A gauge of HIV prevention in South Africa

2009
IN BRIEF
About loveLife

loveLife promotes healthy, HIV-free living among South African teenagers. Organised under the auspices of the loveLife Trust, loveLife combines a sustained high-powered multi-media campaign with nationwide community-level outreach and support programmes for youth. loveLife’s programmes are implemented by a national youth volunteer service corps known as groundBREAKERS in partnership with community-based non-government organisations, schools and government clinics across South Africa. Major funding for loveLife is provided by the South African Government and the Henry J. Kaiser Family Foundation. Additional support is provided by Barloworld, BMW, Cellsmart Technologies, ChangeWright Consulting, Dewey & Le Boeuf, IBM, Independent Newspapers, Jumpstart, Murray & Roberts, Rapport, the South African Broadcasting Corporation, South African Institute for Entrepreneurship, Southern Sun, Ster-Kinekor and the Vodacom Foundation.

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A gauge of HIV prevention in South Africa, 2009

IN BRIEF
The state of the HIV epidemic:
Ten key findings

1. The HIV epidemic has peaked, but the prevalence won’t drop for at least five years even if we halve the rate of new infections

| Table 1. Trends in age-specific HIV prevalence (2002 – 2008) |
|-----------------|-----------------|
| Age group       | Male            | Female          |
| 2 – 14          | Improvement     |                 |
| 15 – 19         |                 |                 |
| 20 – 24         |                 |                 |
| 25 – 29         | Worsening       |                 |
| 30 – 34         |                 |                 |
| 35 – 39         |                 |                 |
| 40 – 44         |                 |                 |
| 45 – 49         |                 |                 |
| 50 – 54         |                 |                 |
| 55 – 59         |                 |                 |
| 60+             |                 |                 |

The prevalence of HIV infection in the total population of South Africa has stabilised at about 11%. Based on the mid-year population projections by Statistics South Africa for 2009, this means that about 5.35 million people are living with HIV.

Even if the incidence of HIV in the South African population is halved by 2013, the prevalence of HIV is likely to remain at current levels for at least the next five years, for the following reasons:

- First, the epidemic in South Africa is still relatively young and it has not yet reached its peak in older age groups. As the highest-incidence cohorts get older, a higher proportion of older people will have HIV – even if the rate of new infections drops in older age groups.
- Second, as more people receive anti-retroviral treatment (ART) and live longer, a higher proportion of the population will have HIV. In effect, this
means that in order for the prevalence to drop, fewer people will need to be infected each year than the number of people who live a year longer on ART.

Assuming that we achieve 90% ART coverage and half the number of new infections that we now have every year, the prevalence of HIV will remain at about 11%, at least for the next five years. In fact, an earlier decline in prevalence may indicate that the ART programme is not working well enough.

For these reasons, the measurement of total prevalence will not be a useful measure of programme impact over the next five years. Even less helpful will be antenatal surveillance – as HIV prevalence among pregnant women will be even more inelastic to change. Consideration should be given to reducing the frequency of antenatal surveillance and increasing the statistical power of cross-sectional population-based surveys to better understand spikes in incidence by age- and risk-group.

2. There are far fewer new infections among teenagers and young adults than there were five years ago.

Figure 1. HIV prevalence among 15 – 24 year olds, by gender

The prevalence of HIV among 15 – 24 year olds has fallen from 10.3% in 2005 to 8.7% in 2008. Although that doesn’t seem like a big drop, it does imply that the rate of new infection has fallen sharply.

The prevalence of HIV among 15 – 19 year old men has been consistently low (about 2.5%) – because teenage boys tend to have sex with girls their own age. On the other hand, the prevalence of HIV among young women aged 15 – 19 years climbed to close to 10% before dropping back to 6.7%. The reason for the rise...
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and fall in prevalence in 15 – 19 yr old women over the past few years is that their sexual partners are typically 20 – 24 year old men - resulting in a time-lag between prevalence changes in men and women of the same age: 20 – 24 year old men had a high prevalence of HIV six years ago, but it has dropped steadily since then.

The consequently lower prevalence among 15 – 19 year old women is now working through into 20 – 24 year old women. There may also be a lot less new HIV infection among 20 – 24 year old women, although we can’t yet say that with certainty.

