REPUBLIC OF SOUTH AFRICA

MILLENNIUM DEVELOPMENT GOALS

Goal 6
Combat HIV/AIDS, malaria and other diseases

UNDP

The South Africa I know, the home I understand

Contents

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COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES					
Goal 6 Indicators	**1994 baseline (or closest year)**	**Current status 2010 (or nearest year)**	**2015 target**	**Target achievability**	**Indicator type**
HIV prevalence among population aged 15-24 years	9.3 *(2002)*	8.7 *(2008)*	< 9.3	**Possible**	**MDG**
Condom use at last high-risk sex	27.3% *(2002)*	62.4% *(2008)*	≈100	**Unlikely**	**MDG**
Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years	1:1 *(2002)*	1:1 *(2008)*	1:1	**Achieved**	**MDG**
Proportion of population with advanced HIV infection with access to antiretroviral drugs	13.9 *(2005)*	41.6 *(2009)*	≈100	**Unlikely**	**MDG**
Incidence of malaria	64 600 *(2000)*	6 800 *(2008)*	< 64 600	**Achieved**	**MDG**
Death rates associated with malaria	*2.0 (2002)*	*0.6 (2007)*	< 2.0	**Achieved**	**MDG**
Number of cases of children under 5 years of age with fever who are treated with appropriate anti-malarial drugs	9513 *(2000)*	603 *(2009)*	< 9513	**Achieved**	**MDG**
Number of households sprayed with insecticide	888 965 *(2000)*	1 757 832 *(2009)*			**Domestic**
• Incidence of tuberculosis	253 *(2004)*	283 *(2009)*	< 253	**Unlikely**	**MDG**
• Prevalence of tuberculosis	134 000 *(2004)*	144 000 *(2008)*	< 134 000	**Unlikely**	**MDG**
• Death rates associated with tuberculosis per 100 000 population	147 *(2002)*	179 *(2007)*	< 147	**Unlikely**	**MDG**
Proportion of tuberculosis cases detected and cured under directly observed treatment short course	65.5 *(2004)*	76.4 *(2008)*	100	**Possible**	**MDG**
Percentage of people that received an HIV test in the past 12 months and know their status	11.9 *(2005)*	24.7 *(2009)*			**Domestic**
HIV prevalence among pregnant women aged 15 – 24 years	22.8 *(2002)*	29.3 *(2008)*	22.8	**Unlikely**	**MDG**
HIV prevalence in men and women aged 15-49	15.6 *(2002)*	16.9 *(2008)*	15.6	**Unlikely**	**MDG**

6.3 Background

Dealing with the challenges of HIV and AIDS continues to be a major global and regional health priority. According to the UNAIDS and WHO (2009), in developing and transitional countries, 9.5 million people are in immediate need of life-saving AIDS drugs and of these, only 4 million (42 %) are receiving the drugs (UNAIDS & WHO 2009). According to UNAIDS, about 67 % of the people living with HIV and AIDS in 2008 were in sub-Saharan Africa. The adult prevalence rate of HIV and AIDS in 2008 for sub-Saharan Africa was 5.2 % compared to a global total prevalence of 0.8 %.

South Africa has the highest number of people living with HIV and AIDS, with this being currently estimated to be about 5.4 million. This accounts for 25% of the HIV disease burden in Sub-Saharan Africa. Only an estimated 38% of those in need of ART were on treatment by 2006 and recent data shows that this number is close to 50% of those in need of ART being treated by end of 2009. On the other hand, the World Health Organisation (WHO) estimates that about 1% of South Africans (482,000) contract Tuberculosis (TB) annually, thereby making the country one of the high burden TB countries globally. At the same time, the concomitant TB and HIV infections and drug-resistant forms of TB are increasing. Weak integration of HIV and AIDS, TB and maternal and child health services has severely undermined and weakened the achievement of programme outputs (UNAIDS & WHO, 2009).

The overall aim of this study is to examine progress on MDG Goal 6: combat the spread of HIV and AIDS, malaria and other diseases (including TB) with regard to South Africa.

Specifically the report :

- examines South Africa's progress in meeting the Millennium Development target with regard to combating the spread of HIV and AIDS, malaria and other diseases (including TB) within South Africa;
- reviews key challenges to the achievement of the Millennium Development Goals (MDGs) in South Africa with particular reference to combating the spread of HIV and AIDS, malaria and other diseases (including TB);
- suggests possible strategies to fast track the achievement of the MDGs with particular reference to combating the spread of HIV and AIDS, malaria and other diseases (including TB);
- suggests key priority activities that government needs to pay maximum attention to;
- suggests formation of strategic partnerships with other development stakeholders in the country; and
- suggests possible strategies for mainstreaming MDGs into the national development agenda.

The internationally agreed quantitative targets regarding combating the spread of HIV and AIDS, malaria and other diseases (including TB) has three components:
(1) Have halted by 2015 and begun to reverse the spread of HIV and AIDS. The indicators for monitoring progress in this are HIV prevalence among the population aged 15-24 years, condom use at last high-risk sex, proportion of the population aged 15-24 years with correct knowledge of HIV and AIDS ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years.

(2) Achieve by 2010 universal access to treatment for HIV and AIDS for all those who need it. The indicator for monitoring progress in this regard is the proportion of the population with advanced HIV infection with access to antiretroviral drugs. However, there is no empirical data on this indicator in South Africa.

(3) Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases. Many aspects of the indicators for measuring these are not relevant to South Africa. The domesticated indicator with regard to South Africa for which empirical data are available are incidence and death rates associated with malaria. The primary MDG target for TB is to halt TB incidence and half prevalence by 2015. The following key indicators are linked to this target:

- Increasing the TB detection rate to above 85 %
- Increasing the treatment success rate to above 85 %
- Reducing the death rate to no more than 14 deaths per 100,000 population

