1. Introduction

The earliest cases of HIV infection in South Africa were identified in the 1980s. Since then HIV and AIDS has been an important public health challenge in South Africa. The first meaningful programme against HIV and AIDS was only initiated by the government of national unity, which took office in 1994. A number of strategic documents and actions guided our interventions. These included the African National Congress Health Plan, NACOSA plan for HIV and AIDS and subsequently the Operational plan for Comprehensive HIV and AIDS Care, Management and Treatment (2004) and finally the National Strategic Plan for HIV and AIDS 2007-2011.

This third report to the United Nations General Assembly Special Session (UNGASS): Declaration of Commitment on HIV and AIDS, by South Africa highlights the achievements and challenges that South Africa has experienced in responding to HIV and AIDS. This Report adheres to the set guidelines and minor deviations have been in the spirit of enriching the country report and providing necessary contextual and South Africa specific information.

The report details examples of best practice in mitigating the impact of HIV and AIDS, and outlines some of the challenges the country faces in meeting set goals. Actions to overcome the challenges are discussed along with the Monitoring and Evaluation mechanisms set in place. The roles of government, civil society and the private sector as well as development partners in addressing the national response provide a sense of the collective national response to HIV and AIDS.

The last few years have seen the strengthening of the monitoring and evaluation system. The majority of the indicators reported on use data from existing data sources that represents the status of HIV and AIDS in the country. Greater harmonization of the country's indicators to the UNGASS indicators has been made possible through a broader information base that is available in the monitoring and evaluation system.

Section two of the report presents an overview of the HIV and AIDS challenges and the policies and programmes in place to address the current situation. The third section of the report is divided into three parts: the first part addresses the funds spent on HIV and AIDS programmes in the country. This is inclusive of the South African government and its line departments, the private sector and the development partners. The second part of section 3 provides information on National Programmes Indicators and performance from 1 January 2006 to 30 September 2007. The third part discusses the items raised in the National Composite Policy Index.

2. Status at a glance

This section covers the participation of various sectors in the process of compiling the Country Progress Report, the current epidemiology of HIV and AIDS in South Africa, the national response, and the UNGASS Indicator Overview.

2.1 Inclusiveness of the stakeholders in the report writing process

The Country's HIV & AIDS and STI National Strategic Plan (NSP) 2007 –2011 was drafted and finalised with active participation of government, the private sector, civil society and development partners. One of the targets of the NSP's Priority Area 3: Research, Monitoring and Surveillance is timely production and submission of the UNGASS Report during the NSP's 5-year period. The Monitoring and Evaluation Framework for the NSP was also drafted and finalised with involvement of all sectors of the South African National AIDS Council (SANAC). This multi-sectoral M&E framework incorporates all the indicators prescribed for UNGASS reporting.

Similarly, this Country Progress Report represents the broad stakeholder consensus position on the progress made and continuing challenges to meet the UNGASS Declaration of Commitment on HIV and AIDS.

The process of compiling the Country Progress Report was taken through various stages of consultation. The initial stage was mainly a preparatory and planning stage. The Department of Health in collaboration with the SANAC secretariat, and supported technically by the country's UNAIDS secretariat, drafted the terms of reference (ToRs) for various data collection and report writing activities. This resulted in three ToRs, namely ToR 1: data collection at national level and report writing; ToR 2: data collection at provincial departments and private sector as well qualitative analyses of responses to open-ended questions in the National Composite Policy Index Questionnaire; and ToR 3: special survey on HIV prevalence and risk behaviours among most-at-risk populations. The first and second ToRs were supported by the country's UNAIDS secretariat and the United Kingdom's Department for International Development (DFID) respectively.

The third ToR will be implemented during 2008. Research on HIV prevalence and risky behaviour among men who have sex with men, gays and lesbians will be conducted during 2008. Two meetings were held in 2007 to consult gay and lesbian organisations on the research project as required by UNGASS indicators on most-at-risk populations. At one of these meetings it was agreed that the current Country Progress Report will use available information from small scale studies to report on the indicators on higher-risk populations.

The second stage involved the collection of data from national, provincial and organisation-based data sources as outlined in the specifications of the ToRs. The public sector departments which participated in providing access to available data were: the Departments of Health (national and provincial), Social Development, National Treasury, Defence, Education, Public Service and Administration and Correctional Services. The Human Sciences Research Council, South African National Blood Transfusion Services, Council for Medical Schemes, donors and development partners, and others made statistics on certain indicators accessible. Private sector organisations including medical schemes (including Discovery Health, New Med, MX Health, Aurum Health), disease management programmes (including Lifeworks, AID for AIDS, Right to Care) and the mining industry (including Angloplaat, Harmony, Goldfields, Impala, Merafe, De Beers) also made information in their databases accessible.

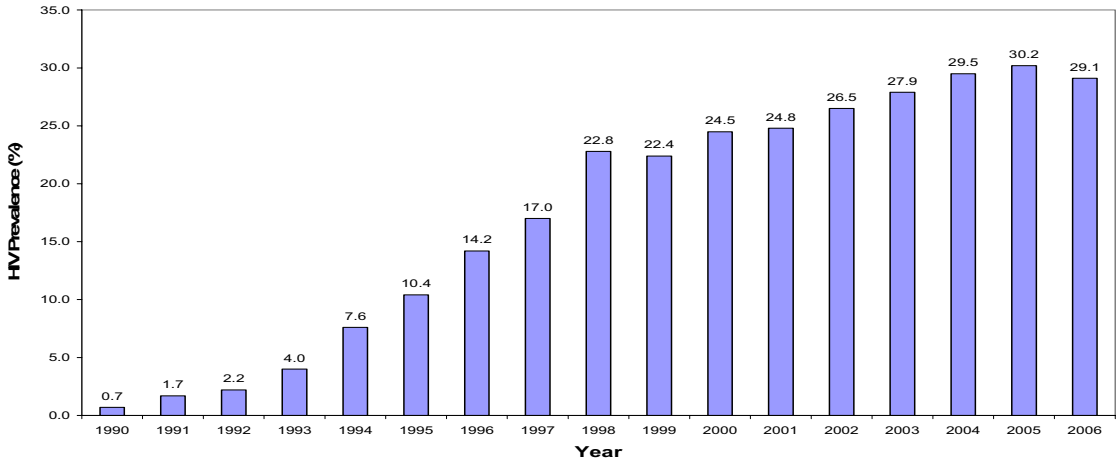
During the second stage, the SANAC's Programme Implementation Committee, chaired by the Director-General of the Department of Health, was fully briefed on the progress of data collection and report drafting. The SANAC's Programme Implementation Committee is representative of 18 sectors and government departments and is broadly responsible to ensure support for the implementation of NSP 2007-2011 interventions. All members of the SANAC's Programme Implementation Committee were requested to complete the National Composite Policy Index (NCPI) Questionnaire. Those who responded to the NCPI Questionnaire did so as elected representatives of their respective sectors and completed the questionnaire with full participation of their sectors. The first draft Country Progress Report was presented and discussed at the meeting of the SANAC's Programme Implementation Committee held on the 6th December 2007. The meeting agreed on a further consultative session arranged for the 3rd week of January 2008, to provide a further opportunity for comment and discussion on the pen-ultimate draft report before finalisation. Data verification was also done with all organisations that provided indicator data with a view to presenting a revised report at the above-mentioned stakeholder meeting.

The third stage entailed discussion of the revised draft Country Progress Report at a larger stakeholder consultative meeting representative of all sectors (approximately 90 participants attended), which was held on the 17th January 2008. The pen-ultimate draft report was revised based on the comments and inputs made at this stakeholder consultative meeting. This revised report was then submitted to the Ministry of Health and the Cabinet.

2.2 Overview of HIV infection

HIV prevalence has been consistently monitored in South Africa through antenatal HIV and syphilis prevalence surveys, which have been conducted since 1990. Figure 1 illustrates antenatal HIV trends from 1990 to 2006.