3. There’s still a spike of new infection in late adolescence, usually associated with leaving school.

*Figure 2. Distribution of HIV prevalence by age and gender, 2008*

The incidence of HIV doubles between the ages of 18 (0.8%) and 20 (1.7%). Cross-sectional studies show that young people at school are relatively protected against HIV, and that marked changes in sexual outcomes for young women are associated with leaving school. Many are aimless, with little prospect of work or further studies in the near future. In the face of new pressures and social expectations, they tolerate risk more. Young men in particular drink too much alcohol, increasing their tolerance of, and demands for unsafe sex.

If this spike of infection in late adolescence is to be tackled, we need to build bridges and footholds for school leavers that create a sense of social support and immediate possibility for personal growth and development.
4. Pregnancy and HIV infection are strongly associated

Figure 3. Correlation between sexual activity, HIV and pregnancy among 15 – 24 year old women

For every two teenagers who are pregnant, one has HIV. This is because:
- the risk of HIV transmission during pregnancy is doubled as a result of physiological changes;¹
- pregnant women are a high-risk group in that they did not use a condom at the time of conception and may be less likely to use protection during pregnancy; and
- pregnancy heightens economic insecurity and school-drop.

We must strengthen efforts to prevent teen pregnancy – particularly by keeping young people in school. But we must also protect pregnant teenagers by stressing the importance of condom use during pregnancy and rapidly reintegrating them into the school system after birth.

¹ There may also be a heightened association with injectable contraceptives. This possibility is the subject of current investigation.
The incidence of vertical transmission in South Africa is still roughly 3% of live births, or about 30,000 babies. This is better than five years ago: the prevalence of HIV among children 2 – 14 years of age has declined, probably reflecting the partial success to date of the national programme to prevent mother-to-child transmission. But, with PMTCT available in virtually all primary care facilities, the number of new infections should be less than 4,000 per year.

We won’t be able to use prevalence figures to gauge the efficacy of the PMTCT programmes, as improved access to anti-retroviral treatment will extend the lifespan of children with HIV and keep the prevalence among 2 – 14 year olds above 1% for the next 5 – 10 years. Near elimination of vertical transmission (< 3,750 cases p.a.) within the next two years should result in a low prevalence (< 0.5%) among 0 – 14 yr olds by 2020.
6. In provinces, the HIV prevalence has settled at three levels – extremely high, very high and high

*Figure 5. Trends in HIV prevalence among people 2 yrs and older, by province*

Provinces seem to have stabilized in three prevalence ranges, namely extremely high (>15%), very high (10-15%) and high (5-10%). Although the Eastern Cape, Limpopo and Northern Cape seem to have stabilised at lower levels than all other provinces except the Western Cape, new economic developments in these provinces could increase rates of infection over the next five years. In particular, attention to the effects of the N2 highway construction through the Eastern Cape and mining expansion in Limpopo need to be proactively mitigated. Without intensive HIV prevention, these developments could create new hotspots that tip provinces such as the Eastern Cape and Limpopo into higher prevalence levels.
7. People living in informal settlements are at highest risk for HIV infection

*Figure 6. Trends in HIV prevalence, by geotype*

HIV prevalence among people 2 years and older, by geotype

The prevalence in urban informal areas is almost twice as high as in other geographical locations, but there are also pockets of high population density and migrant transition in rural districts. People in these areas are exposed to a cocktail of risk factors, including lack of family cohesion and support, a sense of social and economic marginalization and lack of opportunity, and alcohol and drug abuse.

HIV prevention strategies should focus on these areas, and address those factors predisposing to high risk sexual behaviour. Risk behaviour communication alone will have limited impact.
8. Self-reported condom use has shot up in the past few years

*Figure 7. Proportion of people 15 years and older who say they used a condom at last sex*

Self-reported condom use at last sex has increased steadily over the past decade, and sharply in the past three years. The proportion of 15 – 24 year old men who say they used a condom at last sexual intercourse is now close to 90%, and is the most likely explanation for the drop in incidence over the past five years. Among 15-24 year old women, there has been a steady increase as well, although a quarter of women in this age still did not use a condom at last sex.

The proportion of 25 – 49 year olds who report condom use at last sex has almost doubled since 2005. Interestingly, the proportion of women who report condom use in this age group is almost identical to that of men (56-58%).

The proportion of men and women aged 50 years and older who report condom use at last sex (40% and 25% respectively) has increased five-fold in just three years. These trends are encouraging, but must be sustained if condom use is to have a significant impact on incidence rates in older people.
9. No change for the better in terms of multiple sexual partnerships and age-disparate sex

Figure 8. Some key drivers of HIV infection show no improvement

There is no evidence of change in patterns of sexual partnerships in South Africa. A much higher proportion of men report more than one sexual partner in the past year than women. At present, there are no national data reliably describing the frequency of concurrent partners, a likely driver of new HIV infections.