6.4 Introduction

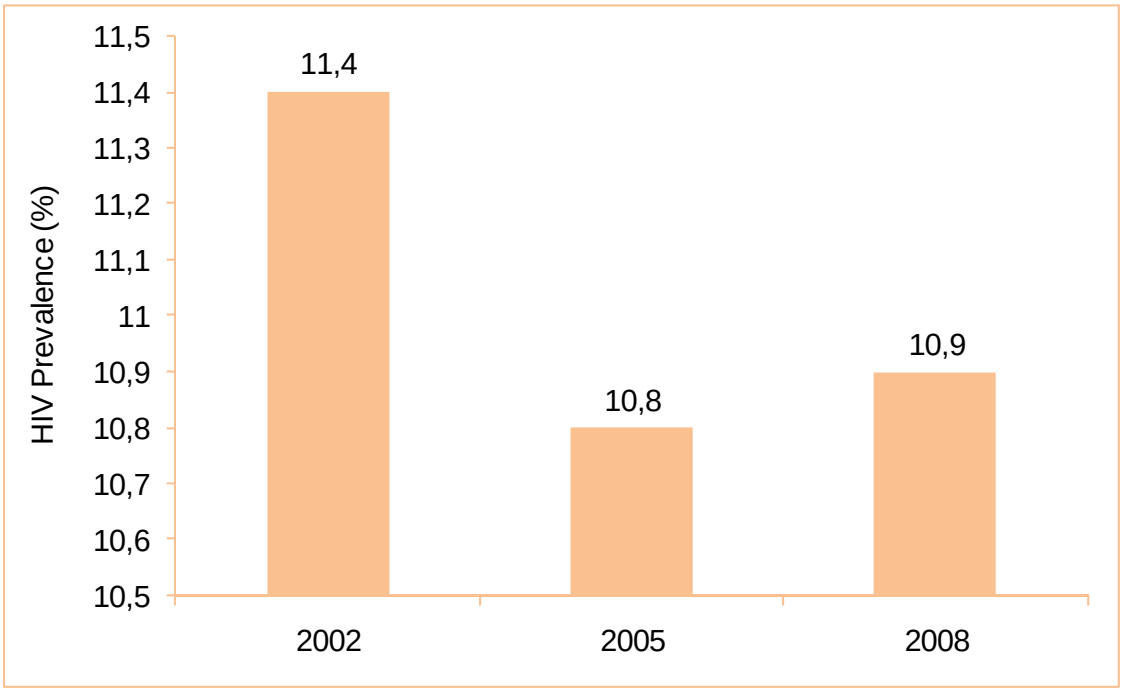
Until recent years, statistics and estimates on HIV prevalence in a population were largely based on women attending antenatal clinics as population-based HIV prevalence statistics were non-existent. Population-based HIV prevalence surveys have increasingly been carried out in many countries including South Africa, and in view of the estimates derived from these surveys, it is now widely recognized that HIV prevalence estimates based on women attending antenatal clinic appear to exaggerate HIV prevalence in the general population (Boerma, Ghys & Walker 2003). The Human Sciences Research Council (HSRC) to date has carried out three population-based HIV prevalence surveys in South Africa - in 2002, 2005 and 2008. The figures presented in this section of the report are based on the HSRC's and antenatal survey results.

Although South Africa is still to conduct a nation-wide TB prevalence survey; notification data, as captured in the Department of Health's TB hard copy and electronic registers, provide useful proxies to estimate the burden of TB in the country.

6.5 HIV Prevalence in the general population

It would appear from Figure 6.1 that the spread of HIV prevalence in South Africa may have stabilized as the HIV prevalence rate among persons aged 2 years and above has changed very little since 2002. However, the prevalence rate of about 11 % among persons aged 2 years and above since 2002 is still high even in comparison with other countries in the African continent. There is a gradient in the level of HIV prevalence moving from Western to Central, Eastern and Southern Africa with South Africa having one of the highest HIV prevalence not only in the world but in sub-Saharan Africa (Udjo 2008). Whereas adult (persons aged 15-49) HIV prevalence in Northern and Western Africa is in the order of less than <1 % and 5 % respectively, it is of the order of 15 % in South Africa.

Figure 6.1: HIV prevalence among persons aged 2 years and above 2002, 2005 and 2008



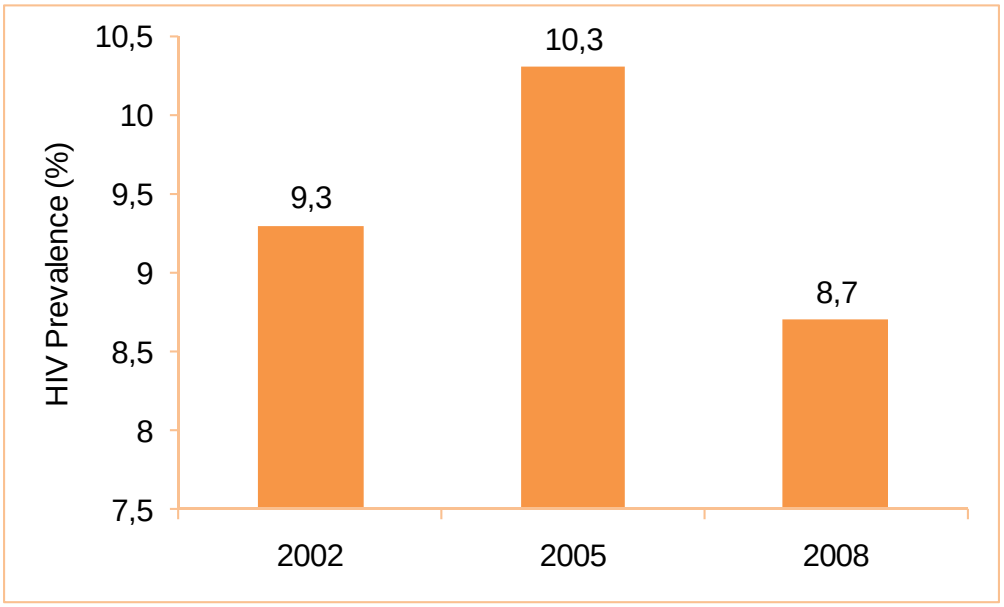
Source: Shisana et al 2009

6.6 HIV prevalence among population aged 15-24

Indicator: HIV prevalence among population aged 15-24 years

Trends in HIV prevalence among persons aged 15-24 years are a good proxy indicator of the course of new infections in the population. The evidence from population-based HIV prevalence surveys in South Africa appears to suggest that the spread of HIV among persons aged 15-24 years, overall has declined in the country since 2005 (Figure 6.2 and Table 6.1). However, some provinces such as the Western Cape and Mpumalanga appear to show fluctuating levels of HIV among persons in this age group since 2005 (Table 6.1).

