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2022 Global AIDS Monitoring Report

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Abbreviations & Acronyms

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

Abbreviations & Acronyms

OVC	Orphans and Vulnerable Children
PCR	Polymerase Chain Reaction
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHC	Primary healthcare
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
SANPUD	South African Network of People Using Drugs
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
UHC	Universal Health Coverage

UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UTT	Universal Test and Treat
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

Introduction

This Global AIDS Monitoring (GAM) report compares performance to established targets for relevant metrics to illustrate the country's progress in 2023 in responding to the HIV epidemic. It also gives the current state of the legislative and regulatory framework supporting the noted accomplishments. This report is produced in line with the 2021 UNAIDS Political Declaration on HIV and AIDS¹. Data for the period January to December 2022 indicate that all respective commitments' targets are unlikely to be met by 2025, and the score card analysis was designed with this in mind. The drivers and challenges are explored, and the score cards are shown under each commitment.

2021 New UNAIDS political declaration on HIV and AIDS

The 2021 Political Declaration on HIV and AIDS is in line with the Global AIDS Strategy 2021–2026 and the Sustainable Development Goals (SDGs). The Global AIDS Strategy, 2021–2026, encourages identifying and addressing the gaps impeding progress towards AIDS eradication by applying an inequities lens and giving priority to the best available data. A common reference point for effective international accountability measures is the GAM process. Lessons learned from previous rounds provide an evidence-based roadmap for prompt, thorough, and high-quality reporting at a streamlined and expedited pace. According to the 2021 Political Declaration, accomplishing specific, deadline-driven goals should serve as a gauge for the AIDS response's

effectiveness. This necessitates regular monitoring of the implementation of pledges and mandates the yearly progress reports from the UN Secretary-General. This report aims to pinpoint obstacles and limitations while suggesting courses of action to expedite South Africa's attainment of its goals.

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 shows how the country is doing in relation to the frameworks and political declaration, including extended targets. The report outlines the epidemic and the

state of the national response, points out obstacles and difficulties, and offers audacious suggestions to hasten target attainment. The fact that the report tracks the government's advancement towards predetermined goals makes it significant for both the country and its regional and global allies. Additionally, the country values the mobilization of resources and advocacy from both domestic and foreign partners. Thus, this GAM 2023 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

In South Africa, the five-year National Strategic Plans (NSPs) govern the implementation of the multisectoral response to HIV, TB, and STIs. The country's response over the previous four years has been described in the NSP (2017–2022). The weight of the HIV and AIDS epidemic demands unwavering political leadership and dedication to make sure that these issues are included in the political agenda. South Africa has ratified several regional and international agreements aimed at easing the pandemic's effects. The country supports

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

² https://www.unaids.org/en/AIDS_SDGs



the universal goals set forth by the Joint United Nations Programme on HIV and AIDS (UNAIDS), which include zero new cases of HIV, TB, or STI infections; zero new cases of parent-to-child transmission of HIV or other STIs; zero new cases of HIV, TB, or STI infections leading to death; and zero cases of discrimination against anyone based on their status².

The NSP is continuously updated and revised every five years, which demonstrates South Africa's commitment to putting an end to the epidemic. Under the direction of NSPs that are in line with and motivated by the overarching UNAIDS vision, the South African National AIDS Council (SANAC) is a multisectoral organisation that oversees the country's response to HIV and AIDS, TB, and STIs. The overriding notion of promoting multisectoral participation of all civil society organisations, political leadership, government departments, business, and development partners is ingrained in the objectives of subsequent NSPs.

Methods and data sources

A retrospective design and analysis were used to determine the state of each political statement and framework, as well as the progress made towards its goals. More precisely, to demonstrate progress made thus far, a methodical desktop analysis of pertinent documents was carried out in relation to every political statement and framework (i.e., policies, plans, regulations, guidelines, reports, etc.) pertaining to the HIV response. This featured a quantitative comparative data analysis (retrospective analysis) to display patterns

over the previous five years. Thembisa Model version 4.6 (henceforth referred to as the Thembisa Model), national policies, strategies, and guidelines; data from national and biobehavioral surveys; data from the district health management information system (DHIS); programme data; scientific publications; GAM 2024 guidelines; and UNAIDS online data were among the data sources utilized to compile the report.

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



Summary scorecard analysis

Table 1 presents a summary scorecard performance of the country against the political declaration and framework targets. The summary shows that the country is likely to meet the targets for commitment 2 (95–95–95 for HIV testing and treatment) and commitment 7 (Universal health coverage and integration) by 2025. This is mainly because for commitment 2, the performance is on the cusp for the first and last 95 while several interventions and focus is increasing on retention and ART coverage. For commitment 7, the passing of the National Health Insurance (NHI) Bill in parliament is a critical enabler that will move the country towards equitable universal health coverage.

Table 1: Summary scorecard analysis

	Is this a priority for South Africa?	Is it addressed in the national strategic plan?	Has South Africa reached the target?	How likely is South Africa to reach the target by 2025?
Political Declaration and Framework 1: Combination HIV prevention for all	Yes	Yes	No	Unlikely
Political Declaration and Framework 2: 95–95–95 for HIV testing and treatment	Yes	Yes	No	Likely
Political Declaration and Framework 3: End paediatric AIDS and eliminate vertical transmission	Yes	Yes	No	Unlikely
Political Declaration and Framework 4: Gender equality and empowerment of women and girls	Yes	Yes	No	Unlikely
Political Declaration and Framework 6: Realize human rights and eliminate stigma and discrimination	Yes	Yes	No	Unlikely
Political Declaration and Framework 7: Universal health coverage and integration	Yes	Yes	No	Likely
Political Declaration and Framework 8: Investment and resources	Yes	Yes	No	Unlikely

Political declaration and framework 1

Combination HIV prevention for all

Overall, data indicate that the number of new HIV infections in South Africa decreased by negative 13%. The statistics also indicate that females over the age of 15 and adults 50+ did not perform as their performance is below the national average in terms of preventing new HIV infections. From a policy standpoint, advocacy interventions like the creation and implementation of the National Drug Master Plan (NDMP), population size estimations, integrated biological and behavioural studies (IBBS), and the founding of groups like the Community-Oriented Substance Use Programme (COSUP) and South African Network of People Using Drugs (SANPUD) continue to highlight the difficulties faced by key and vulnerable populations.

An important first step in tackling Gender -Based Violence (GBV) and Intimate Partner Violence (IPV) as major contributors to the spread of HIV was the creation and implementation of the National GBV and Femicide plan, which addressed the rising incidence of GBV and IPV.

Additional evidence points to the role that combination prevention strategies, including Prevention of Mother to child Transmission (PMTCT) of HIV, Voluntary Medical Male Circumcision (VMMC), increased condom use among youth, increased Pre-Exposure Prophylaxis (PrEP) uptake by key populations, and Post Exposure Prophylaxis (PEP) availability for sexual assault survivors, have played in lowering the rate of new HIV infections.

Political declaration and framework 2

95-95-95 for HIV testing and treatment

By December 2022, South Africa's performance against the UNAIDS 95-95-95 strategy for the control of the HIV pandemic was 94-76-92, which means that as of the end of December 2022, 94% of people living with HIV knew their status, 76% of people living with HIV are on antiretroviral treatment (ART), while 92% of the estimated proportion of patients on ART were virally suppressed at 12 months (DOH Annual Report, 2022).

Political declaration and framework 3

End paediatric AIDS and eliminate vertical transmission

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). A significant number of children are infected with HIV. At the end of 2022, the Thembisa Model estimates show that there were 210,718 children (<15) living with HIV in the country.

Furthermore, an estimated 9,063 children became newly infected with HIV during 2022. About 4% of the 48,412 people who died of AIDS related illnesses during 2022, 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. .

Political declaration and framework 4

Gender equality and empowerment of women and girls

South Africa is a signatory to several international treaties on GBV, and strong legislative framework, for example the Domestic Violence Act (DVA) (1998), the Sexual Offences Act (2007) and the Prevention and Combatting of Trafficking in Human Persons (2013) Act. 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. 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 IPV. .

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). There is still evidence showing an increase in the number of GBV-related crimes and violence.

Political declaration and framework 5

Community leadership

This framework was not required to be reported during the period under review.

Political declaration and framework 6

Realize human rights and eliminate stigma and discrimination

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. However, literature shows that in South Africa, Men who have sex with men (MSM), sex workers and People who use drugs (PWUD) report frequent exclusion from society and high levels of stigma and discrimination in the healthcare setting (Ritcher, 2008; Parry et al., 2009). Judgmental and moralizing views towards sex work, sex between people of the same sex, homosexuality and drug use are frequently expressed within South African communities, and more specifically by individuals working in the healthcare setting, warranting specific attention and address (Lane et al., 2008; Scheibe, Drame, Shannon, 2016).

Political declaration and framework 7

Universal health coverage and integration

The nation's strategic plan (NSP) calls for the unification of the delivery of health services, including those for HIV, TB, STIs, cervical cancer, and HPV, among others. It directs the efforts to eradicate, prevent, and minimise new instances of TB, HIV, and STIs. In 2021, the nation upheld its goal to Universal Health Coverage (UHC) by continuing to spend 8.9% of Gross Domestic Product (GDP) on health care, with a particular emphasis on bolstering robust health systems to provide fair access to treatments. The nation spends a comparatively high amount on health care when compared to other nations with comparable economies.

According to the most recent data on the nation's UHC performance, South Africa's UHC index increased from a score of 36 in 2000 to a score of 67 over the previous 20 years, nearly doubling in size. In 2019, South Africa passed a law establishing a decentralised approach to treating multidrug-resistant tuberculosis (MDR-TB). The dedication to integrating care provision is demonstrated by the cross-referencing of diseases in various ways. To achieve universal health care, the nation is also figuring out how to implement and roll out the National Health Insurance.

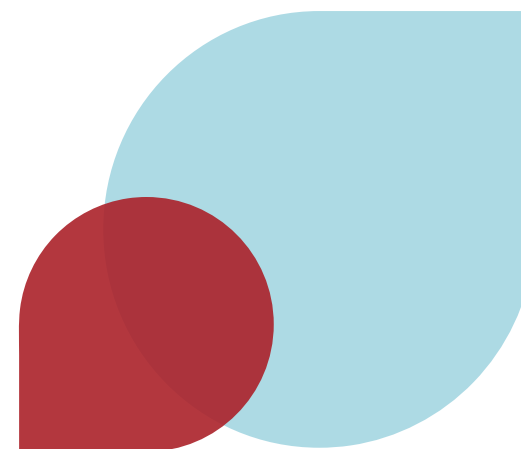
Political declaration and framework 8

Investments and resources

Leading the country's response to HIV, TB, and STIs is the Republic of South Africa's government, which provides the most of the necessary domestic funding. The remaining expenses are covered by external donors like PEPFAR, USAID, the Global Fund, and the private sector (NASA, 2021). The

government's real spending on HIV went from R22.2 billion in 2017–18 to R26.0 billion in 2019–20; however, its share of other spenders fell from 72% to 69% (Table 13). Throughout the review years, donor commitment to the HIV/AIDS crisis in South Africa remained high. The South African 2021 Investment Case report estimates that the nation will require roughly R80 billion to raise retention to 95%, roughly R30 billion to retain human resources, and roughly R50 billion for new ART.

The analysis also shows that even if all interventions are scaled up, the overall yearly cost of the HIV program—which ranges between R20 billion and R25 billion—remains substantially below the budget constraint, proving that it is affordable within the current budget. Civil society organisations (CSOs) expressed concern that, despite the Investment Case report's optimistic outlook, the November 2021 Medium Term Budget Policy Statement (MTBPS) would cause provinces to receive less funding—both through the equitable share and conditional grants—which could lead to the provinces missing important HIV/AIDS targets.



Overview of the HIV/AIDS Epidemic in 2023



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.

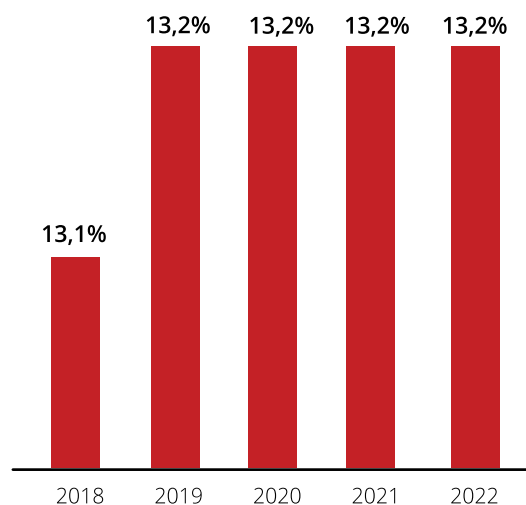
South Africa remains the epicentre of the HIV pandemic with the largest HIV prevalence in the world, coupled with an estimated 20% of all global new HIV infections and about 20 percent of all people living with HIV (PLHIV) being recorded in the country. The overall HIV prevalence for the country is estimated to have slightly decreased from 13.1% in 2018 to 13.2% in 2022 (Figure 1).

The total number of people living with HIV (PLHIV) on Anti-Retroviral Therapy (ART) is correspondingly estimated to have increased from about 7,459,110 in 2018 to 7,786,060 in 2022 (Thembisa Model), representing about 4.4% change.

The slight increase in prevalence can be explained by the declining incidence from 0.44% in 2018 to 0.32% in 2022 (Thembisa Model) as a result of a combination of preventive measures such as PMTCT, VMMC, roll-out of PrEP among high-risk groups such as sex workers, PEP for survivors of sexual assault and increasing number of people enrolling on ART (NDOH 2023).

This trend can cautiously be considered that the country is making progress towards epidemic control.

Figure 1: South Africa HIV prevalence (2018-2022)



Source: Thembisa Model ver. 4.6

Of the estimated 164,228 HIV new infections in 2022, about 102,806 (approximately 63%) were females above the age of 15 years and about 9,063 (5.5%) 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%. The second 95 remains the critical gap in South Africa. 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 females aged 15+ (slightly increasing), ages 25+ and 50+. 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 females 15+ and the general population of the 25+ age groups can be attributed to increased efforts to identify positives and increasing incidence, particularly among the 50+ population.

