOUR					
12	Current school attendance among orphans aged 10-14	98%	98%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008	
12	Current school attendance among non-orphans aged 10-14	99%	99%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey	

UNGASS INDICATOR TABLE, 2008/09					
#	INDICATOR	DATA RESULTS		DATA SOURCE	NUMERATOR / DENOMINATOR AND COMMENTS
		2008	2009		
				2008	
13	Percentage of young women age 15-24 who both correctly identify ways of sexually transmitting HIV and reject major misconceptions about HIV transmission	27%	27%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008	
13	Percentage of young men age 15-24 who both correctly identify ways of sexually transmitting HIV and reject major misconceptions about HIV transmission	30%	30%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008	
14	Percentage of most at risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission • African Females aged 20-34 • African Males aged 25-49 • Males aged 50 Plus (50-55) • High risk drinkers • Recreational drug users • People with disabilities	• 26% • 28% • 28% • 31% • 36% • 21%	• 26% • 28% • 28% • 31% • 36% • 21%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008	
15	Percentage of young women and men who have had sexual intercourse before the age of 15	9%	10%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008; National Communication Survey, 2009 (16-49 years)	
16	Percentage of women aged 15-49 years who had sexual intercourse with more than one partner in last 12 months	4%	7%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008; National Communication Survey, 2009 (16-49 years)	
16	Percentage of men aged 15-49 years who had sexual intercourse with more than one partner in last 12 months	19%	34%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey	

UNGASS INDICATOR TABLE, 2008/09					
#	INDICATOR	DATA RESULTS		DATA SOURCE	NUMERATOR / DENOMINATOR AND COMMENTS
		2008	2009		
				2008; National Communication Survey, 2009 (16-49 years)	
17	Percentage of women aged 15-49 years who had more than one sexual partner in last 12 months reporting the use of a condom during last intercourse	68%	68%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008	
17	Percentage of men aged 15-49 years who had more than one sexual partner in last 12 months reporting the use of a condom during last intercourse	77%	77%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008	
18	Percentage of female and male sex workers reporting the use of a condom with their most recent client	Data not collected	Data not collected	Special survey required	Data systems not in place
19	Percentage of men reporting the use of condom the last time they had sex with a male partner	Data not collected	Data not collected	Special survey required	Data systems not in place
20	Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	Data not collected	Data not collected	Special survey required	Data systems not in place
21	Percentage of injecting drug users reporting the use of a condom during last sexual intercourse	Data not collected	Data not collected	Special survey required	Data systems not in place
IMPACT					
22	Percentage of young women aged 15-24 who are HIV infected	14%	14%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008	
22	Percentage of young men aged 15-24 who are HIV infected	4%	4%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008	
23	Percentage of most at risk populations who are HIV infected: • African Females aged 20-34 • African Males aged 25-49	• 33% • 24%	• 33% • 24%	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008	

UNGASS INDICATOR TABLE, 2008/09					
#	INDICATOR	DATA RESULTS		DATA SOURCE	NUMERATOR / DENOMINATOR AND COMMENTS
		2008	2009		
	• Males aged 50 Plus (aged 50-55) • Men who have sex with men • High risk drinkers • Recreational drug users • People with disabilities	• 6% • 10% • 14% • 11% • 14%	• 6% • 10% • 14% • 11% • 14%		
24	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Data not collected	Data not collected	Cohort study	National data unavailable; site-specific data presented in Section IV
25	Percentage of infants born to HIV positive mothers who are infected	16%	16%	Spectrum modelling	

Annexure 4: SANAC Women's Sector Report On UNGASS HIV & AIDS Declaration of Goals

