



REPUBLIC OF SOUTH AFRICA
2017
GLOBAL AIDS MONITORING (GAM)
REPORT
PROGRESS TOWARDS TARGETS



ACKNOWLEDGEMENTS

SANAC M&E Unit provided technical support and data in the preparation of this report. Additional literature review, data analysis and preparation of this report was conducted by Health Info-Matrix (Pty) Ltd.



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Date of report: 11 June 2018



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ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
ART	Antiretroviral Therapy
ASO	AIDS Service Organization
BBS	Bio-Behavioural Survey
CARMMA	Campaign on Accelerated Reduction of Maternal, Child Mortality in Africa
CDC	Centres for Disease Control
CMS	Council of Medical Schemes
CSW	Commercial Sex Worker
DBE	Department of Basic Education
DHIS	District Health Information System
DoH	Department of Health
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored and Safe
DSD	Department of Social Development
eMTCT	Elimination of Mother-to-Child Transmission
FSW	Female Sex Worker
GBV	Gender Based Violence
HCP	HIV Communication Programme
HCT	HIV, Counselling and Testing
IPV	Intimate Partner Violence
JHHESA	John Hopkins Health and Education in South Africa
MERL	Monitoring, Evaluation, Reporting and Learning
MDG	Millennium Development Goals
MDR/RR-TB	Multi-Drug Resistant/ Rifampicin-Resistant Tuberculosis
MDR-TB	Multi-Drug Resistant Tuberculosis
MNCWH&N	Maternal, Newborn, Child and Women's Health
MSM	Men who have Sex with Men
MSP	Multiple Sexual Partners
MTCT	Mother-to-Child Transmission
NACOSA	National AIDS Convention of South Africa
NCS	National Communication Survey
NDP	National Development Plan
NHI	National Health Insurance
NHLS	National Health Laboratory Services
NSP	National Strategic Plan
NYP	National Youth Policy



ABBREVIATIONS AND ACRONYMS

OST	Opioid Substitution Therapy
PCR	Polymerase Chain Reaction
PEPFAR	(United States) President's Emergency Plan for AIDS Relief
PHIV	People Living with HIV
PICT	Provider-Initiated Counselling and Testing
PMTCT	Prevention of Mother-to-Child Transmission
PWID	People Who Inject Drugs
SANAC	South African National AIDS Council
SMF	Stigma Mitigation Framework
SNCDs	Social Needs Cluster Departments
Stats SA	Statistics South Africa
STI	Sexually Transmitted Infection
SWEAT	Sex Worker Education and Advocacy Task Force
TAC	Treatment Action Campaign
TB	Tuberculosis
TCC	Thuthuzela Care Centre
TVET	Technical Vocational Education and Training colleges
UNGASS	United Nations General Assembly Special Session on Drugs
UNICEF	United Nations International Educational Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States AIDS for International Development
UTT	Universal Test and Treat
VMMC	Voluntary Medical Male Circumcision
WAD	World AIDS Day
WEGE	Women Empowerment and Gender Equity
WHO	World Health Organization

SUMMARY OF PROGRESS ON THE 2020 FAST-TRACK COMMITMENTS AND EXPANDED TARGETS TO END AIDS



South Africa achieved 74% - 70% - 82 % of the 90 - 90 - 90 targets.

COMMITMENT 1: Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020

In 2016, seventy-four percent of People Living with HIV (PLHIV) knew their status; 70% of PLHIV were on ART and 82% of those on ART were virally suppressed.

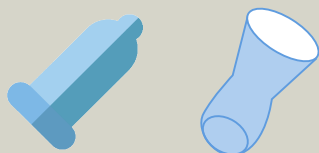


Target Reached!

In 2016, HIV from mother to child was 1.4%

COMMITMENT 2: Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018

South Africa reached its target of mother-to-child transmission in 2016, with a Mother-to-child transmission (MTCT) rate of 1.4% - less than the target of 2% MTCT.



917 253 117 male condoms distributed in 2016
26 055 205 female condoms distributed in 2016

COMMITMENT 3: Ensure access to combination prevention options to at least 90% of people by 2020

In 2016, South Africa expanded combination prevention options to include Pre-Exposure Prophylaxis (PrEP), medical male circumcision and condoms.



78 % of PLHIV report never experiencing discrimination

COMMITMENT 4: Eliminate gender inequalities and end all forms of violence and discrimination by 2020

The majority of PLHIV surveyed in 2013 reported never experiencing discrimination (78%), being physically assaulted by their partner (90%) or experiencing psychological violence (92%).



Within the first year of the *SheConquers* campaign, more than 230 000 adolescent girls, young women and their male partners had an HIV test

COMMITMENT 5: Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020

Within the first year of the *SheConquers* campaign, more than 230 000 adolescent girls, young women and their male partners had an HIV test; over 60 000 adolescent girls received life skills and sexuality education; over 4 600 completed a Parenting Programme; over 15 000 adolescent girls and young women received post-violence care, and 800 men were reached with a gender norms intervention programme.





R373 Million spent on HIV programmes for children in 2016

COMMITMENT 6: Ensure that 97.5% people living with, at risk of, and affected by HIV benefit from HIV-sensitive social protection by 2020.

South Africa Social Security Agency (SASSA)'s coverage rate of 82.5% was rated among the best coverage in the world in targeting the poor for social assistance in 2016. Structural interventions to increase access to education and employment opportunities supported more than 30 000 adolescent girls to remain in school and provided economic strengthening programmes to 4 000 adolescent girls and young women.



R20 million spent on HIV community mobilisation in 2016

COMMITMENT 7: Ensure that at least 30% of all service delivery is community-led by 2020.

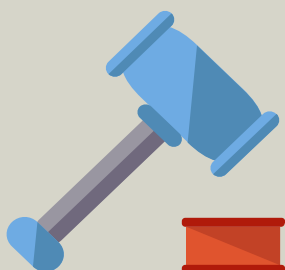
South Africa extended HIV and AIDS health services through community-based delivery agents to the general population and sex workers, Men who have sex with men (MSM), Women who have sex with women (WSW) farm workers, truckers, and youth in schools.



South Africa has increased investment in HIV programmes by 41.6% over the past 5 years

COMMITMENT 8: Ensure that HIV investments increase to US\$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers

In 2016, SA spent 18.1% of total HIV expenditure on prevention, falling short of its target by 6.9%. The country spent a modest 1.1% for social enablers, falling short of its target by 4.9%



COMMITMENT 9: Empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violations of human rights

In 2015, SANAC in conjunction with partners implemented a national communication campaign themed 'I Can't Change My HIV Status But You Can Change Your Attitude' designed to challenge stigmatising attitudes, build understanding of PLHIV and market a national legal assistance programme for individuals experiencing discrimination on the basis of having HIV or TB.



1.2 Million patients registered in the CCMD Programme

COMMITMENT 10: Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage

SA made strides towards universal health coverage through 10 National Health Insurance (NHI) pilot districts using services from 330 General Practitioners and 329 Pharmacy Assistants. To better integrate HIV treatment into chronic disease management, a total of 1 252 000 patients were registered on the Centralised Chronic Medicine Dispensing & Distribution (CCMD) programme.

1. INTRODUCTION

PROGRESS TOWARDS THE 2020 FAST-TRACK COMMITMENTS AND EXPANDED TARGETS TO END AIDS

South Africa is a signatory to the 2016 United Nations Political Declaration on HIV and AIDS; on the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030, adopted at the United Nations General Assembly High-Level Meeting on AIDS in June 2016.

This Political Declaration was built on three previous political declarations: the 2001 Declaration of Commitment on HIV/AIDS, the 2006

Political Declaration on HIV/AIDS and the 2011 Political Declaration on HIV and AIDS.

The 2020 Fast-Track commitments and expanded targets aim to reduce new HIV infections, reduce AIDS-related deaths and eliminate stigma and discrimination. These commitments incorporate an obligation for countries to commit to the 90-90-90 strategy, an ambitious approach to end the AIDS epidemic by 2030¹.

The **90-90-90 strategy** is a new and innovative approach in the treatment of HIV, building momentum so that by 2020:

- 90% of all PLHIV know their status
- 90% of all PLHIV receive sustained ART
- 90% of all people on ART have viral suppression



2. STATUS OF THE HIV EPIDEMIC: PREVALENCE, INCIDENCE AND MORTALITY

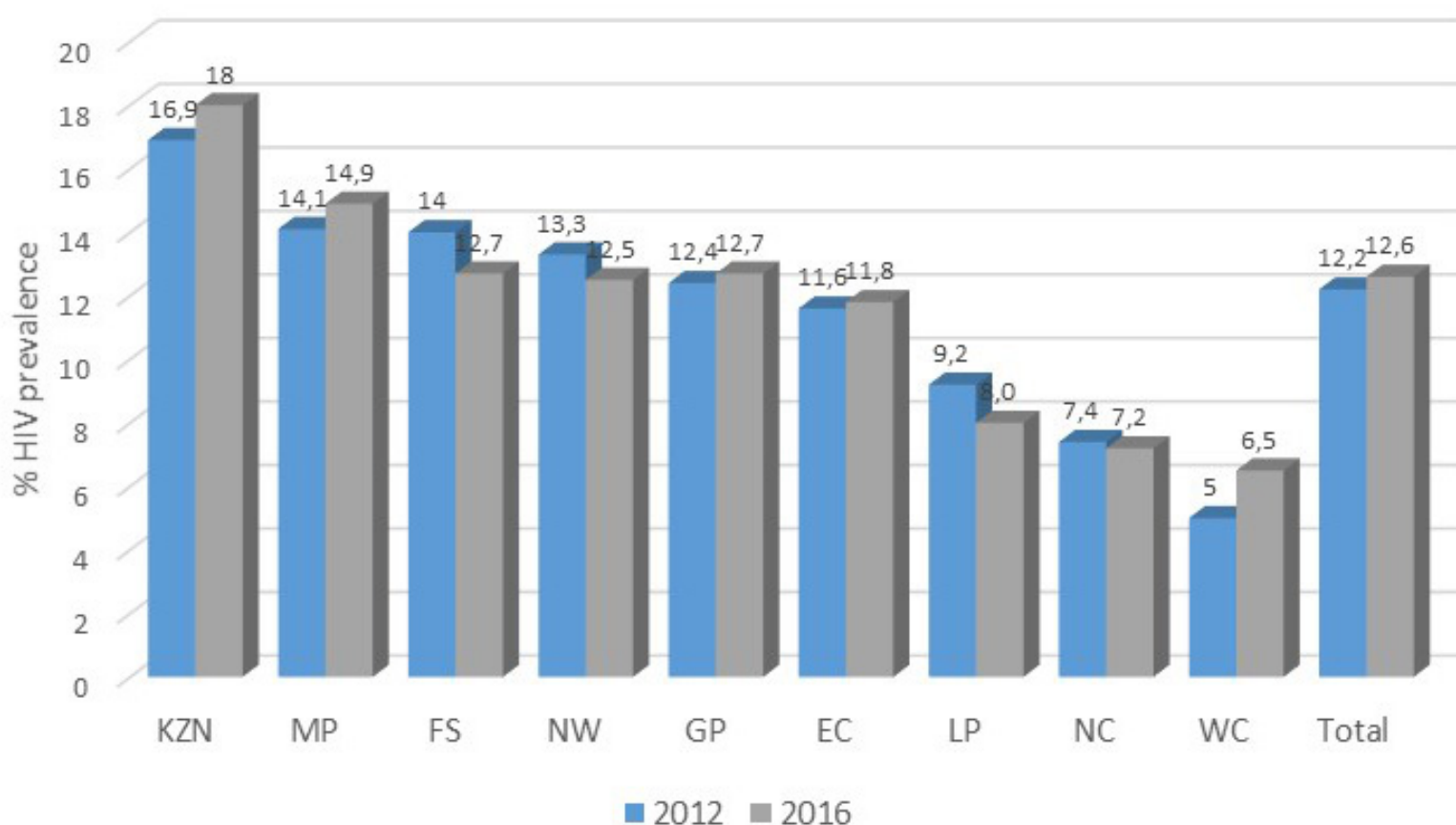
To date, South Africa has one of the highest HIV prevalence rates in Sub-Saharan Africa². The generalized HIV epidemic in the country is heterosexually driven³; with reported high levels of HIV/TB co-infections.

