SOUTH AFRICA GLOBAL AIDS RESPONSE PROGRESS REPORT (GARPR)

2015
Acknowledgements

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### GLOBAL AIDS RESPONSE PROGRESS REPORT SOUTH AFRICA: INDICATORS AT A GLANCE

<table>
<thead>
<tr>
<th>Global target area</th>
<th>Attainable</th>
<th>Is the country on track to reach the target and commitment?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce sexual transmission by 50% by 2015</td>
<td>No</td>
<td>Not on track</td>
</tr>
<tr>
<td>Reduce transmission of HIV among people who inject drugs by 50% by 2015</td>
<td>Some Progress</td>
<td>Ongoing programmes</td>
</tr>
<tr>
<td>Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths</td>
<td>Yes</td>
<td>On track</td>
</tr>
<tr>
<td>Reach 15 million PLHIV with lifesaving antiretroviral treatment by 2015</td>
<td>Yes</td>
<td>On track</td>
</tr>
<tr>
<td>Reduce TB deaths in PLHIV by 50% by 2015</td>
<td>Some Progress</td>
<td>Improvements in mortality rate due to TB among PLHIV</td>
</tr>
<tr>
<td>Close the global AIDS resource gap by 2015 and reach annual global investment of US$ 22-24 billion in low- and middle-income countries</td>
<td>Yes</td>
<td>On track</td>
</tr>
<tr>
<td>Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV</td>
<td>No</td>
<td>Not on track</td>
</tr>
<tr>
<td>Eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realisation of all human rights and fundamental freedoms</td>
<td>Yes</td>
<td>On track</td>
</tr>
<tr>
<td>Eliminate HIV-related restrictions on entry, stay and residence</td>
<td>Yes</td>
<td>On track</td>
</tr>
<tr>
<td>Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts</td>
<td>Yes</td>
<td>On track</td>
</tr>
</tbody>
</table>
1. Status at a glance

The inclusiveness of the stakeholders in the report writing process

The process of reviewing the progress made on the HIV and TB response in South Africa ran parallel with the mid-term review of the National Strategic Plan (NSP) on HIV/AIDS, tuberculosis (TB) and sexually transmitted infections (STIs) 2012-2016. This process included an intensive document review, key informant interviews and workshops with both national and provincial stakeholders. The interim results were reviewed and validated through a multisector Steering Committee for the NSP and National Validation workshop with all respective stakeholders. The key informant interviews included sections relevant to the Global AIDS Response Progress Report (GARPR) as we were, in addition, seeking input into this report.

The GARPR takes into consideration all the inputs from stakeholders including government departments, civil society, development partners and all Provincial Chapters of the South African National AIDS Council (SANAC). Unlike the previous processes for completing the GARPR, the present report did not include the administration of the National Commitments and Policy Instrument (NCPI) tool as per UNAIDS guidance. To this end, this GARPR report writing exercise was inclusive of all relevant stakeholders and their inputs are reflected herein.

The status of the epidemic

South Africa has a high prevalence generalised and heterogeneous HIV epidemic with high levels of TB. Population level HIV prevalence was 12.2% in 2012 with approximately 6.4-million people living with HIV (PLHIV). The HIV epidemic is concentrated in a number of districts nationally, and provincial HIV prevalence ranges from 16.9% in KwaZulu-Natal to 5.0% in the Western Cape. HIV incidence is highest among young women aged 15-24. Concentrated sub-epidemics have also been observed among key populations including sex workers (SW) and men who have sex with men (MSM).

In 2014, there were an estimated 450,000 new TB infections, with 270,000 of the new infections among PLHIV. The TB burden is compounded by cases of multidrug-resistant TB (MDR-TB) and extensively drug resistant TB (XDR-TB).

The policy and programmatic response

South Africa is guided by a comprehensive National Strategic Plan (NSP) for HIV, STIs and TB for 2012-2016 with the goal of reducing new HIV infections by 50% within a combination prevention approach. Noting the importance of key populations, the Department of Health has developed an operational framework that places emphasis on addressing HIV among sex workers (SW), men who have sex with men (MSM) and injecting drug users (IDU).

With respect to Target 1; to reduce sexual transmission of HIV by 50% by 2015, the cornerstones of South Africa’s response include reducing behavioural risk, HIV Counselling and Testing (HCT), condom distribution and uptake, Medical Male Circumcision (MMC), prevention of mother to child transmission (PMTCT), management of sexually transmitted infections (STIs) and tuberculosis (TB), and the scale-up of Anti-Retroviral Therapy (ART). Incidence and prevalence data indicate that the HIV prevention goal will be difficult to achieve, with particular challenges being: early sexual debut, age-disparate relationships, multiple sexual partners, inadequate condom use and low uptake of MMC.

Girls and young women are most vulnerable, and this pattern of vulnerability has prevailed over the past decade with HIV incidence being highest among females aged 15-24 in comparison to all other age and sex categories. While progress has been made in the sphere of HIV education in schools through the Integrated School Health Programme (ISHP), the reach of HIV Communication Programmes (HCPs) has declined. Research and programming is underway to support key populations. HIV testing targets are ambitious; 10-million tests were targeted in 2014/2015 with 95% of this target being achieved.

With respect to Target 2; to reduce transmission of HIV among people who inject drugs, it is recognised that South Africa is a drug trafficking and transit point, and that the IDU population is increasing. While policies and guidelines are being expanded, it remains that there is insufficient data on the extent of drug use, and this constrains the design of effective programmes.

Regarding Target 3; to eliminate new HIV infections among children and substantially reduce AIDS-related maternal deaths, national guidelines have been updated to accommodate new international guidelines on ART. Through various intensified strategies, South Africa has achieved its target of a 6-week MTCT rate of less than 2% (i.e. 1.5% in 2014/2015).

Regarding Target 4; to increase the number of PLHIV on ART, South Africa has adopted recent guidelines for early ART initiation and the introduction of fixed dose combinations (FDCs). Some 73% of adult PLHIV and 75% of children who are PLHIV were estimated to be on ART in 2013/2014, with new client targets also having been exceeded. Retention in care remains sub-optimal, reported to be about 48.3% at 6-months - against a target of 70%.

With respect to Target 5; to reduce TB deaths among PLHIV–there is a strong commitment to TB integration as illustrated by the increase in the proportion of co-infected PLHIV on ART.
from 31.2% in 2013/2014 to 73.3% in 2014/2015 – great strides towards achieving the national target of 85%. While drug resistant TB remains a concern, TB treatment and cure rates are improving and loss to follow-up is declining. While annual AIDS deaths have decreased, TB mortality among PLHIV was estimated at about 72,000 (a rate of 134/100,000) in 2014. Monitoring using a multitier system is being expanded, and it is anticipated that this will improve the overall management and implementation of ART.

With respect to Target 6; to close the global AIDS resource gap, South Africa funds over 90% of its health care expenditure. Goals for addressing HIV are included in the National Development Plan 2030, and an Investment Case has been undertaken to inform prioritisation of interventions going forward. To address inequality in the health care system, a National Health Insurance (NHI) is being piloted in eleven sites. Prominent donors over the past decade have been the Global Fund to fight AIDS, TB and Malaria (GFATM) and the US President’s Emergency Plan for AIDS Relief (PEPFAR). PEPFAR funding is being scaled down through the guidance of a Partnership Framework. To address shifts in funding, SANAC has established a Resource Mobilisation Unit.

With respect to Target 7; to eliminate gender inequalities and address gender based violence (GBV), South Africa’s legislative and rights frameworks provide strong support and there are multiple structures that address the empowerment of women. A National Council against Gender-based Violence (NCGBV) and an Inter-Departmental Management Team have been established to manage violence against women and children interventions, while the Thuthuzela Care Centres (TCCs) continue to support interventions addressing sexual violence. An inter-sector approach is also being followed and training of line officials is being expanded. A girl-focused National Adolescent Sexual and Reproductive Health and Rights Framework Strategy has been adopted, and mainstreaming of gender and rights into operational plans of government departments is a core focus of the Department of Public Service and Administration (DPSA).

With respect to Target 8; to eliminate HIV and TB- related stigma and discrimination, guidance is being provided through a recently completed stigma index. Auditing of services is underway – in particular, to address violations that still occur in health care settings and in relation to sex work and sexual orientation. A number of new guidelines and policies have been developed to incorporate rights in health, employment and education settings.

With respect to Target 9; to eliminate travel restrictions, South Africa has no HIV related travel restrictions. However, immigrants seeking temporary residence are screened for TB and, if found to test positive for TB, are placed on TB treatment. Foreign nationals or refugees are able to access health care services free of charge within public health care settings.

With respect to Target 10; to strengthen HIV integration, South Africa has a range of policies that speak to the integration of programmes addressing poverty and related vulnerabilities. Comprehensive programmes are provided through the Department of Social Development to support poverty affected households as well as orphans, vulnerable children and youth (OV CY). A Draft National Youth Policy also sets out to strengthen access to employment.

**Indicator data in an overview table**

Table 1 provides a summary of the indicators with results for 2014. As can be seen, South Africa has made significant progress in the implementation of a multisector AIDS response programme.
Table 1: Core indicators, South Africa 2014

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young people: Knowledge about HIV prevention (15-24)</td>
<td>29.4%</td>
<td>28.6%</td>
</tr>
<tr>
<td>Sex before the age of 15 (15-24)</td>
<td>10%</td>
<td>10.7%</td>
</tr>
<tr>
<td>Multiple sexual partnerships</td>
<td>7%</td>
<td>12.6%</td>
</tr>
<tr>
<td>Condom use at last sex, people with multiple sexual partnerships (15-24)</td>
<td>63.75%</td>
<td>62.25%</td>
</tr>
<tr>
<td>HIV testing, general population, last 12 months, known results (15-49)</td>
<td>49.1%</td>
<td>66.2%</td>
</tr>
<tr>
<td>HIV prevalence in young people (15-24)</td>
<td>8.7%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Sex workers: % SW reached with HIV prevention programmes</td>
<td></td>
<td>60%</td>
</tr>
<tr>
<td>Sex workers: condom use</td>
<td></td>
<td>81%</td>
</tr>
<tr>
<td>HIV testing in SW</td>
<td></td>
<td>88%</td>
</tr>
<tr>
<td>HIV prevalence in SW</td>
<td></td>
<td>59.6%</td>
</tr>
<tr>
<td>MSM: prevention programmes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSM: condom use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV testing in MSM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV prevalence in MSM</td>
<td></td>
<td>22-48%</td>
</tr>
<tr>
<td>Proportion of men circumcised (15-49)</td>
<td>40.6%</td>
<td>46.4%</td>
</tr>
<tr>
<td>Males circumcisions performed according to national standards, past year</td>
<td></td>
<td>508,404 (NDOH 2014/2015)</td>
</tr>
<tr>
<td>Estimated number of opiate users (injectors and non-injectors)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of people on opioid substitution therapy (OST)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV-positive pregnant women who received ART to reduce the risk of MTCT</td>
<td></td>
<td>91.2% (NDOH 2014/2015)</td>
</tr>
<tr>
<td>Women living with HIV who are provided with ART for themselves / infants during breastfeeding period</td>
<td></td>
<td>57%</td>
</tr>
<tr>
<td>Infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth (EID)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother-to-child transmission of HIV</td>
<td>3.5% (MRC 2010)</td>
<td>1.5% (NDOH 2014/2015)</td>
</tr>
<tr>
<td>Adults and children currently receiving ART among all adults and children living with HIV (Spectrum)</td>
<td>66.2%</td>
<td>Adults - 73% Children - 75%</td>
</tr>
<tr>
<td>Number of adults and children who are still alive and on ART at 12 months after initiating treatment (Spectrum)</td>
<td></td>
<td>400,948</td>
</tr>
<tr>
<td>Estimated HIV-positive incident TB cases that received treatment for both TB and HIV</td>
<td></td>
<td>73.7% (TB/HIV co-infected clients initiated on ART, NDOH 2014/2015)</td>
</tr>
<tr>
<td>Domestic and international AIDS spending by categories and financing sources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Government Expenditure on Health</td>
<td></td>
<td>29.4%</td>
</tr>
<tr>
<td>Total Government Expenditure on HIV</td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td>Total Health Expenditure Budget</td>
<td></td>
<td>30%</td>
</tr>
<tr>
<td>Allocations from other development partners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical or sexual violence from a male intimate partner in the last 12 months among ever-married or partnered women (15-49)</td>
<td></td>
<td>Overall - 5.1% (15-19) - 7.7% (20-24) - 7.3%</td>
</tr>
<tr>
<td>Discriminatory attitudes towards PLHIV (15-49)</td>
<td></td>
<td>35.5 External Stigma among PLHIV 43% Internal Stigma among PLHIV (Stigma Index; 2015)</td>
</tr>
<tr>
<td>Current school attendance rate of orphans aged 10-14 primary/secondary school age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current school attendance rate of children aged 10-14 primary/secondary school age whose parents are alive and who live with at least one parent</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. Overview of the HIV epidemic

HIV prevalence trends

The 2012 Human Sciences Research Council (HSRC) national survey estimated South Africa’s population level HIV prevalence to be 12.2% [95% CI: 11.4–13.1%]. The estimation is substantially higher than the HIV prevalence level estimated in 2008 of 10.6% [95% CI: 9.8–11.6%]. This indicates that South Africa had approximately 6.4 million People Living with HIV (PLHIV) in 2012. The 2014 UNAIDS Spectrum Modelling estimated that 6.6 million [5.9-7.3 million] people of all ages were living with HIV in 2014, with an overall prevalence of 18.2% [95% CI: 16.3 – 20.2%].

HIV prevalence by province

It is important to note that HIV prevalence varies by province, age, sex and location of residence. The 2012 HSRC survey found that KwaZulu-Natal (KZN) and Mpumalanga (MP) had the highest HIV prevalence levels for all ages at 16.9% and 14.1% respectively. The lowest HIV prevalence levels were recorded in the Northern Cape (NC) at 7.4% and the Western Cape (WC) at 5.0%.

According to the 2014 UNAIDS Spectrum estimates, KZN had the highest number of PLHIV in 2014 at a total of 1.8 million [1.2-2.0 million] and highest prevalence at 26% [95% CI: 24.1-28.0]. The NC had the lowest number of PLHIV at 86,000 [66,000-110,000] but second lowest prevalence after WC, with a prevalence of 10.9% [95% CI: 8.4-13.6]. HIV prevalence in the WC was estimated at 6.4% [95% CI: 5.3-7.9].

Figure 1: HIV prevalence by province, South Africa, 2012


(Source: Shisana et al., 2012)
Analysis of district level data in the 2012 HSRC survey indicated that the HIV epidemic in South Africa is more concentrated in 13 districts across three provinces namely – KZN, NW and MP.

**HIV prevalence by age**

As shown in Table 2, the 2012 HSRC survey found that the HIV prevalence among children aged 2-14 years had fallen since 2002 from 5.6% to 2.4%. HIV prevalence among youth aged 15-24 has also decreased from 10.3% in 2005 to 7.1% in 2012. In contrast, the HIV prevalence among persons aged 25 years and older has risen from 15.5% in 2002 to 19.9% in 2012. The 15-49 year age group also experienced an increase in HIV prevalence from 15.6% in 2002 to 18.8% in 2012. These increases in HIV prevalence are noted to reflect the effects on longevity as a result of ART programmes along with new infections.

**Table 2: HIV prevalence by age group, South Africa, 2002, 2005, 2008 and 2012**

<table>
<thead>
<tr>
<th>Age group</th>
<th>2002</th>
<th>2005</th>
<th>2008</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-14</td>
<td>5.6</td>
<td>3.3</td>
<td>2.5</td>
<td>2.4</td>
</tr>
<tr>
<td>15-24</td>
<td>9.3</td>
<td>10.3</td>
<td>8.7</td>
<td>7.1</td>
</tr>
<tr>
<td>25+</td>
<td>15.5</td>
<td>15.6</td>
<td>16.8</td>
<td>19.9</td>
</tr>
<tr>
<td>15-49</td>
<td>15.6</td>
<td>16.2</td>
<td>16.9</td>
<td>18.8</td>
</tr>
<tr>
<td>2+</td>
<td>11.4</td>
<td>10.8</td>
<td>10.9</td>
<td>12.6</td>
</tr>
</tbody>
</table>

(Source: Shisana et al., 2012)

**HIV prevalence by sex**

According to the 2012 HSRC survey, HIV prevalence among females is higher than among males across all age groups with the exception of the 50-54 year age group. In the latter age group, for example, male HIV prevalence is slightly higher than that of females at 15.5%, compared to 14.8% for females.

**Figure 2: HIV prevalence by sex and age, South Africa, 2012**

(Source: Shisana et al., 2012)
Females in the 15-19 year age group are eight times more likely to be HIV positive than in the same age group (5.6% vs. 0.7%). Females in the 20-24 year age group have HIV prevalence that is over three times higher than their same aged male counterparts – 17.4% vs. 5.1%. Figure 3 shows HIV prevalence of females and males across all ages in 2008 and 2012, illustrating that HIV prevalence peaks in the older age bands for 2012. In females, the HIV prevalence peak moved from the 25-29 year age group (32.7%) in 2008 to the 30-34 year age group (36%) in 2012. Equally, among males, the HIV prevalence peak moved from the 30-34 year age group (25.8%) in 2008 to the 35-39 age group (at 28.8%) in 2012.

Figure 3: HIV prevalence in females (a) and males (b) by age, South Africa 2008 and 2012

(Source: Shisana et al., 2012)
HIV prevalence in key populations

South Africa does not have national level data on key populations at higher risk of HIV such as men who have sex with men (MSM), sex workers (SW), or injecting drug users (IDU). An analysis conducted as part of the 2012 HSRC survey identified populations where HIV prevalence was above the national average. It was determined that persons in the following categories were among the populations more likely to be living with HIV: Black African women aged 20-34 years; People living together, not married aged 15-49 years; Black African men aged 25-49 years; Disabled persons aged 15 years and older; and High-risk drinkers aged 15 years and older.

Table 3: Key populations with higher than national average HIV prevalence, South Africa, 2012

<table>
<thead>
<tr>
<th>Key population</th>
<th>n</th>
<th>%</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black African women, 20-34 years</td>
<td>2,532</td>
<td>31.6</td>
<td>28.5-34.9</td>
</tr>
<tr>
<td>People living together, not married, 15-49 years</td>
<td>1,499</td>
<td>30.9</td>
<td>26.5-35.7</td>
</tr>
<tr>
<td>Black African men, 25-49 years</td>
<td>2,120</td>
<td>25.7</td>
<td>22.8-28.8</td>
</tr>
<tr>
<td>Disabled persons, 15+ years</td>
<td>1,055</td>
<td>16.7</td>
<td>12.9-21.4</td>
</tr>
<tr>
<td>High-risk drinkers, 15+ years</td>
<td>1,990</td>
<td>14.3</td>
<td>11.8-17.3</td>
</tr>
</tbody>
</table>

(Source: Shisana et al., 2012)

SANAC, in partnership with the DOH, PEPFAR, the United States Centers for Disease Control and Prevention (CDC), the University of California, San Francisco (UCSF), Anova Health Institute (Anova) and Wits Reproductive Health and HIV Institute (WRHI) conducted a health monitoring survey among female sex workers (FSW) from July 2013 to February 2014. The survey found that HIV prevalence among FSWs was 39.7% in Cape Town, 53.5% in Durban, and 71.8% in Johannesburg. Furthermore, the study found that about 80% of FSW in the age group 30-34 years in Johannesburg and Durban were living with HIV.

In December 2013, UCSF in collaboration with the DOH, SANAC, PEPFAR through CDC, and MSM programme and research stakeholders, began an MSM data triangulation and synthesis assignment to determine and understand South Africa’s response to HIV among MSM. HIV prevalence among MSM was observed to be between 1.89 and 4.65 times higher than non-ASM of the same age except in Ehlanzeni District, where it was comparable. Recent studies show high HIV prevalence among MSM, varying between 22% in Cape Town and 48% in Durban. Overall, the triangulation exercise determined that HIV prevalence among MSM in Cape Town, Durban and Johannesburg has risen by more than 10% from 2008 to 2012.

HIV prevalence among pregnant women attending antenatal clinics The 2013 National Antenatal Sentinel HIV Prevalence Survey found an overall HIV prevalence of 29.7% [95% CI: 28.9-30.5]. Repeat survey data show stable prevalence trends between 2009 and 2013 i.e. 29.4% (2009), 30.2 (2010), 29.5% (2011), 29.5% (2012) and 29.7% (2013). Notwithstanding such stable trends, four out of nine provinces recorded HIV prevalence estimates above the national estimate of 29.7% in 2013. These provinces are: Eastern Cape (EC) at 31.4%; Free State (FS) at 29.8%; KZN at 40.1%; Mpumalanga at 37.5%; and NW at 29.7%.

UNAIDS Spectrum modelling estimated HIV prevalence among women of reproductive age (15-49 years) at 21.3% [95% CI: 19.1-23.6] in 2014. The HIV prevalence for this age group seems to have stabilised in relation to the 21.1% [95% CI: 18.9-23.4] estimated in 2013 and 20.9% [95% CI: 18.8-23.0] estimated in 2012.
HIV incidence

In South Africa, measures of HIV incidence are produced by the HSRC, as well as modelling using the UNAIDS Spectrum model and the THEMBISA model. The 2012 HSRC survey determined HIV incidence estimates using two independent methods – direct HIV incidence measures using a laboratory-based testing algorithm, and indirect HIV incidence estimates using a mathematical model. It was estimated that there were 469,000 new infections among persons aged two years and older, which is equivalent to an HIV incidence rate of 1.07% [95% CI: 0.87-1.27], HIV incidence among youth aged 15-24 was highest among females at 2.54% compared to males at 0.55% – translating into an estimated 139,000 new infections. The total annual number of new infections was estimated to be 125,000 in men (1.29%) and 175,000 in women (1.62%), for the age group 25 years and older. Over the last three decades, the THEMBISA model has been applied to establish trends in HIV incidence, see Figure 5 (a). Among youth and adults aged 15-49 years, the HIV incidence peaked in the late 1990s, with continual decreases occurring through to 2011. Figure 5 (b) below illustrates the HIV incidence by province in 2011/2012. KZN had the highest HIV incidence followed by MP and NW. WC had the lowest HIV incidence, followed by NC.

