

HUMAN AND SOCIAL DYNAMICS (HSD) RESEARCH SEMINAR SERIES

THE CURRENT STATE OF THE HIV/AIDS EPIDEMIC IN SOUTH AFRICA: RESEARCH FINDINGS AND IMPLICATIONS FOR PROGRAMME DEVELOPMENT



2 December 2014, Cape Town



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**Department of Science and Technology (DST)
Human and Social Dynamics (HSD) Research Seminar
The current state of the HIV/AIDS epidemic in South Africa:
Research findings and implications for programme development**

**The Human Sciences Research Council (HSRC)
United Nations Joint Programme on HIV/AIDS (UNAIDS)
University of Cape Town (UCT)
University of Stellenbosch (US)
University of the Western Cape (UWC)**

2 December 2014
Tsogo Cape Sun

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ACRONYMS AND ABBREVIATIONS

A	Answer
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral drug
C	Comment
CI	Confidence Interval
DBE	Department of Basic Education
DST	Department of Science and Technology
DSD	Department of Social Development
HCT	HIV Counselling and Testing
HEAIDS	Higher Education and training HIV/AIDS Training Programme
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
KZN	KwaZulu-Natal Province
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
MRC	Medical Research Council
NDOH	National Department of Health
NGO	Non-Governmental Organisation
NHLS	National Health Laboratory Service
NPO	Non-Profit Organisation
NSI	National System of Innovation
NSP	National Strategic Plan on HIV, STIs and TB
PEPFAR	United States President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother To Child Transmission (of HIV infection)
Q&A	Questions and Answers
Q	Question
RDP	Reconstruction and Development Programme
RCT	Randomised Controlled Trial
SABSSM	South African HIV/AIDS Behavioural Risks, Sero-Status and Mass Media Impact Survey
SANAC	South African National AIDS Council
STI	Sexually Transmitted Infections
TB	Tuberculosis
UN	United Nations UCT University of Cape Town
UNAIDS	United Nations Joint Programme on HIV/AIDS
US	University of Stellenbosch

PREFACE: THE PURPOSE OF DST RESEARCH SEMINARS

The Department of Science and Technology (DST) Human and Social Dynamics Research Seminar Series is designed to: (i) showcase research and knowledge production in the Social Sciences and Humanities (SSH) which is generated by the National System of Innovation (NSI); (ii) serve as a vehicle for disseminating research evidence to wider and diverse audiences; (iii) operate as a platform for the sharing of local and international expertise and experience; and (iv) promote research and knowledge production in the Humanities that benefits and enhances the NSI.

The HSD Research Seminar Series aims to:

- Disseminate scientific research findings and transmit a body of new knowledge (through an interactive process of critical dialogue and collegial critique) to the SSH research community and other interested actors in the NSI;
- Provide an avenue for rated and other researchers, including researchers from rural-based universities, to engage in knowledge dialogues across faculties and with other interested actors in the NSI;
- Present and discuss new and ongoing research, identify research gaps, and suggest new research agendas in SSH with a view to forging closer links between the research communities in these fields;
- Reinforce the visibility of SSH research to the higher education and science council sector;
- Enhance wider public understanding of the SSH, including the value and status of both individual and team-based research; and
- Strategically promote, develop, and coordinate collaborative and interdisciplinary research within and between Higher Education Institutions and Science Councils.

EXECUTIVE SUMMARY

This Research Seminar, which was held on 2 December in Cape Town, formed part of a series facilitated by the Department of Science and Technology aimed at wider dissemination and application of research in the social sciences and humanities. The seminars bring together local and international researchers to discuss the latest research, identify research gaps, suggest new research agendas and explore potential policy relevance. The seminar was attended by representatives of national and provincial governments, researchers from South African universities and research organisations, and experts on HIV and AIDS from South Africa, Botswana and the United States.

The Seminar began with an overview of the 2012 national HIV household survey results by *Profs Olive Shisana and Thomas Rehle* of the HSRC. The survey had three main objectives:

- to obtain national, representative data on HIV for the entire population;
- to estimate HIV prevalence and HIV incidence; and
- to measure behavioural, socio-demographic and health indicators.

The survey also measured the proportion of people who are HIV positive and are receiving antiretroviral treatment.

The total number of people living with HIV in South Africa in mid-2012 was estimated at 6.4 million or 12.2% of the population. The prevalence has increased from 10.6% in 2008. Of note is the higher prevalence in women in most age groups, which although not a new finding remains a cause for concern.

There are some encouraging trends relating to infection in children. For children 0-4 years the prevalence almost halved between 2008 (3.3%) and 2012 (1.7%), which is probably the result of successful prevention of mother-to-child transmission (PMTCT). There has also been a statistically significant decrease in infection for youth aged 15 to 24 between 2005 and 2012. But the picture is very different for adults 25 years and older where there was a quite substantial increase from 16.8% to 19.9% between 2008 and 2012. The peak in prevalence for females has moved from the 25-29 age group in 2008 to the 30-34 age group in 2012.

Direct measurement of antiretroviral drugs in among those found to be HIV-positive revealed that there were over 2 million people on treatment in mid-2012. This amounts to 31.2% of the total population living with HIV and treatment exposure was considerably higher for 0-14 year olds (45%).

Incidence is the most effective means of finding out where we are heading with the epidemic. Direct testing of blood found an overall incidence of 1.07% for those over 2 years of age, 1.72% for 15-49 year olds and 1.49% for 15-24 year olds. Of concern is the finding that incidence is five times higher among 15-24 year old females than for males of the same age. There was close correlation between the directly measured incidence and estimates derived from various mathematical models.

In terms of behavioural findings there is an increasing proportion of the population that now know their HIV status – 10.2% of males in 2005 increasing to 36.4% in 2012, and among females the proportion increased from 13.3% to 46.3%. However, there have been declines in knowledge about HIV and increases in risk behaviour. People reported that they were willing to care for a family member with AIDS but at the same time said they would be unlikely to disclose that a family member was HIV positive. The latter finding suggests that stigma remains a problem.

The following three presentations, by *Eva Kiwango* of UNAIDS, *Dr Fareed Abdullah* of the South African AIDS Council, and *Dr Peter Barron* on behalf of *Dr Yogan Pillay*, National Department of Health, provided comment on the implications of the national household survey for knowing the state of the epidemic and progress with national plans and interventions.

Eva Kiwango described how the surveys help determine progress towards targets set in the National Strategic Plans, the Millennium Development Goals and the UN political declaration of commitments.

An important feature of large national surveys is the ability to provide information on the wide variations in prevalence of HIV at sub-national level.

Dr Fareed Abdullah described how the national surveys had forced SANAC to revise its targets based on earlier models and had highlighted a need for more attention to be paid to prevention. The HSRC results also provided essential information for the recently published report on the National Strategic Plan on HIV, STIs & TB.

Dr Barron summarised the substantial progress made by the National Department of Health in tackling the epidemic. This includes 2.7 million people currently on treatment, which translates to 80% of women and 65% of children and men who are eligible (CD4<350). He acknowledged that the high infection rates in 15-24 year old women, as identified by the HSRC survey, was causing concern and that the department is strengthening programmes and partnerships to address this.

During discussion, two issues arose on several occasions. These were the high prevalence in women and girls and concerns that some targets may be unrealistic. Several delegates voiced grave concern about the high prevalence in girls and called for urgent attention by child protection services among others. The issue of unrealistic targets was related to the 90-90-90 target agreed to by the United Nations (90% of those infected with HIV knowing their status, 90% of those who know their status on treatment, and 90% of these with suppressed viral loads). Several delegates felt that these targets were unrealistic even for well-resourced developed nations, while others subscribed to the opinion that ambitious targets were the best way to fast track action, scale up the response and outrun new infections.

The following sessions called on other stakeholders to give their perspectives on the survey and the epidemic. *Prof Francois Venter*, Wits University, pointed out that despite some limitations the household survey helps to chart the epidemic. He called for 'triangulation of data' and more thorough analysis when data sources do not agree. A further observation was that programmes are sometimes launched for political reasons without sufficient notice being taken of the scientific evidence. A case in point was implementing treatment at CD4<500 when clinics may not be ready for the large increase in cases that this implies and calling on civil society to implement prevention programmes for which the scientific evidence is inconclusive.

Dr Christopher Colvin, University of Cape Town, identified future work that is needed if we are to really know the epidemic in its local context. These include men's experiences with respect to HIV and gender-based violence; HIV counselling and testing (HCT) 'hot spots' where we are failing to find people; the role of sex work criminalisation; heterosexual anal sex as a risk factor; and age-disparate relationships and marriage. An important question is 'how do we sustain focus when the emergency seems to be over, or some people think the emergency is over'?

Dr Sakhumzi Mfecane, University of the Western Cape, highlighted the issue of how men respond to HIV interventions. He proposed that cultural issues form the core of men's response to HIV and further research should be done in this area. We must not simply call for inappropriate behaviour to be 'replaced' with what we 'think is right', because what we think is right may not necessarily be right for everyone.

Dr Donald Skinner, University of Stellenbosch, said that despite some data limitations, the SABSSM reports always provide a nodal point for HIV discussions. He raised concerns about the role of gender violence and drug abuse in the HIV epidemic, particularly for the coloured population, which is showing a small increase in HIV infection prevalence. It appears that there is a misconception that AIDS is a Black African disease which may reduce the likelihood of preventive measures being taken by other population groups.

Seeletso Mosweunyane, National AIDS Coordinating Agency, Botswana, referred to the four surveys that have been done in Botswana. Prevalence of infection is considerably higher in Botswana (18.5%) than South Africa although the scale is smaller, there being only 2 million people in the country. In

many ways the results from Botswana mirror those in South Africa. For example, information about sexual minorities such as sex workers, homosexuals and lesbians is poor, knowledge is declining and self-stigmatisation is a problem.

Dr Fikile Ndlovu, Premier's Office, KwaZulu-Natal, said that research data drives the response to HIV in KwaZulu-Natal but noted that while the survey gives an indication of what is happening it is less clear on what should be done. From a medical point of view the situation is relatively clear but more social science research should be funded to inform social interventions.

Managa Pillay, Higher Education and Training HIV/AIDS Programme, described the survey as extremely helpful and said that their policy and strategy framework had been based on it. However, she expressed concern that it is difficult to understand specific sectors in more detail. Many of the risks highlighted by the survey are common in the higher education sector; these include vulnerable young women, alcohol and drug abuse, age disparate relationships, and mobile populations.

Rev. Canon Desmond Lambrechts, National Religious Association for Social Development, presented the case for greater involvement of religious leaders in HIV prevention. He said that the church was responding to community demand for an appropriate response and that they would be paying particular attention to children and youth.

Dr Faith Kumalo, Department of Basic Education, reported that her department has used the survey to inform its current strategy on HIV and also arranged for the HSRC to present relevant results to their AIDS coordinators. Ideally, they would like to have information at a finer resolution although it was made clear that the sample size limits how much local information is available.

In discussion, the question of providing access to the HSRC's data was raised by several delegates. Prof Shisana noted that the data is in the process of curation, after which it can be made available to other users.

The final session of the seminar invited delegates to discuss four topics in breakaway groups: Treatment; Social and Structural Barriers; Prevention; and Stigma, Discrimination and Human Rights. The Treatment group noted that high numbers of infected children will create a new demand for innovative programmes for young adolescents. Another observation was that with so many people now on treatment the new unique patient identifier could provide valuable additional information if it could be included in the survey questionnaire. An important question to answer is whether people who are HIV positive but do not access care are ineligible for treatment because of their CD4 count or whether they have been lost to follow up. Viral suppression was also mentioned as being worth further investigation because it is an important proxy for adherence to therapy.

The Social and Structural Barrier group discussed barriers that contribute to the high risk of infection for adolescent girls. These include gender norms; poverty and unemployment; the structure of state support; and a breakdown in safety and security, including a distrust of the police. The reported low awareness of HIV status and poor HIV knowledge was thought to be related to stigma, social norms, a kind of fatalism, and denialism. This calls for new commitments to counselling and testing campaigns combined with general awareness raising. The group also identified some gaps including a need to investigate what it is about informal living that increases HIV risk.

The Prevention group was concerned that interventions which work, such as condoms, medical male circumcision, PMTCT and ART, must continue to be promoted while recognising that the 'one size fits all' approach will not work. There was a call for a truly multisectoral approach as opposed to the predominantly biomedical one which currently prevails. In terms of addressing the gaps, one of the issues was the need for budgets to address some of the methodological limitations and investigate those sub-sets of the population for which there is insufficient information.

The Stigma, Discrimination and Human Rights discussion noted that the best people to investigate stigma and human rights around HIV were those who are living with the infection. There are examples

of properly evaluated stigma interventions which should be more widely publicised. There was a call for the HSRC to help standardise a Stigma Index for the general population and to measure experiences of stigmatisation and discrimination.

INTRODUCTION

This seminar presented the key findings from the 2012 South African national HIV household survey (SABSSM4) and discussed the implications of the findings for both HIV/AIDS policy and programming. SABSSM4 is the fourth in a series of national HIV-prevalence surveys that were carried out in 2002, 2005, 2008 and 2012.

The seminar brought together HIV researchers from the HSRC, universities and other research organisations, and policy makers drawn from national and provincial departments including Health, Social Development, Basic Education and Higher Education. It also included experts from the South African National AIDS Council (SANAC) Secretariat and its NGO Sector, Botswana Ministry of Health, United Nations Joint Programme on HIV/AIDS (UNAIDS), the US President's Emergency Fund For AIDS Relief (PEPFAR) and the US Centers for Disease Control. There were 73 participants in all.

SUGGESTED FURTHER READING

1. Rehle TM, Hallett TB, Shisana O, et al. A decline in new HIV infections in South Africa: estimating HIV incidence from three national HIV surveys in 2002, 2005 and 2008. *PLoS ONE* 2010; 5(6): e11094.
2. Shisana O, Rehle T, Simbayi L, Parker W, Bhana A, Zuma K, Connolly C, Jooste S, Pillay V et al. (2005). *South African National HIV Prevalence, Incidence, Behaviour And Communication Survey 2005*. Cape Town: HSRC Press, 2005.
3. Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Zungu N, Labadarios D, Onoya D, et al. *South African National HIV Prevalence, Incidence and Behaviour Survey, 2012*. Cape Town: HSRC Press, 2014.
4. Shisana O., Rehle T, Simbayi LC, Zuma K, Jooste S, Pillay-van-Wyk V, Mbelle N, Van Zyl J, Parker W, Zungu NP, Pezi S, & The SABSSM III Implementation Team. *South African national HIV prevalence, incidence, behaviour and communication survey 2008: A turning tide among teenagers?* Cape Town: HSRC Press, 2009.
5. UNAIDS. *UNAIDS report on the global AIDS epidemic 2013*. UNAIDS / JC2502/1/E. Geneva, September 2013.

THE SEMINAR

The slides used in the presentations summarised below are provided in Appendix 4.

SESSION 1

KEY FINDINGS FROM THE 2012 NATIONAL HIV HOUSEHOLD SURVEY (SABSSM4)

Prof Olive Shisana, HSRC and Prof Thomas Rehle, HSRC

The survey

Prof Shisana began her presentation by explaining that the 2012 national HIV household survey, known as SABSSM4,¹ was the fourth survey in an ongoing series, with the next survey scheduled for 2015. These surveys provide very important information about where we are with the HIV epidemic and they aim to inform policy, evaluate health programmes and advise on progress with the National Strategic Plan on HIV, Sexually Transmitted Infections and TB, and National Health Insurance. SANAC has acknowledged that these surveys are being used to provide a baseline for planning purposes.

The survey had three main objectives:

- to obtain national, representative data for the entire population;
- to estimate HIV prevalence and HIV incidence; and
- to measure behavioural / socio-demographic and health indicators.

The survey includes measuring the proportion of HIV positive people who are receiving antiretroviral therapy. One of the reporting domains describes the locality type (urban formal, urban informal, rural formal, rural informal) but the significance of this is changing because many people have dual living conditions, i.e. homes in both urban and rural areas.

The sampling is based on a 'master sample' which is representative of the entire country. The survey took place between January and November 2012; 38 431 people were interviewed and 28 997 were tested for HIV infection.

Prevalence of HIV infection

The HIV testing makes use of dried blood spots which are screened for HIV antibodies and, for the samples from people two years and older, HIV incidence testing was performed.

The overall number of people living with HIV/AIDS in South Africa was estimated at 6.4 million. This is by far the largest number for any country in the world and is 12.2% of the population. The prevalence has increased from 10.6% in 2008. Of note is the higher prevalence in women in most age groups, which although not new remains a cause for concern (Figure 1).

For the age group 15 to 49 years, the prevalence among males was 14.5%, among females 23.2% and overall 18.8%. By race group (15-49) prevalence in black Africans was 22.7%, among Coloureds 4.6% and Indian, Asians and Whites less than 1%. Analysis by locality for the same age range shows that urban informal areas have the highest prevalence at 29.9%, followed by rural informal areas (22.6%) then rural formal areas (16.1%) and urban formal areas at 14.7%. When comparing the prevalence in different provinces, KwaZulu-Natal is highest at 27.9% with the Western Cape lowest, at 7.8%.

¹ SABSSM is an acronym derived from the full title of the first national HIV survey, which was called the South African HIV/AIDS Behavioural Risks, Sero-Status and Mass Media Impact Survey.

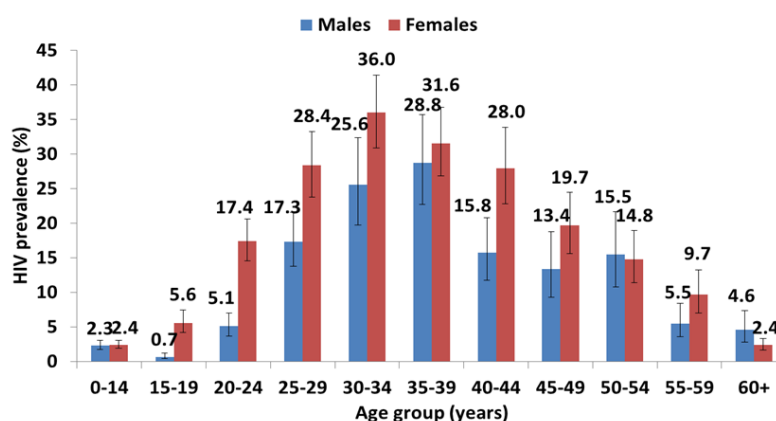


Figure 1: HIV prevalence by age and sex, South Africa, 2012

There are some encouraging trends relating to infection in children. For children 0-4 years the prevalence almost halved between 2008 (3.3%) and 2012 (1.7%), which is probably the result of successful prevention of mother-to-child transmission (PMTCT). For children 2-14, prevalence has declined since 2002, largely due to the effects of PMTCT, but higher survival due to greater availability of ART causes some offset in numbers. This means that there has been little change in prevalence among 2-14 year olds between 2008 and 2012.

