

***Congratulations Professor Brian Van Wyk!
On your appointment as Associate Professor at
the School of Public Health***



SOPH conducts Research for the Western Cape Department of Health (WCDOH)



Prof Helen Schneider



Ms Nikki Schaay

Policy Review and Development of Home and Community Based Care (HCBC)

Background

The context of this research is the initiation of activities in the National Health Insurance (NHI) Pilot District (Eden) as well as the ongoing review of community-based services (CBS) being undertaken by the Western Cape Department of Health (WCDOH), as part of its new strategy, Healthcare 2020.

A key element of NHI is the primary health care (PHC) re-engineering strategy, which, amongst others, proposes a re-organisation of community-based services into ward based PHC outreach teams with a pro-active and comprehensive focus on households and better links to local health and social services. The vision of Healthcare 2020 is a patient-centred, equitable and affordable health system driven by an outcome-oriented approach, achieved through strengthened primary health care and district health systems. To give effect to these principles, the WCDOH commissioned a review of the residential component of de-hospitalised services – now referred to as ‘intermediate care’ – in 2011/12. It is now seeking to conduct a similar review of the other components of the service platform, namely home and community based care (HCBC) and mental health. These processes form the basis of the bid and our proposed approach to technical assistance.

Home and community based services

Home and community based services currently follow two broad models in the province

- 1) a comprehensive model in the ‘rural’ (non-metro) districts in which a single team/NPO provides all the elements of the service (home based care, adherence support and prevention and promotion);
- 2) a dual model in the metro, where a large burden of chronic care needs (communicable and non-communicable) has led to the development of community based follow up systems for HIV/TB and to some extent non-communicable diseases, provided separately from other home based care services.

In addition to the above are the facility based lay counseling services, providing HIV Counselling and Testing (HCT), treatment literacy, and adherence support to patients attending TB and HIV services within PHC facilities, and existing in varying degrees of linkage to community based adherence services.

HCBC services are provided by a variety of community care workers (CCWs) employed by contracted non-profit organisations (NPOs). While there have been efforts to provide standardized, NQF-accredited training for CCWs through the Expanded Public Works Programme (EPWP) there is still considerable variation in the local organisation, package of services, scopes of work and modes of delivery provided by CCWs and NPOs across the province. There is a recognized need for more comprehensive and integrated roles and greater standardization, whilst remaining sensitive to local disease burdens and health

needs. In addition, monitoring and evaluation systems are weak and not integrated into the existing formal health information system.

Terms of reference

The terms of reference provided by the WCDOH are summarised into three main elements below (Box 1) and will form the basis of the proposed activities over the next 6 months. They include a provincial policy review of home and community based, adherence and counselling services (with both a rural and urban perspective); a review of intellectual disability services; and provision of district support for the reorganisation of CBS.

Box 1

- 1 Critique and provide evidence-based analyses of current situation (both rural and metro) with reference to the provision of HCBC, and integrated adherence and counseling services, defining:
 - a. Policy principles, elements and parameters for a framework in respect of the provision of services;
 - b. Service model/s, including Packages of care, integrated pathway to give effect to the patient-centred experience (PCE)
 - c. Define human resource requirements: outreach teams mix, including composition, requisite skills, competencies & KPAs
 - d. Essential cadre to provide HCBC: including conditions of employment & deployment
 - e. M & E systems.
- 2 Critique and provide evidence-based analyses of current situation with reference to the Mental Health Services with a focus on intellectual disability services, defining:
 - a. Policy principles, elements and parameters for a framework in respect of the mental health services;
 - b. Service model/s, including Packages of care, integrated pathway to give effect to the patient-centred experience (PCE)
 - c. Define human resource requirements: Mental Health teams mix, including composition, requisite skills, competencies & KPAs)
- 3 District level support for implementation of HCBC & Adherence support:
 - a. Develop a Districts Support Framework to address reorganization of services (defining target populations, creating NPO-facility clusters, integrating activities, referral systems, community mapping, training plans, support/supervision/quality assurance strategies)
 - b. Conduct rapid assessments of existing best practices, modes of delivery challenges, provision and skills gaps
 - c. Establish a longitudinal process monitoring system for HCBC services.

