



REPUBLIC OF SOUTH AFRICA

**2016 GLOBAL AIDS
RESPONSE PROGRESS REPORT
(QUANTITATIVE REPORT)**

**PROGRESS TOWARDS TARGETS
DESK REVIEW
2012-2015**

SOUTH AFRICA GLOBAL AIDS RESPONSE PROGRESS REPORT (GARPR) 2016

ACKNOWLEDGEMENTS

Team Members (Centre for Statistical Analysis and Research)

Braimoh Bello
Ndivhuwo Rambau

Team Members (South Africa National AIDS Council)

Dr Malekga C. Kganakga
Lifutso Motsieloa
Billia Luwaca
Tsenolo Moruthoane



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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral therapy
ASRH&R	National Adolescent Sexual and Reproductive Health and Rights
ASSA	Actuarial Society of South Africa
CDC	United States Centers for Disease Control and Prevention
CSVR	Centre for the Study of Violence and Reconciliation
CSW	Commercial Sex Worker
DBE	Department of Basic Education
DHIS	District Health Information System
DOH	Department of Health
DOWCPD	Department of Women Children and People with Disabilities
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
DSD	Department of Social Development
eMTCT	Elimination of HIV transmission from mother to child
FSW	Female Sex Workers
GARPR	Global AIDS Response Progress Report
GBV	Gender Based Violence
HCP	HIV Communication Programmes
HCT	HIV Testing and Counseling
HIV	Human Immunodeficiency Virus
IBBS	Integrated Bio-Behavioural Survey
IPV	Intimate Partner Violence
JHHESA	Johns Hopkins Health and Education in South Africa
KGS	Keeping Girls in School
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MDR/RR-TB	Multi-drug resistant/Rifampicin-resistant Tuberculosis
MDR-TB	Multi-drug-resistant tuberculosis
MOT	Modes of Transmission
MRC	Medical Research Council
MSM	Men who have Sex with Men
MSP	Multiple Sexual Partnerships
MTCT	Mother-to-child transmission
NACOSA	National AIDS Convention of South Africa

NCS	National HIV Communication Survey
NDP	National Development Plan
NHI	National Health Insurance
NHLS	National Health Laboratory Services
NSP	National Strategic Plan
NYP	National Youth Policy
OST	Opioid Substitution Therapy
OVC	Orphans and Vulnerable Children
PCR HIV	Polymerase chain reaction Human Immunodeficiency Virus
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV/AIDS
PMTCT PWID	Prevention of Mother-to-child Transmission People Who Inject Drugs
RDS	Respondent Driven Sample
SACENDU	South African Community Epidemiology Network on Drug Use
SAHMS	South Africa Health Monitoring Survey
SAHMS-FSW	South Africa Health Monitoring Survey with Female Sex Workers
SANAC	South African National AIDS Council
SAPMTCTE	South African Prevention of mother-to-child transmission Evaluation
SAPS	South African Police Service
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
TB	Tuberculosis
TCCs	Thuthuzela Care Centres
UN	United Nations
UNGASS	United Nations General Assembly Special Session on Drugs
UNICEF	United Nations International Children's Emergency Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VMMC	Voluntary Medical Male Circumcision
WEGE	Women Empowerment and Gender Equality
WHO	World Health Organisation
XDR-TB	Extensively drug-resistant tuberculosis



STATUS AT A GLANCE

Image	Global target area Attainable	Attained by 2015
	Reduce sexual transmission of HIV by 50% by 2015	No
	Reduce transmission of HIV among people who inject drugs by 50% by 2015	No
	Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths	Yes
	Reach 15 million PLHIV with lifesaving antiretroviral treatment by 2015	Yes
	Reduce TB deaths in PLHIV by 50% by 2015	No
	Close the global AIDS resource gap by 2015 and reach annual global investment of US\$ 22-24 billion in low- and middle-income countries	Yes
	Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV	No
	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	No
	Eliminate HIV-related restrictions on entry, stay and residence	Yes
	Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts	Yes

THE INCLUSIVENESS OF THE STAKEHOLDERS IN THE REPORT WRITING PROCESS

This report reviewed the progress of South Africa towards the commitments and targets set in the 2011 United Nations (UN) Political Declaration on HIV/AIDS by the end of 2015. The report was coordinated by the South African National AIDS Council (SANAC) which manages the country's multi-sectoral response to the HIV epidemic. The process involved an intensive document review, data analysis, data triangulation and synthesis.

STATUS OF THE EPIDEMIC

South Africa has a high prevalence, heterosexually-driven, generalised HIV epidemic, characterised by high levels of tuberculosis (TB) infection. Population level HIV prevalence was 12.2% in 2012 with approximately 6.4-million people living with HIV (PLHIV). By 2015, it was estimated that seven million people were living with HIV. The HIV epidemic is heterogenous across provinces, age groups and genders. HIV prevalence varies from 5.0% in the Western Cape to 16.9% in KwaZulu-Natal. Between 2002 and 2012, although it increased in the general population, the prevalence declined in people aged 24 years and below. Women continue to bear a disproportionate burden of the HIV epidemic with a prevalence of 14.4% in females in 2012, compared to 9.9% in males. There has been a decline in the overall HIV prevalence and incidence among young people. However, HIV incidence among young women aged 15-24 remains very high (2.54%) in 2012. Concentrated sub-epidemics are observed among key populations including female sex workers (FSW) and men who have sex with men (MSM).

The HIV epidemic is fueling the TB epidemic in South Africa. In 2015, PLHIV accounted for 57% of the 454,000 new TB infections. 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's National Strategic Plan on HIV, STIs and TB for 2012-2016 (NSP 2012-2016) guides the country's response to the HIV/AIDS epidemic, as well as to STIs and TB infections. The NSP 2012-2016 was evidence-based and comprehensive and aimed to reduce new HIV infections by 50% while mitigating the impact of the epidemic. The national response, which was a combination strategy of a prevention, treatment, care and support programmes, was carried out within an enabling policy context reflecting South Africa's commitment to achieve the commitments and targets set in the 2011 UN Political Declaration on HIV/AIDS.

SUMMARY OF PROGRESS TOWARDS TARGETS

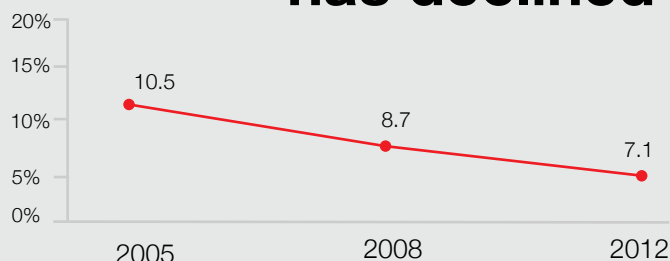
TARGET 1:

TO REDUCE SEXUAL TRANSMISSION OF HIV BY 50% BY 2015

South Africa's response for achieving this target was a combination prevention approach which involved tailoring and coordination of behavioural (reducing sexual risk behaviours), biomedical (increasing condom use and medical male circumcision), and social and structural strategies (addressing underlying determinants such as poverty and gender inequality). Treatment of those already infected is also included within this combination as viral suppression reduces the likelihood of HIV transmission from an HIV positive individual on treatment to an uninfected individual. However, this target was not achieved as the trends in prevalence and incidence data shows. HIV prevalence in young people aged 15-24 years, which is a core indicator in this target, only reduced by 18% from 8.7% in 2008 to 7.1% in 2012 (The NSP target for 2016 was 4.35%). Despite the many prevention programmes, the levels of early sexual debut, multiple sexual partnerships and unprotected sex have actually increased. However, biomedical programmes, such as medical male circumcision (MMC) and treatment coverage, have continued to increase.



HIV prevalence in young people aged 15-24 years has declined



TARGET 2:

REDUCE TRANSMISSION OF HIV AMONG PWID BY 50% BY 2015

South Africa has rapidly updated its policies around drugs use to include harm reduction among people who inject drugs (PWID). Although, a small population in terms of numbers (75,000), the prevalence of HIV (14%) and sexual risk behaviours are high among PWID. Although the target was not achieved, the improved policy environment coupled with the increasing number of programmes and research on this population will be central to achieving the target in the near future.

75,000 PWID



14%

Prevalence of HIV

TARGET 3:

ELIMINATE NEW HIV INFECTIONS AMONG CHILDREN BY 2015 AND SUBSTANTIALLY REDUCE AIDS-RELATED MATERNAL DEATHS

South Africa updated its national treatment guidelines twice in the last five years in line with new international guidelines on ART. Through various intensified strategies, South Africa achieved its 2016 target of 6 weeks MTCT rate of less than 2% by 2015 (1.5% in 2014/2015).



SOUTH AFRICA ACHIEVED ITS 2016 TARGET OF 6 WEEKS MTCT RATE OF LESS THAN 2%

1.5% MTCT rate by 2015

TARGET 4:

REACH 15 MILLION PLHIV WITH LIFESAVING ANTIRETROVIRAL TREATMENT BY 2015

By 2015, over 3.4 million PLHIV were on treatment: a 44% increase in the total number of people on ART since 2012. The updated ART guidelines, together with programmatic efforts, resulted in the attainment of this target. Consequently HIV/AIDS-related deaths declined and life expectancy increased from 60.2 years in 2012 to 62.5 years in 2015. However, concerted efforts are needed to improve retention in care and viral suppression.

LIFE EXPECTANCY INCREASED DUE TO DECLINED AIDS RELATED DEATH

60.2 years

2012



62.5 years

2015

TARGET 5:

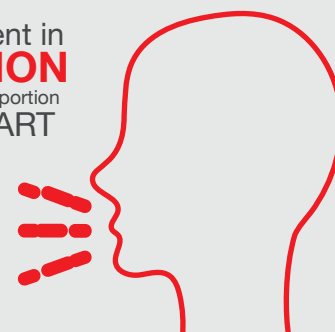
TO REDUCE TB DEATHS AMONG PLHIV BY 50%

Through strong commitment, South Africa has made giant strides towards achieving this target, although the target was not achieved. There has been improvement in TB-HIV integration as demonstrated by the increase in the proportion of co-infected PLHIV on ART from 31.2% in 2013/14 to 87.5% in 2015/16, which far exceeded the target of 75% for 2015/16. While drug resistant TB remains a concern, TB treatment and cure rates are improving and loss to follow-up is declining. Consequently, TB-related deaths in PLHIV continue to decline. The goal of the NSP 2012-2016 was to reduce the number of new TB infections as well as deaths from TB among PLHIV by 50%. But in 2015, the number of deaths was 73,000; representing a 17% decline between 2012 and 2015, thereby missing this target by 33%.

There has been improvement in TB-HIV INTEGRATION
as demonstrated by the increase in the proportion of co-infected PLHIV on ART

31.2%
in 2013/2014

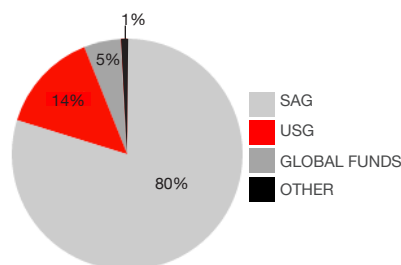
87.5%
in 2015/2016



TARGET 6:

TO CLOSE THE GLOBAL AIDS RESOURCE GAP

South Africa achieved this target through strong political and resource mobilization commitments. The South African Government does not only fund over 80% of its HIV/AIDS and TB expenditure; but has also continued to expand its programmes and increase its spending. Nonetheless, the gap between resource needs and available funding increased from 2.7% in 2013/14 to 5% in 2015/16.

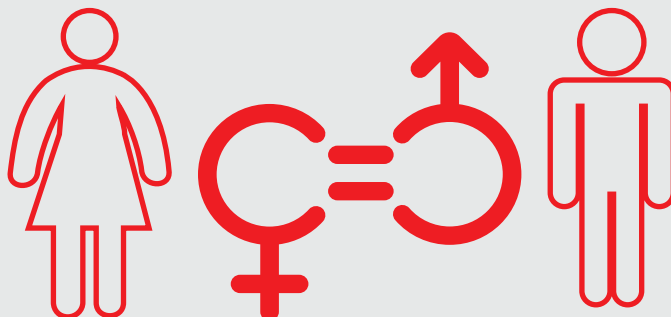


**SOUTH AFRICA
GOVERNMENT
FUNDS 80% OF
HIV/AIDS AND TB
EXPENDITURE**

TARGET 7:

TO ELIMINATE GENDER INEQUALITIES

South Africa's strategy to eliminate gender inequalities is through legislative efforts; inter-sector collaboration; development of frameworks and structures, and initiation of and support for women empowerment programmes. There has been increased mainstreaming of women's rights into government operations, domestic partnerships and access to healthcare. The government's social grant programme of which 85% of the beneficiaries are women is key, while the nationwide Thuthuzela Care Centres (TCCs) continue to provide interventions that address sexual violence. Despite the number of policies and interventions in place, gender-based violence (GBV) remains high. Paucity of data has also been a challenge in accurately assessing the extent and trends of GBV in South Africa.



TARGET 8:

TO ELIMINATE STIGMA AND DISCRIMINATION AGAINST PLHIV

Despite the government's multiple interventions to address discrimination against PLHIV, this target was not achieved by 2015. In South Africa, it is illegal to discriminate against someone in the workplace because of their HIV status. However, it is more difficult to legislate against discrimination in the home and other social settings. The government continues to increase awareness about HIV/AIDS and expand its treatment programme, thereby reducing ignorance and fear around HIV. The government has also put in place the Stigma Mitigation Framework (SMF) as well as monitoring and evaluation to reach this target. But the levels of stigma against PLHIV remains palpable. The People Living with HIV Stigma Index Survey commissioned by SANAC in 2014 reported an overall internal stigma level of 43% and overall external stigma level of 35.5% among PLHIV.

People Living with HIV Stigma Index Survey in 2014

43%

OVERALL INTERNAL
STIGMA LEVEL

35.5%

OVERALL EXTERNAL
STIGMA LEVEL

TARGET 9:

TO ELIMINATE HIV-RELATED TRAVEL RESTRICTIONS

South Africa has no HIV-related travel restrictions as the country's goal is to ensure that comprehensive and specialized health care services are available and accessible to all South Africans and immigrants within the country. The South African Immigration Act of 2002 does not discriminate against any person by refusing entry, stay or residence within the country based on one's health status.



“The South African Immigration Act does not discriminate against any person by refusing entry, stay or residence into and within the country based on one's health status”

TARGET 10:

ELIMINATE PARALLEL SYSTEMS FOR HIV-RELATED SERVICES TO STRENGTHEN INTEGRATION OF THE AIDS RESPONSE IN GLOBAL HEALTH AND DEVELOPMENT EFFORTS

In light of the Social Needs Cluster Departments' respective mandates, HIV integration in South Africa renders itself to several policies. By 2015, South Africa had met this target. The Human Sciences Research Council (HSRC) national survey of 2012 showed that more than 99% of HIV/AIDS orphans aged between 10 and 14 years were enrolled in school. This means that orphans and vulnerable children (OVC) of school-going age are not negatively affected by their status in as far as access to formal education is concerned. The country's policies and social grant system have been central to achieving this target.

99%

HIV/AIDS ORPHANS
aged between
10 AND 14 YEARS
WERE ENROLLED
IN SCHOOL
IN 2012



CHAPTER 1

Overview of the AIDS Epidemic



HIV PREVALENCE TRENDS

Data from multiple rounds of HSRC surveys show that the overall prevalence of HIV in South Africa has not declined in the last decade.¹⁻³ The prevalence has, in fact, increased over the period. In 2012, the prevalence in the entire population was an estimated 12.2% (95% CI: 11.4-13.1) which was a significant increase from the 2008 estimate of 10.6% (95% CI: 9.8-11.6). In absolute numbers, this translated to about 1.2 million more PLHIV in South Africa from 5.2 million people in 2008 to 6.4 million in 2012. Since then, the estimated number of PLHIV has continued to increase (Table 1).

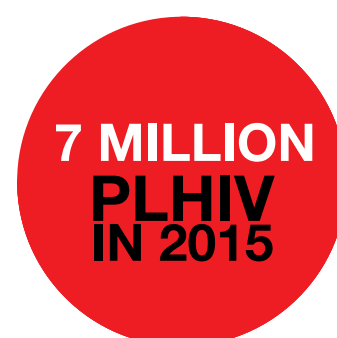
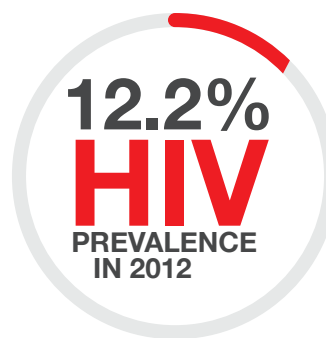


Table 1 Number of PLHIV (millions) in the overall South African population, 2012 to 2015

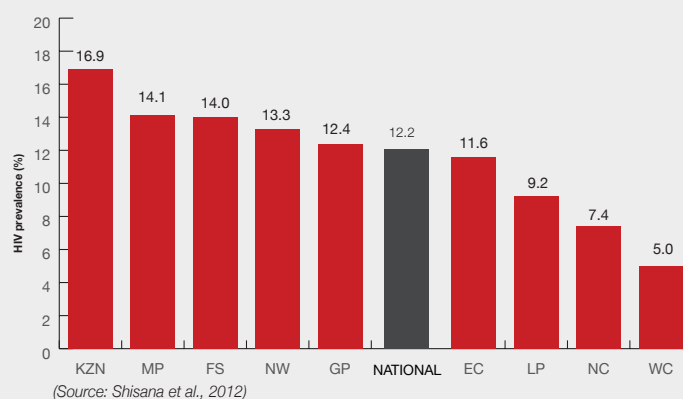
Source of estimate	2012	2013	2014	2015
Spectrum	6.5 million	6.6 million	6.8 million	7.0 million
Statistics South Africa	5.7 million	5.8 million	6.0 million	6.2 million
Thembisa	6.5 million	6.7 million	6.8 million	7.0 million

(Source: UNAIDS, 2016⁴; Statistics South Africa, 2015⁵; Johnson, 2015⁶)

HIV PREVALENCE BY PROVINCE

There are significant disparities in HIV prevalence across provinces in South Africa (Figure 1). The 2012 HSRC survey highlighted four provinces in which the prevalence was higher than the national prevalence. These were KwaZulu-Natal, Mpumalanga, Free State and the North West province. The Northern Cape and Western Cape provinces had much lower levels of HIV infection, with the prevalence in KwaZulu-Natal (16.9%) being about over three times that of the Western Cape (5%). This relative prevalence across provinces was similar in the 2009 HRSC survey.

