migration, to a trend towards increasing mobility and migration by women. Mobility and migration not only increase vulnerability to HIV of mobile individuals, but also sending and receiving communities.[40]

(f) Informal settlement

Informal settlement is associated with higher levels of HIV prevalence in South Africa, with HIV prevalence for people aged 15-49 in urban informal areas being nearly twice that of prevalence in urban formal areas (25.8% vs 13.9%). Informal settlements include social fragmentation that may increase the likelihood of exposure to unsafe sex, but there is also a greater likelihood that individuals at higher risk of HIV including work-seekers, temporary workers, and labour migrants are resident in these areas. Diminished resources of informal settlements including inadequate housing, sanitation and health service access, and these exacerbate overall health risks and reforms in housing policy have been recommended.[41]

4.3 Specific Vulnerable Groups

(a) Women

Women, especially black women, have been on the bottom rung of the ladder in terms of participation in the economic, social, and political life of the country. For many years black women have experienced triple oppression - discriminated against on the basis of their class, race and gender. Some practical challenges facing women because of these three forms of oppression relate to violence against and abuse of women, poverty and poor health status in general.

Acknowledging the fact that gender inequality hinders social and economic development, the current government has made great strides towards empowerment of women and gender equality is one of the critical elements of the transformation agenda in the country. Women are beginning to regain their appropriate place in society and are taking responsibility for their lives. Patriarchal attitudes are changing,

[40] International Organisation for Migration. (2006). HIV/AIDS, population mobility and migration in Southern Africa: Defining a research and policy agenda. Pretoria: IOM

[41] Thomas, E.P. & Twala, S. (The HIV health challenge for people living in informal settlements – are environmental risks and exacerbating factor. Epidemiology: 6(5):S162

with men participating in efforts to address challenges such as violence against women. Gender transformation is part of a broader transformation agenda that also seeks to reduce the gap between rich and poor and between historically disadvantaged black communities and white communities with many more resources. However, the high levels of gender-based violence in the country indicate that a lot still needs to be done in this area.

Notwithstanding the abovementioned achievements, women remain one of the most important vulnerable groups in the country. The difference between men and women is more pronounced in the age groups 20-29 years but particularly striking in the age group 25-29 where the HIV prevalence in the same survey were 33.3% for women compared to 12.2% men.[42] A youth study by the Reproductive Health Research Unit (RHRU, 2002) found that among the 10% of youth who HIV positive, 77% are women are. In additional to biological, economic, social and other cultural vulnerabilities, women are more likely to experience sexual abuse, violence in particular domestic violence including rape.

They take the brunt of caring for sick family members and are the soldiers at the forefront of community-based HIV and AIDS activities. The HIV and AIDS epidemic is clearly feminized, pointing to gender vulnerability that demands urgent attention as part of the broader women empowerment and protection. In view of the high prevalence and incidence of HIV amongst women, it is critical that their strong involvement in and benefiting from the HIV and AIDS response becomes a priority. Teenage females have been underemphasized as a target group, even though pregnancy levels are high in this age group. The fact that the burden of the epidemic falls more on women and girls than on men and boys remains a central challenge to the national response.

(b) Adolescents and young adults (15-24 years):

The United Nations General Assembly Special Session on HIV and AIDS (UNGASS) identified young people aged 15-24 years as a priority group in reducing new HIV infections and set a global target *of reducing incidence of HIV in this group by 20% by*

[42] Health Science Research Council , 2005

2015[43]. Data from a decade or more of extensive national antenatal surveys in South Africa show that HIV prevalence among adolescent girls and young women in this age group may be stabilizing, albeit at very high rates. Prevalence in the age group 15-19 has remained at around 16% for the past five year, while in the 20-24 years it has risen only slightly (28%-30%) over the same period. Although current HIV prevention programmes in South Africa have invested significantly in this age group, they are yet to demonstrate the desired impact. Continued investment and expansion of carefully targeted evidence-based programmes and services focusing on this age group remain as critical as ever. Young people represent the main focus for altering the course of this epidemic. UNAIDS data on the experience of several countries including South Africa, confirm that positive behaviour change is more likely in this group than in older ages.

The greatest increase in pregnancy and HIV infection is associated with school leaving. School-leaving is a time of insecurity for young people, the aspirations that existed in school of getting a job and earning an income are often dashed and personal motivation to achieve and the psychological rewards of school achievement are no longer there and there are family pressures to contribute to household income or to leave. In the absence of career opportunities, many young women find fulfilment and affirmation in being a mother – by definition requiring unprotected sex.

(c) Children 0 – 14 years

Children under the age of 18 comprise 40% of the population of South Africa. In 2004, it was estimated that there are 2.2 million orphaned children (meaning 13% of all children under 18 have lost either a mother or father); nearly half of all orphans were estimated to have lost parents as a result of AIDS[44]. Some of the worst affected children – those in deeply impoverished households – may experience various forms of physical, material and psychosocial deprivation and assaults on their health as a result of poverty and/or a lack of parental care and nurturing environment. Often these children are separated from caregivers and siblings and sent to stay with other relatives or other carers or social networks.

[43] United Nations (2002) United Nations Special Session on HIV/AIDS, United nations New York
[44] UNAIDS, UNICEF, USAID (2004) Children on the Brink 2004, Geneva

A significant number of children in South Africa are living with HIV and AIDS. According to the 2005 HSRC survey, there is an estimated 129 621 children aged 2-4 years and 214 102 children aged 5-9 in 2005 living with HIV or AIDS[45]. HIV is thought to have contributed to an increase of 42% in under-five mortality in this country in 2004.[46] Also, there is evidence to suggest that 60% of hospital deaths were HIV-related in 2005. Children usually do not have sufficient access to AIDS treatment and care because available services are mostly designed for adults. Serious challenges around the skills of health workers and capacity to manage and treat children with AIDS including lack of appropriate ART formulations for treating children remain.

Children are vulnerable to HIV infection through child sexual abuse. Whilst little is known as to the extent of child sexual abuse in South Africa anecdotal estimates suggest that it is quite extensive and thus that it is a risk that needs to be monitored.[47]

(d) People with disabilities

People with disabilities, constitute a significant part of the population (12%). Yet, this group has been particularly neglected in the AIDS response. There are often erroneous perceptions that people with disability are asexual. To date the national response has not addressed the special needs of the various categories of people with disability in terms of prevention, treatment, care and support programmes. People with disability suffer double stigma arising from discrimination as result of their disability status and their HIV status.

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

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45 Shisana, et al (2005) South Africa National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, HRSC, Cape Town

46 Statistics South Africa (2006). Mortality and causes of death in South Africa, 2003 and 2004: findings from death notification. Pretoria: Statistics South Africa.

