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**HIV AND AIDS AND STI
AFRICA, 2007-2011**



STRATEGIC PLAN FOR SOUTH



**AIDS HELPLINE
T 0800-012-322**

(Draft 9)

Acronyms

ABC	Abstain, Be Faithful, Condomise
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral therapy
ASGI-SA	Accelerated Shared Growth Initiative for South Africa
ASSA	Actuarial Science Society of South Africa
ATIC	AIDS Training and Information Centre
BHF	Board of Healthcare Funders
CBOs	Community-based Organisations
CGE	Commission on Gender Equality
CMA	Civil Military Alliance

DENOSA	Democratic Nursing Organisation of South Africa
DOE	Department of Education
DOF	Department of Finance
DOH	Department of Health
DOHA	Department of Home Affairs
DOJ	Department of Justice
DOL	Department of Labour
DOME	Department of Minerals and Energy
DOT	Department of Transport
DOTS	Direct Observed Therapy Short Course
DOSD	Department of Social Development
EDL	Essential Drug List
GCIS	Government Communication and Information Systems
IDC	Interdepartmental Committee on AIDS
IMC	Inter-Ministerial Committee on AIDS
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HRC	Human Rights Commission
HSRC	Human Sciences Research Council
IEC	Information, Education, and Communication
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MEC	Member of Executive Committee
MOH	Ministry of Health
MRC	Medical Research Council
MTCT	Mother-to-child transmission
MTEF	Medium Term Expenditure Framework
NHA	National Health Act
NHC	National Health Council
NHLS	National Health Laboratory Services
NACOSA	National AIDS Co-ordinating Committee of South Africa
NGOs	Non-Government Organisations
NPPHCN	National Progressive Primary Health Care Network
OVC	Orphaned and vulnerable children
PEP	Post-exposure prophylaxis
PLWHA	People living with HIV infection and/or AIDS
PMTCT	Prevention of mother to child transmission

SALC	South African law Commission
SAMA	South African Medical Association
SANAC	South African National AIDS Council
SAPS	South Africa Police Service
SADC	Southern Africa Development Community
SANDF	South African National Defence Force
SMMEs	Small, Medium Macro enterprises
StatsSA	Statistics South Africa
STIs	Sexually Transmitted Infections
SM	Syndromic Management
TB	Tuberculosis
THP	Traditional Health Practitioner
TL	Traditional Leader
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary HIV Counseling and Testing
WHO	World Health Organisation
XDR-TB	Extensively Drug Resistant Tuberculosis

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1. FOREWORD

2. EXECUTIVE SUMMARY

The HIV & AIDS and STI Strategic Plan for South Africa 2007-2011 flows from the National Strategic Plan of 2000-2005 as well as the Operational Plan for Comprehensive HIV and AIDS Care, Management, and Treatment. It represents the country's multisectoral response to the challenge with HIV infection and the wide-ranging impacts of AIDS.

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

In May 2006, the South African National AIDS Council (SANAC), under the leadership of its Chairperson, the Deputy President, Mrs. Phumzile Mlambo-Ngcuka, mandated the Health Department to lead a process of developing a new 5-year NSP, for the years 2007-2011.

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

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

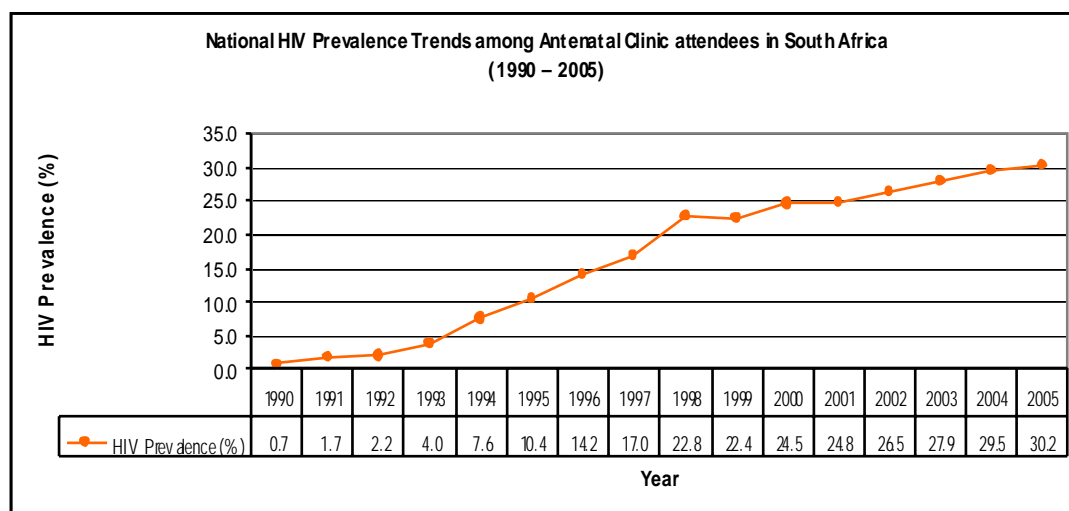
Some key recommendations were:

- A need for a revision of the behaviour change approaches
- Strengthen government implementation
- Consolidate and build existing partnerships
- Strengthen coordination, monitoring and evaluation at the level of SANAC
- Increase the contribution of the business sector, especially with regard to the SMMEs
- Make all interventions accessible to people with disabilities

HIV and AIDS is one of the main challenges facing South Africa today. It is estimated that of the 39.5 million people living with HIV worldwide in 2006, and that more than 63% are from sub-Saharan Africa. About 5.54 million people are estimated to be living with HIV in South Africa in 2005, with 18.8% of the adult population (15-49) affected. Women are disproportionately affected; accounting for approximately 55% of HIV positive people. Women in the age group 25-29 are the worst affected with prevalence rates of up to 40%. For men the peak is reached at older ages, with an estimated 10% prevalence among men older than 50 years. HIV prevalence among younger women (<20 years) seems to be stabilizing, at about 16% for the past three years.

There are geographic variations with some provinces more severely affected. These differences also reflect background socioeconomic conditions as demonstrated by the district level HIV surveillance data in the Western Cape Province. In this province, in 2005, the average was the lowest in the country at 15.7%, but two metropole health areas of Khayelitsha and Gugulethu/Nyanga registered prevalence rates of 33.0% and 29.0% respectively, high above the national average. According to the HSRC Household Survey, people living in rural and urban informal settlements seem to be at highest risk for HIV infection and AIDS.

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



Source: Department of Health, 2006

Although the rate of the increase in HIV prevalence has in past five years slowed down, the country is still to experience reversal of the trends. There are still too many people living with HIV, too many still getting infected. The impact on individuals and households is enormous. AIDS has been cited as the major cause of premature deaths, with mortality rates increasing by about 79% in the period 1997-2004, with a much higher increase in women than in men. Children are a particularly vulnerable group with high rates of mother-to-child- transmission as well as the impacts of ill-health and death of parents, with AIDS contributing about 50% to the problem of orphans in the country. Household level impacts are the most devastating effects of HIV and AIDS in the country. Increases in maternal and childhood mortality are some of the devastating impacts, threatening the country’s ability to realise the MDG targets of 2015.