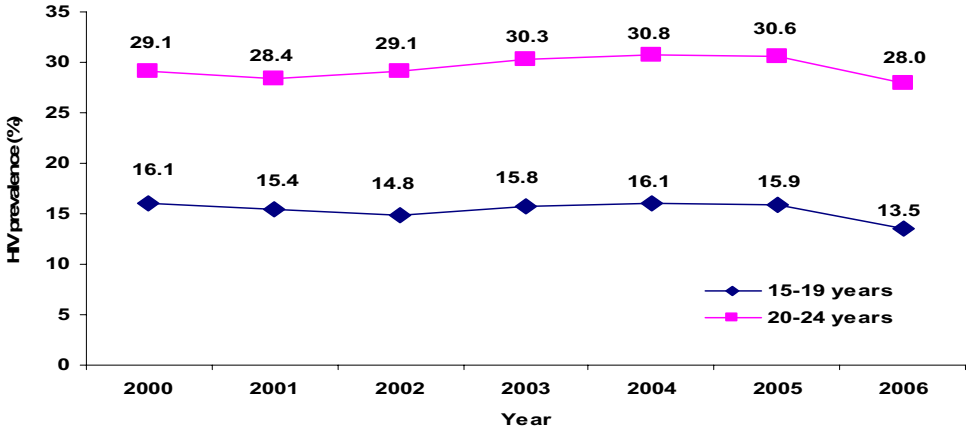
Figure 1: National HIV prevalence trends among antenatal clinic attendees in South Africa: 1990 to 2006



The trends suggest a tendency towards stabilization of the prevalence among pregnant women who access antenatal care services from the public health sector. This has been observed since 2004.

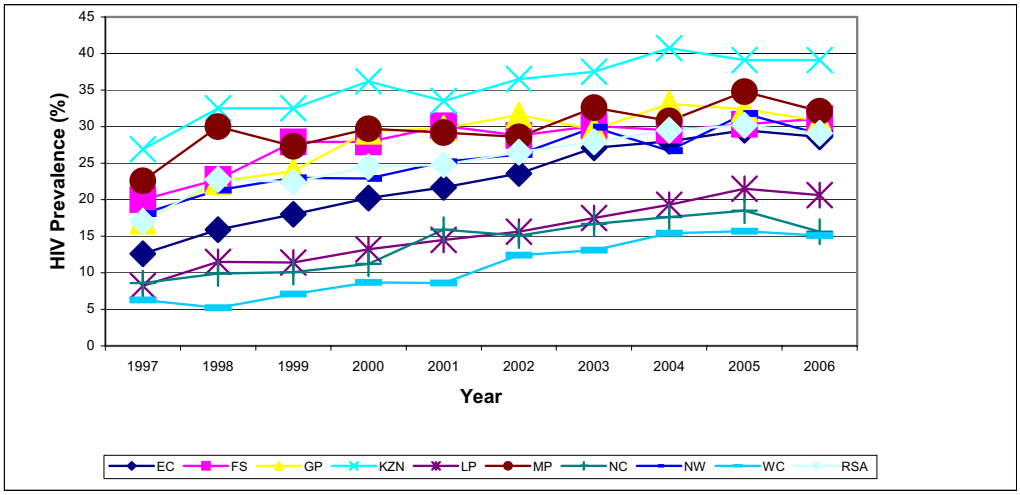
There is a particularly encouraging trend, a decline from 16% in 2004 to 13.5% in 2006 (Figure 2), among women younger than 20 years of age as well as a decline in prevalence in those between 20 and 24 years of age (from 30.6% in 2005 to 28.0% in 2006). This could be the beginning of the long-awaited downward trend of prevalence among pregnant youth in South Africa. At least two more survey rounds with the same 2006 expanded sampling methodology will be necessary to draw a conclusion on the downward HIV trend among pregnant women.

Figure 2: HIV prevalence among young pregnant women, South Africa, 2000 – 2006



HIV prevalence varies considerably throughout South Africa. Some provinces are more severely affected than others (Figure 3), with the highest antenatal prevalence in 2006 being in KwaZulu-Natal (39.1%) and the lowest in the Western Cape (15.1%). The Department of Correctional services reported that the HIV prevalence among their personnel and offenders were 9.98% and 19.8% respectively.

Figure 3: Provincial HIV prevalence trends among antenatal clinic attendees in South Africa, 1997- 2006



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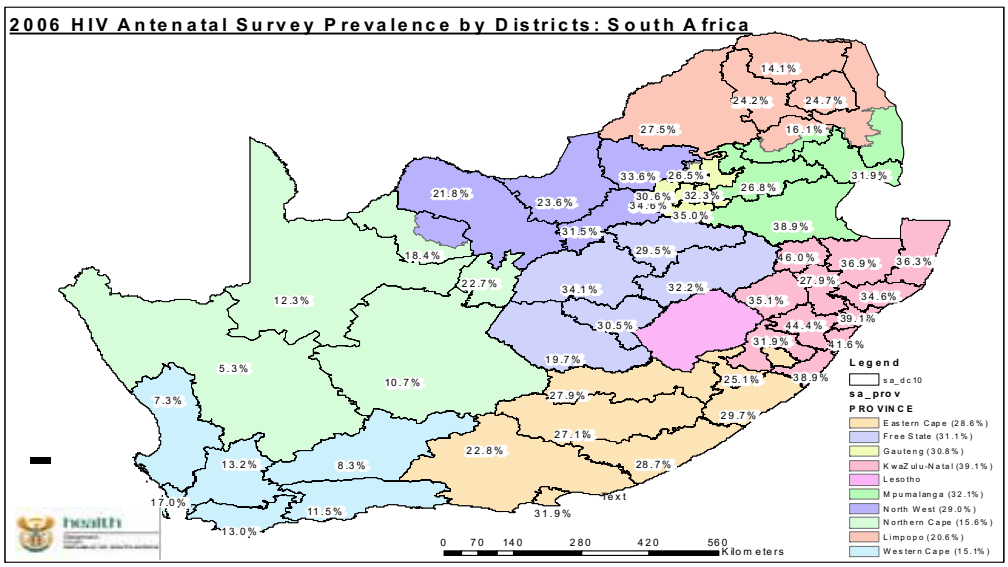
HIV prevalence rates show variations in district prevalence rates as well (Figure 4). It is interesting to note for example that the district with the lowest HIV prevalence is in the Northern Cape (5.3%) where the variation between the lowest and highest district is approximately 17%. Intra-provincial variations are equally wide for provinces such as Free State with ranges between 19.7% and 34.1%; and KwaZulu-Natal 27.9% to 46.0%.

Figure 4: 2006 HIV Antenatal Survey Prevalence by Districts: South Africa



2.3 Policy and programmatic response

In 1992, the National AIDS Coordinating Committee of South Africa (NACOSA) was launched with a mandate to develop a national strategy on HIV and AIDS. Cabinet endorsed this strategy in 1994. A review conducted in 1997, in line with the goals of the NACOSA plan, highlighted the strengths and weaknesses of a health sector which tended to have a disease-specific approach to HIV and AIDS. Some of the recommendations made related to capacity building for implementing agencies, increasing political commitment, increased involvement of people living with HIV and AIDS (PLWHA), and strengthening integration.

Much was done to implement the recommendations of the NACOSA Plan review. These include the appointment of provincial AIDS coordinators; the establishment of the Inter-Ministerial Committee on AIDS; the launch of Partnerships against AIDS by the Deputy President in 1998; development of the HIV and AIDS policy for learners and educators; development of other national policies, including the Syndromic management of STDs; the establishment of the South African AIDS Vaccine Initiative (SAAVI) in 1998; the establishment of South African National AIDS Council (SANAC) in 2000; the establishment of the national interdepartmental committee on HIV and AIDS, the development of a Strategic Framework for a South African AIDS Youth Programme and the establishment of the National Action Committee for Children affected by HIV and AIDS.

Several policies and guidelines have been developed in order to support the implementation of HIV and AIDS strategies in South Africa. This work began in 1994 with the finalisation of the Reconstruction and Development Programme document, from which most of the other policies flowed. Some examples are: Maternal, Child and Women's Health; development of the District Health System; Patients' Rights Charter; the White Paper on Transformation of the Health System in South Africa; workplace policies in all government departments; the Integrated Nutrition Programme; as well as many other relevant policy guidelines. Another important milestone was the approval, by Cabinet, of the National Operational Plan for Comprehensive HIV and AIDS Management, Treatment, Care, and Support (The Comprehensive Plan), in November 2003, the National Policy Framework for Orphan and Vulnerable Children (OVC) (2005) and the National Action Plan for OVCs (2006 – 2008).

In 1999, through a consultative process with stakeholders, a National Strategic Plan (NSP 2000-2005) was developed and has been the cornerstone of the response in mitigating the impact of HIV and AIDS.

Its aim was to strengthen the implementation of the recommendations of the NACOSA Plan review as well as enhance the national response to HIV and AIDS, STIs and TB.