Figure 4: HIV prevalence trends among antenatal women, South Africa, 1990 to 2013

Figure 5: HIV Incidence among youth and adults aged 15-49

The 2014 UNAIDS Spectrum estimates indicate that there were 330,000 [290,000 – 390,000] new infections across all age groups in 2014 – a steady decline from the estimated 410,000 in 2011, 380,000 in 2012, and 350,000 in 2013. Figure 6 depicts estimated new HIV infection trends over the period from 2004-2014.
3. National response to the AIDS epidemic
Progress towards achieving the 2015 targets

Table 4: 2011 UN Political Declaration on HIV/AIDS Targets and Commitments

<table>
<thead>
<tr>
<th>2011 UN Political Declaration on HIV and AIDS: Targets and elimination commitments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reduce sexual transmission by 50% by 2015</td>
</tr>
<tr>
<td>2. Reduce transmission of HIV among people who inject drugs by 50% by 2015</td>
</tr>
<tr>
<td>3. Eliminate Mother-to-Child-Transmission (MTCT) of HIV by 2015 and substantially reduce AIDS-related maternal deaths</td>
</tr>
<tr>
<td>4. Reach 15 million PLHIV with lifesaving antiretroviral therapy by 2015</td>
</tr>
<tr>
<td>5. Reduce TB deaths in PLHIV by 50% by 2015</td>
</tr>
<tr>
<td>6. Close the global AIDS resource gap by 2015 and reach annual global investment of US$ 22-24 billion in low- and middle-income countries</td>
</tr>
<tr>
<td>7. Eliminate gender inequalities and sexual violence and increase capacities of women and girls</td>
</tr>
<tr>
<td>8. Eliminate stigma and discrimination against people living with and affected by HIV</td>
</tr>
<tr>
<td>9. Eliminate HIV-related restrictions on entry, stay and residence</td>
</tr>
<tr>
<td>10. Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response</td>
</tr>
</tbody>
</table>

During the period January 2014 to December 2014, South Africa has continued to make progress towards achieving the 2015 targets and elimination commitments. These accomplishments were determined through a literature review, and stakeholder engagement; through validation workshops.
PREVENTION

Target 1:
Reduce sexual transmission of HIV by 50%, by 2015.

Target 2:
Reduce transmission of HIV among People who Inject Drugs by 50%, by 2015

Target 3:
Eliminate Mother-to-Child-Transmission (MTCT) of HIV by 2015 and substantially reduce AIDS-related maternal deaths

Target 1: To reduce sexual transmission of HIV by 50%, by 2015

<table>
<thead>
<tr>
<th>Is this a priority target for the country?</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the National Strategic Plan address this target?</td>
<td>YES</td>
</tr>
<tr>
<td>Is the country on track to reach the target and commitment?</td>
<td>NO</td>
</tr>
</tbody>
</table>

Target 1: Policy environment

South Africa has a generalised HIV epidemic, with the majority of new infections acquired through sexual transmission. Accordingly, prevention of sexual HIV transmission forms the foundation of the national effort to tackle HIV and AIDS. The NSP on HIV, STIs and TB for 2012-2016 proclaimed a novel period in the country’s fight against HIV. It accentuates the necessity to implement targeted, evidence-based combination prevention interventions in order to reduce new HIV infections by 50%.

Combination prevention follows a cohesive response where behavioural, biomedical and structural interventions are used in a reciprocally supportive way towards real reduction of new infections. The combination prevention package can include HIV counselling and testing (HCT), condom distribution, male medical circumcision (MMC), prevention of mother to child transmission (PMTCT), management of sexually transmitted infections (STIs), and tuberculosis (TB) and scale-up of ART. The socio-behavioural areas of focus include the emphasis on youth and on addressing gendered vulnerabilities.

In accordance with the United Nations (UN) Declaration of Commitment to HIV and AIDS (UNGASS) of 2001, and the recent UN Political Declaration on HIV and AIDS – ‘Intensifying our Efforts to Eliminate HIV and AIDS of 2011’, South Africa is devoted to dealing with HIV among key populations. Grounded on public health and human rights based approaches, the Department of Health (DOH) developed the Operational Framework for HIV, STIs and TB Programmes for Key Populations in South Africa in 2012. The framework is intended to assist health planners to develop, plan, implement, monitor and evaluate programmes that will achieve the key populations’ targets set in the NSP 2012-2016 and incorporates emphasis on sex workers (SW), men who have sex with men (MSM) and injecting drug users (IDUs).

Furthermore, SANAC, in partnership with key role players generated the National Strategic Plan for HIV Prevention, Care and Treatment for Sex Workers and concluded a Sex Workers Size Estimation Survey in 2013. These important initiatives were executed to help address the needs and current gaps identified in key populations’ service delivery, research, and support. Table 5 below summarizes progress made by end of 2014.
Target 1: Highlights and achievements

HIV incidence

As depicted in figure 5 (a) of the THEMBSA model above, the HIV incidence among youth and adults aged 15-49 years peaked in the late 1990s, with steady declines happening through to 2011. Figure 5 (b) shows the HIV incidence by province in 2011/2012 with KZN having the highest and WC the lowest HIV incidence.

The Spectrum 2014 estimates indicate a gradual decline in the number of new infections across all ages – from 410,000 [95% CI: 350,000-460,000] in 2011, to 380,000 [95% CI: 330,000-440,000] in 2012, to 350,000 [95% CI: 300,000-400,000] in 2013 and lastly to 330,000 [95% CI: 290,000-390,000] in 2014. A total decline of 50,000 new infections occurred from 2012 to 2014. The NSP aims to achieve a 50% reduction in adult HIV incidence from 2012 to 2016, and this target is unlikely to be met. Based on Spectrum estimates, Figure 7 illustrates the number of new HIV infections by province, in 2014, KZN, Gauteng (GP) and Eastern Cape (EC) account for over 50% of the total number of new infections in 2014.

Target 1: Current status

Table 5: Target 1, core indicators, South Africa, 2014

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Source</th>
<th>Baseline</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Young people: Knowledge about HIV prevention (15-24)</td>
<td>HSRC Survey, 2008/2012</td>
<td>29.4%</td>
<td>28.6%</td>
</tr>
<tr>
<td>2. Sex before the age of 15 (15-24)</td>
<td>HSRC Survey, 2008/2012</td>
<td>10%</td>
<td>10.7%</td>
</tr>
<tr>
<td>3. Multiple sexual partnerships</td>
<td>HSRC Survey, 2008/2012</td>
<td>7%</td>
<td>12.6%</td>
</tr>
<tr>
<td></td>
<td>HSRC Survey 2008/2012</td>
<td>75.9%</td>
<td>58.4%</td>
</tr>
<tr>
<td>5. HIV testing in the general population in the last 12 months and known results (15-49)</td>
<td>HSRC Survey 2008/2012</td>
<td>49.1%</td>
<td>66.2%</td>
</tr>
<tr>
<td></td>
<td>DOH Annual Report 2014/2015</td>
<td>6,688,950</td>
<td>9,566,097</td>
</tr>
<tr>
<td>6. HIV prevalence in young people (15-24)</td>
<td>HSRC Survey 2008/2012</td>
<td>8.7%</td>
<td>7.1%</td>
</tr>
<tr>
<td>7. Sex workers: prevention programmes (% SW reached with HIV prevention programmes)</td>
<td>SWEAT Report 2012</td>
<td>-</td>
<td>60%</td>
</tr>
<tr>
<td>8. SW: condom use</td>
<td>SWEAT Report 2012</td>
<td>-</td>
<td>81%</td>
</tr>
<tr>
<td>9. HIV testing in sex workers</td>
<td>SWEAT Report 2012</td>
<td>-</td>
<td>88%</td>
</tr>
<tr>
<td>10. HIV prevalence in sex workers</td>
<td>SWEAT Report 2012</td>
<td>-</td>
<td>59.6%</td>
</tr>
<tr>
<td>11. MSM: prevention programmes</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>12. MSM: condom use</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>13. HIV testing in MSM</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>14. HIV prevalence in MSM</td>
<td>MSM Data Triangulation and Synthesis 2014</td>
<td>-</td>
<td>22-48%</td>
</tr>
<tr>
<td>15. Proportion of men circumcised (15-49)</td>
<td>HSRC Survey 2008/2012</td>
<td>40.6%</td>
<td>46.4%</td>
</tr>
<tr>
<td>16. Number of male circumcisions performed according to national standards in the last 12 months</td>
<td>DOH Annual Report 2014/2015</td>
<td>331,668</td>
<td>508,404</td>
</tr>
</tbody>
</table>
According to the 2012 HSRC survey, it was estimated that South Africa had around 469,000 new infections [95% CI: 381,000-557,000] in people aged two years and older from mid-2011 to mid-2012. Furthermore, HIV incidence was estimated to be 17% to 32% lower than it would have been without current levels of availability of ART. Factors underpinning such declines potentially include behaviour-focused approaches such as: 1) strengthening age-appropriate school-based sexuality education; 2) intensifying community-based behavioural prevention programmes, 3) condom promotion and dissemination; 4) scaling up HIV counselling and testing (HCT), and undertaking HIV prevention programmes among sex workers. The use of ART may also have influenced the decline in HIV incidence. However, it should also be taken into account that epidemics follow natural declines, and it is not possible to make definitive causal attributions for incidence declines.

HIV prevalence

The 2012 HSRC survey estimates national HIV prevalence at 12.2% [95% CI: 11.4-13.1]. This estimate is higher than the 2008 national estimate of 10.6% [95% CI: 9.8-11.6]. A decline in HIV prevalence has been observed among children 2-14 years since 2002, decreasing from 5.6% in 2002 to 2.4% in 2012. From 2002 to 2005, the 15-24 year age group experienced an initial upsurge in prevalence, then a decline from 10.3% in 2005 to 7.1% in 2012. HIV prevalence in adults 25 years and older rose from 15.5% in 2002 to 19.9% while the 15-49 age group HIV prevalence increased from 15.6% in 2002 to 18.8% in 2012. HIV prevalence among individuals 2 years and older dropped from 2002 to 2005, stabilised from 2005 to 2008, and then increased to 12.6% in 2012. See Table 6 below.


<table>
<thead>
<tr>
<th>Age group</th>
<th>2002</th>
<th>2005</th>
<th>2008</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-14</td>
<td>5.6</td>
<td>3.3</td>
<td>2.5</td>
<td>2.4</td>
</tr>
<tr>
<td>15-24</td>
<td>9.3</td>
<td>10.3</td>
<td>8.7</td>
<td>7.1</td>
</tr>
<tr>
<td>25+</td>
<td>15.5</td>
<td>15.6</td>
<td>16.8</td>
<td>19.9</td>
</tr>
<tr>
<td>15-49</td>
<td>15.6</td>
<td>16.2</td>
<td>16.9</td>
<td>18.8</td>
</tr>
<tr>
<td>2+</td>
<td>11.4</td>
<td>10.8</td>
<td>10.9</td>
<td>12.6</td>
</tr>
</tbody>
</table>

(Source: Shisana et al., 2012)
Based on the 2014 UNAIDS Spectrum modelling, the estimated HIV prevalence for the 15-49 year age group was 18.2% [95% CI: 16.3 – 20.2] in 2014. Compared to the two previous years, HIV prevalence seems to have stabilised at 18.1% [95% CI: 16.3 – 20.1] in 2013, and 18.8 [95% CI: 16.2 – 19.8] in 2012. This estimate is similar to the 18.8% reported for the same age group in the 2012 HSRC survey.

The last two HSRC surveys indicated an estimated increase of almost 1.2 million PLHIV – from 5,253,493 in 2008 to 6,422,179 in 2012. The 2014 Spectrum estimates indicate that the number of PLHIV in South Africa rose from 5.7 million [5.0-6.3 million] in 2008 to 6.2 million [5.5-6.9 million] in 2012, and to 6.6 million [5.9-7.4 million] in 2014 – translating to an increase of 900,000 PLHIV from 2008 to 2014.

The 2013 National Antenatal Sentinel HIV prevalence survey findings show stable prevalence levels among pregnant women (15-49 years old) at 29.5% in 2012 and 29.7% in 2013 and, this relatively flat pattern has been observed since 2004. In 2013, HIV prevalence among 15-24 year-old pregnant women was 19.9%. HIV prevalence among pregnant women in this age group seems to be stabilising after it had declined from 21.8% in 2010 to 20.1% in 2011 and to 19.3% in 201217 – an 11% decline from 2010 to 2012. The 2014 UNAIDS Spectrum model estimates HIV prevalence among women of reproductive age (15-49 years) at 21.3% [95% CI: 19.1 – 23.6] in 2014. The HIV prevalence for this age group is similar to the 21.1% [95% CI: 18.9 – 23.4] estimated in 2013 and 20.9% [95% CI: 18.8 – 23.0] estimated in 2012.

**HIV Counselling and Testing (HCT)**

Knowledge of one’s HIV status through routine HCT is key to accessing treatment, care and support services. Since the launch of the HCT campaign in 2010, South Africa’s HCT levels are among the highest worldwide. According to HCT programme data, a total of 8,772,423 people were tested in 2011/2012. A total of 18 million tests were targeted in 2012/2013 and eventually, 8,978,177 tests were done (49.8%).

**Table 7: Number of HIV test clients, 2011/2012 to 2014/2015**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of HIV test clients aged 15-49 years</td>
<td>8,772,423</td>
<td>18,000,000</td>
<td>8,978,177 (All ages)</td>
<td>13,000,000</td>
<td>6,688,950 (DOH Annual Report 2013/2014)</td>
<td>10,000,000</td>
<td>9,556,097 (DOH Annual Report 2014/2015)</td>
</tr>
</tbody>
</table>

(Source: DOH Annual Report, 2013/2014)

To intensify HCT uptake, South Africa developed an HCT revitalisation strategy in 2012/2013. The strategy is focused on ensuring that HIV-positive individuals are linked to care; patients are provided with behaviour change counselling, and are screened for TB and non-communicable diseases (NCDs). The Deputy President and the Minister of Health launched this revitalised HCT campaign in December 2013, focusing on raising HCT coverage through the private sector, farms and the higher education sector.

Some 6,688,950 tests were administered to persons aged 15-49 years in 2013/2014 - 51% below the target of 13 million. This number excludes antenatal clinic (ANC) HCT data. Including the latter data, the total number tested in 2013/2014 was 9,713,179. The 2013/2014 target was set with the assumption that the 2010 HCT campaign testing rate would be maintained. Additionally, this HCT target was for all ages and not only for the 15-49 age group (as reported above). In 2014/2015, the national HCT target was set at 10,000,000 and 9,556,097 (95%) was achieved. Consequently, over 35-million HIV tests have been administered since the inauguration of the national HCT campaign in April 2010.17 To further enhance HIV and STIs education as well as generate demand for the services, South Africa planned to launch a five-year social mobilisation and communication campaign in 2014/2015.

**Condom distribution and use**

National condom distribution data shows a decrease in male condom distribution from the 2010 baseline of 492 million to 230,011,696 in 2011, then some improvement to 251,419,268 in 2012, and 352,065,256 in 2013. In 2014, a total of 506,431,299 male condoms were distributed and lastly, about 723,799,877 male condoms were distributed in 2015 – 72% of the 2016 NSP target of 1-billion male condoms was thus achieved. With regard to female condom distribution, a 16% decline from the 2010 baseline of 5.1 million was recorded in both 2011 (4,325,196) and 2012 (4,309,146). In 2013, a 51% increase from baseline was recorded with 7,686,231 female condoms distributed. In 2014, a total of 13,254,328 female condoms were distributed and lastly, 20,700,161 female condoms were distributed in 2015 – approximately 80% of the 2016 target of 25 million female condoms was thus achieved. It is important to note that, based on the estimated number of sex acts nationally, a target of 800,000 male condoms is recommended by the investment case report.
Studies on condom use differ in their findings. The 2012 National Communication Survey (NCS) found that 47% of respondents who had sex in the past year had used a condom at last sex, an increase from 40% found in the 2009 survey. For the 16-24 year age group, the 2012 NCS found last sex condom use at 62.3%, a slight decline from the 63.8% found in the 2009 NCS. Additionally, 76% of respondents had used a condom at last sex with a casual partner, 65% used a condom at last sex with a main or regular partner, and 28% used a condom at last sex with their spouse or live-in partner.22 The 2012 HSRC survey found last sex condom use levels of 36.2%, noting a rise from 2002 to 2008, and then a decline in 2012 among all age groups and both sexes, except among females aged 50 years and older. Among youth aged 15-24 years, condom use at last sex declined from 75.9% in 2008 to 58.4% in 2012. Condom use was also found to have declined markedly among adults, being 34.4% among adults aged 25-49 years and 12.2% among adults aged 50 years and older. The 2013 Joint HIV, TB and PMTCT Review also observed declines in condom distribution and use.

### Table 8: Male and female condom distribution, 2010-2014 (in millions)

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>2010 (Baseline)</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016 NSP Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of male condoms distributed</td>
<td>492 million</td>
<td>230,011,966 (53% &lt; baseline)</td>
<td>251,419,268 (49% &lt; baseline)</td>
<td>352,065,256 (28% &lt; baseline)</td>
<td>506,431,299 (51% of NSP target)</td>
<td>723,799,877 (72% of NSP target)</td>
<td>1 billion</td>
</tr>
<tr>
<td>Number of female condoms distributed</td>
<td>5,100,000</td>
<td>4,325,196 (16% &lt; baseline)</td>
<td>4,309,146 (16% &lt; baseline)</td>
<td>7,686,231 (51% &gt; baseline)</td>
<td>13,254,328 (53% of 2016 NSP target)</td>
<td>20 700 161 (80% of NSP target)</td>
<td>25 million</td>
</tr>
</tbody>
</table>

(Source: DHIS)

The 2012 HSRC survey found last sex condom use levels of 36.2%, noting a rise from 2002 to 2008, and then a decline in 2012 among all age groups and both sexes, except among females aged 50 years and older. Among youth aged 15-24 years, condom use at last sex declined from 75.9% in 2008 to 58.4% in 2012. Condom use was also found to have declined markedly among adults, being 34.4% among adults aged 25-49 years and 12.2% among adults aged 50 years and older. The 2013 Joint HIV, TB and PMTCT Review also observed declines in condom distribution and use.

**Age at sexual debut**

The 2012 HSRC survey found that 10.7% of youth aged 15-24 years had initiated sex before the age of 15 years, an increase from 10% recorded in 2008. Sexual debut before the age of 15 varies between the provinces, although confidence intervals overlap.

<table>
<thead>
<tr>
<th>Province</th>
<th>n</th>
<th>Sex before age 15</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Cape</td>
<td>475</td>
<td>14.2</td>
<td>8.5-22.8</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>558</td>
<td>16.8</td>
<td>11.6-23.6</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>286</td>
<td>10.1</td>
<td>6.3-15.6</td>
</tr>
<tr>
<td>Free state</td>
<td>295</td>
<td>10.3</td>
<td>7.2-14.5</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>852</td>
<td>7.6</td>
<td>4.6-12.4</td>
</tr>
<tr>
<td>North West</td>
<td>309</td>
<td>9.8</td>
<td>6.6-14.5</td>
</tr>
<tr>
<td>Gauteng</td>
<td>480</td>
<td>9.5</td>
<td>6.7-13.1</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>319</td>
<td>7.7</td>
<td>4.1-14.0</td>
</tr>
<tr>
<td>Limpopo</td>
<td>343</td>
<td>11.8</td>
<td>7.8-17.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3,911</td>
<td><strong>10.7</strong></td>
<td><strong>9.1-12.6</strong></td>
</tr>
</tbody>
</table>

(Source: Shisana et al., 2012)
The 2012 NCS found the mean age of sexual debut among youth aged 16-24 years to be 16.9 years, which was similar to the 2009 NCS result of 16.8 years.

Age-disparate relationships
The 2012 HSRC survey found that 19.8% of respondents had a sexual partner who was five or more years older than themselves. Analysis of data from the last three national surveys carried out in 2005, 2008 and 2012 indicate that around a third of young females aged 15-19 were found to have had partners five or more years older than themselves.

The 2012 NCS found that 42% of sexually active respondents had sexual partners five or more years older or younger than themselves. In the 16-24 year age group, having a partner who was five or more years older was reported by 39% of females and 13% of males. Moreover, 10% of females aged 16-24 years had a sexual partner who was 10 or more years older than themselves.

Multiple sexual partners
The 2012 HSRC survey found that 12.6% of sexually active respondents had more than one sexual partner in the last 12 months. Among persons in the 15-24 year age group, the proportion of males reporting having had multiple partners in the past year increased from 23.0% in 2002 to 37.5% in 2012. For females in this age group, the increase was from 6% to 8%.

The 2012 NCS reported that only 40.7% of respondents noted faithfulness as a means to prevent HIV, while only 23.5% indicated partner reduction. Increases in such reporting have however been observed since 2006.

<table>
<thead>
<tr>
<th>Table 10: Ways mentioned to prevent HIV, SA, 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faithfulness</td>
</tr>
<tr>
<td>---------------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Partner reduction</td>
</tr>
</tbody>
</table>

(Source: NCS, 2012)

Key populations programming (including SW and MSM)
Key populations in South Africa include MSM, transgender (trans) persons, SWs, prison populations, specific migrant groups and IDUs. To meet the need for services, research, and support to key populations, the DOH developed an ‘Operational Framework for HIV, STIs and TB Programmes for Key Populations in South Africa’, in 2012.