Proposed Plan of Activities

Over the next six months we propose to undertake the following specific activities:

- Policy review of intellectual disability services (IDS), based on key informant interviews, site visits and document reviews, taking both a rural and an urban perspective (to be undertaken by the Department of Psychiatry, UCT);
- Policy review of HCBC and integrated adherence/counseling services, based on key informant interviews, document reviews and secondary data analysis, at both provincial and district levels, taking both a rural and an urban perspective, and seeking to identify best practice and current thinking on possible reorganisation of services (to be undertaken by UWC and US);
- Working in close collaboration with provincial, district and sub-district stakeholders, conduct an in-depth assessment of HCBC services, including population needs, current provision (package, NPOs, CCW), referral, M&E and other support systems in two sub-districts (representing small town and rural/farming) of Eden district (to be undertaken by UWC and US);
- Development of a framework and recommendations for the reorganization of HCBC services, including M&E systems (to be undertaken by UWC and US).

Health in South Africa: Changes and Challenges since 2009

Bongani M Mayosi, Joy E Lawn, Ashley van Niekerk, Debbie Bradshaw, Salim S Abdool Karim, Hoosen M Coovadia, for The Lancet South Africa team
Published Online November 30, 2012

Since the 2009 Lancet Health in South Africa Series, important changes have occurred in the country, resulting in an increase in life expectancy to 60 years.

Historical injustices together with the disastrous health policies of the previous administration are being transformed.

The change in leadership of the Ministry of Health has been key, but new momentum is inhibited by stasis within the health management bureaucracy. Specific policy and programme changes are evident for all four of the so-called colliding epidemics: HIV and tuberculosis; chronic illness and mental health; injury and violence; and maternal, neonatal, and child health.

South Africa now has the world's largest programme of antiretroviral therapy, and some advances have been made in implementation of new tuberculosis diagnostics and treatment scale-up and integration. HIV prevention has received increased attention. Child mortality has benefited from progress in addressing HIV. However, more attention to postnatal feeding support is needed. Many risk factors for non-communicable diseases have increased substantially during the past two decades, but an ambitious government policy to address lifestyle risks such as consumption of salt and alcohol provide real potential for change. Although mortality due to injuries seems to be decreasing, high levels of interpersonal violence and accidents persist. An integrated strategic framework for prevention of injury and violence is in progress but its successful implementation will need high-level commitment, support for evidence-led prevention interventions, investment in surveillance systems and research, and improved human-resources and management capacities.

A radical system of national health insurance and re-engineering of primary health care will be phased in for 14 years to enable universal, equitable, and affordable health-care coverage. Finally, national consensus has been reached about seven priorities for health research with a commitment to increase the health research budget to 2.0% of national health spending.

However, large racial differentials exist in social determinants of health, especially housing and sanitation for the poor and inequity between the sexes, although progress has been made in access to basic education, electricity, piped water, and social protection.

Integration of the private and public sectors and of services for HIV, tuberculosis, and non-communicable diseases needs to improve, as do surveillance and information systems. Additionally, successful interventions need to be delivered widely. Transformation of the health system into a national institution that is based on equity and merit and is built on an effective human-resources system could still place South Africa on track to achieve Millennium Development Goals 4, 5, and 6 and would enhance the lives of its citizens.

SA reverses decade-long trend of rising death rates

Tamar Kahn, 29 November 2012

South Africa has reversed its decade-long trend of rising death rates, and may for the first time have the health-related Millennium Development Goals within its reach, local scientists reported in medical journal The Lancet

These findings stand in stark contrast to a series of articles in *The Lancet* in 2009, which described a nation overwhelmed by the four colliding epidemics of HIV and tuberculosis; violence; poor maternal and child health; and chronic lifestyle-associated diseases. The authors laid the blame at the feet of governments both before and after the end of apartheid, placing emphasis on the disastrous AIDS policies of former president Thabo Mbeki and his health minister, Manto Tshabalala-Msimang, who for years denied treatment to HIV patients.