A great deal was achieved in the implementation of the NSP 2000 -2005. An assessment of the NSP 2000-2005 was carried out and its findings and recommendations have been used to inform the NSP 2007-2011.

The two primary aims of the NSP 2007 – 2011 are to:

- Reduce the rate of new HIV infections by 50% by 2011; and
- Reduce the impact of HIV and AIDS on individuals, families, communities and society by expanding access to appropriate treatment, care and support to 80% of all HIV positive people and their families by 2011.

The plan has identified 19 goals that are needed to reach the NSP's aims and these are structured under four key priority areas. Interventions have been identified for each of the NSP goals.

Key Priority Area 1: Prevention

The overall target is to reduce by 50% the rate of new HIV infections by 2011. The intention is to ensure that the large majority of South Africans who are HIV negative remain HIV negative and through specific interventions, prevent new infections. Four goals have been set:

- Reduce vulnerability to HIV infection and the impact of AIDS;
- Reduce sexual transmission of HIV;
- Reduce mother-to-child transmission of HIV; and
- Minimise the risk of HIV transmission through blood and blood products.

Key Priority Area 2: Treatment, Care, and Support

The second priority area is to reduce HIV infection and AIDS morbidity and mortality as well as its socio-economic impacts. The overall target is to provide appropriate packages of treatment, care and support to 80% of HIV positive people and their families by 2011. The four main goals of treatment, care and support are to:

- Increase coverage to voluntary counselling and testing and promote regular HIV testing;
- Enable people living with HIV to lead healthy and productive lives;
- Address the special needs of pregnant women and children; and
- Mitigate the impacts of HIV and AIDS and create an enabling social environment for care, treatment and support.

Key Priority Area 3: Research, Monitoring, and Surveillance

The NSP 2007-2011 recognises research, monitoring and evaluation (M&E) as important policy, process and management tools. National, provincial and district level indicators to monitor inputs, process, outputs, outcomes and impact will be used to assess our collective effort. It is recommended that in line with international trends, a sustainable budget of between 4%-7% of the NSP budget is dedicated for the M&E of the NSP. The seven goals of this priority area are to:

- Develop and implement the M&E framework with appropriate indicators;
- Support research in the development of new prevention technologies;
- Create an enabling environment for research in support of the NSP;
- Development and promotion of research on behaviour change;
- Develop and support a comprehensive research agenda including operations, behavioural research, epidemiological trials and other research for new technologies for prevention and care;
- Conduct policy research; and
- Conduct regular surveillance.

Key Priority Area 4: Human Rights and Access to Justice

Stigma and discrimination continue to present challenges in the management of HIV and AIDS. This priority area seeks to mainstream programmes to mitigate these fundamental human rights challenges. The four main goals of this priority area are to:-

- Ensure public knowledge of and adherence to the existing legal and policy provisions;
- Mobilise society, and build leadership of HIV positive people, to protect and promote human rights;
- Identify and remove legal, policy and cultural barriers to effective HIV prevention, treatment and support; and
- Focus on the human rights of women and girls, including those with disabilities, and mobilise society to stop gender-based violence and advanced equality in sexual relationships.

Each of the above NSP Goals has specific objectives with intended interventions and annual targets for the period 2007 -2011. Detailed annual operational plans per priority area have been developed by the 18 sectors of SANAC. These plans include those that are implemented by government departments at national, provincial and municipal levels. The sectors of civil society have also developed operational plans for implementation.

The South African government remains the main source of funding for the national response. Over the years, government has been increasing the budget for HIV and AIDS.

The budget for the HIV and AIDS sub-programme in the national Department of Health grew from R676 million to R3,2 billion at an average annual rate of 24,8 per cent over a seven-year period.

The country's national multi-sectoral response to HIV and AIDS is coordinated by organised structures at different levels in government and non-governmental sectors. Provinces, municipalities, the private sector and a number of community-based organisations are the main implementation agencies. Each government department has focal persons responsible for planning, budgeting, implementation and monitoring HIV and AIDS interventions.

A monitoring and evaluation framework has been developed and was approved by the SANAC Project Implementation Committee in November 2007. The framework provides for the monitoring and evaluation of the 2007-2011 NSP through the organised structures at different levels in government and non-government sectors, including the private sector and civil society organisations.

2.4 UNGASS Indicator Overview

Table 1: UNGASS indicator data

Indicator	2006	2007	Data Source
National Commitment and Action			
Indicator 1: Domestic and international AIDS spending by categories and financing sources	R4 270 716 447	R4 530 175 220	National Treasury, National Department of Health, National Department of Social Development, National Department of Education, Development Partners and the Private Sector
Indicator 2: National Composite Policy Index (Areas covered: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation)	See section 4 and Attachment 1: NCPI		SANAC's Programme Implementation Committee and participants at the Stakeholders' Consultative Meeting held on the 17th January 2008
National Programmes (blood safety, antiretroviral therapy coverage, prevention of mother-to-child transmission, co-management of TB and HIV treatment, HIV testing, prevention programmes, services for orphans and vulnerable children, and education)			

Indicator	2006	2007	Data Source
Indicator 3: Percentage of donated blood units screened for HIV in a quality assured manner ▪ SANBTS ▪ WPBTS	100%	100%	South African National Blood Transfusion Service Western Province Blood Transfusion Service
Indicator 4: Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Enrolment 46% Actual 36%	55% 42%	National Department of Health – National Comprehensive HIV and AIDS Plan Statistics
Indicator 5: Percentage of HIV positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	60%	66%	Provincial Departments of Health
Indicator 6: Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	No data available	50.3%	National Department of Health
Indicator 7: Percentage of women and men aged 25-49 who received an HIV test in the last 12 months and who know their results	No data available	No data available as surveys are conducted at 5-year intervals. The next survey will be conducted during 2008	
Indicator 8: Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results	No data available	No data available as surveys are conducted at 5-year intervals. The next survey will be conducted during 2008	
Indicator 9: Percentage of most-at-risk populations reached with HIV prevention programmes	Not Reported	No data available; a national survey is to be commissioned	
Indicator 11: Percentage of schools that provided life skills based HIV and AIDS education in the last academic year	96%	100%	National Department of Education (Numerator) Statistics South Africa (Denominator)
Knowledge and Behaviour			

Indicator	2006	2007	Data Source
Indicator 12: Current school attendance among orphans and among non-orphans aged 10-14 years ▪ Orphans ▪ Non-Orphans	No data available	No data available	National Department of Education (Numerator) Statistics South Africa (Denominator)
Indicator 13: Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	No data available	No data available as surveys are conducted at 5-year intervals. The next survey will be conducted during 2008	
Indicator 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	Not reported	No data available; a national survey is to be commissioned	
Indicator 15: Percentage of women and men aged 15-24 who have had sexual intercourse before the age of 15	No data available	No data available as surveys are conducted at 5-year intervals. The next survey will be conducted during 2008	
Indicator 16: Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	No data available	No data available as surveys are conducted at 5-year intervals. The next survey will be conducted during 2008	
Indicator 17: Percentage of women and men aged 15-49 who had more than one partner in the last 12 months reporting the use of a condom during their last sexual intercourse	No data available	No data available as surveys are conducted at 5-year intervals. The next survey will be conducted during 2008	

Indicator	2006	2007	Data Source
Indicator 18: Percentage of female and male sex workers reporting the use of a condom with their most recent client	Not Reported	No data available; a national survey is to be commissioned	
Indicator 19: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Not Reported	No data available; a national survey is to be commissioned	
Indicator 20: Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	Not Reported	No data available; a national survey is to be commissioned	
Indicator 21: Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	Not Reported	No data available; a national survey is to be commissioned	
Impact			
Indicator 22: Percentage of young people (pregnant women only) aged 15-24 who are HIV-infected	13.7% (< 20 years) 28.0 %(20-24 years)	No data available	National HIV and syphilis antenatal sero-prevalence survey in South Africa
Indicator 23: Percentage of most-at-risk populations who are HIV infected	Not Reported	No data available; a national survey is to be commissioned	
Indicator 24: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	No data available	No data available	
Indicator 25: Percentage of infants born to HIV-infected mothers who are infected			

3. National response to HIV infection and AIDS

This section of the report presents an analysis of the core set of indicators as outlined in the document entitled "Monitoring the Declaration of Commitment on HIV and AIDS: Guidelines on construction of indicators".

