



THE REPUBLIC OF SOUTH AFRICA

2021 Global AIDS Monitoring Report

ANALYSIS OF CURRENT STATUS AND PROGRESS
TOWARDS TARGETS



Acknowledgements



REPORT PREPARATION TEAM

Prof. Pedro Pisa

Dr. Admire Chikandiwa

Layout, design, and formatting: Tamuka Sanyika

SANAC TEAM

Billia Luwaca

Lifutso Motsieloa

Mashudu Rampilo

Zwebuka Khumalo

Anthony Odama

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Arowana Healthcare

18 Touws Road, Norkem Park Ext 3, Kempton Park, 1618

Email: ahrcsa@gmail.com



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Abbreviations & Acronyms

AGYW	Adolescent Girls and Young Women	GPS	Governance, Public Safety and Justice survey
AIDS	Acquired Immunodeficiency Syndrome	HIV	Human Immunodeficiency Virus
ANC	Antenatal Care	HTC	HIV Testing and Counselling
ART	Antiretroviral Therapy	IPV	Intimate Partner Violence
ARV	Antiretroviral	LGBTI	People with Disabilities, Other Lesbian, Gay, Bisexual, Transgender and Intersex
AYP	Adolescents and Young People	MDR-TB	Multi-drug-resistant TB
CBO	Community-Based Organization	M&E	Monitoring and evaluation
CCMDD	Centralized Chronic Medicines Dispensing and Distribution	MMC	Medical Male Circumcision
CESAR	Centre for Statistical Analysis and Research	MSM	Men who have sex with men
CHC	Community Health Center	MTCT	Mother-to-Child Transmission
CHW	Community Healthcare Worker	MTEF	Medium Term Expenditure Framework
COP	Country Operational Plan	NASA	National AIDS Spending Assessment
COVID-19	Coronavirus Disease 2019	NACOSA	Networking HIV & AIDS Community of Southern Africa
CSO	Civil Society Organizations	NDMP	National Drug Master Plan
DBE	Department of Basic Education	NDoH	National Department of Health
DHET	Department of Higher Education and Training	NDP	National Development Plan
DHIS	District Health Information System	NGO	Non-Governmental Organization
DOJ&CD	Department of Justice and Constitutional Development	NHI	National Health Insurance
DSD	Department of Social Development	NICD	National Institute of Communicable Diseases
EID	Early Infant Diagnosis	NHLS	National Health Laboratory Service
eMTCT	Elimination of Mother-to-Child Transmission	NSP	National Strategic Plan for HIV, TB and STIs
FSW	Female Sex Workers	OST	Opioid Substitution Therapy
GAM	Global AIDS Monitoring	OVC	Orphans and Vulnerable Children
GBV	Gender-Based Violence	PCR	Polymerase Chain Reaction
GDP	Gross Domestic Product	PEPFAR	United States President's Emergency Plan for AIDS Relief
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria	PHC	Primary healthcare

Abbreviations & Acronyms

PLHIV	People living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PrEP	Pre-Exposure Prophylaxis
PSE	Population size estimate
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
SABSSM	South African National HIV Prevalence Incidence, Behaviour and Communication Survey
SAG	South African Government
SAHRC	South African Human Rights Commission
SANAC	South African National AIDS Council
SAPS	South African Police Service
SASSA	South African Social Security Agency
SDG	Sustainable Development Goal
SRH	Sexual and Reproductive Health
Stats SA	Statistics South Africa
STI	Sexually Transmitted Infections
SWEAT	Sex Worker Education and Advocacy Task Force
TB	Tuberculosis
Thembisa	Thembisa Model Version 4.5 Model
TPT	Tuberculosis preventive therapy
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UTT	Universal Test and Treat
WHO	World Health Organization

Introduction

This Global AIDS Monitoring (GAM) report captures the progress made by the country in its response to the HIV epidemic in 2021 comparing performance to targets and previous years performances by indicator. It also provides the status of the legal and policy environment that supported the observed achievements. This report is the first under the 2021 new UNAIDS Political Declaration on HIV and AIDS¹ and represents a departure from previous GAM reports that were based on commitments to political declarations and frameworks. Since the 2020 GAM report, there were no new legal and policy developments that happened in South Africa, therefore, this report adopts the figures used in the 2020 GAM report.

2021 NEW UNAIDS POLITICAL DECLARATION ON HIV AND AIDS

The new Political Declaration on HIV and AIDS, adopted in June 2021, is linked to the Sustainable Development Goals (SDGs)², and aligned to the Global AIDS Strategy 2021-2026³. The 2021 Political Declaration was built on four previous political declarations, namely: the 2001; 2006; 2011; and the 2016 Political Declarations on HIV and AIDS. The Global AIDS Strategy, 2021-2026, promotes using an inequalities lens and prioritizing best evidence to identify and act to close the gaps that are preventing progress towards ending AIDS. The GAM process has often been referenced as a benchmark for successful international accountability mechanisms. The lessons from past rounds serve as evidence-informed road map for timely, high-quality, and complete reporting

at an accelerated and streamlined pace. The 2021 Political Declaration indicates that a successful AIDS response should be measured by the achievement of concrete, time-bound targets. This calls for careful monitoring of progress in implementing commitments and require the United Nations Secretary-General to issue annual progress reports. This report is designed to identify challenges and constraints and recommend actions to accelerate the achievement of targets for South Africa.

In 2021, the international community reviewed progress towards reaching the 2021 targets to end AIDS, notably:

1. *Political declaration and framework 1: Combination HIV prevention for all*
2. *Political declaration and framework 2: 95-95-95 for HIV testing and treatment*
3. *Political declaration and framework 3: End paediatric AIDS and eliminate vertical transmission*

4. *Political declaration and framework 4: Gender equality and empowerment of women and girls*
5. *Political declaration and framework 5: Community leadership*
6. *Political declaration and framework 6: Realize human rights and eliminate stigma and discrimination*
7. *Political declaration and framework 7: Universal health coverage and integration*
8. *Political declaration and framework 8: Investments and resources*

The annual GAM report is the monitoring and evaluation (M&E) document that provides evidence of country progress towards the political declaration and frameworks including expanded targets. The report describes the epidemic and status of the national response, identifies challenges and constraints, and makes bold recommendations to accelerate the achievement of targets.



¹ https://www.unaids.org/sites/default/files/media_asset/2021_political-declaration-on-hiv-and-aids_en.pdf

² <https://sdgs.un.org/goals>

³ <https://www.unaids.org/en/Global-AIDS-Strategy-2021-2026>

Introduction

Additionally, the report is important to the country and its local and international partners in that it documents the country's progress towards agreed upon targets. It is also important to the country for advocacy and resource mobilization from local and international partners. Thus, this GAM 2021 report:

- Describes progress towards the new 2026 targets, hold the country and global partners to account on desired improvements
- Incorporates national and subnational data to inform the increasingly detailed HIV estimates preparation that feeds into GAM reporting
- Informs grant and operational plan preparations and review for participating in resource mobilization from various stakeholders.

POLICY AND PROGRAMMATIC RESPONSE

The HIV, TB and STI multisectoral response in South Africa is implemented as per five-year National Strategic Plans (NSP). The NSP (2017-2022) is the 4th generation strategy that has outlined the country's response over the past four years and is coming to an end. The burden of the HIV and AIDS pandemic calls for undivided political leadership and commitment to ensure that HIV and AIDS become part of the political agenda. South Africa is a signatory to several regional and global commitments to mitigate the burden of the pandemic.

More importantly, the country subscribes to the universal vision of the Joint United Nations Programme on HIV and AIDS (UNAIDS) for zero new HIV, TB and STI infections, zero new transmission of HIV and other STIs from a parent to an unborn baby, zero new deaths caused by HIV, TB and STI infections and a zero discrimination of anyone based on their HIV, TB or STI infection status⁴. The constant revision and updating of the NSP every 5 years highlight South Africa's commitment to ending the pandemic. This is augmented by the existence of the South Africa National AIDS Council (SANAC). SANAC is a multisectoral body that coordinates the country's HIV and AIDS, TB and STI response guided by the NSPs that are aligned and driven by the universal UNAIDS vision. The current 4th generation NSP has eight broad goals which are to:

- accelerate prevention to reduce new HIV, TB and STI infections
- reduce morbidity and mortality by providing treatment, care and adherence support for all
- reach all key and vulnerable populations with customised and targeted interventions
- address the social and structural drivers of HIV, TB and STIs and link these efforts to the National Development Plan (NDP)
- ground the response to HIV, TB and STIs in human rights principles and approaches
- promote leadership and shared accountability for a sustainable response to HIV, TB and STIs
- mobilise resources and maximize efficiencies to support the achievement of NSP goals and ensure a sustainable response; and,
- strengthen strategic information to drive progress towards achievement of NSP goals.

Embedded in each of these goals is an overarching principle of encouraging multisectoral participation of all civil society formations, political leadership, government departments, business and development partners.

METHODS AND DATA SOURCES

A retrospective design and analysis was applied to establish the status and progress towards targets against each political declaration and framework. More specifically, a systematic desktop review of relevant documents against each political declaration and framework (i.e., policies, strategies, laws,



⁴ https://www.unaids.org/en/AIDS_SDGs

guidelines, reports etc.) related to the HIV response to show progress to date was conducted. This included a retrospective analysis to show trends over the last 5 years (quantitative comparative data analysis). The following data sources were used to compile the report: national policies, strategies and guidelines, data from national surveys and bio-behavioral surveys, data from the Thembisa Model version 4.5 (hereinafter referred to as Thembisa Model), district health management information system (DHIS); program data; and scientific publications, GAM 2022 guidelines and the UNAIDS online data.

Under each political declaration and framework, a score card analysis is presented illustrating whether this is a priority for the country, if it is addressed in the national strategic plans, if the country reached the target and if the country is likely to reach the target by 2025 including an accurate reflection of the legal and policy environment that related to each political declaration and framework. Additionally, respective political declarations are explained as follows in the report:

1. Overview of the HIV/AIDS epidemic and epidemiology in the last 5 years: Including trends (using key selected indicators):
 - *Prevalence: Trends, age, sex, geographic areas, key populations*
 - *HIV Incidence*
 - *AIDS Mortality, etc.*
2. Achievements
3. Key challenges
4. Recommendations



Summary of Progress Towards Political Declaration and Framework Targets

Political declaration and framework 1: Combination HIV prevention for all

Data show that, overall, there was a minus 26% decline in the number of new HIV infections in South Africa. The data also show that adults 15+ years performed below the national average regarding reducing new HIV infections with females aged (15-49 years) being the major contributors to this observed relatively low performance. From a policy perspective, advocacy interventions such as the development and adoption of the national drug master plan (NDMP), the conduct of population size estimates, integrated biological and behavioural studies (IBBS), the establishment of organisations such as South African Network of People Using Drugs (SANPUD) and Community-Oriented Substance Use Programme (COSUP) continue to bring to the fore the challenges experienced by key and vulnerable populations. The development and adoption of the National Gender-Based Violence and Femicide strategy⁵, addressing increasing cases of Gender-Based Violence (GBV) and Intimate Partner Violence (IPV) was a key step towards addressing GBV and IPV as key factors in the spread of HIV. Evidence also suggests that combination prevention efforts such as PMTCT, VMMC, increase in condom use among the young population, increases in PrEP uptake by key populations and availability of PEP among survivors of sexual assault have been instrumental in reducing the number of new HIV infections.

⁵ <https://www.justice.gov.za/vg/gbv/NSP-GBVF-FINAL-DOC-04-05.pdf>

Political declaration and framework 2: 95-95-95 for HIV testing and treatment

By December 2021, data show that the country had achieved 93-77-89 against the UNAIDS 90-90-90 targets. From 2016 (7,222,340) to 2021 (7,908,090), there was about 9.5% increase in the estimated PLHIV. This increase has been attributed to new HIV infections and the increasing number of people enrolling on ART and living long. Significant progress has been made towards the first and third 90s in the total population reflecting the leakages in putting people on treatment despite the supportive legal and policy environment. Data also show that females were performing better (80%) than their male counterparts (70%) in terms of enrolling on treatment. Performance data for children indicates poor performance across the 90-90-90 cascade compared to adults. Poor performance among children in the second and third 90s are despite a relatively higher performance (80%) in the first 90. This shows that the country needs to do more to ensure children are linked to treatment and they receive further treatment support in terms of viral load testing and suppression.

Political declaration and framework 3: End paediatric AIDS and eliminate vertical transmission

A significant number of children are infected with HIV. At the end of 2021, the Thembisa Model estimates show that there were 238,244 children (<15) living with HIV in the country. Furthermore, an estimated 10,387 children became newly

infected with HIV during 2021. Close to a quarter (23%) of the 52,016 people who died of AIDS related illnesses during 2021, were children. Despite the consistent reduction in MTCT rates from 2016, data show that the country still needs to do a lot to ensure progress in addressing the HIV epidemic is inclusive of this most vulnerable population through focused interventions that address their vulnerabilities. This may include efforts to ensure knowledge of HIV status before deciding on getting pregnant among the young people, strengthening the mother and child pairing with community-based counsellors for adherence during both ANC and post-partum periods and interventions focused on early health seeking behaviour for children.

Political declaration and framework 4: Gender equality and empowerment of women and girls

In 2020, the country launched the National Strategic Plan on GBV and Femicide 2020-2030 (NCGBVF) to further provide a framework for addressing GBV and intimate partner violence (IPV). With it came the GBV and Femicide response fund, that raised 128 million Rands to address the needs and challenges faced by all, especially women across age, sexual orientation, sexual and gender identities; and specific groups such as elderly women, women who live with disability, migrant women and trans women, affected and impacted by the GBV scourge in South Africa. Despite these positive policy developments, a recent study, by Jewkes et al., 2019, conducted among 3005 FSWs linked to sex worker

programmes in 12 sites across all nine provinces of South Africa reported about 70.4% of FSWs experiencing physical violence and 57.9% were raped with perpetrators including law enforcement officials, their clients, men and intimate partners. This shows that the country still has challenges related to victimization, stigma and discrimination of some populations relating to accessing HIV services which may undermine the efforts being made by different stakeholders.

Political declaration and framework 5: Community leadership

The South African Government (SAG) has created an enabling operational environment for community-based organisations through relatively easy processes of registration, sourcing for funding, both domestic and international and implementing project activities. Various NGOs working on the HIV response implement community systems strengthening programmes targeted at strengthening the resilience of families and ensuring individuals infected and affected by HIV have access to necessary support at community level. The development and implementation of community-led monitoring systems such as the Ritshidze is evidence of community support and empowerment to own the HIV response and take responsibility for action. The government and its stakeholders should expand and scale up the Ritshidze community-led monitoring system to ensure communities take full ownership and manage the HIV response at the local level. There is need for increasing support for strengthening local CBOs capacity to apply for funding, attract and retain human resources and to consistently operate and implement HIV response activities at local level.

Political declaration and framework 6: Realize human rights and eliminate stigma and discrimination

South African statutory laws are inclusive of express measures targeted at preventing unfair discrimination against people living with HIV. Data from the 5th South Africa National HIV Prevalence, Incidence, Behavior and Communication Survey (SABSSM) showed that the levels of internalized (23%) and external (15%) stigma reported in 2020 are lower than those reported in 2014, which were 43% and 35%, respectively (Simbayi et al. 2015).

The stigma index survey report for 2020-2021 (Cloete 2022) shows that about 49.7% and 15.4% of participants reported experiences of internalized and externalized stigma, respectively. Thus, both forms of stigma increased between 2019 and 2021. Endorsement of internalised stigma was higher among males than females, and among participants aged 15–24 than those aged >25 years. Compared with those from other districts, proportionally more participants from the eThekweni district, and proportionally fewer participants from the uMgungundlovu district, endorsed measures of internalised stigma.

Reported experiences of external stigma was higher among females than males, and among those aged 25–29 than 15–24 years. Proportionally, a higher number of participants from the eThekweni district reported experiencing stigma when compared to other districts. In addition, about 5.3% of participants reported being excluded from social gatherings, 9.5% reported that family members made discriminatory remarks toward them regarding their HIV-positive status, and 9.9% reported that other people made discriminatory

remarks towards them regarding their HIV-positive status (Cloete 2022). As stigma and discrimination is experienced at the hands of the duty-bearers, government and its stakeholders need to train healthcare workers and provide information and improve their skills and understanding of human rights issues which may lead to improved quality of healthcare for LGBT people. In addition, there is need for policy development training and sensitization of judiciary and law enforcement; to protect key populations to reduce discrimination, stigmatization and harassment.

Political declaration and framework 7: Universal health coverage and integration

The country's strategic plan (NSP) makes provision for integration of health service provision including HIV, TB, STIs, Cervical Cancer, HPV, among others. It guides the commitment on the elimination, prevention and reduction of new cases of HIV, TB and STIs. During 2021, the country maintained its commitment for Universal Health Coverage (UHC) by sustaining its spending on health (8.9% of Gross Domestic Product)⁶ with a focus on strengthening resilient health systems for equitable access to services. Compared to other countries with similar economies, the country's spending on health is relatively high.

The latest available data on the country's performance on UHC, South Africa's UHC index has almost doubled in the past 20 years, from a score of 36 in 2000 to a score of 67 in 2019.⁷ The National Cancer Strategic Framework for South Africa 2017–2022, is intended to guide the development, implementation, monitoring and coordination of cancer policies, strategies and other cancer-related activities. South Africa also has a clearly articulated National Cervical Cancer Prevention and Control Policy which recommends screening for all women from the age of 30 at 10 yearly intervals until

⁶ <https://www.gov.za/speeches/minister-joe-phaahla-universal-coverage-south-africa-12-dec-2022-0000>

⁷ <https://data.worldbank.org/indicator/SH.UHC.SRVS.CV.XD?end=2019&locations=ZA&start=2019&view=bar>

they are 50 (NDOH. 2017). It also highlights more frequent screening intervals and earlier age to start screening for women living with HIV. South Africa has adopted a policy on the decentralised management of multi-drug resistant tuberculosis (MDR-TB) in 2019. The cross-referencing of diseases in different strategies is evidence of the commitment to integrating service provision. The country is also working on the modalities for the implementation and roll-out of the National Health Insurance towards universal health coverage.

Political declaration and framework 8: Investments and resources

The government of the Republic of South Africa leads the nation's response to HIV, TB and STIs, contributing the largest share of the required domestic funding, while external donors such as PEPFAR, USAID, the Global Fund, and the private sector fund the remainder of the costs (NASA. 2021).

