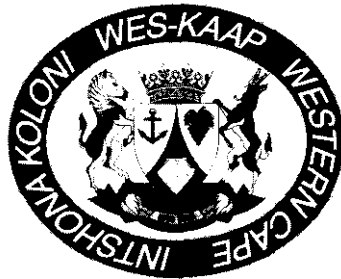


Department of Health

Provincial Administration: Western Cape

The Provincial and District HIV Antenatal Survey Report

Western Cape 2000



THE HIV ANTENATAL SURVEY: WESTERN CAPE 2000
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FOREWORD

The annual antenatal survey is both the only and the most important source of objective data on HIV in the province. This set of data, combined with similar surveys over the past few years, allows us not only to track the epidemic but also to predict its future profile by applying bio-statistical and actuarial tools.'

The decision by the department to conduct district-level surveys is based on the simple principle that management at the district level needs reliable rates for their districts to plan for, and manage the epidemic at the level. Although this report provides survey results for five districts, future reports will provide results for all 25 health districts in the province

The quality of this survey needs special mention and the team that conducted the survey under the leadership of Najma Shaikh needs to be thanked and congratulated, as well as the patients and staff in our maternity facilities and the SAIMR laboratories, where the samples were analysed

Fareed Abdullah. Deputy Director-General: Special Health Projects and Transversal Responsibilities.

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1 INTRODUCTION

The HIV epidemic is a serious public health concern in many developing countries. At present South Africa is experiencing the fastest growing epidemic in the world. One of the main strategies of monitoring and managing this epidemic is through surveillance. Since 1990, the Department of Health has been conducting annual HIV antenatal surveys of public health facilities (Department of Health 1999). This internationally applied method of surveillance forms the cornerstone of measuring the epidemic and remains the primary source of information on the prevalence of HIV in the South African adult population.

During the month of October 2000, the 11th Annual National Antenatal HIV Survey was conducted in each of the nine provinces. This anonymous and unlinked survey is carried out annually at selected public sector clinics throughout the country. The same clinics are used every year and all pregnant women attending these clinics for the first time of their current pregnancy are examined.

The objectives of the National Antenatal Survey are to monitor trends of HIV and syphilis at provincial and national level. The survey is designed only to provide an overall provincial prevalence of HIV infection, and is not intended for analysis of the provincial data by facility or by suburb, since such an analysis might lead to seriously incorrect deductions. For this reason, in addition to the national provincial survey, the Western Cape conducted a pilot survey in five health districts in order to get a district profile of the epidemic. The selected districts were Paarl, Mitchells Plain, Worcester/Robertson, Tygerberg Eastern and George.

2 OBJECTIVES

1. To measure the prevalence of HIV infection among women attending public antenatal clinics in the Western Cape for the year 2000
2. To measure the prevalence of HIV infection of five districts for the year 2000, namely: Mitchell's Plain District, Tygerberg Eastern District, Paarl District, George District, Worcester District.
3. To measure the prevalence of syphilis for the province and for the five districts



3 METHODOLOGY

3.1 PROVINCIAL SURVEY

A cross-sectional survey was carried out in 28 sentinel sites (65 facilities) in the Western Cape. The Proportional Probabilities Sampling (PPS) method was used to select sites and to determine sample size. For the purposes of meaningful trend analysis, the same sites have participated in the survey since 1998, and were thus regarded as sentinel sites. The sample size for the provincial survey was 2 040. An extra tube of blood was taken consecutively from women who attended the facility for a first booking visit.

3.2 DISTRICT SURVEY

The five health districts were selected by health managers on the basis of suspected high HIV-prevalence rates and the need for information to plan the Mother-to-Child Transmission (MTCT) intervention project. The sample size for each district was calculated within 95% confidence intervals. The estimated prevalence of HIV infection and the utilisation rates of first-time attendees were taken into account in the calculations, weighting each site proportionally. There were 65 facilities for the district survey of which 20 overlapped with the provincial survey.

3.3 SENTINEL POPULATION

The study population for the provincial and district survey were pregnant women attending the public health services. The main reasons for conducting the survey among pregnant women is that they are sexually active, and therefore are representative of the general sexually-active population compared to other groups. This group is also an accessible group as drawing of blood for the survey is an integral part of the routine clinical care they routinely receive for the first hooking examination.

3.4 INCLUSION CRITERIA

Women attending the clinic for their first antenatal visit for the current pregnancy were eligible to participate. The clients were given the choice to participate and the numbers of non-responders were noted by age on the reverse side of the data collection form.

3.5 STUDY LOGISTICS AND PLANNING

National and provincial workshops were held to brief the various provincial and regional co-ordinators about the survey. The Western Cape formed a project management team comprising representatives from the four health regions, the Medical Research Council (MRC), and the Provincial AIDS Management Team (PAMT).

An audit was undertaken of the previous survey to finalise the facility lists, verify utilisation rates, and assess the cluster configuration. The sample size per cluster for the provincial survey remained unchanged from the previous year. The regional co-ordinators verified the lists and confirmed participation from the designated sites. A provincial workshop was held to brief the project management team on the methodology and the standard operation procedures.

Laboratory arrangements were confirmed with respect to participation, transportation, storage, and processing of specimens according to standard operational procedures. Posters, guidelines and flow-charts were produced in-house, to inform clients and staff of the survey. The posters were presented in three languages, namely:

English, Afrikaans and Xhosa. Each facility was supplied with a package containing tubes, survey forms, standard operating procedure codes, protocol posters, bar codes, and the contact details of co-ordinators.

The facilities that participated in both the provincial and the district survey received separate packages for the respective surveys. They were requested to reach the provincial survey target for data collection and then commence with the district survey. This was done to prevent contamination of the provincial survey.

The regional co-ordinators were provided with material to aid the regional workshops. These included monitoring forms to evaluate the implementation of the survey; lists of the participating facilities; a register of bar-code numbers; and the sample size allocations for each site. The regional co-ordinators and provincial co-ordinators trained facility staff through workshops and visits to the various sites.

3.6 DATA COLLECTION INSTRUMENT AND PROCESS

The survey was carried out for a period of a month and commenced on 2 October 2000. Unique bar-code numbers were issued in pairs for each participant. One of the paired bar-code stickers, acting as a patient identifier, was placed on the form and the other on the blood-specimen tube.

The district and the provincial survey forms were printed in two different colours in order to differentiate between the two survey data sheets.