3.1 HIV and AIDS Expenditure

Table 2: Domestic and international AIDS spending by financing sources

Category	2006		2007	
	(Rands)	USD	(Rands)	USD
Department of Health	2 405 000 000	343 571 429	2 661 802 000	380 257 429
Department of Social Development	339 000 000	48 497 854	452 000 000	64 663 805
Department of Education	157 695 000	22 527 857	167 905 000	24 020 743
Department of Science and Technology	75 000 000	10 714 286	75000000	10 714 286
Sub-total – Public Sector	2 976 695 000 (69.7%)	425 850 500	3 356 707 000 (74%)	479 656 263
BTC (Belgium Technical Co-operation)	11 032 922	1 576 131	11 032 922	1 576 131
CIDA (Canadian International development Agency	35 354 942	5 050 706	3 057 822	21 404 754
DANIDA	17 803 333	2 543 333	0	0
EU	110 250 000	15 750 000	110 250 000	15 750 000
KfW (German Development Bank)	53 169 644	7595663	4392000	627 428
GTZ (German Technical Co-operation Agency)	5 200 000	742 857	4 250 000	607 142
DED (German Development Services	3 814 250	544 892	2 160 000	308 571
InWEnt (Capacity Building Inst – Germany)	1 070 000	152 857	324 470	46 352
Irish Aid	15 778 000	2 254 000	1 000 000	142857.1429
JICA (Japan Co-operation Agency)	2467785		3 688 367	
SIDA (Swedish International Development Agency)	12 340 000	1 762 857	12 340 000	1 762 857
Royal Netherlands Embassy	0	0	6 004 912	857 844
DFID (Department for International Development)	126 000 000	18 000 000	126 000 000	18 000 000
USG[1]	1 374 597 000	196 371 000	2 925 560 309	399 367 008
Global Fund	564 543 756	80 649 108	564 543 756	80 649 108
UN	27 461 210	3 923 030	27 095 593	3 870 799
NIH	61022605	8 717 515	112 294 378	16 042 054

[1] The USG/Pepfar is not included as the data provided indicates budgeted amounts and not spend

Category	2006 (Rands)	2006 USD	2007 (Rands)	2007 USD
Sub-total Development Partners	1 047 308 447 (24.5%)	149 262 949	988 434 220 (21.8%)	161 645 897
Private Sources	246713000 (5.8%)	35244714	185035000 (4.1%)	26 433 571
Total Commitment	4 270 716 447	610 975 171	4 530 880 220	667 735 731

The public sector continues to be the main single funder (69.7% - 2006; 74% - 2007) of HIV and AIDS programmes in South Africa as reflected in the table above. There are a number of programmes (such as HIV and AIDS Workplace Programmes) undertaken at national, provincial and local government, however these are not reflected as a budget line item but rather are subsumed under the rubric of staff development and staff wellbeing.

The funds spent by the public sector to combat HIV and AIDS and mitigate its impact, have increased from R 5,317 billion in 2006 to R 5,768 billion in 2007.

The HIV and AIDS sub-programme in the Department of Health grew from R676 million to R3,2 billion at an average annual rate of 29,5% over the seven-year period. The reporting period witnessed significant increases in spend for laboratory testing, ART, nutrition and health system upgrades. The Department of Education increased its expenditure from R157 million in 2006 to R167 million in 2007. The Department of Social Development has increased its HIV and AIDS spend from R339 million to R452 million in 2007. It should be noted that the expenditure by the Department of Social Development does not include the range of grants, which are part of the social security system.

As stated in South Africa's 2005 UNGASS report, the growth of HIV and AIDS funding has continued to focus on:

- Life-skills education in schools
- Prevention programmes including social mobilisation on healthy lifestyles and the Khomanani (health promotion) campaign
- Nutrition
- Voluntary counselling and testing
- Mother-to-child prevention programmes
- Management of sexually transmittable infections
- Condom distribution
- Antiretroviral therapy
- Home-based and community-based care
- Non-governmental organisations

- Step-down care

3.2 Prevention

In August 2005, South Africa was part of the WHO/AFRO Regional Resolution to declare 2006 a year of accelerated HIV prevention and a five-year strategy for accelerated HIV prevention was developed. HIV prevention is one of the key priority programmes articulated in the Strategic Plan of the DOH for 2006/2007. In addition, the Africa Health Strategy, which was adopted by Heads of State and Governments of Africa in 2007 also prioritised prevention as the key strategy to halt the spread of HIV.

Information, Education and Communication (IEC) materials in South Africa are of sound technical quality and widely available. All stakeholders disseminate similar messages, articulated around ABC, stigma-mitigation and human and legal rights. The DOH has invested a great deal in the production and dissemination of IEC materials through the mass media. Recent reports on the status of HIV and AIDS communication campaigns have found that a variety of AIDS communication programmes, including Khomanani, Soul City and LoveLife are achieving significant reach and are becoming well known and recognised by the general population. The Life Skills programme has been extended to more than 90% of schools in South Africa and significant progress has been made in building capacity among educators. Behavioural change, however, remains a challenge. For example the reports indicate that consistent condom use among the youth is still not optimal.

Some programmes have been implemented in high transmission areas (HTA) and have grown rapidly due to high demand. These include several initiatives such as the 'Corridors of Hope' service on the major trucking routes in South Africa. The 'Corridors of Hope' service includes HIV prevention messaging, condom distribution and VCT along major transports routes in the country.

Male condom accessibility, judged according to the quantity of condoms procured and distributed, has significantly improved. Condoms are being distributed increasingly via non-traditional outlets, but the number of condoms handed out at these venues has yet to increase.
In addition the numbers of VCT and PMTCT sites have increased during the 2006-2007 period. The DOH has increased the provision of skilled personnel, medicines and other commodities to ensure that access to PMTCT improved.

3.2.1 Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Data for 2006 and 2007 on this indicator are not available. This indicator is collected using population-based surveys. The most recent South Africa Demographic and Health Survey was conducted in 2003 and the next survey will be conducted during 2008.

3.2.2 Percentage of women and men aged 15-24 who have had sexual intercourse before the age of 15 years

Data for 2006 and 2007 on this indicator are not available. This indicator is collected using population-based surveys. The most recent South Africa Demographic and Health Survey was conducted in 2003 and the next survey will be conducted during 2008.

3.2.3 Percentage of women and men aged 15-49 years who have had sexual intercourse with more than one sexual partner in last 12 months

Data for 2006 and 2007 on this indicator are not available. This indicator is collected using population-based surveys. The most recent South Africa Demographic and Health Survey was conducted in 2003 and the next survey will be conducted during 2008**.**

3.2.4 Percentage of women and men aged 15-49 years who had more than one partner in the last 12 months reporting the use of a condom during their last sexual intercourse

Data for 2006 and 2007 on this indicator are not available. This indicator is collected using population-based surveys. The most recent South Africa Demographic and Health Survey was conducted in 2003 and the next survey will be conducted during 2008.

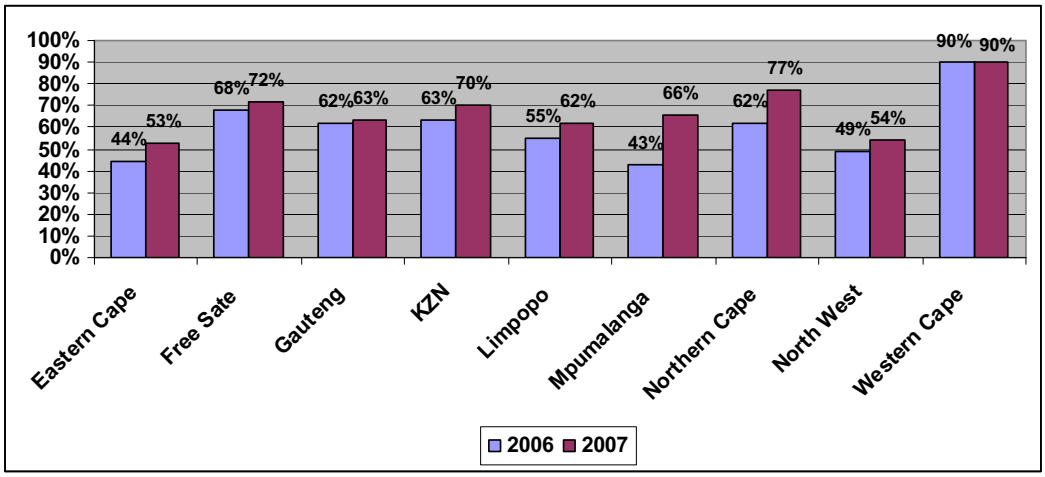
Government has increased the procurement and distribution of condoms substantially in the past few years. In the 2006 376 million male condoms were distributed while 256 million were distributed in 2007. In both 2006 and 2007 3.6 million female condoms were distributed.