In 2009 they reported that South Africa's maternal, infant and child mortality rates were soaring, while life expectancy was falling.

But research published by the Medical Research Council (MRC) in October showed that life expectancy rose 6% between 2009 and last year, from 56.5 to 60 years, reversing the downward trend that began in the 1990s as the HIV epidemic took hold. Between 2009 and last year the infant mortality rate fell 25%, from 40 deaths per 1,000 live births to 30 per 1,000, and the mortality rate for those under five dropped at the same rate, from 56 per 1,000 to 42 per 1,000 over the same period.

"When I first saw these data I said, 'Are you sure this is accurate?', (because such an) improvement in longevity is just amazing," said MRC president Salim Abdool Karim, one of the co-authors of Thursday's *Lancet* article and a co-author of the 2009 series. "You don't get increases in life expectancy (like this) unless you have a major societal upheaval like the combustion engine or the abolition of slavery. In our case we had just one thing, and that is the roll-out of antiretrovirals. In 2009 we were going downhill and what we are seeing now is that we are back on track," he said.

The paper's lead author, Bongani Mayosi, from the University of Cape Town, said the government needed to do more to raise the living standards of poor people, collect better data on health programmes, and tackle the public health systems' administrative and managerial deficiencies, but the recent gains in life expectancy were cause for hope.

"Development of an effective human resource system with data for action could still place South Africa on track for Millennium Development Goals to reduce child mortality, improve maternal health, and combat HIV/AIDS, malaria and other diseases," he said.

"It is vital that we do not lose momentum now, having progressed so far since the disastrous health policies of the last government began to be put right by the current administration."

<http://www.bdlive.co.za/national/health/2012/11/29/sa-reverses-decade-long-trend-of-rising-death-rates>

SOPH Intake for 2013

	<i>Intended number</i>	<i>Total Applied</i>	<i>Preselect Reject</i>	<i>Total Accepted</i>	<i>SA</i>	<i>OTHER</i>
Master of Public Health (MPH)	40	143	13	42	12	Nigeria 9 Uganda 3 Zimbabwe 6 Cameroun 1 Kenya 2 Swaziland 1 Namibia 3 Botswana 2 Zambia 3
Master of Public Health (MPH) - Full Thesis	Few	7	0	1 (+1 selected for MPH)	1	
Post Graduate Diploma in Public Health	40	59	10	20	9	Zimbabwe 5 Namibia 2 Nigeria 1 Tanzania 1 Swaziland 1 Uganda 1
RPL(MPH)		1	0	0	0	0

Measuring Health Disparities

Michigan Public Health Training Center Social Epidemiology and Population Health

Instructors John W. Lynch, Sam Harper

Cost No Charge Downloadable computer file - before you can download the course, you will need to register.

Once registered, you will be able to immediately install it on your hard drive.

The course is password-protected.

- File size is 68.2 MB and will take about five minutes to download with a high-speed bandwidth.
- To obtain course password, click [here](http://bit.ly/PSrJQk). <http://bit.ly/PSrJQk> (There is a link to obtain the password, once you begin the computer-based course.)
- Installation instructions. This computer-based course is PC-based and not Macintosh-compatible.

Course Description

This interactive course focuses on some basic issues for public health practice -- how to understand, define and measure health disparity.

This course examines the language of health disparity to come to some common understanding of what that term means, explains key measures of health disparity and shows how to calculate them.

This course has been made possible through funding from the Health Resources and Services Administration, Centers for Disease Control and Prevention, Michigan Public Health Training Center, Center for Social Epidemiology and Population Health, and Prevention Research Center of Michigan
Website: <http://bit.ly/XCzugt>

This computer-based course provides a durable tool that is useful to daily activities in the practice of public health.

