

LET OUR ACTIONS COUNT



REPUBLIC OF SOUTH AFRICA

2019 GLOBAL AIDS MONITORING REPORT

ANALYSIS OF CURRENT STATUS AND
PROGRESS TOWARDS TARGETS



ACKNOWLEDGEMENTS



REPUBLIC OF SOUTH AFRICA 2019 GLOBAL AIDS MONITORING REPORT

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ABBREVIATIONS AND ACRONYMS

AFSA	AIDS Foundation South Africa	GBV	Gender-based violence
AGYW	Adolescent girls and young women	GBVF	Gender-Based Violence and Femicide
AIDS	Acquired Immunodeficiency Syndrome	GNP+	Global Network of People Living with HIV
ANC	Antenatal care	GPSJS	Governance, Public Safety and Justice Survey
ART	Antiretroviral Therapy	HBV	Hepatitis B Virus
ARV	Antiretroviral	HCT	HIV counselling and testing
CBO	Community-based organisation	HCV	Hepatitis C Virus
CCMA	The Commission for Conciliation, Mediation, and Arbitration	HIV	Human Immunodeficiency Virus
CCP	Comprehensive Condom Programming	HSTAR	HIV testing, Self-testing, Innovation technologies
CD	Constitutional Development	HTS	HIV testing services
CD4	Cluster of differentiation 4	IDU	Injecting drug user
CDC	The Centers for Disease Control and Prevention	IEC	Information, education and communication
CEDAW	The United Nations Convention on the Elimination of all Forms of Discrimination against Women	LGBTI	Lesbian, gay, bisexual, transgender and intersex
CMT	Community Media Trust	LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex, queer & gender non-conforming people
COP19	2019 Country Operational Plan	MDR	Multi-drug resistant
COSUP	Community Orientated Substance Use Programme	M&E	Monitoring & Evaluation
CSE	Comprehensive sexuality education	MMC	Medical male circumcision
CSO	Civil society organisation	MNCWH	Maternal, New-born, Child and Women's Health
DCS	Department of Correctional Services	MSM	Men who have sex with men
DHB	District health board	MTCT	Mother-to-child transmission
DHIS	District health information system	MTEF	Medium Term Expenditure Framework
DoH	Department of Health	MTSF	Medium Term Strategic Framework
DOJ	Department of Justice	NASA	National AIDS Spending Assessments
DoW	Department of Women	NCPI	National Commitments and Policy Instrument
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe	NCR	National Cancer Registry
DSD	Department of Social Development	NDMP	National Drug Master Plan
EID	Early infant diagnosis	NDoH	National Department of Health
EMTCT	Elimination of Mother-to-child transmission	NGO	Non-governmental organisation
FBO	Faith-based organisation	NHI	National Health Insurance
FDC	Fixed-dose combination	NHLS	National Health Laboratory Service
FPET	Family Planning Estimation Tool	NICD	National Institute for Communicable Diseases
FSW	Female sex workers	NMC	Notifiable medical condition
GAM	Global AIDS Monitoring	NPO	Non-profit organisation
		NSP	National Strategic Plan for HIV, STIs and TB (2017–2022)

OST	Opioid Substitution therapy	SANAC	South African National AIDS Council
OVC	Orphans and Vulnerable Children	SASSA	The South African Social Security Agency
PCR	Polymerase Chain Reaction	SDG	Sustainable Development Goal
PEP	Post-exposure prophylaxis	SDI	Same day initiation
PEPFAR	President's Emergency Plan for AIDS Relief	SMART	Specific, Measurable, Achievable, Realistic and Time-bound
PLHIV	People Living with HIV	SSP	Stop Stockouts Project
PMTCT	Prevention of mother-to-child transmission	Stats SA	Statistics South Africa
PrEP	Pre-exposure prophylaxis	STI	Sexually Transmitted Infection
PWID	People who inject drugs	SUD	Substance use disorder
RNA	Ribonucleic acid	TAC	Treatment Action Campaign
RR	Rifampicin-resistant	TB	Tuberculosis
SA	South Africa	UN	United Nations
SABSSM V	South African National HIV Prevalence Incidence, Behaviour and Communication Survey	UNAIDS	The Joint United Nations Programme on HIV/AIDS
SADC	The Southern African Development Community	UNFPA	United Nations Population Fund
SADHS	South African Demographic and Health Survey	UTT	Universal test and treat
SAHMS	South Africa Health Monitoring Study	VHI	Viral Hepatitis Initiative
SAMHMS	South Africa Men's Health Monitoring Study	WATG	We Are the Generation that Will End HIV
SAHRC	South Africa Human Rights Commission	WHO	World Health Organization
SALRC	South African Law Reform Commission	WRHI	Wits Reproductive Health Institute
SAPS	South African Police Service		



INTRODUCTION

2016 UNITED NATIONS POLITICAL DECLARATION ON ENDING AIDS

South Africa, and the world at large, have made significant progress in the fight against HIV/AIDS since the first United Nations (UN) Declaration of Commitment on HIV/AIDS in 2001. Since then, there have been three additional declarations, viz. the 2006 and 2011 declarations, and the 2016 declaration used for the current review. The 2016 Political Declaration on Ending AIDS: on the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030 sets the world on the Fast-Track strategy to end the epidemic by 2030. Through the declaration, all signatory countries, including South Africa, agreed to a laudable agenda to accelerate efforts towards ending the AIDS epidemic by 2030, in support of the sustainable development agenda.

This Political Declaration aimed to reduce new HIV infections and AIDS-related deaths, eliminate stigma and discrimination, and end the AIDS epidemic by 2030. The declaration sought to fast track the AIDS response over the next five years, with tangible results by 2020.

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

Ending HIV/AIDS by 2030, as proposed in the Political Declaration, was premised on achieving clear, concrete, measurable and timebound Fast-Track targets and commitments by 2020. Key commitments include significantly reducing new HIV infections and HIV-related deaths and eliminating HIV-related stigma and discrimination by 2020.

This 2019 Global AIDS Monitoring (GAM) report documents South Africa's progress towards the 10 commitments, while highlighting key successes and challenges. The report comprises the results of an analysis of the country's achievements by the end of 2019, with a 'review period' covering the two years prior (2017 and 2018). The report concludes with concrete recommendations to accelerate the achievement of targets by end 2020.

THE INCLUSIVENESS OF THE STAKEHOLDERS IN THE REPORT WRITING PROCESS

The 2019 GAM 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 technical experts and included synthesis and triangulation of data from diverse sources. The synthesis utilised many data sources (mostly secondary) with the

Thembisa Model Version 4.3, also written as Thembisa Model for short, being a principal source for epidemiological data (HIV prevalence, HIV incidence, data on the 90-90-90 targets, and AIDS-related deaths). Linear trends in data were explored using linear regression models.

STATUS OF THE EPIDEMIC

South Africa has the largest HIV epidemic in the world, with about 7.6 million infected people in 2019. The national HIV prevalence in 2019 was estimated at 13.2% and has been unwavering for the past three years. However, the total number of people living with HIV increased annually over the same period, by more than 100,000 people per annum. The epidemic is heterogenous across geographical and demographic subgroups of the population. Females bear a disproportionate burden of the HIV epidemic, in terms of both total number of existing cases and total number of new cases per annum. The HIV prevalence in persons aged 15 to 49 years in 2019 was 12.8% for males and 25.6% for females. The prevalence remains highest in KwaZulu-Natal and Mpumalanga, although the rate of increase in recent years is faster in other provinces, including the Western Cape and Eastern Cape. HIV prevalence in the country is higher in rural areas than in urban areas. Key populations, including female sex workers and men who have sex with men, continue to play a key role in the HIV transmission dynamics, highlighting concentrated sub-epidemics. The HIV prevalence in these key populations is much higher than the national prevalence.

The HIV incidence continues to decrease in South Africa, from 0.45% in 2017 to 0.36% in 2019. This decline in incidence is evident in males and females of all age groups, although the rate of decline may not be rapid enough to achieve national set targets. South Africa experiences a twin epidemic, and HIV epidemic characterised by a high burden of tuberculosis (TB). As seen with the declining HIV epidemic, the TB burden is also on the decline, in terms of both incident cases and number of deaths. The overall TB incidence reduced by 14% from 421,000 in 2017 to 360,000 in 2019, with an even higher decline (18%) among those with HIV co-infection.

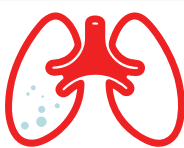
THE POLICY AND PROGRAMMATIC RESPONSE

The National Strategic Plan for HIV, STIs and TB (2017–2022), also written as "NSP 2017–2022" or "the current NSP" guides South Africa's response to the HIV/AIDS epidemic. In line with the 2016 declaration, the NSP 2017–2022 aimed to significantly reduce new HIV infections, increase the number of people on antiretroviral therapy (ART), and decrease HIV-related deaths in the country, among other targets. The current NSP contains the strategic framework for achieving the ambitious targets set in the period under review.

INTRODUCTION

The NSP 2017–2022 involved multi-sectoral partnerships and embraced innovative interventions with community-centred delivery in a supportive legal and policy environment. Furthermore, the NSP 2017–2022 identifies the heterogeneity of the epidemic and sets plans to intensify efforts in geographical areas and sub-populations disproportionately affected by the epidemic. It lays emphasis on impact, with specific, measurable, achievable, realistic and time-bound (SMART) indicators for measuring progress and impact in almost all aspects of the national response.

STATUS AT A GLANCE

COMMITMENT		ACHIEVED BY END 2019	LIKELY TO BE ACHIEVED BY END 2020
	1. Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets by 2020	No	Not 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	
	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	
	7. Ensure that at least 30% of all service delivery is community-led by 2020	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	
	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	
	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



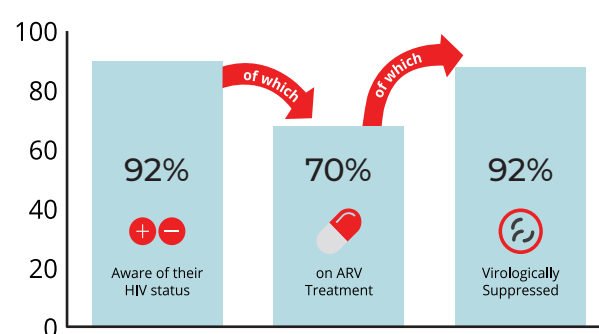
SUMMARY OF PROGRESS TOWARDS COMMITMENTS

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

The overall HIV prevalence in South Africa plateaued at 13.2% between 2017 and 2019. The number of people living with HIV (PLHIV) in the country in 2019 was 7.6 million — the world's largest HIV epidemic. Between 2017 and 2019, the number of PLHIV increased at the rate of 112,000 people per annum ($p=0.024$). The country's efforts to control the epidemic and achieve the UN 90-90-90 targets by 2020 are commendable, having done well to achieve the first and third targets, and geared up to putting more people on treatment to achieve the second target.

In 2019, 92% of PLHIV knew their HIV status, an increase from the 90% in 2018. Also, in 2019, this achievement of the UN first 90 target was seen in both men and women, across all provinces. However, the second 90 target, which requires that 90% of all people with diagnosed HIV infection should be on ART, has not been achieved. In 2019, 7.1 million PLHIV knew their HIV status. To achieve the 90% treatment target, 6.3 million diagnosed people will need to be on treatment by 2020. In 2019, slightly more than 5 million people were on treatment. Reaching the second 90 target by 2020 is an arduous task, considering that the average number of people initiated on treatment per year has been less than 500,000 in the period 2017–2019. However, with political will, improved treatment guidelines, improved government spending, and funding support from PEPFAR, the government is determined to initiate an additional 1.3 million PLHIV on treatment by 2020.

In 2019, 92% of PLHIV on treatment achieved virological suppression; thus, South Africa has achieved the third 90 target of viral suppression among HIV patients on ART. However, this achievement should be interpreted with caution since it is dependent on the second target, which is yet to be achieved. Also, the poor 90-90-90 performance in children is notable.



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

South Africa has shown resolute will and investment in the commitment to eliminate new HIV infections among children. In 2019, the District Health Information System (DHIS) data showed the mother-to-child transmission (MTCT) rate at 10 weeks to be a low 0.7%, which is almost half the 1.3% in 2017. This achievement is due to the success of South Africa's prevention of mother-to-child transmission (PMTCT) programme. In 2019, at least 96% of pregnant HIV-positive women received antiretroviral (ARV) medicines for PMTCT. Also important in this achievement is the country's early infant diagnosis (EID) programme, which, during the review period, had a testing capacity of one million annual tests.

10-week
MTCT rate
0.7%
in 2019



(Source Thembisa Model, V4.3¹)

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 incidence of HIV is declining in South Africa overall, and among men and women of all ages, although the rate of decline is not fast enough to achieve set targets. In 2019, there were 183,000 new HIV infections, a 16% decrease from the 217,000 new infections recorded in 2017. Progress towards Commitment 3 is slow in many aspects and explains why the number of new infections in the country is still high. However, efforts towards combination prevention options gained traction between 2017 and 2019. With 595,000 circumcisions performed in the 2018/2019 financial year, the country achieved (for the first time) its circumcision target of 600,000 for the year. The uptake of HIV pre-exposure prophylaxis (PrEP) is low in the general population, with total uptake during the review period occurring mostly among key populations. Condom use in the general population is equally low. Therefore, combination prevention options are yet to reach 90% of the population.

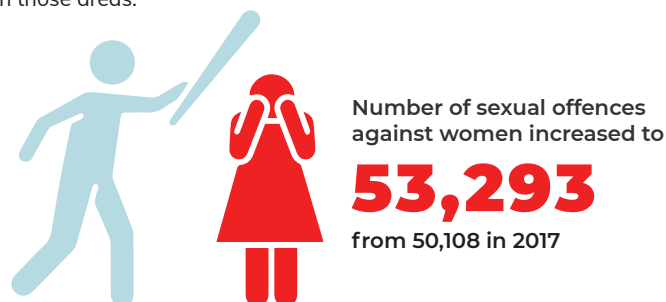
The legal and policy environment for Commitment 3 is robust and progressive, although sex work remains criminalised. Key populations are receiving more programmatic and monitoring attention from the government and non-governmental organisations (NGOs). Nevertheless, there remain significant gaps in the UNAIDS 90-90-90 targets among key populations. Although essential monitoring data for key populations became available in 2018 and 2019, they are sparse for certain groups, such as transgender people and people who inject drugs (PWID). More data and a comprehensive M&E system would be beneficial in assessing overall progress towards this commitment, particularly among key populations.

183,000
new infections in 2019

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

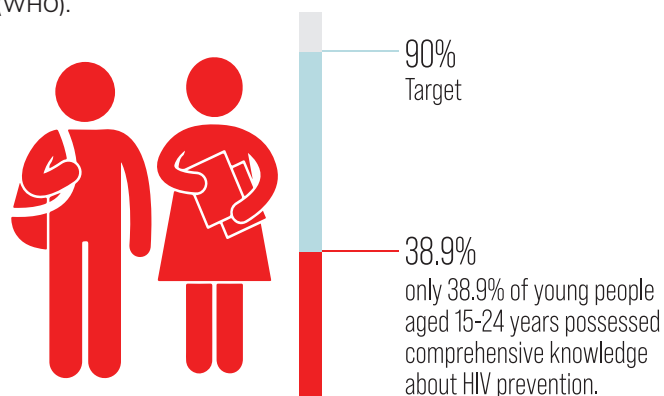
The robust legal and policy environment for this commitment has not translated into tangible results. Programme and research data show that the country is far from eliminating gender inequalities and protecting women and girls against all forms of violence and discrimination. Instead, violent crimes against women are increasing

and economic gender disparities remain unchanged. The South African National Police Service annual crime statistics showed that the number of sexual offences against women increased from 50,108 in 2017 to 53,293 in 2019. During the same period, rape cases increased from 40,035 to 42,289. A woman is killed in South Africa every three hours. Discrimination against PLHIV and key populations is commonplace, with about a fifth of South Africans showing discriminatory attitudes towards PLHIV. HIV-related discrimination in health-care settings, against key populations, is low (< 10%) but does occur. Furthermore, the scarcity of data to monitor some indicators under this commitment makes it difficult to assess overall progress in those areas.



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

Commitment 5 is an area where the country has fared poorly, especially considering the drive for an HIV-free generation by 2030. In 2019, young people aged 15 to 24 years accounted for one-third (34%) of new HIV infections. Despite the government's palpable efforts at youth HIV education, the proportion of young people in the country who have the knowledge and capacity to protect themselves from HIV is way below 90%. The 2017 South African National HIV Prevalence Incidence, Behaviour and Communication Survey (SABSSM V) showed that only 38.9% of young people aged 15-24 years possessed comprehensive knowledge about HIV prevention. The finding was corroborated by a 2018 study in two high HIV burden districts, which reported that less than half (44.7%) of young adults had correct knowledge of HIV prevention. In terms of sexual and reproductive health, the data paint a better picture. In 2019, 79% of reproductive age women (15 to 49 years) in South Africa had their family planning demands satisfied by modern contraceptive methods, which exceeds the 75% guideline from the World Health Organization (WHO).



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



17.8 million
people received
social grant in 2018

Considering that it is a lower-middle-income country, South Africa has done incredibly well to provide social protection to its most vulnerable citizens. The role of social grants in the fight against HIV in South Africa has been documented — from being a safety net that reduces the risk of HIV acquisition, to helping those who are affected, including those who can prove disability and inability to work due to HIV and/or TB. Consequently, South Africa has achieved this commitment.

In 2017, 17.2 million South Africans were receiving some form of social grants from the government. In 2019, the number of beneficiaries increased to 17.8 million — about a third of the total population. Furthermore, the South Africa social protection system has been noted to contain (overtly or covertly) all six UNAIDS vital elements of an HIV-sensitive social protection strategy that reflect deliberate government effort to address Commitment 6. In addition to social grants, the government provides other forms of social protection to vulnerable persons in South Africa. NGOs and international partners also provide social protection, in cash and in kind, to identified beneficiaries in the country.

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

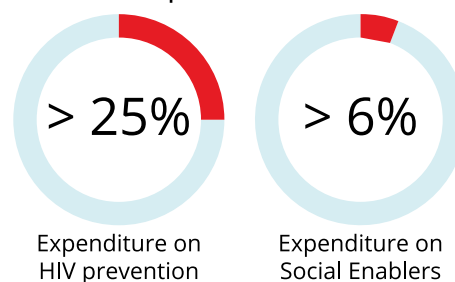


**Civil society
organisations play
key roles in the HIV
response**

The country has achieved Commitment 7, which stipulates that at least 30% of all service delivery is community-led by 2020. This success can be attributed to civil society's historical role in the liberation of the country from its difficult past, and the people-centred constitution that followed. The current NSP highlights the prioritisation of community engagement, dialogue and direct support in the HIV response, so that the most pressing needs of communities are identified and addressed. NGOs are well-integrated in the South African HIV response effort, playing pivotal roles in different aspects. SANAC coordinates NGO participation, working with 18 civil society forums in the HIV response effort. As a result, South Africa performed excellently on the UNAIDS guided questions for this commitment in the National Commitments and Policy Instrument (NCPI—Part A and B) of 2019. However, defined indicators are needed to measure achievement under this commitment and, at the time of this report, the UNAIDS was yet to wrap up its work in this regard.

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

Total HIV/AIDS expenditure in 2018 R28.8 billion



South Africa's achievement of many of the commitments in the UN Political Declaration has been premised on government's political will, backed by funding commitment. South Africa has been able to achieve this commitment due to two factors. First, South Africa funds more than three-quarters of its HIV expenditure. Consolidated HIV expenditure analysis showed that in 2016/17, total expenditure on HIV was R28.8 billion, with the government providing 76% of that. Second, the country has benefited from generous contributions from international donors, with the United States President's Emergency Plan for AIDS Relief (PEPFAR) being the largest. Although a full National AIDS Spending Assessment (NASA) was underway during the period of compiling this report, policy documents and budgetary data show that government spending on HIV increased in the period under review. In the same vein, PEPFAR funding support to South Africa increased between 2017 and 2019.

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
make provision for
this commitment**

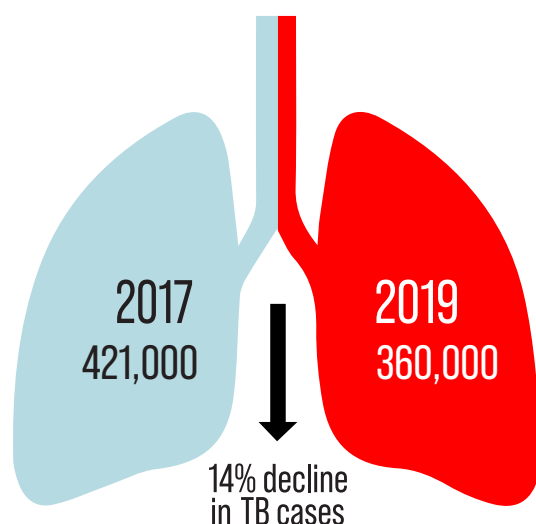
The achievement of Commitment 9 derives from the country's liberal and progressive constitution that protects citizens' rights, including people living with, at risk of, and affected by, HIV. Section 2 of the Constitution provides for a broad range of rights, ranging from basic to political and judiciary rights. Section 27 prescribes access to healthcare services, including reproductive health, to all citizens. Many more policy documents prevent violations of human rights, including those on the basis of HIV status. The law forbids employment discrimination on the basis of a person's HIV status, and there are statutory bodies where aggrieved persons can seek recourse. HIV prevention and treatment services are entirely voluntary.

SUMMARY OF PROGRESS TOWARDS COMMITMENTS

Data from the Governance, Public Safety and Justice Survey (GPSJS) of 2018/19 showed that 80% of the population was aware of the country's constitution and 78% was aware that it protects their rights — an improvement from similar findings in 2016. In 2019, SANAC launched its Human Rights Plan (2019–2022), which has been applauded for its objectives. Among others, it seeks to enhance legal literacy among key and vulnerable populations, and to sensitize and train health workers on patient rights and needs of people living with HIV, TB, and key populations, including their rights as health workers.

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

South Africa has made giant strides in taking AIDS out of isolation through people-centred systems. However, this commitment cannot be thought to have been achieved since universal health coverage and treatment of TB and other infections are not yet fully actualised. The National Health Insurance (NHI) Bill, which provides for free comprehensive healthcare services for all South Africans and permanent residents, was presented to Parliament on 8 August 2019 and is expected to be implemented incrementally, covering the entire country by 2025.



In 2019, an estimated 360,000 South Africans became ill with TB, a decrease from 421,000 in 2017, translating to a 14% decline in three years. This decline was mainly due to the diminishing number of new TB cases among PLHIV: from 255,000 in 2017 to 209,000 in 2019. TB mortality decreased during the same period. The rate of HIV/TB co-management, although high, declined from 91% in 2017 to 85% in 2019. As contained in the 2018 GAM narrative report, data on hepatitis B and C, and gonorrhoea in men, remain sparse.

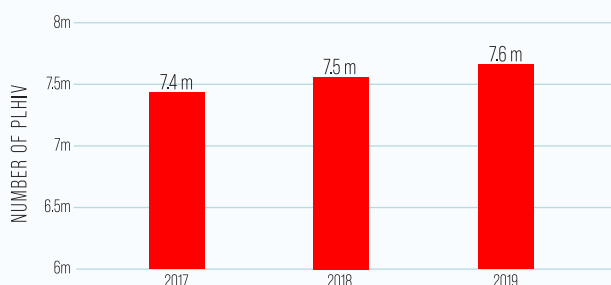


OVERVIEW OF THE HIV/AIDS EPIDEMIC IN SOUTH AFRICA IN 2019

OVERALL HIV PREVALENCE AND TRENDS

The Thembisa estimation model shows that by the end of 2019, there were more than 7.6 million PLHIV in South Africa. From 2017 to 2019, the number increased steadily by slightly more than 100,000 persons per annum (Figure 1).¹ In 2019, the HIV prevalence was 13.2%, the same as it was in 2017, meaning that the prevalence has remained constant from 2017 to 2019.

Figure 1: Total number of people living with HIV in South Africa, 2017 to 2019



(Source Thembisa Model, V4.3¹)

Statistics South Africa (Stats SA) estimated a similar HIV prevalence for South Africa in 2019, i.e. 13.5%, with 7.97 million people estimated to be living with HIV.² As shown in Table 1, these estimates are congruent with the SABSSM V conducted in 2017, which showed the prevalence of HIV in South Africans to be 14%.³

13%
current HIV
prevalence in
South Africa

(Source: SABSSM V)

The epidemiology of HIV in South Africa is highly heterogeneous across geographical and socio-demographic subgroups. The following section is an analysis of the 2019 HIV prevalence across these subgroups.

Table 1: Recent trends in overall HIV prevalence in South Africa, 2017–2019

Data Source	2017	2018	2019
Thembisa Model	13.2%	13.2%	13.2%
Statistics South Africa	13.1%	13.4%	13.5%
SABSSM V	14%	—	—

HIV PREVALENCE BY SEX AND AGE

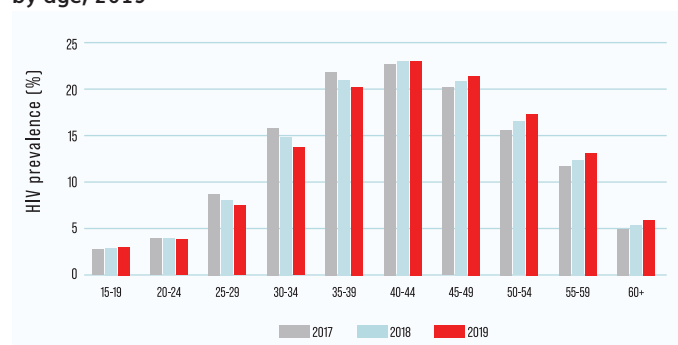
The HIV prevalence in adults (15 to 49 years) was 19.2%: 12.8% for males and 25.6% for females.¹ The HIV prevalence in both males and females increased with age, peaking in the middle age groups, and starting to drop in older persons (Figures 2 and 3). While the pattern is similar for both sexes, the prevalence peaked earlier in women (34 to 39 years) than in men (40 to 44 years).

Adult HIV Prevalence

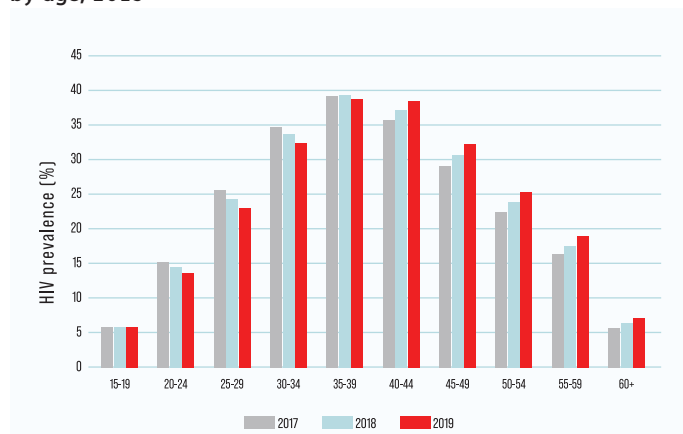
♂ Males **12.8%**

♀ Females **25.6%**

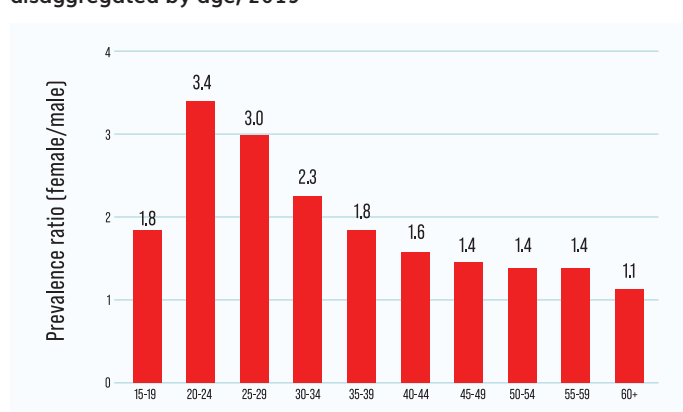
Figure 2: Prevalence of HIV in South Africa males disaggregated by age, 2019



(Source Thembisa Model, V4.3¹)

Figure 3: Prevalence of HIV in South Africa females disaggregated by age, 2019(Source Thembisa Model, V4.3¹)

The HIV prevalence was consistently higher in females than in males for all age groups. The prevalence ratio (the ratio of HIV prevalence in females to HIV prevalence in males) was 2 for adults aged 15 to 49 years. The prevalence ratios disaggregated by age group are shown in Figure 4. Females aged 20 to 24 years were more than three times as likely to be living with HIV as their male counterparts.