Sex worker programming
In association with the Sex Workers Sector and other SANAC sectors, SANAC developed a National Strategic Plan for HIV Prevention, Care and Treatment for Sex Workers and finalised a Sex Workers Size Estimation Survey in 2012/2013. In collaboration with National AIDS Convention of South Africa (NACOSA) and the Sex Worker Evaluation and Advocacy Taskforce (SWEAT), SANAC also conducted a National Sex Worker Programme Evaluation in 2012/2013 through Global Fund to Fight AIDS, TB and Malaria (GFATM) funding. It was found that 60% of sex workers were reached with HIV prevention programmes, 81% reported using condoms with their most recent client, 88% received an HIV test in the last 12 months and knew their results and 59.6% were PLHIV.23 SANAC in partnership with DOH, the US President’s PEPFAR, the CDC, the University of California, San Francisco (UCSF), Anova Health Institute and the Wits Reproductive Health and HIV Institute (WRHI) conducted the South Africa Health Monitoring Survey with Female Sex Workers (SAHMS-FSW, 2013-14).24 The survey addressed behavioural and HIV surveillance among the FSW populations in the largest metropolitan areas of Johannesburg, Cape Town and Durban, allowing for epidemiological analysis (see Figure 8).
It appears that most female sex workers are able to access and have utilised available HCT services. The SAHMS-FSW approximated the female sex worker HIV prevalence in Cape Town at 39.7%, 53.5% in Durban, and 71.8% in Johannesburg. The survey also reported that female sex workers in the three metropolitan cities carry a very high burden of HIV: 1) two in five FSW in Cape Town are PLHIV, 2) over 50% of the FSW in Durban are PLHIV and 3) almost 75% of FSW in Johannesburg are HIV infected. Furthermore, about 80% of FSW in the age group 30-34 years are HIV positive in Johannesburg and Durban.

The SAHMS-FSW 2013-14 also recorded significantly high Syphilis prevalence. Syphilis prevalence was 4.6% in Durban, 16.2% in Johannesburg and 19.9% in Cape Town. These levels are higher than among FSW elsewhere in the region – for example, 0.9% and 1.2% in Nairobi and Swaziland respectively. Substance and alcohol abuse, physical and sexual assault and other psychosocial health problems were also found to affect FSW in the survey.

**Men who have sex with men (MSM)**

With financial assistance from the GFATM, SANAC is collaborating with DOH and development partners to plan, expand and integrate the prevention, care and treatment programming for MSM into the public health service delivery system as part of the national HIV response plan. In December 2013, the UCSF, in association with DOH, SANAC, PEPFAR through CDC in South Africa, MSM programme and research stakeholders, initiated an MSM data triangulation and synthesis activity to better understand the state of, and response to, the HIV epidemic among MSM in South Africa. Over 300 different sources including research and programme data from 2008 and 2013 were reviewed, and Figure 9 shows the findings for HIV prevalence among MSM in comparison to non-MSM in various settings.
The triangulated data show that South Africa has a concentrated epidemic among MSM within the larger generalised HIV epidemic. HIV prevalence was reported to be between 1.89 and 4.65 times more among MSM males than non-MSM males in the same age group, except for Ehlanzeni District where the HIV prevalence is comparable in the two groups. The most recent respondent sampling (RDS) MSM studies show high HIV prevalence among MSM, ranging from 22% in Cape Town to 48% in Durban. Moreover, it was observed that the HIV prevalence among MSM in Johannesburg, Cape Town and Durban has risen by more than 10% from 2008 to 2013.

Medical male circumcision

Studies have shown that male circumcision decreases the risk of acquiring HIV in men during heterosexual intercourse by up to 60%. UN guidance advises that at least 5 million circumcisions would be required in South Africa to impact on population level HIV incidence. In 2010, the country decided to roll-out a national Medical Male Circumcision (MMC) programme with the aim of reaching 80% of HIV negative men aged 15–49 (approximately 4.3 million men) by 2015. A total of 422,262 circumcisions were performed in 2012/2013 while 331,668 circumcisions were performed in 2013/2014. The national target for both financial years was set at 600,000 circumcisions. Lastly, 508,404 were performed in 2014/2015 against a national 2014/2015 target of 1,000,000. Consequently, over 2,600,000 male medical circumcisions were performed in the last five years. Table 11 illustrates slow progress towards set targets.
The 2012 HSRC survey reported higher levels of MMC in men in their twenties and thirties – an age group at higher risk of HIV infection. Although the number of males who are medically circumcised has remained low, with just around one million men medically circumcised between 2008 and 2012, MMC has risen among men 15 years and older. However, MMC levels remain low compared to traditional circumcision.

The 2013 Joint HIV and TB Review found that low uptake of MMC could be attributed to South Africa’s doctor-centred MMC programme. In provinces like the Eastern Cape, Mpumalanga and Limpopo where traditional circumcision is customary, MMC rates were low. Some traditional leaders do not accept MMC as an alternative to traditional circumcision approaches. It appears that South Africa will not reach its target of reaching 80% of HIV-negative men aged 15-49 by 2015. The 2014 NCPI feedback analysis highlights the need for continued engagement with the Traditional Leaders Sector, to advocate for the integration of traditional and medical circumcision.

The DOH is looking at task shifting to address the shortage of doctors to conduct MMC, with a view to enabling nurses to perform MMC and increase the coverage. The feasibility of initiating non-surgically invasive medical devices (e.g. PrePex) is also being explored. South Africa plans to assimilate MMC into HCT campaigns, in combination with an intensified social mobilisation and communication plan to increase demand for MMC services.

Table 11: Number of MMC performed, 2012/2013 to 2014/2015

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<tbody>
<tr>
<td>Number of medical male circumcisions performed</td>
<td>600 000</td>
<td>422 262 (70%)</td>
<td>600 000</td>
<td>331 668 (55%)</td>
<td>1000 000</td>
<td>508 404 (51%)</td>
</tr>
</tbody>
</table>

(Source: DHIS 2013/2014)

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HIV prevention among young women and girls

HIV incidence is highest among girls and young women aged 15-24. USAID, in conjunction with the Centre for Communications Impact (CCI), and in collaboration with SANAC, the then Department of Women, Children and People with Disabilities (DOWCPD), DOH, SANAC Women’s Sector and other stakeholders, developed the Zazi Campaign. The campaign uses TV, radio and print media to address peer pressure and other factors that contribute to HIV and ST infection and unwanted pregnancies with a focus on self-esteem. The Zazi Campaign also promotes HCT uptake.

Through the partnership between PEPFAR, Bill and Melinda Gates Foundation and Girl Effect, the Determined, Resilient, Empowered, AIDS-free, Mentored and Safe (DREAMS) Initiative was announced on World AIDS Day in 2014. The overall goal of DREAMS is to significantly reduce new HIV infections among Adolescent Girls and Young Women (AGYW) between the ages of 15-24 by 40% within two years. With an estimated 2363 new HIV infections per week among AGYW aged 15-24 years (UNAIDS, 2013), South Africa (SA) was selected for DREAMS implementation among the ten eligible countries in Southern and Eastern Africa. This was done in full consultation with SAG and SANAC.

The DREAMS Initiative aims to deliver a core package that combines evidence-based approaches that go beyond the health sector, addressing the structural drivers that directly and indirectly increase girls’ HIV risk, including poverty, gender inequality, gender based violence (GBV) and, a lack of education. Coordinated through SANAC, DREAMS SA is being implemented in five high burden districts and the target sub-populations include adolescent girls 10-14 and 15-19 years in/out of school, OVC, young women 20-24 years of age including sex workers and male sex partners of these AGYW. To ensure adequate prevention of HIV amongst these vulnerable AGYW aged 10-24 years, appropriate interventions will be targeted to the respective subgroups and their male sex partners.

Integrated School Health Programme (ISHP)

The National Department of Health, in partnership with the Department of Basic Education (DBE), is implementing the ISHP in schools. The ISHP is designed to: 1) make Sexual and Reproductive Health (SRH) and youth friendly services accessible in the school setting; 2) enrich prevention efforts among youth; and 3) make certain young people who are HIV negative remain uninfected. As reflected in Table 12, the ISHP’s coverage of quintile 1 and 2 schools dropped significantly from 160% in 2012/2013 to 29% in 2013/2014. Similarly, the ISHP coverage of grade 1 and grade 8 quintile 1 and 2 schools declined substantially in the same period, from 75% to 19.3% for grade 1 and 129% to 11.9% for grade 8. These considerable falls in the ISHP coverage can be attributed to 1) various competing priorities e.g. preparation and introduction of HPV vaccine; 2) limited human resources; and 3) transport.
According to the 2013/2014 DOH Annual Report 2013/2014, school health services have been identified as a policy priority for the health system. As a result, all district plans have to include school health programming. To augment iSHP reporting, two new indicators were introduced in 2013/2014 namely; 1) school grade 1 screening coverage and 2) school grade 8 screening coverage. To improve iSHP capacity, the DOH planned to deploy supplementary iSHP mobile clinics in NHi pilot districts in 2014/2015.

Reach of HIV communication programmes

The 2012 NCS revealed that one or more national HIV communication programmes (HCPs) reached 82% of the population aged 16-55. As regards exposure to HCPs, it was highest in the sections of the population that HCPs aimed to reach – sections with individuals who are most likely to be PLHIV or at greatest risk of infection including younger Africans living in urban informal areas. Nonetheless, HCP reach has declined since 2009, the time when 90% of South Africans aged 16-55 years were exposed to at least one HCP. Social and behaviour change communication (SBCC) is fundamental to altering risk behaviours and practices contributing to the HIV epidemic. According to the 2014 NCPI feedback analysis, exploring ways to improve reach and impact of communication campaigns should persist and SANAC should find innovative approaches for leveraging non-governmental resources to bolster HCPs at grassroots level.

### Table 12: ISHP coverage of Quintile 1 and 2 schools – 2012/2013 to 2013/2014

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>ISHP coverage of Quintile 1 and Quintile 2 schools</td>
<td>160% (9,666 of 13,809 schools)</td>
<td>70%</td>
<td>20.2% (49.8% &lt; target)</td>
</tr>
<tr>
<td>ISHP coverage of Grade 1 learners in Quintile 1 and Quintile 2 schools</td>
<td>75% (297,000 of 495,000 learners)</td>
<td>60%</td>
<td>19.3% (40.7% &lt; target)</td>
</tr>
<tr>
<td>ISHP coverage of Grade 8 learners in Quintile 1 and Quintile 2 schools</td>
<td>129% (80,400 of 402,000)</td>
<td>20%</td>
<td>11.9% (8.1% &lt; target)</td>
</tr>
</tbody>
</table>

(Source: DOH Annual Report, 2013/2014)
Target 2: To reduce transmission of HIV among people who inject drugs by 50% by 2015

Is this a priority target for the country? | YES
---|---
Does the National Strategic Plan address this target? | YES
Is the country on track to reach the target and commitment? | YES

Target 2: Policy environment

Africa is increasingly playing an important role in the trafficking and transit of drugs such as heroin and cocaine. Injecting drug use (IDU) in the region is increasing. South Africa is included in the number of countries affected by drug trafficking, transit and IDU. Needle sharing between IDUs carries a high risk for HIV transmission.

The South African Government (SAG) is dedicated to cutting down the smuggling of illegal drugs into the country as well as minimising drug use. The Central Drug Authority (CDA) was established in 1999 and has created a National Drug Master Plan to: 1) manage the demand and supply of drugs in South Africa; and 2) facilitate an integrated approach to service delivery and the coordination of programmes on the management of drug abuse in all spheres of government and civil society. Additional direction has been made available through the passing of the Prevention of and Treatment for Substance Abuse Bill. 

The Prevention and Treatment of Drug Dependency Act (No. 20 of 1992) guides the Department of Social Development (DSD) with regard to addressing drug use. The Act takes into account the provision of programmes for the prevention and treatment of drug dependency, the establishment and registration of treatment centres and hostels, and the committal of certain persons for treatment and rehabilitation.

Target 2: Current status

Data on people who inject drugs (PWID) is scanty in South Africa. The actual PWID population size was estimated at about 67,000 – 0.2% of general population – in 2013. The HIV prevalence among the PWID population is estimated at 19.4% (i.e. 12,998). Other cross-sectional surveys conducted among PWID in South Africa found an HIV prevalence between 5% and 35%. HIV risks identified in qualitative studies include use of unsterile equipment and sex work among PWID.

A 2013 rapid assessment of HIV and related risk factors among PWID from five cities in South Africa explored injecting and sexual practices among PWID, drawing attention to broader structural and social factors that influence HIV risk among PWID and identified routes of HIV transmission between PWID and the broader population. The study noted that the risk of high HIV incidence among PWID observed in Europe, Asia and Africa, is also present in South Africa.

Table 13: Target 2, core indicators, South Africa, 2011-2014

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated number of opiate users (injectors and non-injectors)</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
</tr>
<tr>
<td>Number of people on opioid substitution therapy (OST)</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
</tr>
</tbody>
</table>

From the assessment of services for PWID, 1,920 of the 1,389,865 people on ART in 2010 were both HIV positive and PWID – equivalent to 0.14%.
Despite the fact that overall PWID numbers are low, the South African Community Epidemiology Network on Drug Use (SACENDU) has found increasing numbers of IDU in South Africa. For example, between 5% and 20% of patients in specialist treatment centres in the WC, NC, KZN and Gauteng are primary drug of abusers of heroin.38 Other key findings of the SACENDU report include: 1) increase in use in younger age groups, especially below 20 years of age; 2) increases in female drug users and less females in treatment centres; 3) provincial increases in use of all forms of psychoactive drugs e.g. methamphetamine, methaqualone, heroin; 4) decreases in referrals by employers and employer payment for treatment; and, 5) increase in heroin injecting by females in the Western Cape.

**Target 2: Highlights and achievements**

While South Africa has laws designed to address drug abuse, ineffective policies and the lack of public health guidelines to prevent and treat HIV infection among PWID constrain the standardisation of drug dependency treatment for PWID. National opioid substitution therapy (OST) and needle and syringe programme guidelines are lacking, leading to the provision of drug dependency treatment services being non-standardised.39

HIV prevention, treatment, care and support services for PWID are scarce and the majority of available social and health services for PWID are provided by civil society organisations (CSOs) e.g. rehabilitation centres, faith-based Organisations (FBOs), the South African National Council on Alcoholism and Drug Dependence (SANCA), with some government departments such as Social Development, Health, Justice and Correctional Services providing support. Some CSOs receive government funding. The World Health Organization (WHO), United National Office on Drugs and Crime (UNODC) and the Joint United Nations Programme on HIV and AIDS (UNAIDS) have recommended a package of comprehensive services for PWID that is not presently offered in South Africa.

Currently, OST is only accessible via the private sector. There is only one national syringe programme targeting MSM who inject drugs, which has been launched in central Cape Town. Limited non-OST drug dependency treatment services are offered at no cost. HCT uptake among PWID is not known and data on PWID on ART is also not available.40

South Africa’s efforts to address IDU and related HIV and other health risks remain inadequate. The government and private sector, as well as CSOs need to augment the response to the gradually escalating injecting drug use by playing an active role in supporting and developing appropriate services for substance users. Very little public communication on the links between HIV and injecting drug abuse, or risks of psychoactive drugs in general has occurred. HIV service uptake and clinical outcomes of PWID data is required to advise policy, decision-making and planning, and lack of data impedes planning and response. Data collection systems need to be reviewed in line with the evolution of drug trafficking and use.

**Table 14: Status and services for PWID and HIV, South Africa, 2014**

| Service type                                                                 | Status                          |
|------------------------------------------------------------------------------|================================|
| No. of PWID that are HIV+*(range)                                             | 12,998                         |
| % of HIV+ PWID**                                                              | 19.4                           |
| No. of HIV+ PWID                                                              | 1,920                          |
| Est. no. of HIV+ PWID receiving ART                                           | Not available                  |
| Availability of Needle Syringe Programme (NSP)                               | Yes                            |
| No. of NSP sites nationally                                                   | 1                              |
| No. of PWID served in last 12 months                                         | No data                        |
| No. of syringes per PWID distributed in 1 year (Jan-Dec 2010)                | No data                        |

(Source: Petersen et al. 2013)
Target 3: To eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths

| Is this a priority target for the country? | YES |
| Does the National Strategic Plan address this target? | YES |
| Is the country on track to reach the target and commitment? | YES |

Target 3: Policy environment

Elimination of mother-to-child transmission (eMTCT) of HIV and reduction of AIDS-related maternal deaths are a priority in South Africa. The country has demonstrated high levels of commitment to the eradication of MTCT by ensuring that the national PMTCT programme is aligned with international guidelines based on current scientific evidence.

In 2013, the World Health Organization (WHO) published updated guidelines on the diagnosis of HIV, the care of PLHIV and the use of antiretroviral drugs for treating and preventing new infections. In March 2013, South Africa reviewed its national PMTCT guidelines to include key policy changes including: 1) administration of a fixed-dose combination (FDC) of ART regardless of CD4 count or clinical stage, during pregnancy and breastfeeding; 2) infant Nevirapine prophylaxis be administered for six weeks (if the mother is on Highly Active ART or not breastfeeding) or throughout the breastfeeding period; and 3) all children younger than five years old living with HIV to be initiated on ART irrespective of CD4 count or clinical stage.

Most recently, the PMTCT guidelines were revised in December 2014 to include lifelong ART for all HIV positive pregnant women and mothers and birth polymerase chain reaction (PCR) for their HIV exposed infants. These policy decisions illustrate South Africa’s commitment to reaching the second goal of the NSP 2012-2016 i.e. ‘to reduce MTCT to less than 2% at six weeks post-birth and to less than 5% at 18 months of age by 2016’. The latest national PMTCT policy modifications take into account lifelong maternal ART and birth PCR, in line with global recommendations.

Target 3: Current status

Table 15: Target 3 core indicators, South Africa, 2014

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Source</th>
<th>Baseline</th>
<th>2014</th>
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<tbody>
<tr>
<td>Percentage of HIV-positive pregnant women who received antiretroviral medicine to reduce the risk of MTCT</td>
<td>2014 UNAIDS Spectrum</td>
<td>-</td>
<td>&gt;95%</td>
</tr>
<tr>
<td>Percentage of women living with HIV who are provided with antiretroviral medicines for themselves or their infants during the breastfeeding period</td>
<td>DOH, 2014/2015</td>
<td>-</td>
<td>91.2%</td>
</tr>
<tr>
<td>Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth/Early infant diagnosis (EID)</td>
<td>NHLS 2014</td>
<td>-</td>
<td>84%</td>
</tr>
<tr>
<td>Mother-to-child transmission of HIV</td>
<td>DOH, 2014/2015</td>
<td>-</td>
<td>1.5%™</td>
</tr>
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</table>
Target 3: Highlights and achievements

MTCT rates

Over the past 14 years, South Africa made a considerable effort in expanding the national PMTCT programme to reach all healthcare facilities. Based on current programme data, South Africa has made substantial advancement towards achieving the NSP 2012-2016 targets. As per Figure 10 below, the Medical Research Council (MRC) evaluation of the national eMTCT programme effectiveness found that the rate of MTCT of HIV at six weeks postpartum fell from 3.5% in 2010 to 2.7% in 2011.42 The 2013/2014 DOH Annual Report reported a further reduction to 2.6% in 2012 and 2.0% in 2013. Based on the National Health Laboratory Service (NHLS) 2014 Early Infant Diagnosis (EID) data, 84% of the estimated 271,068 HIV exposed infants (HEIs) – i.e. 228,891 – were tested and early vertical transmission was measured at 1.8% (4,078/228,891). As such, South Africa has met its 2016 NSP target of a 6-week MTCT rate of less than 2%.

Figure 10: Six-weeks MTCT rates: NHLS vs. MRC data, 2010-2014

Even though new surveys have measured the HIV MTCT rate around 6 weeks, it is noted that Nevirapine prophylaxis may affect the sensitivity of the PCR used in testing for HIV in HEIs. As result, the actual 6-week MTCT rate could be undervalued because all HEIs should be receiving Nevirapine prophylaxis as per the newest national PMTCT guidelines.