In 2016, there was an estimated 7.1 million people living with HIV out of a population of approximately 55 million people in the country⁴. Estimated HIV prevalence in 2016 ranged from 18% in KwaZulu Natal to 6.5% in the Western Cape. The HIV prevalence provincial distribution for the reporting period (Figure 1) is similar to the 2012 distribution as reported in the South African National HIV Prevalence, Incidence and Behaviour Survey.⁵



In 2016
there were
about
7.1 million
PLHIV

Figure 1: HIV prevalence by province, South Africa, 2012 and 2016



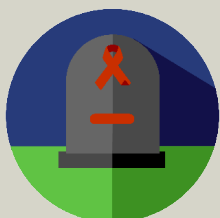
SOURCES: HSRC survey, 2012; Thembisa v3.2 estimates, 2016

In 2016, the number of newly infected individuals was estimated⁶ to be 280 073 infections, with more female new infections (160 603) compared to males (104 439).

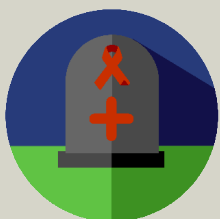
On a positive note, overall estimated HIV incidence decreased in a four year period by 20.8%, from 0,72 in 2012 to 0,57 in 2016. AIDS-related mortality was reported as 110 000 (88 000 - 140 000) for 2016⁷.

In South Africa, the HIV epidemic is exacerbated by tuberculosis (TB) infections⁸. In 2016, it was estimated that 438 000 (304 - 596) people comprised incidence TB cases, with higher incident cases among males: 256 000 (171 000-342 000) compared to females, 182 (121 000–242 000)⁹. The TB mortality rate was on target, at a rate of 46/100 000 among HIV-negative patients and 133/100 000 among HIV-positive patients¹⁰.

TB MORTALITY TARGET REACHED IN 2016



HIV - Patients Target: 50/100 000
Actual: 46/100 000



HIV + Patients Target: 168/100 000
Actual: 133/100 000

3. POLICY ENVIRONMENT AND PROGRAMMATIC RESPONSES

The National Strategic Plan on HIV, Sexually Transmitted Infections (STIs) and TB for 2012–2016 guided and informed the country's response to the HIV epidemic; as well as STI and TB infections. In addition, South Africa has a range of specific laws, policies, strategies and plans to regulate and influence the objectives of the national HIV programmatic response.

The country has continued to position its legal framework and programmatic context

to improve access to prevention, treatment and care to all South Africans, especially highlighting vulnerabilities faced by young women and girls and key populations including PLHIV, Sex Workers (SW), MSM, and People Who Inject Drugs (PWID). These strategic documents have helped to shape an enabling environment whereby stigma and discrimination are addressed; gender inequalities, violence and other forms of discrimination are reduced; and access to justice and legal services is enhanced.



4. OVERVIEW OF THE HIV AND AIDS EPIDEMIC IN THE COUNTRY

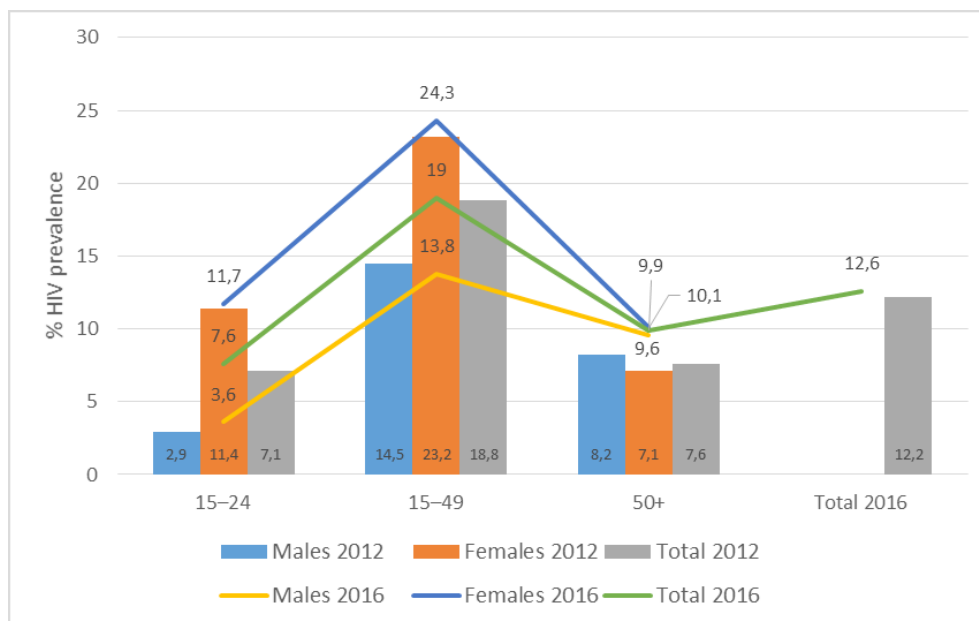
HIV PREVALENCE TRENDS

HIV prevalence estimates for 2016¹¹ show that 7 046 301 people were living with HIV in the country, which translated to a national HIV prevalence of 12.6% (Figure 2).

The prevalence rate among women aged 15

to 49 years was 24.3%; while for males of the same age it was 13.8%; the overall 15 to 49-year age group had an HIV prevalence of 19.0%. The results confirm the disproportionate disease burden of the epidemic among women compared to their male equivalents.

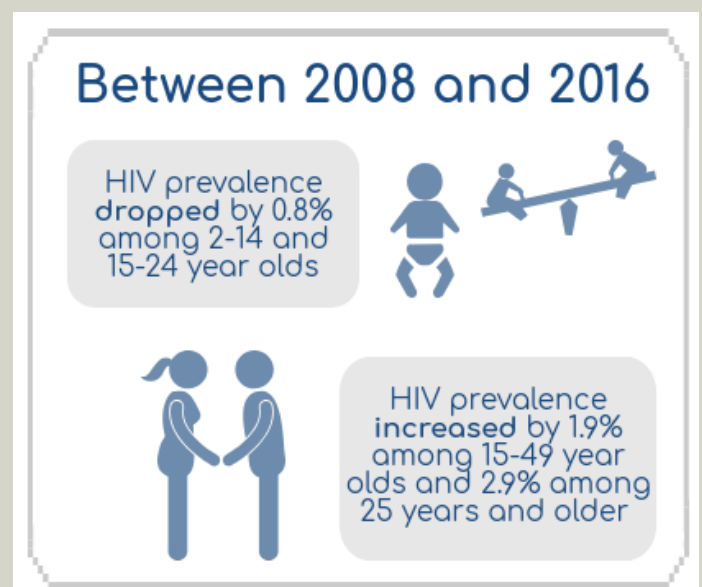
Figure 2: HIV prevalence rate by sex in selected age groups, South Africa, 2012 and 2016



SOURCES: 2012 data from Olive Shisana et al. 2012; 2016 data from Leigh Johnson et al, 2016

HIV PREVALENCE BY AGE

Figure 3 shows HIV prevalence by age based on data from repeat cross-section national population surveys¹² as well as model estimates from the Thembisa model for South Africa since 2002. HIV prevalence among children less than 15 years old was 2.0% in 2016, a slight decrease from the 2012 figure of 2.5%. HIV infection among children aged 0 to 14 years has been slowly decreasing, from 2.8% in 2008, to 2.5% in 2012, and finally, 2.0% in 2016. This is likely a result of the success of the Prevention of Mother-to-Child Transmission (PMTCT) programme. During the same period, prevalence among the older age groups, (25 years or older) has been slightly increasing, most likely due to the success of the ART programme. Over 50% (3 723 118) of

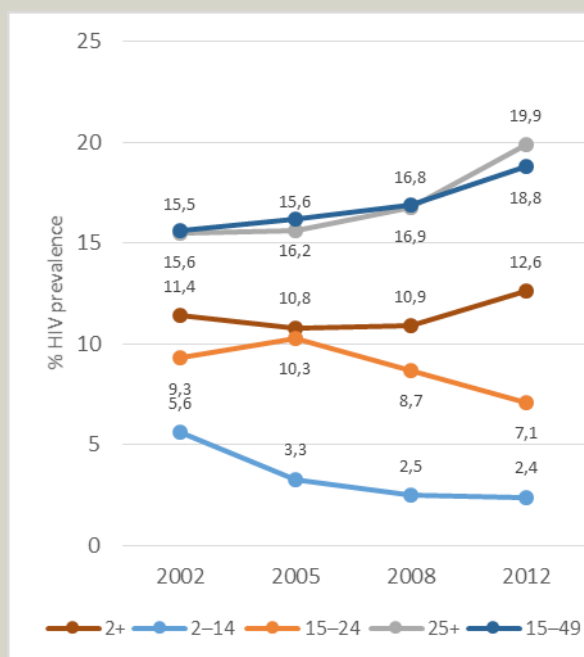


HIV-infected individuals were on ART. Individuals on ART who have low viral loads are less infectious, thus slowing down the growth of the epidemic curve. The difference between incidence HIV cases and people dying from HIV-related illness has an impact on the growth of the epidemic.

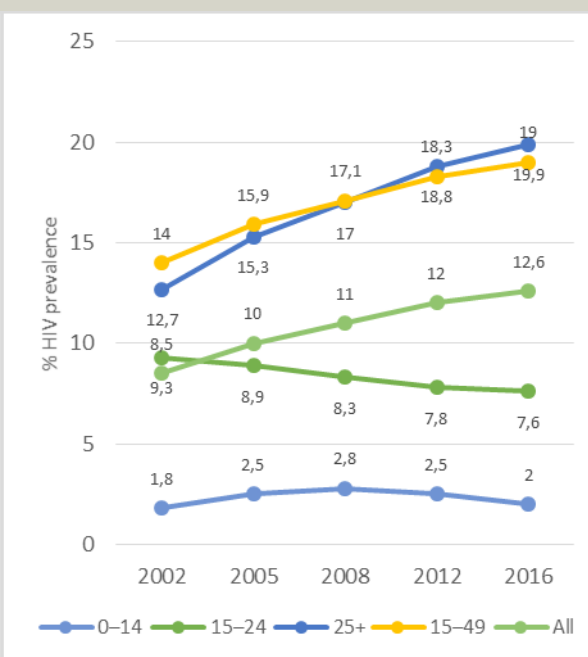
South Africa is among the first countries in

Africa to formally adopt the Universal Test and Treat (UTT) strategy in accordance with the WHO new guidelines on HIV treatment. During his budget speech the Minister of Health announced the country's intention to implement UTT by September of 2016¹³. The move to offer treatment initiation for all age groups, regardless of CD4 count, is a progressive step in mitigating new infections and curbing the epidemic.

Figure 3: HIV Prevalence by Age, South Africa, 2002, 2005, 2008, 2012 and 2016



Source: Olive Shisana et al, 2012



Source: Leigh Johnson et al, 2016



HIV PREVALENCE BY PROVINCE

Similar to previous national HIV survey reports, there were considerable variations in HIV prevalence across provinces in the 2016 estimates¹⁴(Table 1). KwaZulu-Natal (17.6%), Mpumalanga (14.9%), Gauteng (12.7%) and the Free State (12.7%) had prevalence rates above the national average (12.6%). The Western Cape (6.5%), Northern Cape (7.2%), and Limpopo (8.0%) had the lowest HIV prevalence rates which were all below 10%. In relative terms, the epidemic grew faster in the Western Cape (10.2%), The Eastern Cape (9.3%), Limpopo (6.7%) and the Northern Cape (5.9%). The provinces with the lowest relative growth of the epidemic were the high-burden provinces: North West (2.5%), Kwazulu-Natal (2.9%) and the Free State (3.3%).

