PREPARING FOR MICROBICIDE ACCESS
SOUTH AFRICA COUNTRY PROFILE

FEBRUARY 2007

COMPANION VOLUME TO *A COUNTRY PREPAREDNESS ASSESSMENT OF MICROBICIDE ACCESS AND USE IN SOUTH AFRICA*

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PREFACE

With partial funding from the European Community, the International Partnership for Microbicides (IPM) commissioned a series of country profiles that compile information on demography, HIV and health systems in countries hosting or planning to host microbicide trials. They are intended to provide basic overviews that can inform the development of more detailed policy research agendas and support future planning for the introduction of microbicides. They do not set out detailed microbicide introduction strategies or address product-specific challenges.

Constella Futures was commissioned to prepare profiles for India, Nigeria, Rwanda and Tanzania. Studies were also conducted separately in South Africa and Zambia. All reports in the series are available at www.ipm-microbicides.org.

Though IPM commissioned these reports, the recommendations they contain are those of the authors and do not necessarily reflect IPM's views, positions or plans.

ACKNOWLEDGEMENTS

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REPORTS IN THIS SERIES

Prepared by Constella Futures:

- India Country Profile
- Nigeria Country Profile
- Rwanda Country Profile
- Tanzania Country Profile
- Preparing for Microbicides Access: A Synthesis Report

Prepared by Jo Heslop (data are comparable to Constella Futures reports):

- South Africa Country Profile
- Zambia Country Profile

Prepared by Health and Development Africa:

- A Country Preparedness Assessment of Microbicide Access and Use in South Africa

Prepared by JHPIEGO/ Zambia:
Microbicide Country Preparedness Assessment – Zambia: Prospective Introduction of a Microbicide to Prevent or Reduce HIV Transmission

CONTENTS

ACRONYMS

ART	Antiretroviral therapy
CDC	Centers for Disease Control and Prevention
DFID	UK Department for International Development
DHS	Demographic and health survey
DOH	Department of Health
EDL	Essential Drugs List
EU/EC	European Union/European Commission
GDP	Gross domestic product
GFATM	The Global Fund to fight AIDS, Tuberculosis and Malaria
GFCCM	The Global Fund Country Coordinating Mechanism
HIV/AIDS	Human immunodeficiency virus/ Acquired Immunodeficiency syndrome
IPM	International Partnership for Microbicides
MAP	Multisectoral AIDS Programme
MOU	Memorandum of understanding
MSD	Medical Stores Department
MWRA	Married women of reproductive age
NEDLEC	National Essential Drug List Committee
NGO	Non-governmental organisation
OI	Opportunistic infection
OVC	Orphans and vulnerable children
PEP	Post-exposure prophylaxis
PEPFAR	The President's Emergency Plan for AIDS Relief
PMTCT	Prevention of mother-to-child transmission of HIV
PRB	Population Reference Bureau
SANAC	South African National AIDS Council
SANHS	South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey
SRH	Sexual and reproductive health
STI	Sexually transmitted infection(s)
SWAp	Sector-wide approach(es)
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on AIDS
UNDP	United Nations Development Fund
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	
VCT	Voluntary counselling and testing of HIV
WHO	World Health Organization

EXECUTIVE SUMMARY

South Africa is a large country with a population of 47 million. It is an upper-middle-income country, but has one of the highest wealth distribution inequalities in the world, with much of the poverty occurring in the rural areas and among disadvantaged black South Africans. It is only 12 years since the end of apartheid and the country has faced major challenges in creating a democratic, equitable and prosperous South Africa in the face of high unemployment and poverty. The population is ethnically, linguistically and culturally diverse, with significant coloured, white and Indian populations as well as black South Africans, who make up 79 percent of the population.[1]

Use of modern contraceptives is high and this has contributed to the fairly low birth and fertility rates, compared to many other African countries. However, the life expectancy of 47 years is low and has been greatly reduced by AIDS in recent years. Literacy levels and economic activity for women are high, compared to other African countries. However, there are indications of high levels of physical, sexual and economic abuse of women and girls in South Africa.

South Africa is facing a mature, generalised HIV/AIDS epidemic, with an estimated prevalence rate of 18.8 percent. It has been steadily increasing since the early 1990s but shows signs of levelling off. HIV prevalence and vulnerability vary widely between different populations, with young African women being at the highest risk. The high prevalence of intergenerational sex puts women at a higher risk at a younger age. There is a high incidence of mother-to-child transmission. According to UNAIDS, South Africa has the second highest HIV/AIDS burden in the world, with 5.5 people million infected and 1.2 million children orphaned by AIDS.

Median age at first sex for women is 18.4 years and declining, while median age at first marriage (24.2 years) is increasing. This presents a six- or seven-year year period which coincides with the highest incidence of HIV infection in women. Multiple sexual partnerships are much more common in men than women and are more common at a younger age. Frequency of sexual intercourse is higher in the 25-49 age group than with younger or older age groups. Reported STI prevalence is much lower than actual HIV prevalence, but a strong relationship was evident between existence of STIs and HIV.

South Africa's health system has undergone a major transformation since the end of apartheid, moving towards primary care-oriented services in a decentralised system largely run by district health authorities. Access to services is still limited, particularly in rural areas,

[1] Much of the epidemiological and demographic data cited in this paper are sourced from the South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005. In the interest of consistency, racial groups are described by the categories used in the survey.

and there are disparities in funding, and therefore quality and availability, of services between provinces. Chronic staff shortages, as well as HIV/AIDS, add a major challenge to the health system. The government spends more than 10 percent of its budget on health, showing a strong commitment to health. The health service is largely self-reliant, with only 0.5 percent of funding coming from external sources.

There is a prominent private sector in South Africa's health services, with almost a quarter of people using private healthcare services - largely more affluent people covered by "Medical Aid" insurance schemes. This accounts for over half of all expenditure on health. The inequality in the health system is apparent, with the richest quintile spending 47 times more on healthcare than the poorest quintile of population.

Immunisation coverage for infants is fairly low. Contraceptive coverage is fairly high, with injectables, sterilisation and the pill being the most popular methods. Knowledge of family planning methods is high and much higher for modern than traditional methods.

Overall political commitment on addressing HIV/AIDS is high in South Africa, as measured by the National AIDS Effort Index, although policy and planning issues received a low score. However, there has been much controversy locally and internationally about the role of the South African government in addressing HIV/AIDS, particularly around the introduction and scale-up of antiretoviral therapy. The National HIV/AIDS Programme is headquartered within and driven by the HIV/AIDS and STI Unit within the Department of Health, and a multisectoral National AIDS Council has also been set up. The South African government has spent a massive US$1.7 billion on HIV/AIDS in the last three years – similar to Rwanda and Tanzania's total health budget in per capita terms. A principle of the 2003 Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment, is financial self-reliance, and less than 10 percent of HIV funding comes from external sources.

The National Strategic Framework on HIV/AIDS 2000-2005 emphasises prevention and prevention programming to tackle HIV/AIDS, and political commitment in this area is very strong. There are many well-known and popular national mass media awareness campaigns, as well as strong interpersonal behaviour change interventions run through schools, NGOs, community, faith-based and other organisations. Knowledge of HIV is high, but myths prevail and perception of risk is low. VCT has been expanding rapidly in recent years and knowledge of and attendance at VCT centres are high (three in 10 South Africans have been tested for HIV). PMTCT scale-up was initially slow and surrounded by controversy, but coverage has greatly improved in recent years and now stands at 15 percent of those in need.

After several controversies, legal battles and delays, large-scale treatment scale-up is finally underway. The 2003 Operational Plan for Comprehensive HIV and AIDS Care, Management

and Treatment plans to provide treatment for 1.4 million people – the largest such programme in the world. However, in 2005 only one person in eight who was in need was receiving ART. This fell well short of WHO's "3-by-5" targets.

There is a vibrant civil society sector in South Africa and the country is also a centre for operational research on HIV/AIDS. The institutional mapping section (see Annex) summarises some key players in the HIV/SRH sector.

Some recommendations arising from the information gathered in this profile are:

- Microbicides need to be delivered through the public health service, particularly the primary health facilities. Three in four South Africans use public health services and the groups using public facilities the most have the highest vulnerability to HIV (for example, those from informal urban and rural and formal rural settlements). People are used to going to the government clinics for condoms, so the introduction of microbicides into services would not need a major behavioural shift.
- Modern contraceptive use is high and this can be capitalised on to increase access and uptake of microbicides. But this would mean that microbicides need to be fully integrated into family planning services and health staff need to receive sufficient training on microbicides.
- Sensitisation and advocacy with traditional healers will ease the acceptance and uptake of microbicides. Traditional healers are widely used and influential.
- The public sector's condom social marketing and distribution are effective and the public sector is the largest provider of condoms in South Africa. Microbicides piggy-backing onto the condom distribution system would maximise effectiveness, efficiency and sustainability of distribution.
- Social marketing should be specific to targeted groups in all relevant languages if all sections of the target populations are to be reached. Television and radio are more effective than billboard campaigns (according to South Africans responding in a population-based survey). There are many well-known and well-liked mass media campaigns, and working with these could highly increase the profile of microbicides.
- Coordinate with relevant faith-based organisations to integrate microbicides into their work. Eight in 10 South Africans are Christians and FBOs are seen as a primary source of information on HIV prevention.

1 INTRODUCTION

This country profile for South Africa is one of a series of six country profiles commissioned by the International Partnership for Microbicides to look at issues of microbicide access at a country level.

The primary aim of the project is, “to accelerate access of women in less developed countries to microbicides as soon as possible after clinical trials have demonstrated their effectiveness in preventing HIV-infection.” Broadly, the objectives of the project are to identify mechanisms, critical pathways and key procedures necessary to accelerate the availability of microbicides in developing countries.

This country profile for South Africa is meant to be a resource for the microbicides community as it anticipates and begins to plan access to future microbicides. The profile includes summary demographic and health information as well as an overview of HIV/AIDS programming in South Africa. Finally, the profile includes institutional mapping of South Africa, outlining the key players in HIV/AIDS and sexual and reproductive health (SRH). Recommendations for microbicide planning and research in South Africa conclude this report.