The variables collected in both forms included the following: the name of the facility; the date when the survey was started and when it was completed; the name of the contact person; the bar-code number; the laboratory number; the age of the client; the highest level of education attained by the client; the client's race; gravidity; parity; KPK results; HIV results; and the age of the client, if not participating.

Women who were eligible to participate were told of the study during their routine pregnancy education session. They were also informed of the measures undertaken to maintain confidentiality and anonymity, which meant that their names would not be linked to the test results and that their individual results would not be made available to the facility. The women were also informed that they had the choice not to participate and that they would not be disadvantaged in any way, should they have chosen not to participate. They were asked to privately indicate to the nurse that they did not wish to participate during the individual consultation session. Participants were selected consecutively until the target sample size was reached. The age of the non-participant was noted on the back of the form.

Specimens were stored in the refrigerator at 4°C and transported in cooler bags to the laboratory. All blood specimens had to be centrifuged within 24 hours of collection.

3.7 LABORATORY TESTING

The laboratory processing and analysis was done by the SAIMR laboratory in the Western Cape. In line with recommendations laid down by the World Health Organisation (WHO), HIV testing for the surveillance was done with the ELISA (Abbot AxSYM system for HIV1/HIV2). As opposed to the other provinces, a second ELISA test was done if the first assay proved reactive.¹ The Rapid Plasma Reagent Test (RPR test) was used for the active syphilis-screening component of the survey.

¹Due to low HIV prevalence in the Western Cape viz. < 10%.

3.8 QUALITY ASSURANCE

Quality of the survey was examined in terms of adherence to protocol and laboratory analysis.

For the quality of survey implementation, a structured interview was carried out to explore issues such as: the training of staff; expectations with regard to feedback; utilisation rate; non-responders; receipt of supplies; survey commencement and termination; progress with regard to achieving targets; and the transportation and storage of specimens. The quality of the implementation of the survey was carried out by Community Health Registrars from the University of Cape Town.

The National Institute of Virology (NIV) performed the quality-control evaluation for the syphilis and HIV testing. Twenty specimens per province were independently re-tested by the NIV and the outcomes were examined for agreement.

3.9 DATA PROCESSING, MANAGEMENT AND ANALYSIS

The data was captured on EPI 6 for both the provincial and district surveys, while the individual records that were part of the provincial and district survey were captured in both databases. A bar-code register was compiled before the bar-code stickers were issued and copies of the registers were given to the laboratory co-ordinator and regional staff. This information was crucial in order to keep track of missing specimens or data-sheets, and to determine the sample size achieved by facilities. The data also served as identifiers in order to distinguish the district from the provincial specimens. Data was entered twice, assessed for discrepancy, and cleaned where necessary.

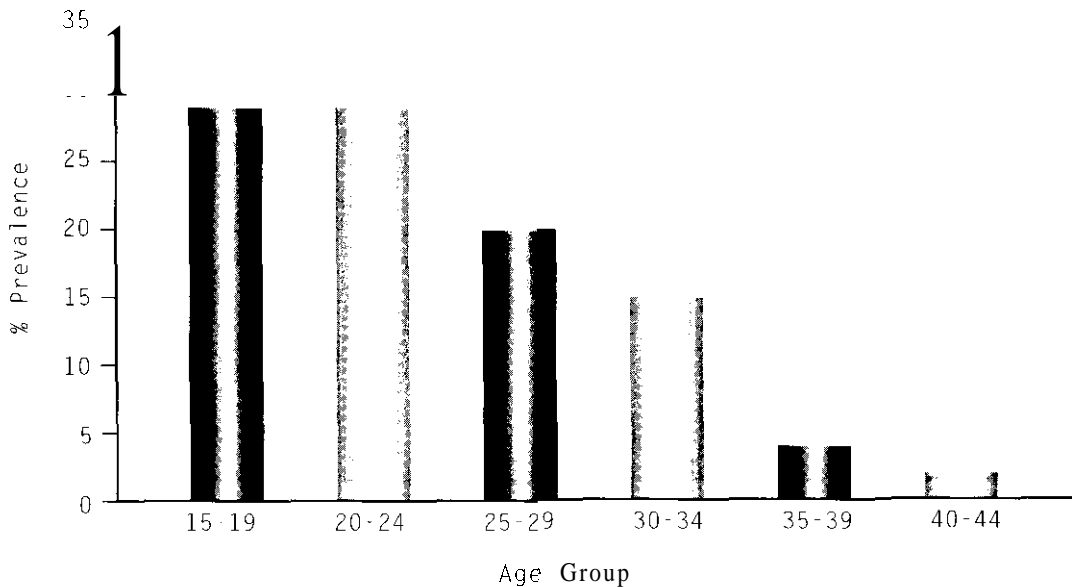
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4.1 PROVINCIAL LEVEL SURVEY

4.1.1 RESPONSE RATE AND DESIGN ERROR

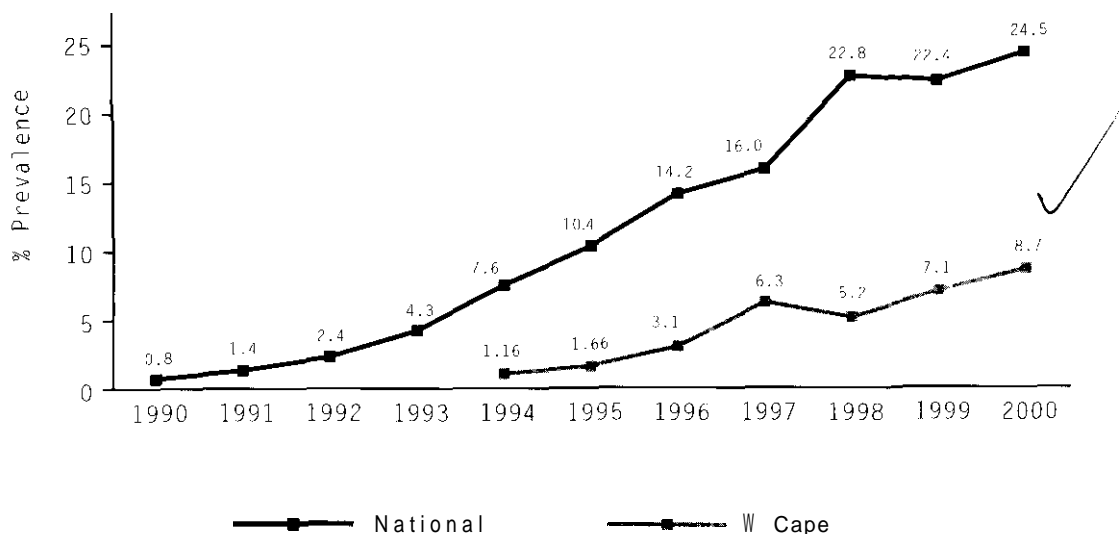
The number of specimens collected for the provincial survey, as a proportion of specified sample size increased from 84% for the year 1999, to 97% for the year 2000. The design error decreased from 5.07 in 1999, to 3.05 for the year 2000.

