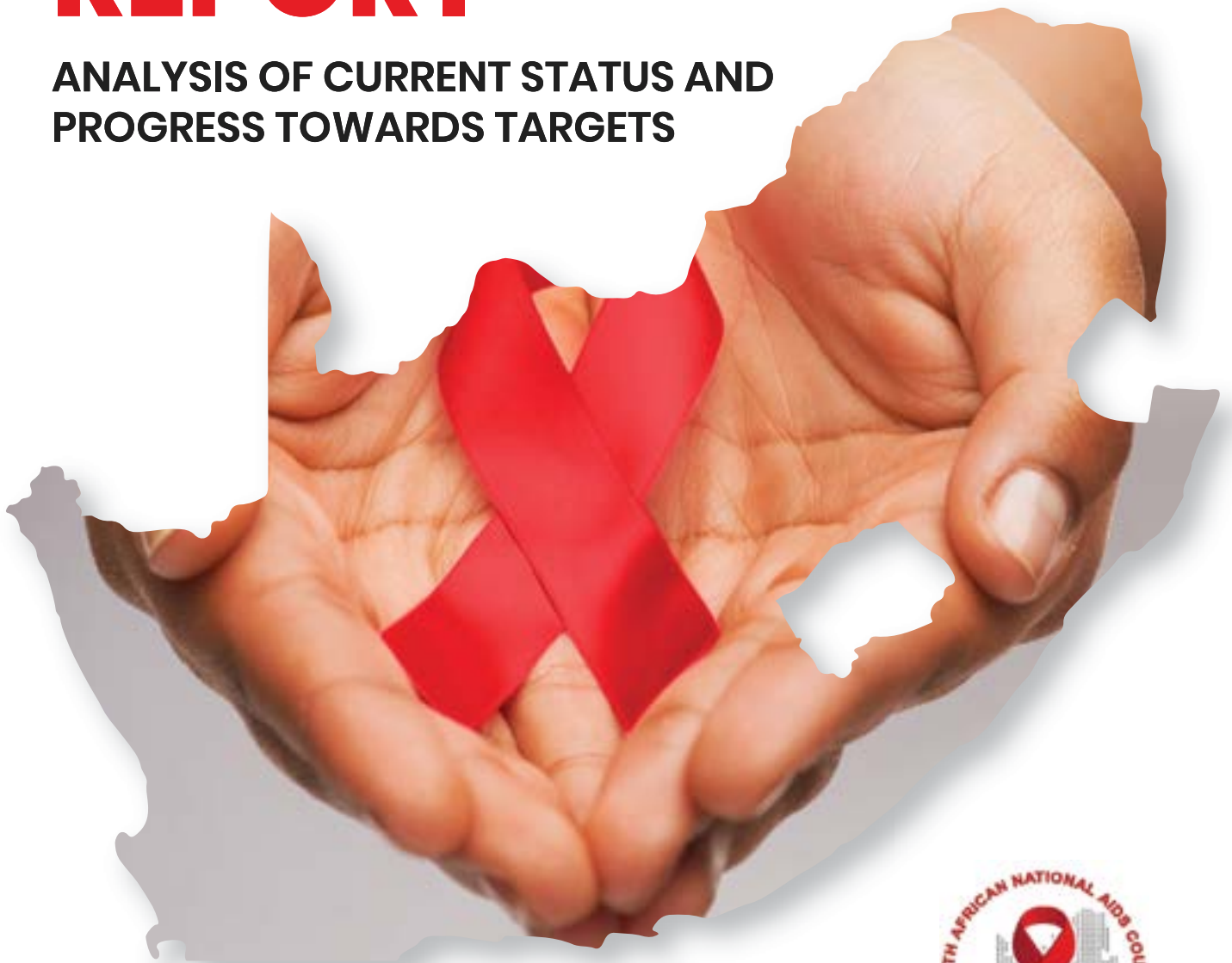


REPUBLIC OF SOUTH AFRICA

2018 GLOBAL AIDS MONITORING REPORT

**ANALYSIS OF CURRENT STATUS AND
PROGRESS TOWARDS TARGETS**





ACKNOWLEDGEMENTS

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ABBREVIATIONS AND ACRONYMS

AGYW	Adolescent Girls and Young Women	MTEF	Medium Term Expenditure Framework
AIDS	Acquired Immunodeficiency Syndrome	NDoH	National Department of Health
ANC	Antenatal Care	NDP	National Development Plan
ART	Antiretroviral Therapy	NGO	Non-Governmental Organisation
ARV	Antiretroviral	NHI	National Health Insurance
AYFS	Adolescent Youth Friendly Services	NICD	National Institute of Communicable Diseases
CBO	Community-Based Organisations	NSP	National Strategic Plan for HIV, TB and STIs
CCM	Country Coordination Mechanism	OOPE	Out of Pocket Expenditure
CDW	Community Development Workers	OST	Opioid Substitution Therapy
CDWP	Community Development Workers Programme	OVC	Orphans and Vulnerable Children
CNDC	Community Nutritional Development Centres	PCR	Polymerase Chain Reaction
COP	Country Operational Plan	PDoH	Provincial Department of Health
CSO	Civil Society Organisations	PLHIV	People living with HIV
DBE	Department of Basic Education	PMTCT	Prevention of Mother-To-Child Transmission
DHET	Department of Higher Education and Training	PrEP	Pre-Exposure Prophylaxis
DHIS	District Health Information System	PSET	Post-School Education and Training System
DoH	Department of Health, National	PWID	People Who Inject Drugs
DOJ&CD	Department of Justice and Constitutional Development	PWUD	People Who Use Drugs
DSD	Department of Social Development	SABSSM	South African National HIV Prevalence Incidence, Behaviour and Communication Survey
EID	Early Infant Diagnosis	SACENDU	South African Community Epidemiology Network on Drug Use
eMTCT	Elimination of Mother-To-Child Transmission	SADHS	South Africa Demographic and Health Survey
GAM	Global AIDS Monitoring	SAHRC	South African Human Rights Commission
GBV	Gender-Based Violence	SANAC	South African National AIDS Council
GBVF	Gender-Based Violence and Femicide	SASSA	South African Social Security Agency
HBC	Home-Based Care	SRH	Sexual Reproductive Health
HIV	Human Immunodeficiency Virus	STAR	Self-testing Africa
HSRC	Human Sciences Research Council	Stats SA	Statistics South Africa
HTC	HIV Testing and Counselling	STI	Sexually-Transmitted Infections
HTS	HIV Testing Services	SWEAT	Sex Worker Education and Advocacy Task Force
ICROP	Integrated Community Registration Outreach Programme	TAC	Treatment Action Campaign
IOM	International Organisation for Migration	TB	Tuberculosis
IPV	Intimate Partner Violence	TCC	Thuthuzela Care Centres
ISHP	Integrated School Health Programmes	Thembisa Model	Thembisa Model Version 4.2
LGBTI	People with Disabilities, Other Lesbian, Gay, Bisexual, Transgender and Intersex	TVET	Technical and vocational education and training
LTF	Loss to Follow-Up/Lost to Follow-Up	UNAIDS	Joint United Nations Programme on HIV/AIDS
MDR-TB	Multi-drug-resistant TB	USAID	The United States Agency for International Development
MMC	Medical Male Circumcision	UTT	Universal Test and Treat
MSM	Men who have sex with men	WHO	World Health Organisation
MTCT	Mother-to-Child Transmission		

INTRODUCTION

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

South Africa is a signatory to the 2016 United Nations Political Declaration on HIV and AIDS; on the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030, adopted at the United Nations General Assembly High-Level Meeting on AIDS in June 2016. This Political Declaration was built on three previous political declarations: the 2001 Declaration of Commitment on HIV/AIDS, the 2006 Political Declaration on HIV/AIDS and the 2011 Political Declaration on HIV and AIDS. The 2020 Fast-Track commitments and expanded targets aim to reduce new HIV infections, reduce AIDS-related deaths, eliminate stigma and discrimination and end the AIDS epidemic by 2030. A cornerstone strategy, being the 90-90-90 treatment targets.

The 2016 Political Declaration indicates that a successful AIDS response should be measured by the achievement of concrete, time-bound targets. This Global AIDS Monitoring (GAM) report documents South Africa's progress towards the ten commitments and identifies challenges and constraints, with recommendations to accelerate the achievement of targets. The review focused on the country's achievements by the end of 2018, with supplementary trends analysis from three years prior.

THE INCLUSIVENESS OF THE STAKEHOLDERS IN THE REPORT WRITING PROCESS

This report reviewed the progress of South Africa towards the commitments set in the 2016 United Nations Political Declaration on HIV and AIDS. 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 generalised mature HIV epidemic, with about 7.5 million infected people. The epidemic is mostly heterosexually driven, and it is characterised by a high burden of tuberculosis (TB). The 2018 prevalence was estimated at 13% and has risen significantly in the past decade. The epidemic is heterogenous across provinces, age groups and sex. Females continue to bear a disproportionate burden of the HIV epidemic, with an overall prevalence of 17.3% in females and 10.3% in males in 2017. The good news is that the incidence of infection has been on the decline in almost all groups. In 2017, the overall incidence rate was 0.48%, a 55% decline from the 1.07% reported in 2012. Concentrated sub-epidemics are evident among key populations including female sex workers and men who have sex with men (MSM). Although the burden of TB, fuelled by the HIV epidemic, remains high, the number of new cases of TB and deaths due to TB has started to decline. In 2017, there were 193,000 new TB cases occurring among people living with HIV, which is a 25% decline from the 258,000 cases reported in 2016.

THE POLICY AND PROGRAMMATIC RESPONSE

South Africa's response to the HIV/AIDS epidemic is guided by the country's National Strategic Plan on HIV, STIs and TB for 2017-2022 (NSP 2017-2022). The NSP 2017-2022 aimed to reduce new HIV infections by about 70%, from 270,000 new infections in 2016 to 88,000 new infections by 2022. It also set targets for reducing new TB infections and sexually transmitted infections (STIs), while mitigating the impact of the epidemic by reducing illness and deaths through the provision of treatment, care and adherence support. The NSP 2017-2022 identifies the heterogeneity of the epidemic and sets plans to intensify efforts in geographical areas and populations which are most affected by the epidemic. The country's plan has been responsive to the 2016 political declaration by setting clear targets for key populations, community-led programmes and programmes for human rights in the context of HIV/AIDS. The use of evidence-based combination intervention remains the fulcrum of the response. The country's NSP continues to enjoy strong political commitment.

STATUS AT A GLANCE

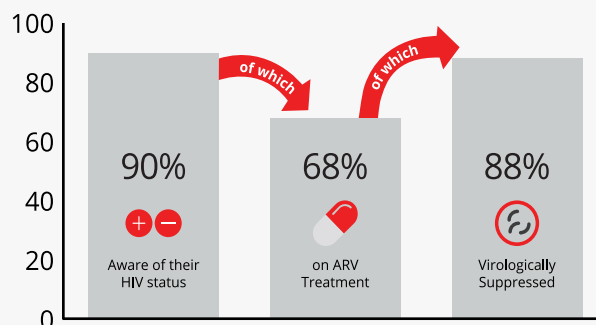
Commitment	Achieved by 2018	Likely to be achieved by 2020
 1. Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020	No	Likely
 2. Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018	Yes	Yes
 3. Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations—gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners	No	Not Likely
 4. Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020	No	Not Likely
 5. Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100,000 per year	No	Not Likely
 6. Ensure that 75% of people living with, at risk of and affected by HIV benefit from HIV-sensitive social protection by 2020	Yes	Yes
 7. Ensure that at least 30% of all service delivery is community-led by 2020	Yes	Yes
 8. Ensure that HIV Investments increase to US\$ 26 billion by 2020, including a quarter for HIV prevention and 6% for Social Enablers	Yes	Yes
 9. Empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violations of human rights	Yes	Yes
 10. Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C	No	Not Likely

SUMMARY OF PROGRESS TOWARDS COMMITMENTS

COMMITMENT 1

ENSURE THAT 30 MILLION PEOPLE LIVING WITH HIV HAVE ACCESS TO TREATMENT THROUGH MEETING THE 90-90-90 TARGETS BY 2020

The number of people living with HIV (PLHIV) in South Africa increased within the past few years to 7.5 million in 2018. Nonetheless, the government has been unyielding in its effort towards turning the tide on the epidemic by achieving the 90-90-90-targets. South Africa is among the countries that have reached the first 90% of the Joint United Nations Programme on HIV/AIDS (UNAIDS) target. The percentage of PLHIV who knew their HIV status was 90% in 2018. Although the achievement of the second target was less than 90% as at 2018, data from the last three years show upward trends in coverage. The percentage of HIV-diagnosed individuals on antiretroviral therapy (ART) increased from 61% in 2016 to 68% in 2018, at the rate of 402,000 net increase in the number of patients per year ($p=0.008$). South Africa's admirable effort, backed by political will, is geared towards putting more people on ART and achieving the second 90% target by 2020. The 90% target set for viral suppression among HIV patients on ART has almost been achieved, at 88.4% in 2018.

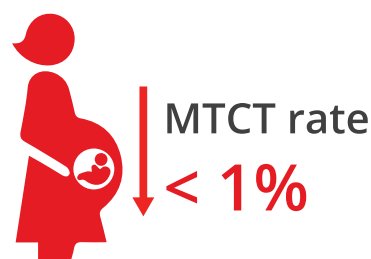


Antiretroviral treatment for PLHIV has had the massive impact of reducing HIV-related deaths, increasing life expectancy and improving the overall quality of life. Within this context, it is also commendable that the cases of antiretroviral medicine stock-out are less frequent than they were in 2015, and they are more rapidly resolved when they occur. However, retention and late diagnosis remain a problem that should be tackled.

COMMITMENT 2

ELIMINATE NEW HIV INFECTIONS AMONG CHILDREN BY 2020 WHILE ENSURING THAT 1.6 MILLION CHILDREN HAVE ACCESS TO HIV TREATMENT BY 2018

The South African government has, through numerous policies and structures, demonstrated commitment to eliminating new HIV infections among children, while ensuring those already infected have access to ART. As a result, this commitment has been achieved before the target year of 2020. The national HIV polymerase-chain-reaction (PCR) birth-testing coverage was 94% for 2017/2018, up from 68% in 2016/17. The mother-to-child transmission (MTCT) at birth, which has been on the decline in the past decade, is now less than 1%.



COMMITMENT 3

ENSURE ACCESS TO COMBINATION PREVENTION OPTIONS, INCLUDING PRE-EXPOSURE PROPHYLAXIS, VOLUNTARY MEDICAL MALE CIRCUMCISION, HARM REDUCTION AND CONDOMS, TO AT LEAST 90% OF PEOPLE BY 2020, ESPECIALLY YOUNG WOMEN AND ADOLESCENT GIRLS IN HIGH-PREVALENCE COUNTRIES AND KEY POPULATIONS—GAY MEN AND OTHER MEN WHO HAVE SEX WITH MEN, TRANSGENDER PEOPLE, SEX WORKERS AND THEIR CLIENTS, PEOPLE WHO INJECT DRUGS AND PRISONERS

The South African government has demonstrated and intensified efforts to provide combination prevention options for the general population and key populations. For example, barely eight months after the World Health Organisation (WHO) released their guidelines for HIV pre-exposure prophylaxis (PrEP), in June 2016, South Africa became the first country to provide sex workers and other key populations with oral PrEP as part of its national HIV programme. Although the number of new HIV infections per annum decreased to 221,000 in 2018, the rate of decline is not fast enough to reach the planned target of 75% reduction between 2010 and 2020. Although the government has started to roll out PrEP, the planned targets are too low to achieve this commitment. Also, although circumcision efforts are palpable, the country has consistently fallen short of the current NSP target of medically circumcising 3 million men from 2017 to 2022. Regarding key populations, including sex workers, MSM and people who inject drugs (PWID), not only are current interventions insufficient, there is a paucity of comprehensive monitoring data to inform progress.

222,000
new HIV infections in 2018

COMMITMENT 4

ELIMINATE GENDER INEQUALITIES AND END ALL FORMS OF VIOLENCE AND DISCRIMINATION AGAINST WOMEN AND GIRLS, PEOPLE LIVING WITH HIV AND KEY POPULATIONS BY 2020

Through its constitution and a plethora of directed acts and frameworks, South Africa addresses the problem of gender inequality and promotes the protection of women and girls against all forms of violence and discrimination. PLHIV and key populations are also protected by law from such discrimination. However, the gap appears to be in the implementation of the laws and regulations. The level of intimate partner violence (IPV) remains high, with 29% of ever-married or partnered women aged 15–49 years old reporting physical or sexual violence from a male intimate partner in the past 12 months in 2017. Additionally, the South African Police Force data show an upward trend in the number of femicides in the country. Key populations, including sex workers and PWID, report high levels of stigma and abuse in the hands of sex partners and law enforcement agents. There is also a scarcity of data to comprehensively monitor indicators under this commitment. For example, although the UNAIDS recommends that stigma indicator should be measured every two to three years, the last national survey on stigma in South Africa was in 2014.



29%
ever-married women
experienced sexual
violence in 2017

COMMITMENT 5

ENSURE THAT 90% OF YOUNG PEOPLE HAVE THE SKILLS, KNOWLEDGE AND CAPACITY TO PROTECT THEMSELVES FROM HIV AND HAVE ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES BY 2020, IN ORDER TO REDUCE THE NUMBER OF NEW HIV INFECTIONS AMONG ADOLESCENT GIRLS AND YOUNG WOMEN TO BELOW 100,000 PER YEAR

Despite the country being armed with laudable national policies regarding the prevention of HIV and access to Sexual Reproductive Health (SRH) services for young people, there has been little progress towards this commitment. The proportion of young people in South Africa with comprehensive knowledge about HIV prevention is sub-optimal – only 38% among males and 42% among females. Not only are these levels of knowledge far below the 90% target, but there has also been a mere 10 percentage points increase for this indicator in the last decade. The percentage of young women who have their demand for family planning satisfied by modern methods is good at about 70%, although it is lower than the 75% considered high by the WHO.



Only 40% of young people
have comprehensive
knowledge of HIV prevention

COMMITMENT 6

ENSURE THAT 75% OF PEOPLE LIVING WITH, AT RISK OF AND AFFECTED BY HIV BENEFIT FROM HIV-SENSITIVE SOCIAL PROTECTION BY 2020

South Africa has achieved this commitment, owing to its commendable social protection programme that targets vulnerable population groups and households. The number of people covered by the social protection system of cash transfers increased by 40% in the last decade, from 12.4 million in 2008 to 17.5 million in 2018. By addressing the structural determinants of HIV infection, the social grant system addresses factors that put young people at risk of HIV. Furthermore, South Africa has a disability grant for patients with chronic diseases who meet disability criteria, which includes PLHIV.



17.5 Million
people received social
grant in 2018

COMMITMENT 7

ENSURE THAT AT LEAST 30% OF ALL SERVICE DELIVERY IS COMMUNITY-LED BY 2020

South Africa is committed to ensuring that at least 30% of all service delivery are community-led. In the country's NSP 2017-2022, there is an emphasis on strengthening the participation of civil society and leadership as a way of encouraging community responses to HIV/AIDS. Against the backdrop of a supportive legal and regulatory system, the country enjoys a vibrant civil society which continues to work unhindered towards providing various types of services around HIV/AIDS. Community-based organisations (CBOs) are participatory in all aspects of HIV/AIDS service delivery, from prevention to treatment, and advocacy to reaching key populations.



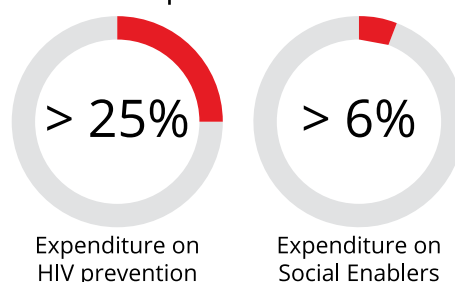
Civil society organisations
are chiefly responsible for
delivering HIV prevention
and treatment services to
key populations

COMMITMENT 8

ENSURE THAT HIV INVESTMENTS INCREASE TO US\$ 26 BILLION BY 2020, INCLUDING A QUARTER FOR HIV PREVENTION AND 6% FOR SOCIAL ENABLERS

South Africa achieved this target through strong political and resource mobilisation commitments. The country has continued to increase its annual investments in HIV/AIDS and TB programmes, with its total expenditure standing at R28.8 billion in 2018. An analysis of spending by intervention category and funder showed that prevention intervention and programme enablers accounted for about 15% and 8% of HIV expenditure respectively. When the government's huge spending on social protection is considered, then the 25% spending target on prevention and the 6% target on social enablers have been exceeded.

Total HIV/AIDS expenditure in 2018 R28.8 billion



COMMITMENT 9

EMPOWER PEOPLE LIVING WITH, AT RISK OF, AND AFFECTED BY HIV TO KNOW THEIR RIGHTS AND TO ACCESS JUSTICE AND LEGAL SERVICES TO PREVENT AND CHALLENGE VIOLATIONS OF HUMAN RIGHTS

South African laws do not criminalise HIV non-disclosure, neither do they impose travel bans, treatment or other restrictions based on someone's HIV status. HIV testing is voluntary for all persons and workplace discrimination because of one's HIV status is disavowed. However, there is significant gap in citizen's knowledge of their rights, with only half of South Africans documented to know their constitutional rights in 2017. South Africa does not seem to currently have concerted programmes, although a few interventions exist, providing citizen education on human rights in the context of HIV. Nonetheless, the robust legal and policy environment of the country and a well-mobilised civil society means that most citizens do not face human rights violations.