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

Whilst the immediate determinant of the spread of HIV relates to behaviours such as unprotected sexual intercourse, multiple sexual partnerships, and some biological factors such as sexually transmitted infections, the fundamental drivers of this epidemic

in South Africa are the more deep rooted institutional problems of poverty, underdevelopment, and the low status of women, including gender-based violence, in society.

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

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

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

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

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

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

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

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

The NSP is based upon a set of key Guiding Principles. These are set out in the document on p.xx. A selection of the key principles is:

- Supportive Leadership
- Effective Communication
- Effective Partnerships
- Promoting social change and cohesion
- Sustainable programmes and funding

The primary aims of the NSP are to:

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

The future course of the HIV and AIDS epidemic hinges in many respects on the behaviours young people adopt or maintain, and the contextual factors that affect those choices. Therefore the NSP aims, particularly, to reduce the number of new infections among people in the 15- 24 age group.

The interventions that are needed to reach the NSP's goals are structured under four key priority areas:

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

Key Priority Area 1: Prevention

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

1. Reduce vulnerability to HIV infection and the impacts of AIDS:

- a. Accelerate poverty reduction strategies and strengthen the safety nets to mitigate the impact of poverty
- b. Accelerate programmes to empower women and educate men and women on women's rights and human rights
- c. Create an enabling environment for HIV testing
- d. Support national efforts to strengthen social cohesion in communities and to support the institution of the family

2. Reducing sexual transmission of HIV:

- a. Develop behaviour change curricula for the prevention of sexual transmission of HIV, adapted to different target groups
- b. Implement interventions targeted at reducing HIV in young people, focusing young women
- c. Scale-up positive prevention in HIV positive people
- d. Increase roll out of prevention programmes for higher risk populations
- e. Increase roll out of workplace prevention programmes
- f. Develop a package of reproductive health and HIV prevention services for integration into family planning, ANC, STI, TB and ARV services
- g. Develop a comprehensive package that promotes male sexual health and which addresses gender and gender-based violence
- h. Introduce programmes to mitigate the impact of alcohol and substance abuse

- i. Introduce programmes and strategies to address stereotype gender identities that contribute to gender-based violence
- j. Increase accessibility and availability of comprehensive sexual assault care including PEP and psychosocial support

3. Reduce mother-to-child transmission of HIV

- a. Expansion of existing mother-to-child transmission services to include: contraception fertility services, reducing unwanted pregnancies and involving men, HIV prevention services in uninfected pregnant women
- b. Scale up coverage of PMTCT to reduce MTCT to less than 5%

4. Minimize the risk of HIV transmission through blood and blood products

- a. Minimise the risk of HIV transmission from occupational exposure in health care providers in the formal, informal and traditional settings through the use of infection control procedures
- b. Minimise exposure to infected blood through procedures associated with traditional and complementary practices
- c. Investigate the extent of HIV risk from intravenous drug use and develop policy to minimize risk of HIV transmission through injecting drug use
- d. Ensure safe supplies of blood and blood products (HIV screening tests for measuring both virus and antibodies)

Key Priority Area 2: Treatment, Care, and Support

Reduce HIV and AIDS morbidity and mortality as well as its socioeconomic impacts by providing appropriate packages of treatment, care and support to 80% of HIV positive people and their families by 2011.

1. Increase coverage to voluntary counseling and testing and promote regular HIV testing

- a. Increase access to VCT services that recognize diversity of needs
- b. Increase uptake of VCT

2. Enable people living with HIV to lead healthy and productive lives

- a. Scale up coverage of the comprehensive care and treatment package

- b. Increase retention of children and adults on ART
- c. Ensure effective management of TB/HIV co-infection
- d. Improve quality of life for children and adults with HIV and AIDS requiring terminal care
- e. Strengthen the health system and remove barriers to access

3. Address the special needs of women and children

- a. Decrease HIV and AIDS related maternal mortality through women-specific programmes
- b. Provide an appropriate package of services that includes wellness, Opportunistic Infections management, ART and nutrition to children and adolescents who are HIV positive and/or exposed

4. Mitigate the impacts of HIV and AIDS and create an enabling social environment for care, treatment and support

- a. Strengthen the implementation of OVC policy and programmes
- b. Expand and implement CHBC as part of EPWP
- c. Strengthen the implementation of policies and services for older people affected by HIV and AIDS
- d. Mainstream the provision of appropriate care and support services to HIV positive people with disabilities and their families

Key Priority Area 3: Research, Monitoring, and Surveillance

The NSP 2207-2011 recognises monitoring and evaluation (M&E) as an important policy and management tool.

1. Implement the monitoring and evaluation (M&E) framework of the NSP 2007-2011

- a. Establish and implement a functional M & E system

2. Support the development of prevention technologies

- a. Support and monitor efforts to develop effective microbicide products in South Africa
- b. Support efforts to implement an appropriate AIDS vaccine

- c. Support and monitor research on male circumcision and HIV prevention

4. Conduct operational research

- a. Conduct research on the cost-effectiveness of other forms of treatment and prophylaxis
- b. Conduct research in support of the implementation of the comprehensive plan
- c. Conduct research on the effectiveness of traditional medicines

5. Conduct policy research

- a. Conduct HIV and AIDS studies in selected departments and provinces

6. Conduct regular surveillance

- a. Conduct national surveillance on HIV and STI risk behaviours, especially among the youth

Key Priority Area 4: Human and Legal Rights

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

1. Ensure knowledge of and adherence to the existing legal and policy framework

- a. Adherence to existing legislation and policy relating to HIV and AIDS
- b. Ensure non-discrimination in access to HIV prevention, treatment and support of marginalized groups.
- c. Monitor HIV-related human rights violations and develop enforcement mechanisms for redress

2. Mobilise society, and build leadership of HIV positive people, to protect and promote human rights

- a. HIV positive people are organized, empowered and mobilized to protect human rights at national, provincial and district levels

- b. Respect for the rights of PLWHAs in employment, housing, education, insurance and financial services and other sectors
- c. Greater openness and acceptance of PLWHAs

3. Identify and remove legal, policy and cultural barriers to effective HIV prevention, treatment and support

- a. Identify and finalise current relevant legislative and policy processes
- b. Identify, amend or repeal discriminatory laws and/or laws that undermine HIV treatment and prevention programmes
- c. Identify cultural beliefs and practices that violate human rights and undermine HIV prevention
- d. Identify and address gaps in existing anti-discrimination legislation

4. Focus on the human rights of women and girls, including those with disabilities, and mobilize society to stop gender-based violence and advanced equality in sexual relationships

- a. Reduce women and girls' vulnerability to HIV infection by reducing poverty amongst women
- b. Ensure that existing laws and policies that protect women and girls from gender-based violence are implemented
- c. Respond adequately to the needs of women in abusive relationships
- d. Ensure that laws, policies and customs do not discriminate against women and girls

This NSP sets out a clear framework for ongoing monitoring and evaluation. It includes a preliminary costing of its main elements and a commitment to raising the very substantial funds that will be needed for its effective implementation.

