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Global AIDS Monitoring Report

2023

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Table of Contents

Acknowledgements	2	Young people: Knowledge about HIV prevention.....	26
Abbreviations and Acronyms	6	Achievements.....	26
Introduction	10	Key challenges	26
Summary of Progress Towards Political Declaration and Framework Targets	13	Recommendations.....	27
Overview of the HIV/AIDS Epidemic in 2023	13	Political Declaration and Framework 2: 95-95-95 for HIV testing and treatment ..	28
South Africa HIV prevalence trends.....	13	Legal and policy environment.....	29
South Africa HIV prevalence by sex and age.....	13	95-95-95- HIV testing and treatment	29
HIV Prevalence by geographical areas.....	14	People living with HIV who know their HIV status	29
South Africa HIV prevalence by province.....	14	People living with HIV on antiretroviral therapy.....	30
South Africa HIV prevalence by district.....	14	People living with HIV who have suppressed viral loads.....	30
HIV prevalence by key populations.....	14	Advanced HIV disease and late HIV diagnosis.....	30
HIV prevalence among antenatal care attendees.....	15	HIV testing volume and positivity.....	31
HIV incidence.....	15	Antiretroviral therapy coverage among people living with HIV in key populations.....	31
Political Declaration and Framework 1: Combination HIV prevention for all	16	AIDS mortality.....	32
Legal and policy environment.....	17	Achievements.....	33
HIV incidence.....	18	Challenges.....	33
Estimates of the size of key populations.....	18	Recommendations.....	33
HIV prevention programmes in prisons.....	21	Political Declaration and Framework 3: End paediatric AIDS and eliminate vertical transmission	35
Safe injecting practices among people who inject drugs	22	Legal and policy environment.....	36
Needles and syringes distributed per person who injects drugs.....	22	HIV testing in pregnant women	36
Coverage of opioid substitution therapy (OST).....	22	Early infant diagnosis.....	37
People who received PrEP.....	23	Vertical transmission of HIV	37
Prevalence of Voluntary Medical Male Circumcision (VMMC)	24	Preventing the vertical transmission of HIV	37
Annual number of males voluntarily circumcised	25	Syphilis among pregnant women.....	38
Condom use at last high-risk sex.....	25	Congenital syphilis rate (live births and stillbirth).....	38
Annual number of condoms distributed.....	25		

Table of Contents

Hepatitis B virus among pregnant women attending antenatal care services	39	Political Declaration and Framework 8: Investment and resources	59
Achievements	39	Legal and policy environment	60
Key challenges	39	Achievements	62
Recommendations	39	Key challenges	62
Political Declaration and Framework 4: Gender equality and empowerment of women and girls	40	Recommendations	62
Legal and policy environment	42	Conclusion	63
Current status and progress	43	References	64
Physical and/or sexual violence experienced by key populations	44		
Attitudes towards violence against women	45		
Gender-responsiveness of HIV services	45		
Achievements	45		
Key challenges	46		
Recommendations	46		
Political Declaration and Framework 6: Realize human rights and eliminate stigma and discrimination	47		
Legal and policy environment	48		
Achievements	51		
Key challenges	51		
Recommendations	51		
Political Declaration and Framework 7: Universal health coverage and integration	52		
Legal and policy environment	53		
Achievements	57		
Challenges	58		
Recommendations	58		

List of Tables

Table 1: Summary scorecard analysis	10
Table 2: HIV prevalence by age and sex (2018-2022)	14
Table 3: Number of new HIV infections and percentage change (2018-2022).....	18
Table 4: Population size estimates, HIV testing, HIV prevalence, condom use and HIV prevention service coverage among key populations.....	21
Table 5: HIV prevention programmes in prisons.....	21
Table 6: People who inject drugs living with HIV (2022).....	22
Table 7: Number of people who received any PrEP product (2019-2022)	23
Table 8: Annual number of males voluntarily circumcised (2018-2022)	25
Table 9: Annual number of condoms distributed (2018-2022)	26
Table 10: ART coverage among key populations (2018-2022)	31
Table 11: Early Infant Diagnosis (2018-2022)	37
Table 12: Performance of MTCT indicators (2018-2022).....	37
Table 13: Crime situation in South Africa	44
Table 14: Proportion of people starting antiretroviral therapy who were tested for hepatitis C virus (HCV) (2020	54
Table 15: Percentage of people on antiretroviral therapy who started tuberculosis preventive treatment (2018-2022).....	55
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	56
Table 17: Total HIV spending in South Africa by Programme Area	61
Table 18: Financing entities contributions to HIV funding in South Africa (2017/18-2019/20 ZAR, %).....	61

List of Figures

Figure 1: South Africa HIV prevalence (2018-2022)	13
Figure 2: South Africa HIV prevalence by province and year	14
Figure 3: People living with HIV, age 15+, September 2022	15
Figure 4: South African legal and policy environment for the prevention of new HIV infections.....	17
Figure 5: PrEP coverage by population group (2022).....	24
Figure 6: Number of VMMC's conducted by age (2018-2022).....	24
Figure 7: Annual number of VMMC's conducted (2018-2022).....	25
Figure 8: Condom use at last sex (2018-2022)	25
Figure 9: HIV testing and treatment legal and policy framework	29
Figure 10: Total HIV infections (2018-2022).....	30
Figure 11: Percentage of all people starting ART at CD4 <500 (2018-2022)	30
Figure 12: HIV testing positivity (2018-2022)	31
Figure 13: 95-95-95 cascade for female sex workers living with HIV (2018)	32
Figure 14: 95-95-95 cascade for men who have sex with men living with HIV (2019)	32
Figure 15: Trends in AIDS mortality among children and adults (2018-2022)	33
Figure 16: Legal and policy framework for ending paediatric HIV and eliminating vertical transmission	36
Figure 17: Knowledge of HIV-positive status by province, in the 2017, 2019 and 2022.....	37
Figure 18: Maternal syphilis screening coverage among antenatal women, in the 2017, 2019 and 2022 Antenatal HIV sentinel surveys.....	38

List of Figures

Figure 19: Syphilis treatment cascade among antenatal women, in the 2022 HIV Antenatal Survey.....	38
Figure 20: South Africa legal and policy environment for declaration and framework 4.....	43
Figure 21: Selected contact crimes against women and children.....	44
Figure 22: Mediclinic Southern Africa supports CBOs to offer GBV services.....	49
Figure 23: HBV, HCV and HIV prevalence, by population (2018).....	53
Figure 24: The comparison between HIV and TB deaths in South Africa (2012 to 2020).....	55
Figure 25: Total expenditure on HIV	60
Figure 26: Total HIV spending by programme area (2017-2020, ZAR).....	62

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		

Abbreviations & Acronyms

OST	Opioid Substitution Therapy
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 4.7 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 evaluates South Africa's progress in responding to the Human Immunodeficiency Virus (HIV) epidemic by comparing its 2023 performance against established targets for key HIV indicators. The report provides a comprehensive assessment of the country's achievements, the current legislative and regulatory landscape, and persistent challenges in achieving global HIV commitments.