Figure 1: HIV Prevalence by province, 2012



HIV PREVALENCE BY AGE

Although the general HIV prevalence increased between 2002 and 2012, the trends differed by age group (Table 2). For the period, the prevalence decreased in the younger age groups of 2 to 14 years and 15-24 years by 57% and 24% respectively. On the contrary, the prevalence increased by 28% from 15.5% to 19.9% in those older than 24 years. This increase in the older age group can be attributed to mainly to increase in ART coverage. Expectedly, the prevalence is higher in the older age groups because HIV prevalence reflects the lifelong risk of HIV acquisition.



HIV PREVALENCE
IN 15-14 YEAR OLDS
DROPPED FROM
8.7% IN 2008 TO
7.1% IN 2012

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

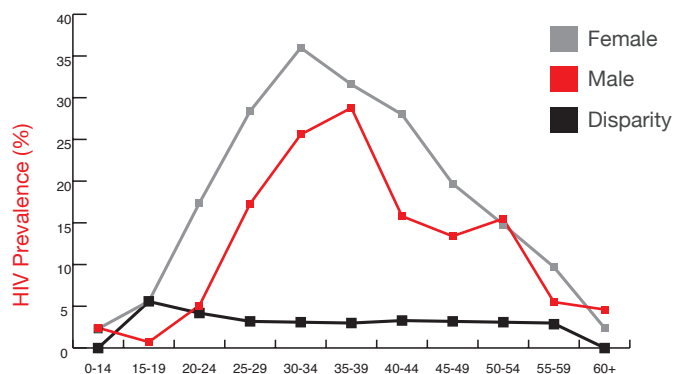
Age group	2002	2005	2008	2012
2-14	5.3	3.3	2.5	2.4
15-24	9.3	10.3	8.7	7.1
25+	15.5	15.6	16.8	19.9
15-49	15.6	16.2	16.9	18.8
2+	11.4	10.8	10.9	12.6

(Source: Shisana et al., 2012)

HIV PREVALENCE BY SEX

According to the 2012 HSRC survey, the overall prevalence of HIV among males and females was 9.9% (95% CI: 8.9–11.0) and 14.4% (95% CI: 13.3–15.6) respectively. Figure 2 presents the HIV prevalence in males and females, by age. The data show that HIV prevalence is consistently higher in women than men, except in two older age groups. The disparity is much higher in the younger age groups and peaked in those aged 15 to 19 years. Girls aged 15 to 19 years were 8 times more likely to be HIV infected than boys of the same age group: 5.6% in girls compared to 0.7% in boys. In both genders, the highest burden of HIV infection is in the middle to older age groups (25 to 44 years), although the infection rate peaked five years earlier in females than in males.

Figure 2: HIV prevalence in males and females by age, South Africa 2012



(Source: HSRC Survey, 2012)

HIV PREVALENCE IN KEY POPULATIONS

Within South Africa's generalized epidemic, there are groups of the general population that have a higher than average HIV prevalence. Key populations are important sub-groups of the population which should be targeted either because they are at higher risk of being infected by HIV or because they play a key role in the spread of HIV. The 2012 HSRC survey identified a number of key populations based on their high HIV prevalence (Table 3). These key populations are notable along with traditional high risk groups which include FSW, MSM and PWID.

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

		n	%	95% CI
	BLACK AFRICAN WOMEN, 20-34 YEARS	2,532	31.6	28.5-34.9
	PEOPLE LIVING TOGETHER, NOT MARRIED, 15-49 YEARS	1,499	30.9	26.5-35.7
	BLACK AFRICAN MEN, 25-49 YEARS	2,120	25.7	22.8-28.8
	DISABLED PERSONS, 15+ YEARS	1,055	16.7	12.9-21.4
	HIGH-RISK DRINKERS, 15+ YEARS	1,990	14.3	11.8-17.3

(Source: HSRC Survey, 2012)

An Integrated bio-behavioural survey (IBBS) conducted in 2014 found that HIV prevalence among FSW varied from 39.7% in Cape Town to 53.5% in Durban and 71.8% in Johannesburg.⁷ A recent (2013 to 2015) comprehensive data synthesis of the HIV epidemic among MSM in South Africa showed that the prevalence of HIV in the group varied from 22% and 48%.⁸ Lastly, the recent estimate of HIV prevalence among PWID is 14%.⁹

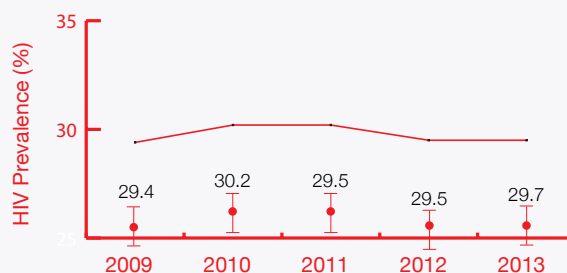
**HIV
PREVALENCE**

FSW: 39.7% TO 71.8%
MSM: 22% TO 48%.5
PWID: 14%

HIV PREVALENCE AMONG PREGNANT WOMEN ATTENDING ANTENATAL CLINICS

The most recent (2013) national survey of antenatal care attendees showed the overall HIV prevalence amongst women who presented for their first antenatal care visit in public health clinics was 29.7% (95% CI: 28.9-30.5).¹⁰ The estimated national HIV prevalence has remained stable over the past ten years as the confidence intervals around the estimates for the period overlap. The HIV prevalence from 2009 to 2013 is shown in Figure 3.

Figure 3: The HIV prevalence among antenatal care attendees, South Africa, 2009 to 2013.



(Source: ANC Sentinel Survey, 2012)

HIV INCIDENCE

The 2012 HSRC survey estimated the annual incidence rate for the entire population, aged two years and above, to be 1.07%, which translates to an estimated 469,000 new infections a year. The rate was higher among females (1.46%) than males (0.71%). Among young adults aged 15 to 24 years, the incidence was 1.49% (139,000 new infections) while among those aged 15 to 49, the incidence rate was 1.72% (396,000 new infections) in that year. Of concern, is the incidence rate of 2.5% among young females aged 15 to 24 years, which translates to 113,000 new infections (a quarter of all infections in the general population). In males of the same age group, the incidence rate was 0.55%. By residence, people living in urban informal settlements had a much higher incidence rate (2.5%) than those living in urban formal areas (1.1%), rural informal areas (0.9%) and rural formal areas (0.8%).

Estimates from the Thembisa and Spectrum models showed that HIV incidence decreased in both sexes and in all age groups between 2005 and 2012.¹¹ Furthermore, estimates from Statistics South Africa (Stats SA) showed a consistent decline in HIV incidence among people aged 15 to 49 years from 1.31% in 2012 to 1.22% in 2015 (From 1.25% in 2012 to 1.02% in 2015 according to the Thembisa model).



CHAPTER 2



NATIONAL RESPONSE TO THE AIDS EPIDEMIC

PROGRESS TOWARDS ACHIEVING THE 2015 TARGETS

The 2011 UN General Assembly Political Declaration on HIV/AIDS set a range of commitments and targets for 2015. South Africa, as part of the international community, committed to achieving these targets guided by the framework of core indicators (Table 4).

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

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

During the period, January 2012 to December 2015, South Africa continued to make progress towards achieving the 2015 targets and elimination commitments. These achievements were determined through a review of literature and systematic synthesis of relevant data.





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TO REDUCE SEXUAL TRANSMISSION OF HIV BY 50%

Is this a priority target area for the country?

Yes

Does the National Strategic Plan address this target?

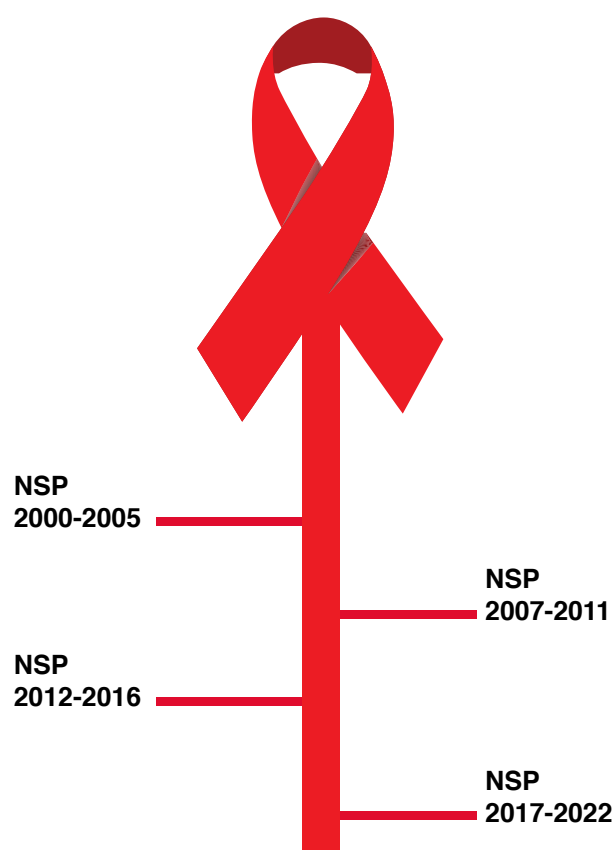
Yes

Did the country reach the target and commitment?

No

POLICY ENVIRONMENT

Figure 4: Target 1 policy timeline, South Africa , 2015



From 2000 to date, the country has guided its HIV response through a series of revised NSPs (Figure 4). Each NSP captures the country's multi-sectoral response to the HIV epidemic and provides guidance to all government departments and sectors of civil society on the national response. The NSP 2012-2016¹¹ was the strategic guide for the national response to HIV, STIs and TB for that period and included preventing new HIV, TB and STI infections as one of its four strategic objectives. There are a number of positive points about the NSP 2012-2016, of which three are outlined below.

- Firstly, the country's response included combination prevention strategies.
- Secondly, the response focused on the general population without neglecting important key populations
- Thirdly, many programs in the NSP 2012-2016 were largely based on evidence of what works.

CURRENT STATUS

South Africa has a generalized epidemic (general population prevalence > 1%) with higher prevalence in pockets of the population (e.g. FSM and MSM). The transmission is mostly heterosexual. Table 5 contains the current status of South Africa regarding key indicators for this target. The last estimates from national surveys for many indicators in the general population were in 2012. The 2016 HSRC survey was only completed in the last quarter of 2015, and results are yet to be released. Data on indicators derived from national programmes were up to date during the period under review.

Table 5: Target 1 core indicators, South Africa, 2008-2015

Core indicator	Source	Baseline 2008	Latest data by 2015*
Young people: Knowledge about HIV prevention (15-24)	HSRC Survey, 2008/2012	29.4%	28.6%
Sex before the age of 15 (15-24)	HSRC Survey, 2008/2012	10%	10.7%
Multiple sexual partnerships	HSRC Survey, 2008/2012	7%	12.6%
Condom use at last sex among people with multiple sexual partnerships (15-24)	NCS 2009/2012 HSRC Survey 2008/2012	63.8% 75.9%	62.3% 58.4%
HIV testing in the general population in the last 12 months and known results (15-49)	HSRC Survey 2008/2012 DOH Annual Reports 2012/2013 and 2014/2015	49.1% 8,978, 177	66.2% 11,898,308
HIV prevalence in young people (15-24)	HSRC Survey 2008/2012	8.7%	7.1%
Sex workers: prevention programmes (% SW reached with HIV prevention programmes)	SWEAT Report 2012 and SAHMS-FSW National Survey Report 2013/14	60%	No data
SW: condom use (last sex)	SWEAT Report 2012 and SAHMS-FSW National Survey Report 2013/14	81%	76.4 to 89.4%
HIV testing in sex workers (ever)	SWEAT Report 2012 and SAHMS-FSW National Survey Report 2013/14	88%	96.1% to 96.7%
HIV prevalence in sex workers	SWEAT Report 2012 and SAHMS-FSW National Survey Report 2013/14	59.6%	57.7 (39.7% to 71.8%)
MSM: prevention programmes	No data	No data	No data
MSM: condom use	GARPR 2015	No data	97.9%
HIV testing in MSM	GARPR 2012 and 2015	27.2%	67.9%
HIV prevalence in MSM	MSM Data Triangulation and Synthesis 2014	No data	22-48%
Proportion of men circumcised (15-49)	NCS 2009/2012 HSRC Survey 2008/2012	43% 40.6%	54% 46.4%
Number of male circumcisions performed according to national standards in the last 12 months	DOH Annual Reports 2012/2013 and 2014/2015	422 262	464,73

*Latest data by 2015. See column on data source for actual date of latest data.



KEY ISSUES

ADULT HIV INCIDENCE DID NOT DECLINE BETWEEN 2012 AND 2015

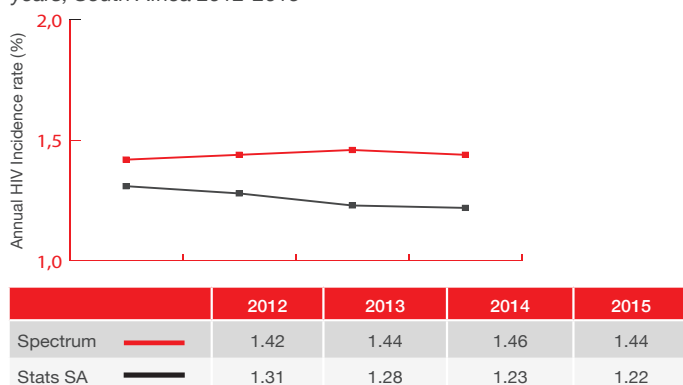
The NSP 2012-2016 aimed to achieve a 50% decline in HIV incidence among adults in South Africa. In 2012, the HSRC survey estimated the annual incidence rate to be 1.72% among men and women aged 15 to 49 years, translating to an estimated 396,000 new infections in that year. For the entire population, two years and above, the incidence rate was 1.07%, which is an estimated 469,000 new infections. The rate was higher among females (1.46%) than males (0.71%). Among young adults aged 15 to 24 years, the incidence was 1.49% (139,000 new infections) while among those aged 15 to 49, the incidence rate was 1.72% (396,000 new infections) in that year. The NSP 2012-2016 used the Actuary Society of South Africa (ASSA) estimate of 0.94% incidence rate in adults in 2012 as baseline (Updated to 1.79 using the Thembeisa model).¹²

All available incidence data (survey and estimates) showed a decline in HIV incidence between 2002 and 2012.¹¹ Since 2012, there has been no other national survey to which the HSRC data can be compared. Using Spectrum estimates, there were no changes from 2012 to 2015: 1.42% and 1.44% respectively (Figure 5). As a result, the estimated number of new infections increased slightly from 370,000 in 2012 to 380,000 in 2015.¹⁰ However, incidence rate estimates from Statistics South Africa showed a slight but consistent decrease from 1.31% in 2012 to 1.22% in 2015 ($p=0.026$).⁵ This means that the NSP 2012-2016 target of decreasing HIV incidence by 50% was not realized.

380,000 NEW INFECTIONS IN 2015



Figure 5: Estimates of annual HIV incidence in men and women 15 to 49 years, South Africa 2012-2015



(Source: UNAIDS, 2016; Statistics South Africa, 2015)

HIV PREVALENCE DID NOT DECLINE BETWEEN 2012 AND 2015

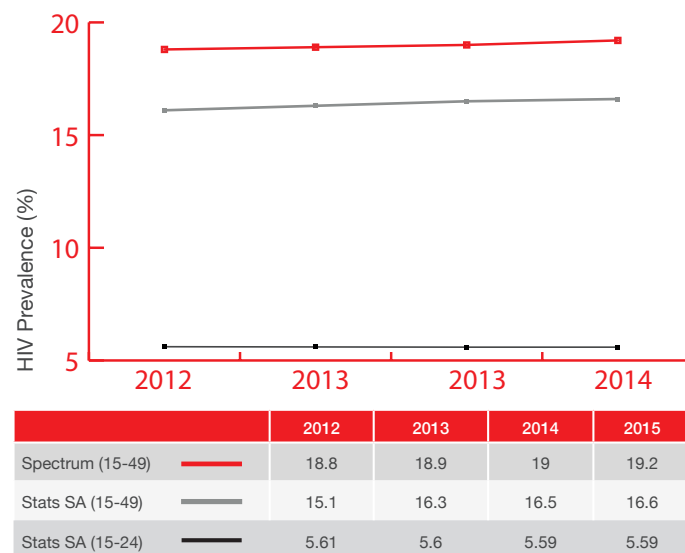
Table 6: HIV prevalence by age, South Africa, 2002, 2005, 2008 and 2012

Age group	HSRC			
	2002	2003	2008	2012
2-14	5.6	3.3	2.5	2.4
15-24	9.3	10.3	8.7	7.1
25+	15.5	15.6	16.8	19.9
15-49	15.6	16.2	16.9	18.8
2+	11.4	10.8	10.9	12.6

Data from four consecutive HSRC national surveys showed that HIV prevalence in the general adult population (15 to 49 years) did not decrease between 2002 and 2012 (Table 6). On the contrary, the prevalence increased significantly at the rate of 1 percentage point per annum ($p=0.043$) from 15.6% in 2002 to 18.8% in 2012. In the overall population aged two years and above, the prevalence remained more or less the same; although the prevalence dipped slightly between 2002 and 2005, it rose again steadily from 2005 to 2012. The results from the antenatal care (ANC) surveys also showed that the HIV prevalence in ANC attendees in South Africa has not changed since 2007. In 2013, the prevalence was 29.7% (95% CI: 28.9-30.2).¹⁰

The data for the younger age groups is more encouraging as HIV prevalence decreased in those under 24 years in the last decade. The NSP 2012-2016 target was to reduce HIV prevalence in young men and women aged 15 to 24 years by 50% from the baseline of 8.7% in 2008 to 4.35% in 2016. The prevalence only reduced by 18% to 7.1% in 2012. Projection data from Spectrum and StatsSA show that the HIV prevalence in men and women aged 15 to 24 years and 15 to 49 years did not change much between 2012 to 2015 (Figure 6).