In conclusion, the NSP must be seen as a dynamic living document that will be subject to regular critical review. It is believed that when all partners, led by SANAC, and with technical support from the Health Ministry, pull together and rally around the identified interventions, the two main aims; that of reducing new infections and mitigating the impact of AIDS on millions of people's lives will be realized.

Many individuals and organization have participated in the development of the NSP 2007-2011. A list of all those involved is provided in Annexure XX. However, our thanks go to all who took time and effort to ensure that South Africa has a National Strategic Plan that seeks to guide the national response to one of the most important challenges facing our new democracy.

3. INTRODUCTION

HIV and AIDS is one of the major challenges facing South Africa today. Some two decades since the introduction of this disease in the general population, the epidemiological situation is still characterized by very large numbers of people living with HIV and a disproportionate effect on particular sectors of society, viz.; young women, the poor, as well as those living in underdeveloped areas in the country. HIV infection and AIDS disease however, affects the lives of all South Africans in many different ways.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organisation (WHO), estimated the number of people living with HIV at the end of 2006 to be 39.5 million worldwide. While approximately 10% of the world's population lives in sub-Saharan Africa, an enormous 64% of all people living with HIV live in this region - including 77% of all women living with HIV. Levels of infection vary throughout the region with countries north and west having adult (15-49) prevalence levels of between 1% and 5%, while southern Africa have prevalence levels of between 10-20%, with some countries (Botswana, Zimbabwe, Lesotho, and Swaziland) even higher. HIV prevalence has declined in some countries, Uganda in the early 1990s, and recently Zimbabwe, Kenya and urban areas of Burkina Faso. These declines seem to be linked to changes in key sexual behaviours. Overall, HIV prevalence in this region appears to be levelling off, albeit at high levels.

The severity of the epidemic is closely linked to the region's poverty, low status of women, and other socio-economic factors. Even with the knowledge of how to protect oneself from infection, such information may not always be usable in daily situations of economic and social disadvantage that characterize the lives of many young people in poor countries.

In 1992, the National AIDS Coordinating Committee of South Africa (NACOSA) was launched with a mandate to develop a national strategy on HIV and AIDS. Cabinet endorsed this strategy in 1994. A review conducted in 1997, in line with the goals of the NACOSA plan indicated the strengths and weaknesses of a health sector only, disease-specific approach to HIV and AIDS. Some of the recommendations related to capacity

building for implementing agencies, increasing political commitment, increase involvement of PLWH, and strengthen integration.

Much was done to implement the recommendations of the NACOSA Plan review. These include the appointment of provincial AIDS coordinators, the establishment of the Inter-Ministerial Committee on AIDS, launch of Partnerships against AIDS by the Deputy President in 1998, development of the Department of Education HIV and AIDS policy for learners and educators, development of other national policies, including the Syndromic management of STDs, the establishment of the South African AIDS Vaccine Initiative (SAAVI) in 1998, the establishment of SANAC, the establishment of the national interdepartmental committee on HIV and AIDS, as well as the development of a Strategic Framework for a South African AIDS Youth Programme.

In 1999, through a consultative process with stakeholders, a National Strategic Plan (NSP 2000-2005) was developed and has been the cornerstone of our response in mitigating against HIV and AIDS. Its aim was to strengthen the implementation of the recommendations of the NACOSA Plan review as well as to enhance the national response to HIV and AIDS and STIs. This plan was lauded by the previous Secretary-General of the United Nations Organisation, Mr Kofi Anan, as one of the best in the world. An assessment of the NSP 2000-2005 has been done and its findings and recommendations are outlined in Section 2.

A number of policies and guidelines have been developed in order to support the implementation of HIV and AIDS strategies in South Africa. This work began in 1994 with the finalisation of the Reconstruction and Development document, from which most of other policies flowed. Some examples are; workplace policies in all government departments, the Integrated Nutrition Programme, Maternal, Child and Woman's health, Development of the District Health System, Patient's Right Charter, the White Paper on Transformation of the Health System in South Africa, the Health Charter, as well as many other relevant policy guidelines. This has been uniform throughout government and sectors of civil society. Another important milestone was the approval by Cabinet of the National Operational Plan for Comprehensive HIV and AIDS Management, Treatment, Care, and Support (The Comprehensive Plan), in November 2003.

The process of redressing the imbalances of the past commenced in 1994 and is progressing with great vigour. Several programmes form the thrust of government interventions and ensure greater access to education, health services, the reduction of poverty, the empowerment of women, and the provision of basic services such as shelter, clean water, and sanitation. The government sees growing a job -creating economy and good governance as imperatives in ensuring sustained development, and has recently embarked upon an Accelerated Shared Growth Initiative for South Africa (ASGI-SA), to which is linked the Joint Initiative on Priority Skills Acquisition (JIPSA) initiative, all led by the Deputy President.

In spite of these improvements and commitments, the systemic challenge of human resources particularly in the health sector, attenuates the expected benefits of these commitments. The provision of health services is labour intensive and a range of both clinical and management skills are required to deliver quality health services in an affordable and equitable manner. There is currently an imbalance in the distribution of health professionals between the public and the private health care sectors, with the majority of doctors, pharmacists, and dentists in particular placed in the private sector. In addition, the migration of health professionals to developed countries has contributed to the problem of recruiting and retaining health professionals in the public health sector. The introduction of a scarce and rural allowance, the improvement of conditions of work in the public sector and the signing of memoranda of understanding with such countries as the UK are designed to manage the trends towards migration and contribute to retention of personnel. Other sectors are also affected by the dearth of the necessary skills to ensure acceleration of development in the country.

The most needy areas such as informal settlements and rural areas are disproportionately affected by shortages in human resources. Government developmental programmes like JIPSA need to be implemented with more vigour. Innovative and efficient ways of leveraging on the private sector need to be developed and introduced.

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

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

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

4. SITUATION ANALYSIS

4.1 HIV and AIDS epidemiology in South Africa

A clear understanding of the nature, dynamics, and characteristics of an epidemic is critical in informing strategies that can be reviewed and adapted to fit local conditions.

UNAIDS and WHO description of the HIV and AIDS epidemics is based on prevalence rates and population affected. These organisations assert that HIV and AIDS is not the same everywhere given the dynamic nature of an epidemic so one country may move from one category to another.

Even within a country there may be a series of multiple, changing and overlapping micro-epidemics, each with its own nature (the populations most affected), dynamics (patterns of change over time) and characteristics (severity of impact). By this definition, the South African HIV and AIDS epidemic is generalised. It is firmly established in the general population and sexual networking in the population is sufficient to sustain the epidemic independent of sub-populations at higher risk of infection. A numerical proxy of HIV prevalence consistently >1% in pregnant women has been used to qualify a generalised epidemic (World Bank and WHO use >5%). By this definition alone therefore, South Africa has a generalised epidemic.

HIV prevalence has been consistently monitored in South Africa including through antenatal HIV and syphilis prevalence surveys, which have been conducted since 1990,

and two national population-based surveys which were conducted in 2002 and 2005.¹ A national prevalence survey of youth was also conducted in 2003/4.² Figure 1 illustrates antenatal HIV trends from 1990 to 2005, and Figure 2 illustrates HIV prevalence by sex and age group in 2005 in the general population.