Although actual expenditure on HIV by the government increased from R22.2 billion in 2017/18 to R26.0 billion in 2019/20, in relative contribution to other spenders, it decreased from 72% to 69% (Table 13). Donor commitment towards combating HIV in South Africa remained strong over the review years. The government of the Republic of South Africa leads the nation's response to HIV, TB and STIs, contributing the largest share of the required domestic funding, while external donors such as PEPFAR, USAID, the Global Fund, and the private sector fund the remainder of the costs (NASA. 2021). Although actual expenditure on HIV by the government increased from R22.2 billion in 2017/18 to R26.0 billion in 2019/20, in relative contribution to other spenders, it decreased from 72% to 69% (Table 13). Donor commitment towards combating HIV in South Africa remained strong over the review years. According to the South African 2021 Investment Case report⁸, the country needs about R80bn to increase retention to 95%, about R30bn for human resources retention, and about R50bn

for the additional ART. The report further indicates that this is affordable under the current budget as the total annual cost of the HIV programme remains well below the budget constraint even if all interventions are scaled up, ranging between R20bn-R25bn annually. Despite the positive outlook from the Investment Case report, following the November 2021 Medium Term Budget Policy Statement (MTBPS), civil society organisations (CSOs) raised concerns that, diminished funding to provinces, both through the equitable share and through conditional grants, may result in crucial HIV/AIDS targets being missed. The February 2021 national budget⁹ saw the baseline of the conditional grant for HIV reduced by a total of R5.8 billion over the next three years.¹⁰

<https://www.heroza.org/publications/south-african-hiv-investment-case-2021-full-report/>
<https://www.treasury.gov.za/documents/national%20budget/2021/review/FullBR.pdf>
<https://www.spotlightnsp.co.za/2021/11/30/opinion-funding-must-be-allocated-to-treat-drivers-of-hiv/>

Overview of the HIV/AIDS Epidemic in 2021

SOUTH AFRICA HIV PREVALENCE TRENDS

While HIV epidemic control is reached when the total number of new HIV infections falls below the total number of deaths from all causes among people living with HIV, the goal is to achieve population based viral suppression among HIV-infected clients and to prevent further transmission of the virus. South Africa remains the epicentre of the HIV pandemic with the largest HIV prevalence in the world, coupled with an estimated 20% of all global new HIV infections and about 20 percent of all people living with HIV (PLHIV) being recorded in the country. The overall HIV prevalence for the country increased from 13% in 2016 to 13.5% in 2021 (Figure 1). The total number of people living with HIV (PLHIV) on ART increased from about 7,222,340 in 2016 to

7,908,090 in 2021 (Thembisa Model), representing about 10% change. The increase in prevalence has been attributed, in successive National Department of Health reports (2016 – 2021), to decreasing HIV incidence, prevention measures such as PMTCT, VMMC, roll-out of pre-exposure prophylaxis (PrEP) among high-risk groups such as sex workers, post-exposure prophylaxis (PEP) for survivors of sexual assault and increasing number of people enrolling on

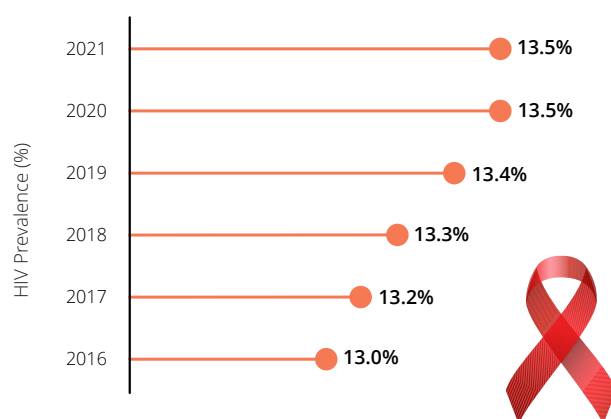
Anti-Retroviral Therapy (ART). Of the estimated 198,311 HIV new infections in 2021, about 124,395 (approximately 63%) were females above the age of 15 years while about 63,529 (~32%) were males above the age of 15 years and about 10,387 (5%) were children below the age of 15 years. According to the Thembisa Model, people of reproductive ages 15-49 years make up the largest proportion of new HIV infections in South Africa, estimated at ~83%.

Table 1: HIV prevalence by age and sex (2016-2021)

	2016	2017	2018	2019	2020	2021
Prevalence in children (<15)	2.2%	2.0%	1.9%	1.7%	1.6%	1.4%
Prevalence in youth (15-24)	7.5%	7.3%	7.2%	7.0%	6.7%	6.5%
Prevalence in males aged 15-24	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%
Prevalence in females aged 15-24	11.3%	11.0%	10.6%	10.2%	9.7%	9.3%
Prevalence in age group 15-49	19.5%	19.6%	19.7%	19.6%	19.4%	19.2%
Prevalence in males aged 15-49	13.8%	13.8%	13.8%	13.6%	13.4%	13.1%
Prevalence in females aged 15-49	25.1%	25.4%	25.5%	25.6%	25.5%	25.3%
Prevalence in age group 25-49	25.1%	25.2%	25.2%	25.1%	24.9%	24.6%
Prevalence in males aged 25-49	18.6%	18.5%	18.2%	17.9%	17.6%	17.2%
Prevalence in females aged 25-49	31.5%	31.8%	32.0%	32.1%	32.1%	32.0%
Prevalence at ages 25+	20.6%	20.9%	21.1%	21.3%	21.4%	21.6%
Prevalence in adults aged 50+	10.5%	11.3%	12.2%	13.1%	14.1%	15.2%
Prevalence in males aged 50+	9.9%	10.6%	11.3%	12.0%	12.7%	13.6%
Prevalence in females aged 50+	10.9%	11.9%	12.9%	13.9%	15.0%	16.3%

Source: Thembisa Model ver. 4.5

Figure 1: South Africa HIV prevalence (2016-2021)



Source: Thembisa Model ver. 4.5

The second 95 remains the critical gap in South Africa. This gap is evident within the 27 high HIV burden districts also supported by PEPFAR implementing partners: all but three districts—including four of the five metro areas—have achieved the first 95, while none have achieved 90% of all PLHIV with known status on ART. Complex barriers to access quality health care, client psychosocial barriers, and treatment hesitancy lead to failed treatment initiations and treatment interruptions.

SOUTH AFRICA HIV PREVALENCE BY SEX AND AGE

Table 2 presents data on HIV prevalence by age and sex. Data show a general decline of prevalence across all age groups except for males aged 15-24 (remaining constant), females aged 15-49, females aged 25-49, and ages 25+. The decreasing prevalence among children and young people aged <24 years can be attributed to prevention interventions in PMTCT, VMMC, and focused interventions such as the Determined, Resilient, Empowered, AIDS-free, Mentored and Safe (DREAMS) programmes. The increase in prevalence among the 25+ age groups can be attributed to increased efforts to identify positives and increasing incidence, particularly among the 50+ population.

HIV PREVALENCE BY GEOGRAPHICAL AREAS

South Africa HIV prevalence by province

Figure 2 compares HIV prevalence by province between 2016 and 2021. The data show that KwaZulu Natal (KZN) and Mpumalanga (MP) had the highest prevalence compared to other provinces. While prevalence remained almost the same between the two provinces (KZN and MP), there was a visible increase in Limpopo (LP), Eastern Cape (EC), Northern Cape (NC), and Western Cape (WC).

<https://www.hivdata.org.za/>

As this analysis was based on quantitative data from the Thembisa model, there is no immediate qualitative explanation of the increase in prevalence among these provinces, beyond what was reported earlier as the effects of prevention and treatment programmes.

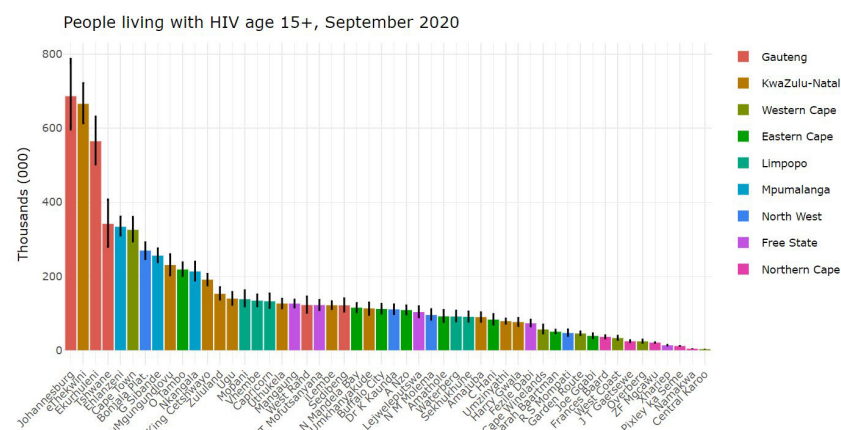
South Africa HIV prevalence by district

The Naomi Model (September 2021) indicates (Figure 3), that certain districts across multiple provinces have the highest prevalence rates across the country. In this case, the first 10 districts with the highest prevalence are in Western Cape, North-West, Gauteng, Mpumalanga, KwaZulu-Natal, and Eastern Cape. This observation buttresses the need for a district focused (focus for impact) approach to enhance service delivery in districts where they are needed the most.

HIV prevalence by key populations

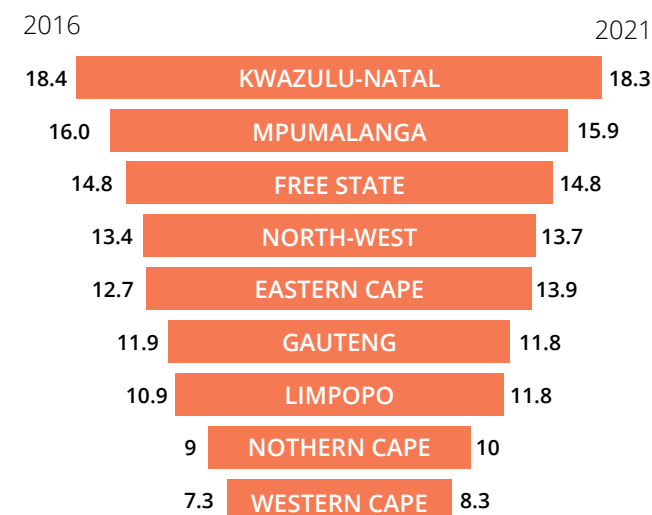
The Thembisa model provides HIV prevalence data for two key population (KP) groups: men who have sex with men (MSM) and female sex workers (FSW).

Figure 3: People living with HIV, age 15+, September 2021



Source: Naomi Model¹¹

Figure 2: South Africa HIV prevalence by province and year



Source: Thembisa Model ver. 4.5

The model shows that HIV prevalence for MSM (18+ years) was almost half (2016=33.3%; 2021=31.7%) of the HIV prevalence for FSW (2016=63.1%; 2021=61.3%).

Compared with the general population (15+), HIV prevalence among KPs was more than double which shows the disproportionate burden carried by KPs in terms of the burden of disease.

HIV prevalence among antenatal care attendees

The 2019 National Antenatal Sentinel HIV Survey shows that the overall HIV prevalence at national level was 30.0% (95% CI: 29.4%–30.6%)¹² (Woldesenbet et al., 2021). This figure was 0.7% points lower than the prevalence reported in 2017 (30.7%, 95% CI: 30.1%–31.3%), although the difference was not statistically significant. The highest overall HIV prevalence was in KwaZulu-Natal (40.9%, 95% CI: 39.6%–42.3%) followed by Eastern Cape (36.5%, 95% CI: 35.2%–37.9%). KwaZulu-Natal reported the highest HIV prevalence nationally for at least the last 5 years. The lowest overall HIV prevalence was in Western Cape at 17.9% (95% CI: 16.2%–19.7%). Nationally and in three provinces (Gauteng, Limpopo, Mpumalanga) participants attending follow-up ANC visits had significantly higher HIV prevalence (P value <0.01) compared to participants attending first-ANC-visit. This result was consistent with the 2017 survey result which also showed higher HIV prevalence among follow-up visit attendees compared to first ANC-visit attendees particularly in Gauteng, Mpumalanga, and KwaZulu-Natal (Ibid).

HIV INCIDENCE

Data from the Thembisa Model shows that, overall, the number of new HIV infections decreased from 285,258 in 2016 to 210,527 in 2021. This represents a minus 26% change between 2016 and 2021. While the political declaration and framework one below deals with HIV incidence in more detail, it is important to note that the highest decline was registered among adolescent boys and young men (ABYM) (15-24) with a minus 47% decline and the lowest change was registered among the 50+ age group with an overall increase from 1,440 in 2016 to 1,861 (29% increase) in 2021.



¹² A confidence interval is defined as the range of values that we observe in our sample and for which we expect to find the value that accurately reflects the population

Political Declaration and Framework 1: Combination HIV prevention for all

SCORECARD ANALYSIS

INDICATOR	RESULT
Is indicator/topic relevant?	Yes
Is it addressed in the national strategic plan	Yes
Has the country reached the framework target?	No
How likely is the country to reach the target by 2025?	Unlikely

LEGAL AND POLICY ENVIRONMENT

The history of the South African legal and policy framework for the prevention of new HIV infections is characterized by frantic developments with new policies being developed and implemented across the country. The policies were targeted at different population groups that were deemed at higher risk of contracting HIV. These included young people (15-24 years), children (<15), pregnant women and key populations. To that end, policies such as those highlighted in Figure 4 were developed and implemented. The emphasis of focus on these population groups in the National Strategic Plan for HIV, TB and STIs 2017-2022 (NSP), Sex Worker strategy and the national drug master plan, among others demonstrated the country's commitment to reduce new HIV infections.

Other key interventions that demonstrated this commitment include the introduction of fixed-dose combination (FDC) to reduce treatment attrition, enhance viral suppression and ultimately reduce the number of new infections (treatment as prevention). Community-based interventions championed by community health workers (CHWs) such as mother-baby pairing also helped ensure HIV positive pregnant and lactating women are put on treatment to eliminate the chance of transmitting HIV to their unborn and born children.

For key populations, continued advocacy activities have resulted in the expansion (although not enough) of interventions around addressing HIV service access by key populations such as PWUD. Examples of such interventions that informed the development and adoption of the national drug master plan (2019-2024) (NDMP) include the conduct of population size estimates, biological and behavioural studies (BBS), the establishment of organisations such as South African Network of People Using Drugs (SANPUD) and Community-Oriented Substance Use Programme (COSUP), among others. In 2020, the South African Government (SAG) developed and adopted the National Gender-Based Violence and Femicide strategy¹³ to address increasing cases of Gender-Based Violence (GBV) and Intimate Partner Violence (IPV).

Figure 4: South African legal and policy environment for the prevention of new HIV infections



Source: Bello et al., 2021

¹³ <https://www.justice.gov.za/vg/gbv/NSP-GBVF-FINAL-DOC-04-05.pdf>

Table 2: Number of new HIV infections and percentage change (2016-2021)

	2016	2017	2018	2019	2020	2021 IR**(%)
Prevalence in children (<15)	2.2%	2.0%	1.9%	1.7%	1.6%	1.4%
Prevalence in youth (15-24)	7.5%	7.3%	7.2%	7.0%	6.7%	6.5%
Prevalence in males aged 15-24	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%
Prevalence in females aged 15-24	11.3%	11.0%	10.6%	10.2%	9.7%	9.3%
Prevalence in age group 15-49	19.5%	19.6%	19.7%	19.6%	19.4%	19.2%
Prevalence in males aged 15-49	13.8%	13.8%	13.8%	13.6%	13.4%	13.1%
Prevalence in females aged 15-49	25.1%	25.4%	25.5%	25.6%	25.5%	25.3%
Prevalence in age group 25-49	25.1%	25.2%	25.2%	25.1%	24.9%	24.6%
Prevalence in males aged 25-49	18.6%	18.5%	18.2%	17.9%	17.6%	17.2%
Prevalence in females aged 25-49	31.5%	31.8%	32.0%	32.1%	32.1%	32.0%
Prevalence at ages 25+	20.6%	20.9%	21.1%	21.3%	21.4%	21.6%
Prevalence in adults aged 50+	10.5%	11.3%	12.2%	13.1%	14.1%	15.2%
Prevalence in males aged 50+	9.9%	10.6%	11.3%	12.0%	12.7%	13.6%
Prevalence in females aged 50+	10.9%	11.9%	12.9%	13.9%	15.0%	16.3%

** Incidence ratio- the number of cases that would occur in a community if the disease rate in a larger reference population (usually the state or country)

occurred in that community Source: Thembisa Model

HIV INCIDENCE

This indicator measures progress towards ending the AIDS epidemic. The overarching goal of the global AIDS response is to reduce the number of people newly infected to less than 200 000 in 2030. Monitoring the rate of people newly infected over time measures the progress towards achieving this goal. This indicator is one of the 10 global indicators in the World Health Organization (WHO) consolidated strategic information guidelines. Data in Table 3 show that, overall, there was a minus 26% decline in the number of new HIV infections in South Africa. The data also show that adults 15+ years performed below the national average with females aged (15-49 years) being the major contributors to this

observed relatively low performance.

Table 3: Key populations size estimates, HIV testing, condom use and HIV prevention service coverage

INDICATORS	2018	Data Source	2019	Data Source	2020	Data Source	2021	Data Source
Total HIV incidence rate	0.48%	Thembisa Model V4.5	0.44%	Thembisa Model V4.5	0.39%	Thembisa Model V4.5	0.39%	Thembisa Model V4.5
Estimates of the size of key populations								
Sex Workers					146,048	JHU	146,048	University of California, San Francisco (2021) Consensus Cascades
MSM					309,686	JHU	91,167	University of California, San Francisco (2021) Consensus Cascades

ESTIMATES OF THE SIZE OF KEY POPULATIONS

Table 3 presents data on population size estimates (PSE), HIV testing, HIV prevalence, condom use and HIV prevention service coverage among key populations. PSE data enables the government and its stakeholders to plan for HIV services for the target populations. Regarding incidence, compared to the general population, HIV prevalence among key populations remains disproportionately high, with sex workers being the most affected.

HIV testing coverage was high across all key populations save for People Who Inject Drugs (PWID) with a relatively lower rate (79.8%). There was limited data on condom use among key populations except for Transgender (TG) people with a 76.6% condom usage rate. Coverage of HIV prevention programmes among key populations remains very low with an achievement below 40% across all categories. The worst affected are TG people with a coverage rate of 2.2%.