47 Kistner, U., Fox, S., & Parker, W. (2004) Child sexual abuse and HIV/AIDS in South Africa: A review. Johannesburg: CADRE/DOH

(e) Incarceration and HIV

Incarceration is a risk factor for HIV and is correlated with unprotected sex and injecting drug use in correctional facilities, but may also include risk of blood exposure as a product of violence and other factors. Interventions for risk reduction include provision of voluntary testing and counselling, condom provision, addressing rape, and addressing intravenous drug use.[48] Male prisoners are predominantly vulnerable but risks extend to female prisoners. Little is known about the extent of HIV in South African correctional services, nor the relationship between known risk factors and HIV acquisition in South Africa. However, a small study in Westville medium security prison near Durban in 2002 found an HIV prevalence of 29.6% amongst male prisoners.[49]

(f) Men who have sex with men (MSM)

Whilst HIV infection amongst MSM was a focus in the early phases of the epidemic in South Africa, there is very little currently known about the HIV epidemic amongst MSM in the country. MSM have also not been considered to any great extent in national HIV and AIDS interventions. Biologically, MSM who practice receptive anal intercourse have an elevated risk for HIV infection. MSM practices are also more likely to occur in particular institutional settings such as prisons, often underpinned by coercion and violence. MSM behaviours and sexualities are wide-ranging and include bisexuality, and the HIV epidemic amongst MSM and the heterosexual HIV epidemic are thus interconnected.[50]

(g) Commercial Sex Workers (CSW)

Sex work is not readily defined but includes a wide range of informal and formal activities that relate to the exchange of sex for material benefit. Key characteristics include frequent and repeated exchange of sex with multiple sexual partners usually for monetary gain. Sex workers are predominantly female. Sex workers are at high risk of HIV infection and are vulnerable as a product of high partner turnover and a limited capacity to ensure safe sex during each and every sexual encounter. Very little

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[48] Jürgens, R. (2006) HIV/AIDS and HIV/AIDS an HCV in prisions: A select annotate bibliography. International Journal of Prisoner Health, 2(2):131-149

[49] Gow, J, Smith, G., Goyer, K., & Colvin, M. (2004). The socio - economic characteristics of HIV in a South African prison. Int Conf AIDS. Abstract no. WePeD6529.

[50] UNAIDS, 1998

is known about HIV prevalence amongst sex workers or their clients in South Africa, but both groups are linked to sexual networks that overlap with the broader epidemic.

(h) Mobile, casual and atypical forms of work

Truck driving, military service and other uniformed services such as security service provision may require regular and sustained travel and may in turn increase the likelihood of multiple sexual partnerships. Such activities have been linked to increased risk of HIV infection.[51] Whilst very little is known about prevalence in these sectors in South Africa, it is likely that risk of infection is higher, and these groups also overlap with the broader epidemic as a product of linked sexual networks.

(i) Refugees

The disruption of services and support systems caused by conflict or unrest in their home countries means that many refugees have limited information about HIV and AIDS, and they are often not familiar with local services or systems in South Africa. In addition, while their legal status guarantees the right to access HIV-related information and services on the same level as South Africans, barriers such as language, cultural traditions and xenophobia often preclude their ability to access these services. Therefore targeted programmes are necessary to ensure that refugees and asylum seekers have access to information and services- including prevention, care, support and treatment- as an integrated component of the national response to HIV and AIDS.

(j) Injecting drug use

South Africa is a conduit country and market for drugs including injecting drugs such as heroin. Needle and syringe sharing is a common practice amongst injecting drug users, and is a highly efficient mechanism for transferring HIV. Intravenous heroin use in South Africa is presently very low, but has the potential to escalate. There are heroin detoxification programmes available in the country, but no formal needle exchange programmes exist.[52]

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[51] Kistner, U., Fox, S., & Parker, W. (2004) Child sexual abuse and HIV/AIDS in South Africa: A review. Johannesburg: CADRE/DOH

[52] Leggett, T. (2005). Intravenous drug use in South Africa. In S. Abdool Karim & Q. Abdool Karim (Eds.), *HIV/AIDS in South Africa*. Cambridge: Cambridge University Press.

4.4 Impacts

Demographic

The demographic impact of HIV and AIDS on the South African population is also apparent in statistics such as the under-5 mortality rate, which has increased from 65 deaths per 1000 births in 1990 to 75 deaths per 1000 births in 2006. Mortality rates in 1990 suggested that a 15-year old had a 29% chance of dying before the age of 60, but mortality rates in 2006 suggest that 15-year olds have a 56% chance of dying before they reach 60. Other estimates provided by the Actuarial Society of South Africa for 2006 include:

- 1.8 million AIDS deaths had occurred in South Africa, since the start of the epidemic.
- Around 740 000 deaths occurred in 2006, of which 350 000 were due to AIDS (approximately 950 AIDS-related deaths per day).
- 71% of all deaths in the 15–49 age group were due to AIDS.
- Approximately 230 000 HIV-infected individuals were receiving antiretroviral treatment, and a further 540 000 were sick with AIDS but not receiving antiretroviral treatment.
- 300 000 children under the age of 18 experienced the death of their mother.
- 1.5 million children under the age of 18 were maternal or double orphans (i.e. had lost a mother or both parents), and 66% of these children had been orphaned as a result of HIV and AIDS.

The economy

The ILO demonstrated in 2004, and again with more recent data in 2006, that the rate of economic growth in countries heavily affected by HIV and AIDS has been reduced by the epidemic's effects on labour supply, productivity and investment over the last decade or more. According to this assessment, 3.7 million labour force participants aged 15 to 64 years were living with HIV or with AIDS in South Africa[53]. However, there is currently no clear evidence on the actual economic impact of HIV and AIDS in South Africa.

[53] (ILO, 2006)

Families and communities

Households experience the immediate impact of HIV and AIDS, because families are the main caregivers for the sick and suffer AIDS-related financial hardships. During the long period of illness caused by AIDS, the loss of income and cost of caring for a dying family member can impoverish households[54].

The problem of orphans and vulnerable children will persist for years, even with the expansion of prevention and treatment programmes. Studies in several districts in South Africa found that the majority of orphans are being cared by grandparents, family members or through self-care in child-headed households[55]. Orphans and vulnerable children are at higher risk for HIV infection, as they face numerous material, emotional and social problems[56]. They also face:

- Discrimination and stigma, as they are often shunned by society, lack affection and are left with few resources;
- Many of them drop out of school due to inability to pay school fees;
- They also often suffer from malnutrition and ill health and are in danger of exploitation and abuse[57].