Table 2: HIV prevalence by age and sex (2018-2022)

Indicator	2018	2019	2020	2021	2022
Total HIV prevalence	13.1%	13.2%	13.2%	13.2%	13.2%
HIV prevalence in males aged 15+	13.0%	13.0%	13.0%	12.9%	12.9%
HIV prevalence in females aged 15+	21.8%	22.0%	22.1%	22.3%	22.4%
Prevalence in children (<15)	1.9%	1.7%	1.6%	1.4%	1.3%
Prevalence in youth (15-24)	7.2%	6.9%	6.7%	6.4%	6.2%
Prevalence in males aged 15-24	3.8%	3.8%	3.8%	3.7%	3.7%
Prevalence in females aged 15-24	10.6%	10.1%	9.6%	9.2%	8.7%
Prevalence in age group 15-49	19.3%	19.2%	19.0%	18.8%	18.4%
Prevalence in males aged 15-49	13.5%	13.4%	13.1%	12.9%	12.5%
Prevalence in females aged 15-49	25.0%	25.0%	24.9%	24.7%	24.3%
Prevalence in age group 25-49	24.7%	24.5%	24.3%	24.0%	23.6%
Prevalence in males aged 25-49	17.9%	17.5%	17.2%	16.8%	16.3%
Prevalence in females aged 25-49	31.4%	31.4%	31.3%	31.1%	30.9%
Prevalence at ages 25+	20.7%	20.8%	20.9%	21.1%	21.1%
Prevalence in adults aged 50+	12.1%	12.9%	13.8%	14.8%	15.8%
Prevalence in males aged 50+	11.2%	11.8%	12.5%	13.3%	14.0%
Prevalence in females aged 50+	12.8%	13.7%	14.8%	16.0%	17.2%

Source: Thembisa Model ver. 4.6

HIV Prevalence by geographical areas

South Africa HIV prevalence by province

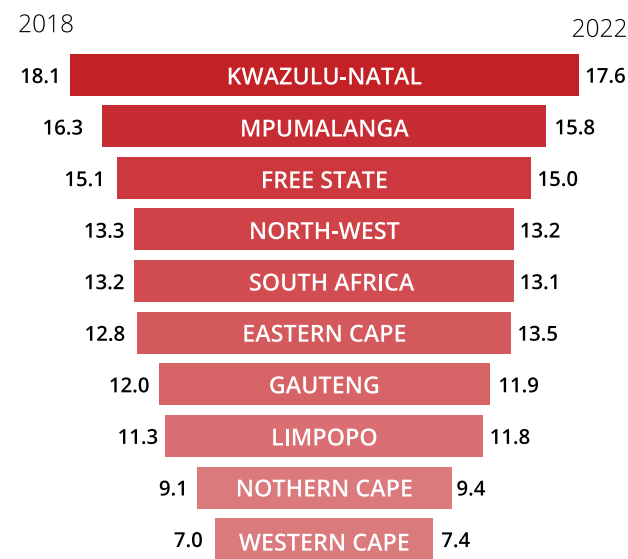
Figure 2 compares HIV prevalence by province between 2019 and 2022. The data show that KwaZulu Natal (KZN) and Mpumalanga (MP) had the highest prevalence compared to other provinces. While prevalence declined across all the other provinces and nationally, there was a visible increase in Limpopo (LP), Eastern Cape (EC) and Western Cape (WC). 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 2022 and calibrated Thembisa 4.6 outputs) 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, Northwest, Gauteng,

Figure 2: South Africa HIV prevalence by province and year



Source: Thembisa Model ver. 4.6

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: MSM and female sex workers (FSW). The model shows that HIV prevalence for MSM (18+ years) was almost half (2018 = 32.3%; 2022 = 29.9%) of the HIV prevalence for FSW (2018 = 64.9%; 2022 = 58.8%). 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.

Thousands (000)

Legend:

- Gauteng
- KwaZulu-Natal
- Western Cape
- Eastern Cape
- Limpopo
- Mpumalanga
- North West
- Free State
- Northern Cape

Province/Municipality	Approximate Cases (Thousands)
Johannesburg	700
Ekurhuleni	630
Township	550
City of Johannesburg	350
Bongweni	350
uMgungundlovu	300
King	250
Cape Town	220
uMgungundlovu	220
uMgungundlovu	200
uMgungundlovu	180
uMgungundlovu	170
uMgungundlovu	160
uMgungundlovu	150
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uMgungundlovu	60
uMgungundlovu	50
uMgungundlovu	40
uMgungundlovu	30
uMgungundlovu	20
uMgungundlovu	10
uMgungundlovu	5
uMgungundlovu	2
uMgungundlovu	1
uMgungundlovu	0.5
uMgungundlovu	0.2
uMgungundlovu	0.1
uMgungundlovu	0.05
uMgungundlovu	0.02
uMgungundlovu	0.01
uMgungundlovu	0.005
uMgungundlovu	0.002
uMgungundlovu	0.001
uMgungundlovu	0.0005
uMgungundlovu	0.0002
uMgungundlovu	0.0001
uMgungundlovu	0.00005
uMgungundlovu	0.00002
uMgungundlovu	0.00001

HIV prevalence among antenatal care attendees

HIV incidence

15



Political Declaration and Framework 1: Combination HIV prevention for all

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 legal and regulatory framework for the prevention of new HIV infections in South Africa has a history marked by frenetic advancements, with new rules being created and put into effect all over the country. The legal and regulatory framework for the prevention of new HIV infections in South Africa has a history marked by frenetic advancements, with new rules being created and put into effect all over the country.

The initiatives were directed towards certain demographic groups considered to have an increased risk of HIV infection. Young adults (15–24 years old), children (under 15), expectant mothers, and important demographics were

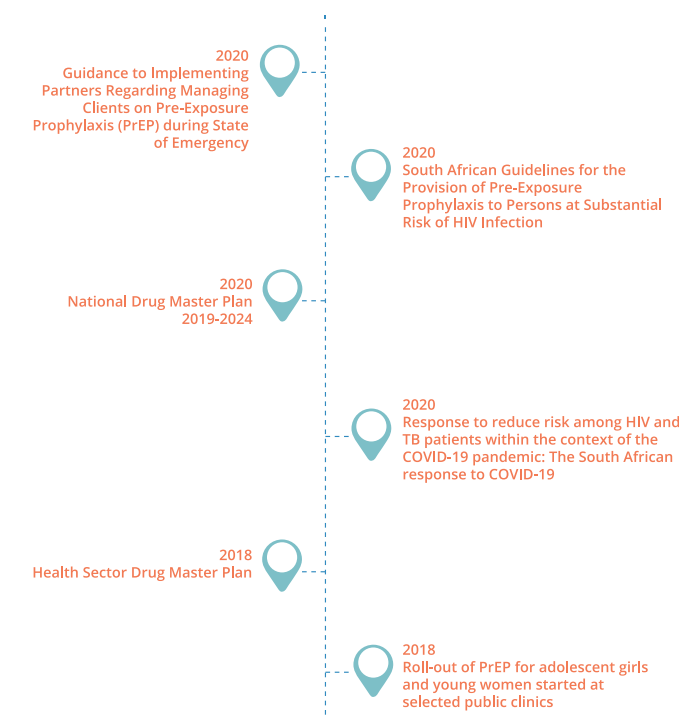
among them. To do this, regulations like the ones shown in Figure 5 were created and put into effect. The country's commitment to lowering the number of new HIV infections is evidenced by the emphasis placed on these demographic groups in the National Strategic Plan for HIV, TB, and STIs 2016–2022 (NSP), the National Drug Master Plan, and the Sex Worker strategy, among other documents.

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 strategy³ to address increasing cases of GBV and IPV. Guidelines that were published in 2020 in response to COVID-19 include *Guidance to Implementing Partners Regarding Managing Clients on PrEP during State of Emergency (sic) COVID-19* (26 March 2020) and *Response to reduce risk*

among HIV and TB patients within the context of the COVID-19 pandemic: The South African response to COVID-19 (17 April 2020).

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



Source: Authors

³ <https://www.justice.gov.za/vg/gbv/NSP-GBVF-FINAL-DOC-04-05.pdf>

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. Data in Table 3 show that, overall, there was a minus 13% decline in the number of new HIV infections in South Africa. The data also show that females 15+ years and adults 50+ years performed below the national average.

Estimates of the size of key populations

Table 4 presents data on population size estimates (PSE), HIV testing, HIV prevalence, condom use and HIV prevention service coverage among key populations. According to the Department of Correctional Services (DCS) data, there were 166,449 in 2020, 140,948 in 2021 and 143,223 inmates/prisoners in 2022.

PSE data enables the government and its stakeholders to plan for HIV services for the target populations. HIV prevalence among key populations remains disproportionately high, with sex workers being the most affected. HIV diagnosis was high for sex workers and MSM but lower for People who inject drugs (PWID) and Transgender (TG) where programme data was used. There were no new data on condom use and coverage with prevention programmes for all key populations.

Table 3: Number of new HIV infections and percentage change (2018-2022)

Number of new infections in South Africa by sex and age	2018	2019	2020	2021	2022	% change (2018-2022)
Total new HIV infections	13,452	12,883	12,659	12,145	11,741	-13%
New infections in males aged 15+	4,815	4,591	4,507	4,318	4,158	-14%
New infections in females aged 15+	7,867	7,551	7,429	7,132	6,916	-12%
New HIV infections in children <15	770	741	723	695	668	-13%
New HIV infections in 15-24 year olds	5,669	5,393	5,252	5,031	4,893	-14%
New HIV infections in 15-24 males	1,493	1,411	1,370	1,313	1,276	-15%
New HIV infections in 15-24 females	4,176	3,982	3,882	3,718	3,617	-13%
New HIV infections in 15-49 year olds	11,928	11,375	11,134	10,649	10,265	-14%
New HIV infections in 15-49 males	4,504	4,277	4,182	3,996	3,835	-15%
New HIV infections in 15-49 females	7,425	7,098	6,952	6,653	6,430	-13%
New HIV infections in 25-49 year olds	6,260	5,981	5,882	5,618	5,372	-14%
New HIV infections in 25-49 males	3,011	2,865	2,812	2,683	2,559	-15%
New HIV infections in 25-49 females	3,249	3,116	3,070	2,935	2,813	-13%
New HIV infections in adults aged 50+	753	767	802	801	808	7%
New HIV infections in males aged 50+	311	314	326	322	323	4%
New HIV infections in females aged 50+	442	454	477	479	486	10%
New HIV infections in FSWs	152	153	161	161	158	4%
New HIV infections acquired by men from FSW contact	606	584	582	562	544	-10%
New HIV infections in MSM	464	443	454	457	456	-2%
New HIV infections in MSM	5,848	5,705	5,563	5,429	5,347	-9%

Source: Thembisa Model ver. 4.6

Table 4: Population size estimates, HIV testing, HIV prevalence, condom use and HIV prevention service coverage among key populations

Indicators	2018	Data Source	2019	Data Source	2020	Data Source	2021	Source	2022	Data Source	2023	Data Source
Total HIV incidence rate	0.48%	Thembisa Model V4.5	0.44%	Thembisa Model V4.5	0.42%	Thembisa Model V4.5	0.39%	Thembisa Model V4.5	0.32%	Thembisa Model V4.6	0.30%	Thembisa Model V4.6
Estimates of the size of key populations												
Sex workers	No data	n/a	No data	n/a	146,048	JHU	146,048	University of California, San Francisco (2021) Consensus Cascades	No data	n/a	No data	n/a
MSM	No data	n/a	No data	n/a	309,686	JHU	309,686	University of California, San Francisco (2021) Consensus Cascades	No data	n/a	No data	n/a
PWID	No data	n/a	No data	n/a	82,500	GI	82,500	University of California, San Francisco (2021) Consensus Cascades	No data	n/a	No data	n/a
Transgender people	No data	n/a	No data	n/a	139,666	Setswe	179,327	University of California, San Francisco (2021) Consensus Cascades	No data	n/a	No data	n/a
Prisoners	164,129	DCS	162,875	DCS	154,449	DCS	155,069	DCS Annual Report	143,223	DCS	No data	n/a
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	58.8%	Thembisa Model V4.6	57.0%	Thembisa Model V4.6
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	29.9%	Thembisa Model V4.6	29.2%	Thembisa Model V4.6
PWID	No data	n/a			21.8%	UNAIDS	14.0%	TIPVAL Study, Nov 2018	No data	n/a	No data	n/a

Table 3: Population size estimates, HIV testing, HIV prevalence, condom use and HIV prevention service coverage among key populations

INDICATORS	2018	Data Source	2019	Data Source	2020	Data Source	2021	Data Source	2022	Data Source	2023	Data Source
HIV prevalence among key populations												
Transgender people	No data	n/a	51.9%	Botshelo Ba			52%	Scheibe et al., 2019	No data	n/a	No data	n/a
Prisoners	No data	n/a	17.0%	DCS	17.5%	DCS	19.60%	DCS Annual Report	19%	DCS	No data	n/a
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	95.0%	Thembisa Model V4.6	95.3%	Thembisa Model V4.6
MSM	75.2%	Thembisa Model V4.4	77.0%	Thembisa Model V4.4	79.5%	Thembisa Model V4.4	89%	Thembisa Model V4.5	89.7%	Thembisa Model V4.6	90.4%	Thembisa Model V4.6
PWID	69.2%	KP Consensus Estimates	No data	n/a	No data	n/a	79.8%	UNAIDS Fact Sheet	30.4%	Programme Data	11%	Programme Data
Transgender people	No data	n/a	96%	Botshelo Ba Trans	No data	n/a	no data	n/a	2.3%	Programme data (GF)	1%	Programme Data
Condom use among key populations												
Sex workers	No data	n/a	No data	n/a	No data	n/a	76%	The Aurum Institute	No data	n/a	No data	n/a
MSM	No data	n/a	No data	n/a	No data	n/a	74%	The Aurum Institute	No data	n/a	No data	n/a
PWID	No data	n/a	No data	n/a	No data	n/a	no data		No data	n/a	No data	n/a
Transgender people	No data	n/a	No data	n/a	No data	n/a	76.60%	HSRC (2019). The Botshelo Ba Trans Study	No data	n/a	No data	n/a
Coverage of HIV prevention programmes among key populations												
Sex workers	No data	n/a	No data	n/a	No data	n/a	no data	n/a	No data	n/a	No data	n/a
MSM	No data	n/a	No data	n/a	No data	n/a	31%	Programme data (AFSA, Beyond Zero, NACOSA)	No data	n/a	No data	n/a

Table 4: Population size estimates, HIV testing, HIV prevalence, condom use and HIV prevention service coverage among key populations

INDICATORS	2018	Data Source	2019	Data Source	2020	Data Source	2021	Data Source	2022	Data Source	2023	Data Source
Coverage of HIV prevention programmes among key populations												
PWID	No data	n/a	No data	n/a	No data	n/a	21.8%	Programme data (AFSA, Beyond Zero, NACOSA)	No data	n/a	No data	n/a
Transgender people	No data	n/a	No data	n/a	No data	n/a	2.20%	Programme data (AFSA, Beyond Zero, NACOSA)	No data	n/a	No data	n/a

HIV prevention programmes in prisons

Table 5 presents data on HIV programmes in prisons and other closed settings. The data show that the number of condoms distributed doubled between 2021 and 2022. About 96% (28,913/30,097) of all inmates living with HIV were receiving antiretroviral therapy. There were 394 (1.31%) people in prisons and other closed settings with TB or co-infected with HIV and TB.

The Department of Correctional Services reported in the annual reports (2021-22) than to improve the quality of life of people living with HIV/AIDS as well as decreasing HIV transmission, the offender viral load suppression rate (at 12 months) was recorded at 97% (1 155/1 192). The TB cure rate of 97% (306/317) was also recorded during the 2022 financial year (DCS annual report, 2022). The offender viral load suppression rate (at 12 months) was recorded at 91% (1 034/1 134) and the TB cure rate of 94% (220/234) during 2021/22 financial year.

Table 5: HIV prevention programmes in prisons

Indicator	2018	2019	2020	2021	2022*
Number of clean needles distributed to people in prisons and other closed settings	No data	No data	No data	No data	0
Number of people in prisons and other closed settings receiving opioid agonist maintenance therapy	No data	No data	No data	No data	0
Number of condoms distributed to people in prisons and other closed settings	2,436,068	1,703,891	1,169,999	1,270,455	2,527,318
Number of people in prisons and other closed settings receiving antiretroviral therapy	27,171	25,522	23,570	24,145	28,913
Number of people in prisons and other closed settings tested for HIV	158,257	57,027	93,333	140,743	66,723
Number or percentage of people living with HIV among people in prisons and other closed settings	14,111	25,825	23,782	24,321	30,097
Number or percentage of people in prisons and other closed settings with hepatitis C	No data	No data	No data	7	No data
Number of people in prisons and other closed settings co-infected with HIV and hepatitis C virus	No data	No data	No data	3.3%	0
Number or percentage of people in prisons and other closed settings with TB or co-infected with HIV and TB	1,777	421	634	790	394 (1.31%)
Number or percentage of people in prisons and other closed settings with TB or co-infected with HIV and TB	421	634	790	394 (1.31%)	No data

Source: *DCS data, 2022; Programme data 2021 (multiple implementing partners)

A review of data shows that hepatitis C data were only reported 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 National Drug Master Plan (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 (2023–2028) refers to the provision of harm reduction services, specifically Opioid Substitution Therapy (OST) and needle-and-syringe programmes. National Guidelines for the Management of Viral Hepatitis (2019) is targeted at individuals at higher risk for Hepatitis C Virus (HCV) (DoH 2019) including people who inject drugs. There were no data available on the number of people on OST and the number of needles and syringes distributed for 2022. In 2019, 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). Data around Hepatitis B Virus (HBV) and HCV epidemiology among PWID in South Africa are limited to programmatic data and small, single site studies

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.