This country profile uses standardised data, where possible, and a standardised format, so that the six country profiles are comparable. This profile does not contain information on regulatory, manufacturing and procurement issues. These are covered in depth in “A Country Preparedness Assessment of Microbicide Access and Use in South Africa,” prepared by Health and Development Africa and Society for Family Health for IPM. It is useful to read these two reports alongside each other as the two are designed to be complementary.

2 METHODOLOGY

The research assistant built the country profile around the outline suggested by IPM. The researchers discussed the best sources for each item and, in some cases, multiple sources were used. Public sources such as UNAIDS, WHO and PRB were used, with every effort made to ensure comparability between country profiles.

The research assistant collected the data and “grey literature” and presented this in a standardised format. The profile was reviewed by IPM.

3 DEMOGRAPHIC INFORMATION

3.1 BASIC DEMOGRAPHIC AND SOCIO-ECONOMIC CONTEXT

TABLE 3.1 DEMOGRAPHIC DATA

Total population *(PRB, 2006).*	47,322,000
Population density per square mile *(PRB, 2006).*	100
Percentage of population living in urban areas *(PRB, 2006).*	53%
GDP per capita *(WHO, 2005).*	US$2376
Human Development Index *(WHO, 2005).*	0.658 (ranked 120th/177)
Percentage of population on under $2 a day *(PRB, 2006).*	34%

South Africa is a large country on the southern tip of the African continent, bordering Namibia, Botswana, Zimbabwe, Mozambique and Swaziland to the north. The country of Lesotho is an enclave surrounded by South African territory. South Africa has the Indian Ocean to the south and east and the South Atlantic Ocean to the west. South Africa has a population of over 47 million. It has a relatively low population density of 100 people per square mile. However, over half of people live in urban areas, particularly in the eastern areas around Johannesburg, as well as coastal areas (the cities of Cape Town, Durban and other towns and cities along the south coast). South Africa is an upper-middle-income country with a GDP per capita of US$2,376 and a Human Development Index of 0.658 (the 58th lowest ranking in the world). However, this masks the fact that it is ranked as the third most unequal society in the world, measured by the Gini coefficient,[2] with one-third of the population living on less than $2 a day. Poverty is mainly rural; 72 percent of the poor live in rural areas, and 70 percent of the rural population are poor.[3]

The diverse racial make-up of South Africa is a result of large-scale settlements of Dutch in the 17th and 18th, centuries followed by the British at the end of the 18th century. White minority rule and apartheid during the second half of the twentieth century intensified the subjugation of black Africans. The first post-apartheid elections took place in 1994 and brought the African National Congress to power. Today, South Africa is composed of a population that is 79 percent black African, 10 percent Caucasian, nine percent coloured (mixed race) and two percent Indian.[4] The black population is heterogeneous, with several ethnic groups, cultures and languages. South Africa has 11 official languages: Afrikaans, English, Ndebele, Northern Sotho, Southern Sotho, Swati, Tsonga, Tswana, Venda, Xhosa and Zulu. English, however, has emerged as more dominant in business and administration. The overall language makeup is 24 percent isiZulu, 18 percent isiXhosa, 13 percent Afrikaans, nine percent Sepedi, eight percent English. Other native African languages account for the remainder. The population is 80 percent Christian (of a multitude of denominations, including: Zion Christian, Pentecostal, Roman Catholic, Methodist, Dutch

[2] GFATM, 2003.
[3] DFID, 2001.
[4] Classification defined in the South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey.

Reformed, Anglican and many others), two percent Islam, twp percent others and 15 percent agnostic.

Pretoria is considered the capital of South Africa, although, strictly speaking, it is merely the administrative capital. Cape Town is the legislative capital and Bloemfontein is the judicial capital. Johannesburg is the main commercial city. The country is divided into nine provinces, each with their own provincial governments; Eastern Cape, Free State, Gauteng, KwaZulu-Natal, Limpopo, Mpumalanga, North-West, Northern Cape and Western Cape. These are further divided into 52 administrative districts.

South Africa has an abundant supply of natural resources and well-developed financial and other business sectors. It acts as an effective business and distribution capital for other countries in the region. However, growth has not been strong enough to cut high unemployment levels, and daunting problems remain from the apartheid era, especially poverty among the disadvantaged groups (particularly black South Africans). Just over a quarter of the population is unemployed. Of those working, almost half work in services and the rest in agriculture and industry. Main exports are gold, diamonds, platinum, other metals and minerals, machinery and equipment.[5]

3.2 Health and Fertility

Table 3.2 Health and Fertility Data

Crude birth rate	23
Crude death rate	18
Projected population increase 2006-2050	2%
Life expectancy at birth	47 years
Life expectancy at birth (male)	45 years
Life expectancy at birth (female)	49 years
Total fertility rate	2.8
Ideal family size – women *(SADHS, 1998.)*	2.9
Ideal family size – men	-
Percentage of married/in union women of reproductive age using contraception	56%
Percentage of MWRA using modern contraception	55%
Unmet need for family planning	-
Age at first marriage *(DHS, 2006).*	24.2 years
Age at first sex *(DHS, 2006).*	18.4 years
Age at first birth *(SADHS, 1998.)*	19.4 years

Source: PRB, 2006, unless otherwise stated.

South Africa's birth rate is much lower than most other countries in sub-Saharan Africa, but its death rate is higher. A previously steadily increasing life expectancy has fallen sharply since the early 1990s and now stands at 47 years, largely because of AIDS. Fertility is low compared to surrounding countries, at 2.8, and there are signs that it is declining further. Ideal family size is similar at 2.9, although it is 3.3 for married women. Contraceptive use is

[5] CIA, 2006.

high, with over half of women using modern methods of contraception. Contraceptive use is higher (and fertility lower) for racial groups other than black Africans, those with a higher level of education, urban people, and those from the Western Cape.

3.3 GENDER

TABLE 3.3 GENDER DATA

Percentage of women aged 15-24 who are literate (can write a simple sentence)	94%
Literate women as a percentage of literate men	101%
Percentage of women aged 15+ who are economically active	48%
Percentage of men aged 15+ who are economically active	61%
Percentage of women with access to newspaper, TV and radio *(DHS, 2005)*	30%

Source: PRB, 2005, unless otherwise stated.

Literacy levels for girls are high in South Africa. Both the proportion of literate women and women's literacy as a percentage of men's literacy are higher than the world average and average for southern Africa. Women are also almost as economically active as men. One in three women has full access to the media. Although some basic gender-related indicators suggest relatively high levels of women's empowerment compared to other parts of Africa, this does not paint the full picture; sexual violence against women is very high in South Africa. Some major findings of the 1998 SADHS include the following:

- One in five married women reported economic abuse (her husband withholding resources for household food, rent or bills and spending it on other things). This was more common in rural areas and women in Free State and KwaZulu-Natal.
- One in 10 women reported that she had been physically assaulted in the year preceding the study; six in 10 of these cases involved a current or ex-partner and the remaining involved (in order of prevalence) community members (neighbours and people known in the school or community), male relatives, strangers and female relatives (usually the mother). Almost two-thirds of the women assaulted by a partner said their assaulters were drunk or on drugs always or sometimes at the time of the assault.
- One in 15 women reported having been forced or persuaded to have sex against their will by a sexual partner. The proportion was higher for white and coloured women, those with a higher level of education and those from the Western Cape. However, it could be that these groups were more open about their experiences and/or that understanding of what constitutes forced or coerced sex is different.

It is likely these data strongly under-represent the true figures of violence against women. Dedicated surveys of violence against women compared with more general surveys, such as the DHS, normally find higher reported levels of abuse. An external validation study was

conducted in three provinces, closely following DHS methods. Reported physical abuse was generally higher, often twice as high and sometimes as much as four times as high.[6]

4 HIV Levels and Trends

4.1 HIV/AIDS Epidemiology

Table 4 HIV Data

HIV prevalence *(UNAIDS, 2006/SANHS, 2005).*	18.8%, 16.2%
# of people living with HIV (adults and children)	5,500,000
# of children (0-14) living with HIV	240,000
# of adults (15-49) living with HIV	5,300,000
# of adult women living with HIV	3,100,000 (58%)
# of children (aged 0-17) orphaned by AIDS	1,200,000

Source: UNAIDS, 2006, unless otherwise stated

South Africa is facing a mature, generalised epidemic, with an estimated prevalence of 18.8 percent. However, there have been some conflicting data recently. The South African Department of Health's 2004 national HIV survey, based on antenatal surveillance, found an HIV prevalence of 29.5 percent;[7] meanwhile the population-based South African National HIV Prevalence, HIV Incidence, Behaviour and Communications Survey 2005 found an overall prevalence of 16.2 percent in the 15-49 age group.[8] The very diverse make-up of South Africa's population means that risk levels vary enormously between groups. Sexually active African women, particularly in the 20-35 age bracket, represent the highest-risk group. This statement is based the fact that a population-based survey and an antenatal-based surveillance survey (which covered basically this same age group) both produced similar results. HIV prevalence has been increasing since the early 1990s. However, there are signs that this is beginning to level off, with 2005 data showing only a very slight increase on data from three years earlier.

