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

Prepared for:

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1. 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 waging the war against HIV infection and AIDS defining conditions.

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 the apartheid regime. This has resulted in a bi-modal society that reflects on the burden of disease. Poverty related diseases of infection that include HIV, water-borne diseases..which occur mainly on the previously disadvantaged communities.

The first few cases of HIV and AIDS were identified in the late 1980s in the country. The *(absence of a positive and definitive)* response from the government of the time did not succeed in slowing down this early phase. 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 around which the process of drawing the National Constitution for the Government of National Unity was on course. The constitution emphasized that there would be a process of progressive realization of objectives. Hailed internationally as one of the best, the Human Rights Bill is one of the fundamental imperatives of our South African Constitution. It is in this Constitution and the National Health Act of 2005 that the right of access to health care, to reproductive health and emergency medical services for all is entrenched.

The process of redressing the imbalances of the past commenced in 1994 and is progressing well and with great vigour. 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 racial, class, and gender ("triple oppression"). Given that the location of power in society is determined by these things, the gender roles in the South African society have favoured men. Patriarchy is entrenched in many cultural norms in the country. Some practical challenges facing women because of this relate to; violence and abuse, poverty, and the health status of women in general .
Since 1994, believing in the appropriateness of the gendered-approach theory in addressing the plight of women, the current government has made many strides towards empowerment of women. This is one of critical elements of the transformation agenda in the country. To date, the adoption of the Constitution, setting up of the national machinery with an Office of the Status of Women in the Presidency and provincial Premier's offices, gender units in each government department, and setting up the Commission on Gender Equality are some of the significant strides taken. Access to decision-making processes and governance in parliament is one of the best in the world. More women are making their mark and being recognised in the private sector. Women are beginning to regain their dignity and taking responsibility for their lives. Patriarchal attitudes are changing, with men showing some anger towards violence against women. The agenda is not for and by

women alone but is informed by a theory that understands the intersection of class, race and gender in the struggle for transformation in the country. The walk is very long ahead.

During the first ten years of this 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 through social grants and other means of capacitation. The country's economy has and continues to experience the most unprecedented growth and is now one of the largest and most popular emerging economies in the world.

However, the gap between the central actors in that economy and those at the periphery is still too wide. 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 for 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. It is believed that these programmes, as they reduce the levels of poverty, will contribute towards the reduction of vulnerability to these conditions.

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). This was government mobilizing sectors of society towards raising national awareness about HIV and AIDS. 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

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 National Comprehensive Plan for the Management, Care, and Treatment, one of the best in the world, guides the design and implementation of programmes. e and support priority area of the national strategic framework, it highlights the centrality of prevention, the importance of nutrition and traditional medicines, and health care systems strengtheningas the obligatory elements for a concrete and sustainable solution. Mention issue

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 responsible alcohol use, drug abuse, non-smoking healthy eating, physical exercise and safe sex practices is very visible in the country. The Health Minister leads this campaign. Every opportunity is used for communicating this message to the South Africans.

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. Work is being done on ensuring safe blood supplies, 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 work done, driven and supported by Government. Most of these programmes are integrated into the broader primary health care system, a system that strongly advocate for and supported by political activists.

Through the implementation of the Comprehensive Plan, there is in every health district in the country a service point for the provision of a range of interventions specify 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 laboratory services and referral system has been enormous.

All of these interventions are funded from the government fiscus. It is one of the fundamental principles of the Comprehensive Plan that ninety percent of the programme is funded by government. The Department of Health, the National Health Council (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 inclusive of provincial government departments. Expenditure on HIV and AIDS activities has improved increased substantially over the past five years. The annual budget allocation for this programme increased from R264 million in 2001 to R1.5 billion in 2005. This reflects not only government's commitment to this programme but also the increase in the scale of implementation and health in general.

The South African approach of locating HIV and AIDS programmes firmly in development programme should bear fruit in the near future. The development of the National Strategic Framework for next five-year term will be informed by this realization.

This is the second South African report to the United Nations General Assembly Special Session: Declaration of Commitment. It outlines the measures that are implemented to address the commitment of Government to move towards an HIV free society.