Aligned with the 2021 Joint United Nations Programme on HIV and AIDS (UNAIDS) Political Declaration on HIV and Acquired immunodeficiency syndrome (AIDS)¹, this report presents data for the period January to December 2023, offering a critical analysis of South Africa's trajectory towards the 2025 HIV response targets.

The findings indicate that while significant progress has been made, most of the targets set for 2025 remain out of reach. Recognizing these challenges, the scorecard analysis within this report has been structured accordingly, offering an in-depth review of the factors driving progress, as well as the barriers hindering the achievement of key commitments.

By highlighting both successes and challenges, this report serves as a strategic tool to guide future HIV response efforts, ensuring that South Africa remains on course to meet its long-term goal of ending AIDS as a public health threat by 2030.

2021 New UNAIDS political declaration on HIV and AIDS

Strengthening Accountability and Accelerating Progress: The 2023 GAM Report

The 2021 Political Declaration on HIV and AIDS, aligned with the Global AIDS Strategy 2021–2026 and the Sustainable Development Goals (SDGs), provides a strategic roadmap for ending AIDS as a public health threat by 2030. The Global AIDS Strategy prioritizes addressing systemic gaps that hinder progress, emphasizing an equity-focused approach and the use of high-quality data to drive targeted interventions.

The GAM process serves as a universal accountability framework, ensuring that national HIV responses are monitored, evaluated, and refined through evidence-based decision-making. The 2021 Political Declaration underscores the importance of setting clear, time-bound targets as benchmarks for assessing the effectiveness of the global AIDS response. To track progress, the declaration mandates regular evaluations and requires annual progress reports from the United Nations Secretary-General. This GAM 2023 report plays a crucial role in identifying persistent barriers, highlighting achievements, and recommending strategic actions to accelerate South Africa's progress toward its HIV response commitments.

Key Focus Areas: The 2021 Political Declaration and Frameworks

In 2021, the global community reviewed progress toward achieving specific HIV response targets, and structured around eight key political declaration frameworks:

- Combination HIV prevention for all: Expanding access to prevention tools such as PrEP, condoms, and harm reduction services.
- 95-95-95 for HIV testing and treatment: Ensuring that 95% of people living with HIV (PLHIV) know their status, 95% of those diagnosed are on ART, and 95% achieve viral suppression.
- Ending paediatric AIDS and eliminating vertical transmission: Preventing HIV transmission from mothers to children and improving paediatric treatment coverage.
- Gender equality and empowerment of women and girls: Addressing gender disparities in HIV vulnerability, access to services, and health outcomes.
- Community leadership: Strengthening the role of civil society, community-based organizations, and key populations in the HIV response.
- Realizing human rights and eliminating stigma and discrimination: Creating an enabling legal and policy environment to protect the rights of PLHIV and key populations.
- Universal health coverage and integration: Ensuring that HIV services are integrated into broader health

systems, promoting accessible, people-centered care.

- Investments and resources: Mobilizing sustainable funding to support the national HIV response.

Significance of the 2023 Global AIDS Monitoring (GAM) Report

This annual GAM report provides critical insights into South Africa's progress in meeting these political declaration targets and extended HIV response commitments. The report is structured to:

- Assess progress toward the 2026 HIV response targets, ensuring national and global accountability.
- Incorporate national and subnational data to enhance the accuracy of HIV estimates feeding into GAM reporting.
- Inform the preparation and review of grant proposals and operational plans, supporting resource mobilization from both domestic and international stakeholders.

By tracking government-led initiatives, identifying challenges, and proposing evidence-based solutions, this GAM 2023 report serves as a key strategic tool for both national HIV programming and regional and global advocacy efforts. The findings reinforce the importance of sustained investments, policy innovation, and multi-sectoral collaboration in accelerating progress toward ending AIDS as a public health threat by 2030.

Policy and Programmatic Response

South Africa's response to the Human Immunodeficiency Virus (HIV), Tuberculosis (TB), and Sexually Transmitted

Infections (STIs) epidemics is governed by five-year National Strategic Plans (NSPs), which provides a structured, multisectoral framework for intervention. The NSP (2017–2022) outlined the country's response over the past five years, ensuring that HIV, TB, and STIs remain high-priority public health issues. The magnitude of the HIV epidemic demands unwavering political leadership and sustained high-level commitment to maintain HIV, TB, and STI interventions at the forefront of the national health agenda. The country has ratified multiple regional and international agreements aimed at mitigating the impact of the epidemics, reinforcing its commitment to the global HIV response. South Africa aligns with the UNAIDS targets, which aim for:

- Zero new HIV, TB, and STI infections
- Zero new cases of parent-to-child transmission of HIV or other STIs
- Zero HIV, TB, and STI-related deaths
- Zero discrimination against individuals based on their health status

South Africa's NSP (2023-2028) demonstrates the country's proactive approach to ending the epidemic. The South African National AIDS Council (SANAC) leads the coordination of the national response, operating as a multisectoral body that brings together government departments, civil society organizations, political leadership, private sector, and development partners. This collaborative governance model is integral to achieving the goals set forth in each NSP cycle, ensuring broad participation and accountability across sectors.

Methods and data sources

A retrospective analysis was conducted to assess the status of each political declaration and framework, measuring progress made toward national and global HIV response goals. The methodology included a desktop review of policy documents, regulations, guidelines, and reports, alongside a quantitative comparative data analysis to assess trends over the past five years. The following data sources were utilized to compile this report:

- Thembisa Model (Version 4.7): South Africa's most comprehensive mathematical model for HIV estimates
- National policies, strategies, and guidelines
- Data from national and biobehavioural surveys
- District Health Management Information System (DHIS) data
- Programmatic data from implementing partners
- Scientific publications and peer-reviewed research
- Global AIDS Monitoring (GAM) guidelines
- UNAIDS online databases and reports

By employing robust data sources and analytical methods, this report provides a comprehensive assessment of South Africa's progress in achieving its HIV, TB, and STI response commitments, while also identifying challenges and strategic recommendations to accelerate future progress.