For the youth between 15 and 24 there has been a statistically significant decrease in infection from 2005 to 2012. But the picture is very different for adults 25 years and older where there is a quite substantial increase from 16.8% to 19.9% between 2008 and 2012. The peak in prevalence for females has moved from the 25-29 age group in 2008 to the 30-34 age group in 2012. This is the result of ART exposure.

Antiretroviral treatment exposure

South Africa has the largest ART programme in the world and in 2012 there were over 2 million people on treatment. This figure is not based on those listed as being in treatment programmes but is measured using the detection of antiretroviral drugs in blood. A greater proportion of females are on treatment than males which reflects males being less exposed to services.

Antiretroviral treatment is one of the real success stories in South Africa. The estimated number of people living with HIV for mid-2012 is 6 422 000 of whom 2 002 000 or 31.2% are on ART. For certain age groups the exposure to ART is much higher with 45.1% of infected 0-14 year olds on treatment and 43% of those over 50 on treatment (Table 1).

Table 1: ART exposure by age group, South Africa mid-2012

Variable	Estimated number of people living with HIV (n)	Estimated number of people on ART (n)	Proportion of people living with HIV on ART (%) [95% CI]
Age group			
0-14	368,879	166,025	45.1 [33.9-56.9]
15-24	720,269	102,868	14.3 [10.0-20.0]
25-49	4,705,506	1,466,412	31.2 [27.4-35.2]
50 and older	610,323	260,490	42.7 [35.7-50.0]
15-49	5,425,776	1,569,280	28.9 [25.6-32.5]
Total	6,422,179	2,002,350	31.2 [28.1-34.5]

HIV incidence estimation

Incidence (i.e. the rate at which new infections are occurring) is the most effective means of finding out where we are heading with the epidemic. SABSSM estimates incidence using two major

approaches. The first is direct incidence estimation using blood specimens and a state of the art multi-assay testing algorithm, which allows for antiretroviral treatment exposure. The second is indirect estimation using mathematical models and data from various sources including repeated national household surveys. These are the latest possible approaches and papers have been published on the methods.

The direct results show incidence among 15-24 year old females nearly five times higher than for males (Table 2).

Table 2: Direct, assay-based HIV incidence rates by age and sex, South Africa 2012

Age Groups	HIV incidence % (95% CI)
Age ≥ 2years	
Total	1.07 (0.87 – 1.27)
Male	0.71 (0.57 - 0.85)
Female	1.46 (1.18 - 1.84)
Age 15-24 years	
Total	1.49 (1.21 – 1.88)
Male	0.55 (0.45 - 0.65)
Female	2.54 (2.04 - 3.04)
Age 15-49 years	
Total	1.72 (1.38 – 2.06)
Male	1.21 (0.97 - 1.45)
Female	2.28 (1.84 - 2.74)

In comparison, the four mathematical models give very similar results to the empirical data (Table 3) which is very encouraging and reflects a robust picture for South Africa when it comes to incidence estimation. However, we cannot rely on models alone because the direct blood-based incidence estimation method provides information on specific sub-groups and specific risk categories which cannot be obtained from the models on a national scale.

Table 3: HIV incidence derived from four mathematical models

Method	Period	15-49 incidence %
Lag avidity/ ARV / VL	2012	1.72
Synthetic cohort	2008-12	1.90
EPP / Spectrum	2011/12	1.52
Thembisa	2011/12	1.47

Looking at the HIV incidence rates by socio-demographic and behavioural variables shows the following. Incidence in urban informal areas (4.42%) is more than three times that in formal areas. Sexually active females aged 15-24 have an incidence of 3.5% and for black African females aged 20-34 the rate is 4.5%. Those with more than one sexual partner in the past 12 months (15-49 years) have an incidence of 2.4 which is 50% higher than the rate for those with only one partner. Information at this level of detail is what is needed for priority setting and incidence data of this kind is particularly helpful.

Behavioural findings

The awareness of HIV status has increased substantially over the period 2005 to 2012. Among males awareness of HIV status increased from 10.2% in 2005 to 36.4% in 2012 and among females there was an even bigger increase from 13.3% to 46.3%.

Condom use still remains important but the initially increasing trend from 2002 to 2008 has now reversed. For young males (15-24) condom use at last sex has dropped from 85% to 68% and for females has dropped from 67% to 50%. There are similar declines among 25-49 year olds.

The number of people reporting multiple sexual partners has increased across all four surveys. Previously this was thought to be related to men working in the cities who could not take their wives along. In these circumstance a rural wife and girlfriend in the city became the normal behaviour. This risky behaviour continues because no one is paying attention to it.

Another challenge is age-disparate relationships in which women tend to have relationships with men who are five years older. This is also increasing and is clearly reflected in the epidemiological profile in which the HIV prevalence for women is the same as men who are five years older. This means that women are not having sex with the same age group which has implications for prevention.

Sexual debut before the age of 15 continues to be a problem and is increasing in males.

The other big problem we have in the country is lack of knowledge. There used to be many billboards saying 'prevent HIV, use a condom', 'HIV is transmitted sexually', 'stick to one partner'. There used to be so many messages on the buses, on billboards, on taxis and on trains but they are no longer common. Correct knowledge about HIV has decreased especially in some high risk groups (Figure 2).

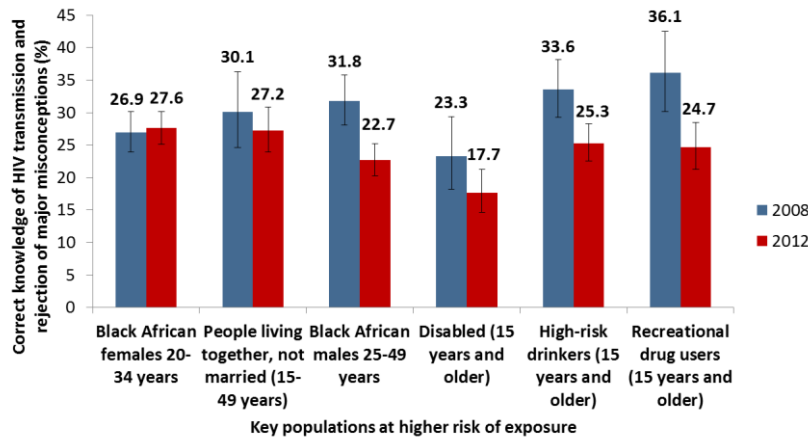


Figure 2: Correct HIV knowledge among key populations, South African 2008 and 2012

Stigma is showing mixed results. A question which asks whether people would buy from a food handler has shown a slight increase in affirmative responses over time. The number of people who would be willing to care for a family member with AIDS has remained high at 92%, and those who think training a person with HIV or AIDS is a waste of money remains relatively low at 17%. However, there has been a marked increase in the proportion of respondents who would want to keep the HIV positive status of a family member secret from 39.9% in 2008 to 50.1% in 2012. So, basically stigma remains much the same or it is growing and this is something that we need to look at.

We need to look at the existing prevention programmes to see what options we have as a country (Figure 3). There are several randomised controlled trials (RCTs) which have shown that male circumcision helps prevent infections. There are no RCTs for treatment of STIs, so this remains controversial, and the jury is still out on the use of microbicides for women. There is good evidence for pre- and post-exposure prophylaxis and treatment for prevention is working well. However, the main focus is on biomedical interventions and programmes do not address the behavioural and social aspects sufficiently.

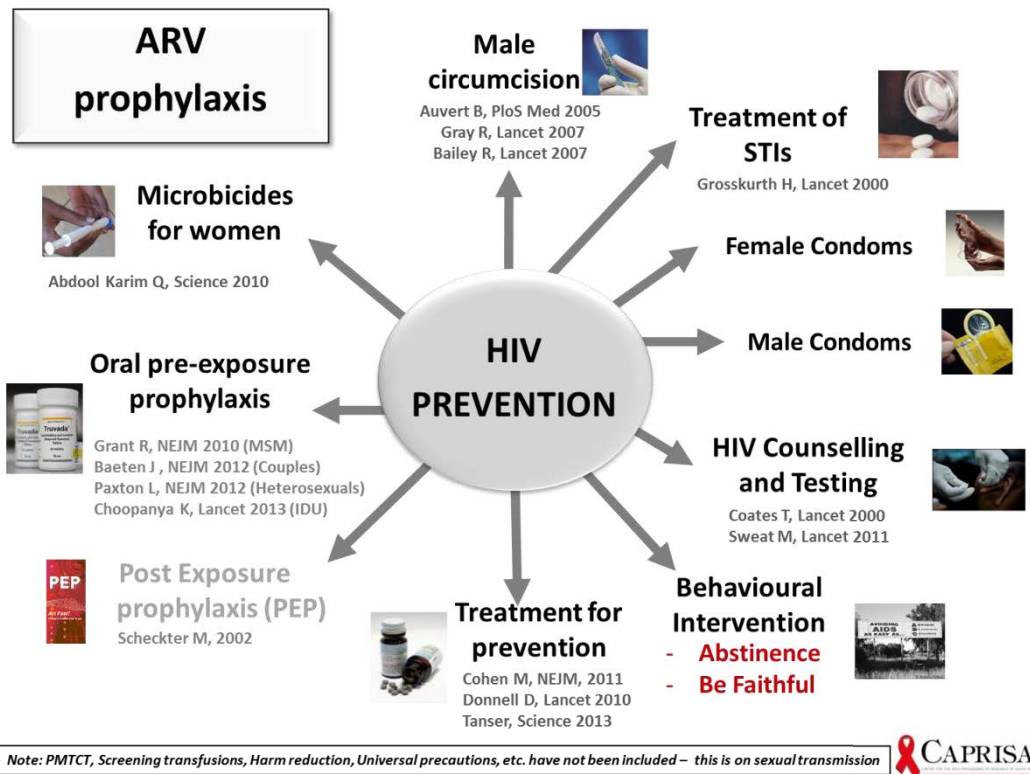


Figure 3: Evidence for prevention programmes

In closing Prof Shisana thanked the SABSSM collaborators, which include Unicef, the Bill and Melinda Gates Foundation, the Centers for Disease Control and Prevention, the Medical Research Council, SANAC, the University of Cape Town and the National Institute of Communicable Diseases. Prof Simbayi added a tribute to the late Mr Nelson Mandela whose Children’s Fund and Foundation funded the first two surveys.

QUESTIONS & ANSWERS (Q&A)

Question (Q): Fikile Ndlovu, KZN Premier’s Office. I would like some more clarity on the issue of locality. How do you differentiate between urban and rural informal areas?

Answer (A): Urban informal areas are the peri-urban areas consisting of squatters and zozos. Rural informal areas are those without formal structures, the former Bantustans. Farms are regarded as formal. In the 2015 survey we will need to re-think this because in areas with farms there are RDP houses, shacks and double storey houses. People go from urban areas to build formal houses in rural areas. Over time I think we will see a change.

Q: Patrick Nadol, US Centers for Disease Control and Prevention. The male female difference is striking. Could you explain the enrolment, refusals, and non-response rate, particularly among the men?

A: There is a very extensive response rate analysis where we check for any differences and biases. For behavioural risk categories we need to see if there is some difference between the ones who were interviewed but not tested and the ones who were interviewed and tested. No significant biases were found. However, we want to explore the unknowns further using Heckman type selection models.

Q: Warren Parker, Consultant. Being able to see incidence and prevalence data over many years has been a real contribution of these repeat surveys. For 2-14 year olds there is high incidence among girls which links to policy in terms of how to address this. Prevalence data makes people focus on high

prevalence provinces but low prevalence provinces may have high incidence. Is there any sense of where that might be going?

A: The blood-based incidence cannot get to province level because the numbers are too small, although we can get provincial estimates from some of the models, e.g. the Tembisa model.

A national household survey cannot do everything, especially at small area level. This is already the largest HIV survey in Africa and we cannot afford the 80,000 sample size needed for finer resolution. But we may select one or two larger provinces for more in depth sampling.

A: Another issue is the response rate for Whites and Indians which is low and therefore the figures are not as reliable. Recall bias is also a problem because recall about behaviour is not perfect whereas biomedical markers are more reliable. We cannot provide reliable data on all 52 districts but for some metropolitan districts the data is better and this is included in the report. We did not do the incidence data for the metro districts but we do have that information.

Q: Moses Mncwabe, Parliament. Has there been any shift towards using the results of the survey to influence the programmes on the ground? Because my assumption is that the purpose of these surveys is to find the gaps and infuse it into the programmes.

A: Before we release the report we have in depth discussion between the National Department of Health (NDOH) and HSRC. We present results to provincial representatives and NDOH staff. We interrogate the results so that they know what we have found and launch the report with the ministers to encourage them to use the information. SANAC is also involved in the process and discusses the findings. They convene meetings to help design interventions, particularly among young women. This helps us to use research to inform policy.

We would like to see more action to address black females 20-34 and males 25-49 as specific target groups. This country is still reeling from the effects of apartheid to the point that we are not able to say black women aged 20 to 34 are at risk of HIV infection and therefore we must have an intervention directed at them. That is where the problem is. We are still running away from the race issue but we need to confront it and see it not as racism, but as a way of addressing a need. If we do not do anything we are not going to lower the HIV incidence in this country. We will never manage this HIV problem unless we actually deal with the question of a targeted intervention for black males and black females. Men who have sex with men are another group that is not being addressed properly.

Q: Seeletso Moswunyane, National AIDS Coordinating Agency, Botswana. How did the survey account for people from other countries? There are various cross-border initiatives which allow people from other countries to access ART in Botswana. What is being done about this in South Africa?

A: We used to ask about migration but people were reluctant to say. But we know there is a migration at the end of the month to get ARVs and our constitution says we must provide health care for everyone. So this survey does not ask where people come from.

Q: Sylvia Leabile, North West Provincial AIDS Council. How do the statistics for Blacks compare to the Whites and Indians?

A: The denominator is important. We look at the proportion of Black people that is HIV positive and what proportion is newly infected. We want to do the same for Whites but we can only get the overall prevalence because only 40% of whites provide samples for testing. It is difficult to estimate incidence from this response rate.

A: The confidence intervals for all the estimates are shown. White and Indian data is not useless but because participation is lower it may be less precise. Gated communities were the ones that tended

to be excluded and so long as you do not construe a scenario that misses higher risk white people then results remain valid.

SESSION 2: THE CURRENT STATE OF THE HIV/AIDS EPIDEMIC IN SOUTH AFRICA

KNOW YOUR EPIDEMIC: THE VALUE OF POPULATION-BASED HOUSEHOLD SURVEYS

Dr Eva Kiwango, Senior Strategic Information Officer, UNAIDS

This presentation focused on the epidemiological insights that population-based HIV surveys provide. A large number of national population-based surveys have been done, mostly in Sub-Saharan Africa, but also in selected countries in Asia, the Caribbean, the US and in Latin America. South Africa and Kenya have conducted the most HIV population-based surveys (Figure 4) and data from these surveys plays a central role in determination of progress towards the commitments and the targets set in the National Strategic Plans, the Millennium Development Goals and the UN political declaration of commitments.

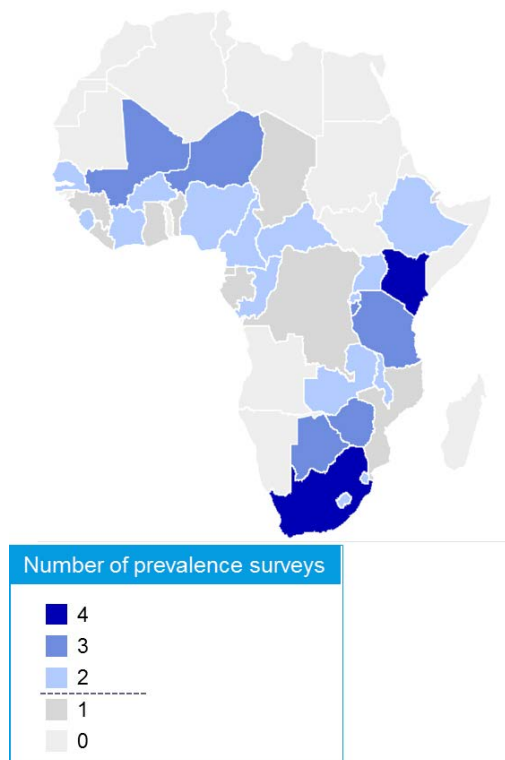


Figure 4: Number of prevalence surveys completed by countries in Africa. (Ghys, Mahy & Rehle, 2014)

Arguably the most important information derived from these surveys is a nationally representative estimate of HIV prevalence and information on regional and global variation. The national surveys have been used to adjust the UNAIDS estimates of prevalence derived from antenatal clinic attendance. Another feature of large national surveys is the ability to provide information at sub-national level. There is often wide regional variation in prevalence and this information is essential for gauging the progress of the national HIV response. Other insights provided by surveys include information on the determinants of infection, for example, condom use at last sex.

UNAIDS Fast Track Targets

During the international AIDS conference, the world took a far-reaching decision to bring an end to HIV and it was decided that we need to fast track action and scale up the response if we are to outrun new infections. The UNAIDS fast track targets known as '90-90-90' for 2020 include:

- 90% of people living with HIV knowing their HIV status;
- 90% of people who know their status on treatment; and
- 90% of people on treatment with suppressed viral loads.

Other targets include:

- reducing the annual number of new HIV infections to 500 000 in 2020, and 200 000 in 2030; and
- achieving zero discrimination.

Achieving these targets will help avert about 21 million deaths and 28 million new infections and prevent 5.9 million infections among children. The intention is to close the gap between people who have access to HIV prevention, treatment, care and support services and those who are being left behind, particularly young women and girls, men who have sex with men, migrants, prisoners, sex workers, people who inject drugs, and children. Children are 37% less likely to have access to treatment than adults.

Future directions and information to be derived from household surveys

1. Expand the age range of samples.

To date few surveys have included children but South Africa's data on HIV prevalence in children 2-14 years suggest a reduction in prevalence. More information is also needed on people over 50 where prevalence appears to be rising.

2. National HIV incidence.

The availability of a reliable HIV incidence assay means that incidence can and should be a routine component of population-based surveys.

3. Immunological Status.

CD4 cell counts in people living with HIV are used to assess the proportion of persons who are eligible for treatment and the number already on ART provides information on the population-level reach of the treatment response.

4. ART coverage.

Sub-national trends in this measure provide crucial information on progress and gaps, and can inform resource allocation to achieve coverage goals according to epidemic distribution. Obtaining information on the characteristics of persons who do not access care is important for programme improvement to more effectively meet the needs of people living with HIV.

5. High transition geographies and populations (hot spots).

Geographic Location: Sub-national HIV prevalence and incidence trends provide crucial information on progress and gaps, and can inform resource allocation to achieve coverage goals according to epidemic distribution and high transmission areas such as informal settlements, truck routes etc.

Populations left behind: Obtaining information on the characteristics of persons who do not access care is important for programme improvement. Groups at risk include young women, adolescents, men who have sex with men, prisoners, sex workers, migrants, and people who inject drugs.