Figure 6.2: HIV prevalence among persons aged 15-24 years 2002, 2005 and 2008



Source: *Shisana et al 2009*

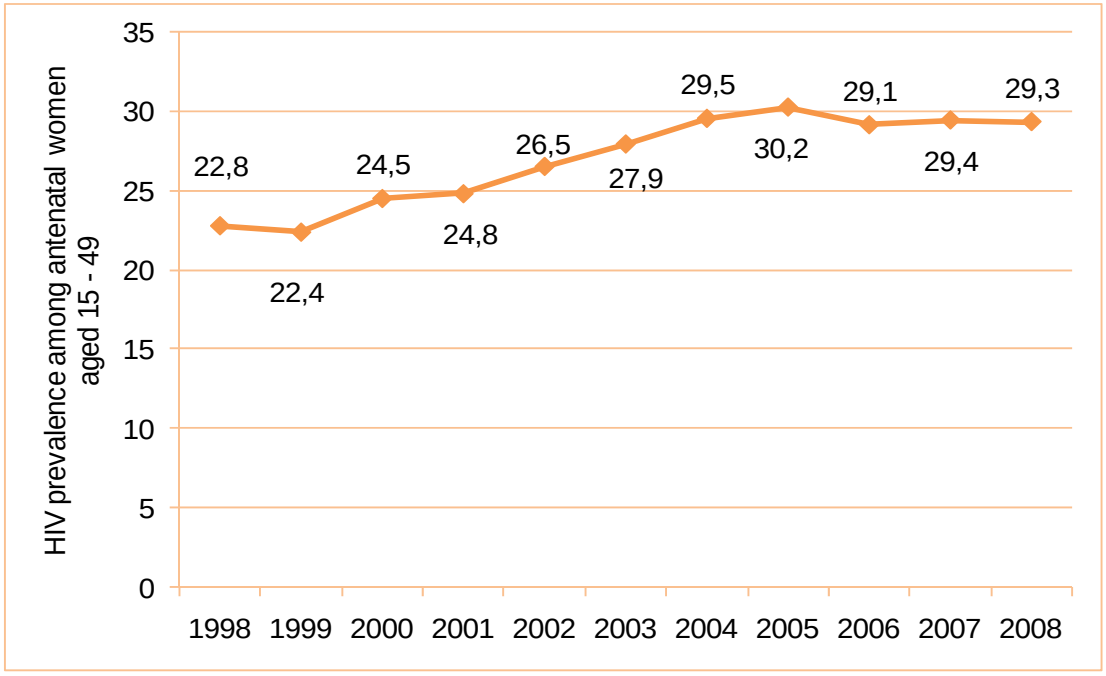
Table 6.1: HIV prevalence among persons aged 15-24 years 2002, 2005 and 2008

Province	2002	2005	2008
Western Cape	11.2	2.3	3.0
Eastern Cape	9.2	11.7	6.6
Northern Cape	11.8	6.4	3.9
Free State	8.7	10.3	3.8
KwaZulu-Natal	7.2	16.1	15.3
North West	8.3	6.6	6.3
Gauteng	11.6	9.0	10.1
Mpumalanga	11.7	10.1	13.5
Limpopo	5.6	7.4	3.9

Source: *Shisana et al 2009*

The data on HIV prevalence in South Africa among antenatal clients aged 15 - 49 years is provided in Figure 6.3 and Table 6.2. HIV prevalence among pregnant women attending antenatal care increased from 22.8 % to 29.3 % during the ten – year period from 1998 to 2008 (Figure 6.3). A closer look at the provincial variations shown in Table 6.2 indicates that the North West province showed a decline in HIV prevalence between 2005 and 2006, however there has been a rise since 2006. Mpumalanga and the Western Cape have also shown a similar trend, as has the Northern Cape. Limpopo's HIV prevalence rate rose in 2008. The Free State has shown a consistent increase in HIV prevalence between 2005 and 2008, whilst Gauteng and the Eastern Cape have both shown consistent decreases in that time-period.

Figure 6.3: HIV prevalence among antenatal clients aged 15-49 years 1998-2008



Source: *National Antenatal Sentinel HIV and Syphilis Prevalence Survey,* Department of Health

Table 6.2: HIV prevalence among antenatal clients aged 15-49 years by province 1998-2008

Province	Year										
	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Western Cape	5.2	7.1	8.7	8.6	12.4	13.1	15.4	15.7	15.1	15.3	16.1
Eastern Cape	15.9	18	20.2	21.7	23.6	27.1	28	29.5	28.6	28.8	27.6
Northern Cape	9.9	10.1	11.2	15.9	15.1	16.7	17.6	18.5	15.6	16.5	16.2
Free State	22.8	27.9	27.9	30.1	28.8	30.1	29.5	30.3	31.1	31.5	32.9
KwaZulu-Natal	32.5	32.5	36.2	33.5	36.5	37.5	40.7	39.1	39.1	38.7	38.7
North West	21.3	23	22.9	25.2	26.2	29.9	26.7	31.8	29	30.6	31
Gauteng	22.5	23.8	29.4	29.8	31.6	29.6	33.1	32.4	30.8	30.5	29.9
Mpumalanga	30	23.8	29.7	29.2	28.6	32.6	30.8	34.8	32.1	34.6	35.5
Limpopo	11.5	11.4	13.2	14.5	15.6	17.5	19.3	21.5	20.6	20.4	20.7

Source: National Antenatal Sentinel HIV and Syphilis Prevalence Survey, Department of Health

6.7 Testing

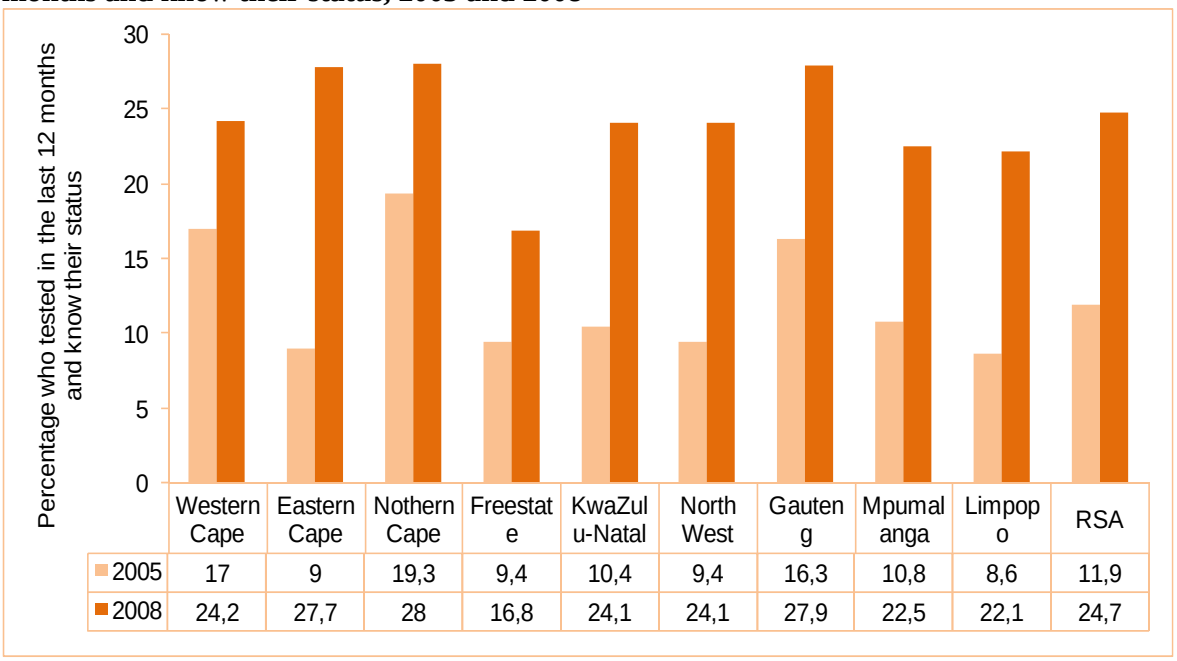
Knowing one's HIV status is important in combating HIV and AIDS. According to the 2009 National Communication Survey (NCS) in South Africa, a total of 61 % of all sexually active people men and women had ever been tested for HIV (48 % of men, and 74 % of women). The discrepancy could be due to that many women are tested during pregnancy. Of those who reported being tested in the past 12 months before the survey, 63 % were men and 59 %

were women. The percentage of both young men and women (aged 15-24 in 2006 NCS, 16-24 in 2009 NCS) who had ever been tested for HIV has increased dramatically - in 2006, 17 % of men and 38 % of women had been tested; in 2009, 31.8 % of men and 71.2 % of women had ever been tested.