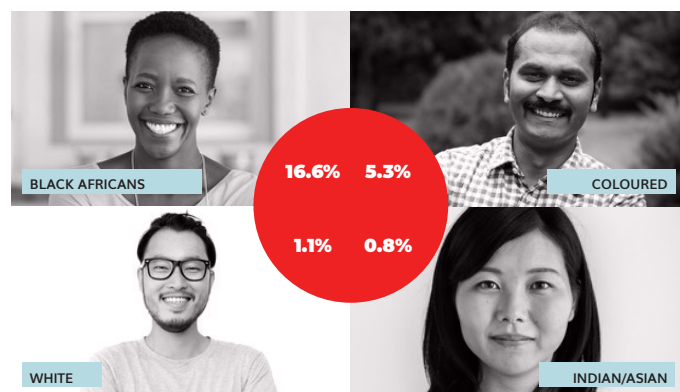
Figure 4: Ratio of HIV prevalence in females to males disaggregated by age, 2019(Source Thembisa Model, V4.3¹)

The good news is that HIV prevalence in females aged 15 to 24 years declined from 10.8% in 2017 to 9.9% in 2019. Unfortunately, the same is not true for males of the same age, where the HIV prevalence increased from 3.6% in 2017 to 3.7% in 2019.¹ This is an important age group for monitoring the epidemic for a number of reasons. First, they have some of the highest rates of new infections. Second, while HIV prevalence in the older age groups reflects cumulative net infection, HIV prevalence in this younger age group is more likely to reflect recent dynamics in new infections. Third, it is expected that this younger age group would be more amenable to HIV risk behavioural interventions than older age groups since patterns of behaviour become established with age.

HIV PREVALENCE BY RACE

In South Africa, race is an important determinant of health as it is strongly linked to education and economic disparities, as well as being a proxy for socio-cultural differences, which are linked to access to health information, care and treatment outcomes. During the period under review, the Thembisa Model did not provide HIV prevalence estimates by race. The 2017 SABSSM, which reported an

overall national HIV prevalence of 14%, provided disaggregation by race (Figure 5). The data showed that the burden of the epidemic in South Africa is overwhelmingly borne by Black Africans (17%), while in White and Asian South Africans, the prevalence is about 1%.³

Figure 5: Prevalence of HIV in South Africa by race group, 2017(Source: Thembisa Model, V4.3¹)

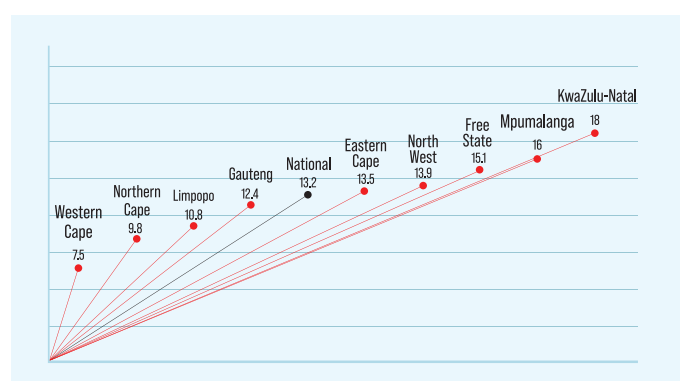
HIV PREVALENCE IN ANTENATAL CARE (ANC) ATTENDEES

South Africa has implemented a series of national antenatal sentinel HIV prevalence surveys since 1990. The most recent survey was conducted in November 2017, with the results available in 2019. The survey showed that the HIV prevalence among antenatal care attendees of public healthcare facilities was 30.7% (95% CI: 30.1%–31.3%), which is a 0.1% decline from the 30.8% prevalence reported in the 2015 survey.^{4,5} The Thembisa Model estimated the HIV prevalence to be 26.1% in 2019.¹ The lower prevalence from the Model is explained, in part, by the inclusion of women attending private healthcare facilities.



HIV PREVALENCE BY PROVINCE

Figure 6 shows the HIV prevalence in all provinces. In 2019, the provincial HIV prevalence was highest in KwaZulu-Natal province (18%) and lowest in the Western Cape province (7.5%).¹

Figure 6: Prevalence of HIV in South Africa by province, 2019(Source: Thembisa Model, V4.3¹)

The Thembisa Model included a trend analysis of adult HIV prevalence in South Africa and all nine provinces, with the following conclusions (Figure 7):

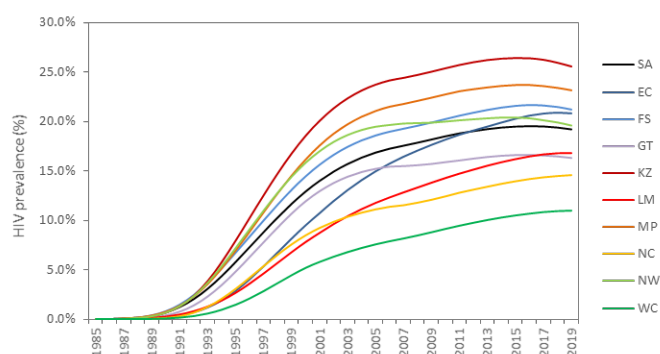
The HIV prevalence increased over time in all provinces.

The prevalence has peaked in KwaZulu-Natal, Mpumalanga, Free State, North West and Gauteng provinces.

The prevalence has been consistently higher in KwaZulu-Natal and Mpumalanga provinces than in other provinces.

The prevalence appears to be increasing most rapidly in four provinces: Western Cape, Eastern Cape, Northern Cape and Limpopo.¹

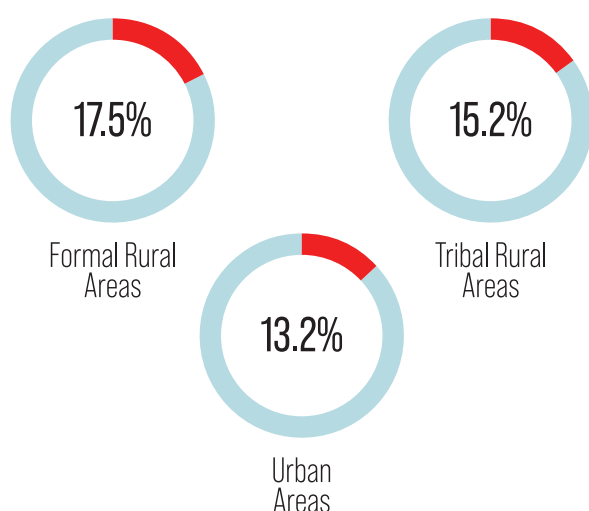
Figure 7: Trends in HIV prevalence in South Africa by province, 1985 to 2019



(Source: Thembisa Model, V4.3¹)

HIV PREVALENCE BY LOCALITY

The 2017 SABSSM reported HIV prevalence across three locality types in the country: urban, formal rural (farms) and informal rural (tribal areas). The data showed that HIV prevalence was lower in urban areas (13.2%) than in rural areas (15.2% in tribal rural areas and 17.5% formal rural areas).³ The pattern was the same when looking at HIV prevalence among youth aged 15 to 24 years, viz. lowest in urban areas (6.8%) and highest in formal rural areas (11.2%).



HIV PREVALENCE IN KEY AND VULNERABLE POPULATIONS

HIV key populations are defined by known high-risk behaviours that put them at high risk of HIV infection and transmission, while vulnerable populations are defined by contextual conditions that may increase their risk of HIV acquisition. South Africa's National Strategic Plan for HIV, TB and STIs 2017–2022 lists key populations for HIV and STIs to include sex workers, transgender people, men who have sex with men (MSM), people who inject drugs (PWID), and prison inmates; and vulnerable populations to include orphans and vulnerable children (OVC), people living in informal settlements, mobile populations, migrants and undocumented foreigners, people with disabilities, and lesbian, gay, bisexual, transgender and intersex (LGBTI) populations.⁶

The HIV prevalence declined slightly in the two largest key populations in South Africa in 2019, compared to previous years. The Thembisa Model estimated that the HIV prevalence in MSM was 25.3% in 2019, down from 26.8% in 2017. In female sex workers (FSW), the HIV prevalence in 2019 was 55.6%, down from 58.7% in 2017.¹

HIV INCIDENCE

The overall HIV incidence rate continues to decline in South Africa

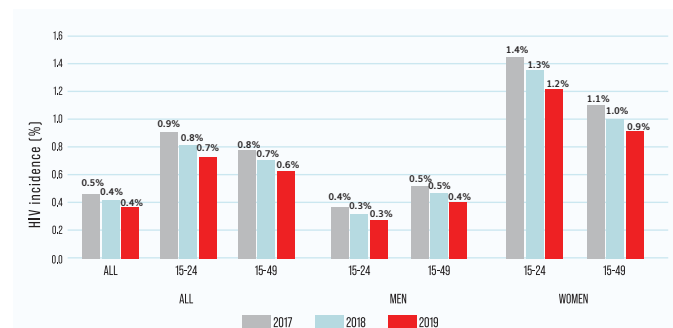
0.45%
0.36%

2017

2019

In 2019, there were 182,597 new HIV infections in South Africa. This is lower than the 217,439 new infections estimated to have occurred in 2017.¹ It is a welcome development that the overall HIV incidence rate continued to decline in South Africa, from 0.45% in 2017 to 0.36% in 2019 (Figure 8). The decline in HIV incidence was evident in both sex and age groups.¹

Figure 8: Incidence of HIV in South Africa by sex and age, 2017–2019



(Source: Thembisa Model, V4.3¹)

The risk ratio (the ratio of HIV incidence in females to HIV incidence in males) showed a similar pattern as the prevalence ratio previously described. It was 2 for adults aged 15 to 49 years and 3 for young adults (15 to 24 years) in 2019. This confirms that the burden of HIV infections remains much higher in females than in males of the same age group, in terms of both number of existing infections and number of new infections.



COMMITMENT ONE

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

SCORE CARD

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

South Africa is remarkably progressive regarding its legislative framework to provide highly effective ART for PLHIV (figure 9). SANAC's National Strategic Plan and the National Department of Health's (NDoH) ART treatment guidelines are two important documents that dictate the legal and policy environment for this commitment. During the previous NSP (2012–2016), the country rapidly expanded ART access to PLHIV through three updated policy instruments.

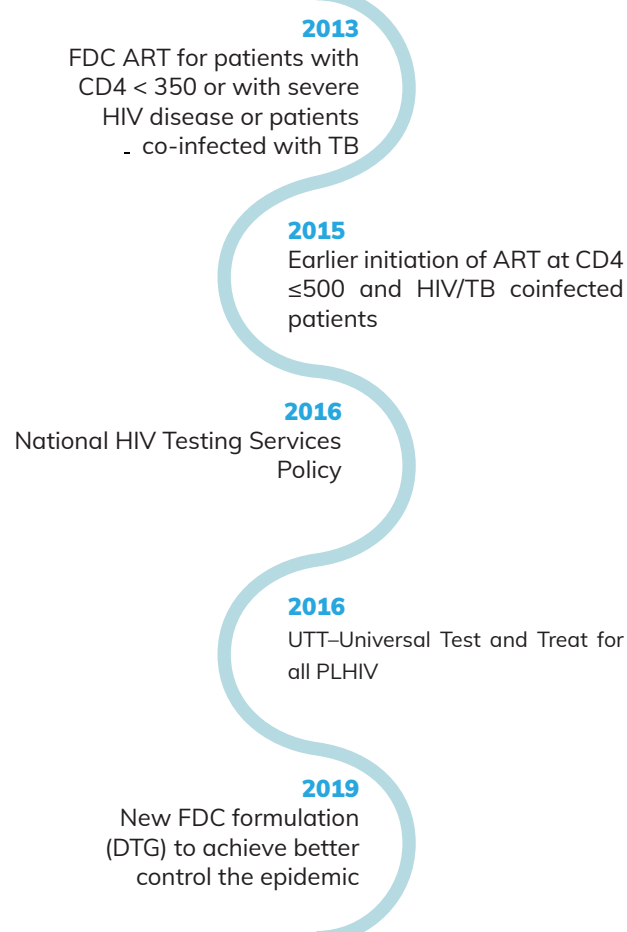
The 2013 update to the treatment guidelines introduced the fixed-dose combination (FDC) ART to improve adherence and retention.⁷

In 2015, another update to the treatment guidelines further increased the threshold to a CD4 count of less than or equal to 500 cells/ μ l.⁷

Then in 2016, the country abolished the CD4 count threshold criterion and introduced the Universal Test and Treat policy for all PLHIV. This progressive policy meant two things. First, all PLHIV, regardless of CD4 count and clinical disease stage qualify for ART in South Africa. Second, PLHIV can start treatment immediately after diagnosis.⁸ In 2017, further guidance from the NDoH advocated for starting treatment on the same day of diagnosis (same day initiation–SDI).^{6,9}

The current NSP term (2017–2022) has seen yet another revision to the country's policy environment for ART. In October 2019, the government released the 2019 ART Clinical Guidelines for the Management of HIV in Adults, Pregnancy, Adolescents, Children, Infants and Neonates.¹⁰ The updated guidelines introduced new FDC formulation that has “a high genetic barrier to resistance, minimal side effects and drug interactions, and provides rapid viral suppression.” It is hoped that this revision will increase access to ART and help achieve a better control of the epidemic.

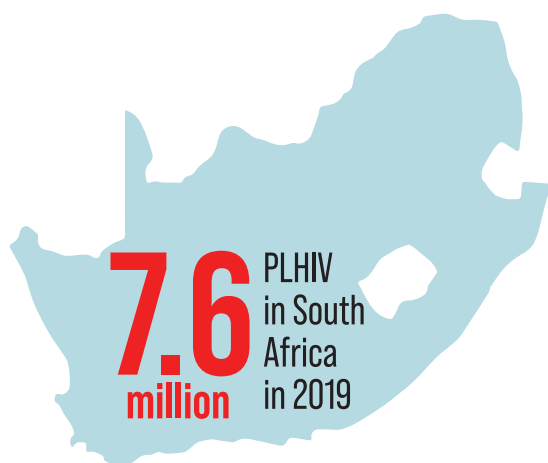
Figure 9: South Africa's legal and policy environment for Commitment 1



CURRENT STATUS AND RECENT TRENDS

NUMBER OF PEOPLE LIVING WITH HIV

The cornerstone of the 2016 Political Declaration on Ending AIDS is to control the HIV/AIDS epidemic through meeting the 90-90-90 targets: 90% of all PLHIV should know their HIV status, 90% of all people diagnosed with HIV should be on ART, and 90% of all people on ART should achieve viral suppression.¹¹ To assess progress towards the achievements of these targets, it is important for countries to generate evidence on the total number of PLHIV.



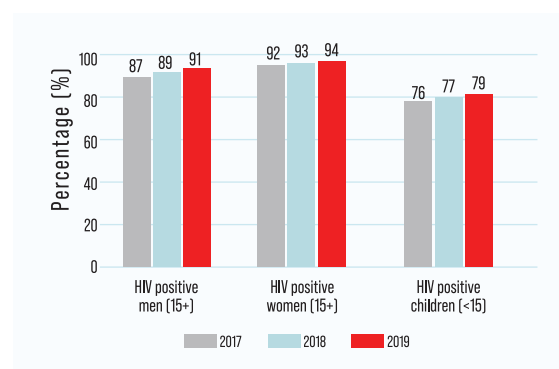
As reported in the previous chapter, the number of PLHIV in South Africa in 2019 was 7.6 million — an increase from 7.5 million in 2018 and 7.4 million in 2017 (Figure 1). This translates to an increase of 112,000 persons annually ($p=0.024$).¹ It is noteworthy that these estimates from the Thembisa Model align with those from Statistics South Africa, although the latter show slightly higher numbers: 7.90 million in 2017, 7.94 million in 2018, and 7.97 million in 2019.^{1,2}

Estimates of number of PLHIV from the Thembisa Model, SABSSM V and Stats SA are in agreement, with <5% variation.

PEOPLE LIVING WITH HIV WHO KNOW THEIR HIV STATUS

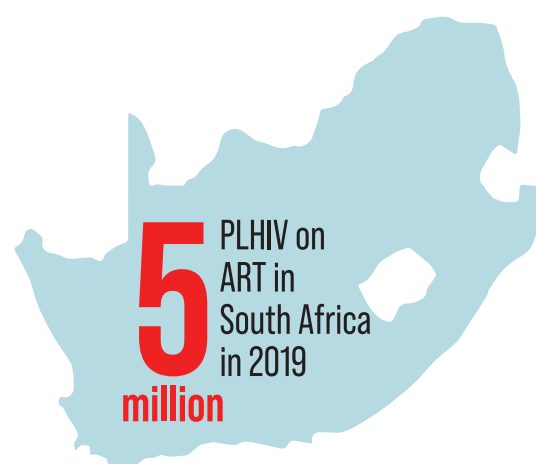
The Thembisa Model shows that, of the 7.6 million PLHIV in 2019, 7.1 million have been diagnosed.¹ This means that 92% of all PLHIV know their HIV status, confirming the country's achievement of the first 90% target, first recorded in the 2018 GAM narrative report.¹² Also, 92% is higher than the 87% set in the current NSP as the target for the 2018/19 financial year. The data are disaggregated by sex and age in Figure 10. Provincial disaggregation showed that this target was achieved across all provinces, with Gauteng province being only one percentage point off (data not shown).

Figure 10: Percentage of people living with HIV who know their HIV status, 2017–2019



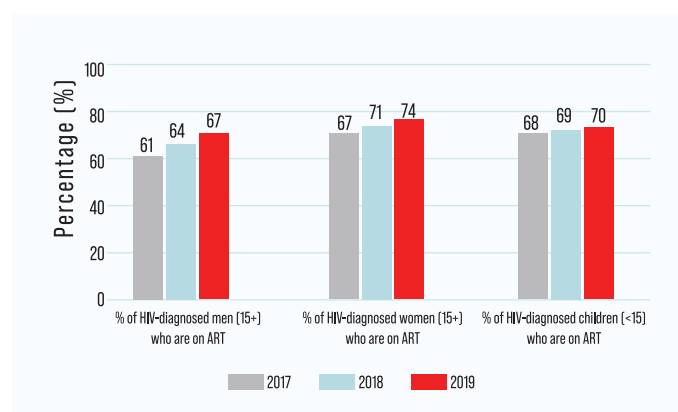
(Source: Thembisa Model, V4.3¹)

PEOPLE LIVING WITH HIV ON ANTIRETROVIRAL THERAPY



Although South Africa is already implementing the largest ART programme in the world, the country is unrelenting in treating more people, towards achieving the second 90% target. Of the 7.1 million PLHIV who know their HIV status, 5.02 million were on ART in 2019, up from 4.4 million people in 2017 and 4.7 million people in 2018.¹ This means that the percentage of HIV-diagnosed people on treatment in 2019 was 71%, which is much lower than the target 90%. Data from the Thembisa Model showed that women were more likely to be on treatment than men from 2017 to 2019 (Figure 11).

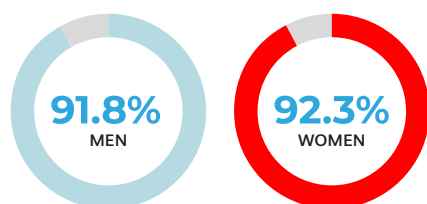
Figure 11: Percentage of people diagnosed with HIV infection on ARV treatment, 2017–2019



(Source Thembisa Model, V4.3¹)

PEOPLE LIVING WITH HIV WHO HAVE SUPPRESSED VIRAL LOADS

The last of the 90-90-90 targets is the final outcome of the logical HIV treatment cascade. The reason for testing people and putting them on treatment is to achieve sustainable virological suppression for improved health and prevention of onward HIV transmission. The fraction of PLHIV on ART who are virologically suppressed (RNA count <1,000 copies/ml) increased steadily in the review period. In 2019, 91.5% of people on treatment achieved viral load suppression,¹ meaning that South Africa achieved the third target in 2019. The achievement of viral load suppression is especially commendable as the proportions in men and women were similar (91.8% and 92.3% respectively).



LATE HIV DIAGNOSIS



Although South Africa's ART programme is implemented according to 'test and treat' guidelines, it is of value to continue to monitor the percentage of PLHIV who are diagnosed late, which is defined in terms of symptoms (having AIDS at the time, or within 12 months, of diagnosis) or in terms of CD4 cell count (having an initial CD4 count less than 200 cells/mm³, or 350 cell/mm³, when expanded, at diagnosis).¹³ Late HIV diagnosis in South Africa (percentages of PLHIV with the initial CD4 cell count <200 cells/mm³), barely reduced from 32.8% in 2017 to 31.5% in 2019.¹⁴ A 2019 scientific paper, using data from TIER.Net showed similarly high levels of late HIV diagnosis, with associated negated health outcomes.¹⁵



Fast-Track Targets by 2020 (90-90-90)

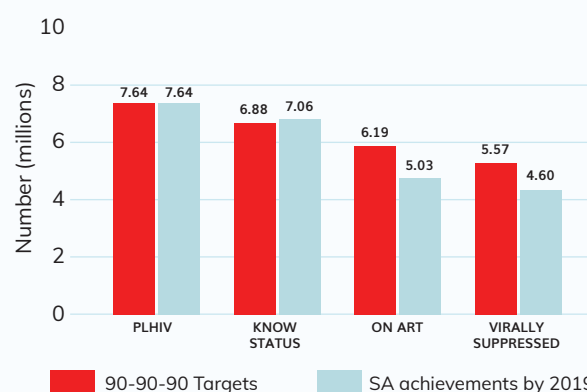
Figure 12: South Africa's achievement of the 90-90-90 targets in 2019 (all PLHIV as denominator)

	UN Target	South Africa's Achievement
All PLHIV Diagnosed	90%	92.4%
All PLHIV on Treatment	81%	65.8%
All PLHIV on ART suppressed	73%	60.2%

(Source: Thembisa Model, V4.3¹)

The 90-90-90 targets mean that 81% of all PLHIV should be put on ART and 73% of all PLHIV should be virally suppressed. Therefore, although South Africa has achieved the third target for those on treatment, this should be interpreted with caution since it lags behind in the second target. Figures 12 and 13 show South Africa's achievements in percentages and numbers.

Figure 13: South Africa's achievement of the 90-90-90 targets by 2019 (numbers)



ANTIRETROVIRAL MEDICINE STOCK-OUTS

The annual national Stop Stockouts survey provides monitoring data on the availability of ARV and TB medicines in South African public health facilities. Inconsistent access to ARV medicine portends patients defaulting on treatment, with associated consequences. The stockout survey data throw light on this important health system factor that can affect adherence to ART. The most recent national stockout survey in South Africa was conducted in 2017 and showed that, of the 1,526 facilities in the study:

- 16% had experienced an ARV or TB medicine stockout in the past three months.
- ARV stockouts were less in 2017 than in 2015.
- Two dosages of efavirenz were the most frequently reported medicines out of stock (13% for 200 mg and 11% for 600 mg), followed by the fixed-dose combination of ARV (9%).
- Most (75%) stockouts were resolved within a month.¹⁶



There has not been another survey since 2017. However, a June 2019 press release by the Stop Stockouts Project (a consortium of six organisations that monitor medicines stockouts in the country and conduct the aforementioned annual surveys) stated:

“The Stop Stockouts Project (SSP) notes with deep concern the continued stockouts of second line Anti-Retroviral (ARV) therapy and shortages of contraceptives across the country. These stockouts have been unresolved since the second half of last year and the situation has now escalated into a crisis. The failure of relevant stakeholders to act swiftly will put scores of lives at risk.”¹⁷

AIDS MORTALITY



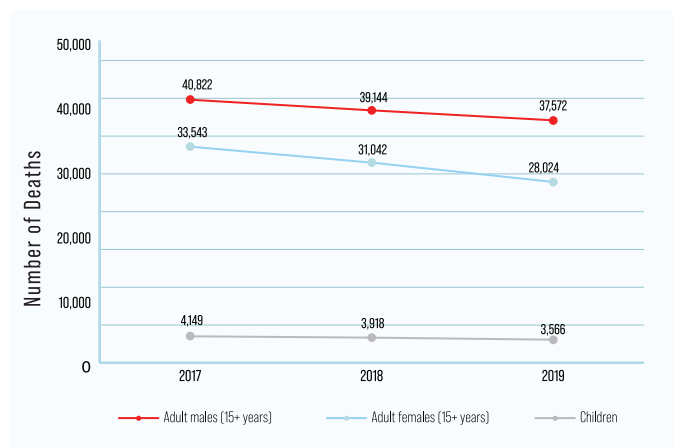
115,000

HIV-related deaths in 2018

In line with the declining HIV incidence and the expanding ART programme in the country, the number of AIDS-related deaths has continued to decrease (Figure 14). There were 79,000 deaths in 2017,

74,000 in 2018, and 69,000 in 2019.¹ This represents a statistically significant declining trend of 4,675 deaths per annum ($p=0.021$). Although there are more women than men living with HIV in the country, men continue to account for more deaths than women. In 2019, men accounted for 54% of AIDS deaths, while women accounted for 43%. The remainder were in children.

Figure 14: AIDS-related deaths in South Africa, disaggregated by age and sex, 2017–2019



(Source: Thembeisa Model, V4.3¹)

HIV TESTING VOLUME AND POSITIVITY

The country's efforts at providing HIV testing services (HTS) and the rate of new infections are captured by this indicator. Data from the DHIS and the Thembeisa Model show that the annual number of HIV tests performed from 2017 to 2019 was 14 to 15 million (Table 2).¹⁸ In the financial year ending 2019 (2018/19), the NDoH reported that 14.9 million HIV tests were performed against the target of 14 million. The positivity rate for the HIV tests performed has declined consistently in the past decade and was at its lowest in 2019: 5.4% for adults and 2.0% for children.¹⁸

Table 2: HIV tests performed and positivity rate in South Africa, 2017–2019

	Total HIV tests performed–DHIS	Total HIV tests performed–Thembeisa Model	Positivity rate–adult HIV tests–Thembeisa Model	Positivity rate–paediatric HIV tests–Thembeisa Model
2017	14,233,123	14,056,267	7.1%	2.5%
2018	13,872,315	14,985,858	6.2%	2.2%
2019	14,874,879	14,592,409	5.4%	2.0%

ACHIEVEMENTS

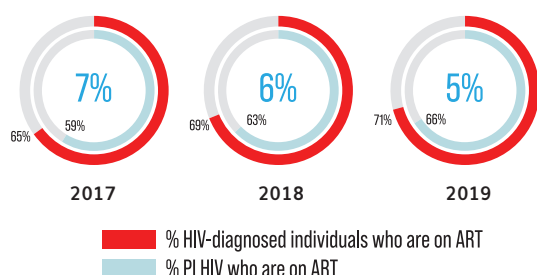
UN FIRST 90 TARGET ACHIEVED IN MEN AND ALL PROVINCES

The country achieved the first 90% target in 2018, but the achievement was not evident in all subgroups, notably men and some provinces. It is commendable that, in 2019, the target was achieved in men and in all provinces. While recent data show that undiagnosed HIV cases in Europe are increasing,²¹ the reverse is the case in South Africa. An analysis of data from the Thembeisa Model showed that the

COMMITMENT ONE

gap between the second 90% target (percentage of HIV-diagnosed individuals who are on ART) and ART coverage (percentage of PLHIV who are on ART) declined consistently in the review period (Figure 15). The gap was 7% in 2017, 6% in 2018, and 5% in 2019.