Between 14% and 21% of the estimated 75,000 people who inject drugs in South Africa are living with HIV. By July 2020, needle-and-syringe services existed in nine South African health districts (Scheibe et al., 2020). 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).

Table 6: People who inject drugs living with HIV

Indicator	All	Males	Females	Transgender	<25	25+
Percentage of people who inject drugs who are living with HIV	19.9%	20%	19.1%	0%	20.5%	19.9%
Number of people who inject drugs who are living with HIV	1,316	1,223	93	0	140	1,176
Number of people who inject drugs tested for HIV	6,559	6,110	488	1	682	5,917

Source: Global fund implementing partners programme data, 2022

In 2022, it was reported, based on data from Global Fund implementing partners only, that out of a sample of 6,599, 19.9% of people who inject drugs were living with HIV (Males = 20.1%; Females = 19.1%; <25 years = 20.5% and >25 years = 19.9%) (Table 6). Note that this data cannot be considered nationally representative as it is Global Fund implementing partners only from selected districts.

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). Programme data from the Networking HIV & AIDS Community of Southern Africa (NACOSA) in 2019 indicates that there were 60 people

injecting drugs receiving OST out of 6,827 opioid-dependent people who inject drugs in Johannesburg (0.9%) at a specified date. This number was 30 out of 1,517 for Cape Town (1.9%). 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 7 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 2022 in the number of people who received PrEP at least once during the reporting period being dominated by women across all age groups. 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.

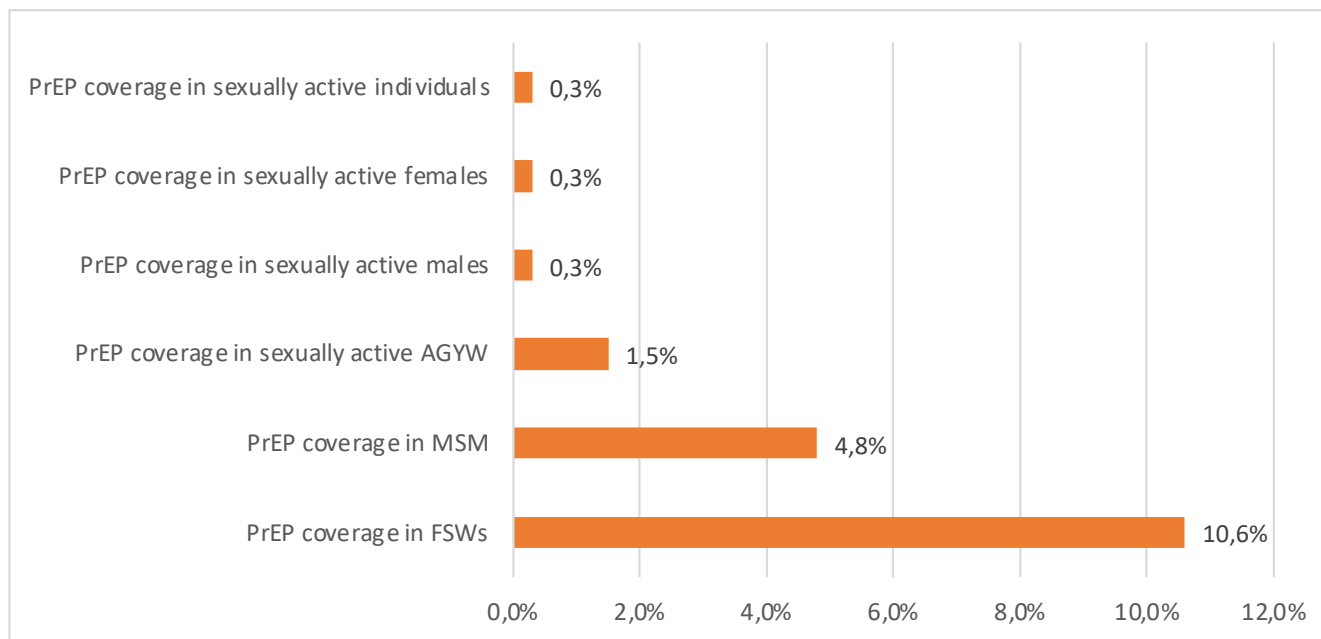
PrEP data from the Thembisa model, for 2022, presents a similar picture in which key populations dominate the uptake of PrEP compared to other vulnerable population groups (Figure 5)

Table 7: Number of people who received any PrEP product (2019-2022)

	Total	Males	Females	Transgender	Gender unknown	First Time
2022						
All	406 170	90 491	315 667	No data	12	333 944
<15	5 568	984	4 584	No data	-	4 955
15-19	109 105	10 115	98 983	No data	7	95 784
20-24	121 824	18 471	103 350	No data	3	102 777
25-49	158 764	55 310	103 452	No data	2	122 236
50	10 909	5 611	5 298	No data	-	8 192
2021						
All	346 667	74 817	217 667	179	4	300 674
<15	4 203	651	3 552	No data	No data	3 637
15-19	95 566	7 036	88 528	No data	2	86 272
20-24	112 687	16 987	95 698	No data	2	99 691
25-49	119 335	46 118	73 217	No data	No data	97 915
50	7 270	3 708	3 562	No data	No data	5 553
2020						
All	106 401	22 867	82 890	644	-	106 401
<15	No data	No data	No data	No data	No data	3 054
15-19	No data	No data	No data	No data	No data	24 154
20-24	No data	No data	No data	No data	No data	41 407
25-49	No data	No data	No data	No data	No data	24 959
50	No data	No data	No data	No data	No data	12 827
2019						
All	42 255	8 714	33 529	12	-	41 474

Source: DOH (PrEP data input form)- based on UNAIDS GAM report (2022)

Figure 5: PrEP distribution by population group



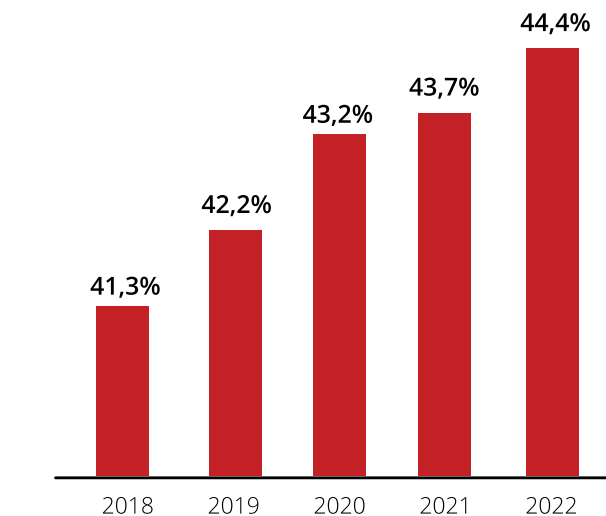
Source: Thembisa Model

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 TG women respondents (45%) had ever heard of PrEP (Poteat 2019; Poteat 2021). Of those who had heard of PrEP, 41% reported knowing other TG women who were taking PrEP. From the same study, a greater proportion of TG women who had never heard of PrEP reported HIV risk perception (Poteat 2020).

Prevalence of Voluntary Medical Male Circumcision (VMMC)

VMMC coverage increased from 41.3% in 2018 to about 44.4% in 2022 (Figure 6). In terms of the annual number of males voluntarily circumcised for the period under review, the data show that there was an increase in the 10-14 age group (29% coverage) with all the other age groups registering a decline or maintaining their performance (Table 8).

Figure 6: Number of VMMCs conducted by age (2018-2022)



Source: Thembisa Model

The increased coverage for this population group is in line with evidence that shows the impact of VMMC on HIV prevention in the long-term as more young people will grow up with a relatively lower risk of HIV infection because of VMMC.

Table 8: Annual number of males voluntarily circumcised (2019-2023)

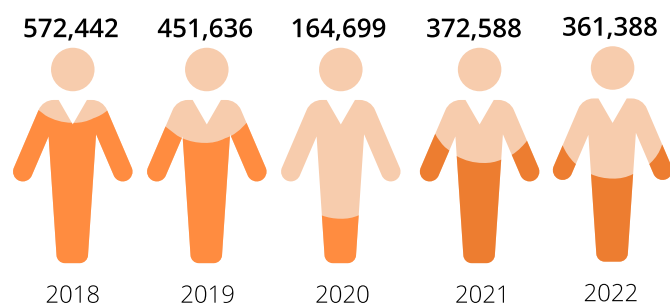
	2018	2019	2020	2021	2022	% change (2018-2022)	2018	2019	2020	2021	2022
Number of neonatal MMC operations	7,289	7,350	7,392	7,297	7,271	0%	34%	29%	64%	39%	35%
Number of MMC operations in males 10-14	5,611	7,468	1,756	4,971	5,988	7%	26%	29%	15%	27%	29%
Number of MMC operations in males 15-19	2,787	3,392	752	2,024	2,485	-11%	13%	13%	7%	11%	12%
Number of MMC operations in males 20-24	1,560	1,892	415	1,058	1,180	-24%	7%	7%	4%	6%	6%
Number of MMC operations in males 25-49	4,083	5,143	1,169	3,123	3,653	-11%	19%	20%	10%	17%	18%
Number of MMC operations in males 50+	178	228	53	142	167	-6%	1%	1%	0%	1%	1%

Source: Thembisa Model

Annual number of males voluntarily circumcised

Figure 7 shows the total number of VMMCs conducted from 2018 to 2022. The data show an initial decline from 2018 to 2020 followed by an increase in 2021 and a slight drop in 2022. The drop in 2020 reflects the challenge associated with COVID-19 service disruption but the programme has started showing recovery signs.

Figure 7: Annual number of VMMCs conducted (2018-2022)

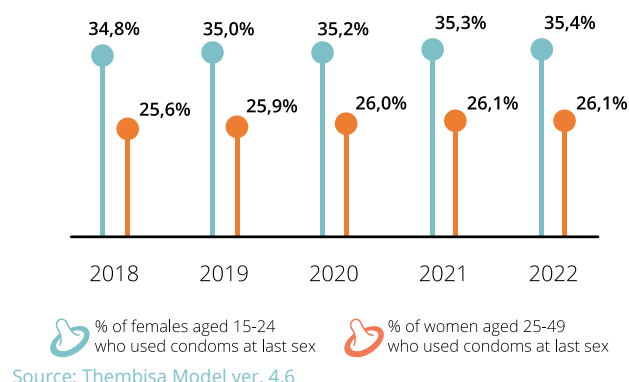


Source: UNAIDS Online tool (based on Department of Health Reports)

Condom use at last high-risk sex

Figure 8 compares condom usage at last sex among females (15-24) and women (25-49) for the period 2019 to 2023. 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 40% throughout the period although it has shown some slight improvement.

Figure 8: Condom use at last sex (2018-2022)



Annual Number of Condoms Distributed

Condom distribution has shown a consistent decline between 2018 and 2022 (Table 9). The numbers dropped from a total of about 743 million in 2018 to around 417 million in 2022. 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.

Table 9: Annual number of condoms distributed (2018-2022)

Condoms	2018	2019	2020	2021	2022
Male	726,202,616	635,981,213	558,190,486	577,572,000	403,740,579
Female	17,658,915	14,919,372	15,896,064	18,036,313	14,138,520
Total number of condoms distributed	743,861,531	650,900,585	574,086,550	595,608,313	417,879,099

Source: UNAIDS Online tool (based on the District Health Information System)

older (15-24 years: 36.1%; 25-49 years: 38.7%; 50+ years:

Young people: Knowledge about HIV prevention

The sixth South African national HIV prevalence, incidence and behaviour survey (SABSSM) summary report was launched in November 2023 and the final report is yet to be finalise and published. This section is therefore based on the fifth survey report until the former is published. 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

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

- The completion of the South African National HIV Prevalence, Incidence and Behaviour Survey, (SABSSM surveys) provides timely data for planning of programmes although the full report is yet to be published
- Despite low coverage, PrEP uptake has consistent increased among key and priority populations including FSWs, MSM, Adolescent Girls and Young Women (AGYW) and women in general compared to men
- The development and adoption of the National GBV and Femicide strategy⁶ to address increasing cases of GBV and 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)

- Despite the COVID-19 challenges, condom distribution has started to increase after 2020
- The increased circumcision coverage for the 10-14 years group is in line with evidence that shows the impact of VMMC on HIV prevention in the long-term as more young people will grow up with a relatively lower risk of HIV infection because of VMMC.

Key challenges

- With a higher HIV burden globally, the country continues to struggle with closing the gap on new HIV infections and reaching its target of incidence reduction by 50% (achieving –minus 13% decline in new HIV infections).
- 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 declining trend among male condom distribution are significantly contributing to the overall observed decline when compared to the female condom distribution since 2018.
- Continued decriminalization of sex work leads to increased vulnerability of sex workers to HIV infection.
- Despite the increase in the rollout of PrEP, evidence still shows that knowledge and uptake of PrEP among key

- populations, for example SWs, remains very low below 20%.
- There is no updated data on harm reduction as the IBBS has not been conducted which limits data driven programming.
- Harm reduction interventions such as OST need to be strengthened and expanded in the new NSP (2023-2028).

Recommendations

- There is need for an evaluation of the implementation and impact of the National GBV and Femicide strategy with the goal to further refine it towards reducing GBV and femicide as key drivers of vulnerability to HIV infection.
- As evidence has found long-acting injectable cabotegravir to be acceptable, safe, and highly effective in preventing the spread of HIV⁷, the country needs to make financial commitments and making the drugs available to all eligible and at-risk populations.
- As HIV incidence is declining slower than the national average 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.
- The country should strengthen and support efforts towards the conduct of IBBS surveys to provide data particularly for key populations to enhance evidence-based programming.

⁷ <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

Political Declaration and Framework 2

95-95-95 for HIV testing and treatment



Scorecard analysis

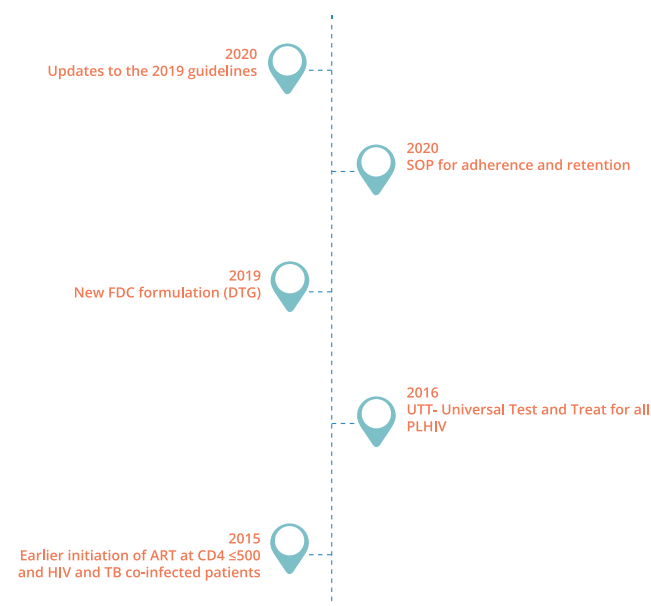
INDICATOR	RESULT
Is indicator/topic relevant?	Yes
Is it addressed in the national strategic plan	Yes
Has the country reached the framework target?	No
How likely is the country to reach the target by 2025?	Likely

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 within 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 9: HIV testing and treatment legal and policy framework



Source: Bello et al, 2021

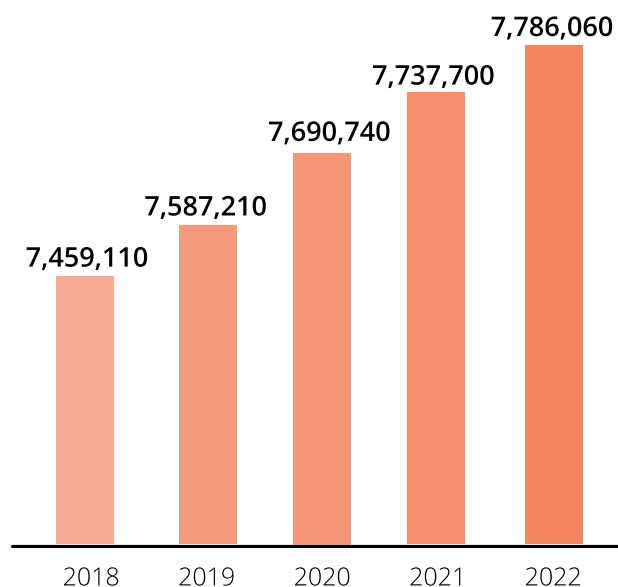
95-95-95. HIV testing and treatment

During the period under review, South Africa's performance against the UNAIDS 95-95-95 strategy for control of the HIV pandemic was 94-76-92, which means that as of the end of December 2022, 94% of people living with HIV knew their status, 76% of people living with HIV are on ART, while 92% of the estimated proportion of patients on ART were virally suppressed at 12 months (DOH Annual Report, 2022).