Psychosocial impacts, mental health and HIV

Interventions to address HIV and AIDS have tended to focus on biomedical interventions including, for example, condoms for HIV prevention, and ART and PMTCT, for people living with HIV. Psychological distress and psychological disorders are also more prevalent amongst PLHA, and the importance of mental health programming in relation to HIV/AIDS has long been overlooked.[58] Less emphasis has been given to the psychosocial impacts of the disease which are related to illness and death of parents, children and other family members; caring for people who are ill and dying of AIDS; and living with and coping with an HIV positive diagnosis. A recent

[54] (Ashford, 2006)
[55] (Letlape et al., 2006; Jooste et al., 2006)
[56] (Skinner, 2006)
[57] (UNICEF)
[58] Baingana, F., Thomas, R., & Comblain, C. (2004). HIV/AIDS and mental health. Washington: World Bank; Freeman, M., Nkomo, N., Kafaar, Z. and Kelly, K. (2007). Mental disorder in people living with HIV/AIDS in a high prevalence developing country context. Forthcoming in The Lancet.

study in South Africa found a higher prevalence of mental disorders amongst PLHA including depression, anxiety, increased anxiety amongst PLHA with children, and alcohol related problems.

The health care system

HIV and AIDS affect both the supply and demand of health care systems. On the 'supply' side of health systems, the human resource effects of HIV are two-fold: the stress and morale impacts of rapidly changing epidemiological, demand and mortality profiles in patients caused by HIV and AIDS, and HIV infection in providers themselves. In a survey of 512 public sector workers in four provinces, 16.3% were HIV infected[59]. An HIV prevalence study at Helen Joseph and Coronation Hospitals with a 91% response rate, found that 13.7 % of 644 nurses were HIV infected and 19% had AIDS defining CD4 cell counts[60].

Education system

The epidemic affects the supply and demand for primary and secondary schooling. On the supply side, infected teachers will eventually become chronically ill, with increased absenteeism, lower morale and productivity.

A South African education sector study found a sero-prevalence of 12.7% among teachers and significant gender, racial and geographical differences[61].

The challenge of HIV and AIDS in South African requires an intensified comprehensive, multi-sectoral national response. This response should:

- address the social and economic realities that make certain segments of society most vulnerable
- provide tools for prevention of infection
- provide services designed to mitigate the wide-ranging impacts of the epidemic.

To achieve this there is a continuing need to guide policy and programmes at all levels and in all sectors and to inspire renewed commitment from all South Africans.

[59] (Shisana et al, 2003)
[60] (Connelly et al, 2007)
[61] (Shisana et al., 2005b)

The South African National Aids Council (SANAC) recommended a rapid assessment of the NSP 2000-2005 as a first step toward developing the NSP 2007-2011. A task team was duly formed to coordinate the assessment, which was done between August and September 2006. This evaluation enabled stakeholders to identify the strengths and weaknesses of the NSP 2000-2005. The NSP 2007-2011 thus partly builds on the findings of this assessment.

5. RESPONSE ANALYSIS

A detailed description of the country's response to the HIV and AIDS epidemic is beyond the scope of this plan. However, this section offers a brief overview of progress made by various agencies in implementing the NSP 2000-2005 as well as some of the gains for the NACOSA period.

The NSP 2000-2005 articulated four priority areas - prevention; treatment, care and support; legal and human rights; and research, monitoring and surveillance.

The final report of the assessment of the NSP 2000-2005 concluded that:

1. All stakeholders in government and civil society embraced the NSP 2000-2005 as a guiding framework during the time of its implementation. Sectoral HIV and AIDS policies and operational plans in South Africa are designed according to the principles and structures charted in the NSP 2000-2005.
2. Participation in the fight against HIV and AIDS has broadened to involve agencies other than the Department of Health and government departments during the time of the NSP 2000-2005.
3. There has been an increase in the levels of HIV and AIDS awareness and in the acceptance of people living with HIV and AIDS. However, behaviour has not changed proportionately to levels of awareness and availability of prevention methods such as condoms.
4. Stigma and discrimination remain unacceptably high.
5. The NSP 2000-2005 gave rise to the establishment and expansion of key programmes such as health education, voluntary HIV counselling and testing (VCT), prevention of mother to child transmission (PMTCT) and antiretroviral

therapy (ART). There has been significant growth in input to and uptake of these programmes over the period of the NSP 2000-2005.

6. The implementation of these programmes tended to be vertical, with capacity deficits evident in their implementation. This is reflective of the health system or lead agency's weaknesses rather than a weakness in the strategic framework.
7. The lack of a clear monitoring and evaluation framework and clear targets and responsibilities was a major weakness of the NSP 2000-2005.
8. The overall co-ordination of activities at SANAC level and within civil society was another major weakness.

Key recommendations for government departments included:

1. Review the approach and content of the Abstain, Be faithful, Condomise (ABC) strategy behind the design of Information, Education and Communication materials (IEC). There should be greater emphasis on strategies that are designed to influence behaviour rather than simply to raise awareness. Also, there should be emphasis on positive messaging - sending a clear message that it is possible to live a happy, fulfilled life with HIV.
2. Strengthen the implementation of government departments' HIV and AIDS plans. Establish an interdepartmental framework to record the experiences of the various departments.
3. Consolidate and build existing partnerships, especially concentrating on increasing the contribution of the private sector.
4. Strengthen co-operative agreements among SADC member states and promote implementation of these agreements to create a regional framework.
5. Strengthen the co-ordination and monitoring and evaluation of the sector within the framework of SANAC.

The key recommendations identified the following needs within civil society:

1. Develop strategies to enable SANAC representatives to fulfil their mandate of co-ordinating activities in civil society.
2. Develop strategies to increase business sector contribution in all aspects of the response to HIV and AIDS, especially small, medium and micro enterprises (SMMEs). Formalise structures in the trained health professional (THP) sector.

3. Establish a monitoring and evaluation plan for all civil society structures. Strengthen co-ordination among all sectors of civil society involved in treatment, care and support activities.
4. Make prevention education and other HIV and AIDS related interventions accessible to people with special needs.

The findings of the assessment on the extent of implementation of the NSP 2000-2005 are summarized as follows:

Prevention:

Information Education and Counselling (IEC) materials in South Africa are of sound technical quality and widely available. All stakeholders disseminate similar messages, articulated around ABC, stigma-mitigation and human and legal rights. The DOH has invested a great deal in the production and dissemination of IEC materials through the existing and popular mass media.

A recent report on the status of HIV and AIDS communication campaigns reported that the government AIDS Communication Programme, Khomanani is the best of all in the country, achieving excellent reach and is well known and recognised by the general population. The target of reaching all schools in South Africa through the Life Skills program has also been achieved and significant progress has been made in building capacity among educators. Behavioural change, however, remains a problem. Reports indicate that consistent condom use among the youth is still not optimal.

All government departments are committed to the prevention of HIV and AIDS. Departments have developed and implemented appropriate policies and plans. There are suggestions, however, that implementation capacity for specific activities within government departments is inadequate.