2. 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. 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.

2.1 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.

2. 2 Main Principles of the Comprehensive Plan

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

2.2.1 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, 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, it is recommended that in order to ensure the sustainability of the programme, the biggest slice of the budget for this care and treatment programme should ideally come from the fiscus.

2.2.2 Promotion of Healthy Lifestyles

Any health care programme must begin with promotion of healthy lifestyles, which includes physical exercise, messages and strategies for prevention of tsubstance abuse, promotion of good nutrition, the practice of safe sex, and effective prophylactic medical care 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 healthy lifestyles among South Africans

2.2.3 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 lifeskills 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), syndromic management of Sexually Transmitted Infection (STIs), Tuberculosis (TB) management, and a large and sustained information, education and communication campaign. Some of these strategies are critical entry points for care and treatment interventions. A key intervention is to delay sexual debut.

2.2.4 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 and food fortification for its people including those living with TB, HIV and AIDS and other health conditions. In the first instance ensuring food security for the vulnerable is most critical. The nutrition component of the Comprehensive Plan builds on this and is fully integrated with existing programmes.

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2.2.5 Universal Care and Equitable Implementation

In line with the provisions of the Constitution of the Republic of South Africa 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.

2.2.6 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. 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.

2.2.7 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 qualityand observe the highest standards of care especially in the context of the more complex clinical care requirements in provision of anteretrovial 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.

2.2.8 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.

2.2.9 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.

2.10 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 centers, University of Cape Town, University of Free State and University on Limpopo to support these activities.

2.2.11 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, housing may not be optimal, 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.(add support systems in communities) To optimise care for HIV and AIDS patients who also have tuberculosis it is important to develop and sustain joint management programmes. Key elements in a containment strategy include the prudent use of educational interventions, antimicrobial agents, , integrated surveillance and monitoring systems in all areas as well as good infection control practice.

2.2.12 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 will also pursue collaboration and harmonisation of strategies within the Region in line with the SADC HIV and AIDS Strategic Framework and Programme of Action 2003 – 2007.

3 NATIONAL COMMITMENT AND ACTION INDICATORS

3.1. 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. The indicators used by UNGASS to measure government commitment on spending on HIV and AIDS are focused on STI control activities, HIV prevention, HIV and AIDS clinical care and treatment and HIV and AIDS. South African government strong commitment in addressing the challenge of HIV and AIDS epidemic is demonstrated by committed 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, security and police, correctional services and defence.

The growth of HIV and AIDS funding has focused on the following programs;
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- Life skills education in schools
- Prevention programmes including social mobilisation on healthy lifestyles and Khomanani 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 response to HIV. Some of the activities include coordinating implementation of the National HIV, AIDS, STI and TB programmes as well as coordination the Comprehensive Plan for HIV and AIDS Care, Management and Treatment and the conditional grants as well as coordinating work done by other government departments. Table 1 below gives the total expenditure estimates on HIV and AIDS by Government.

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 increased from R264 million during 2001/02 to R1, 5 billion in 2005/06 financial years. During the Medium Term

Expenditure framework period, 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.

3.1. 1. 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 in the Social Development Department 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

	Expenditure outcome				**MTEF estimate**		
(000)	Audited	Audited	Preliminary	Adjusted Appropriation			
	2001/02	**2002/03**	**2003/04**	**2004/05**	**2005/06**	**2006/07**	**2007/08**
Social Development	14,954	51,153	69,293	78,890	185,572	190,572	195,176
Department of Education	512,627	521,666	715,740	847,960	928,542	1,114,876	1,170,255
Department of Health	264,820	454,588	686,230	1,235,329	1,531,165	2, 001,920	2,101,717
Public services & Administration	-	52,160	3,158	4,158	10,292	11,279	11,843
Science & Technology	0	0	0	10,000	10,000	10,000	10,000
Correctional services							
Defence							
Total	**792,401**	**1,079,567**	**1,474,421**	**2,176,337**	**2,665,571**	**3,328,647**	**3,488,991**

Source: National Estimates of Expenditures, National Treasury 2005

The total government spending is estimated to be R15 billion during the budget period. These resources cover wide range of prevention programs from different departments. This type of commitment by South African government reinforces 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 programme that includes 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. However, there is a need to conduct a nationwide spending assessment on HIV and AIDS to alleviate these problems.