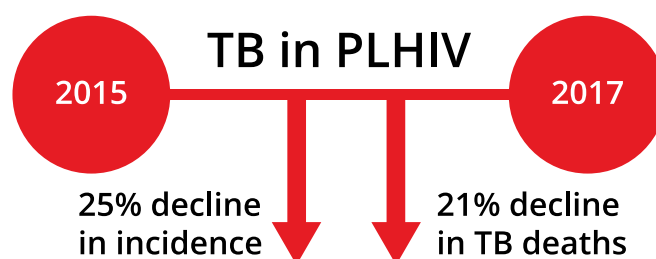


South African laws make provision for this commitment, but the gap is in the empowerment of citizens to know their rights

COMMITMENT 10

COMMIT TO TAKING AIDS OUT OF ISOLATION THROUGH PEOPLE-CENTRED SYSTEMS TO IMPROVE UNIVERSAL HEALTH COVERAGE, INCLUDING TREATMENT FOR TUBERCULOSIS, CERVICAL CANCER AND HEPATITIS B AND C

Through strong commitment and improved funding, South Africa has made giant strides towards achieving this target. Although the target is yet to be achieved, there have been significant improvements in decreasing TB incidence and mortality. In 2017, there were 322,000 new TB infections in the country, with 193,000 of those occurring among PLHIV. In the same year, there were 56,000 TB deaths among PLHIV (72% of all TB deaths). There have also been improvements in treatment initiation and TB-HIV integration. The prevalence of gonorrhoea among males in South Africa has been stable for the past decade. There are no data on hepatitis B testing in the general population.



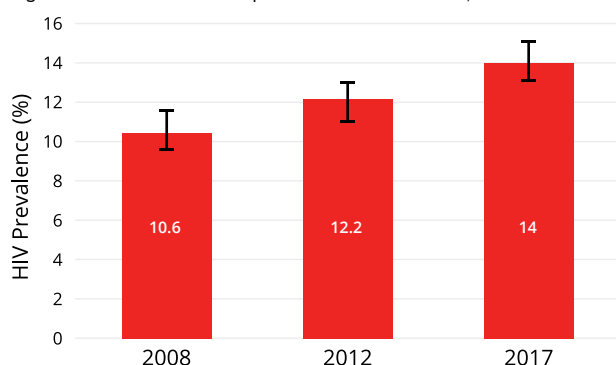


Overview of the HIV/AIDS Epidemic in South Africa

Overall HIV prevalence and trends

Data from cross-sectional surveys and estimation models show that the prevalence of HIV in South Africa has not declined in recent years. It has in fact increased. The latest Human Sciences Research Council (HSRC) South African National HIV Prevalence Incidence, Behaviour and Communication Survey (hereafter SABSSM V)¹ conducted in 2017 showed that the prevalence of HIV among all South Africans was 14%. Figure 1 shows that in the past decade, the prevalence of HIV has increased by 3.4 percentage points from 10.6% in 2008 to 14% in 2017, and the increase is statistically significant, as the confidence intervals do not overlap.

Figure 1: Trends in overall HIV prevalence in South Africa, 2008 to 2017



(Source: SABSSM Survey III-V)¹⁻³

Estimates for the more recent years show similar upward trends in HIV prevalence. Estimates from Statistics South Africa (Stats SA) and the Thembisa Model Version 4.2 (also written as “Thembisa Model”) showed the prevalence to have risen to 13.1% and 12.9% respectively in 2018 (Table 1).

14%
Current HIV prevalence
in South Africa

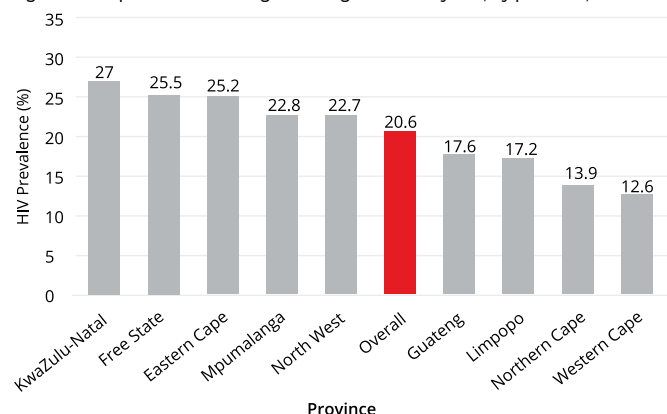
Table 1: Recent trends in overall HIV prevalence in South Africa, 2016 to 2018

Data source	2016	2017	2018
Thembisa Model ⁴	12.7	12.8	12.9
Statistics South Africa ⁵⁻⁷	12.7	12.6	13.1
SABSSM V ¹	-	14	-

HIV Prevalence by province

There is significant variation in adult HIV prevalence by province, ranging from 12.6% in Western Cape Province to 27.0% in KwaZulu-Natal Province (Figure 2). Five provinces have HIV prevalence higher than the country’s overall level of 20.6%, including Kwazulu-Natal, Free State, Eastern Cape, Mpumalanga and North-West provinces. Except for the Eastern Cape Province, all other provinces equally had HIV prevalence higher than the national estimate in the SABSSM survey of 2012. Limpopo, Northern Cape and the Western Cape provinces remained the three provinces with the lowest prevalence in that order, as observed in 2012. Additionally, HIV prevalence increased in all provinces between 2012 and 2017, although the increase was minuscule in Gauteng province.

Figure 2: HIV prevalence among adults aged 15 to 49 years, by province, 2017

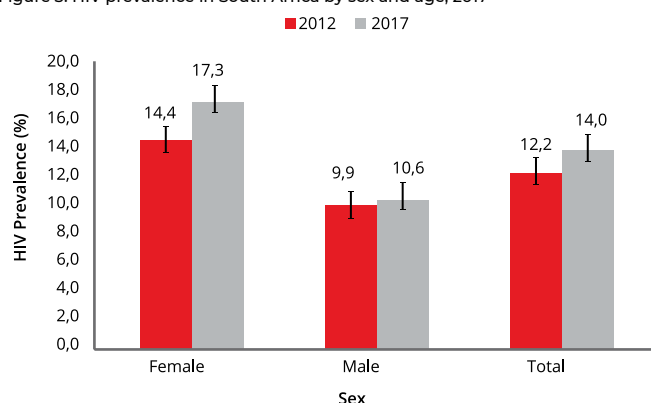


(Source: SABSSM V)¹

HIV prevalence by sex and age

The SABSSM V showed that, overall, the prevalence among females was 17.3%, and among males, 10.6%. In addition to females already bearing the disproportionate burden of HIV infection, the rate of increase is also higher among them. The increase in overall HIV prevalence has been mostly driven by a higher increase among women than men as shown in Figure 3.

Figure 3: HIV prevalence in South Africa by sex and age, 2017



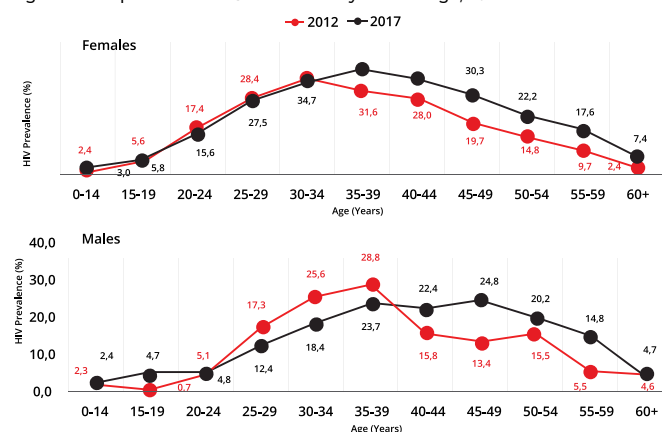
(Source: SABSSM V)¹

The prevalence was 20.6% among adults aged 15 to 49 years; 26.3% among females and 14.8% among males. Among those aged 15 to 64-years-old, the prevalence was 20%, 25% in females and 14.9% in males. Further disaggregation confirmed the relationship between HIV prevalence and age, with prevalence peaking in the 35 to 39-year-olds for both males and females – 23.7% and 39.4% respectively (Figure 4). The data showed that females continue to bear the disproportionate burden of infection compared to males. When prevalence ratio is calculated as prevalence in females relative to males, the disparity between females (15.6%) and males (4.8%) is seen to be highest among those aged 20 to 24 years (PR = 3.3).

Adult HIV prevalence



Figure 4: HIV prevalence in South Africa by sex and age, 2017

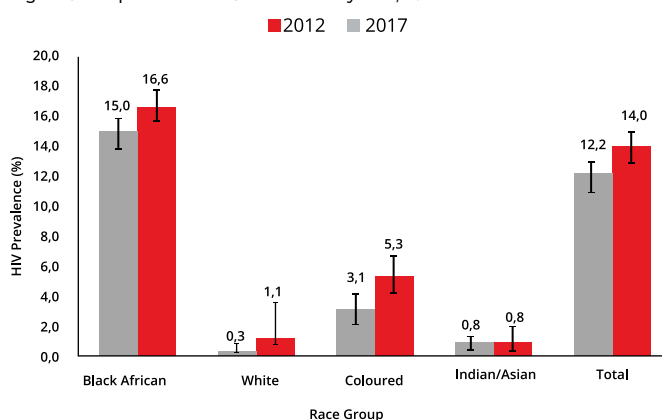


(Source: SABSSM V)¹

HIV prevalence by race

There is also a huge variation in HIV prevalence by race, ranging from about 1% in Asians to about 17% in Blacks. Across all race groups, except for Asians, the prevalence increased between the 2012 SABSSM and the 2017 version (Figure 5).

Figure 5: HIV prevalence in South Africa by race, 2017



(Source: SABSSM V)¹

HIV prevalence in ANC attendees

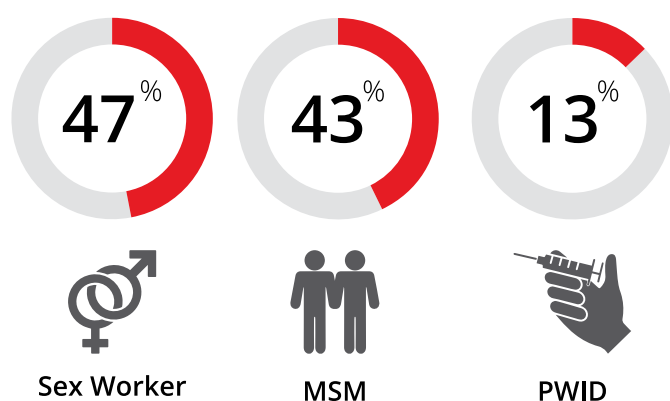
The most recent antenatal care (ANC) survey was conducted in 2015. The results showed that the HIV prevalence in the population was estimated at 30.8% (95% C: 30.0% to 31.6%).⁸ This was the highest point estimate observed in the past five surveys. However, the increase was not statistically significant, as the confidence intervals around the estimates have all overlapped in the past ten years, showing that the estimated

national HIV prevalence among ANC attendees has remained stable over the past decade.⁸

HIV prevalence in key populations

South Africa's National Strategic Plan for HIV, TB and STIs 2017–2022 (also written as “NSP 2017–2022” or “the current NSP”)⁹ defined key populations for HIV and STIs to include sex workers, transgender people, MSM, PWID and prison inmates.

A recent study of 3,443 key population members, including MSM, sex workers and people who use drugs (PWUD), including PWID, showed the overall prevalence of HIV, Hepatitis B (Hep B) and Hepatitis C (Hep C) to be 37%, 4% and 13% respectively. HIV prevalence was highest among sex workers (47%).¹⁰



HIV prevalence in vulnerable populations

The current NSP defined vulnerable populations for HIV and STIs to include adolescent girls and young women, children – including orphans and vulnerable children, people living in informal settlements, mobile populations, migrants and undocumented foreigners, people with disabilities, other lesbian, gay, bisexual, transgender and intersex (LGBTI) populations.

The 2017 SABSSM survey showed the HIV prevalence in children aged 0 to 14 years to be 2.7%. This was somewhat higher than the 1.8% estimated by the Thembisa Model for 2017. The 2017 SABSSM survey showed the prevalence of HIV among adolescent girls (15 to 19 years) and young women (20 to 24 years) to be 5.8% and 15.6% respectively. The Thembisa Model estimated the HIV prevalence among adolescent girls and young women (AGYM) aged 15 to 24 years to be 10.5% in 2018, down from 11% in 2016.

HIV incidence

The 2017 SABSSM survey estimated the overall HIV incidence rate at 0.48%, which translates to an estimated 231,000 new infections a year. In 2017, there were 122,000 new infections among females (incidence rate = 0.51%) and 109,000 new infections among males (incidence rate = 0.46%). The observed overall incidence rate of 0.48% in 2017 was a 55% decline from 1.07% in 2012.

Young adults (15 to 24 years) accounted for 38% of all new infections in 2017

As seen in 2012, the incidence rate was higher among young adults aged 15 to 24 years. In the 2017 survey, it was 1%, which is more than twice the overall incidence rate. This fraction of the population accounted for 38% of all new infections in the country. When the incidence rate among these youths was stratified by sex, it was 1.51% among females (66,000 new infections) and 0.49% in males (22,000 new infections).

The Thembisa Model estimated the overall incidence rate to be 0.51% and 0.44% in 2017 and 2018 respectively. Using these estimates, we see that there has been a general decline in the incidence of HIV in South Africa in the past three years (Figure 6).

Figure 6: HIV Incidence by age and sex, 2016 to 2018



(Source: Thembisa Model⁴)



Commitment One:

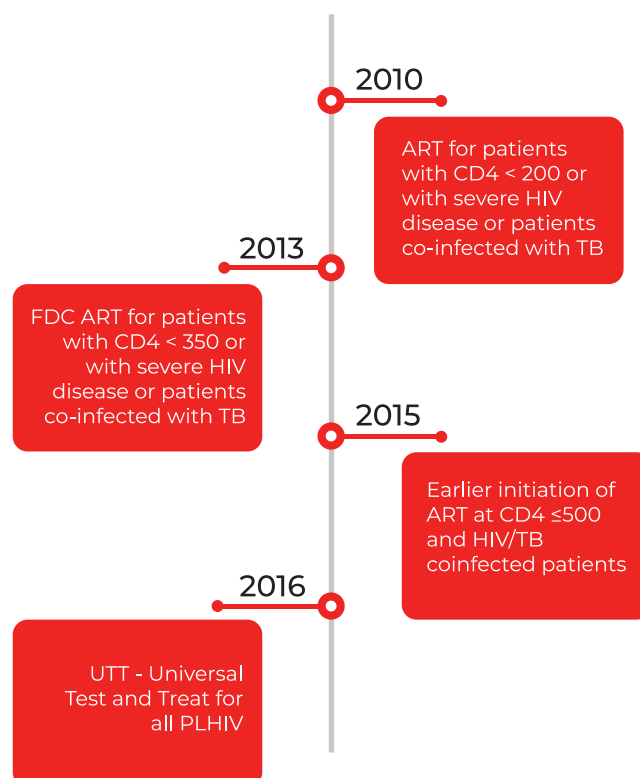
Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020

Is this a priority commitment for the country?	Yes
Does the National Strategic Plan address this commitment?	Yes
Has the country reached the target and commitment?	No
How likely is the country to reach the target by 2020?	Likely

Legal and Policy Environment

South Africa has shown laudable political commitment to ensuring that PLHIV have access to life-saving antiretroviral treatment and live a prolonged healthy life. This is demonstrated through a series of five-year National Strategic Plans (NSPs) for HIV, TB and STIs and treatment policy changes in the past decade. Through these national policy frameworks for HIV care, treatment and support for PLHIV, the country, has over the years, relaxed the threshold for HIV treatment and expanded the ART programme. The most recent of such policy changes heralded the test-and-treat guidelines. Specifically, on May 10 2016, the Minister of Health, Dr Aaron Motsoaledi, announced during his budget speech that the country will implement the WHO evidence-based guidelines on Universal Test and Treat (UTT). Indeed, from 1st September 2016, the HIV/AIDS sub-programme unit of the Department of Health (DoH) implemented the UTT Guidelines. This means that since 2016,

anyone who tests positive to HIV is initiated on treatment, provided they are willing to do so.



Current Status and Recent Trends

Number of people living with HIV

Antiretroviral treatment for PLHIV has had the massive impact of reducing HIV-related deaths, increasing life expectancy and improving overall quality of life. In addition, it is a tool for HIV prevention because PLHIV on treatment and with suppressed viral load are less likely to transmit the virus. However, people can only be put on treatment if they test and know their status. The UNAIDS 90-90-90 target aims to ensure that by 2020, 90% of all PLHIV know their HIV status, 90% of all people with an HIV diagnosis are put on antiretroviral (ARV) treatment and 90% of all people on ARV treatment achieve viral suppression. A starting question, therefore, is: how many people are living with HIV in South Africa?



Current overall HIV prevalence

13%

HIV prevalence in males aged 15+

13.1%

HIV prevalence in females aged 15+

21.3%

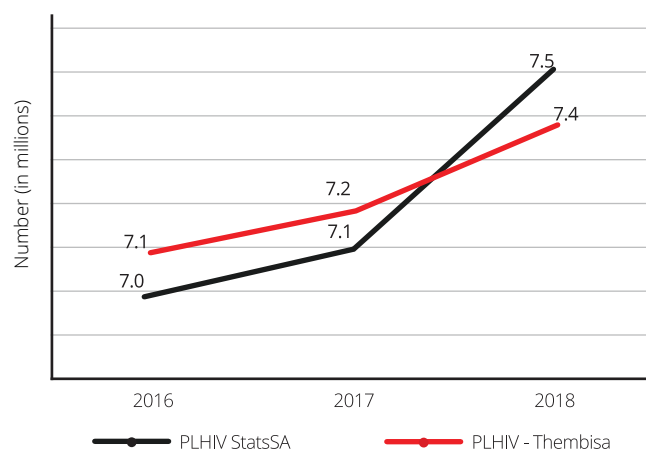
Prevalence in children (<15)

1.7%

The latest SABSSM V estimated the number of PLHIV in South Africa in 2017 to be 7.9 million. In 2018, Stats SA and the Thembisa Model estimated the number of PLHIV in South Africa to be 7.5 million people and 7.4 million respectively (Figure 7)^{3,4}

Using HIV estimates from Stats SA, the number of PLHIV in South Africa increased from 7.0 million to 7.5 million from 2016 to 2018. Using estimates from the Thembisa Model, 7.1 million people were estimated to be living with HIV in the country in 2016. This increased to 7.2 million in 2017 and 7.4 million in 2018. These estimates show that the number of PLHIV has increased significantly in the past three years at the rate of 162,000 people per year, $P=0.03$ (Figure 7).

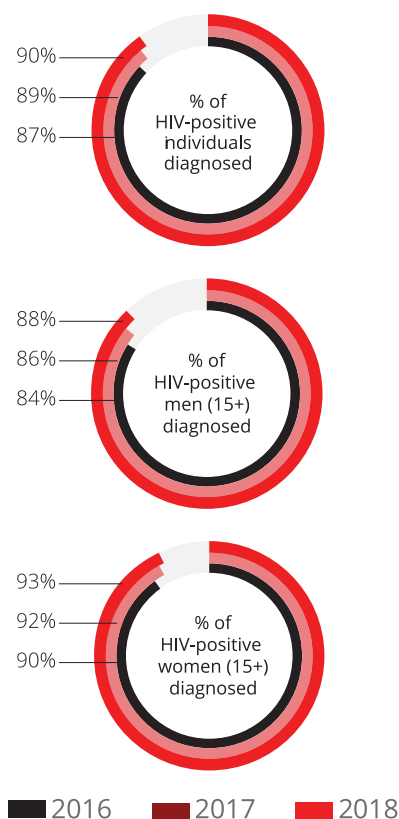
Figure 7: Number of PLHIV in South Africa, 2016-2018



(Source: Thembisa Model⁴; Stats SA⁵⁻⁷)

People living with HIV who know their HIV status

According to the SABSSM V, in 2017, 85% of PLHIV aged 15 to 64 years knew their HIV status. The results from the Thembisa Model showed that the percentage of PLHIV who knew their HIV status was 89% in 2017 and 90% in 2018. Both SABSSM V and Thembisa Model figures show that HIV-positive women are more likely to know their status than men, although men were just beneath the 90% target by two percentage points in 2018.



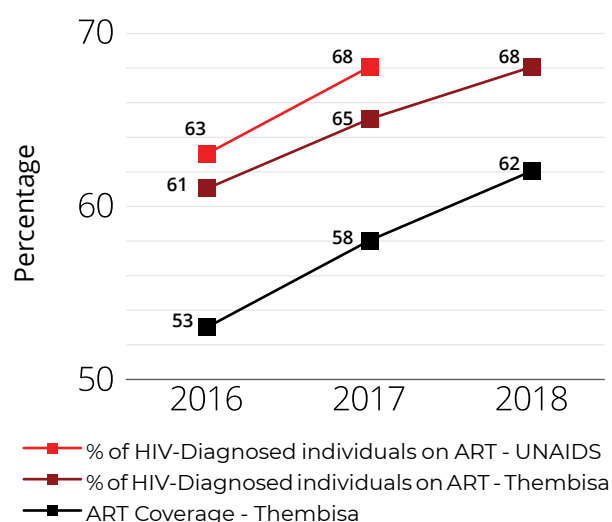
(Source: Thembisa Model⁴)

People Living with HIV on Antiretroviral Therapy

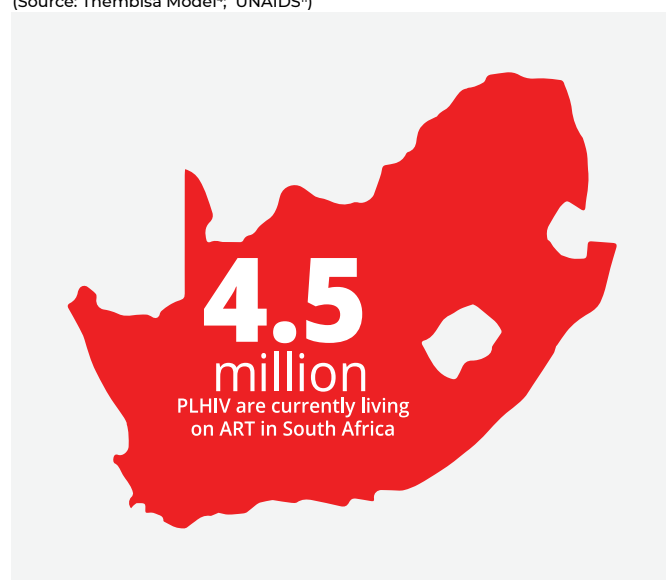
By 2020, 90% of all people diagnosed with HIV should receive long-term combination ART. According to the 2017 SABSSM V, of PLHIV 15 to 64 years who knew their HIV status, only 70.6% were on ART: 77.2% in females and 67.4% in males. However, recent data from the UNAIDS website and the Thembisa Model show slightly lower achievements, albeit both showing upward trends. As shown in Figure 8, the Thembisa Model showed that the percentage of HIV-diagnosed individuals on ART increased from 61% in 2016 to 68% in 2018, at the rate of 402,000 net increase in patients per year ($p=0.008$).

