



A perspective on the HIV epidemic in South Africa

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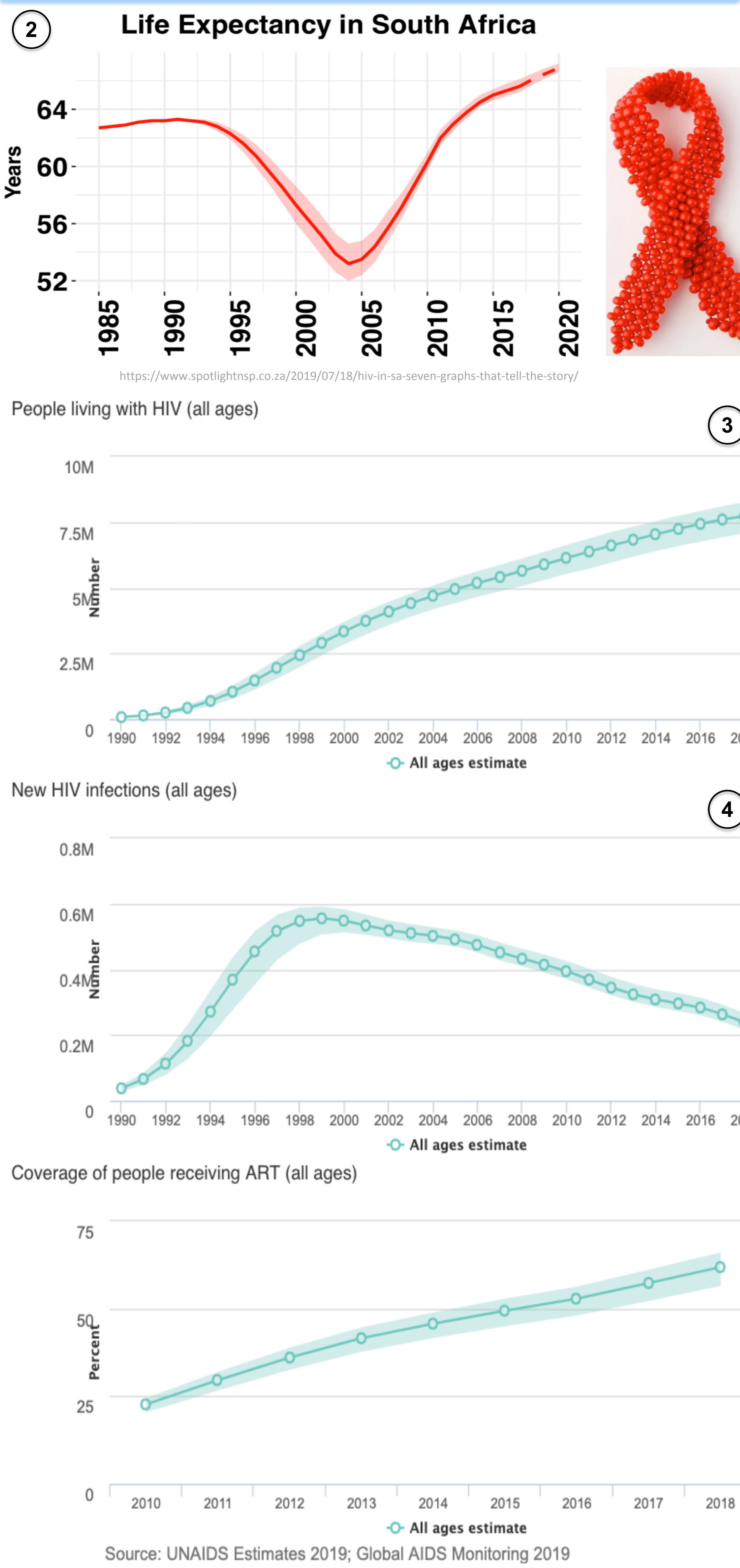
South Africa has come a long way since the early days of the HIV epidemic. Socioeconomic and political factors such as the migrant labour system as well as the government's protracted AIDS denialism¹ conspired to create an epidemic of enormous proportions. Average life expectancy plummeted since the early 1990s until, after years of pressure from advocacy groups, the government commenced the national roll-out of combination ART in 2004.² As in other parts of the world, the number of people living with HIV (PLHIV) still continues to increase despite lower incidence, due to improved life expectancy of patients on ART.^{3,4} One out of every five people with HIV worldwide live in SA.⁵ In July 2019 the Statistician General estimated the national numbers of PLHIV in SA to be 7.97 million (13.5% of population); amongst adults aged 15-49 years, about 19.07% are HIV positive (Stats SA). HIV prevalence is higher in the eastern regions of the country, especially in KwaZulu-Natal (KZN) province.⁶ Antenatal clinic prevalence is even higher⁷ – in some KZN communities up to 60% of women are HIV positive.