Figure 6: Estimates of annual HIV prevalence in the general population South Africa, 2012-2015

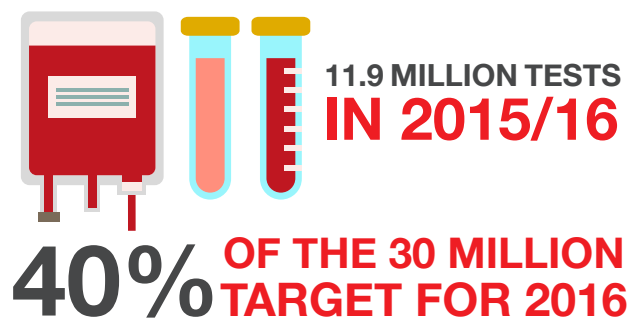


(Source: UNAIDS, 2016; Statistics South Africa, 2015)

HIV COUNSELLING AND TESTING (HCT) INCREASING BUT BELOW TARGET

One of the most commendable aspects of South Africa's HIV response is the HCT campaign drive which has been considered one of the most successful in the world. The national HCT campaign, launched by President Jacob Zuma in 2010, has been imperative for the huge increase in HCT uptake since the launch. Knowledge of one's HIV status is the first step to accessing HIV/AIDS treatment and care services and it is also central to behavioural modification.

In 2012, the National Communications Survey (NCS) found that 38% of respondents (10.7 million) tested in the past year, compared to 32.2% in 2009.¹³ The results were similar to those from HSRC surveys which estimated that 19.9% and 37.5% of adults tested in the past year in 2008 and 2012 respectively. Both surveys showed that women were more likely to test than men. While the government's HCT drive explains the overall increase in HCT uptake, differences in health-seeking behaviour between men and women, and ANC attendance explain the observed differentials by gender. According to Department of Health (DOH) annual reports,¹⁴⁻¹⁷ in 2012/13, 8,978,177 people were tested for HIV infection. This increased to 11,898,308 in 2015/16. However, the 11.9 million tests in 2015/16 represent only 40% of the 30 million target for 2016 set out in the NSP 2012-2016.



AGE AT SEXUAL DEBUT INCREASED IN MALES AGED 15 TO 24 YEARS

The HSRC surveys of 2008 and 2012 showed a slight but not statistically significant increase in the percentage of 15 to 24 year olds who initiated sex before 15 (early sexual debut) from 10% to 10.7%. However, analysis by gender showed different patterns for males and females. Early sexual debut increased steeply in males aged 15 to 24 years from 11.3% to 16.7% while in females it was lower and more stable from 5.9% in 2008 to 5.0% in 2012. It should also be stated that the distribution of early sexual debut varied markedly by province in 2012. It was lowest in KwaZulu-Natal (7.6%) and Mpumalanga (7.7%) and highest in the Eastern Cape (16.8%) and Western Cape (14.2%).

AGE-DISPARATE RELATIONSHIPS ARE INCREASING IN ADOLESCENT FEMALES

Age-disparate sexual partnerships are common and increasing in South Africa. Young women who are in age-disparate relationships are not only exposed to men who have a higher prevalence of HIV infection but are also less likely to negotiate safe sex. Overall, in 2012, the HSRC survey found that one in five women (19.8%) had a sexual partner who was five or more years older than them. In those aged 15 to 19 years, it was 33.6% (27.6% in 2008 and 18.5% in 2005). Among males aged 15 to 19 years, only 4.1% were in age disparte partnerships in 2012 (0.7% in 2008 and 2.0% in 2005).



MULTIPLE SEXUAL PARTNERSHIPS (MSP) ARE INCREASING IN MALES AND FEMALES

Multiple sexual partnerships (MSP) have been on the increase in South Africa. The 2008 and 2012 HSRC surveys reported overall MSP levels of 9.3% and 12.6% respectively. The last two NCS surveys showed similar results (data not shown). Generally, MSP levels have increased over the last three surveys for both males and females of all age groups. MSP levels were higher in males than females and in the younger age group than the older. The NCS 2012 found that knowledge of faithfulness and partner reduction as ways to prevent HIV infection was relatively low. Only 41% of respondents mentioned faithfulness as a means to prevent HIV, while only 24% mentioned partner reduction. Although these proportions have increased since 2006, they remain low.

Table 7: Number of medical male circumcisions conducted, South Africa, 2010-2015

Performance indicator	2010/11 (baseline)	2012/13	2013/14	2014/15	2015/16	2016 NSP target
Number of medical male circumcision conducted	143,000	422,262	331 668	508,404	464,731	1.6 million

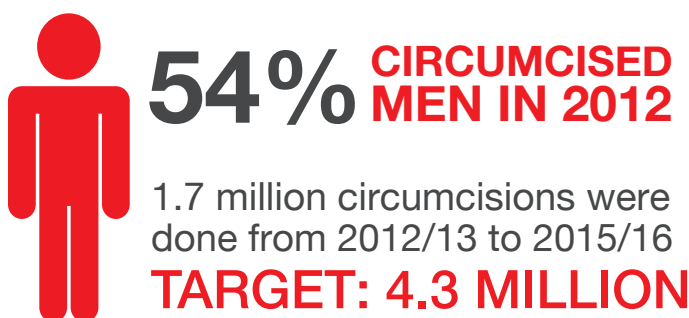
(Source: DOH annual reports 2010/11 to 2015/1613-16)

CIRCUMCISION

Research evidence shows that circumcision reduces the risk of heterosexual HIV acquisition by 60%. UN guidelines recommend that at least 5 million circumcisions would be required in South Africa to impact on population level HIV incidence. Medical male circumcision is part of the combination prevention strategy in South Africa. In 2010, in tandem with the HCT roll-out, the country rolled out the national Voluntary Medical Male Circumcision (VMMC) programme with the aim of reaching 80% of HIV negative men aged 15 to 49 years (approximately 4.3 million men) by 2015.¹ The NSP target for 2016 was 1.6 million circumcisions. A total of 464,731 circumcisions were performed in the financial year 2015/16, which is 29% of the 1.6 million target set for the year (Table 7). Cumulatively, 1.7 million circumcisions were done from 2012/13 to 2015/16. This achievement pales in comparison to the target of 4.3 million circumcisions by 2015.

According to the 2012 NCS, levels of knowledge regarding HIV risk-reduction provided by VMMC were not high (48%), although there have been improvements since 2009 (8%). Also, the prevalence of male circumcision was a moderate 54%, from 43% in 2009. The HSRC survey reported moderate but increased levels of VMMC in 2012 (46.4%). The HSRC survey however reported a higher proportion of VMMC than traditional circumcision in the 15 to 24 year age group, reflecting a shift towards more circumcisions occurring in medical settings. In addition, there were significant variations in VMMC by race, province and rural-urban residence. According to the NCS 2012 survey, 3.5 million men (3.3 million in the HSRC survey) were circumcised in South Africa.

The 2013 National HIV and TB Review also found that VMMC had not reached enough men and attributed the low rates to the doctor-centered approach of the programme.¹⁷ Traditional practices also explained the low rate of VMMC in provinces like KwaZulu-Natal, Mpumalanga and Limpopo where traditional circumcision is more common. As South Africa did not achieve the VMMC target of reaching 80% of HIV-negative men by 2015, there is need for innovative ways to increase the rates of VMMC in the country. This should include engaging with traditional leaders to integrate traditional and medical circumcision as has been achieved in neighbouring Zimbabwe.



ACHIEVEMENTS

INCREASING TREATMENT COVERAGE

ART treatment while reducing the impact of HIV infection also serves as a prevention strategy through viral suppression in those on treatment. South Africa's ART programme has expanded rapidly over the past decade, especially in the last five years. About 3.4 million PLHIV were on treatment in 2015.⁴

CONDOM DISTRIBUTION AND USE

Since 2010, the government's commitment to ensuring safe sex has been demonstrated through the increasing number of male and female condoms distributed annually. In the financial year 2015/16, 840 million condoms were distributed.¹⁷ This represents a 71% increase from the baseline of 492 million condoms in 2010/11 and 84% of the 1 billion target set in the NSP 2012-2016. Based on the estimated number of sex acts nationally, a target of 800 million male condoms is recommended by South Africa's investment case. Female condoms also increased substantially from a baseline of 5.1 million to 27 million in 2015/2016, exceeding the NSP target of 25 million for 2016 (Table 8).

The NCS and HSRC surveys reported different estimates and trends of condom use at last sex. The NCS reported an increase in condom use among sexually-active respondents from 40% in 2009 to 47% in 2012. However, no increase was observed in the 16 to 24 year age-group, with 63.8% and 62.3% condom usage in 2009 and 2012 respectively. On the contrary, the 2012 HSRC survey found lower and declining frequency of condom use at last sex among sexually-active respondents between 2008 and 2012: 45.1% and 36.2% respectively. Among youths aged 15 to 24 years, condom use at last sex declined from 75.9% in 2009 to 58.4% in 2012. Both surveys found that condom use at last sex was higher in sexual encounters with a casual partner than with a regular partner and a spouse. The decline in condom use at last sex is in agreement with the decrease seen in the number condoms distributed between 2010 and 2013.

CONDOM USE AMONG SEXUALLY-ACTIVE RESPONDENTS

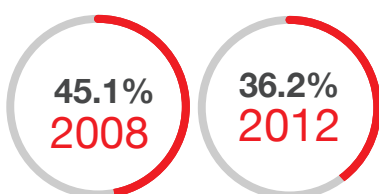


Table 8: Male and female condom distribution, South Africa, 2010-2015

Performance indicator	Number of male condoms distributed	Number of female condoms distributed
2010 (baseline)	492 million	5,100,000
2012	251,419,268 (25% of NSP target)	4,309,146 (17% of NSP target)
2016 NSP target	1 billion	25 million
2015/16	839 874 751 (84% of NSP target)	27 005 805 (108% of NSP target)

Source: DOH Annual Report 2015/16

INCREASING RESEARCH AND PROGRAMMES FOR SEX WORKERS

Commercial sex workers (CSW) are part of the key populations identified by the NSP 2012-2016 as being crucial in the plan to combat HIV/AIDS. As a result, during the NSP 2012-2016 term, SANAC engaged in a number of activities with key stakeholders to evaluate the size of the population, determine the extent of the epidemic and access to HIV/AIDS prevention, treatment and care services.

In 2013, in collaboration with the National Sex Work Technical Working Group, SANAC developed the National Strategic Plan for HIV Prevention, Care and Treatment for Sex Workers.¹⁸ Amongst other objectives, the plan aims to increase coverage and access to comprehensive HIV, STI and TB services for sex workers, their sexual partners and families and their clients. The 2013 Sex Workers Size Estimation Survey, commissioned by SANAC and conducted by Sex Worker Education and Advocacy Task Force (SWEAT), showed that there are an estimated 153,000 sex workers in South Africa, with 90% being FSW. Gauteng (22%), KwaZulu-Natal (16%) and the Western Cape (11%) accounted for half (49%) of the sex workers.¹⁹

SANAC also conducted the first National Sex Worker Programme Evaluation, between 2012 and 2013, in collaboration with the National AIDS Convention of South Africa (NACOSA), SWEAT and international funding partners. The evaluation found that 60% of sex workers were reached with HIV prevention programmes, 81% reported condom use at last sex with most recent client, 88% received an HIV test in the past 12 months and 59.6% were living with HIV/AIDS.²⁰

Also, between 2013 and 2014, SANAC in partnership with the DOH, the US President's PEPFAR, the United States Centers for Disease Control and Prevention (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 in the three biggest metros in South Africa.²¹ The survey found that over 90% of sex workers in each of the three study sites reported that they have ever tested for HIV. Testing in the last 12 months varied from 46% to 71%. HIV prevalence in the study was 39.7% in Cape Town, 53.5% in Durban and 71.8% in Johannesburg. The study also found high syphilis prevalence (4.6% in Durban, 16.2% in Johannesburg and 19.9% in Cape Town). Substance and alcohol abuse, physical and sexual assault and other psychosocial health problems were also found to be common.

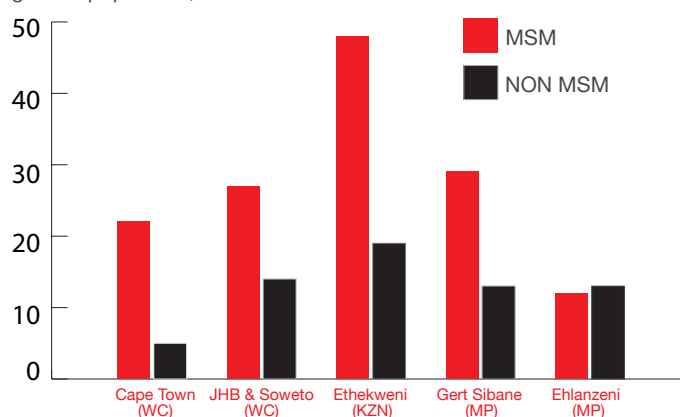
MEN WHO HAVE SEX WITH MEN (MSM)

There have also been recent primary and secondary studies to better understand the extent of the HIV epidemic and access to prevention and treatment and care services among MSM. With financial assistance from the GFATM, SANAC is collaborating with the DOH and development partners to plan, expand and integrate prevention, care and treatment programming for MSM into the public health service delivery system as part of the national HIV response plan.

In 2013, SANAC, in association with UCSF, the DOH and PEPFAR through CDC in South Africa, initiated a comprehensive data synthesis to better understand the state of, and response to, the HIV epidemic among MSM in South Africa. The synthesis showed that HIV prevalence was between 1.89 and 4.65 times more among MSM than non-MSM in the same age group (Figure 8). The adjusted HIV prevalence from respondent-driven samples (RDS) was between 22% and 48% (prevalence from all studies was between 13% and 49%). The trends showed no indications of stabilization as the prevalence in Cape Town, Durban and Johannesburg in 2013 was over 10% higher than in 2008.²²

The synthesis also showed that in 2013, over a third of MSM reported recent symptoms of an STI (28.1% in Cape Town, 39.2% in Johannesburg and 42.7% in eThekweni or Durban). These 2013 levels were higher than data collected earlier in the 2008-2013 period. A fifth of MSM reported recent unprotected anal intercourse. The proportion of MSM who have recently tested for HIV was 48% nationally (61%, 72% and 73% in Johannesburg, Cape Town and Durban, respectively).

Figure 7: HIV prevalence among MSM and non-MSM in the general population, South Africa 2013



(Source: University of California, 2015)

HIV PREVENTION PROGRAMME AMONGST YOUNG WOMEN AND GIRLS

As women continue to bear a disproportionate burden of the HIV epidemic and as recent surveys have reported increasing levels of age-disparate partnerships and multiple sexual partnerships among women, South Africa has responded with a number of HIV programmes targeting young women and girls aged 15 to 24 years. To name a couple, these programmes include:

- The Zazi “Know Your Strength” campaign launched in 2013 under the leadership of the SANAC Women’s Sector in partnership with USAID, JHHESA, DOWCPD and NDOH.²²
- The South Africa Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) project, a global partnership between PEPFAR, Bill & Melinda Gates Foundation and Girl Effect.²⁴

Both programmes build the self-efficacy of women and girls to draw on their inner strength for decisions about their sexual and reproductive health.

INTEGRATED SCHOOL HEALTH PROGRAMME (ISHP)

In 2010, the government committed to reinstating health programmes in public schools in South Africa. In collaboration with the National Department of Health (NDOH), the Department of Basic Education (DBE) is implementing the ISHP in public schools with the aim of building and strengthening existing school health services. The ISHP aims at making sexual and reproductive health and youth-friendly services accessible in schools, enriching prevention efforts (including HCT) among youths and making certain they stay HIV free.

REACH OF HIV COMMUNICATION PROGRAMMES (HCPs)

According to the NCS, in 2012, the majority (82%) of the population aged 16 to 55 years were exposed to at least one of the 11 national communications programmes on HIV/AIDS. However, the reach of HCPs has decreased since 2009, when 90% of the same aged group were exposed to at least one programme. HCPs have shown success in a number of areas related to HIV in terms of building knowledge, developing appropriate attitudes and beliefs, and – as a consequence – changing behaviour patterns. These achievements require continued communication interventions if they are to be sustained. SANAC should find innovative approaches for leveraging NGO resources to bolster HCPs at grassroots level. In some cases, modifications to messaging could increase impact.



2

THE

GOAL

TARGET

To reduce transmission of HIV among people who inject drugs by 50% by 2015

Is this a priority target area for the country?

Yes

Does the National Strategic Plan address this target?

Yes

Did the country reach the target and commitment?

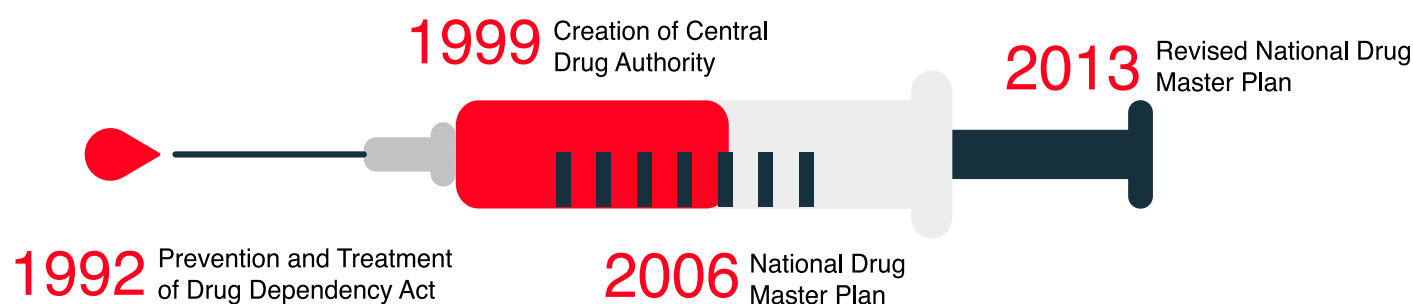
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POLICY ENVIRONMENT

According to the United Nations Office on Drugs and Crime (UNODC), South Africa is the regional hub for drug trafficking and is the largest transit zone for illicit drugs in Southern Africa. Consequently, heroin has become more popular in South Africa with a number of street names including “Junk”, “Smack”, to name a few. According to the South African Community Epidemiology Network on Drug Use (SACENDU) report for 2015, of patients admitted for heroin use as their primary drug of abuse, the percentage that reported injection varied from 8% to 57% across provinces.²⁵

South Africa has rapidly updated its policy environment (Figure 8) in order to achieve an integrated approach to drug control; modelled alongside the three major pillars of the 2009 UNGASS Political Declaration and Plan of Action which include: reduction in demand, reduction in supply and international cooperation. This approach aimed to reduce drug abuse and the health and social burden that stem from it.