The rates of ART initiation differ somewhat by sex. In 2018, the rate was 69% in women aged 15 years and above, and 66% in males of the same age group, while it was 76% in children less than 15 years old. Overall, the ART coverage – the percentage of all PLHIV on ART – for 2018 was 62%.

Figure 8: Percentage of PLHIV diagnosed on antiretroviral therapy, 2016 to 2018



(Source: Thembisa Model¹⁴; UNAIDS¹¹)



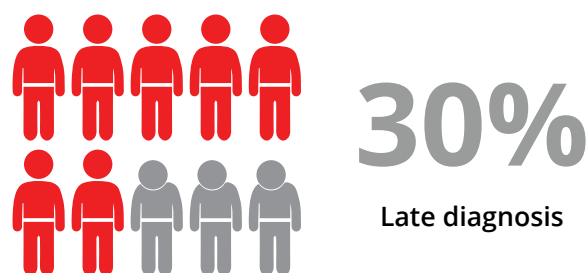
Retention on Antiretroviral Therapy at 12 Months

Data from the district health information system (DHIS) showed retention on ART at 12 months to be 66.2% in 2017 and 57.8 in 2018¹². In 2016, 65.4% of people initiated on ART were retained after 12 months.¹³ Retention in care studies have reported similar percentages as those by the National Department of Health (DoH or NDoH). A national study which converted NHLS data to a cohort study using probabilistic matching techniques showed that retention in the public health system when on ARV therapy was 63% after six years.¹⁴ A local study conducted among women initiating ART in an integrated ANC and ART clinic in Cape Town showed that retention at 12 months was 71%.¹⁵

People living with HIV who have suppressed viral loads

Sustainable virological suppression is the third component of the 90-90-90 targets defined by UNAIDS. The 90% target set for viral suppression among HIV patients on ART has almost been achieved. The 2017 SABSSM V measured viral load suppression in the population. The data showed that 87.5% of PLHIV aged 15 to 64 years on ART were virally suppressed: 89.9% in females and 82.1% in males. Thembisa modelled estimates showed the same result, with the fraction of ART patients virologically suppressed at 88.4% in 2018. In men, women and children on ART, 88.6%, 88.9% and 78.7% respectively are now estimated to virologically suppressed. The achievement of viral load suppression should be interpreted with caution considering that there is a need to scale up achievement towards the second 90 target.

Late HIV Diagnosis



The UNAIDS defines late HIV diagnosis as the percentage of individuals newly diagnosed with HIV who have an initial CD4 cell count less than 200 cells/mm³ (or 350 cell/mm³ when expanded). In 2018, over half (53%) of all patients were diagnosed with CD4 cell count less than 350 cells/mm³ and about a third of patients diagnosed had CD4 count less than 200 cells/mm³.¹²

Antiretroviral Medicine Stock-outs

Antiretroviral medicine stock-outs seek to measure the constant availability of ART to HIV patients. Inconsistent access to antiretroviral medicine has many negative effects including loss-to-follow, viral resistance and mortality. A 2017 national stockout survey of 1526 facilities in South Africa¹⁶ showed insightful results about ARV stockouts:

- Of all participating facilities, 16% had experienced an ARV or TB medicine stockout in the past three months.
- Most facilities experiencing stockouts reported only one item out of stock.
- There was a lower proportion of facilities with stockouts of second-line treatment in the 2017 survey compared to 2015.
- Most (75%) stockouts were resolved in a month.
- Two dosages of efavirenz were the most frequently reported medicines out of stock (13% for 200mg and 11% for 600mg), followed by the fixed dose combination of ARV (9%).



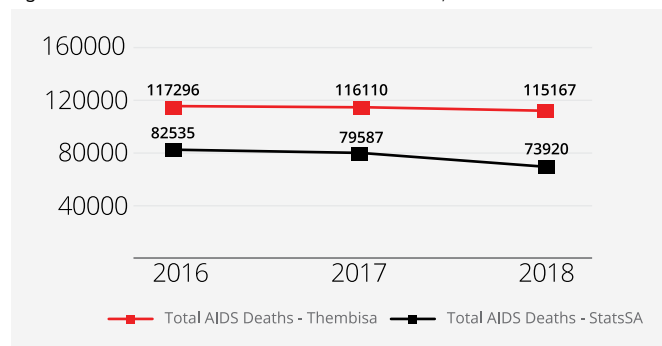
Absence of comprehensive data on stock-out and differences in usage of terminologies have led to the call for a more nuanced understanding of routine stock-out data.¹³

AIDS Mortality



The number of HIV-related deaths continues to decline in South Africa as seen in the past three years, whether using data from Stats SA or from the Thembisa Model. The former showed statistically significant declining trends of 1064 deaths per annum ($p=0.042$). According to Stats SA, there were 115,000 HIV-related deaths in 2018. The deaths reported by Thembisa were slightly lower, but the direction was the same, with 10% decline from 82,535 in 2016 to 73,920 in 2018 (Figure 9). There are more HIV-related deaths in males than females. For example, in 2018, the Thembisa modelled estimates for males stood at 36,646 while in females, the number was 33,585. Deaths in children accounted for 3690.

Figure 9: Trends in HIV-related deaths in South Africa, 2016 to 2018



(Source: Thembisa Model⁴; Stats SA⁵⁻⁷)

HIV testing volume and positivity

The volume of HIV tests performed in South Africa has declined slightly in the past three years, as has the positivity rate. However, the number of tests conducted annually exceed the annual target of 10 million tests (Table 2). Despite over 10 million tests performed annually, the fraction of adults ever tested have only increased marginally to three quarters in 2018.¹⁴ Cumulatively, over 44 million people have been tested for HIV in South Africa since the introduction of HIV counselling and testing in 2010.¹⁹

Table 2: Annual number of HIV tests performed and positivity rate in South Africa, 2016 to 2018

	DHIS	Thembisa	
	Total HIV tests performed	Total HIV tests performed	% of HIV tests with positive results
2016	11,898,308	13,643,800	8.3%
2017	14,233,123	13,042,500	7.4%
2018	13,872,315	12,461,600	6.6%

(Source: Thembisa Model⁴; NDoH¹⁷⁻¹⁹)

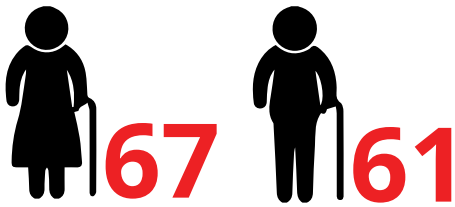
Achievements

Encouraging strides towards 90-90-90

South Africa is among the countries that have achieved the first 90% of the UNAIDS target. It is also notable that the third 90% target for virological suppression has almost been achieved, as shown by different data sources. Although the treatment target has not been met, South Africa has increased the percentage of PLHIV on treatment from 58% in 2015 to 68% in 2018⁴, through its expanded treatment programme.

HIV-related deaths are decreasing, and life expectancy is increasing

Due to increased access to ART, AIDS-related mortality has declined. Data from Stats SA show that life expectancy has continued to increase in South Africa and now stands at 61 years for males and 67 years for females. Cases of antiretroviral medicine stock-out are less frequent than they were in 2015 and they are more rapidly resolved when they occur.



HIV testing volumes remain high

HIV testing remains high, above the 10-million target set annually by the government.

Challenges and Suggestions

Current status of the first 90 target is low in certain subgroups

While HIV testing and knowledge of HIV status have increased and reached the target 90% in adults, it should be noted that there are variations to this percentage across population subgroups. The following groups particularly need attention: children under fifteen, males, females aged 15 to 24 years old and vulnerable groups. For example, three quarters (76%) of children living with HIV knew their status in 2018.⁴

Access to testing and stigma remain two major hurdles to HIV testing. There is a need to explore new innovative ways and inter-sectoral partnerships to surmount these hurdles and increase HIV testing in identified groups. Groups which may fear stigmatisation when accessing HIV testing include adolescents, sex workers, MSM and injecting drug users. Programmes such as youth-friendly testing services, targeted testing services and self-testing will be needed to reach untested groups. The WHO released the guidelines for HIV self-testing in December 2016.²⁰ The roll-out of self-testing services has provided an opportunity to target and increase

HIV testing in identified population groups and communities. The UNITAID-funded self-testing Africa (STAR) programme implemented by the Wits Reproductive Health and HIV Institute (WRHI) in South Africa has between January 2017 and December 2018 distributed 623878 self-testing kits and reached 397778 males, 122103 young people (<25 years) and 1987 sex workers.²¹ The programme is implemented using different channels including workplace, fixed community points, integrated mobile services and sex worker network distribution. The Right to Care's MeIst campaign launched in November 2018 is providing HIV testing services (HTS) to MSM due to the devastating stigma and discrimination they face when seeking healthcare services.²²

Percentage of PLHIV on ART Need to Go Up

The percentage of PLHIV on treatment is still much below the target 90%. At the end of March 2018, the number of PLHIV on ART in the DHIS was 4.1 million people, an increase from 3.8 million patients in March 2017. The estimates provided by the Thembisa Model are slightly higher than those from the country's DHIS because the latter are calculated as at midyear, as opposed to end of March used by the NDoH. By midyear 2018, 4.6 million people were estimated to be on ART in South Africa (Table 3).

To reach the target, 6 million PLHIV would need to be on treatment (81% of all PLHIV). This means that an additional 1.4 million people need to be initiated and retained on treatment (i.e. excluding leakages due to loss to follow-up and mortality forces). All things being equal, this target would be met in about four years, assuming the current (2018) numbers for ART initiation, retention rates and HIV-related deaths remain.

7.5 Million PLHIV

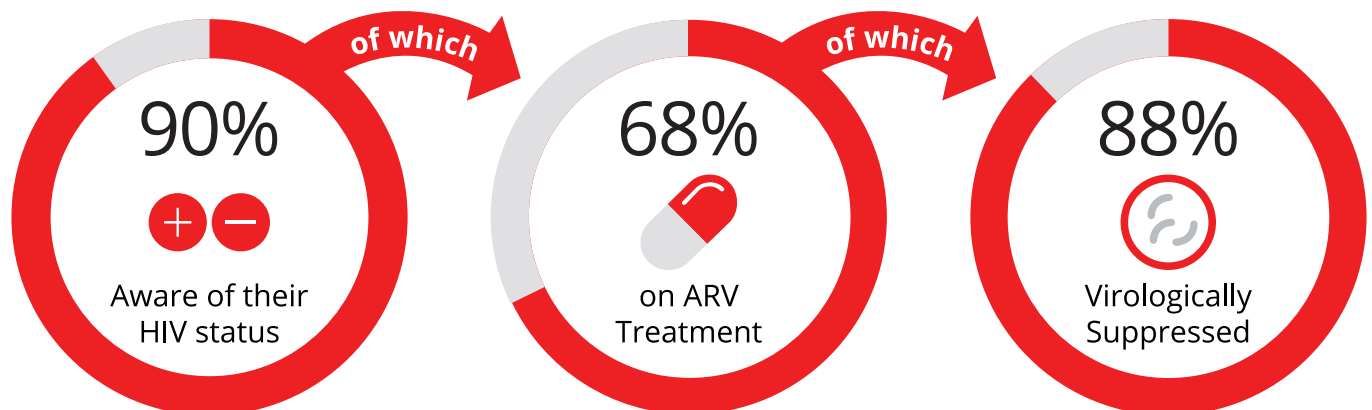


Table 3: Number of people on antiretroviral therapy in South Africa, 2016 to 2018

	NDoH data (DHIS)	Thembisa Model	SABSSM V Survey
2016	3 407 336	3 768 990	
2017	3 831 730	4 180 310	4 401 872*
2018	4 147 853	4 574 380	

(Source: NDOH¹⁷⁻¹⁹; Thembisa Model⁴; SABSSM V¹)

Retention is a key hurdle to meeting the 90-90-90 target by 2020

The key hurdle to achieving the treatment target is the current low retention rates. A retention rate of 90% would have translated to over 6 million people on ART in 2018. However, retention rates are much lower. Of every three people initiated on ART, one is lost to follow-up (LTFU) after 12 months. The national response must continue to explore practical ways to increase retention. Some suggestions have been highlighted in different submissions. Some include the use of:

- Adherence clubs
- Community healthcare workers (CHWs) follow-up programme linkage and patient identifier already solved
- Public mobilisation against stigma
- Workplace policy and support
- Healthcare workers motivation and attitude

Late HIV diagnosis remains high

A related hurdle to low retention rates in the ART programme, is the high rate of delayed diagnosis which portends LTFU and AIDS-related deaths. While innovative testing modalities are required to reach untested groups, research studies are needed to properly document the factors associated with delayed diagnosis and the nuances around it.

Conclusion

South Africa has demonstrated admirable efforts, backed by political will, to achieve this commitment. The efforts have translated into success in the first 90 and last 90 targets. Now, concerted efforts are needed to achieve the treatment target, while improving on documented success. In December 2018, the United States President's Emergency Plan for AIDS Relief (PEPFAR), in what is known as the Surge Plan, revealed that it would be supporting South Africa with over R16 billion Rand to help accelerate epidemic control in the country. The plan which includes components on improving testing and retention will allow for 6.1 million individuals to receive ART in the public health system by December 2020.²³ It appears likely that the treatment target will be reached in 2020, considering the efforts on ground to do so, but there is ample evidence that it will be achieved by 2022 which is the target year of the country's current NSP for HIV, TB and STIs.



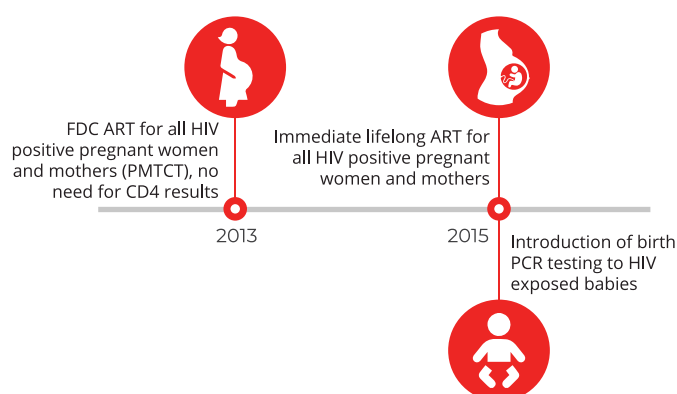
Commitment Two:

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

Is this a priority commitment for the country?	Yes
Does the National Strategic Plan address this commitment?	Yes
Has the country reached the target and commitment?	Yes

Legal and Policy Environment

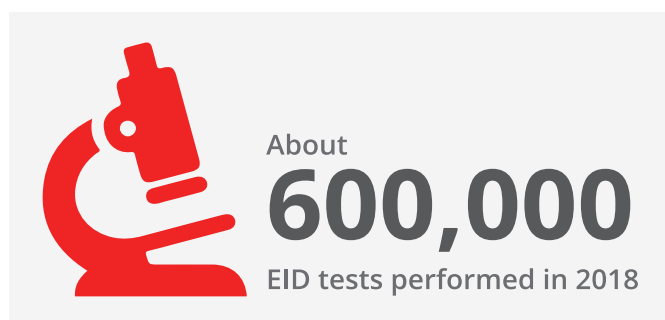
The South African government has, through numerous policies and structures, demonstrated commitment to eliminating new HIV infections among children, while ensuring those already infected have access to ART. For example, before the adoption of the UTT in 2016, the country approved immediate lifelong ART for all HIV-positive pregnant women and mothers in 2015. Also, in June 2015, there were further changes to the prevention of mother-to-child transmission (PMTCT) guidelines, requiring PCR testing to be done at birth for all babies born to HIV-positive mothers. Birth testing was introduced to improve early infant diagnosis (EID) of intrauterine infections and consequent linkage to care. These developments have expectedly involved huge financial investments. The National Health Laboratory Service manages the country's public EID testing services through nine centralised EID laboratories across five provinces. As at 2018, the system managed over 500,000 EID tests annually.



Current Status and Recent Trends

Early infant diagnosis

EID (including birth testing introduced in 2015) is a key component of South Africa's commitment to eliminating new HIV infections among children by 2020. The volume of HIV PCR tests performed has increased annually since 2015. The volume increased from 524,829 in 2016/17 fiscal year to 584,631 tests in 2017/18. The national HIV PCR birth testing coverage was 94% for 2017/2018, up from 68% in 2016/17.^{23, 24, 25} This agrees with the over 95% reported by UNAIDS for EID in 2017.¹⁰



Mother-to-child transmission of HIV

Mother-to-child transmission of HIV in South Africa has been on the decline in the past decade. Data from diverse sources confirm that MTCT rate at birth is now less than 1% and MTCT rate around 10 weeks is around 1% (Table 4).

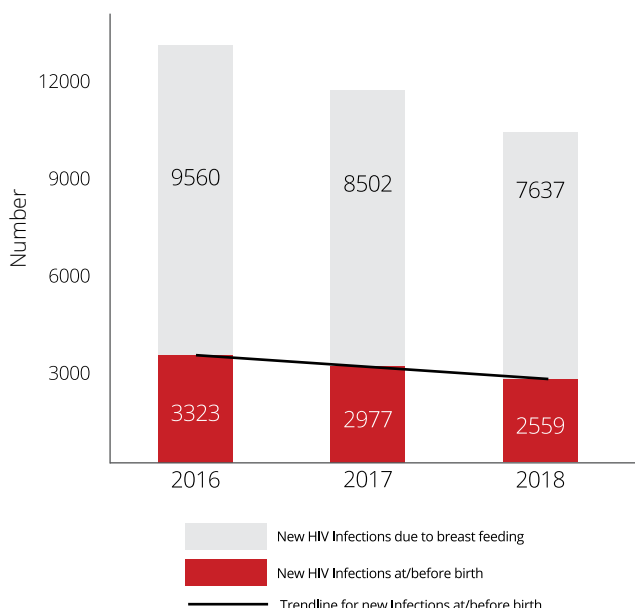
Table 4: Mother-to-child transmission rate in South Africa, 2016 to 2018

Indicator (and data source)	2016	2017	2018
HIV PCR tests with positive results <7d (NHLS)	1	0.9	0.9
MTCT rate at/before birth (Thembisa Model)	1.3	1.2	1
MTCT rate at/before birth from HIV-diagnosed mothers (Thembisa Model)	0.8	0.7	0.7
Infant PCR test positive around 10 weeks rate (NHLS)	1.5	1.2	1.1
Infant PCR test positive around 10 weeks rate (DoH)	1.5	1.3	1.0

(Source: NHLS²⁵; NDOH¹⁷⁻¹⁹; Thembisa Model⁴; SABSSM V)

Using the Thembisa Model, the MTCT rate at birth means that 2,559 babies were born with HIV in South Africa in 2018, down from 3,323 in 2016 (Figure 10). A linear model showed that the number of infected babies at birth declined significantly at the rate of 382 fewer infections per year during this period ($p=0.035$). Most of the MTCTs occur during breastfeeding. As a result, the overall MTCT rate is 4.1% in 2018, equivalent to 10,196 mother-to-child transmitted infections.