3.2 National Composite Policy Index

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.

3.2.1 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 is co-chaired by the Minister of Health. The Council is composed of 16 government representatives and 16 representatives of sectors in civil society. People living with HIV and AIDS, human rights, sports, traditional leaders, women and youth, religious, traditional healers, academics, business, men's sector, children's sector, community, non-governmental organisation and cabinet committee sectors are also 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 resources to respond to the three major communicable diseases, that is AIDS, TB and Malaria.

A decision was taken that provinces should establish provincial AIDS councils, which 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.

3.2.2 Response to the composite index

The composite index is attached in appendix 1

4 NATIONAL PROGRAMME AND BEHAVIOUR

4.1 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 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.

4.2 Workplace HIV and AIDS Control

The UNGASS guidelines are interested in monitoring 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 5.2.1 below. The implementation of the workplace HIV and AIDS policies in the public and private sectors is addressed in the sections below.

4.2.1 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 found to be 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; and
- 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.

4.2.2 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 exits, and awareness materials are mainly sourced through the Department of Health

4.2.3 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.

4.2.4 Impact assessment of HIV and AIDS on organisation

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 private-for-profit sector. Within sector analysis, implementation of workplace policies was found to be highest in the financial services companies (81%) and lowest in the retail sector (12%). 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 3: % of private sector companies implement 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	3.9
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

4.3 Sexually transmitted infections: comprehensive case management

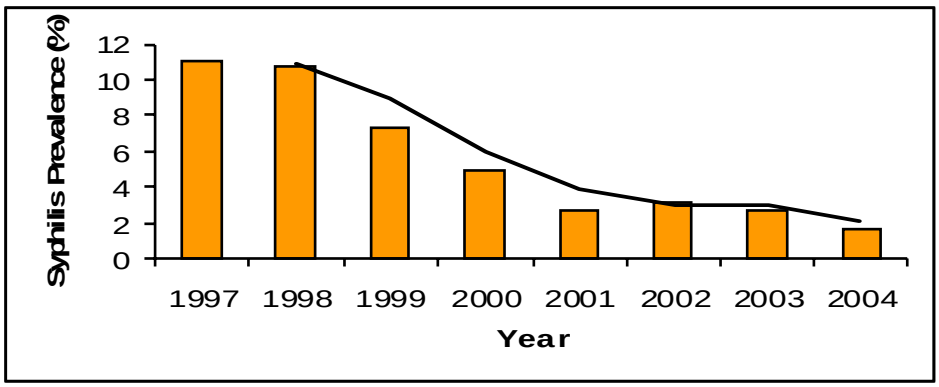
UNGASS Guidelines recommend that information on patients with STIs, who are appropriately diagnosed at health care facilities, treated and counselled, should be obtained through facility surveys, which include observations of provider-client interactions.

4.3.1 Prevalence of Syphilis

The 2004 antenatal survey showed a syphilis prevalence rate of 1.6% Findings from the annual antenatal HIV sero-prevalence surveys show that the prevalence of syphilis among pregnant women has been declining from 11.2% in 1999.

Figure 1 below shows trends in syphilis prevalence since 1998. It is apparent from the graph that there is definite trend towards declining syphilis from 1998 to now (Department of Health, 2004).