Figure 8: Target 2 policy timeline, South Africa, 2015



CURRENT STATUS

Figure 9: Target 2 core indicators, South Africa, 2012-20



There is scanty data on PWIDs in South Africa (Figure 9). In 2013, the estimated number of PWIDs was 67,000. The latest GARPR data reported by South Africa in 2013 showed the estimated prevalence to be 19.4% translating to 12,998 HIV positive PWID.^{26, 27} In 2015, the results of the largest quantitative study ever conducted among PWID in South Africa were published.⁹ The study which surveyed 350 respondents from five cities using snowballing, showed the prevalence of HIV among PWID to be 14%. The prevalence of HIV in the study was higher in females (17%) than in males (14%), although the prevalence among the 11 black females surveyed was 80%. Recent estimate of the number of PWID in South Africa in 2015 is 75,000²⁸, a 10% increase from the 67,000 previously estimated in a 2008 household survey (Table 10). This translates to an estimated 10,500 PWIDs who are HIV positive in South Africa (based on 14% prevalence). It should be noted that the difference in prevalence between the earlier estimate of 19% and the more recent estimate of 14% does not represent a significant decline as the confidence intervals around the estimates overlap. In fact, a 2008 study estimated 12.4% prevalence among PWID in South Africa.²⁹

PWID in South Africa also engage in HIV-risk practices. The aforementioned five-city study found that half (49%) of all participants used contaminated equipment the last time they injected and 26% of females and 13% of males reported that they always shared injecting equipment. A quarter of participants reported having had STI symptoms in the previous 12 months and 22% had ever worked as sex workers. Sex in exchange for drugs or money varied from 42% to 74% across survey sites.

The number of Needle Syringe Programmes sites in the country increased to three in 2015 with one centre each in Pretoria, Durban and Cape Town. Data for the number of PWID served in the last 12 months, as well as, the number of syringes per PWID distributed in one year are now available.

PWID = 75,000

HIV PREVALENCE



PWID IN SOUTH AFRICA

also engage in HIV risk practices.

49% used contaminated equipment the last time they injected

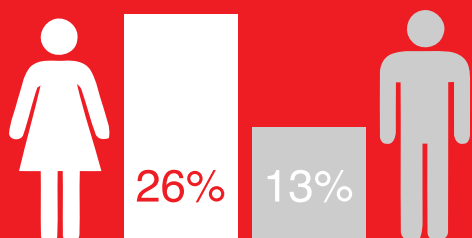


Figure shows that more females share injecting equipment than males.



Participants reported symptoms of an STI in the previous 12 months



Participants had worked as a sex worker

SEX IN EXCHANGE FOR DRUGS OR MONEY
VARIED FROM
42% TO 74%
ACROSS SURVEY SITES.

Table 10: Status and services for PWID and HIV, South Africa, 2012-2015

Service type	Status 2014	Status 2015
No of PWID that are HIV positive	12,998 ¹	10500 ²
% of HIV+ PWID	19.4%	14% ³
Est no of HIV+ PWID receiving ART	Not available	Not available
Availability of Needle Syringe Programme	Yes	Yes
No of needle syringe programmes sites nationally	1	3
No of PWID served in the last 12 months	No data	2100
No of syringes distributed to PWID in one year (Jan-Dec 2015)	No data	234,632

Source ²⁷ Petersen et al. 2013; ²⁸ Global State of Harm Reduction 2016; ⁹ Scheibe et al. 2016

South African National HIV Prevalence, Incidence and Behaviour Survey of 2012 also reported above-national average HIV prevalence and high risk of HIV exposure among recreational drug users: HIV prevalence increased from 10.8% in 2008 to 12.7% in 2012 and MSP increased from 24.1% in 2008 to 32% in 2012.

The number of Needle Syringe Programmes sites in the country increased to three in 2015 with one centre each in Pretoria, Durban and Cape Town. Data for the number of PWID served in the last 12 months, as well as, the number of syringes per PWID distributed in one year are now available.

KEY ISSUES

NEED FOR HARM REDUCTION STRATEGIES

Drug policy and guidelines are central to the effort to reduce HIV transmission in PWID. Yet, the political landscape for drug use in South Africa has been a difficult one. The major criticism being that the fight against drug abuse in South Africa has been more about criminalization and policing than about harm reduction among users. It has been argued that the criminalization of drug use and the resulting stigma only fuels the risk of HIV acquisition in PWID. The revised National Drug Master Plan 2013-2017³⁰ seeks to address these challenges, while developing strategies to reduce the supply and demand for alcohol and illicit drugs. Extensive work to improve harm reduction modalities is in progress.

Although PWID were included as a key target group in the NSP 2012-2016, they are yet to receive required attention. As a consequence, available HIV prevention and harm reduction services for PWID are still lacking, as are Needle Syringe Programmes and opioid substitution therapy (OST) programmes, necessitating scaling up of these programmes.

ACHIEVEMENTS

EMERGING POLICY ENVIRONMENT

The policy environment which has limited HIV interventions among PWID is being updated. The current National Drug Master Plan 2013-2017 which lays the plan for harm reduction programmes was developed during the period under review. In April 2015, South Africa along with other African countries under the African Union adopted the Common African Position for the UNGASS which clustered drug control alongside health, welfare and population matters, and increased pronouncement of human rights. This position also reiterated the need for harm reduction in dealing with drug control, while noting the role of research and data collection.

STEP-UP PROJECT

In July 2015, the first project to provide multi-site harm reduction and HIV prevention services to PWID in South Africa was launched. The project, called the Step-up Project, is run by the TB/HIV Care Association. The Step-up Project operates in Pretoria, Durban and Cape Town providing a variety of services comprising harm reduction packs (including a needle and syringe programme), hygiene commodities and behaviour change interventions using mobile clinics and peer-led outreach. In the last six months of 2015, 2100 unique clients received services and 234,632 syringes were distributed.

This translates to 3 syringes per PWID in South Africa in 2015.³¹ This figure is far less than the internationally recommended target of 200 syringes per PWID per year.

INCREASED ADVOCACY AND FUNDING

The emerging policy environment on drug use in South Africa will encourage civil society to carry out extensive advocacy work to allow harm reduction programmes to run among PWID unhindered. This will lead to increased funding for harm reduction among PWID. The country's recent effort to align its drug policy with its NSP for STIs, HIV and TB has been welcomed by civil society.

GOVERNMENT-SPONSORED OPIOID SUBSTITUTION THERAPY

TB/HIV Care is currently developing an OST demonstration project with the Durban University of Technology to deliver OST to drug users and to explore its benefits in the South African context. This project is supported by the Departments of Health and Social Development.

RESEARCH IN PWID

Research being conducted on the OST demonstration project alongside another being rolled out in Tshwane to generate evidence within South Africa local context to inform the development of national policies around OST.

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To eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths

Is this a priority target area for the country? **Yes**

Does the National Strategic Plan address this target? **Yes**

Did the country reach the target and commitment? **Yes**

POLICY ENVIRONMENT

South Africa is highly committed to eliminating mother-to-child transmission (MTCT) of HIV and the reduction of AIDS-related maternal deaths. This commitment is demonstrated through the enabling policy environment that has been rapidly updated since 2010 to achieve this target (Figure 10).

Figure 10: Target 3 policy timeline, South Africa 2010 to 2015



CURRENT STATUS

Table 11: Target 3 core indicators, South Africa, 2012-2015

Core indicator	Source	2012	2013	2014	2015
Percentage of HIV-positive pregnant women who receive antiretroviral medicine to reduce the risk of mother-to-child transmission	Spectrum	91	>95%	>95%	>95%
Percentage of women living with HIV who are provided with antiretroviral medicine for themselves or their infants during the breastfeeding period	DOH		57	91	
Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	Spectrum	98	79	91	>95
Mother-to-child transmission of HIV	NHLS	2.4	2	1.8	1.3*

*Birth PCR test data

ACHIEVEMENTS

ACHIEVEMENT OF PMTCT TARGET

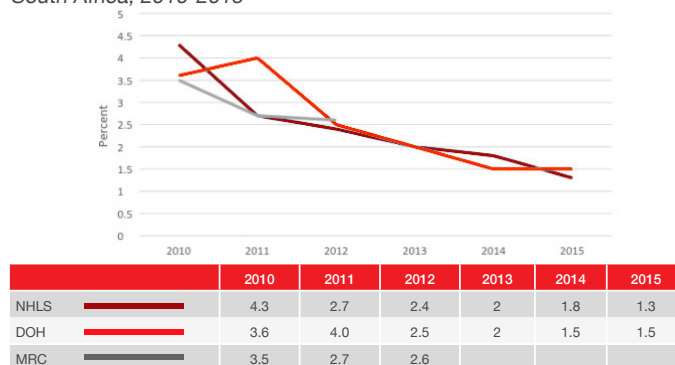
Prevention of mother-to-child transmission (PMTCT) is the first line of defence against the spread of HIV. Elimination of mother-to-child transmission (eMTCT) is defined as a reduction of transmission to such low levels that it no longer constitutes a public health problem (defined as <2% rate of MTCT of HIV at 6 weeks and <5% at 18 months).

The MTCT rates from the NHLS and the DHIS generally agree, although derived using slightly different denominators, and in 2011, there were also big differences in numerators. Between 2010 and 2012, the government, through the MRC, conducted the South African PMTCT Evaluation (SAPMTCTE).^{32,16} The SAPMTCTE was designed to provide more accurate data on the evaluation of the programme. As shown in Figure 11, all three data sources generally agree and confirm that the MTCT rate has been on a steady decline for the period shown (3.5% in 2010 based on the SAPMTCTE data). From 2014, the MTCT rate at six weeks has been below 2% (Table 11). The NSP 2012-2016 set a goal of reducing MTCT to less than 2% at six weeks and less than 5% at 18 months by 2016. This means that by 2015, South Africa had achieved its target for the elimination of MTCT.

UPDATED GUIDELINES

Since 2010, guidelines have been rapidly updated and huge resources have been committed to achieving prevention of mother-to-child transmission (PMTCT) targets. From 2015, South Africa announced that the country's PMTCT programme would provide lifelong ART for pregnant and breastfeeding woman regardless of CD4 count or clinical staging (previously termed Option B+).³⁴ This demonstrates the country's commitment to eliminating MTCT and substantially reducing HIV-related maternal deaths. The guidelines also make provision for birth PCR HIV testing for all HIV-exposed neonates which is repeated at 10 weeks and Rapid HIV testing at 18 months. Infants who test positive with HIV PCR should undergo immediate ART initiation whilst waiting for confirmatory test results.

Figure 11: Six-weeks MTCT rates using NHLS, DOH and MRC data, South Africa, 2010-2015



(Sources: DOH annual reports 2010/11 to 2015/16¹⁴⁻¹⁷; SAMPMTCTE, 2012³²; NHLS, 2015³³)



By 2015, South Africa had achieved its target for the elimination of MTCT.
MTCT rate at 6 weeks < 2%

UNIVERSAL COVERAGE

The country's achievement of the MTCT rates target derives from the universal coverage of PMTCT. By 2013, the percentage of HIV-positive pregnant women who received antiretroviral medicine to reduce the risk of mother-to-child transmission was over 95%, a significant increase from 63% in 2009.^{35, 36} Political leadership and commitment at the highest level, updated policy context, increased funding, task shifting, integration of PMTCT with other health services and performance monitoring are among the innovations adopted by South Africa to enable expanded treatment coverage.

PMTCT CASCADE

Expanding PMTCT services to 100% of public clinics has come with its own gaps and challenges. These challenges are due to existing inequalities across provinces and health districts. One key challenge is late booking for ANC services by pregnant women. In addition, there are other challenges in the health system that affect PMTCT efficiency and quality. These include: re-testing of HIV negative pregnant women at 32 weeks and three monthly thereafter, which is low; post-partum follow up of the mother-baby pairs is suboptimal; and, the low testing rate of babies born to HIV-positive mothers at 18 months, making it hard to determine HIV-infection rate 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.^{35, 36}

EARLY INFANT DIAGNOSIS

Excellent rates of early infant diagnosis (EID) has been achieved. In 2012, 73% of the estimated 270,000 HIV-exposed infants requiring an early PCR were tested. This increased to 87% according to NHLS data (94% according to UNAIDS estimates).^{36, 37} It is noteworthy, however, that the introduction of birth-testing in the new national guidelines of 2015, while important for earlier detection of in-utero infection, requires new operational and monitoring tools to enhance the timely identification, tracing and linkage into care of infected early infants.³⁷

MONITORING AND EVALUATION

To consolidate on the PMTCT success in South Africa, there is need to improve on M & E of the programme, solve existing gaps and challenges and to facilitate early warning system that alert programme managers and facility staff of emerging issues. The 2013 Joint Review identified M & E gaps in the PMTCT programme which 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.³⁸

OTHER ISSUES

A number of issues that are not necessarily related to the PMTCT cascade will continue to be important if the eMTCT of HIV will be achieved. These include the high HIV incidence and prevalence in young women and girls, high levels of teenage pregnancies and public enlightenment of the benefit of early ANC attendance.

4 THE G TARGET

To reach 15 million people living with HIV with lifesaving antiretroviral treatment

Is this a priority target area for the country?

Yes

Does the National Strategic Plan address this target?

Yes

Did the country reach the target and commitment?

Yes



POLICY ENVIRONMENT

The national policy framework for South Africa regarding care, treatment, and support for people living with HIV (PLHIV) is provided in the NSP 2012-2016. At the global level, all countries including South Africa committed to the 2011 UN Political Declaration on HIV and AIDS. At the regional level the NSP 2012-2016 was aligned with African Union frameworks such as the 2011 African Plan towards the elimination of new HIV infections among children by 2015 and to keeping their mothers alive. In line with updated WHO guidelines for HIV/AIDS management, South Africa updated its national guidelines twice within the review period to ensure that they comply with international standards (Figure 12).

Figure 12: Target 4 policy timeline, South Africa 2010 to 2015

2010	2013	2015
ART for patients with CD4 < 200 or with severe HIV disease or patients co-infected with TB	FDC ART for patients with CD4 < 350 or with severe HIV disease or patients co-infected with TB	Earlier initiation of ART at CD4 ≤ 500 and HIV/TB coinfecting patients

CURRENT STATUS

Table 12: Target 4 core indicators, South Africa, 2012-2015

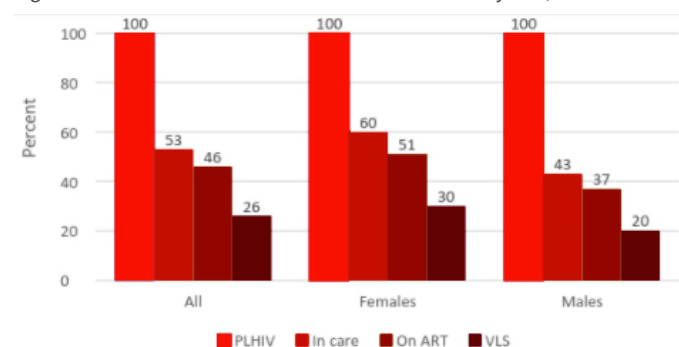
Core indicator	Source	Baseline 2012	2015
Percentage of adults and children currently receiving ART among all adults and children living with HIV	DHIS	Adults: 31.2% Children: 41.5% Total: 31.2%	Adults: 53.4% Children: 46% Total: 52.7
Number of adults and children who are still alive and on ART at 12-month after initiating treatment	DOH tier. net	No data	400,948 [2014]

KEY ISSUES

ART CARE CASCADE

While the mammoth expansion in the country's ART programme has been applauded, key operational challenges still exist within the system. Unfortunately, loss to follow up at all stages along the treatment cascade remains a key challenge for the programme. Programme data on attrition in the HIV care continuum are sparse. A recent analysis which drew data from the NHLS and the DHIS for the period April 2014 to March 2015 (Figure 13) showed that only 53% of PLHIV were in care (60% females and 43% males).³⁸

Figure 13: HIV treatment cascade in South Africa by sex, 2015



(Source HERO, 2016³⁸) VLS=viral load suppression

These figures agree with the results from a population-based study conducted in the North West province in 2014 which showed that among those who were HIV positive; 44.0% of men and 74.8% of women reported ever linking to HIV care, of which 33.1% of men and 58.4% of women were retained in care.³⁹

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 loss to follow-up (LTFU) data for patients started on ART from January to December 2013 shows a national average of 27% LTFU among patients who completed 12 months of ART.⁴⁰ A recent analysis of a cohort of 66,865 patients who initiated ART during 2004/2005 and

followed through March 2015 showed that after nine years, 16.7% were retained when considering retention within the specific clinic. This increased to 55% when considering retention within the health system (i.e. any clinic).³⁸ The NSP target was 94% retention after 12 months and 70% after 60 months. There is need for improvements in HIV diagnosis, treatment initiation and engagement in care to achieve the 90-90-90 target by 2020.

VIRAL LOAD SUPPRESSION IS LOW

By 2015, no district in South Africa had yet achieved the 90-90-90 target of viral suppression.³⁸ As shown in Figure 13, only 26% of PLHIV were virally suppressed.³⁸ The leakages in treatment cascades, loss to follow-up, as well as poor adherence contribute to the low viral load suppression.

LOW ART COVERAGE IN CHILDREN

ART coverage in children living with HIV remains comparatively low. In 2013 and 2014, the rates were reported to be 40% and 49% respectively.^{41, 42} Non-disclosure on the part of parent, lack of sufficient skills for paediatric ART and missed opportunities for HCT in other programmes such as maternal and Child Health (MCH) are the main factors for this low rate.

ACHIEVEMENTS

TREATMENT TARGET ACHIEVED

In the 2012-2014 period, the Department of Health (DOH) set annual targets to enroll 500,000 new clients on ART. In the two financial-years for which data were included in annual performance reports, the Department exceeded the targets by over 100,000 clients. This indicator has not been reported since 2014 (Table 13).