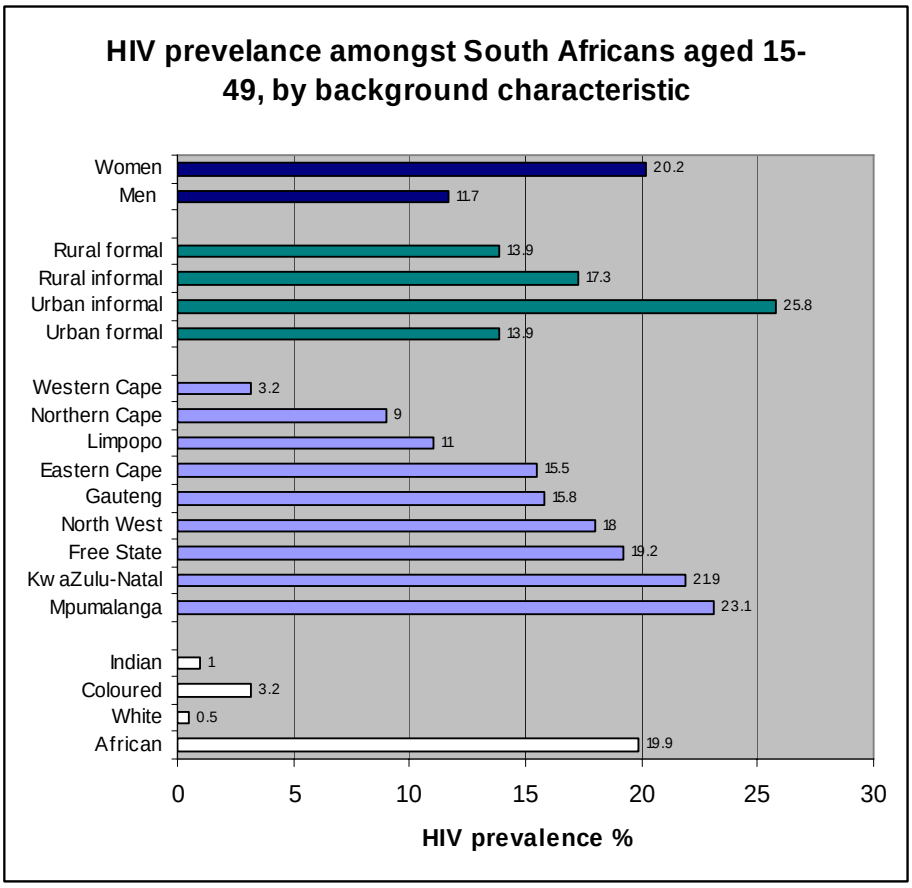
According to UNAIDS, South Africa has the second-largest HIV/AIDS burden in the world after India, with 5.5 million people living with HIV/AIDS. Women are highly vulnerable; in fact the 2005 HIV prevalence survey found adult prevalence to be 20.2 percent for women and 11.7 percent for men (see Figure 4.1.1). Moreover, HIV incidence (infection in the last six months) was eight times higher in young women than young men aged 15-24. HIV risk is higher in urban, informal settlements than in other localities. There are huge racial variations; one black African in five is HIV-positive, compared to less than one in 30 for other groups. However, prevalence in all racial groups is not insignificant. There are also large regional variations, with prevalence ranging from 3.2 percent in the Western Cape to 23.1 percent in Mpumalanga. It is likely that this is, in part, due to demographic variances between provinces. High-risk groups include sex workers (70 percent prevalence found in some areas in the late

[6] SADHS, 1998.
[7] DOH, 2005b.
[8] SANHS, 2005.

1990s), truck drivers (56 percent prevalence in 1999,) as well as young people and women in general.[9]

Figure 4.1.2, as well as illustrating the higher vulnerability of women, shows the sharp increase of risk for women from the age of 15, with an earlier peak in the 25-29 age group, compared to men, whose risk level increases more slowly and peaks later. This is an indication of intergenerational sex (see Section 5.2).The 5.1 percent HIV prevalence in children aged 2-4 shows the high level of mother-to-child transmission. There are 1.2 million children orphaned by AIDS in South Africa and orphans are particularly vulnerable to HIV.

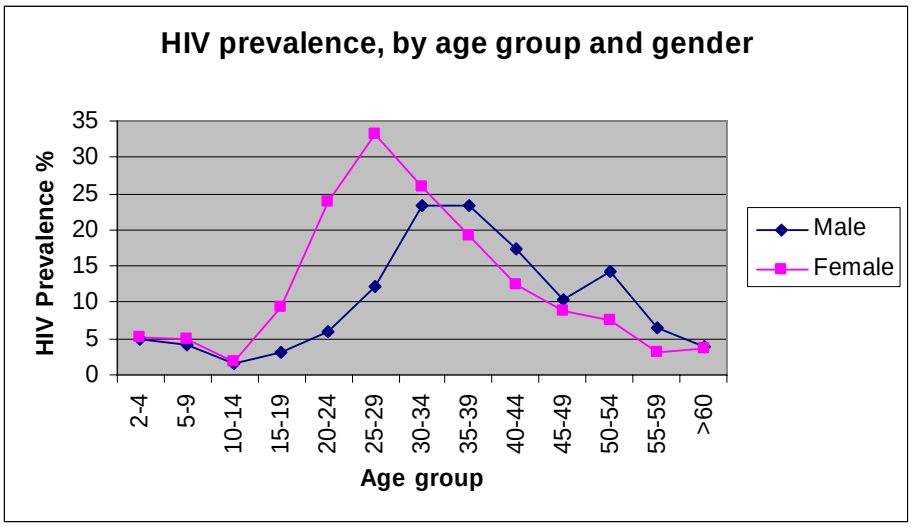
FIGURE 4.1.1



Source: SANHS, 2005.

[9] WHO, 2005.

FIGURE 4.1.2



Source: SANHS, 2005.

4.2 SEXUAL BEHAVIOUR

Age at first sex

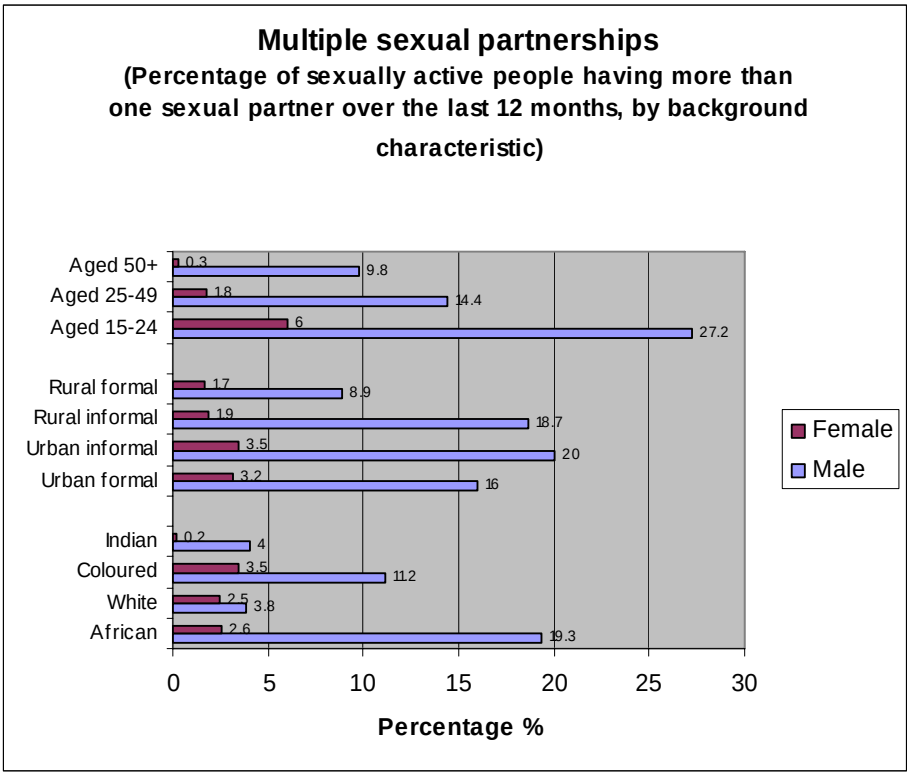
Understanding sexual behaviour can help us understand the cultural, behavioural and gender dynamics that affect risk taking behaviour. Median age at first sex is reported to be 18.4 years for women aged 25-49 (see table 4.2). However, this is based on the 1998 DHS and there are signs that the median age is declining; the 2005 HIV prevalence survey found it to be 17 years.[10] It is also worth noting that women get married at the age of 24.2 years on average, which is much later than in surrounding countries. This is also approximately six or seven years after the average woman's first sexual encounter. This period between the start of sexual activity and marriage is the most dangerous and coincides with the time of highest incidence of HIV infection in young women.

Sexual partnerships

Multiple sexual partnerships are much more common among men than women (see Figure 4.2) and there is a negative relationship between age and number of sexual partners. Men and women followed the same pattern according to location, except for those in rural, informal areas, where the disparity between men and women is wider. Although there was little difference in multiple partners among racial groups for women (except Indian women, who reported fewer partners) the pattern does not follow for men, with African and coloured males reporting higher incidence of multiple partnerships.

[10] SANHS, 2005.

FIGURE 4.2



Source: SANHS, 2005.

Frequency of sexual intercourse

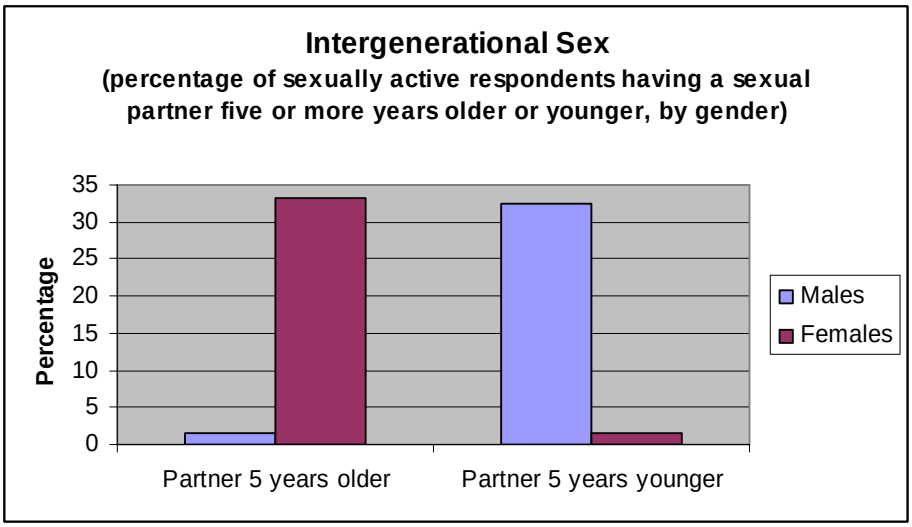
The modal sexual frequency among those aged 15 and over who have had sex in the last 12 months is one to four times per month for all age groups. Adults aged 25-49 reported higher levels of sexual frequency. One quarter of those aged 15-24 had not had sex in the last month, a much higher proportion than other age groups.[11]

Prevalence of intergenerational sex

Two-thirds of South African men and women have sexual partners who are within five years of their own age. However, there is a high prevalence of intergenerational or mixed-age sex, and this almost always means couples in which the woman is younger (see Figure 4.2). Intergenerational sex is known to be a risk factor for HIV, as older age groups have a higher HIV prevalence. This is indeed the case in South Africa; those in mixed-age partnerships had significantly higher HIV infection rates than those with partners of a similar age. This, in part, explains Figure 4.1.2 and the earlier rise in HIV levels for women.