In August 2005, South Africa joined the WHO Afro Regional Resolution to declare 2006 a year of accelerated HIV prevention and a five-year strategy for accelerated HIV prevention was developed. HIV prevention is one of the key priority programmes articulated in the Strategic Plan of the DOH for 2006/2007.

Some programmes have been implemented in high transmission areas (HTA) and have grown rapidly due to high demand. These include several regional initiatives such as the Corridors of Hope service on the major trucking routes in South Africa.

Male Condom accessibility, judged according to the quantity of condoms procured and distributed, has significantly improved during the NSP 2000-2005. Condoms are being distributed increasingly via non-traditional outlets, but the number of condoms handed out at these venues remains low compared to overall distribution.

The number of PMTCT sites has increased during the NSP 2000-2005 period. DOH has provided some skilled personnel, medicines and other commodities to ensure that access to PMTCT increased. The training of health care providers on PMTCT may, however, be lagging behind the expansion of the PMTCT services. Fertility options for women known to be HIV-positive are still lacking. The effectiveness of this programme is still to be established.

The availability of post exposure prophylaxis (PEP) services has also improved during the NSP 2000-2005. Policies are available; and the number of sites and drug availability has improved since 2000. But the percentage of people who have been raped who actually receive PEP is low. This could be due to weak human resource capacity or failings of other support systems (for example, data/information management) for the programme.

Significant investment has been made in infrastructure since 2000 including recruitment of staff, training of staff, and procurement of equipment and supplies for VCT. The proportion of people counselled to those who are tested has improved during the NSP 2000-2005 period, as has the proportion of health care workers being trained to provide the service. The contribution of the private health sector to VCT is minimal, too low in proportion to the resources in that sector.

Treatment, Care and Support:

Standard treatment guidelines for the management of HIV and AIDS related conditions in the public health sector were developed and distributed with training of health care workers. An important milestone in this regards was the development and

approval by Cabinet of the National Operational Plan for Comprehensive HIV and AIDS Management, Treatment, Care and Support (The Comprehensive Plan). This plan united the country in ensuring that a comprehensive package of good quality services is equitably provided to those in need whilst strengthening the health system.

Since the launch of this plan, a lot of resources have been allocated to treatment, care and support within facilities. Policy and guidelines for all aspects of HIV and AIDS were updated to include the use of Antiretroviral drugs and nutrition interventions. Staff training has increased, laboratory services are more accessible, physical infrastructure has improved. In the first year of the implementation of the Comprehensive Plan, accredited service points covered all health districts. Today many accredited service points are already functioning beyond capacity.

South Africa now has the largest number of people enrolled on antiretroviral therapy in the world. There are however many more people in need of this and other related interventions to reduce morbidity and mortality from HIV and AIDS. In particular more eligible adults than children have accessed these services. There is a need to develop more innovative strategies to improve access for children as well. The management of TB poses a specific challenge as the cure rate remains low and resistance increases despite the efforts that have been put into the programme.

Community and home-based care have grown rapidly in South Africa in the last five years. Guidelines have been developed and training is available for home-based carers. In general, communities are responding positively to the need to care for PLWHA. Collaboration between the government and some CBOs is well established, with many receiving funding from the government. The provision of a stipend for home-based carers is an important incentive that also contributes to poverty alleviation. This programme is seen as the department of health's contribution to the national Expanded Public Works Programme (EPWP). Policies for the management of community care givers as well as career path programmes have been developed whilst good quality services are provided to home-bound clients and children in early childhood centres.

The burden of HIV and AIDS on children has increased greatly. The number of Orphans and Vulnerable Children (OVC) has more than doubled in the past three years. The government response to this reality is multi-sectoral, comprehensive and developmental. There is significant inter-sectoral collaboration between relevant government departments and civil society to address the needs of these children.

Research, Monitoring and Evaluation:

South Africa's efforts to develop a vaccine have met with international acclaim. Support from government and other research institutions is very valuable to the initiative. The various scientific teams involved have observed all ethical requirements. HIV vaccine development has strengthened the level of community participation in scientific research and capacity to do research has increased considerably in the country. The challenge is to ensure equitable spread of this development. It is however still a long way before an effective vaccine is available for use.

A number of HIV and AIDS research projects have been commissioned during the NSP 2000-2005 to investigate various treatment options in South Africa. Great emphasis has been placed on ensuring that new drugs are safe - both in the mainstream and traditional health sectors. Studies have been conducted to establish the incidence of HIV. There are still some methodological discussions yet to be concluded in this domain.

Several behavioural surveys of varying methodological strength have been carried out. Some of these were aimed at establishing a baseline against which future surveys could be assessed. The antenatal care survey for the prevalence of HIV among pregnant women was conducted once a year during the time of the NSP 2000-2005.

Human and Legal Rights:

Between 1994 and 2007 South Africa developed a sophisticated legal framework dealing with health, which has respect for human rights at its centre. There are also a number of laws, policies, guidelines and judgments that specifically protect the rights of people living with HIV and AIDS in South Africa. However, information on these rights has not been widely enough disseminated. Linked to this is the failure to

allocate resources for human rights education and protection, leading to the human rights-based response being limited and fragmented and largely driven by NGOs. As a result, poor, marginalised and disabled people face the problem of being unable to afford or have easy access to the legal and judicial system.

During the NSP of 2000-2005 some research has reported a lessening of stigma and the latest evidence suggests the majority of South Africans are willing to care for PLWHA. In addition there have been a number of successful cases challenging unfair discrimination. But despite this the combination of stigmas against HIV, disability and sexual orientation, together with other forms of discrimination, remain a challenge. This continues to deter people, particularly from vulnerable groups, from seeking HIV testing, treatment and support. In addition, much greater openness about HIV remains elusive.

Civil Society Sectors response:

Various sectors of civil society were identified as lead agencies in the implementation of the NSP 2000-2005. Challenges with lack of indicators and , poor coordination make it difficult to provide an accurate account on the performance of these sectors. However, during 2000-2005 many sectors expanded their involvement in HIV Prevention, Treatment, Care and Support. For example, the PLWHA, the business, higher education, traditional health practitioners, people with disabilities, children, and religious sectors are some of the sectors that have made meaningful contributions.

The main challenge is now for the sectors to coordinate and monitor their activities more effectively. There is also a need for sectors to ensure that campaigns on HIV reach to all of their members.

6. DEVELOPMENT OF THE STRATEGIC PLAN 2007-2011:

During 2006 SANAC, under the leadership of the Deputy President, Mrs. Phumzile Mlambo-Ngcuka, mandated the Department of Health (DOH) to lead the development of a national strategic plan to ensure continued guidance strengthening of the national, mullti-sectoral response to HIV and AIDS.

This plan would build onto what has been done, take into account the current state of the epidemic and developments in scientific knowledge, and will establish national targets and monitoring frameworks. Guided by the Minister of Health, Dr Manto Tshabalala-Msimang, SANAC concluded that the National Strategic Plan (NSP) 200-2005 is fundamentally still relevant. This work began in August and September with an assessment of progress in the implementation of the NSP 2000-2005.

