REPUBLIC OF SOUTH AFRICA:
PROGRESS REPORT ON DECLARATION OF COMMITMENT ON HIV AND AIDS

Prepared for:

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FOREWORD

The Republic of South Africa; as a Member State of the United Nations and signatory of the Declaration of Commitment on HIV and AIDS, has made much progress since the last report in 2003 on scaling up interventions to reduce the rate of HIV infection and mitigate the impact of AIDS.

The National Multisectoral HIV and AIDS Strategy, which has been in place since 2000, was implemented with much vigor during the period. A five-year Comprehensive Plan, developed in order to enhance the response so that prevention remains the focus, to ensure the integration of nutrition and food security, to introduce a range of medical interventions and strengthen the health care delivery system, and intensify research and development in indigenous knowledge systems is currently being implemented.

It needs to be noted that the greatest challenge in responding to the problem of HIV and AIDS is the country is lack of reliable and accurate information on a range of relevant issues. Even with this constraint, South Africa has committed resources to ensure that more than 90% of programme interventions are funded through Government fiscus. For this Government, this principle is central to ensuring high standard, good quality and sustainable interventions are implemented.

Government, the private sector and not-for-profit private sector, led by the Health Ministry, have worked collectively towards the achievement of the outputs outlined in the report.

It is important that the context within which all of this work is done be understood. Preventing new infections for the majority of South Africans who are HIV negative takes priority as the most cost effective intervention. Delaying the progression from HIV infection to AIDS through healthy lifestyles and good nutrition is the thrust of our care, treatment and support programme. We shall continue to ensure that people with AIDS, working with them, have access to and can choose from a range of appropriate services including terminal palliative care through community based activities. Social safety-nets are in place to ensure that orphans and vulnerable children remain part of the mainstream of society. It is our aim to ensure that these services are fully integrated into the Primary Health Care System for ease of access and as a means to mitigate stigma and discrimination.

The fight against HIV and AIDS has brought South Africans from different backgrounds - the poor, the wealthy, academics, researchers, urban, rural, illiterate and many other sectors of society - together in an unprecedented manner. We shall continue to utilize this social capital as a formidable force towards victory over HIV infection and the impact of AIDS. In this regard South Africa is ready to take on the challenge of scaling up towards universal access to HIV and AIDS prevention, treatment, care and support.

Overview of the HIV and AIDS situation in South Africa

This is the second South African report to the United Nations General Assembly Special Session: Declaration of Commitment. It is important to provide the socio-political context within which the country has been responding to the spread of HIV infection and the impact of AIDS.

South Africa is a relatively new democracy, a country that is emerging from a history of social disruption, racial and gender discrimination, associated with inequitable distribution of resources affecting the majority of its peoples, as a result of Apartheid. This has resulted in a bi-modal society, which is also reflected in the spread of burden of disease within the population. Poverty related diseases including HIV and AIDS, TB and Malaria are affecting mainly the historically disadvantaged sections of the society.

The first few cases of HIV and AIDS were identified in the 1980s in the country. The absence of a positive and definitive response from the government of the time translated into a lost opportunity. It was not until leadership from the National Liberation Movement, led by the African National Congress in 1992 that there was a definitive programme to raise awareness in society. This was the period when the country was in transition from apartheid to multi-party democracy, based on a new Constitution, which recognized freedom and human rights for all. The constitution emphasized that there would be a process of progressive realization of these rights. It is in this Constitution and the National Health Act of 2005 that the right of access to health care, reproductive health and emergency medical services for all are entrenched.

The process of redressing the imbalances of the past commenced in 1994 and is progressing well and with great vigor. Several programmes to ensure access to education, health services, and reduction of poverty, provision of shelter, clean water and sanitation are the thrust of government's interventions. Growing the economy and good governance are seen as the imperatives to ensure sustained development.

Women in South Africa, and especially black women, have been at the bottom rung in terms of participation in the economic, social, and, political life of the country. They have for a long time experienced triple oppression on the basis of their class, race and gender. Some practical challenges facing women because of these three forms of oppression relate to; violence and abuse, poverty, and poor health status in general.

Since 1994, the current government has made many strides towards empowerment of women and gender equality is one of the critical elements of the transformation agenda in the country. To date, the adoption of the Constitution, the setting up of the national machinery for the promotion of gender equality, such as an Office of the Status of Women in the Presidency and provincial Premier's offices, gender units in each government department, the Commission on Gender Equality, are some of the significant strides taken. There has been deliberate effort to ensure fair representation of women (targets set at up to 50%) in decision-making positions and processes in government and in other sectors of the society. More women are making their mark and being recognised in both the public and private sector.

Women are also beginning to regain their dignity and are taking responsibility for their lives. Patriarchal attitudes are changing, with men participating in efforts to address challenges such as violence against women. Gender transformation is part of a broader transformation agenda of the country that also seeks to reduce the gap between the poor and the rich and between historically disadvantaged blacks and much more resourced white communities.

During the first ten years of democracy, much was achieved towards meeting the basic needs of shelter, clean water and sanitation, food security, the provision of health and other social services.

The country's economy has experienced a significant growth. While accelerating growth, the focus is also on sharing its benefits in terms of increased employment opportunities and more opportunities for historically disadvantaged communities to participate in the mainstream of the economy**.** The sharing of benefits of growth has become critical because the wide gap between the central actors in the economy and those at the periphery. People without the necessary skills and financial prowess are yet to experience the full benefits of this economic "boom". These are the people most at risk of infections and diseases of poverty like HIV, AIDS, and Tuberculosis. Several programmes to increase access to education, skills development, preferential procurement, are being implemented in order to minimise this gap. As these programmes begin to reduce the levels of poverty, they will contribute towards the reduction of vulnerability to these conditions.

The government's Comprehensive HIV and AIDS management programme is firmly located within and aligned to all of these development interventions. The beginning of a national coordinated response to HIV and AIDS dates back to 1992 with the formation of the National AIDS Coordinating Committee of South Africa (NACOSA). A review of NACOSA in 1997 highlighted the need for a multisectoral approach to the problem. This led to the development, through an extensive consultative process, of the National Strategic Framework for HIV and AIDS and STIs 2000-2005.

The four priority areas outlined in that framework are:

- Prevention
- Treatment Care & Support
- Legal and Human Rights
- Research, monitoring and surveillance

In 1996 a Partnership for AIDS programme was initiated whose aim was to bring together the full participation of the wide rage of partners in the HIV and AIDS arena. At the highest policy level a Cabinet Committee for AIDS was established to ensure the active participation of South Africa's highest policy making body in addressing the challenge of HIV and AIDS.

During the implementation of the South African Strategic Framework, programmes have evolved to take account of scientific developments and the availability and affordability of interventions against HIV and AIDS. Currently, the Comprehensive Plan for the Management, Care, and Treatment of HIV and AIDS guides the design and implementation of programmes.

It is therefore just over ten years that an organized response to HIV and AIDS has been implemented in South Africa. Government continues to lead the mobilization of society through formal sectoral arrangements. The South African National AIDS Council is the main but not the only mechanism for civil society engagement. A government led healthy Lifestyle Campaign stressing the importance of good nutrition, physical activity and safe sex practices while discouraging alcohol and fight against drug use and the use of tobacco is visible in the country under the leadership of the Health Minister. Every opportunity is used for communicating these health awareness messages to the South Africans.

A broad range of programme outputs on social mobilization, IEC, life-skills education for children and the youth, condom distribution, STI management, PMTCT, VCT, attests to some of the achievements towards prevention of new infections. There are systems in place to reduce risk of infection through blood transfusion. Work is being done to ensure safe intravenous drug use and infection control in health facilities to minimize the risk of occupational exposure to all blood-borne pathogens. Care, treatment and support services provided in health facilities and in the informal health sector mainly by NGOs also demonstrates the extent of the work done, driven and supported by Government. Most of these programmes are integrated into the broader primary health care system, a system that is strongly advocated for, and supported by political activists.

Through the implementation of the Comprehensive Plan, there are service points in every health district in the country for the provision of a range of interventions including prevention, nutrition, management of opportunistic infections and treatment with antiretrovirals. The investment in the health system through infrastructural upgrades, the improvement in commodity stock management, information management systems, the improved human resources management and capacity development, the strengthening of referral system, laboratory services and has been enormous.

Laboratory services for instance enjoyed upgrades from an initial start up investment of approximately US$ 12 million to the National Health Laboratory Services. This has resulted in a 51% increase in the number of CD4 performing laboratories, and increase from 7 to 10 PCR laboratories and 3 new PCR HIV testing machines in the country. Human resource and facility upgrades in diagnostics has meant that those laboratories which did not previously have capacity, have been accredited and have strengthened support to this programme and other health programmes. By the end of 2005, more than 1 067 771 CD4 tests had been performed in the context of the Comprehensive Plan.

Research to provide evidence for improving current prevention, care and management programmes are seen as critical for effective intervention in the HIV and AIDS challenge. In 1999 South Africa established the South African AIDS vaccine initiative (SAAVI) in which government entered a public private partnership initiative aimed identifying new innovations and candidate AIDS vaccines. Substantive funding (over US$ 15 million) by government and its private partner has been invested in SAAVI. No less than three new centers for pharmacovigilance have also been established to strengthen the HIV and AIDS programme as well as other health programmes.

Similarly, a center for Indigenous Knowledge Systems (IKS) has been established at the Medical Research Council and substantive investment has been made to fund and support research into African traditional medicine investigating safety and efficacy of indigenous products that may lead to alternative prevention and care options for HIV and

AIDS. The programme on African Traditional Medicines occupies an important place in the developing health services that the vast majority of the South African population can identify with. In this regard, the Traditional Health Practitioner's Act was passed in 2004. The main purpose of the Act is to regulate traditional health practices. In addition, A African Reference Centre was launched in 2003 to strengthen indigenous knowledge.

. It is one of the fundamental principles of the Comprehensive Plan that ninety percent of the programme is funded by government to ensure sustainable financing of all HIV and AIDS programmes. The Department of Health, the National Health Council (made up of the Minister and provincial MECs for Health), and Cabinet ensure that such funding is made available and monitor closely the expenditure by the implementing agencies, which are mainly provincial government departments. Expenditure on HIV and AIDS activities has increased substantially over the past five years. The annual budget allocation for this programme increased from R264 million in 2001 to R2.8 billion in 2007/08. This reflects not only government's commitment to this programme but also the increase in the scale of implementation.