Figure 1: NATIONAL ANTENATAL SURVEY 2000: NON-RESPONSE RATE BY AGE IN THE WESTERN CAPE



The non-response in the provincial survey for the year 2000 formed 4% of the total sample specified and the non-responders were predominantly from the 15-29 age group (78% - and see Figure 1).

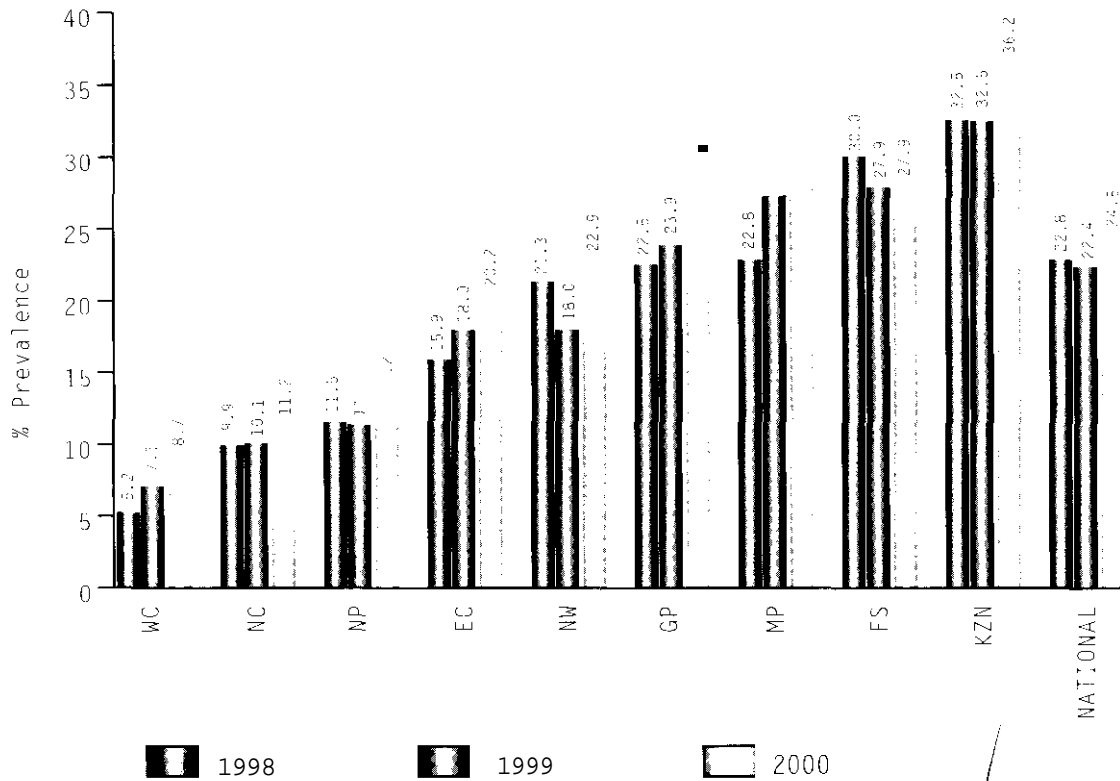
Figure 2. NATIONAL AND WESTERN CAPE HIV TRENDS 1990-2000



4.1.2 PROVINCIAL PREVALENCE

The prevalence of HIV infection in the Western Cape increased from 7.1% in 1999 to 8.7% in the year 2000. This prevalence of 8.7% means that one in every eleven pregnant women examined in the public sector clinics were found to be HIV positive. The percentage increase in prevalence, which crudely indicates the magnitude of change in the burden of disease between two years, showed that between 1999 and 2000 there was a 22.5% increase, compared with a 36.5% increase between 1998 and 1999.