Figure 1: National HIV prevalence trends among antenatal clinic attendees: 1990 – 2005³

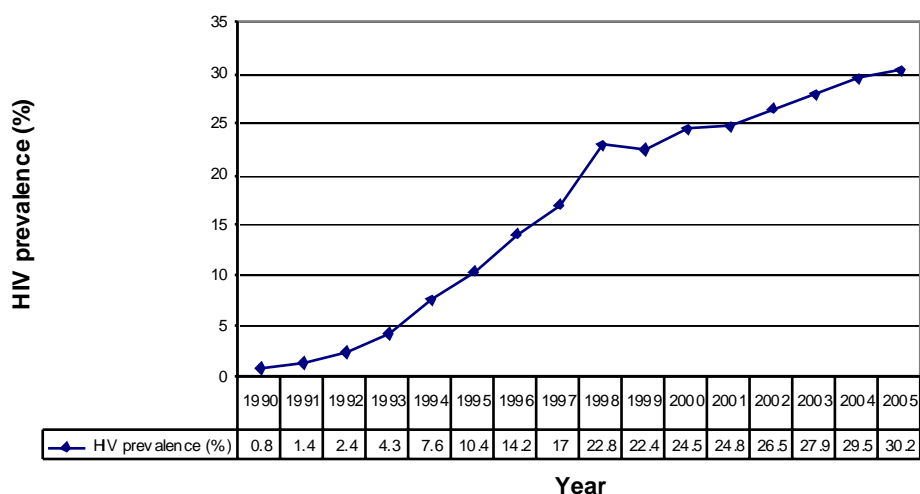


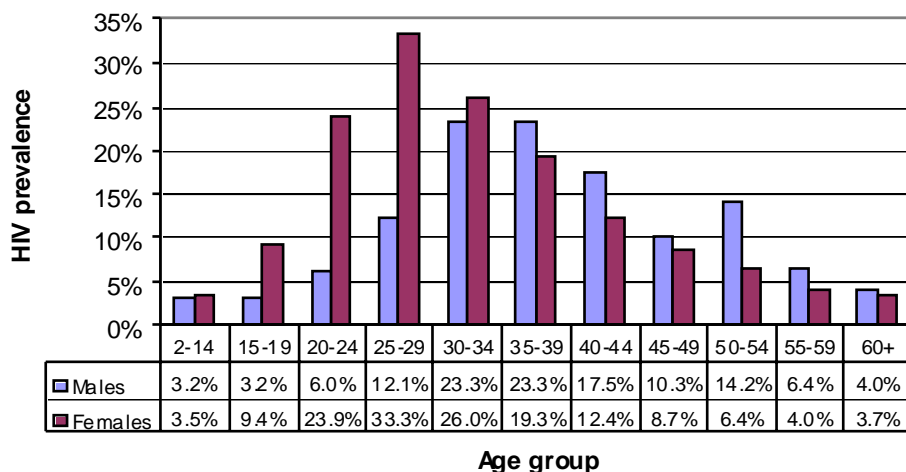
Figure 2: National prevalence by age and sex: 2005⁴

¹ Department of Health. (2006). National HIV and syphilis antenatal sero-prevalence survey in South Africa 2005. Pretoria: Department of Health. Shisana et al Shisana O. 2002. Nelson Mandela / HSRC study of HIV/AIDS: South African national HIV prevalence behavioural risks and mass media. Cape Town: HSRC; Shisana O, Rehle T, Simbaji LC, Parker W, Zuma K, Bhana A, Connolly C, Jooste, S, Pillay V. 2005. South African national HIV prevalence, HIV incidence, behaviour and communications survey. Cape Town: HSRC Press.

² Pettifor, A., Rees, H., Steffenson, A., Hlongwa-Madikizela, L., MacPhall, C., Vermaak, K., et al. (2004). *HIV and sexual behavior among South Africans: A national survey of 15-24 year olds*. Johannesburg: Reproductive Health Research Unit, University of Witwatersrand.

³ Department of Health, 2006

⁴ Shisana, et al (2005)



A number of other national and sub-national studies have been conducted including employees, the military, health workers, educators,⁵ health care workers and hospital patients⁶, amongst children attending health care facilities,⁷ and in various other communities and sectors.

Not all of these data are available in the public domain, and thus it has not been possible to paint a comprehensive picture of the epidemic in different sectors in South Africa.

However, the reasonably comprehensive data that are available have allowed HIV prevalence, incidence and AIDS mortality to be estimated using demographic modelling as shown in Table 1, showing an estimated 5.4 million people living with HIV or AIDS in South Africa in 2006, of which a total of 294 000 were children aged 0-14⁸. These estimates are consistent with those of the Department of Health and UNAIDS of 5.5 million people living with HIV or AIDS of which 235 000 are children for 2005. The annual number of new HIV infections in South Africa peaked in the late 1990s.^{8,9}

⁵ Shisana, O., Peltzer, K., Zungu-Dirwayi, N. & Louw, J. (Eds). (2005). The health of our educators: A focus on HIV/AIDS in South African public schools, 2004/5 survey. Cape Town: HSRC Press.

⁶ Shisana, O., Hall, E., Maluleke, K.R., Stoker, D.J., Schwabe, C., Colvin, M., et al (2002). The impact of HIV/AIDS on the health sector: National survey of health personnel, ambulatory and hospitalised patients and health facilities 2002. Cape Town: HSRC Press

⁷ Shisana, O., Mehtar, S., Mosala, T., Zungu-Dirwayi, N., Rehle, T., Dana, P. et al. (2004). HIV risk exposure among young children: A study of 2-9 year olds served by public health facilities in the Free State, South Africa. Cape Town: HSRC.

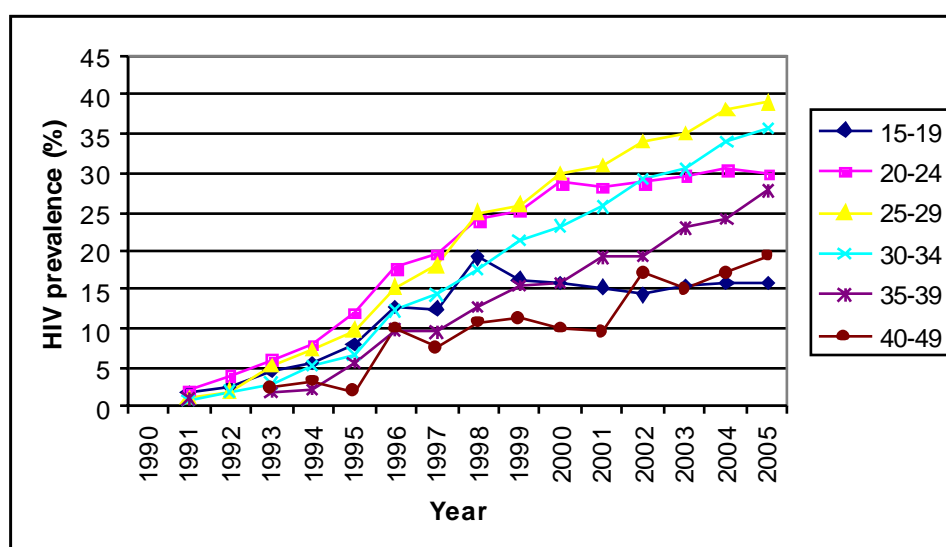
⁸ Dorrington, R. E., Bradshaw, D., Johnson, L. and Daniel, T. 2006. *The Demographic Impact of HIV/AIDS in South Africa. National and Provincial Indicators 2006*. Cape Town: Centre for Actuarial Research, South African Medical Research Council, Actuarial Society of South Africa.

www.commerce.uct.ac.za/Research/Units/CARE/RESEARCH/PAPERS/ASSA2003Indicators.pdf

⁹ Rehle, T. & Shisana, O. (2003). Epidemiological and demographic HIV/AIDS projections: South Africa. *African Journal of AIDS Research*, 2(1). 1-8.