6. Continuum of care (Kenya AIDS Indicator Survey).

A study of the continuum of care among people living with HIV showed that although use of HIV related care is relatively high among those aware of their HIV positive status, only 43% of HIV infected persons aged 15 to 64 years were retained in care.

7. Community viral load suppression.

Viral Load suppression reflects adherence to HIV treatment and quality of ART programmes. These measures inform programmes about the population-level suppressive effect of ART and about further HIV transmission potential. In the Kenya AIDS Indicator Survey only 40% of those infected achieved viral load suppression, whereas 78% of those on ART achieved viral load suppression.

A wealth of epidemiological insights has been garnered from HIV surveys. We now understand how much progress has been made and how far HIV programmes still have to go. We need to fast track the 90-90-90 targets; reduce the annual number of new HIV infections; and work towards achieving zero discrimination.

Additional information that should be derived from population-based surveys includes more sub-provincial level estimates to identify people who are being left behind. Further information is also needed on continuum of care among people living with HIV, immunological status (CD4 cell count) and the extent of viral suppression.

IMPLICATIONS OF THE HOUSEHOLD SURVEY FOR THE NATIONAL STRATEGIC PLAN

Dr Fareed Abdullah, Chief Executive, SANAC

The HSRC survey has had an impact on many levels. For strategy it has highlighted prevention. We have had a great deal of success with treatment but may have got carried away thinking that the whole story is a success story. Incidence is still a problem and while we relied on Spectrum data the picture was over optimistic. In the UNGASS report 2012-13 we claimed that we would reduce sexual transmission by 50%. Spectrum predicted a decline of about 45% and we thought we could therefore achieve 50% by 2015. But the HSRC study blew this way. Unlike countries in the region that are achieving these declines, incidence in South Africa is proving intractable. Reviewing the data for 2008-12 showed a decline in incidence of only 18-20% and although it is coming down faster among the younger age groups this is not where we should be.

The Deputy President's address on World AIDS Day said we are doing well on treatment but there are 469,000 new infections which means we still have a lot more to do. SANAC is struggling with the extreme optimism of UNAIDS which proposes an end to AIDS by 2030 and our National Development Plan offers a more realistic scenario of working towards being AIDS free in the next generation. The SABSSM survey results have had a dramatic impact on the level of strategy.

The behavioural data in the HSRC survey are very different from the National Communication Survey regarding condom use and sexual debut. The results on knowledge about HIV and stigma are also important. On World AIDS Day (1 December) SANAC launched a new multi-year National Stigma Campaign on its web site featuring videos about stigma.

The SANAC web site has just published the first comprehensive report on the National Strategic Plan (NSP) and this places much reliance on the HSRC data. The Tembisa outputs are influenced by HSRC data and Spectrum has also been adjusted using HSRC data. Input of HSRC data into the Tembisa model allows estimates of incidence. The National Strategic Plan depends on HSRC data for its baseline and SANAC invested in the 2012 survey because it would provide a baseline from which to measure progress. This is why SANAC would like to support the next SABSSM study.

This kind of report will also influence resource allocation. If one province bears so much of the burden it should get the appropriate share of resources.

Reducing incidence in young women is the single highest priority in this country. The 5-fold higher incidence for young women compared to young men is strong evidence for this need. But young women are not homogeneous – they are in school, out of school, urban, rural etc. There are many projects aimed at young women and the HSRC data provides justification for them.

Another important issue is the incidence in 2-14 year old girls. There were 29,000 new infections in this group and all of them in girls, which means that it cannot be a carry through of mother-to-child infections. Is this sexual assault or child abuse? This is a staggering finding because there is zero incidence in boys. A response is needed from child protection.

We have the largest epidemic in the world and yet South Africans do not know much about HIV. We need to make investments in information and knowledge. We cannot just sit back and do nothing about basic information.

The other thing which the report blows out of the water is this idea that we have made a lot of progress on condoms. The National Communication Survey shows good progress with condoms but we are fooling ourselves. Condom distribution has gone down for at least two years. We are currently distributing about 400 million condoms which is nowhere near the one billion target. The country with biggest HIV epidemic does not have a national condom promotion programme and we have to do so much more.

It is useful to have a direct measure of ART from blood specimens because this is the best confirmation of the success of the treatment rollout. The District Health Information is quite weak because of the lack of a unique patient identifier. There are two million people on treatment, some on PMTCT and some in private sector but this is a good number. As for the target of 80% coverage of ART for those eligible, this may be quite difficult to do. It may be better to just count the number of people on treatment against a denominator of all those who are HIV positive in the country.

South Africa is doing better than the rest of the continent with regard to number of children on treatment. But the policy is to test and then treat all children who test positive, so we should be doing much better.

About two thirds of HIV infected people know their status but that means around two million do not know they are infected. This calls for a review of the HIV counselling and testing programme because so much of the prevention effort will be linked to the people who test positive.

In conclusion, this report brings out that we need to do more on prevention and that treatment should be seen as part of the prevention intervention. The biggest challenge is how to make all these elements come together to make a difference for young women.

PROGRESS IN ADDRESSING THE HIV EPIDEMIC: A VIEW FROM THE DEPARTMENT OF HEALTH

Dr Peter Barron, presenting on behalf of Dr Yogan Pillay, National Department of Health (DoH)

We have made much progress and the end of AIDS is within reach but we have not reached the end of AIDS yet. There are 2.7 million people on treatment and, at current eligibility of less than 350 CD4 count, this translates to 80% of women and 65% of children and men who are on treatment. This has been achieved by training nurses in all public health facilities so that AIDS treatment is now as widely available as TB treatment.

In order to initiate people on treatment people first have to be tested and in April 2010 the President launched the national HIV counselling and testing campaign. The department is very proud of the achievements of this campaign and in the 20 months after the launch, approximately 1 million people per month were tested, giving a total of 20 million tests. Since that time there has been an annual target of around 10 million people between the ages of 15 and 49 each year and in the most recent quarter for which we have data, namely July to September of this year, 2.2 million people in this age band were tested. On World AIDS Day the Deputy President again called for all South Africans to be tested at least once a year.

In a recent paper, Andrew Boule (UCT) demonstrated viral load suppression of nearly 90% in people who had viral load tests. This means that the more people who are on ARVs, the less the possibility of HIV transmission. The paper concluded that people on ART in South Africa are likely to live as long as those in the US after four years, which is a remarkable success, given the level of resources in this country.

However we still need to help patients adhere to treatment. Information from Peer Net, the information system used to manage HIV, shows a declining proportion that has had a viral load test and adherence over time is declining. But for those that were tested there is viral suppression. A unique patient identifier is being introduced and health professionals are being trained to use data to improve system performance.

Treatment is good for its own sake but is also part of the prevention strategy. As the eligibility criteria for treatment have increased (from CD4<200 to CD4<350 and now CD4<500) the average CD4 count at the start of treatment has moved steadily upward. To ensure that facilities are not overwhelmed by the sheer numbers of patients seeking treatment, stable patients are decanted from facilities by strengthening existing support groups and establishing them where they do not exist. Chronic medicines are now being couriered to stable patients in about 40% of the facilities in the NHI Pilot Districts.

One area of great success is the prevention of mother-to-child transmission. In 2008 the transmission rate from mothers-to-children was 8%. This had decreased to 2.6% in 2012 according to a survey done by the Medical Research Council and the data from the National Health Laboratory Services suggest that in many provinces the rate is now lower than 2%. We are heading towards what is called 'virtual elimination'.

The MRC Burden of Disease unit estimates that the ART programme has been a significant contributor to declines in infant and under 5 mortality as well as increasing life expectancy. In 2009, life expectancy was 57 years and by 2012 this had increased to 61 years. Infant mortality declined from 39 per 1 000 live births to 27, in the same timeframe, and under 5 mortality declined from 56 to 41 per thousand.

There are also many other programme achievements. More than 1.5 million men have been medically circumcised. Our blood transfusion services are among the best in the world and there have been no transmissions from blood transfusions in South Africa. Post exposure prophylaxis is available at more than 230 public health facilities and 53 Thuthuzela Care Centres².

Communication campaigns have been undertaken and the National Communication Survey shows their impact. The last Khomanani campaign was in 2009 but the next communication campaign is planned for the New Year.

We have increased the number of male and female condoms being distributed and expect to have distributed 600 000 males condoms in 2014. The Department works with provinces to ensure that each district has a condom distribution plan to ensure that condoms are available where they are most needed. Another initiative which was identified using focus group research is to provide coloured and scented condoms. These will be available initially at Further Education and Training colleges and later will be more widely available.

In July 2014 the Minister of Health announced that we will be initiating treatment at CD4 and introducing option B+, or life-long ART for all HIV-infected pregnant women regardless of CD4 count. In addition, we are also adopting the UNAIDS 90-90-90 targets to be achieved by 2030 and working hard to make sure that South African ARV prices are the lowest in the world. Laboratory costs are also decreasing and the cost of viral load testing has set the global benchmark. Recent analysis shows that the country can afford this programme.

There is concern about high infection rates in 15-24 year old women and other key populations including sex workers and men who have sex with men. We are in the process of strengthening of our programmes and partnerships in these areas and are committed to doing more.

² Thuthuzela Care Centres (TCCs) were established to improve the process of reporting and prosecution of rape and other sexual offences in a dignified and caring environment. Thuthuzela is an isiXhosa word meaning 'comfort'.

In conclusion, whilst the end of AIDS is not near and a vaccine is still far away, we have made progress in our fight against the epidemic and we have many more tools today than a decade ago or even five years ago. Even as we search for new tools, we must make full use of our existing arsenal. Together we can make a big difference.

Q&A

Comment: Gary Martens, UCT. I want to take issue with 90-90-90 which is a really tough target. In the US, 80% know their status, 36% are on ART and, of these, 78% are suppressed. In France, 81% know their status, 60% are on ART, which is quite a lot better than the US, and 86% are suppressed. That is a huge way from 90-90-90. We have to be very careful about setting targets which even rich countries are not going to achieve.

A: UN is a collection of governments so these proposals were made in consultation with member states and 90-90-90 followed this path. There is consensus that without a new narrative on HIV the epidemic will outrun the efforts. We are doing well but must do more. The targets are ambitious but the countries must make their own plans.

A: We are about halfway to the targets for 2030 and without ambitious targets we will not win against HIV. From a public health perspective the top three priorities in South Africa are HIV and HIV and HIV.

Q: Fikile Ndlovu, KZN: Success with biomedical interventions has been because it was clear who needed to do what but who is responsible for prevention in totality? How do we amend our monitoring tools to align with the findings of this survey?

C: Desmond Lambrechts. This survey is saying a lot of new things and reviewing some old things. Who takes ownership of the information and drives the process forward? This ought to be a multisectoral response but it is no longer multi-sectoral. We should have Justice, Education, Social Development and the rest - not just health. I hoped this conference would make it absolutely clear that children should be seen as a key population, especially the 2-14 year old girls.

A: We are all responsible for prevention. The NDOH is responsible for the medical side of prevention but other departments take care of other aspects.

A: We need a prevention agency as a focal point. There is debate about whether SANAC should do this but we need a serious institutional focus on prevention because bits and pieces done by all the departments is not going to do it.

C: We need policy clarity. If we are going to treat at CD4<500 and have double the number of patients on treatment we may need to make adjustments to the system to use the private sector and NGOs. If we go for the prevent and treat approach of UNAIDS (90-90-90) we will have millions more people to treat. Let's have policy clarity before we decide how to apply it.

SESSION 3

STAKEHOLDER PERSPECTIVES I

Prof Francois Venter, Institute for Sexual & Reproductive Health, HIV and Related Diseases, University of the Witwatersrand

It is important to defend the survey because it helps to chart the epidemic and although it comes in for criticism it is valuable. It helps to triangulate data for incidence and prevalence and modelling data. The ARV component is becoming increasingly important not least because the clinic data is not very reliable. Triangulating the pharmaceutical companies' data with the HSRC survey is going to be incredibly important.

The evidence that knowledge levels are declining is not something to be proud of as a country because it shows we are losing ground in areas where we were doing relatively well.

The state's data tells us that condom access is improving and yet we have other information which shows people are buying condoms more than they get them from the state sector. Despite this, condom use is declining according to this survey. This does not triangulate well and needs further investigation.

We need to be careful about the story we construct – there are alternative theories. The issue of concurrency of partners has fallen away because it does not explain the epidemic. Sugar daddies were said to drive the epidemic but actually the evidence is poor and a recent study, albeit controversial, showed that sugar daddies are protective against HIV. Some data does not triangulate well and I think that we need to explain it with more sophistication. The data is hard, but the explanations attached to the data need better thinking through and I think that possibly the challenger here, to my social science colleagues, is you need to explain this better.

I am pleased that the NDOH is now recognising key groups such as sex workers and men who have sex with men, which were neglected in the past. It is a hard thing to measure, but it might be something that we want to look at. There is no coherent approach for addressing the epidemic among adolescent girls but we should try to reach them while they are still at school.

My final point is about politicians making decisions on our behalf. There were many commissions in this country that said hold off on implementing treatment at CD4<500 because the clinics were not ready, yet they went ahead. There is a rising anger within civil society about the fact that we are being told to implement prevention programmes but are not consulted about their content, and the science behind them is sometimes questionable.

Finally, there are insufficient resources for civil society. We need to get our priorities right, focus them on the adolescent girls and make sure that civil society is robust.

Dr Christopher Colvin, School of Public Health and Family Medicine, University of Cape Town

Both/And: Thoughts on Next Steps in the Response to HIV in South Africa

Prof Colvin began his presentation by summarising several topics that his colleagues in the South African Social Science and HIV Programme had identified as priorities. These included:

- men's experiences with respect to HIV and gender-based violence;
- HIV counselling and testing (HCT) 'hot spots' where we are failing to find people;
- key populations;
- the HIV risks arising from sex work criminalisation;
- under-recognition of heterosexual anal sex as a risk factor; and
- age-disparate relationships and marriage.

These issues help to sketch a landscape for future work if we are to really know the epidemic in its local context. However, ranking individual risk factors for specific vulnerable groups should be approached carefully.

A suggested way forward is a 'both/and' approach. We need both description and theory (not to be confused with the qualitative/quantitative debate). Secondly, we need both evidence and intervention but must decide when we know enough to act. We have not made much progress with living with research and uncertainty. We should be producing robust and diverse forms of interdisciplinary evidence and linking this knowledge production to a parallel process of decision making and intervention. Finally, we need both normalisation and exceptionalism. Rates of stigma have fallen and access to treatment has risen, suggesting normalisation, yet knowledge of basic biomedical facts has declined. How do we sustain focus when the emergency seems to be over or when some people think the emergency is over? In an attempt to strike a balance between exception and norm we must not go back to the old ways of thinking and seeking a biomedical 'magical bullet' when successes with medical interventions such as ART were as much the product of activism, political will and community mobilisation, as they were a product of pharmaceutical science.

Dr. Sakhumzi Mfecane, Department of anthropology and sociology, University of the Western Cape

It is clear that the authors of this report have learnt from previous surveys. I would like to raise the critical issue of how men respond to HIV interventions. Men are lagging behind in terms of HCT, ART and medical circumcision. Men also drive HIV by having multiple sexual partners, early sexual debut, and the age disparities between men and women. There are areas where men are doing better, e.g. condom use, but we need to involve men in interventions, but the question is 'how?' There are suggestions in report, such as mobile clinics and workplace facilities but these interventions do not address the core issues. The core issue is culture. Medical male circumcision is resisted particularly by traditionally circumcising societies. Traditional circumcision is about masculinity and therefore men are reluctant to take the medical option which means that when engaging men we have to tackle cultural issues. A decision was taken in 2008 to not investigate cultural issues before implementing the medical male circumcision programme but it may be time to revisit this.

Cultural issues also play a role in men's use of ART. Men tend to be more critical of western health facilities than women and those taking ARVs suspect that they interfere with masculinity. Those designing interventions with men must be familiar with the context in which men behave. We should include deep ethnographic studies in parallel with the surveys. Not just focus group discussions but deep ethnographic studies.

Our responsibility as researchers and intervention practitioners is not to simply ignore cultural issues or call for them to be 'replaced' with what we 'think is right', because what we think is right may not necessarily be right for everyone in society. Most importantly, it might actually alienate some people leading to more resistance to interventions.

Dr Donald Skinner, Research on Health and Society, University of Stellenbosch

Despite the debates around data limitations, the SABSSM reports always provide a nodal point for HIV discussions and I think we are uniquely privileged to have this survey. We have been studying the epidemic in the coloured population of the Western Cape and particularly among those attending shebeens and using drugs, whose behaviour leads to increased risk. We have qualitative data about new HIV infections in the coloured community and SABSSM also shows an increase in the coloured population, although it is not significant. This may be related to wider drug use over wider age groups and more in women. There are also high levels of gender violence, sexual violence and child abuse plus community violence related to gangs which may disrupt society.

AIDS is often seen as a Black African disease and therefore it is increasingly hidden by coloured communities. This myth that HIV is not an issue in the Coloured community reduces the likelihood of protective behaviour and the stigma puts further pressure on not using protection.

The other big issue is the age and gender distribution of infection, i.e. younger women 18-25 and men over 35. But I think the cross-generation contribution has been oversold. The impact of gender violence, especially sexual violence, is a systematic way of breaking down young women. This stems from existing constructs of power and ideas around masculinity. It is dangerous because men feel invulnerable and women feel disempowered, worthless and damaged, which reduces the felt need to use condoms or to stick to one partner. We have not looked nearly enough at this issue.

Substance use leads to risky sexual practices, including a lack of capacity to stay safe when under the influence. There is formal and informal sex work which may involve the exchange of sex for alcohol or drugs. As underage girls are starting to use substances they are even more vulnerable and for women loss of power in sex exchange and intoxication makes it harder to use condoms. This may also explain why older men are getting infected since they are most often the customers.

There are opportunities for protection strategies that are being missed. These include:

- legalisation of sex work, so that these women and men can be protected;
- decriminalising certain drugs and offering better rehabilitation;
- intervening in a more consistent and higher profile way to reduce gender violence;
- less tolerance of people who commit these offenses or make light of gender violence;
- concerns around the impact of traditional legal systems on women's rights; and
- the need to raise awareness in the coloured community about the potential for the epidemic to rise in this group.

Ms Seeletso Mosweunyane, National AIDS Coordinating Agency, Botswana

Botswana has also done several surveys (2001, 2004, 2008 and 2014) and we can compare notes. Botswana has 18.5% HIV prevalence, which is substantially higher than South Africa, and 1.35% incidence but the population is only 2 million, which is about the same as North West province. Over 21% of women are infected, with 48.5% of women in their thirties infected, but only 2.2% of babies six weeks to 18 months are infected. Testing has increased to 70.2% from 56.4% in the last survey.