[11] SANHS, 2005.

FIGURE 4.2



Source: SANHS, 2005.

STI prevalence

In the national population-based survey, 3.7 percent reported STI symptoms in the previous three months. HIV prevalence was twice as high for those reporting genital sores (28 percent) as those not (14.5 percent), showing the strong relationship between HIV and other STIs.[12]

The 2005 Department of Health's National Antenatal Sero-Prevalence Survey found 2.7 percent of antenatal clinic attendees to have syphilis, a slight increase on 2004 data. Prevalence ranged from 8.5 percent in Northern Cape Province to 1.1 percent in Limpopo. Syphilis prevalence in this instance does not seem to be related to HIV prevalence.[13]

5 HEALTH SYSTEM PROFILE

5.1 DESCRIPTION

At the end of apartheid, the health system was biased towards secondary and tertiary care. It was dominated by doctor-provided care, with resources and access heavily weighted towards the white minority. Efforts have been made since then to refocus the service towards an equitable system and primary care-orientated services. The country has undergone a major transformation, moving towards primary health care delivered through a district health system structure. Some progress has been made to strengthen the management capacity and to delegate decision-making to lower levels.[14,15]

The Health Sector Strategic Framework of South Africa 1999-2004 sets out government priorities in health: reorganisation of support services, legislative reform, improving quality of

[12] Ibid.
[13] DOH, 2005b.
[14] DFID, 2001.
[15] GFATM, 2003.

care, revitalisation of hospital services, speeding-up delivery of an essential package of primary health care through the district health system, decreasing morbidity and mortality through strategic interventions, improving resource mobilisation, improving human resource development and management, improving communication and consultation within the health system and with communities, and strengthening cooperation with partners internationally.[16]

GOVERNMENT HEALTH MANAGEMENT STRUCTURES[17]

District level

The governing body for each district, the district health authority, makes policy decisions on matters affecting the local community. It is responsible for district health services and particularly the primary healthcare system.

Provincial level

The provincial departments of health are responsible for provincial policymaking, drafting provincial legislation, rendering provincial and regional services (largely hospital-based services), which should be provided provincially or regionally because of economies of scale.

National level

The national Department of Health is responsible for national policymaking, developing norms and standards, developing national legislation, monitoring and evaluating national policies, international liaison, and providing services that should be provided at a national level because of economies of scale.

GOVERNMENT HEALTH SERVICE DELIVERY STRUCTURES

Primary healthcare facilities

There are 3,560 public clinics in the country providing services free of direct cost to the consumer.

Hospital-level facilities (district hospitals, central hospitals, regional hospitals and specialised hospitals)

Hospitals operate on four different levels, from district (more local and general) to specialised hospitals, with a referral system operating between them. At hospital level, a fee for services is charged on a sliding scale according to the income of the patient. All healthcare is free for children under six and pregnant and lactating mothers.
Source: DOH, 2006b.

[16] GFATM, 2002.
[17] Krisela Steyn, Jean Fourie, Norman Temple, 2006

Access to services is still limited, particularly in rural areas. There are disparities in funding between the urban and historically better-funded provinces (such as the Western Cape) and those that are predominantly rural (such as Northern Province), affecting staffing levels, quality of services and availability of drugs. There are also chronic staff shortages, particularly in the rural and under-funded areas, due to staff joining the higher-paying private sector or emigrating.[18]

TABLE 5.1 HEALTH-WORKER-TO-POPULATION RATIO

Number of physicians per 100,000 population	77
Number of nurses per 100,000 population	402

Source: WHO, 2006.

Key health-worker-to population-ratios are higher than other countries in southern Africa but are still much lower than what is needed to provide an effective health service (see Table 5.1).

5.2 ANNUAL EXPENDITURE

TABLE 5.2 HEALTH EXPENDITURE DATA

Total annual expenditure on health	US$9,748 million
Per capita expenditure on health	US$206
Percentage of government budget spent on healthcare	10.7%
Total expenditure on health as a percentage of GDP *(PSP-One).*	8.4%

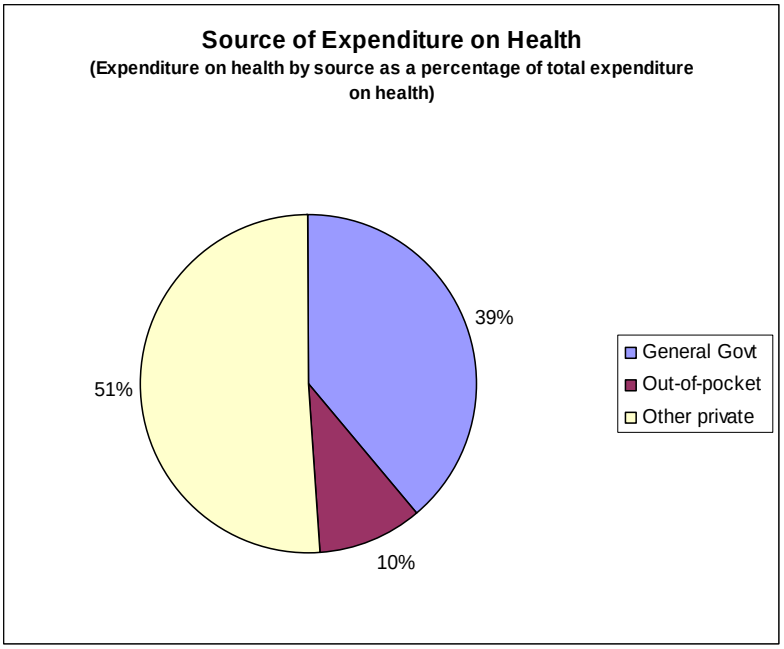
Source: WHO, 2005, unless otherwise stated.

The government spends more than 10 percent of its budget on health, showing a strong commitment to health. This equates to over US$200 per capita, which greatly exceeds the recommended level by the World Bank. Despite this, the health system struggles to cope with a high national disease burden, with an increase in chronic lifestyle diseases as well as HIV/AIDS.[19]

The state covers less than four-tenths of health spending. One tenth is out-of-pocket expenditure, and over half comes from other private sources, most of that through health insurance schemes (see Figure 5.2).

[18] DFID, 2001.
[19] Ibid.

FIGURE 5.2



Source: PSP-One, 2005.

5.3 PROPORTION OF DONOR FUNDING

TABLE 5.3 ESTIMATED HEALTH FUNDING SOURCES IN 2003

Funding source	Amount in USD	Percentage
External (donors)	47m	0.5
Domestic	9,431m	99.5
TOTAL	**9,478m**	**100**

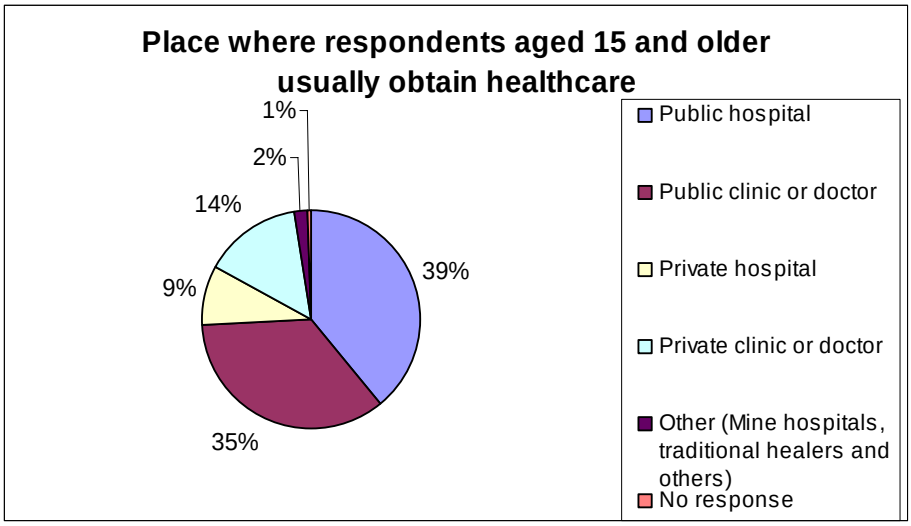
Source: WHO, 2006.

Donor funding to the health sector is extremely low, at 0.5 percent of the expenditure. The South African government places great importance on minimising reliance on other countries and maximising financial sustainability.

5.4 PUBLIC/NOT–FOR-PROFIT/PRIVATE MIX

The private sector grew during the 1990s because of a widely perceived reduction in the quality of public services. Twenty-three per cent of South Africans use private health care services and 74 percent use public (see Figure 6.4.1).

FIGURE 5.4.1



Source: SANHS, 2005.

The inequality in the health system is evident when comparing these figures with expenditure source (Figure 5.2), with over half of spending paying for less than a quarter of services. In fact, a survey conducted in the mid-1990s found that household expenditure on health was 47 times higher in the richest quintile than the poorest quintile (see Table 5.4). This illustrates the two-tier system present in South Africa. About 15 percent of the population is covered by private health insurance or "Medical Aid." The vast majority of expenditure in the private sector is for curative services, and preventative services have traditionally not been well funded by health insurance schemes.[20]

TABLE 5.4 ANNUAL PER CAPITA HOUSEHOLD HEALTH EXPENDITURE (US$) BY QUINTILE (POORER TO RICHER)

Q1	Q2	Q3	Q4	Q5	Ratio Q5:Q1
6	10	19	21	280	47:1

Source: DFID, 2001.