In the largest antiretroviral programme worldwide, more than 4.8 million people (61% of PLHIV) have started taking ART.⁸ UNAIDS's "90-90-90 by 2020" target has already been achieved by certain communities, of which Médecins Sans Frontières' HIV/TB project in Eshowe, KZN was one of the first earlier in 2019, with results of 90-94-95.⁹

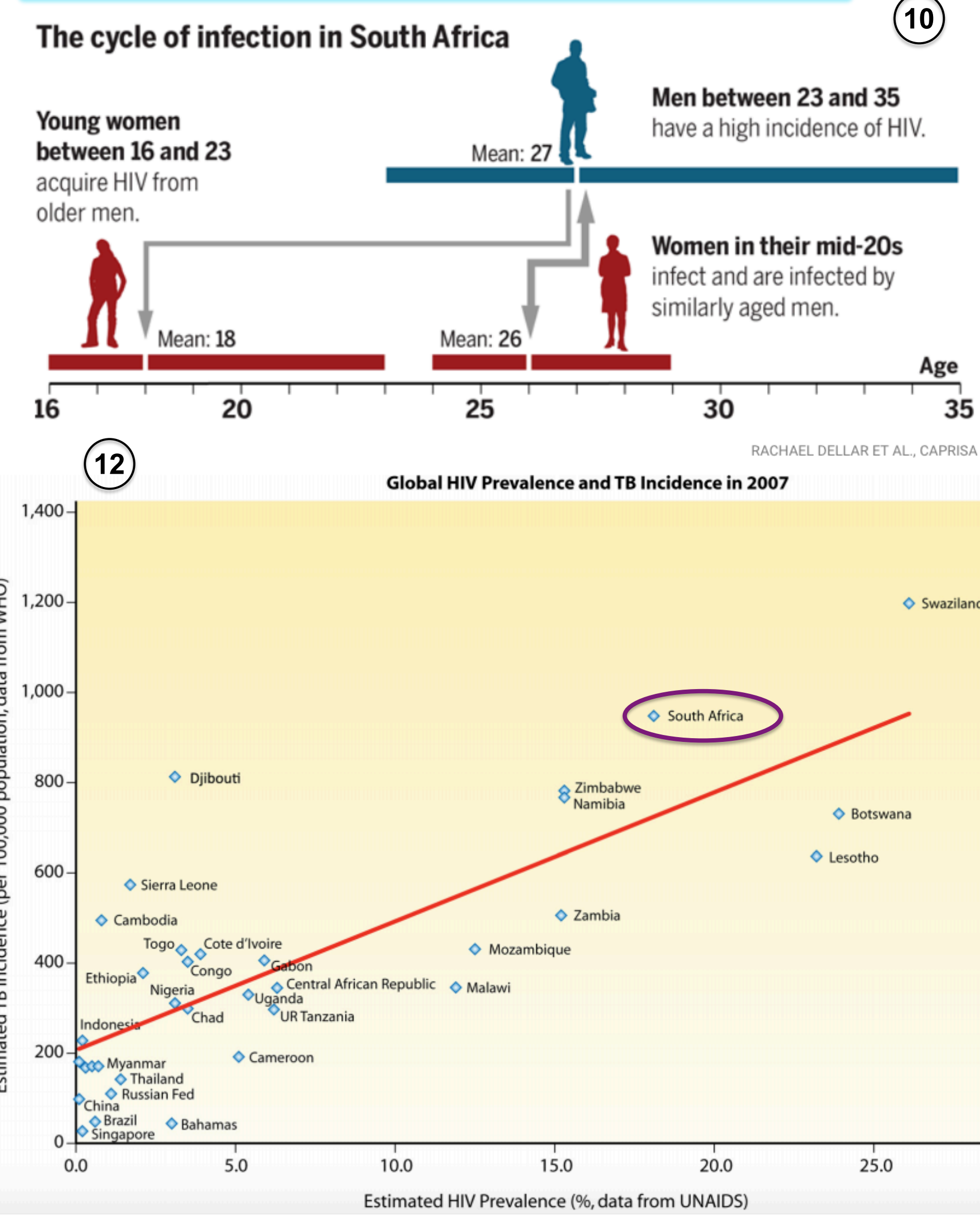
Many challenges remain, including reaching target populations such as adolescent girls / young women and men in general,¹⁰ as well as vulnerable groups like sex workers and sexual minorities in many communities. Furthermore, ongoing expansion of the roll-out contributes to proportionately higher numbers of patients disengaging from care intermittently,¹¹ driving worse clinical outcomes upon their return, increased transmission, and potentially, viral resistance. Lastly, tuberculosis, the leading cause of natural deaths in SA, remains intricately interwoven with the HIV epidemic,¹² and the largest contributor to HIV morbidity and mortality in SA. Over 80% of people who died of TB in 2016 were HIV infected (National Institute of Communicable Diseases – 13 March 2019).