Scorecard Analysis and Report Structure

South Africa remains at the forefront of the global HIV response, demonstrating a strong commitment to ending acquired immunodeficiency syndrome (AIDS), (TB), and

STIs as public health threats by 2030. Guided by the NSP for HIV, TB, and STIs (2023-2028), the country has made significant progress in expanding access to prevention, treatment, and care services, while also addressing structural and systemic challenges that hinder the realization of global HIV targets. In June 2021, South Africa reaffirmed its commitment to achieving the Sustainable Development Goals (SDGs)—particularly Goal 3 on good health and well-being—by adopting the 2021 Political Declaration on HIV and AIDS alongside other United Nations Member States.

This declaration is aligned with the Global AIDS Strategy 2021–2026, which emphasizes equity, inclusivity, and a data-driven approach to tackling the epidemic. The GAM 2023 report provides a comprehensive assessment of the country's progress, measuring performance against established national and global targets while identifying persistent gaps and emerging challenges.

This report presents a scorecard analysis under each political declaration and framework as depicted in the sections below.

Additionally, the report provides an in-depth evaluation of South Africa's HIV epidemic and response over the past five years, covering:

- Epidemiological trends, including HIV prevalence, incidence, AIDS-related mortality, and key population dynamics.
- Major achievements, particularly in treatment expansion, prevention strategies, and policy development.
- Key challenges include rising incidence among specific populations, ART coverage gaps, structural inequalities, and health system constraints.
- Strategic recommendations, offering actionable steps to strengthen prevention efforts, improve ART retention, enhance integration of HIV and TB services, and secure sustainable financing.

While South Africa has made significant strides, including achieving the first and third 95 targets, reducing mother-to-child transmission, and expanding social protection programs, remain critical challenges. Persistent barriers—such as rising new infections among adolescent girls and young women, disparities in ART coverage among key populations, increasing STI incidence, and the impact of Covid-19 on health service delivery—necessitate urgent and targeted interventions.

As South Africa moves towards the UNAIDS 95-95-95 targets, community-driven, equity-focused, and data-informed approaches will be pivotal in addressing

the remaining gaps. The success of this response will require strong political leadership, enhance domestic and international financing, and sustain multi-sectoral collaboration.

The GAM 2023 report serves as a key accountability tool, tracking South Africa's progress and commitments while guiding future efforts towards achieving epidemic control. By leveraging data-driven insights, innovative service delivery models, and strengthened health systems, South Africa can accelerate its path towards ending HIV, TB, and STIs as public health threats by 2030, in alignment with global health goals and national development priorities.

Summary of Progress Towards Political Declaration and Framework Targets

Summary scorecard analysis

Table 1 provides a comprehensive summary of South Africa's performance against the targets set in the seven (excluding Commitment 5) Political Declaration and framework commitments, using a scorecard analysis to assess progress, gaps, and areas requiring intensified efforts.

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

The summary indicates that South Africa is on track 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. For Commitment 2, the country is nearing achievement of the first and third 95 targets, with ongoing interventions aimed at improving ART retention and expanding treatment coverage. Meanwhile, for Commitment 7, the passing of the National Health Insurance (NHI) Bill in Parliament represents a significant milestone in advancing equitable access to healthcare, positioning the country closer to achieving universal health coverage.

Political declaration and framework 1

Combination HIV prevention for all

Data indicate that South Africa has achieved an 18% reduction in new HIV infections, marking significant progress in the national HIV response. However, certain population groups, particularly females over the age of 15 and adults aged 50 and above, have experienced slower declines in new infections, performing below the national average in terms of HIV prevention. This underscores the need for targeted interventions addressing the specific vulnerabilities of these groups. From a policy perspective, including the NSP, several key advocacy interventions have been instrumental in addressing the structural and social barriers that impact key and priority populations. These include the creation and implementation of the National Drug Master Plan (NDMP), population size estimations, and Biological and Behavioral Studies (BBS), all of which provide essential data to guide HIV programming.

Additionally, the establishment of community-led organizations such as the Community-Oriented Substance

Use Programme (COSUP), and the South African Network of People Using Drugs (SANPUD) has strengthened harm reduction efforts and highlighted the ongoing challenges faced by people who use drugs.

Recognizing Gender-Based Violence (GBV) and Intimate Partner Violence (IPV) as key drivers of HIV transmission, the development and implementation of the National GBV and Femicide Strategic Plan has been a critical step in addressing the increasing rates of GBV and IPV. This strategy aims to mitigate the impact of violence on women and vulnerable groups, ultimately contributing to HIV prevention efforts. Moreover, combination prevention strategies have played a significant role in reducing new HIV infections. These include:

- Vertical Transmission Prevention (VTP), ensuring that HIV-positive mothers receive the necessary treatment to prevent transmission to their newborns.
- VMMC, which has contributed to long-term reductions in HIV acquisition among men.
- Increased condom uses among young people, reflecting positive shifts in safer sexual practices.
- Expansion of Pre-Exposure Prophylaxis (PrEP) uptake among key populations, enhancing HIV prevention efforts for those at high risk.
- Availability of Post-Exposure Prophylaxis (PEP) for survivors of sexual assault, ensuring timely intervention to prevent potential HIV infection.

These collective efforts underscore South Africa's commitment to evidence-based, multi-sectoral strategies to combat HIV while addressing broader social determinants of health, particularly among vulnerable populations. However, sustained investment in

prevention, expanded access to services, and enhanced advocacy remain critical to achieving further reductions in new infections.

Political declaration and framework 2

95-95-95 for HIV testing and treatment

As of December 2023, South Africa's performance against the UNAIDS 95-95-95 strategy for controlling the HIV pandemic was 95-81-91 (UNAIDS online tool)³. This indicates that:

- 95% of people living with HIV (PLHIV) knew their HIV status, demonstrating significant success in HIV testing and diagnosis.
- 81% of PLHIV were on antiretroviral therapy (ART), highlighting the need for intensified efforts to improve linkage to care and retention on treatment.
- 91% of individuals on ART achieved viral suppression within 12 months, underscoring the effectiveness of treatment in maintaining viral load suppression and preventing onward transmission of HIV.