1. PROGRESS REPORT ON IMPLEMENTATION OF THE UNGASS DECLARATION OF COMMITMENTS ON HIV and AIDS

In preparing this report we have followed the guidelines on construction of core indicators as outlined in the document on **Monitoring the Declaration of Commitment on HIV and AIDS: Guidelines on construction of indicators, (July 2005).** The report therefore deals with National Commitment and Action Indicators, Knowledge and Behaviour Indicators as well as Impact Indicators. Since the South African HIV and AIDS challenge is a generalised one, the report concentrates on the indicators for generalised epidemics, as outlined in the document referred to above. The report ends with a brief outline of some of the challenges the country faces in meeting the goals it has set itself. This has been provided in order to contribute towards a better understanding of what challenges members states face in implementing the UN commitments on HIV and AIDS.

1.1 NATIONAL COMMITMENT AND ACTION INDICATORS

This part of the report is divided into three sections. The first section deals with amounts of national funds disbursed by the government. Section 2 focuses on the items raised in the National Composite Policy Index. Section 3 provides information on National Programmes Indicators and the increase of the scale of the implementation of the programme as required from items 3 to 9 of the National Commitment.

1.1.1 Government funding on HIV and AIDS

Funding allocated by government to combat HIV and AIDS is an indication of sustained political commitment to fight HIV and AIDS. This is demonstrated by committing increasing resources over the years.

The report will only cover public sector spending whilst future reporting will address even private sector spending. Tools to measure national spending including the private sector are in a process of being refined. All government departments have implemented accelerated HIV and AIDS workplace programs with resources committed to achieve this objective. During the Medium term Expenditure Framework period, all government departments have recorded increased budget allocations i.e. department of health, social development, department of education, public service and administration, safety and security, correctional services and defence.

The growth of HIV and AIDS funding has focused on the following programs:

- Life skills education in schools
- Prevention programmes including social mobilisation on healthy lifestyles and Khomanani (health promotion) campaign
- Nutrition
- Voluntary counselling and testing
- Mother-to-child prevention programmes
- Syndromic management of sexually transmitted infections
- Condom distribution
- Traditional medicines
- Anti-retroviral therapy

- Home based and community based care
- Non governmental organisations
- Step down care

The Department of Health in South Africa carries a major responsibility for co-ordinating South Africa's response to HIV. Some of its activities include coordinating and implementation of the National HIV, AIDS, STI and TB programmes, the Comprehensive Plan for HIV and AIDS Care, Management and Treatment, coordinating community based care programmes, co-ordinating work done by other government departments, and initiatives such as the South African AIDS Vaccine initiative.

The South African government spending priority during 2001-2003 financial years focused primarily on committing resources towards improving the health care system to ensure accessibility to communities including, prevention activities and national program management. The comprehensive HIV and AIDS conditional grant, a grant ring fenced for provincial use on HIV and AIDS related activities, increased from R264 million during 2001/02 to R1,56 billion in 2005/06 financial years. During the current Medium Term Expenditure Framework period (three year cycle), government spending is projected to increase by 78% in real terms. Other specific HIV related expenditures include transfers and subsidies to Non governmental organisations, the South African AIDS Vaccine Initiative, Lifeline, Love Life, SADC HIV Trust, Global Fund for HIV and AIDS, TB & Malaria and the South African National AIDS Council.

Combined government spending on HIV and AIDS

Within government, the Department of Health, Department Social Development and Department of Education in particular have large programmes that deal with HIV and AIDS. Key priority programs are Community-Based Care programmes, the Co-ordinated Action for Orphans and Vulnerable Children programme and the Youth and Gender programme. The Department of Education manages the development and implementation of policies on overall wellness of educators and learners, including HIV and AIDS, and managing and monitoring the implementation of the national school nutrition programme. The specific increases to the baseline over the MTEF2005/06-2007/08 in the Department of Social Development is associated with increases in the HIV and AIDS (community-based care) conditional grant to provinces (R64 million, R60 million and R60 million and Expanding the love Life Groundbreaker partnership (R36 million, R40 million and R40 million).

Table 1: Combined government spending on HIV and AIDS in South Africa (R million)

	2002/3	**2003/4**	**2004/5**	**2005/06**	**2006.07**	**2007/08**
Dept. of Education	654780	837669	966351	1248808	1242507	1304634
Dept. of Health	454558	676230	1107408	1566302	1976920	2082949
Dept of Social Dev.	3653	3376	5245	45562	55266	56025
Dept. Science & Technology			15000	20000	15000	15750
Total	112991	1517275	2094004	2880672	3289693	3459358

It is estimated that when direct and indirect funding for HIV and AIDS programmes are taken into account expenditure by government in the 2005/06 financial year could be as high as R11b. These resources cover a wide range of prevention programs from different departments. This type of commitment by South African government reinforces the World Health Organization pledge that African countries need to accelerate funding HIV prevention programs.

The Department of Public Service Administration is responsible to implement employee health and wellness programmes that include a comprehensive strategy for the management of HIV and AIDS. This strategy supports initiatives to mitigate the impact of HIV and AIDS in the public service. The main thrust is prevention, with significant attention going to other health and wellness issues for public servants and their families. At this stage the funding on wellness program is estimated to be R92 million during the MTEF period. The Department of Science and Technology spends R10 million a year to fund research in vaccine development.

In conclusion, the Government of South African continues to demonstrate a very high level of commitment by increasing public sector funding to implement national response to the challenge of HIV, AIDS, STI and TB.

1.1.2 National Composite Policy Index (A summarised response to the NCPI is provided as Annexure 1)

As is outlined in the background to the document on the National Composite Index (NCPI) 2006, the instrument seeks to measure and assess progress in the implementation of policy, and aims to estimate the amount of effort put into the National HIV and AIDS programmes by national level governments and non-governmental organisations. South Africa's response to the questionnaire is provided in an annexure. This section of the report provides some brief detail on the responses given by expanding on some of the themes suggested by the questionnaire.

1.1.2.1 Strategic Plan and Political Support

South Africa's response to HIV and AIDS is firmly located within a strategic understanding of the broader challenges facing the country today. The South African Government has identified poverty and underdevelopment, including joblessness as the two major challenges we have to tackle as a country. All our national efforts are geared toward dealing with these two major challenges. A special emphasis is being put on ensuring that the majority of our people, who are mainly black women in rural areas do not end up being trapped in a cycle of poverty all their lives. The government has therefore adopted an approach of a developmental state, whose efforts are geared towards bettering the lives of the people through a number of state led measures to accelerate economic growth and to involve people themselves as major players in their own development.

It is this developmental perspective that informs the country's approach to HIV and AIDS. Such a developmental paradigm suggests that fundamental to the fight against AIDS should be a prevention approach, which seeks to deal with all the contextual factors that create a conducive environment for the rapid spread of the condition, while ensuring that people are encouraged, and even empowered to take steps to avoid infection. This dual perspective on prevention, which locates all efforts within both individual behaviour and contextual or environmental factors indicates the political commitment of the government

of South Africa, not to deal with HIV and AIDS in a narrow and limited manner, but to locate it firmly within the national development programme of the country. It is for this reason therefore that all the development plans of the country, since 1994, such as the Reconstruction and Development Programme (RDP), the Growth, Equity, and Reconstruction Programme (GEAR), and the recently adopted Accelerate and Shared Growth in South Africa (ASGISA) programmes have placed the development of the Health System, and the improvement of the quality of life of the people at the centre.

Informed by this perspective, the government developed a Comprehensive Plan for HIV and AIDS Care, Management and Treatment.

The South African environment is one where extensive consultation takes place in virtually in all aspects of socio, cultural and political activity. The recently passed National Health Act (2003) provides a legal framework for the establishment of a range of consultative structures. In the context of existing structures consultation regarding HIV and AIDS is taking place on an ongoing basis and is presented in this report.

South Africa's Comprehensive HIV and AIDS Strategy

The Comprehensive HIV and AIDS Care, Management and Treatment Plan for South Africa is a significant milestone both as a health sector intervention and as a socio-economic enhancement strategy.

This Plan presents a unique approach to disease management and in particular to HIV and AIDS management. It recognises the important role of preventing any further infections in South African society by laying emphasis on strengthened intervention strategies. It further recognises that a traditional approach to disease management which ignores the contextual factor, factors related to historic underdevelopment, the poor social environment and limited social facilities that confront the unwell and the healthy, is not optimal and impedes true advances in good health service provision. The Plan therefore closely integrates into to the broader social and development strategy including the Primary Health Care approach in the delivery of health care. Another important paradigm within which the Plan is conceived and developed is the reality that singular problems including HIV and AIDS can only be addressed successfully in a context where the entire health system is simultaneously being strengthened and developed to adequately sustain equitable and quality programmes.

Pillars of the Comprehensive Plan

The plan is anchored on several important pillars:

a) **A comprehensive programme that includes**:

- Ensuring that the great majority of South Africans who are currently not infected with HIV remain uninfected. The messages of **prevention** and of changing lifestyles and behaviour are therefore the critically important starting point in managing the spread of HIV and the impact of AIDS;
- Improved nutrition and lifestyle choices to ensure and enhance the health benefits of good nutrition and healthy living for those who are infected as well as those who are not infected;
- Enhancing the use of prophylaxis and treatment of opportunistic infections,

- Effective management of those HIV-infected individuals who have developed opportunistic infections through appropriate treatment of AIDS-related conditions;
- Provision of antiretroviral therapy in patients presenting with low CD4 counts to improve functional health status and to prolong life;
- Integration of traditional and complementary medicine into the comprehensive care, management and treatment programme
- Providing a comprehensive continuum of care, support and treatment
- Ensuring the realization of the principle of non-discrimination in the provision of services as a whole and in the provision of HIV and AIDS services in particular.

b) **Strengthening of the National Health System** as a whole in order to ensure the effective delivery of comprehensive HIV and AIDS care and treatment and other equally important healthcare priorities and programme. These include the improvement in laboratory services, in information systems, human resources and capacity development, drug procurements and distribution.

Main Principles of the Comprehensive Plan

The implementation of the Comprehensive Plan is guided by a number of important principles:

- **A Sustainable Programme**

There is currently no cure for AIDS. The best that an AIDS management programme can achieve is to prolong the lives of people living with HIV and AIDS, attaining the best quality of life in those circumstances, so that they can remain productive members of society. Therefore our mainstay in the fight against the spread of HIV infection and the impact of AIDS is prevention. Once people enter into a comprehensive treatment and care programme, treatment must be sustained for the rest of their lives. Within the overall stewardship role of government, the South African Government takes the view that in order to ensure the sustainability, the biggest slice of the budget for this care and treatment programme (over 90 %) should ideally come from the national fiscus. Moreover this approach serves to decrease the logistics associated with donor co-ordination which often presents a major challenge in the health field.