Figure 10: Trends in new mother-to-child transmitted infections, 2016 to 2018



(Source: Thembisa Model⁴)



Preventing the mother-to-child transmission of HIV

South Africa has achieved over 90% coverage of ART for PMTCT in the past three years. In 2017 and 2018 respectively, the percentage of antenatal clients initiated on ART was 95% and 94% respectively. In the fiscal year 2016/2017, to ensure the same success was achieved in all districts, South Africa developed, implemented and monitored remedial plans with all districts that have MTCT rates greater than 2%. Furthermore, in 2017/18, the remedial plan focused on the 17 districts with MTCT rates greater than 1.5%.¹⁹

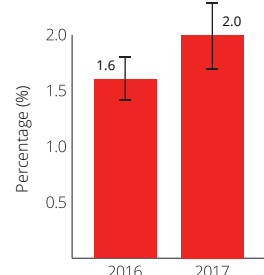


of antenatal clients
initiated on ART in 2018

Syphilis among pregnant women

In South Africa, the management guidelines for STIs require all pregnant women to be tested for syphilis at first antenatal visit, with a repeat test at 32 weeks. Data on syphilis screening in pregnant women is sparse. Before the most recent ANC sentinel surveillance survey of 2015⁸, syphilis prevalence was last measured through the antenatal sentinel surveillance survey of 2011.²⁶ In 2011, the prevalence was 1.6% (95%CI: 1.5%–1.8%), but this increased to 2.0% (95%CI: 1.8%–2.2%) in 2015, with huge variation across provinces. This increase is statistically significant as the 95% confidence intervals do not overlap (Figure 11). Furthermore, data from the DHIS for 2018 showed that 4% of over 1 million tests performed was positive for syphilis.¹²

Figure 11: Prevalence of syphilis in pregnant women, 2011 and 2015



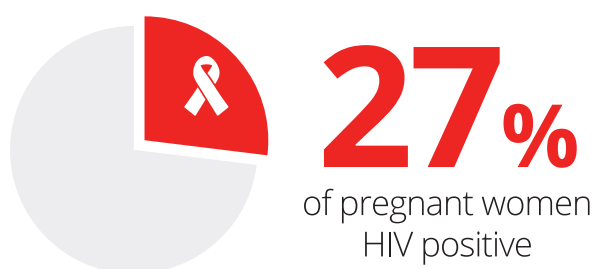
(Source: NDOH^{8, 26})

Congenital syphilis rate (live births and stillbirth)

Data on congenital syphilis is equally scanty. Data from the DHIS for 2018 showed a congenital syphilis rate of 2% (159 positives of 947 tests).¹² According to the National Institute of Communicable Diseases (NICD), between June and December 2017, there were 2,494 laboratory alerts for syphilis-positive test results in infants under two years.²⁷

HIV testing among pregnant women

HIV testing among pregnant women is a key component of the PMTCT programme and it is tied to ANC coverage in the country. In 2017 and 2018, 988,062 and 1,023,576 women respectively were tested for HIV. In both years, 27% were positive.¹²



Achievements

HIV birth testing is nearing 100%

The number of HIV PCR tests performed at birth and all forms of EID test performed annually have been on the increase in the past three years. In 2018, 260,000 birth PCR tests were conducted, up from 230,000 in 2016 (Table 5).²⁵ In 2018, about 600,000 PCR tests were conducted by the NHLS EID unit – including routine PCR test for infants up to 18 months of age and at time of clinical presentation, if the patient presents with signs/symptoms of HIV-infection.²³ As a result, the national HIV PCR birth testing coverage now stands at 94%.¹²

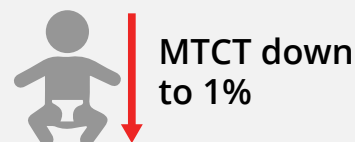
Table 5: Number of early infant diagnosis PCR tests conducted in South Africa, 2016 to 2018

	Total HIV PCR tests performed – birth	Total HIV PCR tests performed – about 10 weeks	Total PCR EID tests
2016	229909	131972	-
2017	246781	161052	524829
2018	259801	177109	584631

(Source: NDOH²⁵)

MTCT rate continues to drop

South Africa achieved its target for the elimination of MTCT (eMTCT) of HIV in 2015. Elimination of MTCT 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). Despite the feat, South Africa has not relented in its PMTCT efforts. Currently, less than 1% of HIV-exposed babies are born with HIV infection.



Testing for syphilis in pregnancy resumed

In the effort to actualise its commitment to dual elimination of HIV and congenital syphilis, South Africa has resumed testing and monitoring for syphilis in pregnant women. Congenital syphilis is preventable, and just like HIV, its prevention will require testing of pregnant women during ANC visits and the use of monitoring data for action.

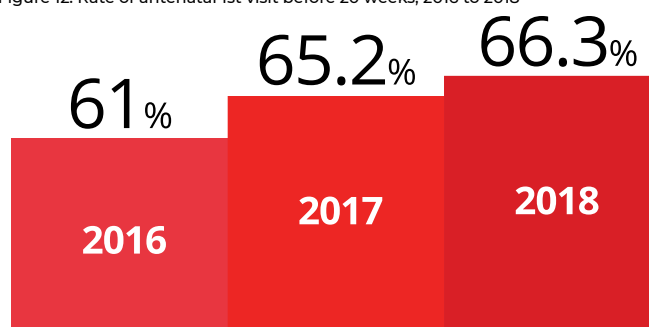


Key Issues

ANC coverage still not optimum

The success of the PMTCT programme is strongly tied to the ANC coverage. ANC coverage (having at least one ANC visit) falls slightly short of 100%, with the South Africa Demographic and Health Survey (SADHS) 2016 reporting 95% coverage.¹³ Despite the excellent coverage, late attendance remains a hurdle to ensuring the benefits of ANC accrue to mothers and their babies. South Africa is keen on covering the ANC coverage gap and improving overall ANC utilisation. In the past three years, the rate of antenatal 1st visit before 20 weeks increased from 61% in 2016 to 66% in 2018 (Figure 12). Furthermore, from April 2017, The NDoH decided that all pregnant women should have at least 8 ANC visits and to encourage first visit by 14 weeks.²⁸

Figure 12: Rate of antenatal 1st visit before 20 weeks, 2016 to 2018



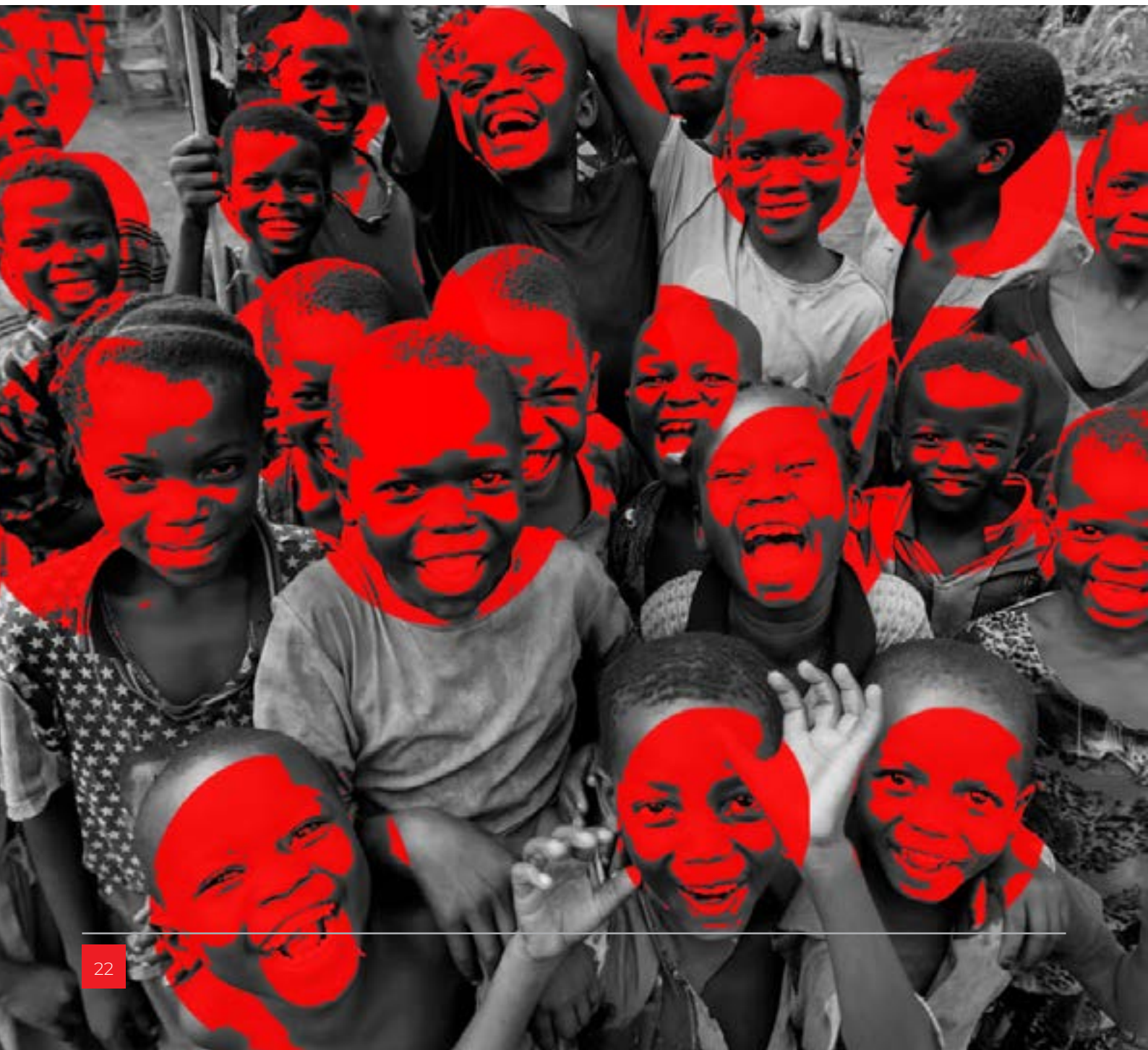
(Source: NDoH¹⁷⁻¹⁹)

Congenital syphilis numbers are rising

While South Africa is winning the war against MTCT of HIV, the rate of congenital syphilis appears to be rising. This is an area of concern for the government. The current congenital syphilis rate of 2% is four times the target of 50 cases per 100,000 live births set out in the current NSP for HIV, TB and STIs. Improved awareness through quality information, improved testing during pregnancy, linkage to care and monitoring of data are key focal areas that require attention.

Conclusion

The South African PMTCT programme, which began 15 years ago, has through strong political will and intersectoral participation achieved tremendous success in the prevention of MTCT of HIV infection as evidenced by recent trends in MTCT rates. However, the programme should now focus on deepening the success, reducing MTCT during postnatal care and congenital STIs, such as syphilis which appears to be rising in recent years.





Commitment Three:

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

Is this a priority commitment for the country?	Yes
Does the National Strategic Plan address this commitment?	Yes
Has the country reached the target and commitment?	No
How likely is the country to reach the target by 2020?	Not likely

Legal and Policy Environment

The South African legal environment addresses most aspects of this commitment. Except for sex workers and PWID, all the other key populations are accorded legal status by the country and cannot be prosecuted under criminal law. Marriages between same-sex individuals have been legalised in South Africa. The current NSP for HIV, TB and STIs 2017-2022 addresses this commitment under Goal 3, with specific plans and details.

The South African government has demonstrated and intensified efforts to provide combination prevention options for the general population and for key populations. For example, the current NSP for HIV, TB and STIs sets targets for the number of medical male circumcisions (MMC) to be

November 2015
The South African Medicine Control Council approved a fixed-dose combination of Truvada for PrEP

June 2016
National launch of oral PrEP for sex workers

April 2017
Rollout of PrEP for MSM started at selected sites

March 2016
Launch of the South African National Sex Worker HIV Plan, 2016-2019

2016
South African National Guidelines for Medical Male Circumcision

April 2018
Roll-out of PrEP for adolescent girls and young women was started at selected public clinics



performed annually, condom distribution and HIV testing in key populations, among others. The right to access health services for the prevention of HIV and STIs is upheld for all who live in South Africa. Additionally, South Africa continues to create policy framework to ensure the control of the HIV epidemic in key populations. Barely eight months after the WHO released their guidelines for HIV PrEP, in June 2016, South Africa became the first country to provide sex workers, and other key populations, with oral PrEP as part of its national HIV programme. Furthermore, there have been recent policy changes regarding this commitment.

Current Status and Recent Trends

HIV Incidence

In 2018, there were an estimated 222,000 new HIV infections, down from 274,000 in 2016. The number of new infections remains highest among females (Table 6). Among adult males

and females aged 15 to 49 years, the estimated number of new cases of 216,000 in 2017 by the Thembisa Model is very close to the 200,000 estimated in the SABSSM in the same year.

Table 6: Number of HIV infections in South Africa by age and sex, 2016 to 2018

Number of new HIV infections	2016	2017	2018
Total new HIV infections	274726	248750	221735
New infections in males aged 15+	101070	90514	79401
New infections in females aged 15+	159247	145364	130858
New HIV infections in children <15	14409	12872	11476
New HIV infections in 15-24 year olds	109079	96932	85275
New HIV infections in 15-24 males	26604	22929	19545
New HIV infections in 15-24 females	82475	74002	65730
New HIV infections in 15-49 year olds	239370	216193	192105
New HIV infections in 15-49 males	92337	82377	71975
New HIV infections in 15-49 females	147032	133816	120131

(Source Thembisa Model⁴)



180

Young women aged 15 - 24 years are infected with HIV every day



130,858

New infections in females aged 15 years and above



79,401

New infections in males aged 15 years and above

222,000

new infections in 2018



11,476

New HIV infections in children <15

Other indicators in this commitment

Table 7: Other indicators relating to Commitment 3, 2016 to 2018

Indicator	2016	Source	2017	Source	2018	Source
HIV incidence	0.57%	Thembisa Model ⁴	0.51%	Thembisa Model ⁴	0.44%	Thembisa Model ⁴
Estimates of the size of key populations						
Sex workers	237717	Setswe et al ²⁹	110000	UNAIDS ¹¹		
MSM	1 095 527	Setswe et al ²⁹	300000	UNAIDS ¹¹		
PWID	75 701	Setswe et al ²⁹	17000	UNAIDS ¹¹		
Transgender people	139 666	Setswe et al ²⁹	5500	UNAIDS ¹¹		
Prisoners	161984	DCS ³⁰	161 054	DCS ³¹	164 129	DCS ³²
HIV prevalence among key populations						
Sex workers	59%	Thembisa Model	47%	VHI ¹⁰	54.9	Thembisa Model ⁴
MSM	27%	Thembisa Model	43%	VHI ¹⁰	26.3	Thembisa Model ⁴
PWID	46%	UNAIDS	21%	VHI ¹⁰ , Scheibe ³⁴		
Transgender people						
Prisoners			9%	UNAIDS ¹¹	8.9%	DCS ³⁵
HIV testing among key populations						
Sex workers						
MSM						
PWID			72% to 98%	TRIPVAL ³³		
Transgender people						
Prisoners	199,750	DCS ²⁸	218,654	DCS ³¹		
Antiretroviral therapy coverage among PLHIV in key populations						
Sex workers			24%	UNAIDS ¹¹	29% to 59%	Aurum Institute ³⁶
MSM			28%	UNAIDS ¹¹		
PWID						
Transgender people						
Prisoners	98%	DCS ²⁸	98%	DCS ³¹	98.8%	DCS ³⁴
Condom use among key populations						
Condom use among sex workers			86%	UNAIDS ¹¹	81% to 90%	Aurum Institute ³⁶
Condom use among MSM			81%	UNAIDS ¹¹		
Condom use among PWID						
Condom use among transgender people						
Coverage of HIV prevention programmes among key populations						
Safe injecting practices among people who inject drugs						
Shared needle last time						
Needles and syringes distributed per PWID			17%	Scheibe ³⁴		
Coverage of opioid substitution therapy	19%	UNAIDS ¹¹	5%	Scheibe ³⁴		
Active syphilis among sex workers						
Active syphilis among men who have sex with men						
HIV prevention programmes in prisons						

Viral hepatitis among key populations (Hepatitis B)						
Sex workers			4%	VHI ¹⁰		
MSM			3%	VHI ¹⁰		
PWID			5%	VHI ¹⁰ , Scheibe ³⁴		
Transgender people						
Prisoners						
Viral hepatitis among key populations (Hepatitis C)						
Sex workers						
MSM			2%	VHI ¹⁰		
PWID			45%	VHI ¹⁰ , Scheibe ³⁴		
Transgender people						
Prisoners						
People receiving pre-exposure prophylaxis (PrEP)						
Prevalence of male circumcision	46%	SABSSM IV ³	62%	SABSSM V ⁴		
Annual number of males voluntarily circumcised	569523	NDoH ¹⁷	493876	NDoH ¹⁸	539892	NDoH ¹⁹
Condom use at last high-risk sex			57.6%	SABSSM V ⁴		

*Empty cells have no data

Achievements

As presented below, recent years have been characterised by positive changes in providing HIV services to key population groups in South Africa.

Supporting legal and policy environment for combination prevention interventions

The NSP for HIV, TB and STIs 2017 to 2022 which is the overarching framework for the HIV epidemic response, provides guidelines for combination prevention interventions for the general and key populations. Specifically, the South African National Policy on HIV PrEP and UTT contains well defined provisions for all key and vulnerable populations, including gay men and other MSM, sex workers and their clients, transgender people, PWID and prisoners and other incarcerated people, as well as young women and migrant populations. Prior to that, the country developed the South African National Sex Worker HIV Plan for 2016-2019.³⁷ There are other legal provisions that protect key populations, such as the National LGBTI HIV Plan for 2017-2022,³⁸ which is aligned to the current NSP for HIV, TB and STIs. This Framework seeks to reach key and vulnerable populations with targeted interventions and promote inclusiveness in the health services sector. It provides a standardised minimum package of services to be implemented by private and public sectors and endorses the provision of PrEP for HIV-negative MSM, including gay and bisexual men and UTT for all LGBTI persons. Although sex work is still criminalised in South Africa, the South African Law Reform Commission recommended partial decriminalisation

in 2017, which meant that only the person buying sex would be acting illegally. This recommendation is yet to be passed into law, and sex workers still face legal prosecution in South Africa.

Provision of PrEP to key and vulnerable populations

Two big achievements have been made regarding PrEP. Firstly, a policy change in 2016 allowed key populations to access PrEP in South Africa, the first country to do so in the world.^{39,40} Secondly, the number of persons in key populations accessing PrEP is increasing and almost reaching set targets. The phased implementation started in 2016 with sex workers; it was expanded to include MSM in April 2017, youths at selected tertiary institutions in October 2017 and AGYW at selected public facilities in 2018. In May 2019, South Africa had rolled out PrEP in 87 facilities across 27 priority districts. Implementation is planned to be scaled up to more than 2000 facilities across the entire country in order to reach the NSP targets. From June 2016 to May 2018, a total of 5,857 persons were initiated on PrEP across 34 sites in South Africa. The majority of the people who have received PrEP were sex workers and MSM.⁴¹



5,857

Persons initiated on PrEP in two years.

4,109

Sex workers

1,537

MSM

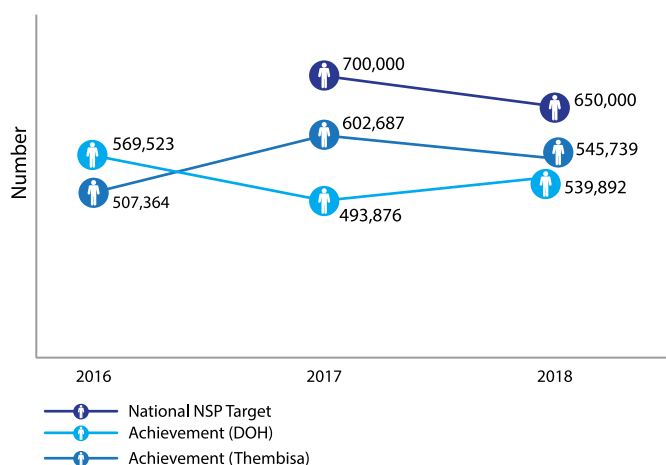
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Youths

Voluntary Medical Male Circumcision is consistent

Voluntary medical male circumcision (VMMC) remains an integral component of South Africa's combination HIV prevention interventions. Data from the DoH and the Thembisa Model report a cumulative number of VMMC for the past three years to be 1.6 million and 1.7 million respectively (Figure 13). The data show that South Africa has not reached the 2016 target of 4.3 million MMC set in 2010. Furthermore, the country has consistently fallen short of the annual target set in the current NSP. The current NSP targets a cumulative 3 million men to be medically circumcised over five years i.e. from 2017 to 2022.

Figure 13: Number of voluntary medical male circumcisions, 2016 to 2018



The 2017 SABSSM reported the prevalence of circumcision among males to be 62%, a significant increase from the 46% reported in 2012. This is plausible, because with a male population of about 15 million people, an annual circumcision of about 500,000 males will increase the prevalence by 16% in five years. Although the current prevalence of male circumcision is welcome, it still falls short of the target coverage of 80%.

Targeted geographical and demographic interventions are needed. There is a potential to scale up MMC in major centres like Cape Town and Tshwane which have high population sizes but recorded relatively lower numbers of MMC. The UNAIDS and the WHO posit that prioritising MMC in young men aged 10 to 29 years will have the greatest public health impact. South Africa will need to consider how to make VMMC more appealing to these groups. Fears and misconceptions will need to be cleverly addressed in these groups, while government continues to engage and work with traditional leaders. The use of media and mobilised communities will be central to these efforts. Nonetheless, the overall outlook for South Africa in 2018 suggests a wider acceptance of MMC by men and provides the opportunity for HIV prevention and linkage to care.



More NGO programmes reaching PWID and reporting data

As at 2016, there were three sites in South Africa providing HIV and harm-reduction services to PWID. This has expanded to five in 2018. The Step-up programme initiated in 2015 by TB/ HIV Care Association for PWID is still operational in three sites, Cape Town, Durban and Port Elizabeth. A similar project, JAB SMART, was started by ANOVA Health Institute in May 2017, with support from the City of Johannesburg health department. The programme is the first of its kind to provide harm-reduction services to PWID and their sexual partners. The JAB SMART project aims to improve access to testing and linkage to care amongst PWID, by providing a comprehensive HIV package and harm-reduction services. The HarmLess Project by OUT-Wellbeing in Pretoria is the fifth site. The services provided by these projects are shown in Table 8. It is noteworthy that in 2017, these programmes started reporting their services data to the South African Community Epidemiology Network on Drug Use (SACENDU), as part of the national drug surveillance reporting for South Africa.^{44, 45}

Table 8: HIV and harm reduction services provided to PWID by key NGOs

	TB/HIV Care Association ⁴²	ANOVA Health Institute ⁴³	Out-Wellbeing 2018 ⁴⁴
Reporting period	Jan to Dec 2018	Jan to Dec 2018	Jan to Jun 2018
No of project sites	3	1	1
Number of PWID served	2037	1869	4349
Number of needles and syringes distributed	433,867	344,073	225,709
Number of needles and syringes distributed per person	213	184	52
Number of people on OST	144	74	-
Number tested for HIV	1136	1340	667
HIV positivity rate	8.9%	46%	28%
Number initiated on ART	56	104	41

Increased Government Involvement

The fact that the JAB SMART project has enjoyed support from the government points to increasing government involvement in programmes targeting injecting drug users. In April 2017, TB HIV Care, in partnership with Durban University of Technology's Urban Futures Centre, launched the opioid

substitution therapy (OST) programme as part of harm-reduction services for PWID. TB HIV Care has a similar centre in Durban. Representatives from the national and provincial departments of health have visited the programme to learn more on its design and implementation.^{44, 45}

Key Issues

Need to increase PrEP coverage and awareness

Despite the achievements in the HIV PrEP programme, more work is needed to increase access to it in public hospitals, especially for young women aged 15 to 24 years among whom HIV incidence remains high. Targeted programmes to increase awareness for PrEP are also needed. PrEP expansion needs to include community knowledge on PrEP with a specific focus on normalising PrEP as part of an HIV combination prevention modality.

