

BROAD FRAME-WORK FOR
HIV & AIDS and STI STRATEGIC PLAN FOR
SOUTH AFRICA,
2007-2011

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health

Department:
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The HIV and AIDS and Sexually Transmitted Infections (STI) Strategic Plan for South Africa 2007-2011 flows from the National Strategic Plan (NSP) of 2000-2005 as well as the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment. It represents the country's multi-sectoral response to the challenge with HIV infection and the wide-ranging impacts of AIDS.

This NSP seeks to provide continued guidance to all government departments and sectors of civil society, building on work done in the past decade. It is informed by the nature, dynamics, character of the epidemic, as well as developments in medical and scientific knowledge. An assessment of the implementation of the NSP 2000-2005 has been useful in defining the capacities of the implementing agencies.

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

This process started with a rapid assessment of the implementation of the NSP 2000-2005. In September 2006, a report of the assessment highlighted the following findings:

- | All stakeholders embraced the NSP 2000-2005 as a guiding framework.
- | It served to broaden the involvement of agencies beyond the Department of Health and gave rise to establishing and expanding key programmes such as health education, voluntary counseling and testing (VCT), prevention of mother-to-child transmission (PMTCT), and antiretroviral therapy (ART).
- | However, stigma and discrimination remain unacceptably high and this has been a deterrent to the use of some of the services.
- | Also, implementation of programmes tended to be vertical, with some serious capacity deficits, especially in the previously disadvantaged rural communities.
- | The two major weaknesses of the NSP 2000-2005 were poor co-ordination at the level of SANAC, as well as lack of clear targets and a monitoring framework.

Some key recommendations were:

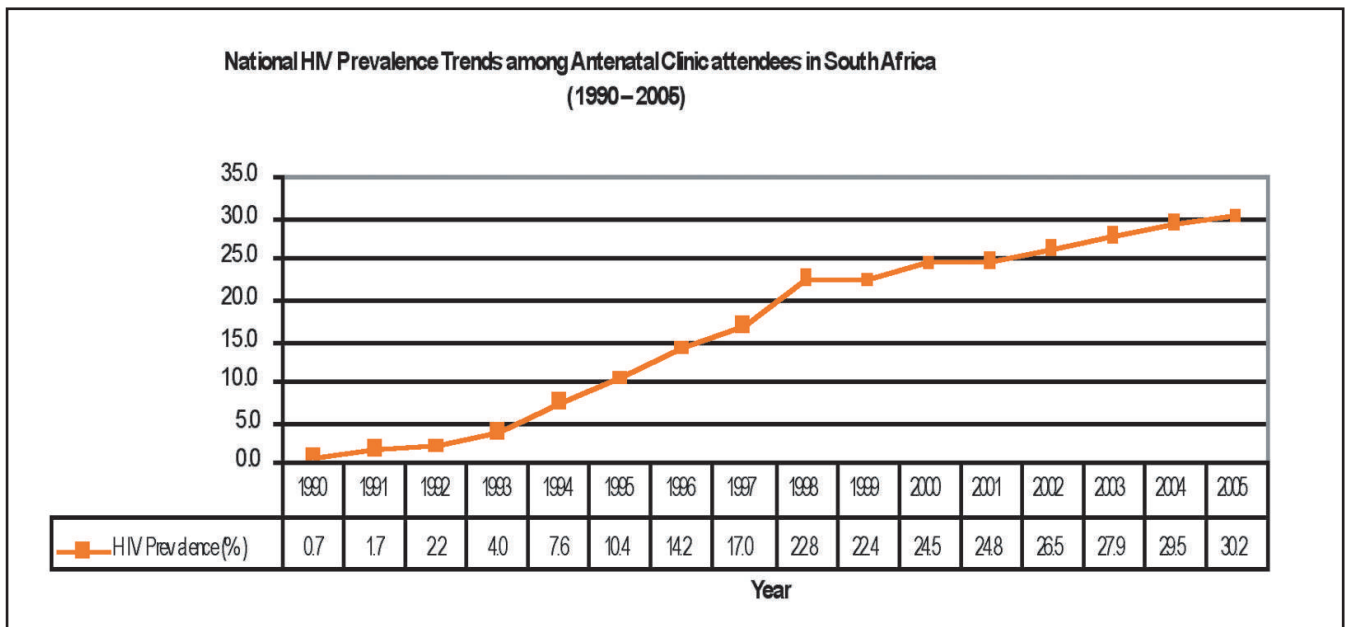
- | A need for a revision of the behaviour change approaches
- | Strengthen government implementation
- | Consolidate and build existing partnerships
- | Strengthen co-ordination, monitoring and evaluation at the level of SANAC
- | Increase the contribution of the business sector, especially regarding small, medium and micro enterprises
- | Make all interventions accessible to people with disabilities.