PMTCT cascade and universal coverage

The 2013 Joint HIV, PMTCT and TB Review revealed that the scale-up of PMTCT services in the past few years has been successful. However, gaps and challenges in achieving quality universal coverage for PMTCT throughout the country occur due to the inequalities across provinces, districts and sub-districts.43 The 2013 Joint Review affirmed that the limitations in the PMTCT cascade continue to be a challenge as a result of: 1) late booking for ANC services by pregnant women; 2) re-testing of HIV negative pregnant women at 32 weeks and three monthly thereafter, which is low; 3) post-partum follow up of the mother-baby pairs is suboptimal; and, 4) very few babies of HIV-positive mothers are tested for HIV at 18 months. The 2014 analysis of the NCPI inputs indicated that CSOs and development partners are supplementing government efforts to bolster the PMTCT cascade in communities.
### Table 16: National PMTCT cascade, 2012/2013 to 2014/2015

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<tbody>
<tr>
<td>ANC 1st visit &lt;20 weeks rate</td>
<td>44%</td>
<td>60%</td>
<td>50%</td>
<td>65%</td>
<td>53.9%</td>
</tr>
<tr>
<td>ANC initiated on ART rate</td>
<td>81.6%</td>
<td>90%</td>
<td>77.5%</td>
<td>93%</td>
<td>91.2%</td>
</tr>
<tr>
<td>Mother postnatal visit within 6 days rate</td>
<td>65.2%</td>
<td>79%</td>
<td>73%</td>
<td>80%</td>
<td>74.3%</td>
</tr>
<tr>
<td>Infant 1st PCR Positive within 2 months rate</td>
<td>2.5%</td>
<td>2.5%</td>
<td>2%</td>
<td>1.8%</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

(Source: DOH Annual Report, 2014/2015)

The 2012/2013 to 2014/2015 DOH programmatic data presented in Table 16 above illustrates that accessing antenatal care before 20 weeks of pregnancy remains a challenge but, there has been a gradual improvement since the 44% reported in 2012/2013. In 2013/2014, it was found to be 50%, against a national target of 60% and, 53.9% in 2014/2015, against the national target of 65%. This can be credited to different factors including: 1) use of private health facilities (data is not captured onto the District Health Information System or DHIS); 2) lack of knowledge about the rationale for early booking; and, 3) socio-cultural issues. The antenatal clinic (ANC) initiated Highly Active ART (HAART) rate dropped from 81.6% in 2012/2013 to 77.5% in 2013/2014, and rose to 91.2% in 2014/2015. The decline in 2013/2014 is ascribed to data capturing challenges experienced after the introduction of FDCs and these were subsequently addressed as reflected in the 2014/2015 results. The mother postnatal visit within 6 days rate has increased and is expected to progress as the ward-based outreach teams’ (WBOTs) coverage increases. The infant first polymerase chain reaction (PCR) positive within 2 months rate has improved noticeably from 2.5% in 2012/2013 to 2% in 2013/2014 to 1.5% in 2014/2015, thereby reaching the 2016 NSP target of below 2% and progressing towards elimination.

Early infant diagnosis

The NHLS data affirms the rapid scale-up of EID since inception of the PMTCT programme in 2000, registering a 100-fold rise in PCR tests to 350,000 by 2012. In 2012, 73% of the estimated 270,000 HIV-exposed infants requiring an early PCR were tested and 75.3% of the estimated 201,191 were tested in 2013. By end of 2014, the early vertical transmission rate had fallen to 1.8% as a result of successful implementation of the national PMTCT programme. The NHLS data thus provides low cost and timely monitoring of facets of the PMTCT programme as the country moves towards achieving virtual elimination of paediatric HIV infection in South Africa.

HAART initiation in the PMTCT setting

The 2013 Joint HIV, TB and PMTCT Review reported that the percentage of HIV-positive pregnant women receiving ART was 83% in 2009, 87.3% in 2010 and 87.1% in 2011. Based on 2014 UNAIDS Spectrum modelling estimates, > 95% of women have received ART to reduce the risk of MTCT from 2010 to 2014. The 2014/2015 DOH Annual Report found that the ANC initiated on HAART rate was 91.2% in 2014/2015 – 1.8% below the national 2014/2015 target of 93%.

Monitoring and evaluation

Monitoring and evaluation of the PMTCT programme is still being refined. The 2013 Joint Review confirmed the gaps in quality of care at service delivery level and the deficiencies in the quality of data. Some of the gaps identified include: 1) inaccurate or incomplete recording and reporting; 2) lack of understanding of key indicators by healthcare providers and stakeholders; and, 3) lack of a systematic process of feedback and monitoring linked to action at all levels of healthcare delivery.

The 2013 Joint Review also found that the programmatic tools like registers and tally sheets were not yet adapted for use with the new guidelines thus causing challenges in monitoring policy changes. Lastly, the programmatic tools are yet to be revised to incorporate the latest 2014 policy adjustments i.e. lifelong maternal ART and birth PCR.
CARE, TREATMENT AND SUPPORT

**Target 4:**
Reach 15 million people living with HIV with lifesaving antiretroviral therapy by 2015

**Target 5:**
Target 5: Reduce TB among people living with HIV by 50%, by 2015

Target 4: To reach 15 million PLHIV with lifesaving antiretroviral therapy by 2015

| Is this a priority target for the country? | YES |
| Does the National Strategic Plan address this target? | YES |
| Is the country on track to reach the target and commitment? | YES |

**Target 4: Policy environment**

South Africa launched its national public sector ART programme in 2004. In the second half of the last decade, the country progressively exhibited serious commitment to reaching eligible PLHIV with lifesaving ART. By the end of financial year 2013/2014, South Africa had more than 2.5 million PLHIV receiving ART.\(^4\) The 2014 Spectrum modelling estimates ART coverage at 46\% [95\% CI: 41-52] among the 15 years and above age group and 66\% [95\% CI: 57-74] among the 0-14 year age group. The country’s ART programme is the largest worldwide, matching the burden of disease.\(^4\) This accomplishment can be attributed to a supportive legislative and policy environment. Since inception of the national HIV programme, South Africa has kept up with new policy developments based on the available local and international scientific evidence. To reinforce its national efforts for scaling up HIV treatment beyond 2015, South Africa has adopted the UNAIDS 90-90-90 targets namely, 90% of people living with HIV knowing their HIV status, 90% of PLHIV who know their status on ART and, 90% of people on treatment having suppressed viral loads, to be reached by 2020.

In alignment with the latest WHO guidelines and with support from development partners, the national HIV and AIDS management guidelines (last updated in March 2013) were again updated in April 2015 to ensure compliance with evidence-based international standards. The most recent changes include the following: 1) CD4 threshold for ART initiation increased from 350 to 500; 2) viral load monitoring prioritisation; 3) lifelong HAART for pregnant women; and 4) birth PCR. Importantly, the 2013 treatment guidelines update comprised the introduction of fixed dose combinations (FDCs) of ART. The transition from triple-drugs to FDCs drastically reduced the costs of ART resulting in an estimated saving of ZAR R 2.2-billion between 2013 and 2014.\(^4\)

**Target 4: Current status**

**Table 17: Target 4 core indicators, 2014**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Source</th>
<th>Baseline</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of adults and children currently receiving ART among all adults and children living with HIV</td>
<td>Spectrum, 2014</td>
<td>66.25</td>
<td>Adults - 73%, Children - 75%</td>
</tr>
<tr>
<td>Number of adults and children who are still alive and on ART at 12-months after initiating treatment</td>
<td>DOH Tier.net</td>
<td>No data</td>
<td>400,948</td>
</tr>
</tbody>
</table>
Target 4: Highlights and achievements

Number of PLHIV on ART

Since 2009, South Africa has had strong political leadership and civil society involvement in HIV response. By the end of 2012, over 17.6 million people had tested for HIV. The 2012 HSRC survey estimated that 31.2% (i.e. 2,002,000) of 6,422,000 PLHIV in 2012 were on ART. The exposure to ART among PLHIV rose from 16.6% in the 2008 survey to 31.2% in 2012. Furthermore, the 2013 Joint HIV, TB and PMTCT Review established that in the period 2009 to 2012, the DOH ART programme data demonstrated a quadruple increase in the number of people on ART. During the 2014 validation workshops, the aforementioned fourfold increase in the number of PLHIV on ART was recognised by stakeholders as one of the greatest accomplishments in the history of the national response to HIV.

Table 18: New clients started on ART, 2012/2013 to 2013/2014

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</thead>
<tbody>
<tr>
<td>Number of new clients put on ART</td>
<td>500,000</td>
<td>612,118</td>
<td>500,000</td>
<td>662,312</td>
<td>Indicator not included in the DOH Annual Report 2014/2015</td>
</tr>
</tbody>
</table>

(Source: DOH Annual Report, 2013/2014)

As illustrated in Table 18 above, South Africa exceeded its target of starting 500,000 new patients on ART in 2012/2013. A total of 612,118 new patients were initiated on ART in 2012/2013. Similarly, South Africa surpassed its 2013/2014 target of 500,000 and initiated a total of 662,312 new patients on ART by end of 2013/2014. Consequently, over 2.5-million PLHIV were receiving ART by end of 20013/14.

Figure 11: Number of PLHIV in SA receiving ART between 2009 and 2014

(Source: UNAIDS Spectrum HIV estimates, 2014)
According to the DOH Annual Report 2014/2015, South Africa had just over 3 million (3,103,902) people of all ages receiving ART by end of 2014/2015 – equivalent to 47% ART coverage at an estimated total PLHIV population of 6,600,000. South Africa has exceeded its NSP 2015/2016 target of three million patients on ART.

South Africa’s accomplishments towards achieving the target for PLHIV on ART can be attributed to several initiatives: 1) the massive HCT campaign launched in 2010 that has resulted over 35-million South Africans being tested by end of 2013/2014; 2) the scale-up and decentralisation of the ART programme through Nurse-Initiated Management of ART (NIMART) - the number of NIMART trained nurses increased from 10,000 in 2011/2012 to 23,000 NIMART by the end of 2012/2013; 3) two key policy changes namely, the change in eligibility criteria for ART initiation from 200 to 350 in 2013 and from 350 to 500 by end of 2014; and, 4) the introduction of FDCs in the public sector.

**TB and HIV integration**

South Africa’s 2014/2015 national target for TB/HIV co-infected clients initiated on ART rate was set at 64%; 73.7% was achieved. This is a huge improvement from the 31.2% that was achieved in 2013/2014. This marked improvement can be attributed to the fact that like pregnant women, TB/HIV co-infected clients are prioritised for ART initiation irrespective of CD4 count. In addition, there is ongoing training and mentoring of clinicians on TB/HIV co-infection and the implementation of TB/HIV guidelines has been intensified. Figure 12 shows the trends in TB/HIV activities data for cohorts 2010-2012.

![Figure 12: Trends of TB/HIV programme activities at outcomes level over time](image)

(Source: Annual TB Report, 2013)

The TB and HIV integration seems to be progressing well and sufficient awareness has been raised to enable further collaborative activities between TB and HIV. Efforts made to ensure patients know their status have led to a gradual increase in the proportion of TB patients with a known HIV status. The number of PLHIV diagnosed with TB is steadily declining, affirming the effect of ART on TB incidence. In an effort to strengthen HIV and TB integration, South Africa recently implemented several activities, namely, the first integrated Joint Health Review of the HIV, TB and PMTCT programme in October 2013, and the development of National Adherence Guidelines for Chronic Diseases [HIV, TB and Non-Communicable Diseases (NCD)] in 2014. The 2013 Joint Review provided a clearer picture of the current situation in terms of integration of these programmes, while the National Adherence Guidelines stipulate concrete actions to ensure that patients with chronic diseases like HIV, TB and non-communicable disease (NCD) co-morbidities are adequately supported to adhere to these long term treatments.
Retention in care

Retaining PLHIV in care continues to be a challenge, particularly in the pre-ART phase. The 2013 Joint HIV, TB and PMTCT Review revealed that at 36-months after patients are initiated on ART, 40% are Lost to Follow-Up (LTFU). The undesirable retention rates observed can be credited to the poorly coordinated, inefficient and ineffective linkages and/or referral systems being implemented within or between communities, health facilities, districts and provinces. These rates can also be ascribed to weak in-facility data management and poor adherence to the ART data management standard operating procedures (SOP) namely, the ART monitoring and evaluation (M&E) SOP. The tool is central to outlining the key roles and functions for effective maintenance of the data management systems and strengthening patient tracing activities using the management reports.

Figure 13 shows the adult lost to follow up at 3, 6, and 12-months for patients started on ART from January to December 2013, by province – with a national average of 27% LFTU among patients who completed 12-months of ART.

The DOH data complete to 120-months in Figure 14 below indicates that retention in care is declining from 78.9% in clients at 6-months ART to 48.3% in clients at 60 months ART respectively.
It is also important to note that due to the design of the data system used within DOH, patients who were previously reported as LFTU who return to care are retrospectively updated. Their return results in the ‘flattening out’ of the retention in care percentage as shown in figure 15. This cannot be controlled for through aggregate data, and this trend is further described by Johnson et al.60 Additionally, it is understood that strengthened patient management and referral systems will result in improved retention and decrease the variability in these figures if patients are effectively managed.

To bolster patient retention and treatment adherence, the DOH continues to augment the clinical mentorship programme, and the monitoring of ART clinical outcomes using TIER.Net system at facility level. The DOH plans to use the cascade approach as well as map and target populations at risk to ensure that they are monitored and supported throughout the continuum of care, including screening, counselling, diagnosis, treatment, retention in care and outcomes. By end 2014, the DOH was in the process of finalising the National Adherence Guidelines for Chronic Diseases (HIV, TB and NCDs) for implementation in 2015. This comprehensive two-part document provides a strategic overview and an implementation guide, and has been developed with high levels of support from development partners.

Viral load monitoring

South Africa monitors individuals receiving ART to ensure successful treatment, identify adherence problems and determine whether and which ART regimens should be switched in the event of treatment failure. All patients on ART receive the WHO recommended standard for monitoring the response to ART – viral load testing.

The 2015 national ART guidelines provide comprehensive guidance regarding viral load monitoring for first line regimens in patients with viral load below 400 copies/ml, 400-1000 copies/ml and above 1000 copies/ml.61 The standardised first and second line regimens are based on efficacy, safety and tolerability and a third Line Review Committee has been set up to coordinate the management of patients who fail the second line regimen.

Viral load suppression (vLS) is reported as the total number of captured viral loads <400 copies/ml. All viral loads captured (vLD) serves as the denominator. Based on DOH programme data, Figure 16 below shows that of active patients on ART in 2014; 59.6% had a viral load done at 96 months in 2014, and 81.0% of the patients were virally suppressed.
Lastly, through the financial assistance from the GFATM, South Africa is conducting HIV drug resistance surveillance and implementing the Central Chronic Medicine Distribution and Dispensing programme (CCMDD). Since the introduction of FDCs for all patients in September 2013, about 900,000 of the 2.5 million patients remaining on ART were on FDCs by end of 2013/2014.63

AIDS related deaths

The Spectrum 2014 HIV estimates show a significant drop in the AIDS related deaths for all ages - from 320,000 in 2010 to 140,000 in 2014, see Figure 17.

Figure 16: Estimates of AIDS deaths in South Africa, 2011-2014

(Source: UNAIDS Spectrum HIV/AIDS estimates, 2014)
Monitoring and evaluation

South Africa adopted a three-tier patient-level ART monitoring system on 31 March 2011. Tier 1 is the paper-based system (ART register), Tier 2 is the electronic register (Tier.Net) and Tier 3 is the networked electronic medical record (eKapa). The system has been rolled out countrywide and significant progress has been made towards reliable reporting of cohort data through Tier.Net. Facility-level data capturers have been trained and most facilities have migrated from Tier 1 to Tier 2. The looming expanded implementation of Tier.Net, which in addition to ART data will include HCT, pre-ART and TB programme data, will help strengthen patient-level surveillance. It is therefore important that the ART M&E SOP is revised by all key stakeholders including clinicians, facility managers, programme managers and health information managers to understand the key and respective roles they play in ART M&E. This will be progressively important as the TB data capture shifts from paper-based management at the facility to digitised data management at the facility level.

This integrated data capture aims to reinforce integrated patient management and also strengthen integrated data management. Accordingly, it can be expected that improved patient tracking and enhanced linkages and retention in care will be accomplished.

Target 5: To reduce TB deaths in PLHIV by 50% by 2015

Is this a priority target for the country? YES
Does the National Strategic Plan address this target? YES
Is the country on track to reach the target and commitment? YES

Target 5: Policy environment

South Africa’s TB burden was ranked third in the world after China and India from 2009 to 2012. Following the 2013 national TB programme data review, it is ranked sixth after India, China, Nigeria, Pakistan and Indonesia. In line with Target 5 of the UN 2011 UN Political Declaration on HIV/AIDS Targets and commitments, the country’s TB policy direction is embraced in the third goal of the NSP 2012-2016 namely, ‘reduce the number of new TB infections as well as deaths from TB by 50% by 2016’.

To reinforce the prevention of TB infection and disease, South Africa’s national TB plan was updated in 2013 and new national TB management guidelines were released in 2014. In cognisance of HIV and TB being the drivers of morbidity and mortality in South Africa, the 2014 TB guidelines focus on the following key issues: 1) reducing transmission of infection in the communities; 2) diagnosing drug-sensitive/susceptible (DS) and drug resistant (DR) TB early; 3) initiating treatment in all patients diagnosed with TB early; 4) retaining patients in treatment and care until completion of treatment; and, 5) preventing TB in PLHIV by initiating all eligible HIV-positive individuals on ART and isoniazid preventive therapy (IPT). Moreover, there are other plans and supporting guidelines for the management of DR-TB, including the decentralisation and deinstitutionalisation of DR-TB services.

Target 5: Current status

Table 19: Target 5 core indicators, South Africa, 2014

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Source</th>
<th>2013/2014</th>
<th>2014/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV</td>
<td>ETR.Net</td>
<td>31.2% (TB/HIV co-infected clients initiated on ART rate)</td>
<td>73.7% (TB/HIV co-infected clients initiated on ART rate)</td>
</tr>
</tbody>
</table>

* TB/HIV co-infected clients initiated on ART indicator was only added to the National Indicator Dataset (NIDS) in 2013/2014 and the national target is 85%
With a TB/HIV co-infection rate of over 60%, the country’s TB epidemic is directly linked to HIV incidence and prevalence. About 270,000 (240,000-310,000) of South Africa’s estimated 450,000 (400,000-510,000) new TB infections in 2014 were in PLHIV. In 2014, total TB incidence was estimated to be 450,000 cases, at a rate of 834 (737-936) cases per 100,000. TB is the primary cause of death for PLHIV - an estimated 72,000 TB deaths occurred among PLHIV in 2014, a death rate of 134 (107-164) per 100,000 population. Figure 18 below, demonstrates a gradual decrease in TB incidence from 2008 to 2014.

**Figure 17: TB incidence for all forms of TB from 1990 to 2014, South Africa**

![Graph showing TB incidence from 1990 to 2014](image)

(Source: WHO Global TB Report, 2015)

Figure 19 depicts the trends of TB cases from 2005 to 2013. The graph illustrates a steady rise in the number of TB cases from 2005 to 2009, which then stabilised, and gradually decreased from 2010 to 2013.

**Figure 18: National all TB cases from 2005 to 2013**

![Graph showing national all TB cases from 2005 to 2013](image)

(Source: Annual TB Report, 2013)
In 2013, South Africa had a total of 328,896 DS-TB registered cases and based on this programmatic data, had a national TB case rate of 621/100,000 population. Commendably, the proportion of registered TB patients screened for HIV has also risen. The TB client tested for HIV rate increased from 85.3% in 2012/2013 to 88.7% in 2013/2014.69 To address the limitations related to diagnosing TB in PLHIV, South Africa introduced the GeneXpert MTB/RIF assay – replacing microscopy as the first diagnostic method; resulting in a rise in the number of MDR-TB cases diagnosed.

However, the elevated caseload of multidrug-resistant TB (MDR-TB) and extensively drug resistant TB (XDR-TB) aggravate South Africa’s TB burden. The number of MDR-TB cases rose from 10,085 in 2011 to 14,161 in 2012.70 From the total of 14,161 cases of MDR-TB diagnosed among notified pulmonary TB cases in 2012, only 5,890 (41.6%) were initiated on treatment.71

The diagnosis-treatment gap for detected cases of MDR-TB continues to widen and this is of serious public health concern. Despite the upsurge in the number of MDR-TB cases, national TB programme data shows a decrease in the number of DS-TB cases (Figure 20). MDR-TB cases are mounting, nearly doubling from 7,350 cases in 2007 to 14,161 in 2012. Besides these rising cases, it is presumed that half of the DR-TB cases remain undiagnosed. Likewise, the rise in nosocomial DR-TB infection among health care workers (HCWs) indicates the greater likelihood of acquiring DR-TB in hospitals.

Figure 19: Trends for notified TB and MDR cases: South Africa (2007-2012)

![Figure 19: Trends for notified TB and MDR cases: South Africa (2007-2012)](source: DOH, 2013)

Table: Trends for notified TB and MDR cases: South Africa (2007-2012)

<table>
<thead>
<tr>
<th>Year</th>
<th>Notified TB</th>
<th>Notified MDR-TB</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>7,350</td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>8,026</td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>9,070</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>7,386</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>10,085</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>14,161</td>
<td></td>
</tr>
</tbody>
</table>

Despite the upsurge in the number of MDR-TB cases, national TB programme data shows a decrease in the number of DS-TB cases (Figure 20). MDR-TB cases are mounting, nearly doubling from 7,350 cases in 2007 to 14,161 in 2012. Besides these rising cases, it is presumed that half of the DR-TB cases remain undiagnosed. Likewise, the rise in nosocomial DR-TB infection among health care workers (HCWs) indicates the greater likelihood of acquiring DR-TB in hospitals.

Figure 20: TB mortality rate (per 100,000 population – excluding HIV+ TB), South Africa, 1990-2014

![Figure 20: TB mortality rate (per 100,000 population – excluding HIV+ TB), South Africa, 1990-2014](source: WHO Global TB Report, 2015)

TB mortality rate has changed over time. As reflected in Figure 21, the TB mortality (excluding HIV+ TB) in South Africa seems to be stabilising in the last few years – estimated at 24,000 (22,000-26,000) cases, with a rate of 44 (41-48) per 100,000 population in 2014.72 With a 2016 NSP TB mortality rate target of 25/100,000 – equivalent to a 50% reduction – South Africa is not on track to reaching its target.
Target 5: Highlights and achievements

TB treatment outcomes for new smear positive pulmonary TB

National TB programmatic data shows an improvement in treatment outcomes for new sputum smear positive pulmonary TB (SS+ PTB) from 2004 to 2012 (See Figure 21). The treatment success rate has gradually increased from 77.1% in 2009 to 78.9% in 2010, to 79.8% in 2011, with 80.8% being recorded in 2012. According to the 2014/2015 DOH Annual Report, TB new client treatment success rate has further improved to 82.5% in 2014/2015. Despite these improvements, the national treatment success rate is still below the NSP target of >85% by 2016 (which also corresponds to the global TB treatment success rate).