National antenatal HIV prevalence has continued to increase in females over 20, although prevalence levels have remained relatively stable amongst young females aged 15-19 and begun to stabilise in the 20-24 age group over the 2001 to 2005 period.¹⁰ Figure 3 illustrates antenatal HIV prevalence patterns by age group since 1991. There was a sharp increase in HIV prevalence in most age groups until about 2000 when the increase slows down. In recent years there has been a discernable increase in HIV prevalence in older age groups.

Figure 3: HIV prevalence of antenatal clinic attendees by age group: 1991 – 2005



¹⁰ Department of Health. (2006). National HIV and syphilis antenatal sero-prevalence survey in South Africa 2005. Pretoria: Department of Health.

Table 1: HIV and AIDS Indicators at mid-2006¹¹

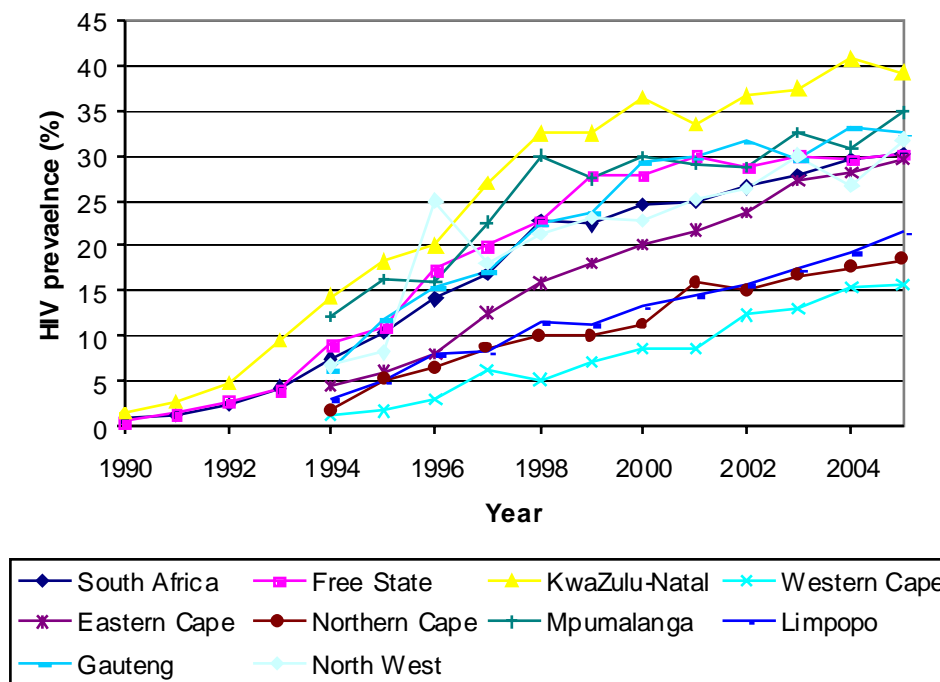
Births	
Uninfected births (over calendar year)	1 057 000
HIV+ births (over calendar year)	38 000
Infected through breastfeeding	26 000
People living with HIV/AIDS	
Total HIV infected	5 372 000
Adults (20-64)	4 880 000
Adult men (20-64)	2 179 000
Adult women (20-64)	2 702 000
Adults (15-49)	4 756 000
Adult men (15-49)	1 946 000
Adult women (15-49)	2 810 000
Youth (15-24)	1 012 000
Male youth (15-24)	181 000
Female youth (15-24)	831 000
Children (0-14)	294 000
New infections	527 000
Prevalence	
Total HIV infected	11.2%
Adults (20-64)	19.2%
Adult men (20-64)	17.8%
Adult women (20-64)	20.4%
Adults (15-49)	18.3%
Adult men (15-49)	15.4%
Adult women (15-49)	21.2%
Youth (15-24)	10.4%
Male youth (15-24)	3.7%
Female youth (15-24)	16.9%
Children (0-14)	1.9%
Incidence	
Total population	1.3%
Adults (20-64)	1.7%
Adult men (20-64)	1.9%
Adult women (20-64)	1.5%
At or before birth (of births)	3.5%
Breastfeeding (no. infected through breastfeeding in year/uninfected births in that year)	2.4%
Number adults (14+) infected by stage	
Stage 1	1 451 000
Stage 2	1 084 000
Stage 3	1 813 000
Stage 4 (not on treatment)	511 000
Receiving antiretroviral treatment	200 000
Discontinued antiretroviral treatment	18 900
Number children (<14) infected by stage	
Pre-AIDS	240 000
Stage 4 (not on treatment)	27 000
Receiving antiretroviral treatment	25 300
Discontinued antiretroviral treatment	1 500
AIDS sick	
New AIDS sick during 2006	479 000
Total AIDS sick mid-year	599 000

¹¹ Note: Numbers rounded to nearest thousand to avoid spurious accuracy. Source: Dorrington, Bradshaw, Johnson and Daniel (2006)

Heterogeneity of the South African epidemic

HIV prevalence varies considerably throughout South Africa. Some provinces are more severely affected than others, with the highest antenatal prevalence in 2005 being in KwaZulu-Natal (39.1%) and the lowest in the Western Cape (15.7%).