- **Promotion of Healthy Lifestyles**

Any health care programme must begin with promotion of healthy lifestyles, which includes physical exercise, prevention of substance abuse, promotion of good nutrition, the practice of safe sex, and effective prophylactic medical care including programmes aimed at prevention of smoking, alcohol and other substance abuse are fundamental to good health. This remains true for all people – both to prevent the spread of HIV to those uninfected, and to sustain the immune systems of HIV-positive people for as long as possible. This programme is integrated with existing health education efforts to promote the well being of South Africans.

- **Reinforcing the Key Government Strategy of Prevention**

In the absence of a cure for AIDS, prevention remains the cornerstone of the country's response to HIV and AIDS. The current range of prevention strategies includes information education and communication (IEC) activities, provision of life skills education to learners in schools and to youth out of school, provision of barrier methods, voluntary counselling and HIV testing (VCT), prevention of mother-to-child-transmission (PMTCT), post-exposure prophylaxis (PEP), and syndromic management of Sexually Transmitted Infection (STIs). Some of these strategies are critical entry points for care and treatment interventions. A key intervention is to delay sexual debut. A concerted effort has been made to increase access to health care and remove barriers to care seeking. Since 1994 health care was offered at no cost to the patient at primary health care facilities. With respect to youth, and a number of other health facilities have been declared 'youth friendly' as they have been designed to promote youth attendance.

- **Integration with Government's Development and Nutrition Strategy**

Good nutrition is essential to good health. The South African government has in place a series of programmes to improve nutrition for its people. Food fortification is significant in the improvement of nutritional status for the general population but more importantly those living with TB, HIV and AIDS and other health conditions. In the first instance ensuring food security for the vulnerable is most critical. In addition other strategies are being implemented to ensure a programme that focuses on sustainability. Nutrition supplementation where necessary, is provided to augment the work aimed at ensuring food security. The nutrition component of the Comprehensive Plan builds on this and is fully integrated with existing programmes.

- **Universal Care and Equitable Implementation**

In line with the provisions of the Constitution of the Republic of South Africa which espouses the principle of progressive realization of rights, the programme is founded upon the principle of universal access to care - universal access to basic and equitable primary health care services, management and treatment for all, irrespective of race, colour, gender and economic status. This programme attempts to address the challenge of providing services in rural and urban settings equitably without compromising the quality of care. The Comprehensive Plan aims to achieve a balance between areas that can readily implement the programme and those that need additional resources and investments to upgrade their general health capacity.

- **Strengthening the National Health System**

The strengthening of the national health system in its totality as a means to ensure the effective delivery of all health services as well as the effective and integrated delivery of comprehensive HIV and AIDS programme is a major focus of the plan. Comprehensive Plan calls for significant additional investments to improve the capacity of the national health care system, in particular the strengthening of human resource capacity, and providing incentives to recruit and retain health professionals in historically underserved areas. The Comprehensive Plan is reinforcing efforts to upgrade health care management information system, to improve patient tracking and referral mechanisms, and to continue with the upgrading and/or refurbishing of public hospital, community health centres and clinics, and to improve efficiency of laboratory services.

- **Quality of Care**

The plan envisions significant investments to ensure that the highest available quality of care is provided to the people of South Africa in line with international and local norms and standards. The care and treatment protocols are based on international best practice. Accreditation procedures to facilitate the provision of antiretroviral drugs help to ensure that the facilities that are approved for the provision of comprehensive care, management and treatment are of good quality and observe the highest standards of care especially in the context of the more complex clinical care requirements in provision of antiretroviral drugs.

The plan also provides for extensive investments in monitoring and research to allow for continual evaluation and improvement in the quality of care. All these efforts will ensure that the best information is available for the benefit of South Africans undergoing care and treatment.

- **Promotion of Individual Choice of Treatments**

South Africans living with HIV and AIDS will be encouraged to make their own informed choices about the types of treatment they wish to seek. A wide range of interventions and options will be provided through this comprehensive package of care. These may include advice on general health maintenance strategies, positive living, exercise, nutrition, African traditional medicines, complementary medicines, and antiretroviral therapy.

- **Providing a Comprehensive Continuum of Care and Treatment**

The Comprehensive HIV and AIDS care, management and treatment programme embodied in the plan builds on the existing programmes as outlined in the five-year Strategic Plan for HIV, AIDS and STIs. Whilst the National Strategic Plan outlines the strategic directions and policies, the Comprehensive Plan highlights how the Strategic Plan is to be operationalised.

- **Ensuring the Safe Use of Medicines**

In keeping with South Africa's commitment to maintaining good ethical standards and ensuring the safety of patients, there has been a strong emphasis on ensuring that health providers are adequately trained to treat patients and further that good monitoring takes place. Measures are in place to inform on the impact of these measures to emphasize the safe use of medicines and the importance of adherence to treatment through the establishment of pharmacovigilance facilities in three centres, University of Cape Town, University of Free State and University on Limpopo to support these activities.

- **Multi-Drug Resistance**

Poor compliance to therapeutic agents results in multi-drug resistance which impacts negatively on treatment outcomes. In situations where patients are poor and have limited resources, patients may find the costs of transportation and obtaining access even to non-fee paying health care facilities challenging. These conditions make adherence to health treatment regimens more difficult. To optimise care for HIV and AIDS patients who also have tuberculosis it is important to develop and sustain management programmes. Key

elements in a containment strategy include the prudent use of educational interventions, anti microbial agents, integrated surveillance and monitoring systems in all areas as well as good infection control practice.

- **Local and Regional Integration**

The programme is being implemented in a manner that promotes and strengthens cooperation among government departments and all spheres of government. It also pursues collaboration and harmonisation of strategies within the Region in line with the SADC HIV and AIDS Strategic Framework and Programme of Action 2003 – 2007.

As will be seen from the above outline of the plan, the South African Government has indeed adopted a multi-sectoral approach to HIV and AIDS. This is underlined also by the fact that various sectors within the overall public sector have their own programmes targeting their sectors, informed by the overall strategic perspective and the comprehensive plan. Education, transport, local government, and many other government sectors have developed sector specific programmes from the national plan. Similarly the private sector, as well as civil society organisations, has a number of programmes to complement and support the comprehensive plan.

South African National AIDS Council

The sectors that have been referred to above come together from time to time to share ideas and to co-ordinate their interventions under the banner of the South African National Aids Council. The South African National AIDS Council (SANAC) was formed in 2000 and is currently chaired by the country's Deputy President and co-chaired by the Minister of Health. The Council is composed of 16 government representatives, who are Ministers and Deputy Ministers responsible for a range of portfolios in government, and 16 representatives of sectors in civil society. People living with HIV and AIDS, human rights groups, sports organisations, traditional leaders, women and youth sectors, religious leaders, labour, traditional healers, academics, the business sector, men's sector, children's sector, disability, community representatives, and non-governmental organisations are all represented in the council.

The mandate of SANAC is to advise government on HIV, AIDS and STI policy and related matters:

- To create and strengthen partnerships for an expanded national response to HIV and AIDS in South Africa;
- To receive reports on sectoral responses to HIV and AIDS; and
- To review the implementation of programmes and strategies of the national multi-sectoral response to HIV and AIDS developed within the framework of the national HIV, AIDS and STI strategic plan.

SANAC also serves as the country co-ordinating mechanism for the Global Fund to fight AIDS, TB and Malaria. The Global Fund is a partnership between governments, private sector, civil society and international agencies aimed at mobilising additional resources to respond to the three major communicable diseases, that is AIDS, TB and Malaria.

Similar Councils have also been established in the Provinces. These would be responsible for driving the response to HIV and AIDS at provincial level. The Provincial AIDS Councils are expected to strengthen and co-ordinate multi sectoral action at all

levels within the provinces and ensure greater alignment and coherent action.

1.1.2.2 Prevention, Care and Support

With regard to prevention, care and support, the Comprehensive plan provided above outlines South Africa's approach to these aspects. A litany of programme outputs on social mobilization, IEC, life-skills education for children and the youth, condom distribution, STI management, PMTCT, VCT, attests to some of the achievements towards prevention of new infections. There are systems in place to reduce risk of infection through blood transfusion. Work is being done to ensure safe intravenous drug use and infection control in health facilities to minimize the risk of occupational exposure to all blood-borne pathogens. Prevention, care, treatment and support services provided in health facilities and in the informal health sector, mainly by NGOs, also demonstrate the extent of the work done, driven and supported by Government. Most of these programmes are integrated into the broader primary health care system, a system that is strongly advocated for, and supported by political activists. Since 2006 has been designated by the World Health Organisation as the year for accelerated prevention of HIV and AIDS, South Africa is hard at work to intensify our prevention strategies and to find new ways to support prevention.

1.1.2.2 MONITORING AND EVALUATION

One of the major challenges of the implementation of the programme in South Africa is the Monitoring and Evaluation environment. Whereas an M&E framework exists, it relies upon existing data collection systems, including antenatal HIV sero-prevalence surveys, National Management Care Information systems. District Health Information Systems, Electronic TB register, STI surveillance, demographic and behavioural surveys, to mention a few. The quality of information obtained through these systems depends largely on the quality of inputs, and although these are improving, there is still a lot of room for improvement.

Another major challenge is the difficulty to measure the extent of the problem of HIV and AIDS in the country, as this is not a notifiable condition. Various researchers use different methodologies for determining prevalence, leading to different and sometimes contradictory conclusions. This makes it very difficult to plan accordingly, as any underestimation or over estimation may lead to major difficulties in the allocation of appropriate resources and the determination of appropriate responses.

Linked to this is the challenge to keep appropriate track of Pharmacovigilance surveillance. This is very critical in an environment where treatment with ARVs is provided to a large number of people. Our ability to monitor adverse incidents as well as progress in treatment is hampered by our limited pharmacovigilance surveillance capacity. The country is currently reviewing the centres for pharmacovilance to see how they can be strengthened. Work on improving the overall M&E system and the country's monitoring capabilities and on building capacity for M&E is also continuing.

1.1.3 NATIONAL PROGRAMMES AND BEHAVIOUR

This section covers national programmes ranging from education, workplace policies, PMTCT, through to services for vulnerable children. It is meant to provide a broad

overview of HIV and AIDS related programmes in a variety of settings.