The methods used were a review of documents supplied by lead agencies implementing the NSP and secondary data analysis. These initial findings were presented to government and civil society for validation. Stakeholders were afforded an opportunity to provide additional information. About two hundred people represented a wide range of different government departments and organisations across various sectors in these workshops in August and September 2006. There were representatives of fifteen different government departments, organisations representing PLWH, faith-based organisations (FBOs), non-governmental organisations (NGOs), community based organisations (CBOs) traditional healers, legal and human rights organisations, organisations representing people with special needs, youth organisations, organised labour, business, the hospitality industry, organised sport and academic institutions.

The first draft of the NSP 2007-2011 was presented at a consultation with all sectors on the 20th October 2006. Inputs from this consultation were incorporated and a second draft was circulated to all stakeholders for further comments. Civil society structures also had an opportunity to consult among themselves at a congress held on 27 and 28 October 2006. Some of the resolutions of this congress were considered. The draft NSP was then presented to SANAC on 31 October 2006. Further consultations with NGOs, PLWHA, women's groups, the youth troika, labour, and the children's sector yielded additional inputs, which were considered. Inputs from other government departments, expert clinicians, researchers and professional organisations were also included.

The DOH and the National Health Council (NHC) interrogated and endorsed the final draft, which was then presented to the civil society section of SANAC on 20 November 2006, where it was decided that more work to enhance the document was to be done

by a task team of experts. A national expert task team was appointed (Annexure A) and the team presented the final draft to a national consultation on the 14-15 March 2007 for endorsement. The NSP 2007-2011 was then adopted by SANAC as the document expressing the national commitment and approach to HIV & AIDS and STIs.

7. PURPOSE OF THE STRATEGIC PLAN 2007-2011

The National Strategic Plan 2007-2011 is designed to guide South Africa's response to HIV & AIDS & STIs control in the next five years. This strategy document draws on lessons learned in responding to HIV and AIDS in the last decade. The NSP builds on existing strengths and successes, considers the policy and legal environment, developments in scientific evidence, international practices, estimated need and current coverage rates demonstrable capacities, projects potential achievements by 2011, is informed by resources available, and looks at innovative ways to address areas of weakness, and sets ambitious targets to meet the broad aims the national response to HIV and AIDS and STIs. Linked to this plan is a Framework for Monitoring and Evaluation.

Practically speaking, the new NSP seeks to strengthen and improve the efficiency of existing services and infrastructure and introduce additional interventions based on recent advances in knowledge.

Whilst the two main goals of the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa are to provide comprehensive care and treatment for people living with HIV and AIDS as well as to facilitate the strengthening of the national health system, the NSP 2007-2011 is not a plan for the health sector alone. Instead, it seeks to be relevant to all agencies working on HIV and AIDS in South Africa, within and outside the government. The underlying basic premise is the recognition that no single sector, ministry, department or organisation can by itself be held responsible for the control of HIV and AIDS.

It is envisaged that all government departments and sectors of civil society will use this document as a basis to develop their own HIV and AIDS strategic and operational plans to achieve a focussed, coherent, country-wide approach to fighting HIV and

AIDS. It will be used as a basis for engagement with national and international partners on matter that pertain to HIV and AIDS. Where there are policy gaps, these will be addressed and financial and other resources will be mobilised accordingly. This alignment and harmonisation of efforts will also enable consistent and effective monitoring and evaluation of the national response to HIV and AIDS, which will enable further revision and improvement of interventions.

8. GUIDING PRINCIPLES

The principles guiding the implementation of the NSP 2007-2011 confirm those articulated in the Constitution, the NACOSA Plan, the Department of Health *White Paper for the Transformation of the Health System in South Africa, 1997*, the Comprehensive Plan, and Batho Pele. These Principles are summarised below:

- **Supportive Leadership:** The NSP should be driven by South Africa's political leadership with the support of leaders from all sectors.
- **Effective Communication:** Clear and ongoing communication is an essential tool for the attainment of the aims of the plan.
- **Effective Partnerships:** All sectors of government and all stakeholders of civil society shall be involved in the fight against HIV and AIDS.
- **Promoting social change and cohesion:** The national movement on moral regeneration and values promotion shall be enhanced to support sustainable behavioural change.

- **Tackling Inequality and poverty**: the NSP affirms government's constitutional duty to take reasonable legislative and other measures to ensure progressive realisation of rights to education, health care services and social security to all people of South Africa. HIV and AIDS interventions will be implemented in a way that complements and strengthens other developmental programmes.
- **Promoting Equality for Women and girls**: The NSP recognises the particularly vulnerable position of women and girls to HIV, AIDS and its social impact. It commits to prioritising interventions focussing on the causes of gender inequality, and the horrific impact that HIV has on many women and girls.
- **Protecting and Respecting Children:** The impact of HIV on the rights of children is enormous. Respect for the best interests of the child dictates that

children's rights and needs must be at the forefront of all interventions for HIV prevention, treatment and support.

- **Recognising Diversity:** The NSP recognises the special needs and diversity of disability rights as human rights and recognises disability as a social and developmental issue.
- **Ensuring Equality and non-discrimination:** The NSP is committed to challenging discrimination against groups of people who are marginalised, including people with disabilities, orphans, refugees, asylum seekers, foreign migrants, sex workers, men-who-have-sex-with-men, intravenous drug users, and older persons. All these groups have a right to equal access to interventions for HIV prevention, treatment and support.
- **Personal Responsibility:** Every person in South Africa has a responsibility to protect themselves and others from HIV infection and to know their HIV status and seek appropriate care and support,
- **Building Community Leadership:** Programmes shall be informed and owned by communities and their leaders.
- **Using scientific evidence:** The interventions outlined in the NSP shall, wherever possible, be evidence-based.
- **Strengthening care systems:** Strengthening of health and social systems, and organisational capacity of NGOs, FBOs and CBOs, is central to effective implementation.
- **Accessibility:** All essential commodities including prevention technologies, medicines, diagnostics tools, nutritional and food supplements, shall be made affordable and accessible.
- **Monitoring Progress**: All interventions shall be subject to monitoring and evaluation.
- **Financial sustainability:** No credible, evidence-based, costed HIV and AIDS and STI sector plan should go unfunded. There should be predictable and sustainable financial resources for the implementation of all interventions. Additional resources from donor agencies shall be harmonised to align with policies, priorities and to fund programme and financial gaps

9. GOALS OF THE NSP 2007-2011

The primary aims of the NSP are to:

- reduce the number of new HIV infections by 50%.
- reduce the impact of HIV and AIDS on individuals, families, communities and society. by expanding access to appropriate treatment, care and support to 80% of all people diagnosed with HIV

In particular young people in the age group 15-24 should be a focus of all the interventions, especially for behaviour change based prevention.