Indicator: Percentage of people that received an HIV test in the past 12 months and know their status

Figure 6.4 further shows that in South Africa as whole and in each of the provinces, there is increasing tendency for people to test and know their HIV status. It might appear from Figure 6.4 that the percentage of persons who know their HIV status in South Africa and in each of the provinces is low (less than 30%), the percentages need to be interpreted with caution. The reference period for the question from which the percentages were computed was the last 12 months. It is possible that a substantial percentage of people may have tested during a time period exceeding 12 months and hence know their status. These persons would not have been captured in the two surveys in which the question was asked. In view of this, the percentages of those who know their HIV status in Figure 6.4 are probably an underestimate.

Figure 6.4: Percentage of people aged 15-49 that received an HIV test in the past 12 months and know their status, 2005 and 2008



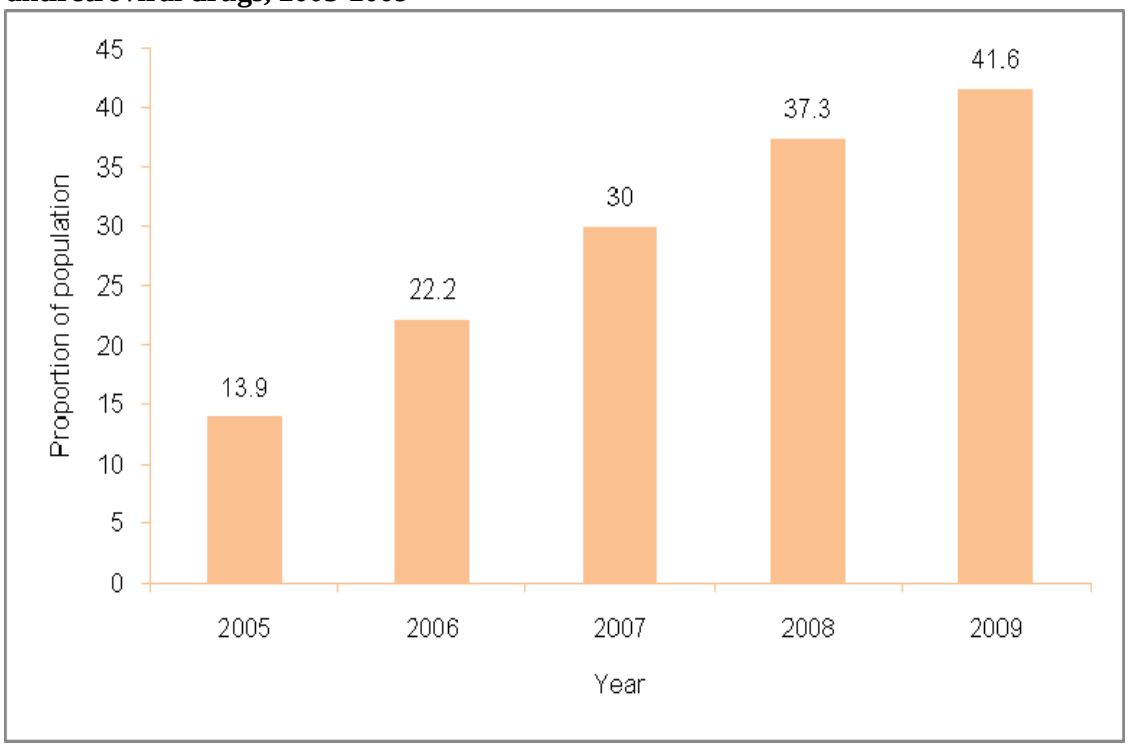
	Western Cape	Eastern Cape	Nothern Cape	Freestate	KwaZulu-Natal	North West	Gauteng	Mpumalanga	Limpopo	RSA
2005	17	9	19,3	9,4	10,4	9,4	16,3	10,8	8,6	11,9
2008	24,2	27,7	28	16,8	24,1	24,1	27,9	22,5	22,1	24,7

Source: *Shisana et al 2009*

Indicator: Proportion of population with advanced HIV infection with access to antiretroviral drugs

The data in Figure 6.5 and Table 6.3 show the proportion of the population with HIV infection in South Africa from 2005-2009 with access to antiretroviral drugs. These statistics were compiled with input from the Department of Health and the ASSA model (2003). There were wide disparities among persons with HIV infection who had access to antiretroviral drugs in South Africa, but the disparities started to disappear in 2009 (Table 6.3). There has been a marked increase in all the provinces from 2005 to 2009 in the proportion of people with HIV who had access to antiretroviral drugs. In South Africa as a whole, this proportion increased from 13.9 % in 2005 to 41.6 % in 2009 (Figure 6.5).

Figure 6.5: Proportion of population with advanced HIV infection with access to antiretroviral drugs, 2005-2009



Source: *National Department of Health, South Africa & ASSA Model 2003*

Table 6.3: Proportion of population with advanced HIV infection with access to antiretroviral drugs by province, 2005-2009

Province	2005	2006	2007	2008	2009
Eastern Cape	15.7	23.1	30.2	37.3	41.6
Free State	4.5	6.2	25.5	33.2	35.5
Gauteng	16.3	22.4	28.1	34.6	34.5
KwaZulu Natal	11.8	22.4	32.1	40.2	47.0
Limpopo	9.6	19.5	26.2	37.0	41.0
Mpumalanga	5.5	14.7	22.7	30.5	39.2
North West	16.6	26.1	30.9	37.2	43.9
Northern Cape	22.5	38.6	43.9	48.3	47.1
Western Cape	33.0	38.3	41.9	45.4	49.5

Source: *National Department of Health, South Africa & ASSA Model 2003*

6.8 Reduction in mother to child transmission of HIV

The Polymerase Chain Reaction (PCR) data illustrated in Table 6.4 indicates that the number of HIV infected babies in South Africa may be declining probably due to the success of the PMTCT programme. According to the data in Table 6.4, the overall national transmission rate of HIV to babies born to HIV-infected mothers is 11 %.