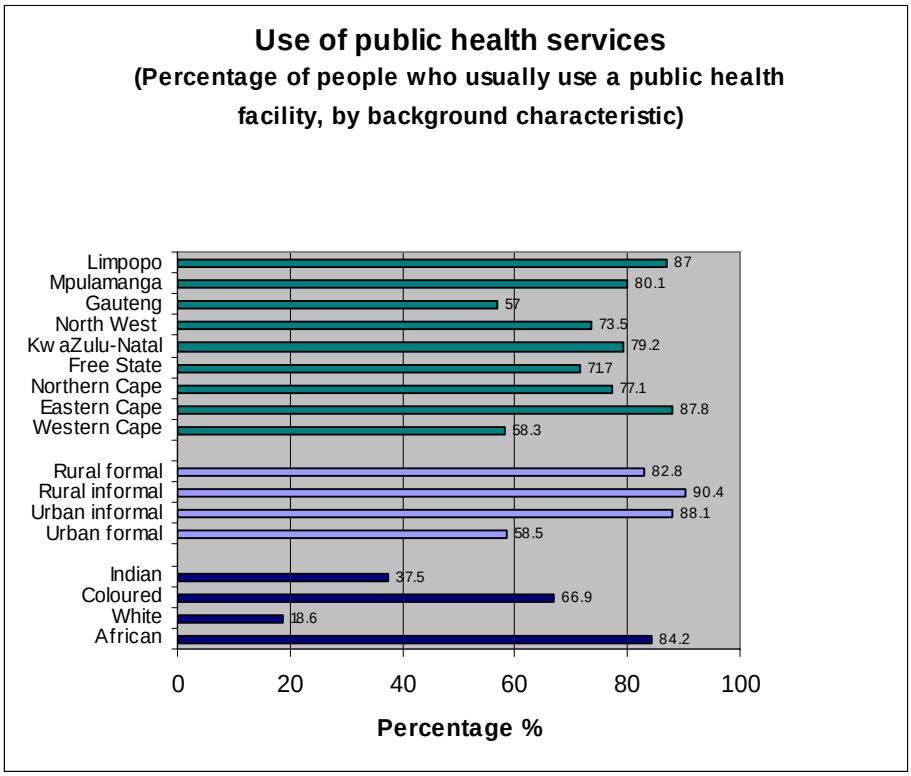
Although a tiny proportion of South Africans use traditional healers as their primary or main source of healthcare, about 80 percent of the population use traditional or complementary medicine, usually alongside conventional health services. Traditional medicines are widely available, affordable and have simple treatment regimens. The government is attempting to formalise and regulate the traditional medicine sector through the passing of a Traditional Health Practitioners Bill. There is a comprehensive database and a strong network of traditional practitioners represented at national, provincial, district and local level.[21]

There is little difference in gender and age for public/private use of health services, although use of private services increases a little with age. Those who are urban, white or Indian and

[20] HDA, 2005.
[21] Ibid.

living in the Western Cape and Gauteng are the least likely to use public services (see figure 5.4.2).

FIGURE 5.4.2



Source: SANHS, 2005.

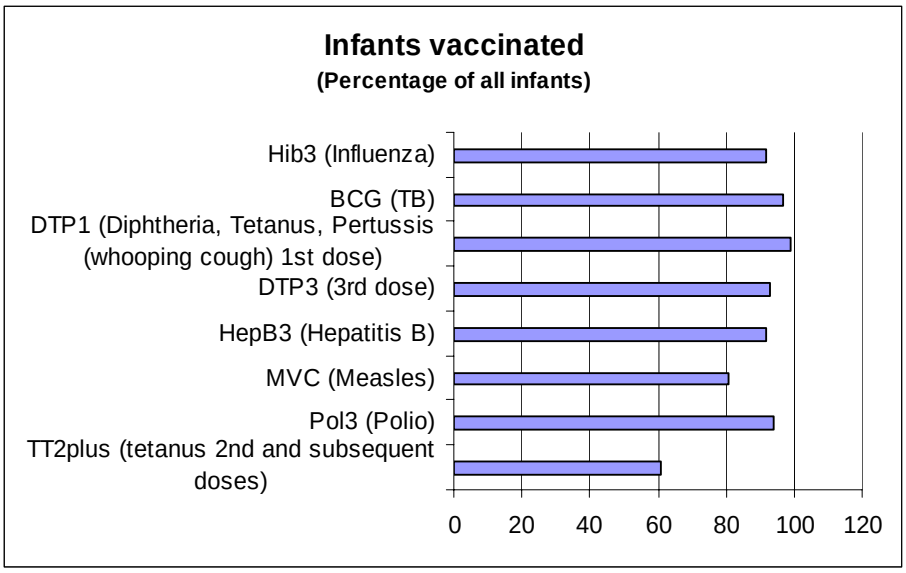
5.5 KEY HEALTH INTERVENTIONS

5.5.1 KEY VACCINES

The 1998 DHS found that only 63 percent of children are fully immunised.[22] This fairly low coverage rate is affected by the dropout rate for subsequent doses for tetanus (see Figure 5.5.1). The Government of South Africa's Department of Health implements the Expanded Programme on Immunisation – South Africa, which recommends that children receive all vaccinations before their first birthday. Coverage is lowest in KwaZulu-Natal and the Eastern Cape and among children of less-educated mothers. Coverage is intermediate compared with other countries in eastern and southern Africa.[23]

[22] SADHS, 1998.

FIGURE 5.5.1



Source: UNICEF, 2006.

5.5.2 CONTRACEPTIVE COVERAGE

More than half of women use modern family planning methods in South Africa. This is very high, even compared to southern Africa, where contraceptive use is higher than other parts of Africa. Very few women use traditional methods of family planning. Although contraceptive use has increased since 1990, it was fairly high even then, with half of women practising family planning.[24] Table 5.5.2.1 shows that women and men in South Africa benefit from a broad range of contraceptive choice, which has been proven to increase overall family planning use. Injectable contraception is the most common method and female sterilisation and the oral contraceptive pill are also popular. Condom use for family planning purposes is low, but is average for southern and eastern Africa. However, these data are from the 1998 DHS and it seems the picture has changed since then, with a shift towards condom use. The 2005 National HIV Survey found 13 percent of women use condoms for family planning, and five percent were sterilised. Use for other methods had changed very little. It must be noted that the 2005 data reflect contraceptive use for all women who had been sexually active in the past year rather than just married women.

[24] UNFPA, 2006.

TABLE 5.5.2 CONTRACEPTIVE METHOD MIX
(Selected methods, married/in union women of reproductive age, 15-49)

Modern methods	Pill	10.6%
	Injection	23.2%
	Condom	1.7%
	Female sterilisation	15.8%
	Male sterilisation	2.1%
	Other modern methods	2.7%
	Total	**56.1%**
Traditional methods	**Total**	**0.9%**
No method	**Total**	**43%**

Source: PRB, 2002.

Knowledge of family planning is high, with 97 percent of women aware of at least one modern method of contraception. Even women without sexual experience have good knowledge; 86 percent know at least one modern method. Most well known methods were injectables (94 percent), the pill (93 percent) and condoms (89 percent). Traditional methods are less well-known than modern methods.[25]

5.5.3 Essential medicines

In principle, as outlined in the National Drug Policy, drug procurement for the public sector is limited to drugs on the Essential Drugs List. The process for selecting drugs for the EDL is based on a comprehensive network of district, provincial and institutional pharmacy and therapeutic committees. The final decision is made by the National Essential Drug List Committee (NEDLEC), appointed by the minister of health. The EDL is not reviewed very frequently – the latest adult hospital EDL is seven years old.

Each province is also entitled to compile a list of additional medicines, not on the EDL, for use within the province according to the morbidity profile and service needs in that province.

There is a precedent for procurement of drugs not on the EDL for public sector use, if the health minister judges that it is a priority for the healthcare needs of the population. For instance, the government recently awarded a tender for antiretroviral drugs to be supplied to facilities nationwide.

The National Drug Policy provides for the development "of joint responsibility between the government and the patient for the financing of drugs. However, in line with National Health Policy, the government will ensure that essential drugs are available to all people in need. To this end, drugs will be provided free of charge at the point of service at the primary care level."[26]

[25] SADHS, 1998.
[26] HDA, 2005.

6 HIV PROGRAMMING

6.1 LEVEL OF POLITICAL COMMITMENT

WHO describes political commitment to fight the HIV/AIDS epidemic as "high."[27] Robust frameworks are in place, including the following:

- South Africa's multisectoral National AIDS Council (SANAC) was established in January 2000, replacing the former interministerial committee, and is chaired by the deputy president. The council consists of representative from 16 ministries, 17 civil society sectors, 18 government departments, and two representatives of the Portfolio Committee on Health;
- Provincial AIDS councils were established in 2001 and provide advisory services to provincial and local governments and to the private sector, NGOs and clinicians;
- The national HIV/AIDS Programme is located within and driven by the HIV/AIDS and STI Directorate of the Department of Health. The directorate sets policy and broad guidelines;
- South Africa's national strategic framework on HIV/AIDS covers the period 2000-2005 and is structured according to four priority areas: Prevention, treatment, care and support; human and legal rights; and monitoring, research and surveillance;
- In November 2003, the government approved an Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa and has drawn up plans to implement the largest treatment programme in the world.[28]

There has been much controversy locally and internationally about the role of the South African government in handling HIV/AIDS issues, and particularly on its commitment to provision of ART (see section 10.3). The National HIV Survey found that 64 percent of South Africans aged 15 and over believed the leaders of the country were "committed" to controlling HIV/AIDS. However, 53 percent thought the allocation of resources to put commitment into practice was inadequate.[29]

6.2 FUNDING FOR HIV/AIDS

South Africa is dedicating substantial resources to the HIV/AIDS response; in 2003 US$1.7 billion was allocated from the national treasury over a three-year period (an average of US$567 million per year).[30] HIV/AIDS funding has been steadily increasing each year over the last few years. The vast majority of HIV/AIDS funding is domestic; one of the fundamental

[27] WHO, 2005.
[28] Ibid.
[29] SANHS, 2005.
[30] UNAIDS, 2004.

principles of the 2003 comprehensive plan is that at least 90 percent is funded by government to ensure sustainable financing of HIV/AIDS programmes.[31] According to an OECD report, South Africa received eight percent of its HIV/AIDS budget from external sources in 2000-2002. This funding constituted 99 percent of health-related donor aid in the country.[32]

Table 6.2 shows major donor funding for HIV/AIDS from 2003 to 2005.