The interventions that are needed to reach the aims of the NSP are structured according to the following four key priority areas:

- Prevention;
- Treatment, care and support;
- Human and legal rights; and
- Monitoring, research and surveillance.

The section that follows focuses in more detail on the interventions that will be pursued in the next 5 years. However it needs to be understood that these priority areas are a continuum in the response to HIV and AIDS.

PRIORITY AREA 1: PREVENTION

The target is to reduce the national HIV incidence rate by 50% by 2011. Identifying and keeping HIV negative people negative is the most effective and sustainable intervention in the AIDS response.

(The unavailability of incidence measures is a cause for uncertainty regarding the reliability of monitoring targets in this regard. Monitoring incidence will be informed by modeling work for quite some time in the NSP period.)

It is thought that as much as 85% of the South African HIV epidemic is caused by heterosexual spread. Vertical transmission from mother to child and less frequently , transmission associated with blood products account for the rest of the infections. The HIV epidemic is complex and diverse that although not fully understood, is known to

be driven by many behavioural, social, and biological factors that both exacerbate and/or facilitate the spread of HIV. It is unlikely that the society will be able to keep up with the demand for health and social services unless there is a significant slowing down in the incidence of newly infected individuals. This situation underscores the central role and importance of HIV prevention.

Goal 1: Reduce vulnerability to HIV infection and the impact of AIDS
Goal 2: Reduce sexual transmission of HIV
Goal 3: Reduce mother-to-child transmission of HIV
Goal 4: Minimise the risk of HIV transmission through blood and blood products

PRIORITY AREA 2: TREATMENT, CARE AND SUPPORT

The target is to provide an appropriate package of treatment, care and support services to 80% of HIV positive people and their families by 2011 in order to reduce morbidity and mortality as well as other impacts of HIV and AIDS.

Key to meeting these targets are:

- Establishing a national culture in which all people in South Africa regularly seek voluntary testing and counselling for HIV. This will necessitate a paradigm shift in health care provision where HIV testing is routinely offered to people attending health services, as well as the identification of new strategies for the provision of counselling and testing outside of health facilities.
- Strengthening the health system so as to create the conditions for universal access to a comprehensive package of treatment for HIV, including antiretroviral therapy, and the integration of HIV and tuberculosis care. The complexity of maintaining more than one million people on antiretroviral therapy at high levels of adherence will emerge as a key medium term challenge and will require systems and resources. This underscores the critical need to ensure that investments in treatment build the capacity of the health system more generally and also contribute to strengthening prevention.
- Draw on and disseminate the growing body of experience and innovation in care, treatment and support strategies across the country, in both public and private sectors.

- Focus on specific issues and groups: the prevention-of-mother-to-child transmission, the care of children and HIV infected pregnant women, and wellness management of people before they become eligible for ART.
- Ensure the effective implementation of policies and strategies to mitigate the impacts of HIV, in particular orphans and vulnerable children, youth headed households, and on the health and educational system as well as support to older people.

The goals for treatment, care and support are structured principally around these key challenges as follows:

Goal 5: Increase coverage of voluntary counselling and testing and promote regular HIV testing

Goal 6: Enable people living with HIV to lead healthy and productive lives

Goal 7: Address the special needs of women and children

Goal 8: Mitigate impacts of HIV and AIDS and create an enabling social environment for care, treatment and support

PRIORITY AREA 3: RESEARCH, MONITORING AND SURVEILLANCE

Goal 9: Implement the monitoring and evaluation framework of the NSP

Goal 10: Support the development of prevention technologies

Goal 11: Support AIDS vaccine development

Goal 12: Conduct operational research

Goal 13: Conduct policy research

Goal 14: Conduct regular surveillance

PRIORITY AREA 4: HUMAN RIGHTS, ACCESS TO JUSTICE AND LAW REFORM

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. But in addition, active and ongoing campaigns that promote, protect, enforce and monitor human rights must be linked to every intervention and mounted at district, provincial and national level. The NSP identifies a range of activities to improve access to justice, in order that people can challenge human rights violations immediately and directly. It sets out issues for law reform in order to create a legal framework that

uniformly assists HIV prevention, treatment, research and surveillance.

GOAL 15: Ensure knowledge of and adherence to the existing legal and policy frameworks

GOAL 16: Mobilise society and build leadership of people living with HIV to protect and promote human rights

GOAL 17: Identify and remove legal, policy, and cultural barriers to effective HIV prevention, treatment and support

GOAL 18: Mobilise society to respect and protect human rights of women and girls, including those with disabilities, to eradicate gender-based violence and advance equality in sexual relationships

Objective	Intervention	5 year target	2007	2008	2009	2010	2011	Lead Agency
GOAL 2: REDUCE VULNERABILITY TO HIV INFECTION AND THE IMPACT OF AIDS								
Accelerate poverty reduction strategies and strengthen safety nets to mitigate the impact of poverty on different target groups	Scale up government poverty alleviation programmes	30%	40%	60%	80%	90%	DSD; DTI; DPLG; SALGA; Business; Spatial development programmes	
Create an enabling environment for HIV testing	Mobilize joint prediction and report on MDG target figures to promote HIV testing and disclosure	annual	Annually	annually	Annually	Annually	DSD; DTI; Private sector; Presidency; NPA	
Support national efforts to strengthen social cohesion in communities and to support the institution of the family	Advocate for the equitable provision of basic social services such as water, sanitation, roads, transport, health services, education especially in rural and urban informal settlements	quarterly campaigns	30%	quarterly campaigns	60%	70%	90%	DSD; DTI; DPLG; SALGA; Business; Spatial development programmes
Develop behavior change curricula for the prevention of sexual transmission of HIV, adapted to different target groups	Develop curricula for the sexual prevention of HIV which include safer sex counselling including information about different sexual practices, decrease partner number, Gender, gender based violence, concurrency, intergenerational sex, male and female condom use, STI recognition and treatment, VCT, contraception, pregnancy testing, appropriate referral Adapt curricula for different target groups including: Young people out of school, primary school children, secondary school children, higher education institutions, pregnant women, older men and women, higher risk groups (see below)	Guidelines and curricula developed	30% develop and implement curricula	Implement quarterly campaigns	Implement 60% quarterly campaigns	Implement 80% quarterly campaigns	Implement 90% quarterly campaigns	DoH, DoE, DSD; DTI; Academics Business; NGOs ETC; Presidency