People living with HIV who know their HIV status

The country is on the cusp of achieving the UNAIDS's 1st 95 in the total population by achieving 94%. Figure 10 presents data on the number of people estimated to be living with HIV between 2018 and 2022. From 2018 (7,459,110) to 2022 (7,786,060), there was about 4,3% increase in the estimated PLHIV (Figure 10). The increase can be attributed to the new number of people being initiated on treatment coupled with improved adherence and more people remaining on ART resulting in reduced AIDS related deaths.

Figure 10: Total HIV infections (2018-2022)



Source: Thembisa Model 4.6

People living with HIV on antiretroviral therapy

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 second 95% target as it achieved 76% of the total population. As of June 2022, like the 1st 95, females performed better than males in the 2nd 95. Children were lagging at 69% performance (DHIS, June 2022).

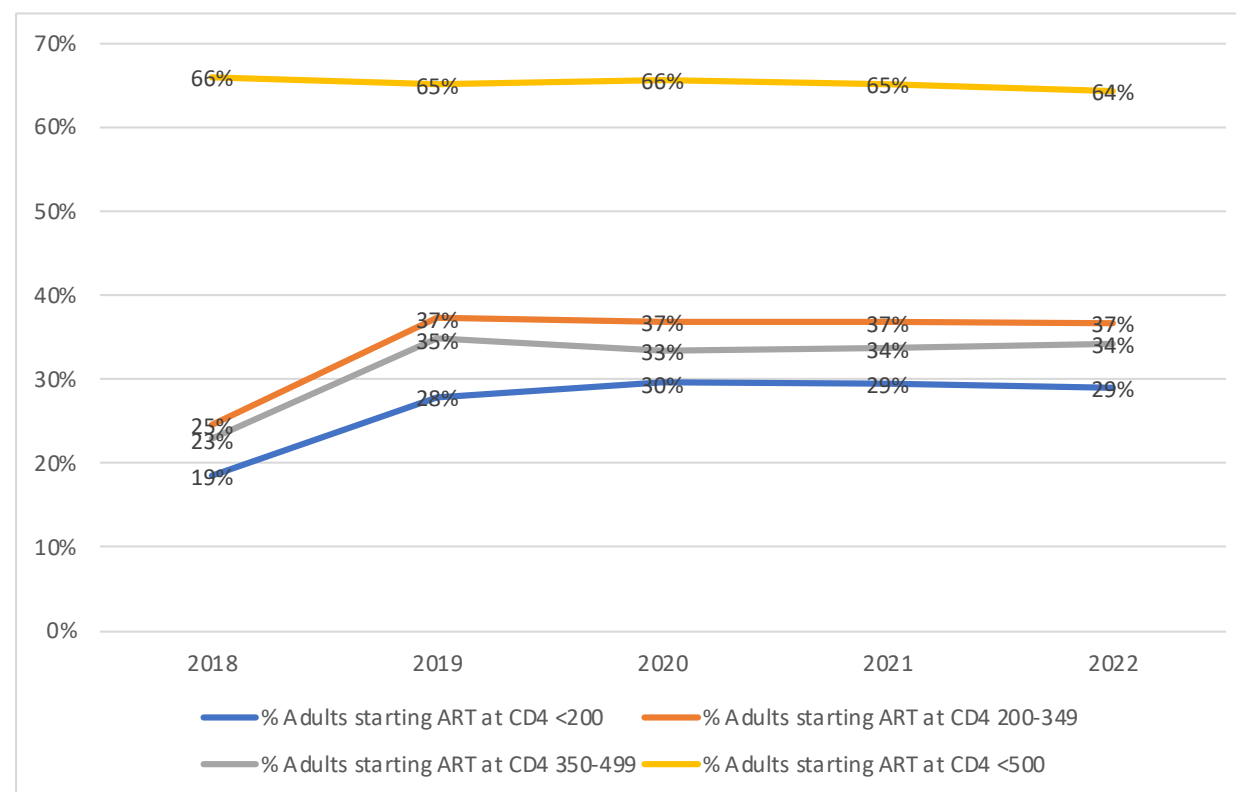
People living with HIV who have suppressed viral loads

As at June 2022, the country almost achieved its 3rd 95 target by achieving 89% for the total population and reaching 90% for adult males and females. However, children are lagging at 63%. Coverage data needs to be interpreted based on the sub-optimal performance of the 2nd 95 at 76% (DHIS, June 2022).

Advanced HIV disease and late HIV diagnosis

As South Africa has adopted the Universal Test and Treat (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 were used for this report (Figure 11).

Figure 11: Percentage of all people starting ART at CD4 <500 (2018-2022)



Source: Thembisa Model 4.6

The Thembisa model estimates show that the percentage of people starting ART with a CD4 count of <500 cells/mm3 dropped from 66% in 2018 to 64% in 2022. 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

In terms of testing volume, the data show that there has been an increase from 14 million in 2018 to 18 million in 2022. Figure 12 present data on HIV testing positivity for children and the whole population (All). The data show that, for children, positivity decreased from 1.6% in 2018 to about 0.7% in 2022. For the whole population, positivity dropped from about 5.9% in 2018 to about 2.7% in 2022.

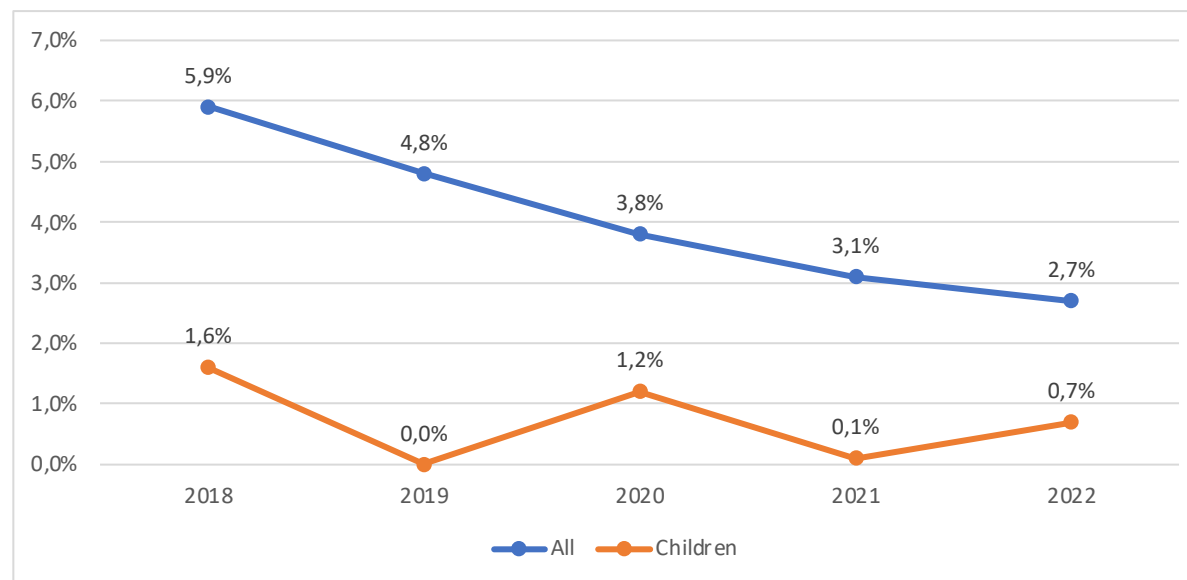
The declining positivity could be an indication of a higher performance in the 1st 95 with fewer people remaining to be diagnosed. These fewer people could mainly be among the hard-to-reach population and those negatively affected by specific factors in terms of accessing HIV testing services. These findings indicate the need for the country to invest more in finding this population and introducing efficient testing approaches such as index testing.

Antiretroviral therapy coverage among people living with HIV in key populations

Table 10 shows ART coverage data among key populations comparing it to the general population. The data show that compared to the general population (73.2%), FSW had a higher proportion of ART coverage (75.6%) while MSMs had an even higher proportion (94.5%) in 2022. PWID and TG also performed higher than the general population at 77.5% and

83.6%, respectively. Coverage data for inmates was available up to 2021 and showed a coverage of 99.3%

Figure 12: HIV testing positivity (2018-2022)



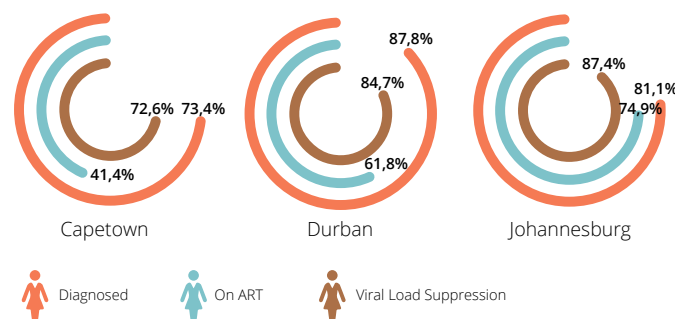
Source: UNAIDS Online Tool

Table 10: ART coverage among key populations

	2018	2019	2020	2021	2022	Data source
ART coverage (General Population)	64.5%	67.0%	69.3%	69.2%	73.2%	Thembisa Model 4.6
ART coverage in FSW (sex workers living with HIV)	No data	91.1%	46.8%	69.5%	75.6%	UNAIDS Reporting Tool
ART coverage in MSM (men who have sex with men living with HIV)	79.9%	67.7%	69.0%	44.1%	94.5%	UNAIDS Reporting Tool
ART coverage in PWID (people who inject drugs living with HIV)	No data	39.3%	40.5%	No data	77.5%	UNAIDS Reporting Tool
ART coverage in TG (transgender people living with HIV)	No data	68.8%	No data	No data	83.6%	UNAIDS Reporting Tool
ART coverage in inmates (prisoners living with HIV)	98.8%	98.8%	99.1%	99.3%	No data	UNAIDS Reporting Tool

While not recently updated, the 2018 IBBS studies for FSW and MSM provide more detailed data for the HIV 95-95-95 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 13).

Figure 13: 95-95-95 cascade for female sex workers living with HIV (2018)

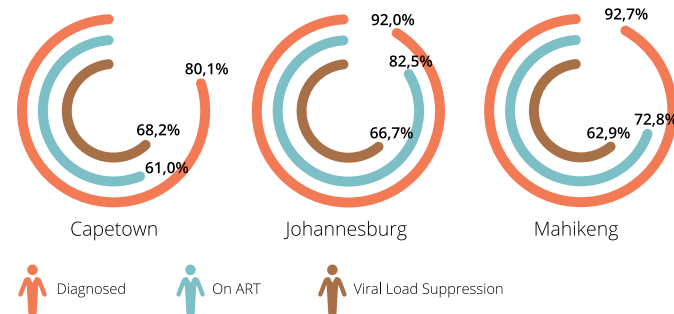


Source: South African Health Monitoring study, 2018

The study report indicates that there is sub-optimal progress towards achieving UNAIDS 95-95-95 targets among FSW, with none of the three 95-95-95 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 14).

Figure 14: 95-95-95 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 95-95-95 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

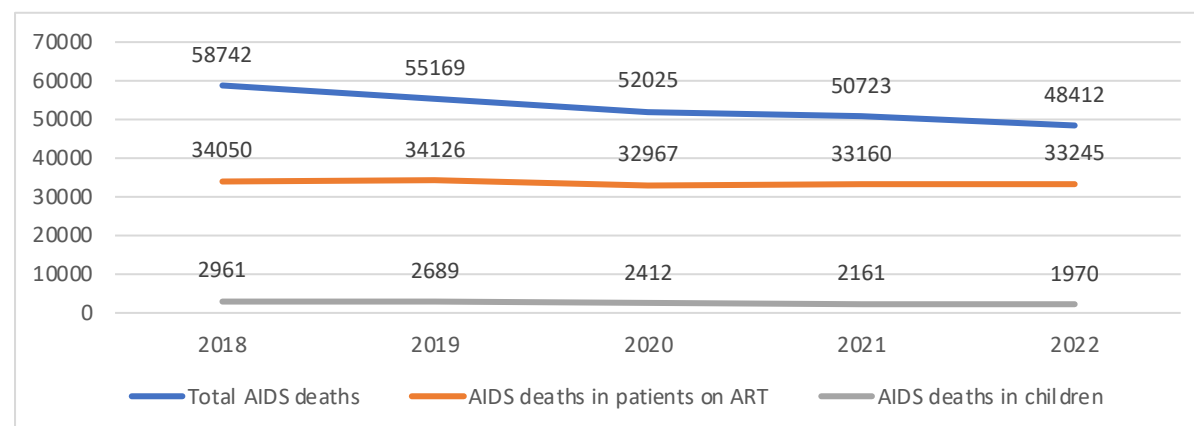
as 61.0% of those aware of their HIV status were on ART, despite the availability of ART for all people living with HIV in South Africa. More than 90% of MSM living with HIV on ART achieved virologic suppression in Johannesburg and Mahikeng, including excellent quality of care and effective treatment. 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 of all ages is 12.7% (SABSSM, 2022), 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 the general population (Scheim et al., 2020); however, the prevalence in TG men in South Africa is unknown. In South Africa, there are an estimated 87,214 TGW, 28,065 TG men and 66,076 gender non-conforming individuals, about 0.3% of the total population (Tshuma et al., 2021). Engagement of TGW 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 15 presents data on AIDS-related deaths among adults and children in South Africa. Generally, the numbers are lower than the latter compared to the former. For all the population and age groups compared, there is generally a

Figure 16: Trends in AIDS mortality among children and adults



declining trend for the period under review. 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 as evidenced by an increase in AIDS deaths among patients on ART.

Management of Cryptococcal Infection

There is currently no data on management of cryptococcal infection cascade. The WHO recommends flucytosine as a key component of any cryptococcal meningitis induction regimen. In 2018, WHO recommended a 1-week combination of amphotericin B deoxycholate and flucytosine for the induction phase. Flucytosine was registered by the South African Health Products Regulatory Authority (SAHPRA) in December 2021. However, the South African standard treatment guidelines currently recommend a 2-week

induction course of amphotericin B deoxycholate and fluconazole for cryptococcal meningitis. A multi-centre observational study to determine the effectiveness of flucytosine containing induction regimens in routine health-care settings in South Africa among inpatients with cryptococcal meningitis and advanced HIV disease was conducted between 2018 and 2020. During the study period, 10,668 individuals aged 18 years or older were diagnosed with laboratory-confirmed cryptococcal meningitis (or disseminated culture-confirmed cryptococcosis) nationally.