Table 1: HIV prevalence by province, South Africa, 2012 and 2016

Province	Prevalence		Change	
	2012 (HSRC)	2016 (Thembisa)	Absolute difference	Relative difference
Western Cape	5,9	6,5	0,6	10,2
Eastern Cape	10,8	11,8	1,0	9,3
Northern Cape	6,8	7,2	0,4	5,9
Free State	12,3	12,7	0,4	3,3
Kwazulu Natal	17,4	17,9	0,5	2,9
North West	12,2	12,5	0,3	2,5
Gauteng	12,2	12,7	0,5	4,1
Mpumalanga	14,2	14,9	0,7	4,9
Limpopo	7,5	8,0	0,5	6,7
Total	12,0	12,6	0,6	5,0

SOURCES: 2012 data from Olive Shisana et al. 2012; 2016 data from Leigh Johnson et al, 2016



HIV PREVALENCE AMONG KEY POPULATIONS

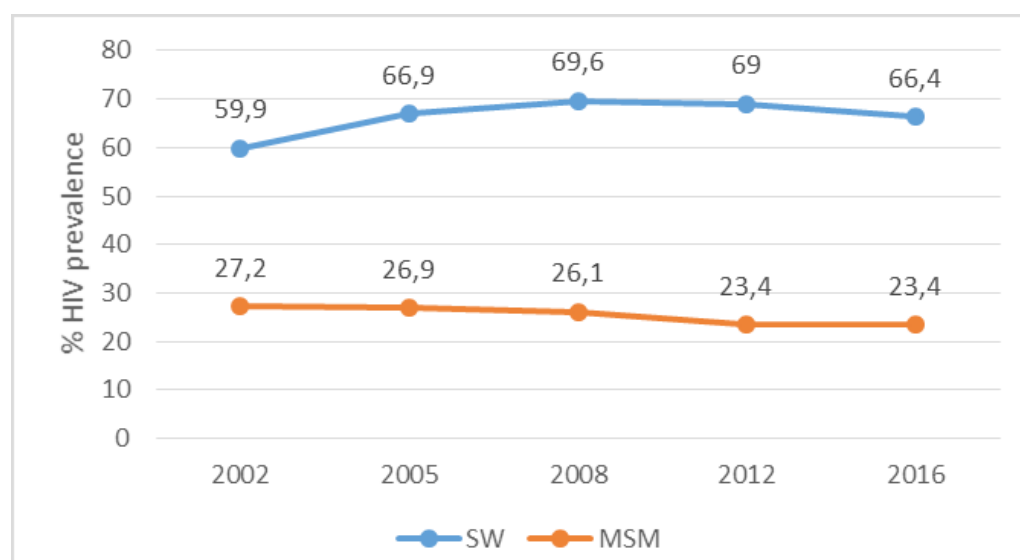
Figure 4 below shows HIV prevalence estimates for two key population groups namely, female sex workers (FSW) and MSM. The HIV prevalence among FSW has remained very high since 2002 (60%) and over the period under review, it grew in relative terms by 10% to 66% in 2016. At the same time the prevalence among MSM saw a decrease from 27.2% in 2002 to 23.4% in 2016. Prevalence remained stable in this group between 2012 and 2016, at 23.4%¹⁵.

A 2014 biological and behavioural survey among Female Sex Workers¹⁶ reported HIV

prevalence among FSW ranging from 39.7% in Cape Town, 53.5% in Durban to 71.8% in Johannesburg. Variations were also observed among MSM in a data triangulation which noted that nearly one-third or more of MSM were already infected with HIV, and reported HIV estimates ranging between 13% and 49%¹⁷. Epidemiological data for people who inject drugs (PWID) is scarce in South Africa.

A 2013 HIV prevalence and risk survey¹⁸ among 450 PWID from five South African cities reported an HIV prevalence of 14% (18% among females and 13% among males). There were no survey data available for SW, MSM and PWID in 2016.

Figure 4: HIV prevalence among key populations for selected years, South Africa



Source: Thembisa v3.2,2016



HIV PREVALENCE IN VULNERABLE POPULATIONS

The National Strategic Plan (NSP) 2012-2016¹⁹ defined a number of sub-groups, namely: Black African women and men, cohabiting people, people living with disabilities, high-risk alcohol drinkers and people who use drugs, at risk for higher levels of HIV infection and transmission. The Strategy recommended that these sub-groups should be targeted for specific prevention, care, treatment and support interventions based on risk and need.

Some of these HIV vulnerable groups were included in the 2012 national prevalence survey²⁰, defined as groups with HIV prevalence above the national average of 12.2% (Table 2). These groups include women aged 20 to 35 years of age, individuals who were cohabiting, men aged 25 to 49 years old, people with disabilities, excessive alcohol drinkers and people who used recreational drugs. Besides these mentioned groups, one group which was under focus on a number of HIV programmes was young women and girls aged 15 to 24 years.

Table 2: Vulnerable populations with HIV Prevalence above 12.2%, South Africa

Key Population	HIV Prevalence
Black African Women aged 20-35 years	30.6%
People living together, not married (Cohabiting)	30.9%
Black African men aged 25-49 years	25.7%
People living with disability aged above 15 years	16.7%
High risk alcohol drinkers aged above 15 years	14.3%
Recreational drug users	12.7%

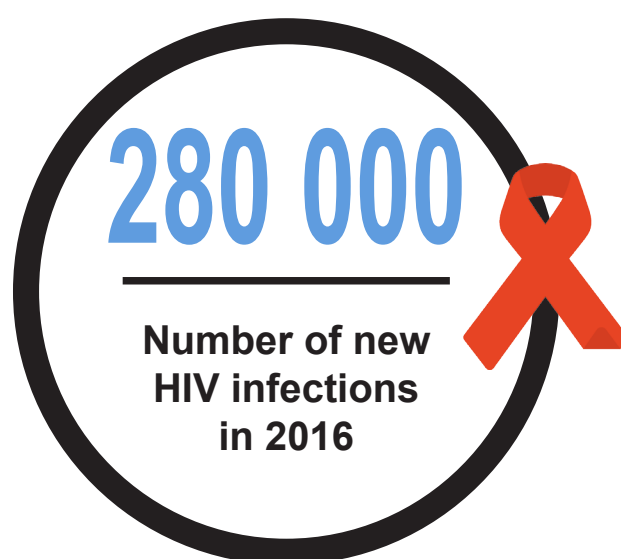
Source: HSRC, 2012

HIV INCIDENCE

The HIV incidence is the number of new HIV infections in a population during a certain period. In South Africa in 2016, the number of newly infected individuals was estimated²¹ to be 280 073 infections; 4 436 at or before birth (in-utero and intrapartum), 10 595 due to breast feeding and 265 042 sexually acquired. There were more female new infections (160 603) compared to males (104 439). The number of new HIV infections for 2016 was lower than the 2012 estimate of 333 759 as well as the 469 000 new infection reported by the 2012 national prevalence study.

Overall estimated HIV incidence in 2016 was

0.57, a 0.15 absolute or 20.8% relative decrease from 2012 (Table 3). HIV incidence was higher among women than men both among young people aged 15 to 24 years, as well as among the reproductive age range of 15 to 49 years. HIV incidence decreased by 13.6% among 15 to 24

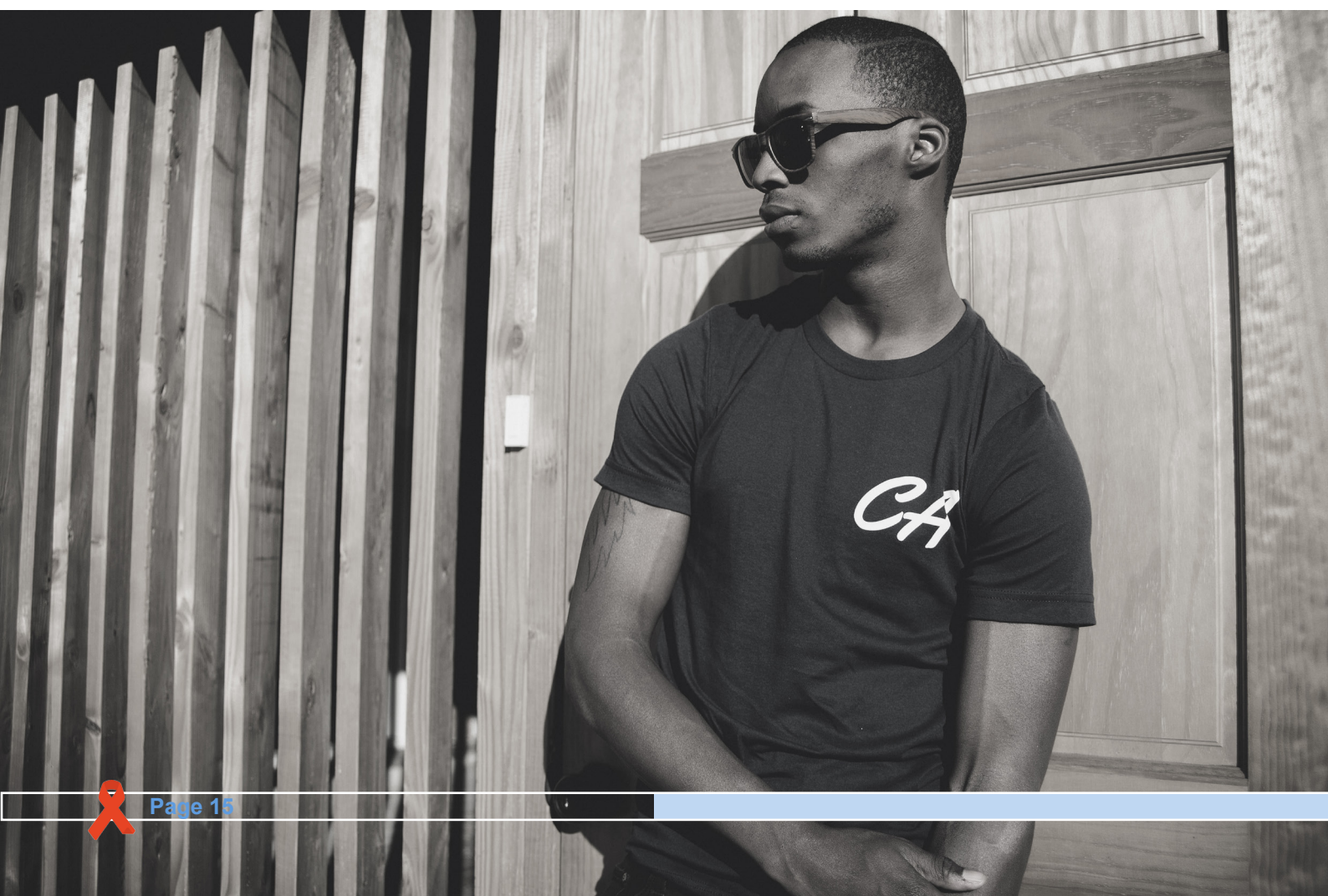


year olds, while it decreased by 18% in the reproductive age group. These results were consistent with findings of Stats SA²² which confirmed a decline in HIV incidence among people aged 15 to 49 years from 1.31% (in 2012) to 1.22% (in 2015). The highest incidence (2.15%) was observed among young women and girls. This was three times higher than the infection among males of the same age group, who reported an incidence rate of 0.71%.

Table 3: HIV incidence by sex and age, South Africa, 2012 and 2016

Age Group	HIV Incidence			Difference	
	Sex	Thembisa Model 2012	Thembisa Model 2016	Absolute Change	Relative Change
15-24	Male	0,88	0,71	-0,17	-19,3
	Female	2,43	2,15	-0,28	-11,5
	Total	1,62	1,4	-0,22	-13,6
15-49	Male	0,92	0,75	-0,17	-18,5
	Female	1,55	1,29	-0,26	-16,8
	Total	1,22	1	-0,22	-18,0
Overall Total		0,72	0,57	-0,15	-20,8

Source: Thembisa v3.2, 2016



COMMITMENT 1



Ensure that 30 million people living with HIV have access to treatment through meeting the 90-90-90 targets by 2020.