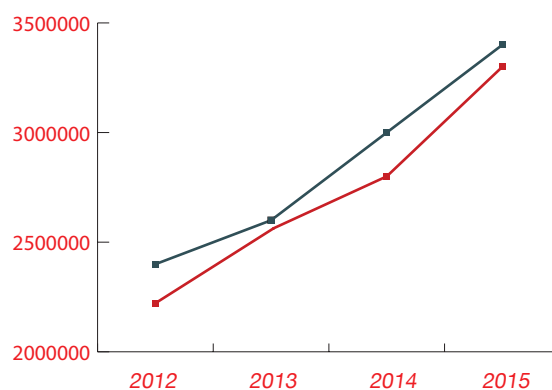
Table 13: Number of new clients started on ART, 2012-2015

Indicator	2012/2013	2013/2014	2014/2015
Number of new clients put on ART	612,118	662,312	Indicator not reported in subsequent years

(Source: DOH annual reports 2012/2013 and 2013/14)

South Africa's ART programme has expanded rapidly since it was launched in 2003 and it is currently the largest in the world. Between 2003 and April 2011, 1.4 million people were initiated on ART. But the expansion of the programme has been even more rapid between 2012 and 2015. Using Spectrum estimates, the total number of people on ART in South Africa in 2012 was 2,350,180. This figure increased to 3,384,160 in 2015. Hence from 2012 to 2015, there was a 44% increase in the total number of people on ART in South Africa (Figure 14).

Figure 14: Number of PLHIV receiving ART in South Africa, 2012-2016



	2012	2013	2014	2015
Spectrum	2150880	2623271	12894524	3318384
DOH	2350180	2658880	3050420	3384160

Source: DOH and UNAIDS Spectrum estimates 2012-2015

ART COVERAGE HAS INCREASED

The Human Sciences Research Council survey of 2012, conducted in the year the NSP 2012-2016 was launched, found that 2,002,000 out of 6,422,000 PLHIV were on ART. This represented a 31.2% treatment coverage, an increase from 16.6% observed in 2008. This 31.2% estimated from the HSRC survey of 2012 was used as the baseline for this review. Due to the expansion of the ART programme, coverage increased from 31.2% in 2012 to 52.7% in 2015. These percentages are similar to the UNAIDS estimates for South Africa. If these percentages were calculated using the number of PLHIV eligible for treatment, the 2015 figure would be 80%. This would mean that the NSP 2012-2016 target was achieved by 2015.

No of PLHIV on ART	ART coverage:	AIDS-related deaths
2,350,180 in 2012	31.2% in 2012	270,000 in 2012
3,384,160 in 2015	52.7% in 2015	180,000 in 2015

(Source: UNAIDS, 2016; Statistics South Africa 2015: DOH Reports 2012- 2015)

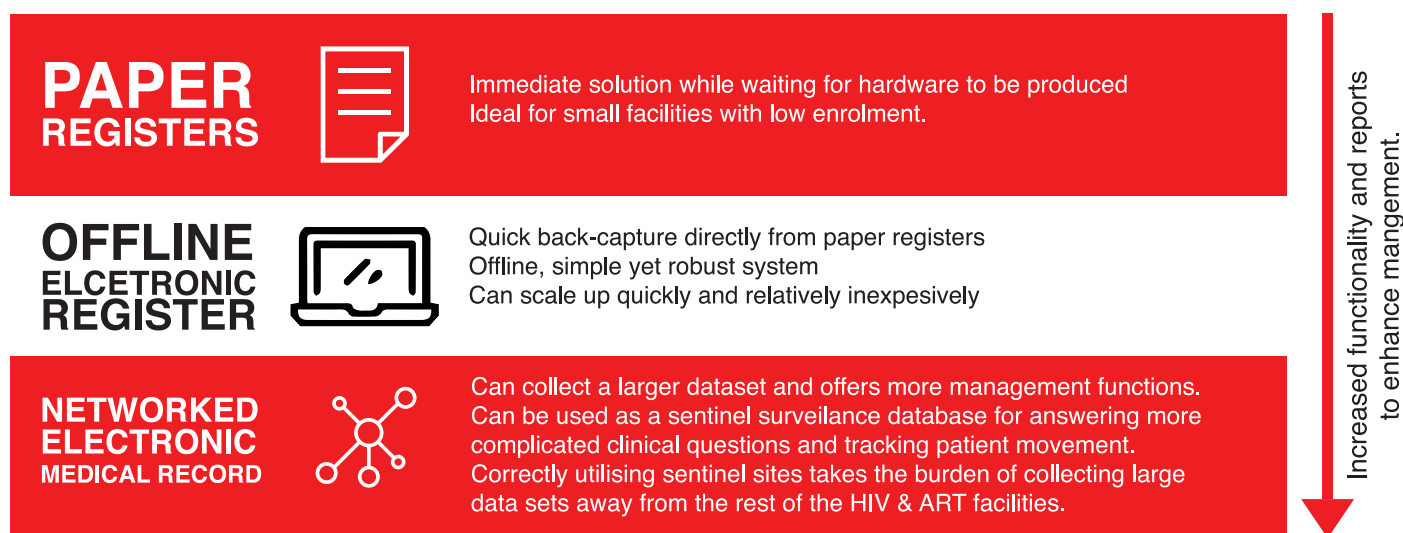
AIDS-RELATED DEATHS HAVE DECLINED

Figure 15 shows the number of HIV-related deaths reported in South Africa from 2012 to 2015 based on Spectrum estimates and Statistics South Africa report. According to Spectrum, an estimated 180,000 deaths related to AIDS were recorded in South Africa for the year 2015. The numbers for Spectrum are higher than the numbers reported by Statistics South Africa but both data showed a general decline in HIV-related deaths from 2012 to 2015. Statistics South Africa analysis shows that the percentage of all deaths attributed to HIV/AIDS declined from about 50% between 2004 and 2005 to about 30% in 2014 and 2015.

MONITORING AND EVALUATION

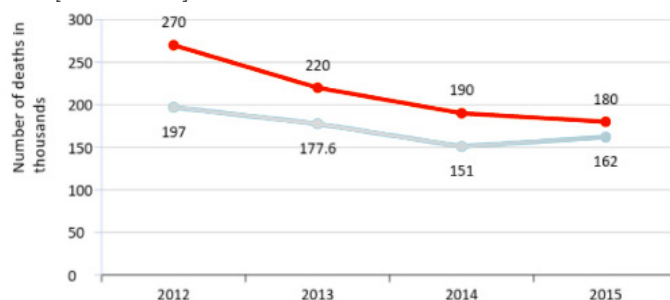
South Africa is one of the few high-HIV burden countries to have adopted a three-tiered approach to monitoring and evaluation of the national health system especially with regards to its ART programme. The three-tiered system combines paper-based and electronic data capturing systems for more effective programme data management and ART monitoring. The first tier is a paper-based system used by clinics that do not have the resources for a computerised system. The second tier is a non-networked electronic register while the third tier makes use of a networked computer network system (Figure 16).

Figure 16: Three-tier framework for monitoring ART, South Africa



(Source: Osler et al., 2014⁵)

Figure 15: Annual number of AIDS-related deaths, South Africa 2012-2015 [in thousands]



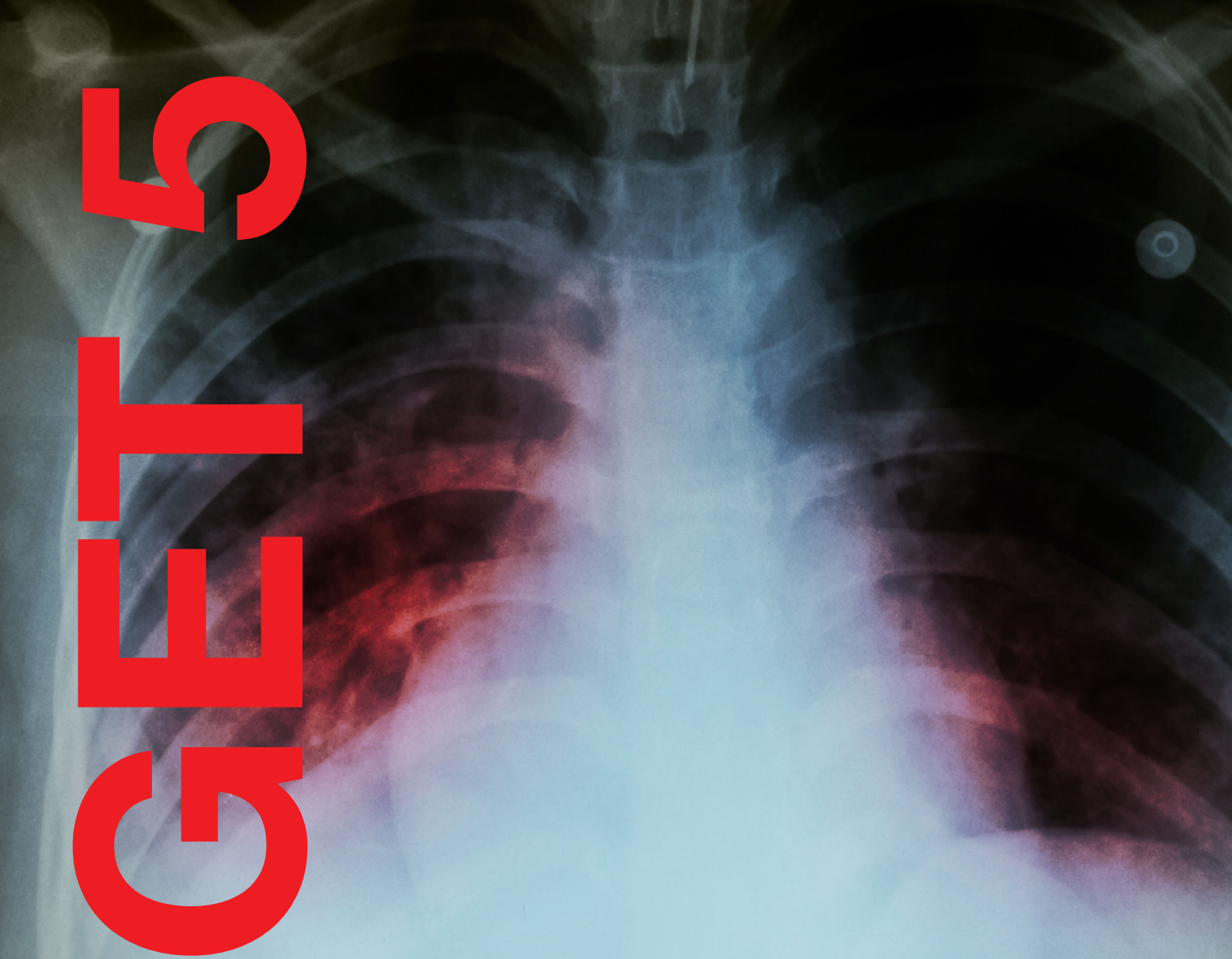
	2012	2013	2014	2015
Spectrum	270	220	190	180
Stats SA	197	177.6	151	162

(Source: UNAIDS, 2016; Statistics South Africa, 2015)

VIRAL LOAD MONITORING

South Africa's national guidelines provide for viral load monitoring (VLM) in patients on ART, in line with WHO guidelines, to ensure adherence, treatment success and choice of drugs. Of the patients who started ART in 2013 and completed 12 months of ART, 46.8% of them were previously reported to have had a viral load test. Of active patients on ART in 2014, 59.6% had a viral load done at 96 months in 2014.²⁵ These rates have increased recently, due to improvement in the data systems. Seventy-five percent of ART patients had received a VL test in the 12 months from April 2014 to March 2015.⁴³ The percentage of ART patients with one or more viral load tests during 2015 in South Africa was 87%.⁴⁴





5 THE GO TARGET

Target 5: To reduce tuberculosis deaths in people living with HIV by 50%

Is this a priority target area for the country?

Yes

Does the National Strategic Plan address this target?

Yes

Did the country reach the target and commitment?

No

POLICY ENVIRONMENT

The strategic guide for the response to the problem of TB for PLHIV is provided by the NSP 2012-2016. In addition, other guidelines have been developed, some of which are captured in Figure 17.

Figure 17: Target 5 policy timeline, South Africa

2012	2013	2014
NSP 2012-2016	Correctional facilities guidelines	National TB Management Guidelines

CURRENT STATUS

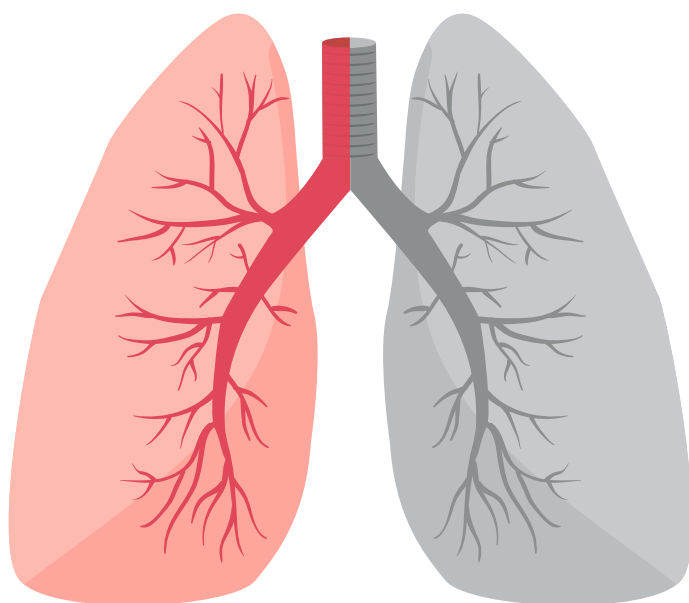
Table 14: Target 5 core indicators, South Africa 2012-2015

Indicator	Baseline 2012/2013	2013/2014	2014/2015	2015/2016
Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	New indicator	31.2%	73.7%	87.5%

(Source: DOH annual reports 2012/13 to 2015/16)

TB mortality remains a major public health burden in South Africa. In 2004, the number of deaths caused by TB in PLHIV was 99,000. This figure fell by 11% to 88,000 deaths in 2012.⁴⁶ The goal of the NSP 2012-2016 was to reduce the number of new TB infections and deaths by 50%. But in the year 2015, the number of deaths was 73,000, a 17% decline between 2012 and 2015. This means that South Africa missed this target by 33%.

The incidence of TB, inclusive of all forms, was estimated to be 454,000 in the year 2015. The rate of TB for the same year was estimated at 834 cases per 100,000 population. It can be seen from Figure 18 that the overall incidence of TB did not change much from 2012 (471,000) to 2015 (454,000). Out of the 454,000 new TB cases in 2015, 258,000 were in PLHIV.^{46, 47} This means that more than half of incident TB cases (56.8%) were reported for PLHIV. The occurrence of TB infections continues to be highly associated with HIV. Incident TB cases among PLHIV declined by 14% between 2012 (301,000 cases) and 2015 (258,000 cases). This means that the goal of the NSP 2012-2016 to reduce new TB infections among PLHIV by 50% was also not achieved.



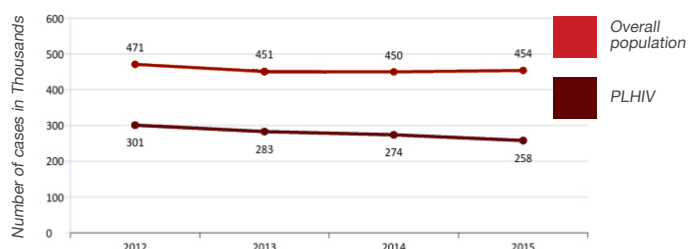
Number of TB deaths in PLHIV

88,000 in 2012
73,000 in 2015
17% decline
Target 50%

Number of new TB cases

301,000 in 2012
258,000 in 2015
14% decline
Target 50%

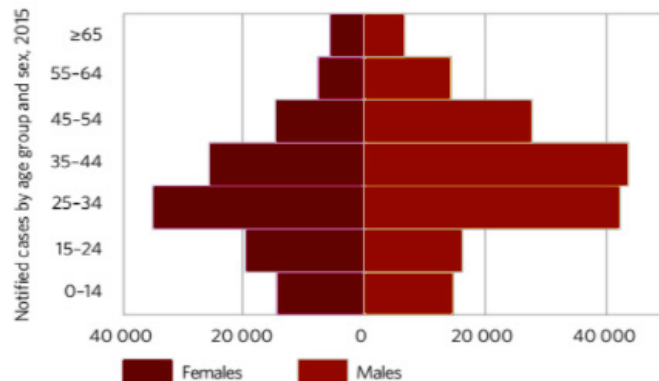
Figure 18: Incidence of TB (in thousands) in the general population and among PLHIV, 2012-2015



Source: WHO Global Health Observatory data 2016

The incidence of TB occurs at all age groups, but is most concentrated among adults aged 25 to 44 years. As Figure 19 shows, more TB cases were reported for men compared to women in this vulnerable age group.⁴⁷

Figure 19: Incidence of TB in the general population by age and sex, 2015



Source: WHO Global TB Report 2016

KEY ISSUES

HIGH TB MORTALITY IN PLHIV

The mortality burden caused by TB was considerably higher among PLHIV compared to HIV-negative TB patients. In 2015, 73,000 TB deaths occurred among PLHIV, while among HIV-negative TB patients, there were 25,000 TB deaths.

TB PROGRAMMES PERFORMANCE NOT OPTIMUM

The DOH annual report for 2015/16 shows that of the ten indicators and respective targets to measure the performance of the TB prevention, screening and treatment effort, four were achieved. This means overall, only 40% of intended achievements were accomplished. It is anticipated that the completion of development and implementation of some programmatic components of the TB control efforts, like the community-based patient tracing system, will improve the success rate for the achievement of set targets in the forthcoming reporting cycle.



