

**Table 10: Number of sexual partners**

Percentage of men aged 15-59 and women aged 15-49 who have had sexual intercourse with two or more partners in the 12 months preceding the survey, according to background characteristics, South Africa 2003

Background characteristic	Men		Women	
	2+ partners	Number of men	2+ partners	Number of women
<b>Age</b>				
15-19	2.8	592	2.9	1,384
20-24	9.8	525	3.7	1,239
25-29	8.7	424	4.0	1,017
30-34	5.7	347	2.3	925
35-39	1.1	341	1.3	997
40-44	1.0	326	1.3	817
45-49	0.0	226	0.6	662
50-54	3.1	185	na	na
55-59	0.0	152	na	na
<b>Residence</b>				
Urban	4.7	2,259	2.4	4,871
Rural	3.6	859	2.7	2,170
<b>Population group</b>				
African	5.0	2,525	2.8	5,801
Coloured	1.8	269	1.5	682
White	2.3	251	1.1	415
Asian	3.2	68	0.5	141
<b>Total</b>	<b>4.4</b>	<b>3,118</b>	<b>2.5</b>	<b>7,041</b>

na = Not applicable

Source: SADHS 2003

**Table 11: Multiple Sexual Partnerships over the past 12 months by characteristics of respondents, South Africa 2005**

Variable	Male			Female		
		One Partner	>one partner		One Partner	>one partner
	n	%	%	n	%	%
Age						
15-24	984	72.0	28.0	1422	92.8	7.2
25 – 49	2095	84.4	15.6	3253	96.7	3.3
50+	814	87.6	12.4	745	97.1	2.9
Total	3893	82.4	17.6	5420	95.8	4.2

Source: HSRC, .2005 South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005. Cape Town: HSRC Press

Table 12 shows HIV prevalence rates among respondents who were sexually active within the last 12 months in relation to the number of partners they have. Although a higher HIV prevalence (20.6%) was reported for respondents who reported that they have more than one sexual partner as compared to those with one partner (16.3%), the difference in HIV prevalence was not significant.

**Table 12: HIV prevalence and number sexual partners in the last 12 months among respondents 15 year and older**

Number of partners	n	HIV+%	95%CI
1 partner	6284	16.3	14.7-18.0
More than 1 partner	518	20.6	15.6-26.6

#### 4.8.2. Percentage of young people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sex partner

Young people: condom use with non-regular partner

The 2003 SADHS results in Table 13 indicate that almost 40 percent of women who had a sexual encounter Only 15 percent of women say they use condoms with their husbands or live-in partners, while 47 percent say they used a condom the last time they had sex with a non-cohabiting partner.

**Table 13: Use of condoms**

Among women 15-49 who had sexual intercourse in the 12 months preceding the survey, the percentage who ever used condoms, and percentage who used condoms during last sexual intercourse, according to type of partner and background characteristics, South Africa 2003

Background characteristic	Ever used condom	Number	Used condom during last sex					
			Used with spouse	Number	Used with non-spouse	Number	Used with any partner	Number
<b>Age</b>								
15-19	49.0	505	(11.1)	26	50.1	478	48.1	505
20-24	50.8	913	20.4	138	53.8	774	48.8	913
25-29	45.4	835	16.3	299	45.9	533	35.2	835
30-34	37.4	765	15.9	427	37.0	337	25.1	765
35-39	30.9	820	14.2	482	42.5	334	25.7	820
40-44	25.0	648	16.6	403	41.0	243	25.7	648
45-49	24.1	420	12.1	299	36.6	120	19.1	420
Total	38.6	4,906	15.4	2,072	46.5	2,819	33.3	4,906

Note: Figures in parentheses are based on 25-49 unweighted cases.

Source: SADHS 2003

Younger women, those in KwaZulu-Natal, and especially, those with more education are also more likely than other women to have used condoms.

#### 4.8.3 Condom use during last sexual encounter in last 12 months

Table 14 summarises proportions of respondents who had sex in the last year who used a condom during their last sexual intercourse. Almost 60 percent both females and males used a condom during the last sexual intercourse. The large majority of respondents who were youth, Africans, with multiple partners, and living in Rural Informal areas were more likely to use a condom in the past 12 months than their corresponding counterparts.