Figure 3: HIV TRENDS BY SOUTH AFRICAN PROVINCES: 1998-2000

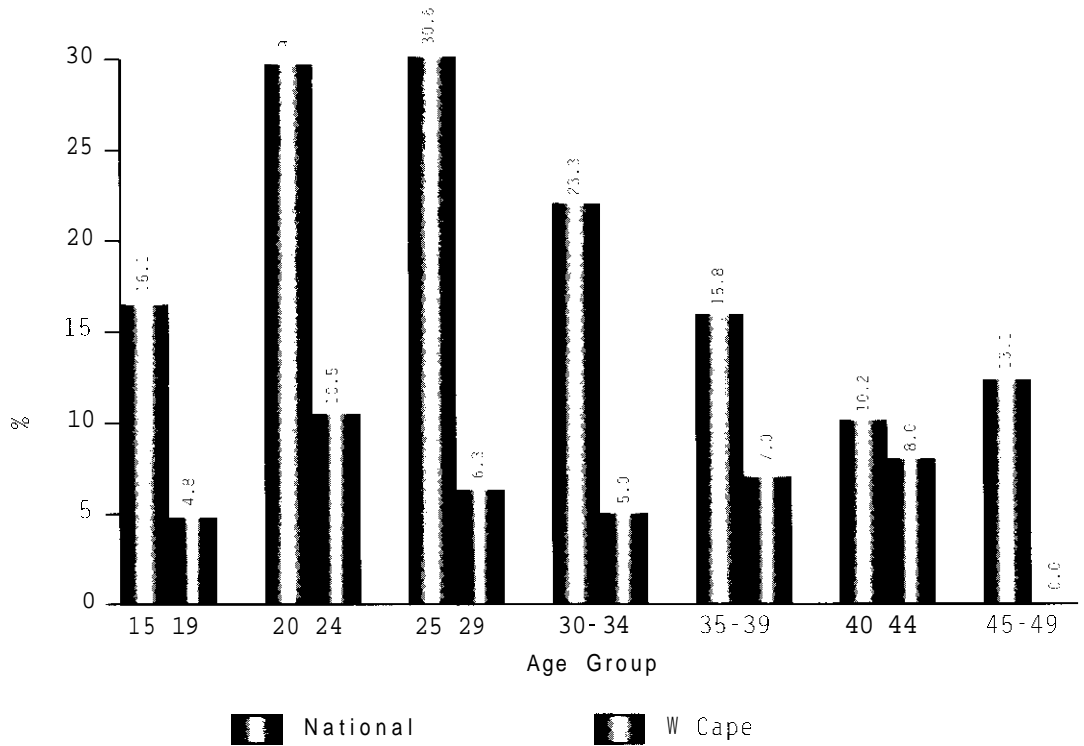


Although the prevalence of 8.7% for the year 2000 in the Western Cape is the lowest in the country, the Western Cape is currently experiencing the fastest growth compared to the other provinces (Figure 3). Provincial and national trends show that the epidemic in this province is lagging 4-5 years behind the rest of the country (Figure 2).

4.1.3 HIV POINT PREVALENCE BY AGE GROUP

It is evident from the provincial survey that the HIV point prevalence is highest among women in the 20-24 age group (Figure 4). This distribution has serious health-service implications for maternal and child health care. While lower rates were observed in the 15-19 year group in the Western Cape, these data should be viewed with caution as the highest number of non-respondents were from this age cohort, and the proportion sampled in this category was small. Similarly, lower rates in the older age cohort should be treated with caution as infertility rates are expected to be higher in this group, while the small sample size may also distort the data.

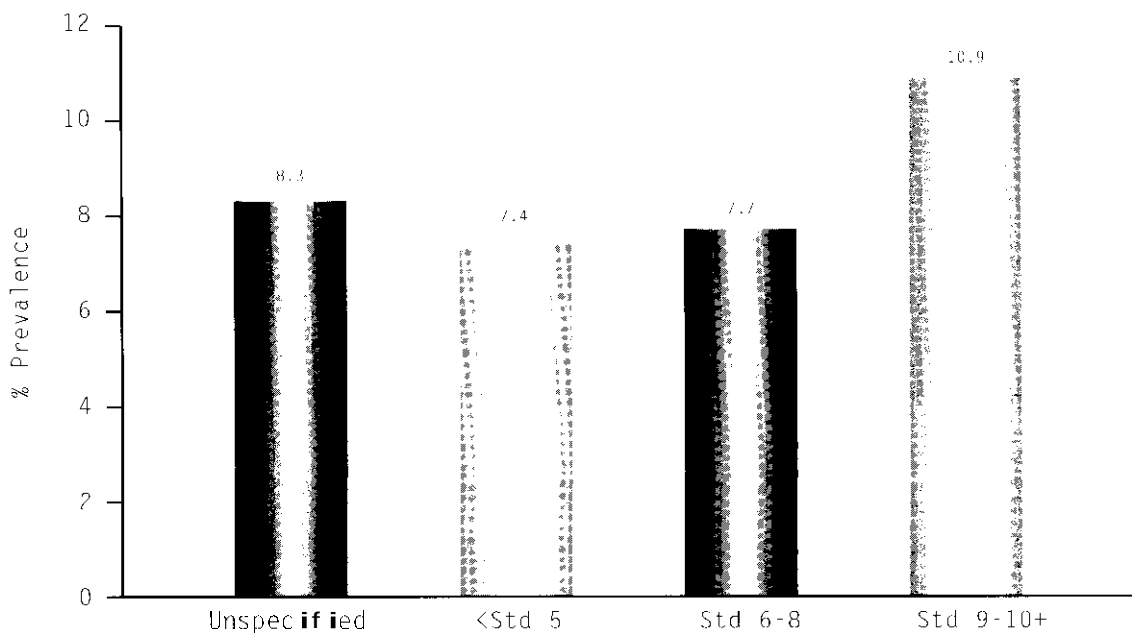
Figure 3 HIV PREVALENCE BY AGE GROUP: WESTERN CAPE AND NATIONAL 2000



4.1.4 EDUCATION

The levels of education attained in the total sample ranged from no formal education to Grade 12 (Figure 5). The provincial survey revealed that those women who attained higher levels of education – namely, senior secondary school level and above – had a higher HIV prevalence compared to women with primary school level or no formal education. The relatively high prevalence of HIV in the unspecified group should be noted as these formed 8.3% of the total sample.

Figure 5: HIV PREVALENCE BY EDUCATION: WESTERN CAPE



4.1.5 SYPHILIS PREVALENCE

The prevalence of syphilis in all women in the Western Cape who were tested for HIV infection was 5.1% in the year 2000 (Figure 6). Unlike the national syphilis trends, which show a decrease in prevalence over the last three years, the Western Cape showed a consistent 16% increase in syphilis infection prevalence between 1998 and 1999, and between 1999 and the year 2000. The prevalence of HIV infection in the syphilis-negative women was 8.5%, while the prevalence of HIV infection in the RPR positive group was 13.7%. The national and provincial rates of syphilis were highest in the 20-29 age group. This pattern of distribution by age is similar for HIV infection.