Figure 4: HIV prevalence of antenatal attendees by province : 1990 – 2005

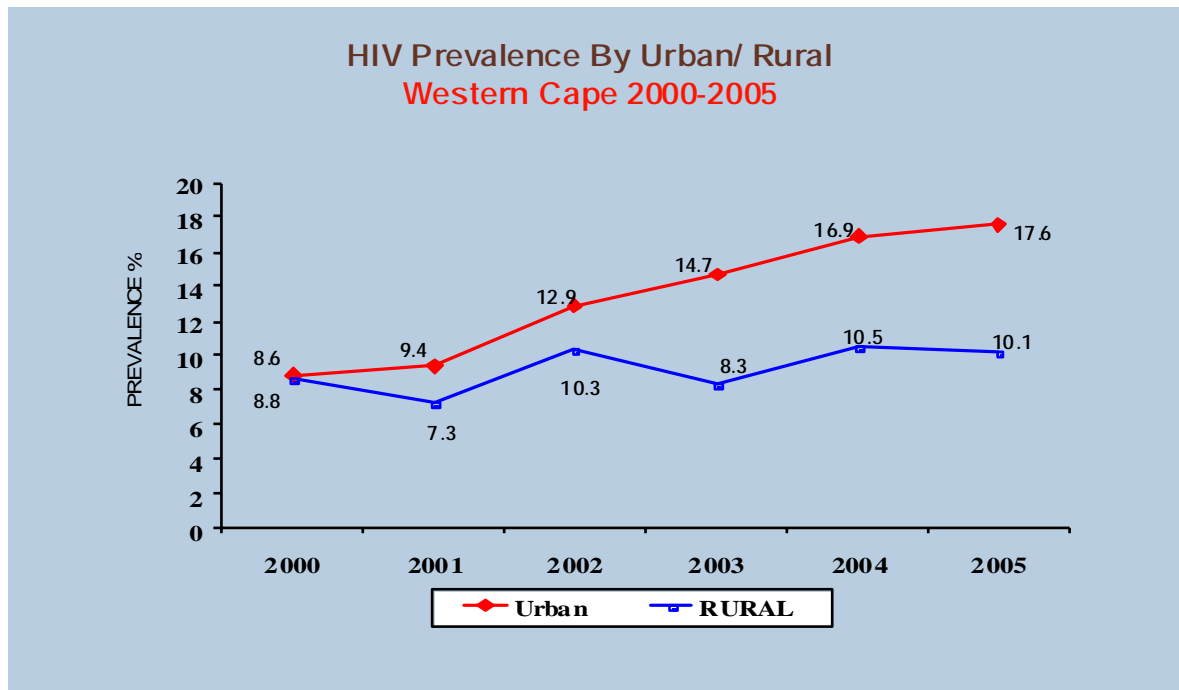


Prevalence also varies sub-provincially by geotype of residence with population-level HIV prevalence (for persons two years and older) in informal urban areas being nearly twice as high as in formal urban areas (17.6% vs 9.1%) in 2005. Levels in informal rural areas were 11.6% and in formal rural areas, 9.9%.¹²

An analysis of sub-provincial antenatal data in the Western Cape has illustrated a high degree of heterogeneity within the province, but also varying growth patterns in the various districts. Districts comprising predominantly informal urban areas have highest overall prevalence.¹³

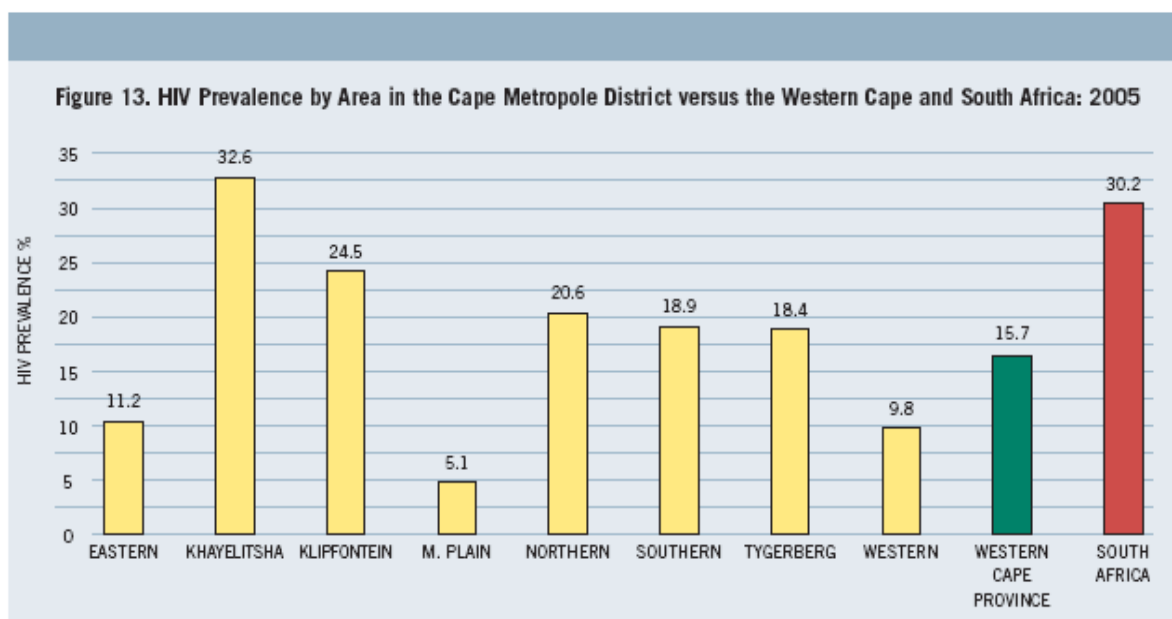
¹² Shisana et al, 2005

¹³ Shai kh N, Abdullah F, Lombard CJ, Smit L, Bradshaw D, Makubalo L Masking through averages--intraprovincial heterogeneity in HIV prevalence within the Western Cape, 2006. S Afr Med J. 2006 Jun;96(6):538-43



The reasons for the variable growth of the epidemic are not clear and a combination of factors are attributed to the variation. It is argued that geographical heterogeneity in HIV tends to reflect the degree of urbanization, in addition to other factors such as sexual risk behaviours, sexual networks, population demographics, unemployment, social deprivation, migration, high population density, unemployment and unstable communities (2, 9, 10).

In the case of the Western Cape, there has been rapid urbanization and migration from rural areas to towns or from other provinces.



National-level HIV prevalence also varies markedly by population group, sex and age group. In 2005, Black Africans were found to be most affected (of the order of six to seven times higher than non-Africans), whilst females aged 15-29 were three to four times more likely to be HIV positive than males in the same age group. HIV was around 3% amongst children aged 2-14, much higher in those aged 15-59 and nearly 4% for people in their sixties.¹⁴

Women bear the brunt of the epidemic of HIV and AIDS. Women account for 55% of people living with HIV and AIDS in South Africa. This phenomenon is more pronounced in the age groups 20-24 years and 25-29 where the HIV prevalence rates are 23.9% for women to 6.0% for men and 33.3% for women to 12.1% for men, respectively.¹⁵ The peak age for HIV infection in women is 25-29 years while for men it is the 30-35 years age group.

There is no single HIV and AIDS epidemic in South Africa. In addition to the pronounced gender dimension, there are other wide variations. These relate to the different new infection, illness and death epidemics. There is clear correlation between poverty and

¹⁴ Shisana et al, 2005

¹⁵ Human Science Research Council, 2005

high HIV prevalence, with communities in informal settlements who often are the poor being most vulnerable. These communities are often also the most underdeveloped, with poor access to social services including HIV and AIDS prevention, treatment, nutrition and care programmes. The vast majority of the population in informal rural and urban settlements are Black African.

Race has recently been identified as a significant risk factor for HIV and AIDS, with black Africans being the most affected. The 2005 HRC survey shows that Black Africans have HIV prevalence more than ten times higher than their White, Coloured and Indian compatriots.

The HRSC data also show that children have a high HIV prevalence. In the 2-4 age group, 4.9% of boys and 5.3% of girls are HIV positive, translating into an estimated 129 621 children. In the slightly older age group of 5-9, 4.2% of boys and 4.8% of girls have HIV - an estimated 214 102 children, and in the 10-14 age group, this figure drops to 1.6% among boys and 1.8% among girls. Work done by the Medical Research Council (MRC) to a large degree corroborates these findings.