3.2.5 Women and men aged 25-49 who received an HIV test in the last 12 months and who know their results

Both the NSP of 200-2005 and the 2007-2011 consider VCT as an important entry point to treatment care and support programmes and to a lesser degree to some of the prevention strategies. The international protocol on HIV testing including the rapid tests is used at health facilities. For the 2006/2007 financial year 1 610 775 men and women were tested at the public health facilities. The majority (90%) of the clients accessing VCT services receive their results on the same day. The outcome of the test is discussed with the clients during the post-test counselling. The clients are also offered a repeat rapid test where the results were negative.

3.2.6 PMTCT uptake by Province

Figure 5: Percentage of HIV positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission



There are approximately 1,000,000 births per calendar year. Based on the antenatal statistics the estimated number of HIV positive pregnant women in 2006 was 302,000 (30.2/1000000) and 290,000 in 2007. Approximately 85% of pregnant women attend antenatal services in the public health facilities. The total number of HIV positive pregnant women identified and enrolled into the PMTCT programme in 2006 was 186,646 (72.7%) and for the period January to September 2007 was 144,506 (56.2%). The decline in 2007 is due to the lack of numerator data for October-December 2007 with the denominator being the same as for 2006.

Overall there was a 6% increase in the percentage of women who received ARVs in the PMTCT programme. The largest increases were observed in the Northern Cape (15%) and Mpumalanga (12%).

3.2.7 Schools that provided life skills based HIV and AIDS education in the last academic year

The Life Skills programme is implemented as part of the Life Orientation Learning Area in schools. It serves to strengthen aspects of the Life Orientation Learning Area and is implemented in the form of school-based support activities. All the other Learning Areas incorporate some aspects of the programme through statistics and the impact life skills have on individual people's future regarding career choice, healthy living, environment, economy, etc. Since the inception of the programme in 2000, the number of schools that implemented the life skills programme across the nine provinces annually are:

- 16533 primary schools
- 5915 secondary schools
- 4148 combined schools
- 521 intermediate schools
- 420 special schools

Although the coverage of life skills programmes in schools to date is 100% and it embodies the principles of the outcome based curriculum, the principles of decision making and problem-solving skills, creative and critical thinking, self-awareness, communication and interpersonal relations the following are unknown:

- The percentage of the life skills curriculum that focuses on HIV and AIDS issues
- The method of delivery of lifeskills education
- The time spent (the minimum time is 30 hours)
- The technical capacity of the educator to deliver the HIV and AIDS lifeskills programme

The Department of Education has embarked on a review process of the life orientation curriculum. It is envisaged that the review will be completed by the end of 2008.

3.2.8 Blood Safety

Percentage of donated blood units screened for HIV in a quality-assured manner

South Africa has two blood transfusion centres. The South African National Blood Service (SANBS) is situated in Johannesburg and covers eight of the nine provinces in the country and the Western Province Blood Transfusion service with its head office in Cape Town services the Western Cape province.

Both services rely on a pool of voluntary blood donors and do not pay for blood donations. In both instances the majority of donors are repeat donors.

Both services collaborate and co-ordinate their services and have similar Standard Operating Procedures (SOP's). Both services have rigorous Quality Assurance programs and are inspected by the South African Quality Assurance Systems (SANAS). SANAS accredits the services according to approved criteria based on technical specifications and an ISO based assessment. The services are also subjected to External QA proficiency testing. 100% of donated blood units are tested for HIV 1 & 2 abs, HCV abs, HBsAg and for syphilis (TPHA). Since October 2005, all individual donations are screened for HIV-1, Hepatitis B and Hepatitis C using nucleic acid amplification technology using Procleix assays on a TIGRIS system (Chiron/GenProbe).

Table 3: Number of blood units from April 2005 till March 2007

Name of the blood centre or blood screening laboratory	SANBS		WPTBS	
Year	2006	2007	2006	2007
Standard Operating Procedures	Yes	Yes	Yes	Yes
External Quality Assurance Scheme	Yes	Yes	Yes	Yes
Donated Blood	713 219	706 948	126 080	128 182
Screened Blood	713 219	706 948	126 080	128 182
Blood Screened in an Quality Assured Manner	713 219	706 948	126 080	128 182

3.3 Treatment, care and support

Since the launch of the National Operational Plan for Comprehensive HIV and AIDS Management, Treatment, Care and Support (The Comprehensive Plan), significant resources have been allocated to treatment, care and support. Policies and guidelines for all aspects of HIV and AIDS were updated. Staff training has increased, laboratory services are improving, and physical infrastructure has improved. In the first year of the implementation of the Comprehensive Plan, accredited service points covered all health districts.

South Africa now has the largest number of people enrolled on antiretroviral therapy in the world. More eligible adults than children have accessed these services. There are efforts to strengthen this area and provide more innovative strategies to improve access for children.

The government's response is multi-sectoral, comprehensive and developmental. There is significant inter-sectoral collaboration between relevant government departments and civil society to address the needs of children infected and affected by HIV and AIDS.

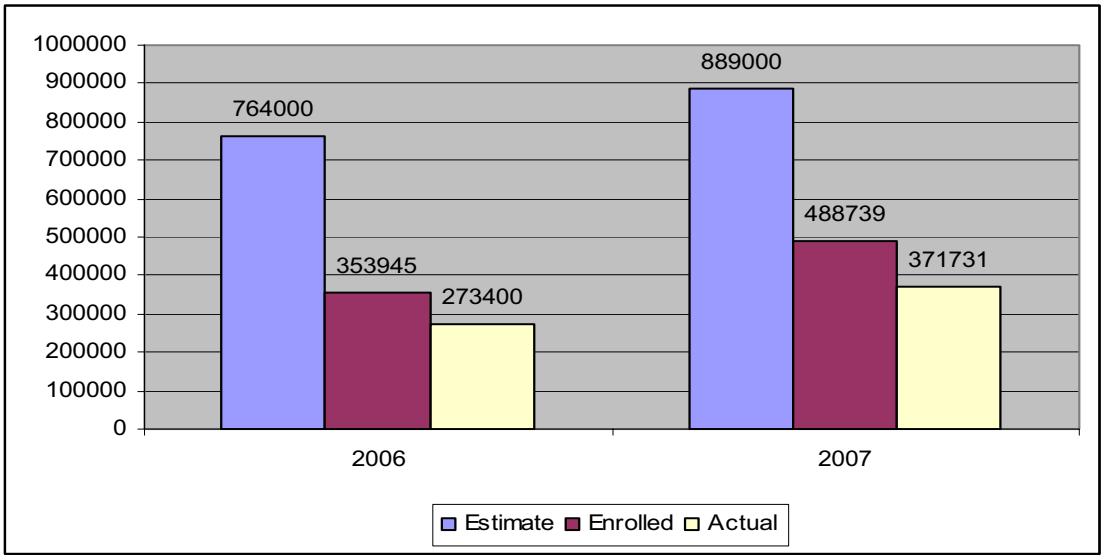
The provision of Home/Community Based Care (HCBC) has grown rapidly in the last five years, with guidelines having been developed and training provided to carers. The programme is currently offered in 70% of sub-districts countrywide, with up to 29 000 carers trained and receiving stipends. With the introduction of the expanded public works programme (EPWP) there is fast tracking of accredited training to carers. There are currently 100 training providers that are assisted with accreditation with the Health and Welfare Sector Training Authority (HWSETA).

Collaboration between the government and some of CBOs, NGOs, and FBOs is well established, with many receiving funding from government and other donors some of which work closely with government. Policies for the management of community caregivers as well as career path programmes have been developed whilst good quality services are provided to home-bound patients and children in early childhood development centres. In addition to the Home-Based Care, the Care and Support programme has strengthened and facilitated the formation of support groups to provide psychosocial support to people living with HIV and AIDS. Paralegals have been mobilized to provide easily accessible legal services to PLHIV. A national framework on HIV and AIDS stigma mitigation to create a supporting environment is being finalised.