As in most societies, men in South Africa typically have partners younger than themselves. However, a significant proportion of young women have sexual partners five or more years older than themselves, – a factor contributing to the spike of HIV infection in 18 – 24 year old women. The high frequency of age-disparate sex in South Africa is probably worsened by the economic disadvantage of women and the lack of social taboo against much older partners.

The proportion of sexually active 15 – 19 year old women with sexual partners ≥ 5 years older seems to have increased substantially in 2008. However, the change is not statistically significant at the p=0.05 level and significant variation over such a short period is unlikely. The true value probably lies somewhere between the point estimates from 2005 and 2008.
10. Most-at-risk groups – both known and emerging – are badly neglected

Figure 9. HIV prevalence among offenders in prisons (2006), compared with national male prevalence 2005

We don’t have good national statistics about the prevalence of HIV in groups that are generally regarded as most-at-risk, including commercial sex workers and men who have sex with men. But local studies have shown very high levels of HIV infection in these groups. Among male offenders in correctional facilities, the prevalence of HIV is extremely high. One-quarter of all prisoners are released every year. Many of them are newly-infected in prisons, possibly leading to high transmission rates in their communities after release.

People with disabilities are often at risk for physical and sexual abuse. They are often neglected in HIV prevention programmes.

The emergence of a generation of orphans in South Africa poses new challenges to the containment of the epidemic – as these young people are more likely to be at risk for HIV infection themselves. By 2010, there will be about 2 million orphans. Concerted national programmes should be in place to ensure that orphaned children and teenagers are included in society, kept at school, are able to access social grants, are protected from physical and sexual abuse, and have enough food.
The state of HIV prevention programmes: ten key findings

1. Still too many opportunities missed in PMTCT

Figure 10. Cumulative probability of HIV exposed infants receiving PMTCT, 2007/8

At best, two-thirds of HIV-exposed babies have the full benefit of PMTCT, this despite the availability of PMTCT in over 95% of primary health facilities. Part of the reason why all HIV-exposed babies don’t get the benefit of PMTCT is that some mothers present very late, or deliver at home, or refuse to take the anti-retroviral medication. But the main reason is that we don’t test all pregnant mothers and we don’t follow through on all those who do test positive.

We also miss opportunities to detect TB, cervical cancer and to offer protective family planning. The rate of transmission of HIV to pregnant women is probably twice as high as to women who are not pregnant. It is critical that condoms – male, female or both, are worn during sex in pregnancy. Women attending antenatal clinics need to know that.
2. Condom availability good, but not enough

Figure 11. Average number of male condoms distributed (per male 15 yrs and older), 2004-2008

![Graph showing average number of male condoms distributed per year from 2004 to 2008.]

Most South Africans believe that ‘condoms are easily accessible’ and 70% report using free government-provided condoms. Ironically, they are less accessible to the high risk groups that need them most. These include commercial sex workers and men who have sex with men. Although the policy of the Department of Correctional Services is that condoms should be provided to prisoners ‘on the same basis as condoms are provided in the community’, this is qualified by a requirement that prisoners should undergo education and counselling regarding AIDS prior to receiving condoms. While education and counselling is desirable, this requirement is an obstacle to the free distribution of condoms in prisons.

Despite the relative ease of access to condoms reported by adults, most districts still have an unacceptably low distribution of condoms\(^2\), especially those districts in provinces with the highest prevalence (KwaZulu-Natal, Mpumalanga and the Free State) which report the least numbers of condoms distributed per adult male! Female condoms are expensive (about R8 each) and made available primarily in family planning settings. Rapid scale-up of female condom provision to women attending clinics for family planning and STI treatment may be a breakthrough strategy for HIV prevention, particularly in reducing the incidence of HIV in people >30 years.

\(^2\) According to the condom logistics information system, 25 condoms per male ≥ 15 yrs were distributed in 2008, while the district health information records distribution of 11.8 condoms per male ≥ 15 yrs. The DHIS may not capture all sites of distribution.
3. Male circumcision offers the opportunity for fresh new gains

*Figure 12. Self-reported circumcision status among men 15 years and older, 2002*

Medical circumcision has been shown to reduce the incidence of HIV transmission to men by up to 60%. If 80% of men were circumcised, 20% of new infections could be averted over the next decade. About a third of South African men say they are circumcised, but incomplete traditional circumcision may not confer the same protective effect as medical circumcision.