Table 6.4: PCR data and estimated transmission rates of mother-to-child, 2009

PC category	Positive	Negative	Not available	Equivocal	Invalid	Total	HIV transmission rate
Eastern Cape	2885	25,422	115	37	190	28,649	10.2
Free State	1,260	8,993	281	30	0	10,564	12.3
Gauteng	6533	53,683	517	117	115	60,965	10.9
Kwa-Zulu Natal	7,190	64,288	1,579	1381	0	74,438	10.1
Limpopo	2,095	13,922	51	255	145	16,468	13.1
Mpumalanga	2,164	14,919	6	286	133	17,508	12.7
Northern Cape	401	3,031	43	3	2	3,480	11.7
North West	1,970	14,449	105	117	107	16,748	12
Western Cape	1,350	15,319	156	9	1	16,834	8
National	25,848	214,025	2,853	2235	693	245,564	10.8

Source: *National Health Laboratory Services, 2009*

According to the 2010 South Africa Country Progress Report on the Declaration of Commitment on HIV/AIDS, the scale up and uptake of PMTCT has increased since the introduction of the programme in 2004. The report argues PMTCT is almost universally available in public primary facilities having achieved the National Strategic Plan for HIV and AIDS and Sexually Transmitted Infections (STIs) 2007 - 2011 (NSP) target of 95 % coverage

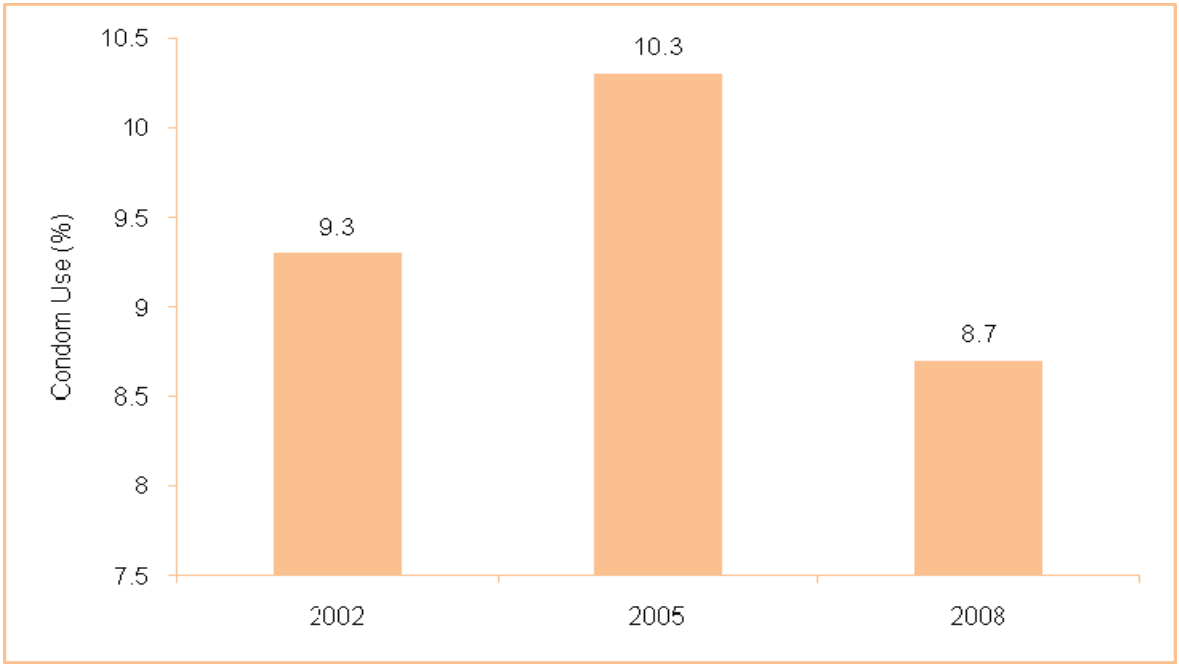
in the public sector antenatal sites in 2008. In South Africa, the PMTCT guidelines were most recently revised and adopted to include the introduction of the dual therapy regimen Nevirapine and AZT (Zidovudine).

6.9 Condom use at last sex

Indicator: Condom use at last sex

Risky sexual behavior is one of the factors that fuels HIV infections. In the fight against HIV infection, protected sex through the use of condoms is promoted in advocacy campaigns and programs. The results from the 2009 Communication Survey in South Africa indicates that condom use is lowest in stable (married or living together) relationships and highest by people with less stable relationships. Only 15 % of married men and women reported use of condoms at last sex as compared to 74-83 % of men and 56-66 % of women with other partners (casual, friends and one-night encounters). The results further indicated that condom use increased with exposure to more communication programmes. For instance, of those not exposed to communication programmes only 33% used condoms, while 50% of those who were exposed to all 11 programmes used condoms. Figure 6.6 suggest that there has been a decrease in the use of condoms among adults aged 15 years and older in South Africa as a whole since 2005.

Figure 6.6: Percentage of adults aged 15 years and over who used condom at last sex 2002, 2005 and 2008



Source: *Shisana et al. 2009*

6.10 Knowledge about HIV and AIDS

Indicator: Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS

Knowledge about HIV and AIDS transmission accompanied by an appropriate reduction of behavioral risks is important in combating and reversing the spread of HIV and AIDS. Results from the 2009 National Communication Survey in South Africa suggest that knowledge of HIV prevention methods is high. The results indicate knowledge level of 87 % for condoms on average across age groups. Knowledge of other HIV prevention methods such as faithfulness, partner reduction and abstinence is lower, but has improved since the 2006 National Communication Survey. The 2009 NCS also indicates that knowledge of treatment allowing people living with HIV to be healthy is high in South Africa and has significantly increased – of those who knew of treatment, 87 % (85 % male and 88 % female) identified antiretroviral therapy (ART) as a treatment, and 73 % know that ART is for life (in 2006, 42 % identified ART and 40 % knew it was for life).

6.11 School attendance by orphans

Indicator: Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years

The extent to which orphans of particular age attend school provides an indication of the impact of orphanhood on children's education. No doubt, some of the orphanhood would be due to AIDS-related mortality of the parents, but others would be due to other causes of death that are not AIDS-related. Any indicator of school attendance of orphans should therefore be interpreted with caution.

According to the General Household Surveys conducted from 2002 – 2008, the ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years is almost 1, which suggests that there is very little difference in school attendance of orphaned children aged 10-14 compared to non-orphaned children in South Africa since 2003. Put differently, the data appears to suggest that in South Africa, orphaned children aged 10-14 years are almost as likely to attend school as non-orphaned children.

6.12 Tuberculosis burden in South Africa

Indicator: Incidence, prevalence and death rates associated with tuberculosis

The UNAIDS and World Health Organisation (2009) estimate that about 1% of South Africans (roughly 490,000) contracted Tuberculosis (TB) in 2008, giving an incidence rate of 949 TB cases per 100,000 population. The detection rate, although still behind the required 85 % has exceeded 70 %. The incidence is much higher in high risk concentrate settings such as the mines and prisons, with the former estimated at between 3,000 and 7,000 cases per 100,000 per population. However, data from the TB Electronic Register (ETR) indicates that the TB incidence might be stabilising with increases in new cases being diagnosed reducing over the years (see Table 6.5).