Figure 21: Trends of TB programme performance, 2004-2012

a) Treatment success rates among new SS+ patients, 2004-2012

b) Cure rates among new SS+ patients, 2004-2012

(Source: DOH Annual TB Report, 2013)
As shown in Figure 22(b), the national TB treatment cure rate has improved from 50.8% in 2004 to 75.8% in 2012. The treatment success rate has risen from 65.5% in 2004 to almost 80.8% in 2012. The defaulter rate dropped from 10.3% in 2004 to 6.2% in 2012. According to the 2014/2015 DOH Annual Report, defaulter rate has declined further, reaching 5.7% by end of 2014/2015. Nonetheless, this is still below the national 2013/2014 target of <5%.

In the last 2-3 years, high treatment completion rates without confirmation of cure at six months post initiation of treatment have resulted in suboptimal cure rates. Likewise, loss to follow-up due to patient migration remains a challenge thus no improvement in the TB defaulter rate from 2012 to 2014, see Table 20.

Table 20: New PTB cure and defaulter rates, 2012/2013 to 2014/2015

<table>
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</thead>
<tbody>
<tr>
<td>TB new client treatment success rate</td>
<td>73.8%</td>
<td>85%</td>
<td>75.9%</td>
<td>82%</td>
<td>82.5%</td>
</tr>
<tr>
<td>TB defaulter rate (new pulmonary TB)</td>
<td>6.1%</td>
<td>&lt; 5%</td>
<td>6.2%</td>
<td>6%</td>
<td>5.7%</td>
</tr>
</tbody>
</table>


In the last 2-3 years, high treatment completion rates without confirmation of cure at six months post initiation of treatment have resulted in suboptimal cure rates. Likewise, loss to follow-up due to patient migration remains a challenge thus no improvement in the TB defaulter rate from 2012 to 2014, see Table 20.

Table 21: Treatment outcomes for smear positive, 2011, by HIV status

<table>
<thead>
<tr>
<th>HIV status (group)</th>
<th>Transferred Out</th>
<th>Treatment Success</th>
<th>Defaulted</th>
<th>Died</th>
<th>Failed</th>
<th>Not Evaluated (lost to follow up)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>4.0%</td>
<td>82.1%</td>
<td>7.4%</td>
<td>3.4%</td>
<td>2.0%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Positive</td>
<td>5.5%</td>
<td>75.4%</td>
<td>6.9%</td>
<td>8.9%</td>
<td>2.1%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Null, unknown or other</td>
<td>6.3%</td>
<td>73.7%</td>
<td>8.8%</td>
<td>7.1%</td>
<td>1.9%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>5.1%</td>
<td>77.6%</td>
<td>7.3%</td>
<td>6.7%</td>
<td>2.0%</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

(Source: ETR, 2013)

In comparison, treatment outcomes for TB patients living with HIV are inferior (75.4% treatment success) to TB patients who are not living with HIV (82.1% treatment success).
TB burden and services

TB services are readily available and accessible. However, patients usually present late. The delayed recognition of TB symptoms results in late diagnoses and more spread of TB infection. Undoubtedly, the scale-up of GeneXpert has improved the diagnosis of TB among patients with suspected TB symptoms. Over 300 GeneXpert machines have been deployed nationwide. In comparison to smear microscopy, GeneXpert doubled the number of laboratory-confirmed TB cases and detected 7% rifampin resistance thus enabling clinicians to adapt regimens based on individual patient treatment needs. Over 1.2 million tests had been performed by March 2013. The 2013 Joint HIV, TB and PMTCT Review found that TB service utilisation remains inadequate, despite the availability of TB services at primary health care (PHC) level. Revised national TB guidelines, SOPs and algorithms have been disseminated nationwide, including to TB programmes in the mines.

TB screening in PLHIV and HIV screening in TB patients

The country experienced a two-fold increase (to 1.26 million) in the number of PLHIV screened for TB from 2010 and 2011. The 2015 WHO Global TB report states that a total of 1,148,477 PLHIV were screened for TB in 2014. Progressively, the TB client tested for HIV rate increased from 85.3% in 2012/2013 to 88.7% in 2013/2014 (Table 22). Nevertheless, this was lower than the 2013/2014 target of 94%. The abovementioned underachievement in the HIV testing in TB client rate can be credited to ETR.net recording weaknesses along with inconsistent HIV screening in TB patients by some of the health workers. The 2013 Joint HIV, TB and PMTCT Review revealed that universal TB screening continues to be a challenge especially among chronic patients.

TB infection control

TB infection control is largely still not adequately applied. Various factors can be attributed to this finding: 1) absence of facility infection control plans, facility risk assessments, related quality assurance (QA), and monitoring checklists for inadequate airborne infection control; 2) limited use and availability of N95 masks; and 3) inadequate infrastructure for proper infection control practices. The 2013 Joint Review found that infection control practices were heterogeneous across and within provinces with ineffective triaging of potentially infectious TB cases, and inadequate ventilation of waiting areas and consultation rooms. Additionally, the utilisation and upkeep of ultraviolet (UV) light differs substantially, and there is over reliance on non-functional and poorly serviced UV lights.

Isoniazid preventive therapy

Augmented TB screening in PLHIV has enabled South Africa to scale up Isoniazid preventive therapy (IPT). The number of PLHIV receiving IPT increased nearly threefold (from 146,000 to 373,000) between 2010 and 2011.

Table 22: TB client tested for HIV rate, 2012/2013 to 2013/2014

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>TB client tested for HIV rate</td>
<td>85.3%</td>
<td>94%</td>
<td>88.7%</td>
<td>Indicator not included in the DOH Annual Report 2014/2015</td>
</tr>
</tbody>
</table>

(Source: DOH Annual Report, 2013/2014)

Table 23: Number of new HIV-positive clients initiated on IPT 2012/2013 to 2013/2014

<table>
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</thead>
<tbody>
<tr>
<td>Number of new HIV-positive clients initiated on IPT</td>
<td>373 074</td>
<td>450 000</td>
<td>337 237</td>
<td>551,787 (WHO, 2015) Indicator not included in the DOH Annual Report 2014/2015</td>
</tr>
</tbody>
</table>

(Source: DOH Annual Report, 2013/2014)
The number of new HIV-positive clients initiated on IPT in 2013/2014 was 337,237, a slight dip from 373,074 achieved in 2012/2013 and below the national 2013/2014 target of 450,000. The 2015 WHO Global TB report cites a total of 551,787 PLHIV provided with IPT in 2014.

Progressively, ongoing training, mentoring and coaching has resulted in more clinicians embracing the national IPT protocols. As a result, South Africa is presently the largest provider of IPT in the world.

On the other hand, the number of PLHIV receiving IPT is still not optimal relative to the PLHIV population size. IPT for eligible adults and children and the M&E thereof should be augmented, with clear recommendations for the age group 5-15 years. Lastly, offering IPT to asymptomatic child contacts of infectious TB cases and mine workers is essential.

**ART initiation in TB/HIV co-infected patients**

In accordance with the country’s national treatment guidelines, TB/HIV co-infected patients are offered lifelong ART. The TB/HIV co-infected client initiated on ART rate was added to the National Indicator Dataset (NIDS) in 2012/2013.

---

**Figure 22: TB cases plotted against ART coverage estimates from 2005-2013**

![Graph showing TB cases and ART coverage from 2005 to 2013](https://via.placeholder.com/150)

(Source: DOH Annual TB Report, 2013)

Figure 23 above shows the TB registrations plotted against the estimated ART coverage from 2005 to 2013. The decline in TB cases seemingly correlates with the raised ART coverage, which probably protects PLHIV from having episodes of TB.

**Table 24: TB/HIV co-infected client initiated on ART rate, 2012/2013 to 2014/2015**

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<tbody>
<tr>
<td>TB/HIV co-infected client initiated on ART rate</td>
<td>New indicator</td>
<td>85%</td>
<td>31.2%</td>
<td>64%</td>
<td>73.7%</td>
</tr>
</tbody>
</table>

(Source: DOH Annual Report, 2013/2014)
As reflected in Table 24 above, South Africa’s 2014/2015 national target for TB/HIV co-infected clients initiated on ART rate was set at 64% and 73.7% was achieved. This is a huge improvement from the 31.2% that was achieved in 2013/2014. This marked improvement can be attributed to the fact that like pregnant women, TB/HIV co-infected clients are prioritised for ART initiation irrespective of CD4 count. Furthermore, there is ongoing training and mentoring of clinicians on TB/HIV co-infection and the implementation of TB/HIV guidelines has been strengthened.

Figure 24 above shows that the age group 1-4 years is the largest group at 37%, followed by the 15-19 age group at 24.8%. The 2013 Joint HIV, TB and PMTCT Review revealed that the management of childhood TB is yet to be fully integrated with HIV and other child health services such as the Expanded Programme on Immunization (EPI) and Maternal and Child Health (MCH). Moreover, the diagnosis of paediatric TB and extra-pulmonary-TB is non-standardised and detailed data on the diagnostic process in children is deficient.

**MDR-TB and XDR-TB**

DR-TB accounts for 2.2% of the total TB burden in South Africa yet, consumes almost half the national TB budget. Conversely, the DR-TB outcomes remain generally poor. As previously mentioned above, from the total of 14,161 cases of MDR-TB diagnosed among notified pulmonary TB cases in 2012, only 5,890 (41.6%) were initiated on treatment. The apparent gap between the number of DR-TB patients diagnosed and DR-TB patients started on treatment is of public health concern.

For the 2011 MDR-TB cohort of about 6,523 patients, treatment success rate was 44.8% despite the fact that there were over four times as many sites offering treatment for MDR-TB as there were in 2009. The MDR-TB death rate was 17.7% in 2011. For the 2011 XDR-TB cohort of 754 patients, treatment success rate was 20.8% and mortality rate was 40.3%. It is obvious that efforts to find more DR-TB cases and initiate them on treatment are intensifying. However, a lot more still needs to be done to improve the treatment outcomes.

Lastly, the escalating number of XDR-TB patients that are non-responsive to current treatment is a serious challenge. Regrettably, there are numerous XDR-TB patients that fail treatment annually, adding to the pool of infectious patients in society.

**TB in children**

Of 328,896 DS-TB cases recorded in 2013, a total of 37,198 (11.3%) were children <15 years and 12,256 (3.7%) were late adolescents. In total, the two age groups make up 15% of all TB cases, with 51% being female and 49% males. The 2012 childhood TB cohort had a total of 53 331, 7.3% higher than in 2013.

Figure 23: Age distribution of the 2013 childhood TB cohort

(Source: DOH Annual TB Report, 2013)
Figure 24: Trends of DR-TB programme performance, 2007-2010

a) MDR-TB treatment outcomes (24 months), South Africa, 2007-2010

b) XDR-TB treatment outcomes (24 months), South Africa, 2007-2010

(Source: DOH, 2013)
Decentralisation of MDR-TB

The decentralisation and deinstitutionalisation of MDR-TB services was ratified by the National Health Council (NHC) of South Africa in August 2011. Accordingly, the national DR-TB management guidelines were updated in 2013. The number of MDR-TB sites has gradually risen since this policy decision was sanctioned. The number of confirmed MDR-TB clients initiated on treatment and the number of districts with a decentralised MDR unit were added to NIDS in 2012/2013.

Table 25: Performance of MDR-TB indicators for the period 2012/2013 to 2013/2014

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</tr>
</thead>
<tbody>
<tr>
<td>Number of confirmed MDR-TB clients initiated on treatment</td>
<td>New indicator</td>
<td>6,900</td>
<td>7,218 (&gt; 4.6%)</td>
<td>11,538 (WHO, 2015)</td>
</tr>
<tr>
<td>Number of districts with a decentralised MDR unit</td>
<td>New indicator</td>
<td>45</td>
<td>26 (58%)</td>
<td>Not reported in 2014/2015</td>
</tr>
</tbody>
</table>

(Source: DOH Annual Report, 2013/2014)

The recorded increase in the number of confirmed MDR-TB clients started on treatment of nearly 5% beyond the 2013/2014 national target of 6,900 MDR-TB clients initiated on treatment illustrated in Table 25 indicates the high numbers diagnosed through GeneXpert and intensified campaigns run in high-risk populations. By end of 2013/2014, 26 (58%) out of the 52 districts in South Africa had a decentralised MDR unit – much lower than the national 2013/2014 target of 45 districts with a decentralised unit. The underachievement in this regard can be attributed to the change in policy from dedicated MDR-TB teams to integrated TB/HIV-MDR-TB teams. This decelerated the MDR decentralisation rate, along with budget inadequacies that have hindered infrastructure upgrading at provincial level.
Target 6: To close the global AIDS resource gap by 2015 and reach annual global investment of US$ 22-24 billion in low- and medium-income countries

<table>
<thead>
<tr>
<th>Target 6:</th>
<th>Close the global AIDS resource gap by 2015 and reach annual global investment of US$ 22-24 billion in low- and medium-income countries</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Target 7:</th>
<th>Eliminate gender and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Target 8:</th>
<th>Eliminate stigma and discrimination</th>
</tr>
</thead>
</table>

<table>
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<tr>
<th>Target 9:</th>
<th>Eliminate travel restrictions</th>
</tr>
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<table>
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<tr>
<th>Target 10:</th>
<th>Eliminate parallel systems, for stronger integration</th>
</tr>
</thead>
</table>

**Target 6: Policy environment**

The context within which South Africa’s HIV response is implemented includes a huge TB and HIV burden, ever changing and ambitious international and local targets for prevention and treatment and a shrinking global economy. The cost of implementing HIV interventions continues to rise globally, with South Africa being affected, as it needs to make very large investments in HIV. The country has a massive ART programme with an enrolment of over 3-million people by December 2014 and has a growing number of HIV prevention interventions being introduced and implemented every year. This means there is need for innovative financing to cater for the growing response. Health Care Financing becomes a critical agenda item that requires political leadership to ensure effective implementation of the multisector response. In developing the NSP 2012-2016, South Africa estimated the total cost of implementation over the 5-year period to be an estimated R 133.5 billion and this amount is expected to continue to rise, given the changing global economy and the effects of inflation and the dollar-rand exchange rates. As such, South Africa, while it has achieved tremendous gains in HIV treatment, requires new ways of financial resource mobilisation and management to sustain such a huge response.

The country has been hailed as one of the countries with a fully funded government public health care system. The government of South Africa has been in the forefront of developing funding models and monitoring their implementation on HIV and TB response. The health care system within the country with the largest ART programme is funded almost entirely from the national fiscus, with funds being complemented by development partners and private sector. The National Treasury is the financial arm of government that allocates, regulates and monitors expenditure across all government departments including the DOH as the custodians of health programmes including TB and HIV.
South Africa’s National Development Plan (NDP) 2030

In seeking to improve the quality of health and general life for all South Africans and people living in the country, the South African Government has strengthened integrated planning through the development of the National Development Plan (2030) which sets out the country’s vision. On health and HIV, the NDP set priorities informed by the health demands of the African Claims of 1943, the health ideals of the Freedom Charter of 1955, the National Strategic Plan for HIV and AIDS 2012-2016, the Plan to end HIV and AIDS by 2030, the Global Plan on TB, the three health goals of the United Nations Millennium Development Goals of 2000, the envisaged United Nations Post-2015 Social Development Goals, the World Health Organisation’s 1998 Alma Ata Declaration on health and the six building blocks of health care system as declared by the WHO. The NDP envisages that by 2030, in relation to HIV, “South Africa has a life expectancy rate of at least 70 years for men and women. The generation of under-20s is largely free of HIV... There has been a significant shift in equity, efficiency, effectiveness and quality of health care provision. Universal coverage is available. The risks by the social determinants of disease and adverse ecological factors have been reduced significantly”[7]. This strategic direction lays the foundation for prioritisation and influences budgeting and allocation of funds for HIV interventions respectively.

SA investment case expenditure tracking

There has been an ever-increasing demand for funding of health care interventions specifically for HIV in South Africa and in previous years, funding was allocated using minimal evidence. In 2014, South Africa embarked on a modelling exercise to establish if current spending in HIV is achieving the required impact. The Investment Case (IC) used all available evidence on HIV interventions and their impact towards HIV incidence and prevalence and also modelled cost impact against cost of various options. A total of three options were presented to guide the country in investment for impact and the IC has been used for various country led resource mobilisation efforts including the drafting of the Global Fund Concept note and will continuously be used to influence budget and prioritisation of interventions going forward.

National health insurance

Healthcare Financing is one of the three issues set out by the government in the NDP that can determine or even dictate whether the noble goals of the NDP on health are achieved or not. In South Africa, this is being implemented in keeping with the principle that healthcare is a basic human right that must be accessible to every individual regardless of their socio-economic status. According to the NDP, South Africa should have achieved universal health coverage with a significant shift in equity by 2030. In 2011, South Africa embarked on a journey to implement the National Health Insurance and has successfully implemented interventions in eleven pilot districts across the country. The phased approach is to implement interventions in the eleven pilot sites to learn and then scale up across the whole country using a solid evidence base. The commitment to National Health Insurance (NHI) at the government level is high, with huge investments set aside for this process including the two NHI conditional grants, the setting up of a fully-fledged directorate at the DOH with human resource allocations on a full time basis to manage the implementation of NHI at national, provincial and district level. Furthermore, a number of health related initiatives are being rolled out in the eleven pilot sites such as the re-engineering of Primary Health Care (r-PHC), general practitioner (GP) contracting, facility improvements leading to the establishment of ideal clinics, and many others. These initiatives will be implemented and expanded to improve access and quality health care respectively. Next steps with regards to NHI include the tabling of the white paper in Parliament.

National Treasury – medium term expenditure framework

The National Treasury is entrusted with the management of funds for the South African Government including funds for Health and HIV. In keeping with sound financial systems to adequately forecast, budget and manage the investments in HIV and Health, the National Treasury as guided by the Public Finance Management Act (1999), has successfully implemented the Medium Term Expenditure Framework (MTEF). This has seen a general improvement in annual expenditure. The National Treasury provides guidance, support and oversight on the management of HIV funds from the Conditional Grant and Equitable Share which all form part of government’s allocation to HIV and TB epidemics.

GFATM and PEPFAR

South Africa has set up a GFATM Coordinating Committee Mechanism (CCM). The mandate for this committee is to ensure that South Africa continues to raise and receive funds from the GFATM. The GFATM continues to fund HIV and TB interventions in South Africa on a varying scale in response to submissions by the CCM. PEPFAR continues to fund South Africa’s HIV and TB response within the mandate as guided by the PEPFAR Partnership Framework in Support of South Africa’s National HIV and AIDS and TB Response (2012/2013-2016/2017). Both the GFATM and PEPFAR have been consistent in their support to South Africa and remain key partners in HIV and TB financing as they supplement government’s resource allocation for these HIV and TB interventions respectively. It is important to note a recent decline in funding from PEPFAR as a product of South Africa’s economic standing as a middle upper income country as well as the general shift in focus for PEPFAR as it evolves into PEPFAR 3 which has a huge emphasis on focus for impact.
Target 6: Current status

Table 26: Target 6, core indicators, South Africa, 2013/2014

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Source</th>
<th>Baseline 2005</th>
<th>2013/2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Government expenditure on health</td>
<td>National Treasury</td>
<td>No baseline data</td>
<td>29.4%</td>
</tr>
<tr>
<td>Total Government expenditure on HIV</td>
<td>SANAC</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Total health expenditure budget</td>
<td></td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Allocations from other development partners (Global Fund and PEPFAR)</td>
<td></td>
<td>20%</td>
<td></td>
</tr>
</tbody>
</table>

Public sector funding the HIV/AIDS, TB and STI multisector response

In keeping with its political commitment to managing HIV and TB in South Africa, the government has invested between R15.7 billion and R19.8 billion over the last three years of the NSP implementation. The largest expenditure is through the DOH HIV Programme, with other departments contributing including the DBE, DHET, DSD, Department of Sport and Recreation (DSR) and Department of Correctional Services (DCS). TB and HIV provincial funds also represent part of overall government funding.

Figure 25 and Table 27 provide a summary of government funding for HIV and TB for 2013/2014 respectively. Various programmes are being implemented among government departments including the provision of comprehensive prevention, treatment, care and support services in prisons through the DCS; HIV prevention services through DSR; the isibindi Programme targeting orphaned and vulnerable children (OVC) and the HIV sub-programme which includes OVCs and home based care services of the DSD; and the Life skills Programme of the DBE. There is continued funding across all sub-programme areas for government departments as highlighted above from 2013/2014 through to 2015/2016, which is a positive achievement in the context of a declining global economy.

Figure 25: South African Government funding for HIV and TB, 2013/2014

Global Fund and PEPFAR funding for TB and HIV interventions

South Africa’s health care expenditure included about 30% from other funding sources – mainly the Global Fund and PEPFAR. The contribution by PEPFAR has declined from 22% total spending in 2011/2012 to 17% in 2013/2014. This is mainly due to changes in PEPFAR’s focus from direct service delivery to technical assistance focusing on health systems strengthening to ensure sustainability.