Figure 1: Syphilis prevalence trends among antenatal clinic attendees: 1997- 2004



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

Table 4: National Syphilis prevalence estimates: Antenatal clinic attendees, South Africa 2000 - 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

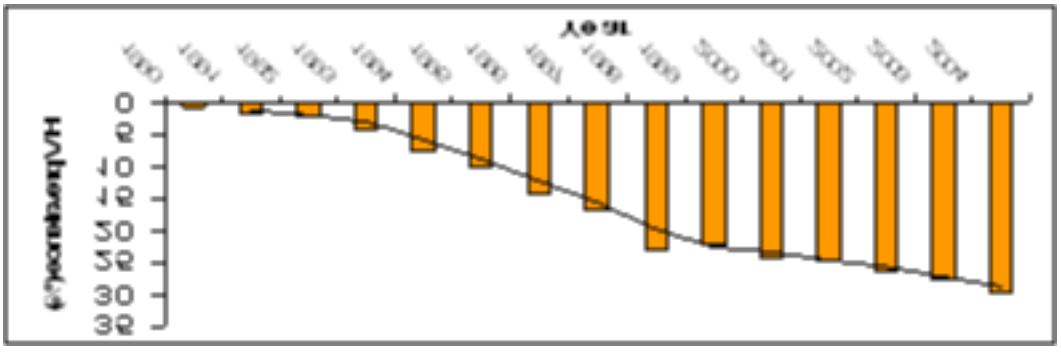
Source: Department of Health: Annual HIV Sero-prevalence survey, 2004

It should be noted that we are aware that we should also be monitoring the treatment of genital herpes. Government is currently in the process of assessing the feasibility and cost of implementing such a system.

4.3.2 Prevalence of HIV

The sero-prevalence surveys show that although there was an almost exponential increase in HIV prevalence levels between 1990 and 1998 there is a stabilization f in HIV prevalence rates (Department of Health, 2005).

Figure 2: *Prevalence of HIV among antenatal care attendees in South Africa, 1990-2004*