Like South Africa, knowledge is also declining, with composite knowledge indicators being 52%. In 2008 we set a target to get 480,000 men circumcised but the target has been reduced to 385,000, although some say this is still too ambitious. Condom use was 90% and is now 82%. Condom use is only increasing in the 15-24 age group. Condoms are free in Botswana but people do not like the smell and say that the female condom is noisy. We also need to do other surveys, apart from the national ones, check what exactly is happening with regard to issues like condom and culture.

We have just completed the Mid Term Review of our National Strategic Framework which ends in 2016. The target was initially set at zero new infections in 2016 but with it currently being 10,000 per year this is unrealistic. We are encouraged by the UNAIDS model and are aiming for zero new infections by 2030. We have identified the youth 15-19 years of age as a priority, especially the females whose prevalence is about 6% compared to 3% in males.

Botswana can learn from South Africa with regard to addressing sex workers, gays and lesbians, but I it does appear that the men are being left behind. MSM are illegal in Botswana and it only very recently that an organisation representing gay rights has been allowed to register.

Our survey results show early sexual debut around 4% so the age of consent for testing has been revised from 21 to 16. We need to consider an action plan that targets the age when people start having sex.

Other small surveys are needed to complement the main national survey because they cannot cover everything. In Botswana we did a survey of support groups and found that people are showing accepting attitudes towards people living with HIV, but the people who are living with HIV are self-stigmatising.

Q&A

Comment: Prof Shisana. There are suggestions that we should do more in-depth studies. We do a lot of in-depth studies at the HSRC using advanced social methodology. This report monitors progress of the country as a whole but the scientific papers go deeper and seek to understand the dynamics of the epidemic.

C: Jaqualine Mangoma, New loveLife Trust. One of the speakers said that there is nothing much that targets adolescent girls in schools. We do have programmes, at loveLife, that focus on both young boys and young girls in school but it seems that we should review some of our programmes to specifically target young girls.

A: Thoma Rehle. With regard to additional and more in-depth studies, the National household survey gives quantitative data and guides what should be done after the survey. But there is little money for further surveys. Second generation surveys were always meant to include the social studies but it never got funded to the extent we hoped for. There is a lot of data already available and we need to be clear about what anthropologic and ethnographic research is needed to design the right interventions. We should consider a National Social Science Research Agenda within the context of SANAC and draw up a list of the deeper research that needs to be done. This is something for the afternoon session and it would be nice to hear something more concrete about what should be done.

C: Marlise Richter, Sonke Gender Justice. I am happy that three of the speakers raised the issue of sex work and specifically the legal and social and structured drivers that increase the risk of sex workers getting HIV, and the potential benefits of decriminalisation. One of the challenges is to think about what methodologies are needed to get more information on key populations such as migrants, LGBTI people and sex workers.

SESSION 4

STAKEHOLDER PERSPECTIVES II

Dr Fikile Ndlovu, HIV and AIDS unit, Office of the Premier, KwaZulu-Natal

Research data drives the response in KwaZulu-Natal (KZN). The report gave a clear indication of what is going on but it is not clear what should be done. For example, what to do with the 29 000 0-14 year olds with new infections. In KZN, children are presenting at clinics with a history of rape looking for post-exposure prophylaxis. We need to do more in KZN and we need more guidance. Investing in interventions needs evidence. From a medical point of view things are relatively clear but we need more money for social science research because the social interventions are less clear.

We hear that knowledge and condom use are going down; is it that people may value condoms more when they buy them? People come to meetings saying that the condoms are being used for all sorts of things but not for their intended use. This is anecdotal but should we be looking at what is going on with condom use?

As for the issue of high prevalence in black females, it is not just young black females, it is all black females. Let us not make a mistake of focussing only on young black females and forgetting females in general. The evidence shows it is not just 15 to 24 but right up to 35.

For the geographical focus, what kind of package should we be offering in the informal settlements?

KZN carries the burden of the epidemic. If we turn around the epidemic there it will affect the whole country but it needs money. The provincial research agenda will need investment and must address social science.

Ms Managa Pillay, Curriculum Development with the Higher Education and Training HIV/AIDS Programme (HEAIDS)

The Higher Education HIV/AIDS Programme within the Department of Higher Education and Training supports the public universities and technical and vocational colleges, looking at the higher education response to HIV and AIDS.

The national survey has been extremely helpful and a lot of our policy and strategy framework has been mirrored upon it, but I think the gap is the level to which we drill down in terms of understanding specific sectors. The national survey provides information for the post schooling sector. HEAIDS has conducted its own research including a knowledge, attitudes and practices study, by the HSRC, in the Technical and Vocational Education and Training environment, and a LGBTI study in partnership with NACOSA. Other studies include a community radio project to understand how students engage with the disease and a curriculum development study to look at how graduate competencies relate to HIV.

So what does this mean for us as the higher education sector and why have we aligned our policy and programmes to the research findings? We have a significant number of the affected population in the higher education (HE) sector and many students are in high prevalence provinces (KZN, MP). Young women are particularly vulnerable and susceptible to infection and young people between the ages of 15 and 35 make up the core of the HE sector population. There is a growing MSM and LGBTI population and alcohol and drug abuse (another epidemic within the sector) is common. There is growing evidence of age disparate relationships and transactional sex. Another factor is that the student population is highly mobile and living away from home or travelling which further increases risk.

Rev. Canon Desmond Lambrechts, Public Health and Religion at the National Religious Association for Social Development (NRASD)

Eighty per cent of the population has a religious affiliation. With the withdrawal of PEPFAR and the Global Fund making similar noises who will be left in communities? The faith sector is the best placed body which will be there when society is traumatised. We can change attitudes by building the capacity of pastors. They educate one another. The current Faith for the Nation syllabus covers gender, stigma and discrimination, environment, abuse and bullying.

Secondly, partnerships have been used. The University of Pretoria's School of Public Health helped develop a health literacy programme for Limpopo. We also work with the departments of Health and Social Development, municipalities and pastors.

The Tear Fund assisted the Anglican church in southern Africa. It helped develop a response to the Anene Booysen rape and killing in Bredasdorp. We have listened to rape survivors' stories and heard about their hurt, their humiliation and their dependence on the men. They asked the church 'how can you help us?' We are now formulating a response based on the grass roots cries of the people.

For children in deep rural areas our intention to put children at the centre. The church is strategically placed to help transform conditions and by paying particular attention to the children and youth we can restore their dignity and afford them opportunities to make a constructive contribution to society.

Prudence Mabele, Positive Women's Network and Civil Society Forum

Drawing on an example of AIDS workers who died in a plane crash, Prudence Mabele said that collaboration is the key. The message of those who died was still presented at the International AIDS Conference in Australia, by their collaborators, thus ensuring that the work continued to go forward. We have collaboration in South Africa as well: SANAC is there, the Department of Health is there, Positive Women's Network is there and many others.

The HSRC study has affirmed what we suspected about young women and the 18 SANAC sectors can now refer back to the HSRC data and say that it is correct. The Positive Women's Network has

research that is looking at the gaps that contribute to gender-based disparities including the most critical policy, legal and structural, social, cultural and economic factors.

We are informed by your work and then moving on from it. The multisectoral approach is essential and the focus has to be on prevention. If girls are missing 50 days of school a year due to lack of sanitary products we need to address this. We must make sure that these coloured and flavoured condoms are available. We must examine the National Strategic Plan and see if women are mentioned specifically or whether they get lost under gender.

Dr Faith Kumalo, Care and Support in Schools, Department of Basic Education

Dr Kumalo expressed thanks for the work being done by the HSRC. The Department of Basic Education (DBE) has used the survey results to inform its current strategy on HIV and also arranged for the HSRC to present their results to their AIDS coordinators. The presentation focussed on those age cohorts for which DBE is responsible, which is about a quarter of the South African population. DBE is currently finalising a policy on HIV and TB, which is first of its kind in the education sector, for staff, pupils and support staff. Policies do not provide programmes but they are a starting point.

Knowledge levels are declining and it is important to recognise that while knowledge does not of itself lead to behaviour change, accurate information is the starting point for people to make the best choices.

Orphans experience higher HIV prevalence but one form of primary prevention is the provision of a comprehensive social network. Provision of schooling, child grants and feeding schemes helps ensure that school attendance for orphans is the same as for other children. This is a significant achievement that should be quoted alongside the successes in ART treatment and PMTCT, because making sure that children are in school, which is a protected environment, means we have done our duty in the HIV war.

There is evidence that girls who perform badly in school drop out and then become pregnant, not the other way around. DBE is tracking poor academic achievement and implementing homework assistance programmes and peer guidance as well as access to sexual and reproductive health services. Those who fall pregnant while at school are encouraged to come back to school. Tangible results including reduced learner pregnancies and, more importantly, reduced HIV prevalence are the expected outcomes. DBE plans to use the lessons learnt to take the programme to scale and begin to prioritise young women and girls who are in school.

In addition to the children in school, the teachers are another important group. There are more than 500 000 teachers who also need support. The national household survey does not give enough information on teachers and funding for another HIV among educators survey is needed.

The SABSSM results are currently presented for the age range 15-24 years but this is too wide for DBE purposes and 7-15 years would be provide more nuanced info. There is also need to provide information down to sub-district level to help target interventions. DBE would like direct access to HSRC data and not just receive tables in response to their questions.

Comment: Prof Shisana. Prof Shisana explained that the data from the SABSSM surveys is in the process of curation, meaning that it will be made available to other users. The 2005 survey has been done and 2008 is being done. It is not practical to give out data until it has been suitably prepared, which includes checking for errors (cleaning) and providing detailed explanations of the sampling and variables used.

SESSION 5

FEEDBACK FROM GROUP DISCUSSIONS

TREATMENT

Facilitators: Prof Francois Venter, WITS and Dr Fikile Ndlovu, Office of the Premier, KwaZulu-Natal

The treatment group noted the high proportion of infected children in the 10-14 year age group. It will be important to determine whether these are the result of PMTCT failure or infections contracted over a longer period, either through sexual abuse or high risk behaviour. Younger adolescents are going to need specific treatment programmes because most of the existing programmes focus on older adolescents.

According to the current incidence data there is going to be massive demand for treatment, which has huge implications for services and confirms the need for good incidence data.

It would also be interesting to see where people are getting their treatment, especially for those who voluntarily disclose that they are on ART. The unique patient identifier has potential in the future and the NHLS profile could be accessed with permission from the patient. The HSRC should think about how the unique patient identifier could be included in future questionnaires.

The next issue discussed was ART and viral suppression, i.e. what percentage of those saying they are on HIV treatment are virally suppressed. There is evidence of low suppression rates at community level (30-40%) but high levels (80-90%) are reported by the NHLS, i.e. for patients attending clinics. This suggests that people reported at the NHLS level might be a reflection of those who are adherents because viral load is a good proxy for adherence. This might be the one survey that shows proper community viral loads across the country which will tell us all we need to know.

Recommendations

There are some areas that need to be looked at in more detail, such as high incidence in particular areas, but we need to think carefully about the questions. It would be interesting to look at distance, time or cost to access a clinic as a determinant of being on ART.

Another issue is people who are HIV positive but do not access care. Is it that they are ineligible because of the CD4 count or are they lost to follow up? Around 40% have apparently been lost to follow-up but what this suggests to us is that mostly people are not lost to follow-up but they move between sites. Finding somewhere to interrogate this issue is going to become more important. The HSRC survey results are good news from an ARV-provider perspective, because the high loss to follow-up does not fit with the current trends and life expectancy. Having evidence that 2 million people are actually on antiretrovirals is invaluable.

Another recommendation was to consider the possibility of cohort study for more detailed follow up of specific issues.

The last recommendation was for the data to be made available to other researchers sooner. Exposure of the data to more eyes would allow more multivariate analysis that may produce alternative theories and improve the analysis.

Q & A

Q: Thomas Rehle. What was the view regarding the necessity of having CD4 counts?

A: Francois Venter. CD4 counts were not considered necessary as a general rule and viral load would be much more important. The only time CD4 count would be really important is in the group of people not accessing antiretrovirals, in order to understand what percentage were within the treatment threshold and should have been getting treatment, but were not. Programmatically, this is an important question to answer.

C: Thomas Rehle. The current survey is based on dried blood spots and moving to whole blood would have major implications.

A: Francois Venter. We recognise that some of these things are difficult to do and we did not discuss the practicalities.

SOCIAL AND STRUCTURAL BARRIERS

Facilitators: Dr Christopher Colvin, UCT and Prudence Mbelle, Soul City: Institute for Health and Development Communication (SCI)

The survey focuses mainly on biological and behavioural issues and does not collect much data on social and structural barriers. We therefore looked at the findings and tried to assess the implications for policy. We looked at four findings and the social and structural factors related to them.

1. High risk for African adolescent girls

Structural barriers include:

- gender norms in local settings;
- poverty and unemployment;
- structure of state support for this specific group; and
- breakdown in safety and security – police not trusted.

Social grants need to be better aligned with life needs and therefore should not stop at 18. Support into the mid-20s might be more appropriate. There should be a better balance in the social spending approach so that it is not just grants but a more developmental approach. Thus, while it is important to ensure that people access the grants they are eligible for there must be mechanisms to help people get off grants as well.

There was concern about policy confusion where different policies seem to work against one another. For example, the Children's Act and the Sexual Offences Act and how these present mixed messages about sexual activity in adolescent boys and girls.

2. Informal settlements as a risk factor

The group considered what it is about informality that creates risk and discussed poverty, social exclusion, housing and other infrastructure policies, and social discrimination. Migration also featured but 'mobility' needs to be understood more broadly. A key issue is that most municipalities do not recognise informal areas and therefore withhold support.

3. Increased prevalence

The next issue discussed was the long term implications of the epidemic when people may spend up to 50 years on ART. More sustainable and perhaps decentralised models of health service delivery will be needed. The group did not have an answer but this is clearly one of the implications of the survey results.

4. Low awareness of HIV status and knowledge.

The reported low awareness of HIV status and poor HIV knowledge was thought to be related to stigma, social norms, a kind of fatalism, and denialism. There is also a lack of political will and civil society engagement plus health systems barriers. The implications are that we need to recommit to HIV counselling and testing campaigns and ensure that counselling and testing are incorporated into awareness raising.

When discussing gaps the discussion recognised that there are theories and concepts that need to be further fleshed out. This may not necessarily be through the survey itself but could require other forms of research. Mobility needs to be explored in more detail and not merely as 'migration'. What is it about informality that makes people vulnerable? It is not merely infrastructure (or the lack of it)

that causes someone to be vulnerable but there is something about the social and physical environment which needs to be measured more precisely.

Other aspects include looking at the life course in finer detail and understanding the later stages of life after many years on ARVs. There need to be different ways of measuring stigma and how this changes over time. Some sexual practices are not easily identified, e.g. heterosexual anal sex, but these behaviours may be important risk factors.

PREVENTION

Facilitators: Dr. Sakhumzi Mfecane, UWC & Dr Faith Kumalo, Department of Basic Education (DBE)

We need to re-emphasise prevention and continue with what works, eg condoms, medical male circumcision, PMCT and ART. But we must recognise that the 'one size fits all' model does not work – the results show that we need to be sensitive to age, sex, race etc.

The discussion agreed that a multisectoral approach is needed rather than the current predominantly biomedical one driven by the Department of Health. But, on the other hand, we may need specific approaches for each sector. A working group should be set up review what needs to be done. A priority must be to address knowledge and more use should be made of television, cell phones and other digital media.

There is a lot of research in South Africa so there is no excuse for not taking action. We have enough information and need to collate the research and apply it.

Another topic of discussion was the need to strike a balance between realistic and moralistic approaches. The report recommends that people should be told to be monogamous but the question arises whether we should be moralistic.

One of the concerns was that too much of the research is problem driven and not solution driven. How can we adapt the solutions that have been developed elsewhere? We need to better understand how people negotiate around risk so that we can avoid trying to impose knowledge on them to say you must do this and not do that.

We should confront real issues and not skirt around difficult topics. Racial disparities are real and have to be handled appropriately without stigmatising particular groups.

In terms of addressing the gaps, one of the issues that arose was the need for budgets to address some of the methodological limitations. There are sub-sets of the population for which there is insufficient information, e.g. Men who have Sex with Men and transsexual behaviour. How do we address the Indian and White poor response rate. They are not in a dire situation so do we need to waste resources on them? Perhaps we could leave questionnaires in mail boxes. However there are concerns that people do not always tell the truth. For example, there were instances of people who said they did not know their HIV status yet the blood test revealed that they were on ART.

C: Prof Shisana. Should we ask whether people are HIV+? If it works in the pilot the question could be included. There were people who said they were not at risk of HIV but were on ART. The issue is how large is the error?

C: Warren Parker. The answer to a question about whether people think they are at risk of HIV is complex. People who know they are infected may answer that they are not at risk. Questions which were quite strong earlier on in the epidemic may now be more problematic because things have changed and a lot of people now know their status. We can look at a battery of additional questions to help us explore this increasingly large population of people who are HIV positive. So we should not look at this data as just informing prevention, it actually informs treatment, care, support and so on.

STIGMA, DISCRIMINATION AND HUMAN RIGHTS

Facilitators: Rev. Canon Desmond Lambrechts, Public Health and Religion at the National Religious Association for Social Development (NRASD) and Ms Managa Pillay, HEAIDS

This group discussed the implications of the stigma findings for HIV programmes. The discussion re-affirmed that people living with HIV and AIDS (PLWHA) should be involved in assessments of stigma and noted that the HSRC is currently carrying out such a survey. Information on stigma is being collected by PLWHA among PLWHA and this should complement the household survey to give a bigger picture of how this population experiences stigma.

From a programming perspective, the group discussed integrating social justice issues into HIV stigma, especially because HIV discrimination intersects with other kinds of discrimination such as race, gender, class and sexuality. The stigma programmes that are developed from the research therefore need to be nuanced according to the target population.

People are looking for evaluated stigma intervention programs among both PLWHA and the general population and there is a need to map who is doing what at a national level. Some examples were mentioned including:

- I-ACT – teaching model, increase in knowledge, decrease in stigmatisation
- a church formation programme that aims to make the church HIV stigma free
- “Positive by association” – de-stigmatising programmes.

Stigma is an attitudinal problem hence, in terms of social norms and values, we have to start early and target, for example, education of the religious leaders. In some cases organisations that should help protect the vulnerable, such as churches, may add to stigmatisation.

Stigma and discrimination are evidence of the absence of the protection of human rights. In order to impact human rights, curricula, social justice issues, contextual issues, and social norms/values have to be targeted.

While the SABSSM report is understandably clearer for prevention programmes the group felt that there is a need for a clearer ‘how-to’ around stigma interventions and programmes. There is a lack of information in terms of experiences of stigma in workplaces, schools, the private sphere and we also do not understand stigma as experienced by people living with HIV in the higher socio-economic brackets. The HSRC should help standardise the Stigma Index for people in the general population and to measure experiences of stigmatisation and discrimination.