Table 27: SAG contribution to HIV and TB funding 2013/2014

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>NDoH HIV Programme</td>
<td>10,968,950,000</td>
<td>12,804,566,000</td>
<td>14,481,069,000</td>
</tr>
<tr>
<td>NDoH TB National Programme</td>
<td>26,042,000</td>
<td>26,729,000</td>
<td>28,113,000</td>
</tr>
<tr>
<td>TB Provincial Programmes</td>
<td>2,680,837,695</td>
<td>2,814,879,580</td>
<td>2,955,623,559</td>
</tr>
<tr>
<td>Provincial HIV Programmes (Equitable Share)</td>
<td>763,562,000</td>
<td>817,634,000</td>
<td>864,958,000</td>
</tr>
<tr>
<td>DoE Lifeskills Programme</td>
<td>231,507,000</td>
<td>221,062,000</td>
<td>226,363,000</td>
</tr>
<tr>
<td>DSD HIV Sub-programme</td>
<td>734,626,000</td>
<td>746,116,000</td>
<td>775,954,000</td>
</tr>
<tr>
<td>DSD Isibindi Programme</td>
<td>325,000,000</td>
<td>350,000,000</td>
<td>378,000,000</td>
</tr>
<tr>
<td>Sport and Recreation</td>
<td>33,700,000</td>
<td>35,300,000</td>
<td>36,600,000</td>
</tr>
<tr>
<td>Correctional Services</td>
<td>51,100,000</td>
<td>53,700,000</td>
<td>56,400,000</td>
</tr>
<tr>
<td>Total</td>
<td>15,797,324,695</td>
<td>17,869,986,580</td>
<td>19,803,080,559</td>
</tr>
</tbody>
</table>

Table 28: Future SA Government budget commitments for HIV and TB

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>HIV only</td>
<td>$1,358,803,365</td>
<td>$1,512,819,576</td>
<td>$1,685,632,106</td>
<td>$1,879,821,160</td>
</tr>
<tr>
<td>% Annual Increase</td>
<td>12%</td>
<td>11%</td>
<td>11%</td>
<td>12%</td>
</tr>
<tr>
<td>TB only</td>
<td>$152,802,052</td>
<td>$160,442,155</td>
<td>$168,464,262</td>
<td>$176,887,475</td>
</tr>
<tr>
<td>% Annual Increase</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>HIV and TB</td>
<td>$1,511,605,417</td>
<td>$1,673,261,731</td>
<td>$1,854,096,369</td>
<td>$2,056,708,636</td>
</tr>
</tbody>
</table>

Source: Global Fund TB and HIV Concept Note (2015)

Global Fund and PEPFAR funding for TB and HIV interventions

South Africa’s health care expenditure included about 30% from other funding sources – mainly the Global Fund and PEPFAR. The contribution by PEPFAR has declined from 22% total spending in 2011/2012 to 17% in 2013/2014. This is mainly due to changes in PEPFAR’s focus from direct service delivery to technical assistance focusing on health systems strengthening to ensure sustainability.

Table 29: Total spending on HIV and TB in South Africa by source (ZAR, %, 2011/2012- 2013/2014)

<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SA Govt</td>
<td>13,293,518,754 (76%)</td>
<td>14,882,754,276 (77%)</td>
<td>17,773,204,828 (80%)</td>
<td>1%</td>
<td>-5%</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>3,870,712,658 (22%)</td>
<td>3,900,724,859 (20%)</td>
<td>3,694,922,752 (17%)</td>
<td>12%</td>
<td>19%</td>
</tr>
<tr>
<td>Global Fund</td>
<td>214,389,089 (1%)</td>
<td>420,631,044 (2%)</td>
<td>661,639,365 (3%)</td>
<td>96%</td>
<td>57%</td>
</tr>
<tr>
<td>Total (ZAR)</td>
<td>17,378,620,502</td>
<td>19,204,110,179</td>
<td>22,129,766,946</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total US$</td>
<td>2,341,059,420</td>
<td>2,261,328,974</td>
<td>2,189,938,541</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The investment case for South Africa

South Africa has developed an Investment Case for HIV and TB. The investment case involved a review of relevant TB and HIV programs, current interventions and their contribution to the multisector HIV and TB response. These findings are critical in informing the country’s next NSP. The investment case identified cost-effective interventions both new and existing as well as the enablers to optimally reach intended impact within the available resources in South Africa. The results of the investment case are critical for budgeting processes and resource mobilisation for the country both at national and international platforms.

It is aimed at informing relevant domestic budgets for GFATM concept notes, donor budgets, the national level MTEF budget, HIV conditional grant and the provincial equitable share.89

The results of this analysis show that three main interventions are cost-saving: 1) condoms; 2) SBCC, and, 3) MMC and they should be optimally funded. The final argument is that if the country spends more now, there will be greater impact with future benefits.

SANAC – Resource Mobilisation Unit

In fulfilling its core mandate to coordinate the multisector HIV response in South Africa, SANAC has set up a resource mobilisation unit, which has continued to coordinate efforts towards a centralised approach to sourcing funding for HIV and TB interventions. The resource mobilisation unit has participated in a number of initiatives including the following:

- SA HIV and TB Investment Case Expenditure Tracking (2015);
- A review of the Conditional Grant for HIV (2014/2015);
- South Africa TB and HIV Global Fund Concept Note (2015);
- An analysis of funding, funding gaps and financial considerations (2014).

Quality programme and cost data through ongoing reviews and assessments

It is noted above that the SANAC Resource Mobilisation Unit has led a substantial number of financial review activities to establish data and evidence for budgeting and financing the TB and HIV response. Working closely with National Treasury and development partners, financial assessments have generated data to guide budgeting and allocation of funds for greater impact. The greatest success has been the Investment Case for South Africa, which provides a yardstick for prioritisation as well as the analysis of funding gaps for the NSP.

The South African Conditional HIV and AIDS grant is the largest pool of funds for the HIV and TB response in the country and a review of this grant was done to gain an understanding of the conditional grant in its entirety, its investment priorities and its contribution to the objectives of the current NSP 2012-2016. The review was an integrated approach encompassing programmatic, financial and economic components of HIV and TB response.90

The conditional grant is provided for annually through the Division of Revenue Bill. Data from the review show an increasing investment in HIV and TB response through the conditional grant. Figure 26 below shows an incremental Conditional Grant allocation over the years; meaning that almost all of the HIV and TB interventions are funded entirely through this grant mechanism respectively.
The findings of the review of the Conditional grant point to equity in allocation of funds across programme areas. Over the past years, the treatment and care programme has received the greatest share of the Conditional grant although there is a steady decline in Financial Year 2013/2014 and a slight increase in allocation of funds for programme management and training. Figure 27 gives an overview of the percentage allocation of the conditional grant to the three programme areas namely; treatment and care, prevention and programme management, and training over the past 5 years.

The Conditional Grant as its name implies, comes with conditions within which the funds should be spent, including allowable and non-allowable expenditure and stringent reporting requirements for both financial and programmatic reporting. The results of this review have been used to influence budgeting processes and its findings have been used for the Investment Case for South Africa and ultimately, the Global Fund Concept Note submissions.
Target 7: To eliminate gender inequalities and gender-based violence and abuse and increase the capacity of women and girls to protect themselves from HIV

<table>
<thead>
<tr>
<th>Is this a priority target for the country?</th>
<th>YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the National Strategic Plan address this target?</td>
<td>YES/NO</td>
</tr>
<tr>
<td>Is the country on track to reach the target and commitment?</td>
<td>NO</td>
</tr>
</tbody>
</table>

Target 7: Policy environment

The HIV pandemic is gendered, with women being more likely to be PLHIV in comparison to men. In South Africa, HIV prevalence is higher among females in comparison to males and gender inequalities have been noted to increase the vulnerability of girls and women. A recent study in South Africa has shown that women who experience violence, often experience multiple and repeated forms of violence. Gender inequalities and associated socio-cultural factors are noted to be drivers of the HIV epidemic and these adversely impact on women and girls. Gender inequalities and associated socio-cultural factors are noted to be drivers of the HIV epidemic and these adversely impact on women and girls.92 TGBV thus becomes a significant structural variable in South Africa’s HIV epidemic as it is estimated that 20–25% of new HIV infections in young women in South Africa are attributable to GBV.93

Access to education is another human rights challenge related to gender inequality in South Africa. Some of the most powerful structural interventions for HIV risk reduction are those that aim to keep girls in school. When accessing HIV and TB services, young women and girls, and key populations face barriers related to prejudice, gender norms, stigma and discrimination. For sex workers, criminalization of sex work in conjunction with stigma and discrimination present human rights barriers to accessing health services.95

For transgender people, access to appropriate health services is extremely difficult. This is especially true of gender confirming care, which has a close link to HIV vulnerability, especially in trans women. The challenges faced by trans people in South Africa in accessing gender-confirming care has been referred to as a form of gender-based violence. While there is a Transgender Unit at Groote Schuur, a public Hospital in Cape Town, the unit faces challenges in being able to offer care to patients. A 2012 study concluded: “It is evident that currently health services are discriminatory and health workers provide sub-standard care to transgender persons.”96

The South African government as a signatory to both international and regional commitments to eliminate gender inequalities and has made strides in setting up structures and programmes to address both institutional and structural drivers to gender inequalities and inequities. The NSP recognises the links between HIV and GBV in relation to prevention, treatment, care and support. The NSP’s main emphasis is placed on rights related to gender equality and the need for transformation in the spheres of economic and social development. Achieving gender equality remains critical for South Africa as it seeks to realise equality, human dignity, freedom and social justice as part of transformation and restructuring.

The main thrust is to develop a comprehensive approach to addressing gender based violence among key players including government, civil society, development partners and communities notably the Ministry in the Presidency responsible for Women, Department for Social Development (DSD), Department of Justice (DOJ), Commission on Gender Equality (CGE) and other relevant stakeholders.

A series of international commitments have either been endorsed or adopted which include the Universal Declaration of Human Rights, the African Charter on Human Rights and Women’s Rights, the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), the Beijing Platform for Action and the Gender Declaration and Protocol. Nationally, the Constitution of South Africa is founded on the principles of equality and equity as propounded by the Women’s Charter of 1954, and this together with its international commitments has led to the development of South Africa’s National Policy Framework for Women’s Empowerment and Gender Equality (2010). This has shaped the government’s approach to eliminating gender and gender-based abuse and violence and increased the capacity of women and girls to protect themselves from HIV.
Target 7: Current status

Table 30: Target 7, core indicators, South Africa, 2014

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Source</th>
<th>Baseline</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of ever-married or partnered women aged 15 – 49 who experienced physical or sexual violence from a male intimate partner in the last 12 months</td>
<td>HSRC Survey (2012)</td>
<td>HSRC 2008</td>
<td>Overall – 5.1% Aged 15-19 – 7.7% Aged 20-24 – 7.3% (HSRC 2012)</td>
</tr>
</tbody>
</table>

* The latest survey which reported on this indicator was done in 2012 and as at 2014, there is no data on this indicator.

Target 7: Highlights and achievements

Sound human rights-based policy and legislative framework

Globally, it has been reported that the status and conditions of women is shifting as the gender gap is shrinking, while there is a widening of the inequality gap in general between the rich and the poor. Law reform in South Africa has seen the removal of various discriminatory laws and enactment of laws that foster an enabling environment for the advancement of women and the achievement of gender equality, which is true for South Africa. Other areas with notable changes include women’s involvement in decision-making at various levels and their participation in the economy.

In relation to the legislative framework, priority has been on sexual offences and domestic violence with considerable attention being given to crimes such as trafficking in women and children and child pornography. Some specific areas targeted by the law include issues of bail – especially for GBv, sentencing of perpetrators of violence, victim empowerment for survivors of sexual assault and integrated responses to gender based violence. The following are some of the legislation that has been revised:

- The Domestic Violence Act 116 of 1998: set up to enforce protection against domestic violence;
- Criminal Procedure Second Amendment Act 75 of 1995: specific to women is the section that deals with bail guidelines applicable to women experiencing GBV;
- The Protection from Harassment Act 17 of 2011: aimed at protection of victims of harassment (including sexual harassment);
- The Prevention and Combating of Trafficking in Person Act 7 of 2013: provides for an offence of trafficking in persons to prevent and combat the trafficking in persons within or across the borders of the Republic; and
- Judicial Matters Second Amendment Act No 43 of 2013: supports the establishment of sexual offences courts. An innovative measure to improve the prosecution and adjudication of sexual offences with a quick turnaround time on convictions.

Existence of institutional mechanisms for the advancement of women

The South Africa National Policy Framework (2000) borne out of national and international gender priorities outlines the mandates, structure and functions of the National Gender Machinery (NGM) for women’s empowerment. The NGM has been set up and is the focal point for women’s empowerment in the country and it is an integrated package whose role is both advisory and to provide technical assistance. The NGM is the blueprint of action and has established the following facilitative structures:

- Parliament: The Joint Committee on the Improvement of the Quality of Life and Status of Women, Women’s Caucuses, Women’s Empowerment Unit;
- Government: Cabinet, the National Office on the Status of Women (OSW) in the Presidency, Provincial OSWs in Premiers’ Offices, Gender Units and Gender Focal Points (GFP) in line departments (at best in the Offices of the Directors-General), gender units/ GFPs in local government structures;
- Independent bodies: The Constitutional Court, other courts, and all Chapter 9 bodies, including the Commission on Gender Equality (CGE); and
- Civil society: non-governmental organisations, religious bodies, the Congress of Traditional Leaders of South Africa (CONTROLESA) and the South African Local Government Association (SALGA). Civil society is the watchdog as it monitors implementation and connects with communities.

All these structures have been set up in South Africa and are delivering on the gender equality agenda. Successes in implementing the agenda have had an impact on GBV and HIV prevalence.

Government has committed to end gender inequality by setting up a national agenda with priorities for the next five years. The following are the key priorities as outlined by the government:

- Job creation, decent work and sustainable livelihoods for women, including funding mechanisms for increasing opportunities for women’s economic empowerment;
Education for women and girls with a focus on science and technology;
Women’s health especially decreasing maternal mortality and the negative impact of HIV and AIDS on women and girls;
Addressing GBV; and
Rural women’s development, land reform, food security and sustainable development for women and girls

All these priorities are set to empower women as a means to an end in reducing gender inequality and inequities. A number of initiatives are already being rolled out especially in health including the “mom connect” programme, cash-transfer programmes for girls and the newly introduced DREAMS programme respectively.

Integrated approach to management of violence against women and children

The National Council against Gender-based Violence (NCGBV) and the Inter-Departmental Management Team have been established to manage violence against women and children interventions. The programmes of the Inter-Departmental Management Team are integrated in the objectives of the National Crime Prevention Strategy, which, with evolution of crime approaches, resulted in the adoption of the Justice Crime Prevention Strategy. This strategy has several components including programmes to address sexual violence as a priority; interdepartmental initiatives to improve criminal justice processes; education and awareness programmes; partnership with civil society; and victim empowerment. The NCGBV is a multisector coordinating mechanism mandated to coordinate the GBv agenda.

Establishment of Thuthuzela Care Centres

The Inter-Departmental Management Team led by the Sexual Offences and Community Affairs (SOCA) Unit established Thuthuzela Care Centres (TCCs). These centres are a critical part of South Africa’s anti-rape strategy, aiming to reduce secondary trauma for the victims, improve conviction rates and reduce the cycle time for finalising cases by surpassing long judicial processes. The TCCs are in operation in public hospitals in communities mainly where rape incidence is particularly high. They are also linked to sexual offences courts, which are staffed by prosecutors, social workers, investigating officers, magistrates, health professionals, NGOs and police, and located in close proximity to the centres.

The centres are managed by a top level inter-departmental team comprising Justice, Health, Education, Treasury, Correctional Services, Safety and Security, Local Government, Home Affairs, Social Development and designated civil society organisations. Considerable resources have been directed towards the TCCs and Domestic Violence Courts which received US$ 6,824,129 through a GFATM grant for 2013–2016. There are currently 44 TCCs with 30,402 matters being handled in 2014/2015. A total of 6,845 sexual offence cases were assessed, 47% of which were referred for prosecution, and which secured a 68% conviction rate – with achievements being in line with targets.

National Strategy for Inter-sector Management of Sexual Offences

In December 2014, a National Strategy for Inter-sector Management of Sexual Offences was finalised. This strategy encourages an inter-sector approach to all matters relating to sexual offences courts. It sets out clear duties and responsibilities of all stakeholders in the establishment and management of these courts. The National Strategic Plan also provides for the minimum uniform personnel required at each sexual offence court and the services that should be accessible to all victims. It has been recommended that all court personnel must undergo the Trauma Debriefing Programme to minimise and eliminate the trauma that they may suffer through dealing with cases of sexual offences on a daily basis. Government developed the Debriefing Programme for the intermediaries and all front line staff servicing victims of sexual assault.

Training of officials

One of the challenges that have been continuously raised with regards to comprehensive management of sexual assault is the lack of capacity among service providers. South Africa has measures in place to capacitate officials handling both the victim and the perpetrator of violence in a form of training and workshops. The SOCA Unit in the National Prosecuting Authority highlights that in 2010/2011 there was an increase in capacitation of prosecutors. During the year 2013/2014, they trained 158 prosecutors on sexual offences, 50 on maintenance, 185 on child justice, 54 on domestic violence, and 193 on trafficking in persons.

Awareness raising

SA has branded the 16 Days of Activism as the campaign against GBV and has also introduced various programmes including imbizos as well as radio and television interviews on sexual offences topics highlighting the measures that are in place for the victims; how implementation of measures are taking place; possible challenges; and the responsibilities of the different role-players. Government officially launched the National Command Centre on Gender Based Violence. Its call centre is utilised by all victims of gender-based violence who receive counselling by trained social workers. The police provide services as required in support of the programme.

During the 2013/2014 financial year, four national public education and awareness raising events to educate members of the public about the Maintenance Act and the services offered at courts was carried out. These campaigns were also carried out at the provincial level in Limpopo, KZN, EC and MP provinces.
Engaging men

Government forged a partnership with Men’s organisations addressing violence against women and children to raise awareness around child poverty and the economic abuse of children. Organisations include Brothers for Life which runs programmes that encompass issues relating to gender. Resources and partnerships directed towards addressing gender vulnerabilities in relation to HIV include support to the Zazi Campaign and Rise Clubs through Soul City (through PEPFAR) and Global Fund.

SANAC’s men’s sector is also active in the Brothers for Life Campaign. It is not clear whether core common indicators and systems for measuring the effects of these campaigns in relation to gender equality and GBV outcomes have been established.

The Girl Child National Adolescent Sexual and Reproductive Health and Rights Framework Strategy

This strategy seeks to provide an integrated action guide on adolescent sexual and reproductive health and rights to stakeholders in the country. The Framework Strategy was adopted by Cabinet in February 2015. The implementation of this strategy will be monitored through an Inter-Ministerial Committee (IMC) that will be set up especially for this process, and the IMC is expected to report directly to Cabinet annually on the progress made in implementation. The intended outcomes of the Strategy is to equip adolescents of both sexes with a sense of inner-belief, self- and mutual respect and build their skills and capacity to make, and take, better decisions on sexual and reproductive health matters concerning them. The strategy aims to also increase their access to these services and information, and, to enable them to feel free to do so. In addition, the Strategy aims to address family and community roles in this regard by building supportive networks for adolescents and enabling active involvement of family and community leaders in initiatives that address adolescent sexual and reproductive health and rights challenges. The Strategy seeks to attain its intended outcomes through increased collaboration among stakeholders including greater collaboration between government and civil society.

Reviewing the mainstreaming of gender- and rights-based dimensions of HIV and TB into core mandates of government departments and SANAC sectors

The Department of Public Service and Administration (DPSA) addresses mainstreaming of HIV and TB, including rights-based dimensions into strategies and plans of all government departments. This includes addressing four domains of response:
1) Reducing the number of new infections and reducing impacts on employees, families and communities;
2) Reducing the burden of disease and enhancing productivity in the public service;
3) Involving key populations in the response and addressing stigma, discrimination, rights and inequality; and
4) Introducing evidence-based practices to support organisational wellness.

A gender equality assessment by the Health Economics and AIDS Research Division (HEARD) of Provincial Strategic and Operational Plans for HIV, STIs and TB highlighted the need for clearer provision for the meaningful involvement of women, improvements to gender equality for service access, strengthened responses to GBV, and improvements in accountability systems.
Target 8: Eliminating stigma and discrimination

| Is this a priority target for the country? | YES |
| Does the National Strategic Plan address this target? | YES |
| Is the country on track to reach the target and commitment? | YES |

Target 8: Policy environment

The South African multisector HIV and TB response is based on an understanding that protecting the rights of people affected by HIV, STIs and TB is not only in keeping with the Constitutional values of the country, but is also integral to an effective response. There is great need to address the impact of stigma, discrimination and human rights violations on access to services for HIV, STIs and TB in South Africa. The main focus is to ensure that rights are not violated when interventions are implemented, and that discrimination on the basis of HIV and TB is not only reduced, but ultimately eliminated. The NSP has set ambitious targets to ‘reducing self-reported stigma related to HIV and TB by at least 50%’ by 2016. In seeking to achieve this ambitious target, a focused approach is being implemented mainly targeting achievable, measurable and mutually reinforcing, interventions and priorities for key populations that are at higher risk of HIV and TB.

The focus of the multisector response is on the following:

• Ensuring that rights are not violated when the interventions under the other three strategic objectives are implemented, and that functioning mechanisms for monitoring abuses and vindicating rights are established;
• Reducing HIV and TB discrimination, especially in the workplace; and
• Reducing unfair discrimination in access to social services.

The role of SANAC in this regard is to provide technical support, coordination and monitoring and evaluation to national government departments and other relevant sectors in implementation of interventions to reduce stigma and discrimination.

South Africa’s response to HIV, STIs and TB recognises the centrality of constitutional values and human rights such as the right to equality, dignity, life, freedom and security of the person, privacy and access to health care. It recognises that the South African legal framework for respecting, protecting, promoting and fulfilling rights in the context of HIV, STIs and TB is largely in place. However, it notes that stigma, discrimination and human rights violations still require addressing, especially in the case of particular populations at higher risk. The NSP highlights the need for attention to be given to addressing stigma and discrimination linked to HIV and TB, which are seen as including dimensions related to sexuality and gender identity. The need for a programmatic approach to stigma elimination is highlighted and includes involvement of people living with HIV. Reference is made to a Stigma Mitigation Framework to be monitored through a Stigma Index, with links and oversight provided by Departments in the Security Cluster in conjunction with the South African Human Rights Commission (SAHRC).