Figure 6: SYPHILIS PREVALENCE TRENDS FOR WESTERN CAPE AND NATIONAL 1998-2000

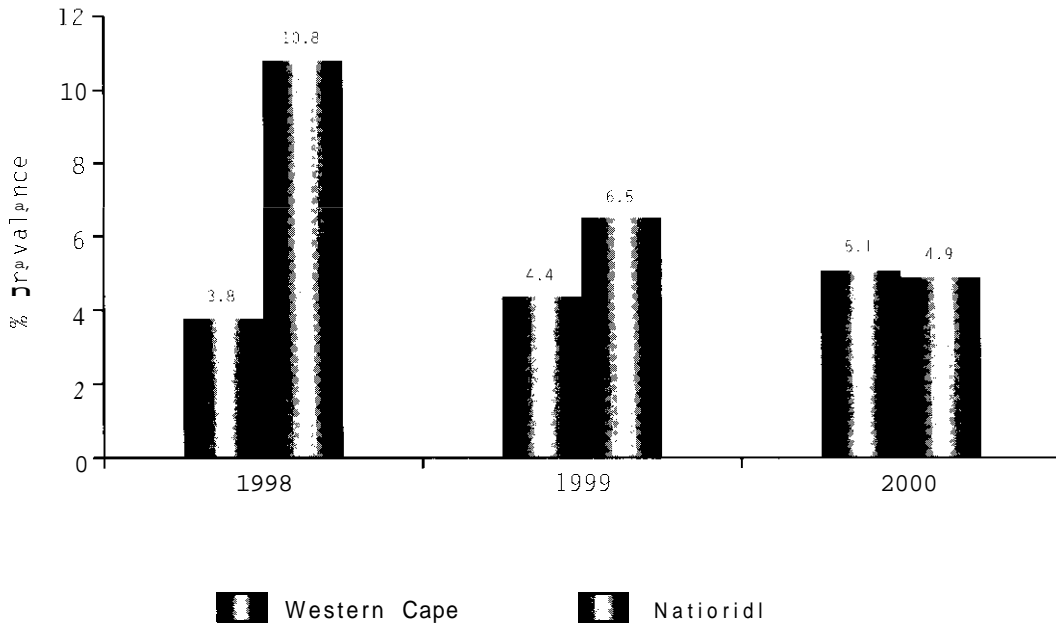


Figure 7: SYPHILIS PREVALENCE BY AGE GROUP: WESTERN CAPE AND NATIONAL 2000

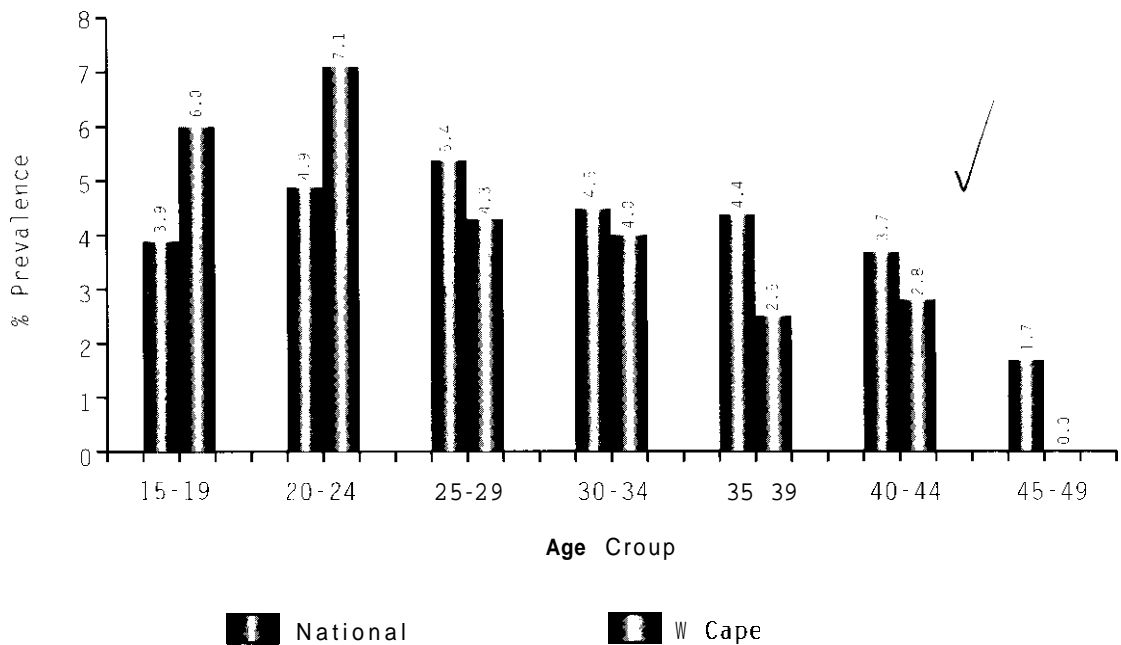
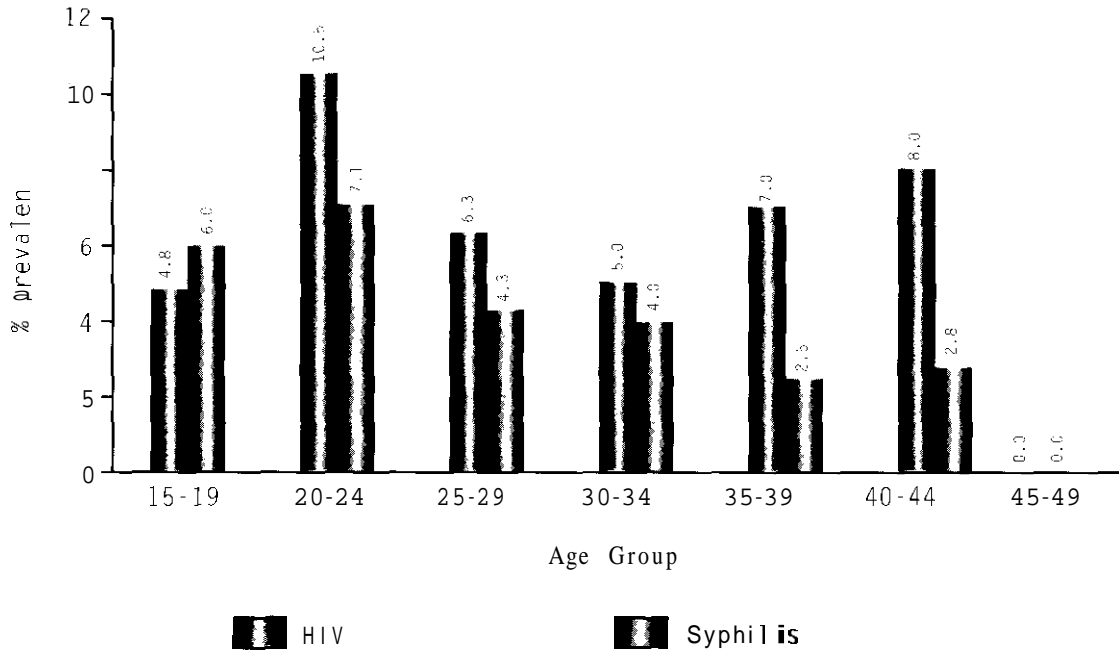


Figure 8 shows HIV prevalence and syphilis prevalence by age group. The highest rates of HIV infection and syphilis infection were observed in the 20-24 age group. Higher rates of syphilis were observed in the 15-19 year age group when compared to the HIV prevalence, while higher HIV rates were observed in other age groups, particularly in the 35 and older age group.