Figure 15: Increase in ART coverage due to increase in number of diagnosed HIV cases



(Source: Thembisa Model, V4.3¹)

The NSP 2017–2022 set a target of 10 million tests for the 2018/19 financial year,⁶ which was exceeded. The 2019 achievement in testing can be attributed to the government's recent accelerated efforts. On 1 December 2018, the UN launched the 'know your status' programme, the first time that global focus was on HIV testing.²² On the same day, South Africa launched the Cheka Impilo Campaign to intensify HIV testing in the country.²³ In addition to accelerated testing efforts, the current test and treat policy helped improve attitudes towards HIV testing. Despite this progress, it should be noted that there are more than 600,000 PLHIV who remain undiagnosed in the country. The government will need sustained efforts and innovative strategies to find them.

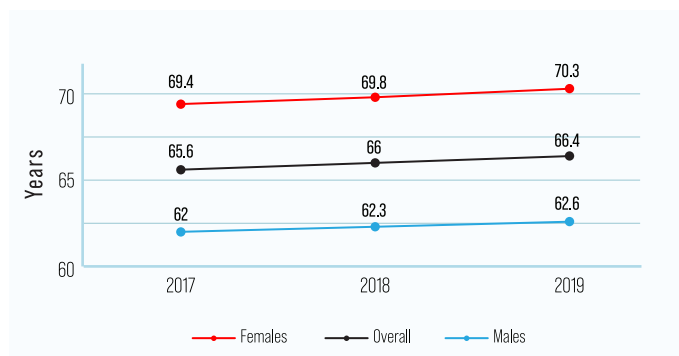
LIFE EXPECTANCY CONTINUES TO INCREASE



Life expectancy for the average South African increased to **66.4 years**

Life expectancy reflects the general mortality levels in a country. The number of AIDS-related deaths has continued to decline, and life expectancy has continued to increase.¹ In 2019, the life expectancy for the average South African increased to 66.4 years: 70.3 years for females and 62.6 years for males (Figure 16). Stats SA estimated slightly lower life expectancies for 2019 (67.7 years for females and 61.5 years for males),² although the trends are the same. The increase in life expectancy in the country has been chiefly attributed to the country's ART programme.²

Figure 16: Life expectancy in South Africa, disaggregated by sex, 2017–2019



(Source: Thembisa Model, V4.3¹)

CHALLENGES

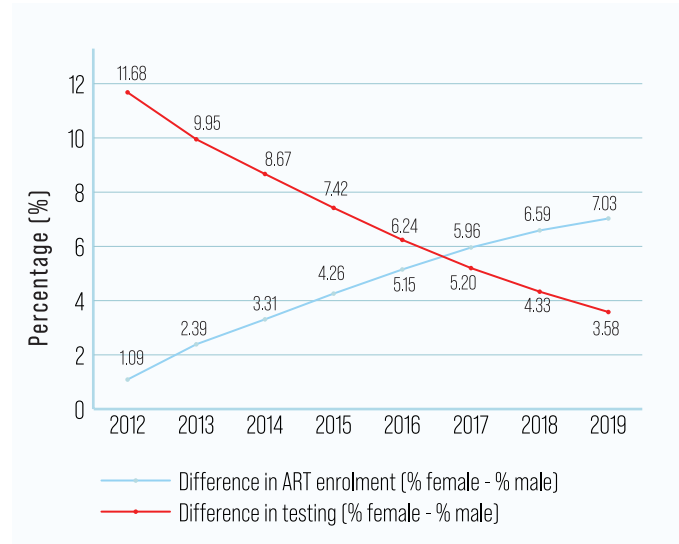
ART PROGRAMME NOT EXPANDING ENOUGH

South Africa runs the largest ART programme in the world. Despite this, the programme is currently not large enough to achieve the second 90% target, owing to the large number of people eligible for treatment. Also, the programme is not expanding rapidly enough to achieve the target by 2020 or by the end of the current NSP term in 2022. The discrepancy in the number of people needing treatment and the number of people on treatment is due to three main forces: the universal test and treat policy adopted in 2016, the recent increase in HIV testing, and the number of new cases not declining rapidly enough. With high levels of new infections and more HIV cases diagnosed, comes the additional burden of putting newly diagnosed persons on treatment.

Since 5 million of the 6.3 million patients eligible for ART are on treatment, there is a lag of 1.3 million individuals who need to be put on treatment, to achieve the second target by 2020. In addition, 90% of the projected number of new cases for 2020 will need to be put on treatment. While it is unlikely that this will be achieved by 2020, the country can look to the end of the current NSP term (2022) to achieve the target.

THE DIFFERENTIAL ART ACCESS BY SEX IS WIDENING

Figure 17: Difference in testing and ART uptake by sex, 2012–2019



(Source: Thembisa Model, V4.3¹)

As the government strives to expand the ART programme to achieve the second 90% target, it is important to note the differential ART access by sex. It is known that females generally outperform males in health-seeking behaviour, but the sex differential in ART uptake is widening each year. This is despite the testing gap between females and males closing, annually (Figure 17). Treatment programmes encouraging men should continue while new channels and approaches should be explored. Perhaps the country's ART programme can learn from the circumcision programme which used innovated methods to extend its reach and achieve its target in 2018/19.¹⁸

HIV TESTING YIELD DECLINING

Although testing numbers have been high in the past three years, particularly in 2019, the yield (positivity rate) has been declining. This is expected as over 92% of all PLHIV in South Africa have been diagnosed. However, in order to reduce the overall number of tests and cost of testing, the national HIV counselling and testing (HCT) programme needs to consider strategies to increase testing yield. Provider-initiated HIV testing (except where the patient opts out), self-testing, and testing in selected settings, e.g. TB clinics and high-risk communities, should form part of such strategies.

POOR 90-90-90 PERFORMANCE IN CHILDREN

Despite the almost perfect coverage of the country's PMTCT programme and excellent levels of early infant diagnosis, children still lag behind in the 90-90-90 targets. Children fare worse in the first and third 90% targets. The percentage of children on ART is lower than that of women and only slightly higher than that of men. The poorer programme performance in children can be explained by biological, individual and structural factors. These factors should be addressed with the aim of providing tailored interventions and improving achievements towards set targets.



COMMITMENT TWO

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

SCORE CARD

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

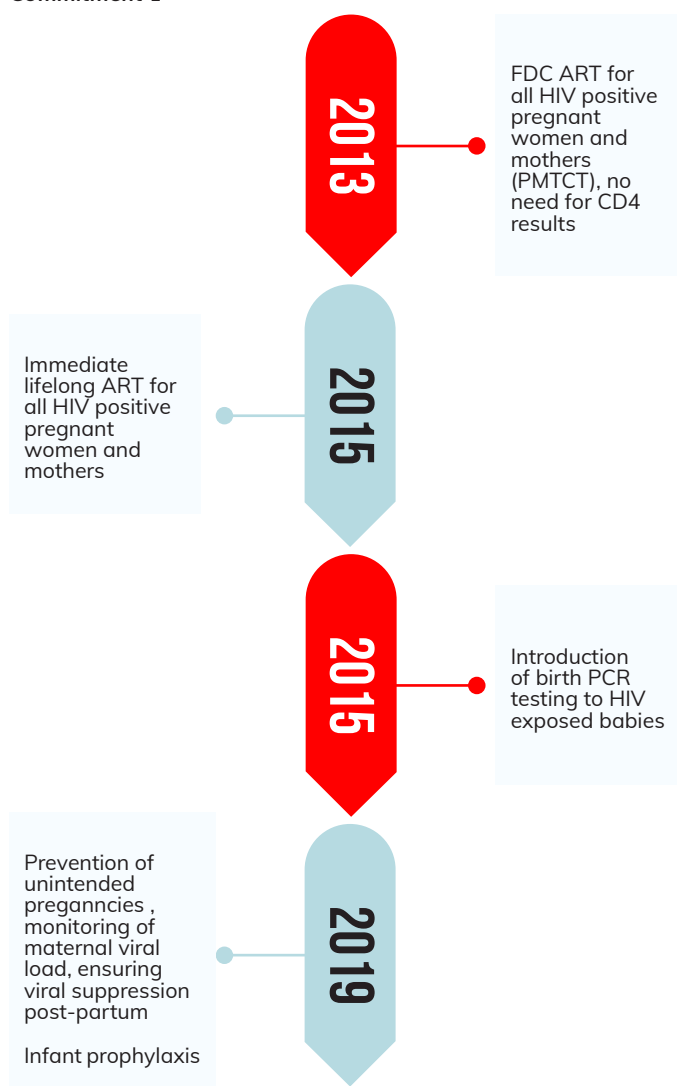
South Africa demonstrated its commitment to eliminating new HIV infections among children by 2020 through a series of policy changes to its PMTCT programme, which began 15 years ago (Figure 18). The country's 2015 update to the PMTCT guidelines was considered a landmark and the turning point, in that it provided lifelong ART to all HIV-positive pregnant women.⁷ The 2015 guidelines also improved on the 2013 guidelines with the stipulation of polymerase chain reaction (PCR) birth testing for all infants born to HIV-positive women for clinical and monitoring purposes. In 2019, there was yet another progressive revision to the PMTCT guidelines.²⁴ The National Guideline for the Prevention of Mother to Child Transmission of Communicable Infections (2019) contains the following major programmatic expansions:

KEY HIGHLIGHTS IN 2019 PMTCT GUIDELINES

- 1  Prevention of HIV infections and unwanted pregnancies among women
- 2  Improving and ensuring virologic suppression among pregnant and breastfeeding women
- 3  Provision of prophylaxis to infants whose mothers are not virologically suppressed during breastfeeding.

These recent policy changes are aimed at further reducing the perinatal and postnatal vertical transmission of HIV infection.

Figure 18: South Africa's legal and policy environment for Commitment 1

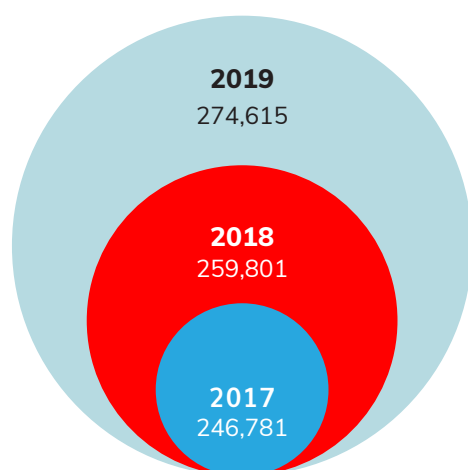


CURRENT STATUS AND RECENT TRENDS

EARLY INFANT DIAGNOSIS

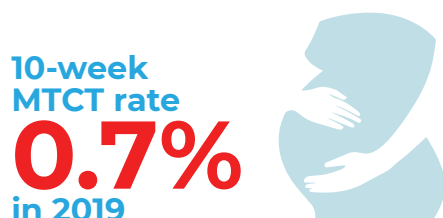
Early infant diagnosis (EID), birth testing of HIV infection using PCR technology, is central to South Africa's PMTCT programme. The annual volume of HIV PCR tests performed at birth has continued to increase since 2015. In 2019, 274,615 tests were conducted, an 11% increase from the 246,781 tests conducted in 2017 (Figure 19).²⁵

Figure 19: Number of HIV PCR tests done at birth in South Africa, 2017–2019



(Source: Thembisa Model; V.4.3¹)

MOTHER-TO-CHILD TRANSMISSION OF HIV



The MTCT rate has continued to drop (Table 3). According to the Thembisa Model, the MTCT at birth was 0.9% in 2017 and 0.8% in 2019.¹ The estimates are similar to those reported by the National Health Laboratory Service (NHLS).²⁵ According to data from the DHIS, the 10-week MTCT rate in 2019 was 0.7%, down from 1.3% in 2016/2017.²⁶

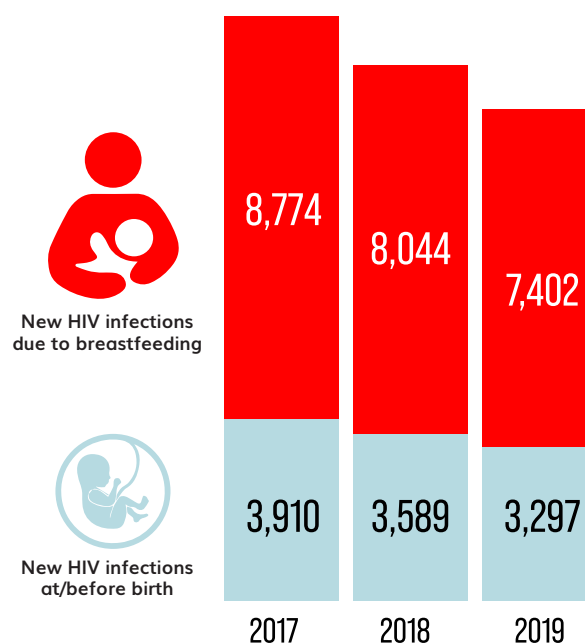
Table 3: Mother-to-child transmission rate in South Africa, 2017–2019

Indicator (and data source)	2017	2018	2019
HIV PCR tests with positive results <7d (NHLS)	0.9%	0.9%	0.8%
MTCT rate at/before birth from HIV-diagnosed mothers (Thembisa Model)	0.88%	0.82%	0.78%
Infant PCR test positive around 10 weeks rate (NHLS)	1.2%	1.1%	0.9%
Infant PCR test positive around 10 weeks rate (DHIS)*	1.3%	0.9%	0.7

(Source: NHLS²⁵, DHIS²⁶; Thembisa Model, V4.3¹)

The Thembisa Model showed that in 2019, there were a total of 10,698 vertical infections, translating to an overall MTCT rate of 3.5. A linear model showed that the total number of mother-to-child transmissions declined significantly at 993 fewer infections per year during the review period ($p=0.021$). Of the 10,698 vertical transmissions in South Africa in 2019, 3,297 babies were born with HIV, down from 3,910 in 2017 (Figure 20). The remainder (69%) of the MTCTs occur during breastfeeding.¹

Figure 20: Trends in new mother-to-child transmitted infections, 2017–2019



(Source: Thembisa Model, V4.3¹)

PREVENTING MOTHER-TO-CHILD TRANSMISSION OF HIV

The PMTCT has continued to expand. The UNAIDS reports that in 2019, of the 310,000 women needing ARVs for PMTCT, 302,936 received them (Table 4). This translates to 97% of pregnant HIV-positive women who received ARVs for PMTCT. This agrees with the 96% reported in the 2018/19 financial year by the NDoH. In 2019, 65,000 new HIV infections were prevented due to PMTCT.

Table 4: Prevention of mother-to-child transmission performance indicators in South Africa, 2017–2019

Indicator	2017	2018	2019
Pregnant women who needed ARV for PMTCT	320,000	320,000	310,000
Pregnant women who received ARV for PMTCT	300,437	304,933	302,936
Coverage of pregnant who received ARV for PMTCT	93%	96%	97%
New HIV infections averted due to PMTCT	62,000	64,000	65,000

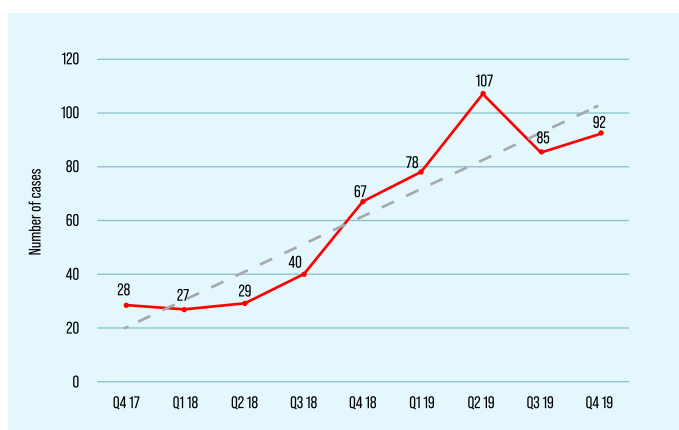
(Source UNAIDS¹⁴)

MATERNAL AND CONGENITAL SYPHILIS

Screening for maternal syphilis at first ANC visit is part of South Africa's ANC package. However, national data on maternal and congenital syphilis are scarce. The 2017 ANC sentinel surveillance survey showed that the maternal syphilis screening coverage in public health facilities in the country was 96.7%, which is higher than the 95% recommended by WHO. However, the 2017 study did not report the maternal syphilis prevalence. The 2015 round of the ANC surveys reported a prevalence of 2.0% (95%CI: 1.8%–2.2%), with huge variation across provinces.

Congenital syphilis is a notifiable medical condition (NMC) in South Africa. According to the National Institute for Communicable Diseases (NICD) NMC data, the quarterly number of congenital syphilis cases notified in South Africa has shown an increasing trend over the past two years ($P < 0.001$), with 362 cases reported in 2019 (Figure 21).²⁷

Figure 21: Quarterly number of congenital syphilis cases in South Africa, 2017–2019



(Source: NICD²⁷)

HIV TESTING AMONG PREGNANT WOMEN

The percentage of pregnant women with known HIV status was 90% in 2019, a decline from 94.8% in 2018.¹⁴ The 2017 ANC survey reported the HIV testing rate among pregnant women to be 99%.⁴



ACHIEVEMENTS

TOWARDS ELIMINATING MTCT

South Africa continues to make progress towards the elimination of MTCT (EMTCT). Elimination in this context means that MTCT is down to a level where it is no longer a public health threat. The WHO constituted a set of impact and process criteria for validating the countries that have achieved the EMTCT. The two impact criteria

are: having less ≤ 50 vertical infections per 100,000 live births, below 2% MTCT rate for non-breastfeeding countries and below 5% MTCT rate for breastfeeding countries.²⁸ Although the number of paediatric infections in South Africa is still more than 50 per 100,000, the MTCT rates at birth and 18 months were down to 0.7% and 3.5%, respectively, in 2019.^{1,26} It should be borne in mind that this achievement was in the context of a high antenatal HIV prevalence.

PROGRESSIVE AND EVIDENCE-BASED POLICY ENVIRONMENT

South Africa's laudable PMTCT programme owes its success to the country's remarkably progressive policy environment. The programme has directly improved the health of HIV-positive women and their babies, and also reduced HIV transmission to the partners of the women. This programme helped South Africa achieve the feat of reducing the MTCT rate at 10 weeks to below 1% by 2019. However, vertical transmission of HIV continues to occur during breastfeeding after birth, when adherence to ARV is sub-optimal, raising the cumulative vertical transmission rate to 3.5% by 18 months. The relatively high post-partum transmission of HIV necessitated the most recent update to the country's PMTCT guidelines in 2019, with the goal of producing an HIV-free generation. The South African policy environment around this commitment is not only progressive but also evidence-based, drawing insights from scientific and operational data.

EXCELLENT PMTCT PROGRAMME

Excellent policies do not always translate to excellent practice, but South Africa has put its money where its mouth is. The country's progressive PMTCT guidelines have translated to an excellent PMTCT programme. The country has pursued its PMTCT programme with zest, investing money and heavy human resources. For example, in 2016/17, two complementary plans — The Last Mile Plan and the Remedial Plan — were implemented. The Last Mile Plan sought to encourage mothers to book for ANC before 20 weeks of gestation to allow for early testing and intervention.²⁹ The Remedial Plan intensified PMTCT in identified districts with poor performance.¹² The result is that in the 2018/19 financial year, 95.8% of pregnant women infected with HIV were started on ART in public health facilities.¹⁸

SUCCESSFUL EID PROGRAMME

The EID programme, which is a collaborative work between the NHLS and the Department of Health (DoH) at the national, provincial and district levels, has also been largely successful. The programme conducts training of staff, and provides technical assistance, through mentoring and monitoring support. By 2019, the programme achieved the NHLS 2020 target of having 80% of EID HIV PCR tests available within 96 hours.³⁰ The programme currently has a testing capacity of one million annual tests, which exceeds the current volume of tests.

KEY ISSUES

MTCT SHOWS VARIATION ACROSS DISTRICTS

Although South Africa has done well to bring the MTCT rate to 0.7%, there is some variation in this achievement across provinces and much more variation across districts and subdistricts. As shown in Figure 22, three provinces (Mpumalanga, North-West and the Eastern Cape) had slightly higher rates while the Northern Cape province had the highest rate (1.4%). This is despite the Northern Cape province having

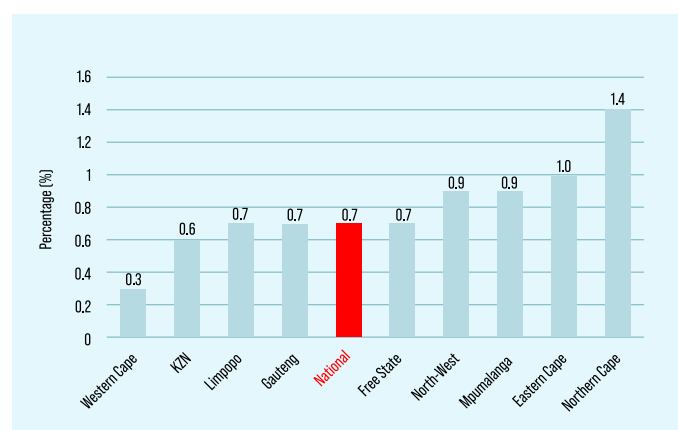
the lowest HIV prevalence among pregnant women in the country.

In 2019, 11 districts had a rate of 1% or more, with John Tao Gaetsewe District having the highest rate of 2.9%. This is despite John Tao Gaetsewe District having one of the lowest HIV prevalence among pregnant women in the country. This variation should be studied and these areas of the country that are lagging behind should be targeted with tailored interventions aimed at achieving the same success observed in the high-performing areas.

DATA ON MATERNAL AND CONGENITAL SYPHILIS

Data on maternal and congenital syphilis should be made more readily available. The 2017 ANC surveillance survey data reported maternal syphilis coverage data but did not report the prevalence of congenital syphilis. Although summary NICD NMC data on congenital syphilis for 2019 have been included in this synthesis, a more detailed report is not widely available. Furthermore, neither the District Health Barometer (DHB) nor the NDoH annual reports contain these data.

Figure 22: HIV mother-to-child transmission rate by province, 2019



(Source: DHB²⁶)



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

SCORE CARD

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

South Africa's legal environment during the period under review provides ample opportunity for achievement of this commitment for the general population and most key populations. The country's 1996 Constitution is progressive and prohibits discrimination on the basis of sexual orientation and protects the human rights of LGBTI people.³¹ MSM and transgender people are granted legal prerogative and denied prosecution in the criminal law system. On 6 December 2018, the Civil Union Amendment Bill was passed in Parliament to enforce civil marriage officers not to opt out of solemnising same-sex marriages on the grounds of their conscience, religion or belief.³²

The general population and key population programmes are aligned with strong country strategic plans and informed by population-size estimations and bio-behavioural data. The South African government, through the NDoH, underlined support for HIV key populations by addressing this commitment under Goal 3 of the NSP for HIV, TB and STIs (2017–2022), and the South African National LGBTI HIV Plan, 2017–2022 (LGBTI HIV Plan). Furthermore, 2019 saw the development of strategic policy documents on sex work and drug use (Table 5).

The launch of the South African National Sex Worker HIV Plan (2016–2019) in March 2016³³ was a clear message that the country is serious about addressing the needs of sex workers and their high risk of exposure to HIV, STIs and human rights violations. During the

review period, SANAC was also planning for a new National Sex Worker Plan 2019–2022, aligned with the NSP 2017–2022. However, sex work and the use of injectable illicit drugs by PWID remain illegal in the country. It is against this backdrop that many organisations, for example Human Rights Watch, continue to make recommendations to Parliament for the introduction of a new law that removes criminal and administrative sanctions against consensual adult sex work and related offences.³⁴

In 2019, the Department of Social Development developed the fourth edition of the National Drug Master Plan (NDMP) 2019–2024, which contains the national drug strategy and sets out measures to control and manage the supply of, and demand for, illegal drugs. These plans demonstrate strong consensus with the strategic direction and policy environment for drug use.³⁵

Table 5: South Africa's legal and policy environment for Commitment 3

YEAR	LAW/POLICY
1996	South African Constitution
2016	National launch of oral PrEP for sex workers
2016	South African National Sex Worker HIV Plan
2016	South African National Guidelines for Medical Male Circumcision
2017	National Strategic Plan for HIV, TB and STIs (2017–2022)
2018	Roll-out of PrEP for adolescent girls and young women was started at selected public clinics
2019	National Sex Worker Plan 2019–2022
2019	National Drug Master Plan 2019–2024
2011	Protection from Harassment Act
2019	Gender-Based Violence and Femicide (GBVF) Declaration
2019	Policy Framework for Gender-Based Violence in the Post-School Education and Training System

CURRENT STATUS

HIV INCIDENCE

HIV incidence continues to decline in South Africa. In 2019, based on the Thembisa Model, the total number of new HIV infections was 183,000, which was lower than the 2018 estimate of 201,000 (Table 6).¹ Women aged 15 to 49 years accounted for 56% of new infections in South Africa. The number of new HIV infections in females aged 15 to 24 years was about four times that in males in the same age group: 49,000 versus 13,000. Table 7 shows data on other important indicators under this commitment.