4. There are still big gaps in behaviour change programmes

*Figure 13. Estimated participation in interpersonal HIV prevention services, 2008*

Although we have achieved a high level of media coverage, there are still major gaps in our national portfolio of behaviour change, namely:

- Insufficient scale of face-to-face programmes, which are associated with changes in sexual behaviour and lower odds of HIV infection;
- Insufficient attention paid to young adults and older people;
- Too little focus on most-at-risk groups.
If we don’t reach enough people with enough intensity, we won’t have done enough to change their sexual behaviour. Although we have made a lot of progress in improving condom use, it is clear that new gains require greater focus on:

- Reducing multiple and concurrent partnerships
- Dealing with high risk tolerance associated with life transitions such as school-leaving in the absence of a job or further educational prospects;
- Alcohol abuse, worsening risk tolerance, is often driven by the same factors; and
- Teen pregnancy (both preventing it and protecting pregnant teenagers by encouraging condom use and school reintegration).

5. Most-at-risk groups scarcely feature on the radar screen

Figure 14. Proportion of high risk groups exposed to HIV prevention media campaigns, 2008

Despite their high incidence of HIV, most-at-risk groups scarcely feature on the radar screen of HIV prevention in South Africa:

- The prevalence of HIV among male prisoners 26-35 years is close to 50% - almost three times higher than their same age counterparts in the general population;
- Studies of men who have sex with men show relatively low condom use and the use of unsafe lubricants; and
- Sex workers, particularly those from marginal communities, are often unable to negotiate condom use and have little recourse to the law. In this regard, the decriminalization of sex workers will improve their access to prevention services and protection.
An immediate imperative is to saturate social networks of most-at-risk groups with male and female condoms, and ensure free and unfettered access to condoms in correctional service facilities.

6. The number of people tested for HIV has increased sharply

*Figure 15. Proportion of people ≥15 years of age who say they have ever been tested for HIV*

There has been a marked increase in the proportion of people 15 years and older who have tested for HIV and who know their status. Half the adult population has now tested for HIV, compared with less than a third in 2005. Men still lag behind women – probably reflecting the higher attendance in public facilities among women especially of reproductive age.

7. We may be missing up to half of all TB cases in HIV positive people

TB and HIV go together. More than half of people with TB in South Africa have HIV. The risk of contracting TB in the first year after HIV infection is twice that of other people. Among HIV positive infants, the risk of contracting TB is 24 times higher. It also appears that TB accelerates the rate of HIV progression and early case detection and treatment is critical in reducing morbidity and its associated health care costs. Our goal should be to reduce the burden of disease and death from HIV and TB, saving considerable health care costs at the same time. This requires better integration of prevention, treatment, care and support.

A starting point is to improve the detection of TB in HIV positive people. A study in Durban found that only half the cases of TB among ART-ready clients were identified.
through smear microscopy, and a high vigilance protocol (including TB culture and chest X-ray) should be implemented for all people testing positive for HIV.

8. Sexually transmitted infections are generally treated poorly and opportunities missed

Over 8.5 million cases of sexually transmitted infections are treated annually in South Africa. People with STIs represent a particularly high risk group, yet studies show that curable STIs are generally treated inadequately – and most opportunities to provide dual contraception, HIV prevention counselling and cervical cancer detection are missed. Treatment of curable STIs, as part of a package deal for people presenting to both public and private health sectors, may contribute to reducing the incidence of HIV among people over 30 in particular.

9. Health service quality needs to be improved, all round – and in specific areas

The poor treatment of curable STIs is a symptom of broader health service quality failures, necessitating a major all-round improvement. At the same time, services for specific groups are particularly inadequate – such as those for men who have sex with men, commercial sex workers, and young people. Health care for men is generally neglected and the introduction of a male circumcision programme provides the opportunity to improve men’s access to sexual, reproductive and other services.