Interventions needed for PWID in the prison and general population

South Africa is part of the drug trafficking network in the world, and the largest market for illicit drugs in Sub-Saharan Africa. This includes the trafficking and use of injectable drugs in the country. According to the SACENDU 2018 report, treatment demand data showed that the number of patients reporting injecting drug use has not declined over the last few years, and that an increased diversity of drugs are being injected.⁴⁵ Yet, the war on drugs in South Africa has been largely expressed as a war on people. This has contributed to the social and structural factors that continue to fuel the HIV epidemic in this group. There are still no government programmes providing PWID with harm reduction and HIV services such as needles and syringes programmes, OST, HIV testing and counselling (HTC) and ART. Government action in this regard will not only provide access to appropriate services for PWID, but will also reduce stigma and exclusion, and inspire community-led interventions for this group.



HIV incidence is not declining fast enough

Although the HIV incidence has been declining in South Africa, the rate of decline is not fast enough to meet the UNAIDS

target of 75% reduction between 2010 and 2020. To meet this target, South Africa would need to reduce its number of new infections to less than 88 000 by 2020 (or 2022 which is the national target to date). This feat can be considered to have a remote possibility given the number of new infections in the past three years.

HIV incidence rate in young women remain very high

The HIV incidence rate in young women aged 15 to 24 years old was 1.5% in 2018, about four times the rate in the general population (0.4%) and among men of the same age group (0.4%). These recent data show that HIV incidence, like HIV prevalence, remain disproportionately higher in young women.

South Africa has a coordinated national strategy for the prevention of HIV among AGYW, and their partners. The She Conquers campaign was launched in June 2016 as a multisectoral coordinated effort aimed at improving the lives of AGYW. In June 2017, the DoH launched the National Adolescent and Youth Health Policy which provides guidance to government departments and partner organisations working with the DoH on how to respond to the health needs of the youth. Other programmes include the Adolescent Youth Friendly Services (AYFS), Integrated School Health Programmes (ISHP) and B-Wise Campaign. These programmes and others implemented by government and partners seek to improve the health of adolescents and youth, with a focus on addressing the factors that make young people more vulnerable to HIV acquisition.

Condom use in high-risk sex is low

In the 2017 SABSSM survey, among respondents who have had sex with a non-marital, non-cohabiting partner in the last 12 months, only 58% reported using condom at last sex. The percentage was slightly higher among males than females.

There are no data for many key populations

In the previous NSP for HIV, TB and STIs (2012 to 2016), transgender people were mentioned as a key population, albeit with no plan for interventions in that group. This has significantly improved in the current NSP where plans and targets have been documented for transgender people and other key populations. However, many key population groups such as transgender and prison populations still do not have data to inform programming. For example, there are no estimates for the size of transgender population in South Africa, neither are there data on HIV outcomes. Also, HIV services data are not available for many key populations (Table 7). For example, PrEP data for PWID and prisoners are not available.



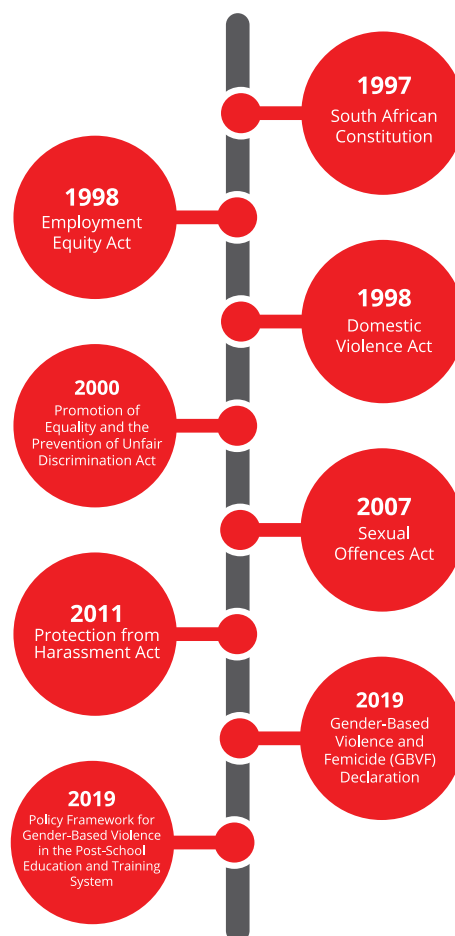
Commitment Four:

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

Is this a priority commitment for the country?	Yes
Does the National Strategic Plan address this commitment?	Yes
Has the country reached the target and commitment?	No
How likely is the country to reach the target by 2020?	Not likely

Legal and Policy Environment

The South African constitution has made provisions for all PLHIV and key populations to live in the country without any form of discrimination. The Promotion of Equality and Prevention of Unfair Discrimination Act, 2000 (PEPUDA or the Equality Act No. 4 of 2000) is a comprehensive South African anti-discrimination law which includes HIV/AIDS. The law also specifically lists sex, gender and sexual orientation and other characteristics as barred areas for discrimination. This Act is in congruence with the South African constitution which guarantees equality for all people living in South Africa, and the Employment Equity Act, 1998 which guarantees protection against discrimination in the workplace. These and other recent laws and policies regarding this commitment are shown in the policy timeline.



Current Status

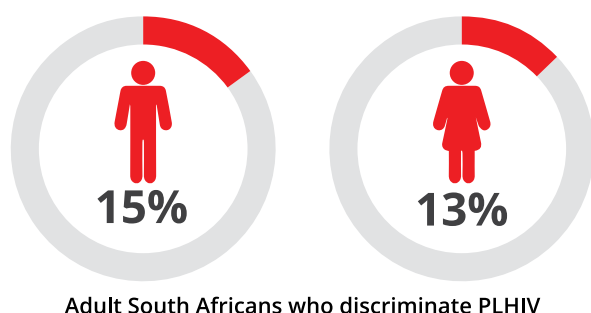
Discriminatory attitudes towards people living with HIV

Table 9: Indicators for Commitment 4

Number of new HIV infections	2016	2017	2018
Percentage of men and women aged 15-49 who report discriminatory attitudes towards PLHIV		15.3% - males* 13.2% - females	
Percentage of sex workers who avoid healthcare because of stigma and discrimination	No data		
Percentage of MSMs who avoid healthcare because of stigma and discrimination	No data		
Percentage of PWID who avoid healthcare because of stigma and discrimination	No data		
Percentage of transgendered people who avoid healthcare because of stigma and discrimination	No data		

(Source: SABSSM V)

The PLHIV Stigma Index Survey in South Africa was last conducted in 2014 among PLHIV aged 15 years and above, in all nine provinces. The survey reported overall internal stigma to be 43% and overall external stigma to be 35.5%.⁴⁶ Although the last two Stigma Index surveys were conducted in 2012 and 2014 respectively, no further survey has been conducted since then. The UNAIDS recommends that this indicator should be measured every two to three years. A recent study conducted in Durban among tertiary education students reported perceived stigma to vary by community (41% on campus and 47% in students' home communities). The perception of stigma was shown to be significantly associated with preferred place of HIV testing.⁴⁷



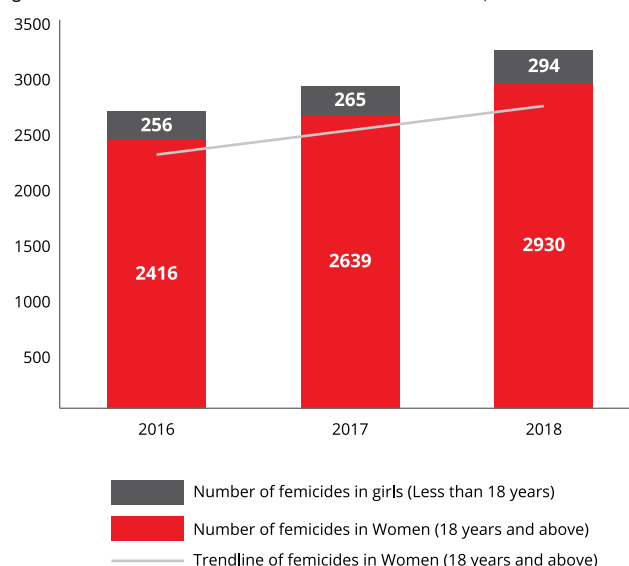
The 2017 SABSSM survey showed that 15% of males and 13% of females aged 15 to 49 years showed discriminatory attitudes towards PLHIV.¹ Comparison could not be made between these figures and those from the 2012 SABSSM survey due to changes in the questions used. However, the figures are similar to those from a study conducted among students and staff members of technical colleges in South Africa. Approximately 21% of students and 14% of staff in the study reported that they did not want to be associated with HIV-positive people. More male students (23%) than female students (19%) showed HIV-related discrimination.⁴⁸

Prevalence of recent intimate partner violence

According to the SABSSM 2017 survey, the proportion of ever-married or partnered women aged 15–49 years old who experienced physical or sexual violence from a male intimate partner in the past 12 months was 29.1%. This proportion was slightly lower in HIV+ women (25.2%) compared to HIV-negative women (32.7%). Owing to the unavailability of surveillance data for trends analysis of IPV numbers, femicide data serves as a proxy. A review of the literature shows that over half (50 to 60%) of femicides in South Africa are committed by intimate partners.⁴⁹ According to the South African Police Force data, 2 672 women and girls were killed in 2016. (Figure 14) The trends analysis showed that during the review period, 257 additional women were killed yearly from 2 416 in 2016 to 2 930 in 2018 ($p=0.049$).



Figure 14: Trends in the number of femicides in South Africa, 2016 to 2018



(Source: South African Police Service Annual Report⁵⁰⁻⁵²)

Experience of HIV-related discrimination in health-care settings

Most studies on stigma in healthcare settings in South Africa are qualitative and do not estimate the extent of this experience. A qualitative study in two South African cities

documented healthcare workers self-reported attitudes and discrimination towards sex workers, MSMs and PWID. Members of these key populations in the study internalised stigma and discrimination they experienced at health facilities.⁵³ Another study found that many women have unmet needs for reproductive health such as female condoms and pap smears. The sex workers described healthcare providers as “abusive” and “hostile” personnel who sometimes withhold treatment or refer out sex workers for no obvious reasons, while also explicitly blaming sex workers for their illnesses.⁵⁴

Key issues

No data on many indicators

Although the role of stigma and discrimination in late HIV diagnosis and the low levels of retention in the country is well known, there is a paucity of comprehensive monitoring data on the outcomes. There are also no surveillance data on IPV. Surveys that include standardised indicators, definitions and methods are needed and should be repeated at defined intervals.



No recent comprehensive data on HIV-related stigma

Stigma still exists

Significant strides have been made in HIV/AIDS education in the 21st century, but widespread stigma still exists around HIV/AIDS, especially towards marginalised key populations. Despite progressive South African laws which do not discriminate against anyone on grounds of gender or sexual orientation, MSM and transgender people are still marginalised by society and they experience stigma and discrimination. This exposes them to suboptimal services, and sometimes, total exclusion from formal healthcare settings. The 2017 study on HIV key populations in South Africa showed that, despite 95% of study participants intending to seek healthcare, only 25% actually did, for reasons including previous experience of stigma.³¹ The study revealed that about 6% to 8% of PWID reportedly experienced stigma in healthcare settings, while 26 to 30% experienced stigma from the police.³¹

Comprehensive efforts needed to reduce levels of stigma

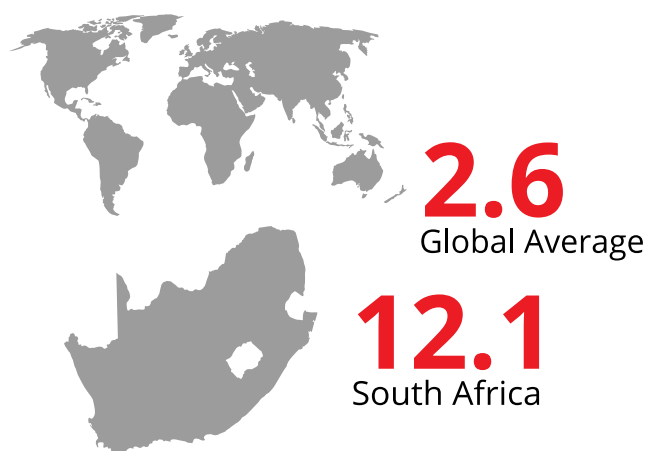
There are a few programmes implemented by civil society and government to address HIV-related stigma. But these efforts have not been comprehensively organised into a strong coordinated agenda to curb the high levels of stigma

that continue to threaten the goal to eradicate HIV/AIDS. It is notable that the current NSP for HIV, TB and STIs (2017 to 2022), through Goal 5, provides a strong focus on eliminating stigma and discrimination through various means, including community education, training of healthcare providers and legal processes. SANAC would have to ensure that this national stigma mitigation plan is implemented to success. Such an agenda should include a robust surveillance system.

IPV is high in South Africa, including in primary and secondary schools

Data from the WHO show that South Africa's femicide rate was 12.1 per 100,000 in 2016, almost five times the global average of 2.6. Young adolescents in primary and secondary school are not exempted from the bane of IPV in the country. The SeViSSA baseline study among primary and secondary school students in Khayelitsha found high levels of sexual violence, including intimate partner violence, among those in heterosexual dating relationships.⁵⁵ The study found that 35% of primary and secondary school students have experienced sexual violence in an intimate partnership in the 12 months preceding the study, with a significant proportion forced to have sex out of fear.

Femicide rate per 100,000



35%

of primary and secondary school students have experienced IPV in the past year.

Is there political will to eliminate GBV?

The rising incidence of gender-based violence (GBV) in South Africa may suggest that the state lacks the political will or strategy to curb the scourge. South Africa must demonstrate the will to address structural and cultural determinants of GBV, implement existing laws and policies, and address the gaps in accountability and the criminal justice system.

Achievements

Renewed political commitment to eliminating GBV

Despite gaps in implementation, there is no doubt about South Africa's political commitment to eliminate gender inequalities and GBV. Recent efforts include the Gender-Based Violence and Femicide (GBVF) Declaration and the Policy Framework for Gender-Based Violence in the Post-School Education and Training System (PSET), both in 2019.

In the GBVF declaration of 2019, President Cyril Ramaphosa set a roadmap to a South Africa free from GBV and femicide. The declaration called all South Africans to combat GBV through a coordinated multi-sectoral effort. He also promised developing a national strategy and allocation of resources for increased efforts. The renewed commitment includes adequate resourcing of Thuthuzela Care Centres (TCCs) and strengthening of sexual offences courts. The Policy Framework for the PSET system sets out the strategic intent of the Department of Higher Education and Training (DHET) to curb the scourge of GBV in PSET institutions and protect young women. The scope of this Policy Framework is the entire national PSET system – institutions and organisations, including universities, technical and vocational education and

training colleges, and community education and training (CET) colleges, as well as skills providers. The framework applies also to all students, whether full-time or part-time, residential or online, as well as all staff of institutions and organisations.

Government and civil society interventions

There are several government-initiated interventions which have been established to respond to the high GBV incidence in the country. The 16 days of activism against women and children is one such example. It can however be argued that the campaign may need to be revamped in order to achieve desired momentum and impact. The Stop Gender Violence Campaign is a national coalition of civil society organisations (CSOs) working together to end GBV. The She Conquers campaign is a three-year government-initiated campaign that aims to improve the lives of AGYM in South Africa. TCCs are one-stop facilities that have been introduced as a critical part of South Africa's anti-rape strategy, aiming to reduce secondary trauma for the victim, to improve conviction rates and to reduce the cycle time for finalising cases.

There are a number of programmes implemented by non-governmental organisations (NGOs) targeting key populations. The Witwatersrand's Reproductive Health and HIV Institute's Key Populations Programme provides interventions for transgender people and sex workers. The programme addresses risk-taking behaviours, and provides HIV care, treatment and prevention services for these key populations across seven districts in South Africa. There are programmes on PWID implemented by ANOVA and HIV and TB Care. Some of these programmes have used innovative approaches, including the use of peer educators, to reach 'hidden' members of key populations.



Commitment Five:

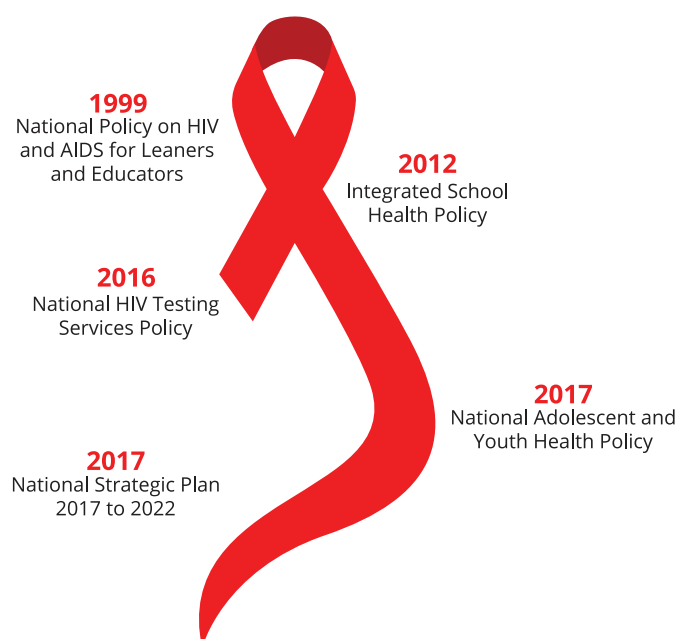
Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100,000 per year

Is this a priority commitment for the country?	Yes
Does the National Strategic Plan address this commitment?	Yes
Has the country reached the target and commitment?	No
How likely is the country to reach the target by 2020?	Not likely

Legal and Policy Environment

There are several national policies aligned to global frameworks and adapted to the local context regarding the prevention of HIV and access to SRH services for young people. The NSP 2017-2022 specifically expresses the provision of sensitive and age-appropriate SRH health services and comprehensive sexuality education. Other national frameworks aligned to this commitment include the National HIV Testing Services Policy of 2016, which places emphasis on testing of adolescents and young women in schools and broader communities; the National Adolescent and Youth Health Policy (AYHP) of 2017 which targets 10-24-year olds with the aim of providing adolescent and youth-friendly health services; and the Integrated School Health Policy of 2012, which provides a framework for the design of the curriculum to include practical information about HIV/AIDS and TB, SRH and substance

abuse, among other health issues which increase the risk of HIV infection. These policies involve several government departments and connect local institutions with bilateral organisations on youth-focused interventions.



Current Status

Young people: Knowledge about HIV prevention

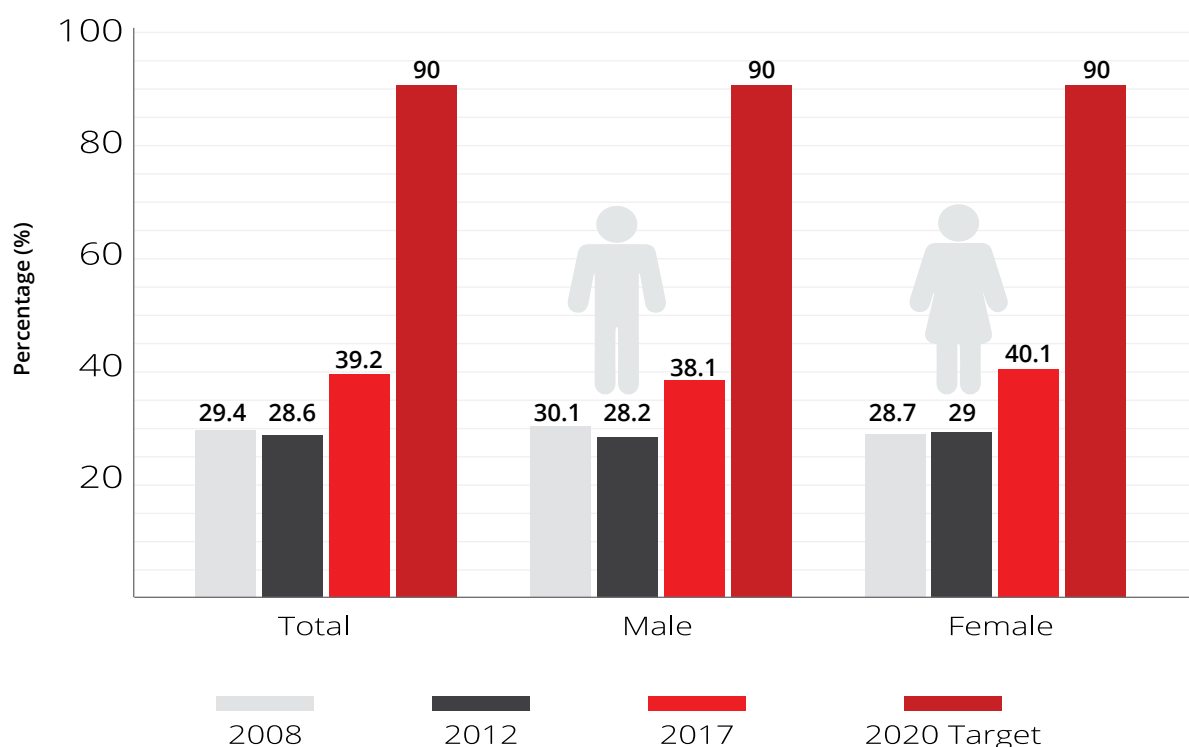
Table 10: Percentage of young people (15 to 24 years) with comprehensive knowledge of HIV prevention

Indicator	All Males (15-24)	All Females (15-24)
Comprehensive knowledge of HIV prevention	38.1	40.1
Risk of HIV transmission can be reduced by having sex with only one uninfected partner who has no other partners	69.1	68.8
A person can reduce the risk of getting HIV by using a condom every time they have sex	84.1	84.2
A healthy-looking person can have HIV	84.6	86.7
AIDS cannot be cured	73.7	77.8
A person cannot get HIV from sharing food with someone who is infected	77.9	83.9

(Source: SABSSM V)

The proportion of young people in South Africa with comprehensive knowledge about HIV prevention was only 38% among males and 42% among females (Table 10). These levels of knowledge about HIV prevention are still far below the 90% target. It is notable that of the five questions that makes up this composite indicator, young people in South Africa scored the lowest on the first question about faithful monogamous sexual partnership for HIV prevention. The trends graph using data from the last three SABSSM surveys showed that South Africa has not achieved much regarding this indicator, a mere 10 percentage points increase in the last decade (Figure 15).