February 2010

Executive Summary

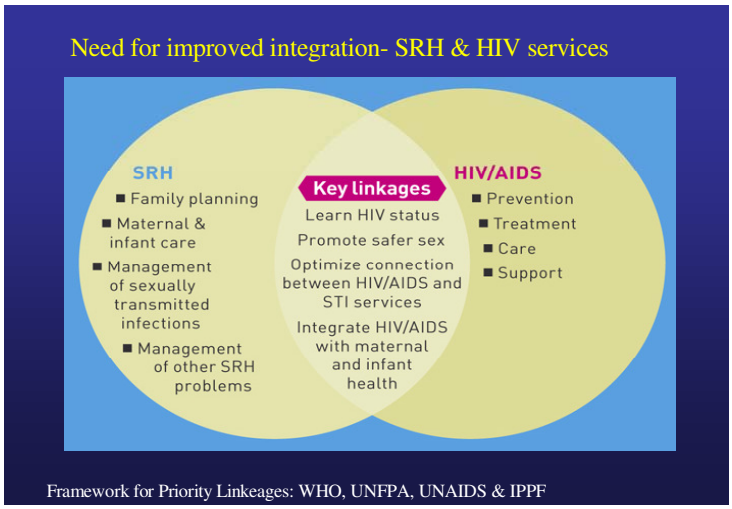
The Women Sector report tracks the progress made by the South African Government towards achieving the UNGASS HIV&AIDS goals that relate to Women and Girls' Sexual and Reproductive Health and Rights (SRHR). It maps the SRHR responses implemented in the 2008-2009 UNGASS reporting period, and gives qualitative accounts of the experiences of women, girls and children in relation to the UNGASS indicators outlined by UNAIDS. The report goes beyond official statistics provided in the Government Report to analyse the experiences of the beneficiaries, to state what has worked well during the reporting period, and highlight those areas needing further work.

Problem Statement: The Case for the Integration of HIV&AIDS and SRHR

The association between Sexual and Reproductive Health (SRH) and HIV&AIDS has been proven and widely acknowledged. Most HIV infections are sexually transmitted or associated with pregnancy, childbirth or breastfeeding. In addition, reproductive ill-health and HIV&AIDS are both perpetuated by the same challenges- poverty, gender inequality and social marginalization of the most vulnerable populations among others.

Despite these associations, the responses to SRHR and HIV&AIDS have largely been separate and not integrated-with HIV&AIDS not seen as a sexual and reproductive health issue, but most often, only as an infectious disease. This artificial separation of HIV&AIDS from other SRHR issues has had an adverse effect on the response to HIV&AIDS, and has compromised efficiency and effectiveness within the health system.

There is evidence to show that creating closer linkages between reproductive health and HIV prevention, care and treatment would result in significant public health benefits, and facilitate the achievement of international development goals and targets such as the MDGs and UNGASS goals. The table below captures the argument, and outlines the opportunities for integration.



Over the last few years, the South African Government has heeded this call, and made attempts towards integrating HIV&AIDS and SRHR responses.

SRHR and HIV&AIDS Progress in 2008/2009

The key progress areas in this reporting period are:

- The creation of a Ministry for Women, Children and Persons with Disabilities, along with the establishment of a Parliamentary Portfolio Committee on Women, Children, Youth and Persons with Disability. The two structures should increase parliament's ability to assess the extent to which legislation promoting women's rights is resourced and implemented. This has already had positive benefits- evidenced in the public hearings held by the Portfolio Committee as part of the review of the implementation of the Domestic Violence Act. The hope is that the new structures will translate into legislation and programming that addresses the vulnerabilities of women and girls, and empowers them to triumph over many of the challenges they are facing-including SRHR and HIV&AIDS.
- The Department of Health has formed a committee for the integration of HIV&AIDS and Sexual and Reproductive Health in the public Sector, a move that could begin to address a lot of the issues highlighted in this report.
- The Government has announced a change in HIV treatment guidelines for pregnant women with effect from April 2010. In terms of the new policy, pregnant women will qualify for ART when their CD4 count is 350 or less; and treatment will start from 14 weeks of pregnancy as opposed to the last term of pregnancy. All HIV-positive children under one year will also get ARVs. These policy changes are expected to improve the lives of women and children living with HIV&AIDS.
- The promulgation of the Sexual Offences Act, No 32 of 2007 has brought an additional instrument for responding to Violence Against Women.

The key areas needing further work are:

Legislation and Policies

The development of an overarching SRHR policy which integrates HIV&AIDS into SRHR programmes, and conversely, SRHR into HIV&AIDS programmes with a focus on women of all ages. The integration of the two has important public health benefits that have been proven both in SA and elsewhere.

Review the Domestic Violence (DV) legislation to adequately address issues of HIV/AIDS and SRHR of abused women; and develop an overarching policy framework with implementation guidelines. The lack of an overarching policy framework impedes the effectives of services rendered to women experiencing DV. Establishing a framework will ensure service norms and standards in relation to training, implementation, monitoring and reporting requirements. The newly established Ministry for Women, Children and Persons with Disabilities has a unique opportunity to use the report of the Portfolio Committee on the DV hearings to compel the changes that have been recommended and adopted by Parliament.