5. NATIONAL RESPONSE TO THE HIV AND AIDS EPIDEMIC

POLICY ENVIRONMENT

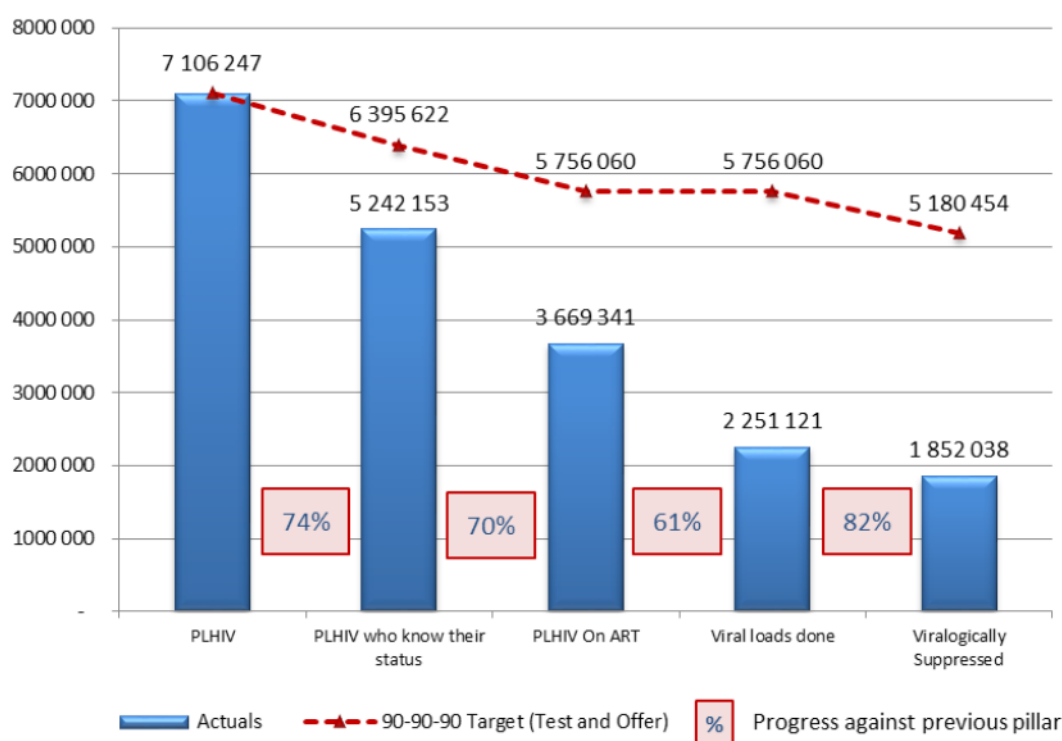
In order to reach the ambitious 90-90-90 targets, South Africa instituted the National consolidated ART guidelines in 2015, and the Department of Health (DoH) implemented a Circular on Universal Test and Treat for HIV positive patients in 2016, effectively expanding treatment access and coverage to all people living with HIV in the country²³.

90-90-90 STRATEGY STATUS

South Africa has the largest HIV treatment programme in the world, with over 3.7 million people on ART out of an infected population of around 7.1 million individuals. This has resulted in reduced morbidity and mortality among the population, thus improved life expectancy. The country is making progress towards its 90-90-90 targets. The SA NDoH data presented at the 2016 AIDS conference showed that 74% of PLHIV knew their status;

70% of PLHIV were on ART and 82% of those on ART were virally suppressed (Figure 5). While the country reported fairly high results, the data also indicates that 26% of South Africans living with HIV are not aware of their HIV status. Once HIV-infected persons are on treatment, and their viral load is under control (virally suppressed), these individuals will become less infectious, thus reducing the risk of onward transmission.

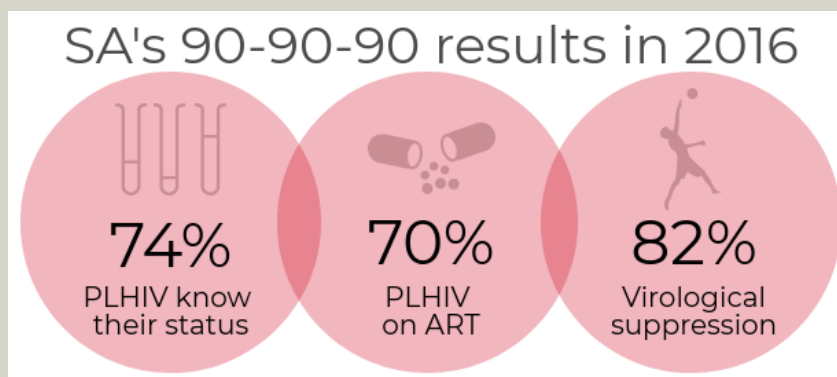
Figure 5: 90-90-90 cascade, total population, South Africa, Dec 2016



SOURCE: Diseko, L. South Africa NDoH DIP TWG. 8th SA AIDS Conference Presentation, 2017

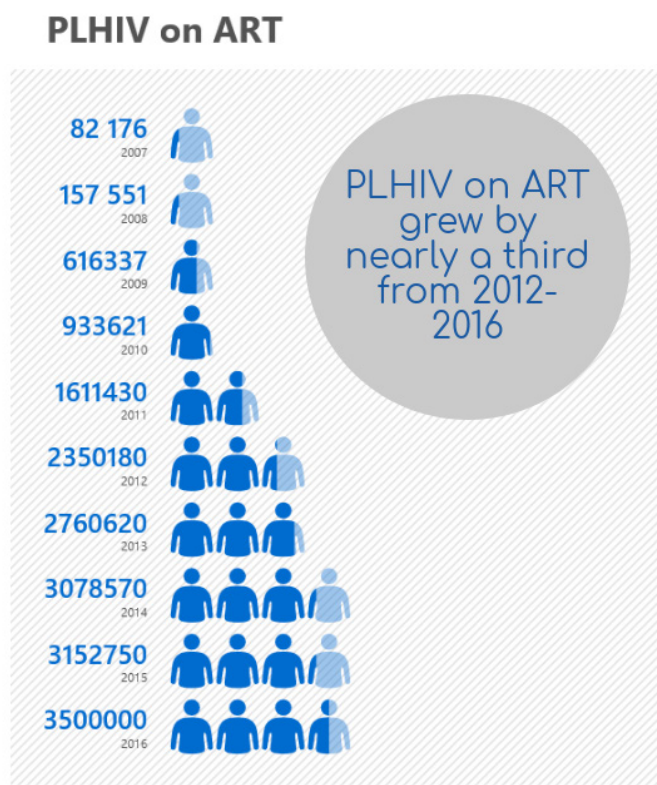


With the largest ART programme in the world, South Africa had over 3.67 million people on ART during the period under review. While SA reported 70% of PLHIV on ART, this falls short of the 2nd 90 target by 20%. South Africa revised its policies to enable more people access to ART; from the CD4 criteria to the adopted guideline of Universal Test and Treat.



The third 90 shows that 82% of PLHIV had suppressed viral loads among those who were on ART, a significant achievement in the response. The data suggests that SA may achieve the third 90 target by 2020, if it is able to capture those unaware of their status, bring them on treatment, and retain treatment adherence.

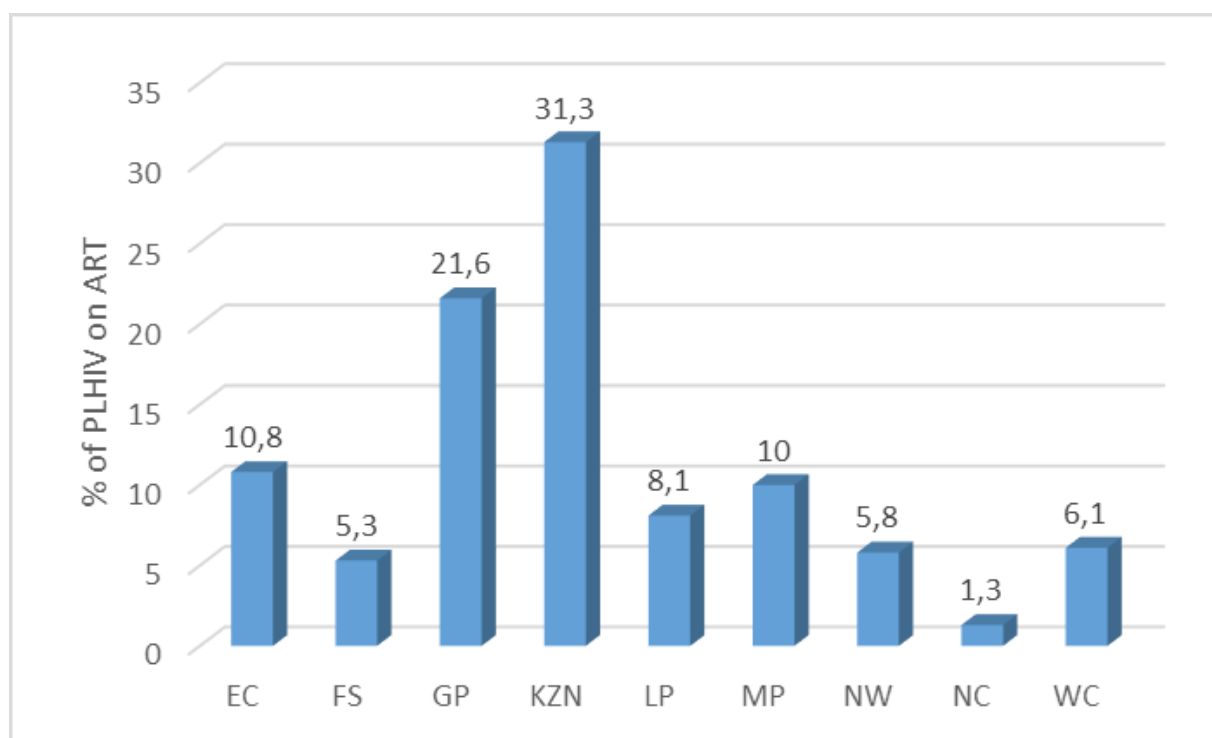
PEOPLE LIVING WITH HIV ON ART



By the end of 2016, 3 929 398 adults and children living with HIV were receiving ART, representing 55.7% of an estimated 7 060 000 PLHIV in the country. Of these, the majority (53%) were aged 15 years and older, and 2.4% of PLHIV on ART were younger than 15 years of age²⁴. During the period under review ART was mainly provided through the public sector, comprising roughly 80% of the reported PLHIV on treatment. The estimate of 20% private sector ART provision is likely underrepresented, as the available data was provided by the Council for Medical AID Schemes (CMS), which reported data for registered medical aid schemes only, hence excluding all other entities in the private sector.

There were variations in the number of PLHIV on ART across provinces. KwaZulu Natal (KZN) Province had the highest number of PLHIV on ART (1 149 826, 31.3%). Northern Cape had the fewest people on ART (46 815, 1.3%). Two provinces, Gauteng and KZN combined, reported more than half of PLHIV on ART (1 941 461, 52.9% in 2016 (Figure 6).

Figure 6: Percentage of PLHIV on ART, South Africa, 2016



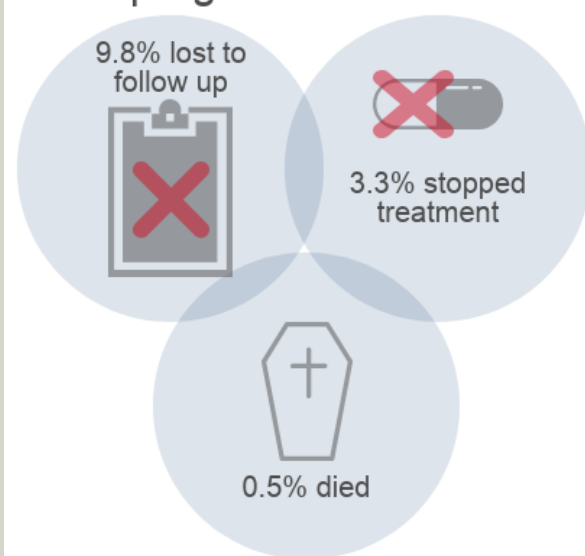
SOURCE: DHIS, 2016

RETENTION ON ART AT 12 MONTHS

At the end of December 2016, 67.9% of adults and children (513 243 out of 756 313) who had enrolled on ART in 2015 were still on ART twelve months later. Of all PLHIV enrolled in the programme in 2016, 9.8% (50 312) were lost to follow up, 3.3% (16 906) had stopped therapy and 0.5% (2 752) died by the end of the reporting period.

The 9.8% lost to follow up rate may be associated with internal migration. With the introduction of an Electronic Patient Management System (EPMS) called TIER.Net in 2011, South Africa is moving towards improved collection of patient-level data on HIV Counselling and Testing (HCT), pre-ART and ART

PLHIV who left the ART programme in 2016



services, as well as TB. However, as the rollout strategy focused on the larger ART sites, many health facilities remain with a paper-based system²⁵, thus limiting the ability of the health system to accurately track movements of PLHIV on ART. As the TIER.Net system is rolled out to all health facilities, this will improve the ability to track ART patients as well as to serve as a case-based HIV surveillance system for the country.

AIDS-RELATED MORTALITY

The NSP had set out as a target, a 50% reduction in deaths due to AIDS-related causes, from a baseline of 43.6% in 2011 to 21.8% mortality in 2016. Data from the District Health Information System (DHIS) shows that AIDS-related deaths were estimated at 270 per 100 000 for the reporting period. However WHO reported AIDS-related mortality of 110 000 (88 000-140 000) for South Africa²⁶. Death notification data reported by StatsSA²⁷ for the same period, indicated 21 830 deaths (4.8%) attributed to HIV disease out of 456 612 total deaths. HIV-related deaths ranked 5th overall after TB (6.5%), diabetes mellitus (5.5%), other forms of heart disease (5.1%) and cerebrovascular diseases (5.1%) as the leading causes of death in the country.