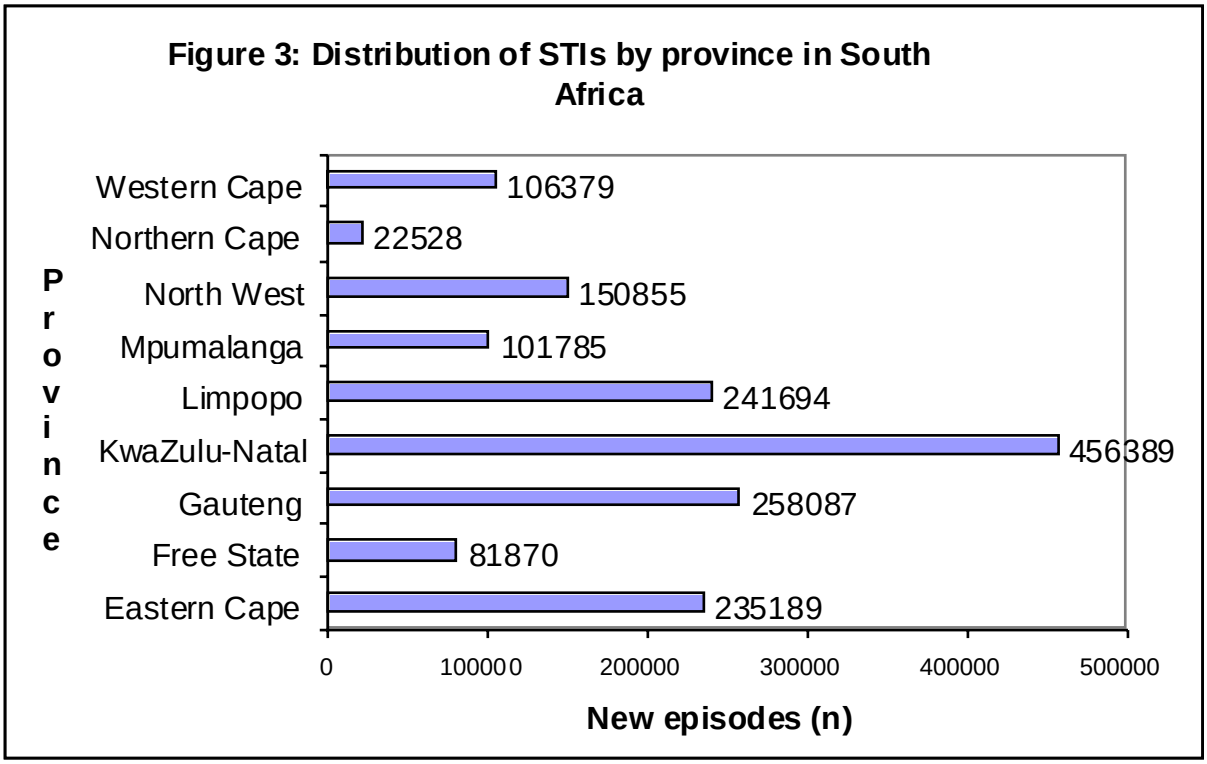


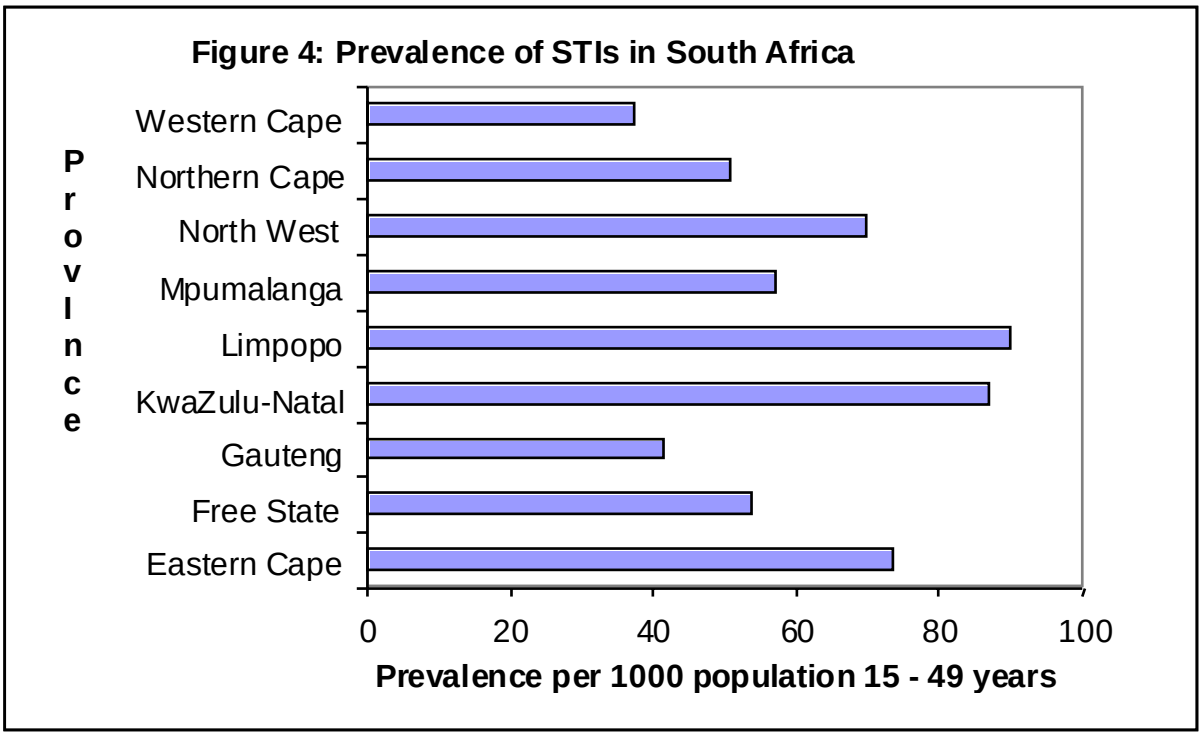
Source: Department of Health: Annual HIV Sero-prevalence survey, 2004

5.3.3 Percent of men aged 15 and over who report having a painful urination or penile discharge, genital sores or either

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.

Figure 3: Distribution of STIs by province in South Africa





4.3.4 Availability of STI services at primary care facilities

The biennial National Primary Health Care Facilities Survey, 2003 shows that 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).

Table 5: STIs infection treated in the public health facilities

	Jan-Dec 2003	Jan-Dec 2004	Jan-Nov 2005
STI treated - new	1,253,873	1,812,257	1,641,321
Male urethral discharge treated - new	324,229	489,740	436,012
STI slip issued	942,918	1,456,909	1,364,683
STI partner treated	299,782	431,255	367,717

Source: Routine Information: District Health Information System

4.4 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 3064 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, and formula milk for feeding in public sector health facilities throughout the country.