Review and update contraception and abortion policies-with a view to providing comprehensive SRHR services and choice to People living with HIV&AIDS (PLHIV). This would include support for women living with HIV to plan families, address unintended pregnancies and prepare for safe, desired pregnancies. The high numbers of young women on ART implies that there are significant numbers of young women living with HIV who are reproductively healthy, and whose desire to start families is strong. A clear policy addressing this issue in a comprehensive manner is critical. It is also critical to finalise Medical abortion guidelines and train the public sector for effective implementation.

Finalise the integration of cervical cancer as an SRHR issue into the HIV policy, and make the HPV vaccine available to women and girls in the public sector.

Finalise the delayed National Policy Framework of the Sexual Offences Act, no 32 of 2007, to ensure co-ordinated implementation, monitoring and evaluation.

Decriminalise sex work to protect the health of sex workers, and of the public that utilises their services.

Structures and Tools

Develop a unified M&E framework that is informed by human rights; takes SRHR and quality of care issues into consideration more effectively; and allows for collection of disaggregated data on SRHR and HIV&AIDS at national, provincial and local levels. While an M&E framework for the NSP exists, the framework is not supported by community-based data collection structures, and women and SRHR organisations have found it difficult to feed the information they collect on lesbian, gay, bisexual, transgender and intersex (LGBTI's) and other Most at Risk Populations (MARPS) into the existing system.

Create systems that Monitor and Report Violations to the set service delivery standards.

Political Commitment, Resources and Financing

Ensure the adequate resourcing- financial and human- of the women SANAC sector and women representation in provincial AIDS councils

Improve access to services for under-serviced vulnerable populations such as LGBTIs, sex workers, and women with disabilities. Although people from all sexual orientations and physical abilities are welcome to attend health centres in SA, many of the women groups mentioned above still experience physical barriers and high levels of stigma, discouraging them from using the services. Some of these groups are also classified as MARPS, making their access to HIV&AIDS and SRHR services that much more critical.

Recommit to the implementation of the Maputo Plan of Action which aims to provide universal access to SRHR for all citizens, and provide technical skills in government departments to enable this.

Recommit to the implementation of the UNGASS Declaration and improved reporting that fully captures civil society experiences every two years.

Service Delivery

Improve the provision of service by TCC centres on the basis of recommendations given by CSOs outlined in section C of this document.

Increase the understanding and enforcement of GBV prosecution and sentencing guidelines within the justice sector.

Programme Content

Develop new elements of the sexuality education curricula that respond to new evidence on the disproportionate impact of HIV on women and girls. 60% of all people living with HIV are women and girls; and girls aged 15-24 had a 13% HIV prevalence, compared to 3% for boys of the same age.

Develop a large scale programme that works with traditional leaders and communities to resolutely interrogate cultural norms and traditional practices-only in as far as they increase women and girl vulnerability to HIV and other SRHR abuses.

Review Nursing, Medical and Community Health Worker curricula to integrate SRHR, HIV&AIDS care, as well as screening, counselling and referral of women experiencing domestic and sexual violence.

Regulate the training curriculum and the protocol for community health workers and counsellors to improve the quality of their service in VCT, PMTCT and ART where applicable.

Review and update ARV treatment guidelines to cover relevant SRHR issues beyond ARVs.

Implement large-scale programmes for abused women which provide economic opportunities and create conditions where women are no longer dependent on men for survival.

Research

Fund research to improve understanding of:

- The epidemic among Women who have sex with Women (WSW), LGBTI groups, and other minority MARPS that are specific to SA;
- Implementing integrated SRHR & HIV services targeting men and boys;
- The linkages between HIV, SRHR and GBV and how their integration reduces risk for women and girls.
- Upscale sites where SRHR and HIV&AIDS integration is happening and conduct action research to provide more information on successful practice.

Promotion and Advocacy

Promote and provide the Female Condom (FC) on a large scale throughout SA. The FC can be integrated through community-based distribution; STI and family planning services; HIV/AIDS/ STI prevention programmes with vulnerable populations, adolescent and reproductive health programmes, social marketing, work-place initiatives, peer education and male motivation programmes.

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