While South Africa has achieved the first and third 95s, the second 95 target remains a challenge, signaling the need for enhanced interventions to improve ART uptake and retention in care. Addressing this gap will be crucial in ensuring that more people who are diagnosed with HIV not only initiate treatment but also remain adherent to therapy, ultimately contributing to the broader goal of epidemic control.

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

South Africa has established several legal and policy strategies to address the impact of HIV and AIDS on children as part of a comprehensive national response. The Children's Act (2010) explicitly protects children from discrimination based on their health status under Section 6(2)(d), ensuring equal rights and protections for children living with HIV. By the end of 2023, Thembisa Model estimates that 172,868 children under 15 were living with HIV, with 8,242 new infections recorded during the year. Additionally, children accounted for 3% of the 50,141 AIDS

-related deaths in 2023. The impact of HIV and AIDS on children extends beyond health, exposing them to stigma, discrimination, increased caregiving responsibilities, financial instability, and emotional distress. Addressing these challenges requires early HIV diagnosis and treatment, strengthened social protection programs, elimination of stigma and discrimination, and enhanced VTP efforts. South Africa's legal framework provides a strong foundation for protecting affected children, but effective implementation remains key to ensuring their well-being.

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

South Africa is a signatory to several international treaties on Gender-Based Violence (GBV) and has established a strong legislative framework to address these issues. Key legislation includes the Domestic Violence Act (1998), the Sexual Offences Act (2007), and the Prevention and

Combatting of Trafficking in Human Persons Act (2013). The South African Constitution further reinforces the country's commitment by affirming equality, human dignity, life, freedom, and security of the person as fundamental rights. To strengthen its response, South Africa launched the National Strategic Plan on GBV and Femicide (NCGBVF) 2020–2030 in 2020, providing a structured framework to address GBV and intimate partner violence (IPV). Despite these efforts, GBV remains a significant challenge.

The South Africa National HIV Prevalence, Incidence, Behavior, and Communication Survey V revealed that 29.1% of ever-married or partnered women (ages 15–49) experienced physical or sexual violence from a male intimate partner in the past 12 months (Simbayi et al., 2019). This rate increased during the COVID-19 pandemic (Gill, 2021), highlighting the compounding impact of crises on GBV prevalence.

The Governance, Public Safety, and Justice Survey (GPSJS) reported that 53,773 victims of sexual offences reported crimes to the South African Police Service (SAPS) in 2023/24, a slight decrease from 54,040 in 2022/23. However, despite this decline, evidence indicate a continued rise in GBV-related crimes and violence (South African Police Service Report, 2022, 2023; Bello et al., 2021). Addressing GBV effectively requires enhanced law enforcement, community engagement, survivor support services, and multi-sectoral collaboration to break the cycle of 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 that offers 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, ensuring protection against unfair discrimination and harassment. However, despite these legal protections, stigma and discrimination remain pervasive, particularly for men who have sex with men (MSM), sex workers, and people who use drugs (PWUD).

Research indicates that these groups frequently experience social exclusion and discrimination within healthcare settings (Ritcher, 2008; Parry et al., 2009). Judgmental and moralizing attitudes toward sex work, same-sex relationships, homosexuality, and drug use are commonly expressed in South African communities, including by healthcare professionals, which undermines access to essential services (Lane et al., 2008; Scheibe, Drame, Shannon, 2016). Addressing these barriers requires targeted policy enforcement, sensitization training for healthcare workers, and strengthened legal accountability to ensure equitable access to healthcare and social services for all populations.

Political declaration and framework 7

Universal health coverage and integration

South Africa's new NSP emphasizes the integration of health service delivery, encompassing HIV, TB, STIs, cervical cancer, and human papillomavirus (HPV), among other critical health concerns. The NSP provides a strategic framework to eliminate, prevent, and reduce new infections of HIV, TB, and STIs while ensuring a coordinated and unified response across healthcare services. In 2021, South Africa reaffirmed its commitment to Universal Health Coverage (UHC) by allocating 8.9% of its Gross Domestic Product (GDP) to healthcare. This investment underscores the nation's focus on strengthening health systems to ensure equitable access to quality care. Compared to countries with similar economies, South Africa continues to dedicate a significant proportion of its budget to healthcare.

According to recent UHC performance data, the country's UHC index has nearly doubled over the past two decades, increasing from 36 in 2000 to 67 in 2020. In 2019, South Africa enacted legislation to support a decentralized model for managing multidrug-resistant tuberculosis (MDR-TB), further demonstrating its commitment to integrating care delivery across multiple disease areas. Additionally, the country is actively working toward the implementation and rollout of National Health Insurance (NHI) as part of its broader strategy to achieve UHC. The cross-referencing of diseases within national policies and service delivery models highlights the government's dedication to comprehensive and inclusive healthcare reform.

Political declaration and framework 8

Investments and resources

The Government of the Republic of South Africa leads the national response to HIV, TB, and STIs, providing most domestic funding required for these programs. External donors, including PEPFAR, USAID, the Global Fund, and the private sector, supplement the remaining funding (NASA, 2021). While government expenditure on HIV increased from R22.2 billion in 2017/18 to R26.0 billion in 2019/20, its overall share of total spending declined from 72% to 69% (Table 14), reflecting an increasing reliance on external partners.

Despite this declining proportion of domestic spending, donor commitment to South Africa's HIV/AIDS response remained strong throughout the review period. According to the 2021 South African Investment Case report, the country will need approximately R80 billion to increase ART retention to 95%, R30 billion to sustain the healthcare workforce, and R50 billion to fund new ART initiations.

The report further highlights that even with the full scale-up of interventions, the annual HIV program cost, estimated between R20 billion and R25 billion, remains within the government's budget constraints, demonstrating the financial feasibility of sustaining HIV programs. However, civil society organizations (CSOs) have raised concerns about potential funding cuts. The November 2021 Medium-Term Budget Policy Statement (MTBPS) indicated reductions in provincial allocations through both the equitable share and conditional grants. This could jeopardize provinces' ability to meet critical HIV/AIDS

targets, potentially undermining gains made in prevention, treatment, and care.