1.1.3.1 Life Skills-based HIV Education in schools

The Department of Education is responsible to address the issue of HIV and AIDS in the education and training system. The main areas of focus have been the implementation of life skills and HIV and AIDS programmes in schools, training of master trainers to train teachers, lay counsellors and peer educators. Life Skills: HIV and AIDS is taught at primary and secondary schools throughout South Africa as part of the designated sexuality education programme of the 'Life Orientation Learning'. As of December 2002, about 54.5% of schools have had training. There was a total 41 872 teachers trained in life skills covering 14 545 primary and secondary schools in the country. One to four teachers per school have been trained, however this varies with provinces.

The 2004/05 Annual Report of the Department of Education reported that the Life Skills and HIV and AIDS Education Programmes distributed 10800 HIV and AIDS pamphlets to the provinces during 2005. A total of 22 425 educators and learners are reported to have been trained as master trainers and peer educators with a view to offer care and support to those infected with and affected by HIV and AIDS.

1.1.3.2 Workplace HIV and AIDS Control

According to the UNGASS guidelines the report has to cover two aspects of the workplace policies and procedures. The first is the prevention of stigmatisation and discrimination on the basis of HIV infection in relation to staff recruitment and promotion, and employment, sickness and termination benefits. The second aspect is the workplace based prevention, control and care programmes covering the basic facts about HIV and AIDS, specific work related, HIV transmission hazards and safeguards, condom promotion, VCT, STI diagnosis and treatment and provision of HIV and AIDS related drugs.

In South Africa, the first aspect is addressed through a comprehensive legislative and policy framework, which is described in section below.

Legislative Context for Workplace HIV and AIDS control

In accordance with the *Constitution of South Africa Act No 108 of 1996* all persons have a right to equality, freedom and security of the person, privacy, fair labour practices and access. This includes people living with HIV and AIDS.

South Africa has put in place a legislative and policy framework for the protection of employees and job applicants infected with HIV against discriminatory and unfair labour practices. The laws and policies are applicable in both private and public sector. Specific public service regulations prescribing minimum standard for public sector HIV and AIDS workplace programmes are also available.

The National Health Act of 2003 provides the legislative framework which provides for the rights of all South Africans to good health. Other relevant pieces of legislation include:

The *Employment Equity Act No 55 of 1998* prohibits unfair discrimination against an employee, or applicant for employment, in any employment policy or practices, on the basis of his/her HIV status. In any legal proceedings in which it is alleged that employer has discriminated unfairly, the employer must prove that any discrimination or differentiation was fair. There have been a few legal challenges in this regard, which resulted in reinstatement in more than 90% of cases. The law prohibits all forms of testing in the workplace especially those that are designed to discriminate against those who are infected. The prohibition goes as far as prohibiting pre-employment testing for HIV or when applying for work unless the Labour court has given the employer permission to do so.

The *Labour Relations Act No 66 of 1995* prohibits dismissal of an employee on the basis of HIV and AIDS status. However, the Act allows for termination of services only when a person is no longer able to work and stipulates that fair dismissal procedures are followed. The Act does not cover members of the South African Defence Force and the National Intelligence Agency.

The *Occupational Health and Safety Act No 85 0f 1993* regulates the creation of safe working environment. This may include ensuring that measures are put in place to ensure that risk of occupational exposure to HIV is minimised. Guidelines have been developed on post exposure prophylaxis to reduce sero-conversion and to give guidance on how cases of occupationally acquired HIV are to be handled.

The *Mine and Safety Act No 29 of 1996* provides for safe working environment in the mines.

The *Compensation for Occupation Injuries and Disease Act No 130 of 1993* makes provision for compensation of employees injured /infected with a disease while at work.

The *Basic Conditions of Employment Act No 75 of 1997* makes provision for basic conditions of employment including a minimum of sick leave days.

The Medical Scheme Act, No 131 of 1998 stipulates that a registered medical aid scheme may not unfairly discriminate directly or indirectly against its members on the basis of their state of health. The Act prescribes that schemes cannot exclude from membership based on a medical condition and this includes HIV. The Act further prescribes that all schemes shall offer a minimum level of benefits to its members. The medical schemes are required to pay in full without co-payments or use of deductibles for the diagnosis, treatment and care costs of the prescribed minimum benefits conditions. The prescribed minimum benefits are to be reviewed at least every two years and the review will focus specifically on the development of protocols for medical management of HIV and AIDS. The current prescribed minimum benefits for HIV infection are:

- HIV voluntary counselling and testing
- co-trimoxazole as a preventive therapy
- Antiretroviral therapy
- Screening and preventive therapy for TB
- diagnosis and treatment of sexually transmitted infections
- pain management in palliative care
- treatment of opportunistic infections

- prevention of mother-to-child transmission of HIV
- post- exposure prophylaxis following occupational exposure or sexual assault.

Promotion of Equality and Prevention Unfair Discrimination Act No 4 of 2000
The Act prohibits unfair discrimination in all sectors. Although HIV is not included as a ground upon which unfair discrimination is prohibited, it is found as a directive principle at the end of the Act.

The *Code of Good Practice on Key Aspects of HIV and AIDS and Employment (No. 21815, December 2000*) sets out guidelines for employers – public and private – and trade unions to implement to ensure that employees with HIV and AIDS are not unfairly discriminated in the workplace. The code provides for**:**

- Creation of non-discriminatory environment
- Dealing with HIV testing, confidentiality and disclosure
- Providing equitable employee benefits
- Dealing with dismissals
- Managing grievances procedures.

The Code also provides guidelines for employers, employees and trade unions on how to manage HIV and AIDS within the workplace. These guidelines cover:

- Creating a safe working environment
- Procedures for management of occupational incidents and claiming for compensation
- Measures to prevent the spread of HIV
- Supporting those infected or affected by HIV and AIDS.

The Code also promotes mechanism to ensure cooperation firstly between employers, employees and trade unions in the workplace and secondly, between the workplace and other stakeholders at a sectoral, local and provincial and national level.

The *Public Service Regulations* was first published in January 2001 and subsequently amended in June 2002 to include minimum standards for departmental HIV and AIDS programmes. These regulations are mandatory for all national and provincial departments.

The *Public Service Regulation 2002* stipulates that the working conditions should support effective and efficient service delivery and should as reasonably possible take into account the employees' personal circumstances including HIV and AIDS. In particular the regulation prescribes specific measures, procedures and services with regard to occupational exposure, non-discrimination, HIV testing, confidentiality and disclosure, health promotion programme and monitoring and evaluation. These regulations are underpinned by laws applicable to the workplace.

In conclusion, South Africa has enacted protective legal requirements on the workplace and HIV and AIDS. It is within this legislative and policy context that workplace HIV and AIDS programmes are being pursued in South Africa.

Workplace HIV and AIDS policies and programmes in the public sector

A survey of current HIV and AIDS responses by national and provincial departments (Department of Public Service 2002) showed that:

- The departments with developed HIV and AIDS policies endorsed the principle of non-discrimination on the basis of HIV status
- Many departments have prevention programmes in place such as awareness and active condom distribution campaigns - some departments have integrated HIV and AIDS prevention into existing programmes
- With regards to testing, confidentiality and disclosure, some departments reported voluntary disclosure by certain employees through Voluntary Counselling and Testing (VCT) services
- Employee Assistance Programmes (EAP) are available in most departments and many HIV and AIDS responses have been integrated into or linked to departmental EAPs
- Leadership commitment by and support from top and middle management is varied
- Dedicated budgets for HIV and AIDS generally do not exit, and awareness materials are mainly sourced through the Department of Health.

Workplace HIV and AIDS policies and programmes in the private sector

The South African Business Coalition on HIV and AIDS (SABCOHA) describes a workplace HIV and AIDS policy as an organization's position that guides and sustains the awareness, prevention, treatment and care programmes. The policy should both provide guidelines as to how a business should respond to HIV positive employees, and also provide a framework for action to reduce the spread of HIV and AIDS and manage its impact. SABCOHA maintains that policies should attempt to strike a balance between productivity and profitability on the one hand, and a humane, fair and socially responsible response on the other.

Impact assessment of HIV and AIDS on organisations

HIV and AIDS awareness programmes; Voluntary HIV testing and counselling programmes; HIV and AIDS education and training; Condom distribution; Encouraging treatment for STIs and TB; Universal infection control procedures; Creating an open accepting environment; Wellness programmes for employees affected by HIV and AIDS; The provision of antiretrovirals or the referral to relevant service providers. Education and awareness about antiretroviral and treatment literacy programmes; Counselling and other forms of social support for infected employees; Reasonable accommodation for infected employees; Strategies to address direct and indirect costs of HIV and AIDS; Monitoring, evaluation and review of the programme.

Since 2003 SABCOHA has been conducting annual surveys to measure progress with implementation of workplace HIV and AIDS programmes amongst a sample of business sectors in South Africa. The surveys conducted by the Bureau for Economic Research (BER), Stellenbosch University includes respondents in the mining, manufacturing, retail, wholesale, motor trade, building and construction, financial services and transport and storage sectors.

The 2005 survey, which was conducted between July 20 and September 6, 2005, included a sample of 1032 companies. The survey sample consisted of 317 manufacturers, 201 building and construction companies, 153 retailers, 77 wholesalers, 38 vehicle dealers, 92 mines, 111 transport and storage companies and 43 financial services companies.

The findings of the 2005 SABCOHA/BER survey indicated varying levels in the progress with implementation of the workplace HIV and AIDS policies in the private-for-profit sector. Implementation of workplace policies was found to be highest in the financial services companies (81%) and lowest in the retail sector (12%). Workers in the labour intensive sectors in particular transport, building and construction, and retail seem to be poorly implementing workplace HIV and AIDS policies. However, inter-sector analysis shows that about 37.9% of the companies surveyed were implementing the workplace policies with manufacturing sector being highest (14%) and the vehicle dealers being lowest (0.9%).

Table 2: % of private sector companies implement in workplace HIV and AIDS policies in 2005

Sectors surveyed	Number of companies surveyed	Number of companies implementing policies	Percentage of companies within each sector implementing policies	Percentage of the total surveyed companies implementing policies
Financial services	43	35	81	3.4
Mining	92	55	60	5.3
Transport and storage	111	58	52	5.6
Manufacturing	317	149	47	14.4
Wholesale	77	19	25	4.8
Building and construction	201	48	24	4.65
Vehicle dealers	38	9	24	0.87
Retail	153	18	12	1.74
Total	1032	391		37.9

Adapted from: SABCOHA/BER 2005

1.1.3.3 Sexually transmitted infections: comprehensive case management

Reporting on this aspect is meant to cover information on patients with STIs who are appropriately diagnosed at health care facilities, treated and counselled, should be obtained through facility surveys, which include observations of provider-client interactions.