The in-hospital mortality among patients treated with flucytosine was significantly lower than that observed among those treated with other regimens and like the mortality reported in 2022 clinical trials evaluating flucytosine-containing regimens. The study concluded that flucytosine combination treatment could be delivered in routine care in a resource-limited country with a substantial survival benefit. However, only a minority of South Africans with cryptococcal

meningitis are currently treated with flucytosine, thus urgent action to address access has the potential to avert thousands of avoidable deaths from cryptococcal meningitis in South Africa and other countries in the African region each year (Mashau et al., 2022).

Achievements

- The country has achieved the 1st 95 and is on the cusp of achieving the 3rd 95, although the latter should be cautiously interpreted as it depends on the 2nd 95. (coverage) which is currently sub-optimally performing
- AIDS-related deaths among children have consistently declined from 2,961 in 2018 to 1,970 in 2022.

Challenges

- Children continue to lag across all the 95-95-95 performance compared to the adult population.
- ART coverage remains low at 79% for the general population.
- Late diagnosis of HIV as over 60% of the population are starting ART with a CD4 count below 500. A significant proportion of adults (28%) start ART with a CD4 count below 200.
- Based on IBBS data from 2018, key populations, like children, continue to lag in terms of achievement of 95-95-95 targets.

Recommendations

- Design and implement interventions targeted at enhancing children's HIV diagnosis, treatment and viral suppression
- Focus on interventions that promote ART initiation and

- retention among the general population
- Intensify messaging around timely knowledge of HIV status and early initiation of ART to increase the number of people starting ART with high CD4 count and reduce HIV incidence.
 - As evidence shows that there is zero risk of sexual transmission when HIV positive person's viral load is undetectable, South Africa should intensify efforts to develop messaging materials about "Undetectable equals Untransmittable" (U = U) sharing the science of HIV treatment as prevention (TasP) which can benefit the psychological well-being of PLHIV, reduce stigma, and motivate long-term ART adherence.
 - Intensify efforts to make timely data available on KPs and design interventions focused on improving HIV prevention, treatment, and retention of KPs including interventions focused on reducing stigma and harm reduction.
 - As only a minority of South Africans with cryptococcal meningitis are currently treated with flucytosine, urgent action is needed to address access with potential to avert thousands of avoidable deaths from cryptococcal meningitis.



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

Political Declaration and Framework 3

End paediatric AIDS and eliminate vertical transmission



Scorecard analysis

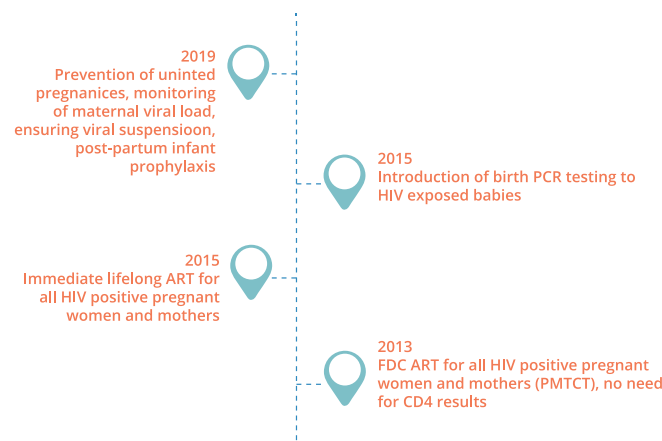
INDICATOR	RESULT
Is indicator/topic relevant?	Yes
Is it addressed in the national strategic plan	Yes
Has the country reached the framework target?	No
How likely is the country to reach the target by 2025?	Unlikely

Legal and policy environment

A significant number of children are infected with HIV. At the end of 2022, the Thembisa Model estimates show that there were 210,718 children (<15) living with HIV in the country. Furthermore, an estimated 9,063 children became newly infected with HIV during 2022. About 4% of the 48,412 people who died of AIDS related illnesses during 2022, 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 16 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



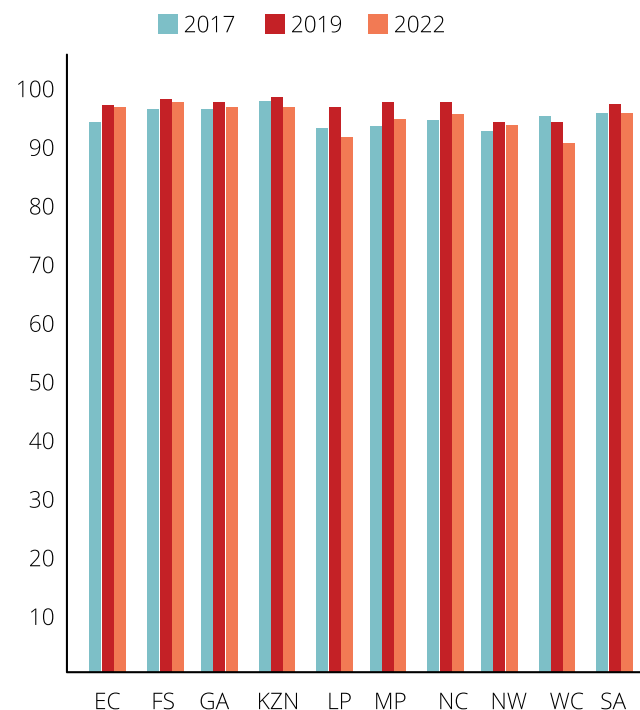
Source: Bello et al., 2021

HIV testing in pregnant women

According to the Antenatal care (ANC) survey report (2022), based on medical record review data, HIV testing was offered to 99.9% (35 498) of ANC attendees as part of routine care and almost all (99.97%, 34 982) either accepted the offer or already knew their HIV-positive status. Nationally, of 10 726 participants found to be HIV-positive by enzyme immunoassay (EIA) test, 96.0% (10 300) already knew their HIV-positive status at the time of the survey. Of those who knew their HIV-positive status, excluding 133 participants whose treatment status was not reported, 98.8% (10 166) had been initiated on ART at the time of the survey (Figure 17).

At a provincial level, the proportion of those who already knew their HIV-positive status ranged from 90.9% (Western Cape) to 97.8% (Free State). ART initiation among those who knew their HIV-positive status was the lowest in Western Cape (97.8%) and highest in Northwest (99.4%). The proportion of EIA-positive participants who knew their status and were on ART was slightly higher in the 2022 survey compared to the 2019 survey (98.8% vs 96%).

Figure 17: Knowledge of HIV-positive status by province, in the 2017, 2019 and 2022



Source: ANC survey report, 2022

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. 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 245,311 of infants born to women living with HIV received a virological test for

HIV within two months of birth. About 2,639 infants tested positive (1.1%).

Table 11: Early Infant Diagnosis (2018-2022)

	2018	2019	2020	2021	2022
Percentage of infants born to women living with HIV receiving a virological test for HIV within two months of birth	94.1%	95.90%	96.90%	98.10%	98.6%
Number of infants who received an HIV test within two months of birth during the reporting period.	253,718	260,905	268,247	264,250	244,713
Test result- Positive	1,555	1538	1381	1298	1,118
Test result- Negative	252,163	259,367	266,866	269,485	No data

Source: UNAIDS Online Tool

Vertical transmission of HIV

The Thembisa model data (Table 12) show that Mother to child transmission (MTCT) of HIV rate at/before birth was at 0.91% with MTCT rate at/before birth from HIV-diagnosed mothers at 0.66%. Postnatal MTCT rate to 18 months, from HIV-diagnosed mothers was 0.43% in 2022. The 2020 GAM report states 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).

Table 12: Performance of MTCT indicators (2018-2021)

Indicator	2018	2019	2020	2021	2022
Mother-to-child transmission rate	3.29%	3.07%	2.95%	2.84%	2.74%
MTCT rate at/before birth	1.08%	1.00%	0.99%	0.94%	0.91%
MTCT rate at/before birth from HIV-diagnosed mothers	0.76%	0.72%	0.71%	0.68%	0.66%
Postnatal MTCT rate to 18 months, from HIV-diagnosed mothers	0.50%	0.47%	0.44%	0.44%	0.43%

Source: Thembisa Model 4.5

Preventing the vertical transmission of HIV

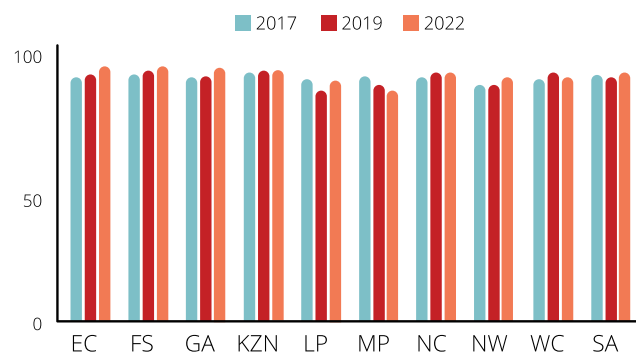
This indicator measures the number of pregnant women living with HIV who delivered during the past 12 months and received antiretroviral medicines to reduce the risk of MTCT of HIV. According to the ANC survey report (2022), of those who knew their HIV-positive status prior to current pregnancy and whose treatment status was reported (7 296), 6 173 (84.2%) were initiated on ART prior to pregnancy.

This translates to 76.5 % of all EIA positive participants who had already initiated ART prior to pregnancy. Knowledge of HIV-positive status prior to pregnancy significantly improved by 17.3% between 2017 (60.8%, 95% CI: 59.9 – 61.7) and 2022 (78.1%, 95% CI: 77.3 – 78.8) while initiation of ART prior to current pregnancy decreased significantly between 2017 and 2022 (91.9% vs 84.2%). ART initiation among those who had knowledge of HIV status prior to pregnancy was significantly (P value = 0.000) lower among women of 20–24 years (80.5%) compared to women who are 35–49 years (85.4%).

Syphilis among pregnant women

According to the ANC survey 2022, maternal syphilis screening coverage was 97.5% at national level, representing a 1.1%-point increase in syphilis screening coverage from 2019 (96.4%) (Figure 19). All provinces had greater than 90% syphilis screening coverage. Syphilis screening coverage data were missing for 2.5% of participants.

Figure 18: Maternal syphilis screening coverage among antenatal women, in the 2017, 2019 and 2022 Antenatal HIV sentinel surveys



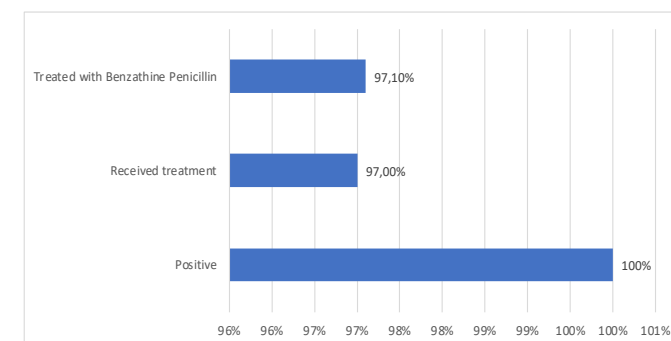
Source: 2019 Antenatal HIV sentinel survey

If we assume that all missing responses indicate that participant did not receive the screening test, and include them as such in the denominator, the national coverage for syphilis screening decreases from 97.5% to 95.0%.

Of the women who were screened for syphilis, 2.6% (992) were positive, 78.2% (27677) were negative, 18.4% (5 516) had pending results, 0.9% (n = 262) did not have results in file. In total, 19.2% were missing results among those who had a test (either because they were pending in the laboratory or not in file) like 20.5% in 2019. Western Cape Province had the lowest percent of results (2.6%), and Gauteng Province had the highest percent of missing results (31.7%). After excluding the pending results and the results not in file, the prevalence of syphilis (per medical record review data) among those who had a syphilis test result, was 3.1 % (95% CI: 2.9 – 3.3) at national level. The highest syphilis prevalence was in KwaZulu-Natal Province at 4.4% (95%CI: 4.0 – 5.0) and the lowest was in Limpopo Province at 1.4% (95% CI: 1.0 – 1.9).

Of 941 participants who were syphilis-positive and whose syphilis treatment status was reported, 97.0% (911) received treatment for syphilis. Of those treated for syphilis and had type of treatment data reported (847), 97.1% (827) were treated with at least one dose of Benzathine Penicillin (BPG) – these translates to 85% coverage of syphilis treatment with at least one dose of BPG among all syphilis-positive participants (Figure 19). If we assume that all missing responses mean that the subjects did not receive treatment for syphilis and include as such the missing data in the denominator, the coverage of syphilis treatment and treatment with BPG decreases from 97.0% to 92.2% and from 97.1% to 89.1%, respectively.

Figure 19: Syphilis treatment cascade among antenatal women, in the 2022 HIV Antenatal Survey



Source: 2019 Antenatal HIV sentinel survey

Congenital Syphilis Rate (Live Births and Stillbirth)

Congenital Syphilis (CS) is a category 2 notifiable medical condition (NMC) in South Africa- which means all health care workers are required to notify cases through paper-based or electronic case notification forms (CNF) within 7 days of diagnosis. Health care providers use a standard NMC CNF to notify cases. According to the national case reporting system, in 2022, out of the 965,543 number of live births, 832 were reported CS cases (live births and stillbirths) in the past 12 months resulting in 0.1% CS cases. In 2020 (373/1,031,414) and 2021 (160/1,025,793) cases were reported representing 0%.

Challenges in CS surveillance included the lack of awareness of the CS case definition, completed paper-based notifications not reaching the notifiable medical condition surveillance system (NMCSS) and the limited ability of the system to distinguish improved notifications from increase

in disease burden (Morifi et al, 2021). The ANC survey (2022) reported that the proportion of women who had tested positive for syphilis increased by 0.5 percentage points (2.6% to 3.1%) and by 19% between the 2019 and 2022 surveys. The syphilis seroprevalence estimate increased by one percentage point since 2015. The increase in maternal seroprevalence mirrors the sustained increase in congenital syphilis notifications (21) the number of Rapid Plasma Reagin (RPR)-positive infants since 2017 (22) as well as the increase in the relative contribution of syphilis as a cause of genital ulcer disease in recent years.

Hepatitis B Virus Among Pregnant Women Attending Antenatal Care Services

There was no data available for this indicator up to 2022. It is expected that reporting will begin in 2023. A study conducted to assess the prevalence of HBV in a cohort of pregnant women not living with HIV enrolled 1,194 HIV sero-negative pregnant women at their first antenatal visit (Davey et al., 2022). In this study, there were 8 point of care test (POCT) and laboratory confirmed HBV cases among 1,194 women.

The overall prevalence of 0.67% (95% CI = 0.34–1.32%). In women born before 1995 (before universal HBV vaccination had started in South Africa), 8 of 622 women were diagnosed with HBsAg; the prevalence was 1.29% (95% CI = 0.65–2.52%), and in women born in 1995 or after (n = 572); the prevalence was 0% (95% CI = 0.0–0.67%). The study concluded that the prevalence of HBV was very low in pregnant women not living with HIV and was only in women born before the HBV vaccine was included in the Expanded Program of Immunization (EPI). There was no data on the number of pregnant women attending antenatal care services with a positive HBsAg who then received HBV DNA testing and/or HBeAg and

the number of pregnant women attending antenatal care services who met eligibility criteria and received antiviral treatment.

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 MTCT rate has consistently declined from 3.29% in 2018 to 2.74% in 2022.
- The national coverage for syphilis screening at 95.0% is commendable and demonstrates the country's effort to address vulnerabilities faced by women living with HIV.