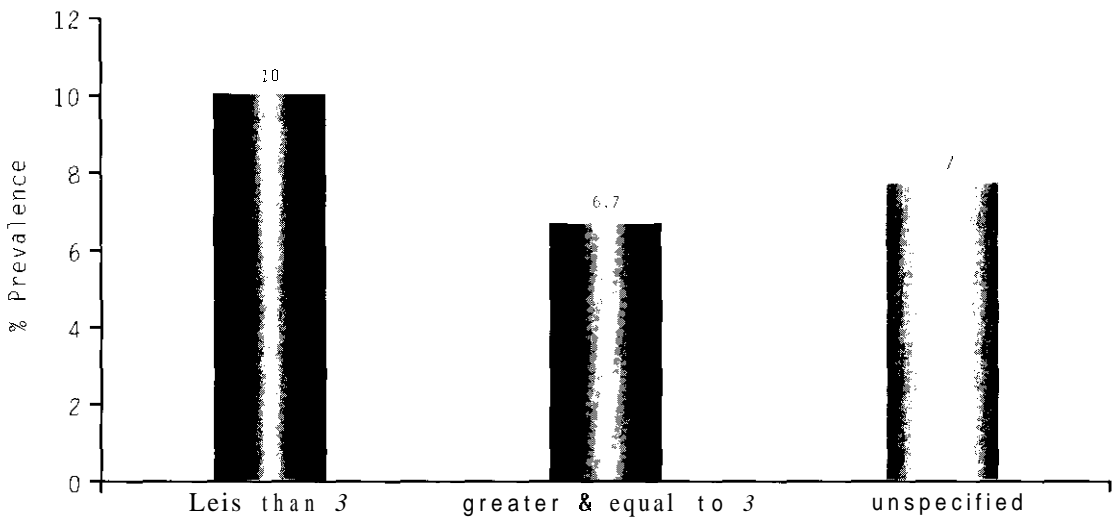
Figure 8: SYPHILIS AND HIV PREVALENCE BY AGE GROUP: WESTERN CAPE 2000



4.1.6 GRAVIDITY

Women who reported fewer than three pregnancies had a higher prevalence of HIV infection when compared to women with three and more pregnancies (Figure 9). Since younger women generally are expected to report lower gravidity, an appearance of high prevalence among those with lower gravidity is in line with previous findings of high HIV prevalence in the 20-29 age group.

Figure 9: HIV PREVALENCE BY GRAVIDITY: WESTERN CAPE 2000



4.2 DISTRICT SURVEY

4.2.1 RESPONSE RATE

Women in the age group 15-29 formed 76% of non-participants for the district. The coverage for the district survey ranged from 84% to 114%.

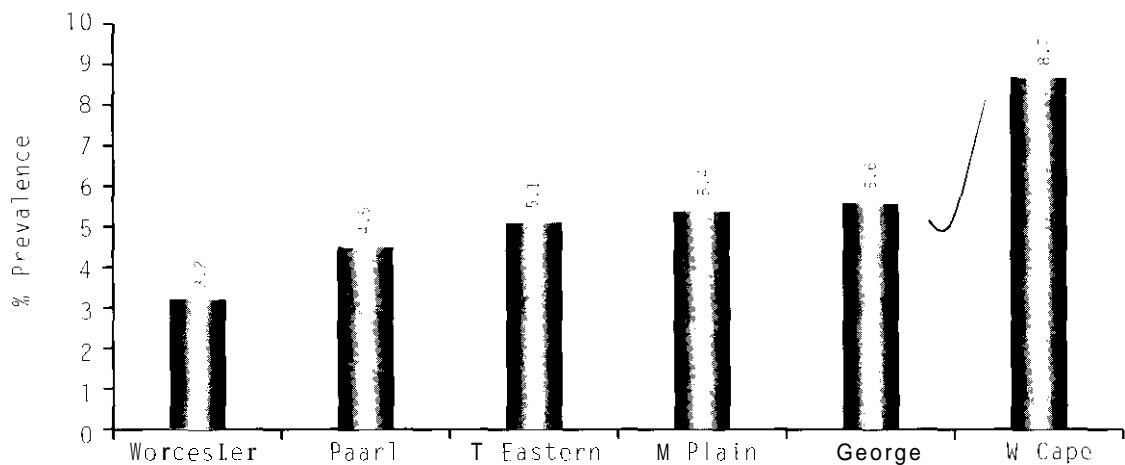
Table 1. SAMPLE SIZE AND RETURNS BY HEALTH DISTRICT AND REGION

Region	District	Sample size	Samples Returned
Cape Metropole	Mitchells Plain	400	392
Cape Metropole	Tygerberg Eastern	400	401
West Coast/Winelands	Paarl	265	265
Boland/Overberg	Worcester/Robertson	340	389
South Cape/Karoo	George	256	216

4.2.2 HIV PREVALENCE BY HEALTH DISTRICT

The prevalence of HIV infection ranged from 3.2% in the Worcester/Robertson Health District compared to 5.6% in George (Figure 10). The variation in HIV prevalence between the districts suggests that certain districts are in a more advanced stage of the Western Cape HIV epidemic than others.

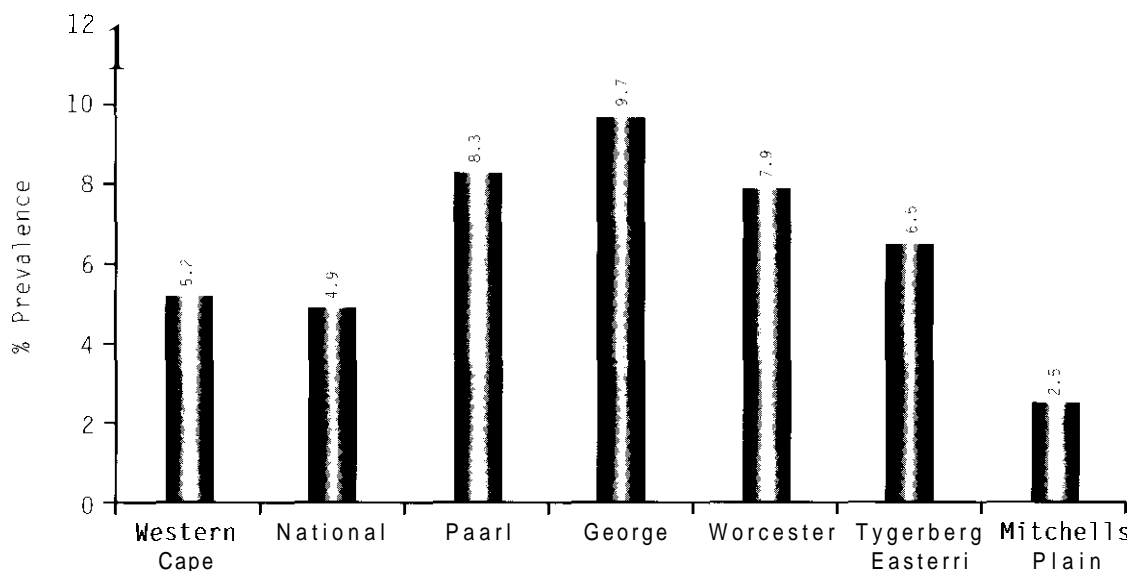
Figure 10: HIV PREVALENCE BY DISTRICTS: WESTERN CAPE 2000