Overview of the HIV/AIDS Epidemic in 2023

South Africa HIV prevalence trends

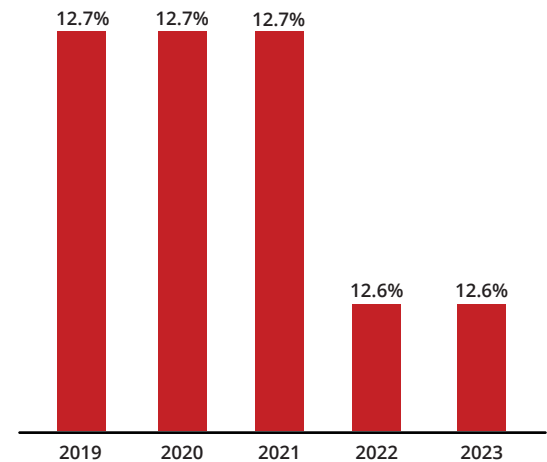
Achieving HIV epidemic control requires that the number of new HIV infections is lower than the total mortality rate among people living with HIV (PLHIV). The overarching goal is to attain population-level viral suppression among individuals on treatment while curbing the transmission of the virus. South Africa continues to be the epicenter of the global HIV pandemic, accounting for the highest number of PLHIV worldwide.

The country also bears a significant burden, contributing approximately 20% of all new HIV infections globally and hosting around 20% of the world's PLHIV. Nationally, HIV prevalence has exhibited a marginal decline, decreasing from an estimated 12.7% in 2019 to 12.6% in 2023 (Figure 1). Concurrently, the number of PLHIV on antiretroviral therapy (ART) has increased significantly, rising from approximately 5,095,690 in 2019 to 5,861,140 in 2023, marking a 15% increase (Thembisa Model 4.7).

This slight reduction in prevalence is primarily attributed to a decrease in HIV incidence, which fell from 0.35% in 2019 to 0.28% in 2023 (Thembisa Model 4.7). The decline is largely due to the expansion of combination prevention strategies, including the VTP, voluntary medical male circumcision (VMMC), the scaled-up availability of pre-exposure prophylaxis (PrEP) for high-risk groups such as sex workers, post-exposure prophylaxis (PEP) for survivors

of sexual violence, and the continuous increase in ART coverage (NDOH 2023).

Figure 1: South Africa HIV prevalence (2018-2023)



Source: Thembisa Model ver. 4.6

In 2023, South Africa recorded an estimated 181,376 new HIV infections. Of these, approximately 59.3% (107,508) occurred among females aged 15 and older, while 5.6% (10,226) were among children under 15. According to the Thembisa Model, individuals aged 15-49 years account for around 88% of all new infections, highlighting the continued vulnerability of the reproductive-age population. A critical gap persists in achieving the second

95 target, as barriers such as limited access to quality healthcare, psychosocial challenges, and treatment hesitancy contribute to failed treatment initiation and interruptions. HIV prevalence remains uneven across provinces, with Mpumalanga reporting the highest incidence and Western Cape the lowest. Since 2010, KwaZulu-Natal has achieved the most significant decline in incidence (75%), whereas Western Cape, Limpopo, and Northern Cape recorded the slowest reductions (47%).

Key populations continue to face a disproportionately high HIV burden, with an estimated 54% of female sex workers and 30% of men who have sex with men (MSM) living with HIV. Among women aged 25-49, HIV prevalence is estimated at 30%, while prevalence among men and children remains significantly lower (Thembisa Model 4.7).

South Africa HIV prevalence by sex and age

Table 2 provides a detailed analysis of HIV prevalence by age and sex, indicating an overall decline in prevalence across most age groups. However, two demographic groups show a notable exception to this trend: females aged 15 and older, where a slight increase was observed between 2020 and 2022, and adults aged 50 and above, where prevalence has continued to rise steadily over time. The decline in HIV prevalence among children and young people under the age of 24 can largely be attributed to

the successful implementation of targeted prevention strategies. The VTP has significantly reduced vertical transmission rates, ensuring fewer infants are born with HIV. VMMC has played a crucial role in lowering HIV acquisition risks among adolescent boys and young men, contributing to reduced prevalence in this age group. Additionally, focused prevention initiatives, such as the Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) program, have been instrumental in addressing social and structural factors that increase HIV vulnerability among adolescent girls and young women. These interventions, alongside improved awareness and access to HIV prevention tools such as PrEP, have contributed to the observed decline in prevalence among younger populations.

Conversely, the slight increase in prevalence among females aged 15 and older, as well as among the 50+ age group, can be attributed to multiple factors. For females, this trend reflects increased HIV case-finding efforts and expanded testing coverage, leading to a higher number of diagnosed cases. The growing availability of HIV services, particularly among key populations and in high-prevalence settings, has improved case detection rates, revealing the true burden of HIV in this demographic.

However, a persistently high incidence rate among adolescent girls and young women remains a major concern, as gender disparities, socio-economic challenges, and structural barriers continue to fuel new infections in this group. Among adults aged 50 and above, the rising HIV prevalence is influenced by both improved survival rates due to ART and ongoing new infections within this demographic. As more PLHIV benefits from long-term ART, the proportion of older individuals living with HIV

has increased. Additionally, HIV prevention efforts have historically focused on younger populations, potentially leaving gaps in prevention strategies for older adults. The increasing incidence in this group suggests the need for tailored interventions to address age-specific risks, including improved HIV education, promotion of condom use, and integration of HIV services within routine geriatric and primary healthcare settings.

Overall, while significant progress has been made in reducing HIV prevalence among younger populations through targeted prevention strategies, ongoing challenges persist in addressing new infections among adolescent girls and young women and ensuring adequate prevention and treatment coverage for older adults. Tailored, age-specific interventions will be critical to sustaining progress and achieving epidemic control across all demographic groups.