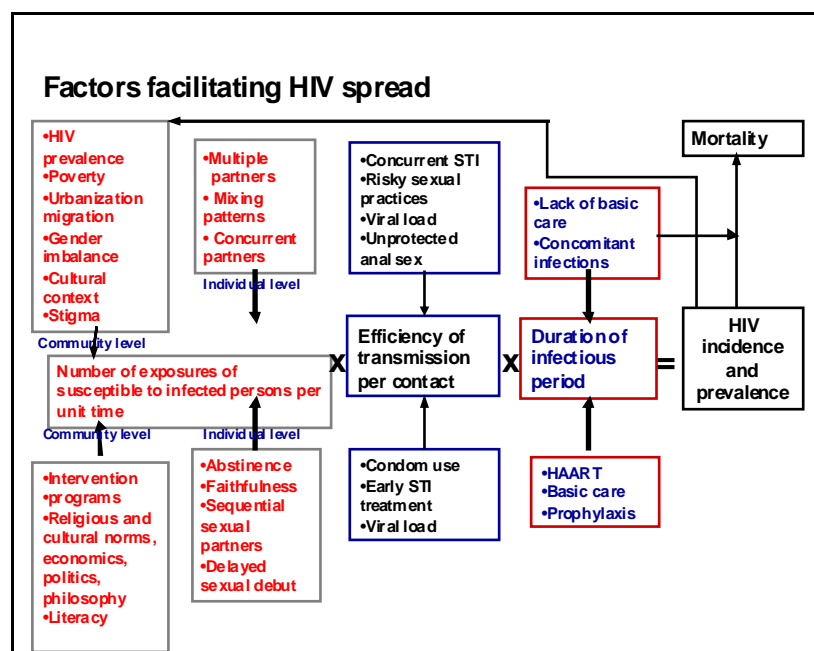
4.2 Major causes and determinants of the epidemic in South Africa

The context for these social and sexual networks is that of a newly democratic society emerging from a history of social disruption and racial and gender discrimination associated with inequitable distribution of resources as a result of Apartheid. The inequitable distribution of resources massively disadvantaged the majority of the population. This has resulted in a bimodal society, which is also reflected in the spread of disease within the population. Poverty related diseases including HIV and AIDS, TB and malaria affect mainly the previously disadvantaged sections of the population.

Many factors influence the heterogeneity and overall high levels of HIV prevalence in South Africa as illustrated in Figure 6¹⁶. These include biological, individual and social/contextual factors.

¹⁶ Rehle, T., Lazzari, S., Dallabetta, G., & Asamoah-Odei, E. (2004). Second generation HIV surveillance: better data for decision making. *Bulletin of the World Health Organization*, 82, 121-127.

Figure 5: Factors influencing the reproductive rate of HIV transmission



Source: adapted from Rehle et al, 2004

Whilst HIV is spread predominantly through unprotected sexual intercourse, other modes of infection remain important and are summarised below.

- Mother to child HIV transmission: HIV is transmitted to approximately one third of babies of HIV positive mothers if there is no medical intervention. Use of antiretroviral drugs, obstetric practices including caesarean delivery, and safe infant feeding practices can reduce transmission to very low levels.¹⁷
- Blood transfusion: The risk of HIV transmission via infected donor blood is high. However, donor and biological screening procedures allow for risk of HIV transmission through blood donation to be contained. Such procedures are followed rigorously in South Africa and risk is estimated to be very low – 1:400 000.¹⁸

¹⁷ Brocklehurst P, Volmink J. (2002). Antiretrovirals for reducing the risk of mother-to-child transmission of HIV infection. Cochrane Database Syst Rev 2: CD003510.

¹⁸ Heyns, A. & Swanevelder, J. (2005). Safe blood supplies. In S. Abdool Karim & Q. Abdool Karim (Eds.), HIV/AIDS in South Africa. Cambridge: Cambridge University Press.

- Exposure to blood: In healthcare settings HIV can be transmitted between patients and health care workers in both directions via blood on sharp instruments, and may also be transmitted between patients through re-use of contaminated instruments. A number of studies have highlighted the importance of infection control measures in such settings as well as post-exposure prophylaxis in the case of sharp instrument injuries.¹⁹ Exposure to blood can also occur in a wide range of institutional settings and in emergency situations where people are injured. Universal precaution practices including use of gloves and other protective measures are recommended.
- Intravenous drug use (IDU): IDU has long been recognised as a high risk practice for HIV transmission, as needles and syringes may be shared between users. The extent of intravenous drug use in South Africa is under-researched, mainly because of the legal environment and stigma associated with this behaviour. In regions where HIV occurs amongst intravenous drug users, prevalence is very high.²⁰

Contextual Factors

(a) Poverty

Poverty does not operate on its own as a risk factor for infection with HIV. Its effect needs to be understood within a socio-epidemiological context. It works through a myriad of interrelations, including unequal income distribution²¹, economic inequalities between men and women which promote transactional sex²², relatively poor public health education and inadequate public health system²³. Poverty-related stressors arising from aspects of poverty in townships such as poor and dense housing, and inadequate transportation, sanitation and food, unemployment, poor education,

¹⁹ Colvin, M. (2005). Impact of AIDS – the healthcare burden. In S. Abdool Karim & Q. Abdool Karim (Eds.), *HIV/AIDS in South Africa*. Cambridge: Cambridge University Press. 336-350.; Shisana, O., Mehtar, S., Mosala, T., Zungu-Dirwayi, N., Rehle, T., Dana, P. et al. (2004).

²⁰ UNAIDS, 2006a

²¹ Gie, R. et al. (1993). The socio-economic determinants of the HIV/AIDS epidemic in South Africa: A cycle of poverty. *South African Medical Journal*, 83, 223-224.

²² Halperin, D. & Allen, A. (2001). Is poverty the root cause of African AIDS? *AIDS Analysis in Africa*, 11(4), 1, 3, 15.

²³ Mitton, J. (2000). The sociological spread of HIV/AIDS in South Africa. *Journal of the Association of Nurses in AIDS Care*, 11(4), 17-26.

violence, and crime, have also been shown to be associated with increased risk of HIV transmission²⁴.

(b) Gender and Gender-based violence

HIV in sub-Saharan Africa constitutes some 64% of the global total of 24.5 million people living with HIV.²⁵ Levels of infection vary throughout the region with countries in the north and west having adult (15-49) prevalence levels of between 1% and 5%, while those in the southern Africa have prevalence in the region of 10% to 20%, with some countries (Botswana, Zimbabwe, Lesotho and Swaziland) even higher. HIV prevalence has declined in some African countries, starting with Uganda in the early and late 1990s followed by Zimbabwe and urban areas of Ethiopia, Kenya and Malawi.²⁶ These declines appear to be linked to a combination of factors including changes in key sexual behaviour: delayed sexual debut amongst young people, declines in partner turnover and increased condom use with casual sexual partners.