4.2.3 SYPHILIS BY DISTRICT

The prevalence of syphilis ranged between 2.5% to 9.7% in the district survey (Figure 11). It is evident that the rural regions such as Paarl, George and Worcester reported higher syphilis prevalence compared to the urban districts, namely Tygerberg Eastern and Mitchell's Plain.

Figure 11: SYPHILIS PREVALENCE BY DISTRICTS: WESTERN CAPE 2000



4.3 QUALITY OF ASSURANCE SURVEY

Results of the 20 specimens retested for quality-control measures for HIV and RPR testing by the NIV yielded 100% agreement between the Western Cape SAIMR laboratory and NIV.

RESPONSES TO STRUCTURED INTERVIEWS ADMINISTERED ON CLINICAL STAFF DURING SURVEY.

Structured interviews were conducted with clinical staff participating in the survey in order to assess adherence to the standard operating procedures developed for the implementation of the survey. The results of the interviews were as follows:

Table 2: RESPONSE BY CLINICAL STAFF REGARDING SURVEY IMPLEMENTATION

Variable	Yes	(%)	No	(%)
Did you provide training in the form of workshop or on site?	27	100%	0	0%
Did you provide with a copy of the protocol?	24	96%	1	4%
Did you receive the equipment on time?	27	100%	0	0%
Were transport arrangements for specimens adequate?	23	96%	1	4%
Did you find the posters useful?	15	75%	5	25%
Did you find the flow chart diagrams useful?	10	45%	12	55%
Did your facility experience problems with consent?	1	4%	25	96%

Co-ordinators were also asked how they would like to receive feedback after the survey was completed. Responses are noted in Table 3.

Table 3: TYPE OF FEEDBACK REQUESTED BY SENTINEL SITE STAFF (N 23)

Type of feedback	Percentage
meeting	48
written	43
both	9

5 DISCUSSION

The results of the national survey show that the prevalence of HIV infection in the Western Cape increased from 7.1% in 1999 to 8.7% in the year 2000. This prevalence of 8.7% for the year 2000 means that one in every eleven pregnant women examined in the public sector clinics were found to be HIV positive. Although the Western Cape has the lowest HIV prevalence in the country, the percentage increase between the year 1999 and 2000 was the highest. The provincial trends over the last decade, in comparison to the national trends, show that this province is lagging 4-5 years behind the rest of the country. The Western Cape should not be complacent, therefore, as there is still an opportunity to intervene and prevent the escalation of the HIV problem witnessed in the other provinces.

The provincial survey result of 8.7% is intended only to estimate the overall provincial prevalence of HIV infection. Any analysis of the provincial data set by a facility or by a suburb can lead to seriously incorrect deductions. In addition to the national survey, therefore the Western Cape has, for the first time, conducted five district surveys over and above the provincial survey. The methods followed were the same as those of the national survey. The reason for conducting the district surveys was that since the districts are so diverse - it is expected that the HIV prevalence will differ from region to region and from district to district.

The five-district survey revealed that the prevalence of HIV infection ranged between 3.2% to 5.6%. Although the districts examined in the survey showed lower rates than the provincial rate of 8.7%, there are some districts such as Khayelitsha and Guguletu, which have shown much higher HIV-prevalence rates from the data gathered for the Mother-to-Child-Transmission program (Ahdullah et al, 2001). The provincial rate of 8.7% masks the variation between districts within the province and the presence of high HIV-prevalent districts. It also implies that certain districts within the province may be in a more advanced stage of the epidemic, compared to districts that have lower rates. It would therefore be important to expand the district survey in this province in order to differentiate the high from the low prevalence areas. This information is crucial for allocating resources and planning interventions.

Since the highest proportion of non-participants were from the younger age group, it suggests the need for further investigation with respect to their reasons for not participating. Their reasons for non-participation is of concern, as it may be linked to the quality of health services, or young women's own fears with regard to their HIV status. This poses a challenge for the implementation of the voluntary testing and counselling strategy, the life-skills programmes, and the efforts to improve accessibility of health care services for younger women.

The steady rise of STI infections in the Western Cape is of some concern, especially since the national trends showed a decline over the last three years. The prevalence of HIV and syphilis infection by age group showed the highest prevalence in the 20-24 age group. The higher rates of syphilis in the 15-19 year age group when compared to HIV prevalence re-emphasises the need to screen STI infections early in this group as a preventive HIV strategy. Higher rates of HIV infections in older women compared to current STI infections may be attributed to the fact that older women tend to be better at diagnosing and seeking care for STIs. It is also important to note that the relatively low rates of HIV in the 15-19 age group may be due to higher non-response rate in this age category as well as with the smaller sample size in the younger age group. The rural regions reported higher STI prevalence compared to the Metropole region, highlighting the need to allocate resources and improve STI preventive strategies in these regions.

The higher prevalence of HIV among women who have syphilis, compared with women who were without syphilis in the provincial survey, is important for service delivery. Individuals who present with STI should be counselled for voluntary testing, screening and appropriate interventions. It is important to note that syphilis is a preventable and treatable infection and therefore the diagnosis, treatment and prevention of STI should be integrated with the broader HIV strategy.

The variation in HIV prevalence by education levels suggests that women with slightly higher levels of education have higher rates of infection. Hence prevention programmes (such as lifeskills programmes) which target adolescents and young adults are critical.