Figure 15: Trends in comprehensive knowledge of HIV prevention among young people in South Africa, 2008 to 2019



(Source: SABSSM III to V¹⁻³)

Demand for family planning satisfied by modern methods

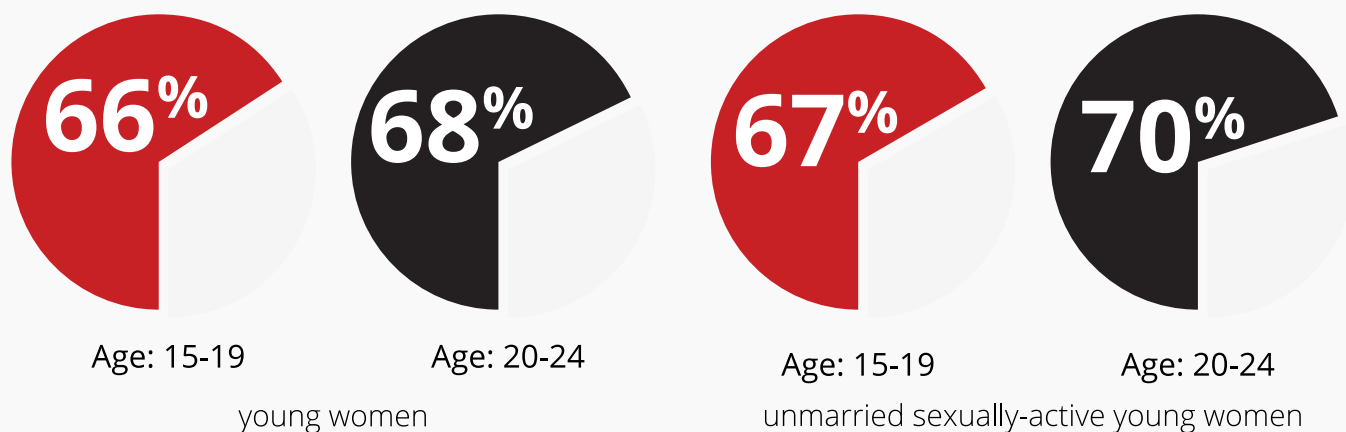
The most recent population data on this indicator came from the 2016 SADHS, which showed that percentage of young women who had their demand for family planning satisfied by modern method was 66% for 15 to 19-year olds, and 68% for 20 to 24-year olds. When the analysis was restricted to unmarried sexually active young women, the corresponding percentages were 66.7% and 70%.¹³

Achievements

Robust policies to achieve this commitment

South Africa has put together a number of comprehensive policies (including in the last two years) and well-designed programmes to educate young people and increase access to sexual and reproductive health services. These include training and education at school, provision of HTC services and healthcare provision through youth-friendly services. All public schools in South Africa are legally obliged to provide HIV education as part of the Life Orientation subject, with the aim of empowering learners with the requisite knowledge and skills to protect themselves from HIV infection. In addition, under the guiding framework of the Children's Act, the Department of Basic Education (DBE) collaborates with DoH, Department of Social Development (DSD) and other partners to facilitate access to social welfare, which bolsters the capacity of young people to protect themselves from HIV.

Demand for Family Planning Satisfied



Key issues

Levels of family planning satisfaction can be improved

Family planning is linked to both health and economic outcomes in young women. The percentage of young women who have their demand for family planning satisfied by modern methods is good at about 70%, although it is lower than the 75% considered high by the WHO. This gap needs to be addressed in two steps; i) understanding the variation in coverage, ii) providing appropriate interventions that look at demand (knowledge and norms) and supply (provision and healthcare system) of modern contraception. Unlike the previous NSP, the current NSP specifies the provision of contraception for young women.

Knowledge about HIV prevention among young people is very low

The goal to reduce HIV infection among young women cannot be achieved with low levels of knowledge and high levels of misconceptions about HIV Prevention. The low levels of comprehensive knowledge of HIV prevention among young women in South Africa is concerning. Additionally, there has been no significant improvements achieved in the past decade. There is an urgent need for a concerted effort among the different programmes on adolescent and young women to increase knowledge and eliminate these misconceptions. These efforts should be spearheaded by the HIV and AIDS Life Skills Education Programme and the ISHP. The quality of the messaging in existing interventions should be assessed, as should the methods of delivery.



Commitment Six:

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

Is this a priority commitment for the country?	Yes
Does the National Strategic Plan address this commitment?	Yes
Has the country reached the target and commitment?	Yes

Legal and Policy Environment

South Africa operates one of the most inclusive social protection systems in Africa, targeting vulnerable population groups and households. Although the conception and adoption of the system preceded the HIV epidemic due to other historical factors, it is sensitive to the needs of people living with HIV. The right to social security is enshrined in Section 27 of the Constitution which states that, "Everyone has the right to have access to social security, including, if they are unable to support themselves and their dependants." The National Development Plan (NDP) Vision 2030 aims to tackle the problems of poverty, inequality and unemployment. Goal 4, Objective 4.3, of the National Strategic Plan (NSP) for HIV, TB and STIs 2017-2022 specifically identifies the need to "scale up access to social protection for people at risk of and those living with HIV and TB in priority districts". Under this objective, the government seeks to ensure that all eligible PLHIV receive social grants, as well as scaling up food security and nutritional support to the affected people.

1996
South African
Constitution

2012
National
Development
Plan

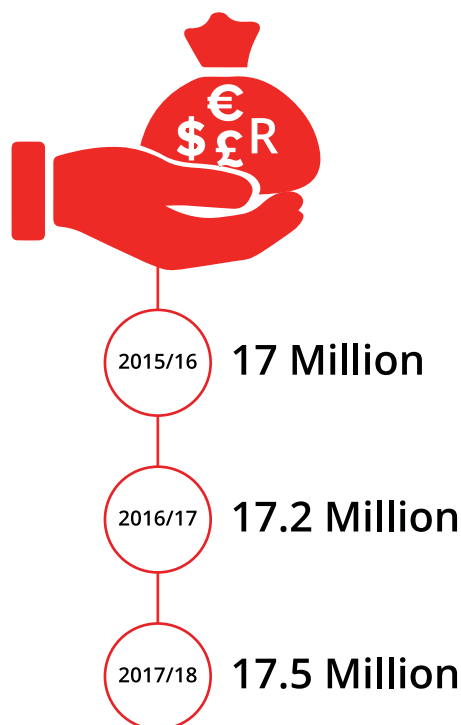
2004
Social
Assistance Act

2017
National
Strategic Plan
(NSP) 2017-2022

Current Status

The number of people covered by the social protection system of cash transfers increased by 40% in the last decade, from 12.4 million in 2007/08 to 17.5 million in the 2017/18 financial year (Figure 16).⁵⁴ In the past three years, the safety net grew by 518,361 people (3%). As at 2018, the 17.5 million people on social grants translated to 30% of the total South African population benefiting from the social security system.

Figure 16: Number of people on social grant in South Africa, 2015/16 to 2017/18



(Source: SASSA⁵⁶⁻⁵⁸)

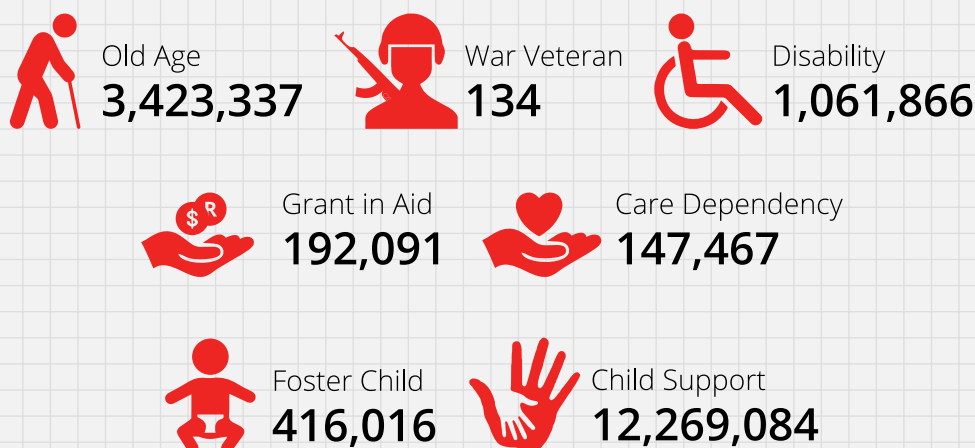
Achievements

A robust social security programme

The 2017/18 South African Social Security Agency (SASSA) Annual Report⁵⁸ notes that 90% of the eligible population is covered by social grants, one of the highest in the world. However, the aim of the state is to achieve 100% social grants coverage for all deserving people. To complement the cash transfers in fighting poverty and hunger, the DSD implements the Community Nutritional Development Centres (CNDCs) in key districts across the country. Between 2016 and 2017, the number of CNDC centres increased from 167 to 212, and the number of beneficiaries, from 258,947 to 302,357. The delivery of social protection programmes also includes Social Relief of Distress (SRD) to rescue individuals and households from destitution. SRD increased from 461,750 awards in 2016/17 to 573,196 awards in 2017/18. SASSA implemented the Integrated Community Registration Outreach Programme (ICROP) programme which targets the poorest wards in the country. During the 2017/2018 fiscal year, there were 685 identified wards having access to social assistance through ICROP, up from 631 wards in 2016/17.

In addition to the impoverishment of households affected by HIV, the epidemic also increased the number of orphans in the country. As at 2018, there were an estimated 3 million orphans in South Africa.⁵⁹ As a result of the expansion of the child support grant for orphans and vulnerable children, South Africa ensures that orphans of school-going age attend school. Furthermore, South Africa has free education in most of the public schools, and also implements nutrition programmes in public primary and secondary schools.⁶⁰

TOTAL GRANTS (2017/18) - 17,509,995



Social grants help to militate against HIV risk factors

Social grants to those who are economically disadvantaged do not only reduce the risk of HIV infection, but also improve health outcomes in those on treatment. By addressing the structural determinants of HIV infection, the social grant system addresses factors that put young people at risk of HIV. The DSD has reported that a large number of beneficiaries of social grants have completed secondary education. Out of the total number of learners from households receiving social grants who sat for the senior certificate examinations in 2016, 80% qualified for tertiary education, while 59% of the learners who passed Grade 12 in 2017 were from households receiving social grants.⁶¹

Studies have examined the impact of cash transfers and in-kind social assistance programmes in rural South Africa, with findings that cash alone reduced the risk of HIV incidence for adolescent girls by 37% and 45% if combined with care.⁶² As at 2017, South Africa was engaging about 30,000 young women from high HIV burden districts from Western Cape and KwaZulu Natal in 'cash plus care' programmes which have proven to be more effective at reducing HIV incidence compared to cash transfers alone.⁶³

Key issues

Many children who meet criteria are left out

The DSD draws attention to the fact that although the coverage of South Africa's social grant system has reached 90%, there are still one million children who meet the criteria for eligibility who are not covered. This exclusion from social assistance continues to be a priority for SASSA.⁵⁸ As the NSP for HIV, TB and STIs 2017-2022 aims to renew focus on children and put emphasis on eliminating new infections, and building resilience in families, it is important that this gap is filled.

Can South Africa do more in social grants for PLHIV?

South Africa has a disability grant for chronic diseases patients who meet disability criteria which includes PLHIV. The grant for PLHIV who qualify for the disability grant is short-term (6 to 12 months), lasting for the duration the person is expected to regain full function if they adhere to treatment. However, the dropout rate from the government's ART programme after 12 months is high. Peltzer (2012) showed that a large number of ART patients were found to be in receipt of a disability grant, which declined significantly over the duration on ART (52.3% at 6 months and 9.8% at 20 months).⁶⁴ Another study in four health facilities in four provinces indicated that disability grant alleviated the burden of healthcare-related costs for ART patients.⁶⁵ The study highlighted the appropriateness of the disability grant for PLHIV and recommended improved collaboration between the DSD and DoH in improving access to the grant for potential recipients.

Some other studies have measured out of pocket expenditure (OOPE) and the incidence of catastrophic health expenditure to households with HIV patients.⁶⁶⁻⁶⁸ OOPE are due to direct and indirect medical and non-medical costs, including costs due to transport, nutrition, time away from work and reduced productivity. This presents the question of whether economic hardship is an explanation for defaulting on treatment and whether the criteria for social grant for PLHIV should be relaxed to cover more people. As the current NSP aims to "scale up access to social protection for people at risk of and those living with HIV and TB in priority districts", this should become an area of interest for South Africa's well-mobilised civil society that has been pivotal in pushing the government to move further in the fight against HIV/AIDS.



There are out-of-pocket expenditures associated with ART that portend dropout from therapy



Commitment Seven:

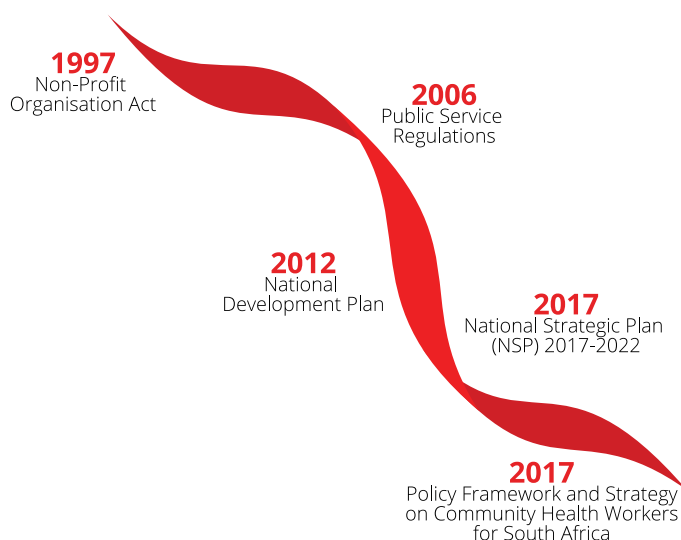
Ensure that at least 30% of all service delivery is community-led by 2020

Is this a priority commitment for the country?	Yes
Does the National Strategic Plan address this commitment?	Yes
Has the country reached the target and commitment?	Yes

Legal and Policy Environment

South Africa is committed to ensuring that at least 30% of all service delivery are community-led. This is reflected in the National strategic plan for HIV, TB and STIs (2017-2022), and the PEPFAR's Country Operational Plan (COP) 2018 Strategic Direction Summary. The on-going NSP 2017-2022 provides the strategy and framework of a multi-sector partnership for South Africa to overcome HIV, TB and STIs as public health and social challenges. Drawing from the sixth goal of the NSP, there is an emphasis on strengthening the participation of civil society and leadership as a way of encouraging community responses to HIV/AIDS. While the NSP sets out to achieve increased access to health services through more innovative service delivery approaches that are tailored for the population, it does not clearly have a roadmap to deliver community-led services. This gap in the NSP is provided for within the broader regulatory framework of the country, including the country's constitution and associated laws and policies governing the operations of NGOs, service delivery in public service as well as other guidelines for HIV/AIDS intervention in the country.

On a broad spectrum, South Africa's legal framework does not present significant obstacles or difficulties for CSOs operating in the country to function. It, in fact, strives to provide a generally enabling and supportive environment for CSO activities. In this way, civil organisations are afforded the rights and opportunity through the country's legal and policy environment. Additionally, the policy environment encourages external funding to support CSOs working in the sphere of HIV/AIDS, TB and STIs interventions.



Achievements

Enabling legislative and policy environment

CSOs working in health contexts within which HIV and AIDS, TB and STIs advocacy and interventions are situated, are covered within the broad ambience of enabling policy environment.

The Non-Profit Organisations Act 1997, among other legislations, serves to provide a smooth process for NGOs and CSOs to work in South Africa. The DSD is the custodian of this Act and helps with registration and funding for many CSOs working in the country. Since 2012, there has been a movement towards amending this piece of legislation to more effectively speed up registration for new NGOs, CSOs and CBOs. The government has since been working towards this amendment to address these and other important aspects of CSOs, NGOs, and CBOs' active participation in various development work, including HIV/AIDS service delivery.

The Public Service Regulations 2016 provides a context for the management of public service delivery in South Africa. Some of the provisions within this regulation include the emphasis of the role of Community Development Workers (CDWs) within the context of the Community Development Workers Programme (CDWP). Essentially, one of the objectives of this programme entails leveraging CDWs to improve service delivery to the public, and this includes HIV/AIDS-related services.

In a similar policy-driven effort to effectively integrate community-led service delivery processes within national strategies, the NDoH reports that in October 2017, "the National Health Council approved the new Policy Framework and Strategy on Community Health Workers for South Africa."⁶⁹ The framework "aims to ensure equitable distribution of comprehensive community-based primary healthcare (PHC) services that contribute to improved health and well-being among the individuals, households and communities being served." Approximately R1.4 billion has been identified for CHW salaries in 2018/19.

Vibrant civil society

Against the backdrop of this veritable legal and regulatory system, a vibrant civil society continues to work unhindered, towards providing various types of services to PLHIV as well as creating awareness and leading advocacy on HIV/AIDS-related issues in South Africa. For example, the Treatment Action Campaign (TAC) mobilisation was pivotal to the provision of antiretroviral drugs (ARVs) for PLHIV in SA. Independent evaluation showed that the fast-tracking of the implementation of the Domestic Violence Act, which passed into law, was the direct result of Soul City's advocacy campaign.⁷⁰



Increased financial support

Within this context, some remarkable milestones were recorded such as funding for many NGOs working in the area of HIV/AIDS. In 2018, the comprehensive HIV, AIDS and TB grant was "reconfigured to elevate the importance of community health services – a component worth R4.4 billion to help provinces standardise the work of PHC outreach teams and integrate them into the national health system."⁷¹

Significant community contribution to HIV service delivery

South Africa has effectively harnessed the contribution of CSOs in the HIV response. The Networking HIV and AIDS Community of South Africa (NACOSA) is a network of over 1,800 CSOs working together to turn the tide on HIV, AIDS and TB in Southern Africa. According to an independent evaluator, "NACOSA's capacity-building programme has a direct, tangible benefit on organisations and their capacity to deliver efficient and sustainable services in communities."⁷²

Their contribution of the community in the provision of ART to PLHIV in South Africa is well-known. Additionally, in the drive towards universal ART drugs service delivery in South Africa, community-led strategies such as the ART adherence clubs are playing a vital role. Adherence clubs which have been piloted in certain districts have demonstrated the capacity to prevent the over-use of resources, reduce time spent by patients at clinics and reduce workload for clinics. This is based on the principles of the adherence clubs which include the distribution of groups' medications either at the clinic or

community level, with a focus on stable patients who have experienced a degree of immune recovery and are able to adhere to ART.⁷³ Table 11 shows details of the adherence club model in Khayelitsha, Cape Town.

The PEPFAR-South Africa Treatment Surge Plan aims to accelerate epidemic control in the country by increasing the number of people on ART and ensuring that about 6.1million people are on ART by December 2020. The plan acknowledges that achieving this target requires a radical approach to interventions and service delivery by investing in crucial areas, including facility-based health workers, community health workers and community ARV delivery.²³ This has accounted for PEPFAR's funding of strategic community HIV and AIDS interventions, including community-based care and support for PLHIV.⁷⁴ These grants are offered directly to CSOs, mainly local CBOs, working in these aforementioned areas of work; and they are designed to facilitate, expand and improve service delivery to PLHIV in different districts and communities in South Africa.

Another key contribution by CSOs to the HIV response is the ability to achieve results in areas inaccessible to government, such as marginalised communities. A key example is targeted interventions to key populations such as migrant populations, sex workers and PWID. CSOs have been central in delivering HIV prevention and treatment services to these populations. Africa, as shown in prior chapters of this report, most of the HIV prevention and treatment services delivered to key populations in South Africa are delivered by NGOs, sometimes using the peer-delivery model.



Key issues

Despite the generally positive policy environment for CSOs and CBOs to operate within South Africa, there are still challenges that militate against effective and functional contribution towards efficient community-led HIV/AIDS service delivery.

Registration process

A fundamental issue here has to do with the process of registration for organisations. The centralised and often difficult process of submission, documentation and reporting negatively impact on local CBOs generally.

New indicator

Finally, reporting on this indicator lacks structure within government departments, especially as it pertains to HIV/AIDS service delivery. This is an important growth area that can be improved to assist with proper record-keeping and assessment of milestones achieved therein. District and community-level indicators and targets will help in this regard.

Table 11: Adherence club model, Khayelitsha, South Africa

SOUTH AFRICA - Khayelitsha Model	
Context	Urban
Target Group	Stable patients on ART
ART refill	Every two months at health facility/community
Clinical visit for patient	Yearly for viral load and clinical consultation
Referral mechanism back to clinic	By lay worker and self-referral
Number of clubs and patients	231 clubs, ±5900 patients
Patient uptake	23% of patients on ART (including community clubs)
Retention in Care	97% at 40 months
Extended functions	Utilizing alternative health points to support management and drug supply for community clubs
Resource needs	Lay workers as facilitators of clubs; resources for club outreach.
National response	Adoption and quick roll out in City of Cape Town and Western Cape province; National Development of Health provisional endorsement.