Disaggregated by sex, HIV disease was the second-leading cause of death among males (11 021 deaths or 4.6%), and it was ranked sixth among females (10 724 or 5.8%). Although TB was ranked as the leading cause of death among males (18 153 or 7.6%), it only ranked 5th among females (11 246 or 5.2% of all deaths among females).

While TB remained the top-ranked cause of death among those aged 15 years and above, HIV was the second- and third-ranked cause of death among those aged 15 to 44 years and 45 to 64 years old respectively.

VIRAL SUPPRESSION

A significant achievement was made in that by the end of 2016, eighty-two percent of PLHIV had suppressed viral load among those who are on ART²⁸. Data from the DHIS showed that the proportion of patients with suppressed viral loads above 15 years was 27.4% (1 835 554); and those below 15 years was 17.3% (63 082).

COMMITMENT 2

Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018.

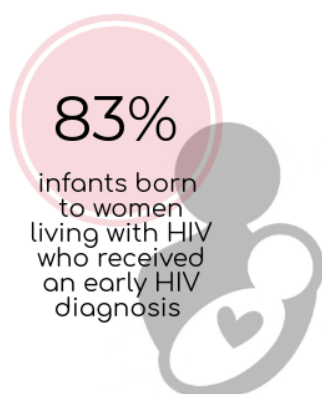


POLICY ENVIRONMENT

The 2012-2016 NSP catered for the elimination of new HIV infections among children. Additionally, South Africa put the following policies and strategies into place to further reduce this burden: 2014 Health sector HIV prevention Strategy²⁹, the 2015 National consolidated ART guidelines³⁰, and the 2016 National HIV testing Services Policy³¹.

The country has progressed significantly in its efforts to eliminate new HIV infections as demonstrated by the PMTCT programme which is supported by the above policies and strategies. Treatment to HIV-infected pregnant and post-partum women and the administering of prevention prophylaxis to their new-born children has seen massive reduction in mother-to-child transmission in-utero, intra-partum and post-partum.

EARLY INFANT DIAGNOSIS



The numerator for early infant diagnosis of HIV is based on infant polymerase chain reaction (PCR) test at birth. For this test, infants are tested once between age 0 and 1 year. By the end of 2016, 82.6% of infants aged 0–1 year were tested for HIV within two months of birth.

MOTHER-TO-CHILD TRANSMISSION (MTCT) OF HIV



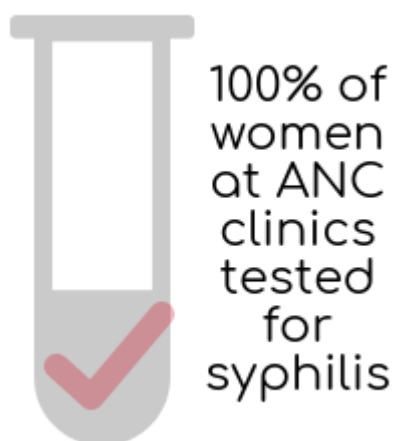
The National HIV programme has come far, with notable achievements in reductions in mother-to-child transmission of HIV from the very high levels in the early 2000s³². At the end of the reporting year, the rate of infants newly infected with HIV from mother-to-child transmission among women living with HIV was reportedly 1.4% based on PCR tests at birth, which was the lowest rate among all Southern African countries with similar epidemics. This is an achievement of note, in that South Africa had reached its 2016 targets of <2% MTCT rate at six weeks, and <5% MTCT rate at 18 months.

PREVENTING THE MOTHER-TO-CHILD TRANSMISSION OF HIV



Approximately 96% (254 543) of women living with HIV who delivered within the past 12 months of the reporting period received antiretroviral medicines. The denominator may exclude women who received single-dose nevirapine, which is normally reported in coverage of antiretroviral medicines for PMTCT.

COVERAGE OF SYPHILIS TESTING IN WOMEN ATTENDING ANC SERVICES



The testing for syphilis among pregnant women is a process indicator used to assess the validation of eliminating the MTCT of syphilis. By the end of 2016, all women (100%) attending any antenatal care (ANC) clinic visit were tested for syphilis. The DoH programme data reports³³ 100% coverage of syphilis testing among women attending ANC services 'at first prenatal visit' (<13 weeks gestation).



COMMITMENT 3



Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations

POLICY ENVIRONMENT

The 2012-106 NSP was intended to achieve the ambitious target of reaching 90% of the population with combination prevention programmes. South Africa also supplemented this plan with a 2014 Health sector HIV prevention strategy, the 2015 National consolidated ART guidelines, and in 2016, a revised National HIV testing services policy.

Evidence from periodic surveys reveal the existence of HIV sub-epidemics in the country. The sub-epidemics are concentrated among some of the key populations, such as SW, MSM and PWID. While the above policies and strategies highlight young women and girls as a priority population; the lack of size estimation and of epidemiological data among SW, MSM and PWID constrains service coverage among these groups.

HIV PREVENTION PROGRAMMES IN PRISONS

In reaching all key populations, 1 967 109 condoms were distributed to prisoners, 156 049 were tested for HIV, and 25 190 prisoners were started on ART in 2016. There are no specific targets for prisoners in the NSP 2012–2016.

PRE-EXPOSURE PROPHYLAXIS (PrEP)

PrEP was initiated as a prevention method among key population groups (SW and MSM) in South Africa. PrEP is intended to help at risk HIV negative people reduce their risk of HIV infection by taking a daily pill. This intervention was piloted with selected priority and key population groups, with the criteria as: a person who is HIV negative status and meets the clinical requirements, is offered PrEP as part of combination prevention package. PrEP strategies under evaluation in South Africa included daily treatment or intermittent dosing related to risk of HIV exposure, which usually involved the addition of a post-exposure dosage³⁴. Under the 2014-2016 Health Sector Strategy, key

populations recommended for this prevention option were MSM and SW; with other sub-groups under consideration including girls and young women, PWID, discordant couples and pregnant women.

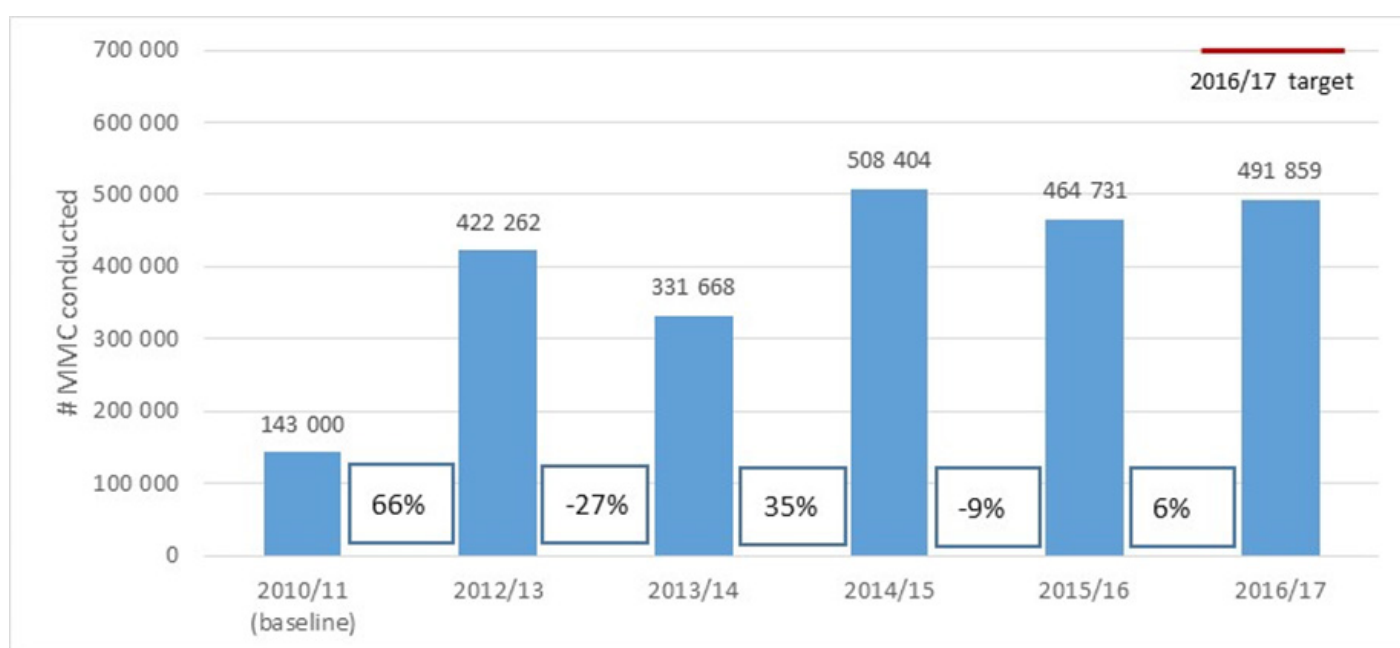
A total of 744 individuals comprised of 663 females, 79 males and 2 transgender persons received PrEP in the reporting period. The majority of people receiving PrEP were in KZN Province (48%), followed by Gauteng (32%) and Limpopo (17%). PrEP was administered to the fewest people in Mpumalanga (2%) and the Northern Cape (1%)³⁵.



MEDICAL MALE CIRCUMCISION (MMC)

As part of offering a combination prevention package, South Africa continued to offer a programme of medical male circumcision. Male circumcision has fluctuated over the five-year period of the implementation of the NSP (2012-2016), with the initial peak of 66% between 2010/11 and 2012/13; however, this dropped considerably (by 27%) the following year (Figure 7). MMC was reportedly at its highest in 2014/15 at 508 404 MMC performed; this dropped by 9% in 2015/16. The number of MMCs performed in 2016/17 increased by 6% from the previous year; however, fell far short of the National Department of Health's target of 700 000 MMCs for that period³⁶.

Figure 7: Medical male circumcisions conducted, South Africa, 2010 - 2017



SOURCE: NDoH Annual reports, 2010/11 to 2016/17

In 2016; a total of 204 383 males were voluntarily circumcised in selected metropolitan cities, with the greatest number of males circumcised in Ekurhuleni (130 415, 63.8%), followed by Johannesburg (40 318, 19.7%) and Tshwane (16 818, 8.2%). Fewer men were circumcised from Mangaung (7 889, 3.9%), Cape Town (5 683, 2.8%), Nelson Mandela Bay (2 511, 1.2%) and Buffalo City (749, 0.4%)³⁷.

CONDOM DISTRIBUTION AND USE

Male and female condom distribution took an upward trend since 2010 (Table 4).

Table 4: Male and female condom distribution, South Africa, 2010, 2012, 2015 and 2016

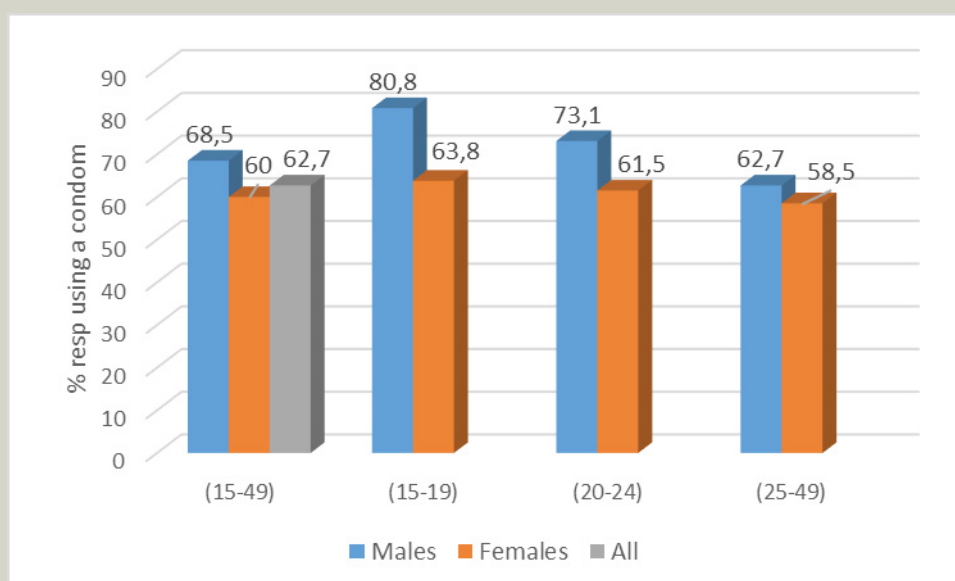
Year	# Male condoms distributed	# Female condoms distributed
2010	492 000 000	5 100 000
2012	251 419 268	4 309 146
2015/16	839 874 751	27 005 805
2016/17	917 253 117	26 055 205

Source: NDoH Annual Reports, 2015/16 - 2016/17

Of primary concern is the use of condoms, particularly among the youth and in instances of high-risk sex. The 2016 Demographic and Health Survey reported that approximately 81% of males aged 15 to 19 years reported using a condom the last time they had sex with a non-marital, co-habiting partner (Figure 8). This trend declined to 73% among 20 to 24 year olds and 63% among 25 to 49 year olds. The same study indicated that women res-

pondents reported less condom use, from a high of 64% among 15 to 19 year olds, down to 62% among 20 to 24 year olds and 59% among 25 to 49 year olds. Overall, males in the 15 to 49 age range reported higher condom use (68.5%) than women (60%) and both sexes combined (63%)³⁸.