HIV and AIDS is one of the main challenges facing South Africa today. It is estimated that of the 39,5 million people living with HIV worldwide in 2006, more than 63% are from sub-Saharan

Africa. About 5,54 million people were estimated to be living with HIV in South Africa in 2005, with 18,8% of the adult population (15-49) affected. Women are disproportionately affected; accounting for about 55% of HIV-positive people. Women in the age group 25-29 are the worst affected with prevalence rates of up to 40%. For men the peak is reached at older ages, with an estimated 10% prevalence among men older than 50 years. HIV prevalence among younger women (<20 years) seems to be stabilising, at about 16% for the past three years.

There are geographic variations with some provinces more severely affected. These differences also reflect background socio-economic conditions as demonstrated by the district level HIV-surveillance data in the Western Cape. In this province in 2005, the average was the lowest in the country at 15,7%, but two metropole health areas of Khayelitsha and Gugulethu/Nyanga registered prevalence rates of 33,0% and 29,0% respectively, high above the national average. People living in rural and urban informal settlements seem to be at highest risk for HIV infection and AIDS.

Figure 1: National HIV prevalence trends among antenatal clinic attendees in South Africa: 1990-2005



Source: Department of Health, 2006

Although the rate of the increase in HIV prevalence has in past five years slowed down, the country is still to experience reversal of the trends. There are still too many people living with HIV, too many still getting infected. The impact on individuals and households is enormous. AIDS has been cited as the major cause of premature deaths, with mortality rates increasing by about 79% in the period 1997-2004, with a much higher increase in women than in men. Children are a particularly vulnerable group with high rates of MTCT as well as the impacts of ill-health and death of parents, with AIDS contributing about 50% to the problem of orphans in the country. Household

level impacts are the most devastating effects of HIV and AIDS in the country. Increases in maternal and childhood mortality are some of the devastating impacts, threatening the country's ability to realise the millennium development goals targets of 2015.

The South African HIV and AIDS epidemic is defined as a generalised one, with ability to propagate on its own in the general population if unchecked. The vulnerable groups and the factors involved have been discussed, but some groups (commercial sex workers, men who have sex with men, commercial migrants, refugees, intravenous drug users and others), may be at higher risk than the general population.

While the immediate determinant of the spread of HIV relates to **behaviours** such as unprotected sexual intercourse, multiple sexual partners and some biological factors such as STIs, the fundamental drivers of this epidemic in South Africa are the more deep-rooted institutional problems of poverty, underdevelopment and the low status of women, including gender-based violence, in society.

Closely linked to HIV and AIDS is the Tuberculosis (TB) epidemic. The increase in the past few years of incidence and mortality from TB and recently the emergence of the extreme drug-resistant TB (XDR-TB) has been linked to a considerable extent to immune suppression caused by HIV and AIDS. Once more, poverty and an underdeveloped district health system are the other important factors in this regard. Double stigma associated with dual infection with TB and HIV has become a deterrent to health-seeking behaviours among many South Africans. The effective management of dual infections relies heavily on community-based interventions.

The reversal in the prevalence of syphilis among pregnant women in the past five years is an indication of the gains from the introduction of syndromic management of STIs in 1995 as well as the introduction of the primary healthcare system. The main hurdles with STI control relate to the management of 'partners', emergence of resistant strains of some bacteria, as well as the importance of viral STIs in the spread of HIV.

All of this demands intensification of the multisectoral national response to HIV and AIDS. It calls for a better co-ordination and monitoring. The NSP will need to recognise and address the special needs of people with disabilities.

The NSP 2007-2011 was developed through an intensive and inclusive process of drafting, collection and collation of inputs from a wide range of stakeholders; through e-mails, workshops and meetings. SANAC had an opportunity to interrogate the drafts on three occasions.