There were lower levels of condom use among those aged over 50 years of age group (25.2% for males and 18.7% for females).

**Table 14: Condom use during the last sexual intercourse by characteristics of respondents**

VARIABLE	MALE		FEMALE	
	n	%	n	%
Age (Years)				
15-24	837	84.8	1062	73.0
25-49	1312	53.4	1610	55.3
50+	290	25.2	204	18.7
<b>TOTAL</b>	<b>2439</b>	<b>59.5</b>	<b>2876</b>	<b>59.0</b>

Source: HSRC, 2005 South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005. Cape Town: HSRC Press

#### **.8.4 Summary findings from computed UNGASS indicator NPBI-8: “Young people’s condom use with non-regular partner”**

The proportion of young people (15-24 years old) using condoms during sexual intercourse with a non-regular partner is reported in Table 15. Similar proportions were reported for condom use with a non-regular partner among people living in urban and rural areas when analyzed separately for males, females and both sexes. A higher proportion of urban males (64.4%) reported condom use with a non-regular partner than all young people living in urban areas (55.1%). A similar pattern was observed for rural males (62.9%) when compared to all young people living in rural areas (52.8%). The converse was seen for females where the proportion of females living in urban areas (42.7%) that used a condom during sex with a non –regular partner was lower than all young people living in urban areas (55.1%). A similar pattern of condom use was observed when comparisons were made between males (63.7%), females (41.8%) and all young people (52.7%).

#### **4.8.5 HIV prevalence and condom use with a non-regular partner among respondents**

Table 15 shows HIV prevalence rates among respondents who were sexually active within the last 12 months and their condom use. HIV prevalence was higher in condom users than in non-condom users. However, the interpretation of this seemingly paradoxical finding should take into consideration the fact that condom use was also strongly associated with multiple sexual partners. Having multiple partners was associated with higher HIV prevalence as was shown earlier. Therefore, sexual activity (number of sexual partners) likely operates as a possible confounder in the correlation between condom use and HIV prevalence.

**Table 15: HIV prevalence and condom use with a non-regular partner among respondents**

Used condom the last time you had sex with non-regular partner?			
Response	n	HIV+%	95%CI
Yes	473	18.2	13.4-24.3
No	605	14.0	10.48-18.5

#### 4.8.6 Percentage of young women and men who have had sex before the age of 15

The South African Behavioural Surveillance Survey (BSS) Baseline Survey 2003 indicated that by the age of 15 years, a quarter of the respondents had experienced first sexual intercourse. More than half (54%) of the population are sexually experienced by the age of 17 and by the age of 20, as many as 90% are sexually experienced (Department of Health, 2003).

It was found the overall median age at first sex for the youth aged 15 to 24 years as a group in HSRC study was 17 years for both sexes. This result is consistent with that of the South African Behavioural Surveillance Survey (BSS) Baseline Survey 2003

**Table 16: Youth persons ever had sexual intercourse**

Age group (years)	Male	Female	Both Sexes	Source
12-19	50.7	42.7	46.3%	SABSS 2003
20-24	79.3	72.3	75.1	SABSS 2003
15-24	53.9	62.3	57.9	HSRC, 2005

HSRC reported that the 'South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey' found very few children in the 12-14 year age group reporting engaging in sexual activities. Almost three-fifths (57.9%) of youth had ever sex. A higher proportion of females (62.3%) as compared to males (53.9%) reported ever having had sex. There was little variation between males and females in their sexual experience when examining each age as over half of each sex had had sex by the age of 18 years.

## 5. IMPACT INDICATORS

### 5.1 Reduction of HIV prevalence

#### Indicator : Percentage of Young People Aged 15 –24 years who are HIV infected

The “Mid-Year Population Estimates, South Africa, 2005” (Stats SA, May 2005) estimated the number of young people aged 15 –24 years to be 9.5 million in 2005, representing 20.30% of the total South African population.