Figure 8: Condom use at last sex high-risk sex, South Africa, 2016



SOURCE: DHS, 2016



COMMITMENT 4



Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020

POLICY ENVIRONMENT

The NSP 2012-2016 Strategic Objective 1 focuses specifically on addressing the structural, social, economic and behavioural factors that drive the HIV and TB epidemics which includes gender norms and gender-based violence. The Plan specifically identifies as a high risk for HIV, young women aged 15- 24 years, pregnant women of the same age group, and survivors of physical and/or intimate partner violence. The plan also identifies transgender persons at higher risk for HIV, at risk for sexual abuse and are considered marginalised from accessing prevention, care and treatment services. Similarly, the fourth strategic objective of the NSP focuses on ensuring protection of human rights and access to justice, and addressing stigma, discrimination, human rights violations and gender inequality. One successful element of the NSP was the 'She Conquers' national campaign, which also provided awareness and information on gender, violence against women and girls, alcohol and drug use and stigma and discrimination.

The country's legal framework provides people living with HIV full protection under the Constitution of the Republic. This framework also supports access to SRH services, for example, access to sexual and reproductive health services, HIV testing and HIV treatment by adolescents without parental consent; married women may also access sexual and reproductive health services and HIV testing without spousal consent.

South Africa has also crafted specific laws to eliminate gender based violence (GBV) and reduce all forms of violence against women, girls and children in general, supported by the country's commitment to The African Charter on the Rights and Welfare of the Child.

STIGMA AND DISCRIMINATION

High levels of stigma were evident, with 79.0% of respondents reporting that they would not buy food from a shopkeeper or food seller living with HIV³⁹. However, in 2014, a Stigma Index study⁴⁰ among 10 473 PLHIV aged 15 years and older in 18 districts across South Africa found evidence of positive strides towards reducing stigma and discrimination aimed at PLHIV. The majority of respondents (78%) reported having never experienced discrimination; 90% reported never being physically assaulted by their wife/husband or partner while 92% reported not experiencing psychological violence in the last year.

With regard to health care services, 73% of the respondents indicated that their HIV status was not disclosed to other people without

their consent by a health care professional and 65% expressed confidence that their medical records will be kept completely confidential. The majority of respondents (87%) indicated that health care professionals never discouraged them from having children. Of concern is that 7% of respondents reported that they were forced to be sterilized.

Of those who reported stigma and discrimination due to their HIV status, 42% were victims of gossip, 37% experienced discrimination, 35% were victims of verbal assault and harassment and 27% victims of physical harassment and assault. There were no additional data available to determine trends in stigma and discrimination beyond the 2014 Stigma Index study.



GENDER-BASED VIOLENCE

Disaggregated information on sexual offences and domestic violence in South Africa is not readily available nor accessible, however, the most recent available statistics from the South Africa Parliament Research Unit indicate high levels of violence against women⁴¹. Selected 2011-2012 contact crime statistics compiled by this unit show that common assault crimes were slightly higher among women (48%) than men (45%); and that the rates of all sexual offences were greater among women (48.5%) and children (40.1%), as compared to men (11.4%).

In terms of criminal prosecution for domestic abuse matters, data⁴² show that in 2011, only a third (27.1%) of cases were finalised, while more than half (54.8%) of cases were withdrawn from criminal prosecution. The South African Police Services (SAPS) reported intensifying training of police members in improving services rendered to victims of domestic violence and sexual offences, with 19 000 members trained between 2013-2015. Additionally, SAPS reported victim-friendly rooms in all 1140 police stations (100%) by the end of the 1st quarter 2015/16.



COMMITMENT 5



Ensure that 90% of young people have skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020



POLICY ENVIRONMENT

The 2012-2016 NSP catered for improved access to sexual and reproductive health and rights, particularly among young people. Additional policies for which South Africa is a signatory that support this aim includes the 2016 Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH&N) and Nutrition in South Africa as well as the National Strategic Plan for a Campaign on Accelerated Reduction of Maternal, Child Mortality in Africa (CARMMA), launched in 2013.

YOUNG PEOPLE

During the reporting period, there were no new data on knowledge about HIV prevention among young people. However, the 'She Conquers' national campaign (2016) was launched to deliver biomedical, socio-behavioural and structural interventions, aimed to increase access to information, services and support, particularly for adolescent girls and young women.



The NDoH reported⁴³ that in the 22 priority sub-districts within the first year of the She Conquers campaign, more than 230 000 adolescent girls, young women and their male partners had an HIV test. Of those that were tested, eight percent were found to be HIV positive and linked to care (3 000 of those that were positive were men). In the same period, over 60 000 adolescent girls received life skills and sexuality education. Over 4 600 comple-

ted a Parenting Programme aimed at young mothers and parents of teenagers. In terms of gender-based violence, over 15 000 adolescent girls and young women received post-violence care, and 800 men were reached with a gender norms intervention programme.

The 15 to 24 year age group is a transitional period, where young people enter adulthood and most people initiate sex. This is a high risk period for HIV infection. The 2016 Thembisa model reported an overall HIV prevalence of 7.6% among this group; with higher infections among females (11.7%) than males (3.6%). The 2012 National HIV Prevalence, Incidence and Behaviour Survey reported the overall HIV prevalence among 15 to 24 year olds as 7.1%. HIV incidence in the same group in 2016 was estimated at 1.4%, with females being 3 times more likely to be newly infected (2.2%) compared to males (0.7%). These trends are similar to previous surveys.

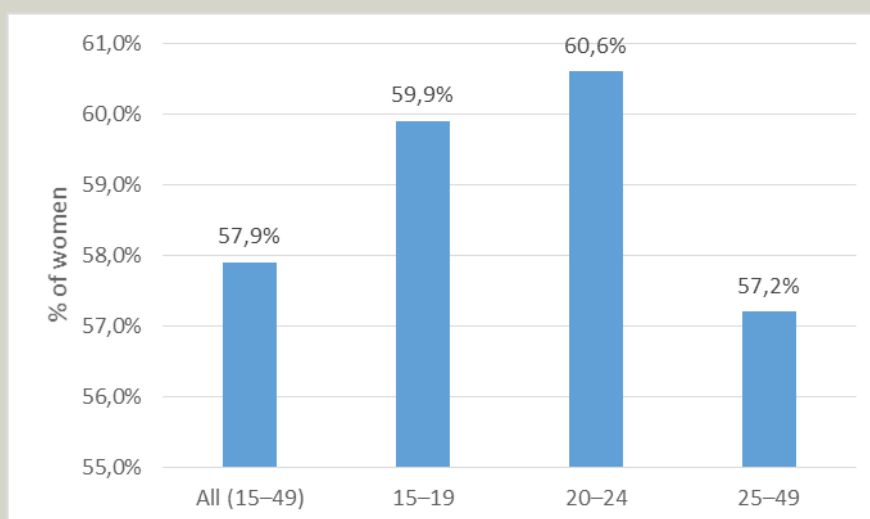
HIV prevalence estimates among 15 to 49 year olds was 19%, 13.8% among males and 24.3% among females⁴⁴. In the 2012 survey these figures were 14.4% among males, 23.2% among females and 18.8% overall. The estimated incidence in the 15 to 49 year age group in 2016 was 1%, 0.8% among males and 1.29% among females⁴⁵.

FAMILY PLANNING

The demand for modern methods of family planning among women in the reproductive age group 15 to 49 years has been increasing, due to their changing roles in society, the sharing of child-rearing responsibilities between the sexes, and higher levels of education. To meet their changing societal roles, women are demanding family planning methods that satisfy their career and lifestyle choices. These range from permanent methods for women who choose not to have children, to a range

of temporary, short- and long-term methods that prevent HIV and sexually transmitted infections and ultimately, conception. This has given women a range of choices, based on the type of family planning method, to meet the ever-increasing needs of modern societies. Figure 9 shows that approximately 61% (437) of women aged 20 to 24 years had their demand for family planning satisfied by modern methods in the reporting period⁴⁶.

Figure 9: Family planning demand satisfaction, South Africa, 2016



Source: DHS, 2016



COMMITMENT 6



Ensure that 75% of people living with, at risk of and affected by HIV benefit from HIV-sensitive social protection by 2020

POLICY ENVIRONMENT

The implementation of the NSP is underpinned by and aligned with an understanding of the broader, high-level planning frameworks, including South Africa's Constitution and the Millennium Development goals (MDG), to maximise the developmental agenda of government. In each of the strategic priorities, government departments take greater cognisance of how their plans can mitigate the HIV and TB epidemics.

An important structural component related to the HIV epidemic is poverty. According to UNAIDS, social protection "...encompasses economic, health financing, insurance, employment assistance and social care to reduce poverty, inequality, exclusion and barriers to accessing basic services"⁴⁷. Successful social protection programmes focus on alleviating poverty and inequality of vulnerable individuals, households and communities. Social protection is sensitive when it is inclusive of people who are at risk of HIV infection or are susceptible to the consequences of HIV infection.

Social assistance is provided through the South African Social Security Agency (SASSA), South Africa's largest safety net against destitution and poverty and promotes social and financial inclusion. During the reporting period, SASSA was highly effective in targeting the poor for social assistance with a coverage rate of 82.5%, rated among the best coverage in the world. While the majority of social grants were aimed at child support (70% of all grants

distributed at the value of 51,476,941 ZAR), SASSA estimated 1.83 million children were excluded from support in the period under review⁴⁸. The urgency to enable full inclusion of all eligible infants to reduce the infant mortality rate had resulted in SASSA employing additional staff to conduct outreach programmes and home visits to promote early enrolment of infants.

SASSA implemented the Integrated Community Outreach Programme (ICROP) programme which targets the poorest wards in the country. During the period under review, 631 ICROP and 31 Mikondzo¹ interventions reached out to impoverished communities with mobile teams to increase awareness on the processes involved in applying for social grants. This resulted in an increase in new applications, exceeding the projected target by 47%.

Additionally, the 'She Conquers' national campaign provided structural interventions aimed to increase access to grants and other forms of school assistance, bursaries and access to post-school education and opportunities for employment, mentorship and internships. Within the first year of the campaign, more than 30 000 adolescent girls received support to remain in school, through academic and homework support, the second chance programme, and Girls & Boys Empowerment Programmes. More than 4 000 adolescent girls and young women attended economic strengthening programmes⁴⁹.

1 Project Mikondzo is a special service delivery improvement initiative by the Department of Social Development, SASSA and the National Development Agency, targeting 1 300 wards in 23 district municipalities. Service delivery improvement interventions focus on five priority areas of: early childhood development, child youth development, substance abuse, gender based violence and the strengthening of the non-profit organisation sector.



KNOWLEDGE IS THE KEY for LIFE

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CONSERVATION

31 to election

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S	K	K	U	A
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M	A	A	C	A
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Ensure that at least 30% of all
service delivery is
community-led by 2020

POLICY ENVIRONMENT

The NSP 2012-2016 Strategic Objective 1 focused specifically on addressing the structural, social, economic and behavioural factors that drive the HIV and TB epidemics; one of these sub-objectives included strengthening community systems to expand access to services.

The NDOH formed partnerships with 31 Non-Governmental Organisations (NGOs) rooted in communities to support the Department in extending HIV and AIDS health services. Services provided by community delivery agents ranged from: social mobilisation and demand creation for HIV counselling and testing and MMC; HIV prevention strategies (including HIV testing, TB/NCD screening, and PMTCT); and psychosocial and treatment adherence support.



31

NGOs supported to expand HIV services

Strategies were aimed at the general population as well as vulnerable and key populations, including: sex workers, MSM, WSW, farm workers, truckers, and youth in schools and Technical Vocational Education and Training (TVET) colleges⁵⁰.