The impact of HIV and AIDS in South Africa has led to many innovative responses to the need for care and support for adults and children. These responses are largely influenced and shaped within the cultural milieu including the values of Ubuntu (humanity) and the roles played by extended family structures, the traditional leaders and traditional healers. Significant among the responses is the development of community based models of palliative care to address the needs of clients and household members by providing home and community based services that are appropriate and that provide timely care and support within the continuum of care which extends across the health and other sectors. Approximately 5% of sub-districts have palliative care centres countrywide. The National Palliative care guidelines have been developed to provide standard guidance for programme direction, implementation and professional practice.

3.3.1 Adults and children with advance HIV infection receiving antiretroviral therapy

Figure 6: Estimated number of persons in need of ART[2] and actual number of persons receiving ART by year



The proportion of HIV-infected persons who need ART in a given year is linked to the evolution of the rate of HIV infection within the country and all the socioeconomic and biological factors that predispose the HIV positive peoples' progression to the AIDS stage.

The estimated number of people needing treatment (children and adults at WHO Stage 4) in South Africa was 764,000 by the middle of 2006 of which a total of 353,945 (46%) enrolled in the ART programme and 273,400 (36%) were initiated on the ART programme in 2006. In 2007 - 889,000 people need treatment of which 488,739 (55%) enrolled and 371,731 (42%) initiated on the ART programme. Approximately 55% of the people receiving treatment were female and 45% male. The estimated number of children (<15years) needing treatment was 52,000 in 2006 and 65,000 in 2007 of which 23,369 received treatment in 2006 and 32,060 in 2007.

Of the total number of patients enrolled the majority were in the public sector (78%), a similar trend followed for initiation (72%) in 2006. Similarly in 2007, approximately 75.6% enrolled and 68% were started on treatment.

[2] The ASSA model was used for the estimates. WHO is currently refining the model which will be discussed within the country shortly.

Approximately 76,217 (22%) received treatment funded through medical schemes, the private sector and development partners for 2006 and 28% in 2007.

The public health sector has continued to ensure universal coverage for persons without medical aid cover by increasing the number of accredited service points providing Comprehensive HIV and AIDS services. By the end of 2007, 362 public health facilities covering more than 80% of the 254 local municipality and metropolitan councils provided the service. In comparison, there were a total of 273 public health facilities accredited by the end of 2006. These facilities are linked to 55 laboratory sites conducting CD4 count tests, 11 laboratories conducting viral load tests and seven laboratories performing Polymerase Chain Reaction (PCR) tests. Laboratory services are critical elements of this programme. Despite the progress being made, some of the main challenges that are being addressed in the scaling up of services includes recruitment of adequate numbers of human resources, strengthening the district based referral systems with effective utilisation of primary health care facilities, promotion of healthy lifestyles and strengthening of national health information systems.

3.3.2 TB cases that received treatment for HIV and TB

Out of the estimated 5.4 million South African infected with HIV, it is estimated that one third (1.8 million) will develop TB in their lifetime. It is therefore critical to provide adequate and effective care to co-infected individuals. A package of prevention and care has been in place since 2002. The total number of TB cases reported in 2006 was 316,863 (669/100,000). It is estimated that 55% are HIV positive. However not all TB patients know their HIV status, either because of not having had a HIV test or because of unwillingness to be tested for HIV. In 2006, approximately 40% of all TB patients were tested for HIV.

In 2006, it was estimated that 26% of the HIV positive TB patients were referred for HIV care (Prophylaxis of opportunistic infections and/or ART). This increased to 50.3% for the period January to September 2007. Most provinces routinely monitor whether TB patients who were found to be HIV positive were referred for HIV care.

3.3.3 Adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

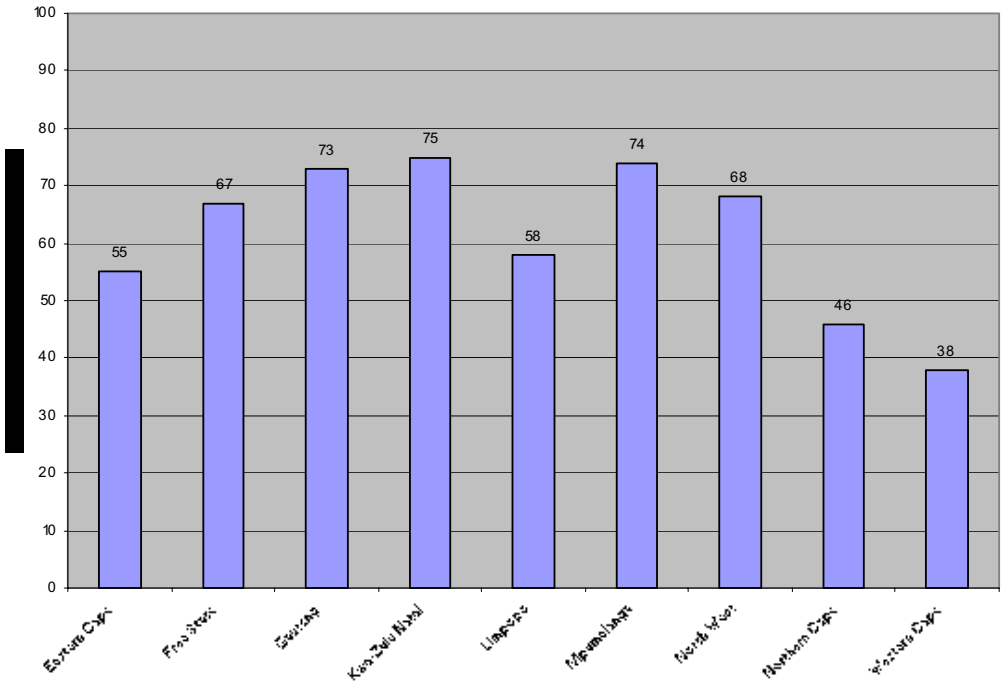
The data that measure the percentage of adult and children with HIV known to be on treatment 12 months after initiation of ARVs is not accurately collected at present.

3.3.4 Current school attendance among orphans and among non-orphans aged 10-14 years

The calculation of this indicator presented a challenge. The numerator was based on enrolment numbers in public schools and the denominator was sourced from census data. It was therefore agreed that the information may be inaccurate and should not be reported at this stage.

3.3.5 Orphan Support: The percentage of orphaned and vulnerable children aged 0-17 years whose households received free basic external support

Figure 7: Distribution of OVC receiving external support across provinces



It is estimated that 1,577,200 children aged 0-17 years are directly affected by HIV and AIDS through circumstances such as HIV infection at birth or through sex, living in a house with a sick or elderly caregiver, being abandoned, living in a house that cares for many children or who are multiple bereaved or frequently mobile.

All the provinces are providing external support to orphaned and vulnerable children. A total of 1,057,900 (67%) are receiving free external support of which approximately 800,000 (10% of the 8 million child support grants disbursed) are through child

support grants and 449,009 children are in foster care and receiving foster care grants. Other forms of support include feeding schemes, care centres and child and youth workers assisting child-headed households and the distribution of 174,182 food parcels to households and the remainder were provided with school fees, uniforms and counselling services.

3.4 Impact Indicators

Table 4: Percentage of young people aged 15-24 who are HIV-infected

Age Group (Yrs)	HIV Prevalence (CI 95%) 2004	HIV Prevalence (CI 95%) 2005	HIV Prevalence (CI 95%) 2006
<20	16.1 (14.7 – 17.5)	15.9 (14.6 -17.2)	13.7 (12.8 – 14.6)
20 – 24	30.8 (29.3 – 32.3)	30.6 (29.0 – 32.2)	28.0 (26.9 – 29.1)

Based on the results of the annual antenatal HIV survey, it is estimated that 29.1% of pregnant women attending antenatal clinics were HIV positive in 2006 compared to 30.2% in 2005. An important finding was a significant decline in HIV prevalence amongst participants under the age of 20 years. In this group the HIV prevalence was estimated at 13.7% in 2006 in comparison to 15.9% in 2005. HIV prevalence in the 20-24 year age-group in 2006 (28%) had also decreased in comparison to 2005 (30.6%).

A decline in prevalence in the age group 15–24 years is suggestive of a decline in the incidence (new infections). These statistics suggest a sustained change in behaviour among young people including engaging in safer sexual practices such as being in mutually faithful relationships.