ACHIEVEMENTS

TB-HIV INTEGRATION

The number of patients on integrated TB and HIV treatment increased by 76.7% between 2012 and 2015. There were 30,000 HIV-positive people with active TB who were on integrated treatment in 2012, and the number increased to an estimated 53,000 in 2015. The National DOH set a target of initiating treatment for 75% of TB/HIV co-infected clients in the 2015/2016 financial year and exceeded the target, as 87.5% were initiated.¹⁶

TREATMENT SUCCESS

As of 2016, 78% of the 319,752 new and relapse cases of TB infection registered in 2014 were successfully treated (Table 15).⁴⁷ This represents 249,406 people who were treated for TB. A similarly high success rate of TB treatment was achieved among PLHIV. Estimates from WHO TB data show that 76% of HIV-positive TB patients registered in the year 2014 have been successfully treated. Less than 50% success rates were realised among Multi-drug resistant/Rifampicin-resistant Tuberculosis (MDR/RR-TB) and Extensively drug-resistant Tuberculosis (XDR-TB) cases on second-line treatment registered in the year 2013. Over the last four years (2011 to 2014), improvements in treatment success rates among HIV-positive TB patients have been observed.

Table 15: Treatment success rate and cohort size

Category	Success	Cohort
New and relapse cases registered in 2014	78%	319,752
Previously treated cases excluding relapse, registered in 2014	63%	4,652
HIV-positive TB cases, all forms, registered in 2014	76%	183,697
MDR/RR-TB cases started on second-line treatment in 2013	48%	10,614
XDR-TB cases started on second-line treatment in 2013	24%	611

(Source: WHO Global TB Report 2016)

DOMESTIC FUNDING FOR TB PREVENTION AND TREATMENT

Most funding for TB prevention and treatment programmes comes from domestic sources. The national budget for TB programmes financing was US\$425 million 87% of which came from domestic sources while 8% was internationally funded and 5% was unfunded.

TB PROPHYLAXIS

The percentage of PLHIV, newly enrolled in care and were on preventive care in 2015 was 38%. Internationally, South Africa accounted for the largest share (45%) of PLHIV who were on preventive treatment for latent TB infection (LTBI).⁴⁷





GO THE G TARGET

To close the resource gap

Is this a priority target area for the country?

Yes

Does the National Strategic Plan address this target?

Yes

Did the country reach the target and commitment?

Yes



POLICY ENVIRONMENT

Health care financing is a critical component for the actualisation of national HIV response targets and the role of various stakeholders in driving this process cannot be overemphasised. It must be stated that South Africa remains at the forefront of countries (especially in Sub-Saharan Africa) with a fully funded government public health care system. There are a number of funding policy documents and structures for HIV/AIDS funding, ranging from the conditional grants funding model managed by the DOH to the National Development Plan, National Health Insurance (NHI) and partnership funding by the Global Fund and PEPFAR.

CURRENT STATUS

Table 16 Target 6, core indicators, South Africa, 2012-2015

Indicator	Source	Baseline 2012	2015/2016
Total government expenditure on health	National Treasury	11.5% ¹	14.0% ¹
Total government expenditure on HIV	SANAC	77.5% ¹	79.8% ²
Total health expenditure budget	National Treasury	11.9% ³	11.5%
Allocation from other development partners (Global Fund, PEPFAR etc)	SANAC	22.5% ¹	20.2% ²

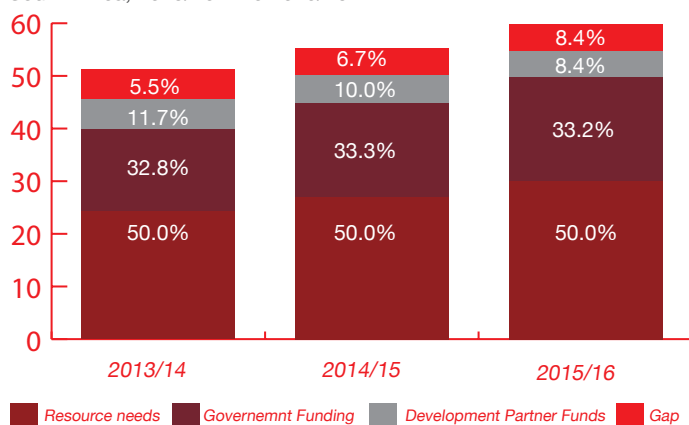
¹Source: SANAC, South Africa HIV/TB Concept Note; ²GAP report; ³National Treasury 2016 PWC

KEY ISSUES

HIV/AIDS FUNDING GAP

Although government funding for HIV/AIDS programmes has been increasing, the gap between resource needs and available funding continues to widen (Figure 20). The gap of R2.7 billion in 2013/14, doubled to R5.0 billion in 2015/16. The widening of the gap is explained by the government's expansion of HIV/AIDS, TB and STI services and dwindling partner funding.⁴⁸

Figure 20: Gap between resource needs and funding for HIV and TB in South Africa, 2013/2014 to 2015/16



(Source: SANAC, 2014)

ACHIEVEMENTS

INCREASING GOVERNMENT FUNDING FOR HIV/AIDS PROGRAMMES

Over the last five years (2011/12 to 2015/16), government funding for HIV/AIDS programmes through the Department of Health has increased from an expenditure budget of ZAR 7.95 billion in 2012/13 to ZAR 14.32 billion in 2015/16.¹⁶ It is noteworthy that funds for provincial HIV/AIDS intervention programmes constitute an integral part of government funding for HIV/AIDS across the country. This budgetary increase signifies the high level of government commitment to aggressively tackle the HIV scourge in the country (Figure 21). The Comprehensive HIV/AIDS Grant, which accounts for almost the entire HIV/AIDS budget has also increased substantially, from R8.8 billion in 2012/13 to R13.7 billion in 2015/16.

HIV/AIDS FUNDING GAPS ARE INCREASING

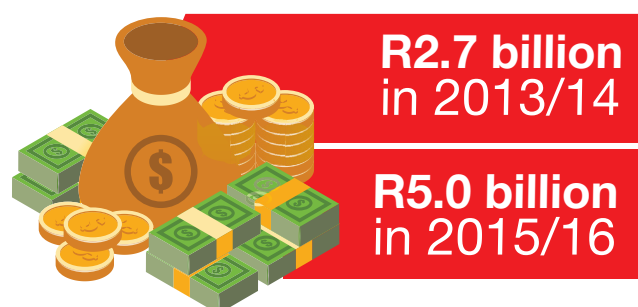
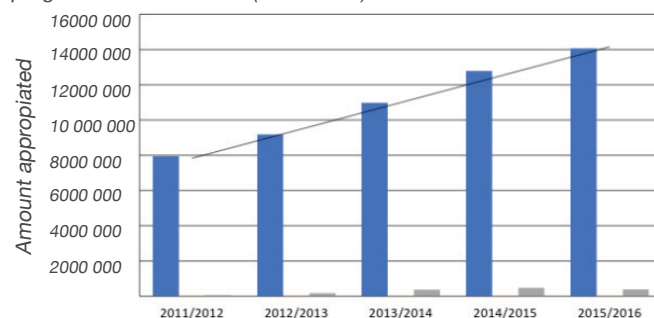


Figure 21: Final appropriated funds (thousands) for specific programmes within DOH (2012-2016)



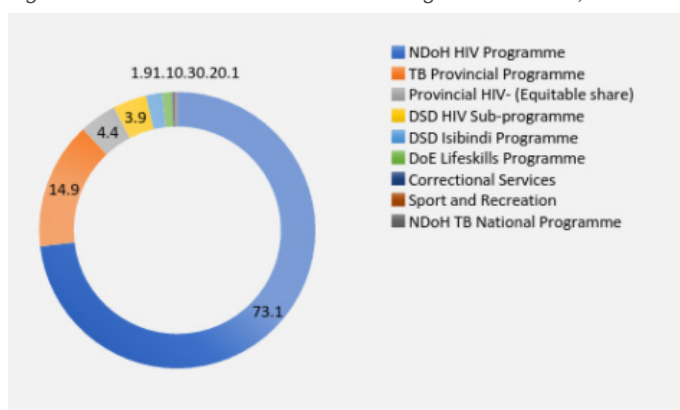
	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016
HIV/AIDS	7950551	9182503	10978412	12786142	14060158
Tuberculosis	17,954	20,510	24,778	23,455	22,989
Health Financing and NHI	49,355	172,956	366,499	483,460	393,789

(Source: DOH annual reports, 2011/12-2015/16)

HIV/AIDS FUNDS ARE FROM MANY GOVERNMENT DEPARTMENTS

Expenditure on HIV/AIDS by the DOH accounted for about three quarters of government expenditure in 2015/16 financial year. Other government departments contribute varying but smaller amounts towards HIV/AIDS spending in South Africa (see Figure 22 for 2015/16 relative contributions).

Figure 22: South African Government funding for HIV and TB, 2015/2016



(Source: SANAC, 2014)

PARTNERSHIP FUNDING FOR HIV/AIDS INTERVENTIONS

Although funding for HIV/AIDS intervention programmes in South Africa is overwhelmingly drawn from the government, this is complemented by funds from other sources, such as PEPFAR and the Global Fund. These two major funding partners account for about 25% of the overall expenditure, while other funders contributed less than 1% of total TB/HIV funding for South Africa. Partner funding has, however, been declining in the past five years.

SANAC – RESOURCE MOBILISATION UNIT

SANAC has continued to live up to the dictates of its mandate which entails coordinating programmes and interventions around HIV/AIDS across the various sectors and provinces in South Africa. The Resource Mobilisation Unit has more than doubled its efforts to harmonise funding strategies designed to respond to the HIV/AIDS pandemic in South Africa. Some of the initiatives that constitute an organic part of the activities and actions of the Resource Mobilisation Unit include amongst others:

- South African 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); and
- An Analysis of Funding, funding gaps and financial considerations (2014).

INVESTMENT CASE FOR SOUTH AFRICA

South Africa developed the Investment Case for HIV and TB as a veritable means to review programmes and interventions implemented in the country to reverse these epidemics across sectors. This has also been useful in creating more awareness regarding sensitive funding gaps that require filling and provides more opportunities for engaging or leveraging other funding avenues and donor resources.



1 GET GO TARGET

To eliminate gender inequalities

Is this a priority target area for the country?

Yes

Does the National Strategic Plan address this target?

Yes

Did the country reach the target and commitment?

No

POLICY ENVIRONMENT

According to a report by The Centre for the Study of Violence and Reconciliation (CSVR), South Africa was ranked fourth in Africa in terms of making progress towards fully comprehending and tackling issues that surround gender inequality.⁴⁹ Along this line, the South African government signed a number of policies to protect the rights of women and reduce gender based violence (GBV) – Figure 23. In addition, South Africa is a signatory of several international policies, for example, the Beijing Declaration 1995 and the Maputo Protocol (Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa) of 2003.

Figure 23: Target 7 policy timeline, South Africa



CURRENT STATUS

Table 17: Target 7 core indicators, 2012–2015

Performance indicator	2012	2015
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	All: 5.1% 15–19: 7.7% 20–24: 7.3%	No data

Source: (HSRC 2012)



As shown in Table 17, the 2012 HSRC survey reported that 5.1% of ever-married or partnered women aged 15 to 49 years experienced physical or sexual violence from a male intimate partner in the last 12 months (7.3% among women aged 20 to 24 years). Apart from the HSRC survey, there is no survey data representative of the South African population that reported intimate partner violence (IPV) in the last five years. A 2011 SANAC-commissioned study on GBV in four provinces showed that past-year IPV varied from 6% in the Western Cape and Limpopo provinces to 13% in Gauteng.⁵⁰ These figures are close to, but higher than, the 5.5% reported in the 2012 HSRC survey.

KEY ISSUES

HIGH LEVELS OF GBV

Although available data are difficult to compare, they show that GBV still remains a problem in the country. Some studies report that up to 40% of South African women have experienced sexual and/or physical interpersonal violence in their lifetime.⁵¹ Furthermore, estimates suggest that up to half of all women in South Africa will be raped in their lifetime and that 25% of girls are likely to be raped before the age of 16 years.⁵² A study conducted by the MRC in three provinces of South Africa found that 1 in 4 women in the general population have experienced physical violence at some point in their lives. Intimate partner violence is equally as common. The levels of IPV are also high among PLHIV. A study of 623 HIV positive women initiating ART in a Cape Town clinic revealed that 21% experienced IPV in the last 12 months.⁵³

Although plagued with underreporting, crime statistics are useful for comparing trends over time. South African crime statistics show that reported cases of rape are on the decline, albeit at a slow rate. Between 2008/9 and 2014/15 recorded cases dropped by only 7.4%, from 46,647 to 43,195. With regards to the trends in overall sexual offences, the South African Police Service (SAPS) reported 60,888 cases in 2012/13 and 51,895 in 2015/16, representing a 15% decline. The data showed that sexual violence was the most common form of GBV.⁵⁴

CULTURAL PRACTICES THAT FUEL GBV

Gender inequality, due to its social and cultural context is multifaceted. Religious beliefs, customs and cultural traditions sometimes increase HIV infection risk among women and young girls through GBV. For example, young women in rural areas may be exposed to HIV/AIDS due to cultural practices like “ukhuthwala” and virginity testing. Ukhuthwala describes the culturally legitimate abduction of a female with the intention of marrying her. Often, the females in question are young girls who are abducted by older men, thus putting them at risk of HIV acquisition. Similarly, studies have shown that virginity testing, which can be argued to be an expression of gender inequality puts young girls at risk of being raped, mainly because perpetrators believe the myth that having sexual intercourse with a virgin cures HIV/AIDS. The public health response to GBV in South Africa will have to address such cultural issues.

ACCESS TO HEALTHCARE

Women and girls, especially those in rural areas, may face barriers to health access mainly due to the gender roles assigned to them. Often, this is done through restricted movement and autonomy in making health decisions. Women and girls may also lack the resources to access healthcare due to their disadvantaged living context and socioeconomic status. Also important, is a culture of silence related to sexual and reproductive health issues, including HIV/AIDS.

RESPONDING TO EMERGING EVENTS

In 2016, there was a public uproar when the “blesser-blessee” practice gained prominence in South Africa. Although not entirely new, it recently gained popularity through social media. While South African laws on sexual offences prohibit adults from engaging in sexual relations with children under the age of 18 years, an offence termed statutory rape, timely public health responses are needed to address such events as they occur.

AWARENESS OF SERVICES

It is notable that many adults in South Africa are not aware of what to do or where to go to seek help when experiencing or observing GBV. According to the National Communications Survey (NCS) of 2012, 27% of adults knew of services available to women who have experienced violence in the home.



Only 27% of adults in 2012 knew of services available to women who have experienced violence in the home

LACK OF DATA

It is difficult to assess the exact extent, patterns and trends of GBV in South Africa for a number of reasons. Firstly, GBV is determined differently across studies. Some measures include IPV, assault, and rape. Secondly, there are few nationally representative surveys that report GBV measures, the most recent being the 2012 HSRC survey which reported IPV. The 2008 HSRC survey did not report IPV, making it difficult to compare change over time. Thirdly, GBV reported in different studies is usually self-reported and the questions are not always standardised and the reference periods sometimes vary.

ACHIEVEMENTS AND HIGHLIGHTS

GOVERNMENT-INITIATED INTERVENTIONS

There are a number of services offered to women by the government, through the Department of Social Development (DSD) to eliminate gender inequalities in South Africa. The government social protection programme, which 85% of the beneficiaries are women, is important for addressing gender inequalities. Another intervention is the establishment of Thuthuzela Care Centres (TCCs) which are run by the DSD together with other government departments including Justice, Health, Education, Treasury, Correctional Services, Safety and Security, Local Government, and Home Affairs. The TCCs are in operation in public hospitals in communities mainly where rape incidence is particularly high and have become a critical component of South Africa's anti-rape strategy, reducing post-rape trauma for the victims and improving conviction rates.

THE GOVERNMENT IS WORKING

85% of social grants recipients are women

Yet another intervention is the Hlayisani White Door Centre of Hope which the DSD launched in Mpumalanga province in 2015. The main purpose of the centre is to provide temporary shelter, food and clothes to abused women. The centres have blossomed in other provinces and the Eastern Cape currently boasts of 100 White Door Centres. Other government departments have initiated other programmes to address gender inequality. An example is the B'avumile Skills Development Initiative of the Department of Trade and Industry.

CONCERTED AFRICAN EFFORT

The African Union declared 2015 as the year of Woman Empowerment and Development towards Africa's Agenda 2063. At the summit held for this declaration, heads of states pledged to eliminate all barriers to political, social and economic participation faced by African women by 2020.

AWARENESS CAMPAIGNS

The "16 Days of Activism for No Violence against Women and Children" is an international awareness campaign that takes place every year in South Africa and is aimed at eliminating GBV. South Africa adopted the campaign in 1998 as one of the intervention strategies towards creating a society free of violence against women.

LEGISLATIVE EFFORTS

It is also important to acknowledge the strides that have been taken by the South African government in updating the policies to protect young women, girls and children. In 2012, the Department for Women Children and People with Disabilities (DWCPD) initiated the Women Empowerment and Gender Equality (WEGE) Bill. The main purpose of this bill was to ensure women's access to basic health care and most importantly, sexual reproductive health and rights. There have also been policies that seek to address the underlying socioeconomic inequalities, such as the Strategic Framework for Gender Inequalities within the Public Service (2006-2015).

NGOS' WOMEN'S EMPOWERMENT PROGRAMMES

There are a number of programmes initiated by NGOs to empower young girls and women in South Africa. In 2016, The Soul City Institute launched the RISE young women's programme which aims to use social mobilization, advocacy and mass media to empower young women by building their sense of autonomy. The ZAZi campaign under the leadership of the SANAC Women's Sector addresses a number of HIV-related issues including GBV. Like RISE, the ZAZi Campaign, launched in 2013, encourages women and girls to draw on their inner strength, power, and self-confidence to know themselves and what they stand for in order to guide the decisions they make about their future.

OTHER PROGRAMMES

There are a number of other programmes aimed at eliminating gender inequalities which include men and other population groups as their target. For example, the Stepping Stones and Creating Futures programme which target 18 to 24 year old men and women started in 2014 and aims to reduce IPV, encourage sexual health and improve the psychological well-being of youths living in urban informal settlements in South Africa.



80

THE

GOAL

TARGET

AREA

To eliminate stigma and discrimination against people living with HIV

Is this a priority target area for the country?

Yes

Does the National Strategic Plan address this target?

Yes

Did the country reach the target and commitment?

No



POLICY ENVIRONMENT

In South Africa, HIV stigma continues to be an important factor of HIV incidence and HIV-related deaths. South Africa's response therefore finds it necessary to recognise the importance of human rights and constitutional values with respect to this target (Figure 24).