Table 3: Key populations size estimates, HIV testing, condom use and HIV prevention service coverage

INDICATORS	2018	Data Source	2019	Data Source	2020	Data Source	2021	Data Source
PWID					82,500	GI	34,000	University of California, San Fransisco (2021) Consensus Cascades
Transgender people					139,666	Setswe	179,327	University of California, San Fransisco (2021) Consensus Cascades
Prisoners	164,129	DCS	162,875	DCS	154,449	DCS	155,069	DCS Annual Report
HIV prevalence among key populations								
Sex workers	63.2%	Thembisa Model V4.5	62.1%	Thembisa Model V4.5	60.9%	Thembisa Model V4.5	59.5%	Thembisa Model V4.5
MSM	32.10%	Thembisa Model V4.4	31.7%	Thembisa Model V4.4	31.1%	Thembisa Model V4.4	30.5%	Thembisa Model V4.5
PWID					21.8%	UNAIDS	14.0%	TIPVAL Study, Nov 2018
Transgender people			51.9%	Botshelo Ba			52%	Scheibe et al., 2019
Prisoners			17.0%	DCS	17.5%	DCS	19.60%	DCS Annual Report
HIV testing among key populations (Percentage of PLHIV diagnosed)								
Sex workers	91.6%	Thembisa Model V4.4	92.3%	Thembisa Model V4.4	93.4%	Thembisa Model V4.4	95%	Thembisa Model V4.5
MSM	75.2%	Thembisa Model V4.4	77.0%	Thembisa Model V4.4	79.5%	Thembisa Model V4.4	89%	Thembisa Model V4.5
PWID	69.2%	KP Consensus Estimates					79.8%	UNAIDS Fact Sheet
Transgender people			96%	Botshelo Ba Trans			no data	
Prisoners							99.90%	DCS Annual Operational Plan
Condom Use among key populations								
Sex Workers							76%	The Aurum Institute
MSM							74%	The Aurum Institute
PWID							no data	
Transgender people							76.60%	HSRC (2019). The Botshelo Ba Trans Study
Prisoners							no data	
Coverage of HIV prevention programmes among key populations								
Sex workers							no data	
MSM							31%	Programme data (AFSA, Beyond Zero, NACOSA)
PWID							21.8%	Programme data (AFSA, Beyond Zero, NACOSA)
Transgender people							2.20%	Programme data (AFSA, Beyond Zero, NACOSA)
Prisoners							no data	

Source: Bello et al., 2021

HIV PREVENTION PROGRAMMES IN PRISONS

Table 4 presents data on HIV prevention programmes in prisons. The data show a declining trend in the number of condoms distributed among prisoners between 2016 (1,967,109) and 2021 (1,270,455). Similarly, the number of prisoners tested for HIV, PLHIV among prisoners and prisoners receiving ART declined during the same period. However, the number of prisoners with TB/HIV co-infection increased from 497 in 2016 to 790 in 2021.

A review of data shows that hepatitis C data were only reported for the first time in 2021. About seven (7) prisoners were reported to be infected with hepatitis C during 2021 while about 3.3% were co-infected with HIV and hepatitis C during the same period.

SAFE INJECTING PRACTICES AMONG PEOPLE WHO INJECT DRUGS

South African health policy supports evidence-based interventions for people who use drugs. For example, the NDMP (2019–2024) recommends access to the WHO-recommended package of comprehensive HIV prevention, treatment and care services for people who inject drugs. Similarly, the South African National Strategic Plan on HIV, TB and STIs (2017–2022) refers to the provision of harm reduction services, specifically Opioid Substitution Therapy (OST) and needle-and-syringe programmes. There was no data available on the number of people on OST and the number of needles and syringes distributed for 2021. Previously, it was reported that needle and syringe services distributed an average of 76 needles per person using the service per year, ranging from 52 per person in Pretoria to 174 in Cape Town (Scheibe et.al 2019).

Table 4: HIV prevention programmes in prisons

Indicator	2016	2017	2018	2019	2020	2021
Number of condoms distributed to prisoners	1,967,109	0	2,436,068	1,703,891	1,169,999	1,270,455
Number of prisoners receiving antiretroviral therapy	25,190	0	27,171	25,522	23,570	24,145
Number of prisoners tested for HIV	156,049	0	158,257	57,027	93,333	140,743
Percentage of people living with HIV among prisoners			8.90%			*19.6%
Number of people living with HIV among prisoners	37,029	0	14,111	25,825	23,782	24,321
Number of prisoners with TB or co-infected with HIV and TB	497	0	1,777	421	634	790
Percentage of prisoners co-infected with HIV and hepatitis C virus						3.3%

Source: UNAIDS Online Tool

The NDMP (2019–2024) includes these two interventions as part of the WHO-recommended package of services. The South African National Hepatitis Action Plan recommends access to viral hepatitis services that include access to harm reduction services for people who inject drugs.

National Guidelines for the Management of Viral Hepatitis (2019) is targeted at individuals at higher risk for HCV (DoH 2019) and this include: people who inject drugs; recipients of blood, blood products and solid organ transplant before 1992; unsafe medical injection practices; occupational exposure; chronic haemodialysis; high-risk/traumatic sexual practices; men who have sex with men; use of intranasal cocaine; piercing, tattooing or acupuncture; surgical procedures without proper sterilisation procedures, traditional/cultural practices such as circumcision and scarification rituals. Despite existing policies that embrace drug harm reduction, population- and individual-level interventions have focused largely on the singular goal of abstinence. This greatly impacts the human rights of people who use drugs and their communities. The failure to

implement comprehensive harm reduction measures violates the country's obligations in international human rights law and public health.

As in many settings globally, in South Africa, people who use drugs are criminalised and face high levels of stigma and discrimination (Scheibe et al., 2017). Access to harm reduction services is limited and almost exclusively provided by non-profit organisations. The first needle and syringe service in South Africa was established in Cape Town in 2012, focusing on men who have sex with men (MSM) (Semugoma et al., 2017). In 2015, this service transitioned to a different service provider and was accessible to a wider range of PWID.

In the same year, needle and syringe services were established in Durban and Pretoria (Scheibe et al., 2017) and small OST demonstration projects have been operating in these cities since 2017 (Scheibe et al., 2018). To date, harm reduction services have focused on HIV risk reduction, with very little focus on HCV (Scheibe et al., 2017).

Data around HBV and HCV epidemiology among PWID in South Africa are limited to programmatic data and small, single site studies. More recently, 27% of MSM that use drugs who participated in a study in Cape Town (n = 41) were HCV antibody positive. Among them, 80% had injected heroin or methamphetamine in the previous 3 months (Semugoma et al., 2017).

NEEDLES AND SYRINGES DISTRIBUTED PER PERSON WHO INJECTS DRUGS

Harm reduction approaches and related interventions are supported by a large body of evidence. Explicit support for needle-and-syringe services is included in the South African National Strategic Plan for HIV, TB and STIs (2017–2022), the National Drug Master Plan (2019–2024) (The overarching South African government policy outlining the national response regarding drug control and related interventions) and the National Hepatitis Action Plan. By July 2020, needle-and-syringe services existed in nine South African health districts (Scheibe et al., 2020).

Between 14% and 21% of the estimated 75,000 people who inject drugs in South Africa are living with HIV. For HIV epidemic control among people who inject drugs, the WHO recommends needle and syringe programmes (providing 300 needles per person per year), OST (coverage of at least 40%), HIV testing and counselling, and that all people diagnosed with HIV initiate antiretroviral therapy (Scheibe et al., 2019). In total, 7316 people accessed the needle and syringe programmes (361 in Port Elizabeth, 541 in Durban, 700 in Cape Town, 1365 in Johannesburg, 4349 in Pretoria) (*Ibid*).

COVERAGE OF OPIOID SUBSTITUTION THERAPY (OST)

In South Africa, OST is provided as maintenance as part of out-patient services through private practitioners, through self-funded programmes at selected tertiary hospitals and through university- and civil-society-implemented programmes. OST programming is supported by the National hepatitis action plan and guidelines, the National Strategic Plan for HIV, TB and STIs (2017-2022), the Health Sector Drug Master plan (2019-2025) and the National Drug Master Plan (2019-2024) (see Figure 5).

Figure 5: South African policy framework supporting OST programming



OST, as maintenance, boasts higher retention in treatment and reduced use of un-prescribed opioids than managed withdrawal (detoxification); however, despite the sub-optimal outcomes of the latter, detoxification is still widely used (Bruneau et al., 2018).

Methadone, buprenorphine, and buprenorphine-naloxone are registered for OST use in South Africa. Efforts are underway to get these medications onto the Essential

Medicine List (EML) for use at primary care level, to lower cost and support clinicians around safe and effective OST service delivery. In South Africa, naloxone can be administered only by healthcare professionals. A 2019 harm reduction coverage study in three cities in South Africa (Pretoria, Durban, Cape Town), demonstrated that only 260 people were on OST, representing only 4% coverage across cities (from 0% in Port Elizabeth, 1% in Durban, n = 8, 4% in Pretoria, n = 157, to 8% in Cape Town, n = 55). Only 24% (n = 1773) of people were tested for HIV over the period.

HIV testing ranged from 15% in Pretoria and 26% in Johannesburg to 49% in Port Elizabeth and 57% in Cape Town. Of those tested, an average of 33% (598 of 1773) were diagnosed with HIV. Diagnosis rates ranged from 3% in Cape Town to 45% in Johannesburg.

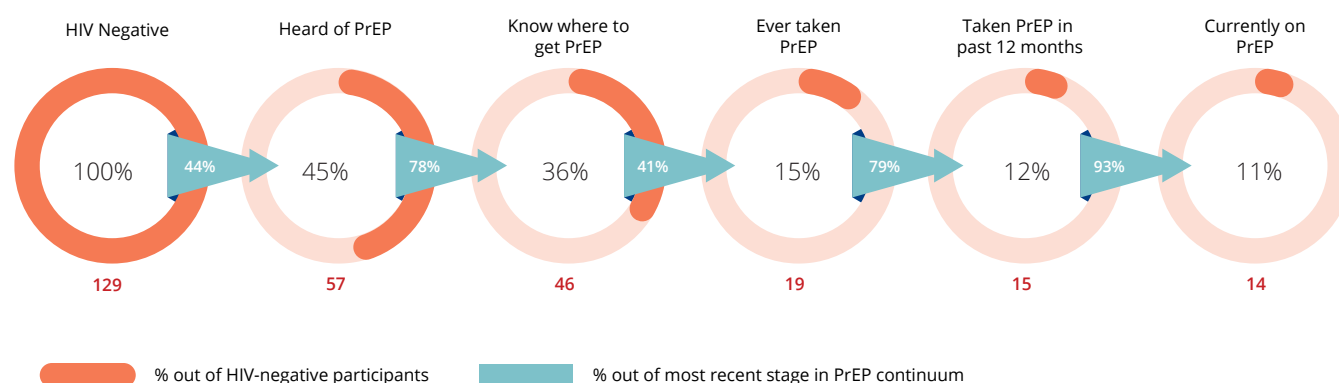
On average, only 20% of those diagnosed with HIV had started ART. This again ranged from 6% in Durban to 65% in Johannesburg (Scheibe et al., 2019).

PEOPLE WHO RECEIVED PREP

Table 5 presents data on people receiving PrEP products during the reporting period. The data show that there were more females accessing PrEP compared to males and very few TG people accessing PrEP. The reason for having more females could be due to the country's focus on key populations such as female sex workers. This focus on sex workers is observed in the number of people who received PrEP at least once during the reporting period with the following observed distribution: sex workers, 6,508; TG people, 179; MSM, 90; PWID, 21 and Prisoners, 2,104. The data point to the need to expand the availability of PrEP and other prevention interventions for key populations to reduce new HIV infections in this population.

A study conducted in South Africa focusing on improving engagement of TG women in PrEP or HIV treatment and care stated that half of HIV negative transgender women respondents (45%) had ever heard of PrEP (Poteat 2019; Poteat 2021).

Figure 6: PrEP care continuum amongst HIV-negative transgender women



Source: Pateat et al., 2020

Table 5: Number of people who received any PrEP product

Number of people who received any PrEP product at least once during the reporting period						
	Total	Males	Females	Transgender	Gender unknown	Number
All	346,667	74,817	271,667	179	4	300,674
<15	4203	651	3,552			3,637
15-19	95,566	7036	88,528		2	86,272
20-24	112,687	16,987	95,698		2	99,691
25-49	119,335	46,118	73,217			97,915
50+	7,270	3,708	3,562			5,553
If disaggregation by specific age groups are not available, please provide the total number of people who received PrEP aged 15+				179		
Age unknown	7,606	317	7,110	179		7,606
Number of people who received any PrEP product for the first time in their lives during the reporting period	300,674	62,555	237,936	179	4	300,674

Source: DOH (PrEP data input form)- based on UNAIDS GAM report (2021)

Of those who had heard of PrEP, 41% reported knowing other transgender women who were taking PrEP. From the same study, a greater proportion of transgender women who had never heard of PrEP reported HIV risk perception (Poteat 2020). The data from this study show that the actual usage of PrEP among this population declines from these higher knowledge proportions (Figure 6).

PREVALENCE OF VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC)

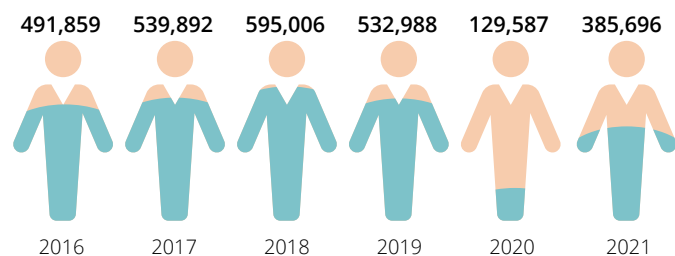
VMMC coverage increased from 49% in 2016 to about 60.8% in 2021. Data by age show that young people aged 10-14 and those in the 25-49 age categories had the highest number of circumcisions conducted during the 2016-2021 period (Figure 7).

This distribution agrees with both science around the impact of VMMC on HIV infection and the population focus by the country in terms of VMMC during the period.

ANNUAL NUMBER OF MALES VOLUNTARILY CIRCUMCISED

Figure 8 presents data on the total number of VMMCs conducted for the period 2016 to 2021. The data show an initial increase from 2016 to 2018 followed by a slight drop in 2019 and a substantial drop in 2020 before an increase in 2021. The drop in 2020 reflects the challenge associated with COVID-19 service disruption but the 2021 performance is encouraging as it shows an upward trend and slowly returning to pre-COVID-19 performance levels.

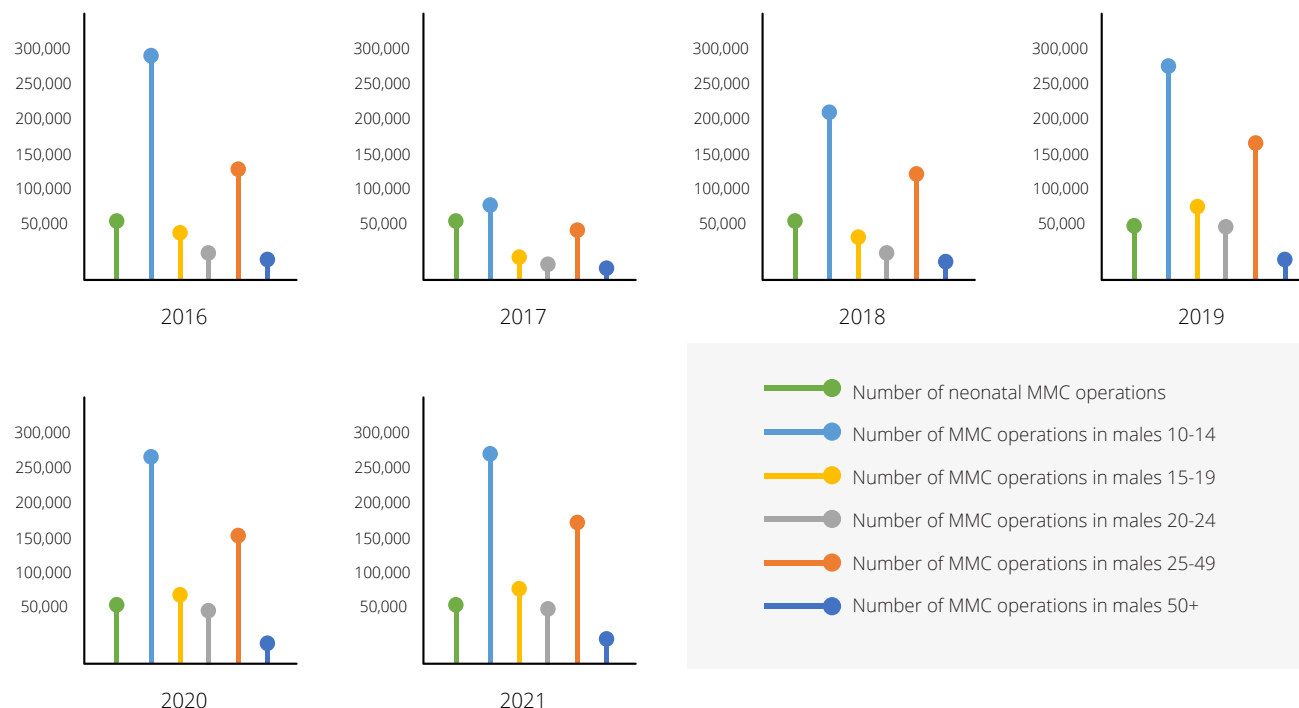
Figure 8: Annual number of VMMCs conducted (2016-2021)



Source: DOH annual reports

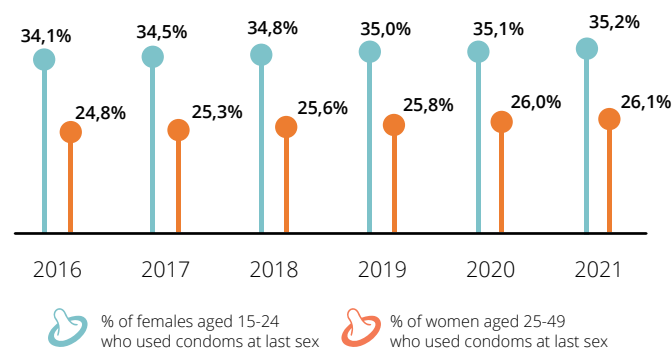
Figure 9 compares condom usage at last sex among females (15-24) and women (25-49) for the period 2016 to 2021. Overall, the data show a higher condom usage among the younger population (15-24) compared to the older population (25-49). Generally, condom usage was very low for both populations with performance below 30% throughout the period although it has shown some slight improvement.

Figure 7: Number of VMMCs conducted by age (2016-2021)



Source: Thembisa Model

Figure 9: Condom use at last sex (2016-2021)



Source: UNAIDS Online Tool

ANNUAL NUMBER OF CONDOMS DISTRIBUTED

Condom distribution has shown a fluctuating decline between 2016 and 2021 (Table 6). The numbers dropped from a total of about 943 million in 2016 to around 550 million in 2021. The declining number of condoms distributed poses a threat to the country's efforts to prevent new infections and with data showing its usage remains low.

⁷ <https://www.justice.gov.za/vg/gbv/NSP-GBVF-FINAL-DOC-04-05.pdf>

Table 6: Annual number of condoms distributed (2016-2021)

Condoms	2016	2017	2018	2019	2020	2021
Male	917,253,117	685,834,938	726,202,616	642,886,644	536,110,671	534,959,326
Female	26,055,205	25,376,969	17,658,915	16,632,792	16,803,855	17,303,835
Total number of condoms distributed	943,308,322	711,211,907	743,861,531	659,519,436	552,914,526	552,263,161

Source: National DoH annual report

YOUNG PEOPLE: KNOWLEDGE ABOUT HIV PREVENTION

A person's degree of accurate knowledge about HIV transmission is a prerequisite for their engaging in HIV prevention practices. However, such knowledge does not necessarily result in behavioural change or an effort to prevent HIV infection. According to the South African national HIV prevalence, incidence and behaviour survey (2017), the extent of accurate knowledge about the sexual transmission of HIV and the rejection of misconceptions about HIV transmission, among people aged 15 years and older was low. Just over a third of people (36.3%) aged 15 years or older displayed accurate knowledge about the sexual transmission of HIV, with no difference between males and females. Younger age groups were substantially more knowledgeable about the transmission of HIV than adults aged 50 years and older (15-24 years: 36.1%; 25-49 years: 38.7%; 50+ years: 30.8%). Regarding the racial breakdown, among people aged 15 years and older, whites (50.2%) had the highest proportion of accurate knowledge, followed by Indians/Asians (42.8%). Coloureds (38.8%) and black Africans (34.2%) had similar levels of accurate knowledge (Shisana et al., 2017).