TABLE 6.2 MAJOR EXTERNAL FUNDING SOURCES, 2003-2005

Donor		Funding
EU	2002-08	€133,500,000
USAID	1996-2005	US$89,500,000
Global Fund	Round 1&2	US$65,000,000
PEPFAR	2004	US$52,500,000-70,000,000
AusAID	2003-08	AU$ 52,700,000
DFID	2004-08	GBP 30,000,000
Belgium	2003-08	€10,200,000
KfW Germany	2003-05	€9,000,000
UNCT Theme Group	2003	US$6,500,000
GTZ	2000-08	US$5,500,000
CDC	2003-05	US$4,300,000
UNAIDS (PAF funds)	2000-03	US$750,000

Source: UNAIDS, 2004.

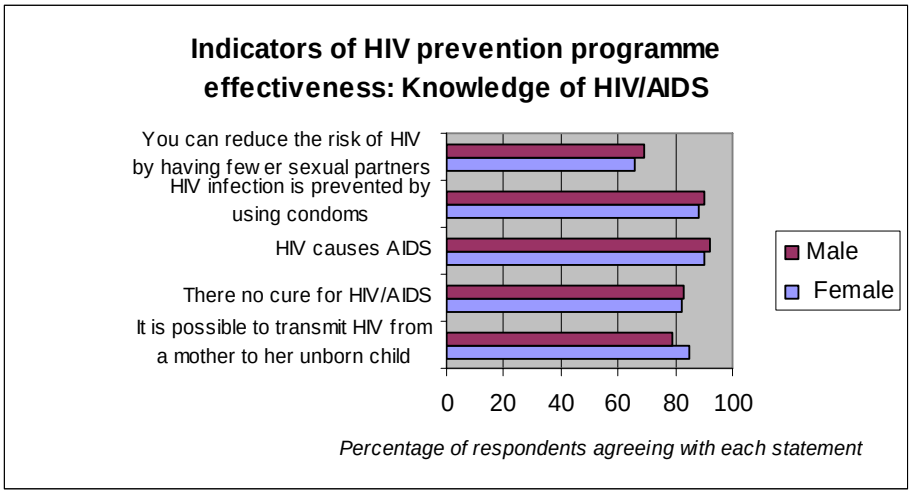
6.3 COVERAGE OF HIV/AIDS INTERVENTIONS

Prevention coverage

Knowledge of HIV prevention is high for women and men in South Africa (see Figure 6.3.1), which is a sign of effective HIV-prevention programming. However, there are still some significant misconceptions or uncertainties, particularly on whether reducing sexual partners reduced HIV risk and whether HIV causes AIDS. Meanwhile, Figure 6.3.2 illustrates how poverty is a significant barrier to knowledge of HIV prevention. Perceived risk is another important determinant of safe sexual behaviour. Perception of risk is low; in fact half the respondents in the 2005 National HIV Survey who were found to be HIV-positive did not think they were at risk of HIV infection. Men are more likely to believe they won't get infected than women, and younger people (aged 15-24) and older people (aged 50+) felt less at risk than other adults.[33] This suggests a need for HIV-prevention programmes to move beyond awareness-raising to encourage internalisation of knowledge and individual assessment of personal risk to HIV.

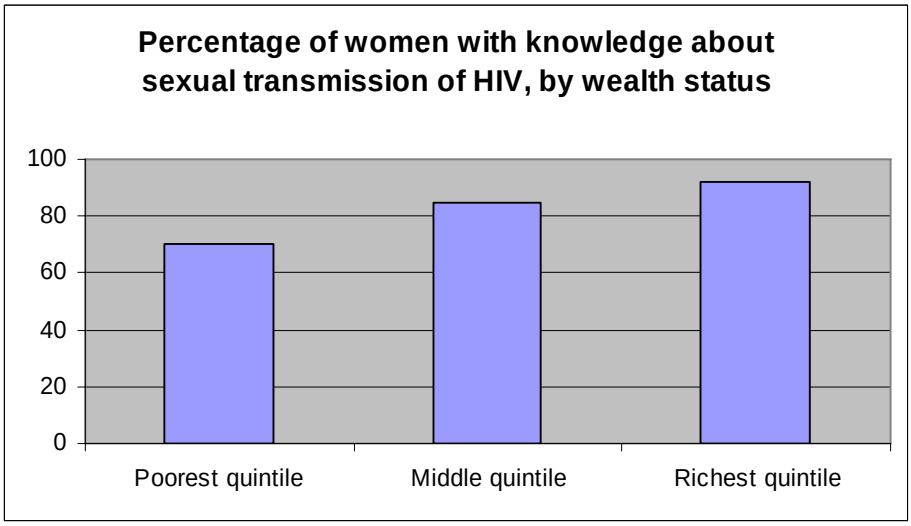
[31] DOH, 2006.
[32] Ndlovu, 2005.
[33] SANHS, 2005.

FIGURE 6.3.1



Source: DOH, 2006.

FIGURE 6.3.2



Source: PRB, 2004.

In terms of the reach and effectiveness of awareness campaigns, a national survey found the following:

- When people were asked (unprompted) what made them take HIV/AIDS more seriously, television and radio were the most common reply, but interpersonal communication also featured highly. Billboards and signage were mentioned the least out of the top 12 sources.
- There are many mass media campaigns, including Soul City, loveLife and Takali Sesame, that have different target audiences and formats (such as television and radio, print and outdoor media). Awareness of them is high, particularly among younger age groups. Perception of usefulness by those aware of them is also high – around 80 to 90 percent for the various campaigns.

- Other useful sources of information were, in order of importance: friends, health facilities, family members (excluding parent or carer), school, workplace, religious institution/FBO, community meeting, AIDS/welfare organisation, pharmacy, traditional healer and telephone helpline
- There are signs that interpersonal communication on HIV/AIDS is high; four-fifths of people aged 15 and above are comfortable talking about HIV/AIDS to at least one family member and two-fifths of those aged 25-49 had given advice to others on HIV/AIDS in the past year.
- The most common HIV/AIDS activities that people are involved in are workplace AIDS meetings (for full-time workers), attending a play or educational event and community meetings.[34]

Government HIV/AIDS strategy places an emphasis on prevention.

> *"[A] developmental paradigm suggests that fundamental to the fight against AIDS should be a prevention approach, which seeks to deal with all the contextual factors that create a conducive environment for the rapid spread of the condition, while ensuring that people are encouraged, and even empowered, to take steps to avoid infection. This dual perspective on prevention, which locates all efforts within both individual behaviour and contextual or environmental factors, indicates the political commitment of the government of South Africa not to deal with HIV and AIDS in a narrow and limited manner, but to locate it firmly within the national development programme of the country."* [35]

The growth of HIV and AIDS funding has focused on the following programmes, further indicating a commitment on prevention:

- Life skills education in schools
- Prevention programmes including social mobilisation on healthy lifestyles and Khmanani (health promotion) campaign
- Nutrition
- VCT
- PMTCT
- Syndromatic management of STIs
- Condom distribution
- Traditional medicines
- ART
- Home-based and community-based care
- NGOs
- Step-down care.[36]

[34] SANHS, 2005.
[35] DOH, 2006.
[36] Ibid.

There is a national life-skills-based HIV/AIDS education programme in primary and secondary schools. Implementation of the programme varies geographically. By the end of 2002, 55 percent of schools had received training.[37]

Voluntary counselling and testing have also been expanding rapidly in recent years. There are over 2,500 VCT centres, which is high compared to surrounding countries (see Table 6.3.2). The number of people accessing voluntary counselling and testing services increased from 412,696 in 2002-3 to 690,537 the following year. The 2005 National HIV Survey found the following:

- Almost eight in 10 people were aware of a nearby place where they could get an HIV test; people in rural formal areas were the least likely to know
- 30 percent of South Africans have been tested for HIV; this is a big increase from 20 percent in 2002;
- Married respondents were more likely to have been tested than their unmarried counterparts (39 percent compared to 26 percent);
- Satisfaction of VCT is high; with over 85 percent saying they were satisfied or very satisfied with the service;
- Three-quarters of African respondents and over half of coloured respondents had been tested in the public sector. The majority of White and Indian respondents used the private sector.[38]

In 2000, the government announced plans to provide two PMTCT sites per province (18 in total) in South Africa. The following year, the Treatment Action Campaign took the government to court, seeking an order to make nevarapine available in all state hospitals and clinics, and won. The Department of Health showed reluctance to fully distribute the drug, questioning its safety.[39] However, further roll-out has been ensued and there are now 3,064 operational PMTCT centres in 2005, which covers 15 percent of the population in need (see Table 6.3.2). This accounts for higher coverage than most surrounding countries. Twenty-three percent of infants born to infected mothers are HIV-positive.

TABLE 6.3.2 USE OF HEALTH SERVICES FOR HIV PREVENTION

# of VCT sites	2,582
# of VCT sites per 1,000,000 population	55.1
# of people tested at VCT sites (cumulative)	690,537
# of sites providing PMTCT services	3,064
Percentage of HIV+ pregnant women receiving treatment for PMTCT *(UNAIDS, 2006).*	14.6

Source: WHO, 2005.

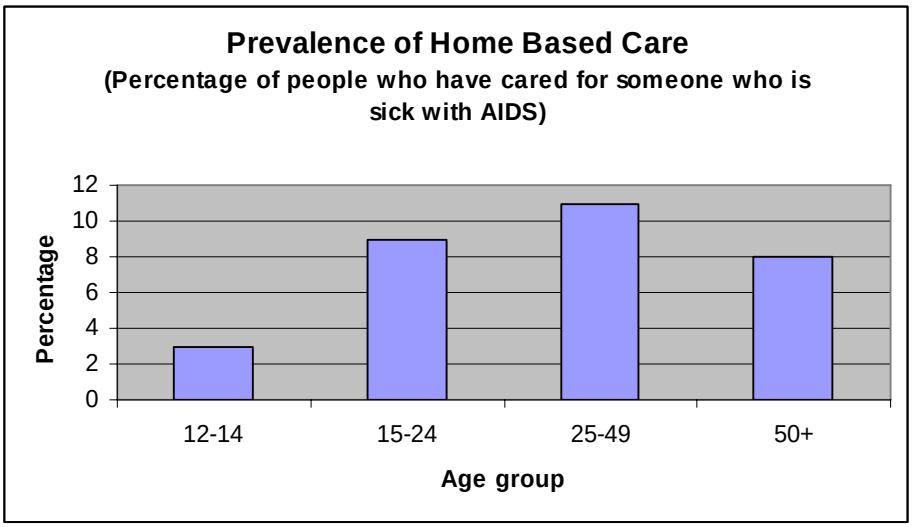
A pilot programme exists to provide post-exposure prophylaxis (PEP) through the public sector to victims of rape or occupational exposure.[40]

[37] Ibid.
[38] SANHS, 2005.
[39] Avert, 2006.
[40] WHO, 2005.