Using available PMTCT data on the NPBI-4 formula, an estimated 78.7% 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 6: 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 (nevirapine) *(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	78.7%		

With respect to the table above the current policy of government is the drug used is nevirapine as there is yet insufficient evidence to support the use of other therapeutic agents. In addition, the numbers provided in the table are estimates as the weak health system, including the information management system makes it very difficult to be precise.

[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

4. 5. HIV treatment

5.5.1 Public Sector

The availability of antiretroviral therapy in accredited public health facilities commenced in the first quarter of 2004 as part of the Plan for Comprehensive HIV and AIDS Care, Management and Treatment 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 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 someone else who can help with the child's ART.

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

However, as noted previously, given the lack of a patient information system, it is very difficult to collect data to monitor the indicators listed above.

There are challenges in implementing an optimal patient monitoring system that enables collection of reliable statistics. The existing monitoring system is being progressively strengthened and there is an ongoing process to strengthen and expanding 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. At present the Catholic Relief Services submit monthly reports on its ART project.

4.5.2 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 Forms from disease management programmes, mining sector, the South African HIV Clinician Society and other partners were requested to submit information.

The following companies that provide ART for their infected employees:

- De Beers, which is not one of the 25 biggest companies in South Africa, 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

4.5.2.1 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).

4.5.2.2. 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. We also do the programme for Sasol, a non Anglo Company.

4.5.2.3 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.

4.5.2.4 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.

Table 7: Percentage of people with advanced HIV infection receiving antiviral combination therapy *

NPBI-5: HIV treatment: antiretroviral combination therapy		
Date Sources: Department of Health, Pepfar-South Africa, Aurum Institute for Health, Aid for AIDS, **life**works, Implats Platinum		
Data collection period: January 2005- December 2005		
Numerator: -		
1	Number of people receiving ARV therapy at the beginning of the year (Jan 2005);	
2	Number of people who commence treatment in the last 12 months (January - December 05),	
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 strengthening.

*number reported is not yet known, as the patient monitoring system is not yet able collect information to this level of detail in a reliable manner.

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.

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

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

South Africa is implementing an accreditation process which 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, there were 204 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 8: 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
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 ART to their clientele in the private settings.

4. 6 Support for Children affected by HIV and AIDS

Government has implemented a number of programmes to support children in general. These include the provision of free education and health care for children as well as social grants for vulnerable children. Government has also 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.

The Department of Social Development initiated a monitoring and evaluation programme. The type of data collected through OVC programmes include, among others:

- Information on children and households;
- Number of volunteers and caregivers;
- Number of support services provided;
- Assistance needed, given and source of material assistance; and
- Skills training provided.

4.6.1 Orphans and vulnerable children and access to child grants

The Department of Social Development reported that a total of 7 297 292 children are receiving social grants in South Africa, as at January 2006. Not all of these children are orphans. 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. As of January 2006, the number of children receiving 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 equipping community volunteers to enable them to stand on their own. 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.

4. 7 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.

4.8 Young people's knowledge about HIV prevention

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 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.

4.8.1 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 9: 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-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 10: Number of sexual partners

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

Background characteristic	Men		Women	
	2+ partners	Number of men	2+ partners	Number of women
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 11: Multiple Sexual Partnerships over the past 12 months by characteristics of respondents, South Africa 2005

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

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

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

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

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

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

Young people: condom use with non-regular partner

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

Table 13: Use of condoms

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

			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.