10. Clear, to-the-point political leadership is needed

The confusion of the past needs to be swept away with clear, to-the-point political leadership. This should be evidenced by:

- Clear communication about Government’s unequivocal commitment to preventing HIV and TB;
- Allocation of sufficient resources for HIV prevention;
- Expansion of Government communication about specific programmes (including PMTCT, ART, and routine testing); and
- Joint, active and enabling Government, corporate and civil society partnership for HIV prevention.
The ten top strategies for new gains in HIV prevention

These strategies are contemplated in the national operational plan for HIV prevention:

1. **Increase the supply of male and female condoms significantly**

   An increase in male condom supply and use is the main reason why the HIV incidence has declined to date. Yet some of the worst affected areas have the lowest distribution and high risk groups are poorly supplied.
   - Male condom distribution should be increased to 45 condoms per male £15 yrs.
   - Condom supply should be saturated among high risk groups, including prisoners, commercial sex workers and men who have sex with men.
   - Female condom supply should be increased significantly (at least 6-fold) particularly to protect women who are regular partners of men who have other sexual partners, and are often least able to negotiate male condom use.

2. **Eliminate missed opportunities for PMTCT and refocus on protecting the health of pregnant women**

   - The earlier HIV positive women receive PMTCT, the lower the risk of transmission. Women should be encouraged to book as early as possible for antenatal care to identify those in need of PMTCT services.
   - PMTCT should be a priority with rigorous and uniform adherence to protocols to avoid missed opportunities to avert infection.
   - HAART should be initiated as early as possible for all HIV+ mothers-to-be with CD4 count £ 350 to prevent transmission and to enable mothers to be healthy during the formative stages of their children’s lives.
   - PMTCT should be an entry point for other services, including PAP smear, family planning, condom provision and counselling and early TB detection.

3. **Scale up focused behaviour change programmes to achieve high levels of inter-personal coverage**

   A national portfolio of behaviour change programmes should be implemented at scale (at least 67% face-to-face coverage). Based on the trajectory-of-life
approach, it makes sense to define four main age groups, namely:

- 6 – 11 year olds
- 12 – 17 year olds
- 18 – 29 year olds
- 30 years and older

These programmes should target those at high risk – living in informal settlements, school leavers, the unemployed and those attending for STI and family planning services.

Behavioural initiatives and school-based initiatives aimed at 6 – 11 years and 12 – 17 years should include specific programmatic components for orphans and vulnerable children and teenagers. These should address their HIV prevention needs by:

- Ensuring they are included in society
- Keeping them at school
- Helping with the access of social grants
- Seeking to prevent physical and sexual abuse
- Strengthening food and economic security.

Development-specific initiatives should be established to ensure intensive HIV prevention in new areas of development; among others, the:

- N2 highway project through the Eastern Cape
- The trans-Kalahari highway project
- Mining expansion in Limpopo and other provinces.

All new major developments should be required to submit AIDS impact assessments and HIV prevention plans, and should be held to account for their implementation.

The focus of intervention for known groups most-at-risk (including men who have sex with men, commercial sex workers, and prisoners in correctional facilities) should be condom promotion linked to increased supply.

The lack of protection of people with disability is of real concern, and support programmes for people with disability should specifically address issues of physical and sexual abuse and HIV prevention. Similarly, the Department of Justice should be alert to the heightened vulnerability of disabled people to sexual abuse.
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4. Focus on reducing risk tolerance

Life transitions are associated with bursts of new infection, which significantly increase the lifetime probability of HIV. These transitions include school-leaving, job seeking and life in an informal settlement. Here the problem is not so much lack of information as a tolerance of risk. We should now focus on reducing the tolerance of risk, by creating new structures of support for school leavers, developing their personal initiative and skills to navigate life transitions, and creating new links to opportunity.

5. Focus on reducing teen pregnancy and protecting pregnant teenagers

The physiological changes of pregnancy (and possibly oral contraception) predispose to HIV infection. For every two pregnant teenagers, one is HIV positive. Girls under 15 who have sex are a particularly vulnerable sub-group, who typically have sex with older men without a condom. A growing number are orphans. We should be addressing the factors causing their vulnerability and protecting them at the same time by ensuring easy access to condoms and improving their ability to negotiate condom use. Keeping young people at school, and reintegrating learners who are pregnant or who have given birth, is probably the best protection for teenagers against HIV. The lack of social grants for 16-18 year olds, living in child-headed households with no alternative source, encourages transactional sex – and extension of the child care grant for these young people should be prioritised.

6. Introduce routine testing in all public health facilities

Provider-initiated HIV testing (with opt out) will increase the uptake of PMTCT and ARVs, reduce stigma and facilitate earlier diagnosis of TB. It is a cost-effective breakthrough strategy that has been shown to be well-accepted by communities.