**Table 17: 2005 Mid-year population estimates of young people aged 15 –24**

Age group	RSA		Total
	Male	Female	
15-19	2,450,900	2,447,200	4,898,100
20-24	2,334,600	2,286,600	4,621,200
15-24	4,785,500	4,733,800	9,519,300
<b>Total RSA pop</b>	<b>23,070,300</b>	<b>23,817,900</b>	<b>46,888,200</b>
% of national population aged 15 -24			20.30

Source: Statistics South Africa (2005) Mid-year estimates

The Department of Health estimates HIV prevalence based on blood samples taken from pregnant women attending antenatal clinic. The antenatal survey provides the best available estimates of HIV infection. HIV prevalence of young people aged 15 to 19 and also the 15 to 24 year age groups gives a fairly good estimate of relatively recent trends in HIV infection.

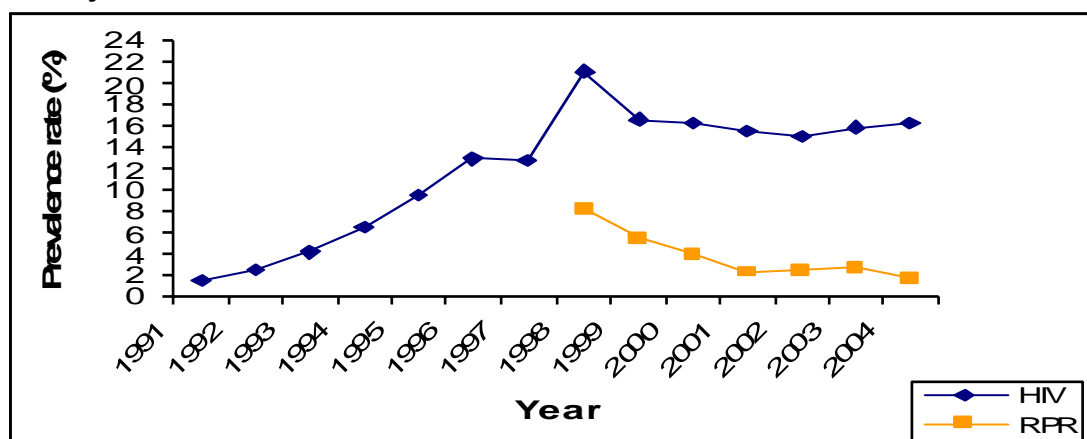
Table 18 shows HIV infection by age among women aged 15 to 20 year age group. This shows that new infections (HIV incidence has stabilized and may be declining. 24 years from the annual Antenatal Prevalence Survey from the year 2002 to 2004. It shows the number of women tested of each age (indicated in brackets) as well as the proportion of those who tested HIV positive in each age. The table shows that HIV infection increases with age indicating a higher risk among the older teenagers and women in the early twenties.

**Table 18: Annual Antenatal Survey Prevalence of HIV among pregnant women aged 15-24 years 2002 to 2004**

Age in years	2002 % HIV+	2002 No. HIV+(n)	2003 % HIV+	2003 No. HIV+(n)	2004 % HIV+	2004 No. HIV+(n)
15	7.2	10 (145)	8.5	12 (145)	10.0	16 (163)
16	8.3	32 (386)	9.4	36 (390)	9.1	37 (406)
17	11.7	73 (639)	12.5	91 (740)	12.3	79 (635)
18	16.1	153 (959)	19.1	176 (931)	19.0	163 (874)
19	18.7	188 (1036)	19.4	180 (947)	19.9	198 (1001)
20	23.4	257 (1121)	23.0	247 (1093)	25.1	255 (1033)
21	25.7	242 (955)	27.5	295 (1089)	28.5	294 (1030)
22	31.1	328 (1068)	28.1	257 (937)	31.1	311 (1016)
23	33.5	332 (1008)	36.3	409 (1142)	34.7	322 (943)
24	32.3	284 (900)	37.1	326 (891)	35.5	340 (970)
15 - 19	14.7	463 (3211)	15.8	495 (3198)	16.2	493 (3079)
20 – 24	29.1	1443 (5052)	30.3	1534 (5152)	30.8	1522 (4992)
15 – 24	23.5	1906 (8263)	24.8	2029 (8350)	25.2	2015 (8071)

Source: National HIV and Syphilis Antenatal Sero-Prevalence Survey in South Africa 2004 (Department of Health)

Figure 5 below shows HIV and syphilis trends among women aged below 20 years since 1991 for HIV and 1998 for syphilis. There has been a decline in syphilis rates among teenagers between 2003 and 2004.