MAIN CONCLUSIONS AND RECOMMENDATIONS

General issues

- The value of national HIV prevalence and incidence surveys was widely recognised and the current series of four surveys is one of the most complete records of HIV surveillance in Africa. SANAC in particular acknowledged the value of the HSRC survey for baseline and strategic planning purposes and has committed to supporting the next SABSSM study. UNAIDS has used the national surveys to adjust its estimates of prevalence derived from antenatal clinic attendance and National and Provincial Departments also acknowledged the value of the surveys for informing policy.
- The number of people living with HIV/AIDS in South Africa was estimated at 6.4 million. This is by far the largest number for any country in the world and the prevalence has increased from 10.6% in 2008 to 12.2% in 2012.
- For people aged 15 to 49 years, urban informal areas have the highest prevalence at 29.9%, followed by rural informal areas (22.6%) then rural formal areas (16.1%) and urban formal areas at 14.7%.

- KwaZulu-Natal continues to have the highest prevalence at 27.9% and the Western Cape the lowest, at 7.8% (for 15 to 49 year olds).
- Encouraging trends include an almost halving of the prevalence in children 0-4 years of age between 2008 (3.3%) and 2012 (1.7%). Prevalence is also declining in children 2-14 years of age, largely due to the effects of PMTCT, but higher survival due to ART diminishes the apparent gains to some extent.
- The impact of ART on HIV prevalence was particularly evident among adults 25 years and older where there has been a quite substantial increase in prevalence from 16.8% in 2008 to 19.9% in 2012.
- There were over 2 million people on treatment in 2012 and the proportion of people living with HIV on ART was 31.2% in mid-2012.
- Incidence testing gives the clearest assessment of where we are heading with the epidemic and direct blood-based incidence estimation gave very similar results to several indirect estimation methods using mathematical models. Of concern is the five-fold higher incidence in females aged 15-24 compared to males.
- Detailed incidence data covering different socio-demographic and behavioural variables is particularly helpful for priority setting.
- Although awareness of HIV status has increased between 2005 and 2012, self-reported key behavioural indicators such as condom use, multiple sexual partners, age-disparate relationships and early sexual debut have all worsened. Related to this finding is evidence that knowledge about HIV and AIDS has declined.
- Some questions relating to attitudes regarding people living with HIV and AIDS showed that stigma remains a problem and warrants further attention.
- UNAIDS called for further examination of changing prevalence in children 2-14 and the over 50s. They also confirmed that now that there is a reliable incidence assay it should be included routinely in population-based surveys. Further information is needed on continuum of care among people living with HIV, immunological status (CD4 cell count) and the extent of viral suppression.
- According to SANAC, reducing incidence in young women, which the survey showed to be five times higher than in men, is the single highest priority in the country.
- There were 29 000 new infections girls aged 2-14 and none in boys of the same age. Sexual assault or child abuse appears to be a likely explanation and warrants urgent attention from child protection services.
- About one third or 2 million of those infected with HIV do not know their status; there should be a review of the counselling and testing programme because most of the prevention efforts are linked to the people who test positive.
- UNAIDS has agreed on the '90-90-90' targets for 2020 in consultation with member states. This sets targets of 90% of infected people knowing their status, 90% of these being on treatment and 90% virally suppressed. Some delegates felt that these targets are unrealistic since they are not even being achieved by developed countries with small case loads and large resources. However, it was argued that 'without a new narrative on HIV, the epidemic will outrun the efforts'.
- There are some apparent disparities between the state's data and the survey results. For example, condom distribution is increasing according to NDOH but the survey shows declining use. These apparent anomalies warrant further investigation.
- Concern was expressed about programmes that are sometimes pushed through despite objections having been voiced by those who have to implement them. Much of the burden for implementing prevention programmes falls on civil society organisations that are not adequately resourced and better consultation appears to be needed.
- Cultural issues play an important part in the uptake of interventions such as medical male circumcision and ART. A case was made for more in-depth ethnographic studies to better understand the context in which men behave.
- In a similar context, the issue of gender violence, especially in the coloured community, warrants further attention.

- It was proposed that a National Social Science Research Agenda, within the context of SANAC, should be drawn up to list the deeper research that needs to be done.
- Making sure that children remain in school, which is a protective environment, was described by the Department for Basic Education (DBE) as an important part of HIV prevention. Pregnancy was said to be a consequence of dropping out of school rather than the cause of it and programmes to help ensure that girls remain in school and facilitate return to school after drop out (for whatever reason) are to be encouraged. DBE plans to use the lessons learnt from a pilot to take the programme to scale and begin to prioritise young women and girls who are in school.
- Several delegates expressed a desire for direct access to the HSRC data in order to do their own analysis. Prof Shisana explained that the data is in the process of curation after which it will be made available to other researchers. It is not practical to give out data until it has been suitably prepared, which includes checking for errors (cleaning) and providing detailed explanations of the sampling methods and variables used.

Treatment

- The unique patient identifier may provide valuable additional information about people on ART. The HSRC should consider including the unique patient identifier and consent for its use in future questionnaires.
- Viral load is an important proxy for adherence to therapy and the HSRC survey has the potential to provide invaluable information about community viral loads.
- Further information about people who are HIV positive but not on treatment is needed. It is important to establish whether people are ineligible for treatment due to their CD4 count, whether they have been lost to follow-up, or have not accessed treatment at all.
- Some of the more in-depth questions require a cohort study which although costly could be done on a much smaller scale than the national survey.

Social & Structural Barriers

- The issue of social grants that cease at the age of 18 was raised and it was felt that some grants should continue into the early 20s. At the same time, a developmental approach must ensure that people not only access grants but also are empowered in ways that allow them to get off the grant as well.
- Further studies are needed to establish what it is about informality that makes people vulnerable. It is not merely infrastructure (or the lack of it) that causes someone to be vulnerable but there is something about the social and physical environment which needs to be measured more precisely.
- Given the increasing coverage of ART there will be a need to study the population of people who could be on ART for 50 years or more.

Prevention

- We must continue with interventions that work (e.g. condoms, medical male circumcision, PMTCT and ART) but must recognize that the 'one size fits all' model will not work. Interventions must be specifically designed according to age, sex, race, locality etc.
- Addressing the declining knowledge about HIV and AIDS is a priority and more use should be made of television, cell phones and other digital media.
- We must not skirt around difficult topics. Racial disparities in HIV risk are real and while we must be careful not to stigmatise particular groups it is in nobody's interest to conceal the true risks.

Stigma, Discrimination and Human Rights

- Stigma and discrimination are an abuse of human rights and interventions need to address curricula, social justice, contextual issues, and social norms or values.
- Stigma is an attitudinal problem hence, in terms of social norms and values, we have to start early and target leaders. In some cases organisations that should help protect the vulnerable, such as churches, may add to stigmatisation.

- Delegates felt that the HSRC should help standardise a Stigma Index for people in the general population to measure experiences of stigmatisation and discrimination.

APPENDIX 1: PROGRAMME

Chair: Prof Leickness Simbayi, HSRC
Rapporteur: Prof John Seager, Consultant

08:00 - 09:00	Registration, Tea & Coffee
09:00 - 09:10	Introduction
09:00 - 09:10	Welcome & Opening Remarks <i>Dr Temba Masilela, HSRC</i>
09:10 – 10:10	Session 1
09:10 - 09:40	Key findings from the 2012 national HIV household survey (SABSSM4) <i>Prof . Olive Shisana, HSRC and Prof Thomas Rehle, HSRC</i>
09:40 - 10:10	Q & A
10:10 -10:30	Tea break
10:30 – 11:30	Session 2: The current state of the HIV/AIDS epidemic in South Africa
10:30 – 10:45	Know Your Epidemic: The value of household-based, population-level surveys <i>Dr Eva Kiwango, UNAIDS</i>
10:45 – 11:00	Implications of the household survey for the National Strategic Plan <i>Dr Fareed Abdullah, South African National AIDS Council</i>
11:00 – 11:15	Implications of the household survey for national HIV policies and programmes <i>Dr Peter Barron for Dr Yogan Pillay, National Department of Health (DoH)</i>
11:15 – 11:30	Q&A
11:30 – 12:15	Session 3
11:30 - 12:00	Stakeholder perspectives II <i>Moderator: Dr Warren Parker (Consultant)</i>
	<ol style="list-style-type: none"> 1. <i>Prof Francois Venter, Institute for Sexual & Reproductive Health, HIV and Related Diseases, WITS</i> 2. <i>Dr Christopher Colvin, School of Public Health and Family Medicine, UCT</i> 3. <i>Dr. Sakhumzi Mfecane, Department of anthropology and sociology, UWC</i> 4. <i>Dr Donald Skinner, Research on Health and Society (RHS), University of Stellenbosch (US)</i> 5. <i>Ms Seeletso Mosweunyane, National AIDS Coordinating Agency, Botswana</i>

12:00 - 12:15	Q&A
12:15 – 13:00	Session 4
12:15 - 12:45	<p>Stakeholder perspectives II <i>Moderator: Dr Warren Parker (Consultant)</i></p> <ol style="list-style-type: none"> 1. <i>Dr Fikile Ndlovu, HIV and AIDS unit, Office of the Premier, KwaZulu-Natal</i> 2. <i>Ms Managa Pillay, Curriculum Development with the HEAIDS, HESA</i> 3. <i>Rev. Canon Desmond Lambrechts, Public Health and Religion at the National Religious Association for Social Development (NRASD)</i> 4. <i>Prudence Mbelle, Soul City: Institute for Health and Development Communication (SCI)</i> 5. <i>Dr Faith Kumalo, Care and Support in Schools, Department of Basic Education (DBE)</i>
12:45- 13:00	Q&A
13:00 – 14:00	LUNCH
14:00 – 15:30	Session 5
14:00 – 15:30	<p>Breakaway groups <i>Themes:</i></p> <ol style="list-style-type: none"> 1. Treatment <i>Facilitators: Prof Francois Venter, WITS and Dr Fikile Ndlovu, Office of the Premier, KwaZulu-Natal</i> <i>Rapporteurs: Prof John Seager, Consultant</i> 2. Social and structural barriers <i>Facilitators: Dr Christopher Colvin, UCT and Dr Sue Goldstein, Soul City: Institute for Health and Development Communication (SCI)</i> <i>Rapporteurs: Dr Jeremaih Chikovore, HSRC</i> 3. Prevention <i>Facilitators: Dr. Sakhumzi Mfecane, UWC & Dr Faith Kumalo, Department of Basic Education (DBE)</i> <i>Rapporteurs: Mr Sean Jooste, HSRC</i> 4. Stigma, discrimination and human rights <i>Facilitators: Rev. Canon Desmond Lambrechts, Public Health and Religion at the National Religious Association for Social Development (NRASD) and Ms Managa Pillay,</i> <i>Rapporteurs: Ms Allanise Cloete, HSRC</i>
15:30 – 15:50	Tea

15:50 – 16:50

Session 6

15:50 – 16:50 Feedback from Groups

Themes:

1. Treatment

Facilitators: Prof Francois Venter, WITS and Dr Fikile Ndlovu, Office of the Premier, KwaZulu-Natal

2. Social and structural barriers

Facilitators: Dr Christopher Colvin, UCT and Dr Sue Goldstein, Soul City: Institute for Health and Development Communication (SCI)

3. Prevention

Facilitators: Dr. Sakhumzi Mfecane, UWC & Dr Faith Kumalo, Department of Basic Education (DBE)

4. Stigma, discrimination and human rights

Facilitators: Rev. Canon Desmond Lambrechts, Public Health and Religion at the National Religious Association for Social Development (NRASD) and Ms Managa Pillay,

16:50 – 17:00

Session 7: Concluding session

16:50 – 17:00 Closure and the way ahead

Prof Leickness Simbayi, HSRC

Ooo000 – Departure - 000ooo

APPENDIX 2: BIOSKETCHES

DR CHRISTOPHER COLVIN

Christopher J. Colvin is a medical anthropologist living and working in Cape Town, South Africa. He has a PhD in socio-cultural anthropology from the University of Virginia and a Masters in Public Health from the University of Cape Town (UCT) in epidemiology. He has lectured in anthropology, public health, epidemiology, African studies, and comparative literature at Columbia University, Johns Hopkins University, the University of Virginia as well as the Universities of Cape Town, the Western Cape, and Stellenbosch in South Africa. He is currently Senior Research Officer in Social Sciences and HIV/AIDS, TB and STIs at UCT's School of Public Health and Family Medicine. He is also Head of the Division of Social and Behavioural Sciences. His research interests include HIV and masculinity; health activism and community health governance; trauma, subjectivity and narrative; and the interface between communities and health systems in the context of HIV/AIDS, TB and maternal and child health. He also has an interest in conducting and developing methodological approaches for systematic evidence synthesis of social science research in public health.

DR EVA KIWANGO

Eva Kiwango has been the Senior Strategic Information Advisor for the UNAIDS Country office in South Africa since July 2011. She is involved in the generation of national and sub-national HIV estimates; implementation of HIV and TB surveys and surveillance; collation, triangulation and synthesis of HIV data; development of a national HIV and TB Investment Case; and programme reviews and reporting of the national HIV and TB response. She is currently interested in micro-epidemic analysis and mapping of high-transmission geographies and key populations to inform targeted HIV prevention, treatment and care response. Prior to moving to South Africa, Eva was the UNAIDS Global Team Leader for Monitoring and Evaluation in Geneva from 2008 and 2011. In this capacity, she collaborated with key partners such as the GFATM, WHO, UNICEF, UNFPA, DFID, CDC, OGAC, USAID, and the Bill and Melinda Gates Foundation to provide strategic thought leadership on monitoring and evaluation of national and global AIDS responses. She led the development of national HIV research and evaluation agenda's in the Democratic Republic of Congo, Kenya, Lesotho, Namibia, Thailand, Uruguay, Bolivia, and Nicaragua. Eva joined UNAIDS in 2004, and was assigned to Mozambique where she worked with the National AIDS Council and Ministry of Health to strengthen results based planning and monitoring and evaluation of the national HIV response. She worked for the UN Economic Commission for Africa from 2001 -2004 as a technical advisor responsible for supporting development policy, programming, and M&E in countries like Sudan, Botswana, Uganda, Zambia, Zimbabwe, Tanzania and the Seychelles. From 1995 to 2001, Eva worked in Tanzania for USAID and DANIDA, and consulted for the national TB and Leprosy programme in the Ministry of Health and Social Welfare. Eva has extensive training in RBM and monitoring and evaluation, an MSc degree in policy and planning from the London School of Economics, and a BA degree in Sociology and research from the University of Dar-es-Salaam, Tanzania.

DR FAITH KUMALO

Dr. Faith Kumalo is a public health practitioner. She is currently the Chief Director for Care and Support in Schools, in the Department of Basic Education where she oversees the development, implementation and monitoring of policies, strategies and programmes for Care and Support in the schooling sector. These include the School Nutrition Programme; Care and Support for Teaching and Learning; HIV and TB; Learner Pregnancy Prevention and Management; School Health; Psychosocial Support; as well as Alcohol and Drug Use prevention and management. She has led the development of a number of key strategies and programmes in the sector including the South African Conceptual Framework for Care and Support for Teaching and Learning; the DBE Integrated Strategy for HIV, STIs and TB 2012-2016; Guidelines for Peer Education Programmes for Learners in South African Schools; the DBE Strategy for the Prevention and Management of Alcohol and Drug Abuse in South African School; and the DBE (draft) Policy on HIV, STIs and TB.

Dr. Kumalo has qualifications in Medicine, Child Health, Clinical Evidence and Health Management as well as a Masters degree in Public Health (majors in Health Policy and Management).

CANON DESMOND LAMBRECHTS

I am an ordained priest in the Anglican Church of Southern Africa for the past 33 years. Was employed Director for programmes within the Anglican Aids and Health Care Trust . Currently employed as Director of Public Health and Religion at the NRASD (National Religious Association for Social Development). Chair of the Religious Sector for SANAC and Trustee on the SANAC BOARD. Presented and facilitated at several international, national and local conferences. (London, USA, Madagascar, Nairobi and SA)

Currently enrolled at the University of the Western Cape for the PHD Degree in Practical Theology. Fellow of the Graduate School of Business and Duke University USA, For the Emerging Leaders Programme. Passionate about issues relating to Health and Religion.

DR TEMBA MASILELA

Temba Sipho B. Masilela, has been the Deputy Chief Executive Officer for Research at the Human Science Research Council (HSRC) since November 2010 and is directly responsible for research strategy, research management and the knowledge-policy interfaces of the HSRC. His wide-ranging research interests revolve around issues of knowledge, policy, and power and before joining the HSRC in July 2006, he worked for a number of years as a special adviser to the minister of social development in the government of South Africa. He has also been an Associate Fellow of the Department of Social Policy and Intervention at the University of Oxford, UK; and a Research Fellow at the Institute for Development Studies, University of Nairobi, Kenya. He has also worked in the areas of corporate citizenship and reputation management, in both commercial (Telkom SA Ltd) and academic settings (Centre for Corporate Citizenship, University of South Africa), and has cross media experience having work in both the print and telecommunications industries. He has more than 25 years of research and policy management experience and his most recent publication is a chapter "From the RDP to the National Development Plan: The mirage of a super ministry" in the State of the Nation 2013-14. Temba holds PhD and MA degrees in communication for development from the University of Iowa, USA; and a BA degree in economics and politics from the University of Nairobi, Kenya.

DR. SAKHUMZI MFECANE

Dr Sakhumzi Mfecane is a Senior Lecturer in department of anthropology and sociology, University of the Western Cape (UWC). He holds a PhD from Wits University where he was a joint-PhD student at Wits Institute for Social and Economic Research (WISER) and Amsterdam School of Social Sciences (ASSSR). Before joining UWC in 2010, he was a senior researcher for Centre for Study of AIDS Development, Research and Evaluation (CADRE). From 2002-2005 he worked for Human Sciences Research Council, as a Chief Researcher. His main research interest is on men's health and masculinity with specific focus on HIV and AIDS. Dr Mfecane has published on a number of topics related to HIV, such as: Orphans and Vulnerable Children (OVC); Stigma; PMTCT (Prevention of Mother-to-Child Transmission of HIV); and Masculinity. He also worked as a consultant for "Soul City" (One-Love Campaigns); "Brothers for Life"; and "Intersexions (TV Drama series).

MS SEELETSO MOSWEUNYANE

Seeletso Mosweunyane serves as the Chief Research officer at the National AIDS Coordinating Agency in Botswana. She holds Master's degree in Public Health from Latrobe University, Australia and BA Social Sciences (University of Botswana). She has been the research for the past 13 years, 6 of which has been at NACA as the Head Of Research division. She has been a team lead of two National Incidence, Prevalence and behavioural surveys (BAIS III 2008 and BAIS IV 2013). Ms Mosweunyane is also the coordinator of the local conference (National HIV, STI and Other Related Infectious Research Conference: NHASORC) which brings approximately 500 local professionals to share research findings on HIV and developing the Research Agenda. The last conference was in May 2010 following the release of BAIS III with the next scheduled for February 2016.