COMMITMENT 8



Ensure that HIV investments increase to US\$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers

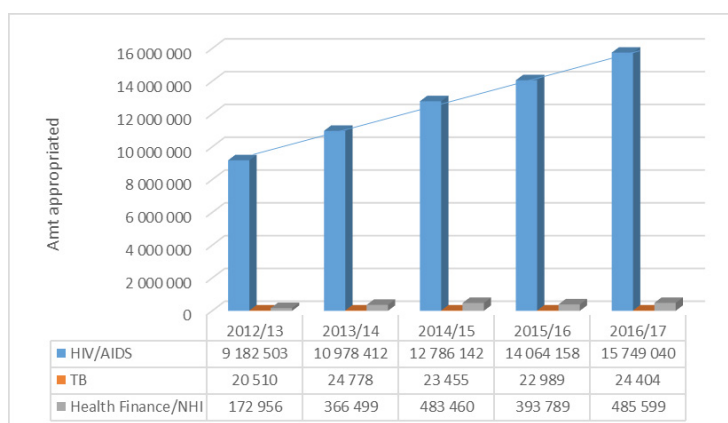
POLICY ENVIRONMENT

The 2012-2016 NSP catered for increased investment in HIV and HIV/TB. Evidence shows that South Africa continues to increase its investment in HIV and Tuberculosis programming, with substantial incremental growth over the five-year period of the implementation of the NSP (2012-2016) (Figure 10). From 2012 to 2017, the country increased its investment in HIV programmes by 41.6% and increased TB programme funding by 15%.

Of the total HIV expenditure, the majority of funding sources were public funds, equal to R20 376 156 286, or 77% of total expenditure. International financing (from the United States President's Emergency Funding for AIDS Relief, the Global Fund, etc) equalled R5 995 907 877, or 23% of the total amount spent⁵¹.

South Africa continued to invest in TB/HIV co-infection, diagnosis and treatment, spending a total of R3 571 547 201 in the period⁵². Twenty percent of these funds (R713 091 952) were spent on TB screening and diagnosis in PLHIV, while the bulk of the funding (80%, or R2 858 455 248) was allocated to TB prevention and treatment for PLHIV.

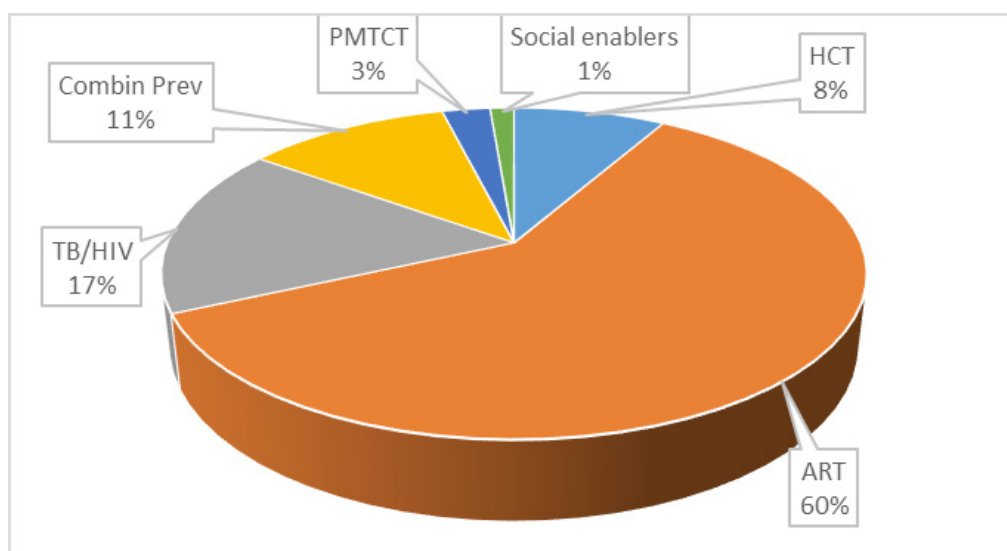
Figure 10: Appropriated funds (thousands) for specific DoH programmes, South Africa, 2012-2017



SOURCE: DoH annual reports, 2012/13-2016/17

In 2016, South African government spent about 18.1% of its total HIV expenditure on HIV prevention, falling short of the 25% target by 6.9%. The country spent a modest 1.1% for social enablers, falling short of the 6% target by 4.9%, Figure 11⁵³.

Figure 11: Total HIV expenditure by category, South Africa, 2016/17



SOURCES: BAS records, USG EA data, GF PUDRs



KEY POPULATIONS

During the 2016/17 fiscal year, the government of South Africa expended a significant amount of funds on prevention, promotion of testing and linkage to care programmes devoted entirely to key populations and vulnerable groups: a total of R 154 220 571 for sex workers and their clients; R 88 315 993 for young women and adolescent girls; R 66 008 608 for people who inject drugs; and R 49 000 000 for prisoners. Additional expenditure from the Global Fund South Africa grant supported mass media communication aimed at key and vulnerable populations and the provision of a comprehensive TB/HIV and STIs prevention package for inmates in Correctional Centres⁵⁴.

HIV PREVENTION

The total investment made in the condom programme in 2016/17 was R 508 469 828; the country spent R 1 061 284 704 on MMC in the same period. A total of R2 404 990 713 was spent on combination prevention programmes⁵⁵.

HIV-RELATED PROGRAMME AREAS

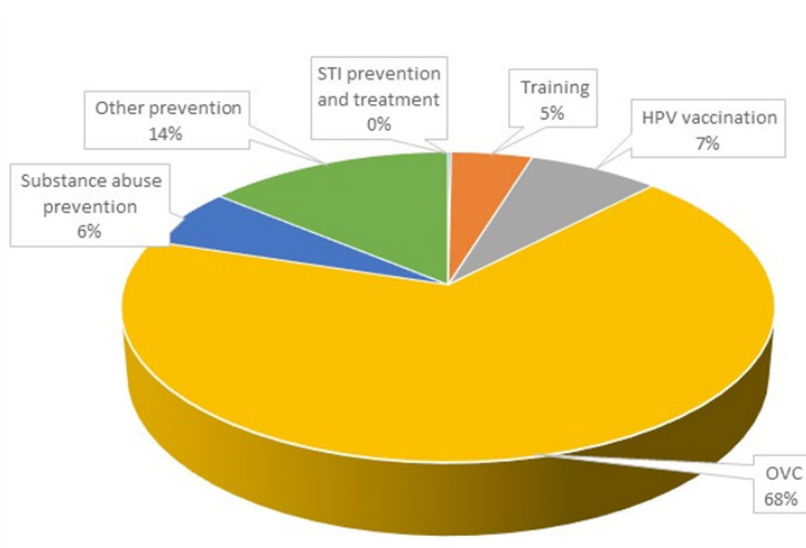
As part of the national HIV response, in 2016 South Africa spent R88 million on gender programmes, equal to about 0,3% of the total HIV spend. A further R20 117 754 was spent on community mobilization, and R373 160 075 were invested in programmes for children and adolescents⁵⁶.



OTHER ESSENTIAL PROGRAMMES

To supplement the core HIV programmes, South Africa also devoted a total of R2 625 138 861 to other essential programmes outside the suggested framework of core HIV and AIDS programmes (Figure 12). The majority of the funds allocated to essential programmes focused on orphans and vulnerable children (68%, R1.7 b); followed by other prevention activities (14%, R3.6 m), HPV vaccination (7%, R1.9 m), substance abuse prevention (6%, R1.6 m), training (5%, R1.2 m) and STI prevention and treatment (0%, R4.4 m)⁵⁷.

Figure 12: National spend on essential related programmes, South Africa, 2016-17



SOURCES: BAS records, USG EA data, GF PUDRs

9 COMMITMENT



Empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violations of human rights



POLICY ENVIRONMENT



The NSP (2012-2016) was located within the constitutional framework of South Africa and strives towards its ideals of human dignity, non-racialism, non-sexism and the rule of law.

In 2015, the SA National AIDS Council (SANAC) and Legal Aid South Africa signed a Memorandum of Understanding to tackle persistent forms of stigma and discrimination that continue to affect people infected with HIV and/or TB. Quality legal advice and services in matters relating to HIV and TB stigma and discrimination were provided by paralegals at the call centre and promotion of access to legal services at justice centres across the country. Additionally, SANAC in conjunction with partners has implemented a national communication campaign designed to challenge stigmatising attitudes, build understanding of PLHIV and market the Legal Aid SA service.

A new handbook was published by LexisNexis South Africa, *HIV and the Law in South Africa: A Practitioner's Guide*⁵⁸. The purpose of the book is to facilitate easy access to the law relating to HIV and AIDS in South Africa, and in turn, aid in fighting injustice against people living with and affected by HIV and AIDS.



Chronic Diseases

Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C



POLICY ENVIRONMENT

The National Health Insurance (NHI) is a financing system that aims to ensure the provision of essential healthcare to all South African citizens and legal long-term residents, regardless of employment status and ability to make a direct monetary contribution to the NHI Fund⁵⁹. The NHI is intended to improve equity in access to quality healthcare, as supported by the Constitution.

During the period under review, South Africa reported significant strides in working towards universal health coverage through the piloting of innovative models of human resources for

health and chronic medication dispensing schemes. In the 10 National Health Insurance (NHI) pilot districts, the department purchased private health practitioner services from 330 General Practitioners and 329 Pharmacy Assistants.

In order to improve service delivery and integrate HIV treatment into chronic disease management, a total of 1,252,000 patients were registered on the Centralised Chronic Medicine Dispensing & Distribution (CCMDD) programme⁶⁰.

TUBERCULOSIS

In South Africa, the HIV epidemic is exacerbated by tuberculosis (TB) infections⁶¹. Living conditions in many informal settlements of inner cities and peri-urban areas are conducive to the spread of TB infections.

TB infections are further compounded by pervasive health inequalities, which have seen a rise in HIV/TB co-infections. In 2015, PLHIV accounted for 57% of the 454 000 new TB infections. The TB burden is compounded by the emergence of multi-drug resistant TB (MDR-TB) and extensively drug resistant TB (XDR-TB)⁶². Full integration of HIV and TB services remain a challenge, as only 51.3% (385 932) of all newly enrolled patients in HIV care were started on treatment for latent TB infection, against a target of 85% for 2016⁶³.

The U.S. Centers for Disease Control and Prevention (CDC) supported the NDoH to scale up PHC services to improve the management of HIV/AIDS services. This resulted in training of 375 health care workers in the Drug Resistance TB Management for The Introduction of the 9-Month Regimen; and the printing of 7000 TIER.Net Aligned HIV Testing Services Registers, 8000 revised HIV Counselling and Testing registers, and 15 000 Pocket book of

Hospital Care for Children. This support also aided 786 health facilities to achieve the Ideal Clinic status⁶⁴.

The Global Fund during this period supported investing for impact against tuberculosis and HIV, achieving the following goals within the timeframe1:¹

- 82,1%.of cases with drug resistant TB (RR-TB and/or MDR-TB) began second-line treatment;
- 7,9% of individuals from key populations reached with mass media communication;
- 36,0% of inmates diagnosed with TB and started on TB treatment in Correctional Centres;
- 80,5% of HIV-positive registered TB patients given anti-retroviral therapy during TB treatment; and
- 60.1% of targeted adults and children living with HIV were put on ART⁶⁵.

1 NB: the data reflected here represent only a proportion of annual national targets.

SEXUALLY TRANSMITTED INFECTIONS (STI)

The human papilloma virus (HPV) vaccine targeting girls in Grade 4 was introduced to protect them against cervical cancer – a major cause of death especially among black women. The NDOH provided free HPV vaccinations for grade four school girls in all public and special schools. The first year of the programme reached 63% of eligible grade four school girls with the HPV vaccination, covering 75% of the targeted schools⁶⁶.

Recommended action on the behavioural and social determinants of the HIV epidemic in South Africa includes prevention and early treatment of STIs. This requires the regular tracking of STIs among the population. In the reporting period, 1.4% (269 818) of men reported urethral discharge⁶⁷.

There were gaps of STI prevalence data for key populations, however one 2013 study found nearly a third (28.1%) of MSM living in Cape Town reporting an STI in the previous 12 months, and under half (42.7%) of MSM in Durban estimated to have had symptoms of an STI in the same period¹. The same study showed lower rates of STIs among MSM in Gert Sibande district, with only 7.2% estimated to have had at least one symptom of an STI; in Ehlanzeni district, 4.6% were estimated to have had at least one symptom of an STI⁶⁸.