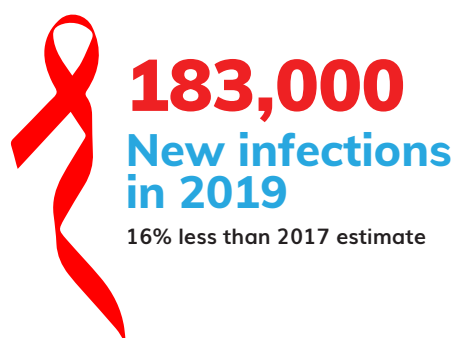


Table 6: Number of HIV infections in South Africa by sex and age, 2017–2019

Indicator	2017	2018	2019
Total new HIV infections	217,439	201,269	182,597
New infections in males aged 15+ years	73,594	66,867	59,300
New infections in females aged 15+ years	129,534	121,172	111,038
New HIV infections in children <15 years	14,311	13,231	12,260
New HIV infections in 15-24 year olds	78,838	70,508	62,688
New HIV infections in 15-24 year old males	17,740	15,275	13,161
New HIV infections in 15-24 year old females	61,098	55,234	49,527
New HIV infections in 15-49 year olds	188,093	173,029	155,962
New HIV infections in 15-49 year old males	67,693	61,049	53,800
New HIV infections in 15-49 year old females	120,400	111,980	102,162

OTHER INDICATORS

Table 7: Other indicators under Commitment 3, 2017–2019

Indicator	2017	Data Source	2018	Data Source	2019	Data Source
3.1 HIV incidence	0.45%	Thembisa ¹	0.41%	Thembisa ¹	0.36%	Thembisa ¹
3.2 Estimates of the size of key populations						
Sex workers	110,000	UNAIDS ¹⁴	24,000*	SAHMS 2018 ³⁶		
MSM	300,000	UNAIDS ¹⁴				
PWID	17,000	UNAIDS ¹⁴	6,032**	TipVal ³⁷		
Transgender people	5,500	UNAIDS ¹⁴				
Prisoners	161,054	DCS ³⁸	164,129	DCS ³⁹	162,875	DCS ⁴⁰
3.3 HIV prevalence among key populations						
Sex workers	56.0%	Thembisa ¹	56.5%	Thembisa ¹	54.8	Thembisa ¹
MSM	27.2%	Thembisa ¹	26.4%	Thembisa ¹	25.6%	Thembisa ¹
PWID	21%	Scheibe ⁴¹	15%-58%	TipVal ³⁷		
Transgender people	59%					
Prisoners	9%	UNAIDS ¹¹	8.9%	DCS ³⁵	11.1	UNAIDS ¹⁴
3.4 HIV testing among key populations						
Sex workers	89.7%	Thembisa ¹	90.6%	Thembisa ¹	91.4%	Thembisa ¹
MSM	76.1%	Thembisa ¹	78.1%	Thembisa ¹	80.0%	Thembisa ¹
PWID			72%-98%	TipVal ³⁷		
Transgender people						
Prisoners	218,654	DCS ³⁸				
3.5 Antiretroviral therapy coverage among PLHIV in key populations						
Sex workers	58.3	Thembisa ¹	63.0	Thembisa ¹	66.4	Thembisa ¹
MSM	39.3	Thembisa ¹	43.7	Thembisa ¹	47.1	Thembisa ¹

COMMITMENT THREE

Indicator	2017	Data Source	2018	Data Source	2019	Data Source
PWID						
Transgender people						
Prisoners	98%	DCS ³¹	97%	DCS ⁴⁰	99%	DCS ⁴⁰
3.6 Condom use among key populations						
Sex workers	86%	UNAIDS ¹¹	81%–90%	Aurum Institute		
MSM	81%	UNAIDS ¹¹				
PWID						
Transgender people						
3.7 Coverage of HIV prevention programmes among key populations						
Sex workers						
MSM						
PWID						
Transgender people						
Prisoners						
3.8 Safe injecting practices among people who inject drugs						
3.9 Needles and syringes distributed per PWID						
3.10 Coverage of opioid substitution therapy						
3.11 Active syphilis among sex workers						
3.12 Active syphilis among MSM						
3.13 HIV prevention programmes in prisons						
3.14 Viral hepatitis among key populations (Hepatitis B)						
Sex workers	4%	VHI ⁴²				
MSM	3%	VHI ⁴²				
PWID	5%	Scheibe ⁴¹				
Transgender people						
Prisoners						
3.14 Viral hepatitis among key populations (Hepatitis C)						
Sex workers						
MSM	2%	VHI ⁴²				
PWID	45%	Scheibe ⁴¹				
Transgender people						
Prisoners						
3.15 People receiving pre-exposure prophylaxis (PrEP)						
3.16 Prevalence of male circumcision						
3.17 Annual number of males voluntarily circumcised						
3.18 Condom use at last high-risk sex						

 (Source: NICD²⁷)

Empty cells have no data; *In South Africa's three biggest cities. *Two cities in South Africa. VHI–Viral Hepatitis Initiative

There is a dearth of data on the population of PWID in South Africa. The 2017 TipVal study conducted in Tswane and Cape Town estimated the population size of PWID to be 4,514 (plausible range 1,970–7,800) and 1,518 (plausible range 909–2,000) for the respective cities.³⁷

The 2018 South Africa Health Monitoring Study (SAHMS 2018), commissioned by the NDoH and SANAC, estimated the population size and HIV prevalence in female sex workers in the three biggest cities in South Africa: Cape Town, Durban, and Johannesburg. The estimated population size and the HIV prevalence were highest in Durban and lowest in Cape Town (Table 8).³⁶ The equivalent survey among MSM in 2019 (SAMHMS 2019) did not estimate population size, but estimated HIV prevalence, with the highest prevalence seen in Johannesburg.⁴³ The HIV prevalence reported in these two key populations (Table 8) are in agreement with those reported by the Thembisa Model (Table 7).

Table 8: Population estimate and HIV prevalence among FSWs and MSM in three metros in South Africa, 2018–2019

City	Population Estimate	Prevalence % (95 % Confidence Interval)	Data source
FSWs			
Cape Town	6,680 (4,560–9,200)	42.5 (37.4–47.8)	SAHMS 2018 ³⁶
Durban	9,300 (8,620–10,000)	77.7 (72.9–81.9)	
Johannesburg	7,980 (5,530–11,010)	58.3 (52.9–63.5)	
MSM			
Cape Town	Not measured	26.8 (22.6–31.4)	SAHMS 2018 ⁴³
Mahikeng	Not measured	16.7 (14.0–19.8)	
Johannesburg	Not measured	44.3 (39.2–49.6)	

ACHIEVEMENTS

CONDUCTIVE AND PROGRESSIVE LEGAL AND POLICY ENVIRONMENT

The enactment of the Civil Union Amendment Bill in the South African parliament in 2018³² enhanced the enabling environment for HIV preventive measures for the LGBTI community. Specifically, the amendment bill repealed Section 6 of the Civil Union Act, 2006, which had allowed civil marriage officers to opt out of solemnising same-sex marriages on the grounds of conscience, religion or belief.⁴⁴ The repeal of Section 6 in its entirety serves to provide no constitutional basis to continue marital discrimination against LGBTQI communities.

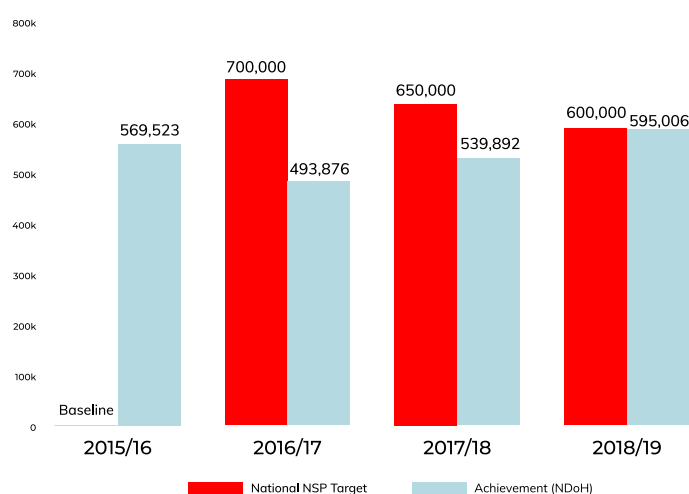
The South African National LGBTI HIV Plan 2017–2022 provides a framework of consolidated guidance to reverse the burden of disease from HIV, STIs and TB, and to promote a rights and evidence-based environment for LGBTI people in South Africa, through a multi-sectoral approach.⁴⁵ The Plan is not only a first for the country and the African continent, but it is also the first of its kind globally. Additionally, in 2019, South Africa launched the National Human Rights Plan.⁴⁶ which serves as a response by government, the private sector and civil society to human rights and gender-related barriers to HIV, STI and TB services. This plan focuses on eliminating the stigma and discrimination associated with these diseases in accordance with

Goal 5 of the NSP 2017–2022.

RECENT MEDICAL MALE CIRCUMCISION SUCCESS

The NSP 2017–2022 included a plan to perform three million voluntary medical male circumcisions (MMCs) over the five-year term, translating to 600,000 MMCs per year.⁶ This target was not met in the first two years of the term (Figure 23). However, in the 2018/19 financial year, 595,006 MMCs were performed nationally, which is 99% of the annual target. The success is attributed to new initiatives that included partnerships with traditional leaders for MMCs to be conducted during traditional ceremonies. While this success is welcomed, efforts should be heightened to eliminate the deficits in the first two years and achieve the cumulative five-year target of three million circumcisions.

Figure 23: Number of voluntary medical male circumcisions performed, 2016/17–2018/19



DEMAND CREATION FOR PrEP

As part of the combined HIV prevention strategy, key populations have been prioritised in the provision of daily pre-exposure prophylaxis (PrEP) in conjunction with other appropriate prevention methods. The Thembisa Model estimates that 11,763 people used PrEP from 2017 to 2019, with 8,231 people using PrEP in 2019 alone. Sex workers and MSMs accounted for 55% of the usage. PrEP uptake among sex workers and MSM has been increasing gradually, with peer-led programmes resulting in higher demand. In addition, new programmes that differentiate transgender women from MSM in strategic plans were embraced by both communities.

With the goal of creating demand for oral PrEP, the NDoH has made palpable awareness efforts with *We Are the Generation that Will End HIV* (WATG), as the slogan used in all NDoH information, education and communication (IEC) and social mobilisation materials.⁴⁷ In 2018, a survey conducted by the Wits Reproductive Health and HIV Institute found that WATG-branded IEC materials played a positive role in PrEP decision-making among FSWs and MSM.⁴⁷

GOVERNMENT HIV HARM REDUCTION PROGRAMMES FOR PWID

The NDMP 2019–2024 outlines evidence-based strategies to reduce harm among PWID through comprehensive programmes which include needle and syringe exchange programmes; opioid Substitution therapy (OST); HIV testing services (HTS); HIV and STI



prevention and treatment; condom and lubrication programmes with sexual partners; targeted information, education and communication (IEC) programmes; prevention, vaccination, diagnosis and treatment for viral hepatitis; and TB prevention, diagnosis and treatment programmes. Thus, the current NMDP expands on existing harm reduction programmes for PWID in South Africa. Furthermore, through multisectoral engagement, the NDMP addresses and targets substance use and misuse in prisons through security strategies to prevent drugs entering the correctional centres, reducing demand by means of educational programmes, harm reduction strategies and recovery programmes for prisoners suffering from substance use disorder (SUD).

NGOs EXPANDING HIV HARM REDUCTION PROGRAMMES FOR PWID

Harm reduction programmes and health services for PWID have been traditionally driven by NGOs in South Africa. These programmes continued and expanded their reach and services in 2019.

Specifically, TB HIV Care Association's Step-Up Project expanded its harm reduction, health and psychosocial services to people who use drugs in four sites in South Africa's provinces of the Western Cape (Cape Town), the Eastern Cape (Port Elizabeth), and KwaZulu-Natal (eThekweni and Durban) — Table 9. Viral hepatitis B and C testing services, and the provision of antiviral therapy for persons with confirmed Hepatitis C Virus (HCV) or Hepatitis B Virus (HBV) infection are available for PWID in these sites. Similarly, Anova Health Institute's Jab Smart Project provides harm reduction and HIV prevention services for PWID in parts of the City of Johannesburg by improving access to HIV services and harm-reduction services. The HARMless Project implemented by OUT-Wellbeing in Pretoria in Gauteng province operated in all regions of the city and commenced implementation in the Ehlanzeni District in Mpumalanga in December 2019. The Department of Family Medicine at the University of Pretoria's Community Orientated Substance Use Programme (COSUP) also offers harm reduction services by providing needles and syringes to PWIDs in several administrative regions of Pretoria.

Table 9: HIV and harm reduction services provided to PWID by key NGOs, 2018 and 2019

	TB/HIV Care Association (Step-Up Project)		ANOVA Health Institute (JAB SMART project)		OUT-Wellbeing (HARMless Project)	
Reporting period	Jan-Dec 2018	Jan-Dec 2019	Jan-Dec 2018	Jan-Dec 2019	Jan-Dec 2018	Jan-Dec 2019
No of project sites	3	4	1	1	1	2
Number of PWID served	2,037	5,342	1,869	5,037	7,115	4,727
Number of needles and syringes distributed	433,867	524,396	344,073	315,330	485,703	464,737
Number of needles and syringes distributed per person	213	98	184	63	68	98
Number of people on OST	144	33	74	76	-	-
Number tested for HIV	1,136	1,165	1,340	634	954	1,487
Percentage of PWID living with HIV on ART	9%	9%	46%	31%	28%	34%
Number initiated on ART	56	22	104	29	74	367
Achievement (NDoH)	569,523	493,876	539,892			595,006

KEY ISSUES

IS FEMALE CONDOM USE A MISSED OPPORTUNITY FOR HIV PREVENTION?

Female condom distribution is an important component of the NSP 2017–2022 for the general, key and vulnerable populations. However, key knowledge gaps in female condom programming continue to exist and this is exacerbated by limited data available. In the NSP 2017–2022, under Goal 1 (to reduce new HIV, TB and STI infections), a target of 40 million female condoms was set for the financial year 2018/19, but the performance was below this target as the NDoH distributed 17.7 million female condoms in the 2018/19 financial year.¹⁸ A study published in 2019 reported that female condom use in South Africa ranged from 2.9% to 38.7%.⁵²

A 2019 evaluation of the South African National Female Condom Programme showed that the programme conforms with the recommended United Nations Population Fund (UNFPA) 10-Step Strategic Approach to scale up Comprehensive Condom Programming (CCP).⁵³ The evaluation also showed that a National Condom Distribution Plan exists.

Government health facilities have their distribution targets and are required to report the numbers of male and female condoms distributed to the DHIS. However, there is a need to make female condoms more accessible, particularly among experienced users. Additionally, promoting access through male engagement may promote acceptability of this prevention intervention. Attitudinal change towards female condoms among service providers may influence female users and improve uptake. More research and programme evaluations need to be conducted to understand users' knowledge, attitudes and perceptions towards female condoms. Overall, awareness and marketing of female condoms, especially among female sex workers, needs to be promoted as an alternative prevention measure.

CRIMINALISATION OF SEX WORK

The National Sex Worker HIV Plan (2016–2019) acknowledged the legal status of sex work as a key impediment for the implementation of the National Strategic Plan (NSP) for HIV, TB and STIs. However, debate has ensued around full decriminalisation of sex work in South Africa amidst the release of the South African Law Reform Commission's (SALRC) report in 2017.⁵⁴ The report recommended that the country should continue to criminalise sex work. As a secondary option, it submitted partial decriminalisation, in which the buyers but not the sellers of sex should be prosecuted. Debate continues around this controversial issue as more campaigns advocating for sex work decriminalisation seek to reduce vulnerability of this key population. However, during the period under review, new legislation had not been passed and sex workers still faced legal prosecution under the criminal law system.



LACK OF DATA AND REPORTING SYSTEMS FOR KEY POPULATIONS

The provision of targeted interventions to key populations has increased in the past few years. However, the coordination of programmes and credible data remain areas of concern. The SANAC and the NDoH need to map all key populations partners nationally; review the indicators being used, data collected and methods of data collection; and consolidate efforts into a harmonised data system.



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

SCORE CARD

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

South Africa's legal and policy environment, informing the interventions for the elimination of gender inequalities and all forms of discrimination, are guided by the Constitution of the Republic (Act 108 of 1996) Chapter 2: The Bill of Rights. Among other guarantees, the Bill of Rights states that no person must be discriminated against, irrespective of their gender or sexual orientation, and that everyone has the right to healthcare.³¹ The country has ample pieces of legislation in place that seek to eliminate discrimination against women and girls, PLHIV and key populations (Table 10).

In response to the changing needs of the population, the Department of Women (DoW) realigned its mandate to focus specifically on women and, in 2015, presented its 2015-2020 Strategic Plan.⁵⁵ The Plan aimed to accelerate socio-economic transformation involving women's empowerment and promotion of gender equality through mainstreaming, advocacy, and monitoring and evaluation (M&E). The reconfiguration of the DoW gave further expression to the National Policy Framework for Women's Empowerment and Gender Equality, hereafter referred to as the National Gender Policy Framework.⁵⁶ The National Gender Policy Framework, approved in 2000, mandates directors-general and ministers to implement gender mainstreaming in their departments. The implementation and coordination of all the priority aspects of the National Gender Policy Framework fall under the Ministry of Women in the Office of the Presidency.⁵⁷

The Gender Policy Framework, like the 2015-2020 Strategic Plan, is aligned to the Southern African Development Community (SADC) Protocol on Gender and Development, which calls for the

empowerment of women to eliminate discrimination and to achieve gender equality through the development and implementation of gender responsive legislation, policies, programmes and projects.⁵⁷ South Africa's rich legal and policy framework on this commitment is in alignment with international legal instruments. Examples of regional and international commitments to women's empowerment and gender equality, to which South Africa is a signatory, include:

- The United Nations Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), ratified in December 1995
- The Beijing Declaration and Platform for Action, signed in December 1995
- The African Union Heads of States' Solemn Declaration on Gender Equality in Africa, ratified in August 2004.⁵⁷

Table 10: South Africa's legal and policy environment for Commitment 4

YEAR	LAW/POLICY
1996	South African Constitution
1996	Commission on Gender Equality Act
1997	Basic Conditions of Employment Act
1998	Employment Equity Act
1998	Domestic Violence Act
2000	Promotion of Equality and the Prevention of Unfair Discrimination Act
2003	The Broad-Based Black Economic Empowerment Act
2007	Sexual Offences Act
2011	Protection from Harassment Act
2019	Gender-Based Violence and Femicide (GBVF) Declaration
2019	Policy Framework for Gender-Based Violence in the Post-School Education and Training System

CURRENT STATUS AND RECENT TRENDS

Table 11: Indicators for Commitment 4

YEAR	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 MSM 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	
Prevalence of recent intimate partner violence		30%	
Percentage of men and women aged 15-49 years who report HIV-related discrimination in healthcare settings			

(Source: SABSSM V14)

DISCRIMINATORY ATTITUDES TOWARDS PEOPLE LIVING WITH HIV

The UNAIDS website (<https://aidsinfo.unaids.org/>)¹⁴ provides data for different countries on discriminatory attitudes towards PLHIV, using two measures: willingness to buy fresh vegetables from a shopkeeper or vendor, knowing this person had HIV; and the perception that children living with HIV should be able to attend school with children who are HIV negative. For South Africa, 16.9% of responses were discriminatory for both measures. The results are similar to those from the last PLHIV Stigma Index Survey in which 21% of the respondents reported being gossiped about and 15% experienced discrimination because of their HIV-positive status.⁵⁸

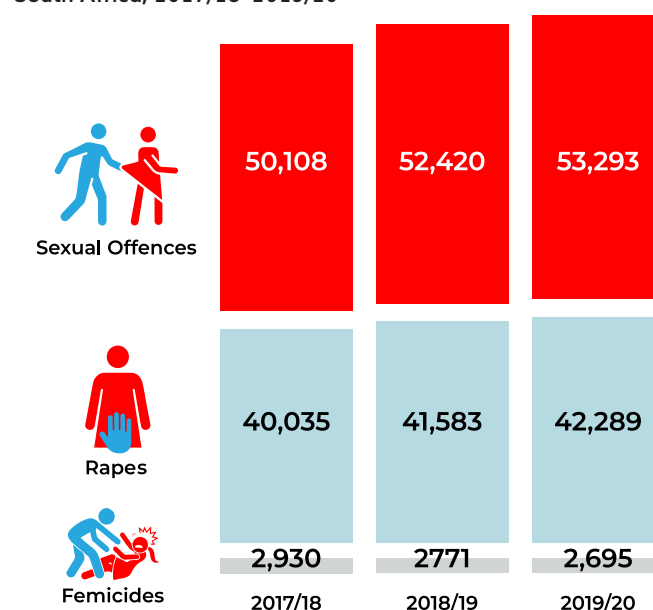
AVOIDANCE OF HEALTH CARE AMONG KEY POPULATIONS BECAUSE OF STIGMA AND DISCRIMINATION

There are currently no programme data on this indicator. However, there are scientific papers and reports that provide a picture of the progress made in South Africa in creating healthcare environments free from discrimination against key populations. One is a qualitative study investigating healthcare access in Bloemfontein (Free State Province) and Mafikeng (North West Province), in which healthcare workers described their attitudes towards key populations.⁵⁹ The study demonstrated insufficient relevant knowledge and skills that are vital for managing the health needs and vulnerabilities facing key populations. The FSW, MSM and PWID who participated in the study described experiences of stigmatisation by healthcare providers and other community members.

PREVALENCE OF RECENT INTIMATE PARTNER VIOLENCE

An estimated one third of women aged 15-49 years who were interviewed in 2017 reported that they had recently experienced intimate partner violence.³ The rates of intimate partner violence are similar across all age groups, at around 30%. The annual crime statistics report released by the South African National Police Service is valuable for monitoring this indicator. The data show that, although femicide has declined gradually in recent years, the 2019 rate in South Africa was five times higher than the global average.⁶⁰⁻⁶² Furthermore, the number of violent crimes against women has increased steadily from 2017 to 2019, driven by an increase in the number of sexual offences and rapes (Figure 24).

Figure 24: Trends in the number of sexual crimes and femicides in South Africa, 2017/18–2019/20



(Source: SAPS⁶⁰⁻⁶²)

INDICATOR 4: EXPERIENCE OF HIV-RELATED DISCRIMINATION IN HEALTH-CARE SETTINGS

The data to measure progress towards this indicator were not yet available, partly because of the relatively short time from the year (2017) in which this indicator was added to Commitment 4.⁶³ However, a 2018 behavioural surveillance survey conducted in Tshwane and Cape Town reported low levels of discriminating behaviour in the healthcare settings for PWID: 8.7% in Tshwane and 6.2% in Cape Town (Table 12). Most of the reported stigmatizing behaviour comprised verbal insults from police, at restaurants, and when seeking employment or housing.³⁷

ACHIEVEMENTS

A ROBUST LEGAL AND POLICY ENVIRONMENT

South Africa has developed a laudable legal and policy environment that is inclusive and progressive and protects the rights of women and other disadvantaged groups. To complement this, the reconfiguration of the DoW to ensure better streamlining of the issues of gender inequalities is an achievement for South Africa.

In November 2018, the President of South Africa, Cyril Ramaphosa, declared the presidential summit against gender-based violence and

Table 12: Stigmatising behaviour reported by PWID in previous 12 months

Place/type of discrimination	Tshwane (n=544)			Cape Town (n=348)		
	n	%	95% CI	n	%	95% CI
Healthcare	38	8.7%	6.2-11.3%	29	6.2%	3.0-9.3%
Employment	115	19.3%	14.4-24.2%	122	32.8%	27.0-38.6%
Church/religious services	24	3.4%	0.5-6.2%	22	5.1%	2.3-7.9%
Restaurant/bar	133	23.2%	18.3-28.0%	51	10.8%	6.8-14.9%
Housing	73	15.2%	11.5-18.9%	77	19.8%	14.2-25.3%
Police assistance	140	25.9%	21.1-30.6%	125	29.7%	23.8-35.6%
Verbal insults	267	45.5%	40.0-51.0%	239	57.0%	50.7-63.4%

(Source: TipVal Study³⁷)

femicide. The declaration promised to be an historical turning point in the fight against gender-based violence (GBV) as it provided the opportunity for government, civil society and social movements to work constructively towards a singular and common purpose.⁶⁴ The November 2018 declaration against GBV was followed with the March 2019 launch of the Booysens Magistrate's Court, a new sexual offences court, to affirm the rights of women and girls in the country.⁶⁵

CRIME REPORTING IS INCREASING

It is notable that the increasing trend in the prevalence of sexual offences is partly due to the increase in awareness and reporting, which is central to winning the war against GBV. The recently published "Victims of Crime Survey 2018/19" by Statistics South Africa revealed that the percentage of victims of sexual offences who reported at least one incident to the police was 88%, an increase from 73% observed in the 2017/18 survey.⁶⁶

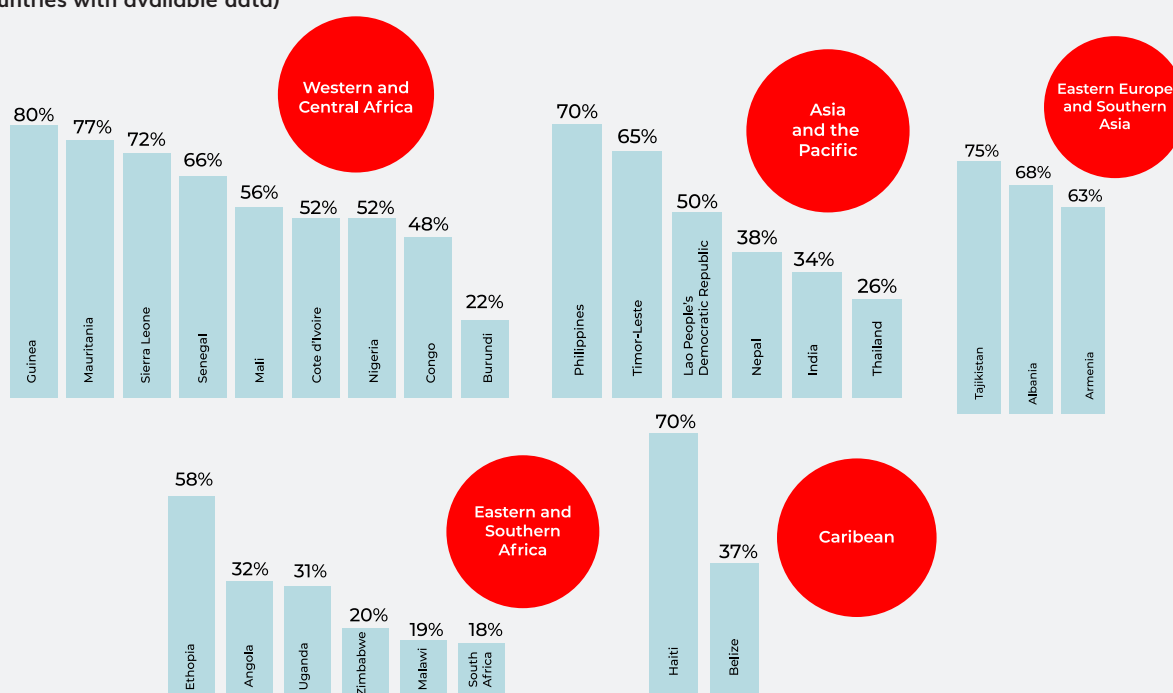
IMPRESSIVE PROGRAMME EFFORTS

South Africa continues to initiate and support efforts to end discriminatory attitudes towards PLHIV through awareness programmes. For example, Colour my HIV, an HIV prevention and empowerment campaign, was launched on World AIDS Day in 2018, and is led by and focusses on young people across South Africa.⁶⁷ Every August, South Africa celebrates Women's Month. The 2019 Women's Month was commemorated under the theme "What Women Want" (social media hashtag #WhatWomenWant) aimed at encouraging bold expression by women about what they want to see happening in order to realise equality.⁶⁸

COMPARATIVE GLOBAL SUCCESS

Globally, the percentage of people harbouring discriminatory attitudes towards PLHIV has been reported to be lowest in South Africa, amongst countries with available data (Figure 25). This is largely due to the efforts of the country towards this commitment.⁶⁹

Figure 25: Percentage of people aged 15-49 years who report discriminatory attitudes towards PLHIV, 2014–2018 (countries with available data)



KEY ISSUES

DISCRIMINATORY ATTITUDES TOWARDS PLHIV PERSIST

Despite the progress that has been made in creating HIV/AIDS awareness, a sizable proportion of the population still holds discriminatory attitudes towards PLHIV. The existence of discriminatory attitudes towards PLHIV perpetuates both the epidemic and gender inequalities, since women constitute the majority of PLHIV. HIV-related stigma causes constant fear of discrimination among women, which results in isolation and exposure to violence from prejudiced community members. Furthermore, the stigma associated with HIV forces women to conceal their HIV status from family members, spouses, or partners, which negatively affects their chances of seeking health care.⁷⁰

GENDER-BASED VIOLENCE REMAINS HIGH

Gender inequalities remain high and unabated, with only a slight decrease in the number of femicides per year in the period under review. Sexual offences and rape increased during the same period. The number of femicides recorded in 2019 (2685) although lower than the number recorded in 2017 (2930) shows that a woman is killed in South Africa every three hours.

