HIV / AIDS ANTENATAL

SURVEY REPORT

2001

Compiled by:
Data Analysis Unit

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HIV ANTENATAL SURVEY REPORT FOR 2001

1. INTRODUCTION:

HIV/ Aids is the most serious and devastating disease that faces the world today. People ask themselves why the epidemic presents itself in a more devastating way in poorer countries and prejudicially think that this is due to improper or irresponsible behaviour attributed to individuals and communities. In reality we are confronted with much more complex problems which irreversible are referred to and collapsing of public and health services, the communities have no access to confidential and trustful services, molded to their necessities of information on prevention and STD care, counselling, treatment and sexual reproductive health.

In 1990 the National Department of Health instituted a mechanism to monitor the HIV epidemic in South Africa and since then a series of anonymous unlinked surveys of HIV have been conducted yearly amongst women attending antenatal clinics in public facilities as a mechanism of monitoring the progressions of HIV epidemic in South Africa. These annual surveys are the cornerstone of the HIV epidemic in the country and have become an important planning tool.

2. AIMS AND OBJECTIVES OF THE HIV SURVEY:

The aim of the survey is to obtain data/ statistics that will help health personnel in planning, decision making, implementing and evaluating programmes that are aiming at the prevention and control of the HIV/ Aids epidemic.

Specific objectives of the HIV/ Antenatal survey:

- To determine the prevalence of HIV in women attending antenatal care clinics.
- To monitor trends of HIV infection in women attending antenatal clinics.
- To determine the prevalence of HIV in each region and in different age categories.

3. SURVEY METHODOLOGY:

3.1 Sample size and sentinel sites:

A systematic cluster random sample was used. This sample is similar to the techniques used in previous years i.e. 58 sites were selected in the Free State province and the sample size of the Free State was 1200 but due to problems only 1113 (92.8%) blood specimen were taken. The clinics were selected on the basis of high first antenatal visits. At each selected site/ clinic all first time antenatal clinic attendants were selected. As only public sector are sampled there is an inherent under representation of race groups e.g. number of White and Indian women are typically small.

3.2 Data collection:

Data was collected by the health personnel in the selected sites over a period of one month e.g. the survey started on the 1 October to 30 October 2001. Every consecutive woman attending antenatal clinics for the first time during the current pregnancy was included in the sample. Before withdrawing the blood from the clients permission, consent and information on the reasons for taking blood was given to clients.

3.3 Quality control:

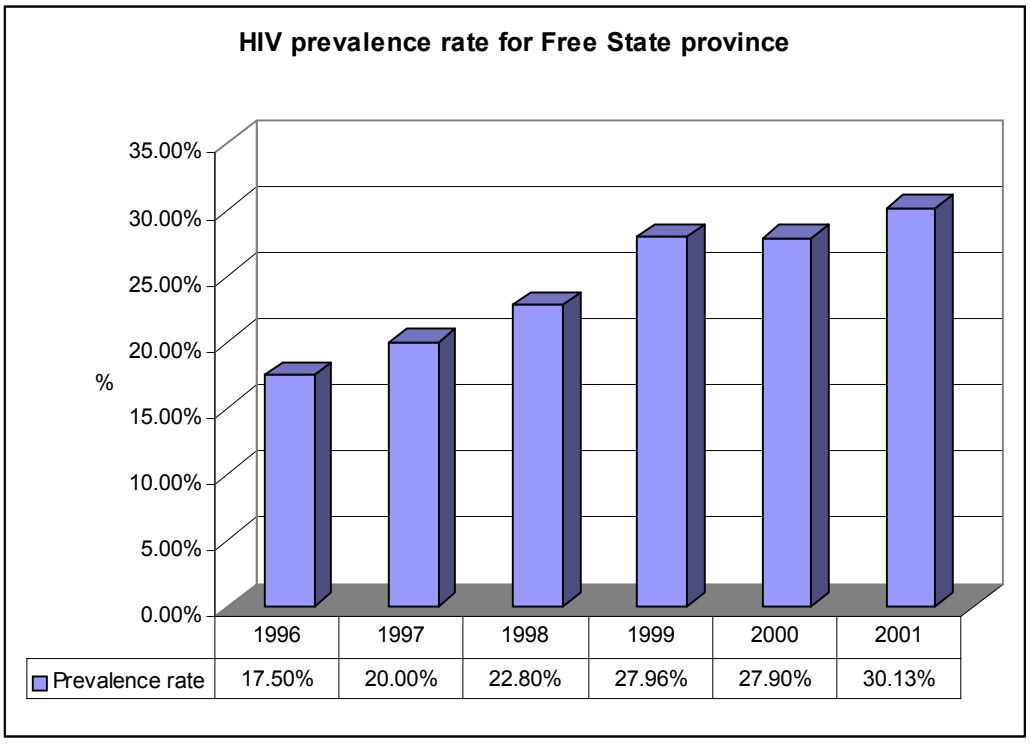
Quality control was done by managers, coordinators and statistical advisors from the provincial office. Of the total clinics (58), 35 (60.3%) were visited for quality control.