Her main interest is Health Policy specifically Evidence based policy. She is currently working on BAIS IV Policy report . She is also the Principal investigator of:

- Measurement of Stigma and Discrimination Among PLWH in Botswana,
- HIV, TB, Hepatitis B and C sero-prevalence and behavioural survey in Botswana Prisons.

She has developed the first ever National HIV and AIDS Research Agenda for Botswana, 2011-2016.

DR FIKILE NDLOVU

Dr Fikile Ndlovu received her Bachelor of Medicine and Bachelor of Surgery from the University of KwaZulu-Natal. Dr Ndlovu has over eight years of senior managerial experience in the public sector. Currently she is the manager of the HIV and AIDS unit at the Office of the Premier of KwaZulu-Natal coordinating the HIV/AIDS, TB and STI Multisectoral response in the province. Dr Ndlovu was part of the team in 2011 and 2012 on Global Health Leadership Institute at Yale University in the Global Health Conference. She is currently serving on the scientific programme committee for the 7th South African AIDS Conference in 2015.

DR WARREN PARKER

Dr Warren Parker works globally in the areas of HIV/AIDS, public health and communication. This includes the development of policies and strategies, programme design, programming for social mobilization for health, and evaluation of communication and health interventions. He has served as a lead and co-researcher on various behavioural and HIV seroprevalence surveys as well as a wide range of qualitative and participatory research. He has contributed to establishing, expanding and evaluating a wide range of public health and communication interventions including the HIV focused youth drama series, Tsha Tsha, and the Prevention in Action Programme which addresses prevention of gender-based violence. He co-founded the Centre for AIDS Development, Research and Evaluation (CADRE) in South Africa in 2000, and served as Executive Director until early 2009.

MS MANAGA PILLAY

Ms Pillay was appointed as Programme Manager: Curriculum Development with the HEAIDS Programme in November 2013 to specifically manage the Discretionary Grant awarded to HEAIDS through the National Skills Fund to capacitate and enable academics in the post schooling sector to integrate HIV and AIDS into their respective curricula.

Managa holds a Masters degree in Philosophy in HIV and AIDS Management from Stellenbosch University. She is a social worker by training who worked in the public sector for the Department of Social Development both in the capacities of Chief social worker, school social worker and regional probation officer for a period of 10 years.

Managa joined the HEAIDS team for the first time in 2006 when she was asked to join the national office of the HEAIDS Programme as part of the technical team.

As a Programme Manager and Consultant Managa worked on the establishment of the HIV Unit at the merged institution of the Tshwane University of Technology (TUT), as well as with the Health Economics AIDS Research Division at the University of KwaZulu-Natal where she led a USAID funded support initiative to the National Department of Basic Education.

In a voluntary capacity Miss Pillay serve on the Board of the Leratong Hospice in Attridgeville since 2005 and has served in the capacity of the Chair of the Board for the past two years.

DR YOGAN PILLAY

Dr Yogan Pillay is currently employed as Deputy Director-General: HIV/AIDS, TB and Maternal, Child and Women's Health in the National Department of Health, South Africa. In this capacity he is responsible for the following Clusters:

- Maternal, Child and Women's Health
- HIV & AIDS and STI's
- TB Management and Control.

PROF THOMAS REHLE

Professor Thomas M Rehle serves as a Director and Senior Programme Advisor in the Human Sciences Research Council (HSRC) programme on HIV / AIDS, Sexually Transmitted Infections and TB, based in Cape Town, South Africa. He is also a Visiting Professor of International Health at the University of Cape Town, School of Public Health and Family Medicine. Prof Rehle holds an MD from the Ludwig Maximilian's University of Munich, an MSc degree from the London School of Hygiene and Tropical Medicine and a PhD in Medical Sciences from the University of Antwerp.

Prof Rehle has over 25 years of expertise in tropical public health and disease control interventions. His leadership in HIV/AIDS programming resulted in the inception and implementation of many country programmes worldwide. From 1987 to 1993, Prof Rehle directed the German Support Programme on AIDS for Developing Countries implemented by the German Agency for Technical Cooperation (GTZ). During his tenure with Family Health International (1996-2001), he was responsible for the design and implementation of the overall evaluation strategy of two global AIDS Control and Prevention Projects (AIDSCAP and IMPACT) which represented the flagship implementation projects for USAID's response to the global AIDS pandemic with annual budgets of \$50 to \$70 million. He was leading a team that pioneered the development of innovative evaluation tools and data collection methods that became part of technical UNAIDS/WHO guidelines for Second Generation HIV Surveillance and M&E of national HIV / AIDS prevention and care programmes. He was the lead editor and author of the reference guide on Evaluating Programmes for HIV/AIDS Prevention and Care in Developing Countries: A Handbook for Programme Managers and Decision Makers (Family Health International, 2001). In May 2005, Prof Rehle joined the HSRC as a director and senior programme advisor to provide strategic direction for the research portfolios of Population Health and HIV/AIDS, STIs and TB. His research areas at the HSRC include infectious disease epidemiology, HIV/AIDS intervention research, epidemiological modeling and the design and analysis of national, population-based surveys. He served as a principal investigator on the South African national HIV household surveys (2005, 2008 and 2012) and the first South African National Health and Nutrition Examination Survey (SANHANES 2012).

Prof Rehle has served on many international scientific committees and advisory boards. He is a member of the UNAIDS Reference Group on Estimates, Modeling and Projections and serves on the Steering Committee of the WHO Working Group on HIV Incidence Assays. Prof Rehle is a Member of the Academy of Science of South Africa. His publication record spans the authoring and co-authoring of more than 180 publications and presentations in scientific journals, books and international conferences.

PROF JOHN SEAGER

Prof Seager is a freelance research consultant with over 30 years public health research experience in Africa. His research has covered AIDS and development, tuberculosis, diabetes care, urban health systems, and social determinants of health. He holds a BSc (Hons) in Zoology and a PhD in Ecology and Population Dynamics at the University of Wales and has completed advanced training in Epidemiology and Public Health in the US, UK and South Africa. He is an Extraordinary Professor in the School of Public Health at the University of the Western Cape and an Extraordinary Professor at the University of Stellenbosch, where he is a member of the Transdisciplinary Sustainability Analysis Modelling and Assessment Hub.

His main research interest is social determinants of health among the poor in developing countries. Recent work includes health systems evaluation, HIV and AIDS, homeless populations and social aspects of climate change. Prof Seager serves on the editorial advisory board of Development Southern Africa and is a reviewer for local and international journals. His publication record spans the

authoring and co-authoring of more than 60 journal articles, 50 research reports and 100 presentations at scientific meetings.

PROF OLIVE SHISANA

Prof Olive Shisana holds a Doctor of Science degree from The Johns Hopkins University, Broomberg School of Public Health where in 1999 she was admitted into the Society of Scholars for her outstanding contribution to public health. She is the Chief Executive Officer of the Human Sciences Research Council (HSRC); previously she served in the same organization as an Executive Director of a South African national research programme on Social Aspects of HIV/AIDS and Health. Before that she served as professor of health systems at the National School of Public Health at the Medical University of Southern Africa and later as executive director of Family and Community Health at the World Health Organisation in Geneva. She is a principal or co-principal investigator of HIV surveillance studies and of SANHANES-1, and has published articles on social epidemiology of HIV and national health insurance. She serves as chair of the Ministerial Advisory Committee on National Health Insurance. Currently she serves as president of the International Social Sciences Council, an organisation based in Paris UNESCO, and serves on the UNESCO High Panel on Science and Technology for Development.

PROF LEICKNESS SIMBAYI

Prof Simbayi holds a Doctor of Philosophy (D.Phil.) degree in Experimental Psychology from the University of Sussex in England, United Kingdom. He is a registered Research Psychologist with the Health Professions Council of South Africa's Professional Board of Psychology and a Member of Academy of Science of South Africa (ASSAf). He is the Executive Director of the HIV/AIDS, STIs and TB (HAST) research programme of the Human Sciences Research Council (HSRC). He is also currently an Honorary Professor in the Department of Psychiatry and Mental health at the University of Cape Town. During the past 13 years Prof Simbayi has mostly conducted his research in the area of social aspects of HIV/AIDS and sexually transmitted infections (STIs). In particular, his research has focused on second-generation HIV surveillance, HIV/AIDS-related stigma and discrimination, orphans and vulnerable children, determinants of HIV infection (such as poverty, alcohol and drug use, gender-based violence, sex in the presence of blood, multiple sexual partnerships, and male circumcision), and theory-based HIV social and behavioural risk reduction interventions including positive prevention which targets people living with HIV/AIDS who are aware of their status. He has published 121 peer-reviewed scientific articles in both local and international journals, 22 research reports, 15 abstracts, and 13 book chapters. He also co-edited a book entitled HIV/AIDS in South Africa 25 Years on: Psychosocial Perspectives which was published by Springer of New York in 2009. He is currently a member of the Civil Society Reference Group to the World Health Organisation's HIV Department, the Southern Africa Development Community (SADC) HIV/AIDS Unit's Technical Advisory Committee (TAC) and the Southern Africa Social and Behavioural Sciences Working Group (SASBWG) of the HIV Vaccine Trials Network (HVTN).

DR DONALD SKINNER

My original professional role was in psychology and I am a registered clinical psychologist and have completed a PhD in this field. I then moved more in the field of research and obtained an MPH focusing on biostatistics and research design. In addition to my other roles at Stellenbosch University I now teach Qualitative Research and supervise masters and PhD students. I am preparing a course in Participatory Research Methods to be run in 2015.

I am currently the Director of Research on Health and Society (RHS), a research unit at the University of Stellenbosch in Cape Town, South Africa. The goal of RHS is to improve the health status of South Africans and advance our understanding of public health and social development problems internationally, through the examination of relationships of cognition, behaviour and health with social conditions (e.g., poverty, violence, community cohesion, access to resources). RHS conducts research in partnership with faculty and students at Stellenbosch University and other universities, as

well as community and governmental organizations. I have expertise in South African health and culture and have a great deal of experience conducting qualitative and quantitative HIV-related research in South Africa. I have been the local PI on multiple NIH-funded studies related to HIV/AIDS, substance abuse, violence and gender issues. Some of these studies include looking at the risks for women within the environment of shebeens, the HIV risk attached to tik use, development of training programmes to assist parents to talk to their children about sex and HIV, male medical circumcision and the mental health impact of orphaned and vulnerable children.

Previous posts include being the research officer at an NGO working with victims of violence, director of the AIDS and Society Research Unit at UCT and as senior research specialist at the HSRC. I have a long history of involvement in health issues, including the struggle against apartheid in the health sector, and have worked closely with non-government organizations. It is primarily from the latter roles that my belief in the participatory methods arose and where I received a lot of my practical training in the methods.

PROF FRANCOIS VENTER

Prof Francois Venter is currently Deputy Executive Director, Wits Reproductive Health and HIV Institute (Wits RHI, previously RHRU and ECHO) and an associate professor in the Department of Medicine, University of the Witwatersrand. He is an honorary consultant in Infectious Diseases at the Charlotte Maxeke Johannesburg Academic Hospital. Dr Venter is past President of the Southern African HIV Clinicians Society, which has over 3 000 members throughout Africa. His interests include access to HIV care in resource limited settings, clinical syndromes associated with HIV, and treatment of key populations, including sex workers and truckers.

*The current state of the HIV/AIDS epidemic in South Africa
Research findings and implications for programme development
DST, HSRC, UNAIDS, UCT, US, & UWC Human and Social Dynamics Research Seminar 2 December 2014*

APPENDIX 3: ATTENDANCE

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1	Dr	Fareed	Abdullah	Chief Executive	SANAC	012 395 9675 012 395 9073	fabdullah@sanac.org.za
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18	Ms	Lungiswa	James				
19	Mr	Benjamin	Janse van Rensburg	Programme Manager	NACOSA	084 461 6915	benjamin@nacosa.org.za

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54	Mr	Mohamed Z	Rahim		Parliament		mcollins@parliament.gov.za zrahim@parliament.gov.za

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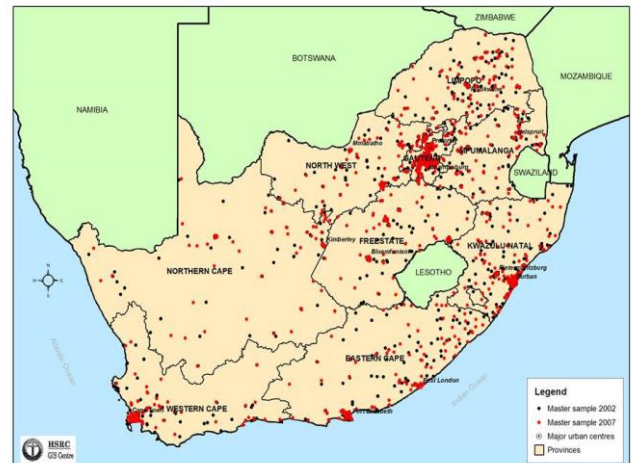
No.	Title	Name	Surname	Position/Department	Organisation	Telephone/Cell	E-mail address
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57	Ms	Christina	Roberts		US Centers for Disease Control and Prevention (CDC)		wrn7@cdc.gov
58	Mr	Leon	Roets		Higher Education HIV/AIDS Programme (HEAIDS)		Roetshjl@unisa.ac.za;
59	Prof	John	Seager		Rapporteur	082 443 0553	johnrseager@yahoo.co.uk
60	Prof	Geoff	Setswe	Deputy ED	HSRC		gsetswe@hsrc.ac.za; ssamuels@hsrc.ac.za
61	Prof	Olive	Shisana	CEO	HSRC		Oshisana@hsrc.ac.za
62	Prof	Sibusiso	Sifunda		HSRC		ssifunda@hsrc.ac.za
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70	Mr	Peter	Van der Ben		AMB recording		
71	Ms	Ina	Van der Linde	Media	HSRC		IvdLinde@hsrc.ac.za
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APPENDIX 4: PRESENTATIONS

Key findings from the 2012 national HIV household survey (SABSSM4)

Olive Shisana & Thomas Rehle
 Human Sciences Research Council (HSRC)

Human and Social Dynamics (HSD) Research Seminar
 Cape Town, 2 December 2014



Background

- This is the fourth national population-based survey, three similar surveys were conducted by the same team in 2002, 2005 and 2008.
- The study has provided an important gauge of the HIV epidemic of South Africa.
- The results are used to both inform and evaluate important health programmes such as the National Strategic Plan (NSP) on HIV/AIDS, STI and TB, and the National Health Insurance, among others.



National HIV Household Survey South Africa 2012

- Survey period: January 2012 – November 2012
- **38,431 interviewed**
- **28,997 tested for HIV**

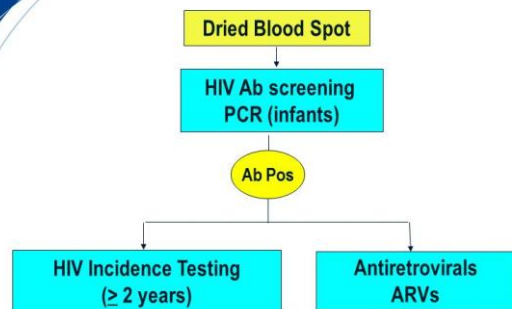


National HIV Household Surveys South Africa

- Main survey objectives:
 - to obtain national, representative data for the entire population
 - to estimate HIV prevalence & HIV incidence
 - to measure behavioral/ socio-demographic and health indicators
- Reporting domains:
 - Age
 - Sex
 - Race
 - Locality type (urban formal, urban informal, rural formal, rural informal)
 - Province

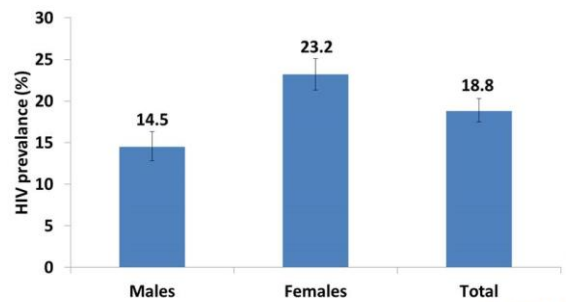


Laboratory Testing



HIV PREVALENCE

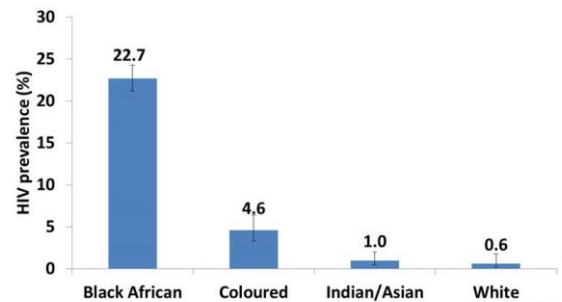
HIV prevalence by sex (15-49 years), South Africa, 2012



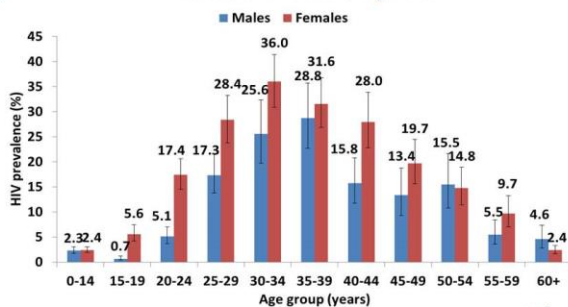
National HIV Household Survey South Africa 2012

- HIV prevalence, total population: **12.2%** (2008: 10.6%)
- **6.4 million living with HIV/AIDS**

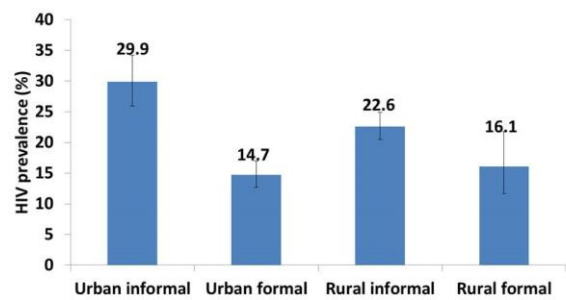
HIV prevalence by race group (15 – 49 years), South Africa 2012



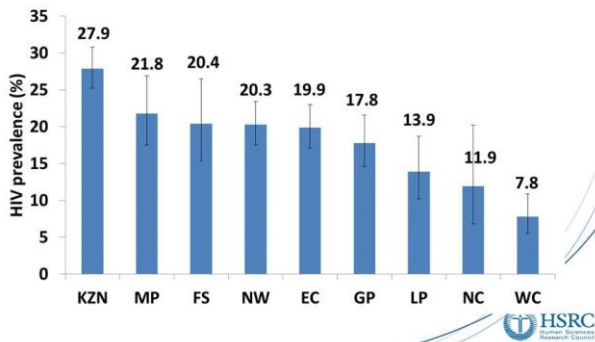
HIV prevalence by age and sex, South Africa, 2012