The material is divided into four content sections.

Parts I and II review what health disparities are, how they are defined, and provide an overview of common issues faced in measuring health disparities. **Parts III and IV** introduce users to a range of health disparity measures, providing advantages and disadvantages of each, and discuss how best to use different measures to communicate and evaluate health disparity in our communities.

Learning Objectives

By the end of the first content section (which includes Part I What are Health Disparities? and Part II Issues in Measuring Health Disparities), you will be able to:

- Identify the dimensions of health disparity
- List three definitions of health disparity
- Interpret health disparity in graphical representations of data
- Explain relative and absolute disparity
- Describe how reference groups can affect disparity measurement

By the end of the second content section (which includes Part III Measures of Health Disparities and Part IV Analytic Steps in Measuring Health Disparity), you will be able to:

- Describe at least three complex measures of health disparities
- List strengths and weaknesses of at least three health disparity measures
- Summarize the analytic steps in measuring health disparity

Course Methodology

This course, while self-paced, can be expected to take between two to three hours to complete. The various health disparity measures are explained with interactive slides and audio commentary. Real-world examples illustrate concepts and carefully thought-out exercises help build knowledge.

To ensure delivery to your inbox, please add EQUIDAD@LISTSERV.PAHO.ORG to your address book.

Minister of Health calls for speedy establishment of Sexual Offences Courts

Women, Children and People with Disabilities Minister Lulu Xingwana has called for the harsher sentencing of perpetrators of violence against women and children and for the sexual offences courts to be re-established speedily.

"By giving women and child abusers harsher sentences, our courts are continuing to play a role in sending a message to these abusers that their actions will not be tolerated. Those who commit atrocities and murders against women and children must rot in jail. They do not deserve bail or parole. They must not be allowed to share the same spaces with our women and children, nor must they be allowed to roam our streets. We also urge the Minister of Justice to speed up the re-establishment of the sexual offences courts," said the minister.

Xingwana said the Domestic Violence Act must be heightened to ensure that the perpetrators of abuse towards women and children are dealt with effectively. She was speaking at the launch of the 16 Days of Activism for No Violence Against Women and Children campaign in Kimberley in the Northern Cape on Sunday. The minister said on this important day, South Africans must pause and ponder the real impact of gender-based violence. These include direct costs relating to health care services, judicial services, social services and other related

services.

She said gender-based violence robbed women and children of the opportunity to become productive citizens of the country. "It denies them their constitutional rights and condemns them to a life of perpetual fear. They are therefore prevented from enjoying the fruits of our freedom and democracy."

Despite South Africa's constitutional and legislative protection, violence based on gender and sexual orientation remained at unacceptable levels. The violence can take different forms such as sexual harassment, abuse, assault, rape, domestic violence and other cultural practices that are harmful to women and children, such as *ukuthwalwa* (arranged marriages) and *ukungenwa* (the practice where the female spouse has to marry the younger brother of her deceased husband).

The minister called for a partnership between government and civil society organisations to deal with the scourge of violence directed at women and children. "Government cannot do this alone and therefore depends on mutual partnerships with non-governmental and women's organisations, business, faith-based organisations, traditional leaders, political parties, various sectors of society and communities," she said.

The success of the 16 Days of Activism campaign was dependent on the partnership between government and various sectors of society including the media. "We believe that the unacceptably high levels of gender-based violence require the collective efforts of all South Africans," she said.