4. SURVEY RESULTS:

4.1 HIV prevalence rates for Free State province 1996 – 2001

The HIV prevalence rate for the Free State province is reflected in the line diagram below.

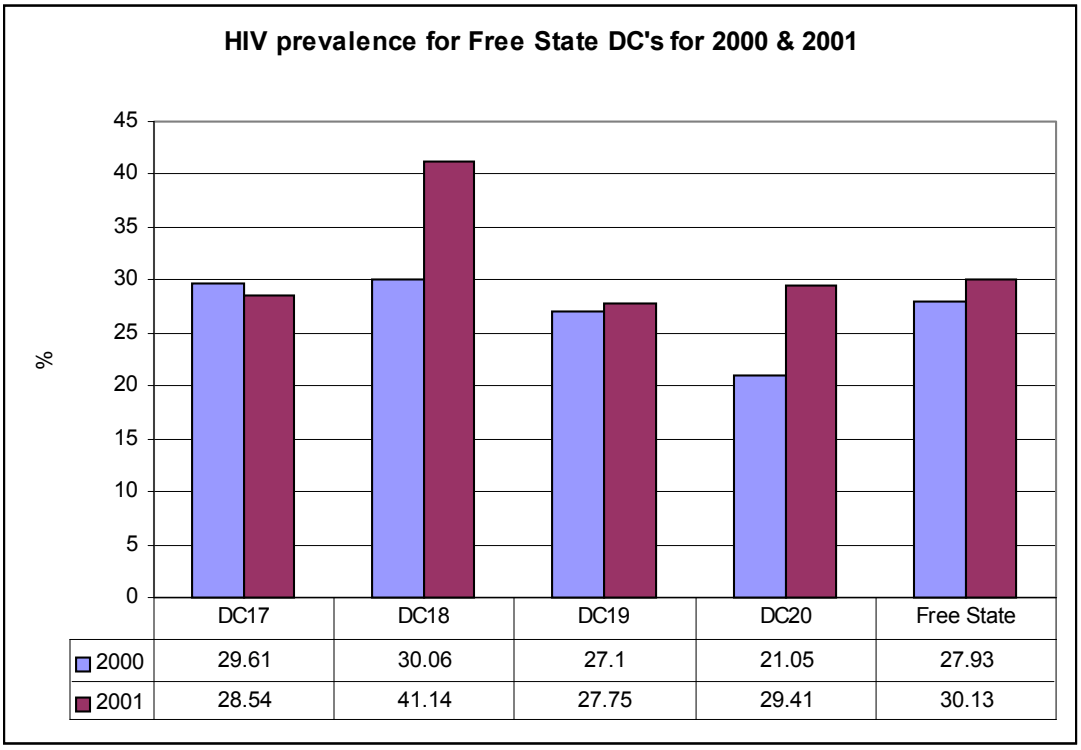
Diagram 1: ***HIV prevalence rates for Free State for 1996 – 2001***



4.2 HIV prevalence rate for DC's of the Free State

4.2.1 HIV prevalence rate for Free State DC's

Diagram 2: *Comparison of HIV prevalence rate for DC's for 2000 and2001*



DC16 was excluded from the survey due to the small numbers of first antenatal visits. DC18 (41.14%) is having the highest prevalence rate, followed by DC20 (29.41%) and DC17 (28.54%).