(Source: UNAIDS⁷⁵)



Commitment Eight:

Ensure that HIV Investments increase to US\$ 26 billion by 2020, including a quarter for HIV prevention and 6% for Social Enablers

Is this a priority commitment for the country?	Yes
Does the National Strategic Plan address this commitment?	Yes
Has the country reached the target and commitment?	Yes

Legal and Policy Environment

The entire gamut of tackling HIV in the country is centred around improved and adequate funding. South Africa's commitment to this cause, especially within this review period, remains enshrined in the National Strategic Plan (NSP) for HIV, TB and STIs (2017-2022). One of the goals of the NSP 2017-2022 entails the mobilisation of "resources to support the achievement of the NSP goals and ensure a sustainable response" to these public health challenges. Drawing inspiration from the country's progressive stride in the mission to end HIV, TB and STIs as public health threats by 2030, the NSP has been central to the strategies and frameworks within government departments, national, provincial, municipal and

other stakeholders' interventions. Other policy frameworks that give support to this commitment are the NDP 2030 which envisions a health system that works for everyone, with a sharp reduction in the country's disease burden; and the 2017/18 Medium Term Expenditure Framework (MTEF), within which budgetary allocations to pursue these goals are structured, amongst others. All of these are geared towards dealing with the pursuit of adequate investment in HIV, especially investments in treatment, prevention and addressing social enablers

Current status and recent trends

Table 12: Commitment 8: Core indicators, South Africa, 2015-2017 (Amount in ZAR'000)

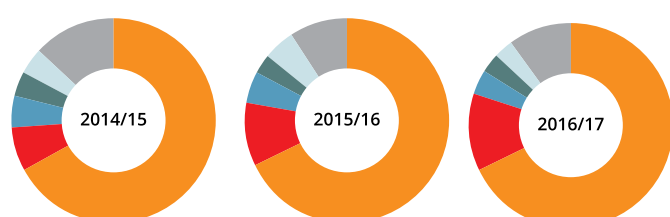
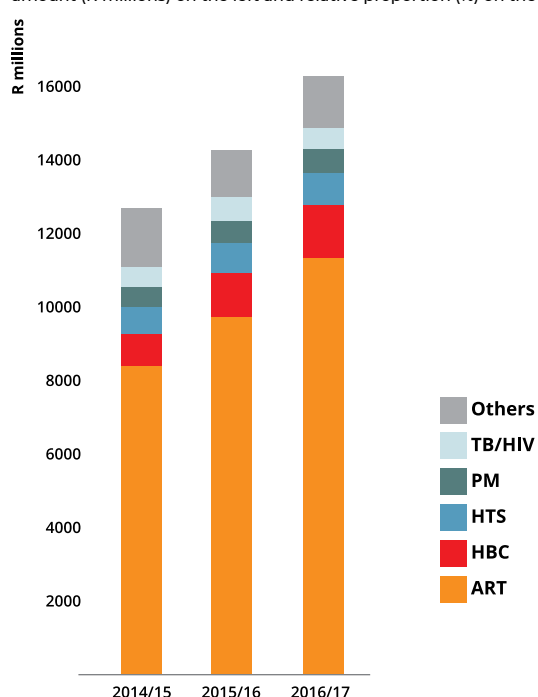
Indicator	Source	2014/15	2015/16	2016/17	2017/18
Total government expenditure on health	National Treasury Budget Reviews 2015 to 2018 ^{75,76}	144,558,000	159,377,000	170,888,000	191,685,000
Total government expenditure on HIV	Guthrie et. al. ⁷⁷	22,472,142 (16%)	25,809,603 (16%)	28,814,217 (17%)	
Allocation from South African government	Guthrie et. al. ⁷⁷	17,289,358	19,395,406	21,816,005	
Allocation from other development partners (PEPFAR, USAID, Global Fund)	Guthrie et. al. ⁷⁷	5,182,784	6,414,197	6,998,213	

Spending by programme

Spending on ART accounts for a significant proportion of all HIV expenditure. As South Africa expands its ART programme steadily, increase in ART spending continues to drive overall increase in HIV/AIDS expenditure. In 2016/17, ART spending accounted for 70% of all provincial departments of health's expenditure. This was closely followed by home-based care at 9% and HTC services, which was 5%. Programme management was 4%, TB/HIV was 4% and other expenditures amounted to 8% (Figure 17).

An analysis of spending by intervention category and funder, showed that prevention intervention and programme enablers accounted for about 15% and 8% of HIV expenditure

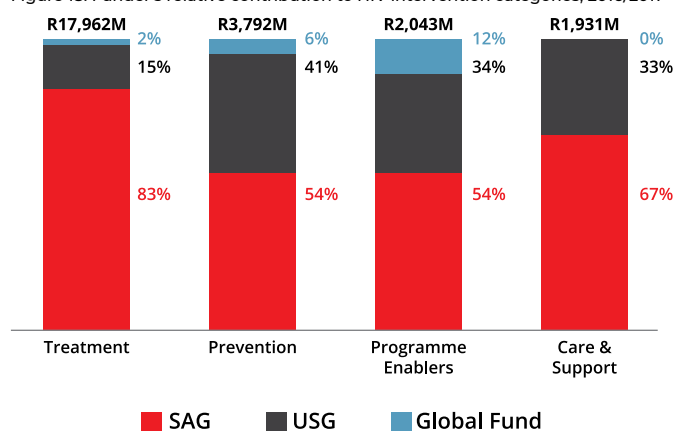
Figure 17: Combined provincial department of health spending, in absolute amount (R millions) on the left and relative proportion (%) on the right



(Source: Guthrie et al⁷⁷)

respectively (Figure 18). The government funded the majority of treatment costs, 54% of prevention (including youth interventions, condoms, human papilloma virus vaccination and workplace interventions) and programme enablers expenditure (including gender empowerment, substance abuse prevention, training and advocacy, communications and social mobilisation). Most of the DSD spending on HIV in 2016/17 (11% of domestic HIV spending) went to social programmes on prevention and social enablers. This explains why the 6% spending target on social enablers has been exceeded. The 25% spending target for prevention would also be achieved if the department's huge spending on social protection is considered.

Figure 18: Funder's relative contribution to HIV intervention categories, 2016/2017



(Source: Guthrie et al.⁷⁷)

Achievements

Consistent increase in HIV/AIDS budget and expenditure

It is noteworthy that between 2016 and 2018, South Africa and her development partners continued to increase their financial commitments to HIV-related programmes. As shown in Table 12, the recent years' budgetary allocations for HIV/AIDS increased consistently from R22.5 billion in 2015 to R28.8 billion in 2018. This increase showed a discernible trend of R3.2 billion increase per annum ($p=0.019$).

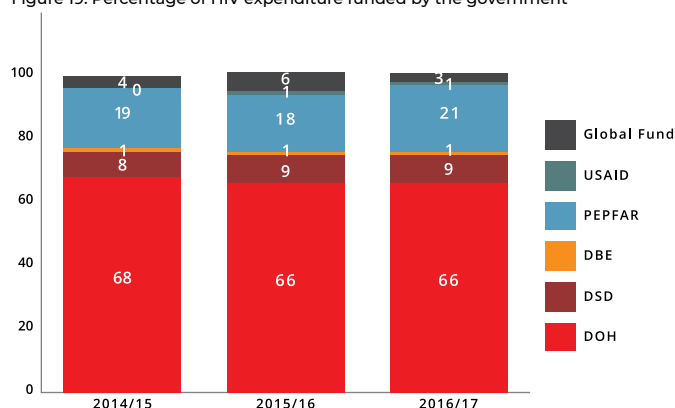


R28.8 billion HIV expenditure in 2018

Significant government spending for HIV/AIDS programmes

It is noteworthy that HIV/AIDS financing in South Africa is primarily shouldered by the government. As shown in Figure 19, domestic allocation from the government has contributed between 75% and 77% of total HIV expenditure in recent years.

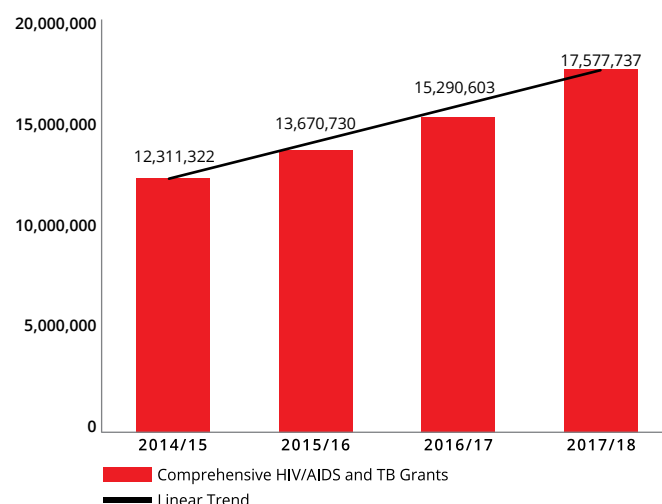
Figure 19: Percentage of HIV expenditure funded by the government



(Source: Guthrie et al⁷⁷)

A crucial component of South Africa's funding for HIV/AIDS and TB is the Conditional Grants system which consists of the National Tertiary Services, Comprehensive HIV/AIDS Grants, Health Facility Revitalisation, Health Professionals Training and Development, and the National Health Insurance (NHI), amongst others. Among these components, the Comprehensive HIV/AIDS Grants received the highest financial investment, especially in the last two years – 2016/17 and 2017/18. These grants account for 90% of total DoH spending on HIV. As shown in Figure 20, in the past four years, this grant has shown significant upward increase of R1.7 billion annually ($p=0.001$) and is projected in the 2018 MTEF to increase yearly for the next three years post-2018.

Figure 20: Comprehensive HIV/AIDS and TB Grants (R'000), 2014/15 to 2017/18



(Source: NDoH⁷⁷⁻⁷⁹, National Treasury^{71/75/76})

External Funding Support for HIV/AIDS programmes remain strong

South Africa continues to benefit from successful partnerships with a number of external donors in the quest to increase investments in the fight against HIV/AIDS. In this case, after the government, PEPFAR has been the second major contributor in financial investments for HIV/AIDS programmes in South Africa.⁷⁷ The Global Fund and other bilateral and multilateral partners in the private and humanitarian sectors follow them. Cumulatively, contributions from PEPFAR, The United States Agency for International Development (USAID) and the Global Fund increased from R5.2 billion in 2015 to R7 billion in 2017.⁷⁷

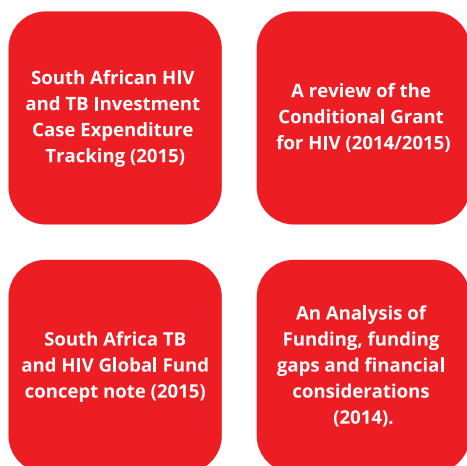
Investment Case for HIV and TB in South Africa

South Africa has maintained its momentum in monitoring and tracking programmes, interventions as well as investments dedicated towards the fight against the pandemics of HIV/AIDS, TB and STIs. The country's investment case for HIV and TB continues to guide investment trajectories across different sectors of the economy. It has also been crucial in coordinating the contribution of public, private and humanitarian partners to drive the 90-90-90 framework and actualising the objectives of the National Strategic Plans for HIV, TB and STIs 2017-2022.

SANAC – Resource Mobilisation for South Africa

SANAC has continued to make significant strides towards achieving 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 intensified its efforts to harmonise funding strategies designed to respond to the HIV/AIDS pandemic in South Africa. One of such effort is the development of the South African Country Coordination Mechanism (CCM) which is a partnership made up of key players in the country's HIV

response. The role of the CCM is to submit funding proposals to the Global Fund based on identified funding needs at national level. Other initiatives that constitute an organic part of the activities and actions of the Resource Mobilisation Unit include amongst others:

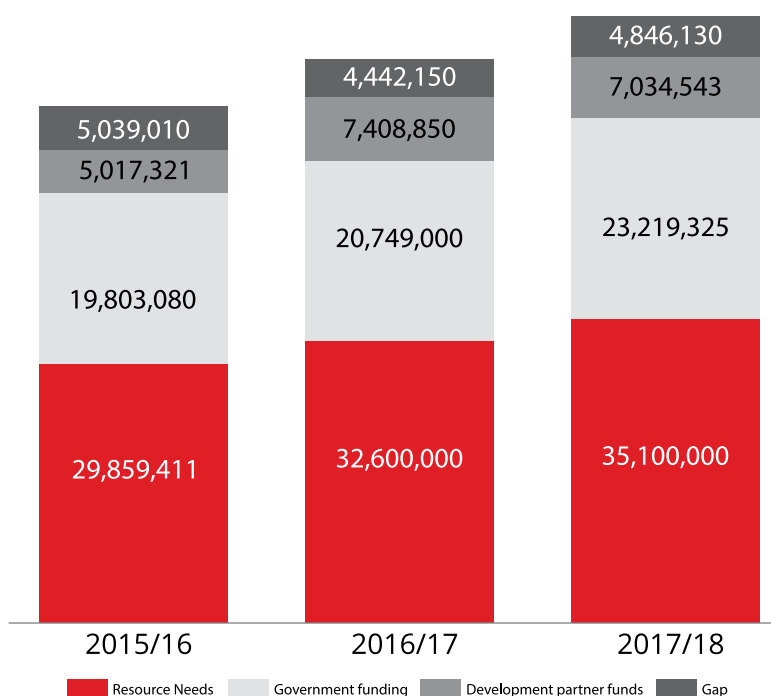


Key issues: investment commitment gap

South Africa has done commendably well in its HIV funding programme, both in terms of its domestic allocation and donor support from international funders. However, there are further strides to be made. The NSP 2017-2022 estimated that R207 billion will be required to implement national strategies regarding HIV/AIDS, STIs and TB, amongst others, over the duration of the NSP. The cost for this implementation is estimated to rise from R35.1 billion in 2017/18 to R45.7 billion in 2021/2022 for the country.

Figure 21 shows the resource gap in the past three years. Analysis of the funding gap demonstrates that the country still requires so much to bridge the gap between the implementation needs in the NSP and the available financial investments within the country. This remains a crucial area that requires more attention in this drive to eliminate the threats of HIV, TB and STIs as public health challenges in South Africa. It should be noted that private sector contribution will

Figure 21: Consolidated resources and funding gap in HIV spending (2016 to 2018)



(Source: SANAC^{9,78} National Treasury ^{71,75,76})



Commitment Nine:

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

Is this a priority commitment for the country?	Yes
Does the National Strategic Plan address this commitment?	Yes
Has the country reached the target and commitment?	Yes

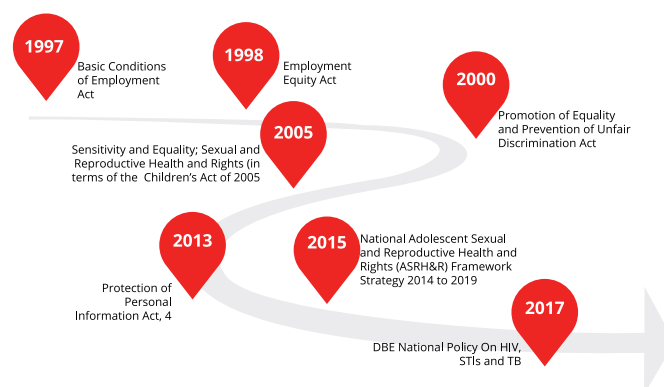
Legal and Policy Environment

South Africa's response to the epidemic has mainly drawn on the shielding role of the law, which is premised on fundamental human rights – that include access to healthcare – for all citizens. The South African Constitution guarantees the right to privacy (which includes confidentiality) while also disavowing the discrimination of persons in private or public workplaces directly or indirectly, pre-employment or during employment, based on their HIV status. This includes unfair discrimination and stigma in the workplace based on real or perceived HIV status, including dealing with HIV testing, confidentiality, and disclosure. The Hoffman versus South African Airways case in the Constitutional Court as far back as the year 2000 is a reminder of this.

The expectation for human rights in the context of HIV/AIDS is unambiguously embodied in the country's response to AIDS, as emphasised in the current NSP. For example, 5Cs – Consent, Confidentiality, Counselling, Correct test results and Connection – are the foundation of effective HTS as contained in the National HIV Testing Services Policy, 2016. The DBE

National Policy on HIV, STIs and TB repeatedly emphasise the rights of all learners, educators and school officials who are living with, or affected by HIV, STIs and/or TB in the basic education sector.

The Choice on Termination of Pregnancy Act gives women the right to have safe and legal termination of pregnancy, regardless of a woman's HIV status. The Criminal Law Amendment Act, 2007 recognises the possibility of a sexual offense victim being exposed to HIV infection and allows for a victim of a sexual offence at risk of HIV infection to have access to post-exposure prophylaxis (PEP). A few other, but not all, legal provisions which form the basis for achieving this commitment are shown in the policy timeline.



Current status

Plans for this commitment

The current NSP highlights plans to strengthen citizens' capacity to respond to HIV-related human rights abuses. According to the NSP, the South African Human Rights Commission (SAHRC) and the Commission for Gender Equality will continue to refer cases of human rights violations to Equality Courts for redress. Also, the NSP contains plans to improve citizens' access to legal services, with investments in community-centred rights and legal literacy programmes. Law makers, law enforcement agencies and citizens at large will be recipients of these legal literacy programmes.

Achievements

Civil society support for access to justice



Although South Africa's constitution is one of the most respected in the world, meaningful access to justice remains largely a function of economic resources. As demonstrated in other aspects of the HIV response, the civil society in South Africa also plays a big role towards achieving this commitment by ensuring that people living with, at risk of, and affected by HIV know their rights and access legal services to get justice regarding the prevention and violation of human rights. A case in point is that of 15 inmates against Westville Prison in KwaZulu-Natal, which was assisted by the AIDS Law Project, (ALP) a non-profit human rights-based law firm, to access the essential antiretroviral treatment through a court order in 2006.⁷⁹ The ALP requested the removal of restrictions that stopped prisoners from accessing treatment and the court ruled in its favour. Volunteers from the TAC brought the case in itself to the attention of ALP. In May 2018, the Sex Worker Education and Advocacy Task Force (SWEAT) helped sex workers to apply to the High Court in Pretoria, asking that the Primrose Community Police Forum be interdicted from beating, threatening and harming sex workers.⁸⁰

In 2017, SANAC signed a memorandum of understanding with Legal Aid South Africa to provide quality legal advice and services in matters relating to HIV and TB stigma and discrimination. Legal Aid SA is an independent statutory body which offers professional legal services to those who do not have the means to access legal services. This laudable initiative will see legal services provided to aggrieved citizens by paralegals at the call centres and promotion of access to legal services at justice centres across the country.

Legal rights education

Although the DoH provides basic information to the public through information, education and communication (IEC) materials at health care facilities, South Africa does not seem to have many programmes focusing on citizen education as regards their rights in the context of HIV. In 2018, the SAHRC developed IEC materials to enlighten the general public on some of the key rights of persons living with, or affected by HIV/AIDS, in order to empower them to claim and assert their rights. Legal rights education in HIV-related matters is not only relevant to the general populace, but also for trained legal professionals. HIV and the Law in South Africa: A Practitioner's Guide is a peer-reviewed book "intended as a useful resource to enable legal practitioners to provide efficient and professional legal advice to PLHIV in such contexts as the workplace, access to healthcare, and the rights of women and children."⁸¹

Key Issues

Sub-optimal legal literacy levels

A key aspect of this commitment is community awareness on rights and justice in the context of HIV. When citizens (particularly marginalised groups) become aware of their legal rights, they can use the knowledge as a tool to fight injustices. However, a recent survey of 24,897 South Africans conducted by Foundations for Human Rights in partnership with the Department of Justice and Constitutional Development (DOJ&CD) demonstrated the low levels of legal and rights literacy in the country – only 51% of South Africans being aware



of their constitutional rights.⁸² This percentage varied between 48% among Black Africans and 68% among Whites.

These results show that there is a gap in awareness that needs to be filled. Human rights abuses are both a driver of HIV infection and a determinant of positive health outcomes in HIV care. There is a need for the government, in collaboration with civil society and the private sector, to create awareness around issues of human rights in the context of HIV. Different approaches and platforms are needed, with the language of instruction taken into consideration. Such enlightenment interventions can be bolted onto existing stigma and discrimination campaigns.



Commitment Ten:

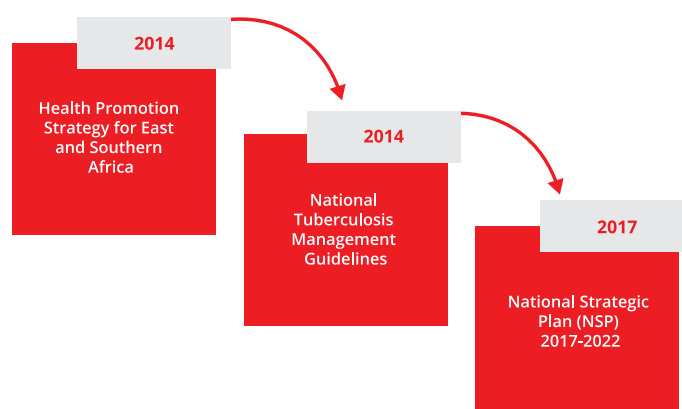
Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C

Is this a priority commitment for the country?	Yes
Does the National Strategic Plan address this commitment?	No
Has the country reached the target and commitment?	Not Likely

Legal and Policy Environment

Goal 1 of the National Strategic Plan (NSP) for HIV, TB and STIs 2017-2022 seeks to accelerate prevention to reduce new HIV and TB infections and STIs. It specifically addresses key populations and vulnerable groups such as adolescents, people in prisons, LGBTI, MSM and sex workers with the aim of taking HIV/AIDS out of isolation. Additionally, the NSP 2017 to 2022 and the wider legal environment in South Africa caters for the implementation of positive programmatic interventions targeted at migrants and communities affected by migration. For instance, The NSP plans to increase cross-border cooperation and improve responses for migrant labourers, especially with respect to TB. Also, as outlined in the Health Promotion Strategy for East and Southern Africa, the DoH has partnered with the International Organisation for Migration (IOM) to provide health services for HIV/AIDS prevention, provision of ART and TB treatment to migrants and host communities in Limpopo province. Service integration, especially for HIV and TB, and provision of Hepatitis B and HPV vaccines to PLHIV, are provided for in the current NSP. South

Africa also draws its political commitment from international agreements such as the WHO End TB Strategy of 2015 and the Moscow Declaration to End TB 2017.