Care coverage

Care is difficult to measure, as much of it takes place in the home. A variety of community- and home-based care initiatives have emerged to meet the massive health and social needs generated by the epidemic. These initiatives operate mostly from a religious or non-governmental organisation (NGO) base, but work in close cooperation with local formal health, welfare and other social sectors, providing a spectrum of services from support group activities to palliative home-based care and orphan placement. Less than 12 percent of all age groups have cared for someone with AIDS (see Figure 6.3.3).

FIGURE 6.3.3



Source: SANHS, 2005.

The Department of Social Development has initiated an orphans and vulnerable children's (OVC) programme, whose activities include identification of orphans and vulnerable children, counselling, material support (including basic food provision and home-based care), HIV awareness and prevention programmes and training for caregivers. By the end of 2005, over 120,000 orphans and children made vulnerable because of HIV/AIDS were receiving support services. Approximately 7.3 million children are receiving childcare grants in South Africa; 1.5 million of these have lost one or both parents. The government has also expanded OVC services by working with NGOs as intermediaries and providing grants and training.[41]

Treatment coverage

By March 2005, 44,600 people were reported to be receiving ART from 103 public facilities. With additional people receiving treatment through private sources, this takes the total receiving ART to 104,600. This provides for one in eight people needing treatment and only one in 20 in government facilities (see Figure 6.3.4).

[41] DOH, 2006.

It is likely that the number of people receiving treatment in public facilities has increased since then as part of the government's scale-up programme. In February 2006, 204 facilities were fully functional and providing ART services, with at least one in each of the 53 health districts and 63 percent of sub-districts being covered. Coverage varies by province, from five ART centres in Free State (one per district) to 42 in the Western Cape (seven per district).

The private sector provision of ART mostly consists of healthcare companies serving more affluent sections of the community, with some NGOs providing for some of the most vulnerable groups. The Medical Scheme Act of 1998 does not allow discrimination by medical insurance schemes on the basis of health and prescribes a minimum benefits package for HIV infection, including ART, STI treatment, TB screening and treatment, pain management, treatment of OIs, VCT, PMTCT and PEP (in cases of sexual assault or occupational exposure).[42]

There has been much controversy about political commitment around access to ART.

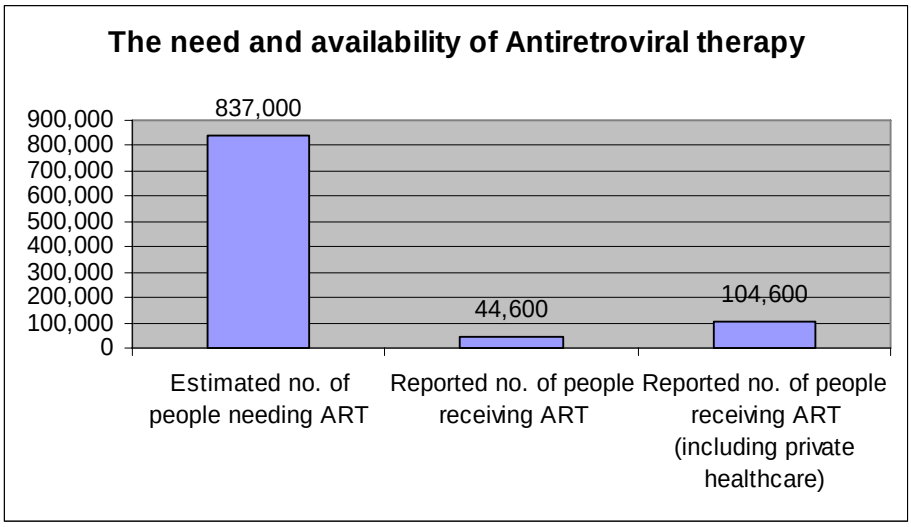
- In 1995, the then-deputy president, Thabo Mbeki, acknowledged the seriousness of the epidemic;
- In 1997, a national review of South Africa's response to the epidemic found that there was a lack of political leadership;
- In 2000, Mr. Mbeki suggested poverty, rather than HIV, was the principal cause of HIV after consulting 'dissident' scientists;
- In 2003, the Treatment Action Campaign (TAC) laid culpable homicide charges against the ministers of health and trade and industry, claiming their responsibility for the deaths of HIV-positive people in South Africa;
- Later that year, the government finally approved a plan to make ART publicly available. This was, in part, a result of a court battle in which GlaxoSmithKline and other pharmaceutical companies agreed to allow low-cost generic versions of their drugs to be produced in South Africa. This made South Africa one of the first African countries to produce its own drugs;
- In 2006, 15 prisoners in Durban's Westville Prison took the government to court to attempt to force them to provide drugs through the prison system, and won. The government was ordered to provide free treatment to those prisoners and anyone in a similar situation. However, there are still large numbers of prisoners without access;
- The health minister has recommended the African potato and other traditional vegetables to help fight off AIDS, but this has no scientific backing.[43]

However, the 2003 Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment places more emphasis on treatment than previously and ART coverage has

[42] DOH, 2006.
[43] Avert, 2006.

increased. General ART guidelines were introduced in 2004 and ART guidelines for children in 2005. Many large companies provide ART for their staff.[44]

FIGURE 6.3.4



Source: WHO, 2005.

MEASURING THE EFFORT

Prevention

The Policy Project has sought to measure the effort of the HIV prevention programme using its 'AIDS Programme Index'. It found that although no additional prevention programmes have been introduced, perceptions of the level of effort of implementing these programmes has improved (on the basis of opinions of senior people in the national AIDS programme) (see Table 6.3.1). South Africa's prevention scores are very high for east and southern Africa and globally.[45]

TABLE 6.3.1 PREVENTION NATIONAL EFFORT

Scores (out of 100)		
	2001	**2003**
Implementation of activities score	92	92
Perception of overall effort	70	80
Total prevention effort score	81	86

Implementation of activities in 2003 (beyond the pilot stage to a significant proportion of the target populations, both urban and rural)

Implemented:

- An active programme to promote accurate HIV/AIDS reporting by the media
- A functioning logistics system for condoms and essential HIV/AIDS drugs
- A social marketing programme for condoms
- School-based AIDS education for youth

[44] DOH, 2006.

[45] Data from the Policy Project is now four years old and should be used with caution. However, the use of a single metric does provide the opportunity to make comparisons across different countries.

- Behaviour change communications
- Voluntary counselling and testing
- Special programmes for other vulnerable populations
- Blood safety
- Nationwide programme to prevent mother-to-child transmission of HIV
- Programmes to ensure safe injections in healthcare settings
- Special programmes for sex workers
- Special programmes for men who have sex with men

Not implemented

- Special programmes for injecting drug users

Source: Policy Project, 2003.

Care and Treatment

Although there were no new treatment activities implemented between 2001 and 2003, the perceived effort in implementing these programmes increased (see Table 6.3.3). This gives South Africa a national effort score for care and treatment of 78, which is significantly higher than for most countries in the region.

TABLE 6.3.3 CARE AND TREATMENT NATIONAL EFFORT

Scores (out of 100)		
	2001	**2003**
Implementation of activities score	76	76
Perception of overall effort	70	80
Total prevention effort score	73	78

Implementation of activities in 2003 (beyond the pilot stage to a significant proportion of the target populations, both urban and rural)

Implemented:

- HIV screening of blood transfusions
- Psychosocial support for PLHA and their families
- Palliative care
- Treatment of common HIV-related infections (pneumonia, diarrhoea, oral thrush, vaginal candidiasis and pulmonary TB)
- Nutritional care
- STI prevention (including condom use) and care
- Universal precautions
- Treatment of HIV-associated malignancies (Kaposi's sarcoma, lymphoma and cervical cancer)
- Treatment of extensive herpes
- Cotrimoxazole prophylaxis among HIV-infected people
- Intensified case-finding and treatment for TB
- Preventative therapy for TB among HIV infected people
- Systematic antifungals for systemic mycosis
- Post-exposure prophylaxis of occupational HIV exposure and for rape
- Highly active antiretroviral therapy (HAART)

Not implemented

- Diagnosis and treatment of HIV-related infections that are difficult to diagnose and treat
- Advanced treatment of HIV-related malignancies

Source: Policy Project, 2003.

6.4 SOCIAL MARKETING AND COMMODITY DELIVERY MECHANISMS

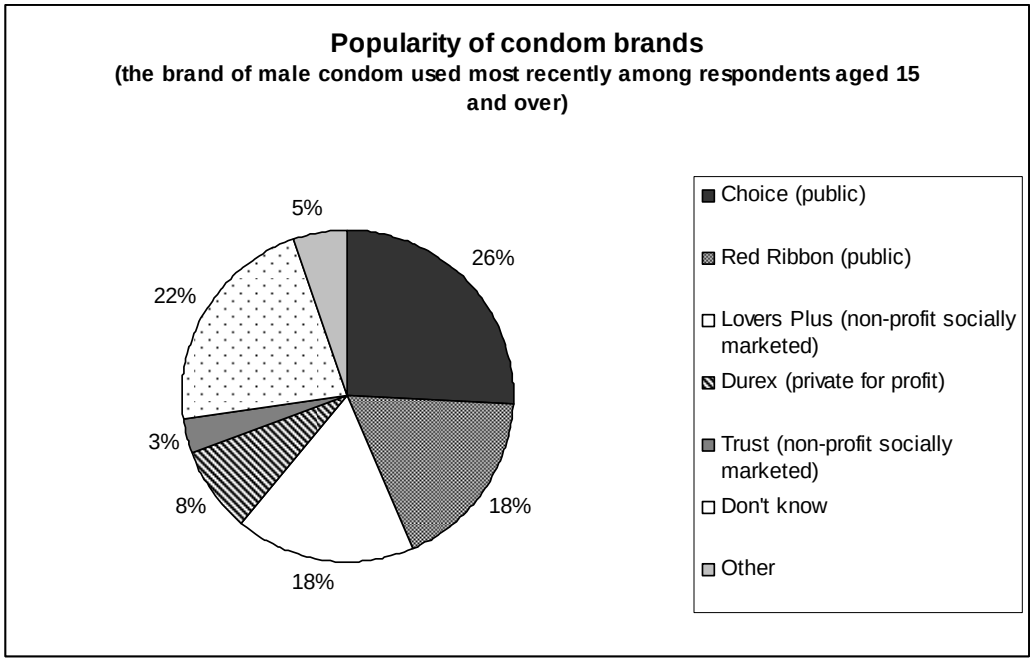
Major socially marketed condoms in South Africa include:

Organisation	Product	Details
Population Services International/Society for Family Health	Lovers Plus – male condom, Trust – female condom, Care, female condom	Lovers Plus since 1992. Care since 1998. Trust since 2001. Trust Studded since 2004.