4.2.2 HIV prevalence rate for DC's of Free State for 1998 – 2001

Table 1: *Comparison of HIV prevalence rate for DC's of Free State for 1998 – 2001*

DC	1998	1999	2000	2001
DC17	23.84	26.64	29.61	28.54
DC18	25.75	31.88	30.06	41.14
DC19	21.50	27.90	27.10	27.75
DC20	20.92	27.55	21.05	29.41
Free State	22.80	27.96	27.93	30.13

When looking at the above table, DC18 is having high prevalence rate for all the years. See the table above.

4.3 HIV prevalence rate by age group

4.3.1 HIV prevalence rate by age group for Free State province 2000 and 2001

***Table 2:** HIV prevalence by age for the Free State province for 2000 and 2001*

Age group	2000		2001	
	Number positive	% Positive	Number positive	% Positive
< 20 years	20	11.70	41	18.98
20 – 24 years	92	29.30	104	31.90
25 – 29 years	103	33.99	111	42.86
30 – 34 years	61	32.45	55	32.93
35 – 39 years	22	26.83	20	18.69
40 – 44 years	4	17.39	4	11.76
45 and older	0	0.0	0	0.0
Total	**302**		**335**	

4.3.2 Age group per DC (Free State province) for 2001:

***Table 3:** Age group per DC for 2001*

Age group	DC17		DC18		DC19		DC20	
	# Pos	% Pos	# Pos	% Pos	# Pos	% Pos	# Pos	% Pos
< 20 years	15	11.63	10	15.38	14	12.61	2	6.67
20 – 24 years	41	31.78	20	30.77	34	30.63	9	30.0
25 – 29 years	38	29.46	19	29.23	44	39.64	10	33.3
30 –34 years	24	18.60	14	21.54	9	8.11	8	26.67
35 – 39 years	10	7.75	1	1.54	8	7.21	1	3.33
40 – 44 years	1	0.78	1	1.54	2	1.8	0	0.0
Total	**129**		**65**		**111**		**30**	

In DC17 and DC18 HIV is most prevalent in the age group 20 – 24 years and in DC19 and DC20 it is most prevalent in 25 – 29 years.

When looking at the global picture of HIV prevalence rate per age group it is evident that HIV/ Aids is more common in the 25 – 29 years (42.86%). This may be due to the fact that the young people tend not to perceive their own actions as affecting their health. They hold traditional beliefs of disease causation or they discount the risk of becoming ill or dying in the future against the value of satisfying their immediate needs including excitements. Girls are less likely to know about HIV infection and Aids, and how to protect themselves from HIV

infection because of the cultural norms that girls and young women should not know about sexual health.

Sexual and reproductive health information and services are generally not available to young unmarried people. Providers of services for older, married people can be judgmental and critical of sexually active youngsters. Services are not designed to meet adolescents needs and even the provision of family life education in schools has provoked serious conflict in the society.

Certain leaders and parents often mistakenly believe that sexual health education leads to earlier or increased sexual activity. There is an urgent need to reach out to children and young people using effective methods that empower them to be the agents for their own and their communities good health and development.

5. CONCLUSION:

Comparing these results from the 2000 HIV/Aids Antenatal results there has been an increase of 2.2% this indicates that a greater effort to reduce HIV in the province is needed. Looking at DC18 and DC20 there is an increase of 11.8% and 8.36% respectively - this may be due to pre-existing social conditions e.g. unemployment (mines are closing down). There is a need for implementing strong and decisive strategies for the most vulnerable and affected groups.

6. ACKNOWLEDGEMENTS:

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