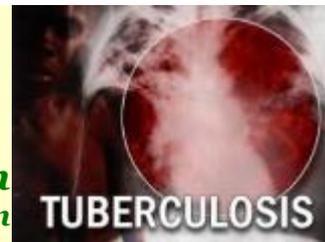
This year marks the 13th anniversary of the national campaign which began in 1999. The theme for this year is: "From Peace in the Home to Peace in the World: Let's Challenge Militarism and End Violence Against Women". Xingwana emphasised the need for concerted efforts to promote the campaign in rural areas, including in farming and mining communities. "Those most severely affected by violence are in these areas and may not be aware of the resources and services available to them to help them cope with their circumstances. "I urge all South Africans to join this fight. When we know that someone is being abused in our own home or in our neighbour's house, we have a duty to report it," she said.

Xingwana encourage South Africans not to be afraid to be witnesses in court especially in cases of abuse. "We also have a duty to stand in court as witnesses to make sure that these abusers are prosecuted successfully," she said. Domestic violence was not something that should be left to families to resolve. "An uncle who rapes a niece needs to face the full might of the law," she said.

Xingwana said the reality was that victims of violence were reluctant to come forward and seek legal advice and social support. "This could be due to lack of knowledge about their rights and the social stigma around domestic violence. We must also accept the sad reality that financial dependency on husbands, fathers, partners and family members increases their vulnerability to domestic violence, rape, incest, abuse, and murder. We remain convinced that empowering women will help us win the war against poverty, inequality, unemployment and abuse," she said.

25 Nov 2012SAnews.gov.za

<http://www.sanews.gov.za/news/12/12112515451001>



100 years of failure to control TB transmission

Anso Thom

Tuberculosis transmission rates in South Africa and more specifically Cape Town have not changed at all over the past 100 years, even though people are living longer and being cured because of treatment. Many are cured, only to be infected again.

Addressing the 1st Southern African HIV Clinicians Society conference today, University of Cape Town Professor Robin Wood presented fascinating data on TB in Cape Town and New York over the past 100 years. While both cities had similar TB epidemics in 1910, Wood was able to show how the US city managed to over time control the transmission rates and ultimately the mortality rates (27 people died in 2010), while in Cape Town the opposite happened and 3 000 people died in 2010.

“With the arrival of HIV, survival rates dropped like a stone,” Wood said in reference to South Africa. In New York long-term survival has continued. Wood showed that “something horrible” started happening in Cape Town in the 80s and 90s. Among HIV positive patients, one-third of TB cases were found to be retreatment TB cases, meaning they had been cured, but infected again.

The pattern of high transmission was also corroborated by the fact that there were high levels of TB disease among children. In Cape Town, the majority of the population is infected before adulthood, again showing that transmission rates have not changed. Incidence rates among children are considered a measure of whether a TB control programme is functioning effectively. Wood said that although the development of drugs in the forties has changed the mortality incidence, TB cases are now living only to get TB a second time.

“There is a failure to control transmission,” he said, adding that there was no evidence from the New York data that treatment alone had changed matters. Posing the question as to what was driving the TB epidemic, Wood shared a novel study they were conducting which involved strapping a small device to individuals, measuring where they were most exposed to re-breathed air and in turn to airborne diseases such as TB.

Some of the data showed that children were most at risk in their homes and crèches with evidence of “quite a bit of risk” when using public transport. Among the 18 to 24 year olds the risk was less in the household, but very high when using public transport and also in some work situations.

Wood said a large part of the problem was that the world was stuck on discussing the “ineffective” such as Directly Observed Treatment Strategies for TB versus the “unobtainable” which involved social development.

http://www.health-e.org.za/news/article.php?uid=20033913&utm_source=Infoblast+Mailer&utm_medium=email&utm_campaign=Health-e+News+29+November+2012&utm_term=

The 2011 National Antenatal Sentinel HIV & Syphilis Prevalence Survey in South Africa



health

Department:
Health
REPUBLIC OF SOUTH AFRICA

EXECUTIVE SUMMARY

The National HIV Prevalence

The estimated 2011 national HIV prevalence was 29.5% (95% CI 28.7-30.2%) showing a slight drop of 0.7% from the 2010 national HIV prevalence. The 2011 confidence interval includes the 2010 point estimate of 30.2% and the 2011 estimate is also in line with estimates from 2007-2009. This indicates a stable prevalence of HIV infections among pregnant women aged 15-49 years and attending their first antenatal care during their current pregnancy in public health clinics in South Africa over the past 5 years as indicated below:

29.4% (95% CI: 28.5-30.1) in 2007
29.3% (95% CI: 28.5-30.1) in 2008
29.4% (95% CI: 28.7-30.2) in 2009
30.2% (95% CI: 29.4-30.9) in 2010
29.5% (95% CI: 28.7-30.2) in 2011.