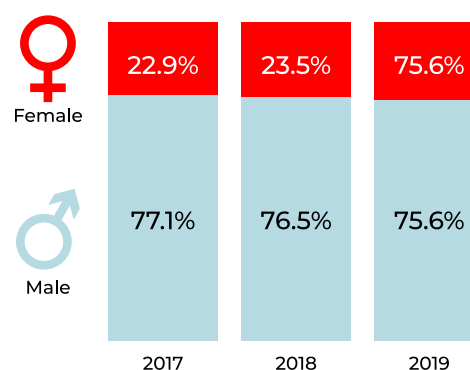
CRIMINAL JUSTICE SYSTEM

The gap between the robust legal environment and the realities facing women with regard to gender inequalities and GBV, which have continued unabated in South Africa, is one of the key issues for Commitment 4. This undesirable situation is largely because existing laws have not been implemented optimally. Arrests for gender-based offences are few, investigations are largely poorly conducted, and the conviction rate is low.

SOCIOECONOMIC DISPARITIES

Although more women are entering the workplace, and sectors that were previously male-dominated, much still needs to be done to eradicate gender inequalities in South Africa. Women remain gravely underrepresented in skilled positions. For example, nearly all directors-general in South African government departments are men.⁷¹ Furthermore, the representation of women in top management positions barely changed from 2017 to 2019 and remained low at 26.4% while men occupied 75.6% of positions (Figure 26).⁷² The economic disadvantage of women has long been shown to increase vulnerability to HIV infection, locally and globally.⁷³ Consequently, addressing economic gender inequalities remains germane to the quest for gender equality.

Figure 26: Sex representation in top management positions



(Source: Quarterly Labour-force Survey 2019, cited in Chothia, 2020⁷²)

PAUCITY OF DATA

There is a lack of monitoring data for some of the indicators under this commitment, which hampers the assessment of progress being made in the country. Surveys that include standardised indicators, definitions and methods are needed, and should be repeated at defined intervals. Since the last Stigma Index Survey in 2014,⁵⁸ there has been no follow-up survey, although email communication with the international study team, Global Network of PLHIV (GNP+), confirmed that plans to implement the next round are underway.



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

SCORE CARD

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

South Africa's legal and policy environment demonstrates alignment to this commitment through a number of laws and policies (Table 13). First, the Constitution guarantees equitable access to healthcare for all, including youth and adolescents.³¹ Second, the National Strategic Plan 2017-2022 includes strategies to minimize HIV infection among adolescents and young women.⁶ Third, the National Integrated School Policy 2012 provides for comprehensive sexuality education that focuses on increasing the knowledge of HIV prevention, increasing levels of condom use, and decreasing incidence of multiple sexual partners among youth and adolescents.⁷⁴ Fourth, the National Youth Policy 2015-2020, in alignment with global and regional policies, makes provision for youth empowerment with regard to their health, with emphasis on reducing the burden of HIV infection among the youth.⁷⁵

Furthermore, the National Adolescent and Youth Health Policy 2017 prescribes youth-friendly services and social protection (child support grants, free education, and school meals) for adolescents and young people.⁷⁶ Also, the National Policy on HIV, STIs and TB provides for the prevention, treatment and care of all stakeholders in the basic education sector, including learners in all public and independent primary and secondary schools in the country.⁷⁷ "By definition, the Basic Education Sector contains almost all the nation's children at any one time."⁷⁷ The policy uses a rights- and evidence-based approach to guide the strategies for a comprehensive HIV/AIDS response in the sector. Its goals include increasing learners' knowledge of HIV and improved access to HIV, STI and TB prevention. It includes new and bold strategies, such as the provision of condoms in schools.

Table 13: South Africa's legal and policy environment for Commitment 5

YEAR	LAW/POLICY
1999	National Policy on HIV for Learners and Educators
2012	Integrated School Health Policy
2015	National Youth Policy (2015-2020)
2015	National Adolescent and Sexual Reproductive Health and Rights Strategy (2014-2019)
2016	National HIV Testing Service Policy
2017	National Adolescent & Youth Health Policy
2017	National Policy on HIV, STIs and TB for Learners, Educators, School Support Staff and Officials in all Primary and Secondary Schools in the Basic Education Sector
2017	National Strategic Plan for HIV, TB and STIs (2017-2022)

CURRENT STATUS AND RECENT TRENDS

In line with UNAIDS guidelines, two key indicators were used to assess this commitment.

- Percentage of women and men aged 15–24 years who correctly identify both ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission.
- Percentage of women of reproductive age (15–49 years) who have their demand for family planning satisfied with modern methods.

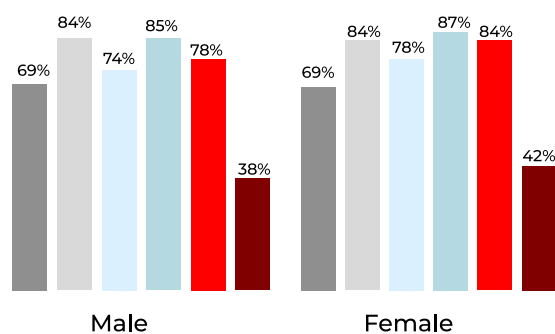
KNOWLEDGE ABOUT HIV INFECTION AND PREVENTION

Recent data on knowledge about HIV prevention among youth and adolescents in South Africa show that the country still has a long way to go in achieving the 90% target. According to the SABSSM V in 2017, only 38.9% of young people aged 15–24 years possessed comprehensive knowledge about HIV prevention: 38.1% of males and

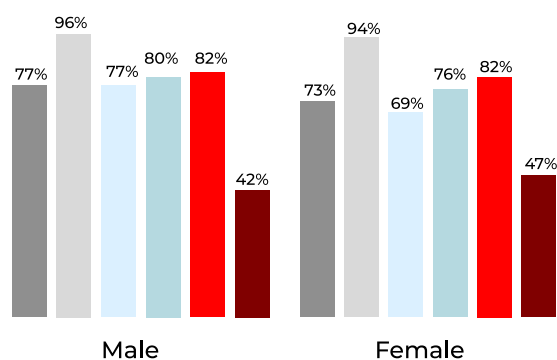
42.1% of females (Figure 27).³ A 2018 study conducted by Shamu et al. in high HIV burden districts in South Africa (OR Tambo and Nkangala) equally showed limited knowledge about HIV prevention among South African youth (Figure 27).⁷⁸ The study used the same set of questions as the SABSSM V.

Figure 27: Knowledge about HIV prevention among young people aged 15–24 years

SABSSM, 2017



Shamu et al., 2019



- HIV risk can be reduced by having fewer sex partners
- Risk of getting HIV can be reduced by using a condom every time they have sex
- AIDS can't be cured
- A healthy-looking person can have HIV
- A person can get HIV by sharing food with someone who is infected with the virus
- Comprehensive knowledge of HIV prevention

(Sources: SABSSM V3 and Shamu et al.⁷⁸)

DEMAND FOR FAMILY PLANNING

For their own health and that of their babies, women engage in family planning using different modern and natural methods. But not all women are exposed to the risk of pregnancy. Therefore, the need and demand for family planning is measured among women who want to stop or space childbearing. This indicator measures the extent to which women's demands for family planning in the country are met.

The most recent South African Demographic and Health Survey (SADHS) conducted in 2016 showed that 76% of women of reproductive age (15–49 years) have their demands for family planning satisfied by modern methods.⁷⁹ The SADHS data remain the primary national data source for this indicator. Nevertheless, FP2020, using available national surveys, service statistics, and data on distribution of contraceptive commodities to generate yearly data, shows that this percentage has increased slightly from 2017 to 2019 (from 78.1% to 78.9%).⁸⁰

ACHIEVEMENTS

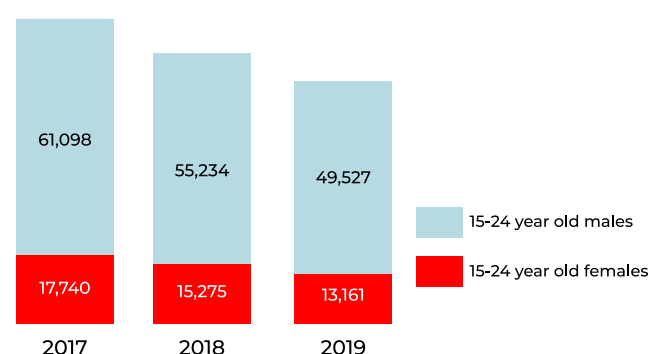
PALPABLE EFFORTS TOWARDS YOUTH HIV EDUCATION

Although the levels of HIV knowledge remain low in South Africa, the government's efforts at improving this, through an enabling policy environment, is undeniable. In this environment, government and civil society programmes on comprehensive sexuality education (CSE) have influenced social norms and provided accurate information around safe sex to youth and adolescents. The vast majority of young people understand that condom use can reduce the risk of HIV infection and that a person cannot get HIV by sharing food with an infected person.

DECLINE IN HIV INCIDENCE AMONG YOUNG PEOPLE

There was a decline in HIV incidence among young people aged 15–24 years. In 2017, there were 79,000 new infections in this age group, which declined by 20% to 63,000 in 2019. The decline was more pronounced in males (25%) than in females (19%)¹ — Figure 28.

Figure 28: Number of new HIV infections in males and females aged 15 to 24 in South Africa, 2017–2019



(Source: Thembeisa Model v4.3¹)

LEVEL OF FAMILY PLANNING IS SATISFACTORY

The majority (79% in 2019) of women of reproductive age (15 to 49 years) in South Africa have their family planning demands satisfied by modern methods. This exceeds the 75% in the WHO guideline. It also exceeds the 56% reported for Africa in 2017, while being similar to the 78% reported worldwide.⁸¹ Sexual and reproductive services, HIV education, and access to family planning services have improved over the years and have increased women's demand for modern contraceptives. Track20's Family Planning Estimation Tool model showed that in 2019, 7.9 million women were using modern methods of contraception in South Africa, resulting in the prevention of 2.9 million unintended pregnancies, 265,000 unsafe abortions and 2,500 maternal deaths.⁸⁰



women of reproductive age have their family planning demands satisfied by modern methods

KEY ISSUES**LIMITED KNOWLEDGE ABOUT HIV PREVENTION**

South Africa has not been able to achieve the UNAIDS 90% target for youth knowledge on HIV prevention. Without knowledge and other skills, young people in South Africa will not be capacitated to win the battle against the epidemic. The low levels of knowledge among South African youths explain the high number of new HIV infections among young people and the slow rate of decline. Since knowledge is often associated with structural factors, it is important to know which demographic and geographical subgroups of the population negatively affect the overall performance, so that appropriate interventions can be tailored for them. For example, limited knowledge around HIV prevention was found to be more prevalent among Blacks, people out of school and work and those in rural areas.^{82,83} According to South Africa Child Gauge 2018, 34.3% of young people aged 15 to 24 years were not in employment, education, or training in 2017.⁸⁴ These subgroups of youth are more likely to have limited access to comprehensive sexuality education. Data on the coverage of HIV education programmes for this category of young people are sparse.

HIGHER PREVENTION OF PREGNANCY THAN HIV INFECTION

Women aged 15 to 24 years appear to focus more on pregnancy prevention than on HIV prevention. While the majority of youth know that condom use can prevent HIV infection, this does not appear to translate into practice. Two thirds (65%) of sexually active young women (15 to 24 years) reported modern contraceptive use in 2016, with less than one third (18 to 27%) reporting condom use.⁷⁹ The SABSSM V reported condom use at last sex among young women in this age group to be 49.8%.³

It is important to understand the behavioural and structural factors that impede the translation of condom use knowledge to behaviour in this group. It may be expedient to distribute condoms to young people via schools. Although the policy environment provides for it^{77,85}, placing condom dispensers in schools has been met with opposition from sections of the society, which has stalled implementation. Also, the low levels of condom use in this group make it important to prioritise biomedical interventions, including ART, PrEP and circumcision, as additional preventive measures.

CHAMPIONING MALE PARTNER INVOLVEMENT

Male partner perceptions and power dynamics about the use of condoms and contraceptives play a major role in their uptake among young women and girls. But many programmes that seek to improve these outcomes in young women continue to exclude their influencers. Therefore, there is need for interventions that focus on women to consider male involvement. In a country where persons aged 15 to 24 years account for one third (34%) of new HIV infections, all hands need to be on deck to control the epidemic in this group.



COMMITMENT SIX

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

SCORE CARD

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 has an established social protection system that is anchored in the Constitution of the Republic. The Bill of Rights Section 27(1) provides that every citizen has the right to appropriate social security if they are unable to provide for themselves.³¹ The Constitution provides that the State is required to ensure that there is progressive realisation of the socioeconomic (basic nutrition, shelter, health care services and social services) rights of vulnerable population groups by employing appropriate legislative and other measures within its available resources.⁸⁶

The South African Government administers HIV-sensitive social protection through the Department of Social Development (DSD) which is mandated to provide social protection services, among other objectives pertaining to social development.⁸⁷ In addition to deriving its core mandate from the Constitution, the DSD is empowered by other legislative instruments to ensure social protection for diverse vulnerable groups in the country (Table 14). Furthermore, there are other government bodies that ensure social protection through different legal and policy documents. The National Health Insurance Policy of 2017, which draws from the Constitution and provides a uniform health system for all South Africans, is one such instrument.⁸⁸ To achieve Commitment 6, the NSP 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”.⁶

In the wider context, South Africa is a signatory to regional and international declarations to ensure social protection for vulnerable citizens. The Southern African Development Community (SADC), through Article 19 in the Charter of Fundamental Social Rights in SADC

(2003), mandates member countries to provide social protection to citizens.⁸⁹ The SADC Code on Social Security (2007) reiterates this.⁹⁰

Table 14: South Africa's legal and policy environment for Commitment 6

YEAR	LAW/POLICY
1996	South African Constitution
1992	Social Assistance Act
1997	Welfare Laws Amendment Act
2003	National Health Insurance Act No. 61
2003	Charter of Fundamental Social Rights in SADC
2004	South African Social Security Agency Act
2004	Social Assistance Act
2007	SADC Code on Social Security
2012	National Development Plan 2030
2017	National Strategic Plan (NSP) 2017–2022
2017	National Health Insurance Policy Document
2019	National Health Insurance Bill

CURRENT STATUS AND RECENT TRENDS

SOUTH AFRICA'S SOCIAL GRANTS

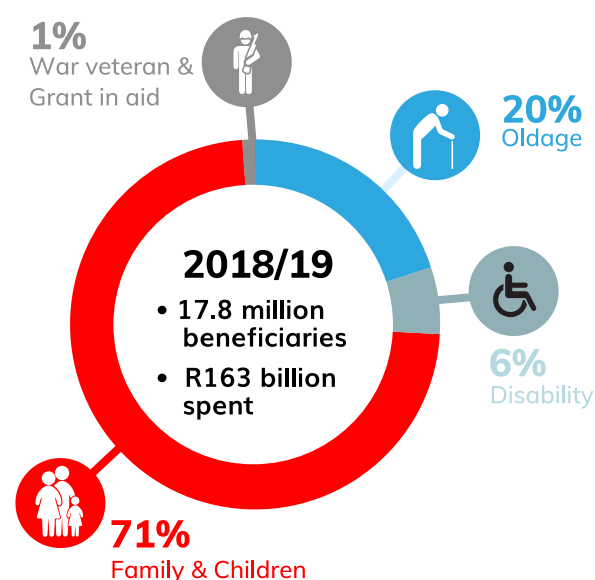
As of March 2019, there were 17.8 million South Africans receiving social grants, up from 17.5 million in the previous year (Table 15).⁹¹ This means that about one-third (31%) of South Africans benefit from the country's social protection. Child support grants (73%) and old age grants (20%) account for the majority of grants. Disability grants account for 6%. The total expenditure on social grants increased from R139 billion in the 2016/17 financial year to R163 billion in the 2018/19 financial year.⁹¹

COMMITMENT SIX

Table 15: Number of South Africans on different types of social grants, 2017–2019

Grant type	2016/17	2017/18	2018/19
Child Support	12,081,375	12,269,084	12,452,072
Old Age	3,302,202	3,423,337	3,553,317
Disability	1,067,176	1,061,866	1,048,255
Foster Child	440,295	416,016	386,019
Grant in Aid	164,349	192,091	221,989
Care Dependency	144,952	147,467	150,001
War Veteran	176	134	92
Total	17,200,525	17,509,995	17,811,745

(Source: South African Social Security Agency (SASSA)⁹¹)



HIV-SENSITIVE SOCIAL PROTECTION

According to UNAIDS, the six key elements of an HIV-sensitive social protection strategy that reflect deliberate government efforts to address commitment 6 are that it:

Refers to HIV

Recognises PLHIV as key beneficiaries

Recognizes key populations as key beneficiaries

Recognizes young women as key beneficiaries

Recognizes people affected by HIV as key beneficiaries

Addresses unpaid work in the HIV context.⁹²

The South African social protection system has been noted to contain all six vital elements, overtly and mostly covertly.⁹² Although the country's social grant system is not set up to directly benefit people infected with HIV, its role in alleviating poverty is enormous. On the one hand, HIV/AIDS can trigger individuals and households into poverty. On the other hand, poverty is a risk factor for HIV acquisition. The child support grant, which is paid to more than 12 million people, 95% of whom are women, has been shown to improve the education levels of children, empower otherwise vulnerable women, and contribute to alleviating poverty. Scientific studies have shown associations between South African social grants and HIV risk reduction.⁹² Furthermore, South Africans who have mental or physical disabilities due to HIV and/or TB are eligible for disability grants if deemed unable to work by a doctor.⁹³

ACHIEVEMENTS

A COMPREHENSIVE AND EXPANDING SAFETY NET

The provision of different types of social grants to cater for social groups that are vulnerable to poverty is a commendable achievement for South Africa. The safety net continues to expand. The government's

OTHER FORMS OF SOCIAL PROTECTION

Social grant payments are not the only forms of social protection provided to vulnerable persons in South Africa. Linked to this is free basic education in public schools for orphans and learners attending schools designated as no-fee schools based on the economic levels of the communities in which they are situated.⁹⁴ Orphans are also exempted from paying fees.⁹⁴ This child- and adolescent-sensitive social protection has the potential to interrupt risk pathways to HIV infection and foster resilience by reducing high-risk sexual liaisons among adolescents.⁹² "A study in rural South Africa found that each additional year of educational attainment was associated with a 7% reduction in the risk of HIV infection after controlling for age, sex, wealth and other variables."⁹²

Furthermore, to curtail generational poverty, the Department of Social Development plans to complement the social protection programme with developmental programmes "aimed at empowering communities toward sustainable livelihoods."⁹¹ Studies have reported the impact of such programme augmentation in reducing HIV incidence.⁹² Programmes that invest in communities to stimulate the growth of local economies is one such example. Additionally, in 2018, through SASSA's Social Relief of Distress programme, more than 1,000 cooperatives were assisted to access economic opportunities worth more than R110 million.⁹¹

IMPROVED EFFICIENCY IN GRANTS PROCESSING

Concurrent with the expansion of the country's safety net to include more vulnerable persons, the government has significantly reduced the turnaround time for processing social grant applications. Apart from disability grants that require medical certification, the processing duration for most grant applications was one day during the period under review, in comparison to three months a decade ago.⁹¹

DONOR-SPONSORED SOCIAL PROTECTION



In the country, there are other programmes that involve cash transfers to vulnerable populations, especially young women. For example, cash transfers are a component of the core package of evidence-informed interventions within the U.S. President's Emergency Plan for AIDS Relief's (PEPFAR) Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) programme.⁹⁵ The DREAMS programme aims to reduce HIV infections among girls and young women in South Africa. Additionally, DREAMS aims at addressing HIV as a health issue, besides confronting the structural drivers of increased HIV risk for young women, which include poverty, gender inequality, sexual violence, and lack of access to education and economic empowerment. The programme has noted that in the four years of programme implementation, 2015 to 2019, the country has seen year-on-year reductions in new HIV infections among girls and young women aged 15-24.⁹⁵ It is however noteworthy that HIV incidence is declining in both sexes and all age groups in South Africa.

KEY ISSUES

NO SOCIAL GRANTS FOR PLHIV OR THOSE TREATING TB

There have been debates and submissions about the need to have social grants for HIV- and TB-affected households. These illnesses can often impoverish household through direct and indirect out-of-pocket expenditure, which can have negative impact on treatment adherence, treatment outcomes and risk of new infections among those unaffected. Social grants that help households to afford direct expenditure, such as food and transport costs, and indirect expenditure, such as time taken off work, can go a long way to mitigating the economic impact of HIV and TB.

NO SOCIAL GRANTS FOR KEY POPULATIONS

It has been reported that, while key populations account for a significant proportion of new HIV infections, they only currently receive a fraction of HIV spending.⁹⁶ Perhaps, the government needs to consider the role that social grants can play in helping key populations (such as sex workers and homeless kids who inject drugs) overcome the epidemic.



COMMITMENT SEVEN

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

SCORE CARD

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

DEFINITION OF THE COMMITMENT

UNAIDS conceptualises community responses as community-led activities in response to HIV, such as advocacy, campaigning and participation of civil society in decision-making, monitoring and reporting on progress made in delivering HIV responses.⁹⁷ It also involves direct participation of communities and community-based organisations in HIV service delivery and participatory community-based research.⁹⁷ Consequently, governments must commit to building people-centred health and social systems for all by expanding community-led service delivery to cover at least 30% of all service delivery by 2030.¹¹

LEGAL AND POLICY ENVIRONMENT

South Africa has well-established integrated legal frameworks and policies that guide responses to Commitment 7. The current NSP acknowledges the need to strengthen community-based responses to HIV through the implementation of a core package of multi-sectoral services aimed at addressing the physical, emotional, educational and social needs of children and families.⁶ The NSP highlights the prioritisation of community engagement, dialogue and direct support to allow for the most pressing needs of communities to be identified and addressed. Furthermore, the NSP recognises the need to increase the capacity, competencies and capabilities of government and civil society organisations (CSOs), providers for an effective roll-out of quality HIV, TB and STI interventions and services.⁶ The deliberate expression to involve civic organisations, by the NSP 2017–2022, is rooted in the Non-profit Organisation (NPO) Act (No. 71 of 1997), amended by the Non-profit Organisations Amendment Act (No. 17 of 2000) from the Constitution of the Republic of South Africa.⁹⁸ The objectives of the NPO Act include the following:



To provide for an environment in which non-profit organisations can flourish



To establish an administrative and regulatory framework within which non-profit organisations can conduct their affairs



To encourage NPOs to maintain adequate standards of governance, transparency and accountability, and to improve those standards



To create an environment within which the public may have access to information concerning registered NPOs



To promote a spirit of co-operation and shared responsibility within government, by donors, and amongst other interested persons in their dealings with NPOs.

The NPO Act is one of the legal instruments that provides a framework for the realisation of the rights of citizens expressed in the Bill of Rights of the Constitution — especially the right to health. Consequently, the aims of Commitment 7 are aligned with the objectives of the Constitution and the associated Acts of Parliament. At the global level, South Africa is a signatory of the 2016 Political Declaration on Ending AIDS which charts various fast-track targets aimed at eliminating the epidemic by 2030.

CURRENT STATUS AND RECENT TRENDS

UNAIDS-guided questions for policy monitoring, through the National Commitments and Policy Instrument (NCPI–Part A and B) 2019,¹³ are pertinent for assessing South Africa's current status regarding this commitment. Table 16 provides answers to these questions.

Table 16: UNAIDS questions for evaluating progress towards Commitment 7

Question	Answer
Does your country have a national policy promoting community delivery of ART?	Yes
Are there any of the following safeguards in laws, regulations and policies that provide for the operation of CSOs/community-based organisations (CBOs) in your country?	
Registration of HIV CSOs is possible	Yes
Registration of CSOs/CBOs working with key populations is possible	Yes
HIV services can be provided by CSOs/CBOs	Yes
Services to key populations can be provided by CSOs/CBOs	Yes
Reporting requirements for CSOs/CBOs delivering HIV services are streamlined	
Regulatory barriers to community-led service delivery	
Restrictions requiring that HIV services only be provided in health-care facilities	No
Restrictions on providing services to key populations	No
Overly restrictive criteria for eligibility for community-based service delivery	No

(Source: South African Social Security Agency (SASSA)⁹¹)

The indicators and targets for Commitment 7 are yet to be fully defined, as the following activities are still to be undertaken by UNAIDS regarding the Commitment (scheduled dates of action are in brackets in the list below)⁹⁹:

STEP 1	Definition development for indicators (June 2019)
STEP 2	Development of initial indicators for field testing (disaggregation of service delivery by type of service provider) (August 2019)
STEP 3	UNAIDS Monitoring Technical Advisory Group reviewed disaggregation proposal as part of annual GAM guidelines review process (September 2019)
STEP 4	New disaggregation integrated in guidelines for 2020 GAM reporting for testing (2020)
STEP 5	National AIDS Spending Assessments (NASA) review (in 2020)
STEP 6	Convene task team to participate in indicator performance review and recommend good practices to ensure access to funding for CBOs and constituency-based networks (2020 to 2021)

However, the HIV response environment for South Africa is already characterised by the features that are aligned to the aims of Commitment 7. A number of NGOs, including NPOs, CBOs, and faith-based organisations (FBOs), are well-integrated in the South African HIV response effort. A number of PEPFAR funded activities, which are

aligned to the NSP 2017–2022, are in existence in 27 HIV/AIDS high-burden districts in South Africa.¹⁰⁰ PEPFAR partners with more than 100 local and international NGOs, which work in more than 2,500 health facilities where they strive to make HIV treatment accessible to the public and prevent new infections.¹⁰¹ Examples of these NPOs include:

- AIDS Foundation South Africa (AFSA): the first registered AIDS NGO in South Africa
- Treatment Action Campaign (TAC)
- Right to Care: one of the first NGOs to provide HIV treatment to the public
- LoveLife
- Desmond Tutu HIV Foundation
- Nkosi's Haven
- Mothers2Mothers: employs mentor mothers from communities to educate and support other women and their families to enable them to access healthcare, start treatment and stay in care.

ACHIEVEMENTS

ENABLING LEGAL ENVIRONMENT

One of the main achievements of South Africa regarding Commitment 7 is the conducive legal environment that enables various types of civic organisations to provide HIV response services to communities. Owing to the role of civil organisations in the fight against apartheid, and its systemic discrimination (including access to health), the South African Government enshrined, in the new Constitution of democratic South Africa, the conducive legal space for civil organisations to function.

DIVERSE AND COORDINATED CIVIL ORGANISATION PARTICIPATION

As of March 2015, there were an estimated 136,453 civil society organisations involved in the South African HIV response.⁷³ In 2017, a new civil society forum was created to provide a platform for civil society and government to work together. As part of that coordination for concerted efforts, there are 18 civil society forums working with SANAC in the HIV response effort. These forums include: PLHIV, sex workers, faith, higher education, sport, arts & culture, labour, research, law & human rights, youth, men, women, NGOs, traditional leaders, traditional health practitioners, health professionals, people with disabilities, children, and LGBTIQ+ people.⁶

NGO-SUPPORTED ART PROGRAMME

South Africa's civil organisations have left their marks on the HIV response in many ways — a notable aspect being in the ART programmes. One of the civil society organisations, the Treatment Action Campaign (TAC) formed in 1998, was instrumental in the introduction of ARVs as a part of maternal health services when, in 2002, it successfully obtained a Constitutional Court ruling that the South African Government must provide ARVs for the prevention of mother-to child-transmission.⁷³ Many NGOs continue to support the government in the provision of ARV treatment and care to PLHIV.