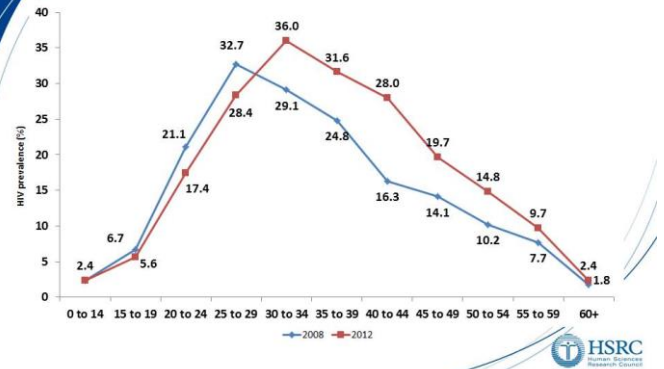
HIV prevalence by locality type (15 – 49 years), South Africa 2012



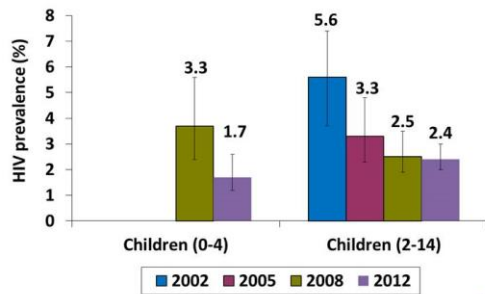
HIV prevalence by province (15-49 years), South Africa, 2012



HIV prevalence among females, South Africa 2008 and 2012



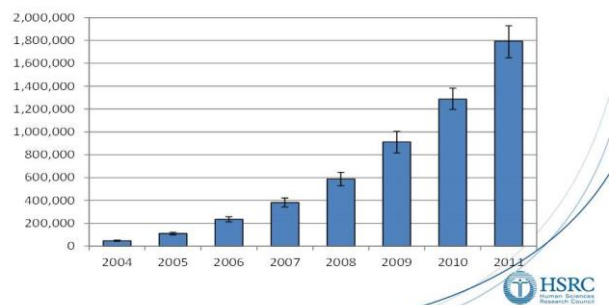
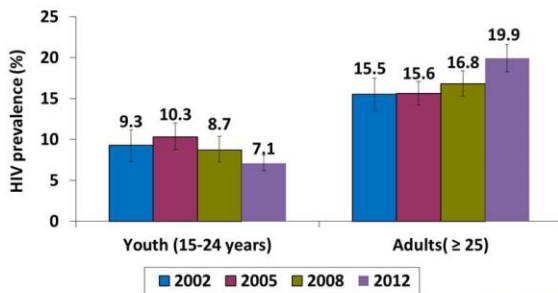
Trends in HIV prevalence in children, South Africa 2002-2012



ANTIRETROVIRAL TREATMENT (ART) EXPOSURE

→ need to test for ARVs in HIV surveys!

ART rollout in South Africa (L. Johnson, SAJHIVMED 2012)



ART Exposure, South Africa mid-2012

Variable	Estimated number of people living with HIV (n)	Estimated number on ART (n)	Proportion of people living with HIV on ART (%) [95% CI]
National	6,422,000	2,002,000	31.2 [28.1-34.5]
Males	2,531,000	651,000	25.7 [21.2-30.8]
Females	3,873,000	1,344,000	34.7 [31.4-38.2]



Estimating HIV Incidence South Africa 2012

1. Direct HIV incidence using blood specimens

- Multi - assay testing algorithm

2. Indirect HIV incidence using mathematical models

- HIV incidence estimation from HIV prevalence data collected in repeated national population-based surveys
- EPP/Spectrum; Thembisa

Social science that makes a difference



ART Exposure by Age Group, South Africa mid-2012

Variable	Estimated number of people living with HIV (n)	Estimated number of people on ART (n)	Proportion of people living with HIV on ART (%) [95% CI]
Age group			
0-14	368,879	166,025	45.1 [33.9-56.9]
15-24	720,269	102,868	14.3 [10.0-20.0]
25-49	4,705,506	1,466,412	31.2 [27.4-35.2]
50 and older	610,323	260,490	42.7 [35.7-50.0]
15-49	5,425,776	1,569,280	28.9 [25.6-32.5]
Total	6,422,179	2,002,350	31.2 [28.1-34.5]



Direct, assay-based HIV incidence rates by age and sex, South Africa 2012

Age Groups	HIV incidence % (95% CI)
Age ≥ 2years	
Total	1.07 (0.87 – 1.27)
Male	0.71 (0.57 - 0.85)
Female	1.46 (1.18 - 1.84)
Age 15-24 years	
Total	1.49 (1.21 – 1.88)
Male	0.55 (0.45 - 0.65)
Female	2.54 (2.04 - 3.04)
Age 15-49 years	
Total	1.72 (1.38 – 2.06)
Male	1.21 (0.97 - 1.45)
Female	2.28 (1.84 - 2.74)

Social science that makes a difference



HIV INCIDENCE ESTIMATION

Comparison with mathematical models

Method	Period	15-49 incidence %
LAg avidity/ ARV / VL	2012	1.72
Synthetic cohort	2008-12	1.9
EPP/Spectrum	2011/12	1.52
Thembisa	2011/12	1.47



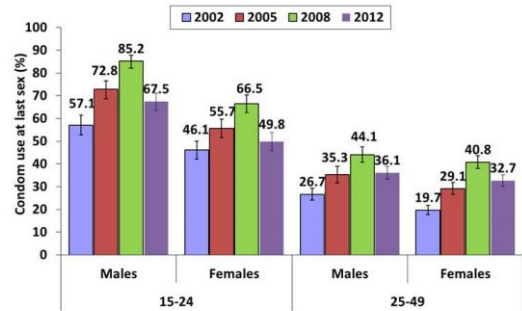
HIV incidence rates by socio-demographic and behavioral variables South Africa 2012

Variables	HIV incidence % (95% CI)
Locality type (15 years and older)	
Urban formal	1.29 (1.03-1.55)
Urban informal	4.42 (3.42-5.09)
Selected at-risk populations	
Sexually active females 15-24 yrs	3.53 (2.83 - 4.23)
Black African females 20-34 yrs	4.54 (3.64 - 5.44)
Number of sexual partners in the past 12 months (15-49 yrs)	
One partner	1.67 (1.33 - 2.01)
More than one partner	2.43 (1.95 - 2.91)

Social science that makes a difference



Condom use at last sex by age and sex, South Africa 2002-2012

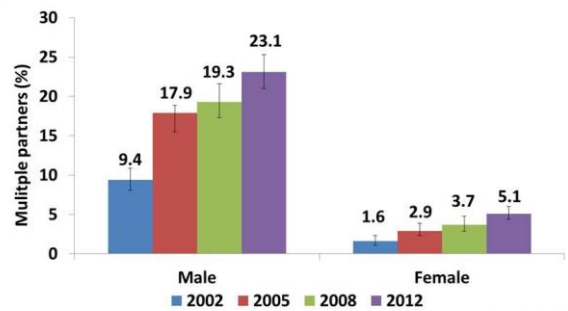


Behavioural Findings

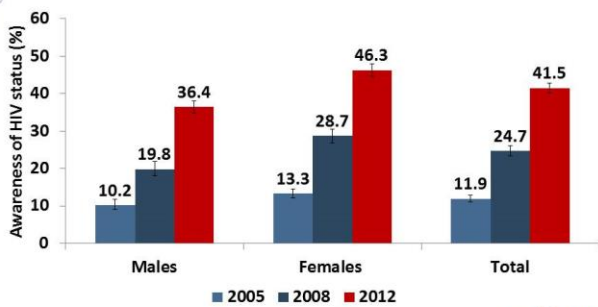
Social science that makes a difference



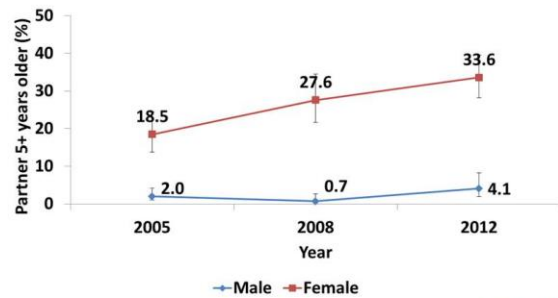
Multiple sexual partnerships (15-49 years), South Africa 2002-2012



Awareness of HIV status among those who tested in the last 12 months, by sex (15 years and older), South Africa 2005-2012

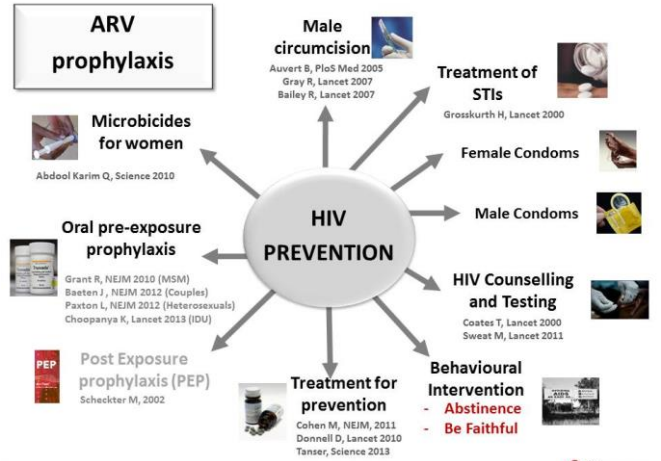
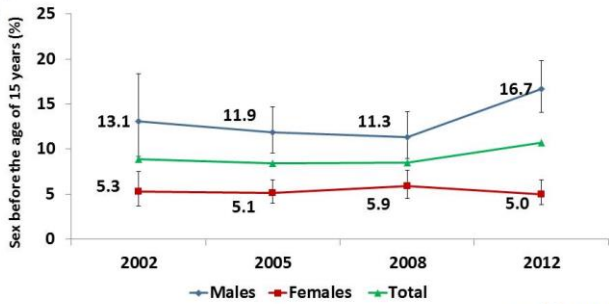


Age-disparate sexual relationships in the 15-19 years age group South Africa 2005-2012



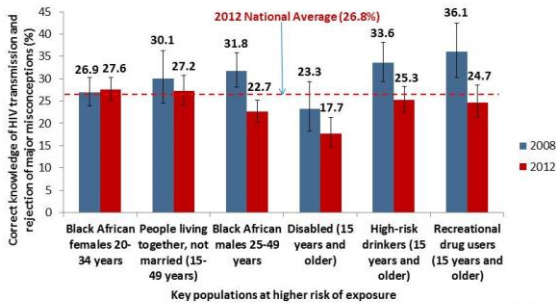
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Sexual debut before age 15 years (15-24 years), South Africa 2002-2012



Note: PMCT, Screening transfusions, Harm reduction, Universal precautions, etc. have not been included – this is on sexual transmission CAPRISA

Correct HIV knowledge among key populations, South Africa 2008 and 2012

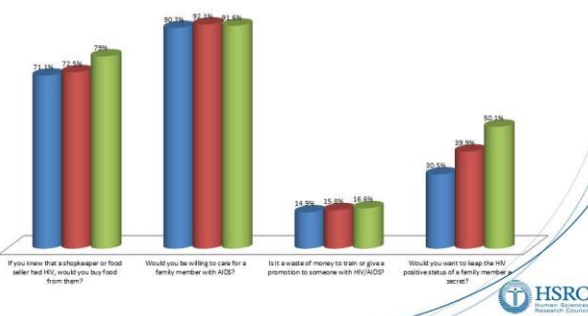


Research Collaborators



Trends of HIV-related stigma in South Africa, 2005, 2008, 2012

Percentages of respondents aged 15yrs and older who agreed with 4 statements about PLHIV asked in the past 3 surveys



Funders

This research has been supported mainly by the President's Emergency Plan for AIDS Relief (PEPFAR) through CDC under the terms of Cooperative Agreement Numbers 5U2GPS000570-05 , 3U2GGH00357-02 and U2GPS001328.



Know Your epidemic: The value of population-based household surveys

Eva Kiwango
 Senior Strategic Information Advisor
 United Nations Joint Programme on HIV/AIDS
 (UNAIDS)

Zero new HIV infections.
 Zero discrimination.
 Zero AIDS-related deaths.



1918 – 2013
 THANK YOU



Presentation Outline

1. Information and epidemiological insights provided by population based surveys for high transmission geographies and priority populations;
2. UNAIDS Fast Track Targets
3. Highlight future directions and additional information that is derived from population-based surveys in order to measure critical HIV program outcomes and impacts.
4. Summary key points

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 Zero discrimination.
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Determination of progress towards National Strategic Plan, MDGs, and the UN political declaration of commitments' HLM targets.



1
 Have sexual transmission



2
 Have infections among PWID



3
 Eliminate new HIV infections among children and have AIDS-related maternal deaths



4
 15 million people on HIV treatment



5
 Have TB deaths among people living with HIV



6
 Close the global resource gap and achieve annual investment of US\$ 22B-24B



7
 Eliminate gender inequalities and sexual violence and increase capacities of women and girls



8
 Eliminate stigma and discrimination



9
 Eliminate travel related restrictions



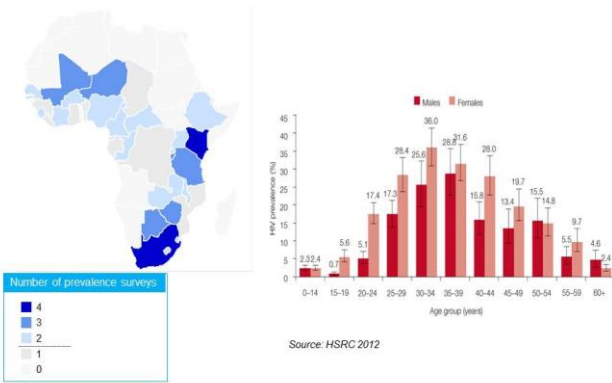
10
 Eliminate parallel systems, for stronger integration

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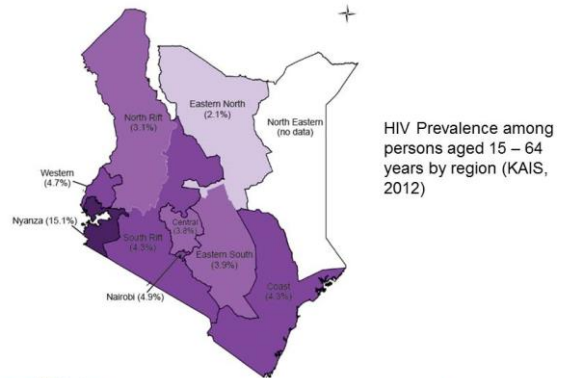
Information and epidemiological insights: HIV prevalence by sex and age



Source: P. Ghys, M. Mahy, T. Rehle CROI 2014
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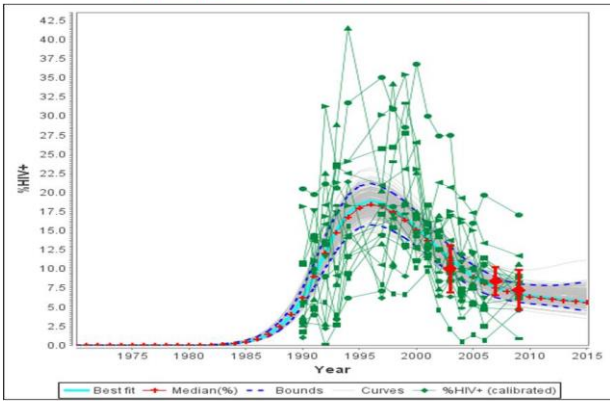
Information and Epidemiological insights: Sub-national HIV Prevalence



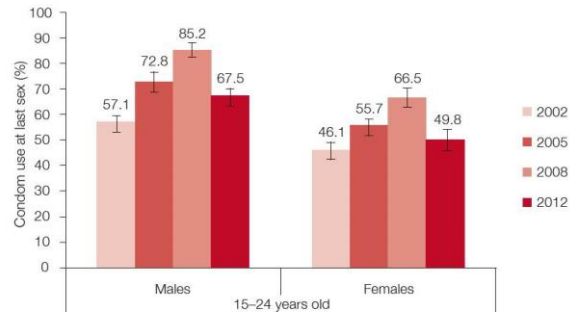
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Information and epidemiological insights:
 Adjusting estimated prevalence from ANC data



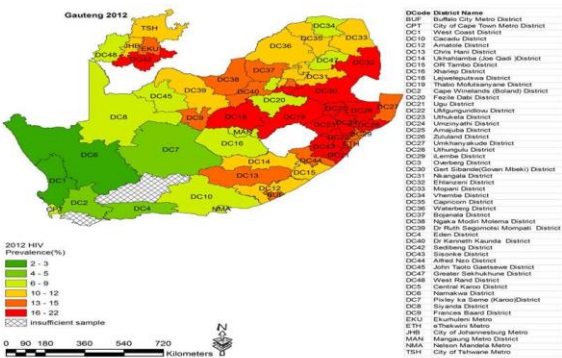
Information and epidemiological insights: Condom Use at last sex by age groups and sex. South Africa 2002, 2005, 2008 and 2012 (Source: HSRC)



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Information and Epidemiological insights: Sub-national HIV Prevalence (Source: HSRC 2012)



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2. UNAIDS Fast Track Targets

Zero new HIV infections.
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Fast-Track action towards achieving the 90-90-90 by 2020

The Fast-Track Targets include:

- 90% of people living with HIV knowing their HIV status.
- 90% of people who know their status on treatment.
- 90% of people on treatment with suppressed viral loads.
- **Other targets include**
 - reducing the annual number of new HIV infections to 500 000 in 2020 and 200 000 in 2030; and
 - achieving zero discrimination

Zero new HIV infections.
Zero discrimination.
Zero AIDS-related deaths.



Future Directions

1. Expanding the age range of the sampled population:

- Surveys can provide additional information on the HIV epidemiology
- At the lower end among children (to date few surveys have included children)
 - South Africa: HIV prevalence among children aged 2 -14 years suggest a reduction in HIV prevalence (PMTCT, children aging out of cohort?)
- At the higher end among people over 50 years of age.
 - Important levels of HIV prevalence among 50+

Zero new HIV infections.
Zero discrimination.
Zero AIDS-related deaths.



The Fast Track targets are firmly based on an approach to leaving no one behind

- Close the gap between people who have access to HIV prevention, treatment, care and support services and people who are being left behind —young women and adolescent girls, men who have sex with men, migrants, prisoners, sex workers, people who inject drugs.
- We also need to focus on children and adolescents, who continue to be left behind (UNAIDS GAP report 2012).
 - AIDS is the leading cause of death among adolescents in Africa.
 - Children are 37% less likely to have access to treatment than adults.

Zero new HIV infections.
Zero discrimination.
Zero AIDS-related deaths.