ACHIEVEMENTS

- From a policy perspective, advocacy interventions such as the development and adoption of the national drug master plan (NDMP), the conduct of population size estimates, biological and behavioural studies (BBS), the establishment of organisations such as South African Network of People Using Drugs (SANPUD) and Community-Oriented Substance Use Programme (COSUP) continue to bring to the fore the challenges experienced by key and vulnerable populations
- The development and adoption of the National Gender-Based Violence and Femicide strategy¹⁴ to address increasing cases of Gender-Based Violence (GBV) and Intimate Partner Violence (IPV) is a key step towards addressing GBV and IPV as key factors in the spread of HIV
- Evidence suggests that combination prevention efforts such as PMTCT, VMMC, increase in condom use among the young population, increases in PrEP uptake by key populations and availability of PEP among survivors of sexual assault have been instrumental in reducing the number of new HIV infections (NDOH Annual Report, 2021)
- Increasing availability of data from different studies including PSE and BBS on key populations help informed

evidence-based planning for key populations programme

KEY CHALLENGES

- With a higher HIV burden globally, the country continues to struggle with closing the tap on new HIV infections and reaching its target of incidence reduction by 50% (achieving –minus 31% decline in new HIV infections)
- HIV incidence continue to increase among females in the 50+ age group. For example, the number of new HIV infections among this group increased between 2016 and 2021 from 14,589 to 15,393, respectively
- Delivery in 10 to 19 years in facility rates increased by almost double from 7.3% in 2016/17 to 13.2% in 2019/20 (District Health Barometer 2020). This is a proxy for risky sexual behaviour among the young population
- The COVID-19 epidemic and its related restrictions negatively impacted the HIV response through temporary suspension of research, diversion of key resources for HIV care, treatment and support, and limited patient access to health care facilities (Karim and Baxter 2022)
- The country continues to struggle with reaching the second 90 targets having only achieved 78% of all clients eligible for HIV treatment.
- Continued decriminalization of sex work leads to increased vulnerability of sex workers to HIV infection
- Condom use among 15-49 years remains very low ranging between 26% (15-24 years) to 35% (25-49 years)
- Despite the increase in the rollout of PrEP, evidence still shows that knowledge and uptake of PrEP among key populations, for example TGs, remains very low below 50%
- A 2019 study in three cities in South Africa (Pretoria,

¹⁴ <https://www.justice.gov.za/vg/gbv/NSP-GBVF-FINAL-DOC-04-05.pdf>

Durban, Cape Town), on harm reduction coverage, demonstrated that only 260 people were on OST, representing only 4% coverage across cities (from 0% in Port Elizabeth, 1% in Durban, n = 8, 4% in Pretoria, n = 157, to 8% in Cape Town, n = 55)

- Despite the South African National Strategic Plan for HIV, TB and STIs (2017–2022), the National Drug Master Plan (2019–2024) and the National Hepatitis Action Plan including needle-and-syringe programmes, continued human rights violations among those needing these services hamper efforts to contain HIV among them.

RECOMMENDATIONS

- There is need for political and financial support to ensure that the well-developed policy, institutional and legal framework in the country finds expression at community level where PLHIV access HIV services. This can be achieved through making funds more available to community-based organisations and supporting active participation of political leadership at that level
- Intensify the development and implementation of innovative models and interventions targeted at behaviour change, such as 'You Only Live Once' and 'Men championing change' programmes, particularly among the young people to reduce risky sexual behaviour and new HIV infections.
- Given that most people are living longer on ART and that some methods of HIV prevention, such as VMMC, have been proven to be effective, government and its stakeholders should sustain communication messaging emphasizing that everyone in the country is still at risk of HIV. This could include the development of educational interventions to capture specific risk factors for each

target group

- As evidence suggest that HIV infection among children is high during breastfeeding, there is need to expand community level interventions that worked well for antenatal care such as the pairing of pregnant and lactating mothers with community-based counsellors to ensure adherence to treatment for those who are HIV positive and PrEP for those who are HIV negative
- Voluntary medical male circumcision and condom use increase, particularly among young people have been shown to have significantly contributed to reduced HIV incidence. The country needs to expand on these services through interventions seeking to promote consistent and correct usage of condoms and increase VMMC coverage
- As evidence has found long-acting injectable cabotegravir to be acceptable, safe, and highly effective in preventing the spread of HIV¹⁵, the country needs to make financial commitments and making the drugs available to all eligible and at-risk populations
- As incidence has increased among the 50+ age group, and particularly among women, the country should conduct studies to investigate factors that maybe influencing this trend with the goal to develop and implement interventions to stop this increase.

¹⁵ <https://www.who.int/news/item/28-07-2022-who-recommends-long-acting-cabotegravir-for-hiv-prevention#:~:text=WHO%20today%20released%20new%20guidelines,substantial%20risk%20of%20HIV%20infection.>

Political Declaration and Framework 2: 95-95-95 for HIV testing and treatment

SCORECARD ANALYSIS

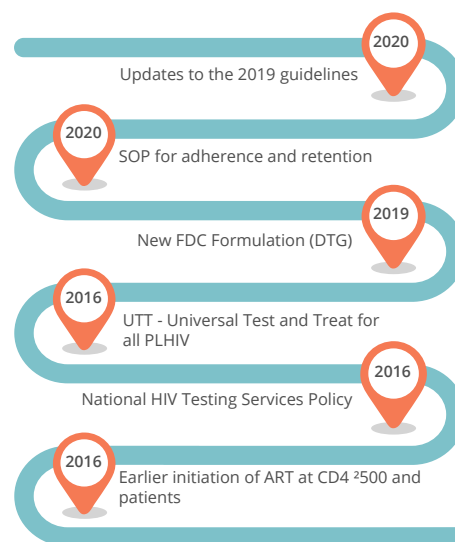
INDICATOR	RESULT
Is indicator/topic relevant?	Yes
Is it addressed in the national strategic plan	Yes
Has the country reached the framework target?	No
How likely is the country to reach the target by 2025?	Unlikely

LEGAL AND POLICY ENVIRONMENT

Since the 2020 GAM report, there hasn't been changes to the policy and legal environment for HIV testing and treatment with the recent treatment guidelines being the 2019 ART Clinical Guidelines for the Management of HIV in Adults, Pregnancy, Adolescents, Children, Infants and Neonates (Figure 10). These guidelines were anchored by the 2016 Universal Test and Treat (UTT) guidelines of 2016 which aimed to making ART available to all PLHIV irrespective of CD 4 count while the 'same-day initiation' guidelines of 2017 aimed to put PLHIV on treatment withing seven days of diagnosis. The 2020 report highlights the March 2020 NDoH updated Adherence guidelines as another important development under which the Standard Operating

Procedures (SOPs) were developed as a minimum package of interventions to support linkage, adherence and retention in care. The aim of the SOPs is to enable the delivery of differentiated effective care to stable HIV clients within the healthcare system. The SOP provides standardized updated education and counselling, innovative strategies for repeat prescription, and patient tracing and reengagement, amongst others.

Figure 10: HIV testing and treatment legal and policy framework



Source: Bello et al., 2021

95-95-95. HIV TESTING AND TREATMENT

Figure 11 presents the 90-90-90 cascades for PLHIV in South Africa as of December 2021. The data show that the country is lagging in terms of ART and viral load coverage across all population types.

Significant progress has been made towards the first and third 90s in the total population reflecting the leakages in putting people on treatment despite the supportive legal and policy environment.

Data also show that females were performing better (80%) than their male counterparts (70%) in terms of enrolling on treatment. Performance data for children indicates poor performance across the 90-90-90 cascade compared to adults.

Poor performance among children in the second and third 90s are despite a relatively higher performance (80%) in the first 90. This shows that the country needs to do more to ensure children are linked to treatment and they receive further treatment support in terms of viral load testing and suppression.

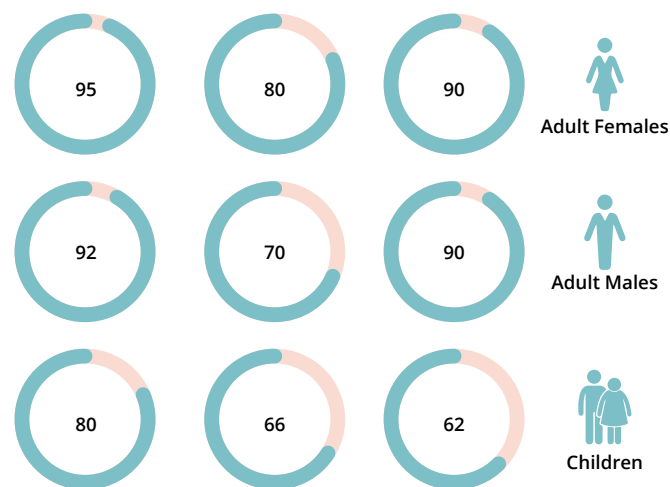
Figure 11: 90-90-90 cascades for PLHIV

SA is currently at 93-77-89 for the total population serviced through the public and private sector.



Source: DOH (2022)

Results for each of the sub-populations vary, with

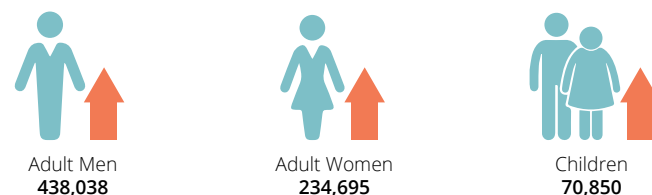


Source: DOH (2022)

Number of people living with HIV

Figure 12 presents data on the number of people estimated to be living with HIV between 2016 and 2021. From 2016 (7,222,340) to 2021 (7,908,090), there was about 9.5% increase in the estimated PLHIV. This increase has been

To achieve 90-90-90 targets, SA must increase the number of:



Source: DOH (2022)

Data available in the private sector indicates that an additional:



Source: DOH (2022)

attributed to new HIV infections and the increasing number of people enrolling on ART and living long.

1st 90- People living with HIV who know their status

The country has achieved the UNAIDS's 1st 90 in the total population by achieving 93%. However, children are still performing below the target at 80%. Females were ahead of males in terms of knowledge of HIV status having reached 95% compared to 92% for males.

2nd 90- People living with HIV on ART

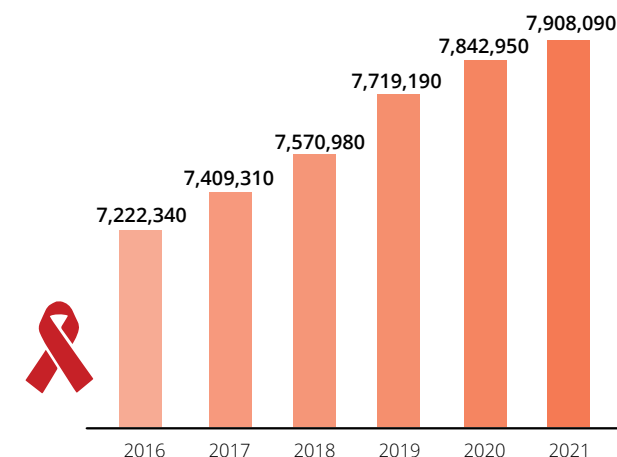
Enrolling more people on ART has been shown to reduce the number of new infections, if those on ART are virally suppressed and to reduce AIDS-related mortality with

increased treatment adherence. Data estimates indicate that the country has not reached the 90% target as it achieved 77% in the total population. Like the 1st 90, females performed better than males in the 2nd 90. Children are lagging at 66% performance.

3rd 90- People living with HIV who have suppressed viral loads

The country almost achieved its 3rd 90 target by achieving 89% for the total population and reaching 90% for adult males and females. However, children are lagging at 62%. However, the 3rd 90 should be interpreted with caution since it is dependent on the 2nd 90.

Figure 12: Total HIV infections (2016-2021)



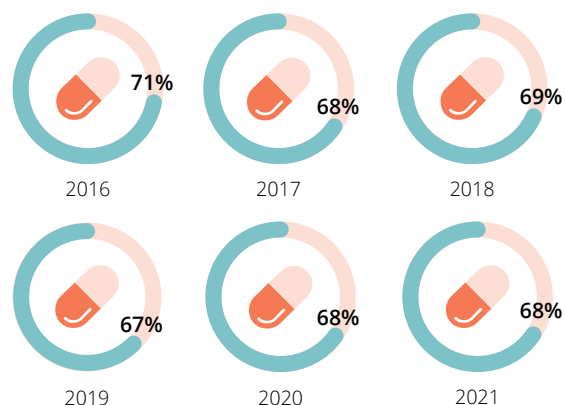
Source: Thembeisa Model 4.5

LATE HIV DIAGNOSIS

As South Africa has adopted the UTT policy and the same day initiation, the number of PLHIV starting ART with CD4 count of

less than 500 was considered a proxy for late HIV diagnosis. Data from the Thembisa Model was used for this report.

Figure 13: Percentage of all people starting ART at CD4 <500



Source: Thembisa Model 4.5

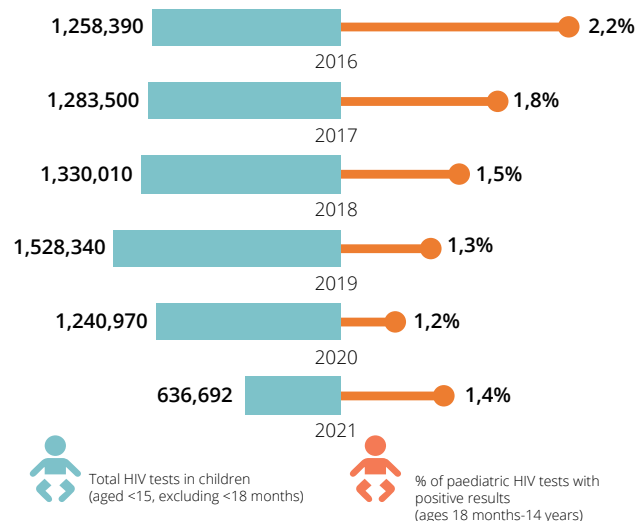
The Thembisa model estimates show that the percentage of people starting ART with a CD4 count of <200 cells/mm³ dropped from 71% in 2016 to 68% in 2021. There hasn't been any improvement on this indicator since the first drop from 71% in 2016 to 68% in 2017. This high number of people starting ART late is a proxy indication of the late diagnosis of HIV and the delays in starting ART among those who are diagnosed.

HIV TESTING VOLUME AND POSITIVITY

Figures 14 and 15 present data on HIV tests conducted and positivity for children and adults, respectively. The data show that, for children, positivity decreased from 2.2% in 2016 to 1.4% in 2021. What is interesting is the observation that in 2021, with substantially reduced volume of tests, positivity increased compared to the 2020 performance. For adults, positivity dropped from about 7.4% in 2016 to about

3.3% in 2021 (Thembisa Model). This drop is still within the high testing volumes. The declining positivity could be an indication of a higher performance in the 1st 90 with fewer people remaining to be diagnosed. These fewer people could mainly be among the hard-to-reach population and those negatively affected by specific factors in terms of accessing HIV testing services. These findings indicate the need for the country to invest more in finding this population and introduce efficient testing approaches such as index testing.

Figure 14: Children HIV tests and positivity

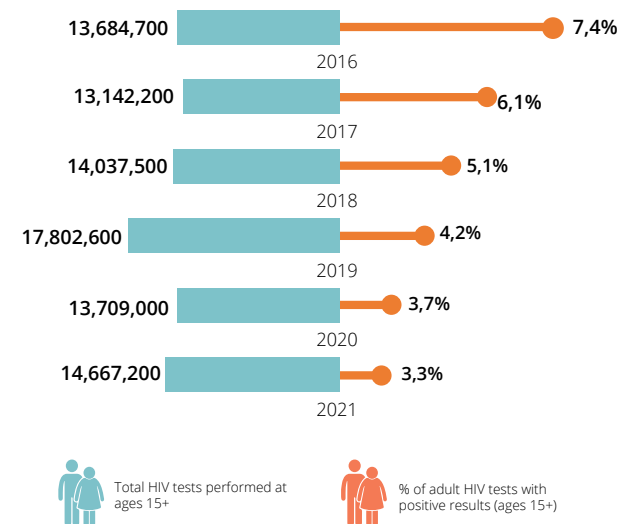


Source: Thembisa Model 4.5

ANTIRETROVIRAL THERAPY COVERAGE AMONG PEOPLE LIVING WITH HIV IN KEY POPULATIONS

Table 8 shows ART coverage data among key populations comparing it to the general population. The data show that compared to the general population (69.2%), FSW had a higher proportion of ART coverage (73.8%) while MSMs had a lower proportion (54.1%). Both FSW and MSM had an

Figure 15: Adults HIV tests and positivity



Source: Thembisa Model 4.5

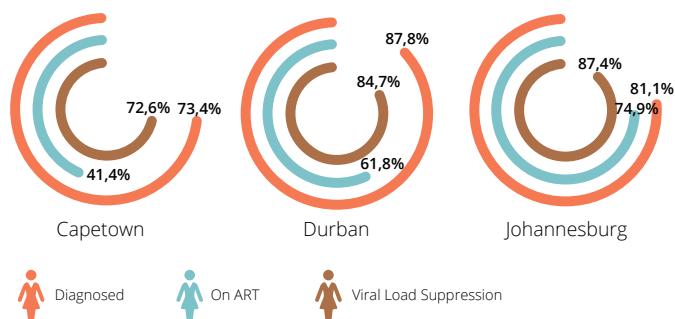
almost similar percentage basis point increase between 2016 and 2021 in terms of ART coverage. However, ART coverage among inmates (prisoners) was consistently high progressing towards 100% in 2021. ART coverage data for PWID and TG groups was not available at the time of writing this report.

The IBBS studies for FSW and MSM provide more detailed data for the HIV 90-90-90 cascade by city although its coverage data will be different from the Thembisa Model estimates. According to available data (no new data) from 2018, the proportion of FSW living with HIV who were aware of their HIV status ranged from 73.4% to 87.8%. Among FSW aware of their HIV status, 41.4% to 74.9% were on ART. Lastly, viral load suppression among FSW aware of their HIV status and on ART ranged from 72.6% to 87.4% (Figure 16).