Table 2: HIV prevalence by age and sex (2019-2023)

Indicator	2019	2020	2021	2022	2023
Total HIV prevalence	12.7%	12.7%	12.7%	12.6%	12.6%
HIV prevalence in males aged 15+	12.3%	12.2%	12.2%	12.1%	12.0%
HIV prevalence in females aged 15+	21.4%	22.5%	21.5%	21.5%	21.4%
Prevalence in children (<15)	1.6%	1.5%	1.3%	1.2%	1.0%
Prevalence in youth (15-24)	6.7%	6.4%	6.2%	6.0%	5.8%
Prevalence in males aged 15-24	3.6%	3.6%	3.6%	3.5%	3.5%
Prevalence in females aged 15-24	9.8%	9.3%	8.9%	8.4%	8.1%
Prevalence in age group 15-49	18.5%	18.3%	18.0%	17.7%	17.3%
Prevalence in males aged 15-49	12.6%	12.4%	12.1%	11.8%	11.5%
Prevalence in females aged 15-49	24.4%	24.2%	23.9%	23.5%	23.1%
Prevalence in age group 25-49	23.8%	23.5%	23.1%	22.7%	22.3%
Prevalence in males aged 25-49	16.6%	16.3%	15.8%	15.4%	15.0%
Prevalence in females aged 25-49	30.9%	30.6%	30.3%	29.9%	29.4%
Prevalence at ages 25+	20.3%	20.3%	20.3%	20.3%	20.2%
Prevalence in adults aged 50+	12.1%	13.8%	13.8%	14.7%	15.5%
Prevalence in males aged 50+	11.1%	11.7%	12.4%	13.1%	13.7%
Prevalence in females aged 50+	12.9%	13.8%	14.8%	15.8%	16.8%

Source: Thembisa Model ver. 4.7

HIV Prevalence by geographical areas

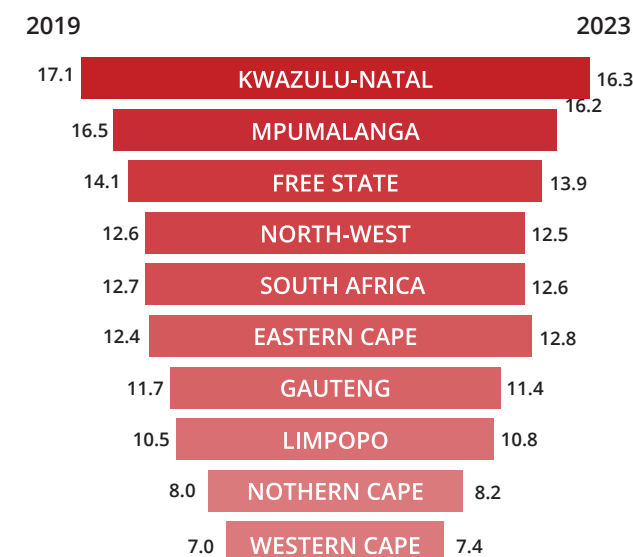
South Africa HIV prevalence by province

Figure 2 illustrates the provincial variations in HIV prevalence between 2019 and 2023, highlighting both reductions and increases across different regions. KwaZulu-Natal (KZN) and Mpumalanga (MP) continue to report the highest HIV prevalence, despite experiencing slight declines over the period. In 2019, KwaZulu-Natal had the highest prevalence at 17.1%, which decreased to 16.3% in 2023, while Mpumalanga followed closely with a reduction from 16.5% to 16.2%. These provinces remain

the epicenter of

the HIV epidemic, reflecting the significant burden of HIV within their populations. Notably, HIV prevalence declined in most provinces and at the national level, with South Africa's overall prevalence decreasing marginally from 12.7% in 2019 to 12.6% in 2023. However, three provinces—Limpopo, Eastern Cape, and Western Cape—exhibited an increase in HIV prevalence. Eastern Cape saw an increase from 12.4% in 2019 to 12.8% in 2023, while Limpopo's prevalence rose from 10.5% to 10.8%. Western Cape, which has the lowest HIV prevalence nationally, experienced a slight rise from 7.0% to 7.4%.

Figure 2: South Africa HIV prevalence by province and year



Source: Thembisa Model ver. 4.7

The factors driving these provincial variations are complex and may include differences in HIV prevention efforts, testing coverage, treatment adherence, migration patterns, and demographic shifts. The observed increase in prevalence in some provinces could be partially attributed to improved case identification and expanded access to HIV testing, leading to a more accurate reflection of the true disease burden. Additionally, while many provinces saw declines, the rate of reduction varies, with North-West, Free State, and Gauteng reporting only slight decreases.

Overall, the data underscores the need for targeted, region-specific HIV prevention and treatment strategies, particularly in provinces with rising prevalence. Enhanced ART adherence, intensified combination prevention

programs, and increased community-level interventions remain critical to sustaining progress and reducing new infections across all provinces.

South Africa HIV prevalence by district

The Naomi Model (December 2023) and Thembisa 4.7 outputs highlight substantial variations in HIV prevalence across South Africa's districts (Figure 3). The data indicates that certain districts, particularly in Gauteng, KwaZulu-Natal, Western Cape, Eastern Cape, Mpumalanga, and North-West, have the highest number of people living with HIV (PLHIV). These findings reinforce the need for a district-focused approach that prioritizes high-burden areas for enhanced prevention, treatment, and care services. Key Observations from the Data:

1. High Burden Districts

- The top 10 districts with the highest HIV burden are primarily concentrated in Gauteng, KwaZulu-Natal, Western Cape, Eastern Cape, and Mpumalanga.
- Johannesburg (Gauteng) and eThekweni (KwaZulu-Natal) have the largest estimated populations of PLHIV, exceeding 600,000 and 500,000, respectively.
- Other high-burden districts include Ekurhuleni, Tshwane (Gauteng), Cape Town (Western Cape), and Buffalo City (Eastern Cape), each with significant numbers of PLHIV surpassing 200,000.

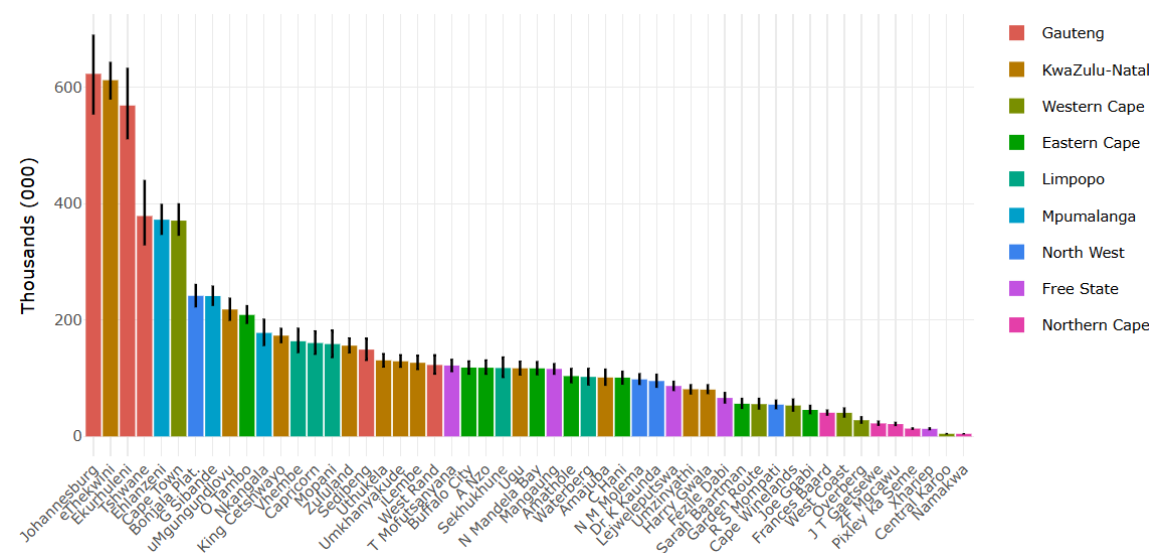
2. Provincial Distribution of HIV Burden