The national multisectoral response to HIV and AIDS is managed by different structures at all levels. Provinces, local authorities, the private sector and a range of community-based organisations (CBOs) are the main implementing agencies. Each government department has a focal person and team responsible for planning, budgeting, implementation and monitoring HIV and AIDS

interventions. In this plan, communities are targeted to take more responsibility and to play a more meaningful role.

Cabinet is the highest political authority, and the responsibility of dealing with common HIV- and AIDS-related matters has been deferred to the InterMinisterial Committee on AIDS (IMC) composed of eight Ministries. SANAC is the highest national body that provides guidance and political direction, as well as support and monitoring of sector programmes. The newly formed SANAC will operate at three levels, namely:

- | High-level council – the actual SANAC, chaired by the Deputy President
- | Sector level – with sectors taking responsibility for their own organisation, strategic plans, programmes, monitoring and reporting to SANAC
- | Programme-level organisation – led by the social cluster.

The Health Ministry is an ex officio member at all of these levels; with the National Health Council that is chaired by the Minister, being the policy-making body for the health sector. The Directors-General of the social cluster are organised to ensure integrated implementation of the relevant government programme of action. The HIV and AIDS and STI Cluster of the Department of Health has its central role as bringing to the attention of the above bodies, all the NSP-related matters. Implementing agencies should, as far as it is possible, and dictated by their idiosyncrasies, establish structures to ensure effective execution of the outlined objectives. In most cases these structures are in place but may require strengthening in one way or the other.

The principles upon which the NSP 2007-2011 is premised are the following:

- | All government departments and civil society sectors shall be involved in the fight against HIV and AIDS
- | Government shall take crucial responsibility for education, healthcare and welfare of all the people of South Africa
- | HIV- and AIDS-competent communities shall form the essential unit of effective programme implementation
- | Special focus will be given to the vulnerable state of children, women, people with disabilities, people living with HIV and AIDS and other marginalised groups so that they do not suffer discrimination
- | There shall be meaningful involvement of people living with HIV and AIDS at all levels of the national response
- | All interventions shall be evidence-based and sensitive to culture, religion, age, gender, language and social circumstances of the people at all times
- | Stigma and discrimination based on fear and misinformation as well as disrespect for human rights shall be addressed
- | Social mobilisation and the national movement on moral regeneration and values promotion shall be strengthened to support sustainable behaviour change

- I Strengthening the national health and social systems as well the systems of non-governmental organisations, faith-based organisations, CBOs, and the private sector is central to effective implementation
- I All interventions shall be subject to monitoring and evaluation through a formal framework
- I No credible, evidence-based, costed HIV and AIDS and STI Strategic Plan should be unfunded. Predictable and sustainable financial resources shall be made available, mainly by government, but also by business and donor agencies, guided by the prescripts on the Plan
- I All necessary commodities shall be made available and affordable in an equitable manner. This refers to the whole chain of manufacturing and procurement.

The two broad aims of the NSP 2007-2011 are:

- n To reduce the number of new infections (especially among young people in the 15-24 age group. The future course of the epidemic hinges in many respects on the behaviours young people adopt or maintain, and the contextual factors that affect those choices)
- n To reduce the impact of HIV and AIDS on individuals, families, communities and society.

The four key priority areas are:

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

Key Priority Area 1: Prevention

Reduce by 50% the rate of new HIV infections by 2011. The intention is to ensure that the large majority of HIV-negative South Africans remain HIV negative.

1. Reducing vulnerability through:

- a. Poverty eradication
- b. Women empowerment, including reducing the rate of gender-based violence
- c. Accelerated development.

2. Reducing the rate of sexual transmission through:

- a. Use a wide range of communication modalities to improve health-seeking behaviour and adoption of safe sex practices
- b. Ensure that a large proportion of youths (14 to 17 years of age) delay the initiation of sex
- c. Reducing incidence rates among high risk and other marginalised groups (commercial sex workers, men who have sex with men, economic migrants, refugees and other mobile populations, intravenous drug users and others)
- d. Strengthening the implementation of workplace programmes
- e. Improve access to and use of male and female condoms
- f. Increase access to a comprehensive package for the management of sexual assault