Table 6.5: Incidence of TB and percentage increases 2005-2009

Year	New TB cases	Increase (%)
2009	139,468	0.5
2008	138,803	2.5
2007	135,468	3.3
2006	131,100	4,5
2005	125,460	6.4*

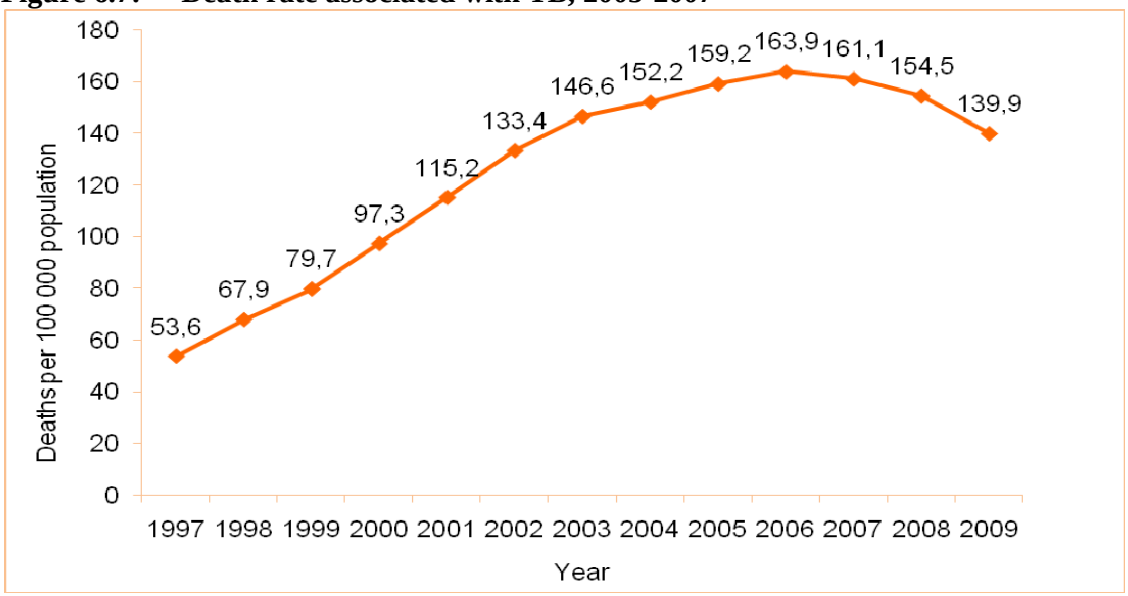
Source*: Electronic TB Register*, Department of Health, South Africa

Current HIV/TB co-infection rates exceed 70% with TB being the most common opportunistic infection among them. Due to late detection, poor treatment, management and failure to retain TB patients on treatment, drug-resistant forms of TB, DR-TB (multi-drug resistant – MDR TB - and extensively drug resistant –XDR TB) have increased significantly, with about 5,000 and 500 diagnosed respectively in 2009. Although the current policy by the Department of Health is that all DR-TB patients should be hospitalised until they are cured, there are about 2,000 beds available for DR-TB treatment and management.

As indicated in Figure 6.7, the death rate associated with TB increased from 64.2 deaths to 77.0 deaths per 100,000 population in South Africa. The provincial variation of deaths related to TB is indicated in Table 6.6. The data also shows that there has been an increase in TB related mortality in five provinces in South Africa, with the rates in Mpumalanga and Northern Cape rising in 2007 after a drop in 2006 and Western Cape and Gauteng both showing decreases. StatsSA also reported that TB was the highest reported condition in the deaths recorded in 2008. The results from the 2009 National HIV Communication Survey in South Africa indicate that the majority of respondents know what the duration of TB treatment is (75 % male and 80 % female). However, knowledge of the curability of TB in people living with HIV needs to be addressed (49 % of men and 45 % of women believe people with HIV cannot be cured of TB).

* Based on 2004 new cases (117,971)

Figure 6.7: Death rate associated with TB, 2005-2007



Source: *Mortality and causes of death in South, 1997-2009; Findings from the death notification*, Statistics South Africa

Table 6.6: Death rate associated with TB by province, 1997-2009[1]

Province of death occurrence	**Year of death occurrence**						
	1997	1999	2001	2003	2005	2007	2009
Western Cape	43,3	61,5	80,4	88,0	86,5	96,1	75,4
Eastern Cape	65,8	94,4	126,2	166,9	178,1	171,9	167,4
Northern Cape	79,4	94,0	128,3	181,0	186,3	153,2	127,7
Free State	76,1	111,5	148,5	208,5	200,9	206,0	178,4
KwaZulu-Natal	71,8	104,9	169,5	214,1	238,0	240,8	197,3
North West	57,9	92,0	126,1	157,9	163,9	167,1	144,4
Gauteng	39,1	63,2	92,4	107,3	119,1	114,3	100,6
Mpumalanga	43,0	73,4	113,9	154,2	185,2	193,8	170,2
Limpopo	24,1	34,3	47,3	70,5	79,5	92,5	89,8
RSA Total	53,6	79,7	115,2	146,6	159,2	161,1	139,9

Source: *Mortality and causes of death in South, 1997-2009; Findings from the death notification*, Statistics South Africa

[1] Different municipal boundaries were used over the years therefore the provinces are not completely comparable. In 1997-2006 the 2001 boundaries were used, in 2007-2008 the 2005 boundaries were used while in 2009 the 2011 municipal boundaries were used.

Indicator: Proportion of tuberculosis cases detected and cured under directly observed treatment short course

Table 6.7: Number of registered cases of TB and successful completion rates 2004-2008

Year	Number of registered TB cases	Successful completion (%)
2008	143,872	76.4
2007	143,222	73.9
2006	139,516	73.8
2005	142,049	70.8
2004	133,685	65.5