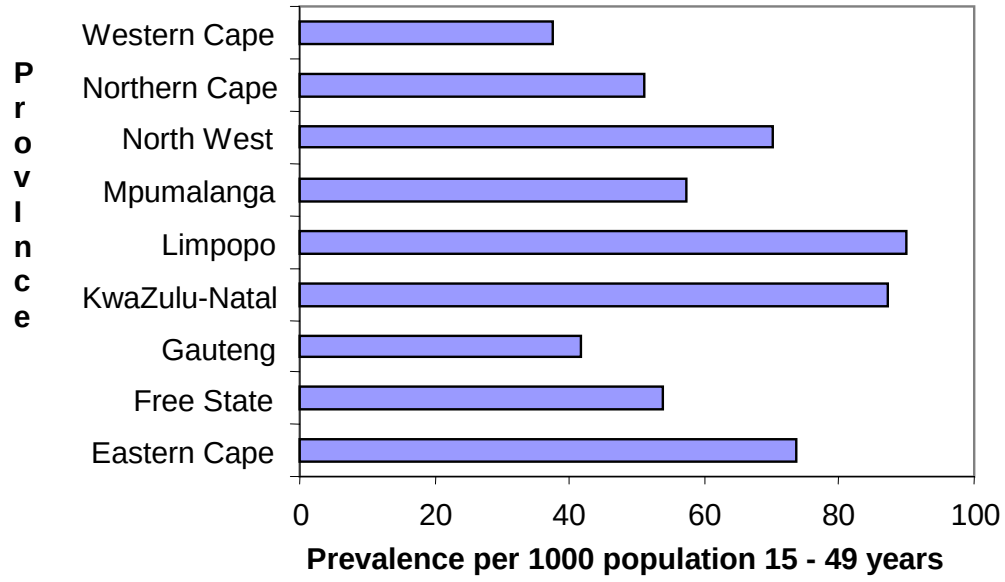
Availability of Sexually transmitted Infection (STI) services at primary care facilities

Services for prevention and care of STIs using the syndromic management approach are widely available in South Africa. The biennial National Primary Health Care Facilities Survey, 2003 showed that over 84% of health facilities in the country were effectively treating STIs. Further, the high percentage of facilities offering the service remained

virtually unchanged since 1998, an indication that the service is a well established component of the basic primary health care services (Health Systems Trust 2003).

Available routine data on syphilis infections shows that there are wide differences in syphilis rates between different geographic areas (provinces). This is shown in figure 1.

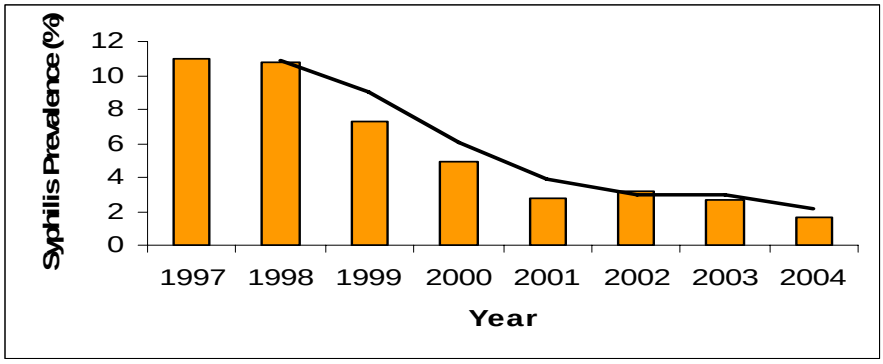
Figure 1: Prevalence of STIs in South Africa



Prevalence of Syphilis

The most reliable estimates of STI trends available uses syphilis as a proxy indicator and is obtained from the annual survey of women attending antenatal clinics. The 2004 antenatal survey showed a syphilis prevalence rate of 1.6%. This demonstrates a declining trend in syphilis from 11.2% in 1999 (figure 2).

Figure 2: Syphilis prevalence trends among antenatal clinic attendees: 1997- 2004



Source: Department of Health: Annual HIV Sero-prevalence survey, 2004

Table 3: National Syphilis prevalence estimates: amongst women attending antenatal clinics 2002- 2004

	2002 RPR+	2003 RPR+	2004 RPR+
Age group			
<20 years	2.4	2.6	1.7
20- 24 years	3.5	2.8	1.8
25-29 years	3.7	3.0	1.3
30-34 years	3.2	2.8	1.5
35-39 years	2.8	2.1	1.5
40 years+	1.3	1.6	0.7
National prevalence.	3.2	2.7	1.6

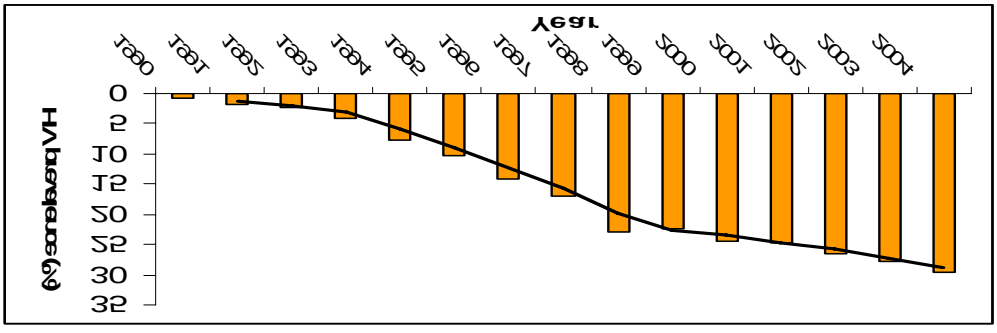
Source: Department of Health: Annual HIV Sero-prevalence survey, 2004

The national prevalence of new episodes of STI syndromes according STI data from the PHC minimum data set was 63 per 100,000 population aged between 15 and 49 years.

Prevalence of HIV

Antenatal surveys are designed to provide an estimate of HIV trends in populations. The trend in South Africa, shown in figure 3 demonstrates an exponential increase between 1990 and 1998 followed by a stabilization between 1998 and 2004. (Department of Health, 2005).

Figure 3: Prevalence of HIV among women attending antenatal clinics in South Africa, 1990- 2004 (Department of Health, 2004)



1.1.3.4 Prevention of Mother-to-Child Transmission: Antiretroviral Prophylaxis (HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT)

The prevention of mother to child transmission (PMTCT) programme has expanded significantly since its inception in September 2001. A total of 3 064 facilities offered PMTCT services during 2005. The PMTCT programme aims to prevent or reduce mother to child transmission of HIV, provision of voluntary counselling and testing and where appropriate, nevirapine or other appropriate medicine, and formula milk for feeding in public sector health facilities throughout the country.

Using available PMTCT data on the NPBI-4 formula, an estimated 55% of pregnant HIV+ women received nevirapine to reduce the risk of MTCT in public sector facilities in 2004.

Because of the challenges that are inherent in strengthening the health care system and monitoring these programmes, we are not yet able to establish the number of children who have been saved as a result of this intervention.

Table 4: Prevention of MTCT: antiretroviral prophylaxis

NPBI-4	**Prevention of MTCT: antiretroviral prophylaxis**		
Data source: name	DOH: PMTCT Statistics (January 2004-December 2004), DOH: Annual antenatal HIV sero-prevalence survey (October 2004)		
Data source: type	Programme monitoring data, HIV Surveillance		
Data collection period (day/month/year)	DOH: PMTCT Statistics (January 2004-December 2004), DOH: Annual antenatal HIV sero-prevalence survey (October 2004)		
PART I: Data requirements	**Public sector**	**Private sector**	**Total**
NUMERATOR			
1. Number of HIV-infected pregnant women provided with ARV therapy to reduce the risk of MTCT at the end of 2004	261 421[1]	Not available	
DENOMINATOR			
2. Number of women who gave birth in the last 12 months	1118198[2]	Not available	
3. HIV prevalence in pregnant women (%)	29.7[3]		
4. Estimated number of HIV-infected pregnant women in the country at the end of 2004	332,105.	Not available	
To calculate line 4 multiply line 2 by line 3, and divide the product by 100			
PART II: Indicator computation			
INDICATOR SCORES BY HEALTH SECTOR			
5. Divide the number of HIV-infected pregnant women provided with therapy(neverapine) *(line 1) by the relevant sector by the number of HIV-infected pregnant women in the country (line 4) and multiply the result by 100			

With respect to the table above the current policy of government is monotherapy (nevirapine) as there is yet insufficient evidence to support the use of other theraputic agents. In addition, the numbers provided in the tables are estimates

[1] This figure is the number of women reported to be receiving PMTCT services at the end of 2004

[2] Estimated number of births is calculated using age specific fertility rate from the 1998 SA Demographic and Health Survey for each age group multiply by the number of women as per mid-year estimates in each age group.

[3] National prevalence figure from the 2004 Annual Antenatal HIV sero-prevalence survey 2005

1.1.3.5 HIV Treatment: Antiretroviral Combination Therapy

Public Sector

The availability of antiretroviral therapy in accredited public health facilities commenced in the first quarter of 2004 as a component of the Comprehensive HIV and AIDS Care, Management and Treatment Programme for South Africa. The National Antiretroviral Treatment Guidelines, published in 2004, are used for the assessment, enrolment and management of persons who are eligible for ART. During 2005 the National Antiretroviral Treatment Guidelines for children were published. The first edition National Antiretroviral Treatment Guidelines states the following patient eligibility criteria for adults and adolescents:

The medical criteria are as follows:

- CD4 count <200 cells/mm^3 irrespective of WHO stage, or
- WHO Stage IV disease irrespective of CD4 count

Psycho-social considerations (not exclusion criteria):

- Demonstrated reliability, i.e. patient has attended three or more scheduled visits to an HIV clinic.
- No active alcohol or other substance abuse.
- No untreated active depression.
- Disclosure: it is strongly recommended that patients have disclosed their HIV status to least one friend or family member OR have joined a support group.
- Insight: patients need to have accepted their HIV-positive status: They need to have insight into the consequences of HIV infection and the role of ART before commencing therapy.
- Patients should be able to attend the antiretroviral centre on a regular basis or have access to services that are able to maintain the treatment chain. Transport may need to be arranged for patients in rural areas or for those far away from the treatment site.