According to the UNAIDS SPECTRUM model the estimated national HIV prevalence among the general adult population aged 15-49 years old has remained stable at around 17.3% since 2005. In 2011, an estimated 5,600 000 [5 300 000-5 900 000] people living with HIV resided in South Africa. The estimated number of new infections was 1.43% in 2011 compared to 1.63% new infections in 2008.

HIV Prevalence by Province

KwaZulu-Natal has recorded a notable decrease in HIV prevalence which is promising, whereas Mpumalanga has recorded an increase in the past four years which is worrisome. The HIV prevalence estimates across provinces are variable in year to year changes. There is however a notable drop in the 2011 HIV prevalence recorded in KwaZulu-Natal with an estimate of 37.4% (95% CI: 35.8-39.0%). The upper limit of the 2011 confidence interval is lower than the 2009 and 2010 estimates of 39.5% indicating a decline by 2.1% in HIV prevalence in this province. Mpumalanga province has shown an increase in estimated HIV prevalence of 2.0% from 34.7% in 2009 to 36.7% (95% CI 34.3-39.2%) in 2011. There was an increase in HIV prevalence in Free State from 30.6% in 2010 to 32.5% in 2011, and the North-West from 29.6% in 2010 to 30.2% in 2011. Limpopo is showing a steady increase from 21.4% in 2009 to 22.1% in 2011.

HIV Prevalence Estimates projected in the general Population

The estimated provincial HIV prevalence in the general population (15-49 years) for 2010 and 2011 is shown below.

Province	2010	2011
Eastern Cape	16.0	16.02
Free State	19.47	19.58

Gauteng	16.0	16.09
KwaZulu-Natal	24.59	24.7
Limpopo	12.9	12.92
Mpumalanga	23.94	24.11
North West	18.83	18.89
Northern Cape	9.2	9.23
Western Cape	4.72	4.75
South Africa	17.3	17.3

HIV prevalence by District

The districts are clearly heterogeneous with respect to the epidemic, with prevalence rates ranging from a high of 46.1% in Gert Sibande in Mpumalanga, the highest district HIV prevalence ever recorded in this province, followed by Ugu and Mkhanyakude in KZN which recorded 41.7% and 41.1% respectively. The lowest HIV prevalence was 6.2% in Namaqua in the Northern Cape. When data are pooled over the five years this heterogeneity persists. The new Buffalo City district has recorded the highest HIV prevalence of 34.1% in the Eastern Cape.

The district that recorded the highest HIV prevalence of 46.1% in 2011 was Gert Sibande in Mpumalanga. The HIV prevalence in this district increased by 7.9% from 38.2% recorded in 2009. In 2011 only 3 districts recorded HIV prevalence above 40% viz:Ugu, UMkhanyakude and Gert Sibande in Mpumalanga compared to 5 districts in 2010. In 2011, twenty six (26) out of the 52 districts recorded HIV prevalence rates below the national average of 29.5% compared with 28 out of 52 districts that recorded below the national average of 30.2% in 2010. There were 24 out of 52 districts that recorded HIV prevalence rates above the national average in 2010; whereas there were 25 out of 52 districts that recorded HIV prevalence rates above the national average in 2011.

There was considerable variation in HIV prevalence rates between the 52 health districts observed over the four-year period 2008-2011, particularly where the sample size in a district was small, where districts were merged (i.e. Tshwane and Metsweding) and where there are new district demarcations like Buffalo City, making it difficult to interpret any trends in the current report.