As a fifth year medical student in 2002 I completed an elective rotation at Tugela Ferry¹³ in deep rural KZN, and returned there again as a community service doctor in 2005. The interim change was almost palpable. Whereas three years earlier, medical wards were overfilled with emaciated patients simply dying of AIDS, the availability of ART since 2004 had transformed the expectations of both patients and doctors alike, and had provided a long overdue sense of hope. Despite many obstacles, patients were generally getting better and surviving. A subset of TB patients, however, failed to improve. The largest XDR-TB outbreak in the world at that stage was starting to unfold in the same community¹⁴. It was this dual epidemic and its ramifications that, years thereafter, inspired me to follow a career in clinical infectious diseases, with special emphasis on HIV and TB. I was fortunate enough to have been able to work in these fields in SA's public health sector for many years, thereafter on an HIV project¹⁵ with MSF in Cape Town's Khayelitsha township, and currently in an HIV & ID physician practice in the private health sector in Christiaan Barnard Memorial Hospital¹⁶ in Cape Town.

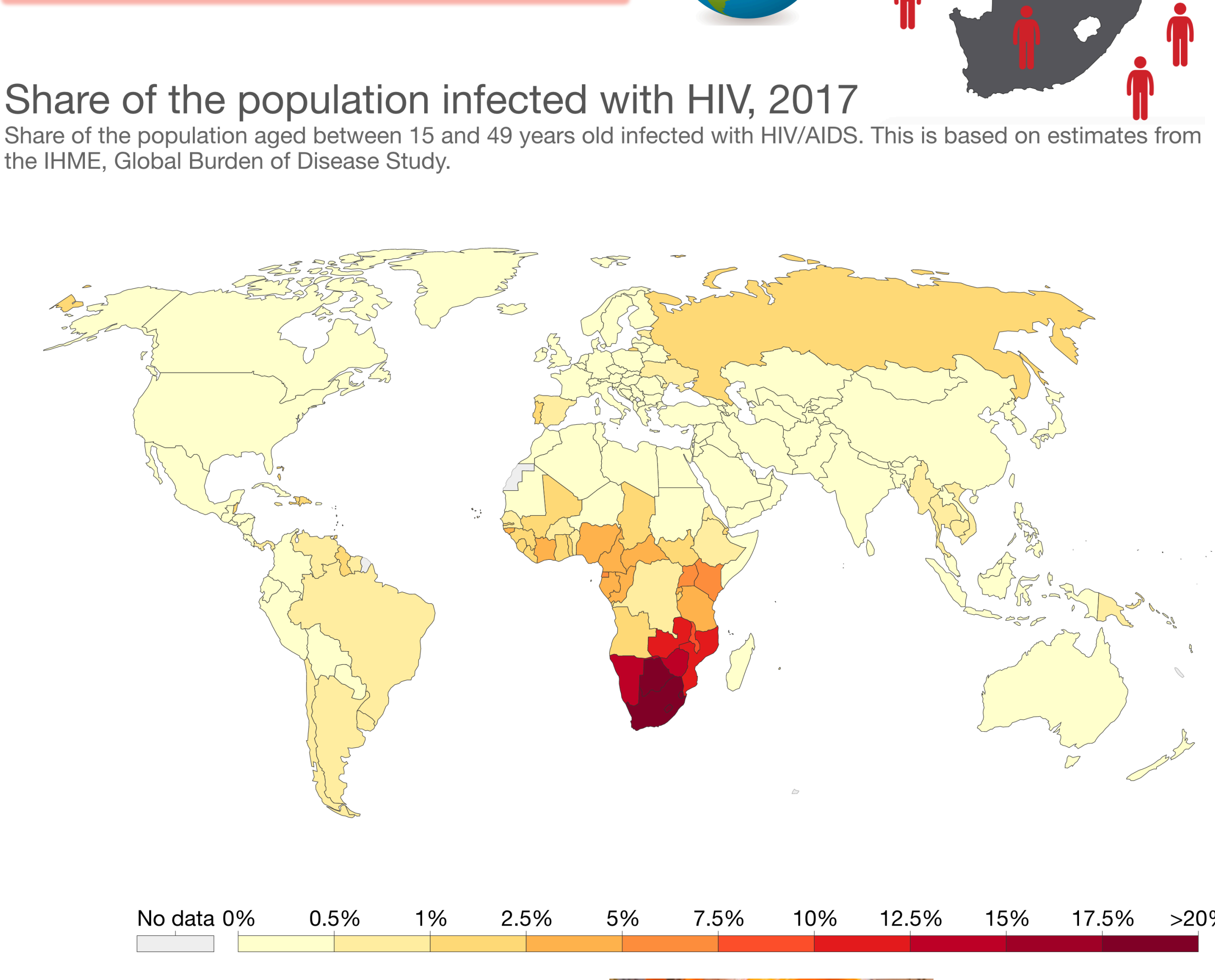
The epidemic's trajectory



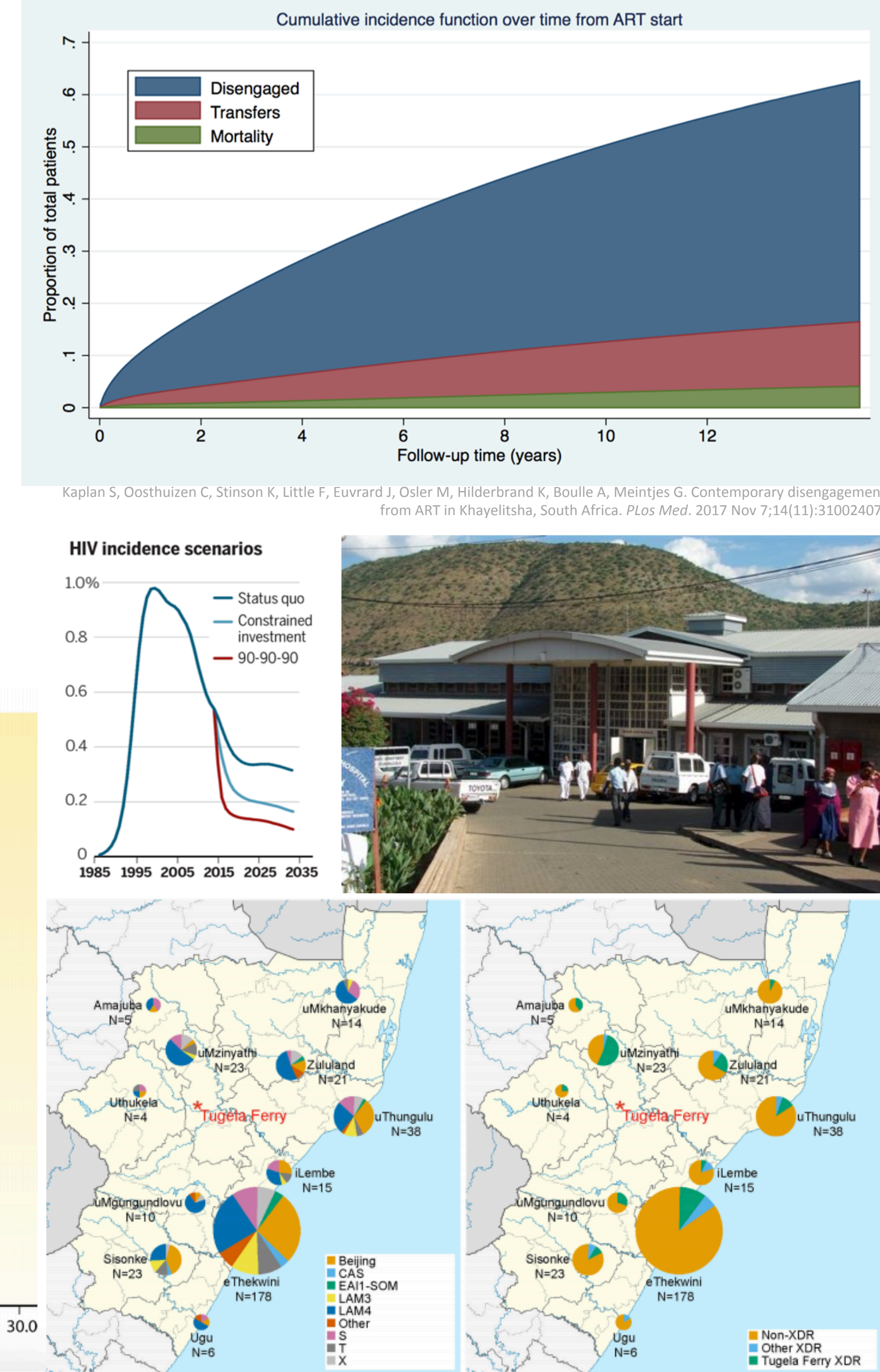
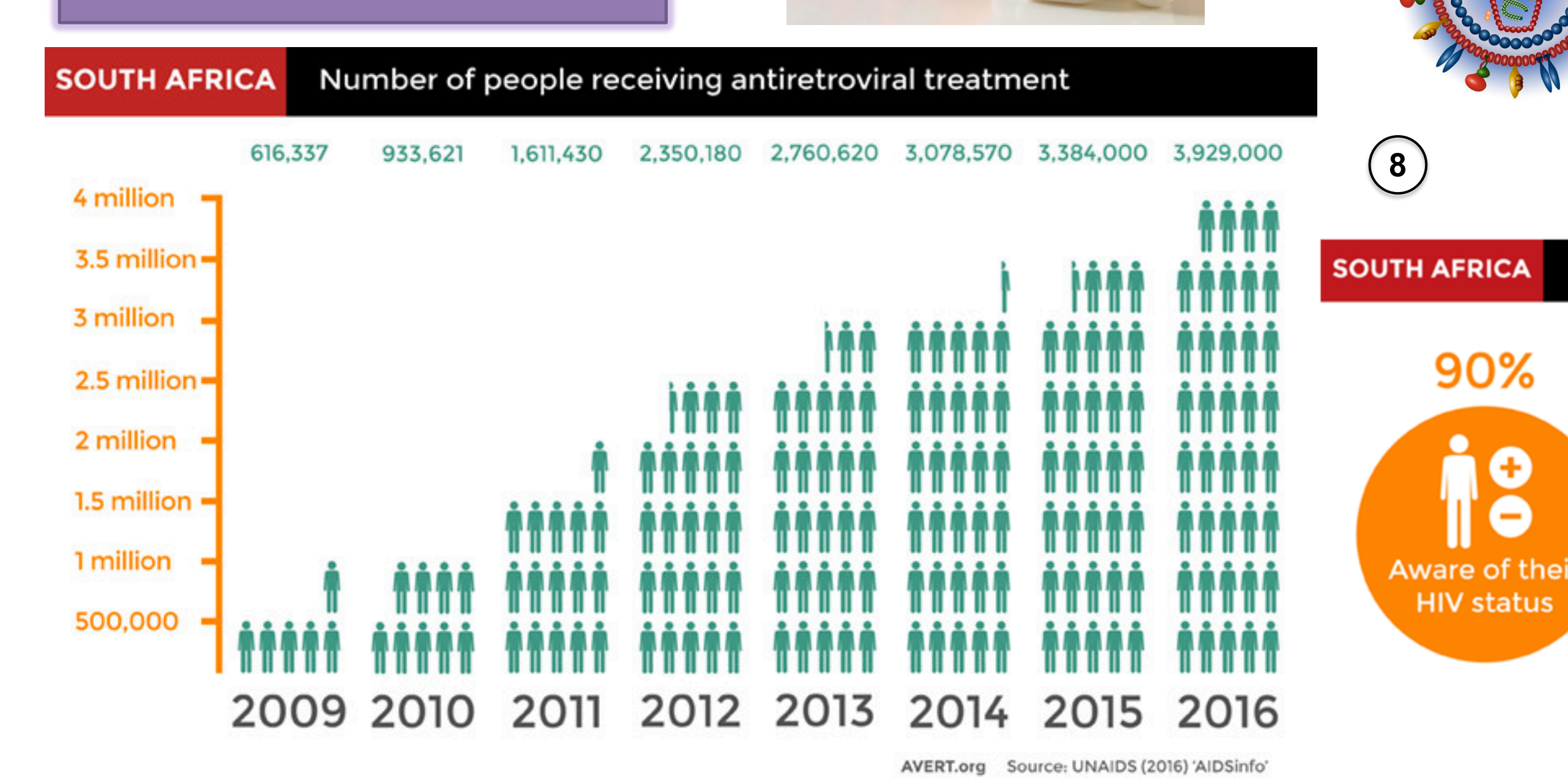
Remaining challenges