- g. Ensure effective management and control of STIs in the public and private health sectors
 - h. Reduce the spread of HIV through prevention programmes for people living with HIV
 - i. Ensure adequate access to all relevant services for youths 15-24
- 3. Reduce the rate of HIV incidence among children < 5 years through the PMTCT programme**
- a. Increase PMTCT coverage by increase geographic access as well as uptake by pregnant women
 - b. Minimise the risk of HIV transmission and maternal mortality through providing ART for eligible pregnant women
- 4. Minimise the risk of HIV transmission from accidental occupational exposure through adherence to infection-control procedures and provision of post-exposure prophylaxis according to national guidelines**
- 5. Reduce the risk of blood transmission by ensuring provision of safe blood and blood products for medical use as well as reduce the risk among intravenous drug users.**

Key Priority Area 2: Treatment, Care and Support

Reduce HIV and AIDS morbidity and mortality as well as its socio-economic impacts by providing appropriate packages of treatment, care and support to 80% of HIV positive children and adults and their families.

- 1. Improve HIV screening and diagnosis through VCT among the 15-49 as well as early diagnosis for HIV exposed infants
 - a. Increase geographic access as well as uptake of VCT
 - b. Expand access to PCR testing for infants
- 2. Improve the health outcomes of asymptomatic HIV-positive adults and children
 - a. Facilitate the strengthening of the public health system, particularly the District Health System
- 3. Improve the health outcomes of symptomatic HIV-positive adults and children
 - a. Ensure effective management of the TB/HIV dual epidemics
 - b. Reduce morbidity and mortality from HIV and AIDS in adults and children (ART, nutrition, cotrimoxazole, management of opportunistic infections)
- 4. Mitigate the impact of HIV and AIDS on individuals, families and communities
 - a. Build and support HIV and AIDS competent communities in most at risk local municipalities
 - b. Strengthen the implementation of community-home-based care services and palliative care as part of the Expanded Public Works Programme

- c. Strengthen the implementation of social safety network programmes for orphans and vulnerable children
- d. Mainstream the provision of treatment, care and support programmes for youths, people living with HIV, older persons, and people with disabilities and their families.

Key Priority Area 3: Research, Monitoring, and Surveillance

The NSP 2007-2011 recognises monitoring and evaluation (M&E) as an important policy and management tool. HIV and AIDS research is a fairly new field and research is underway.

1. Develop and implement an M&E framework for the NSP 2007-2011
2. Support scientific research on promising interventions like microbicides, male circumcision, vaccines and others
3. Conduct operational research to improve the efficiency in implementation and effectiveness of programmes
4. Conduct policy research to keep up with scientific developments, e.g. acute retroviral diseases, traditional medicines, ART, nutrition, PMTCT and other areas
5. Conduct regular surveillance to monitor impacts and relevance of interventions.

Key Priority Area 4: Human and Legal Rights

Stigma and discrimination continue to present challenges in the management of HIV and AIDS. This priority area seeks to mainstream these in order to ensure conscious implementation programmes to address them.

1. Creating an appropriate social environment for acceptance and openness for people living with HIV
2. Monitoring human rights abuses and enforce mechanisms for redress
3. Ensure adherence to legislation and policy relating to HIV and AIDS

The NSP 2007-2011 highlights the need to focus on the youth aged between 15 and 24 as a special target group. It is envisaged that challenges with human and financial resources shall be addressed in order to gradually realise the ambitious targets of this plan.

Once finalised, government departments and sectors of civil society are expected to use this as the framework for the development of tailored strategies and operational plans. Work on costing of the plan is underway and the principle of predictable and sustainable funding for credible and evidence shall be upheld. Structural arrangements, capacity-building, as well as communication strategies are part of the management processes outlined. In conclusion, this NSP is seen as a dynamic document that is subject to regular critical review that will be undertaken at different levels. It is hoped that when all partners pull together to

scale up to universal access to all the identified interventions, guided by this NSP, led by SANAC, and with technical support from the Ministry of Health, the goals of reduction of the rate of new HIV infections and the impacts of AIDS can be realised.

Many individuals and organisations have participated in the development of the NSP 2007-2011. A list of all those involved will form part of the final document, which shall be adopted by the new SANAC in March 2007. However, our thanks go to all who took time and effort to ensure that South Africa has a National Strategic Plan that seeks to guide the national response to one of the most important challenges facing our new democracy.