HIV Prevalence Estimate by Age

There are distinctly different risk factors that lead to HIV infection among infants and adults, hence age is an important risk factor and is central to monitoring the epidemic among the highly sexually active group, while at the other end of the age spectrum vertical transmission from the infected mother is the most important and significant risk factor.

HIV prevalence estimate is the most important indicator used to provide empirical evidence when monitoring HIV incidence (new infections). The survey participants aged 15-24 years accounted for 49.4% of the survey participants. HIV prevalence in this age group has been suggested as a proxy measure for average incidence in the youth because of sexual onset and hence prevalent infections are assumed to be recent while this age group is less likely to be affected by AIDS mortality. The HIV prevalence among the 15 - 24 year old pregnant women was 21.8% (95% CI: 21.0 - 22.6) in 2010 compared with 20.5 % (95% CI:19.7 21.3) in 2011, a decline of 1.3%. The specific AIDS MDG target is that by 2015 the expected HIV prevalence reduction should be 25% less than the baseline prevalence of 23.1% in 2001. The findings of monitoring trends in this age group in South Africa show that we should not relent of our collective efforts to achieve this AIDS MDG target.

There was a slight increase in HIV prevalence among young women in the age group 15 - 19 years from 13.7% in 2009 and 14.0% in 2010, followed by a decline of 1.3% to 12.7% in 2011, however, these changes in prevalence were not statistically significant. There was an increase in HIV prevalence in pregnant women aged above 35 years. In 35-39 year old women the 2011 estimated prevalence was 39.5% (95%CI: 37.5-41.5%) compared to the point estimate of 35.4% in 2009.

Syphilis Prevalence

The national prevalence of syphilis shows a 0.1% increase where the prevalence was 1.5% (95% CI: 1.4-1.7) in 2010 to 1.6% (95% CI: 1.5-1.8) in 2011.

Mpumalanga syphilis prevalence increased from 2.1% in 2010 to 4.1% in 2011, which makes it the province with highest syphilis rate, whereas in the past four years the Northern Cape recorded the highest prevalence of syphilis. In Gauteng there was a slight drop of 2.9% in 2009 to 2.0% in 2011. From 2012 the monitoring of the trends in syphilis prevalence in this survey will be dropped. However, the routine monitoring of syphilis prevalence among pregnant women during the antenatal care will remain. In the 2012 survey we have started to pilot monitoring of Herpes Simplex HSV2 which usually causes genital herpes and is transmitted primarily by direct contact with sores, most often during sexual contact. The findings will be reported in the 2012 report.

Conclusion

The HIV prevalence of 29.5% in 2011 is in line with the prevalence observed in the past four previous years. To avoid a resurgence of the HIV and AIDS epidemic in South Africa, HIV prevention efforts need to be urgently strengthened and sustained. Furthermore, ecological correlations between the trends in HIV prevalence, and behavioral changes that will focus on reducing the incidence of infection exposure factors, especially in districts that record more than 30% HIV prevalence, is warranted. Further in-depth epidemiological investigations on what could be causing the variation between the districts and between provinces in the identified epicentres could assist in understanding the different patterns of the transmission potential of the virus.

The 2011 report has shown beyond reasonable doubt that there is no significant correlation between HIV and *Treponema pallidum* the aetiological agent for active syphilis as co-factor for HIV infection. In the 2012 antenatal sentinel HIV survey we will be piloting and testing for Herpes simplex and investigating whether infection is significantly correlated to increased risk of HIV infection.

We will establish systems to track measures such as AIDS-related mortality by age, by sex, by district, by province and monitor loss to follow up, monitor number of patients on different regimes, monitor Pharmacovigilance (drug side effects), monitor drug resistant patterns and treatment failures and HIV incidence rate.

Full Text available at <http://www.doh.gov.za/>