**Figure 5: HIV and syphilis prevalence among Antenatal attending young women under 20 years in South Africa: 1991-2004**


Source: Department of Health (2005). National HIV and Syphilis Antenatal Sero-Prevalence Survey in South Africa 2004. Note: RPR trends by age are shown from 1998 when these data became available

Population-based national household surveys were conducted in 2001 and 2004. They found HIV prevalence rate among youth aged 15 – 24 was of 9.1% in 2004.

## .2 HIV treatment: survival after 12 months on antiretroviral therapy

Indicator - Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy.

Data on this indicator are not currently available but are expected as implementation of the programme progresses.

## 5.3 Reduction in mother-to-child transmission

Indicator – Percentage of infants born to HIV positive mothers who are infected

Using the UNGASS formula of  $\{T*(1-e)+(1-t)\}^*v$ , the percentage of infected infants born to HIV positive mothers was estimated as 23.0%.

**Table 19: Reduction in mother to child transmission**

NPBI-11-1		Reduction in mother to child transmission	
Data source: name			
Data source: type			
Data collection period (day/month/year): 01/04/2004 to 30/03/2005			
<b>Part 1:</b>			
Data requirements		%	
1. Proportion of HIV+ pregnant women provided with ARV treatment <sup>6</sup>	T		15%
2. MTCT rate in the absence of any treatment %	v		25.0
3. Efficacy of treatment provided (proportionate reduction in MTC rate)	e		0.5
<b>List below 3 most common forms of treatments provided during the last 12 months and percentages of all treatment that each represents</b>			
Nevirapine			
Cotrimoxazole prophylaxis			
<b>Part 2: Indicator computation</b>			
Indicator Score			
4. Calculate the indicator score using formula			
$\{T*(1-e)+(1-t)\}^*v = \{0.15*(1-0.5)+(1-0.15)*25\} =$			23.0
T = the proportion of HIV+ infected pregnant women provided with antiretroviral treatment was (see NPBI-4 above);			
v = MTCT rate in the absence of any treatment (Recommended default value is 25%). The Department of Health model uses a transmission rate of 30%; and			
E = efficacy of treatment provided (Recommended default values is 50%)			

There are huge challenges related to the determination of the effectiveness of this

<sup>6</sup> NPBI-4 above shows calculation of T.

programme in reducing mother to child transmission. Most of these challenges are because of very low HIV screening rates of babies born to mothers who have been identified to be HIV infected on the PMTCT programme. With testing only done at 15 to 18 months and even later for breastfed babies, the return rate for testing is very low. The Department is in the process of commissioning research for a thorough review of the national PMTCTC programme.

## **6. MAJOR CHALLENGES FACED AND ACTIONS NEEDED TO ACHIEVE THE GOALS/TARGETS**

### **Health Systems Challenges**

- Health systems challenges remain amongst the most pressing. Addressing the shortage of health personnel in the public health sector in general and in the accredited service points.
- The shortage of scarce skills including doctors, pharmacists and nurses is a major challenge facing the public health sector in South Africa.
- The programme is implemented in the context of a country that has recently emerged from institutionalised inequalities. Most of the communities are still challenged by poverty and underdevelopment.
- Ensuring implementation of the plan does strengthen health systems and improves quality of care. The implementation of the National Health
- Management Information System remains a major challenge
- Integration of the Comprehensive HIV and AIDS services within the Primary Health Care approach
- Management of African Traditional medicine (registration, training, referral systems and research)

### **Comprehensive Plan Implementation Challenges**

- A comprehensive response to HIV and AIDS requires sustainable financing that allows for progressive planning, effective implementation and continuous monitoring. This includes in the first instance mobilization of domestic resources. Where donor funding is utilised these funds need to be aligned to national priorities.
- Ensuring all monitoring and evaluation activities (public and private sectors) in the country are harmonised with and guided by the reporting schedule and indicators as contained in the Monitoring and Evaluation Framework.
- Prevention needs to remain the cornerstone of Comprehensive HIV and AIDS Plan. Communities need to continuously appreciate this and not misunderstand the role of treatment in relation to preventing or spreading infections.
- Implementation of focussed pharmacovigilance surveillance in the selected surveillance sites and improving reporting of all adverse drug reactions by health professionals
- Integration of the social mobilisation and communication aspects of the Comprehensive HIV and AIDS Plan with existing health promotion activities. The campaign on healthy lifestyle should be catalyst in attitudes and behavioural change among individuals and communities.
- Expansion of the number of accredited service points to ensure coverage at all local municipalities. More attention need to be given to expand paediatric treatment
- Ensuring that Home-Community Based Care, support groups, NGO's and others are actively involved in nutrition issues with special emphasis on HIV and AIDS.
- Ensuring that all children who are infected and affected by HIV and AIDS have access to services
- Addressing the lack of capacity in implementing the TB/HIV activities. HAST committees have been established in most of the district but most of them are not active.
- Follow-up of babies on the PMTCT programme and exclusive feeding by mothers in the programme;