Key challenges

- While knowledge of HIV-positive status prior to pregnancy significantly improved by 17.3% between 2017 (60.8%) and 2022 (78.1%), initiation of ART prior to current pregnancy decreased significantly between 2017 and 2022 (91.9% vs 84.2%).
- ART initiation among those who had knowledge of HIV status prior to pregnancy was significantly lower among women of 20–24 years (80.5%) compared to women who are 35–49 years (85.4%).
- The prevalence of syphilis (per medical record review data) among those who had syphilis test result, was 2.6% in 2023 compared to 2.6% in 2019 and 2.0% prevalence in 2015 which shows that the prevalence is not declining after increasing in 2015.

Recommendations

- There is a need to strengthen primary STI prevention and STI prevention among pregnant women and their

partners through symptom screening, rapid testing and treatment, partner notification and referral for voluntary male circumcision if not already circumcised.

- Other interventions such as doxycycline post-exposure prophylaxis (PEP to be taken within 24 hours of unprotected intercourse, could be investigated as an intervention to reduce STIs, including syphilis in the general population with spill-over effects among pregnant women. Studies from the United States showed that Doxycycline PEP was associated with a 66% reduction in new STIs among PrEP users and 62% reduction among PLHIV.
- The ANC survey (2022) recommends that promoting male circumcision and condom use as strategies for primary prevention of maternal and congenital syphilis warrants further focus for inclusion in existing prevention strategies.
- With approximately 20% women who did not have syphilis test results on file from the ANC survey (2022) there is greater need to emphasise the need for rapid syphilis testing to ensure women get results on the same day and initiate treatment early. Efforts should be made to introduce and roll-out dual and single rapid syphilis tests in ANC services nationally, along with a quality assurance programme to ensure good quality testing and results. These tests will allow the immediate identification of women who may have active syphilis for confirmatory testing and immediate treatment.



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



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

South Africa is a signatory to several international treaties on GBV, and strong legislative framework, for example the Domestic Violence Act (DVA) (1998), the Sexual Offences Act (2007) and the Prevention and Combatting of Trafficking in Human Persons (2013) Act. 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

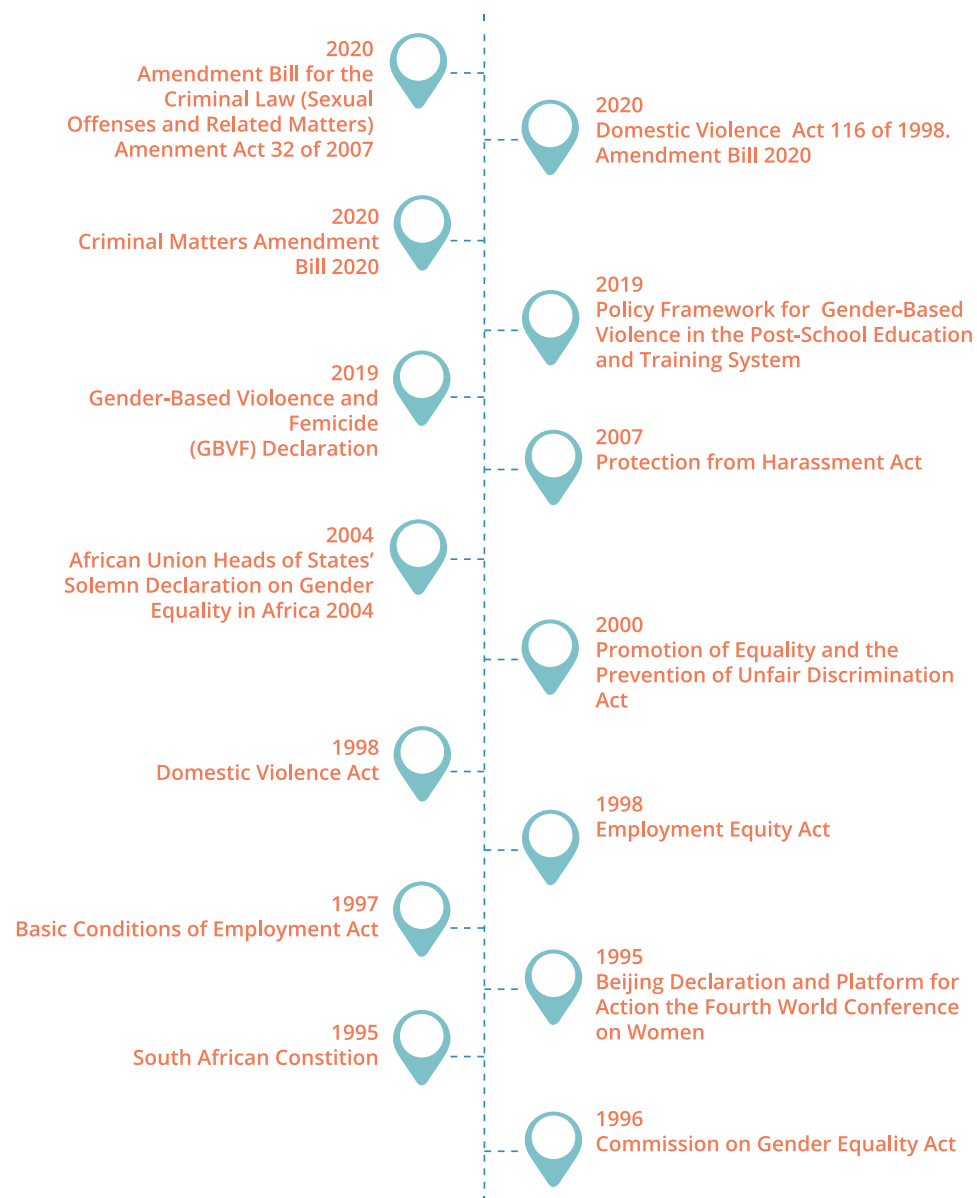
Policy Framework for Women's Empowerment and Gender Equality — commonly known as the Gender Policy Framework (National policy framework, 1996)— the National Development Plan Vision 2030, and the Gender Equality Amendment Act No. 17 of 2013 (National Development Plan, 2013). The Employment Equity Act 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 GBV, 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 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 20 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 Office on the Status of Women (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.

Figure 20: South Africa legal and policy environment for declaration and framework 4



Source: Bello et al., 2021

Current status and progress

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 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.

As the country works towards achieving and sustaining gains in reducing new infections, **HIV prevention, stigma and discrimination reduction** including **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. Table 13 shows GBV and sexual-related offences recorded by the South African Police Service (SAPS) between 2018/19 and 2022/23 years. Data shows a general increase in such crimes being reported which is a sign that the country still grapples with GBV which is a core determinant of HIV incidence.

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

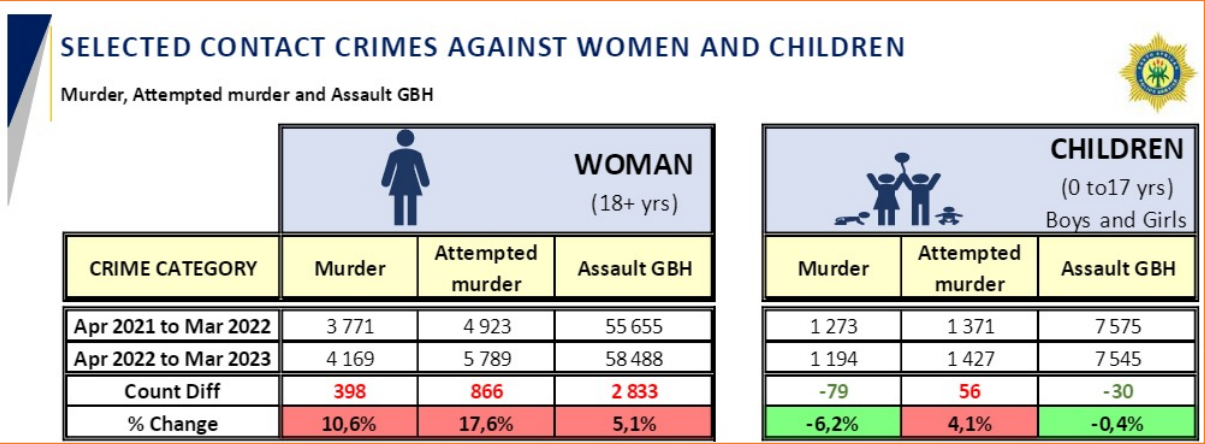
Table 13: Crime situation in South Africa

	2018-19	2019-20	2020-21	2021-22	2022-23	% change
Rape	41,583	42,289	36,330	41,739	42,780	2.8%
Sexual assault	7,437	7,749	7,025	7,798	7,483	0.6%
Attempted sexual offences	2,146	2,076	1,800	2,027	2,376	10.7%
Contact sexual offences	1,254	1,179	1,059	1,130	859	-31.5%

Source: South African Police Service, 2024⁸

There is no recent data on the percentage of people in a

Figure 21: Selected contact crimes against women and children



Source: South African Police Service, 2024⁹

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). There is still evidence showing an increase in the number of GBV-related crimes and violence (Figure 21).

Physical and/or sexual violence experienced by key populations

key population who report having experienced physical and/or sexual violence in the last 12 months. A literature review provides useful data that can be used to understand the country's situation. FSW living with HIV can experience violence related to both their positive HIV status and their occupation. The legal and political environments contributing to the criminalization of sex work and the dual stigmas associated with sex work and HIV serve as barriers to HIV treatment and prevention, linkage to ART, and retention in

⁸ https://www.saps.gov.za/services/downloads/2023-2024%20_Annual_WEB.pdf

⁹ https://www.saps.gov.za/services/downloads/2023-2024%20_Annual_WEB.pdf

care among FSW (Baral et al., 2012). Increased HIV-related stigma is also associated with lower ART adherence and higher viral load, as well as mental and physical health outcomes (Zeng et al., 2020). In a 2019 study (Jewkes et al., 2019), conducted as a multi-stage, community-centric, cross-sectional survey among 3,005 FSWs linked to sex worker programmes in 12 sites across all nine provinces, South African programmes reported the following in 2018: 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 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 2015 (Hands off needs assessment report, 2016).

South Africa is one of only twelve countries in the world, and the only one in Africa, to explicitly protect Lesbians, Gay, Bi-sexual, Transgender Queer, & more identities (LGBTQ+) people in its constitution. However, LGBTIQ South Africans still face many barriers to full equality. In 1996, South Africa became the first country to ban discrimination based on sexual orientation constitutionally. In 2002, it became legal

for same-sex couples to adopt, and marriage equality became a reality in 2005. Since 2003, transgender South Africans have been able to attain legal gender recognition. However, despite progressive legislation and public support for the human rights of LGBTIQ people expressed by the country's policymakers at a local, national, and international level, shocking violence and the murder of LGBTIQ people, as well as harassment and bullying in public services, such as education and health care, continues to be staggering. Local activists report that police response is often slow.

Attitudes towards violence against women

Data for the indicator on the percentage of women and men aged 15 to 49 years who agree that a husband is justified in hitting or beating his wife for specific reasons is obtained through a population-based survey which has not yet been released although a summary report was produced in 2023. The indicator is constructed from responses to the following question among respondents: In your opinion, is a husband justified in hitting or beating his wife in the following situations? The latest available data for this indicator is from a 2016 survey and shows that about 25% (2,930/11,717) agreed with the statement (Population-based survey - Demographic and Health Survey (2016).

Gender-responsiveness of HIV services

During the time of compiling this report, there was no data on the percentage of health facilities providing gender-responsive HIV services. However, most facilities, if not all, are providing services that recognize gender-differences with support from various funding partners and government. For example, programmes such as DREAMS, provision of PEP for GBV survivors, and a gendered approach to PrEP provisioning demonstrate the country's commitment to address gender

issues and intersectionality in HIV service provision. The private health sector has also been instrumental in mainstreaming gender in health care (including HIV) service provision. For example, Mediclinic Southern Africa collaborates with community-based organisations (CBOs) to offer the most appropriate clinic environment for receiving survivors of GBV (Figure 22).

Figure 22: Mediclinic Southern Africa supports CBOs to offer GBV services



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 IPV.
- Active involvement of the private sector partners such as Mediclinic towards the creation of a conducive

environment for access to post-GBV services by survivors.

Key challenges

- About 25% of women and men aged 15 to 49 years agreed that a husband is justified in hitting or beating his wife for specific reasons. This reflects that the cultural norms and practices that perpetuate GBV are still rife in communities.
- FSWs still report experiencing all forms of violence including sexual, physical and harassment from law enforcement agencies which exposes them to HIV infection.

Recommendations

- The country's National Council on Gender-Based Violence and Femicide (NCGBVF) strategy and its implementation needs to be evaluated considering increasing cases of GBV as indicated by data from the South African Police Services (SAPS).
- A need for targeted interventions, such as information education, at both facility and community level is critical in addressing the cultural norms, beliefs and practices that perpetuate GBV and femicide



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

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 TGW 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.

Discriminatory Attitudes Towards People Living With HIV

There was no national survey data for this indicator as 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. A population-based cross-sectional survey of households in South Africa (2017), provided data used to update the Online UNAIDS tool and indicated that in 2017, about 7.5% of the surveyed people believed that children living with HIV should not attend school with children who are HIV negative while 12.6% indicated they would not buy vegetables from a vendor if they knew that the person is HIV positive. 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).

Internalized Stigma Reported by People Living With HIV

At the time of reporting, there was no updated data on the percentage of people living with HIV who report internalized stigma. A study conducted in 2022 and published in 2023 study in South Africa to investigate community perceptions of stigma as well as discriminatory attitudes towards PLHIV found that slightly less than half (44%) endorsed the devaluation statement that PLHIV feel worse about themselves and over a third (37%) agreed that PLHIV feel guilty about their HIV status. A significantly high percentage of respondents endorsed fears about disclosure. About three quarters (73%) endorsed the belief that disclosing HIV serostatus is risky, 86.6% agreed that PLHIV are very careful

as to whom they tell their status, and 41% would want HIV infection in family to remain secret (Mokgatle and Madiba, 2023).

Stigma and Discrimination Experienced by People Living With HIV in Community Settings

Data for percentage of people living with HIV who report experienced stigma and discrimination in the general community in the last 12 months was not available at the time of reporting. In a study aimed at examining community perceptions of stigma as well as discriminatory attitudes towards PLHIV and measure disclosure concerns to understand if and how these perceptions might influence the uptake of HIV disclosure interventions in South Africa revealed that the willingness of the general population of HIV-negative individuals to engage with HIV prevention and disclosure interventions has not been established in South Africa (Mokgatle and Madiba, 2023).

The study further reported that disclosure acceptability was relatively low, as only 60.2% of the respondents agreed that disclosure is acceptable and 69.7% agreed that PLHIV should disclose. A high proportion (81%) endorsed disclosing sexual partners, disclosing to children with perinatal HIV (84.5%), and disclosing parents' own HIV status to children (82.3%). Disclosure to non-family members was not acceptable (48.8%). Almost all (94%) respondents would encourage participation in disclosure interventions. Respondents indicated a significant degree of stigmatisation in the community, with a moderately high mean perceived stigma score of 2.9 (SD = 1.8) and over half (56.8%) of the respondents endorsing moderately high levels of perceived stigma in communities. On the other hand, disclosure

concerns were very high with 75% of respondents endorsing disclosure concerns. The mean disclosure concern score was 3.1 (SD = 1.2). For community discriminatory attitudes, the stigma score was 1.5 (SD = 1.6) and for internalised stigma the score was 1.5 (SD = 1.6), considered as representing low stigmatising attitudes.

Experience of HIV-related Discrimination in Health-care Settings

There was no new data on percentage of people living with HIV who report experiences of HIV-related discrimination in healthcare settings. According to research presented at the 24th International AIDS Conference in Montreal¹⁰, people living with HIV in Africa, especially key populations and adolescents, are experiencing stigma in healthcare settings while accessing care. Even staff living with HIV in health facilities were reported to conceal their status for fear of being stigmatised by their colleagues.