STIs among 450 PWID from five South African cities reported similarly high rates, with a quarter of participants reporting symptoms of an STI in the previous 12 months⁶⁹.

1 Only one self-reported STI data point exists in Durban.



6. DISCUSSION AND RECOMMENDATIONS

ACHIEVEMENTS

South Africa has made great strides in improving the quality and access to HIV and HIV/TB services, and addressing some of the key determinants of the HIV epidemic. Some of the most significant achievements were notably: Revision of policies, strategies and plans to expand service delivery coverage, particularly to young people and adolescent girls and young women specifically;

- condom distribution, which distributed about 800 million condoms;

- among people who tested for HIV, almost all of them know their HIV status;

- a decrease in the number of new HIV infections by 27.5%, from 3 67 946 in 2011 to 2 66 618 in 2016;

- among those living with HIV, 85% know their HIV status -- a good measure of first 90 of the 90-90-90 global target;

- although viral load testing results were only 60%, among those patients who had viral load tests conducted, 81% showed viral suppression; and

- TB mortality rate was on target, at a rate of 46/100 000 among HIV-negative patients and 133/100 000 among HIV-positive patients.

STRATEGIC INFORMATION (SI) ENVIRONMENT

One of the principles of the NSP is reliance on sound evidence. In order to fulfil this principle, SANAC monitors the country's multi-sectoral HIV, STI and TB response and provides annual reports on progress towards targets and commitments; at provincial, national and global levels. SANAC serves as the central entity to coordinate response of the epidemic in the country. SANAC's SI Unit is responsible for monitoring a wide range of HIV, TB and STI indicators; some of which are monitored with programme data while other indicators are monitored periodically through survey data.

The SI Unit relies on secondary data which is provided by government departments, civil society, private sector as well as non-governmental organisations. The challenge with secondary data is that the data are not always available to ensure timely reporting of all indicators. The period under review is guided by a Focus For Impact (FFI) strategy which is at the heart of the NSP. FFI prioritises on the collection of timely use of high-quality data to guide and inform programmes and policies. Additionally, FFI aims to intensify concentrated efforts on the 27 high burden districts that account for 82% of all PLHIV and for the majority of new infections.

CHALLENGES AND RECOMMENDATIONS

Despite the significant progress made by the national response thus far, South Africa faces a number of challenges to be addressed, beyond 2016 and into the next period of the National Strategic Plan.

For the 90-90-90 strategy to be realised, it is important to identify operational areas that will promote or hinder its success. Reporting global 90-90-90 figures is not the most effective way of identifying where the strategy is working and where it is failing. Disaggregated 90-90-90 indicators by

sex, age, high burden districts or any other high risk groupings will help in designing appropriate, targeted programmes. There is need to intensify HIV Testing Service programmes as well as find new, innovative ways of reaching those population groups that do not easily access HIV testing by the current methods. Identifying this missing 26% of the first 90 is critical to reduce horizontal transmission among the adult population. Key challenges and some recommendations are presented in Table 5.

Table 5: South Africa challenges and recommendations, 2016 GAM reporting period

Challenges	Recommendations
Relatively high HIV incidence rates among young women and girls, considered one of the most vulnerable groups for HIV infection in the country ⁷⁰ . It is estimated that 1 983 young women and girls aged 15 to 24 years old are infected with HIV every week in SA.	High-risk and vulnerable groups, including young women and girls and people with disabilities, require innovative tailored combination prevention strategies.
TB/HIV co-infection was still one of the leading causes of morbidity and mortality. There were an estimated 454 00 new cases of TB with 280 000 of being co-infected with HIV as well , with a high mortality among TB/HIV co-infected patients. Working and living conditions around mining conditions increase the risk of TB infection. The seasonal migratory patterns of mine workers and their family members also results in the spread of TB.	Initiatives that address regionality of the TB epidemic, such as the TB in Mining Sector (TIMS) programme, are required to reduce the impact of TB in South Africa and its neighbouring countries.
The number of people regularly testing and thus knowing their HIV status, although relatively high, still fell short of its target. Although South Africa has the largest HIV programme in the world with over 50% of PLHIV on ART, this achievement is low relative to the 90% target.	Improve HIV testing by promoting new methodologies such as self-testing and through private providers as part of National Health Insurance, ensuring linkage to care.



Challenges	Recommendations
High levels of stigma and discrimination towards HIV- and HIV/TB-infected individuals. According to the 2014 HIV national stigma survey, over a third (36%) of people living with HIV reported experiencing some form of external stigma⁷¹. High levels of stigma may discourage people from testing for HIV and it may also result in people delaying initiation on treatment. Poor adherence to TB and/or HIV treatment, which may also be associated with alcohol and substance abuse, results in poorer outcomes that lead to increased morbidity and mortality as well as treatment resistance issues.	Tailor HIV communication and testing campaigns to address localised stigma and discrimination, and to encourage early initiation on treatment. Incorporate gender based violence and wellness topics.
Delays between diagnosis and initiation on treatment, especially among males, made HIV outcomes for this group disproportionately poor compared to female programmes.	Implement HIV prevention care and support programmes to include men and young boys.
South Africa experienced some of the highest levels of gender based violence, which is associated with high levels of HIV infection. High levels of alcohol and substance abuse, also associated with high levels of HIV infection. Both in- and out-of-school youth including TVET college and university students were some of the vulnerable groups who were at increased risk of HIV infection.	Despite the legal framework and growing attention to the area of gender based violence and violence against women and children, more work is required to raise the level of the national response to significantly mitigate gender inequalities, violence and discrimination among women and key populations. Tailor HIV programming inclusive of all sexes and incorporate comprehensive sexuality education, sexual reproductive health and rights, gender based violence, and wellness topics.

Challenges	Recommendations
Structural factors, including high levels of poverty, inequality and unemployment, are associated with high levels of HIV infection. According to national surveys, some of the highest HIV infection rates were observed in urban informal settlements ⁷² .	Consider the inclusion of cash transfer and economic strengthening opportunities to complement HIV prevention, treatment and care programming.
Size estimates of key populations were not easily available as few surveys have been conducted to generate such estimates. The logistics and technical expertise necessary for such surveys makes it prohibitive to conduct such studies.	Consider funding and investment options to conduct size population estimates for key populations.
There were no specific targets for prisoners in the NSP 2012-2016.	Ensure that HIV prevention programmes are in place for key population and vulnerable groups, and to track HIV incidence, prevention programmes and ART initiation and retention.

CONCLUSION

Despite these challenges, South Africa continues to advance in its national response to the HIV epidemic, through the introduction of a number of progressive HIV and HIV/TB associated policies. The country implements the largest HIV programme in the world that is increasingly nationally funded. As a result, HIV incidence seems to have stabilised and is possibly reducing among certain age and sex groups; and finally, HIV-related deaths have been progressively decreasing.



ANNEX 1: SUMMARY OF PROGRESS ON THE 2020 FAST-TRACK COMMITMENTS AND EXPANDED TARGETS TO END AIDS

COMMITMENT 1: Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020

Indicators	2017 Progress
1.1 People living with HIV who know their HIV status	87.0%
1.2 People living with HIV on antiretroviral therapy	52.8
1.3 Retention on antiretroviral therapy at 12 months	67.9%
1.4 People living with HIV who have suppressed viral loads (adults 15 years+)	79.1%
1.5 Late HIV diagnosis	13.6%
1.6 Antiretroviral medicine stock-outs	Data not available
1.7 AIDS mortality	269.7 per 100 000

COMMITMENT 2: Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018

Indicators	2017 Progress
1.1 People living with HIV who know their HIV status	87.0%
1.2 People living with HIV on antiretroviral therapy	52.8
1.3 Retention on antiretroviral therapy at 12 months	67.9%
1.4 People living with HIV who have suppressed viral loads (adults 15 years+)	79.1%
1.5 Late HIV diagnosis	13.6%
1.6 Antiretroviral medicine stock-outs	Data not available

COMMITMENT 3: Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations (gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners)

Indicators	2017 Progress
3.1 HIV incidence	5.8571/1000 pop
3.2 Estimates of the size of key populations	Data not available
3.3 HIV prevalence among key populations:	
3.3a HIV prevalence among Sex workers	65.5%
3.3b HIV prevalence among MSM	23.1%
3.3e HIV prevalence among prisoners:	
Number of prisoners living with HIV	37 029
Number of prisoners with TB or HIV/TB co-infected	497
3.4 Knowledge of HIV status among key populations	Data not available
3.5 Antiretroviral therapy coverage among people living with HIV in key populations	Data not available
3.6 Condom use among key populations	Data not available
3.7 Coverage of HIV prevention programmes among key populations	Data not available
3.8 Safe injecting practices among people who inject drugs	Data not available
3.9 Needles and syringes distributed per person who injects drugs	Data not available
3.10 Coverage of opioid substitution therapy	Data not available
3.11 Active syphilis among sex workers	Data not available



COMMITMENT 3: Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations (gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners)

Indicators	2017 Progress
3.12 Active syphilis among men who have sex with men	Data not available
3.13 HIV prevention programmes in prisons:	
Number of prisoners tested for HIV	156 049
Number of condoms distributed in prisons	1 967 109
Number of prisoners on ART	25190
3.14 Viral hepatitis among key Populations	Data not available
3.15 People receiving pre-exposure prophylaxis	744
3.16 Prevalence of males 15–49 who are circumcised	50.9%
3.17 Annual number of males voluntarily circumcised	497 186
3.18 Condom use at last high-risk sex	62.7%

COMMITMENT 4: Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020

Indicators	2017 Progress
4.1 Discriminatory attitudes towards people living with HIV	Data not available
4.2 Avoidance of HIV services because of stigma and discrimination among key populations	Data not available
4.3 Prevalence of recent intimate partner violence	Data not available

COMMITMENT 5: Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100 000 per year

Indicators	2017 Progress
5.1 Young people: Knowledge about HIV prevention	Data not available
5.2 Demand for family planning satisfied by modern methods	57.9%
- Women 15–24 years old newly infected with HIV	2.04%
- Condom use at last high-risk sex among young women 15–24	Data not available

COMMITMENT 6: Ensure that 75% of people living with, at risk of and affected by HIV benefit from HIV-sensitive social protection by 2020

Indicators	2017 Progress
Indicators to be included in Global AIDS Monitoring 2018	Not applicable

COMMITMENT 7: Ensure that at least 30% of all service delivery is community-led by 2020

Indicators	2017 Progress
Indicators to be included in Global AIDS Monitoring 2018	Not applicable

COMMITMENT 8: Ensure that HIV investments increase to US\$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers

Indicators	2017 Progress
8.1 Total HIV expenditure	R 26 372 064 162
8.1A Expenditure on HIV testing and counselling	R 1 789 701 425



COMMITMENT 8: Ensure that HIV investments increase to US\$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers

Indicators	2017 Progress
8.1 Total HIV expenditure	R 26 372 064 162
8.1A Expenditure on HIV testing and counselling	R 1 789 701 425
8.1B Expenditure on antiretroviral therapy	R 12 890 287 366
8.1C Expenditure on HIV-specific laboratory monitoring	0
8.1D Expenditure on TB and HIV	R 3 571 547 201
8.1E Expenditure on the five pillars of combination prevention	R 2 404 990 713
8.1F Expenditure on preventing the mother-to-child transmission of HIV	R 565 471 862
8.1G Expenditure on social enablers	R 280 956 833
8.1H Expenditure on cash transfers for young women and girls	0

COMMITMENT 9: Empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violations of human rights

Indicators	2017 Progress
National Commitments and Policy Instrument	Completed

COMMITMENT 10: Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C

Indicators	2017 Progress
10.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	119 336

COMMITMENT 10: Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C

Indicators	2017 Progress
10.2 Proportion of people living with HIV newly enrolled in HIV care with active TB disease	Data not available
10.3 Proportion of people living with HIV newly enrolled in HIV care started on TB preventive therapy	51.3%
- TB deaths among people living with HIV	Data not available
10.4 Men with urethral discharge	1.4%
10.5 Gonorrhoea among men Hepatitis B and C	Data not available
10.6 Hepatitis B testing	Data not available
10.7 Proportion of people co-infected with HIV and HBV receiving combined treatment	Data not available
10.8 Hepatitis C testing	Data not available
10.9 Proportion of people co-infected with HIV and HCV starting HCV	Data not available
10.10 Cervical cancer screening among women living with HIV	Data not available



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