Source: TB Electronic Register, Department of Health

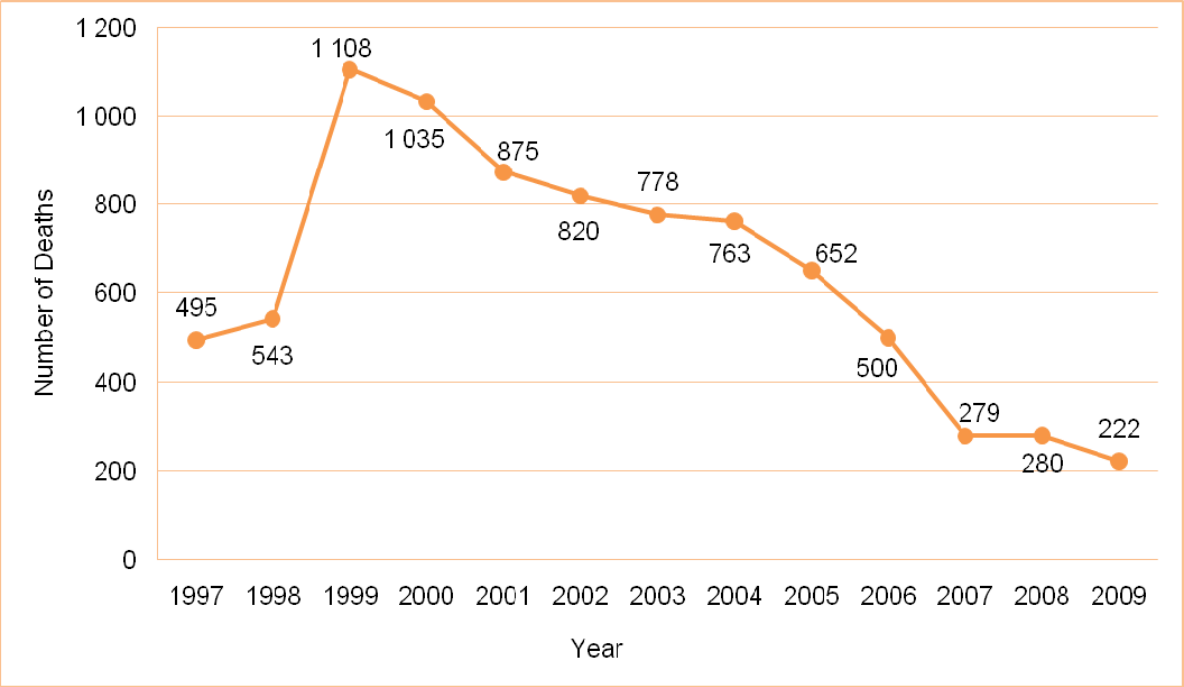
Whereas the successful completion rate associated with TB treatment was 65.5 % in 2004, this rate had increased to 76.4 % by 2008 (Table 6.7). Although South Africa still lags behind the stated MDG target of at least 85 % successful completion of TB treatment, there is a positive trend in the successful completion rates in South Africa that has developed over the years as indicated in Table 6.7.

6.13 Malaria

Indicator: Incidence and death rates associated with malaria

Malaria is endemic in only three provinces in South Africa, namely, Limpopo, Mpumalanga and KwaZulu-Natal. The number of deaths that would normally occur in each of those provinces are almost equivalent to the number of deaths that would occur in the rest of the provinces added together (i.e. Western Cape, Eastern Cape, Northern Cape, Free State, North West and Gauteng). Figure 6.8 and Table 6.8 depicts the number of malaria deaths in South Africa from 1997 to 2009 using the Mortality and causes of death in South; Findings from the death notification. It is evident from Figure 6.8 that malaria cases has declined from a very high 1108 deaths in 1999 to 222 deaths in 2009. This is indicative of an 80% decline in the number of malaria deaths in South Africa between 1999 and 2009. This is a huge achievement towards meeting the health - related millennium development goals.

Figure 6.8: Number of deaths due to malaria, 1997-2009



Source: *Mortality and causes of death in South, 1997-2009; Findings from the death notification,* Statistics South Africa

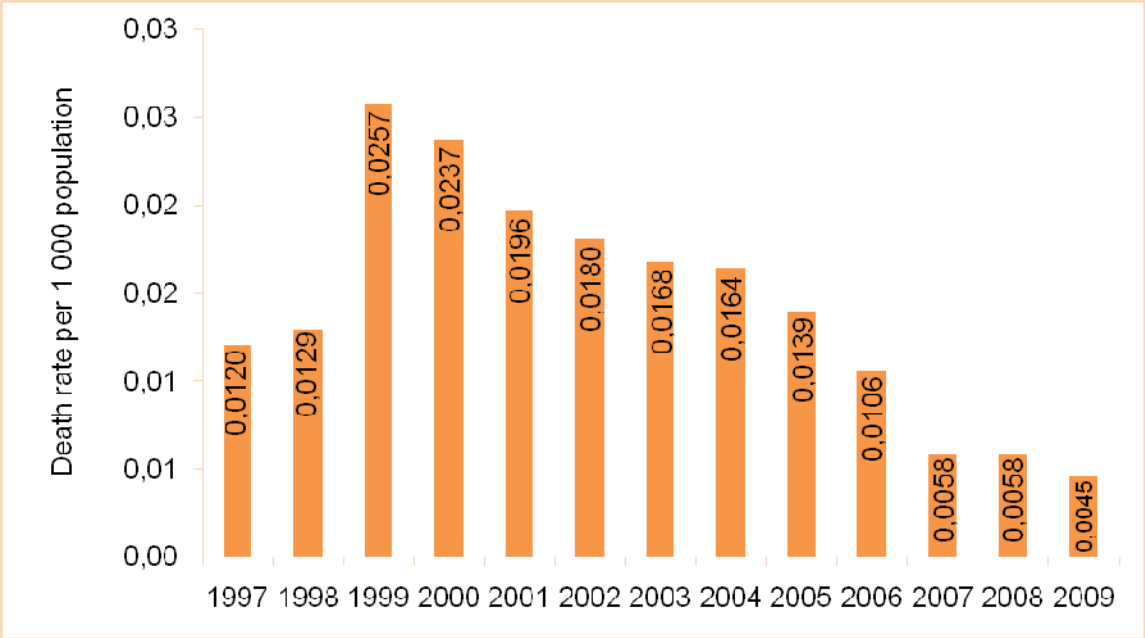
Table 6.8: Number of deaths due to Malaria by province, 1997-2009

	KwaZulu-Natal	Mpumalanga	Limpopo	Rest of SA
1997	95	82	170	148
1998	154	87	160	142
1999	305	177	380	246
2000	321	155	324	235
2001	110	169	377	219
2002	83	144	359	234
2003	63	113	359	243
2004	60	128	313	262
2005	55	82	296	219
2006	41	82	183	194
2007	34	58	59	128
2008	22	33	80	145
2009	18	31	570	103

Source: *Mortality and causes of death in South, 1997-2009; Findings from the death notification,* Statistics South Africa

As seen in Figure 6.9 and the death rate due to malaria in South Africa has remained very low at 4-10 per thousand since 1999. The number of deaths due to Malaria decreased from 360 per annum in 1999 to 54 in 2008; this represents a decrease of 85% over the period.