A bottom-up approach to the HIV response using community-based patient clubs has yielded positive results in South Africa. For example, in Khayelitsha in the Western Cape, 97% of club patients remained

COMMITMENT SEVEN

in care over a period of 40 months compared to 85% of those who qualified for clubs but remained in mainstream, clinic-based care.⁹⁷ Compared to people in clinic-based care, club participation reduced loss to follow-up by more than 65% and almost halved the proportion of people with detectable viral loads. The importance of initiatives like patient clubs in the HIV treatment response lies not only in health outcomes but also in reduced cost of care. A cost-effectiveness study showed that the cost per patient year using the ART patient clubs model was US\$58, which was just above half of the cost in the mainstream model of care of US\$109.⁹⁷

MORE HIV TESTING OPTIONS

Non-governmental organisations have also played an integral role in the development of innovations in HIV testing technologies. For example, the Wits Reproductive Health Institute (WRHI) has spearheaded HIV Self-Testing Africa (HSTAR), a South African developmental programme evaluating HIV self-test products in Africa.¹⁰² Through such support and innovative work done by civic organisations, an array of HIV testing options is now available in South Africa, one of which is self-testing kits (Figure 29).¹⁰³ Trials have shown that 88% of those who refuse to use traditional testing methods accept the offer of HIV self-testing.^{104,105} The provision of different types of HIV tests is a positive contribution to the HIV response at a time when testing yield is declining and South Africa needs innovative strategies to diagnose more PLHIV especially among undertested populations.

Figure 29: Types of HIV tests available in South Africa

Type of Test	What do they test for?	When can HIV be detected?	How long does it take to get results?	Reliability
3rd generation antibody test	HIV antibodies	3 months after exposure	Few days to few weeks	High
4th generation antibody/antigen tests	HIV antibodies and p24 viral proteins	1 month after exposure	Few days to few weeks	High
Rapid tests	HIV antibodies	3 months after exposure	Within 20 minutes	Satisfactory for uncomplicated infection
Self-testing kits	HIV antibodies	3 months after exposure	Within 20 minutes	Satisfactory, results must be followed at healthcare clinic

(Source: Avert103)

NGO PARTICIPATION IN OTHER ASPECTS OF THE COUNTRY'S HIV RESPONSE

The WRHI also partnered with the Tshwane District Department of Health for health systems strengthening in a programme aimed at improving and expanding comprehensive clinical and non-clinical differentiated HIV care and treatment services to enhance the HIV epidemic control in South Africa.¹⁰⁶ The involvement of civil society stakeholders has also enabled the country to achieve the aforementioned success regarding MMC in the 2018/19 period.¹⁸

This achievement was made possible by the NDoH's partnership with traditional healers and NGOs such as The Aurum Institute, Community Media Trust (CMT), TB/HIV Care, Right to Care, and Get Down Productions, in the 2018 Project 300k Winter Campaign to drive uptake of MMC.^{18,107} In Table 17, the status of the various features of community-led HIV service provision, as adapted from UNAIDS, is reported for the country.⁹⁷

Table 17: State of community-led HIV service provision in South Africa

Item	Status
HIV prevention	
Distribution of prevention commodities	Yes
Delivery of behaviour change interventions	
Prevention of mother-to-child transmission related services (linkage to care, adherence support, ART delivery, home-based care)	
Services for key populations through specifically designed combination prevention services, including harm reduction and peer education	
Integration of HIV prevention services into sexual and reproductive health and rights services	

Item	Status
Confidential and voluntary HIV testing and counselling	
Testing services at the community level for the general population	Yes
Testing, counselling and linkage to care services for key populations	
Peer support in accessing testing (including home testing) and counselling, and in coping with results	
Different types of counselling	
HIV treatment	
ART and other medicine provision and delivery	Yes
Treatment education	
Treatment services for key populations	
Services addressing coinfections, including TB and hepatitis C	
Adherence support	
Demand creation and service uptake	
Raise awareness of available services	Yes
Mobilise communities for demand creation	
Broker access and referrals to services	
Care and support	
Palliative care, including home-based care	Yes
Psychological support	
Food and nutrition support	
Care for children and families	
Economic empowerment and income generation	
Rights and legal services	
Programmes to reduce stigma and discrimination	Yes
Services to address and end gender-based violence	
Legal services	
Legal and human rights literacy	
Task-shifting and task-sharing	
Community health workers	Yes
Training and sensitisation of service providers	Yes
Including health-care personnel, lawmakers and law enforcement officials	

KEY ISSUES**REDUCED FUNDING**

One of the key issues facing civil society organisations is funding constraints due to the drop in external funding, which has rendered many more dependent on government financing.⁷³ While domestic funding may be a more sustainable model, the shift has increased competition among organisations and can lead to underfunding and the demise of NGOs.⁷³ Also, if government funding of NGOs is not handled with integrity and honesty, it can potentially undermine the ability of civil society to rigorously challenge government policy, where necessary.

**ABSENCE OF DEFINED INDICATORS, DATA AND REPORTING STRUCTURE**

Another issue stems from the fact that the indicators for Commitment 7 are yet to be defined. As UNAIDS wraps up its work in this regard, there is need for SANAC to champion the development of the necessary framework and structure for the reporting of indicators for this commitment. There are many organisations involved in the provision of HIV services in South Africa but there is no established structure and system that captures each organisation's quantitative achievements and then collates them into a centralised national database that can be used to track the country's annual progress on community-led provision of HIV services.



COMMITMENT EIGHT

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

SCORE CARD

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

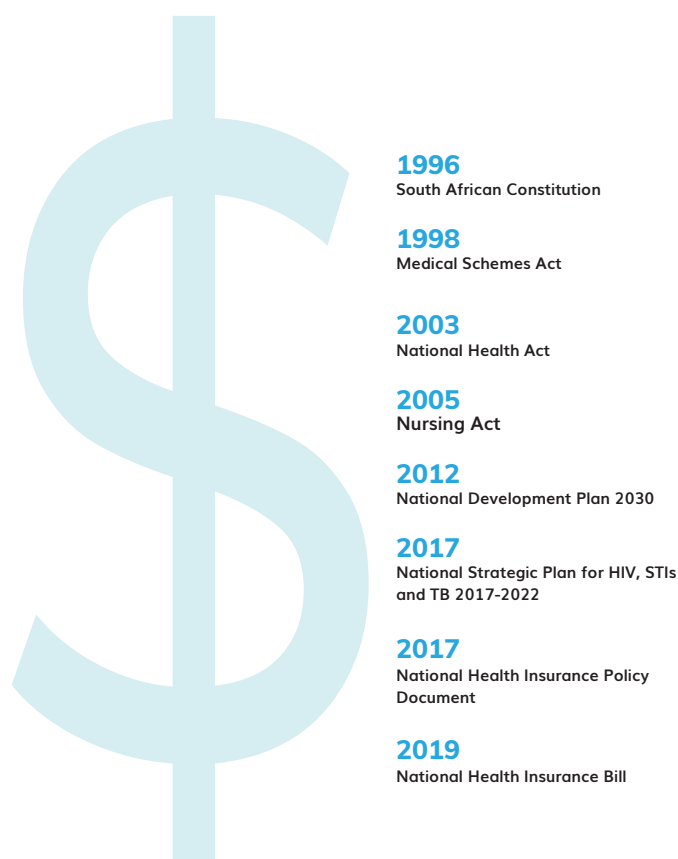
LEGAL AND POLICY ENVIRONMENT

South Africa's health expenditure hinges on a plethora of policies that provide for a healthy life for all South Africans. Primarily, the Constitution, provides for access to healthcare as a basic right for all citizens.³¹ The National Development Plan (NDP) 2030 provides more specific targets regarding the health of South Africans. With respect to HIV, these targets include: to ensure that the generation of under-20s is HIV-free, have all PLHIV on ARV and increase the life expectancy to a minimum of 70 years, amongst others.¹⁰⁸ Underlying these higher-level legal and policy documents are more specific policy instruments which provide for the massive HIV expenditure in South Africa.

The Department of Health derives its mandate from the National Health Act (2003), which, inter alia, dictates that the department provides funding and an implementation framework for a "structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws".⁸⁸ The Act envisages equal right to healthcare for all South Africans. The 2019-2024 Medium Term Strategic Framework (MTSF), with HIV targets aligned to the current NSP, provides the framework and budget for government HIV expenditure in particular and health expenditure in general.¹⁰⁹ In the longer term, The National Health Insurance (NHI) is South Africa's planned health financing policy, which establishes

a NHI Fund for equitable health financing.¹¹⁰ The key policies that provide for HIV investment in South Africa are listed in Figure 30.

Figure 30: South Africa's legal and policy environment for Commitment 8



CURRENT STATUS AND RECENT TRENDS

TOTAL HIV EXPENDITURE

Table 18: Commitment 8: Core indicators, South Africa, 2016/17–2019/20 (Amount in R million)

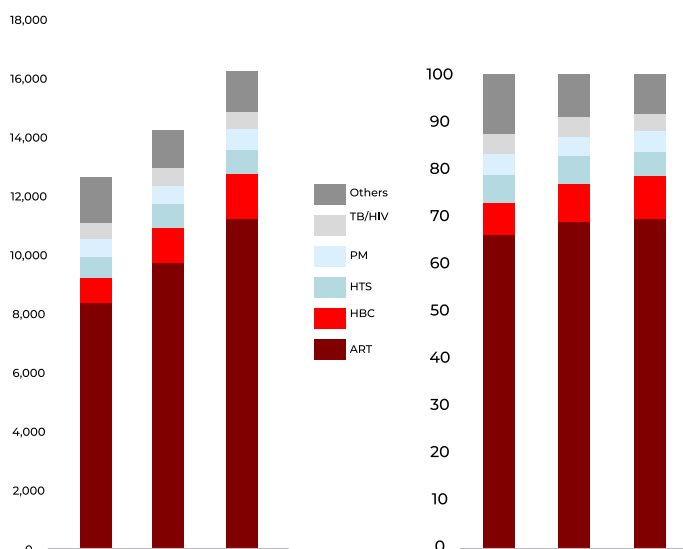
Indicator	Data source	2015/16	2016/17	2017/18	2018/19
Total government expenditure on health	National Treasury Budget Reviews ^{111–114}	159 377	170 888	191 685	205 448
Total government expenditure on HIV	Guthrie et. al. ¹¹⁵	25 809	28 814		
Allocation from South African government	Guthrie et. al. ¹¹⁵	19 395	21 816		
Allocation from other development partners (PEPFAR, USAID, Global Fund)	Guthrie et. al. ¹¹⁵	6 414	6 998		

The most recent data on total government expenditure on HIV was from a consolidated analysis published in 2018 covering the financial years 2014/15 to 2016/17.¹¹⁵ The data showed that by 2016/17, total HIV/TB expenditure in South Africa stood at R28.8 billion, with 76% coming from government allocation (Table 18). At the time of writing this report, a comprehensive National AIDS Spending Assessment (NASA) by SANAC was underway to cover the period 2017/18 to 2019/20.

TOTAL HIV EXPENDITURE BY PROGRAMME

The 2018 report showed that ART expenditure accounted for the highest proportion of total HIV expenditure.¹¹⁵ As South Africa expands its ART programme steadily, increase in ART spending continues to drive overall increase in HIV 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 at 5% (Figure 31).

Figure 31: Combined provincial department of health spending, in absolute amount (R millions) on the left and relative proportion (%) on the right

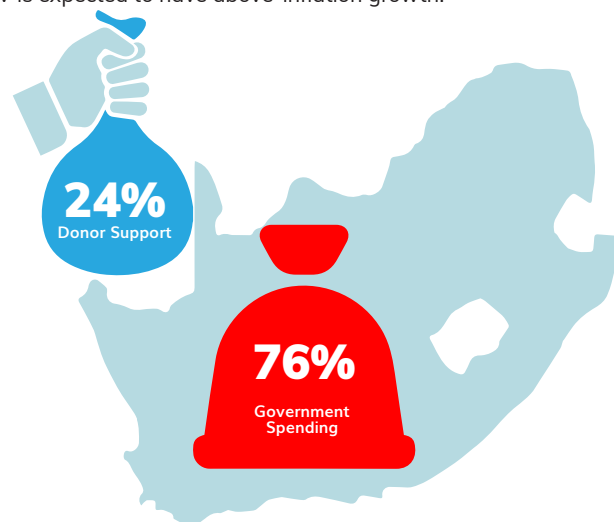


(Source: Guthrie et. al.¹¹⁵)

ACHIEVEMENTS

GOVERNMENT FUNDING FOR HIV IS INCREASING

According to an analysis of health budget and expenditure in the 2018 MTEF, allocations to provincial health programmes were under pressure for trimming but HIV/AIDS remained in the Minister of Health's non-negotiable spending category.¹¹⁶ In fact, spending on HIV is expected to have above-inflation growth.

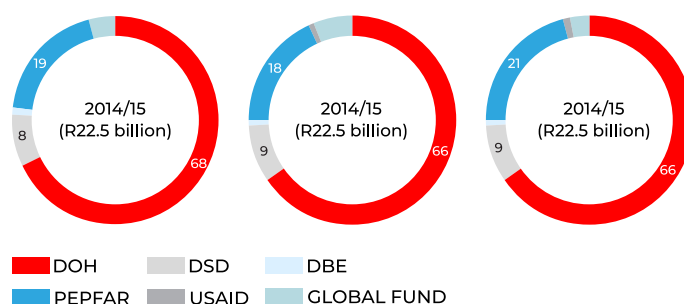


Although another NASA is underway, CESAR consultants conducted a supplementary analysis, using recent grouped HIV spending data from the Treasury and the NDoH. Both sets of data indicated that government HIV spending has continued to increase.^{18,109} For example, according to the MTEF 2019–2021, the amounts set aside in the district health budget for HIV, TB, malaria and community outreach services are: R22 billion in 2019/20; R24 billion in 2020/21; and R28 billion in 2021/22.¹⁰⁹

SOUTH AFRICA FUNDS MAJORITY OF ITS HIV/AIDS EXPENDITURE

South Africa shoulders over two thirds of its HIV expenditure, with the remaining coming from global partners.¹¹⁷ This responsibility by the government has increased over the years, reaching 76% in 2016/17 (Figure 32).

Figure 32: Percentage of HIV expenditure funded by the South African Government

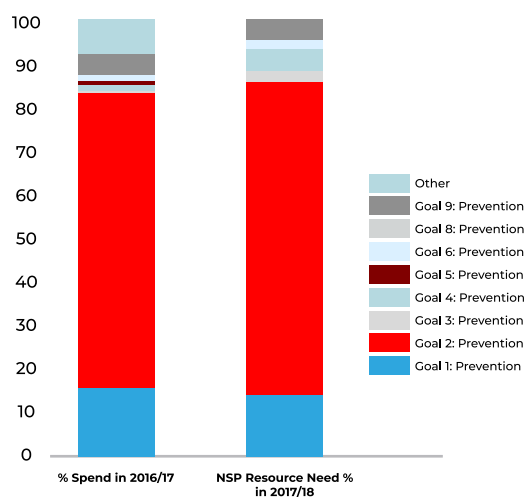


(Source: Guthrie et. al.¹¹⁵)

EXPENDITURE TARGET FOR HIV SOCIAL ENABLERS MET

The analysis by Guthrie et al. showed that in 2016/17, the country spent 8% of its HIV expenditure on programme enablers (which include social enablers), thereby achieving the UN target of 6% (Figure 33).¹¹⁵ However, the proportional expenditure on prevention was 15% and did not reach the UN target of 25%.

Figure 33: Proportional spending by NSP goal versus NSP prioritisation (2016/17–2017/18, %)

(Source: Guthrie et. al.¹¹⁵)

EXTERNAL FUNDING SUPPORT FOR HIV/AIDS PROGRAMMES REMAIN STRONG

South Africa's HIV expenditure continues to benefit from funding support by global partners. A case in point is PEPFAR, the second biggest contributor to HIV expenditure in South Africa (after government). In April 2019, PEPFAR announced a cut in funding support for South Africa due to poor programme performance. The potential harm to the country's HIV response resulting from such a cut was widely discussed. However, in May 2019, the decision was rescinded following further planning meetings and deliberations, and South Africa received R10 billion for the 2019/20 financial year.^{118,119} This amount was more than PEPFAR's contribution in prior years and accounted for 20% of PEPFAR's HIV expenditure across 56 countries^{115,119} The Global Fund also continued to provide funding support to South Africa during the review period.

ISSUES

UNIVERSAL TEST AND TREAT (UTT) WILL INCREASE FUNDING CHALLENGE

The current test and treat policy for PLHIV already puts tremendous strain on HIV spending in South Africa. It is within this context that the South African Government welcomed PEPFAR's decision to increase its funding for the 2019 Country Operational Plan (COP19). The COP19 funding will help South Africa put more people on treatment to reach the second 90 target by 2020. Since PLHIV require lifelong treatment, the lack of certainty on the duration about such donor support is worrying. Also, the COP19 funding came with conditions to be met by South Africa, as did the COP18 funding. High-income countries HIV funding support to low- and middle-income countries has decreased in recent years.¹¹⁷

UNEQUAL SPENDING ACROSS DISTRICTS

While South Africa has performed remarkably well in its financial investment in the HIV response, it is noteworthy that variation in spending capacities across provinces and districts exists. This requires attention, especially because HIV expenditure does not always correlate with HIV burden.



COMMITMENT NINE

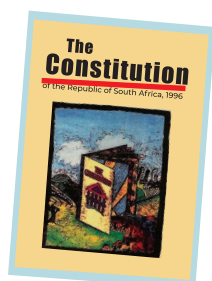
Empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violation of human right

SCORE CARD

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 has the reputation of having one of the most liberal and progressive constitutions in the world. Committed to leaving behind its difficult past and associated repugnant laws, the country constituted liberal laws and policies that protect the rights of its citizens who include people living with, at risk of, and affected by HIV. The Bill of Rights, Section 2 of the Constitution, provides for a broad range of rights, ranging from basic to political and judiciary rights, including processes for administrative action, access to court and dictates for arrest and detainment.³¹ It interdicts direct and indirect unfair discrimination against any person on any grounds, including religion, race, sex and gender (including sexual orientation). Section 27 of the Constitution prescribes access to healthcare services, including reproductive health, to all citizens, meaning that people living with or at risk of HIV can access healthcare services like any other person.³¹



South Africa's liberal constitution forms the basis for Commitment 9 achievements

Deriving from the country's governing charter, other legislative instruments exist to protect the rights of citizens in labour, health and other spheres of national life. Labour legislation in the country prevents employees from being discriminated against or dismissed because of their HIV status. The Employment Equity Act prohibits discrimination of employees on the grounds of HIV and testing of employees to determine their HIV status.¹²⁰ The Code of Good

Practice of HIV and AIDS and Employment (No 21815 December 2000) sets out guidelines for employers to ensure employees with HIV/AIDS are not discriminated against in the workplace.¹²¹ The Commission for Conciliation, Mediation, and Arbitration (CCMA) exists to assist employees whose rights to equity and indiscriminate in the workplace have been violated.

The HIV-related provisions of the Sexual Offences Act of 2007 provide for services for victims of sexual assault, including access to post-exposure prophylaxis (PEP) and compulsory HIV testing of alleged perpetrators.¹²² The Protection of Personal Information Act of 2013 protects citizens against wilful or accidental sharing of an individual's HIV status by any party.¹²³ The sexual rights of adolescent girls and young women (AGYW) are protected by the National Adolescent Sexual and Reproductive Health and Right Framework Strategy (2019–2022), which addresses sexual rights and grants access to reproductive healthcare services for young women and girls at risk of HIV. Additionally, it makes provision for safe abortion, use of contraceptives and related treatments.¹²⁴ Other legal mechanisms that favour the achievement of this commitment are listed in Table 19.

Table 19: South Africa's legal and policy environment for Commitment 9

Year	Law/Policy
1998	Employment Equity Act
2000	Promotion of Equity and Prevention of Unfair Discrimination
2007	Sexual Offences Amendment Act
2013	Protection of Personal Information Act
2017	National Policy on HIV, STI and TB
2019	National Adolescent Sexual and Reproductive Health and Right Framework Strategy (2019–2022)
2019	Human Rights Plan for HIV and TB
2017	National Health Insurance Policy Document
2019	National Health Insurance Bill

ACHIEVEMENTS

NATIONAL COMMITMENT

South Africa's legal policies and frameworks are laudable for advancing the human rights of people at risk of, living with or affected by HIV. Access to health and human rights are central to the National Strategic Plan for HIV, TB, and STIs (2017–2022).⁶ Furthermore, SANAC commenced a three-year Human Rights Plan (2019–2022) in support of the NSP.⁴⁶ This plan is set to guide the implementation of focused interventions with the aim of eliminating human rights barriers to healthcare services through HIV- and TB-related laws. The goals of the plan include:

- To reduce stigma and discrimination among people living with HIV or TB
- To sensitize and train health workers on patient rights and needs of people living with HIV, TB and key populations, including their own rights as health workers
- To sensitize lawmakers and enforcers on the rights of people living with HIV and TB, particularly sex-workers and drug users
- To enhance legal literacy among key and vulnerable populations
- To strengthen legal support services and
- To monitor and review relevant laws and policies.⁴⁶

COLLABORATIVE EFFORTS

There are notable collaborative efforts from individuals, civil society, cooperate organisations and the government to collectively protect and promote the rights of people living with and at risk of HIV. Non-governmental organisations, such as the AIDS Legal Network, the AIDS Consortium and the Legal Resource Centre, offer training, advice and legal assistance to communities in this regard. Many NGOs, such as Soul City and Love Life, use HIV mass education programmes to promote HIV awareness including HIV-related rights.

The South Africa Human Right Commission (SAHRC) engages both the public and private sectors to raise awareness and protect the rights of all people, including people living with, at risk of, and affected by HIV.¹²⁵ Notable efforts include the creation of an HIV human rights helpline (a toll-free line) in some provinces and the publication of HIV/AIDS and human rights educational booklets to facilitate uninterrupted access to services information and support. The implementation of the Human Rights Plan, as well as the scaling up of programmes that eliminate barriers to human rights services in the context of HIV and TB, supported by The Global Fund and legal and human rights groups, is another positive response aimed at ensuring that this commitment is achieved.¹²⁶

IMPROVED KNOWLEDGE OF HUMAN RIGHTS

Data from the Governance, Public Safety and Justice Survey (GPSJS) of 2018/19 showed that 80% of the population was aware of the country's constitution and 78% was aware that the constitution protects their rights.¹²⁷ The 2018/19 GPSJS is the first of a series of planned surveys. However, 2016 data from a survey conducted by the Department of Justice and Constitutional Development (DoJ&CD) demonstrated the low levels of legal and rights literacy in the country, with only 51% of South Africans being aware of their constitutional rights.¹²⁸ Although the questions used in both studies were not the same, the data indicate that there is progressive improvement in knowledge and perception of human rights and justice in the country.

Furthermore, the GPSJS data showed that 77% of South Africans believed that people's rights to access healthcare is protected in the country.

KEY ISSUES

LAWS AND IMPLEMENTATION

Despite the robust human rights-related legal environment of the country, poor implementation of laws persists. As a result, human rights violations still occur, especially with key populations. In addition, the legal protection of high-risk groups, such as sex workers and drug users, is sub-optimal. For example, sex work remains criminalised in the country.

KEY POPULATIONS ACCESS TO CARE

Diverse factors, including the attitudes of healthcare workers, impede the ability of certain key populations, such as female sex workers and PWID, to access care.⁵⁹ The overt or covert discrimination of persons on the basis of their gender and sexual orientation can deny people at risk or affected by HIV their rights to equity and healthcare.





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

SCORE CARD

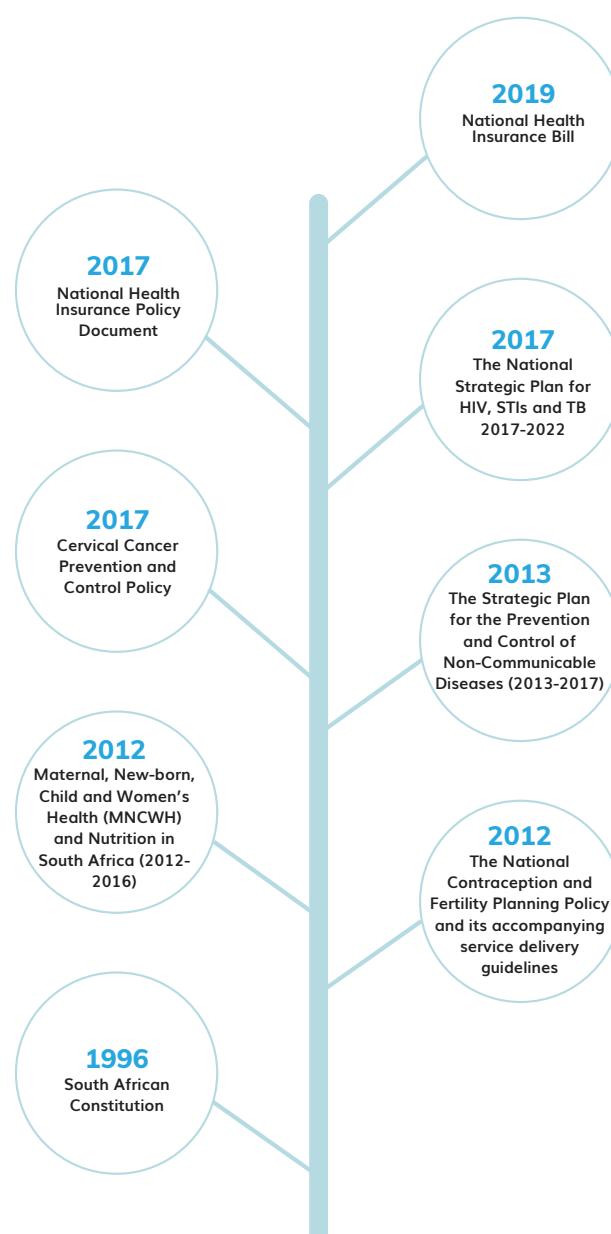
Is this a priority commitment for the country?	Yes
Does the National Strategic Plan address this commitment?	Yes
Has the country reached the target and commitment?	No
How likely is the country to reach the target by 2020	Not likely

LEGAL AND POLICY ENVIRONMENT

The South African Constitution protects the equality and rights of all persons in the country.³¹ The NSP 2017–2022 makes important provisions for the implementation of a human rights-based approach to health that excludes no one.⁶ The country has shown tremendous traction towards policies and systems for universal health coverage, with the fulcrum being the NHI Bill, which provides for free comprehensive healthcare services for all South Africans and permanent residents.¹¹⁰ Although the services of the NHI are yet to be listed, it provides for HIV, TB, Hepatitis B and other 'notifiable conditions of public health concern' for undocumented immigrants.¹¹⁰ The NHI Bill was introduced to Parliament on 8 August 2019 and by December 2019, over a third of the NHI public hearings had been completed.¹²⁹

South Africa has domestic policies and guidelines in place that facilitate the integration of service provision to comprehensively address cervical cancer prevention and control. The Cervical Cancer Prevention and Control Policy (2017) aims to improve women's health and well-being by decreasing cervical cancer-related morbidity and mortality.¹³⁰ Cervical cancer prevention and control is also part of a broad-based sexual and reproductive health programme implemented by the NDoH. In 2019, the NDoH released the National Hepatitis Guidelines for health workers in implementing interventions for addressing transmission and treatment of hepatitis infections. These and other policy documents that speak to this commitment are listed in the Figure 34.