5.1 QUALITY ASSURANCE AND CLINICAL **STAFF** RESPONSE

The quality assurance evaluation measures undertaken showed that the laboratory testing conformed to the NIV laboratory standards completely.

Examination of the operational aspects of the survey showed that the majority of the participating facilities were informed and trained for the survey through workshops or on-site training. All the facilities that were interviewed reported that they received the equipment on time and the majority found the protocols useful. Many of the facilities were already familiar with the survey protocol as they had participated in the previous Antenatal Survey. Except for one site, all the facilities reported no problems with regard to the transportation of specimens. Difficulties that were encountered with courier services were addressed promptly by the regional co-ordinators.

Audio-visual material developed for the survey met with mixed reactions. The posters, which informed the clients about the survey, were more favourably rated than the flow charts that were meant to guide the clinical staff on the processes to be followed. All except one clinical site participating in the interviews reported that they did not encounter any problems with consent procedure. The concerns raised by one particular objector were based on a moral objection to the unlinked survey.

5.2 STRENGTHS AND LIMITATIONS

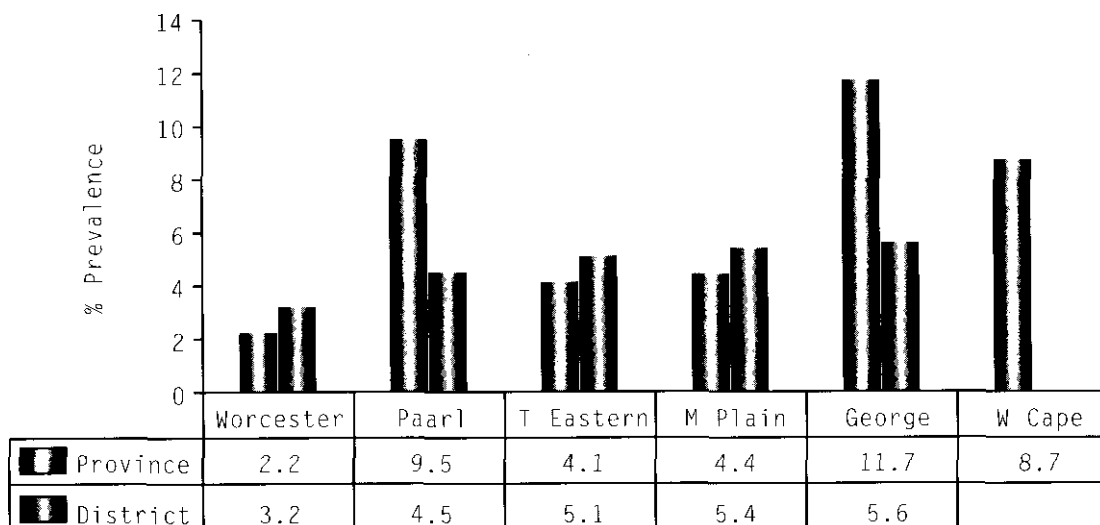
The Annual Antenatal Survey is currently the only existing national surveillance activity to determine trends in the HIV epidemic among the sexually active population in South Africa. The information from this survey serves as an important management tool for health care providers, policy makers, and non-governmental organisations.

When interpreting the results of the survey, there are several considerations to be taken into account. The information is only representative of women who attend public-sector clinics, and not of all pregnant women in the province (Department of Health 1999). Caution is advised that these varying rates are not to be explained by race group as neither the provincial or district surveys were designed to make comparison by race.

Furthermore, it is well known that the public service clinics are poorly attended by White and Indian women and therefore a very small number of all such women are tested in the survey, which may lead in turn leading to a misrepresentation of women classified under these groups (Department of Health 1998).

Users of the provincial-level survey data are cautioned about performing sub-provincial analyses as the results show that using the provincial data to make district-level analysis leads to under-estimation or over-estimation of the HIV prevalence. This is demonstrated in Figure 12 where data for the five districts examined for the district-level survey were compared to the district data derived from the provincial survey. The findings highlight discrepancies in the form of under-estimation as well as over-estimation of HIV prevalence. This can lead to serious incorrect deductions about the extent of the problem if one were to use the provincial survey for district-level analysis.

Figure 12: PROVINCIAL VERSUS DISTRICT SURVEY WESTERN CAPE
DISTRICT PREVALENCE 2000



The district-level surveys are intended to provide information at a more local level and further to provide critical information for planning, monitoring and evaluating interventions at a local level (e.g. Mother-to-Child-Transmission interventions). Managers therefore need to consider investing in a complete roll-out of the district survey in order to allocate resources, design, and monitor and evaluate interventions.

6 THE PROVINCIAL STRATEGY

As a result of the rapidly increasing HIV rates, two very important structures have been established in the province in order to give the necessary attention to the epidemic at the highest possible level. These structures will provide strategic guidance to the implementation of the provincial HIV/AIDS programme.

One such structure is the Provincial Aids Council (PAC). Representation on the PAC is in the process of being finalised. This structure consists of representatives of the Departments of Health, Education and Welfare; the ruling party and the official opposition party; clinicians, as well as representatives from the faith-based organisations, the non-governmental organisations, the business sector and organisations for people living with HIV/AIDS. Through this structure, strategic guidance will be provided to the provincial HIV/AIDS programme and the controversy that has for ages crippled HIV/AIDS interventions will be institutionalised and properly managed.

The second important structure is the Provincial Interdepartmental Aids Committee (PIDAC). This is a structure that brings together government departments in a partnership against HIV/AIDS. The main purpose of the PIDAC is to provide strategic guidance to the different departments in establishing the implications of the HIV epidemic for each department. This might help in determining precisely how the activities of these departments may reduce the spread of the infection, as well as the possible role each department can play in managing the epidemic.

Another important development was the elevation of the HIV/AIDS unit at provincial level to a directorate level. This was necessary to give the epidemic the attention it deserves. The HIV/AIDS Directorate will continue to oversee the following important interventions, which have been identified as priorities:

- Life-skills programme in schools
- A programme to reduce the risk of Mother-To-Child-Transmission (MTCT) of HIV
- Home-based care
- Appropriate treatment of sexually transmitted infections (STIs)
- Voluntary testing and counselling (VCT)
- Prevention and treatment of opportunistic infections among people living with HIV/AIDS
- Condom distribution through health and other appropriate sites.



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