Sources: SANHS, 2005; PSI, 2006.

South Africa has an effective condom distribution system. Seventy percent of sexually active South Africans did not pay for their last condom used. Use of free condoms is highest amongst Africans, younger age groups and those who are rural and living in the Eastern Cape and Limpopo provinces. The two most popular brands of condom are public sector condoms (see Figure 6.4), which have 44 percent of the market. Socially marketed condoms Lovers Plus and Trust) have 21 percent of the market. Two-thirds of people accessed their condoms from government clinics or hospitals and a quarter bought their condoms from a pharmacy.[46]

FIGURE 6.4



Source: SANHS, 2005.

[46] SANHS, 2005.

6.5 SCALE-UP PLANS

3-by-5 Initiative

WHO describes the progress towards the "3-by-5" Initiative: "In 2003, WHO and UNAIDS estimated South Africa's total antiretroviral therapy need to be about 750 000 people, and the WHO "3-by5" treatment target for 2005 was calculated as 375,000 people (based on 50 percent of estimated need). The Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa aims to provide antiretroviral therapy access to more than 1.4 million people by 2008. The plan originally committed to supplying 53,000 South Africans with antiretroviral therapy in state facilities by March 2004, but the time frame for this target was extended to March 2005. The government has declared a national treatment target for the end of 2005 of 190,000 people.

Estimates indicate that increased government commitment to budget the expansion of antiretroviral therapy could bring public investment to a total of US$210 million for 2004–2005. An additional US$8.4 million is expected to be available for treatment programmes during 2004-2005 from South Africa's Global Fund grants. The United States President's Emergency Plan for AIDS Relief is expected to provide about US$22.25 million for scaling up antiretroviral therapy in 2005, and contributions for scaling up antiretroviral therapy from other bilateral donors could total up to US$12.5 million over the same period."[47]

Based on these expected commitments, WHO estimates that South Africa will face a funding gap of at least US$800 million to US$860 million to reach the "3-by-5" treatment target of 375,000 people by the end of 2005.[48]

Global Fund

South Africa submitted three successful Round 1 proposals for TB and HIV to the Global Fund, of which about US$27.2 million has been disbursed to date. South Africa also submitted a successful Global Fund Round 3 proposal for HIV/AIDS for total funding over five years of about US$66.5 million and approved two-year funding of US$15.5 million. About US$8.2 million has been disbursed to date. This grant is intended to strengthen and expand the current prevention, treatment and care programmes and access to antiretroviral therapy through the public health system, specifically in the Western Cape Province.[49]

[47] WHO, 2005.
[48] Ibid.
[49] Ibid.

7 Recommendations for Microbicide Planning and Research

7.1 Implications

- The South African government's emphasis and political commitment on HIV-prevention could provide a favourable environment for the introduction of microbicides. The nature and cost of the product will be important factors in this.

7.2 Recommendations

- Three in four South Africans use public health services and the groups using public facilities the most have the highest vulnerability to HIV (for example, those from informal urban and rural and formal rural settlements). People are used to going to the government clinics for condoms so the introduction of microbicides into services would not need a major behavioural shift. Reaching vulnerable populations with microbicides in South Africa will need to include distribution through public sector channels.
- Modern contraceptive use is high and this can be capitalised on to increase access and uptake of microbicides, but this would need microbicides to be fully integrated into family planning services and health staff to receive sufficient training on microbicides.
- Sensitisation and advocacy with traditional healers will ease the acceptance and uptake of microbicides – traditional healers are widely used and influential.
- The public sector social marketing and distribution of condoms is effective, and the public sector is the largest provider of condoms in South Africa. Microbicides piggy-backing on the condom distribution system would maximise effectiveness, efficiency and sustainability of distribution.
- Social marketing should be specific to targeted groups in all relevant languages if all sections of the target populations are to be reached. Television and radio are more effective than billboard campaigns (according to South Africans responding in a population-based survey). There are many well-known and well-liked mass media campaigns and working with these could highly increase the profile of microbicides.
- Coordinate with relevant faith-based organisations to integrate microbicides into their work. Eight in 10 South Africans are Christians and FBOs are seen as a primary source of information on HIV prevention.

7.3 Data Gaps and Challenges

Very few data were available on access and availability of essential medicines. There was also a lack of useful information on HIV external funding, for example, absolute and proportion of external funding by source by financial year.

The most recent Demographic and Health Survey, which contains many important statistics used in these series of country profiles, was issued in 1998 and South Africa has changed a lot since then. Although a DHS has taken place since then, the report has not yet been released as some data are still being verified. This has made it difficult to paint a coherent picture of the demographic, behavioural and HIV situation, as data from 1998 have been combined with data from 2005 (such as from the national HIV survey). This should be borne in mind when reading these sections.

It should also be remembered that this report is based on desk research (from international and standardised sources where possible) only and is intended as an overview rather than an in-depth analysis on issues for the introduction of microbicides. It is useful to read this report in conjunction with the Health and Development Africa and Society Family Health report for further information on these issues.

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ANNEX – SUMMARY INSTITUTIONAL MAPPING

This section includes summary information on key responsibilities, main programmes and influences, as well as a brief commentary on key alignments or issues in working with these institutions, NGO advocacy, government policy process and levels of donor collaboration.

KEY AGENCIES WORKING IN HIV AND SEXUAL AND REPRODUCTIVE HEALTH

Organisation	Responsibilities/activities
Government agencies	
South African National AIDS Council (SANAC)	Coordinates national multisectoral response, CCM for the Global Fund
Department of Health – HIV/AIDS and STI Directorate	Overall leadership, management and coordination of the health sector response to HIV/AIDS
Department of Social Development	Coordinates social development response to HIV/AIDS – particularly community- and home-based care programmes
Department of Education	Coordinates national life skills education programme in schools
South African AIDS Vaccine Initiative (SAAVI)	Public/private partnership initiative to identify new innovations and candidate AIDS vaccines
Donors	
William J. Clinton Foundation	Support for national treatment planning and negotiations with pharmaceuticals industry to lower the prices of ARVs
Pangaea Global AIDS Foundation	Support for national treatment planning
USAID	Technical assistance for provincial-level care and support training programmes for home-based care - VCT in Eastern Cape and Soweto, psychosocial services for people infected and affected by HIV/AIDS, programme with 20 CBOs providing support to OVCs in four provinces
CDC	Strategy development, including the National Voluntary Counselling and Testing Strategy, district and provincial-level capacity building and training for VCT, PMTCT, TB and HIV
PEPFAR	Human resource capacity-building
AIDS Foundation of South Africa	Supports local community-based interventions
EU	Supporting programmes to improve access to prevention of HIV infection and care and support to PLHA
DANIDA	Support for programmes addressing violence against women, poverty alleviation and HIV/AIDS
Multilateral agencies	
UNAIDS	Supports leadership and coordination of the national HIV/AIDS response, government-donor coordination, policy development
WHO	Technical support in adapting the Integrated Management of Adult and Adolescent Illness (IMAI) approach
NGOs	
Institute for Democracy in South Africa	Governance and HIV/AIDS programmes
The Future Foresight Group	Supports the development of innovative strategies for HIV/AIDS management

Red Cross/Red Crescent	Home-based care training and services
Lifeline	Training for counsellors
Childline	Runs treatment centres and community safehouses, runs a free helpline for children/young people
South African Council of Churches	Provides ART through church-run projects
Médecins sans Frontières	Provision of ART to 1,000 people in the Western Cape province through the flagship Khayelitsha programme (in partnership with Provincial Department of Health). Care and treatment programme in Lusikisiki (former Transkei)
AIDS International Training and Research Program	Human resource capacity-building
International Training and Education Centre on HIV (I-TECH)	Human resource capacity-building
KwaZulu-Natal HIV/AIDS Civil Society Network	Network of 90 NGOs supporting the government in rolling out ART in the province
National Association of people Living with HIV/AIDS	Support for PLHA
Treatment Action Campaign (TAC)	Support for PLHA, advocacy and campaigning for ART access, IEC programmes on availability, affordability and use of HIV treatments
AIDSLink	Material and psychosocial support, including legal support, counselling, food and clothing
Planned Parenthood Association of South Africa	IEC activities
Soul City	Mass Media IEC/BCC programmes aimed at youth plus community outreach
loveLife	Mass Media IEC/BCC programmes aimed at youth plus community outreach. Works with the National Adolescent Friendly Clinic Initiative (NAFCI) to improve access to services for young people
Kaiser Family Foundation	HIV/AIDS counselling
Marie Stopes International	HIV/AIDS counselling
AIDS Consortium	Network of over 300 organisations and 200 individuals active in IEC programmes, supports community based interventions
South Africa Business Coalition on HIV/AIDS	Conducts IEC activities targeted at private sector organisations to improve workplace programmes
National Association of People Living with HIV/AIDS (NAPWA)	Network of support groups for PLHA
Society for Family Health (SFH)/Population Services International	Social marketing programmes
Research organisations	
AMREF	Operational research
Centre for AIDS Development, Research and Evaluation	Operational research
Human Sciences Research Council	Operational research
National Institute for Communicable Diseases	Operational research
South African Medical Research Council (MRC)	Operational and clinical research
The Centre for the AIDS Program of Research in South Africa (CAPRISA)	Operational and clinical research

Source: WHO, 2005; DOH, 2006; GFATM, 2003, 2002.