PRIORITY AREAS FOR STRATEGIC PLAN 2007-2011

PRIORITY AREA 1: PREVENTION: 50% reduction in HIV incidence rate by 2011

[illegible] ARV services	[illegible] lubricants STI symptom recognition	Review and formulate [illegible] guidelines	Implement services	Implement services	Implement services	Implement services	[illegible] NGOs [illegible] institutions, DoE
	Integrate HIV wellness and prevention services for people living with HIV into treatment and care services, including palliative and home-based care [illegible]	20% of [illegible] 40%	50% of [illegible] 60%	70% of [illegible] 80%	85% of [illegible] 90%	100% of [illegible] 90%	DoE, DoH, PWA [illegible]
	[illegible]	50% of districts	60% of districts	70% of districts	80% of districts	100% of districts	DoSD, NGOs [illegible] sector,
	[illegible]	Reduce services by	Reduce services by	Reduce services	Reduce services by	Reduce services by	NGOs, [illegible]
	Develop [illegible] guidelines	Develop 10%	implement 20%	implement 30%	implement 40%	Implement 50%	Religious [illegible]
	[illegible] condoms [illegible] informal	30% implement	50%	60%	80%	90%	[illegible] organisations
	Enhance and support wellness and [illegible]	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	DoH, PWA [illegible]
	[illegible] strategies aimed at youth [illegible] enhance knowledge and improve [illegible]	quarterly campaigns 50% of services [illegible]	quarterly campaigns 80% of services	quarterly campaigns 90% of services	quarterly campaigns 100% of services	quarterly campaigns 100% of services	[illegible] NGOs [illegible] sector [illegible] youth [illegible]
Introduce programmes to mitigate the impact of alcohol and substance use	[illegible]	Develop and Implement	40%	facilities	facilities	facilities	[illegible]
Increase roll out of prevention programmes for higher risk populations [illegible] workplace prevention programmes	[illegible] customised prevention package to [illegible]	Review and formulate new policies and guidelines 50% of services	Implement services 60% of services	Implement services 70% of services	Implement services 80% of services	Implement services 100% of services	[illegible]
	[illegible]	40%	60%	80%	100%	100%	[illegible]
	[illegible]	20% of districts	50% of districts	70% of districts	85% of districts	100% of districts	[illegible]
	[illegible] including STI management, VCT and rapid HIV testing facilities [illegible] hospitality industry, including access to VCT and provision of male and female condoms, STI symptom recognition and STI services	quarterly campaigns	quarterly campaigns	quarterly campaigns	quarterly campaigns	quarterly campaigns	[illegible] NGOs, [illegible] Soul City, Khomanani), [illegible] religious institutions, [illegible] leaders, medical aids

Introduce programmes and strategies to address stereotype gender identities that contribute to gender based violence	Develop and implement evidence based programmes including a communication strategy that provides clear messages on the non-acceptability of coercive sex, addresses gender stereotypes and addresses the stigmatisation of rape survivors	Programmes evaluated and implemented	quarterly campaigns	quarterly campaigns	quarterly campaigns	quarterly campaigns	NGOs, DoSD, academics
	Private sector and government support to roll-out integrated microfinance and gender education interventions starting in the poorest areas	Develop and implement at least 1 per province	4 per province	8 per province	16 per province	32 per province	NGOs, DoSD, academics
Increase the accessibility and availability of comprehensive sexual assault care including PEP and psychosocial support	Increase the proportion of facilities offering the comprehensive package of sexual assault care in accordance with the National Policy on Sexual Assault Care of NDOH	40%	60%	80%	100%	100%	DoH
	Increase the proportion of facilities providing post-sexual assault care that offer PEP to all survivors testing HIV negative	30%	50%	60%	70%	90%	DoH
	Increase the number of districts with accessible social and mental health services able to support child and adult victims of gender-based violence	20%	40%	60%	80%	100%	DoH, DoSD, NGOs

GOAL 3: Reduce mother-to-child transmission of HIV

Objective	Intervention	5 year target					Lead Agency
		2007	2008	2009	2010	2011	
Expansion of existing mother to child transmission services to	Implement programmes to reduce the percentage of all unwanted pregnancies through scaling up contraceptive services in public sector	20% increase	40%	60%	80%	90%	DoH

Scale up coverage of PMTCT to reduce MTCT to less than 5%	Implement the provision of psychosocial support services for HIV-positive women during and after pregnancy / Increase the proportion of public sector ANC sites providing PMTCT	10% (sub-districts) in public sector ANC services / 25%	40% / 45%	60% / 100%	80% / 100%	90% / 100%	DoH, NGOs, DoSD
	Provide nutritional support to HIV-infected women choosing to	5%	10%	30%	40%	40%	DoH, DoSD, NGOs
	Review guidelines for PMTCT and programmes in health districts and interventions / Exclusively breastfed ...	Evaluate and develop progammes / Annual	Introduce into 20% health districts / Annual	40% / Annual	60% / Annual	80% / Annual	NGOs, DoH, academics / DoH
	Provide formula milk to children of HIV positive women choosing not to breast feed / ... the use of optimal prophylaxis regimen	50%	45%	45%	42%	40%	DoH
	Expand PMTCT guidelines to include postnatal services and implementation / Increase proportion of pregnant women tested through provider initiated VCT for all pregnant women	Develop and implement guidelines / 70%	Annual / 85%	Annual / 90%	Annual / 95%	Annual / 95%	DoH, academics
	Develop a policy and guidelines about VCT in pregnancy including consideration of provider initiated testing, and frequency of testing	Develop and implement	Annual review	Annual review	Annual review	Annual review	DoH
	Increase the proportion of the estimated population of HIV-infected pregnant women in need who receive PMTCT prophylaxis	6O%	7O%	80%	90%	95%	DoH, NGOs, DoE
	Increase the proportion of facilities that meet quality standards for infant feeding counselling	60%	75%	85%	90%	95%	DoH

GOAL 4: Minimise the risk of HIV transmission through blood and blood products

Objective	Intervention	5 year target 2007	2008	2009	2010	2011	Lead Agency
Minimise exposure to infected blood through procedures associated with traditional and complementary practices	Provide adequate training of traditional healers/practitioners on universal precautions	30%	50%	70%	80%	100%	Traditional practitioners organisations
	Provide information to public raising awareness of HIV risk through unsafe traditional practices	70%	90%	100%	100%	100%	DoH, NGOs
	Provision of supplies to practice safe traditional practices	30%	50%	70%	80%	100%	Traditional practitioners organisations

Objective	Intervention	5 year target 2007	2008	2009	2010	2011	Lead Agency
Investigate the extent of HIV risk from Intra venous drug use (IDUs) and develop policy to minimise risk of HIV transmission through injecting drug use	[illegible]	[illegible]	[illegible]	[illegible]	100%	100%	[illegible]
	Develop policy for HIV prevention in IDUs and review annually	Policy developed	Annual review	Annual review	Annual review	Annual review	DoH, DoSD, DoSS, NGOs
	Develop and continuously update guidelines on minimising HIV risk in injecting drug use	Develop and implement guidelines	Annual	Annual	Annual	Annual	DoH, NGOs