- Gauteng has the highest number of PLHIV overall, with Johannesburg, Ekurhuleni, and Tshwane collectively contributing a substantial portion of the national burden.
- KwaZulu-Natal districts, including eThekweni, uMgungundlovu, and King Cetshwayo, also rank among the highest in terms of HIV prevalence.
- Mpumalanga and Eastern Cape contribute notably, with Ehlanzeni (Mpumalanga) and Buffalo City (Eastern Cape) leading in their respective provinces.

3. Implications for Service Delivery

- The concentration of PLHIV in specific districts underscores the need for targeted resource allocation.
- A "focus for impact" strategy is essential, directing testing, treatment, and prevention programs toward high-burden urban centers while ensuring adequate service expansion in rural districts.
- The data further emphasizes the importance of differentiated service delivery models, including community-based ART, mobile clinics, and decentralized treatment approaches to improve access.

Figure 3: People living with HIV, age 15+, September 2023



Source: Naomi Model³

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

4. Gaps and Considerations

- Despite overall progress, some rural districts in Limpopo, Free State, and Northern Cape have relatively lower recorded PLHIV numbers, which may indicate under-detection or limited access to healthcare services.
- Enhanced case-finding strategies, particularly among key populations, migrants, and hard-to-reach communities, are critical to improving linkage to care and treatment initiation.

A district-specific response remains central to achieving HIV epidemic control in South Africa. The identification of high-burden districts presents an opportunity for strategic interventions, ensuring that resources are allocated where they are needed most. By implementing a data-driven approach, South Africa can strengthen its HIV response and accelerate progress toward the UNAIDS 95-95-95 targets.

HIV Prevalence by Key Populations

HIV continues to disproportionately affect key populations in South Africa, with men who have sex with men (MSM) and female sex workers (FSW) experiencing significantly higher prevalence rates than the general population. According to the Thembisa Model 4.7, HIV prevalence among MSM aged 18 and older declined slightly from 33.1% in 2019 to 30.1% in 2023, while among FSW, prevalence dropped from 60.6% to 53.6% over the same period. Despite these declines, the burden of HIV among these populations remains alarmingly high, with prevalence rates more than twice that of the general population aged 15 and older, where national prevalence stood at 12.6% in 2023.

Among female sex workers, the latest estimates indicate that 54% are living with HIV, making them one of the most affected groups in the country. Their heightened vulnerability is driven by multiple intersecting factors, including limited access to healthcare, stigma, criminalization, and high exposure to gender-based violence (GBV). These structural barriers not only increase their risk of acquiring HIV but also hinder their access to consistent treatment and preventive services.

Similarly, MSM continue to face a high HIV burden, with 30% of men aged 18 and above in this group living with HIV. The challenges they encounter—ranging from discrimination and stigma to legal and social barriers in accessing health services—have contributed to persistent disparities in HIV prevention and treatment. Despite efforts to expand targeted interventions, gaps remain in ensuring adequate coverage of Pre-Exposure Prophylaxis (PrEP), HIV self-testing, and stigma-free healthcare services for MSM. In comparison to these key populations, HIV prevalence among men in the general population remains significantly lower than among women, particularly in younger age groups. Young women aged 15-24 face disproportionately higher risks of HIV infection due to a combination of biological, socio-economic, and behavioral factors, which continue to fuel new infections. However, HIV prevalence among children remains notably lower than among adults, reflecting the success of VTP in reducing vertical transmission rates.

These disparities highlight the urgent need for tailored, community-led interventions that address the specific challenges faced by key populations. Expanding access to PrEP, increasing peer-led outreach programs, and integrating HIV services into broader sexual and

reproductive health frameworks will be essential in closing these gaps. Additionally, policy reforms to decriminalize sex work and combat discrimination against MSM could significantly enhance access to healthcare and improve health outcomes. Strengthening differentiated service delivery models, such as mobile clinics and drop-in centers tailored for key populations, will be crucial in ensuring that those most at risk receive the care and support they need.

Achieving epidemic control in South Africa will require a more inclusive, targeted approach that prioritizes the needs of key populations, reduces barriers to healthcare access, and ensures that HIV prevention and treatment services reach those who need them most.

HIV prevalence among antenatal care attendees

The 2022 National Antenatal Sentinel HIV Survey shows that the overall HIV prevalence among pregnant women attending antenatal care was 27.5% (95% Confidence Interval [CI]: 27.0 – 28.1), reflecting a 2.5 percentage-point decline from the 2019 estimate⁵. This decrease suggests progress in reducing HIV prevalence among expectant mothers, likely due to the scale-up of PMTCT programs, increased antiretroviral therapy (ART) coverage, and improved maternal health interventions. Despite the overall decline, significant provincial disparities persist. KwaZulu-Natal recorded the highest HIV prevalence among antenatal attendees at 37.1% (95% CI: 35.8 – 38.4), followed by the Eastern Cape at 32.9% (95% CI: 31.5 – 34.2). Conversely, the Western Cape reported the lowest prevalence at 16.3% (95% CI: 15.0 – 17.6). These variations highlight the differing HIV burdens, healthcare access, and effectiveness of prevention programs across regions.

At the district level, uMkhanyakude in KwaZulu-Natal reported the highest HIV prevalence among antenatal attendees at 44.0% (95% CI: 37.6 – 50.6), underscoring the need for targeted intervention strategies in high-burden areas⁵. Additionally, 27 districts recorded HIV prevalence rates exceeding the national average, reinforcing the need for a district-level response to close HIV prevention and treatment gaps.