7. Institute a high-vigilance protocol for TB detection among people with HIV

A high-vigilance protocol for people testing positive for HIV should include sputum culture for AFBs in all newly diagnosed HIV positive people who are smear negative– and chest x-ray among those symptomatic for TB if the culture is negative.
Infant and child morbidity related to TB could be significantly reduced through heightened vigilance – active exclusion of TB in mothers-to-be, 6 monthly chest X-rays for HIV-exposed infants, and immediate chest X-rays for HIV-exposed infants and infants in high risk areas who fail to thrive.

8. **Introduce a package deal for people presenting with STIs**

A package deal should ensure HIV testing, curable STI treatment, male and female condom provision, PAP smear, alcohol abuse counselling and information resources. As half the cases of STIs are treated in the private sector – many by cash practice GPs – syndromic treatment medications should be subsidized by the State (with precautions to prevent abuse of the system).

9. **Implement an intensive national quality improvement programme**

This programme should build on the focused quality improvement programmes that have been implemented with success, but at insufficient scale. They include:

- Youth friendly service initiatives
- Disability friendly services
- Post-exposure prophylaxis;
- Syndromic management of STIs; and
- PMTCT.

Although each has a specific focus (and different outreach), the quality improvement components should be adapted to provide an integrated programme for quality improvement for HIV prevention.

10. **Initiate a male circumcision programme**

Male circumcision (MC) also provides new opportunity to reach men who don’t attend health services as frequently as women do, and MC should be provided as part of a package of male health services – including counseling on alcohol abuse, condom provision, and treatment of STIs.

Knowledge of the full effects of male circumcision is still evolving. There are very real concerns that male circumcision may have a negative effect on women if sexual intercourse is initiated within six weeks of circumcision, or if circumcised men feel that they can engage in riskier sexual practice. In the short-term, key messages regarding the partial protective effect of circumcision should be integrated into national communication.
Financing of HIV prevention:
Five facts

1. **A fully-funded, comprehensive national HIV prevention portfolio will save money**

Comprehensive HIV prevention is cost-effective and is the only way in which South Africa will be able to afford the costs of treatment in the long-term. Sensitivity analysis by Stover (2006) shows that, even if a low range of impact effectiveness is used to calculate the cost-effectiveness of comprehensive prevention (compared to the treatment, and care costs) of infection, HIV prevention saves money (US$657 per infection averted). When probable impact of HIV prevention is compared to the costs of treatment and care for 5 years, the savings are R4,200 per infection averted. When compared with 10 years prevention and treatment, the cost savings increases to R15,600 per infection averted.

It will cost over a R1 billion a year more than our current commitment to HIV prevention, but will save R1 billion more every year in infections averted over the next five years. That saving will be tripled within a decade.

2. **Government funding is supplemented by donors, but the extent and distribution of donor funding are not known**

Figure 16. Flow of funding for HIV/AIDS programmes in South Africa
Donor support is vital to extending HIV prevention and other services to underserved communities. However, there is not a standard system of reporting and the scale and distribution of donor funding is not known.

3. **We spend about R6 billion of public funds on HIV/AIDS programmes**

*Figure 17. Public funding for HIV/AIDS programmes FY 08/09 (by function)*

The estimated total public expenditure on HIV/AIDS programmes (excluding foster care grants) in FY 2008/9 was R6.084 billion (USD 760.5 million). The proportion of total expenditure allocated to HIV prevention is 15%.

4. **We spend about R1 billion a year on HIV prevention**

*Figure 18. Allocation of public funding for HIV prevention FY 08/09, by activity*

Total public expenditure on HIV prevention in 2008/9 was R914.5 million (USD 114.3 million). In general, the public investment portfolio for HIV prevention in
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FY 08/09 looks balanced, but the total pie is still inadequate. Over half (52%) of behaviour change programme expenditure is the allocation to intra-curricular programmes in schools. This is an appropriate investment, but additional funding is required to fill gaps related to it and other aspects of behaviour change programmes.

5. We need R1 billion a year more for HIV prevention

Figure 19. Funding gap for HIV prevention FY 09/10 (based on estimates to achieve required programme scale)

Although it will be difficult to find an additional R1 billion in the current financial context, the costs of not finding the money are much higher. Already, well over R4 billion is spent each year on treatment, care and support. Inevitably, there will be some programme failures – in the same way that there is a significant mortality associated with the anti-retroviral treatment programme. But there is now enough evidence both in South Africa and internationally to show that HIV infection can be significantly reduced when countries are committed enough to achieving this goal. A 50% reduction in HIV incidence by 2013 will be difficult, but possible if we commit the required energy and resources.