Southern Africa remains the most affected region, and the HIV epidemic in South Africa is interlinked with epidemics occurring in neighbouring countries. South Africa, Swaziland, Lesotho and Botswana reported the highest antenatal HIV prevalence levels in the world in 2006.²⁷ HIV prevalence is relatively low in neighbouring Mozambique, although is increasing rapidly along transport routes²⁸ and there is some evidence that prevalence may have peaked in Botswana²⁹.

The severity of the epidemic is closely linked to the region's poverty, women's relative lack of empowerment amongst women, high rates of male worker migration, and other social and cultural factors. Even with knowledge of how to protect oneself from infection, such information may not always be usable in daily situations of economic and social disadvantage that characterise the lives of many young people and women in poor countries.

(c) Cultural Attitudes and Practices

The relationship between culture and HIV is under-researched. There is some evidence that cultural attitudes and practices expose South Africans to HIV infections. First, gender inequalities inherent in most patriarchal cultures where women are

²⁴ Kalichman, S.C., Simbayi, L.C., Kagee, A., Toefy, Y. & Jooste, S. (2006). Association of Poverty, Substance Use, and HIV Transmission Risk Behaviors in Three South African Communities. *Social Science & Medicine*, 62, 1641-1649.

²⁵ UNAIDS. (2006a). 2006 report on the global AIDS epidemic. Geneva: UNAIDS

²⁶ UNAIDS, 2006a; Hallet et al, 2006; Cheluget et al, 2006; Bello et al, 2006; Kirungi et al, 2006; Mahomva et al, 2006

²⁷ UNAIDS, 2006a

²⁸ UNAIDS. (2006b). December 06: AIDS epidemic update. Geneva: UNAIDS

²⁹ Dorrington, R. E., Moultrie, T. A. and Daniel, T. 2006. *Modelling the impact of HIV/AIDS in Botswana*. Gaborone: UNDP and NACA, Botswana.

accorded a lower status than men impact significantly on the choices that women can make in their lives especially with regards to when, with whom and how sexual intercourse takes place³⁰. Such decisions are frequently constrained by coercion and violence in the women's relationships with men. In particular, male partners either have sex with sex workers or engage in multiple relationships, and their female partners or spouses are unable to insist on the use of condoms during sexual intercourse for fear of losing their main source of livelihood.

Second, there are several sex-related cultural beliefs and behavioural practices such as rites of passage to adulthood especially among male youth, rites of marriage such as premarital sex, virginity testing, fertility and virility testing, early or arranged marriages, fertility obligations, polygamy, and prohibition of post-partum sex and also during breastfeeding, and rites related to death such as levirate (or spouse inheritance) and sororate (a widower or sometimes a husband of a barren woman marries his wife's sister) are also believed to spread HIV infection³¹.

HIV infection is also believed to occur during some of the traditional health practices conducted by traditional healers when they use unsterilised sharp instruments such as knives, blades, spears, animal horns and thorns during some of the healing practices and/or recommend sex with a virgin as part of their treatment of patients.

(d) Stigma, denial, exclusion and discrimination

HIV and AIDS is perhaps one of the most stigmatised medical conditions in the world. Stigma interferes with HIV prevention, diagnosis, and treatment and can become internalized by people living with HIV and AIDS.³² In the UNGASS declaration, governments committed themselves to, among other things, confront stigma, denial and eliminate discrimination by 2003. Although still prevalent, AIDS stigma appear to be declining in South Africa as shown by the findings of the 2005 national HIV and AIDS household survey, when compared to the 2002 survey.³³

³⁰ Meyer-Weitz, A., Reddy, P., Weijts, W., van den Borne, B. & Kok, G. (1998). The socio-cultural contexts of sexually transmitted diseases in South Africa: Implications for health education programmes. *AIDS Care*, 10, 539-555.

³¹ Simbayi, L. (2002). Psychosocial and cultural determinants of HIV/AIDS in the SADC region. (Chapter 3). *HIV/AIDS in Southern Africa: A review paper*. Cape Town: HSRC Press.

³² UNAIDS (2006). Report on the global AIDS epidemic. Geneva: UNAIDS.

³³ Shisana, O., Rehle, T., Simbayi, L.C., Parker, W., Zuma, K., Bhana, A., et al. (2005a). *South African national HIV prevalence, HIV incidence, behaviour and communication survey*. Cape Town: HSRC Press

A recent large survey conducted among 1 054 people living with HIV and AIDS (PLWHA) in Cape Town found high levels of internalised stigma.³⁴ This is mostly due to the fact that HIV infection, as with other STIs, is widely perceived as an outcome of sexual excess and low moral character, with a consequent strong culture of silence by PLWHA because of fear of rejection and isolation by close relatives and the community at large. Stigma appears to be more severe for women than for men.³⁵

One of the consequences of the problem of stigma, exclusion and discrimination of people living with HIV and AIDS is that it forces people who are infected to hide their condition and to continue engaging in high-risk behaviour.³⁶ Another consequence is denial. Both silence and denial about HIV and AIDS are lethal because they prevent people from accurately assessing their own personal infection risk.

(e) Mobility and labour migration

Poverty and unemployment are linked to economic disempowerment and this affects sexual choice-making and exposure to wider sexual networks. Over and above gender vulnerability that flows from economic disempowerment, individuals who engage in work-seeking, mobile forms of work or migrant labour are at increased vulnerability to HIV as a product of higher likelihood to have multiple sexual partners, higher exposure to sex for exchange of money, amongst other risk factors.³⁷ Mobile individuals include informal traders, sex workers, domestic workers, cross-border mobility, seasonal agriculture workers, migrant workers (e.g. mine-workers, construction workers, and soldiers), long-distance truck, bus and taxi drivers, travelling sales persons and business travellers.³⁸ These forms of mobility are pervasive in southern Africa. Various studies have illustrated the higher likelihood of mobile groups to be HIV positive.³⁹ Migration patterns in South Africa have shifted from being predominantly male

³⁴ Simbayi, L.C., Strebel, A., Cloete, A., Henda, N., Mqeketo, A., Magome, K., & Kalichman, S.C. (In press). Internalized AIDS Stigma, AIDS Discrimination, and Depression among Men and Women Living with HIV/AIDS, Cape Town, South Africa. *Social Science & Medicine*

³⁵ Achmat, Z. (2001). (Untitled). Verbatim transcript of the address to the AIDS in Context Conference held at the University of the Witwatersrand on 7th April 2001. [Available from: <http://www.tac.org.za>]

³⁶ Qwana E, Mkhaya M, Dladla N & Lurie M (2000). An analysis of reasons for wanting and not wanting to disclose HIV status. Paper presented at the International AIDS Conference held in Durban.

³⁷ International Organisation for Migration. (2006). HIV/AIDS, population mobility and migration in Southern Africa: Defining a research and policy agenda. Pretoria: IOM

³⁸ International Organisation for Migration and UNAIDS. (2003). Mobile Populations and HIV/AIDS in the Southern African Region: Desk Review and Bibliography on HIV/AIDS and Mobile Populations. Pretoria: IOM

³⁹ International Organisation for Migration. (2006). HIV/AIDS, population mobility and migration in Southern Africa: Defining a research and policy agenda. Pretoria: IOM