4. Qualitative Analysis of Responses to the National Composite Policy Index

4.1 Public Sector Response

The consultative meeting – held on the 17 January 2008, saw representation by eleven of the 18 civil society organisations, government departments and development partners. The information detailed below is a summary of the written responses received from the sectors and the comments made during the consultative session. (Attachment 1 has a complete response from Government and Civil Society as per the questionnaire).

In South Africa, the national response to HIV and AIDS is founded on the principle of universal access to basic and equitable services including equitable access to health care services. However, this principle is yet to be fully realised, largely because South Africa inherited a health and social system that excluded the majority of the population from social services and economic opportunities.

The first high-level political body that was established to oversee the South African response to HIV and AIDS was the Inter-Ministerial Committee (IMC) on AIDS established at the end of 1997 and chaired by the Deputy President. The main objectives of the IMC were to provide leadership, political oversight, and guidance to the HIV and AIDS programme in South Africa. In January 2000, the South African National AIDS Council (SANAC) was established in order to ensure meaningful participation of all sectors in the implementation, coordination and monitoring of a multi-sectoral national response to AIDS as detailed in the NSP 2000-2005.

Following a review in 2006, SANAC was restructured to improve its efficiency and is chaired by the Deputy President of South Africa, co-chaired by a representative from the non-governmental sector, and includes representatives from government, civil society people living with AIDS, and the private sector. The membership of SANAC constitutes 18 sectors of civil society and 8 government ministries. It is the primary co-ordinating body for the management of HIV and AIDS in South Africa that operates through a secretariat and meets regularly.

A review of the NSP 2000-2005 together with a number of national and sub-national studies, played a major role in informing the current NSP 2007-2011. There is an improved definition of the nature, dynamics and character of HIV and AIDS in South Africa as outlined in the situational analysis in the NSP 2007-2011. This situational analysis has informed the strategic approach especially with targeted interventions according to most at risk population groups. In addition, there was a need to address critical youth-specific interventions, since young people are both the key to South Africa's future, and also essential to the success of any strategy.

An inclusive process was applied in the development of the NSP 2007-2011 . The process has deepened partnership, ownership and increased responsibility amongst all key stakeholders. Most development partners have aligned and harmonised their development plans with the NSP. Those partners that have not yet done so, aim to ensure alignment at the beginning of their next programming cycle.

The NSP, which represents South Africa's comprehensive multi-sectoral response to the challenges of HIV and AIDS, articulates two aims, cascading into four key interventions, which are underpinned by 19 goals in order to guide South Africa's response to HIV and AIDS and STIs control in the next five years.

The following four key priority areas have been identified as necessary for the achievement of the NSP:

1. *Prevention*: Government considers prevention as the mainstay and the most sustainable response to HIV and AIDS. All sectors are committed to the prevention of HIV and AIDS with Government, civil society and the private sector having developed and implemented appropriate policies and plans. Although tools to empirically measure incidence are still under development, a decrease in prevalence over the last three years especially amongst the age group less than 20 years of age serves as a proxy indicator to suggest a decrease incidence in this group. Efforts need to be sustained to maintain this trend especially amongst the 25 – 49 year age group. The NSP outlines the recommended intervention for the 2007-2011. In addition, HIV prevention is one of the key priority programmes articulated in the Strategic Plan of the DOH for 2006/2007.

2. *Treatment, Care and Support:* it is estimated that 5.4 million South Africans are HIV positive. The challenge is to identify those affected people to provide a comprehensive package of services to reduce morbidity and mortality and to mitigate the wide-ranging impact of HIV and AIDS. The target is to provide an appropriate package of treatment, care and support services to 80% of people living with HIV and their families by 2011. A set of interventions has been outlined under this priority.

3. *Research, Monitoring and Surveillance*: the review of the NSP 2000-2005 highlighted the need for an M&E framework. This was remedied through the development and adoption of a comprehensive multi-sectoral M&E framework in December 2007. This development is in line with the recommendations of the "three ones principles". Work is underway to operationalise the M&E framework through the development of appropriate systems and organisational structures.

4. *Human Rights and Access to Justice:* HIV and AIDS is a human rights issue. A major objective of the NSP is to create a social environment that encourages many more people to test voluntarily for HIV and, when necessary, to seek and receive medical treatment and social support. Respect for and the promotion of human rights must be integral to all the priority interventions of the NSP. In addition, active and ongoing campaigns that promote, protect, enforce and monitor human rights must be linked to every intervention and mounted at district, provincial and national levels. The NSP identifies a range of activities to improve access to justice, in order that people can challenge human rights violations immediately and directly. It sets out issues for law reform in order to create a legal framework that uniformly assists HIV prevention, treatment, research and surveillance.

4.2 Civil Society Response

Civil society participated in the process of compiling the UNGASS report. The National Composite Policy Index (NCPI) Questionnaire was sent to 18 sectors represented in the SANAC's Programme Implementation Committee. Out of the 18 sectors represented in SANAC, completed NCPI questionnaires were received from the following 5 sectors: Children; Higher Education; Human Rights; Women; and Disability. This is not an adequate representation of the Civil Society sector as the remaining 13 sectors did not submit completed NCPI questionnaires. The responses from the five sectors were consolidated into a joint NCPI Part B: Civil Society report. This report was discussed at the UNGASS Report Consultative meeting where eleven of the 18 sectors representing civil society participated in the discussion of the draft submission (Attachment 1: NCPI).

The issues that emerged from the civil society submission include: the views and perspectives on the roles and/or effectiveness of institutions such as National Health Research Ethics Council and the Medicines Control Council; implementation of policy on access to ART; the availability of dual therapy for PMTCT; access to justice etc.

5. Best practices

The national response to HIV and AIDS continues to receive the highest political leadership. Responsibility for dealing with ongoing HIV and AIDS related matters have been given to the Inter-Ministerial Committee on AIDS composed of eight Ministries. SANAC is the national body that provides strategic and political guidance as well as support and monitoring of sector programmes. The strengthened SANAC operates at three levels:

- A high level plenary, meeting twice per annum, chaired by the country's Deputy President;
- Sector level coordination – with sectors taking responsibility for their own organisation, strategic plans, programmes, monitoring and reporting to SANAC; and
- Programme level organisation –led by the social sector cluster of government.

The participatory process of the development and adoption of the NSP 2007-2011 indicates increasing collaboration among all stakeholders. The civil society conference held in September 2006 was one of the promising events indicating willingness for cooperation amongst the government, civil society and private health sectors.

The ‘gold standard’ of stewardship has been the process for the adoption of the NSP, which demonstrated that it is possible to build consensus and bring together different stakeholders across sectors, including the public and private sectors, in the interests of public good to overcome challenges of the HIV and AIDS.

South Africa is implementing one of the most well developed Comprehensive HIV and AIDS Plan. Mother-to-child transmission prevention programmes and voluntary counselling and testing programmes expanded coverage over the last year and are now available in almost all public sector facilities. The 60% of known HIV positive pregnant women are receiving appropriate services.

By November 2007, the comprehensive HIV and AIDS programme had approximately 408 000 patients on treatment at 362 sites across 52 health districts, compared to 143 434 patients on ART in March 2006. This is in addition to the persons treated in the private sector and by non-governmental organisations (NGOs). This number is set to rise to over 600 000 patients by 2009/10. The increase in patients on ARV treatment reflects ongoing expansion as service points are accredited, counselling and testing, human resources and laboratory infrastructure are put in place. There has also been a rapid increase in numbers of HIV, CD4 and viral load tests performed by the National Health Laboratory Service. HIV and AIDS programmes will continue to strengthen under the new national strategic plan, alongside an expansion of prevention programmes.

Spending on conditional grants within the Department of Health has been fairly strong, with particularly significant spending improvement on the HIV and AIDS grant. The District *health services* is the largest budget programme at provincial level, with spending expected to double from R14,1 billion in 2003/04 to R29,2 billion by 2009/10. This rate of growth is driven mainly by increased spending on primary health care and HIV and AIDS services. To mitigate the impact of HIV and AIDS and to provide for the faster uptake of treatment by HIV and AIDS patients, an additional R1,7 billion was allocated in the 2007 Budget.

6. Major challenges and remedial actions

The majority of the growth and development strategies including the poverty reduction strategy, Accelerated Growth Strategy for South Africa have mainstreamed HIV and AIDS so that resources are allocated to ensure that the response to HIV and AIDS is appropriate and adequate. In spite of these improvements and commitments, the systemic challenge of human resources particularly in the health sector, attenuates the expected benefits of these commitments. A number of challenges have been identified:

1. ***Issues of inequality*** - many of the historically disadvantaged areas such as informal settlements and rural areas are disproportionately affected by shortages in human resources. Government developmental programmes like JIPSA will be implemented with more vigour. Innovative and efficient ways of leveraging the private sector will be developed and introduced.