### **Multi-sectoral Issues**

- Ensuring institutional coordination among the various departments that are giving assistance to people facing food and nutritional insecurity and building mechanisms to facilitate referral of individuals across programmes
- Coordination of a multisectoral response that addresses the vulnerability of HIV infection and progression to AIDS after infection. In particular PRS, gender inequality and other development programmes
- Ensuring that orphans and children made vulnerable by HIV and AIDS receive appropriate psychosocial care/support

## **7. SUPPORT REQUIRED FROM COUNTRY'S DEVELOPMENT PARTNERS**

The government has sound mechanisms for the coordination of donor activities through the International Development Cooperation unit within the National Treasury. However, due to the very high number of funding activities in HIV and AIDS, the Department of Health has established a Donor Coordination Forum to ensure that activities of development partners are geared to support the attainment of the Strategic Plan of the Department of Health as contained in the Strategic Framework 2001-2005.

There are several issues where development partners should play a significant role, especially in strengthening the programmatic capacities at provincial, district and local government level – working with both government and supporting community based initiatives.

An area that requires definite assistance is in ensuring that we capture and document good practices. Documenting good practices also plays an important role in being able to communicate efforts.

The joint efforts of government, civil society and development partners towards common goals, as expressed in the Strategic Plan, are crucial to a coordinated response to HIV and AIDS, STIs and TB in South Africa.

## **8. MONITORING AND EVALUATION ENVIRONMENT**

The Monitoring and Evaluation Framework: Comprehensive HIV and AIDS Care, Treatment and Management Plan for South Africa list a number of indicators covering all components of the plan. This M&E framework relies upon existing data collection systems including annual antenatal HIV sero-prevalence survey, National Management Care Information Systems, District Health Information Systems, Electronic TB Register, STI surveillance, demographic and behavioural Surveys to mention a few. The framework also relies upon data collected through new surveillance systems including focused pharmacovigilance surveillance.

The implementation plan for the M&E framework is being done in a phased staggered fashion. Phase 1 which involved the collection of the selected set of 5 indicators. This has been largely paper-based as the strengthening of the National Management Care Information Systems is work on progress. During this phase, a national M&E training project was conducted in all nine provinces. More than 370 persons were trained, data flow process strengthened and data collection tools were revised or designed.

### **Government funds spent on HIV and AIDS**

Ideally, a complete picture of government expenditure on the four components of HIV and AIDS should include expenditure data from all government sectors and the three spheres of government. However, expenditures are not always disaggregated by these four components. The National Treasury's Estimates of National Expenditures is the main source of expenditure information at the national level. A national HIV and AIDS health account is being explored.

### **Percentage of schools with teachers who have been trained in life-skills-based education and who taught it during the last academic year.**

The National Life skill unit responsible for coordination of HIV and AIDS life skills education has been sensitised to the importance of monitoring this indicator. It should be explored whether collection of this indicator could be done through existing data collection mechanisms of the Department of Education. The Departments of Education annually conducts a school survey.

### **Percentage of large enterprises/companies that have HIV and AIDS workplace policies and programmes.**

The Department of Public Service and Administration and Department of Labour have been sensitised to the monitoring of workplace HIV and AIDS programmes. The Department of Public Service Administration is responsible for the monitoring of workplace HIV and AIDS programmes in the public sector. The South African Business Coalition on HIV/AIDS conduct regular surveys on the implementation of the workplace programme in a sample of private companies across all sectors of the economy.