A South African qualitative study explored the manifestations of HIV-related stigma in clinical settings. Most participants were living with HIV, had a median age of 25, and included key populations (sex workers, lesbian, gay, transgender and bisexual persons). The Human Sciences Research Council reported that most of the key populations and youth faced discrimination in health centres.

A 34-year-old lesbian respondent said: *"In the clinics, they will be like 'oh, a lot of LGBTQ+ people are HIV positive, why, what is going on in this community?' So yes, stigma is there."* Young people living with HIV particularly faced stigma when accessing sexual health services. A 17-year-old female respondent said: *"You know, we cannot even collect condoms and so on. You collect condoms they be like, 'so this one is*

already doing the nasty business, you see."

Stigma and Discrimination Experienced by 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 TG 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 LGBT 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 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 was no data for this indicator measured as specified by UNAIDS. However, research done on 804 participants from the LGBT communities reported that most (60%) of

¹⁰ <https://www.aidsmap.com/news/aug-2022/africa-heart-hiv-stigma-within-healthcare-settings>

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% of FSW (Duby et al. 2018) and 60% of MSM (Mbeda et al. 2020) reported avoiding seeking healthcare for fear of stigmatization.

People Living With HIV Seeking Redress for Violation of Their Rights

While there is no data on the proportion of people living with HIV who have experienced rights abuses in the last 12 months and have sought redress, the South African Human Rights Commission (SAHRC) has produced and publicized its Complaints Handling Procedures, which detail the procedure to be followed in the investigation of any alleged violation of human rights.

Further, the SAHRC has adopted special measures and guidelines to cater for complaints specific to the violation of children's rights, through the Child Friendly Complaints Handling Procedure. Both procedures are available on the SAHRC website. Equality Courts have been set up to assist members of the public to seek relief if they are subjected to unfair discrimination, hate speech or harassment. These courts are meant to make it easy for anyone to bring their cases to court and for the issue to be resolved and finalised quickly. Court officials are trained to assist members of the public who wish to use the Equality Court. Legal representatives are not always needed in the Equality Courts as the procedures in these courts have been simplified to support access to justice.

The SAHRC assists members of the public to argue matters before the Equality Court. Every Magistrates Court is like an Equality Court; therefore one can contact the SAHRC or the nearest Magistrates Court. The Commission for Conciliation, Mediation and Arbitration (CCMA) assists employers and employees with workplace related disputes, including those relating to violations of the right to equality in the workplace based on unfair discrimination.

Discriminatory Attitudes Towards People Living With HIV Among Health Facility Staff

Like other indicators under this section, there was no data on the percentage of health facility staff who report discriminatory attitudes towards people living with HIV. However, as reported before data in literature shows that about 30% of FSW (Duby et al. 2018) and 60% of MSM (Mbeda et al. 2020) reported avoiding seeking healthcare for fear of stigmatization. Even staff living with HIV in health facilities were reported to conceal their status for fear of being stigmatised by their colleagues.¹¹

Discriminatory Attitudes Towards People From Key Populations Among Health Facility Staff

Data on the percentage of health facility staff who report discriminatory attitudes towards people from key populations in South Africa was not available at the point of reporting. Literature shows that in South Africa, MSM, sex workers and PWUD report frequent exclusion from society and high levels of stigma and discrimination in the healthcare setting (Ritcher, 2008; Parry et al., 2009).

Judgmental and moralizing views towards sex work, sex between people of the same sex, homosexuality and

drug use are frequently expressed within South African communities, and more specifically by individuals working in the healthcare setting, warranting specific attention and address (Lane et al., 2008; Scheibe, Drame, Shannon, 2016). Public sector healthcare providers receive scant professional training to support key populations, as highlighted by a review of undergraduate training at one of South Africa's medical schools (Muller, 2013). As such, healthcare workers lack the appropriate skills or knowledge necessary to be adequately equipped to provide these much-needed services (Muller et al., 2018).

Discriminatory Attitudes Towards People From Key Populations Among Police

Sex workers, PWUD, MSM, women who have sex with women and TG people in South Africa frequently experience high levels of stigma, abuse and discrimination. Evidence suggests that such abuse is sometimes committed by police officers, meaning that those charged with protection are perpetrators. This reinforces cycles of violence, increases the risk of HIV infection, undermines HIV prevention and treatment interventions and violates the constitutional prescriptions that the police are mandated to protect. KPs in South Africa have reported multiple forms of abuse perpetrated by police officers. SWs' experiences of harassment, assault, rape, extortion and condom confiscation by police officers and the denial of access to medication while in custody are well-documented (Sisonke Sex Worker Movement, 2011; Women's Legal Centre, 2012).

Similarly, research confirms that stigma and discrimination based on sexual orientation and gender identity by police officers occurs both within communities and in police facilities (Breen, et al., 2011). At a national consultation in

Cape Town, PWUDs identified negative engagement with law enforcement as their primary concern (United Nations Office on Drugs and Crime, 2014). This was confirmed during a 2015 programmatic mapping study (Lambert, 2015), and in a report highlighting PWUDs' experiences including harassment, violence, the confiscation and breakage of injecting equipment, and extortion by law enforcement officers in three cities where a needle and syringe programme is operating (Step Up Project, 2015).

Achievements

- There are clear procedures laid out for people experiencing violence to obtain justice and redress although access to the systems for redress needs to be evaluated and made more efficient.
- 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 Non-Governmental Organisation (NGO), Sex Workers Education and Advocacy Taskforce (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

- Almost a quarter of LGBTI communities are denied healthcare and 31% reported being called names or

being insulted by healthcare staff at some point.

- 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.
- Female sex workers (FSW) still report high stigmatization rates and of being made to feel guilt, shame and a loss of dignity because 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).

Recommendations

- To mitigate clinical stigma, the HSRC recommends peer-driven delivery approaches especially for key populations and vulnerable groups, and suggests that healthcare workers should adopt a person-centered approach, focusing on the needs of those accessing care.
- Relationships between law enforcement agencies and key populations need to be re-examined and reconstituted to enable appropriate responses and services as evidence suggests that KPs are continuously harassed at the hands of these agencies.
- 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.

¹¹ <https://www.aidsmap.com/news/aug-2022/africa-heart-hiv-stigma-within-healthcare-settings>



Political Declaration and Framework 7: Universal health coverage and integration

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?	Likely

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

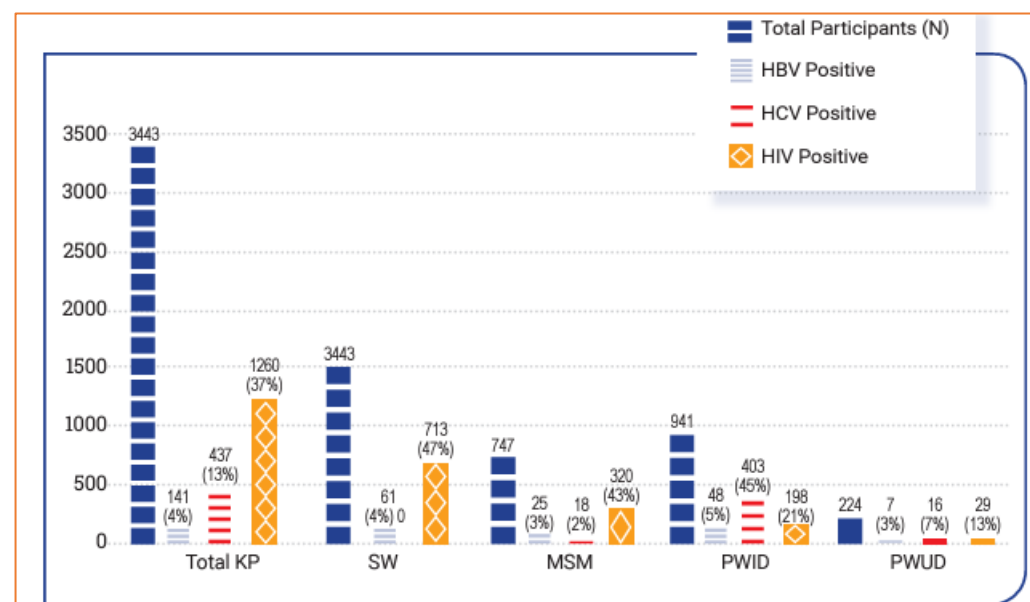
management of multi-drug resistant tuberculosis (MDR-TB) in 2019. It is also important to highlight that these policies are well aligned to relevant regional and global frameworks such as the Global Plan to end TB 2023-2022 (Stop TB Partnership 2022).

Viral Hepatitis Among Key Populations

In 2020, the prevalence of hepatitis B coinfection with HIV among key populations was reported to be 7.9%

(18/227) among PWID with no disaggregations. For the same period, the prevalence of hepatitis C coinfection with HIV among key populations was 65.2% (148/227) among PWID. A 2019 viral hepatitis C study among 3,443 key populations in South Africa reported that overall, HBV, HIV and HCV prevalence was 4%, 37% and 13% respectively. Figure 23 shows the distribution of the three infections within the total study cohort and the breakdown by sub-population.

Figure 23: HBV, HCV and HIV prevalence, by population (2018)



Source: https://www.nicd.ac.za/wp-content/uploads/2019/03/Results_SA_Viral_Hepatitis_Study_2018.pdf

HBV ranged between 3 and 5% across the four subpopulations, consistent with observed background HBV prevalence in the broader South African population. HIV prevalence was highest amongst SW and MSM at 47% and 43%, respectively, and lowest in PWUD at 13%. Substantial regional variation in HIV prevalence was observed ranging from 3% amongst PWUD in Cape Town to 80% amongst SW recruited in Pietermaritzburg (data not shown). HCV prevalence varied considerably between subpopulations. PWID had the highest prevalence of HCV at 45%. This ranged from 29% in Durban to 73% in Pretoria. The prevalence amongst PWUD was also high at 7%. 2% of MSM were found to be HCV positive and many of these individuals also reported having injected drugs in the past (NICD, 2019).

An HCV-HBV co-infection prevalence of 0.7% was observed for the total study group. The prevalence across the individual sub-populations ranged between 0 and 2.4%, with the highest prevalence observed among the PWID group. HCV-HIV co-infection prevalence of 3.7% was observed overall, with PWID again having the highest at 12.7%. This was largely driven by the HCV-HIV co-infection prevalence of 29% observed in Pretoria and likely reflects the high proportion of HCV infections in this group and the longer culture of injecting. Few participants tested positive for both HBV and HIV, with only a 2.2% overall prevalence which was similar across sub-populations. Co-infection with HIV-HBV-HCV was only observed among PWID and was <1%.

Hepatitis C testing

Data on the proportion of people starting antiretroviral therapy who were tested for hepatitis C virus (HCV) was available for 2020 only. The data was also not sourced from an ART initiation program but a hepatitis C program

treatment implemented by a not-for-profit (NPO) in Tshwane. Table 14 below presents data on the proportion of people starting antiretroviral therapy who were tested for hepatitis C virus (HCV).

Table 14: Proportion of people starting antiretroviral therapy who were tested for hepatitis C virus (HCV)

Indicator	Total	Males	Females	<15	15+	PWID
Proportion of people starting antiretroviral therapy who were tested for hepatitis C virus (HCV)	100%	100%	100%	No data	100%	100%
Number of adults and children starting antiretroviral therapy who were tested for hepatitis C during the reporting period using the sequence of antiHCV antibody tests followed by HCV polymerase chain reaction (PCR) for those who are anti-HCV positive	36	35	1	0	36	36
Number of adults and children starting antiretroviral therapy during the reporting period	36	35	1	0	36	36

Source: Programme data (Sediba Hope Medical Centre, NPC in Tshwane)

People coinfectd with HIV and Hepatitis C Virus starting Hepatitis C Virus treatment

Based on implementing partner (Sediba Hope Medical Centre) programme data (clinical records of health care facilities), the proportion of people coinfectd with HIV and HCV starting HCV treatment was 94.4% (34/36) in 2020. Data was not available for other years.

Syphilis prevalence among key populations

This indicator measures the prevalence of syphilis in specific key populations (SW, MSM and TG). There was no data reported for the period 2019 to 2022. A South African prospective cohort study conducted in 2019 reported a high rate of repeat sexually transmitted diseases among MSM (van Liere et al., 2019). In this study, a high rate of incident sexually transmitted diseases within 55 days (median) of follow-up (78% retention) among symptomatic MSM (n = 78) in South

Africa (188 per 100 person-years; 95% confidence interval, 1.2–2.7); 16 newly acquired and 10 with persistent positivity was observed. This highlights the need to strengthen prevention efforts, whereas introduction of diagnostics is urgently warranted.

Men With urethral discharge

Based on data from the DHIS, the percentage of men reporting urethral discharge in the past 12 months data was available for 2022 (1.8%); 2021 (1.6%), 2020 (1.4%) and 2019 (1.6%). Generally, the trend has been increasing between 2019 and 2022.

Gonorrhoea among men

There was no data available for the rate of laboratory-diagnosed gonorrhoea among men in countries with laboratory capacity for diagnosis between 2019 and 2022. However, a study conducted in KwaZulu-Natal province to measure the population prevalence of STIs and to assess the association between STIs and HIV, CD4 cell counts and HIV viral load in a high HIV burden setting found that prevalence of Neisseria gonorrhoeae was 2.8% among 15-49 years age group for both males and females. HIV viral load ≥400 copies

per mL was associated with an increased probability of N. gonorrhoeae (aPR=1.91, 95% CI 1.36–2.70) (Kharsany et al., 2020).

Co-management of Tuberculosis and HIV treatment

Data on people living with HIV estimated to have incident tuberculosis (TB) that received treatment for both TB and HIV is available for 2022 and digitized in the patient information system in health facilities. For 2022, there were 83,169 HIV-positive new and relapse TB patients started on TB treatment during the reporting period who were already on antiretroviral therapy or started on antiretroviral therapy during TB treatment within the reporting year (Male = 44,367; Female = 38,802; <15 =2,191; 15+ = 80,978). According to the Department of Health (DOH), the increase from 2021 (73,117) to 2022 (83,169) is mainly because the 2021 numbers were affected by COVID-19 and its impact on the health system and patients' access to facilities/lockdown levels.

People living with HIV newly enrolled on HIV treatment with Tuberculosis disease

The number of people living with HIV newly enrolled on HIV treatment diagnosed with tuberculosis (TB) disease for 2022 was 32,847 (7%) compared to 27,287 (5.6%) in 2021. As with HIV/TB co-infection, the observed lower numbers in 2021 were reportedly due to COVID-19 and its impact on access to health care (DOH, 2022).

People living with HIV on antiretroviral therapy who started Tuberculosis preventive treatment

Table 15 shows data on the percentage of people on antiretroviral therapy who started tuberculosis preventive

treatment from 2018 to 2022. The data shows a fluctuating trend with 2020 performance being at its highest and other years maintaining performance below 70%. It is recommended that performance on this indicator be reviewed with the goal to ensure increased coverage of TB preventive therapy as TB is among the leading causes of death among PLHIV in South Africa.

Table 15: Percentage of people on antiretroviral therapy who started tuberculosis preventive treatment (2018-2022)

Indicator	2018	2019	2020	2021	2022
Percentage of people on antiretroviral therapy who started tuberculosis preventive treatment during the reporting period	65%	69.3%	93.1%	62.8%	61.8%
Total number of people newly enrolled on antiretroviral therapy during the reporting period who also started TB preventive treatment during the reporting period	453,149	509,762	356,872	306,598	288,342
Total number of people living with HIV newly enrolled on antiretroviral therapy	697,551	736,078	383,403	488,052	466,485

Source: UNAIDS Online Tool

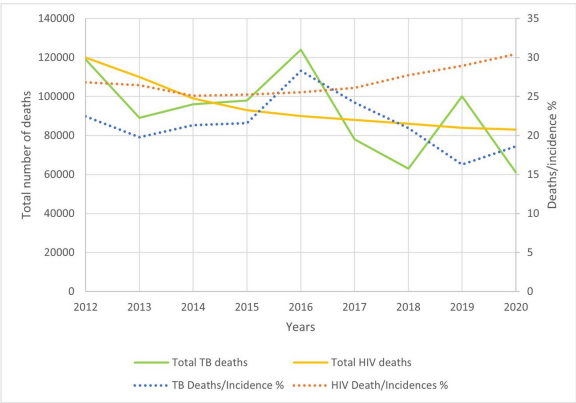
South Africa's substantial genomic research on TB has unveiled genetic variations linked to increased TB susceptibility, providing important insights into its pathogenesis. This dedication extends to TB vaccine research, exemplified by the South African Tuberculosis Vaccine Initiative (SATVI), which contributes to clinical trials worldwide (Visca et al., 2021).