Current status

Indicators of burden of TB

TB mortality remains a major public health burden in South Africa. South Africa remains a high-burden TB country, and it is one of the 14 countries included in each of WHO's three lists for high-burden TB countries. The first list is for TB, the second for multidrug resistant TB and the third for TB/HIV co-infection. However, South Africa seems to be gaining traction in the fight against TB. The latest available data showed that in 2017, there were 322,000 new TB infections in the country, with 193,000 of those occurring among PLHIV (Figure 22).

322,000

Total number of new TB infections in 2017

193,000

New TB infections in PLHIV in 2017

129,000

New TB infections in HIV-negative people in 2017



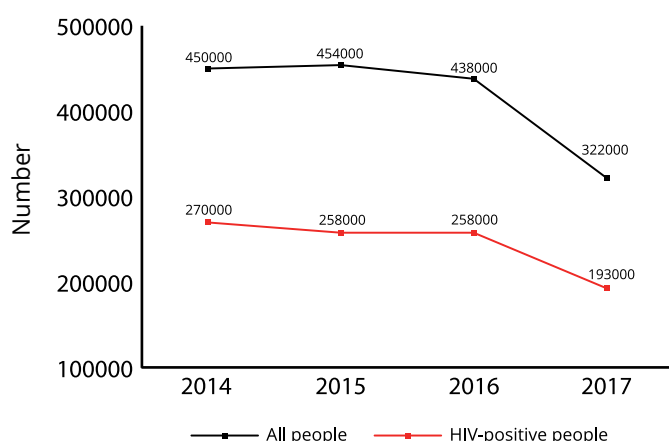
2.2 million incident cases of gonorrhoea in 2017

revealed an overall prevalence of 4%, 6.4% among PLHIV and 2.6% among those without HIV.⁸⁷ A study among PWID, reported a 5% seroprevalence.¹⁰

National data on cervical cancer screening and treatment for South Africa are not yet available. However, there has been a concerted effort by the DoH and its partners to drive awareness of cervical cancer, which accounts for the majority of female deaths due to cancer in South Africa. Published cancer data for South Africa showed that about 7,735 new cases of cervical cancer were diagnosed in 2012, with cervical cancer being the most common cancer in women aged 15–44 years. The age-standardised incidence rate was estimated to be 32 per 100,000 persons for South Africa compared with 14.0 per 100,000 persons globally.⁸⁸ At the national level, DoH runs a countrywide campaign, which started in 2014 administering Human Papillomavirus Vaccination (HPV) to girls in grade 4 (9–13 years old) as a primary prevention method against cervical cancer. This campaign runs from February to March in quintile, and between one to four schools every year.⁸⁹ In 2014, the national programme vaccinated 87% of eligible grade 4 learners from the target schools.⁹⁰ The country's DHIS data showed that the screening coverage for cervical cancer in women aged 30 to 49 years was 61% in 2017/18.¹³

The time-series plot for the past four years shows that the incidence of TB has begun to decline in the most recent years. The decline in the last year is somewhat questionable due to the steepness of the slope. If the data are correct, it would mean that the country has achieved the NSP target of reducing TB incidence by at least 30%, from 834/100,000 population in 2015 to less than 584/100,000 by 2022. The incidence rate for 2017 was 567/100,000.

Figure 22: Incidence of TB in the general population and among PLHIV, 2014–2017



(Source: Global TB Reports^{83–85}, UNAIDS¹¹)

In 2017, there were 56,000 TB deaths among PLHIV (72% of all TB deaths). This is down from the 73,000 deaths recorded in 2015.

Other indicators

A recent publication of estimated trends in prevalence of gonorrhoea using the Spectrum-STI tool showed that the prevalence of gonorrhoea in males has been stable in South Africa. In 2017, the estimates were 3.5% (1.7% to 6.1%) for prevalence and 2.2 (1.1–3.8) million for incident cases.⁸⁶ There are no data on hepatitis B testing in the general population. However, a population-based survey in KwaZulu-Natal

Achievements

Decreasing TB incidence and mortality

Although the burden of TB remains high, especially among PLHIV, it is welcoming that the numbers have continued to drop in the past decade. Between 2015 and 2017, there was a 25% decline in incidence and 21% decline in TB deaths among PLHIV. These achievements are due to other achievements upstream in the cascade of care, from the previously discussed increase in TB funding to improvement in treatment initiation and success.

NEW CASES	YEAR	MORTALITY
454,000	2015	96,000
438,000	2016	82,000
322,000	2017	78,000

In 2017, there were a total of 56,000 TB deaths among PLHIV (72% of all TB deaths). This is down from the 73,000 deaths recorded in 2015.

Improvement in TB treatment initiation

The decline in TB incidence and mortality has been largely driven by improvement in ART and TB treatment coverage. There have been significant improvements in initiating new TB clients on treatment over the recent years. The District Health Barometer 2017/2018 report showed that 91% of TB incident cases were initiated on treatment, a rise from 73% in the preceding 2016/2017 period.⁹¹ Within this context, the treatment success rate remains considerably high and rising (84% in 2017). In prisons, 97% of inmates diagnosed with TB started treatment, with a cure rate of 87%.³²



TB/HIV co-management

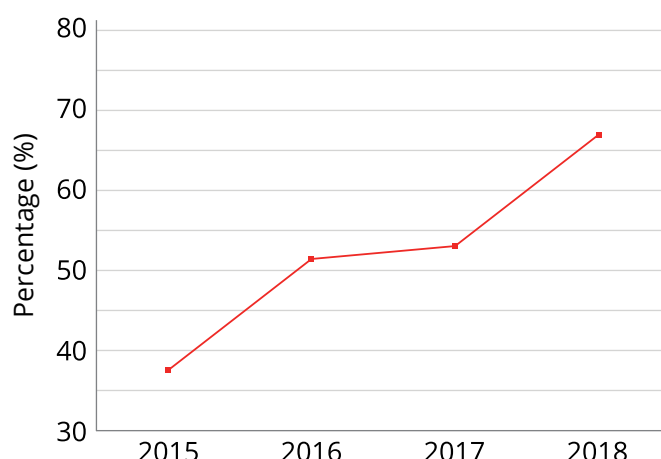
Improvement in TB/HIV co-management

Similar improvement has been achieved with the co-management of TB/HIV. The proportion of TB clients co-infected with HIV on treatment was 89% in 2017. This achievement has hovered between 88% and 92% between 2015 and 2017.⁹¹ It will be lower when estimated incident cases, rather than notified cases, are used as the denominator.

TB preventive therapy among PLHIV initiated on ART

The proportion of PLHIV and newly enrolled on ART who were started on TB preventive therapy has been increasing annually from 2015 to 2018 as shown in Figure 23.

Figure 23: Percentage of PLHIV newly enrolled on ART who were started on TB preventive therapy



(Source: UNAIDS⁹¹)

Key issues

Huge variation in treatment success

Although all diagnosed TB patients should be ideally started on treatment, the 91% success rate achieved in 2017/18 is commendable. However, there are huge variables in this achievement across health districts, with seven districts achieving below 75%.

Hepatitis B and C

The national viral hepatitis management guidelines were approved in September 2018 and implementation was planned to start on the 1st of April 2019. During the period under review, the data for measuring progress towards the achievement of hepatitis B and hepatitis C targets were not yet available.



Discussion

Best practices and achievements

Supportive legal environment and strong political commitment

South Africa has one of the most progressive constitutions in the world. Additionally, the country has enjoyed strong political will from successive governments which have shown strong political commitment in the fight against HIV/AIDS and TB. As a result, all ten commitments in the UN 2016 political declaration benefit from the supportive legal and policy environment in South Africa. There is no commitment that cannot be pursued in South Africa due to hindrances from the constitution or lack of policy documents. Although it was illegal to sell sex and inject drugs in South Africa during the period under review, the constitution and other policy documents allow members of these and other key and vulnerable populations to access healthcare, including HIV services, just like all citizens. In addition, NGOs provided specific HIV unhindered services to key populations.

Availability of M&E data and evidence-based response

The HIV response in South Africa is evidence-based. The evidence-based response derives from the government's heavy investment in the DHIS and the rich culture of research and data reporting in the country. These are enhanced by an advanced information and communication technologies environment. The availability of a robust DHIS, periodic research surveys (such as the SABSSM and the SADHS), and annual estimates (such as those from Stats SA and the Thembisa Model), means that the government has ample data to inform programming and the overall HIV/AIDS and TB response.

Increase in ART coverage

South Africa's antiretroviral treatment programme is the biggest in the world with 4.5 million people on treatment.

A programme of such magnitude requires heavy financial and human resources, as well as investment in logistical and IT infrastructure. The annual number of people initiated on treatment in the last few years is commendable. Additionally, South Africa is currently working to further expand the coverage by 33% in the next two years to a target of six million people by 2020.

The recently introduced Central Chronic Medicines Dispensing and Distribution (CCMDD) programme for patients on antiretrovirals, and other chronic medications is abetting the ART programme. The medicine distribution model allows over two million patients on treatment to receive their ARV drugs at various pick-up points near their homes or workplaces, such as churches and libraries. This synthesis also showed that cases of antiretroviral medicine stock-out are less frequent than they were in 2015 and they are more rapidly resolved when they occur.

TB Treatment success

Equally, South Africa has achieved notable success in all aspects of TB management. Firstly, treatment initiation among new cases has increased significantly to 91% in 2017, from 73% in 2016. Secondly, the treatment success rate has also increased from 77% in 2014 to 84% in 2017, just a percentage point below the 85% target set by the WHO. Thirdly, the co-management of TB/HIV has been on the increase, as has been the proportion of PLHIV who were started on TB preventive therapy. These improvements in management have led to a concomitant decline in TB incidence and mortality.

Early infant diagnosis

The country has done tremendously well in the volume of EID tests carried out, both in terms of the sheer volume of tests conducted and the coverage. The national HIV PCR birth testing coverage was 94% for 2017/2018.

Decline in HIV incidence and mother-to-child transmission rate

The HIV prevalence in the country has continued to decrease in all demographic subgroups of the population. However, the decline is below the desired rate and there is need to intensify efforts to achieve more in this regard. Also, the MTCT rate is now below 1%.

Key and vulnerable populations gaining more attention

South Africa has increased the attention given to key and vulnerable populations for HIV interventions. In comparison to the country's previous national strategic plan, the current NSP clearly documented key and vulnerable populations that need attention, outlined the interventions needed and set clear targets for these interventions. SANAC is also strengthening HIV surveillance and monitoring in key populations through periodic surveys targeting these groups. Along the same line, in 2017, NGOs targeting PWID programmes started reporting their services data to the SACENDU, as part of the national drug surveillance reporting for South Africa.

Increased community participation in healthcare delivery

In 2017, the government adopted the Policy Framework and Strategy for Ward Based Primary Healthcare Outreach Teams 2018/19 - 2023/24. Although PHC CHWs have since 2012 been established, registered and are reporting their activities in the DHIS, the DoH hopes that, "implementing this policy framework and strategy will contribute enormously to building a sense of ownership in the public health system, with members of the community actively participating in keeping their families healthy and caring for those in need." This development does not only ensure that Commitment 7 of the UN declaration is achieved, but it will also help to attain the achievement of other targets in the HIV/AIDS and TB response.

Innovative testing modalities

South Africa has continued to explore new methods to increase the percentage of PLHIV who know their HIV status. The roll-out of self-testing services in 2017 has provided an opportunity to target and increase HIV testing in identified population groups and communities. The programme has recorded huge success in terms of the number of testing kits distributed, but also, in terms of being able to reach the male population that is usually known to have low testing rates, and key populations such as sex workers. Some NGOs implementing this intervention continue to explore ways to increase linkage to care and monitoring of testing data through the provision of detailed information material and use of bar-coded testing kits.

Robust safety net programme

South Africa's social security programme provides a safety net in various forms of grants for about a third of the population – mainly economically-disadvantaged individuals. These interventions reduce structural and economic vulnerabilities that increase the risk of HIV infection. Also, South Africa has a disability grant for patients with chronic diseases, including PLHIV, who meet disability criteria.

Resource mobilisation for the response

SANAC, which leads South Africa's response to the national HIV and AIDS, TB & STIs epidemics, has been unrelenting in its effort to source funds for the HIV/AIDS epidemic response, especially in the light of increasing targets and spending each year. Through its Resource Mobilisation Unit, SANAC continues to intensify its efforts to raise funds domestically and internationally, through many strategies, including representation to the government and efforts of its CCM. The CCM is a partnership made up of key players in the country's HIV response, tasked with the responsibility of submitting funding proposals to the Global Fund based on country needs for key and vulnerable populations.

Traction in NHI legislation and implementation

South Africa's pursuit of quality universal healthcare for all citizens through the NHI gained traction during the review period. Part of this step entails a closer move towards the presentation, and possibly, consequent adoption of the 2018 NHI Bill by Parliament, which when attained, will ensure free access to quality healthcare for all citizens, in both public and private health facilities. There has also been implementation evidence and learnt lessons from the NHI pilot project. During the February 7, 2019 State of the Nation's address (SONA), President Cyril Ramaphosa reiterated South Africa's commitment to achieving universal access to quality health care for all South Africans.

Challenges and recommendations

Poor implementation of certain provisions

Although South Africa is reputable for its liberal constitution which supports the HIV response in the country, legislation and policies are not an end in themselves. There are aspects of the HIV response provided for by law that are not currently being implemented. For example, despite robust legislations disavowing GBV and gender inequalities in general, gaps in the implementation of the laws and regulations contribute to the high level of gender-based and IPV seen in the country. The same is true for HIV-related stigma.

South Africa recognises GBV and HIV-related discrimination

as human right violations and obstacles to the fight against HIV/AIDS and TB. The country, however, needs to be more decisive in its implementation of existing laws that forbid these maladies. In addition to victim empowerment programmes implemented by the government, the criminal justice system needs to intensify efforts to bring more perpetrators to book and make them face the wrath of the law. Amongst other needed changes, government officials expected to implement the laws should be trained in their respective duties viz-a-viz expectations and procedures. For example, police officers and healthcare workers should be trained to protect the needs and rights of the victims, and to prevent secondary victimisation and traumatising, as stipulated by the law. Furthermore, adequate resourcing of implementing officers and more efficient inter-government departmental collaboration are needed.

HIV prevention knowledge and behaviours are low

This synthesis revealed that there is a big gap in HIV behaviour intervention uptake. The abysmally low level of comprehensive knowledge about HIV prevention among young people is worrying. What is probably more worrying is the fact that there have been little improvements in the progress achieved with this indicator in the past decade. The percentages were even lower among those aged 15 to 19, almost all of whom have completed junior secondary. The low level in this demographic group is one explanation, among others, for having the highest HIV incidence in the country. Comprehensive HIV prevention education is clearly an important means of addressing risk behaviours among young people. This calls for urgent need to consider the content, platforms, and methods of reaching young people with HIV prevention messaging in the country. This is especially important for mainstream government programmes such as the School Health Programme.

In addition to the mainstream programmes, there are also other governmental and non-governmental programmes focusing on youth health. These non-school-based programmes provide opportunities for adolescents who are not in school to access HIV prevention education, although the reach of these types of programmes for out-of-school adolescents is not known. As evidence of the impacts of youth-based programmes are still emerging, it has become expedient for SANAC to commission an impact evaluation review of these programmes. Such a synthesis should document empirical epidemiological effectiveness and cost-effectiveness of these programmes, with the aim of scaling up those programmes with the most adaptable models and best outcomes. It is vital to know what works and what is scalable amongst the many programmes targeting young people.

On HIV prevention behaviour, the 2017 SABSSM survey showed suboptimal levels of condom use in high-risk sex – that is, sex with a non-marital, non-cohabiting partner. These levels of risk behaviours portend high HIV incidence, unless concerted and innovative efforts are set in place to arrest them.

Treatment gaps exist

South Africa has done well in expanding its treatment coverage. However, there are two major hurdles that still need to be surmounted. Firstly, more people need to be put on treatment in order to reach the treatment target of 90% - UN's second 90 target. Secondly, attrition from the ART programme should be curtailed from the current 33%. In addition to the resources required for this expansion, new modalities for ensuring adherence to treatment among those initiated should be explored. The role of CHWs in achieving both milestones have been well documented, for example, in HTC, community-based adherence clubs and for defaulter tracing.

The lack of a reliable patient tracking system was the main explanatory reason for poor patient tracking when they defaulted on treatment or moved to a new location. This problem now seems to have been resolved in the form of the Health Patient Registration System (HPRS), although at the end of 2018, not all health facilities were on the system. Use of communication technology for health promotion should be considered for patients on treatment whose characteristics predict LTFU. Facility-level characteristics, such as high patient volumes and healthcare workers' attitudes, that are determinants of loss-to-follow-up should be addressed.

Human rights knowledge is low

The experience and/or fear of stigma, discrimination and IPV explain late HIV diagnosis in many PLHIV and LTFU among those on treatment. Increasing the level of human rights knowledge is important for addressing these events and increasing HIV testing and treatment. However, only half of South Africans know their constitutional rights. The government should strengthen interventions to provide citizens and PLHIV with HIV-related legal education on different platforms, using the language they understand. Opportunities to partner with CSOs and private organisations exist for this commitment.

The private sector can do more

The 2016 UN declaration highlighted that, "Although governments have adopted the 2016 Political Declaration on Ending AIDS, the vision extends far beyond the government sector, reaching private industry and labour groups, faith-based organizations, and NGOs and other civil society entities, including those representing people living with HIV." As previously highlighted, South Africa's civil society has already

contributed immensely towards the HIV response in the country. There are opportunities for the private sector to support the HIV response in South Africa more than it currently does. They can provide and support HIV prevention education to young people on a large scale, while also providing an enlightenment campaign on HIV-related human rights. Furthermore, they can increase their funding commitments in the climate of uncertain HIV/AIDS funding.

STIs are not receiving sufficient attention

While the country is turning the tide on HIV/AIDS and TB as evident in the declining incidence and deaths from both epidemics, the incidence of some STIs may have remained stable, while others are on the increase. The prevalence of syphilis in pregnant women increased significantly from 1.6% in 2011 to 2% in 2015. Data from the NICD showed that congenital syphilis may also be increasing. The scarcity of data on STIs makes it difficult to decipher overall and recent trends in many STIs. It is recommended that the government should incorporate STI measurements into population and sentinel surveillance surveys. Testing for syphilis during ANC visits should also be normalised as stipulated in the country's management guidelines for STIs.

PrEP targets are too low

One of the contributing factors to the declining HIV incidence in the country is increased uptake in biomedical interventions, including ART and VMMC, which South Africa has strengthened in recent years. While VMMC reduces the risk of HIV acquisition in men, ART, through VLS, reduces HIV transmission in the population. The little gain in risk behaviour reduction, as seen in the levels of HIV prevention knowledge and condom use during high-risk sex, implies the need for more work to increase biomedical interventions. However, the target set for PrEP as a prevention method in the current NSP seems low. Public funding of PrEP is important, not only for key populations, but also for vulnerable populations, including young girls and women. It is important for SANAC to consider a revision of these targets and explore methods for its implementation.

VMMC numbers are behind target

Voluntary medical male circumcision is part of South Africa's comprehensive strategy for HIV prevention. During the review period, the number of voluntary medical male circumcisions fell behind annual targets. As stated above, biomedical interventions are vital in South Africa's HIV response. The percentage of men circumcised has increased, but it is still below the desired target. Government-led coordinated interventions in the areas of mass media, peer-education and

community mobilisation will continue to be important in increasing the circumcision numbers. Collaboration between government and traditional leaders for the integration of medical and traditional circumcision have shown positive results in many communities. Best practices that show results in other communities should be implemented in communities with low circumcision rates.

HIV services are still not optimal in key populations

Although key populations have received increased attention in the current NSP, the extent of HIV services in these populations are still not ideal. HIV services to PWID, for example, are mainly provided by NGOs and the coverage for many services are low. Harm reduction services are also low or non-existent. The government needs to do more in providing HIV and harm reduction services to PWID and other key populations.

Paucity of data to monitor some indicators

During the review period, there was a scarcity of data to comprehensively monitor a few of the commitments' indicators. For example, although the UNAIDS recommends that stigma indicators should be measured every two to three years, the last national survey on stigma in South Africa was in 2014. There were no data on estimates of size or HIV prevalence of the transgender population in South Africa, neither were there data on HIV outcomes. There were also no data for measuring progress towards the achievement of hepatitis B and hepatitis C targets.

Sourcing HIV funds

HIV funding from South Africa's development partners has been characterised with uncertainty in the past year. In light of this, it is imperative for the country to explore additional funding sources. The South African government will need to explore the country's private sector, whose contribution to HIV spending has hitherto been minute.

Conclusions

This synthesis showed that South Africa is turning the tide on HIV/AIDS and TB. While many challenges still exist, the country has done tremendously well in its response to the twin epidemics, especially in the more recent years. Through a robust policy environment, strong political commitment and expanded treatment programmes, the number of new cases of HIV and TB infections, and the number of deaths due to both epidemics have been dwindling. The key areas of struggle remain HIV risk behaviour modification in the general population and comprehensive interventions for key populations.

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