The following priorities are identified in the NSP:

• Conduct a review and assessment of remaining laws and policies that may impact negatively on the response to HIV, STIs and TB in an attempt to address any barriers and shortcomings that may undermine the rights of individuals.
• Ensure that the provision of services for HIV, STIs and TB is done in a manner that upholds the dignity of individuals especially those living with HIV and who have TB infection.
• Address the support of women and young girls’ sexual and reproductive health and rights, including the right to access comprehensive services and the right to reproduce.
• Continue deliberations on the decriminalisation of sex work.
• Address the importance of collaborative, national campaigns to address unfair discrimination in the workplace, public amenities and communities in general.
• Address the need for strengthening workplace responses to HIV and TB in all sectors of the economy, especially the vulnerable sectors such as domestic and farm workers.

Target 8: Current status

Table 31: Target 8 core indicators, South Africa, 2014

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Source</th>
<th>Baseline</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of women and men aged 15-49 who report discriminatory attitudes towards PLHIV</td>
<td>SANAC Stigma Index Survey</td>
<td>No baseline data</td>
<td>35.5 External Stigma among PLHIV 43% Internal Stigma among PLHIV (Stigma Index; 2015)</td>
</tr>
</tbody>
</table>

The Stigma Index focused on PLHIV and the data reported is for internal and external stigma amongst PLHIV based on their experiences not on the perpetrators.
**Target 8: Highlights and achievements**

**Reducing HIV and TB related stigma and discrimination**

Various national population-based surveys conducted over the past decade have demonstrated low levels of stigmatising attitudes towards PLHIV among the South African population.\footnote{187,188} Stigma and discrimination are, however, complex phenomena, extending to internalised stigma as well as experiences of discrimination that are not readily identified in surveys of the general population. In 2013/2014 South Africa embarked on a nationwide Stigma Index for People Living with HIV, a study to establish the extent to which PLHIV experience stigma and discrimination.

The survey was commissioned by SANAC’s PLHIV sector through the Human Rights Technical Task Team drawing on a sample of more than 10,000 participants living with HIV. The study found high levels of internalised stigma (43%), and a concern was raised that more marginalised PLHIV may be more severely affected. A minority of PLHIV experienced social exclusion from family, religious, educational and workplace activities.

The overwhelming majority of PLHIV did not experience discrimination in relation to work, education or health service provision. Fear of some form of discrimination remained present among around a quarter of respondents. Levels of disclosure of HIV status among PLHIV were high with 90% sharing their status with partners, 85% sharing their status with other family members and 66% sharing their status with friends and neighbours.

Most reported that responses by family members and health care workers to disclosure were supportive. It was noted that internalised stigma should be addressed through expanding support systems to PLHIV. Stigma related to TB was also explored in the study, with gossip, insults and teasing being reported as negative outcomes by more than a third of PLHIV respondents.

**Auditing interventions to identify potential for human rights abuses**

It is expected that HIV and TB interventions take reasonable measures to guard against rights violations. All government departments and private and community-level entities with responsibility for co-ordinating, conceptualising and/or implementing interventions and related policies are expected to conduct an audit to assess whether any such intervention or policy may result in a violation of human rights when, or as a result of being, implemented as identified in the NSP. There have been a number of important pieces of research that have contributed towards identifying human rights violations across the country and the laws, policies, programmes and practices that contribute towards these violations. However, there is absence of a comprehensive systematic audit of laws, policies and programmatic interventions nor of SANAC having co-ordinated or monitored such an audit.

In general it appears that there is a largely protective legal framework in place and findings of rights-based protection in access to health care; but it was found that stigma, including internal stigma, discrimination and gender inequality, was still high and that access to human rights, although existing on paper, was not a lived reality. For example:

- 7% of female PLHIV reported coerced or forced sterilisation in health care settings,\footnote{190} and high levels of discrimination were experienced by women living with HIV and sex workers in their interactions with health care workers;\footnote{191}
- Section 27 has consistently drawn attention to the human rights violations against patients with MDR and XDR-TB held in ‘prison-like’ conditions in facilities;\footnote{192}
- Violations of the rights of sex workers by law enforcement officials continues to take place and the continued criminalisation of sex work is a concern;
- The SAHRC notes ongoing, systemic unfair discrimination against sexual minorities, persistent criminal hate speech and acts against African lesbian, gay, bisexual, transgender and intersex (LGBTI) people and poor levels of awareness even at the level of the judiciary.\footnote{193}

**Examples of research on HIV related human rights violations**

Findings from the HIV and TB Review (2013) provide evidence that a number of existing interventions and policies do, in fact, respect human rights in their conceptualisation and implementation. The review highlights that, in general, human rights are respected with regard to access to health care services. For example, informed consent was provided prior to HCT; ART eligible clients are referred appropriately, patients with drug-resistant TB are managed as per guidelines, women are not denied their sexual and reproductive health and rape survivors are provided with appropriate PEP services.

SANAC in partnership with the National Association of People Living with HIV/AIDS (NAPWA), Positive Women’s Network (PWN), the Treatment Action Campaign (TAC), HSRC and UNAIDS conducted the National People Living with HIV Stigma Index Study in 2013/2014. Respondents in Gauteng noted the Stigma Index study as an achievement in providing further information on human rights violations in the country. The findings of this study found instances of discrimination (e.g. coercive treatment in access to sexual and reproductive health services) but also noted that in many instances, PLHIV reported that their rights were not violated (e.g. in access to health care services more generally). The findings will also help to direct institutions and organisations in their assessment of the possibility for human rights violations in their HIV and TB-related interventions and policies.

A collaborative project between the Women’s Legal Centre, Sisonke and the Sex Worker Education and Advocacy Task Force (SWEAT) documented human rights violations by police officers against sex workers in 2012,\footnote{194} and findings have been used to inform sex worker programming. A report by the PWN on gender equality, harmful gender norms and GBV and the critical policy, legal and structural gaps have been useful in identifying priority interventions.\footnote{195}
There are also indications that government departments as well as private and community-level entities have developed SOPs, guidelines, policies and programmes to guide interventions such as HIV testing, provision of ART and TB treatment, the provision of Post-Exposure Prophylaxis (PEP) to rape survivors, the provision of services to sex workers and the management of HIV in prisons, and the like. Most of these include provision for protection of the rights of affected populations including key populations at higher risk of HIV exposure. This tends to indicate that sectors are operating in terms of an understanding of human rights violations and how to respond appropriately. So, despite the absence of a formal and co-ordinated audit of all laws, policies, programmes and practices, it appears that there is a good understanding of where and how human rights violations are taking place and which populations are most affected.

**Guarding against rights violations as part of policy development and programme planning**

This focal area is extremely broad and does not include core programmes and indicators, making it difficult to measure the response. The 2014 NSP Progress Report noted various achievements, for instance, that there are various rights-based health care guidelines and policies in existence as has been mentioned above. There has been a human rights assessment of all governmental HIV and TB-related plans.

**Examples of some of the newly developed rights-based policies and guidelines, among others:**

- The SANAC (2012) Key Populations Policy Brief, which guides rights-based programming for key populations such as MSM, sex workers, prisoners, migrants, transgender people and people who use drugs.
- The DoH 2013 Guidelines for the Management of TB, HIV and STIs in Correctional Centres which, include a detailed focus on the rights of prisoners in the context of HIV and TB, including the right to voluntary testing and treatment and protection from isolation and segregation.
- The DOH 2013 National Complaints Management Protocol for the Public Health Sector of South Africa that strives to strengthen and uphold a patient’s right to complain about health rights violations.
- The DOH 2014 National Tuberculosis Management Guidelines which recognises the rights of all patients, notes the impact of stigma on treatment adherence and encourages healthcare providers to adopt rights-based attitudes, provides counselling and support for treatment adherence and encourages voluntary treatment.
- The DoH 2015 National Consolidated ART Guidelines which include the promotion of human rights and health equity as a guiding principle, provide for voluntary HIV testing with informed consent and protect women’s and children’s health rights, among other aspects.
- The DBE 2015 Draft National Policy on HIV and TB which integrates rights-based guiding principles such as the rights to access to education; counselling, treatment, care and support; information; equity and protection from discrimination; fair labour practices; gender equality; privacy and confidentiality; reasonable accommodation; safety, security and health.
- The DOL 2012 revised Code of Practice on HIV and AIDS and the World of Work which is aligned with the International Labour Organisation (ILO) Recommendation concerning HIV and AIDS and the World of Work No 200 of 210.
- The DOL 2012 revised Code of Practice on HIV and AIDS and the World of Work which is aligned with the International Labour Organisation (ILO) Recommendation concerning HIV and AIDS and the World of Work No 200 of 210.
- Ongoing research and documentation of the forced sterilisation of women with HIV by civil society; as well as
- Continued and ongoing work towards the decriminalisation of sex work through the work of the South African Law Reform Commission reporting to the Ministry of Justice, the Commission for Gender Equality as well as through the work of civil society.

**Examples of HIV and human rights based programmatic interventions include:**

The ZAZi campaign under the leadership of the SANAC Women’s Sector and Department of Women, Children and People with Disabilities, with support from the USAID/Johns Hopkins Health and Education South Africa (JHHESA) and PEPPAR, addresses GBV including sexual violence. A behaviour change communication campaign led by Soul City and aimed primarily at young women aged 15-24, includes addressing stigma, discrimination and gender equality issues.

Campaigns against GBV in partnership with the SANAC Men’s sector, the PEPPAR-funded Brothers for Life campaign and the national previous Department for Women, Children and Persons with Disabilities (DWCPD). The Thuthuzela Project which aims to support increased access to justice for sexual assault. Training of health care providers and law enforcement officials is taking place in relation to the rights of rape survivors to PEP and access to justice. The human rights components of the National Sex Worker Programme, which includes training for and working with health care workers and police to reduce rights violations as well as working towards the decriminalisation of sex work, to challenge legal barriers to the provision of health services to sex workers. (A process is underway to extend the national strategy to men who have sex with men and people who inject drugs.)

The DOH National STI Care and Treatment Course for Health Care Workers includes training on health rights issues for key populations such as sex workers, MSM and prisoners and information on health services for survivors of sexual and gender-based violence. The DOH 2013 Guidelines for the Management of TB, HIV and STIs in prisons include a concrete programme of action for responding to stigma, discrimination and human rights violations in prisons, in accordance with the NSP.
Monitor human rights abuses and increase access to justice and intervention, and build capacity within public institutions and civil society

SANAC, SAHRC and other relevant institutions are entities in a position to monitor human rights abuses involving those living with HIV and TB or who are at the greatest risk of infection, as well as the appropriate referral to legal service providers of those whose rights have been violated. At national level, SANAC has made recent progress in setting up systems to ensure effective monitoring of human rights abuses and increasing access to justice.

According to the SAHRC Annual Report 2014, the SAHRC upgraded the Flowcentric data system and training of legal officers and data capturers to improve the effectiveness of complaints handling and achieved case finalisation for 93% of the 9,217 cases received. Complaints trends analysis conducted in terms of rights violated does not provide information relating to HIV or TB-related complaints. Currently, the SAHRC plans to focus attention on improving its reach and accessibility to marginalised communities through convening human rights clinics in rural and peri-urban areas. The SAHRC has also reported on health and equality rights issues. The SAHRC's Economic and Social Rights Report [Section 184(3)] notes that various programmes have been introduced to promote the health of vulnerable populations and clinic access has improved. However, it notes concerns relating to access to health including increased maternal mortality, poor access to community health centres, especially in rural areas, lack of medicines and qualified doctors for primary health care and the poor quality of health services. The SAHRC (2012) Equality Report also notes that various programmes have been introduced to promote the health of vulnerable populations and clinic access has improved. However, it notes concerns relating to access to health including increased maternal mortality, poor access to community health centres, especially in rural areas, lack of medicines and qualified doctors for primary health care and the poor quality of health services. The SAHRC (2012) Equality Report also notes that various programmes have been introduced to promote the health of vulnerable populations and clinic access has improved. However, it notes concerns relating to access to health including increased maternal mortality, poor access to community health centres, especially in rural areas, lack of medicines and qualified doctors for primary health care and the poor quality of health services.

Legal Aid South Africa continues to provide legal aid in civil and criminal matters to poor and vulnerable persons, with a strong focus on children. According to Legal Aid SA, assistance was provided in relation to 776,301 criminal and civil legal and advice matters during 2013/2014 through their 64 Justice Centres and 64 Satellite Offices across South Africa. Legal Aid SA’s pro bono agreements with all provincial law societies enable them to link clients with private attorneys providing pro bono legal services, increasing coverage of civil matters. Unfortunately, the report does not provide information relating to HIV and TB cases.

The Department of Justice has conducted a review of the Sexual Offences Courts for purposes of strengthening access to justice for sexual offences and has developed a new model for the courts across the country. The Thuthuzela model, which includes over 50 centres across the country, has referred a number of sexual offence complaints for prosecution, but there is a need to analyse the low conviction rates and withdrawal of sexual offences. A UNAIDS review of Stigma Index studies conducted across Southern and East Africa showed that undertaking the Stigma Index studies served to empower and build the capacity of PHIV support networks, helping them to support their membership in understanding and applying their rights. The national Stigma Index Study involved the efforts of large numbers of people living with HIV and their support networks, potentially building capacity in this regard.

HIV and TB wellness programmes

The Department of Labour has recently revised the Code of Practice on HIV and AIDS and the World of Work, in alignment with the ILO Recommendation No 200 of 210, both of which have been officially approved by Parliament.

Developing and implementing a national campaign against unfair discrimination

SANAC has launched a national communication campaign to address stigma and discrimination in response to the findings of the Stigma Index Study which is being conceptualised and implementation will start in 2014/2015. SABCOHA has developed a tool for monitoring and evaluating private sector responses to HIV and TB in the workplace, but not all companies are using the tool.

Providing training to prevent unfair discrimination

The NSP aims to provide human rights training through all public and private bodies providing training in HIV, STIs and TB, to prevent unfair discrimination by social service providers. This intervention is to be led by the Department of Higher Education and Training (DHET) in collaboration with the departments of basic education, health and social development, other relevant government departments, professional associations, trade unions and national non-profit bodies that develop professional practice guidelines, and professional associations.

Higher Education and Training HIV/AIDS Programme (HEAIDS) has been funded to equip academic staff at public universities and Technical and Vocational and Training (TVET) Colleges with the skills to integrate and address HIV in their curricula. HEAIDS will create a pool of experts in the area of HIV curriculum development and use in a position to train other academics in integrating HIV content into the curriculum across different disciplines, including human rights components of responses. In addition, a partnership with NACOSA will develop programmes to address the needs of LGBTI students and staff at higher education institutions. It is, however, unclear whether the HEAIDS programme is sufficient to address the training needs across the country. For instance, gaps identified by the Positive Women’s Network (PWN) emphasises the further need for training for health care workers on the specific sexual and reproductive health and rights of women and girls. The Civil Society Priorities Charter has emphasised the need for on-going training on HIV and human rights for all communities, to increase awareness of rights and access to justice.
Target 9: To eliminate travel restrictions

<table>
<thead>
<tr>
<th>Is this a priority target for the country?</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the National Strategic Plan address this target?</td>
<td>YES</td>
</tr>
<tr>
<td>Is the country on track to reach the target and commitment?</td>
<td>YES</td>
</tr>
</tbody>
</table>

Target 9: Policy environment

South Africa’s goal in provision of health care services is to provide comprehensive services to all South Africans and people living in it. The country has an increasing migrant base mainly due to its economic status within Southern Africa. Health service provision is free in the public sector with minimal fees to access specialised services at tertiary hospitals. The South African Immigration Act does not discriminate against any person by refusing entry into the country based on one’s health status. Foreign nationals in South Africa, whether they are in the country legally or illegally, are afforded health care services.

Target 9: Current status

Health services are provided in public health facilities across the country and routine screening at ports of entry is done for diseases such as the Ebola virus and foot and mouth. A number of migrants access the country for specialised medical care as the country has an advanced health care system and the Immigration Act allows for one to apply for temporary residence to access such medical care through the ‘medical treatment visa’.

Target 9: Highlights and achievements

South Africa is still bound and abiding to the United Nations International Covenant on Civil and Political Rights adopted in 1966. This covenant states that all countries should have respect for people’s human rights and their freedom and this includes rights to health services too. A key feature to seeking temporary residence in South Africa is the request to screen for TB through a radiology assessment and a general medical examination to screen for any disease generally.

However, while screening is done, the health status of an immigrant does not have any bearing on their movement into the country. The new immigration system that is being provided through Visa Facility Centres and at the different countries through the South African Consulates now provide bio-metric screening as part of visa application and it also captures general health status components.

The DOH has recognised the need to build systems that promote people’s access to basic health services regardless of their migration status. The NSP has identified key focal areas to provide health services and this includes farms, border areas and informal settlements where migrants are most likely found and as such, are afforded health care services accordingly.

There is growing need for all countries bordering South Africa to engage in discussions to better manage health service provision for the migrant population. TB and HIV service provision needs to be complementary across borders respectively.
Target 10: To strengthen HIV integration

| Is this a priority target for the country? | YES |
| Does the National Strategic Plan address this target? | YES |
| Is the country on track to reach the target and commitment? | NO |

Target 10: Policy environment

South Africa has a widening gap between the rich and the poor as the middle class is slowly becoming non-existent thereby widening the poverty gap. The DSD is entrusted to provide comprehensive services to the general population with special focus on vulnerable populations including orphaned and vulnerable children, the elderly and people with disabilities. South Africa has one of the largest Social grant mechanisms aimed at providing social security nets for the vulnerable populations. The package of services from DSD includes provision of prevention, treatment, care and support health services, impact alleviation and mitigation, economic support through social grants and provision of psychosocial support. DSD works closely with the DOH and DBE. These three departments are classified as the most critical Social Needs Cluster Departments that are at the core of the wellbeing of the people living in South Africa.

It is recognised that HIV contributes to orphaning as well as to vulnerability of children and youth when it occurs in household settings. HIV impacts on care arrangements of children, and vulnerabilities intersect with increased risk of HIV acquisition. The need for scaling up initiatives at community level to reduce vulnerabilities and impacts related to HIV and TB and to protect the rights of orphans and vulnerable children, including children in youth headed households, is highlighted in the NSP as a core mandate of DSD. Emphasis is placed on addressing health, social, economic and educational needs for OVCs. It is vital to keep young people in school and also to provide support mechanisms for post school opportunities. Service provision for children is guided by the Children's Act.

The NSP recognises that education is protective in relation to HIV vulnerability, with school attendance being linked to lower HIV prevalence levels. Maintaining school attendance and mitigating against dropout rates are seen as critical interventions, particularly for girls. Parent-child communication is also emphasised. To mitigate post-school vulnerabilities, it is recommended that mentoring, training and employment for school-leavers be prioritised. Opportunities to be fostered include targeted programmes for vulnerable youth such as the Expanded Public Works Programme (EPWP), and programmes addressing vulnerability of young people attending institutions of higher learning, through the DHET.

Target 10: Current status

Table 32: Target 10 core indicators, South Africa, 2014

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Source</th>
<th>Baseline</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current school attendance rate of orphans aged 10 – 14 (primary/secondary school age)</td>
<td>Child Gauge 2014</td>
<td>99%</td>
<td></td>
</tr>
<tr>
<td>Current school attendance rate of children aged 10 – 14 (primary/secondary age) both of whose parents are alive and who live with at least one parent</td>
<td>Child Gauge 2014</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

NB: 7 – 15 years is a compulsory schooling age hence attendance is 100%
Target 10: Highlights and achievements

Legislative and policy developments to promote and safeguard sexual, reproductive, health and human rights among children and youths

South Africa has embarked on numerous policy developments and amendments aimed at improving the livelihoods of children and youth. There have been recent amendments to the Sexual Offences Act in defining the age of a child to 18 years and this changes the age of consenting teenagers and the traditional practice of Ukuthwala is no longer a valid defence against criminal charges of child trafficking and rape. On the sexual and reproductive health front, the National Adolescent Sexual and Reproductive Health and Rights Framework Strategy (2014 – 2019) is being finalised and it seeks to target the needs of marginalised key populations and to reduce teenage pregnancy. The Department of Basic Education has also drafted a National Policy on HIV, Sexually Transmitted Infections (STIs) and Tuberculosis (TB) which seeks to reduce the incidence of TB and STIs among learners and educators as these place additional stress on teaching and learning.

Mitigating the impact of HIV and TB on orphans, vulnerable children and youth

In 2012, there were around 25-million children and youth living in South Africa. Among these, around 18-million were children aged 0-17, the majority of whom live in poverty. Maternal, paternal and double orphans comprised 19% of children in this age group – most of whom are in the care of a family. Less than 1% of children live in child-headed households. Apart from orphaning and poverty, vulnerability of children and youth includes other factors – for example; disability, living with HIV, living in households affected by illness, being exposed to physical or sexual abuse in family and community settings, being exposed to alcohol or drugs, being LGBTI, or being exposed to exploitation. A grant of US$ 3,946,325 has been allocated through the GFATM towards programmes for MSM in higher education institutions for the 2013-2016 period.