Table 7: ART coverage among key populations

Indicator	2016	2017	2018	2019	2020	2021	Data source
ART coverage	53.6%	59.7%	63.9%	67.0%	69.3%	69.2%	Thembisa Model 4.5
ART coverage in FSW (sex workers living with HIV)	55.7%	63.4%	68.4%	71.8%	74.2%	73.8%	Thembisa Model 4.5
ART coverage in MSM (men who have sex with men living with HIV)	37.1%	43.3%	47.6%	51.1%	54.0%	54.1%	Thembisa Model 4.5
ART coverage in PWID (people who inject drugs living with HIV)	-	-	-	-	-	84%	Scheibe et al., 2020
ART coverage in TG (transgender people living with HIV)	-	-	-	-	-	91%	TG PSE Study, 2021 ¹⁶
ART coverage in inmates (prisoners living with HIV)	0.0%	93.90%	98.80%	98.80%	99.10%	99.30%	DCS Annual Report, 2021

Figure 16: 90-90-90 cascade for female sex workers living with HIV (2018)



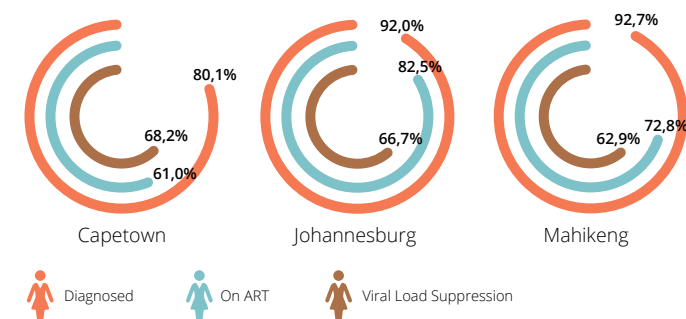
Source: South African Health Monitoring study

The study report indicates that there is sub-optimal progress towards achieving UNAIDS 90-90-90 targets among FSW, with none of the three 90-90-90 targets being achieved across all three survey cities. These findings underscore the need for strengthening HIV testing services and case finding.

However, even more efforts are required to facilitate linkage to ART following diagnosis. Notably, an extremely low proportion on FSW aware of their HIV status were on ART, despite the availability of ART for all people living with HIV in South Africa, at the time the survey was conducted. Particularly in Cape Town, less than half of the HIV-positive FSW aware of their HIV status were on ART. Lastly, additional efforts are required to promote adherence to ART and retention of HIV-positive FSW on ART to ensure virologic suppression and reduced risks of onward HIV transmission.

As it relates to MSM, the South African men' health monitoring study (2019) reported that the proportion of MSM living with HIV who were aware of their HIV status was low, ranging from 62.9% in Mahikeng to 68.2% in Cape Town. Among MSM aware of their HIV status, 61.0% (Cape Town) to 82.5% (Johannesburg) were on ART. Viral load suppression among MSM aware of their HIV status and on ART ranged from 80.1% (Cape Town) to 92.7% (Mahikeng) (Figure 17).

Figure 17: 90-90-90 cascade for men who have sex with men living with HIV (2019)



Source: South African men health monitoring study 2019

According to the study, the findings highlight sub-optimal progress towards achieving the UNAIDS 90-90-90 targets among MSM in all three cities. Despite a strategic mix of facility-based and community-based HIV testing approaches, less than 70% of MSM living with HIV were aware of their HIV status. Similarly, among MSM living with HIV, as low as 61.0% of those aware of their HIV status were on ART, despite the availability of ART for all people living with HIV in South Africa. More than 90% of MSM living with HIV on ART achieved virologic suppression in Johannesburg and Mahikeng, including excellent quality of care and effective treatment. In Cape Town, programme evaluations may provide further insights into areas amenable to interventions for promoting adherence and retention in care of MSM living with HIV and on ART.

Available data show that HIV prevalence among the South African general population aged 15–49 is 19.1% (UNAIDS 2020), while prevalence among transgender women (TGW) is much higher: 63% in Johannesburg and approximately 50% in Cape Town and Buffalo City (Cloete et al., 2019). Globally HIV prevalence among transgender men is 10 times that of

¹⁶ Tshuma, N., Mtapuri, O., Ndagurwa, P., Nyengerai, T., Maphosa, T., Mushavhanamadi, K., Shiku, C. Beyond Zero key team (2021) Population size estimates among transgender people in South Africa, Beyond Zero

the general population (Scheim et al., 2020); however, the prevalence in transgender men in South Africa is unknown. In South Africa, there are an estimated 87,214 TGW, 28,065 transgender men and 66,076 gender non-conforming individuals, about 0.3% of the total population (Tshuma et al., 2021). Engagement of transgender women in HIV, STI and TB prevention, treatment and care is complicated because of transphobic stigma experienced in healthcare settings, lower self-efficacy amongst transgender women, inadequate provider knowledge and an overall lack of gender-affirming healthcare (Scheibe et al., 2018).

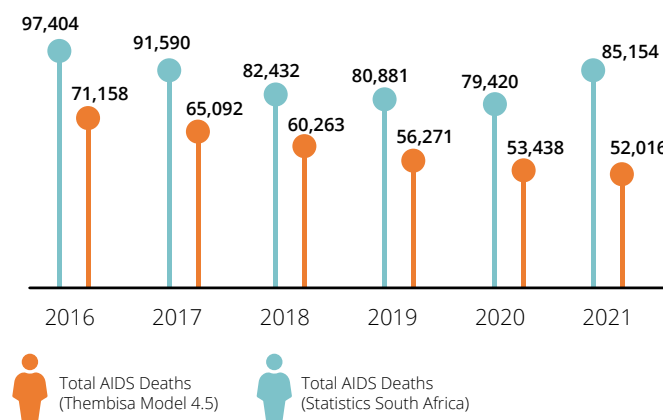
AIDS MORTALITY

Figure 18 compares the trends in AIDS-related deaths as reported by Statistics South Africa and those from the Thembisa Model estimates. Generally, the numbers are lower than the latter compared to the former. While the data show a similar trend between the Thembisa Model and StatsSA estimates, the latter seems to have included the impact of COVID-19 in its data showing an increase from 2020 while the former may not have included the impact of COVID-19. Thus, commentary is focused on data from StatsSA.

According to StatsSA, the estimated number of AIDS-related deaths declined consistently between 2016 from 97,404 to 79,420 in 2020 with a slight increase in 2021 to 85,154. Access to ART was reported as having changed significantly over time, altering the pattern of mortality over time. Access to ART has extended the lifespan of many who would have otherwise died at an earlier age, as evidenced in the consistent decline of AIDS deaths, in South Africa. However, the presence of the COVID-19 pandemic has hampered the ability of the health sector to extend life expectancy in South Africa in the year 2021. A slight increase in AIDS related

deaths is apparent in the year 2021, despite efforts to ensure ART rollout and better regimens of treatment (DHIS, 2021). The proportion of AIDS related deaths relative to all deaths declined as the proportion of COVID-19 related deaths increased significantly in the year 2021.

Figure 18: Trends in AIDS mortality as reported by StatsSA compared to the Thembisa Model estimates (2016-2021)



ACHIEVEMENTS

- The country exceeded its first 90 target by achieving 93% of all PLHIV who know their status among the total population
- Increased availability of HIV treatment supported by an enabling policy environment result in more people enrolling on treatment and living longer as evidenced by a consistent increase in PLHIV
- ART coverage among inmates (prisoners) was consistently high progressing towards 100% in 2021

KEY CHALLENGES

- Despite achieving the first 90 target, the country faces

challenges with putting all HIV diagnosed individuals on treatment as evidenced by a 78% performance. Poor performance in the second 90 across all population groups with children lagging at 66%.

- In addition to low treatment coverage, estimates show that the percentage of people starting ART with a CD4 count of <200 cells/mm3 still remain high at 68% in 2021. There hasn't been any improvement on this indicator since the first drop from 71% in 2016 to 68% in 2017
- Among key populations, data from 2019 and 2020 studies shows relatively poor performance when compared to the general population which reflects challenges with access to HIV services among these population groups

RECOMMENDATIONS

- As the country moves towards achieving 95% of all PLHIV who know their status, targeted interventions are needed to reach the potentially hard-to-reach population who are not yet diagnosed
- Poor performance among children in the second and third 90s are despite a relatively higher performance (80%) in the first 90. This shows that the country needs to do more to ensure children are linked to treatment and they receive further treatment support in terms of viral load testing and suppression.

Political Declaration and Framework 3: End paediatric AIDS and eliminate vertical transmission

SCORECARD ANALYSIS

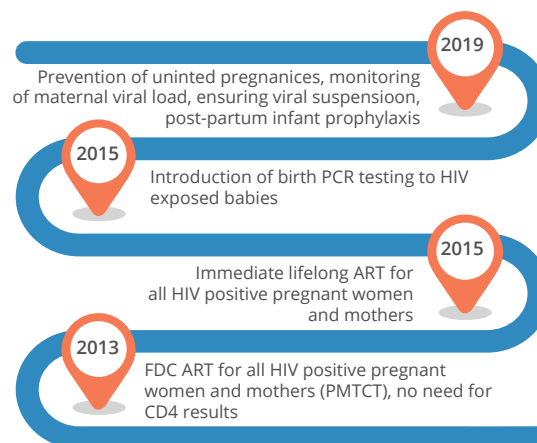
INDICATOR	RESULT
Is indicator/topic relevant?	Yes
Is it addressed in the national strategic plan	Yes
Has the country reached the framework target?	No
How likely is the country to reach the target by 2025?	Unlikely

LEGAL AND POLICY ENVIRONMENT

A significant number of children are infected with HIV. At the end of 2021, the Thembisa Model estimates show that there were 238,244 children (<15) living with HIV in the country. Furthermore, an estimated 10,387 children became newly infected with HIV during 2021. Close to a quarter (23%) of the 52,016 people who died of AIDS related illnesses during 2021, were children. The impact of HIV and AIDS on a child begins as soon as their parent contracts HIV and includes stigma and discrimination, physical care for the ill parent, loss of family income and use of resources for medical care, uncertainty and fear. Against this background the country has developed several legal and policy strategies that ought to be used as part of a comprehensive response to deal with the impact of HIV and AIDS on children. For

example, child specific provisions protecting children from discrimination based on their health status. South Africa has dedicated children's legislation that protects children from being discriminated against because of their "health status" (section 6(2)(d) of Children's Act (2010). The breadth of such provisions ensures that HIV is not exceptionable and aims to ensure that discrimination on the grounds of a child's health status does not occur. Children can also access contraceptives independently from the age of 12 (Section 134, Children's Act (2010, South Africa). Figure 19 below provides additional frameworks that are being used to protect children from acquiring HIV and to treat those who are diagnosed positive.

Figure 19: Legal and policy framework for ending paediatric HIV and eliminating vertical transmission



Source: Bello et al., 2021

HIV TESTING IN PREGNANT WOMEN

The percentage of pregnant women with known HIV status was 97% in 2021. Of the 1,048,939 pregnant women attending antenatal clinics and/or giving birth at a facility who were tested for HIV during pregnancy, at labour and/or delivery, or those who already knew they were HIV-positive at the first antenatal care visit, about 259,043 (25%) were identified HIV-positive. The 2019 antenatal sentinel survey reported that, based on medical record review data, HIV testing was offered to 99.8% (33,440/33,508) of ANC attendees as part of routine care and almost all (99.9%, 33,427) either accepted the offer or already knew their HIV-positive status. Nationally, of 11 321 participants found to be HIV positive by EIA test, 97.6% (11,046) already knew their HIV-positive status at the time of the survey (Table 9).

From the ANC survey (2019), nationally, of 10,778 EIA positive participants whose timing of (HIV) diagnosis was reported, 72.7% (7,912) knew their HIV-positive status before pregnancy. Of those who knew their HIV-positive status before pregnancy and whose treatment status was reported (7,735), 93.3% (7,207) were initiated on ART before pregnancy. This translates to 66.2% of all EIA positive participants who had already initiated ART before pregnancy.

Table 8: HIV among antenatal care attendees

	2016	2017	2018	2019	2020	2021
Percentage of pregnant women with known HIV status (based on population-based denominator)	no data	82.00%	97.00%	97.20%	0.00%	97.00%
Number of pregnant women attending antenatal clinics and/or giving birth at a facility who were tested for HIV during pregnancy, at labour and/or delivery, or those who already knew they were HIV-positive at the first antenatal care visit.	no data	988,062	1,023,576	1,066,422	1,095,716	1,048,939
Total identified HIV-positive women	no data	no data	no data	no data	no data	259043
Number of pregnant women giving birth in the past 12 months (population-based denominator)	no data	1,204,854	1,054,871	1,097,597	0	1,081,565

Source: DHIS

As in the 2017 survey, in 2019, knowledge of HIV status before pregnancy was reported to be significantly lower among younger women (15–19 years and 20–24 years: 47.6% and 59.4%, respectively) compared to older women (35–49 years: 85.1%).

EARLY INFANT DIAGNOSIS

Current testing guidelines recommend that HIV-exposed infants should have a routine HIV Polymerase Chain Reaction (PCR) test at birth, at 10-weeks for those who tested negative

at birth, and at six months for those who tested negative at 10 weeks, unless indicated by HIV-related symptoms.

Table 10: Performance of MTCT indicators (2016-2021)

	2016	2017	2018	2019	2020	2021
Mother-to-child transmission rate	4.22%	3.73%	3.41%	3.18%	3.07%	2.98%
MTCT rate at/before birth	1.31%	1.19%	1.10%	1.03%	1.02%	0.99%
MTCT rate at/before birth from HIV-diagnosed mothers	0.92%	0.83%	0.77%	0.73%	0.72%	0.71%
Postnatal MTCT rate to 18 months, from HIV-diagnosed mothers	0.62%	0.54%	0.50%	0.47%	0.44%	0.44%

Source: Thembisa Model 4.5

Table 9: Early Infant Diagnosis

	2016	2017	2018	2019	2020	2021
Percentage of infants born to women living with HIV receiving a virological test for HIV within two months of birth	82.60%	98.10%	94.10%	95.90%	96.90%	98.10%
Number of infants who received an HIV test within two months of birth during the reporting period.	204,273	253,705	253,718	260,905	268,247	264,250
Test result- Positive	2,072	2,175	1,555	1,538	1,381	1,298
Test result- Negative	202,201	245,637	252,163	259,367	266,866	269,485

Source: UNAIDS Online Tool

In South Africa, HIV-PCR tests conducted at birth (within seven days after birth) are used for monitoring this indicator (Bello et al., 2021). Table 10 shows that about 264,250 (98%) of infants born to women living with HIV received a virological test for HIV within two months of birth. About 1,298 infants tested positive (0.5%).

VERTICAL TRANSMISSION OF HIV

The Thembisa model data (Table 11) shows that MTCT rate at/before birth was at 0.99% with MTCT rate at/before birth from HIV-diagnosed mothers at 0.71%. Postnatal MTCT rate to 18 months, from HIV-diagnosed mothers was 0.44% in 2021. The 2020 GAM report state that the Thembisa Model estimates are more reliable as they are for the entire country compared to other datasets that may only represent public health facilities (Bello et al., 2021).

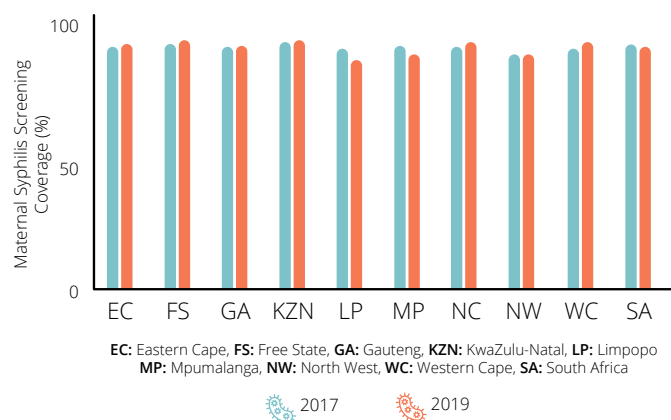
PREVENTING THE VERTICAL TRANSMISSION OF HIV

This indicator measures the number of pregnant women living with HIV who delivered during the past 12 months and received antiretroviral medicines to reduce the risk of mother-to-child transmission of HIV. The UNAIDS reports that in 2021, of the 269,485 women needing ARVs for PMTCT, 254,786 received them. This translated to 95% of pregnant HIV-positive women who received ARVs for PMTCT in 2021, down from 97% in 2020.

SYPHILIS AMONG PREGNANT WOMEN

According to the ANC survey, maternal syphilis screening coverage was 96.4% at national level, representing a decline of 0.3% points in syphilis screening coverage from the level in 2017 (96.7%) (Figure 20). All provinces had greater than 90% syphilis screening coverage. Of those who had syphilis screening, 2.1% (95% CI: 2.0%–2.3%) were positive for syphilis, 79.4% were negative, 17.3% were awaiting result and 1.2% results were not in file. Syphilis screening coverage data were missing for 3.3% of participants. If we assumed that all missing responses indicated that the subjects did not receive the screening test, and include them as such in the denominator, the national coverage for syphilis screening drops to 93.1%.

Figure 20: Maternal syphilis screening coverage among antenatal women, in the 2017 and 2019 Antenatal HIV sentinel surveys

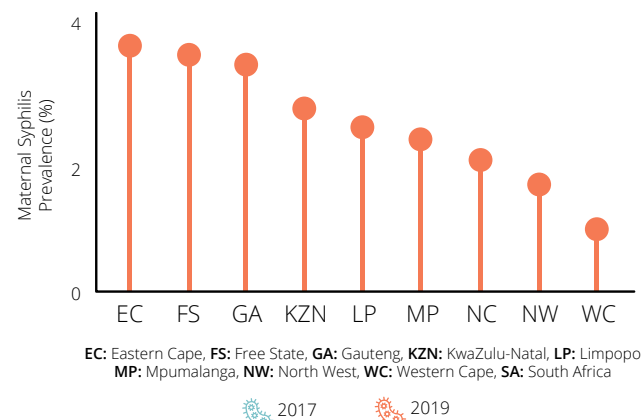


Source: 2019 Antenatal HIV sentinel survey

After excluding the pending results and the results not in file, the prevalence of syphilis (per medical record review data) among those who had syphilis test result, was 2.6% (95% CI: 2.4%–2.9%) (793) at national level (Figure 21). Compared to

the prevalence of syphilis in 2015 (which was 2.0% based on laboratory testing), the current syphilis prevalence represents a 30% increase in prevalence between 2015 and 2019. The highest syphilis prevalence was in Eastern Cape at 3.8% (95% CI: 2.6%–5.4%) and the lowest was in Limpopo at 1.4% (95% CI: 1.0%–1.8%).

Figure 21: Syphilis prevalence among antenatal women, in the 2019 Antenatal HIV sentinel survey



Source: 2019 Antenatal HIV sentinel survey

From the 2019 ANC survey, of 729 participants confirmed as syphilis positive and whose syphilis treatment status was reported, 92.3% (671) received at least one dose of treatment for syphilis. Of those treated for syphilis and had type of treatment reported (599), 93.1% (553) were treated with at least one dose of Benzathine penicillin G (BPG) – these translate to 85.1% of all syphilis positive participants treated with one dose of BPG.