2. ***Operationalisation of the HIV & AIDS & STI Strategic Plan by SANAC sectors***: Since the adoption of the NSP by SANAC, processes have been under way to develop sector plans at national, provincial and district level with annual operational plans that would be based on realistic objectives that are linked to the NSP's objectives, interventions and targets.

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

4. ***Prevention -*** Whilst the NSP affirms that VCT remains the primary model, the NSP expands this model to include HIV testing that is offered by health providers to specified groups of people attending health facilities. It also proposes to identify new strategies for the provision of counselling and testing outside of health facilities.

These new initiatives including the effectiveness of male circumcision require further investigations and empirical evidence before the adoption of national policies.

5. ***Facilitating Treatment, Care and Support: Affordability of Medicines -*** It is estimated that, at current prices, the provision of anti-retroviral therapy will account for about 40% of the total cost of the NSP. This much needed service will soon be unaffordable at current drug prices. A number of legal opportunities can be exploited in order to make medicines more affordable e.g. amending the Patents Act, finalising of regulations establishing international benchmarks for medicine prices and removing obstacles to the timeous registration of essential medicines including the restructuring of the Medicines Control Council.

6. ***Strengthening Human Resources for Health:*** - A major threat to the full implementation of the NSP's interventions to provide prevention treatment, care and support is the unavailability of sufficient quantities of skilled personnel. South Africa has already found innovative ways to mobilise local communities to participate in the provision of services. These strategies have been successful in promoting greater access to services. Some examples include defining clear roles and responsibilities for the use of community development workers, community care givers and lay counsellors. These groups however do not replace the skilled personnel.

7. ***Sustainability of Financing*** **-** Weaknesses of existing monitoring and evaluation systems have made it very difficult to adequately cost the NSP because of uncertainty around baseline performance and outputs. Nonetheless, the cost implications of the NSP are extremely large; for example, if the NSP target of 80% of HIV positive people receive ART was achieved this would exceed 20% of the health budget. This poses challenges for both the affordability and sustainability of the NSP.

8. ***HIV and AIDS spend*** - the actual amount spent on workplace based HIV and AIDS programmes by government ministries and private sector is unknown because it has not been compiled across the sectors yet. The annual reports do not report on workplace based HIV and AIDS specifically. Reference is made to HIV and AIDS as part of the wellness programme or a broader staff development programme. The international development sector is equally challenged in that estimates for amounts budgeted or earmarked for HIV and AIDS activities are easily available, however the actual spend is extremely difficult to establish.

9. ***Monitoring and evaluation*** - although monitoring and evaluation has improved considerably over the past two years by both public and civil society sectors a number of challenges still remain:

- Data on most-at-risk populations – data was not reported on in the previous and current UNGASS reports. Efforts have been made to conduct small studies e.g. the study on taxi drivers a population group that is considered high risk. A major study currently being designed for implementation in mid-2008 is the study on MSM, gays and lesbians.
- Routine collection of data on those who are still alive and are on ARVs 12 months after initiation: the provinces that had made an effort to collect the data are using different assumptions, denominators and numerators. The National Department of Health is considering collecting this data through cohort studies.
- The lack of consistency across the provinces in computing some of the indicators will be addressed by the Department of Health.

- Data relating to OVCs: this report depended largely on the social grants information to establish the number of households receiving external support. With the full implementation of the OVC register and the development of a monitoring and evaluation system for OVC, it is envisaged that better quality data would be available.

7. Support from the country's development partners

7.1 Overview

A number of international development partners (Table 2) are currently supporting the national departments, provincial departments and civil society organisations to implement programmes to mitigate the impact of HIV and AIDS in South Africa. The development partners have supported South Africa both at a strategic level as well as at an operational level. Examples of this support include the following:

- Review of the National Strategic Plan 2000-2005 as well as the task teams that developed the NSP 2007-2011 and its M&E framework. It also includes the provision of logistical support for various national stakeholder consultations;
- Hosting of international conferences - UNICEF, WHO and UNAIDS supported the hosting of the second international PMTCT Global Partnership Forum in South Africa;
- Capacity building – one of the key areas of support is capacity building across all components of the HIV and AIDS programme. The purpose is to contribute to a strengthened South African response to HIV and AIDS, with stronger, co-ordinated support from the international community. The strategic aim is to build the capacity of partners to develop, implement, monitor and evaluate their plans. Capacity building of organisations and networks of PLWHA, combating violence against women and children, and mitigation of stigma and discrimination in relation to HIV and AIDS was also key capacity building programmes;
- Systems strengthening - support the strengthening of new operating systems, standard operating procedures, adaptation of an operational IT system, and inclusion of measurement systems. This included strengthening the institutional capacities of local non-governmental organizations and community-based organizations;
- Direct assistance to the Departments and civil society organisations to scale-up existing services e.g. effective OVC programmes; training for doctors, nurses and other health care workers to deliver services; funding supports NGO partners to expand treatment to specific target groups, including people with TB, women, men, and people in workplace settings and funding of ARV treatment through general practitioners;

- Assistance to government departments to strengthen monitoring and evaluation systems – in 2006 in collaboration with the National Department of Social Development, the establishment of the National M&E System for HCBC programme was commenced. During the period under review similar support was provided to national and provincial Departments of Health.
- Supporting HIV and AIDS research and information sharing to share the South African expertise in the area of research and data collection as well as the approaches taken by other countries in the region in addressing HIV and AIDS.

7.2 Actions that need to be taken by development partners to ensure achievement of the UNGASS targets

The following actions need to be taken by development partners to ensure achievement of the UNGASS targets:

- It is critical for development partners to work in a more coordinated manner and engage with the government of South Africa at a more strategic level so as to avoid duplication of services.
- The joint European Union Country Strategy Paper (EU CSP) agreed between South Africa and the EU in 2007 provides an opportunity for all EU development partners – and development partners more broadly - to harmonise their support. Given the current lack of donor participation in policy dialogue and decision making bodies such as SANAC, the EU CSP Working Group on AIDS (chaired by the government of Sweden) may be one mechanism to enhance dialogue among donors and with the government of South Africa.
- A critical element of ensuring that UNGASS targets are achieved is coordination. The Three Ones principle represent an appropriate framework for achieving this goal, because the emphasis is on coordination and collaboration among development partners and the South African Government to work toward harmonizing activities in alignment with the National Strategic Plan.
- Development partners should further strive to rationalize data collection procedures at all levels to ensure that methodologies and measurements are in line with the National Strategic Plan's monitoring and evaluation framework. This will mostly involve enhancing the currently disparate health management information systems in the HIV and AIDS domain to be more compatible with respect to reporting to a unified, minimum set of NSP indicators.

8. Monitoring and evaluation environment

A framework for ongoing monitoring and evaluation (M&E) of the goals, objectives and interventions of the National Strategic Plan for HIV & AIDS and STI, 2007-2011 was developed with the participation of SANAC sectors, stakeholders and communities. The M&E framework of the NSP proposes four interlinked levels:

- Monitoring HIV and AIDS, focusing on HIV incidence, prevalence, morbidity and mortality;
- Monitoring the proximate determinants of the disease;
- Monitoring the implementation of the NSP's interventions focusing on the inputs, outputs and intermediate outcomes; and
- Conducting process, outcome and impact evaluations of the NSP.

The M&E framework proposes a set of guiding principles, describes the various levels of M&E, defines core and an expanded set of indicators, describes the institutional arrangements and supporting agencies for the implementation of the M&E plans and highlights the capacity requirements for an effective M&E system.

Mechanisms are being put in place to improve data collection to ensure quality, valid and accuracy of data. Information on indicators is made available incrementally as the data collection system matures and grows over time. Long-term outcome and impact are to be assessed after a period of time following the implementation of the plan. The M&E Framework uses indicators that are already developed and agreed upon by WHO, UNAIDS and GFATM. It adopts a logical approach of input, process, output, outcome and impact indicators to ensure ongoing monitoring and evaluation of the goals and objectives of the plan. The success in operationalising the M&E framework is a collective responsibility. Although the implementation of the framework will be phased in gradually, the collection of baseline information, readiness assessment of the existing M&E system and compiling the 2008 UNGASS Country Report were prioritised.