Figure 24: Target 8 policy timeline, South Africa



CURRENT STATUS

Table 18: Target 8 core indicators, South Africa, 2014

Core Indicator	2012	2013	2014	2015
Percentage of men and women aged 14-49 who report discriminatory attitudes towards PLHIV	No data	No data	Internal Stigma among PLHIV: 43% External Stigma among PLHIV: 35.5%	No data

(Source: People Living with HIV Stigma Index Survey in South Africa 2014)

The People Living with HIV Stigma Index Survey, conducted in 2014 among PLHIV aged 15 years and above in all nine provinces of South Africa, reported overall internal stigma to be 43% and overall external stigma 35.5% (Table 18). Female respondents and those who were aged 15 to 24 years reported higher levels of internal and external stigma. Furthermore, the study was the first to report on TB-related stigma in South Africa. A third (34%) of the respondents never disclosed their TB status outside of the household, while 36% reported being teased, insulted or sworn at because of their TB status.⁵⁵

PLHIV AGED 15 YEARS AND ABOVE



KEY ISSUES

HUMAN RIGHTS, POLICY & SUPPORT

The need for policy and support for human rights in the national response has received increased attention. This was also highlighted in the 2012 critical review of the NSP 2012-2016 by the AIDS Legal Network. This is especially important for women who are more likely to experience HIV-related discrimination.

Women may be blamed for bringing HIV into the family. They may also face particular stigmas related to pregnancy and childbirth, such as, being held responsible for infecting their children. Negative consequences of HIV disclosure for women include abandonment by their partners and violence. Women have reported that they have been coerced into sterilisation on the basis of their HIV status. A 2012 South African study for the Her Rights Initiative interviewed 22 women who were forcibly sterilised with no justice. Eighteen of these women were coerced into signing consent waivers, which protected the medical staff from any form of liability.

ACHIEVEMENTS

REDUCING LEVELS OF STIGMA AND DISCRIMINATION

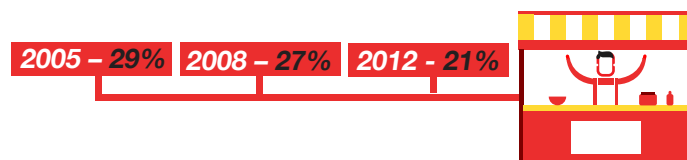
Although, the levels of overall stigma reported in the 2014 PLHIV Stigma Survey were high, two things should be noted. Firstly, the results are not easily comparable to previous national surveys. Secondly, levels of stigma when using individual stigma items (as opposed to composite stigma) were low.

For example, the majority of respondents reported never having been excluded from social gatherings (90-97%), verbally assaulted and harassed (84%); physically harassed (91%) or ever having experienced psychological violence (92%) in the last 12 months.⁵⁶ These results are similar to those from the NCS 2012 which showed that 87% of the respondents agreed (or strongly agreed) that they will remain friends with someone living with HIV/AIDS.

Results from consecutive HSRC surveys, which allowed for comparison over time, showed that the levels of stigma have been on a slow decline in the past decade. For example, in 2005, 2008 and 2012, the percentage of respondents who would not buy food from a food seller they knew had HIV was 29%, 27% and 21% respectively.

ARE STIGMA LEVELS REDUCING?

The percentage of respondents who would not buy food from a food seller they knew had HIV



STIGMA MITIGATION FRAMEWORK

South Africa has done well in developing the Stigma Mitigation Framework (SMF) within which stigma mitigation strategies and monitoring of impact can be conducted. This national framework is to ensure that HIV-related stigma and discrimination is adequately combated through multi-sectoral efforts. Although the framework has been under development for over a decade, there has been traction in the last two years to implement it.

MONITORING AND EVALUATION

In 2014, South Africa conducted the first national stigma and discrimination survey. This means that standardized tools and baselines research data now exist for monitoring this target in the population. This survey comprised more than 10,000 participants living with HIV and was commissioned by SANAC's PLHIV sector through the Human Rights Technical Task Team.

STRENGTHENING LEGAL INTERVENTIONS

The South African Human Rights Commission's Flowcentric Complaints System has been upgraded to improve the handling and investigation of complaints of human rights violations. The upgrade included training of legal officers and data capturers to improve the effectiveness of complaints handling and achieved finalisation for 93% of the 9,217 cases received in the 2014/15 financial year.⁵⁷ In 2015, SANAC announced a number of measures to tackle different forms of stigma and discrimination faced by people affected with HIV and/or TB. These measures include legal advice and litigation services offered through the nationwide network of Justice Centres run by Legal Aid South Africa.

EXPANDING ART AND OTHER PROGRAMMES

The progressive expansion of the ART programme in South Africa can be viewed as a contributory intervention for reducing stigma since it reduces HIV symptoms, absenteeism from work, weakens the link between AIDS and death, and enhances the overall quality of life. Also, one of the arguments for making HIV home-based test kits accessible to the public is that, individuals will be able to purchase HIV test kits, in the same way they purchase pregnancy test kits, thereby promoting the normalisation of HIV and decreasing stigma.

OTHER STIGMA INTERVENTION PROGRAMMES

A number of programmes aimed at eliminating stigma are being implemented in South Africa. The Siyam'kela Project, is one of such programmes. The main purpose of the project is to pave the way for a stigma mitigation process by developing well-researched indicators for HIV/AIDS-related stigma and discrimination. World AIDS Day is very symbolic and is commemorated to address HIV-related stigma and discrimination. Soul City edutainment TV programmes have addressed issues relating to AIDS, including living positively and HIV-related stigma and discrimination.



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To eliminate HIV-related restrictions on entry, stay and residence

Is this a priority target area for the country? **Yes**

Does the National Strategic Plan address this target? **Yes**

Did the country reach the target and commitment? **Yes**



POLICY ENVIRONMENT

South Africa has no HIV-related travel restrictions as the country's goal is to ensure that comprehensive and specialized health care services are available and accessible to all South Africans and immigrants within the country. The South African Immigration Act of 2002 does not discriminate against any person by refusing entry, stay or residence into and within the country based on one's health status.⁵⁸ However, immigrants seeking temporary residence are screened for TB and, if positive, are placed on TB treatment.

South Africa does not discriminate against any person by refusing entry, stay or residence into and within the country



CURRENT STATUS

Health care services are rolled out in public health facilities to South Africans and immigrants. Given the advanced health care system in South Africa, a good number of immigrants gain entry into the country for general and specialized health care services and there have been no reports of denied service provision to migrants on grounds of their HIV status. In fact, the 2002 Immigration Act (Section 16) permits foreign nationals to apply for medical treatment visas which allow them access to medical care in the country.

Furthermore, medical tourism has become a popular term within migration, and South Africa is a major destination. The majority of medical tourists to South Africa are from within Africa - the so-called South-South migration which accounts for 80% of the total medical travel flow to South Africa. Fewer medical tourists from Europe and the Americas also visit the country. The high rate of medical tourism to South Africa (especially from neighboring Southern African countries) can be linked to the high prevalence of HIV/AIDS in the region and the lack of adequate health care provision within these countries compared to South Africa. These movements are both formal (institutional) and informal (individual) in nature.

ACHIEVEMENTS

LEGAL PROVISION FOR UNIVERSAL HEALTHCARE ACCESS

The Bill of Rights enshrined in the South African Constitution, is the supreme legal instrument in South Africa that provides for the civil, political, and socio-economic rights of all who reside in the Republic. It stipulates that everyone has the right to access health care services, including reproductive health care. With specific reference to immigrants, the 2002 Immigration Act provides the framework for various categories of immigrants to access the Republic. The Act is also complemented by a plethora of immigration policy documents, white and green papers developed by the Department of Home Affairs, to guide immigration issues within South Africa. In the same vein, the 2015 National Health Insurance (NHI) White Paper makes provision for foreigners with "refugee" and documented "asylum seeker" status to receive basic health coverage under the NHI. This provision does not mention any restriction based on an individual's HIV status.

In light of this, issues of restrictions based on HIV/AIDS status constitute a breach of the Constitution and are therefore not contained in the South African Immigration Act or any policy regarding immigrants. Thus, although prospective immigrants applying to enter South Africa are required to be screened for TB (through radiology assessment) and to undertake a general medical examination to ascertain overall well-being, these assessments are not used to restrict prospective immigrants from accessing the Republic but for surveillance and for treatment, in the case of TB.

THE NATIONAL STRATEGIC PLAN (2012-2016)

The government, in its efforts to tackle the scourges of HIV and TB in South Africa, through the NSP, prioritized migrants (including cross-border migrants) and identified key focal areas to provide health facilities such as farms, border areas, as well as, informal settlements. The NSP identified that conditions associated with migration increase the risk of HIV and TB infections, thus highlighting the need for progressive discussions for more effective management of health service provision for migrant populations.



TARGET 10



To eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in health and development efforts.

Is this a priority target area for the country?

Yes

Does the National Strategic Plan address this target?

Yes

Did the country reach the target and commitment?

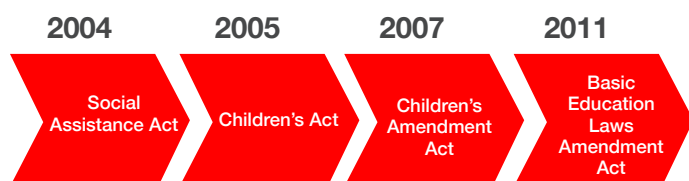
Yes



POLICY ENVIRONMENT

South Africa's NDP Vision 2030 aspires to eliminate poverty and reduce inequality in the country through economic growth and expansion of the reach of social development. An aspect pertinent to social development is HIV integration. Strengthening HIV integration involves broadening the scope of the HIV response, incorporating it in the wider health systems framework and other non-health socio-economic developmental programmes. In South Africa, the DSD, which is mandated to coordinate and implement programmes aimed at improving the social circumstances of vulnerable populations, plays the central role of strengthening HIV integration. The DSD is complemented by the DoH and the DBE. These three departments form the critical Social Needs Cluster Departments (SNCDs) and are respectively guided by complementary policy frameworks that contribute towards strengthening HIV integration. In the light of the SNCDs' respective mandates, HIV integration in South Africa renders itself to several policies (Figure 25).

Figure 25: Target 10 policy timeline, South Africa



CURRENT STATUS

South Africa has managed to meet its core targets for indicators set as monitoring measures for assessment of progress towards Target 10. The HSRC survey of 2012 showed that more than 99% of HIV/AIDS orphans aged between 10 and 14 years were enrolled in either primary or secondary school. This means that these children, who fall within the age range of compulsory school attendance, are not negatively affected by their orphanhood status in as far as access to formal education is concerned.

Table 19: Target 10 core indicators, South Africa, 2015

Performance indicator	Source	Baseline	2015
Current school attendance rate of orphans aged 10 - 14 (primary/secondary school age)	SABSSM survey, 2008/2012	98%	99.5%
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	SABSSM survey, 2008/2012	98%	99.3%

ACHIEVEMENTS

LEGISLATIVE AND POLICY DEVELOPMENTS TO PROMOTE AND SAFEGUARD SEXUAL, REPRODUCTIVE, HEALTH AND HUMAN RIGHTS AMONG CHILDREN AND YOUTHS

South Africa has prioritised the livelihoods and welfare of children and youth as demonstrated by amendments of relevant policies for protection and promotion of the rights and interests of young people. In the recent years, there have been amendments to the Sexual Offences Act No.6 of 2012⁶⁰, Criminal Law (Sexual Offences and Related Matters) Amendment Act No.15 of 2015⁶¹, and Prevention and Combating of Trafficking in Persons Act No.7 of 2013.⁶² Traditional practices like ukuthwala no longer constitute valid defence against criminal charges of child trafficking and rape. In 2015, the National Adolescent Sexual and Reproductive Health and Rights (ASRH&R) Framework Strategy (2014–2019) was finalised. The ASRH&R focuses on several priority areas that include creating effective community supportive networks for adolescents; and formulating evidence based revisions of legislation, policies, strategies and guidelines on ASRH&R. Furthermore, the Department of Basic Education has, during the lifespan of the NSP 2012–2016, developed a National Policy on HIV, STIs and TB which aims to reduce the incidence of infections among learners thereby enhancing their learning and development.

MITIGATING THE IMPACT OF HIV AND TB ON ORPHANS, VULNERABLE CHILDREN AND YOUTH

In South Africa, children aged below 18 years are the most affected by poverty with 63% living in households below the upper bound of the poverty line in spite of rates of poverty having been on the decline in the past decade. According to The United Nations International Children's Emergency Fund (UNICEF), there are about 3.7 million orphans in South Africa, with more than 50% having lost their parents to HIV/AIDS mortality.⁶³ As of 2014, most orphans in South Africa lived in poor households. Further, 150,000 children are estimated to be living in child-headed households. Besides orphanhood and poverty, children and youth in South Africa experience several vulnerabilities such as physical and sexual abuse, living with HIV, disability and exposure to drug abuse. Commitments to address these and other vulnerabilities have been made in the past five years. The social assistance programme has contributed towards the decline in the levels of poverty among children.

SOCIAL GRANTS

The number of people covered by social grants has been increasing during the lifespan of the NSP 2012–2016. There were about 16 million social grant recipients in the 2012/13 financial year and this increased to almost 17 million by end of the 2015/16 financial year.⁶⁴ The majority of beneficiary children (92.2%) lived with the caregiver in the same household. South Africa also increased social assistance spending annually over the past five years. With each financial year, total spending on social assistance increased by more than 5 billion. The increased spending on social grants implies increased commitment

Table 20: Social assistance spending 2012/13 to 2015/16, SASSA 2016.

Category	2012/13	2013/14	2013/14	2014/15
Old Age	40 475 021 000	44 064 239 000	49 039 940 000	53 132 206 342
War Veteran	9543000	7657000	6157000	4843209
Disability	17 636 570 000	17 768 631 000	18 741 885 000	19 165 931 340
Foster Child	5 335 049 000	5 332 093 000	5 413 209 000	5 406 785 714
Care Dependency	1 877 412 000	1 993 084 000	2 211 583 000	2 394 455 743
Child Support	38 087 990 000	39 623 748 000	43 718 425 000	47 308 536 379
Grant In Aid	237 974 000	274 092 000	371 121 000	503 080 357
Social Relief of Distress	239 289 000	533 047 000	455 718 000	407 015 691
Total	103 898 848 000	109 596 591 000	119 958 038 000	128 322 854 775

(Source: SASSA Annual Report 2015/16)

3.7 MILLION ORPHANS

Current school attendance rate of orphans

AGED 10–14 99.5%

Current school attendance rate of non-orphans

AGED 10–14 99.3%



RETAINING YOUNG PEOPLE IN SCHOOLS AND PROVIDING POST-SCHOOL EDUCATION AND WORK OPPORTUNITIES

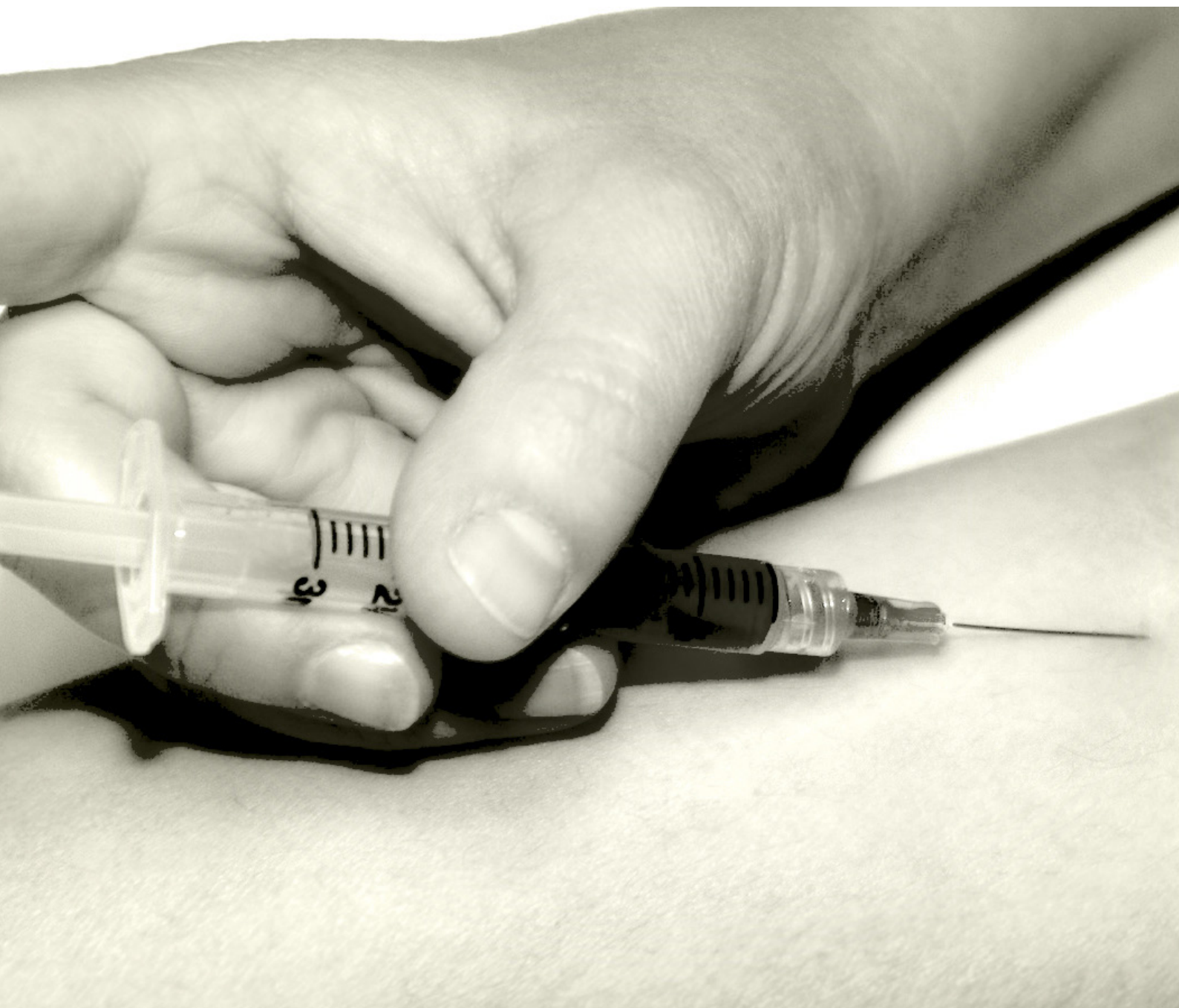
Retaining young people in school reduces the risk of HIV. Concerns about learner retention in school remain prominent in South Africa especially with regards to girls and young women who are a vulnerable group to HIV. It has been observed that the majority of girls who drop out of school do so due to pregnancy. For example, the National Income Dynamics Survey found that an estimated 33% of girls who dropped out of school between 2010 and 2014 did so because of teen pregnancy and childbirth. In response to the problem of school dropout, the DBE launched the Keeping Girls in School (KGS) programme. The programme has three main goals, namely: to decrease new HIV infections in girls and young women, decrease teenage pregnancy and to retain girls in school until final year in secondary school.