The final decision to treat will be taken by the multi-disciplinary team at the ART centre, who will initiate treatment .The patient or caregiver must be involve in this decision.

The first edition of the National Guidelines for the management of HIV –infected Children (2005) states that patients should satisfy clinical and social criteria before being accepted for treatment.

Clinical criteria

- Confirmation of diagnosis of HIV-infection
- Recurrent (>2 admission per year) hospitalisation or prolonged hospitalisation (>4weeks) for HIV-related illness OR
- The patient satisfies the provisional WHO Stage III/IV disease (see Appendix 1) OR
- For symptomatic patients, CD4 percentage <20% if under 18 months OR <15% if over 18 months

Social criteria
These criteria are extremely important for the success of the programme – the principle is that adherence to treatment must be at least probable.

- At least one identifiable caregiver who is able to supervise the child for administering medication. (All efforts should be made to ensure that the social circumstances of vulnerable children, e.g. orphans, are addressed so that they too can receive treatment)
- Disclosure to another adult living in the same house is encouraged so that there is someone else who can help with the child's ART.

Monitoring & Evaluation Framework

Given the challenge related to establishing a fully functioning patient information system, an access data based system was established and is used along with a laboratory information system to collated available programme and patient information.

The first phase of implementing the Monitoring and Evaluation Framework for the comprehensive HIV and AIDS plan was to collect data every month on:

- cumulative number of patients assessed
- cumulative number of patients on treatment
- CD4 counts and viral loads done
- Number of accredited health facilities.

The existing monitoring system is being progressively strengthened. The second phase of the monitoring programme will expand the expanding the reporting indicators to include: the number of reported ART data elements to include patients lost to follow-up, deaths, adherence, adverse events, ART regimens, and by gender and age groups. Discussions are ongoing with both non-profit and for-profit private sectors to ensure the harmonisation of indicators.

In addition to strengthening the public sector reporting indicators, the second phase of implementing the monitoring plan strengthen the private sector monitoring component in an attempt to have a reasonable estimate of service provision South Africa as a whole.

Private –for- Profit and Non-profit Sectors

Disease management programmes, individual sector initiatives (especially the mining sector) and private doctors provide ART therapy in the private for profit sector. The not profit non-government sector is also a source for ART therapy mainly in the hospice settings and faith based organisations such as Catholic Relief Services.

The Department of Health has initiated a process and discussions with both non-profit and for-profit private sectors to share information and harmonise data collection and flow. For the purpose of reporting of persons on ART, data was requested on the NPBI-5 Form from disease management programmes, mining sector, the South African HIV Clinician Society.

The following are some of the companies that provide ART for their infected employees:

- De Beers, provides treatment access including after retrenchment or medical boarding
- Anglo American provides treatment to its current employees
- Daimler Chrysler has about 72 employees on ART, 75% of patients were on HAART, 20% on dual therapy and 4 % in MTCT programme
- BMW South Africa has about 60 employees enrolled in its on –site wellness programme
- Nedcor has about 83 employees enrolled in its HIV and AIDS management Programme
- Anglo Gold has about 1434 employees enrolled in its wellness management programme.

Aid for AIDS

The Aid for AIDS (AfA) programme provides comprehensive HIV and AIDS management solutions for medium to large businesses as well as medical aid schemes. The Sunday Times of January 15, 2006 reported that more than 53 medical schemes and several companies are clients of AfA.

It was reported January 2006 reported that there were 25 000 private medical aid members who are enrolled in the Aid for AIDS programmes and that more 70% of these patients are currently on antiretroviral drugs. There was initially a steady monthly increase in uptake in the four years between 1998 and 2001 and thereafter, enrolment has become more constant from month to month (Hislop and Regensberg, 2004).

Aurum Institute for Health Research

The Aurum Institute for Health Research is a section 21, not for profit, public benefit organization which does health research and health programme development that focuses on HIV & TB. In terms of the ARV programme for the companies, Aurum Institute develops guidelines, trains the company health staff, collects and analyzes data and report back on findings to the companies. Currently, the Aurum Institute manages the ARV programmes for the Anglo American Companies, including Anglo Gold Ashanti, Anglo Platinum, Anglo Coal, Mondi Paper & Packaging, Tongaat Hulletts, Highveld Steel, Scaw Metals, Anglo Base Metals. They also have a programme for Sasol.

Catholic Relief Services

The Catholic Relief Services (CRS) has two projects, the South African Bishop Conference and International Youth Development, providing antiretroviral therapy in 24 private not-for-profit facilities points in seven provinces.

Lifeworks

Lifeworks provides its clients with services ranging from providing all aspects of HIV and AIDS diagnosis and health care, to the provision of ART treatment guidelines, the training of clinicians and caregivers and the monitoring and evaluation of medical programmes.

Lifeworks' HIV and AIDS corporate clients include: Atlas Copco Group, South African Breweries (SAB), Amalgamated Beverage Industries (ABI), Cadburys (SA), bhpbilliton Group (SA), Care International (SA & Lesotho), Coca-Cola Canners of Southern Africa, Danzas, Lafarge Group, Lesotho Brewing Co., Microsoft Africa, Shell & BP SA Petroleum Refineries, Pfizer Laboratories, SAB-Miller Plc (Africa), Soul City, Swaziland Breweries & Mozambique Aluminium.

It must be noted that there many other NGOs and CBOs that provide a range of treatment services through support from international donors. The challenge we face is one of ensuring that all of these adhere to treatment protocols that are approved by the government, since many of their patients end up having to be looked by public service points.

Percentage of people with advanced HIV infection receiving antiviral combination therapy

There are major challenges associated with reporting the number of individuals who are on treatment. The South African programme because it is one of the largest and one of the most comprehensive in the world faces the greatest challenge as regards establishing adequate monitoring systems. The current electronic patient information system is still under development and pharmacovigilance centres are gradually being developed and strengthened so as to provide adequate information of patients who discontinue treatment, deaths, side effects, those lost to follow up etc. The estimates provided below should therefore be read with the as ballpark estimates.

Given these (numerator) limitations and the further difficulty that estimates of the total number of individuals in a population (denominator) is another estimate with a fairly wide error margin as it is made on the basis of several assumptions; a great deal of caution needs to be placed on estimating the percentage of people with advanced HIV infection who are receiving antiretroviral therapy.

Table 5: Percentage of people with advanced HIV infection receiving antiretroviral combination therapy

NPBI-5: HIV treatment: antiretroviral combination therapy		
Date Sources: Department of Health, -South Africa, Aurum Institute for Health, Aid for AIDS, **life**works, Implats Platinum, Pepfar etc.		
Data collection period: January 2005- December 2005		
Numerator: -		
1	Number of people receiving ARV therapy at the beginning of the year (Jan 2005);	51040
2	Number of people who commence treatment in the last 12 months (January - December 05),	121620
3	Number of people receiving ARV therapy at the start of the year who died during the year 2005	
4	Number of people for whom treatment was discontinued for other reasons	
5*	Number of people receiving ARV therapy at the end of the year (2005)= (lines 1+2)- (lines 3+4)	
Denominator:-		

6	Number of people with people with HIV infection in the total population[4]	
7	Percentage of people with HIV who are at advanced stage of infection[5]	
8	Number of people with advanced HIV infection is a product of the last two above points. (multiply line 6 by line 7 and dividing the product by 100)	
9	Percentage of people with advanced HIV infection receiving antiviral combination therapy (divide line 5 by line 8 and multiply by 100	

NB. There are gaps in information which will be in time be filled as monitoring tools and systems strengthen.

A number of private sector organisations (including Goldfields, Harmony Gold, BHP, SA National Defence Force, Private Practitioners) were requested to provide data but had not provided the information at the time of the writing the report. Therefore the calculated figure of 17.38% is an estimate.

Health facilities with the capacity to deliver appropriate care to people living with HIV and AIDS

South Africa is implementing an accreditation process that aims to ensure that any public health facility accredited to provide antiretroviral therapy complying with a minimum set of standards that ensures good quality of care. Accreditation process is co-ordinated nationally with teams consisting of national and provincial managers visiting all facilities identified for accreditation by the provincial Departments of Health. A specially designed accreditation tool is used to guide discussions with various representatives of the facilities and to also gather information that is used to make recommendation on the accreditation status. The facilities that do not comply with the minimum standards are required to develop plans for immediate implementation and are then accredited following the improvements made.

At the beginning of February 2006, 204 facilities were fully functional and providing ART services at the end of December 2005. All 53-health districts have at least one (1) health facility providing ART services and 63% of the 252 sub-districts have full coverage.

Table 6: Number of Health Districts and Public Health Facilities per Province

Province	Number of Health Districts	Operational Health facilities End December 2005
Eastern Cape	7	20
Free State	5	5
Gauteng	6	29
KwaZulu-Natal	11	54

[4] Estimates of the 2004 HIV sero-prevalence survey
[5] UNGASS recommended 15% default

Limpopo	6	23
Mpumalanga	3	12
Northern Cape	5	11
North West	4	8
Western Cape	6	42
Total	53	204

It should however, be noted that there many private for profit and non-profit making organisation that also offer antiretroviral treatment to their clientele in the private settings.

1.1.3.6 Support for Children affected by HIV and AIDS

The Department of Social Development has initiated the Orphans and vulnerable Children's (OVC) Programme whose activities include identification of vulnerable children, counselling, material support, including basic food provision and home-based care. The programme also provides HIV awareness & prevention programmes and training for caregivers.

Through this programme the rights of children are being addressed in order to ensure that they have access to appropriate social services, to education, access to family care, and to nutrition. An important aspect of the programme includes a skills development programme, which builds the capacity of women and youth in the community. Caregivers are identified in communities and receive training in caring and support of vulnerable groups for which they receive a stipend.

By the end of 2005, 121 095 orphans and other children made vulnerable as a consequence of, among others, HIV & AIDS had been identified and are receiving appropriate care and support services including counselling. The aforementioned programme managed to reach 142 015 families. All the children and families identified receive psychosocial support. 11 209 children were referred for foster care placement.

1.1.3.7 Orphans and vulnerable children and access to child care grants

The Department of Social Development reported that a total of 7 297 292 children are receiving grants in South Africa, as at January 2006. It is estimated that at least 2.6% of these children (195 556 children) were placed in foster care. Although there are a number of reasons for the placement but it is assumed, by the Department of Social Development, that at least 90% of the children are placed in foster care because of orphan-hood. However, it must be noted that children are not classified as Aids orphans as opposed to road accident orphans, etc, because this may itself be a basis for stigmatisation and discrimination. As of January 2006, the number of children receiving a child support grant where one parent or both parents are deceased is estimated to be 1 497 696.