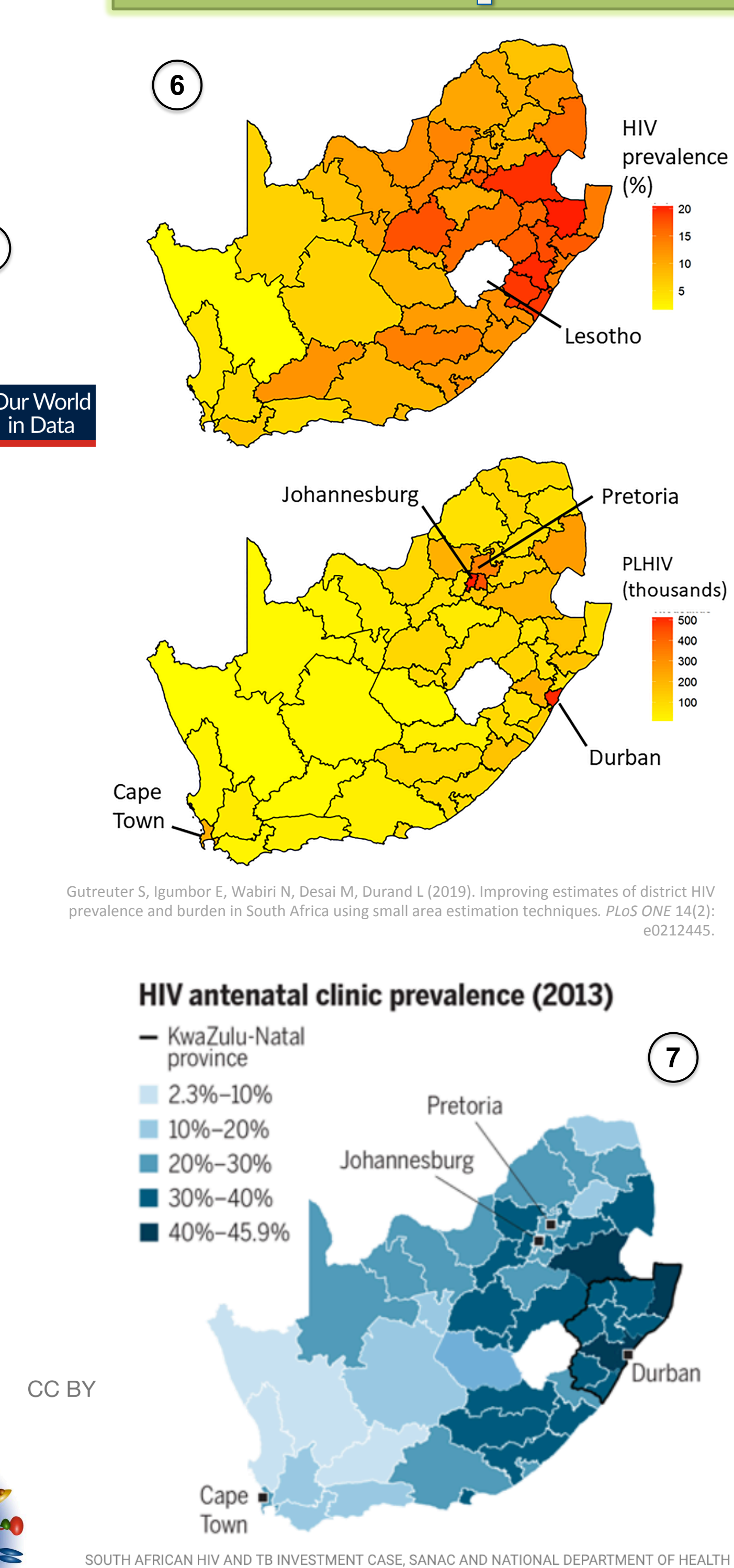
The global picture



Access to ART



The local picture



Some successes