ACHIEVEMENTS

- Over 99% of women attending ANC know their HIV status which is an entry point to PMTCT services. This result is

encouraging and presents an opportunity for eliminating HIV infections during pregnancy and breastfeeding

- The mother-to-child transmission rate has consistently decline from 4.22% in 2016 to 2.98% in 2021
- The increasing percentage of ANC women who are tested and know their status is demonstration of the country commitment to eliminating MTCT

KEY CHALLENGES

- In the 2019 ANC survey, knowledge of HIV status before pregnancy was reported to be significantly lower among younger women (15–19 years and 20–24 years: 47.6% and 59.4%, respectively) compared to older women (35–49 years: 85.1%), increasing the risk of MTCT
- As reported in the 2020 GAM report, the lack of a unique identifier makes cohort tracking and analysis difficult for Early Infant Diagnosis leaving room for duplicate data
- The prevalence of syphilis (per medical record review data) among those who had syphilis test result, was 2.6% compared to 2.0% prevalence in 2015 which represents a 30% increase in prevalence between 2015 and 2019

RECOMMENDATIONS

- As may be applicable to all frameworks and associated indicators, the country should rollout nationally the use of the Unique Identifier for all health clients across different health information systems to allow for patient tracking across geographical areas and services
- Promote and advocate for HIV testing among young people, particularly young women as they make decisions to get pregnant to reduce the risk of MTCT. This could be achieved through health education in youth friendly centres and other community health promotion or advocacy initiatives.

Political Declaration and Framework 4: Gender equality and empowerment of women and girls

SCORECARD ANALYSIS

INDICATOR	RESULT
Is this a priority for South Africa?	Yes
Is it addressed in the national strategic plan?	Yes
Has South Africa reached the target	No
How likely is South Africa to reach the target by 2025?	Unlikely

LEGAL AND POLICY ENVIRONMENT

Gender equality is pivotal in the Bill of Rights, embedded in the South African Constitution. Gender equality drives efforts towards eliminating health, social and economic disadvantages because of one's gender (DoJ, Bill of Rights, 1996). The legal structures of equality have been operationalized through the adoption of various national policy frameworks and acts of parliament by the South African government, clearly aiming to eliminate discrimination against women.

These include the National Policy Framework for Women's Empowerment and Gender Equality — commonly known as the Gender Policy Framework (National policy framework, 1996)— the National Development Plan Vision 2030,³⁶ and

the Gender Equality Amendment Act No. 17 of 2013 (National Development Plan, 2013). The Employment Equity Act No. 55 of 1998 states codes of good practice, including prohibiting employers from compelling employees and job applicants to undergo HIV testing (Employment equity Act, 1998). Additionally, Chapter 9 of the Constitution of South Africa, states the following “People living with HIV/AIDS and their families are entitled to full and equal enjoyment of all rights and freedoms in the Bill of Rights (Human Rights Commission, 1996)

The South African constitution sets the framework for an effective legislative response to Gender Based Violence, affirms equality, human dignity, life, freedom, and security of the person. The Commission on Gender Equality plays the primary role in advancing the empowerment of women and gender equality, a pivotal pillar needed as South Africa tries to reach the 95-95-95 targets. South African statutory bodies complement the work of the Commission on Gender Equality in several important ways.

In 2020, the country launched the National Strategic Plan on GBV and Femicide 2020-2030 (NCGBVF) to further provide a framework for addressing GBV and intimate partner violence (IPV). With it came the GBV and Femicide response fund, that raised R128 million to address the needs and challenges faced by all, especially women across age, sexual orientation, sexual and gender identities; and specific groups

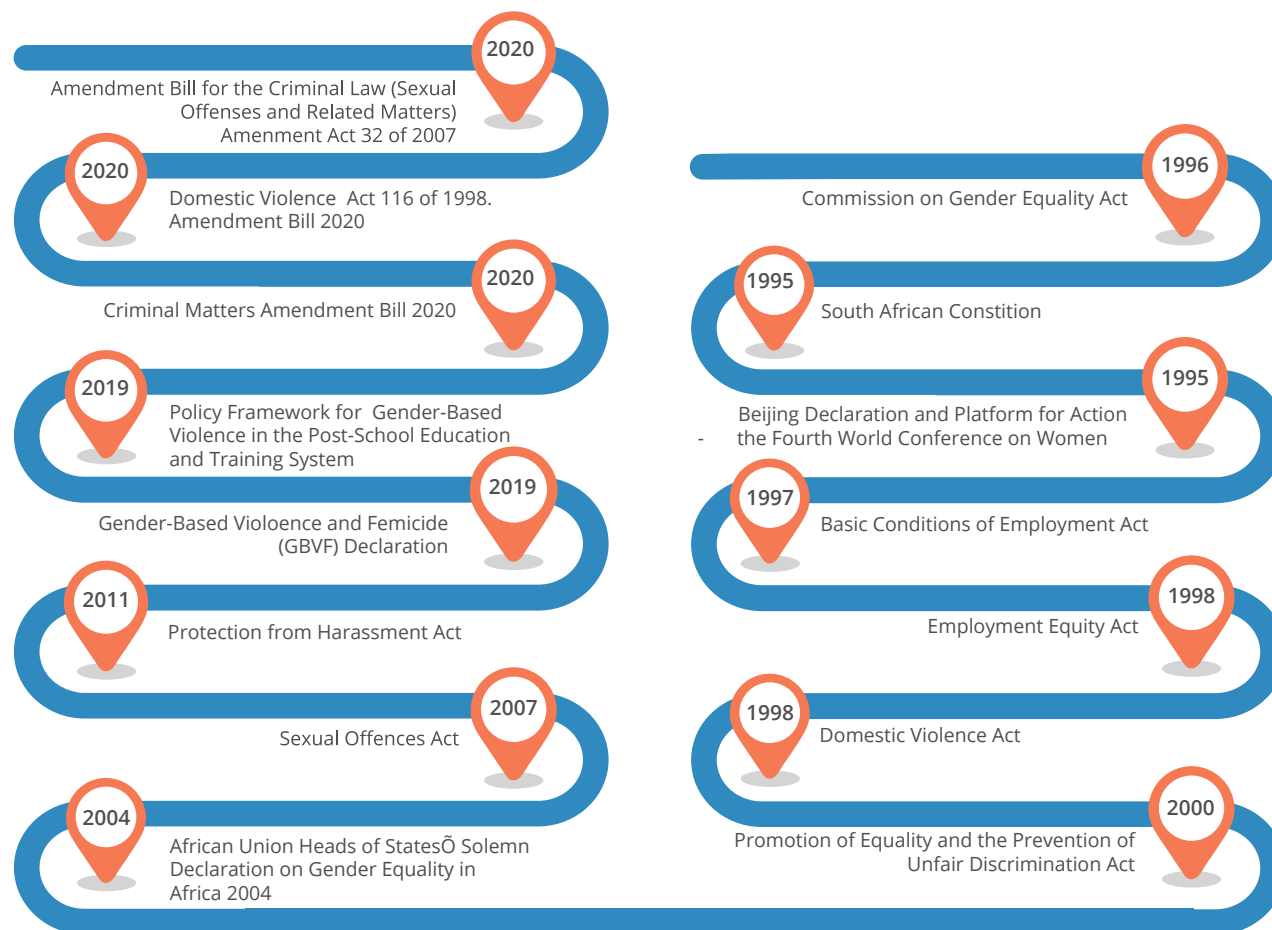
such as elderly women, women who live with disability, migrant women and trans women, affected and impacted by the GBV scourge in South Africa. Figure 22 presents the progress made in terms of policy developments to address gender equality and empowerment of women and girls. The accountability of the national gender programme resides with the Presidency, this was structured to ensure that Provincial OSWs and departmental Gender Focal Points can account on the one hand to the Premiers, Members of the Executive Committee (MECs) and Provincial Directors-General and to Ministers and Directors-General as well as to the National OSW on matters of programme delivery.

This dual accountability improves cohesiveness and integration of programmes delivery in a cost-effective manner. The legislation covers physical violence, sexual violence, psychological violence, emotional violence, economic violence, explicitly criminalizes marital rape, protects former spouses and unmarried intimate partners. It is therefore inclusive of all forms of familiar and intimate partner violence.

CURRENT STATUS AND PROGRESS

In Sub-Saharan Africa, 67 percent – or an estimated 280,000 – of annual new HIV infections in young people occur in AGYW. Data show that AGYW are up to 14 times more likely to become HIV-infected than their male counterparts. In 2014, PEPFAR announced the flagship programmes

Figure 22: South Africa legal and policy environment for declaration and framework 4



Source: Bello et al., 2021

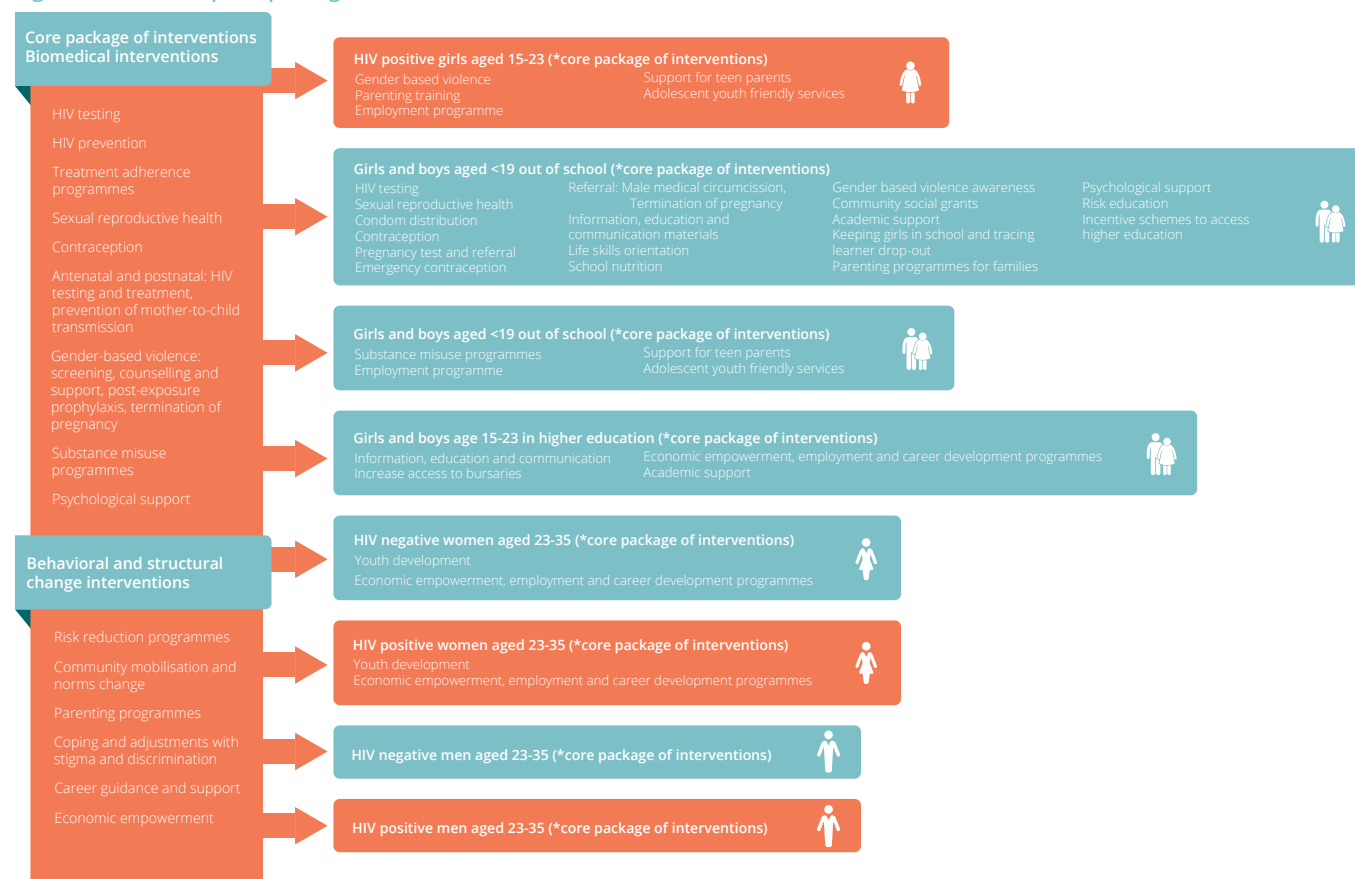
DREAMS as a public private partnership on World AIDS Day with private sector partners: the Bill & Melinda Gates Foundation, Girl Effect, Gilead Sciences, Johnson & Johnson, and ViiV Healthcare focusing on interventions that can reduce HIV rates among AGYW. DREAMS approach is centered on a comprehensive, multi-sectoral package of core interventions

to address key factors that make girls and young women particularly vulnerable to HIV. These include structural factors, such as gender-based violence, exclusion from economic opportunities, and a lack of access to secondary school. DREAMS layers multiple interventions at once so that AGYW are surrounded with critical support to keep them safe

from HIV and other risks. DREAMS is implemented across 15 countries, including South Africa. DREAMS has driven a greater global focus on the unique risks and opportunities experienced by AGYW. In South Africa, over 24 districts are implementing DREAMS, and as of FY19 over 116 000 AGYW were reached (Dreams fact sheet, 2020). Though new infections are slightly declining overtime, according to UNAIDS, adolescent girls and young women (AGYW) aged 15–24 years comprised 19% of new HIV infections in 2017 —of which 80% were living in sub-Saharan Africa (UNAIDS, 2019). This gender disparity is particularly striking in South Africa, where the HIV prevalence of AGYW aged 15–24 years old is four times higher than males of the same age (Shishana et al, 2014). An urgent focus on women and girls is in place, with empowerment being a primary intervention in reducing the impact of HIV in these groups. A key area needing significant improvements is ensuring a coordinated and targeted approach across various stakeholders involved.

The She Conquers Programme launched in 2016, seeks to reduce HIV infections, improve overall health outcomes, and expand opportunities for adolescent girls and young women to decide their own futures, moved beyond a focus on disease transmission and associated stigma to a narrative of empowering women. She Conquers primarily targeted women aged 15-24 years, although interventions also target others in the HIV transmission cycle, such as older men and women (de Oliveira et al. 2017; She Conquers, 2016). Core interventions (Figure 23) were implemented by a diverse group of partners to collectively tackle the social and structural determinants of HIV, and include programmes on sexual and reproductive health, HIV testing, gender-based violence, positive parenting, and post-schooling education and employment (She Conquers, 2016).

Figure 23: She Conquers package of interventions



Source: She Conquers. <http://sheconquerssa.co.za>

The key factors cited to have ensured success included successful alignment: strong strategic planning; committed high level leadership; alignment to existing coordinating structures; leveraged resources; mobilization of partners for integration; and engagement with adolescent girls and young women to ensure a relevant and responsive campaign. As the country works towards achieving and sustaining gains in reducing new infections, **HIV prevention**,

stigma and discrimination reduction including **gender-based violence (GBV) case identification** remain critically important and need to be scaled and optimized, more especially for children, adolescents, youth, men, and key populations at-risk where the rate of new infections remains substantial (State gov. 2022). These groups are often the most vulnerable to acquiring HIV and are disproportionately affected by high rates of intimate partner violence and

sexual violence and face the greatest barriers to accessing services needed to protect themselves. Locally developed, evidence-based, person-centered prevention interventions and risk-reduction messages are being developed and implemented in partnership with other PEPFAR-funded prevention and OVC partners in supported districts, including facilities, schools, churches, community-based organizations, and district Operation Sukuma Sakhe (OSS) structures. The primary aim is to contribute to HIV epidemic control through the prevention of new HIV infections and reduction of stigma and discrimination for those who are HIV positive by strengthening the integration of HIV and violence prevention and clinical post-violence response services across key HIV service delivery points including psychosocial support, HIV testing, Sexual and Reproductive Health Services (including PEP and PrEP) and HIV care and treatment. PrEP demonstration projects in South Africa highlight that young women have high interest in starting PrEP, yet early drop-off rates, between 30 and 60% within the first 3 months, reveal significant challenges in their ability to maintain use (Eakle et al 2017; Pillay, 2017). A need for targeted interventions at both facility and community levels is critical. These could further be enhanced through effective risk screening, if incorporated into all health facility entry points.

South Africa has national protocols and guidelines for educating personnel dealing with cases of sexual abuse against children and other forms of GBV against women. In terms of protecting key populations and PLHIV from violence, the country has general criminal laws prohibiting violence, specific legal provisions prohibiting violence against people based on their HIV status or belonging to a key population, programmes to address intimate partner violence, workplace violence, police abuse and torture and ill-treatment in

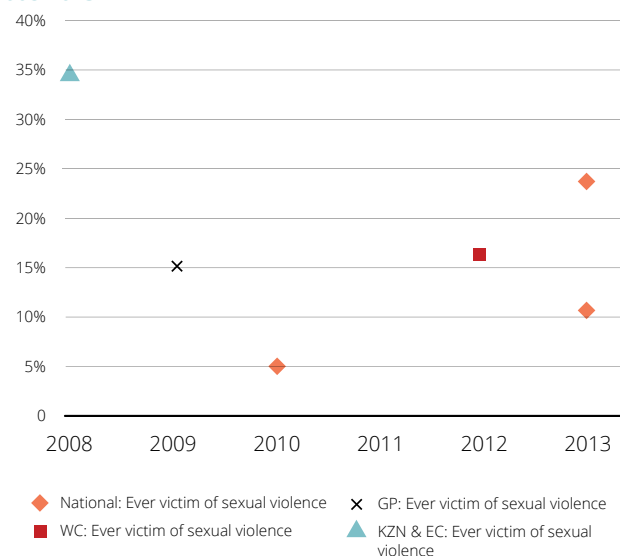
prisons. The country's service delivery points provide elements of comprehensive post-rape care as per World Health Organization (WHO) guidelines. The elements are: (1) first-line support, psychological first aid and psychosocial support; (2) emergency contraception; (3) STI prophylaxis or treatment; (4) HIV post-exposure prophylaxis (PEP); and (5) safe abortion to the full extent of the law. All these services are provided in >80% of health facilities (NCPI, 2021). Women in South Africa, have free legal services available if they experience violence. The establishment of the Thuthuzela Care Centres within the police stations is one way of ensuring the provision of both legal and social support to victims of violence (SANAC NCPI report, 2021).