One method of expanding OVC responses has been to encourage NGOs to act as intermediaries, providing support services to NGO and CBO partners. More emphasis has been placed on training community volunteers. Achievements in this regard include:

- 5 127 caregivers received stipends, and 5 083 received training on HIV counselling, lay counselling, project management, care and support
- A total of 629 support groups were strengthened or supported
- 278 NGOs received financial support.

During 2005, the Department of Social Development embarked on a campaign to promote the OVC Programmes Initiative through which additional resources were to be made available to partners to enable scaling up Orphans and Vulnerable Children (OVC) programmes. A policy framework, guidelines and action plan is in place to address the needs of orphans and vulnerable children.

1.1.3.8 Blood Safety

South Africa is self-sufficient for blood products and all blood products are procured from voluntary, non-remunerated blood donors. All products are processed, and screened for the presence of transmissible diseases and red cell antibodies before being released for eventual administration to patients.

2. KNOWLEDGE AND BEHAVIOUR INDICATORS

2.1 Young people's knowledge about HIV prevention, Youth Risk Behaviour and Condom Use

The government, together with its social partners, strengthened its information, education and communication (IEC) programmes including health promotion focussing on youth and adolescents. Examples of these programmes include the Beyond Awareness Campaign, life-skills education at schools, peer education, mass media programmes including those of Khomanani, LifeLine, LoveLife, Soul City, educational and health promotion information, etc. Recent studies suggest great improvement in the area of knowledge, behaviour and perceptions of HIV and AIDS among youth.

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

The responses to the questions related to knowledge and perceptions generally showed that there is a high level of awareness of prevention methods and other information to reduce risk. As in all other programs of this nature, the true challenge lies in translating this knowledge to sustainable behavioural change.

Table 7: Knowledge of HIV among young male and female respondents aged 15 24

		Male	Female	Both sexes
Is it possible to transmit HIV from a mother to her unborn child?	Yes	78.7	84.9	81.6
	No	7.9	9.0	7.7
	Don't know	13.4	7.8	8.5
There is a cure for HIV and AIDS	Agree	6.2	6.1	6.2

	Disagree	82.7	82.3	82.5
	Not sure	11.1	11.6	11.5
HIV causes AIDS	Agree	91.5	90.4	90.9
	Disagree	2.8	2.9	2.4
	Not sure	5.8	6.7	6.3
HIV infection is prevented by using condoms	Agree	89.6	88.3	89.0
	Disagree	6.5	5.6	6.1
	Not sure	3.9	6.1	4.9
You can reduce the risk of HIV by having fewer sexual partners	Agree	68.9	65.5	67.3
	Disagree	23.2	25.9	24.4
	Not sure	7.9	9.1	8.5

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

Table 8: 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

	Men		Women	
Background characteristic	2+ partners	Number of men	2+ partners	Number of women
Age				
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
Residence				
Urban	4.7	2,259	2.4	4,871
Rural	3.6	859	2.7	2,170
Population group				
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
Total	**4.4**	**3,118**	**2.5**	**7,041**

na = Not applicable

Source: SADHS 2003

Table 9: 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 10 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 10: 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

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

The 2003 SADHS results in Table 11 indicate that 33 percent of women who had a sexual encounter with any partner used a condom.

Table 11: 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

			Used condom during last sex					
Background characteristic	Ever used condom	Number	Used with spouse	Number	Used with non-spouse	Number	Used with any partner	Number
Age								
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.

Condom use during last sexual encounter in last 12 months

Table 12 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 Informal settlement 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 12: Condom use during the last sexual intercourse by characteristics of respondents

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

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

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%).

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

Table 13 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 13: 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

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

It is estimated that the overall median age at first sex for the youth aged 15 to 24 in the general population is17 years for both sexes. This result is consistent with that of the South African Behavioural Surveillance Survey (BSS) Baseline Survey 2003. The BSS further showed that by the age of 15 years, a quarter of the respondents had experienced first sexual encounter. By the age of 20, as many as 90% are sexually experienced (BSS, Department of Health, 2003).

Table 14: Youth persons ever had sexual intercourse

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

The 'South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey' (HSRC, 2005) 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 had of each sex had had sex by the age of 18 years.

3. IMPACT INDICATORS

3.1 Reduction of HIV prevalence

Estimates of people in the 15 – 49 year age group with HIV infection are estimated from the antenatal survey and from population based surveys. Trends are modelled from antenatal survey information. The recent national population survey estimated that 9.1% of the population had HIV infection (HSRC, 2005).

HIV prevalence of people in younger age groups 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.

Figures 4a and 4b and table 15 shows HIV infection by age among women aged 15 to 20 year age group. This shows that new infections (HIV incidence) has stabilized.

Figure 4a: Trends in HIV infection in women by age group

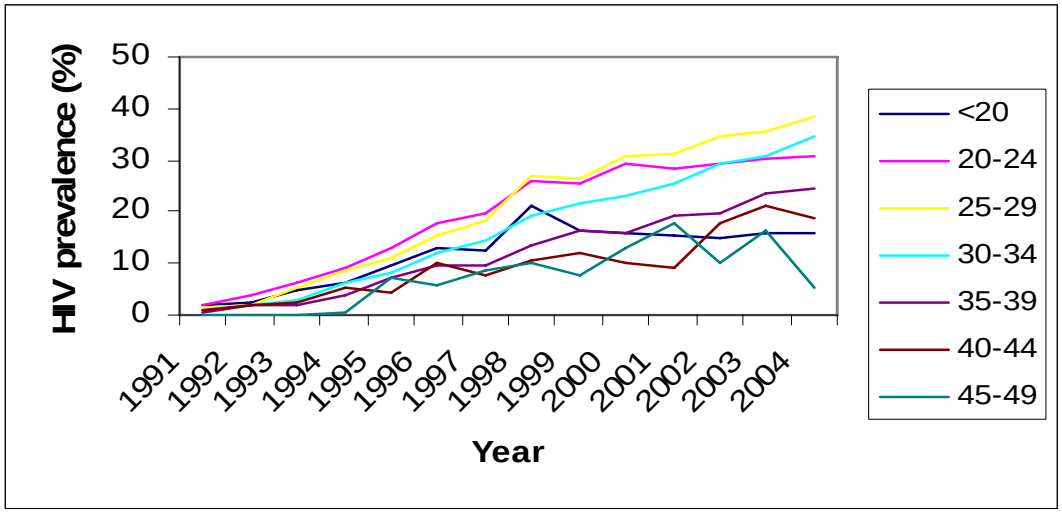


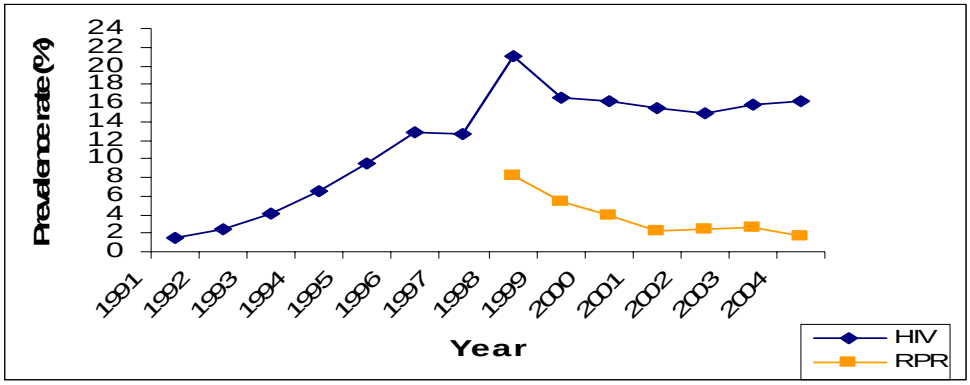
Table 15: Annual Antenatal Survey Prevalence of HIV among pregnant women aged 15-24 years 2002 to 2004

Age in years	2002 % HIV+	2002 No. HIV+(n)	2003 % HIV+	2003 No. HIV+(n)	2004 % HIV+	2004 No. HIV+(n)
15 - 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 4a 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 as illustrated in figure 4b.

Figure 4b: HIV and syphilis prevalence among 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

3.2 HIV treatment: survival after 12 months on antiretroviral therapy

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

3.3 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 16: 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			
Part 1:			
Data requirements	**%**		
1. Proportion of HIV+ pregnant women provided with ARV treatment[6]	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
List below 3 most common forms of treatments provided during the last 12 months and percentages of all treatment that each represents			
Nevirapine			
Cotrimoxazole prophylaxis			
Part 2: Indicator computation			
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 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] NPB I-4 above shows calculation of T.

4. CONCLUSION

This report has outlined South Africa's efforts towards meeting the **UNGASS Declaration of Commitments targets.** While a lot of progress has been made in this regard, there are still many challenges facing the country. Key among these is the challenge of building a health system that is able in both its quality and quantity to provide adequate health care to its citizens. Addressing the shortages of health personnel in the public health sector is one of the major challenges we face in building such a system. Coupled with this are other system challenges, such as the development of a proper health information system, quality pharmacovigilance institutions, Strong patient support and follow up structures, and other system related challenges.

There is also a challenge of ensuring proper coordination of development support in this area. More and more donor agencies want to get involved in funding some aspect or the other of the response to HIV and AIDS in the country. This leads to uncoordinated activities, often resulting in minimum impact and more confusion. This becomes more dangerous for the country as donors support treatment programmes by NGOs, which do not conform to the protocols used in the public sector, thus raising concerns about sustainability and impact on patients.

But above all, the country continues to face the challenge of poverty and underdevelopment. The challenge of the second economy, as it is called in South Africa, which refers to the majority of our people who live in conditions of poverty characterised by joblessness, lack of skills, homelessness, lack basic services and infrastructure remains the most critical challenge, even in dealing with HIV and AIDS. For poor people without water and proper sanitation, without proper nutrition, with already compromised immune systems as a result of hunger and disease, the UNGASS commitments do not mean anything, if they are not located within other commitments such as the Millennium Declaration to halve poverty by 2015.