Figure 34: South Africa's Legal and policy environment for Commitment 10



CURRENT STATUS AND RECENT TRENDS

INDICATORS FOR TB BURDEN

TB incident cases and mortality

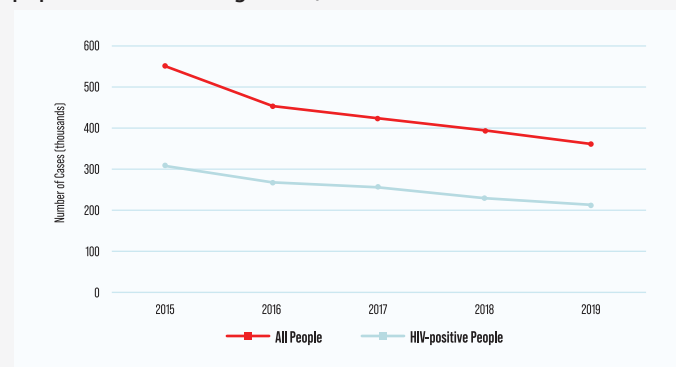
The WHO has revised the estimates for TB cases and deaths in South Africa twice in the past three years. The 2017 revision led to lower estimates of TB incidence.¹³¹ A second revision in 2019 was occasioned by the availability of national TB prevalence survey data from South Africa. This revision led to estimates that are “somewhat higher (though with considerable overlap in uncertainty intervals for pre- and post-survey estimates)”.¹³² It should be borne in mind, that a change in the estimation method implemented in a particular year also corrects estimates for prior years.

Figure 35 shows the trends in TB incidence in South Africa, using the most recently revised estimates. In 2019, an estimated 360,000 South Africans became ill with TB, down from 421,000 in 2017. In the last three years (2017–2019), this decline was largely driven by the diminishing number of new TB cases among PLHIV: from 255,000 in 2017 to 209,000 in 2019.^{131,132}

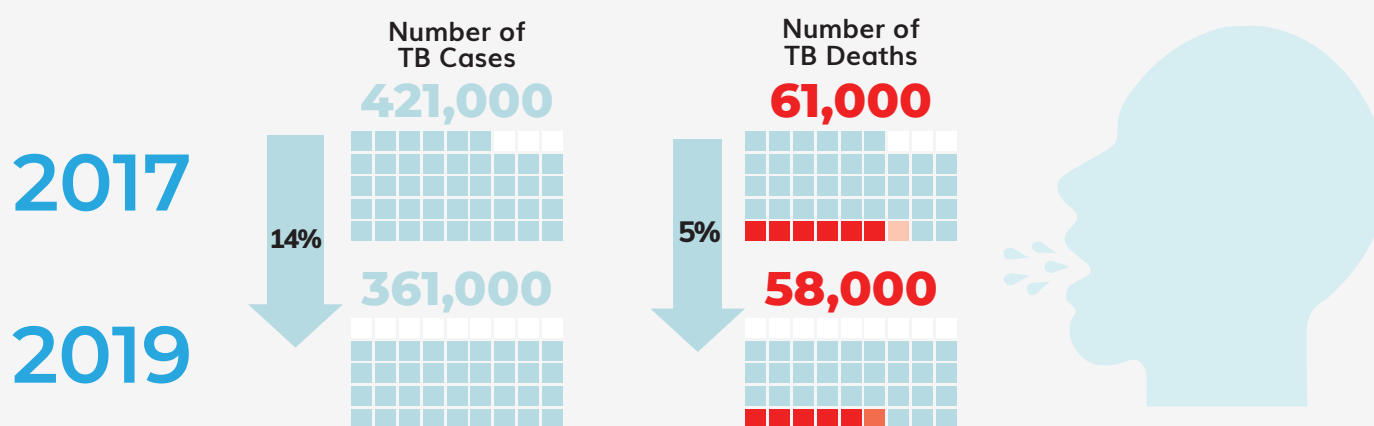
The total number of TB deaths in South Africa in 2019 was 58,000, down from 61,000 in 2017. In 2019, there were 36,000 TB deaths

among PLHIV (62% of all TB deaths) — a marked reduction from the 56,000 deaths recorded in 2017.^{131,132}

Figure 35: Incidence of TB (in thousands) in the general population and among PLHIV, 2015–2019



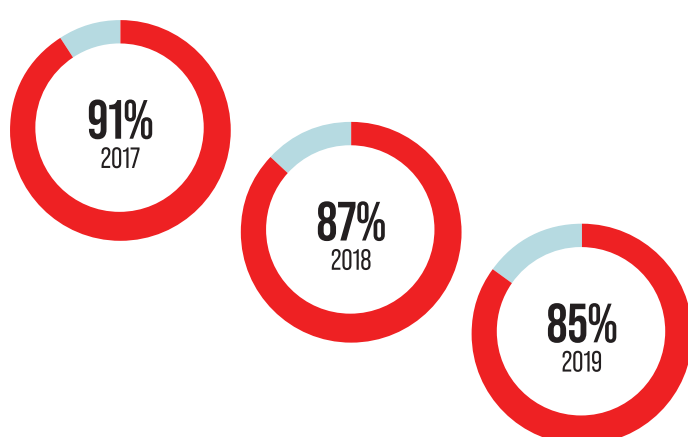
(Source: WHO^{131–133})



Co-management of tuberculosis and HIV treatment

The WHO recommends that all TB patients who are HIV-positive should be started on ART as soon as possible, but within the first eight weeks of starting TB treatment. ART coverage for notified HIV-positive TB patients in South Africa dwindled in the period under review, from 91% in 2017 to 85% in 2019 (Figure 36).

Figure 36: Percentage of notified HIV-positive TB patients on ART, 2016–2019



(Source: WHO^{131–134})

Proportion of people living with HIV newly enrolled in HIV care started on TB preventive therapy

The 2020 Global TB Report showed that, of the 736,078 people who started ART in 2019, 509,762 started TB preventive therapy, translating to 69% coverage.¹³² In 2017, the coverage was 53% (375,650 of the 710,083 PLHIV started on ART received TB preventive therapy).¹³⁴

OTHER INDICATORS FOR THE COMMITMENT

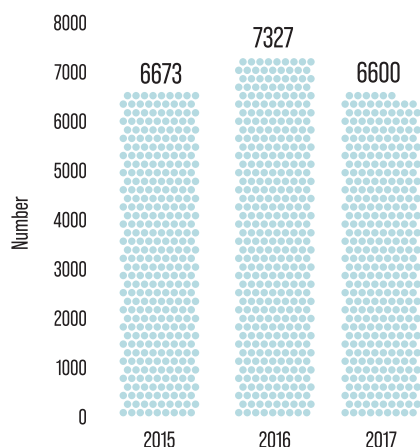
Hepatitis B and C

Accurate Hepatitis B and C data for the general population are generally lacking, although regional data do give an indication of the burden of these infections. A 2019 publication, using data on 9,812 men and women collected from 2014 to 2015, showed that Hepatitis B prevalence was 6.4% among PLHIV and 2.6% among the HIV negative individuals in KwaZulu-Natal Province.¹³⁵ In the general population, the seroprevalence for Hepatitis C is thought to be much lower than 1%, and data from the blood transfusion services consistently point towards a low seroprevalence.¹³⁶ Among 215 heterosexual males who took part in a cross-sectional study in Cape Town in 2014, 0.5% were sero-positive for Hepatitis C.¹³⁷ Important data on hepatitis C in key populations are presented under Commitment 3 in this report.

Cervical cancer

Cervical cancer is the second most common cancer among women in South Africa, after breast cancer.¹³⁸ Although cervical cancer treatment coverage is used by the WHO as a proxy for cancer detection and treatment,²⁶ the data for South Africa are relatively limited. The most recent data from the National Cancer Registry show that 6,600 women were diagnosed with cervical cancer in 2017, similar to the 6,673 cases diagnosed in 2015 (Figure 37).^{138,139}

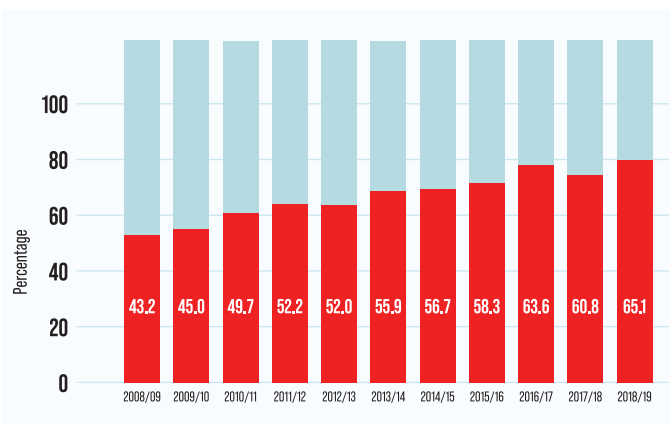
Figure 37: Number of cervical cancer cases diagnosed in South Africa, 2015–2017



(Source: NCR^{138–140})

The South African Cervical Cancer Prevention and Control Policy recommends that from the age of 30 years, women should undergo screening for cervical cancer once every 10 years.²⁶ Cervical cancer screening data from the DHIS for women aged 30 years and older show that the country's coverage, although low, has improved in the past decade (Figure 38).²⁶

Figure 38: Cervical cancer screening coverage among women aged 30 years and older, 2008/09–2018/19



(Source: DHB²⁶)

ACHIEVEMENTS

AN OVERALL DECLINING TB INCIDENCE

South Africa is committed to reducing TB mortality rates in line with the WHO End TB Strategy and the Sustainable Development Goal (SDG) expectations. The country's achievement in this regard is demonstrable in the declining TB incidence and mortality. Accounting for adjustments in the methods and inputs for the estimation of TB incidence in the country, the overall incidence has declined considerably in the last three years, with a statistically significant downward trend ($p=0.006$) (Figure 35). Overall, the TB incidence reduced by 14% from

2017 to 2019, with a greater decline (18%) among those with HIV co-infection. Much of the reduction in TB-related incidence and mortality has been due to the scale-up of ART and improvements in treatment initiation and preventive therapy.

PROGRESSIVE POLICY ENVIRONMENT FOR VIRAL HEPATITIS

In 2019, South Africa approved its National Hepatitis Guidelines which were developed in line with the latest WHO recommendations for direct acting antiviral drugs.¹⁴¹ A laudable National Hepatitis Action Plan 2017–2021 is also in place.¹⁴² This Action Plan has been hailed as “one of the first examples of an investment case that combines tools for costing, impact modelling, cost-effectiveness analysis, and fiscal space analysis for scaled-up HBV and HCV disease control scenarios.”¹⁴² Over the initial five-year period (2017 to 2022), the R3.8 billion Action Plan would “avert 13,000 HBV-related and 7,000 HCV-related deaths. If scale-up continues beyond 2021 in line with WHO goals, more than 670,000 new infections, 200,000 HBV-related deaths, and 30,000 HCV-related deaths could be averted.”¹⁴²

KEY ISSUES

TREATMENT GAP FOR MDR AND RR TB

According to WHO Global TB reports, South Africa had 13,005 cases of multi-drug resistant (MDR) or rifampicin-resistant (RR) TB in 2019, of which 67% were placed on treatment.¹³² In 2017 and 2018, 63% and 72%, respectively, were started on treatment.^{131,134} While it will be of value to interrogate these numbers, the low percentages show that progress in detection of MDR TB cases is outstripping the capacity to provide treatment.

LIMITED DATA ON KEY INDICATORS

The lack of relevant data is a limitation in the country's response to this commitment. While there are reliable data to make an overall impression in the trends of TB incidence and mortality, there are no data for monitoring many indicators under this commitment, such as gonorrhoea and urethral discharge in men, and hepatitis B and C testing and infection rates. This makes it difficult to determine the extent of the problem, monitor changes over time or allocate interventions and resources for these health outcomes.

DECLINING CO-MANAGEMENT OF HIV AND TUBERCULOSIS

Although the rate of co-management of HIV and TB is high, it decreased annually in the period under review. According to data from the WHO, the percentage of notified HIV-positive TB patients on ART declined from 91% in 2017 to 85% in 2019 (Figure 31).

LOW LEVELS OF CERVICAL CANCER SCREENING AND AWARENESS

Although cervical cancer is recognised as a major public health problem in South Africa, the levels of cervical cancer screening in the general population are low. Twenty years after the introduction of a national policy on cervical cancer, the overall cervical cancer screening coverage stands at only 65%, with considerable provincial variation. This shows that barriers to early presentation and diagnosis of cervical cancer persist. Low level of awareness is one such barrier.

DISCUSSION AND RECOMMENDATIONS

BEST PRACTICES AND ACHIEVEMENTS

ROBUST LEGAL AND POLICY ENVIRONMENT

South Africa has a robust legal and policy environment for achieving all 10 commitments set in the 2016 UN Political Declaration. This supportive environment derives from the country's Constitution, which includes provision for human rights, and access to health and social security. Armed with the Constitution, the government's political will to end AIDS has translated into progressive policies for achieving set targets. This synthesis identified that, in 2019 alone, there were progressive updates to legal and policy instruments to enhance the achievement of all but two of the 10 commitments. For example, the 2019 update of the ART treatment guidelines is expected to further increase the number of people who test and initiate treatment and improve virological suppression among those on treatment.

EXCELLENT HIV TESTING PROGRAMME

Since the launch of the HIV Counselling and Testing (HCT) campaign in 2010, South Africa has not relented in its efforts to encourage South Africans to know their HIV status. In fact, the country intensified its testing programme in the review period (2017 to 2019) and achieved unprecedented testing volumes, exceeding the annual targets set in the NSP. Furthermore, in 2019, the NDoH exceeded its target of 14 million tests.

As a result of these consistent efforts, the percentage of PLHIV who know their HIV status increased gradually to 92% in 2019, exceeding the 90% UN target. What is equally impressive is that, despite the large number of PLHIV, this achievement was observed in men who have, for a long time, lagged in this area. Multisectoral and multi-program collative efforts have resulted in the achievement of this first UN 90 target in all provinces. At a time when the number of undiagnosed HIV cases is increasing in parts of Europe, this achievement is laudable.

NSP 2019 TARGET FOR MEDICAL MALE CIRCUMCISION ACHIEVED

The country's HIV prevention programme achieved another success in 2019, in the form of the number of MMCs conducted. Partnering with traditional leaders/authorities and NGOs in the roll-out of the MMC programme in the 2018/19 period enabled South Africa to reach its annual target of adult circumcisions for the first time since the launch of the programme. NDoH leadership, PEPFAR funding, CDC and implementation partnerships, and innovative approaches, including maximised winter operations, were imperative to this achievement. This accomplishment provides motivation for what can be achieved in terms of MMC outputs in the remaining years of the current NSP term. The NDoH already plans to heighten MMC health promotion on mass media, and to continue the winter campaigns on MMC during the 2019/20 financial year. Furthermore, the multi-stakeholder partnerships and innovative operations should be considered in other aspects of HIV programming.

MASSIVE ART PROGRAMME FOR PLHIV AND INCREASING LIFE EXPECTANCY

South Africa runs the largest ART programme in the world. The introduction of the universal test and treat policy for all PLHIV in 2016 further increased the number of people on treatment. As of 2019, five million people were on treatment. The programme, which includes laboratory and data monitoring frameworks, requires massive logistical operations, and enormous human and financial resources. The results are palpable: declining HIV deaths and annual increase in life expectancy over the last decade. It is notable that the country's ART programme is one of the few on the African continent that is funded primarily by government as opposed to foreign donors.

SUCCESS IN ELIMINATING MTCT

Elimination of MTCT (EMTCT) is critical to ending the AIDS epidemic by 2030. Although South Africa has not yet achieved the WHO impact criterion of new vertical infections being less than 50 per 100,000, it has achieved that of the MTCT rate being less than 5% for breastfeeding countries. The MTCT was at an all-time low in 2019. Considering that this achievement is within the context of a high antenatal HIV prevalence, makes it even more commendable. This success has been made possible by:

- Investments in the PMTCT programme
- Championing male partner involvement
- Increase in ANC uptake
- Increase in HIV testing
- Increase in ART coverage of HIV-positive pregnant women
- Improved early infant diagnosis
- Follow up of exposed infants
- HIV treatment and care for HIV infected mothers
- Improved data systems.

The NDoH's use of technology, for example, in the MomConnect programme, has been crucial to recent progress in the ANC and PMTCT programmes. Furthermore, the combined efforts of policymakers, healthcare providers, local and international partners and community representatives need to be applauded and continued for the sustainability of this achievement.

HIGH LEVELS OF VIROLOGICAL SUPPRESSION

The benefits of ART for PLHIV only accrue if patients adhere to treatment and achieve virological suppression. By 2019, over 90% of men and women on ART achieved virological suppression. The large number of PLHIV on ART and the excellent levels of virological suppression explain the declining HIV and TB mortality in the country, as well the decreasing HIV incidence, since virological suppression also reduces the risk of HIV onward transmission from the infected person on treatment to an exposed person. South Africa has been

DISCUSSION AND RECOMMENDATIONS

able to achieve this through its universal test and treat policy for ART, efforts at reducing HIV stigma, and community-led service provisions, which have improved adherence in many patients.

TB BURDEN IS DECLINING

South Africa's effort to curtail the burden of TB, the country's leading cause of death, is yielding positive results. The burden of TB in the country — incidence and mortality rates — is declining substantially. The reduction has been due to the scale-up of ART and improvements in treatment initiation and preventive therapy. This decline in overall TB incidence and mortality is largely driven by the decline among PLHIV. As the country works to expand the number of people on ART and adherence to treatment, the TB burden is expected to decline even further in the coming years. TB screening improvements, availability of better-quality data, high IPT uptake among HIV patients and supportive supervision, and community TB education, are among the efforts that have reduced the burden of TB in the country. Government efforts, partnership programmes, and private participation have contributed to strengthening TB care initiatives at provincial, district and community levels.

IMPROVED KNOWLEDGE OF HUMAN RIGHTS

South Africa is committed to ending AIDS in a manner that is consistent with human rights considerations. To achieve this, it is important for citizens to be aware of their rights, including access to healthcare. By comparing recent human rights survey data to earlier survey data, this report shows that the knowledge and perception of human rights and justice is increasing in the population. This improvement is attributable to efforts by government and civil society at educating the public on their rights regarding HIV/AIDS, healthcare and broader matters.

SAFETY NET CONTINUES TO EXPAND

South Africa understands that health occurs within a social context. Therefore, to mitigate the risk and impact of HIV and other health outcomes, the country has continued to expand its social grant programme for the poor and vulnerable. By 2019, about a third of the population was receiving social grants, with the majority being child support grants received by women. The country has been able to achieve this feat by continuously increasing its budget for this chunk of national expenditure. Furthermore, the NHI, the national healthcare financing system, is in its final stages of development, having been presented to Parliament and having undergone public hearing in 2019. When implemented, the NHI will provide universal health coverage to all South Africans by 2025.

AVAILABILITY OF DATA

Data for monitoring South Africa's progress towards the 10 commitments have improved in quantity and quality. For example, as a result of the recently concluded TB Prevalence Study, the WHO was able to revise its estimates of TB incidence and mortality in the country. The data from the SABSSM V study of 2017 have been useful for programme decisions and for estimation models such as the Thembisa Model. Programme data from the DHIS and testing data from the NHLS remain invaluable for assessing the status of many GAM indicators and progress towards key commitments. Also notable is that more programme data on key populations became available in the review period, with bio-behavioural data being available on sex workers and MSM in 2018 and 2019, respectively. Recent data

from Stats SA on citizens' knowledge and perception of human rights and justice in the country form part of this achievement. Furthermore, in line with Goal 8 of the NSP, SANAC structures at national and provincial levels embarked on mid-term and other reviews to inform planning and adjustments in programme implementation.

IMPRESSIVE COMMUNITY INVOLVEMENT

From the TAC winning a landslide court victory that introduced ARVs to public health facilities to Médecins Sans Frontières running the first routine public ARV clinic in the country, South African civil society played a mammoth role in triggering the country's response to HIV. Although the HIV response is now led by government, civil society organisations continue to be pivotal in the response. Through involvement in SANAC and partnerships with NDoH, Provincial DoHs, DSD and other government institutions, they support different aspects of the HIV response. As part of its multi-faceted and multi-sectoral approach, the SANAC working structure includes 18 civil society sectors in its civil society forum — a testament to the involvement of the community in the country's response to HIV, TB and STIs.

Civil society does not only act in partnership with the government. Many local and international NGOs implement HIV programmes in partnership with international organisations. For example, PEPFAR partners with more than 100 local and international NGOs working in more than 2,500 healthcare facilities, where they work in HIV prevention and treatment programmes.

CHALLENGES AND RECOMMENDATIONS

UTT PROGRAMMATIC IMPLEMENTATION CONCERNS

While there is widespread support for the UTT policy, and the SDI on ART initiative, there is strain on the country's health care system. Concerns remain that this may lead to clinic overcrowding, long waiting times and, eventually, poorer health service delivery. The quality of reported data may also be affected. More healthcare workers will need to be recruited to mitigate health system capacity constraint and training will be vital. National ARV stockouts should be prevented or at least resolved more rapidly when they occur. The government's centralised procurement of vital medicines such as antiretrovirals (ARVs), and its new medicine dispensing model, has been praised and should continue. Strategies for the delivery of medicines should be reviewed for efficiency, and the use of relevant technology, such as the Pelebox Smart Locker, should be embraced.

ACHIEVEMENT OF THE SECOND 90 TARGET BY 2020 IS A CHALLENGE

The country continues to embark on strategic efforts aimed at achieving the second UN 90% target and ensuring that the declining ART coverage gaps are completely resolved. The introduction of the UTT policy has had a profound impact on ART coverage across South Africa, but it also means that all 7.6 million PLHIV are eligible for treatment. To achieve the second 90 target by 2020, at least 1.3 million people will need to be on treatment. Sustained efforts and innovative strategies are needed to accelerate ART coverage. The required resources and operational logistics are huge, and time is short. Although this target is unlikely to be achieved by 2020, this synthesis has illustrated that, with enhanced programmatic efforts, it can be achieved by 2022 when the current NSP term ends.

ART UPTAKE IN MEN NEED TO INCREASE

An analysis of testing data and ART data by sex showed interesting patterns. As men closed the testing gap by catching up with women, the gap in ART uptake during the review period was widening. This shows that men were not initiating treatment as fast as they were testing. While men have done well to increase HIV testing, they need to do likewise in enrolling for ART. Treatment in men is important in controlling the epidemic because of unequal power balances in many heterosexual relationships, especially among adolescent girls and young women who are often infected by older men. The UTT and SDI policies, as well as recent updates in treatment guidelines, are opportunities that can be used to increase ART initiation in men. Male-specific messaging will be important to achieve the desired goal.

90-90-90 LAGGING FOR CHILDREN

The HIV MTCT rate at birth might have decreased to a low level in South Africa, but two things should be noted. First, vertical infections continue to occur after birth. Second, children younger than 15 years have achieved less than 80% for each of the 90-90-90 targets, well below the levels achieved by adult men and women. This calls for strengthening of the HIV care cascade among children, from the postnatal period to adolescence. Although the national HIV testing policy of 2016 listed adolescents as a priority group, the focus was on those aged 15 years and older. The child and adolescent population aged 1 to 14 years is relatively understudied. So, important questions would need to be answered in order to design appropriate interventions. *Of the more than 300,000 existing infections in this age group, where are most of the infections concentrated? Since the PMTCT programme is remarkably successful, where are the gaps in ART initiation concentrated? How can adherence and virological suppression be improved among children?*

LOW PROPORTION OF MDR TB PATIENTS STARTED TREATMENT

The fact that not all diagnosed MDR/RR-TB patients are started on treatment indicates that the rate of diagnosis is outstripping the rate of treatment. This should not be the case for this deadly form of TB, and the problem needs to be investigated and resolved.

ADOLESCENTS AND YOUNG WOMEN NEED CONCERTED EFFORTS

South Africa's HIV response needs to be critical in terms of programmes targeting adolescents and young women in the age group 15 to 24 years. First, they had the highest HIV incidence rate in the country and contributed one third of all new HIV infections in 2019. Second, the rate of decline of new HIV infections is faster among males than females in the 15 to 24 year age-group. Third, certain underlying attributes of this age group do not predict better HIV outcomes in the near future.

Despite the national HIV response hitherto, comprehensive knowledge among youth in South Africa remains low (less than 50%) and has barely increased in the last decade. What is interesting is that this low knowledge appears to be due to denial and disinformation. Of the five questions in the comprehensive knowledge scale, the two questions that scored the lowest in 2017 and 2019 were: *HIV risk can be reduced by having few sexual partners* (67% in the SABSSM V) and *AIDS can't be cured* (76% in the SABSSM V). These observations point to issues that should be considered when designing HIV knowledge

interventions for young people in South Africa.

It remains a problem that sexually active adolescents are not using condoms. Although comprehensive HIV knowledge is low, the knowledge on consistent condom use has been relatively high (84% in the SABSSM V). While low condom use might be explained by incomplete knowledge, the availability of condoms is a key factor. Recent updates of HIV prevention policy for South Africa schools recommend that condoms should be available in schools, but this part of the policy remains at issue. While some schools and HIV prevention programmes welcome the provision of condoms to adolescents, others frown upon the idea. Detailed analysis of HIV prevention programmes targeting youth is needed. Concerted efforts and consistent messaging across programmes may yield more dividends. Correct use of condoms remains one of the most effective way to prevent pregnancies, HIV and STIs. New strategies should focus on widely expanding condom distribution by making condoms available at non-orthodox outlets like truck stops, hair salons, petrol stations and schools.

THE CHALLENGE TO CONTINUE 2018/19 MMC ACHIEVEMENT

Having attained the annual MMC target in 2018/19, the challenge now is for South Africa to continue along the same lines and eliminate the deficit of the first two years of the current NSP term. The MMC programme is negatively affected by insufficient skilled personnel, which limits the reach of the programme. In provinces like Limpopo (Maruleng municipality and surrounding areas) and Mpumalanga (Bushbuckridge), MMC services are available for a limited period in a year in some clinics due to insufficient personnel. Those who wish to be circumcised leave their names and contact details with the nearest clinic and wait to be called when the programme starts. In such areas, the number of MMCs performed is determined by service provider supply and not demand in the community. The national MMC programme should therefore consider training more health workers to provide MMC services throughout the year or, at least more frequently, in places where there is shortage of staff.

LACK OF DATA AND REPORTING STRUCTURES ON KEY INDICATORS

The lack of data in some aspects of the HIV response hampers the M&E of key indicators for associated commitments. For example, the annual Stockouts survey, which provides evidence on medicines shortages across the country, was last conducted in 2017. Gonorrhoea and urethral discharge in men, hepatitis B and C testing, and cervical cancer screening among women living with HIV, are among the areas that suffer from lack of consistent data. In some cases, there is a complete lack of an M&E framework, where indicators and data systems have not been properly defined. For example, there is no M&E framework for stigma and discrimination for the country, thus there are no clearly documented indicators and survey questions for this area of concern.

Although more data for monitoring indicators in key populations have become available in the last few years, it is not known if there is an M&E system with defined indicators, and the periodicity for their measurements is also unknown. Also, as shown under Commitment 3, data are not available for many indicators that relate to key populations. The same is true for human rights- and community-led service delivery. SANAC, working with government, civil society and other partners, will need to champion the development of M&E

DISCUSSION AND RECOMMENDATIONS

systems and data availability for the aforementioned areas. This can be extended to a unified and comprehensive data reporting system (and centre) for all HIV, TB and other indicators under the 10 commitments — the so-called Situation Room or Data Warehouse.

STRUCTURAL FACTORS FUELLING THE EPIDEMIC IN WOMEN

Women are doing well in terms of HIV testing, ART initiation and virological suppression, but HIV incidence remains higher in women than in men. The higher HIV incidence in women is not unrelated to socio-structural HIV risk factors, such as GBV, stigma and discrimination. Gender-based violence continues to plague South African women and girls. Although the country is armed with ample legislation to ward off this public health menace, the deficiency in implementing those laws remains a hurdle. As a result, gender-based crimes and sexual offences continue to fester. Data from multiple sources leave no doubt that South Africa has one of the highest rates of GBV in the world, and that the number of violent crimes against women (including sexual offences and rapes) increased steadily from 2017 to 2019.