NATIONAL YOUTH POLICY

There have been two generations of the National Youth Policy (NYP) with the first one drafted for the 2009-2014 period. Currently, South Africa is in its second generation NYP which covers the 2015-2020 period (NYP2020). The motivation for the NYP is the high youth unemployment rate which needs to be addressed in order to fight the adverse effects of HIV/AIDS in the country. The policy acknowledges the gendered high morbidity and mortality rates among the youth due to HIV/AIDS. The NYP2020 was drafted in alignment with the NDP Vision 2030 policy framework and is geared to building on NYP2014.

SUPPORT FROM INTERNATIONAL ORGANISATIONS

UNICEF is supporting South Africa's government in its role to provide adequate services that reach the most vulnerable children. To this end, UNICEF helps with the development and implementation of national strategies and systems. Priority areas include training, monitoring and evaluation, accessing birth registration and social grants, ensuring sufficient reach of prevention and early intervention services, and strengthening alternative care systems for children deprived of family care.



BEST PRACTICES

POLITICAL LEADERSHIP

South Africa's political leadership continue to provide motivation and support for the national response to the HIV epidemic. This is demonstrated through public commitment and HIV prevention messaging from political leaders, HIV/AIDS funding and policy and programmatic responses. SANAC, with the country's Deputy President as Chairperson, continues to consolidate the country's political leadership in the fight against HIV/AIDS. In 2015, President Jacob Zuma welcomed a UNAIDS report, "How Aids Has Changed Everything – Meeting the MDG Targets" on the progress made by South Africa in the fight against HIV/AIDS, but cautioned South Africans not to put their guard down yet.

UPDATED POLICY ENVIRONMENT

This synthesis showed that South Africa has an enabling policy environment to achieve all ten targets. The policy context often derives from laws enshrined in the country's constitution or from international guidelines. In most instances, the country has specifically designed policies in response to the epidemic. One good example of the enabling policy environment is the country's rapidly updated treatment guidelines for pregnant women and mothers to achieve the elimination of mother-to-child transmission.

ELIMINATING MOTHER-TO-CHILD TRANSMISSION

One of the greatest highlights of the national response in the past NSP term was that by 2015, the country had achieved the elimination of mother-to-child transmission which is defined as a reduction of transmission to such low levels that it no longer constitutes a public health problem (measured as <2% rate of MTCT of HIV at 6 weeks and <5% at 18 months). This was achieved through evidence-based accelerated programme scale-up within a national framework that included monitoring and evaluation.

ELIMINATION OF GENDER INEQUALITIES

Eliminating gender inequalities is central to ending HIV/AIDS in South Africa. It is therefore commendable that the country's response has given focus to policy and structural interventions, as well as empowerment programmes, that aim to eliminate gender inequalities. There currently exist a number of government-initiated programmes, like the Thuthuzela Care Centres (TCCs), empowerment programmes that target women and girls, as well as those that target men and boys. Female sex workers have also received increased attention in the last three years with respect to access to prevention and treatment services, eliminating human rights abuses and improving M & E.

MAJOR CHALLENGES

PREVENTION

HIV RISK BEHAVIOURS ARE NOT ABATING

Despite the many HIV prevention programmes in South Africa, early sexual debut, multiple sexual partnerships and unprotected sex have not declined in the general population. The levels of some behaviours have actually increased. Risk behaviours are also high among MSM and PWID. The high and increasing levels of these behavioural drivers portend high HIV incidence with time and indicate that South Africa needs to think critically about its HIV prevention strategies.

KEY POPULATIONS (INCLUDING WOMEN AND GIRLS)

Key populations have received increased attention in South Africa between 2013 and 2015. However, many continue to face discrimination and stigma and experience barriers to seeking healthcare. For key populations like FSW and PWID, these vulnerabilities derive from the criminal status of their activities. Yet for other key populations like MSM, women and girls, it is due to marginalization arising from social norms. These differences in underlying causes of vulnerabilities are important for designing evidence-based interventions.

VOLUNTARY MEDICAL MALE CIRCUMCISION

The levels of circumcision among men remain low, despite increasing trends. According to the 2012 NCS, only 54% of men were circumcised (46.4% in the 2012 HSRC survey). Cumulatively, 1.7 million circumcisions were done from 2012/13 to 2015/16. This achievement pales in comparison to the target of 4.3 million circumcisions by 2015. A number of factors are responsible for this. Firstly, knowledge of HIV risk-reduction provided by VMMC is only moderate. Secondly, the doctor-centered approach of the programme has limited its expansion. Thirdly, there has also been resistance to VMMC from some traditional leaders.

PEOPLE WHO INJECT DRUGS (PWID)

Despite recent progress in the policy environment around drug use, the political landscape remains a difficult one. More efforts have been put into criminalization and policing than into harm reduction among users. As a consequence, PWID have been relatively left behind in South Africa's response to HIV. HIV prevention and harm reduction services are low. Although some NGOs now provide HIV prevention and harm reduction services, the reach is still low and not all services are provided. There are still currently no OST programmes.

TREATMENT, CARE AND SUPPORT

LOW ART COVERAGE IN CHILDREN

Despite the extremely high PMTCT coverage in South Africa (>95%), ART coverage in children living with HIV remains comparatively low. In 2013 and 2014, the rates were reported to be 40% and 49% respectively. Non-disclosure on the part of the parent, lack of sufficient skills for paediatric ART and missed opportunities for HCT in other programmes, such as MCH, are the main factors accounting for this low rate.

RETENTION IN CARE

Retention of PLHIV in care remains a challenge in the HIV care and treatment programme. The percentage of adults lost to follow-up after 12 months was 27% among patients who started ART from January to December 2013. Data from the DOH complete to 120 months indicate that retention in care declined from 79% in clients at six months ART to 48% in clients at 60 months.

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. In 2015/16, 22% of MDR TB patients were lost to follow-up. Also, treatment outcomes remain poor with MDR-TB treatment success rate of 47%, mortality rate of 22%; XDR-TB treatment success rate of 20.8% and mortality rate of 40.3% in 2011 (DOH Annual Report: 2013/2014).

IMPACT ALLEVIATION

ADEQUACY OF RESOURCES FOR THE MULTISECTOR RESPONSE

Despite existing funding mechanisms and increasing domestic funding for HIV and TB programmes, the gap between resource needs and available fund has widened. The gap is likely to widen further as the government widens its prevention and treatment programmes. This is compounded by disappointment from civil society on the allocation of funding for programme implementation. Civil society argues that funding for HIV/AIDS interventions is primarily for large-scale government-led interventions and is not fairly and equitably distributed to them.

ELIMINATING GENDER INEQUALITIES AND STIGMA

Despite government's concerted efforts to eliminate gender inequalities, some issues still exist. It should be admitted that enormous work will be required to eliminate inequalities and stigma as these are social events. More so, they are difficult social constructs to measure. Although SANAC has done significant work in developing a framework for measuring and monitoring these outcomes, more work will be needed to reduce their levels in the community

REMEDIAL ACTIONS

PREVENTION

EVIDENCE BASED INTERVENTIONS FOR SEXUAL RISK BEHAVIOURS

There is urgent need for evidence-based interventions that address the high and rising HIV sexual risk behaviours in the country.

EARLY SEXUAL DEBUT AND INTERGENERATIONAL SEX

Social behaviour change communication (SBCC) programmes that use mass media, social media, community dialogues and other approaches will be important to address behavior change. Interventions that address structural inequalities that lead to these behaviours are also needed. The government's social protection programme is important for this. Other interventions that provide economic empowerment to women and out-of-school girls are needed. Also, research data show that interventions that keep girls in schools are important for reducing HIV acquisition in this group.

The national response should consider more programmes, like The Zazi Campaign and DREAMS, which empower young women with life skills for making sexual and reproductive health decisions. The government's school health programme is particularly important for this and should be continued and strengthened. Interventions that address the source of infections for young women and girls, which are mainly older men, are needed. In addition, MSP and unprotected sex were particularly high among younger men, among whom young women are likely to select sexual partners.

CONDOM USE

Although knowledge of condom use is excellent, actual condom use is only moderate to high. The national response will need to consider expanding SBCC programmes to maintain and increase the levels of condom use in targeted groups, especially the youth. It is important that the government's condom distribution programme maintains the success achieved in 2015/16, which showed marked improvement compared to previous years.

KEY POPULATIONS

In the past NSP term, the national response gave attention to key populations, for example, CSW, MSM, and migrants. The response should continue to build on this momentum especially with regards to providing HIV prevention and treatment services. Three factors are important. Firstly, there is need to update the policy environment around sex work, in order to reduce human right abuses, GBV, stigma and discrimination that diminish HIV prevention efforts. Secondly, coverage of key populations with HIV prevention and treatment services should be expanded. Thirdly, data collection and M & E within these groups should be carried out timeously and systematically.

PWID

For PWID, there is need for the development of specific harm-reduction guidelines to enable the implementation of the National Drug

Master Plan as current efforts are inadequate. There is also a need to introduce a comprehensive package of services which cater for both dependency treatment and provision of HIV services. In addition, access to these services for PWID should be expanded. Government-supported intervention programmes are needed. Supportive policies, including guidelines for OST and other harm reduction principles in primary health care settings, are necessary. Lastly, research and M & E activities within the group will need to increase.

MODES OF TRANSMISSION (MOT) ANALYSIS

There is a need for the country to undertake detailed epidemiological review and modes of transmission (MOT) analysis. Previous analyses have been overtaken by events. This will enable programme planners to know the major sources of infections and their relative contributions to short-term incident cases. The analysis should give focus to understanding the state of epidemic at the provincial and district level. This will help to guide the investment of funds and intensify prevention programmes in identified sub-groups of the population.

BIOMEDICAL INTERVENTIONS

Current evidence shows that HIV sexual risk behaviours are not abating. Therefore, in addition to remedial actions for risky sexual behaviour, the response should strengthen current efforts to increase biomedical interventions like MMC and ART. While MMC reduces the risk of HIV acquisition in men, ART, through VLS, reduces HIV transmission in the population.

MMC

The government should explore innovative ways to increase the rates of VMMC to a sufficient scale that can impact HIV incidence. Efforts should include engaging with traditional leaders to integrate traditional and medical circumcisions, as has been achieved in neighbouring Zimbabwe. This should be done alongside continued SBCC programming which highlights the benefit of MMC, the need for partner reduction and consistent condom use with circumcision. Also, efforts in certain sub-groups should be heightened as the VMMC rate varies significantly by race, province and rural-urban residence. Districts with high HIV incidence should also be prioritized.

HCT

Awareness and knowledge of HIV status is the key to accessing a comprehensive package of care for HIV prevention and treatment. Mass media and social media SBCC will continue to be important. Provider initiated counselling and testing (PICT) or routinely offered HCT (ROCT) should be institutionalised and strengthened at all public and private health facilities. Home testing, now available in South Africa, and workplace testing campaigns should be promoted.

PMTCT AND TREATMENT

There are operational procedures within the PMTCT cascade that should be improved. Re-testing of HIV negative mothers every three months during pregnancy and breastfeeding should be implemented as per national guidelines. In addition, the implementation of "Option B+" Plus should be intensified. While the introduction of birth-testing in the new national guidelines of 2015, is important for earlier detection of in-utero infection, it requires new operational and monitoring tools to enhance the timely identification, tracing and linkage into care of infected early infants.

TREATMENT, CARE AND SUPPORT

ART FOR ADOLESCENTS AND CHILDREN

Coverage of ART for children and adolescents is a key area that requires attention. Already existing programmes and structures like the ISHP, youth-friendly programmes and MCH departments should be used to design creative strategies to improve uptake of HCT and linkage to care in this group. Lastly, the role of men in maternal and child HIV programmes should be encouraged.

RETENTION IN CARE

Retention in care levels are still below national targets. The national response will need to employ approaches that work in some settings and scale them up in other settings where retention is low. Recommended strategies include psychosocial support, training of healthcare workers



to increase empathy and reduce stigma and discrimination. Technology and unique identifier to effectively track patients within the local clinic and the wider healthcare system will be of value. The use of technological innovations, such as SMS, and efforts by WBOT should play an active role in patient follow-up.

VIRAL LOAD MONITORING

The level of viral load monitoring among patients on ART is substantial but should be improved. Also important, is ensuring an effective M & E system with the necessary technology to track VL testing and report valid follow-up statistics.

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. Also, efforts should be made to reduce the TB mortality rate among PLHIV.

IMPACT ALLEVIATION

HIV FUNDING MODEL

Partner funding has been dwindling for the past few years. This decline is likely to continue. There is, therefore, need to explore alternative funding sources in addition to government commitment. A good alternative source is private business funding. Private business in South Africa is already putting some funds into HIV programmes, but this needs to be increased and better coordinated.

In addition to exploring additional sources of funding for HIV/AIDS programmes, SANAC should consider involving civil society in the allocation of funds for HIV programmes. The country's allocation of domestic and donor funds should be inclusive and participatory, meaningfully engaging members of civil society. As there may be worries about the capacity of many civil organisations to implement HIV programmes effectively, criteria for such funding can be made transparent; for example, alignment of programmes with national priority areas and the ability to demonstrate impact. Although, many NGOs have played a crucial role in the country's response to HIV and AIDS over the years, SANAC should consider an audit of existing civil organisations in different sectors to determine which organisations have the capacity to effectively implement HIV programmes and contribute to the national response to HIV/AIDS, TB and STIs.

ELIMINATING GENDER INEQUALITIES

Eliminating gender inequalities will be central in ending HIV/AIDS because of its role in HIV transmission and access to treatment. Because gender inequalities are embedded in norms and existing structures, interventions to tackle them need to be comprehensive and far reaching across many sectors of society. Community-based, clinic-based and institution-based interventions are needed. Social and behaviour communication change messaging needs to be clear and resounding. Also, structures for providing support to women who have experienced GBV and for prosecuting perpetrators need to become more visible and effective. Policies around sex workers and other key populations should be reviewed and updated to minimise human rights abuses in these groups.

It is important to develop a functional M & E framework for the different forms of GBV. This should include devising early and sensitive indicators for measuring them. SANAC and stakeholders in civil society have also 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.

The linking of SRH and HIV response has gained momentum recently. SRH services can provide a platform for reaching women and girls, not only with HIV interventions, but also as an effective entry point for GBV services. The national response will need to promote this linkage in South Africa.

What is also needed is competency training of health care workers so that they can be capacitated to optimally manage survivors of sexual assault especially among key populations. This should be complemented by the provision of health services pack to address the needs of key populations and those who are victims of GBV.

ADDRESS STIGMA AND DISCRIMINATION

Like gender inequalities, eliminating stigma and discrimination is important to ending HIV/AIDS and TB. Community-based, clinic-based and

institution-based interventions are also needed to address stigma and discrimination. The People Living with HIV Stigma Index Survey commissioned by SANAC in 2014 does not only provide strategic information for designing stigma interventions, but also provides a framework for monitoring stigma in the country. The next questions should be on which interventions are needed and where.

MONITORING AND REPORTING OF IMPACT ALLEVIATION TARGETS

It has previously been suggested that SANAC needs to develop a centralised mechanism for tracking all sectoral plans and human rights indicators to ensure ongoing M&E of human rights violations and responses in terms of strategic objective 4, at national level.

SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

South Africa receives support from a number of development partners for the national response to the scourges of HIV/AIDS, TB and STIs in the country. Support from development partners is both financial and technical. Although financial support has dwindled in the last few years, development partners contributed about a fifth of the total expenditure for the national response in 2015. Development partners also provide technical support in the form of research, programme implementation and policy formulation, analysis and implementation. These supports come at the different levels of government and with civil society as part of strengthening their contribution to the national multi-sectoral response.

These partnerships are facilitated through a number of frameworks and structures. The South African government has bi-lateral and multi-lateral agreements with development partners. An example is the Partnership Framework Implementation Plan (PFIP), signed by representatives of the U.S. government and South African government in 2012. 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.

South Africa needs to continue to consider ways to cover the resource gaps resulting from declining partner funding and ensure judicious use of partner funds on programmes that are most likely to produce the big-gest impact on HIV prevention and mitigation.

MONITORING AND EVALUATION ENVIRONMENT

SANAC monitors South Africa's multi-sectoral HIV/AIDS response and provides global, national and provincial annual reporting on progress towards targets and commitments. As a result, it is the central repository for all data on the epidemic and response in the country. This function falls within the M & E unit of SANAC. The unit is led by an M & E Manager and supported by M & E staff at SANAC's National Office and M&E Officers based in each of the nine Provincial AIDS Councils (PACs). The unit is also supported by international partners like PEPFAR and the CDC who provide technical support.

SANAC monitors a wide range of HIV/AIDS and TB indicators, some of which are monitored with programme data and others by periodic survey data. Data on the different indicators are supplied by different government departments and civil society. As a result, data are not always readily available for all indicators, especially those on impact alleviation indicators.

In 2014, SANAC developed an M & E framework for the national HIV response, harmonizing existing government M & E systems for the response. In addition to providing yearly global progress report to the UN, SANAC also produces progress reports targets and objectives set in the NSP. In 2016, for example, it published its enhanced progress report of the South African NSP 2012-2016. SANAC also embarks on an M & E assessment of all the nine PACs to guide support to respective provinces. Lastly, SANAC also, in the last NSP 2012-2016 term, embarked on activities to strengthen the M & E environment for the national response by improving on the quality of indicators and strengthening data source and systems.

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