Objective	Intervention	5 year target 2007	2008	2009	2010	2011	Lead Agency
Minimise the risk of HIV transmission from occupational exposure in health care providers in the formal, informal and traditional settings through the use of infection control procedures	Continuously update Guidelines for infection control	Annual	Annual	Annual	Annual	Annual	DoH, academics
	Ensure continuous supplies of PEP drugs in public and private sector facilities	80%	90%	100%	100%	100%	DoH, private health care sector
	Ensure availability of barrier nursing supplies, equipment and biohazard disposal systems in all formal health care facilities	80%	90%	100%	100%	100%	DoH, private health care sector
	Continuously update guidelines for infection control procedures	Annual	Annual	Annual	Annual	Annual	DoH, health care academics
	Ensure rapid and easy access to post occupational exposure services, including testing and PEP, and [illegible]	80%	90%	100%	100%	100%	DoH, private health care sector
	Enforce the implementation of infection control in all formal health care facilities	80%	100%	100%	100%	100%	DoH
	Promote the implementation of infection control in informal settings	Develop and disseminate promotional strategy and materials	Annual	Annual	Annual	Annual	DoH, NGOs

Ensure safe supplies of blood and blood products (HIV screening tests for measuring both virus and antibodies)	Continuously update guidelines for ensuring safe blood and blood supplies	Annual	Annual	Annual	Annual	Annual	DoH, Blood Bank, academics
	Screening of all blood supplies with best available technology including viral detection	100%	100%	100%	100%	100%	DoH, Blood Bank, academics
	Awareness of risk of HIV transmission in donors and recipients	100%	100%	100%	100%	100%	DoH, Blood Bank, academics

PRIORITY AREA 2: Treatment, Care and Support

The target is to provide an appropriate package of treatment, care and support services to 80% of HIV positive adults and children as well as their families by 2011 in order to reduce morbidity and mortality as well as other impacts of HIV and AIDS.

GOAL 6: INCREASE COVERAGE OF VOLUNTARY COUNSELLING AND TESTING AND PROMOTE REGULAR HIV TESTING

Objective	Intervention	5 year target					Lead Agencies
		2007	2008	2009	2010	2011	
6.1 Increase access to VCT services that recognise diversity of needs	Implement provider-initiated VCT in all health settings, with a special focus on STI, TB, antenatal, familiy planning and general curative services	50% of all health facilities in country (public, private, NGO, FBO)	60% of all health facilities in country (public, private, NGO, FBO)	70% of all health facilities in country (public, private, NGO, FBO)	80% of all health facilities in country (public, private, NGO, FBO)	80% of all health facilities in country (public, private, NGO, FBO)	DOH, All sectors
	Develop standards and career pathways for counsellors as mid-level workers according to the National Qualifications Framework	Draft Policy developed	Final Policy ratified and approved by relevant decision making bodies	20% of VCT counsellors received accredited training	50% of VCT counsellors received accredited training	80% of VCT counsellors received accredited training	DOH, DSD, DPW, JIPSA SETA
	Increase the number of adults who have ever had an HIV test, with a focus on men	25%	35%	50%	60%	70%	DOH, Youth sector & other All sectors

6.2 Increase uptake of VCT	Increase the proportion of adults tested in the last 12 months	6%	11%	18%	22%	24%	DOH, Youth sector & other All sectors
	Increase the proportion of newly diagnosed HIV positive adults accessing wellness services	20%	35%	50%	65%	75%	DOH,DPLG, communities, All sectors

GOAL 7: ENABLE PEOPLE LIVING WITH HIV TO LEAD HEALTHY AND PRODUCTIVE LIVES

Objective	Intervention	5 year target					Lead Agencies
		2007	2008	2009	2010	2011	
7.1 Scale up coverage of the comprehensive care and treatment package	Review and update clinical and programmatic guidelines for the management of HIV and AIDS	Annually	Annually	Annually	Annually	Annually	DOH, communities, NGOs, All sectors
	Improve enrolment in and quality of positive living interventions through wellness programmes	**30% eligible clients enrolled in wellness porgrammes**	40%	50%	60%	75%	
	Increase the proportion of adults started on ART who are still on ART after completing one year treatment	85%	85%	85%	85%	85%	
	Increase the number of adults starting ART	120,000 (24% new AIDS cases)	180,000 (35%)	285,000 (55%)	370,000 (70%)	420,000 (80%)	
	Increase the proportion of adults started on ART outside hospital setting	30%	40%	50%	60%	70%	
	Increase the proportion of adults started on ART by nurses	10%	20%	40%	50%	60%	
7.2 Increase retention of children and adults on ART	Increase proportion of adults on ART monitored by nurses	20%	40%	50%	60%	70%	

	Maintain the percentage of people on ART with undetectable viral loads after completing one year of treatment	80%	80%	80%	80%	80%	

Objective	**Intervention**	**5 year target**					**Lead Agencies**
		2007	**2008**	**2009**	**2010**	**2011**	
	Actively trace people on ART who are more than a month late for a clinic/pharmacy appointment	60% of defaulters	70% of defaulters	80% of defaulters	85% of defaulters	85% of defaulters	DOH; communities, NGOs, All sectors
	Implement facility and community based adherence support strategies and programmes	100% sub-districts	100% sub-districts	100% sub-districts	100% sub-districts	100% sub-districts	
	Ensure effective linkage and successful referral between ART facilities and social welfare services	30% of facilities	40% of facilities	60% of facilities	80% of facilities	90% facilities	

7.3 Ensure effective management of TB / HIV co-infection	Screen adult TB patients for HIV and HIV positive adults for TB	40%	60%	80%	90%	90%	DOH; communities, private sector; NGOs; CBOs
	Improve CD4 monitoring of TB/HIV co-infected patients	25%	60%	75%	90%	100%	
	Increase percentage of TB/HIV co-infected adults receiving cotrimoxazole	10%	15%	25%	35%	40%	
	Increase the proportion of eligible clients started on INH prophylaxis	10%	15%	25%	35%	40%	

7.4 Improve quality of life for children and adults with HIV and AIDS requiring terminal care	Provide a comprehensive package of a palliative care to eligible children and adults	200,000	250,000	250,000	250,000	225,000	DOH; DSD; private sector; communities NGOs; CBOs
7.5 Strengthen the health system and remove barriers to access	Build the capacity of health workers to provide comprehensive care, treatment and support	45% of PHC staff	55%	70%	80%	90%	DOH; other departments; private sector; NGOs; CBOs
	Improve drug supply management to decrease the number of facilities experiencing drug stock-outs	<5%	<2%	0%	0%	0%	DOH, private sector
	Increase the proportion of facilities with acceptable turn around times for essential laboratory tests	70% of facilities	80% of facilities	90% of facilities	100% of facilities	100% of facilities	DOH, NHLS