While a less-than-capable justice system takes a large chunk of the blame for the spate of GBV in the country, the role of societal stigma and discrimination are equally important. Like GBV, stigma and discrimination against PLHIV remains in the country. These three socio-structural determinants of HIV work synergistically to fuel the HIV epidemic, especially among women. South Africa has many programmes in place — including its massive social grants programme — to correct the economic disadvantage that portends HIV acquisition. It will now have to do the same for other socio-structural risk factors of HIV if the country is to experience an HIV-free generation by 2030. There was some traction on the part of government within the review period to suggest that the government is ready to act decisively against GBV.

The presidential summit against GBV and femicide in 2018, the launch of a new sexual offences court to affirm the rights of women and girls in the country, and the drafting of the National Gender-Based Violence and Femicide Strategic Plan are steps in the right direction. It is to be seen whether these actions will translate into implementation that turns the tide on the high GBV incidence in the country. The approach adopted by the government will need to be proactive, multi-strategic, multi-sectoral and comprehensive. The government needs to adequately enforce existing laws and address the underlying drivers of GBV, such as poverty and unhealthy gender stereotypes.

STRUCTURAL FACTORS FUELLING THE EPIDEMIC IN KEY POPULATIONS

Although South Africa has done remarkably well in creating a policy environment for achieving the 10 commitments, some work remains to be done, regarding structural factors that fuel the epidemic in key populations. A key factor is the criminalisation of sex work, which promotes GBV and hinders health-seeking behaviour. Another consideration is the poor economic realities of certain key populations that contribute to the increasing risks of HIV infection. This synthesis highlighted the opportunity for government to consider appropriate and relevant structural interventions to interrupt HIV transmission among key populations.

CONCLUSION

South Africa has the largest HIV epidemic in the world, which has put the country's health, social and economic systems under strain. From its HIV prevention efforts to running the largest ART programme in the world, the country is unrelenting in its determination to end AIDS by 2030. HIV testing is high, virological suppression is high among those on treatment, HIV and TB incidence and deaths are declining and MTCT is at all-time low. Of the 10 commitments in the UN Declaration, the country achieved five by 2019. Despite these successes, considerable work remains to be done: the high HIV incidence in youth and women needs attention; more PLHIV need to be put on treatment; critical enablers of HIV need to be arrested and funding to achieve these needs to be secured. Armed with political will and funding commitments, the country has shown grit to fight and defeat the epidemic, but the remaining battles will require sustained efforts in some aspects of the HIV response and heightened efforts in others.

REFERENCES

1. Johnson, L. F. et al. Estimating the impact of antiretroviral treatment on adult mortality trends in South Africa: A mathematical modelling study. *PLOS Medicine* 14, e1002468 (2017).
2. Statistics South Africa. Mid-year population estimates, 2019. <https://www.statssa.gov.za/publications/P0302/P03022016.pdf>.
3. Simbayi LC, Zuma K & Zungu N. South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2017. (2019).
4. Woldesenbet SA & Kufa T, Lombard C, Manda S, Ayalew K, Cheyip M. The 2017 National Antenatal Sentinel HIV Survey, South Africa. (2019).
5. National Department of Health. The 2015 National Antenatal Sentinel HIV and Syphilis Survey, South Africa. (2017).
6. South African National AIDS Council. South Africa's National Strategic Plan for HIV, TB and STIs 2017-2022. https://sanac.org.za/wp-content/uploads/2017/06/NSP_FullDocument_FINAL.pdf (2017).
7. National Department of Health. National Consolidated Guidelines for The Prevention of Mother-To-Child Transmission of HIV (PMTCT) And The Management of HIV in Children, Adolescents and Adults. (2014).
8. National Department of Health. Implementation of the Universal Test and Treat strategy for HIV positive patients and differentiated care for stable patients. [https://sahivsoc.org/Files/22%208%2016%20Circular%20UTT%20%20Decongestion%20CCMT%20Directorate%20\(2\).pdf](https://sahivsoc.org/Files/22%208%2016%20Circular%20UTT%20%20Decongestion%20CCMT%20Directorate%20(2).pdf) (2016).
9. Mshweshwe-Pakela, N. et al. Feasibility of implementing same-day antiretroviral therapy initiation during routine care in Ekurhuleni District, South Africa: Retention and viral load suppression. *Southern African Journal of HIV Medicine* 21, 6 (2020).
10. National Department of Health. 2019 ART clinical guidelines for the management of HIV in adults, pregnancy, adolescents, children, infants and neonates. <https://www.nicd.ac.za/wp-content/uploads/2019/11/2019-ART-Clinical-Guidelines-25-Nov.pdf> (2019).
11. Political declaration on HIV and AIDS: on the Fast Track to accelerating the fight against HIV and to ending the AIDS epidemic by 2030. https://www.unaids.org/sites/default/files/media_asset/2016-political-declaration-HIV-AIDS_en.pdf (2016).
12. Bello B, Ndagurwa P, Luwaca B, Motsieloa L, B. South Africa 2018 Global AIDS Monitoring Report. (2019).
13. UNAIDS. Global AIDS monitoring 2019: Indicators for monitoring the 2016 Political Declaration on Ending AIDS. (2019).
14. UNAIDS. AIDS Info. <https://aidsinfo.unaids.org/>.
15. Lilian, R. R. et al. Baseline CD4 and mortality trends in the South African human immunodeficiency virus programme: Analysis of routine data. *Southern African Journal of HIV Medicine* 20, 10 (2019).
16. Stop Stockouts Project. Stop Stockouts 4th National Survey Report (2017). <https://stockouts.org/Download/Stop%20Stockouts%20National%20Report%20Oct%202018%20High%20res.pdf> (2018).
17. Stop Stockouts Project. SSP alarmed at second line ARV and contraceptive shortages across South Africa. [https://stockouts.org/Content/Files/Stockouts%20of%20Dumiva%20and%20contraceptive%20\(1\).pdf](https://stockouts.org/Content/Files/Stockouts%20of%20Dumiva%20and%20contraceptive%20(1).pdf) (2019).
18. National Department of Health. National Department of Health Annual Report: 2018/2019. https://www.gov.za/sites/default/files/gcis_document/201911/health-annual-report.pdf (2019).
19. National Department of Health. National Department of Health Annual Report: 2016/2017. <http://www.health.gov.za/index.php/2014-08-15-12-56-31?download=2450:annual-report-2016-2017> (2017).
20. National Department of Health. National Department of Health Annual Report: 2017/2018. https://www.gov.za/sites/default/files/gcis_document/201810/doh-annual-report-2018.pdf (2018).
21. European Centre for Disease Prevention and Control/WHO & Regional Office for Europe. HIV/AIDS surveillance in Europe 2019-2018 data. file:///C:/BB/CESAR/Consultancy/2020/SANAC%20GAM/Resources/General%20pop/Undiagnosed%20cases%20in%20Europe.pdf (2019).
22. De Cock, K. M., Barker, J. L., Baggaley, R. & El Sadr, W. M. Where are the positives? HIV testing in sub-Saharan Africa in the era of test and treat. *AIDS* 33, 349-352 (2019).
23. SANAC. The National Wellness Campaign: Cheka Impilo! <https://sanac.org.za> <https://sanac.org.za/the-national-wellness-campaign-cheka-impilo>.
24. Wessels, J. et al. The updated South African National Guideline for the Prevention of Mother to Child Transmission of Communicable Infections (2019). *Southern African Journal of HIV Medicine* 21, 8 (2020).
25. National Health Laboratory Service Corporate Data Warehouse. Data on PMTCT: Email Communication. (2020).
26. Massyn N, Barron P, Day C, Ndlovu N, Padarath A, editors. The District Health Barometer 2018/19. <https://www.hst.org.za/publications/District%20Health%20Barometers/District+Health+Barometer+2018-19+Web.pdf> (2019).
27. National Institute for Communicable Diseases. Congenital syphilis quarterly surveillance report-

REFERENCES

- March 2020. https://www.nicd.ac.za/wp-content/uploads/2020/09/CSS-Quarterly-Report_March20_updated160420_submitted.pdf (2020).
28. World Health Organization. Global guidance on criteria and processes for validation: elimination of mother-to-child transmission of HIV and syphilis, 2nd edition. (2017).
29. Goga, A. et al. 13 Eliminating mother-to-child transmission of HIV in South Africa, 2002–2016: progress, challenges and the Last Mile Plan. 10 (2017).
30. National Health Laboratory Service. National Health Laboratory Service. Annual Report: 2018/2019. http://www.nhls.ac.za/assets/files/an_report/NHLS_AR_2018.pdf (2019).
31. South Africa, South Africa, & Department of Justice and Constitutional Development. The Constitution of the Republic of South Africa, 1996: as adopted on 8 May 1996 and amended on 11 October 1996 by the Constituent Assembly. (2015).
32. National Assembly Passes the Civil Union Amendment Bill–Parliament of South Africa. <https://www.parliament.gov.za/press-releases/national-assembly-passes-civil-union-amendment-bill> (2018).
33. South African National AIDS Council. South African National Sex Worker Plan 2016–2019. https://sanac.org.za/wpfd_file/south-african-national-sex-worker-hiv-plan-2016-2019/ (2016).
34. Wheeler, S. & Gernholtz, L. Why sex work should be decriminalised in South Africa. (Human Rights Watch, 2019).
35. Department of Social Development. National Drug Master Plan (4th Edition) 2019–2024., https://www.gov.za/sites/default/files/gcis_document/202006/drug-master-plan.pdf.
36. Aurumn Institute and Anova Health Institute. South African Health Monitoring Survey: A Biological and Behavioural Survey among Female Sex Workers in South Africa (SAHMS 2018). https://auruminstitute.org/images/Docs/FSW_Summary_Sheet-cleared.pdf.
37. University of California San Francisco; Anova Health Institute, National Institute for Communicable Diseases. Brief Report of the TipVal Study: An Integrated Bio-Behavioral Surveillance Survey among People who Inject Drugs. (2018). <https://globalhealthsciences.ucsf.edu/sites/globalhealthsciences.ucsf.edu/files/ibbs-intro.pdf> (2018).
38. 31. Department of Correctional Services. Department of Correctional Services Annual Report 2016/2017. 226 (2017).
39. 31. Department of Correctional Services. Department of Correctional Services Annual Report 2017/2018. 226 (2018).
40. Department of Correctional Services. Department of Correctional Services Annual Report 20018/2019. Annual Report 240 (2019).
41. Scheibe, A. et al. Understanding hepatitis B, hepatitis C and HIV among people who inject drugs in South Africa: findings from a three-city cross-sectional survey. *Harm Reduct J* 16, 28 (2019).
42. The viral hepatitis C initiative for key populations in South Africa. <http://www.tbhivcare.org/wp-content/uploads/2018/11/HEPCA4.pdf> (2018).
43. Aurumn Institute and Anova Health Institute. South African Men's Health Monitoring Survey: A Bio-Behavioural Survey among Men who have Sex with Men in South Africa (SAMHMS 2019). https://auruminstitute.org/images/Docs/South_Africa_Mens_Health_Monitoring_Study_SAMHMS2019_cleared_20Oct20.pdf.
44. Republic of South Africa. Civil Union Act, 2006. Government Gazette 497, (2006).
45. South African National AIDS Council. South African National LGBTI HIV Plan 2017–2022. (2017).
46. SANAC. South Africa Human Right Plan.
47. Pillay, D. et al. Factors influencing uptake, continuation, and discontinuation of oral PrEP among clients at sex worker and MSM facilities in South Africa. *PLOS ONE* 15, e0228620 (2020).
48. Dada, S., Burnhams, N., Erasmus, J., Lucas, W., Parry, C., Bhana, A., et.al. Monitoring alcohol, tobacco and other drug abuse treatment admissions in South Africa (2019). <http://www.samrc.ac.za/sites/default/files/attachments/2019-04-30/SACENDUFullReportPhase44.pdf> (2019).
49. Dada, S., Burnhams, N., Erasmus, J., Lucas, W., Parry, C., Bhana, A., et.al. Monitoring alcohol, tobacco and other drug abuse treatment admissions in South Africa (2019). <https://www.samrc.ac.za/sites/default/files/attachments/2019-10-16/SACENDUFullReportPhase45.pdf> (2019).
50. Dada, S., Burnhams, N., Erasmus, J., Lucas, W., Parry, C., Bhana, A., et.al. Monitoring alcohol, tobacco and other drug abuse treatment admissions in South Africa (2020). https://www.samrc.ac.za/sites/default/files/attachments/2020-10-08/SACENDU%20Full%20Report_Phase%2046_Final.pdf (2020).
51. Dada, S., Burnhams, N., Erasmus, J., Lucas, W., Parry, C., Bhana, A., et.al. Monitoring alcohol, tobacco and other drug abuse treatment admissions in South Africa (2020). <https://www.samrc.ac.za/sites/default/files/attachments/2020-11-18/SACENDUFullReportPhase47.pdf> (2020).
52. Haffeejee, F. & Maharajh, R. Addressing Female Condom Use among Women in South Africa: A Review of the Literature. *International Journal of Sexual Health* 31, 297–307 (2019).
53. Beksinska, M. et al. Lessons from the evaluation of the South African National Female Condom Programme. *PLOS ONE* 15, e0236984 (2020).
54. South African Law Reform Commission. South African law reform commission report, project 107: sexual offences adult prostitution. <https://www.justice.gov.za/salrc/reports/r-pr107-SXO-AdultProstitution-2017-Sum.pdf>.
55. Department of Women. Department of Women, Strategic Plan 2015–2020. (2015).
56. South Africa's National Policy Framework for Women's Empowerment and Gender quality.
57. Department of Environmental Affairs. National Gender Policy Framework. https://www.environment.gov.za/projectsprogrammes/environment_sector_

- genderstrategy/policy_framework.
58. Peltzer, K. & Pengpid, S. Prevalence and associated factors of enacted, internalized and anticipated stigma among people living with HIV in South Africa: results of the first national survey. *HIV/AIDS* (Auckland, NZ), 11, (2019).
 59. Duby, Z., Nkosi, B., Scheibe, A., Brown, B. & Bekker, L.-G. 'Scared of going to the clinic': Contextualising healthcare access for men who have sex with men, female sex workers and people who use drugs in two South African cities. *South Afr J HIV Med* 19, (2018).
 60. FACTSHEET: South Africa's crime statistics for 2018/19–Page 2019–The Citizen. <https://citizen.co.za/news/south-africa/crime/2178462/factsheet-south-africas-crime-statistics-for-2018-19/2019/>.
 61. South African Police Service Annual Report 2018/2019. 460 https://www.gov.za/sites/default/files/gcis_document/201911/sapsannualreport20182019.pdf (2019).
 62. South African Police Service Annual Report 2019/2020. 460 https://www.gov.za/sites/default/files/gcis_document/202012/south-african-police-service-annual-report-20192020.pdf (2020).
 63. Global AIDS Monitoring 2018: Indicators for monitoring the 2016 United Nations Political Declaration on Ending AIDS. Relief Web <https://reliefweb.int/report/world/global-aids-monitoring-2018-indicators-monitoring-2016-united-nations-political>.
 64. Declaration of the Presidential Summit Against Gender-Based Violence and Femicide. <https://www.gov.za/speeches/declaration-presidential-summit-against-gender-based-violence-and-femicide-2-nov-2018-0000> (2018).
 65. President Cyril Ramaphosa: Launch of Declaration against Gender-Based Violence and Femicide and opening of Booyens Magistrate's Court | South African Government. <https://www.gov.za/speeches/president-cyril-ramaphosa-launch-declaration-against-gender-based-violence-and-femicide-and>.
 66. Risenga Maluleke. Governance, Public Safety and Justice Survey Victims of Crime 2018/19. (2019).
 67. Young people change the narrative on HIV in South Africa. https://www.unaids.org/en/resources/presscentre/featurestories/2019/february/20190226_colour-my-hiv.
 68. South African Government. Women's Month 2019. <https://www.gov.za/WomensMonth2019>.
 69. HIV-related discrimination far too high. https://www.unaids.org/en/resources/presscentre/featurestories/2019/november/20191112_hiv-discrimination.
 70. Armstrong-Mensah, E. et al. HIV Stigma among Women and Adolescent Girls in South Africa: Removing Barriers to Facilitate Prevention. *MJA* 3, 69–74 (2019).
 71. Ramaphosa: 'SA sliding backwards on women's rights'. The South African <https://www.thesouthafrican.com/news/ramaphosa-gender-based-violence-womens-rights-2020/> (2020).
 72. Andrea Chothia. South Africa's workforce: How long will it take to equalise? The South African <https://www.thesouthafrican.com/lifestyle/gender-equality-transformation-in-south-africa-workforce/> (2020).
 73. HIV and AIDS in South Africa. Avert <https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/south-africa> (2015).
 74. National Department of Health. Integrated School Health Policy 2012. <https://serve.mg.co.za/content/documents/2017/06/14/integratedschoolhealthpolicydobeanddoh.pdf> (2012).
 75. The Presidency. National Youth Policy 2015–2020. 36 (2020).
 76. Wits RHI. National adolescent and youth health policy 2017. <http://aviwe.wrhi.ac.za/national-adolescent-youth-health-policy-2017/> (2017).
 77. Department of Basic Education. National Policy on HIV, STIs and TB for Learners, Educators, School Support Staff and Officials in all Primary and Secondary Schools in the Basic Education Sector. <https://www.education.gov.za/Portals/0/Documents/Policies/Policy%20on%20HIV%20STIs%20%20TB.pdf?ver=2018-03-23-115911-213> (2017).
 78. Shamu, S. et al. Knowledge, attitudes and practices of young adults towards HIV prevention: an analysis of baseline data from a community-based HIV prevention intervention study in two high HIV burden districts, South Africa. *BMC Public Health* 20, 1249 (2020).
 79. National Department of Health (NDoH), Statistics South Africa (Stats SA), South African Medical Research Council (SAMRC), and ICF. South Africa Demographic and Health Survey 2016. <https://dhsprogram.com/pubs/pdf/FR337/FR337.pdf> (2019).
 80. FP2020. South Africa: FP2020 Core Indicator Summary Sheet: 2018–2019 Annual Progress Report. http://www.familyplanning2020.org/sites/default/files/Data-Hub/2019CI/South_Africa_2019_CI_Handout.pdf.
 81. United Nations, Department of Economic and Social Affairs, Population Division. World Family Planning 2017–Highlights. https://www.un.org/en/development/desa/population/publications/pdf/family/WFP2017_Highlights.pdf (2017).
 82. De Wet, N., Akinyemi, J. & Odimegwu, C. How Much Do They Know? An Analysis of the Accuracy of HIV Knowledge among Youth Affected by HIV in South Africa. *J Int Assoc Provid AIDS Care* 18, 2325958218822306 (2019).
 83. Peltzer, K., Matseke, G., Mzolo, T. & Majaja, M. Determinants of knowledge of HIV status in South Africa: results from a population-based HIV survey. *BMC Public Health* 9, 174 (2009).
 84. Hall, K. et al. South African child gauge 2018. (2018).
 85. Condom Access in South African Schools: Law, Policy, and Practice. <https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1000006>.
 86. Reddy, T. & Sokomani, A. Overview of the South African social security system. (2008).
 87. South African Government. Social development. <https://www.gov.za/about-sa/social-development> (2019).
 88. Department of Health. National Health Act: National

REFERENCES

- Health Insurance Policy: Towards universal health coverage. 80 (2017).
89. Southern African Development Community. Charter of the Fundamental Social Rights in SADC (2003). (2003).
90. Southern African Development Community. Code on Social Security in the SADC. (2007).
91. 57. South African Social Security Agency. SASSA Annual Report 2018/19. <https://www.sassa.gov.za/annual%20reports/Documents/SASSA%20Annual%20Report%202018-2019.pdf> (2019).
92. UNAIDS. Social protection: a Fast-Track commitment to end AIDS — Guidance for policy-makers, and people living with, at risk of or affected by HIV. 54 (2018).
93. Govender, V., Fried, J., Birch, S., Chimbindi, N. & Cleary, S. Disability Grant: a precarious lifeline for HIV/AIDS patients in South Africa. *BMC Health Services Research* 15, 227 (2015).
94. South African Government. Education. <https://www.gov.za/about-sa/education>.
95. U.S. PEPFAR Expands DREAMS Program, Investing R1.4 billion in South Africa's Young Women. U.S. Embassy & Consulates in South Africa <https://za.usembassy.gov/u-s-pepfar-expands-dreams-program-investing-r1-4-billion-in-south-africas-young-women/> (2020).
96. Fast-Track or Off Track? How insufficient funding for key populations jeopardises ending AIDS by 2030. <https://aidsfonds.org/assets/work/file/Factsheet%20general.pdf><https://aidsfonds.org/assets/work/file/Factsheet%20general.pdf>.
97. UNAIDS and Stop AIDS Alliance. The critical role of communities in reaching global targets to end the AIDS epidemic. (2015).
98. South African Government. Nonprofit Organisations Act 71 of 1997. <https://www.gov.za/documents/nonprofit-organisations-act>.
99. Sprague, L. Progress report on defining and measuring community-led responses. 9.
100. PEPFAR is Saving Lives in South Africa. U.S. Embassy & Consulates in South Africa <https://za.usembassy.gov/our-relationship/united-states-presidents-emergency-plan-for-aids-relief-pepfar-2/pepfar-is-saving-lives-in-south-africa/>.
101. PEPFAR Partnerships with South African Organizations. U.S. Embassy & Consulates in South Africa <https://za.usembassy.gov/our-relationship/united-states-presidents-emergency-plan-for-aids-relief-pepfar-2/pepfar-partnerships-with-south-african-organizations/>.
102. Wits RHI. HSTAR. <http://www.wrhi.ac.za/expertise/detail/hstar>.
103. Avert. Types of test. Avert <https://www.avert.org/infographics/types-test> (2017).
104. Moore A, Cassidi T, Steele SJ, Shroufi A, Ntuli N, Ndani L. Self-testing: an effective means of increasing HIV-testing and status awareness. <http://programme.ias2017.org/Abstract/Abstract/4517>.
105. Lippman, S. A. et al. High Acceptability and Increased HIV Testing Frequency Following Introduction of HIV Self-Testing and Network Distribution among South African MSM. *J Acquir Immune Defic Syndr* 77, 279–287 (2018).
106. Wits RHI. Wits RHI CDC Tshwane HIV Services Strengthening Programme. <http://www.wrhi.ac.za/expertise/detail/wits-rhi-cdc-tshwane-hiv-services-strengthening-programme>.
107. National Department of Health. Voluntary Medical Male Circumcision: Project 300K Winter Campaign 2018 South Africa. <https://www.knowledgehub.org.za/system/files/elibdownloads/2019-10/300k%20Report%20-%20FINAL%20.pdf> (2018).
108. South Africa & National Planning Commission. National development plan. (National Planning Commission, 2011).
109. National Treasury. Medium-Term Strategic Framework 2019–2024.
110. National Health Insurance Bill. (2019).
111. National Treasury, Republic of South Africa. Budget Review 2015. <http://www.treasury.gov.za/documents/national%20budget/2018/review/FullBR.pdf>.
112. National Treasury, Republic of South Africa. Budget Review 2016. <http://www.treasury.gov.za/documents/national%20budget/2018/review/FullBR.pdf>.
113. National Treasury, Republic of South Africa. Budget Review 2017. <http://www.treasury.gov.za/documents/national%20budget/2018/review/FullBR.pdf>.
114. National Treasury, Republic of South Africa. Budget Review 2018. <http://www.treasury.gov.za/documents/national%20budget/2018/review/FullBR.pdf>.
115. Guthrie, T. et al. Consolidated Spending on HIV and TB in South Africa (2014/15–2016/17). 146.
116. Health Budget Brief South Africa. <https://www.unicef.org/esa/sites/unicef.org.esa/files/2019-03/UNICEF-South-Africa-2018-Health-Budget-Brief.pdf>.
117. Avert. Funding for HIV and AIDS. Avert <https://www.avert.org/professionals/hiv-around-world/global-response/funding> (2015).
118. Government welcomes PEPFAR HIV funding. SAnews <https://www.sanews.gov.za/south-africa/government-welcomes-pepfar-hiv-funding> (2019).
119. South African Government Welcomes PEPFAR HIV Funding Commitment. U.S. Embassy & Consulates in South Africa <https://za.usembassy.gov/government-welcomes-pepfar-hiv-funding-commitment/> (2019).
120. Employment Equity Act, 55 of 1998. https://www.gov.za/sites/default/files/gcis_document/201409/a55-980.pdf.
121. Oliphant, M. N. Code of Good Practice on HIV and AIDS and the World of Work. 19 (2012).
122. Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007. https://www.gov.za/sites/default/files/gcis_document/201409/a32-070.pdf.
123. Protection of Personal Information Act. 76 (2013).
124. the National Adolescent Sexual and Reproductive Health and Right Framework Strategy (2014–2019).

125. South Africa Human Right Commission. HIV/AIDS and human rights.
126. Global Fund. Baseline assessment–South Africa Scaling up Programs to Reduce Human RightsRelated Barriers to HIV and TB services. https://www.theglobalfund.org/media/8147/crg_humanrightsbaselineassessmentsouthafrica_report_en.pdf (2017).
127. Statistics South Africa. Statistical release: P0340 Governance and Access to Justice. 77 (2019).
128. Foundations for Human Rights, Department of Justice and Constitutional Development. A short report on awareness of, attitudes and access to constitutional rights. http://fhr.org.za/files/4915/5178/5240/19032018_FHR_Seja_baseline_short_report_draft_4_2.pdf (2018).
129. Parliament of South Africa. National Health Insurance (NHI) Bill. <https://www.parliament.gov.za/project-event-details/54>.
130. National Department of Health. Cervical Cancer Prevention and Control Policy. (2017).
131. World Health Organization. Global tuberculosis report 2018. (2018).
132. World Health Organization. Global tuberculosis report 2020. <https://apps.who.int/iris/bitstream/handle/10665/336069/9789240013131-eng.pdf> (2020).
133. World Health Organization. World health data platforms: indicators. <https://www.who.int/data/gho/data/indicators>.
134. World Health Organization. Global tuberculosis report 2019. (2019).
135. Samsunder, N. et al. Seroprevalence of hepatitis B virus: Findings from a population-based household survey in KwaZulu-Natal, South Africa. *Int J Infect Dis* 85, 150–157 (2019).
136. Vermeulen, M. et al. Use of Blood Donor Screening to Monitor Prevalence of HIV and Hepatitis B and C Viruses, South Africa. *Emerg Infect Dis* 23, 1560–1563 (2017).
137. Gogela, N. A., Sonderup, M. W., Rebe, K., Chivese, T. & Spearman, C. W. Hepatitis C prevalence in HIV-infected heterosexual men and men who have sex with men. *South African Medical Journal* 108, 568–572 (2018).
138. National Cancer Registry. Cancer in South Africa 2017 full report. https://www.nicd.ac.za/wp-content/uploads/2020/12/NCR_2017_Final_02dec2020.pdf.
139. National Cancer Registry. Cancer in South Africa 2015 merged report. https://www.nicd.ac.za/wp-content/uploads/2020/04/ncr_2015_merged.pdf.
140. National Cancer Registry. Cancer in South Africa 2016 full report. https://www.nicd.ac.za/wp-content/uploads/2020/04/NCR_2016_Report_updated_14April2020.pdf.
141. National Department of Health. National guidelines for the management of viral hepatitis. (2019).
142. Hecht, R. et al. The investment case for hepatitis B and C in South Africa: adaptation and innovation in policy analysis for disease program scale-up. *Health Policy Plan* 33, 528–538 (2018).