Deaths due to both HIV and TB have been decreasing from around 120,000 in 2012 to around 83,000 for HIV and 61,000 for TB (Figure 24) in 2020 (Olivier, et al., 2023). It is, therefore, clear that the prevention of TB deaths has been more successful than the prevention of HIV deaths over the last 8 years in South Africa. This is illustrated by the death divided by incidence percentage dotted lines in the graph. TB incidence has decreased to around 18% in 2020, whereas

HIV incidence has been rising steadily to around 30% in 2020.

Despite commendable efforts, achieving the ambitious “End TB” and “End HIV” goals set by the World Health Organization (WHO) for 2030 remains intricate due to socio-economic disparities, health care constraints, and political dynamics (Olivier, et al., 2023).

Figure 24: The comparison between HIV and TB deaths in South Africa (2012 to 2020)



Source: <https://link.springer.com/article/10.1007/s42399-023-01568-z>

Percentage of people living with HIV on antiretroviral therapy who completed a course of tuberculosis preventive treatment among those who initiated tuberculosis preventive treatment

Table 16 presents the percentage of people living with HIV currently on ART initiating tuberculosis (TB) preventive treatment and who completed a course of TB preventive treatment in 2022. Data shows that only 49.3% of the PLHIV on ART who started TB preventive therapy completed the course based on 2021 cohort. Data for Transgender, disaggregations by regimen and monotherapy were not available.

A study conducted in South Africa (Jarrett et al., 2020) provide some insights into challenges with TB preventive therapy. Measuring adoption, fidelity, acceptability, and sustainability of the interventions, the study found that adoption, fidelity, and acceptability of the interventions were moderately high. However, nurses believed they could not sustain their increased prescriptions of isoniazid preventive therapy (IPT), and though many patients intended to ask nurses about IPT, few did. Most patients attributed their behavior to an imbalance of patient-provider power. The study further noted that complicated guidelines without adequate oversight or improved patient-provider communication will hinder preventive treatment implementation.

Number of women living with HIV who were screened for cervical cancer using any screening test

For women living with HIV, the South African policy on cervical cancer recommends screening be done at three-year intervals starting as soon as HIV is diagnosed (Denny

Table 16: Percentage of people living with HIV currently on ART initiating tuberculosis (TB) preventive treatment and who completed a course of TB preventive treatment in 2022

Indicator	All	Started ART in 2021	Started ART prior to 2021	0-5 years	5-15 years	Males (15+)	Females (15+)	Transgender
Percentage of people living with HIV on ART who completed a course of TB preventive treatment among those who initiated TPT	49.3%	44.3%	65.7%	40.9%	54.4%	47.8%	50.1%	No data
Number of people on antiretroviral therapy who completed TPT among those who initiated any course of TPT during the previous year (e.g. 2021 cohort for 2023 reporting)	204,162	140,482	63,680	608	2020	69,316	132,218	No data
Number of people on antiretroviral therapy who initiated any course of TPT during the previous year (insert same cohort year as numerator: e.g., 2021 for 2023 reporting)	414,353	317,387	96966	1,487	3,710	145,146	264,010	No data

Source: UNAIDS Online Tool (based on DOH- HIV patient registers)

and Kuhn, 2017). South African data showed that women living with HIV had a higher prevalence of HPV infection than women who were HIV-negative because of sexual behavior and immune suppression due to HIV infection (Hopkins et al., 2021; Ntuli et al., 2020). Despite public awareness and health promotion activities to encourage women to screen, uptake remains low in South Africa. Data from the National Health Laboratory Services (NHLS) and the programme data from implementing partners show that the number of women living with HIV who were screened for cervical cancer in the last 12 months using any screening test increased from 134,338, in 2020, to 336,174 in 2022.

Cervical precancer treatment in women living with HIV

According to the DOH's cervical cancer prevention and control policy¹², to protect those women who do not benefit from primary prevention, secondary prevention will be necessary for at least two decades after implementing the HPV vaccination programme. Secondary prevention will be achieved by providing screening for the early detection of high-risk pre-cancerous lesions, and treatment of these lesions. Accordingly, cervical cancer screening continues to be offered by the public healthcare system free of charge to all eligible women as a national priority. However, there was no data on percentage of women living with HIV, who screened positive for cervical precancer who received

treatment for precancerous lesions in the last 12 months.

Treatment of invasive cervical cancer in women living with HIV

Data on the percentage of women living with HIV with suspected invasive cervical cancer who were treated within the last 12 months was not available at the point of reporting. However, in South Africa, all women in whom cervical abnormalities have been detected (positive screening test) should be managed appropriately depending on the screening result. In most cases precancerous lesions can be treated on an outpatient basis using relatively non-invasive procedures. The methods that are available for the treatment of cervical lesions are Cervical Intraepithelial Neoplasia (CIN), CIN2, CIN3, and adenocarcinoma in situ, ablation therapy, Electro coagulation diathermy (ED), Cryotherapy, Laser cauterisation (or vaporization), Excision methods and large loop excision of the transformation zone (LLETZ) (DOH, 2017).

People living with HIV receiving multi-month dispensing of antiretroviral medicine

Data on the proportion of people living with HIV and currently on antiretroviral therapy who are receiving multi-month dispensing of antiretroviral medicine is available up to 2022. The data from the Central Chronic Medicines Dispensing and Distribution (CCMDD) shows that about 25% of people living with HIV currently enrolled on antiretroviral therapy received less than 3 months dispensing of antiretroviral medicine. This was a decrease from 74% in 2021.

Coverage of differentiated service delivery antiretroviral therapy models among

people living with HIV currently on antiretroviral therapy
Differentiated service delivery (DSD) models aim to increase

the responsiveness of HIV treatment programmes to the individual needs of antiretroviral therapy (ART) clients to improve treatment outcomes and quality of life.

There is currently no data on the percentage of people enrolled in differentiated service delivery (DSD) antiretroviral therapy models among all people living with HIV on antiretroviral therapy at the end of the reporting period. A study to describes the expansion of CCMDD toward national scale (Liu et al, 2021) shows that from March 2016 through October 2019, the number of health facilities offering DSD increased from 972 to 3436 (representing 94.6% of all facilities in the participating districts), and the number of external pick-up points increased 12-fold over the observation period, from 164 to 2037.

As the numbers of facilities and external pick-up points (PuPs) increased, so did the number of patients served by CCMDD. The number of registered patients has expanded over 8-fold, reaching a total of 2,993, 044 registered patients and 2,069,039 active patients (69.1 % of registered patients were active) by October 2019. In the year between November 2018 and October 2019, the proportion of active patients relying on clinic-based fast lanes decreased from 55 to 52% while the proportion using external PuPs increased from 31 to 35% ($p < 0.001$). By the end of the study period, 734,005 active CCMDD patients were collecting from external pick-up points, a 73% increase in patient volume to those locations for the year.

Viral suppression among people living with HIV engaged in differentiated service delivery antiretroviral therapy models

There was no data available for the percentage of people living with HIV engaged in differentiated service delivery (DSD) antiretroviral therapy models who have virological suppression during the reporting period. A study conducted to determine whether the CCMDD program in South Africa's differentiated ART delivery model impacts clinical outcomes (Wang et al., 2024) found that among 390 PLHIV participating in CCMDD, VL suppression and retention in care was very similar among CCMDD-eligible patients who participated in the program compared to patients who did not participate in the program (aRR: 1.03; 95% CI 0.94–1.12). VL suppression alone (aRR: 1.02; 95% CI 0.97–1.08) and retention in care alone (aRR: 1.03; 95% CI 0.95–1.12) were also similar between CCMDD-eligible PLHIV who participated in the program and those who did not.

Achievements

- Despite the challenges experienced with hi-HIV-HCV co-infection rates, it is encouraging to note that 100% of patients initiating ART supported by implementing partner programmes are tested for HCV.
- Deaths due to both HIV and TB have been decreasing from around 120,000 in 2012 to around 83,000 for HIV and 61,000 for TB in 2020.
- The number of women living with HIV who were screened for cervical cancer in the last 12 months using any screening test increased from 134,338 in 2020, to 336,174 in 2022 and 438,380 in 2022.
- About 25% of people living with HIV currently enrolled on antiretroviral therapy received less than 3 months dispensing of antiretroviral medicine. This was a decrease from 74% in 2021.

¹² <https://www.health.gov.za/wp-content/uploads/2021/07/cervical-cancer-policy.pdf>

Challenges

- HCV-HIV co-infection prevalence of 3.7% was observed overall, with PWID having the highest at 12.7%. This was largely driven by the HCV-HIV co-infection prevalence of 29% observed in Pretoria and likely reflects the high proportion of HCV infections in this group and the longer culture of injecting.
 - The number of people living with HIV newly enrolled on HIV treatment diagnosed with tuberculosis (TB) disease for 2022 was 32,847 (7%) compared to 27,287 (5.6%) in 2021.
 - There is an increasing trend in STI infection, for example, urethral discharge, increasing from 1.6% in 2019 to 1.8% in 2022.
 - The percentage of people on antiretroviral therapy who started tuberculosis preventive treatment during the reporting period is still relatively low at 61.8%.
 - Completion rate of TB preventive therapy is still low at 49.3%.
 - Prevalence of curable STIs was higher in the younger age groups among whom a peak in HIV incidence occurs.
 - STIs threaten the goal of achieving HIV epidemic control in this high HIV burden region.
 - Complicated IPT guidelines without adequate oversight or improved patient-provider communication will hinder preventive treatment implementation.
- therapy initiation within health facilities.
 - High HCV prevalence and low uptake of referrals support the need for expanded, community-based HCV screening, diagnosis and treatment, particularly for PWID.
 - Integrated HIV and HCV prevention services, including needle and syringe programmes, opioid substitution therapy (OST) and harm reduction initiatives, are all critical as HIV and HCV share the same transmission route.
 - Increased HCV education and awareness is required. There needs to be comprehensive post-test counselling to ensure that all clients understand their HCV status, the risks of not accessing care and the benefits of treatment. Ideally, this should be supplemented with psychosocial support to build a sense of self-worth and the desire to access treatment.
 - Higher than expected HCV prevalence among PWUD (7%) warrants further investigation and implementation of appropriate services.
 - The high prevalence of STIs provides compelling evidence for enhanced surveillance for STI control
 - Future IPT guidelines should provide comprehensive instructions to cover all potential patient and medication stockout scenarios, be written in simple language, and be communicated with visual diagrams like decision trees.
 - More research is needed to evaluate the effectiveness and sustainability of multi-level interventions that concurrently educate nurses and patients on IPT, provide sustained support to nurses through text messaging and district-level monitoring, and promote patient-centered communication.
 - National IPT guidelines should be unambiguous and easily implemented after minimal training on patient

eligibility and appropriate medication durations, nurse-patient dynamics should empower the patient, and district-level support and monitoring should be implemented.

Recommendations

- There is need to educate clinical professionals on the need to intensify STI testing among PLHIV and promote treatment among key and vulnerable populations
- Community-based support is needed to encourage completion of TB preventive therapy among PLHIV. This should be coupled with strengthening preventive



Political Declaration and Framework 8: Investment and resources

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.

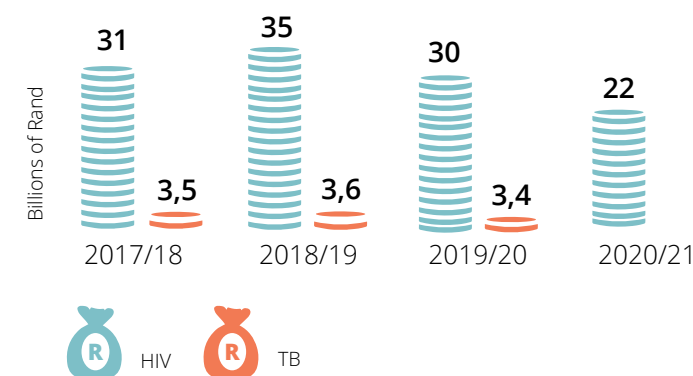
There is good alignment between the NSP 2017–2022 and the National Development Plan (NDP): Vision 2030 (South African Government 2012). The NDP enshrines a health system that works for everyone and produces positive health outcomes, resulting in a significant reduction in the burden of diseases. South 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. There was no new data available on investment and resources during the reporting period. Therefore, data reported here is up to 2021.

Current Status and Progress Domestic Public Budget on HIV

- For the period up to 2021, 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 has not yet been 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 17). 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).

Table 17: 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: NASA report (2017-2020)

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).

Antiretrovirals: Unit Prices and Volume

Table 12 shows expenditure on ART accounted for most 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. 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 (Table 18).

Table 18: 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: NASA report (2017-2020)

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

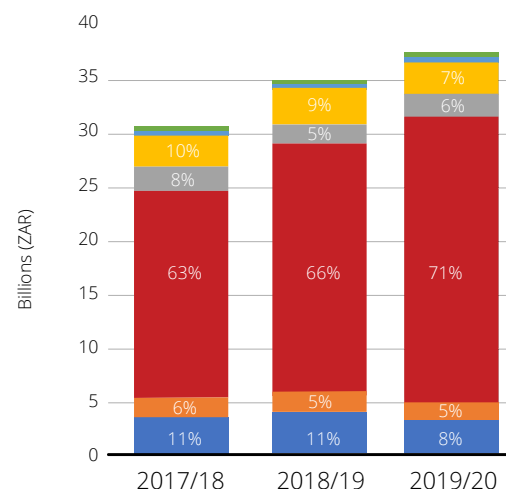
As TB tops the leading causes of natural deaths in South Africa, it is important that the TB funding is increased to ensure that TB services remain available, accessible and of acceptable quality with good health outcomes.

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, the 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 28 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, the 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 later')
- 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.

Conclusion

To put the country and the rest of the world on track to eradicate AIDS as a public health threat by 2030 and hasten the process of accomplishing the Sustainable Development Goals (SDGs), particularly Goal 3 on good health and well-being, South Africa joined other nations in June 2021 in adopting a political declaration on HIV and AIDS. An update on the political declaration and framework targets for South Africa was given in this report. All the pledges are in agreement that it is unlikely that the goals will be met by 2025, and the score card analysis was designed with this in mind.

The drivers and challenges are explored, and the score cards are shown under each commitment. With decreased incidence, more people on ART, lower rates of MTCT of HIV, attainment of the first and third 95s, maintenance of social protection floors, and a decline in AIDS-related mortality, the nation has achieved tremendous progress towards this target. The government and its partners have worked together to actualize these efforts, especially in the areas of prevention, research, therapy, and other focused interventions. Even with this advancement, reaction players' efforts are still beset by serious obstacles.

These noteworthy concerns include rising rates of risky sexual activity among teenagers, poor rates of HIV treatment coverage, particularly among children and critical populations, rising incidence among females over 50, and health system issues made worse by the COVID-19 pandemic, to name a few. Innovative methods grounded in community-led initiatives and supported by resilient health systems are required to identify, initiate, and keep all PLHIV on ART as the nation moves closer to the UNAIDS 95-95-95 targets.

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