Future Directions

2. National HIV Incidence:

- The recent development and availability of a reliable HIV incidence assay means that HIV incidence can and should be measured as a routine component of population-based surveys.

3. Immunologic Status (CD4 Cell Count):

- Measurement of CD4 cell counts in people living with HIV is used to assess the proportion of persons who are eligible for treatment (already on ART as well as not on ART); and
- Provides information on the population-level reach of the treatment response.

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3. Highlight future directions and additional information that is derived from population-based surveys in order to measure critical HIV program outcomes and impacts.

Zero new HIV infections.
Zero discrimination.
Zero AIDS-related deaths.



Future Directions

4. ART Coverage:

- Subnational trends in this measure provide crucial information on progress and gaps, and can inform resource allocation to achieve coverage goals according to epidemic distribution.
- Obtaining information on the characteristics of persons who do not access care is important for program improvement to more effectively meet the needs of people living with HIV.

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Future Directions

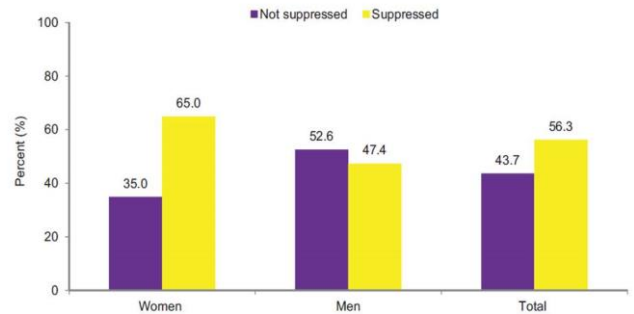
5. High transmission geographies and populations:

- **Geographic Location:** Sub national HIV prevalence and incidence trends provide crucial information on progress and gaps, and can inform resource allocation to achieve coverage goals according to epidemic distribution.
 - District
 - High-Transmission Areas: e.g. informal settlements, truck routes etc.
- **Populations left behind:** Obtaining information on the characteristics of persons who do not access care is important for program improvement.
 - Young women, adolescents, men who have sex with men, prisoners, sex workers, migrants, people who inject drugs.

Zero new HIV infections.
Zero discrimination.
Zero AIDS-related deaths.



Viral load suppression among HIV-infected women and men aged 15-64 years in HIV discordant relationships, KAIS 2012

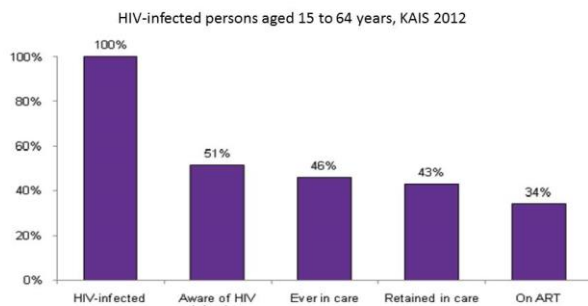


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Zero discrimination.
Zero AIDS-related deaths.



Future Directions

6. Continuum of Care among People Living with HIV



Zero new HIV infections.
Zero discrimination.
Zero AIDS-related deaths.



4. Summary Key Points

1. A wealth of information and epidemiological insights provided by HIV surveys - understand how much progress has been made and how far HIV programs still have to go to achieve population-level coverage and quality
 - » Fast Track Targets 90-90-90;
 - » reducing the annual number of new HIV infections; and
 - » achieving zero discrimination
2. Additional information that should be derived from population-based surveys in order to measure critical HIV program outcomes and impacts.
 - » Sub-provincial level estimates of people who are being left behind by geographic area (micro-epidemics)
 - » Continuum of Care among People Living with HIV
 - » Immunologic Status (CD4 Cell Count)
 - » Viral Suppression

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Zero discrimination.
Zero AIDS-related deaths.

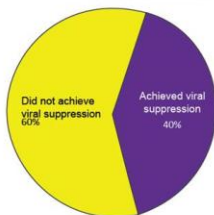


Future Directions

7. Community viral load suppression:

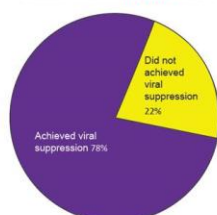
- Viral Load suppression reflects adherence to HIV treatment and quality of ART programs.
- These measures inform programs about the population-level suppressive effect of ART and about further HIV transmission potential.

Viral suppression among HIV-infected persons aged 15-64 years, KAIS 2012



Zero new HIV infections.
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Zero AIDS-related deaths.

Viral suppression among HIV-infected persons aged 15-64 years on ART, KAIS 2012



Key References

1. CDC (2014): COPFY14 Supplemental Guidance Clarification on Information, Design and Cost Considerations for Population-based Surveys to Measure HIV Outcomes and Impact (draft version)
2. Ghys P D, Mahy M, Rehle T (2014): Know Your Epidemic, Know Your response: Data for Action: Population Surveys: What Do They Show? Presentation at CROI 2014
3. Shisana, O, Rehle, T, Simbayi LC, Zuma, K, Jooste, S, Zungu N, Labadarios, D, Onoya, D et al. (2014) *South African National HIV Prevalence, Incidence and Behaviour Survey, 2012*. Cape Town, HSRC Press.
4. NDOH, CDC and UNAIDS (2014): Mapping HIV micro-epidemics in South Africa: Insights on high transmission geographies and key populations (draft)
5. UNAIDS (2014): UNAIDS Fast Track: Ending the AIDS Epidemic by 2030
6. UNAIDS RST report
7. UNAIDS Global report

Zero new HIV infections.
Zero discrimination.
Zero AIDS-related deaths.





FACULTY OF HEALTH SCIENCES
UNIVERSITY OF CAPE TOWN

Both/And: Thoughts on Next Steps in the Response to HIV in South Africa

A/Prof. Christopher J. Colvin
Division of Social and Behavioural Sciences
UCT School of Public Health and Family Medicine



cutting edge research | world class training and education | partnering for patient-centred health services

Suggested Highlights

Men's experiences/practices wrt HIV and GBV
HCT 'hot spots'
Key populations
HIV risks of sex work criminalisation
Under-recognition of heterosexual anal sex as a risk factor
Age-disparate relationships and marriage

University of Cape Town

Faculty of Health Sciences

'Both/And' in our Response

Both description and theory
Both evidence and intervention
Both normalisation and exceptionalism

University of Cape Town

Faculty of Health Sciences

COMMENTARY ON SABSUM 4

Donald Skinner
Research on Health and Society
Stellenbosch University

- The SABSUM reports are always key points at which to consider the growth and direction of the epidemic in South Africa.
- This particular survey report comes at a point where incidence appears to be reducing generally.
- This is also a point at which ARVs have become more generally available, so prevalence levels remain very high.
- Our role is to highlight issues that we felt were important to us that were highlighted in the results.

Epidemic in the Coloured population

- In our research among Coloured people attending shebeens and taverns, and amongst those using tik \ methamphetamine we have been finding increasing levels of HIV.
- In the community where our research is, clinic nurses reported at least one person a day testing positive amongst local Coloured community.
- Western Cape DoH person reported higher levels of HIV+ results amongst young women and older men amongst those presenting for testing in the clinics.
- The latter two points were felt to be new and increasing over time. But this is not scientific and no formal review of the clinic stats has been done.

SABSUM 4 data

	2005	2008	2012
White	0.6	0.3	0.3
Indian/ Asian	1.6	0.3	0.6
Coloured	1.9	1.7	3.1
Black/ African	13.3	13.6	15.0

- This trend is supported in the ante natal data.
- Although change still within the confidence limits, it is concerning.
- There are areas of concern around risk which appear to be increasing.
- High and increasing levels of substance use.
- Alcohol use is very high, and from our research appears to be increasing amongst women.
- Tik \ methamphetamine use high in both men and women.

Age gender distribution of infection

- The pattern remains of women getting infected younger, from 18 to 25; and men older from 35 up.
- While the emphasis on cross generational relationships is important I do feel that other important considerations need greater attention.

Gender violence

- The impact of gender violence especially sexual violence, as a means of transmission and as a systematic way of breaking down young women so that they cease to protect themselves.
- This stems from existing constructs of power and ideas around masculinity.
- Dangerous as men feel invulnerable, and women feel disempowered, worthless and damaged.
- Reduces the felt need to use condoms or to stick to one partner.

- High levels of gender violence, domestic violence, sexual violence and child abuse.
- Generally high levels of community violence and gang activity.
- High levels of stigma in the Coloured community. AIDS is seen as a Black African disease. So it remains hidden.
- The myth also reduces the need for protection behaviour.

Substance use

- Substance use and the risky sexual practices that are associated with it, including sexual exchange and lack of capacity to stay safe when under the influence.
- Sexual exchange is formal and informal sex work, and direct exchange for alcohol or drugs.
- Underage girls are starting to use substances and they are even more vulnerable.
- For women loss of power in sex exchange and intoxication makes it harder to use condoms.
- These may also explain why older men are getting infected as they are most often the customers.

Opportunities for protection strategies are being missed

- Legalisation of sex work, so that these women and men can be protected.
- Decriminalising of certain drugs and offering better rehabilitation
- Intervening in a more consistent and high profile way to reduce gender violence.
- Less tolerance of people who do commit these offenses or make light of gender violence
- Concerns around the impact of traditional legal systems on women's rights
- Need to raise awareness in the Coloured community about the potential for the epidemic to rise in this group

Information Sharing on BAIS IV To HSRC Research Seminar

S Mosweunyane
NACA

BAIS series

- To provide up to date information on HIV&AIDS
 - » Prevalence
 - » Incidence
 - » Behavioral patterns
- | | |
|------|---|
| 2001 | behavioral survey |
| 2004 | behavioral + HIV prevalence |
| 2008 | behavioral + HIV prevalence + Incidence |
| 2012 | behavioral + HIV prevalence + Incidence
+ GIVING Back Test results |

MAGNITUDE OF BAIS IV

- National undertaking
 - 8 000 households
 - 17 400 individuals aged 10 to 64 years old
 - 21 000 individuals aged 6 months +
- 33 teams
- Field work 2 months

15 January-15 March 2013

Summary of Results

- HIV Prevalence: 10-64 **18.5** (2013)
– 17.6 (2008)
- HIV Incidence (6 weeks + **1.35** (2013)
 - 18 months 1.45 (2013)
 - app 10 000 new infections
- Females highly affected
- 35-39 (**48.5%**)

conti

- Increase demand creation for SMC
- Men sector, left behind
- HIV in 50+ age group
- HIV IN Eastern corridor esp F/Town, S/Phikwe
- Policies (Advocacy!!!!), SW, MSM.
- Revised HIV policy consent age of testing

Summary conti

- Prev 6 wks -18 months: 2.2%
- Ever tested 70.2% from 56.4
- Composite knowledge: 41% to 52%
- stigma: **3.5%** but stigma survey self stigma is **31%**
- SMC 24% from 11.2%
- MCP 15.8 from 11.2
- Consistent condom use: 82% from 90%
- Self stigma
- With move to 500 cd4, is it not time to have regional pharmaceutical producing or procuring art, sadc cross boarder
- Discordant couples (silent)
- Time for absorption and utilisation of results

Where are we?

- MTR Completed 4 wks ago (zero by 2016)
 - prioritize critical areas for maximum impact

Females:

Youth

- 15-19 (females twice as infected)
- Key populations (close gap). Bonela Clinic, ART to prison population through Red Cross
- Strengthen capacity of providers (communities)

- Botswana AIDS Impact Survey 2013 (NACA)
- Botswana Stigma Survey.

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Human and Social Dynamics Research Seminar
 02 December 2014

Ms Managa Pillay

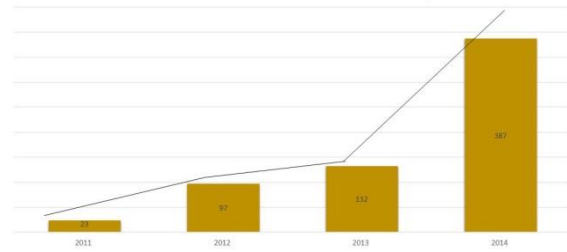


Context – who are we?



The Higher Education and Training HIV/AIDS Programme (HEAIDS) is an initiative of the Department of Higher Education and Training that is undertaken by Higher Education South Africa (HESA) to support public universities and Technical and Vocational Education and Training colleges (TVETs) in responding to the HIV/AIDS pandemic through their core functions of learning and teaching, research and innovation, and community engagement.

Growth in both HEI and TVET campuses



Profile - stats



HEIs:

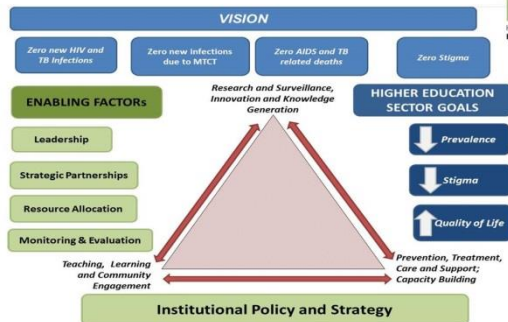
- 23 HEIs – provincially spread (urban – rural)
- 953 373 Students with 48 340 staff, student enrolment proportionally higher here, higher no of contact students
- 67% African
- 54% female and 46% male
- Age band 18 – 35, with at least 83% being enrolled in undergraduate degrees, certificates or diplomas (significant portion between the ages of 18-24 years of age)

TVETs:

- 50 colleges – provincially spread (urban – rural)
- 657 690 students and 16 928 staff
- Highest student enrolments in Gauteng and KZN respectively
- Majority of students enrolled are black (African, coloured and Asian) and female – 58%

Ref: Statistics on Post school education in South Africa 2011 and 2012

A Mainstreamed Higher Education Response



Research – baseline and on-going.....



2006-2014/2015

- Sero-prevalence and KAB Study – 2010 – 23 000 students and staff (funded by the European Union)
- KAB-TVET study: Partnership with Global Funds/US Government & HSRC-Sample of 6500 Student and staff across 50 TVETs; (policy and programme framework 2015)
- LGBTI-Study: Partnership with Global Funds-Study of 9000 student sample targeting LGBTI population
- Future Beats-Community radio Youth Development baseline study;
- First Things First University Evaluation study;
- Academic Curriculum development - baseline/situational analysis study at TVETS and desktop study – integration of HIV into curricular

<http://www.heAIDS.org.za/>

Our reach



2012 survey - conclusions and implications for post schooling sector



- Prevalence increase significantly – gender and race and age:
 - Race – Black African highest prevalence
 - Age – 15-24
 - Gender – vulnerability of females greater in the 15-34 age band
 - Females 15-19 more likely to have sex older sex partners
- Locality disparities – susceptibility increased in informal rural, Urban informal – rural localities higher susceptibility

Shisana, O, Rehle, T, Simbayi LC, Zuma, K, Jooste, S, Zungu N, Labadarios, D, Onoya, D et al. (2014) South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press.

The current state of the HIV/AIDS epidemic in South Africa
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Implications (cont.)



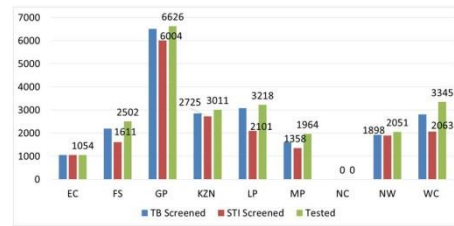
- Decline condom use, never having used a condom
- Multiple sex partners
- Age disparate relationships in females (33% had partner 5 years their senior)
- Increased susceptibility due to alcohol and drug abuse
- Significant % of respondents believed that they would not acquire HIV

What does this mean for Us

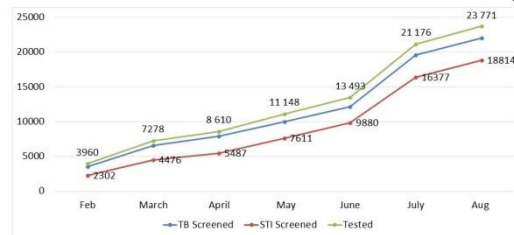


- We have a significant number of the affected population in our midst
- High presence of students in high prevalence provinces (KZN, MP..)
- Young women – particular vulnerability and susceptibility to risk of infection
- Young people between the ages of 15 - 35 make up the core of our population in the HE sector
- Profile of the population – black African male and females in the majority
- Teenage Pregnancy as well as general pregnancy rates very high
- Growing MSM and LGBTI populations
- Alcohol and drug abuse (another epidemic within sector)
- Growing evidence of age disparate relationships and transactional sex
- Significant number of institutions urban and semi-urban environments
- Highly mobile population, significant number of students contact and thus living away from home or travelling
- Urban infrastructure – residential living, inner city capabilities to cope with influx of students

Testing & Screening data per province: January – September 2014



Testing Cumulatively
 January – August 2014



33% First Time Testers



Community Engagement
 THE BIG SEVEN

Teaching & Learning
 (Education, awareness and Skills Development)



First Things First
 First Priority of Every South African to Look after his/her Health
 HCT/TB/STI/General Health & Wellness Programme

Partners: DHET, DOH, Global Fund, USAID, PEPFAR, SANAC, GLOBAL FUND

Brand Ambassador: Honourable Deputy Minister of Higher Education and Training Mr Mduzuzi Manana, MP
 BEST HCT CAMPAIGN AWARD FOR AFRICA 2011-13



Men's Health Brothers for Life Programme



- Men's Health;
- Medical Circumcision;
- Gender-Based Violence and Rape;
- Prostrate and Other Cancers;
 - Condoms;
 - Family planning.



PARTNERS: DHET, DOH, Global Fund, USAID, PEPFAR, JHESA, SANAC

Brand Ambassador: Honourable Minister of Health Dr Aaron Motsoaledi, MP



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Women's Health and Empowerment ZAZI Programme

- Female Health;
- Gender-Based Violence;
- Intergenerational Sex/Sugar Daddies;
- Female Condoms;
- Cervical and Breast Cancer;
- Family Planning.



PARTNERS: DHET, Department of Women, Department of Health, Global Funds, JHESA, USAID, PEPPAR, SANAC



HEAIDS is a perfect example in South Africa of various government departments, civil society, donors and the private sector working together towards a common goal.



Alcohol and Substance Prevention Programme

- Screening, education and awareness
- Graduate Competencies
- Youth Development
- Responsible drinking

Partners: DHET, DSD, DoH, Global Funds, UNODC, DCOSA, UNESCO, SANAC



LGBTI Programme

- To support LGBTI population;
- De-stigmatise LGBTI;
- Graduate Competencies among LGBTI.

Partners: Global Fund, NACOSA, DHET, SANAC



Future Beats

Youth Development and HIV Prevention through Campus/Community Radio and Social Media



Academic Curriculum development and Integration Programme



- Capacitating academics to integrate HIV/TB/STIs issues into curricular;
- Capacitating next labour generation - discipline specific competencies
- Private Sector, DPSA, ILO and Department of Labour

Partners: DHET, NSF, SANAC, SETAs, QCTO