Figure 6.9: Death rate associated with malaria cases 1999-2009

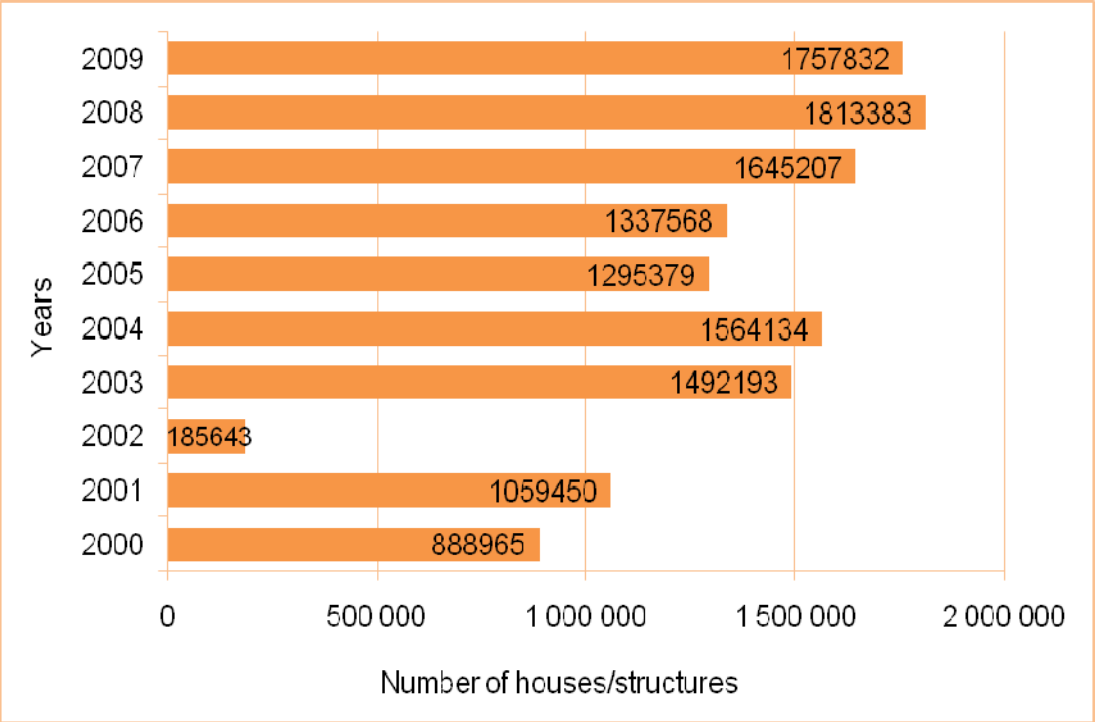


Source: *Mortality and causes of death in South, 1997-2009; Findings from the death notification,* Statistics South Africa

Indicator: Number of households sprayed with insecticide

Figure 6.10 shows the number of houses or structures sprayed with insecticide between 2000 and 2009. The trend is generally incremental, particularly from 2004 to 2009. An increase of 12.4 % in the number of houses or structures sprayed with insecticide was witnessed during this period.

Figure 6.10: Number of houses or structures sprayed at least once 2000-2009



Source: *Malaria Cases and Fatalities,* Department of Health

6.14 Policies and program in place to combat the spread of HIV and AIDS in South Africa

Dealing with HIV and AIDS is a public health issue in general and specifically among women, a reproductive health issue. Some of the key challenges in combating the spread of HIV and AIDS in South Africa include stigma about revealing one's HIV status, intergenerational sex, concurrent sexual partnerships and violence against women.

There are adequate policies and programs in place to combat the spread of HIV AND AIDS in South Africa. Cooper, Morroni, Orner, Moodley, Harries, Cullingworth & Hoffman (2004) have highlighted major legislative and policy changes influencing reproductive health in South Africa as follows:

- **1994**
  - Department of Health established partnerships to plan, process and review HIV AND AIDS policy, focusing on the prevention of new HIV infections and treatment of AIDS-related opportunistic infections.
  - Free public health services for pregnant women and children under six years of age.
- **1995**
  - Government ratifies the United Nations Convention on the Elimination of All Forms of Discrimination Against Women.
- **1996**
  - Choice on Termination of Pregnancy Act provides a legal framework for the provision of abortion services.

- **1997**
  - Maternal death made a notifiable condition; Standing National Committee for Confidential Enquiries into Maternal Deaths.
  - Patients' Rights Charter launched, giving patients the knowledge and right to address issues of equality in health care services.
- **1998**
  - New Population Policy introduced, delinked from population growth.
  - South African National AIDS Council formed.
  - Domestic Violence Act passed.
- **1999**
  - Prevention of Mother-to-Child transmission (PMTCT) of HIV programmes introduced in the Western Cape Province.
- **2000**
  - National Guidelines for Cervical Screening Programme launched.
- **2001**
  - PMTCT programme introduced in Gauteng province.
- **2002**
  - Treatment Action Campaign and Children's Rights Centre win a court application ordering government to implement a comprehensive PMTCT programme to prevent mother-to-child HIV transmission and to roll out PMTCT services country-wide.
  - National Contraception Policy Guidelines launched.
  - Government approves the provision of HIV post-exposure prophylaxis to survivors of rape in public sector facilities.
- **2003**
  - Government approves plan to provide antiretroviral drugs to people with AIDS through public sector health services.
- **2004**
  - Sexual assault legislation under review to amend the definition of rape and enforce heavier sentences.

Notable policy frameworks influencing reproductive health in South Africa since 2004 include the following:

- **2006**
  - Broad framework for HIV and AIDS and STI strategic plan for South Africa 2007-2011.
- **2007**
  - A policy on quality in health care for South Africa.
- **2008**
  - A policy and guidelines for the implementation of the PMTCT programme.

6.15 Key actions required to fast track the achievement of the MDG 6

Some of the actions recommended by the Higher Education Study for combating the spread of HIV AND AIDS in South Africa, even though made in the context of the

Higher Education Institutions in South Africa, are relevant to the general population as a whole. Some of actions the study recommended include the following:

- Voluntary Counseling and Testing (VCT) should be aimed at every person knowing their status as VCT has little influence on HIV negative individuals;
- knowledge of post-exposure prophylaxis after rape should be promoted;
- promote understanding of the higher risk of intergenerational sex;
- promote understanding of the risk of concurrent sexual partners; and
- need for HIV-positive people to begin to receive treatment before they become sick, especially in the light of increasing evidence that effective treatment should start far earlier than previously thought (Higher Education South Africa 2010).
- Strengthen infection control in both facilities and households
- Intensify case finding by among other means, active contact tracing
- Reduce TB treatment defaulting

Since the Government to a certain extent is doing all of these, perhaps the main key action that is proposed is for Government to intensify actions in these areas as well as in the implementation of other policies and programs in place aimed at combating HIV and AIDS. However, it must be noted that Government alone cannot be expected to combat the spread of HIV and AIDS, malaria and other diseases (including TB). It requires the concerted efforts by Government, civil society and individuals. Individuals need to take responsibility as well in combating the spread of HIV and AIDS and TB by minimizing risk behavior that fuels infection and spread of the conditions.

With regard to Malaria, the national malaria programme will be redirected towards malaria elimination and the Department of Health will work with countries like Swaziland, Mozambique, Zimbabwe and Botswana to ensure that this is achieved.

6.16 Partnership

In the light of the above, and in an attempt to combat the spread of HIV AND AIDS in South Africa, it is proposed that Government may strengthen partnerships with international donors (partners), non-Governmental Organizations, civil society, private sector and other sectors.

6.17 Conclusion

The majority of people in South Africa are aware that ART is a treatment for HIV and that it needs to be taken for life. This is a boost on communication efforts on treatment literacy over the past few years, and needs to be sustained. HIV prevalence levels are still high in South Africa compared to other countries in Northern, Western and Middle Africa. However, it would appear that the prevalence of HIV may have stabilized in the country. Efforts in the mitigation of malaria should be strengthened. The recent trend in the successful completion of TB treatment in South Africa that has developed over the years should be sustained.

6.18 References

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