Social grants

South Africa has a well-established infrastructure of social grants provision through the DSD and this is one of government’s most successful social policy tools in combating child poverty. In 2012 more than 10-million children were supported by grants including 10,927,723 supported by Child Support Grants, 536,747 supported by Foster Child Grants and 114,993 supported by Care Dependency Grants. Social protection through grants, among other initiatives in South Africa, has been noted to improve the wellbeing of children and families and has also been associated with lower HIV-related risk behaviours among orphans and vulnerable adolescents. A review by the Children’s Institute of budgets allocated through DSD found that initiatives such as the isibindi Project were relevant and valued, as were fund transfers to NGOs and links to the EPWP. However, it was noted that resources were unevenly distributed and this limited their impact. A grant of US$ 2,179,349 has been allocated to the DSD for data capture, and US$ 17,442,626 for indirect support to OVC services through the GFATM for the 2013-2016 period.

Figure 28: Number of people accessing social grants over the years (2000/2001 – 2013/2014)

Source: OECD Economic Surveys South Africa, July 2015 Overview
Retaining young people in schools and providing post-school education and work opportunities

Concerns have been raised in the literature regarding the links between barriers to schooling, early school leaving and HIV vulnerability – particularly for girls and young women in southern Africa. South Africa has very high levels of school attendance, with 97.4% of children aged 7-17 attending school in 2012, with attendance increasing over the past decade. There is also gender-parity in school attendance. The gender parity index (GPI) is 1.06 at secondary school level, with more girls than boys likely to attend school, increasing to 1.13 for the last three years of schooling. Levels of early school leaving among girls in the later stages of schooling is much the same as that of boys. Reasons for dropout among both sexes include financial factors, disaffection, failure, illness or disability. A small minority of all girls who drop out do so because of pregnancy (10%). A grant of US$ 3,282,082 has been allocated through the GFATM for a teachers’ survey and programmes to keep girls in school. The Draft DBE Hiv, STIs and TB Strategy complements school attendance with a strengthened focus on addressing HIV prevention and mitigation in schools.

Draft National Youth Policy to strengthen employment

Youth unemployment in South Africa is very high post-school, with a rate of 53.6% being noted by the World Bank in 2013. The recent Draft National Youth Policy 2014, takes into account the vulnerability of young people to HIV, and seeks to consolidate and mainstream youth development throughout government policies, programmes and the national budget. The draft policy is linked to the National Development Plan (NDP) among other economic development policies.

Challenges underpinning slow progress to date include lack of coordination, duplication, fragmentation and poor capacity within the National Youth Development Agency (NYDA). Measures to be undertaken include Youth Brigades, increasing youth targets in EPWP programmes, inclusion in community work, boosting internships, youth enterprise creation, rural development, and improving capacities within the education system. Strategies to include and address HIV are well detailed including a strong focus on supporting adolescent sexual and reproductive health and rights. Collaboration between schools and organisations such as Soul City and LoveLife, in conjunction with the EPWP had improved links to post-school employment.

HEAIDS has provided long-term guidance to HIV-related strategies in universities and TVET colleges in South Africa. A baseline HIV and socio-behavioural survey was conducted in universities in 2009, and has been utilised to guide strategy, although trends have not been determined through follow up surveillance. A more recent study has established HIV-related behavioural patterns in TVETs, although did not survey HIV prevalence. Nonetheless, baseline data is now established to guide strategy and inform trends.

4. Major challenges and remedial actions

Major challenges: Prevention

Behavioural drivers: As reflected under Target 1, most of the indicators related to HIV prevention in young women and girls and behaviour change are suboptimal. Age at sexual debut, age-disparate relationships and the extent of multiple sexual partners remain challenging. It is apparent that South Africa will not meet its 2016 NSP targets. 2014 programmatic data shows that despite the declines from the 2010 baseline of 491 million reported in previous years i.e. 53% of baseline in 2011, 49% in 2012 and 29% in 2013, 506,431,299 condoms were distributed in 2015 and this is still 51% of the NSP 2016 target of 1 billion condoms. With respect to female condom distribution, from a 2010 baseline of 5.1 million, female condom distribution rose by 51% from baseline to 7,686,231 and was 13,254,328 in 2014. This is about 53% of the NSP target of 25,000,000 female condoms distributed by 2016.

Young women and girls: HIV incidence among girls and young women aged 15-24 years is the highest of all age and sex categories in the general population and this is a cause for concern in South Africa. Key Populations: MSM and sex workers experience discrimination and stigma, and barriers to accessing care that contribute to their vulnerability to HIV, despite constitutional and legal protection. Currently, there is no national MSM programme and most MSM services are provided by NGOs. In the view of the SANAC Sex Worker Sector and a growing number of NGOs providing services and support to sex workers, the on-going criminalisation of sex work undermines several constitutional rights, including: increasing the overlapping vulnerabilities of sex workers, violence, abuse by law enforcement officials, harassment, HIV acquisition and lack of access to health and justice services.
Male Medical Circumcision: MMC rates are low, with only about one million men having been medically circumcised between 2008 and 2012. In addition, MMC rates remain low compared to traditional circumcision. Based on the 2013 national HIV and TB review findings, MMC is not reaching enough men and this can partly be attributed to the fact that the MMC programme is doctor-driven. The lack of uniformity of traditional practices and resistance from some of traditional leaders to embrace MMC remains a challenge to the uptake of the programme. Unless there is a marked increase in MMC going forward, the country may not meet its target of circumcising 80 per cent of HIV-negative men aged 15-49 by 2015.

People Who Inject Drugs: There is still limited response in addressing drug use and drug-use-related HIV and other health risks in South Africa. Anecdotal evidence points to poor knowledge and awareness of the health risks involved in drug use. Similarly, knowledge of substance related HIV transmission is not yet widespread. Incorrect or unspecific information is known to be disseminated. Although close to 20% of PWID are also HIV positive, service availability is insufficient. M&E in this area of response is also lacking. Lastly, because drug use and possession are criminalised in South Africa, effectively reaching drug users with harm reduction and other prevention, care and support strategies will remain challenging.

Major challenges: Treatment, care and support

ART coverage in children: Despite the massive expansion of the national ART programme, similar strides have not been made regarding the provision of ART for children and adolescents including disclosure among children and adolescents. This is partly compounded by the poor skills among health care workers to conduct HCT among these groups as well as the non-disclosure by parents among those who have been tested. Similarly, opportunities for HCT through other programmes such as TB, STIs and MCH (EPI, IMCI) have not been optimally utilised. According to the 2013 national HIV, TB and PMTCT review findings, ART coverage among children is low, at 40%. In addition, there is limited training and implementation of NIMART for paediatric ART.

Retention in care: Retention of PLHIV in care remains the utmost challenge of the national HIV care and treatment programme especially in the pre-ART period. The adult LFTU at 3, 6, and 12-months for patients started on ART from January to December 2013 shows a national average of 27% LFTU among patients who completed 12 months of ART.

The declining retention rates seen can be attributed to inefficiencies in referral systems between communities, health facilities, districts and provinces. The ineffective and inadequate patient tracking systems also contribute to high defaulter rates. In the absence of a structured pre-ART care and support programme, the implementation of the pre-ART module on TIER.Net similarly remains a challenge.

Viral load monitoring: Nationally viral load monitoring remains suboptimal with viral load done at 59.6% for calendar year 2014 – against a national target of 80%.

TB in children: The detection and management of TB in children remains a challenge. The management of childhood TB is not fully integrated with HIV and other child health services. The diagnosis of paediatric TB and extra-pulmonary-TB is non-standardised and detailed data on the diagnostic process in children are lacking.

MDR-TB and XDR-TB: The apparent gap between the number of M/XDR-TB patients diagnosed and patients started on treatment is of concern. Despite significant investment of financial resources into the management of DR-TB, the treatment outcomes remain poor i.e. MDR-TB treatment success rate– 44.8%, mortality rate – 17.7%; XDR-TB treatment success rate – 20.8% and mortality – 40.3% in 2011 – (DOH Annual Report: 2013/2014)

Major challenges: Impact alleviation

Adequacy of resources for the multisector response: Mechanisms are in place for funding HIV and TB interventions but they are not adequate – especially in relation to the role of civil society in the multisector response vis-à-vis funding allocated to them for programme implementation. Funding is primarily for large-scale government led interventions and excludes civil society. There are general equity challenges with regard to the allocation of funds for HIV and AIDS interventions.

Absence of clear monitoring mechanisms for impact alleviation indicators: There is an absence of national core indicators to measure impact alleviation. If indicators are there, the challenge is with data sources or the disaggregation of data. Social and public health constructs and indicators are not adequately aligned with statutory definitions, and this inhibits the development of effective and measurable strategies. South African police statistics provide some insight into the extent of sexual offences in the country, although the absence of disaggregated data limits potential for interpretation and trend analysis. Attention is given to gender rights and GBV prevention through various campaigns, although it would be useful to understand the extent of commonalities between outcome and change goals, and mechanisms suitable for monitoring change against common core indicators.
5. Remedial action

Remedial action: Prevention

Evidence-based interventions are needed to urgently address the following behavioural determinants:

Condom use: Knowledge of condom use as an HIV prevention method is high. HCPs have been successful in increasing condom use in all relationship types. However, HCPs need to sustain the messaging, focusing especially on the importance of correct and consistent condom use with all sexual partners.

Male and female condom procurement, distribution, and marketing: This is one of the six basic programmatic activities in the UN Investment Framework and as such, the existing male and female condom distribution system gaps need to be strengthened to meet the NSP targets. Promoting consistent use of both male and female condoms remains focal to prevention opportunities.

Sexual debut (before 15 years): Interventions to reduce early sexual debut are needed. SBCC is vital to changing risk behaviour and social conditions that drive the HIV epidemic. SBCC programmes should continue to promote delaying age of sexual debut. However, in view of the declining age of sexual debut, it is critical that HCPs promote and emphasize condom use from first sexual experience.

Multiple sexual partners (especially among young males aged 15-24 years): Reducing partner turnover and overall numbers of sexual partners is a key component of an effective HIV-prevention response. It is vital that HCPs continue to promote partner reduction and faithfulness and present such messaging within the framework of combination HIV prevention. It is also imperative that both females and males be targeted for risk reduction interventions.

Age-disparate relationships (among females aged 15-19 years): There is need to design and implement evidence-based interventions including SBCC activities that discourage age mixing between older men and younger girls. HCPs need to emphasize and sustain messages on the increased risk to young women of sex with older men particularly unprotected sex where the prevalence of HIV is higher - focusing especially on condom use in these relationships.

Young women and girls: Through initiatives like DREAMS, prevention programmes targeted at young women and girls in and out of school, in informal settlements and rural areas, in higher education institutions, the unemployed and those who are engaged in sex work should continue to be strengthened. ISHP collaboration between DBE and DOH should be sustained to ensure the provision of SRH services within schools. Evidence shows that retention in school, provision of tertiary education and employment opportunities reduce vulnerability of young people to HIV infection.

Key population programming: There is need to: 1) review and evaluate key populations programmes to determine progress so far, and revise and strengthen where appropriate; 2) roll out key population programmes, ensure optimal coverage and strengthen the monitoring and evaluation of these programs; 3) strengthen the national HTA programme in line with the National Framework for HIV, STI and TB programmes for key populations; 4) consider new interventions for key populations e.g. pre-exposure prophylaxis (PrEP), ensure 80% coverage and strengthen the monitoring and evaluation of these programmes.

MMC: The UN Investment Framework recommends MMC in countries with high HIV prevalence and low rates of circumcision.132 Intensified rollout of the national MMC programme as part of a package of sexual and reproductive health services (for adults and neonates) should be continued in order to deliver MMC on a sufficient scale to cause national-level HIV incidence reductions. The demand for safe MMC should be generated thus it is important that SA continues to increase awareness of the risk-reduction benefits of MMC and ensure male-friendly MMC facilities are available to ensure that supply meets the demand created, and focus in high incidence districts remains. Improved demand creation at a community level targeting the males aged 25-49 years is essential for maximum impact. More should be done to increase acceptability of MMC among groups that practice traditional circumcision. Partner reduction and correct and consistent condom usage should still be promoted among circumcised males.

HCT: Awareness and knowledge of HIV status is the key to accessing a comprehensive package of care for HIV prevention and treatment. Provider initiated HCT (PICT) or routinely offered HCT (ROCT) should be institutionalised and strengthened at all public and private health facilities. Equally, exposure to HCPs is associated with a higher probability of individuals discussing getting tested with their sexual partner(s), and with a greater chance of having been tested for HIV thus HCP messaging should continue to encourage HCT uptake.

PWID HIV prevention, care and treatment: This focal area needs to be strengthened including incorporating harm reduction services such as needle and syringe programmes into HIV services so as to improve PWID service delivery and data collection. Service providers require further training to support this focal area.

PMTCT: Re-testing of HIV negative mothers every three months during pregnancy and lactation should be implemented as per national guidelines. In addition, the implementation of the PMTCT Option B Plus should be intensified.
Remedial action: Treatment, care and support

**ART for adolescents and children:** Specific strategies should be designed in order to increase access to ARTs for adolescents and children. These strategies should include the different point of care where children and adolescents can be reached in order to link them to HCT and ART programmes e.g. through the MCH departments and through the school health programme under PHC re-engineering. Psychosocial support and disclosure in children and adolescents should also be prioritised.

**Retention in care:** To address the suboptimal loss to follow up (LTFU), evidence-based strategies to improve retention in care and adherence to treatment should be prioritised for scale up and financial resources allocated accordingly – and in line with the National Adherence Guidelines for Chronic Diseases (HIV, TB and NCDs). Psychosocial support is needed to improve adherence to treatment, retention in care, as well as reduce stigma (especially internalised stigma) and discrimination. This should be made available to all PLHIV and TB patients. The existing deficiencies in the linkages to care and patient tracking systems need to be adequately addressed including optimal application of Tier.Net to include HCT, pre-ART, ART and TB programme data and the use of a national unique patient identifier.

**Viral load monitoring:** There is need to improve viral load monitoring and the reporting thereof.

**MDR-TB management:** Creative ways should be explored to improve DR-TB treatment outcomes including closing the diagnosis versus treatment gap. There is an urgent need to support the introduction and use of new drugs like Bedaquiline and the reporting thereof.

Remedial action: Impact alleviation

**Increasing government budgeting for key programmes with highest impact:** There is need for innovative funding for the HIV and TB response beyond PEPFAR and GFATM. Resource mobilisation needs to tap into private business and further explore the benefits of public-private partnerships. There is need to consider incentive funding including Social Impact Bonds as a unique way to promote investment interest from the private sector and high-net-worth individuals. These bonds are contractual agreements whereby results-based donors only pay for delivery of agreed outcomes. This model provides upfront working capital to service providers while promoting accountability.

**Meaningful involvement of civil society in resource mobilisation and equitable allocation of funds:** There is need for the SANAC Resource Mobilisation Unit to create space for civil society to participate meaningfully in resource mobilisation efforts including application for GFATM funding. While challenges exist with regards to civil society capacity to show evidence of impact on their interventions, it is important for multisector collaboration that will yield funding for civil society to function optimally and complement government efforts at the community level.

**Focus on addressing gender based violence especially for key populations:** Interventions need to be comprehensive to address some of the challenges facing key populations, especially transgender persons. There is need for sensitisation and clinical competency training of health care workers and packing of health services to address the needs of key populations. Service providers also need to be capacitated to optimally manage survivors of sexual assault especially among key populations.

**Consider the recommendations of the Gender Equality Assessment:** The findings of the Gender Equality Assessment suggest some immediate steps that need to be taken including the need to strengthen the involvement, participation and prioritisation of women, in all their diversity, in the HIV and TB response if this is not taking place. Meaningful involvement of women and girls living with HIV requires not only representation but also steps to improve meaningful participation such as mobilisation, capacity building and funding. Prioritisation of women in programmes also requires identifying and addressing the particular needs of key stakeholder populations such as girl children, women in sex work, lesbian, bisexual and transgender women, women and girls with disabilities and migrant women.

**Strengthen programmes to address physical and sexual abuse in children:** The recent findings indicating high levels of physical and sexual abuse in childhood suggest that this focal issue has been given poor attention to date, yet is strongly linked to a range of vulnerabilities and causal and consequential pathways related to HIV.

**Develop early warning systems for GBV:** The Civil Society Priorities Charter, developed by all sectors of SANAC as well as the Secretariat’s and Civil Society co-chairs of each PC has furthermore recommended the development of an early warning system to highlight punitive laws, policies, programmes and practices in order to address them and hold government accountable.

**Continue to strengthen the monitoring and reporting of impact alleviation targets** including GBV, human rights violations and access to justice and stigma and discrimination. SANAC as the coordinating body needs to develop a centralised mechanism, through SANAC, for tracking all sectoral plans and human rights indicators to ensure ongoing M&E of human rights violations and responses in terms of SO4, at national level.

**Address stigma and discrimination** – a milestone in South Africa has been the completion of the Stigma Index and the results thereof. It is important for the country to use evidence from this study to tailor-make interventions that will address issues of stigma and discrimination against PLHIV and TB.
6. Support from the country’s development partners
(if applicable)

The South African government has bi-lateral and multi-lateral agreements with development partners who support the HIV/AIDS and TB national response. The agreements with development partners are coordinated through the office of International Relations within the Donor Coordination Unit. However, some of the memorandums of understanding are signed directly with DOH for specific programmes.

Support from development partners is both technical and financial support. Partners support policy formulation, analysis and implementation at the different levels of government, other partners provide direct service delivery as part of complementing SAG efforts in implementing programmes in line with the HIV and TB national response. The support from development partners is also extended to civil society as part of strengthening their contribution to the national multisectoral HIV and TB response accordingly. A number of frameworks have been developed to coordinate the efforts of development partners such as the PEPFAR Partnership Framework, The Global Fund Country Coordinating Mechanism including a special forum within which development partners are represented and they share their plans and reports with SAG.

To reach the global targets, there is need for a coordinated approach between SANAC and its development partners to focus for impact and provide adequate resources to ensure activities are implemented as planned. A common agenda should be developed and development partners be held accountable on an on-going basis.

7. Monitoring and evaluation environment

Overview

The complexity of the HIV/AIDS response necessitates that multisector interventions incorporate a comprehensive and functional M&E system. As outlined within the NSP, the responsibility to monitor and evaluate the implementation of the NSP lies within the SANAC Secretariat. The SANAC secretariat is the hub within which data on the HIV and TB response is housed as stakeholders account on their efforts towards the realisation of the goals as set in the NSP. Realisation of the goals and objectives of the NSP translate to South Africa reaching the targets as set out in the Political Declaration on HIV/AIDS.

During the second quarter of 2013/2014 the secretariat established an M&E unit. The unit is staffed by an M&E manager at the SANAC Head Office and nine M&E Officers based in each of the nine Provincial Aids Councils (PACs). In addition, UNAIDS and CDC provide ongoing technical support and the USAID funded Futures Group Sexual HIV Prevention Programme (SHIPP) has seconded a Senior M&E expert to the Secretariat. This is an effort to create a coordinated M&E system to allow for data collection and create readily available information to be used to guide the SA response and to report on any global commitments.

In keeping with good M&E principles and as part of adopting the ‘three ones’ approach, SANAC led the development of an M&E framework for the NSP. The M&E framework takes into account existing M&E systems being implemented within government departments and sectors and gives direction as well as synergising all existing sectoral M&E systems. The framework is currently being reviewed.

The Secretariat produced its first report on progress against the goals, objectives and targets set in the NSP 2012-2016 in 2014 and data from this report has been used to complete the Global AIDS Response Progress Report for 2013 - 2014. The report covered the first year of the current NSP implementation, and progress made in each of the NSP’s four strategic objectives and recommendations to remedy challenges as presented in the report. In fulfilling the recommendation of the NSP (2007-2011) mid-term Review, the second report covering the second year of NSP implementation will be published. Secondly, the SANAC secretariat embarked on an M&E assessment of all the nine Provincial AIDS Councils and results of this activity are being used to guide support to these structures respectively. The secretariat also managed to undertake an annual review of Provincial Strategic Plans guided by the set indicators in the NSP and reports have been published accordingly.

One of the main challenges identified in the 2012 NSP progress report was weaknesses in the M&E system regarding core indicators selected for monitoring progress, indicator definitions, targets set and the baseline results/ values used in the NSP. Consequently, the review of the current NSP indicators was included in the NSP MTR process conducted this year. The review of the NSP indicators was carried out in the form of a workshop attended by M&E experts from government sectors, bilateral agencies, sectors and PACs.
Further consultations were conducted with parties who were not able to attend the workshop. The main objective of the workshop was to review the NSP indicators and targets and make practical recommendations for the remaining period of the NSP and beyond.

The GARPR reporting is being prepared by SANAC through the monitoring and evaluation unit with the support of UNAIDS country office for the second year now. All applicable GARPR indicators are reported on the online reporting tool and as well as on this narrative report. In an effort to validate data SANAC called a workshop to openly present data and discuss report findings before formal submission. The workshop participants included civil society members, development partners, private sector and NGOs.

Challenges
- Progress towards achieving the targets not adequately measured by the listed NSP indicators, with some of the sub-objectives having no valid and reliable indicators to measure achievements;
- Data for some GARPR indicators especially impact alleviation is based on national surveys that are not done on an annual basis hence there is “no data” to track progress against set targets; and
- Lack of operational routine reporting system by all partners contributing to the HIV response which affects representativeness and completeness of data.

Remedial actions planned
- Finalisation and operationalisation of the revised multi-sector NSP M&E framework
- Development of a data repository mechanism and coordinated reporting on the NSP
- Development targets for children in the NSP to allow for reporting on GARPR;
- The next NSP targets should be aligned to the 90:90:90 ambitious target; and
- Coordinated mechanisms to be built into the routine programming to generate data or information on a continuous basis to provide evidence for programme planning and decisions-making hence, the need for an updated M&E system.

8. Annexes

ANNEX 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV and AIDS
9. Endnotes

2. DOH Annual Report 2014/2015
5. Ibid.
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11. Summary of preliminary results from Thembisa Provincial Models; 2015
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69. DOH Annual Report, 2013/2014
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