Planning for the Workplace survey should involve the Interdepartmental Committees on HIV and AIDS, SANAC, Department of Public Service And Administration, Department of Trade and Industry, Department of Labour, South African Business Coalition on HIV and AIDS, organised Labour and Business. The workplace survey will require funding.

**Percentage of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT**

This indicator will be sourced from the PMTCT programme monitoring data. Attention is currently given to ensuring that good quality data and improving its collection.

**Percentage of patients with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled**

This indicator uses observation tool to collect the data through the facilities survey. It was not feasible to incorporate this component to the fieldwork for the 2003 Biennial Facilities Survey, which commenced at the beginning of March 2003. This Biennial Facilities survey is conducted at mainly primary care clinics and community health centres.

The next biennial facilities survey should incorporate to the observation tool to collect information on the patients with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled.

**Percentage of people with advanced HIV infection receiving ARV combination therapy**

It is difficult to collect data on the percentage of the people who are on ARVs. At the time of the production of the progress report the Department of Health and National Treasury had set up a task team to investigate the cost implications of public sector provision of Antiretroviral therapy.

**Percentage of respondents 15-24 years of age who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention**

As in the 1998 SADHS, this indicator will remain as part of this survey. In addition the biennial risk behavioural survey as envisaged will also be important source of monitoring data for this indicator.

**Percentage of people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner.**

As in the 1998 SADHS, this indicator will remain as part of this survey. In addition the biennial risk behavioural survey will also be important source of monitoring data for this indicator.

**Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV (*where applicable*)**

Not applicable in South Africa – injecting drug use is not a major mode of transmission.

Ratio of orphaned to non-orphaned children 10-14 years of age who are currently attending school. As in the 1998 SADHS, this indicator will remain as part of this survey.

**Percentage of young people aged 15-24 years of age who are HIV infected**

Data for this indicator is collected through the annual HIV sero-prevalence surveys. The

only limitation is that the survey is done on pregnant women. Various initiatives are currently discussed to ensure collection of population based prevalence data.

**Percentage of infants born to HIV infected mothers who are infected**

The annual HIV sero-prevalence survey provides estimates of the number of children born with HIV.

According UNGASS guidelines, the determination of the percentage of infants born to HIV mothers who are infected depends on the availability of reliable data on number of women on the MTCT programmes well as efficacy rate of the MTCT programme. One of the major challenges is follow up of women and infants who were on the MTCT programme.

**ANNEX 1**

<b>Strategic Plan</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
1. Multisectoral strategic plan to combat HIV/AIDS			
2. Country integrated HIV/AIDS into general development plan			
3. Functional multisectoral HIV/AIDS management/coordination body			
4. Functional national HIV/AIDS body for interaction among government, the private sector and civil society			
5. Functional HIV/AIDS body for coordination of civil society organisation			
6. Impact evaluation of HIV/AIDS on its socio-economic status for planning purposes			
7. HIV/AIDS Strategy for national uniformed services (armed and civil defence forces)			
<i>Index for Strategic plan</i>			
<b>Prevention</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
1. Policy or strategy on information, education and communication			
2. Policy or strategy on reproductive and sexual health education for young people			
3. Policy or strategy on IEC and other health interventions for groups with high or increasing rates of HIV infection			
4. Policy or strategy that promotes IEC and other interventions for cross-border migrants			
5. Policy or strategy to expand access, including among vulnerable groups, to essential preventive commodities			
6. Policy or strategy to reduce Mother-to-child HIV infection			
<i>Policy Index for Prevention</i>			
<b>Human Rights</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
1. Laws and regulations that protect against discrimination of people living with HIV/AIDS			
2. Laws and regulations that protect against discrimination of people identified as being especially vulnerable to HIV/AIDS			
3. Policy to ensure equal access for men and women to prevention and care, with emphasis on vulnerable population			
4. Policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed by ethics committee			
<i>Policy Index for Human Rights</i>			
<b>Care and Support</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>

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1. Policy or strategy to promote comprehensive HIV/AIDS care and support, with emphasis on vulnerable groups

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2. Policy or strategy to ensure access to HIV/AIDS related medicines, with emphasis on vulnerable groups

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3. Policy or strategy to address the additional needs of orphans and other vulnerable children

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*Policy Index for Care and Support*

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***Composite Policy Index***

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