4.8.3 Condom use during last sexual encounter in last 12 months

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

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

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

VARIABLE	MALE		FEMALE	
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

.8.4 Summary findings from computed UNGASS indicator NPBI-8: "Young people's condom use with non-regular partner"

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

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

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

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

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

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

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

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

Table 16: Youth persons ever had sexual intercourse

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

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

5. IMPACT INDICATORS

5.1 Reduction of HIV prevalence

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

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

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

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

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

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

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

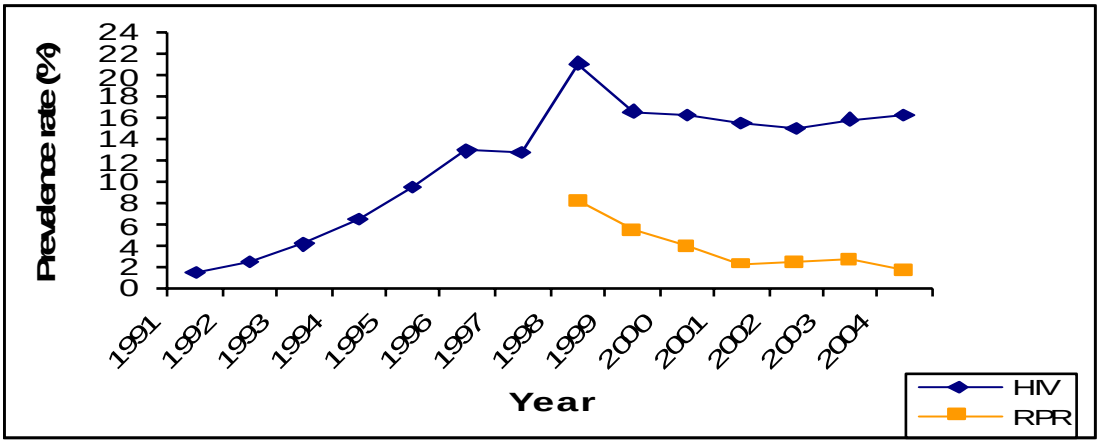
Table 18: Annual Antenatal Survey Prevalence of HIV among pregnant women aged 15-24 years 2002 to 2004

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

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

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

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



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

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

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

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

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

5.3 Reduction in mother-to-child transmission

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

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

Table 19: Reduction in mother to child transmission

NPBI-11-1	**Reduction in mother to child transmission**	
Data source: name		
Data source: type		
Data collection period (day/month/year): 01/04/2004 to 30/03/2005		
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

[6] NPB I-4 above shows calculation of T.

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

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

Health Systems Challenges

- Health systems challenges remain amongst the most pressing. Addressing the shortage of health personnel in the public health sector in general and in the accredited service points.
- The shortage of scarce skills including doctors, pharmacists and nurses is a major challenge facing the public health sector in South Africa.
- The programme is implemented in the context of a country that has recently emerged from institutionalised inequalities. Most of the communities are still challenged by poverty and underdevelopment.

- Ensuring implementation of the plan does strengthen health systems and improves quality of care. The implementation of the National Health
- Management Information System remains a major challenge
- Integration of the Comprehensive HIV and AIDS services within the Primary Health Care approach
- Management of African Traditional medicine (registration, training, referral systems and research)

Comprehensive Plan Implementation Challenges

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

Multi-sectoral Issues

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

7. SUPPORT REQUIRED FROM COUNTRY'S DEVELOPMENT PARTNERS

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

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

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

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

8. MONITORING AND EVALUATION ENVIRONMENT

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

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

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

Percentage of schools with teachers who have been trained in life-skills-based education and who taught it during the last academic year.
The National Life skill unit responsible for coordination of HIV and AIDS life skills education has been sensitised to the importance of monitoring this indicator. It should be explored whether collection of this indicator could be done through existing data collection mechanisms of the Department of Education. The Departments of Education annually conducts a school survey.

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

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

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

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

.

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

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

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

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

Percentage of people with advanced HIV infection receiving ARV combination therapy

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

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

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

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

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

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

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

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

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

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

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

Percentage of infants born to HIV infected mothers who are infected

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

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

ANNEX 1

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

1. Policy or strategy to promote comprehensive HIV/AIDS care and support, with emphasis on vulnerable groups
2. Policy or strategy to ensure access to HIV/AIDS related medicines, with emphasis on vulnerable groups
3. Policy or strategy to address the additional needs of orphans and other vulnerable children
Policy Index for Care and Support
Composite Policy Index

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