ANNEXURE 1: NATIONAL COMPOSITE POLICY INDEX (NCPI)

Indicator	Period	Value
NCPI-A-I-1 : Country has developed a national multi-sectoral strategy/action framework to combat HIV/AIDS	2005	Yes
NCPI-A-I-2 : Country has integrated HIV/AIDS into its general development plans	2005	Yes
NCPI-A-I-3 : Country has evaluated the impact of HIV and AIDS on its economic development for planning purposes	2005	Yes
NCPI-A-I-4 : Country has a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services, military, peacekeepers and police	2005	Yes
NCPI-A-I-R : Strategy planning efforts in the HIV and AIDS programmes overall Rating	2005	8
NCPI-A-II-1 : The head of the government and/or other high officials speak publicly and favourably about AIDS efforts at least twice a year	2005	Yes
NCPI-A-II-2 : Country has a national multisectoral HIV and AIDS management/coordination body recognized in law? (National AIDS Council or Commission)	2005	Yes
NCPI-A-II-3 : Country has a national HIV and AIDS body that promotes interaction between government, people living with HIV, the private sector and civil society for implementing HIV and AIDS strategies/programmes	2005	Yes
NCPI-A-II-4 : Country has a national HIV and AIDS body that is supporting coordination of HIV-related service delivery by civil-society organizations	2005	N/A
NCPI-A-II-R : Political support for the HIV/AIDS programme overall rating	2005	8
NCPI-A-III-1 : Country has a policy or strategy that promotes information, education and communication (IEC) on HIV and AIDS to the general population	2005	Yes
NCPI-A-III-2 : Country has a policy or strategy promoting HIV and AIDS related reproductive and sexual health education for young people	2005	Yes
NCPI-A-III-3 : Country has a policy or strategy to promote information, education and communication and other preventive health interventions for most-at-risk populations	2005	Yes
NCPI-A-III-4 : Country has a policy or strategy to expand access, including among most-at-risk populations, to essential preventative commodities. (These commodities include, but are not limited to, access to confidential voluntary counselling and testing, condoms, sterile needles and drugs to treat sexually transmitted infections.)	2005	Yes
NCPI-A-III-R : Policy efforts in support of prevention overall rating	2005	9
NCPI-A-III-5 : Prevention activities have been implemented in 2003 and 2005 in support of the HIV-prevention policy/strategy	2003	Yes
NCPI-A-III-R2 : Efforts in the implementation of HIV prevention programmes overall rating	2005	8
NCPI-A-IV-1 : Country has a policy or strategy that promotes information, education and communication (IEC) on HIV and AIDS to the general population	2005	Yes
NCPI-A-IV-2 : Activities have been implemented under the care and treatment of HIV and AIDS programmes	2003	Yes
NCPI-A-IV-R : Efforts in care and treatment of the HIV/AIDS programme overall rating	2005	8
NCPI-A-IV-3 : Country has a policy or strategy to address the additional HIV and AIDS-related needs of orphans and other vulnerable children (OVC)	2005	Yes

NCPI-A-IV-R2 : Efforts to meet the needs of orphans and other vulnerable children overall rating	2005	9
NCPI-A-V-1 : Country has one national Monitoring and Evaluation (M&E) plan	2005	Yes
NCPI-A-V-2 : The Monitoring and Evaluation plan includes something	2005	Yes
NCPI-A-V-3 : There is a budget for the Monitoring and Evaluation plan	2005	Yes
NCPI-A-V-4 : There is a Monitoring and Evaluation functional Unit or Department	2005	Yes
NCPI-A-V-5 : There is a committee or working group that meets regularly coordinating Monitoring and Evaluation activities	2005	Yes
NCPI-A-V-6 : Individual agency programmes have been reviewed to harmonize Monitoring and Evaluation indicators with those of your country	2005	No
NCPI-A-V-7 : Degree (Low to High) to which UN, bi-laterals, other institutions are sharing Monitoring and Evaluation results?	2005	5
NCPI-A-V-8 : The Monitoring and Evaluation Unit manages a central national database	2005	Yes
NCPI-A-V-9 : There is a functional Health Information System	2005	Yes
NCPI-A-V-10 : There is a functional Education Information System	2005	Yes
NCPI-A-V-11 : Country publishes at least once a year an evaluation report on HIV and AIDS, including HIV surveillance reports	2005	Yes
NCPI-A-V-12 : Extent to which strategic information is used in planning and implementation?	2005	9
NCPI-A-V-13 : In the last year, training in Monitoring and Evaluation was conducted	2005	Yes
NCPI-A-V-R : Monitoring and evaluation efforts of the HIV and AIDS programme overall rating	2005	6
NCPI-B-I-1 : Country has laws and regulations that protect people living with HIV and AIDS against discrimination	2005	Yes
NCPI-B-I-2 : Country has non-discrimination laws or regulations which specify protections for certain groups of people identified as being especially vulnerable to HIV and AIDS discrimination	2005	Yes
NCPI-B-I-3 : Country has laws and regulations that present obstacles to effective HIV prevention and care for most-at-risk populations	2005	No
NCPI-B-I-4 : The promotion and protection of human rights is explicitly mentioned in an HIV and AIDS policy/strategy	2005	Yes
NCPI-B-I-5 : The Government has, through political and financial support, involved vulnerable populations in governmental HIV-policy design and programme implementation	2005	No
NCPI-B-I-6 : Country has a policy to ensure equal access, between men and women, to prevention and care	2005	Yes
NCPI-B-I-7 : Country has a policy to ensure equal access to prevention and care for most-at-risk populations	2005	Yes
NCPI-B-I-8 : Country has a policy prohibiting HIV screening for general employment purposes (appointment, promotion, training, benefits)	2005	Yes

NCPI-B-I-9 : Country has a policy to ensure that HIV and AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee	2005	Yes
NCPI-B-I-10 : Country has monitoring and enforcement mechanisms	2005	Yes
NCPI-B-I-11 : Members of the judiciary have been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work	2005	No
NCPI-B-I-12 : Legal support services are available in the country	2005	Yes
NCPI-B-I-13 : There are programmes designed to change societal attitudes of discrimination and stigmatization associated with HIV and AIDS to understanding and acceptance	2005	Yes
NCPI-B-I-R : Policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS overall rating	2005	8
NCPI-B-I-R2 : Effort to enforce the existing policies, laws and regulations overall rating	2005	7
NCPI-B-II-1 : Extent to which civil society has made a significant contribution to strengthening the political commitment of top leaders and national policy formulation	2005	8
NCPI-B-II-2 : Extent to which civil society representatives have been involved in the planning and budgeting process for the National Strategic Plan on HIV and AIDS or for the current activity plan (attending planning meetings and reviewing drafts)	2005	8
NCPI-B-II-3 : Extent to which the complimentary services provided by civil society to areas of prevention and care are included in both the National Strategic plans and reports	2005	5
NCPI-B-II-4 : Country has conducted a National Periodic review of the Strategic Plan with the participation of civil society	2005	Yes
NCPI-B-II-5 : Extent to which country has a policy to ensure that HIV and AIDS research protocols involving human subjects are reviewed and approved by an independent national/local ethical review committee in which people living with HIV and caregivers participate	2005	5
NCPI-B-II-R : Efforts to increase civil-society participation overall rating	2005	6
NCPI-B-III-1 : Prevention activities have been implemented in 2003 and 2005 in support of the HIV-prevention policy/strategy	2003	Yes
NCPI-B-III-R : Efforts in the implementation of HIV prevention programmes overall rating	2005	7
NCPI-B-IV-1 : Activities have been implemented under the care and treatment of HIV and AIDS programmes	2003	Yes
NCPI-B-IV-R : Efforts in care and treatment of the HIV/AIDS programme overall rating	2005	6
NCPI-B-IV-2 : Country has a policy or strategy to address the additional HIV and AIDS-related needs of orphans and other vulnerable children (OVC)	2005	Yes
NCPI-B-IV-R2 : Efforts to meet the needs of orphans and other vulnerable children overall rating	2005	7

ANNEXURE 2: STATUS AT A GLANCE

National Commitment & Action

Expenditures

1. Amount of national funds disbursed by government on HIV and AIDS:

R'000	2002/03	2003/04	2004/05	2005/06	2006/07
Dept of Health	454,588	676,230	1,107,408	1,566,302	1,976920
Spending by 4 govt depts, including health	1,112,991	1,517,275	2,094,004	2,880,672	3,289,693

Policy Development and Implementation Status

2. National Composite Policy Index: 85.4% (83.4% in 2003)

National Programmes: education, workplace policies, STI case management, blood safety, PMTCT coverage, ART coverage, and services for orphans and vulnerable children

3. Percentage of schools with teachers who have been trained in life-skills based HIV and AIDS education and who taught it during the last academic year: data not available
4. Percentage of large enterprises/companies which have HIV and AIDS workplace policies and programmes: 37.9% in the private sector and in all government departments in the public sector
5. Percentage of women and men with STIs at health care facilities who are appropriately diagnosed, treated and counselled: estimated to be 60-65% in public sector and 45-50% in the private sector.
6. Percentage of HIV positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT: 75% geographical access coverage with 55% uptake by estimated number of HIV positive pregnant women.
7. Percentage of women and men with advanced HIV infection receiving antiretroviral combination therapy: data not available
8. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child: 85%
9. Percentage of transfused blood units screened for HIV: 100%

Knowledge and Behaviour

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

		Male	Female	Both sexes
Is it possible to transmit HIV from a mother to her unborn child?	Yes	78.7	84.9	81.6
	No	7.9	9.0	7.7
There is a cure for HIV-AIDS	Agree	6.2	6.1	6.2
	Disagree	82.7	82.3	82.5
HIV causes AIDS	Agree	91.5	90.4	90.9
	Disagree	2.8	2.9	2.4
HIV infection is prevented by using condoms	Agree	89.6	88.3	89.0
	Disagree	6.5	5.6	6.1
You can reduce the risk of HIV by having fewer sexual partners	Agree	68.9	65.5	67.3
	Disagree	23.2	25.9	24.4

(Target: 90% by 2005; 95% by 2010)

11. Percentage of young women and men who have had sex before the age of 15: 25.0%

12. Percentage of young women and men aged 15-24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months: data not available

13. ****** Percentage of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner: 69.0%

14. ****** Ratio of current school attendance among orphans to that among non-orphans, aged 10-14: data not available

Impact

15. ** Percentage of young women and men aged 15-24 who are HIV infected: 10.3%

(Target: 25% in most affected countries by 2005; 25% reduction globally by 2010)

16. Percentage of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy: data not available

17. Percentage of infants born to HIV infected mothers who are infected: 23.0%

(Target: 20% reduction by 2005; 50% reduction by 2010)

** Millennium Development Goals

ANNEXURE 3. DATA SOURCES AND REFERENCES

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