Though the South Africa National HIV Prevalence, Incidence, Behavior and Communication Survey V showed that 29.1% of ever married or partnered women aged 15-49 years experienced physical or sexual violence from a male intimate partner in the past 12 months (Simbayi et al., 2019), this increased during the COVID pandemic (2020), with notable patterns by underlying factors (Gill, 2021). The Governance, Public Safety and Justice survey (GPSJS) noted that only 60% of victims of sexual offences reported the crime to SAPS during 2019/20 compared to 88% in 2018/19.47 Consequently, the total number of sexual offences reported to SAPS in 2020/21 was lower than that in 2019/20 (South African Police Service Report, 2018, 2019, 2020; Bello et al., 2021). In a recent study, by Jewkes et al., 2019, conducted as a multi-stage, community-centric, cross-sectional survey among 3005 FSWs linked to sex worker programmes in 12 sites across all nine provinces South African programmes reported the following in the past year: 70.4% of FSWs experienced physical violence and 57.9% were raped by (i) policemen (14.0%)

- (ii) clients (48.3%)
- (iii) other men (30.2%)
- (iv) and/or and intimate partner (31.9%)

Sexual IPV was associated with food insecurity, entering sex work as a child, childhood trauma exposure, post-traumatic stress disorder (PTSD), drinking alcohol to cope with sex work, working more days, partner controlling behaviour, having an ex-client partner, and having no current partner to protect from ex-partners (Jewkes et al., 2019). This further substantiates the "hands off programme" prior report on sex work and violence in South Africa, that further concluded that 71 percent of sex workers experienced violence in the past year (Hands off needs assessment report, 2016). South Africa is a largely patriarchal society with heteronormative social norms.

Figure 24: Sexual violence among MSM in South Africa, 2008-2013



Source: MSM in South Africa Data Triangulation Project, 2015

Many males in South Africa who have male sexual partners experience stigma and discrimination because of socio-cultural norms around masculinity and negative perceptions of sexual partnerships between individuals of the same sex (Figure 24).

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- (ii) clients (48.3%)
- (iii) other men (30.2%)
- (iv) and/or and intimate partner (31.9%)

A 2016 South African Demographic and Health Survey reported that one in four women older than 18 years of age experienced some form of GBV in their lifetime; women in the survey were more likely to report physical (21%) compared with emotional (17%) or sexual violence (6%) (National Department of Health (NDoH et al., 2019).

ACHIEVEMENTS

- In 2020, the country launched the National Strategic Plan on GBV and Femicide 2020-2030 (NCGBVF) and a targeted fund that provided a framework for addressing GBV and intimate partner violence (IPV)
- Continued support for and implementation of targeted HIV prevention, treatment and support interventions such as the DREAMS programme demonstrating the power of public private partnerships in addressing the HIV challenge

KEY CHALLENGES

- PrEP demonstration projects in South Africa highlight that young women have high interest in starting PrEP, yet early drop-off rates, between 30 and 60% within the first 3 months, reveal significant challenges in their ability to maintain use (Eagle et al 2017; Pillay, 2017)
- The South Africa National HIV Prevalence, Incidence, Behavior and Communication Survey V showed that 29.1% of ever married or partnered women aged 15-49 years experienced physical or sexual violence from a male intimate partner in the past 12 months (Simbayi et al., 2019) with increases being recorded during the COVID pandemic (2020), with notable patterns by underlying factors (Gill, 2021)
- FSWs still report experiencing all forms of violence including sexual, physical and harassment from law enforcement agencies which exposes them to HIV infection

RECOMMENDATIONS

- As the country works towards achieving and sustaining gains in reducing new infections, HIV prevention, stigma and discrimination reduction including gender-based violence (GBV) case identification remain critically important and need to be scaled and optimized, more especially for children, adolescents, youth, men, and key populations at-risk where the rate of new infections remain substantial
- A need for targeted interventions at both facility and community level is critical. These could further be enhanced through effective risk screening, if incorporated into all health facility entry points.

Political Declaration and Framework 5: Community leadership

SCORECARD ANALYSIS

INDICATOR	RESULT
Is this a priority for South Africa?	Yes
Is it addressed in the national strategic plan?	Yes
Has South Africa reached the target	No
How likely is South Africa to reach the target by 2025?	Unlikely

LEGAL AND POLICY ENVIRONMENT

The community led approach is extremely important in stakeholders trying to achieve the NSP goals for South Africa. In terms of governance, South Africa has clear guidelines on how to operationalize community-led organizations. These include registration of organizations led by PLHIV and other key populations groups. The need to strengthen and integrate HIV services and services to key populations can be provided by community-led organizations, including streamlining of reporting requirements for community-led organizations delivering HIV exists in South Africa.

CURRENT STATUS AND PROGRESS

A need to integrate and scale up, locally led development and delivery of HIV/TB services through resilient district

health systems, local partners, civil society organizations (CSOs), community-based organizations (CBOs), faith-based organizations (FBOs) and the private sector exists across the country. Increasing capacity and fostering success by catalyzing innovation and mobilizing cross-sector partnerships will ensure success. Ending the HIV and TB epidemics requires government, community, civil society, and private sector engagement. A need to support indigenously led innovation, leadership, and implementation by leveraging community (including Traditional Health Practitioners), civil society, and private sector partnerships to improve service delivery and client outcomes and to address the social determinants of health that support client retention in care exists.

South Africa allows monitoring and research funding led by communities, from domestic funding, social contracting or other mechanisms allowing for community led advocacy funding. PLHIV, women, gay men and other MSM, sex workers, transgender people, and PWID participate in developing national policies, guidelines and/or strategies relating to their health in the country. The following are key activities to improving community targets, impact, and participation:

- Strengthening the work between existing stakeholders and PLHIV-led, other community-based organizations, traditional Health Practitioners, and community members, through existing and new forums, to directly

provide HIV/TB services that improve client outcomes with a specific focus on retention in care. Technical capacity required includes training and skills building to provide community adherence counseling and even assist with the facilitation of community-based case finding and multi-month dispensing

- Capacitating community led organizations to serve as a referral pathway when clients are facing complex factors (e.g., social, and economic barriers) that are outside of the scope of health facilities that threaten the ability of patients to adhere to priority public health interventions
- Supporting the creation of partnerships with a range of private sector actors with the capacity to contribute to addressing factors affecting client health-seeking behavior and/or factors impeding the health system. The private sector can augment health care services in one of two ways– either by providing services directly, or enhancing services that already exist
- Strengthening of district health management teams to mobilize all role players (from all partners, including locally led community-based organizations, provincial and district AIDS Councils) to coordinate, collaborate and use resources effectively for the achievement of program results, including joint annual and quarterly planning and review meetings.

ACHIEVEMENTS

- The South African Government (SAG) has created an

enabling operational environment for community-based organisations through relatively easy processes of registration, sourcing for funding, both domestic and international and implementing project activities

- Various NGOs working on the HIV response implement community systems strengthening programmes targeted at strengthening the resilience of families and ensuring individuals infected and affected by HIV have access to necessary support at community level
- The development and implementation of community-led monitoring systems such as the Ritshidze is evidence of community support and empowerment to own the HIV response and take responsibility for action

KEY CHALLENGES

- While systems for community-led monitoring have been developed and piloted, they are only available in some facilities and communities
- Community-based organisations often lack the knowledge and skills to successfully apply for available funding and to attract and retain the required skilled human resources for effective project implementation
- With limited political support for coordination at the district and local government level, there is often lack of financial resources for community-based organisations to operate

RECOMMENDATIONS

- The government and its stakeholders should expand and scale the Ritshidze community-led monitoring system to ensure communities take full ownership and manage the HIV response at the local level
- There is need for increasing support for strengthening local CBOs capacity to apply for funding, attract and retain human resources and to consistently operate and implement HIV response activities at local level

Political Declaration and Framework 6: Realize human rights and eliminate stigma and discrimination

SCORECARD ANALYSIS

INDICATOR	RESULT
Is this a priority for South Africa?	Yes
Is it addressed in the national strategic plan?	Yes
Has South Africa reached the target	No
How likely is South Africa to reach the target by 2025?	Unlikely

LEGAL AND POLICY ENVIRONMENT

South African statutory laws are inclusive of express measures targeted at preventing unfair discrimination against people living with HIV. The South African Human Rights Commission, established in terms of Chapter 9 of the Constitution of the Republic, states clearly that, "People living with HIV/AIDS and their families are entitled to full and equal enjoyment of all rights and freedoms in the Bill of Rights"(Commission; 2017) The Employment Equity Act No. 55 of 1998, particularly, defines the codes of good practice, including prohibiting employers from compelling employees and job applicants to undergo HIV testing ("Employment Equity Act, 1998." 1998). South Africa is the only African country to offer constitutional protection against discrimination based on sex, gender and sexual orientation.

The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 ("the Equality Act") was enacted to give effect to section 9 of the Constitution – to prevent unfair discrimination and harassment. In 2011 the Equality Court in *Lallu v Van Staden* held that a neighbour's verbal abuse of a transgender woman amounted to harassment, hate speech and unfair discrimination ("*Lallu v Van Staden*" 2011). The Court awarded damages for infringement of the transwoman's dignity and costs for remedial psychological counselling.

CURRENT STATUS AND PROGRESS

Discriminatory attitudes towards people living with HIV

There are no recent national survey data for this indicator as the sixth round of the SABSSM was underway at the time of writing this report. Data from the 5th SABSSM showed that most people (between 85% and 92% of survey participants) held positive attitudes towards people who live with HIV (Simbayi et al. 2019). Up to two thirds of the respondents who said they would keep a relative's HIV status a secret, suggesting an affirmation of human rights and respect towards the family member to ensure their dignity.

In the absence of national data, the serial South African Stigma Index surveys provide some valuable data into evaluating this indicator. The 2020/21 edition of the stigma survey reported that the proportion of PLHIV who

experienced external stigma in the 12 months preceding the survey, ranged from 10% in the Thabo Mofutsanyane district of the Free State province to 27.4% in eThekweni, KwaZulu Natal province (Cloete et al. 2022). Overall, the levels of internalized (23%) and external (15%) stigma reported in 2020 are lower than those reported in 2014, which were 43% and 35%, respectively (Simbayi et al. 2015).

Experience of stigma and discrimination among key populations

Collectively referred to as 'key populations', men who have sex with men (MSM), injecting drug users (IDU), sex workers (SW), specific migrant sub-groups, prisoners and transgender people are part of every community in South Africa (UNAIDS. 2011). A key population can be defined as any population that meets the following three criteria (Fund 2013): epidemiologically, the group faces increased risk, vulnerability and/or burden with respect to at least one of the three diseases (HIV, STIs and TB); access to relevant services is significantly lower for the group than for the rest of the population and faces frequent human rights violations, systematic disenfranchisement, social and economic marginalization and/or criminalization. A 2019 publication based on research done on 804 participants from the Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) communities, reported that almost a quarter of participants had been denied healthcare and 31% reported being called names or being insulted by healthcare staff at some point.

Similarly, a study among female sex workers (FSW) showed high stigmatization rates and of being made to feel guilt, shame and a loss of dignity as a result of the discrimination by healthcare providers and other community members (Duby et al. 2018).

Avoidance of health care among key populations because of stigma and discrimination

There were no data for this indicator measured as specified by UNAIDS. However, research done on 804 participants from the LGBTI communities, reported that most (60%) of the individuals sought care from NGOs compared to 25% in public and 15% in private healthcare facilities (Müller 2019). More importantly, 64% had disclosed their Sexual Orientation and Gender Identity Expression (SOGIE) to the healthcare provider and 44% had tried to hide their SOGIE-related health concern from their healthcare provider (Müller 2019). Other studies showed that about 30% and 60% of MSM (Mbeda et al. 2020) and FSW (Duby et al. 2018) reported avoiding seeking healthcare for fear of stigmatisation.

ACHIEVEMENTS

- The levels of internalized (23%) and external (15%) stigma reported in 2020 are lower than those reported in 2014, which were 43% and 35%, respectively (Simbayi et al. 2015)
- Community-based key population networks, such as those established by the NGO SWEAT, with a focus on protecting the human rights of sex workers and providing necessary support are effective in advocating for the promotion of human rights at community level
- Between 85% and 92% of survey participants expressed accepting attitudes towards people living with HIV which is a steady improvement over the five waves of the SABSSM surveys (Simbayi et al. 2019).

KEY CHALLENGES

- Female sex workers (FSW) still report high stigmatization rates and of being made to feel guilt, shame and a loss of dignity as a result of the discrimination by healthcare providers and other community members (Duby et al. 2018)
- There remains significant stigma and discrimination in healthcare facilities towards key populations (Mbeda et al. 2020). This often results in limited if not lack of access to healthcare as members of the key population avoid seeking healthcare (Duby et al. 2018; Müller 2019)
- Research studies show that LGBT issues are seldom covered in the healthcare worker curriculum (Luvuno et al. 2019). It is also challenging to address this issue due to lack of data on the South African LGBT population, as sexual orientation does not form part of the routine data set

RECOMMENDATIONS

- Training of healthcare providers will provide information and improve their skills which may lead to improved quality of healthcare for LGBT people
- Training and sensitization of judiciary and law enforcement officials is needed on policy developments meant to protect key populations to reduce discrimination, stigmatization and harassment

Political Declaration and Framework 7: Universal health coverage and integration

SCORECARD ANALYSIS

INDICATOR	RESULT
Is this a priority for South Africa?	Yes
Is it addressed in the national strategic plan?	Yes
Has South Africa reached the target	No
How likely is South Africa to reach the target by 2025?	Unlikely

LEGAL AND POLICY ENVIRONMENT

The country's policies for universal health coverage and integration are guided by the Constitution which provides for access to healthcare for all (South Africa 2015). The National Cancer Strategic Framework for South Africa 2017–2022, is intended to guide the development, implementation, monitoring and coordination of cancer policies, strategies and other cancer-related activities. South Africa also has a clearly articulated National Cervical Cancer Prevention and Control Policy which recommends screening for all women from the age of 30 at 10 yearly intervals until they are 50 (NDOH. 2017). It also highlights more frequent screening intervals and earlier age to start screening for women living with HIV. South Africa adopted a policy on the decentralised management of multi-drug resistant tuberculosis (MDR-TB) in

2019. It is also important to highlight that these policies are well aligned to relevant regional and global frameworks such as the Global Plan to end TB 2023–2022 (Stop TB Partnership 2022).

CURRENT STATUS AND PROGRESS

Co-management of tuberculosis and HIV treatment

This indicator measures the proportion of HIV-positive incident cases that were on ART and TB treatment. Data from recent years have seen annual reductions in the coverage of co-management of TB and HIV in South Africa, from 49% in 2017 to 42% in 2019 (Bello B 2021).

People living with HIV who started tuberculosis preventive treatment

According to DHIS data reported by the NDoH, there were 383,403 people on ART who were eligible for tuberculosis preventive therapy (TPT) in 2020. Of these, 356,872 started TPT, representing a 93% achievement for this indicator (SANAC. 2020).

Urethral discharge and gonorrhoea among men

A 2018 scientific paper on the trends of STIs in South Africa also reported stable incidence rates of *Neisseria gonorrhoeae* and *Chlamydia trachomatis* from 1990 to 2017 (Kularatne et al. 2018). *Neisseria gonorrhoeae* and *Chlamydia trachomatis* together cause about 95% of male urethritis syndrome.

ACHIEVEMENTS

- Improved data enhances evidence-based decision making. The 2018 TB Prevalence Survey — South Africa's first TB prevalence survey, which included 35,191 participants — is most notable amongst recent data (NDOH 2018). The survey findings have been used by the WHO to refine TB estimates for the country and are being used by the country for developing strategies, programs and interventions. For instance, the high level of asymptomatic cases in the survey lent support to the use of digital x-rays for TB diagnosis in many communities as well as gene expert among pregnant women.
- TPT uptake increased during the period under review, from 67% in 2018 to 93% in 2020. This improvement is likely attributable to advocacy work for improved TPT, availability of shorter and safer TPT regimens, and as well as intensified programming by the NDOH

KEY CHALLENGES

- The WHO recommends HPV DNA testing, which is the most sensitive of all methods and has a very high negative predictive value and as such a very good alternative to cytology screening (WHO. 2021). In South Africa, although HPV DNA testing has been endorsed and included in guidelines for cervical cancer screening, it is not yet widely available in the public sector (NDOH. 2017)

- The 2018 National TB prevalence survey reported that almost two-thirds of patients were asymptomatic (NDOH 2018). This revealed that the TB screening approach based on symptoms had low sensitivity especially in pregnancy which necessitates the need for molecular methods (Gene-Xpert) to improve the case finding rate (Orazulike et al. 2021). Similarly, the use of syndromic diagnosis for gonorrhoea is fraught with limitations that approach has limited sensitivity (Gupta and Sharma 2019)
- The data for evaluating this framework are very scarce. For example, the data for Hepatitis C testing among PLHIV, or for cervical cancer screening among women living with HIV are not available
- Available data show that the COVID-19 lockdown impacted negatively on TB detection and treatment. NICD analysis showed that the national lockdown in

response to COVID-19 was associated with a two-thirds decline in median daily GeneXpert TB tests, and a 33% decline in the number of TB diagnoses between February and May 2020 (NICD 2020).

RECOMMENDATIONS

- The government should ensure the inclusion of Hepatitis C data in the National Indicator Dataset (NIDS) to ensure it is collected and readily available to inform programme decision making
- There is need for government and its stakeholders to improve TB diagnostic methods implementing systems with high sensitivity to improve case finding.

Political Declaration and Framework 8: Investments and resources

SCORECARD ANALYSIS

INDICATOR	RESULT
Is this a priority for South Africa?	Yes
Is it addressed in the national strategic plan?	Yes
Has South Africa reached the target	No
How likely is South Africa to reach the target by 2025?	Unlikely

LEGAL AND POLICY ENVIRONMENT

The country's Constitution places obligations on the State to realize the socio-economic rights of citizens, such as the right to have access to affordable and quality health care (South Africa 2015). The commitment and strategy towards addressing these obligations are currently articulated in the NSP 2017–2022, which outlines the strategic framework for a multi-sectoral partnership approach towards addressing the HIV and TB epidemics. One of the goals of the NSP is to “mobilize resources to support the achievement of the NSP goals and ensure a sustainable response” to HIV, TB and STIs. This confirms that South Africa's approach to ending HIV, TB and STIs as public health threats by 2030 is centred on the provision of adequate and targeted funding to various and relevant key players.

There is good alignment between the current NSP 2017–2022 and the National Development Plan (NDP): Vision 2030 (South African Government 2012). The NDP enshrines a health system that works for everyone and produces positive health outcomes, resulting in a significant reduction in the burden of diseases. South Africa is also committed to the global commitment set in Goal 3 of the Sustainable Development Goals (SDGs), which is to ensure healthy lives and promote wellbeing for individuals of all ages. More importantly, the SDG Goal 3 envisages the end to epidemics of AIDS and tuberculosis by 2030 (UNAIDS. 2022a).

The National Health Insurance (NHI) is South Africa's planned health financing policy which seeks to achieve equitable health financing (Health. 2019). It was approved by the Cabinet in 2019 and is still under several rounds of review. It is anticipated that when fully implemented, the NHI will provide universal access to quality health care for all South Africans as enshrined in the Constitution (Health. 2019). This policy is also expected to include HIV financing that will ensure HIV prevention, care, and treatment services as part of the benefits package.

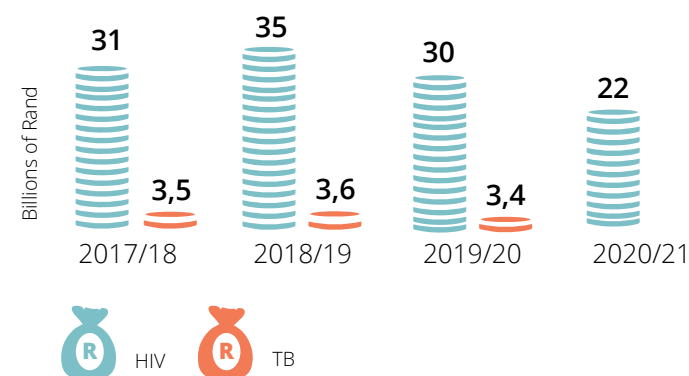
CURRENT STATUS AND PROGRESS

Domestic public budget on HIV

- During the period under consideration, the total expenditure on HIV decreased from R30.6 billion in 2017/18 to R21.6 billion in 2020/21 (Figure 25). This

equates to a 40% decline in expenditure during this period. The expenditure on TB remained relatively static at approximately 3 billion (UNAIDS. 2022b)

Figure 25: Total expenditure on HIV



Source: NASA report (2017–2020)

The National AIDS Spending Assessment+ NASA+ 2017–2021 report is not yet published. However, based on the 2017–2020 report, the largest proportion (at least two thirds) of the funds on HIV are spent on HIV care and treatment (Table 12). The total expenditure on HIV care and treatment increased from R19.7 billion in 2017/18 to 26.7 billion in 2019/20 (NASA. 2021). Notwithstanding the prevention benefit of increasing access to HIV treatment, it was concerning to note the decreasing expenditure for prevention in nominal and proportional terms (from 11% to 8% of the total purse) (NASA. 2021).

Table 12: Total HIV spending in South Africa by Programme Area

Total HIV spending per programme	2017/18	2018/19	2019/20	% 2017/18	% 2018/18	% 2019/20
Prevention	3,405,503,382	3,944,661,024	3,153,501,544	11%	11%	8%
HIV testing and counselling (HTC)	1,815,308,172	1,865,758,359	1,702,404,025	6%	5%	5%
HIV Care and Treatment	19,407,752,141	23,151,117,433	26,714,078,912	63%	66%	71%
Social protection & economic support	2,204,626,592	1,895,973,920	2,188,478,809	7%	5%	6%
Social enablers	52,157,390	15,441,119	43,688,212	0.2%	0.0%	0.1%
Program enablers and systems	2,863,491,877	3,301,191,957	2,827,762,856	9%	9%	8%
Development synergies	353,309,896	389,417,895	475,089,467	1%	2%	1%
HIV-related research	486,985,306	532,636,515	456,759,436	2%	2%	1%
Total HIV spending (ZAR)	30,589,134,755	35,096,198,222	37,561,763,260	100%	100%	100%

Source: UNAIDS Online Tool

Antiretrovirals: unit prices and volume

As shown in Table 12, expenditure on ART accounted for the majority of the NDoH's expenditure on HIV programs. The NDoH spent R14.2 billion on ART in 2019/20 at the cost of R2,850 per unit (UNAIDS. 2022b). The cost of ARVs in South Africa in the 2019/20 financial year averaged at US\$ 98 per unit. ARVs constituted half of the total cost of HIV treatment, care and support (NASA. 2021).

Total HIV expenditure by source and for key programmes

The government of the Republic of South Africa leads the nation's response to HIV, TB and STIs, contributing the largest share of the required domestic funding, while external donors such as PEPFAR, USAID, the Global Fund, and the private sector fund the remainder of the costs (NASA. 2021).

Although actual expenditure on HIV by the government increased from R22.2 billion in 2017/18 to R26.0 billion in 2019/20, in relative contribution to other spenders, it

decreased from 72% to 69% (Table 13). Donor commitment towards combating HIV in South Africa remained strong over the review years.

Table 13: Financing entities contributions to HIV funding in South Africa (2017/18-2019/20 ZAR, %)

HIV Funding Entities (ZAR)	2017/18	2018/19	2019/20	% 2017/18	% 2018/18	% 2019/20
Government of South Africa	3,405,503,382	3,944,661,024	3,153,501,544	11%	11%	8%
PEPFAR	1,815,308,172	1,865,758,359	1,702,404,025	6%	5%	5%
Global Fund	19,407,752,141	23,151,117,433	26,714,078,912	63%	66%	71%
Other bilateral funding entities	2,204,626,592	1,895,973,920	2,188,478,809	7%	5%	6%
Other multilateral funding entities	52,157,390	15,441,119	43,688,212	0.2%	0.0%	0.1%
INGOs and Foundations	2,863,491,877	3,301,191,957	2,827,762,856	9%	9%	8%
Other International entities	353,309,896	389,417,895	475,089,467	1%	2%	1%
Medical insurances	486,985,306	532,636,515	456,759,436	2%	2%	1%
Private sector/domestic corporations	1,535,165	2,174,185	2,856,535	0.0%	0.0%	0.0%
Local NGOs	310,676	1,686,451	6,013,849	0.0%	0.0%	0.0%
Total HIV (ZAR)	30,589,134,755	35,096,198,222	37,561,763,260	100%	100%	100%

Source: UNAIDS Online Tool

PEPFAR funding increased by 55% from R5.8 billion in 2017/18, to R9.1 billion in 2019/20. However, Global Fund spending declined during this period.

ACHIEVEMENTS

Consistent increase in HIV/AIDS budget and expenditure

The country has done substantially well in securing funding for HIV programs. This is both in terms of its domestic funding and support from international funders.

During the period under review, South Africa and her development partners increased financial investments in HIV programs. The R7 billion increase in total funding over the three-year period is really a laudable achievement.

Prioritizing ART program

The HIV expenditure pattern by the South African Government shows a prioritization of PLHIV for treatment. This is consistent with the need to achieve the 95-95-95 target. Also, treating PLHIV is cost saving in the long run, as it reduces HIV-related health burdens and new HIV infections and increases life expectancy.

KEY CHALLENGES

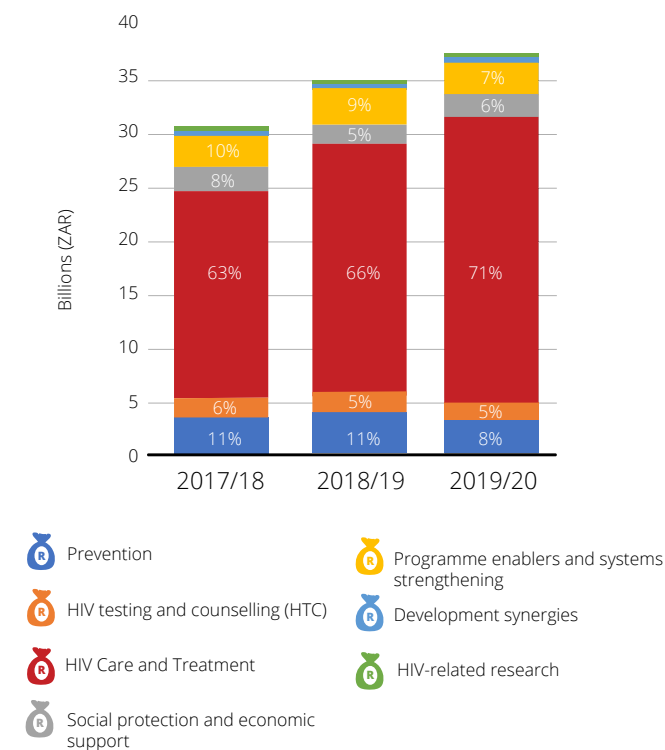
Low TB funding

As TB tops the leading causes of natural deaths in South Africa, it is important that the TB funding is increased to ensure that TB services remain available, accessible and of acceptable quality with good health outcomes.

Decreasing amounts spend on HIV prevention

It is worrisome to note decreased investments in HIV prevention as South Africa still faces high HIV incidence rates. According to UNAIDS, HIV prevention budget should constitute 25% of the budget allocation for HIV and AIDS interventions. The NASA report indicates a downward trend (from 11% in 2017/18 to 9% in 2019/20 on HIV prevention funding over the three-year period, as illustrated in Figure 26 below. Research is required to identify leading causes of new infections and the best ways to prevent them, with adequate resources allocated to effective interventions.

Figure 26: Total HIV spending by programme area (2017-2020, ZAR)



Source: NASA report (2017-2020)

RECOMMENDATIONS

- As HIV expenditure is showing a declining trend between 2017 and 2021, government and its stakeholders should develop a model for increasing domestic funding harnessing the potential of the private sector
- Notwithstanding the prevention benefit of increasing access to HIV treatment, government and its stakeholders should increase investments into prevention programmes to close the tap on new HIV infections which will be beneficial in the future of the HIV response ('Spend now to save latter')
- HIV-related research has received relatively less budget allocation and most of it has been funded by international agencies which presents a sustainability risk as donor funds are declining. Government and its stakeholders should mobilise domestic funding to support research activities that will generate data to inform the national response

Summary of key achievements, challenges and recommendations

ACHIEVEMENTS

Advances in policy development to address key factors of HIV transmission and treatment adherence

- In line with international efforts to end HIV by 2030, the country adopted the new Political Declaration on HIV and AIDS which is a demonstration of commitment at national level to address the HIV epidemic.
- The country has consistently developed, reviewed and updated the National Strategic Plan for HIV, TB and STIs to ensure effective coordination of the response.
- With COVID-19, the country's attention was drawn to the need to address GBV and IPV. Resultantly, in 2020, the country launched the National Strategic Plan on GBV and Femicide 2020-2030 (NCGBVF) and a targeted fund that provided a framework for addressing GBV and intimate partner violence (IPV).
- As evidence shows diminished performance for KPs along the HIV cascade, the development and adoption of the NDMP and the continued enabling environment for the operation of organisations such as South African Network of People Using Drugs (SANPUD) and Community-Oriented Substance Use Programme (COSUP), among others, reflects commitment to addressing the structural challenges faced by KPs in accessing HIV services.
- Efforts to improve ART coverage, patient retention

and treatment adherence leading to improved viral suppression were supported through the introduction of same-day initiation strategy and the fixed-dose combination (FDC).

Government supports about 70% of all the HIV expenditure in the country

The country has done substantially well in securing funding for HIV programs. This is both in terms of its domestic funding and support from international funders. During the period under review, South Africa and her development partners increased financial investments in HIV programs.

Decreasing incidence and increasing prevalence

South Africa continued to experience a decline in incidence as measured by new HIV infections while prevalence has increased. The increase in prevalence has been attributed to decreasing HIV incidence coupled with increasing number of people initiating ART, prevention measures such as PMTCT, VMMC, roll-out of PrEP among high-risk groups such as sex workers and PEP for survivors of sexual assault, inter-alia.

Increasing availability of data for decision making

The past three years have seen a spike in research and studies being conducted to provide data for decision making. Examples of such studies include the PSEs, IBBS, stigma index survey and other research and clinical trials conducted under the medical research council and other similar institutions.

Achievement of the 1st and 3rd 90s

The results of the policy, strategy and implementation plans are seen at the patient outcomes level. The achievement of the 1st 90 as an entry point to HIV care and treatment followed by viral suppression is a good indicator for progress being made in containing HIV.

Resilient social protection floors

The country has seen an increase in the number of people receiving social grants as a way of cushioning the most vulnerable from poverty, which is a key driver of HIV transmission, morbidity and mortality. In addition, with the onset of COVID-19, the government introduced a social relief of distress grant in mitigation and response to the adverse effects of COVID-19.

Declining AIDS mortality

According to StatsSA, the estimated number of AIDS-related deaths declined consistently between 2016 from 97,404 to 79,420 in 2020 with a slight increase in 2021 to 85,154. Access to ART was reported as having changed significantly over time, altering the pattern of mortality over time averting AIDS related deaths that would have otherwise occurred.

CHALLENGES

Impact of COVID in attaining NSP goals

The COVID-19 pandemic has had a significant impact on the country's progression towards its targets. South Africa

has the highest number of COVID-19 (34%) cases in Africa, accounting for 43% of all reported COVID-19-related deaths on the continent. The country accounts for 20% of all people living with HIV and ranked third in the world for new TB infections in 2019. While South Africa's investments in its HIV and TB responses enabled it to pivot rapidly to respond to the emerging COVID-19 epidemic, it negatively impacted the HIV and TB response through temporary suspension of research, diversion of key resources for HIV and TB control, and patient access to health care facilities; the full extent of this has yet to emerge.

Low HIV treatment coverage

While the country reached its first 90 and is close to reaching the third 90, its challenge remains with the initiation of patients diagnosed with HIV. The challenge is more pronounced among key populations and children compared to the general population.

Poor performance on the 90-90-90 cascade for among children

Despite tremendous progress in the fight against HIV and AIDS, outcomes for treatment and care among children remain low. Sadly, disparities in the HIV response continue to result in failure to meet the unique needs of children living with or are at high risk of HIV.

Continued human rights violation

Key populations such as FSWs still report high stigmatization rates and of being made to feel guilt, shame and a loss of dignity as a result of the discrimination by healthcare providers and other community members (Duby et al. 2018). There remains significant stigma and discrimination in healthcare facilities towards key populations (Mbede et

al. 2020). This often results in limited if not lack of access to healthcare as members of the key population avoid seeking healthcare (Duby et al. 2018; Müller 2019).

Government expenditure has shown a decline

Despite comparatively high government investments into HIV programs with over 70% expenditure coming from government, the proportion of government expenditure has been declining (from 72% in 2017/18 to 69% in 2019/20) with some program areas such as research and prevention not receiving much support raising sustainability questions considering declining donor funding.

Lack of unique patient identifier

With the movement of people across geographic and system boundaries, it is difficult for health information systems and service providers to track service provision and retain patients on treatment. The lack of unique identifiers across systems undermines the ability to have access to patient health information by service providers to effectively provide services.

Decreasing amounts spend on HIV prevention

It is worrisome to note decreased investments in HIV prevention as South Africa still faces high HIV incidence rates. According to UNAIDS, HIV prevention budget should constitute 25% of the budget allocation for HIV and AIDS interventions. The NASA report indicates a downward trend (from 11% in 2017/18 to 9% in 2019/20 on HIV prevention funding over the three-year period).

Declining incidence albeit at a slower rate

With a higher HIV burden globally, the country continues to struggle with closing the tap on new HIV infections and

reaching its target of incidence reduction by 50% (achieving -31% decline in new HIV infections). HIV incidence continue to increase among females in the 50+ age group. For example, the number of new HIV infections among this group increased between 2016 and 2021 from 14,589 to 15,393, respectively.

Worrying increase in delivery among adolescents

Delivery in 10 to 19 years in facility rates increased by almost double from 7.3% in 2016/17 to 13.2% in 2019/20 (District Health Barometer 2020). This is a proxy for risky sexual behaviour among the young population. Teenage pregnancy indicates risky, coerced and unprotected sex for many girls, with consequences of contracting sexually transmitted infections in general, including HIV. Adolescent girls and young women have the highest rate of acquisition of HIV, and the current (2021) HIV incidence rate for females aged 15 - 24 is 1.14% compared to 0.30% for their male counterparts (Thembeisa model 4.5., in Johnson et al.).

RECOMMENDATIONS

Leverage community, civil society, and private sector partnerships to improve service delivery and client outcomes

As the number of people on treatment increases and the burden becomes heavier for the health system, the government needs to leverage the communities, civil society and the private sector by investing in innovative approaches that decentralise the management of HIV to the communities and incentivise the participation of the private sector.

Strengthen health system resilience and community-led monitoring

Health systems are uniquely placed at community level, they

are designed, led and organized by communities themselves to address local needs and reach the most marginalized and vulnerable people. Thus, the government needs to strengthen them to deliver integrated, people-centered services to address an individual's multiple health needs at different points in their lives, improving overall health with a more cost-effective and efficient approach. Strengthen community systems and community-led programming through such initiatives as Ritshidze system should be a priority for scaling nationally for community ownership and system accountability.

Increasing domestic funding for HIV

Globally, donor funding is declining. With an anticipated global economic recession, the amount of international funding is likely to drop further. The government needs to work with the private sector and devise ways in which domestic funding for HIV can be increased. This could include incentive schemes for the private sector to contribute both in cash and kind towards the management of HIV.

Intensify efforts to address human rights violations

Government needs to intensify both institutional and programmatic efforts to curb the challenges related to human rights violations for PLHIV in general and key and vulnerable populations in particular. For example, at institutional level, government needs to fast track the decriminalisation of sex work while at programme level intensify the training of healthcare providers to provide information and improve their skills which may lead to improved quality of healthcare for LGBT people. In addition, scale-up the training and sensitization of judiciary and law enforcement officials on policy developments meant to protect key populations to reduce discrimination,

stigmatization and harassment.

Strengthen GBV and IPV interventions

As the country works towards achieving and sustaining gains in reducing new infections, HIV prevention, stigma and discrimination reduction including gender-based violence (GBV) case identification remain critically important and need to be scaled and optimized, more especially for children, adolescents, youth, men, and key populations at-risk where the rate of new infections remains substantial. There is need for political and financial support to ensure that well-developed policy, institutional and legal framework in the country find expression at community level where PLHIV access HIV services

Continued support for behaviour change among young people

The country should intensify the development and implementation of innovative models and interventions targeted at behaviour change particularly among the young people to reduce risky sexual behaviour and new HIV infections.

Strengthen prevention efforts ('Invest now, save later')

As evidence has found long-acting injectable cabotegravir to be acceptable, safe, and highly effective in preventing the spread of HIV, the country needs to make financial commitments and making the drugs available to all eligible and at-risk populations for incidence reduction.

Research agenda

While a lot of research work is being conducted as indicated above, there is need for the country to develop a research

agenda to guide more targeted research. For example, as incidence has increased among the 50+ age group, and particularly among women, the country should conduct studies to investigate factors that maybe influencing this trend with the goal to develop and implement interventions to stop this increase.

CONCLUSION

In June 2021, South Africa joined other countries in adopting the political declaration on HIV and AIDS to get the country, and the world, on track to end AIDS as a public health threat by 2030 and accelerate progress towards achieving the Sustainable Development Goals (SDGs), Goal 3 on good health and well-being. This report provided a status update on progress against the political declaration and framework targets for South Africa.

Across all the commitments, a consensus of likely not achieving set targets by 2025 exists and this is guided the score card analysis used. Under each commitment, the score cards are presented, and drivers and challenges are discussed. A The country has made significant strides towards this goal through reduced incidence, increasing the number of people on ART, reduced mother-to-child transmission rates, achievement of the 1st and the 3rd 90s, sustained social protection floors and declining AIDS related mortality.

These efforts have been realised through the concerted efforts of government and its partners particularly in prevention, research, treatment and other targeted interventions. Despite this progress, significant challenges remain that undermine the efforts of response players. Such notable challenges include the increasing incidence

among the 50+ females, increasing risky sexual behaviour among adolescents, low HIV treatment coverage and especially among children and key populations, health system challenges accentuated by the COVID-19 epidemic, among others. As the country progresses towards the UNAIDS 95-95-95 targets, innovative models rooted in community-led approaches and anchored by resilient health systems are needed to identify, initiate, and retain all PLHIV on ART.

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