These findings emphasize the importance of enhanced antenatal HIV screening, early ART initiation, and strengthened community-based prevention initiatives, particularly in provinces and districts with persistently high prevalence. Moving forward, integrating HIV and maternal health services, ensuring equitable ART access, and addressing structural barriers will be essential in further reducing HIV prevalence among pregnant women and preventing vertical transmission.

HIV incidence

According to Thembisa Model 4.7, the total number of new HIV infections in South Africa declined from 181,376 in 2019 to 149,277 in 2023, reflecting an 18% overall reduction over this period. This decrease underscores the impact of intensified prevention strategies, expanded ART coverage, and targeted interventions aimed at reducing HIV transmission.

Among different demographic groups, the largest decline in new infections was observed among males aged 25–49 years, with a 22% reduction, highlighting the effectiveness of prevention programs such as VMMC, increased condom use, and improved linkage to treatment. In contrast, the smallest reduction occurred among females aged 50 and older, who experienced a 2% increase in new infections over the same period.

This trend suggests ongoing challenges in reaching older women with HIV prevention messaging and services, emphasizing the need for age-specific interventions to curb new infections in this group.

While further details on HIV incidence trends are discussed under Political Declaration and Framework One, these findings reinforce the importance of continuing to scale up prevention and treatment strategies across all age groups, ensuring that no population is left behind in South Africa's fight against HIV.

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

South Africa’s legal and regulatory framework for HIV prevention has evolved rapidly over the years, with numerous policies and regulations being introduced to curb new infections across the country. These efforts have been strategically directed at high-risk demographic groups, including young adults (15–24 years), children under 15, pregnant women, and other key populations. To address the epidemic effectively, targeted policies and regulations—such as those illustrated in Figure 4—have been developed and implemented. The country’s strong commitment to reducing new HIV infections is further demonstrated in key policy documents, including the National Strategic Plan for HIV, TB, and STIs (2016–2022)

(NSP), the National Drug Master Plan, and the Sex Worker Strategy. For key populations, sustained advocacy efforts have contributed to the expansion of HIV services, though significant gaps remain in service accessibility. One of the major areas of progress has been HIV interventions for people who use drugs (PWUD). The development and adoption of the National Drug Master Plan (2019–2024) (NDMP) was informed by several critical initiatives, including population size estimates, biological and behavioral studies (BBS), and the establishment of key organizations such as the South African Network of People Using Drugs (SANPUD) and the Community-Oriented Substance Use Programme (COSUP). These initiatives have laid the groundwork for harm reduction strategies, which are essential to reducing HIV transmission among PWUD.

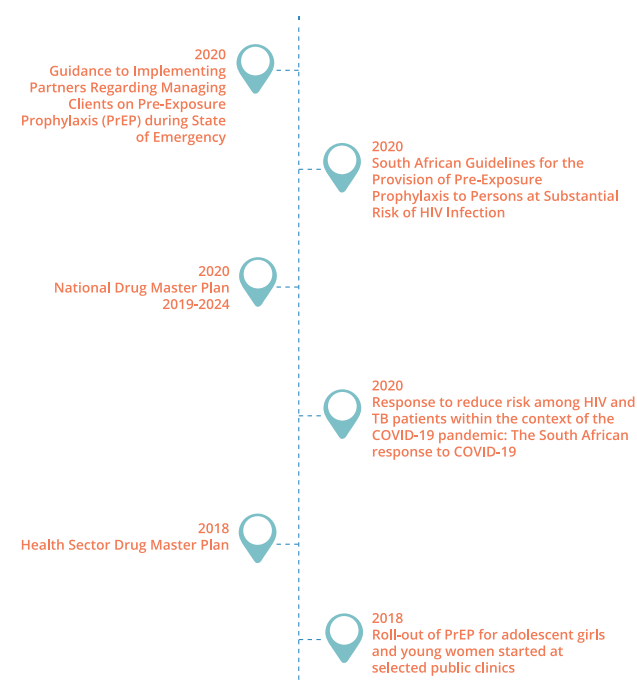
Recognizing the growing impact of gender-based violence (GBV) and intimate partner violence (IPV) on HIV vulnerability, the South African Government (SAG) developed and adopted the National Gender-Based Violence and Femicide Strategy in 2020. This strategy aims to strengthen legal protections, expand survivor support services, and enhance law enforcement responses to GBV and IPV, both of which are significant drivers of HIV risk, particularly among women and girls. Additionally, the COVID-19 pandemic necessitated urgent regulatory

interventions to safeguard HIV and TB patients amid national lockdowns and restricted healthcare access. In response, the government issued critical guidelines, including:

- Guidance to Implementing Partners Regarding Managing Clients on PrEP During the State of Emergency – COVID-19 (26 March 2020)
- Response to Reduce Risk Among HIV and TB Patients Within the Context of the COVID-19 Pandemic: The South African Response to OVID-19 (17 April 2020)
- These policies ensured continued access to HIV prevention and treatment services during the pandemic while mitigating the risks associated with healthcare disruptions.

South Africa’s evolving legal and policy landscape reflects its commitment to combatting HIV through a multi-sectoral approach. While significant progress has been made in expanding services and legal protections for vulnerable groups, gaps in implementation, funding, and accessibility remain challenges. Strengthening advocacy, policy enforcement, and targeted interventions will be critical in achieving long-term epidemic control.

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



Source: Authors

HIV incidence

HIV incidence serves as a critical indicator for measuring progress toward ending the AIDS epidemic. The global goal is to reduce new HIV infections to fewer than 200,000 by 2030, aligning with international commitments to epidemic control. As shown in Table 3, South Africa recorded an 18% decline in new HIV infections, reflecting steady progress in reducing transmission. This reduction highlights the impact of intensified prevention efforts, expanded access to ART, and targeted interventions aimed at high-risk populations. However, continued focus

on scaling up combination prevention strategies will be essential to sustaining this downward trend and achieving global targets.

Estimates of the size of key populations

Table 4 presents critical data on population size estimates (PSE), HIV incidence, HIV prevalence, testing coverage, condom use, and prevention service coverage among

key populations (KPs) in South Africa. These insights help inform targeted interventions and resource allocation to address the disproportionate HIV burden among high-risk groups.

Table 3: Number of new HIV infections and percentage change (2019-2023)

Number of new infections in South Africa by sex and age	2019	2020	2021	2022	2023	% change (2018-2022)
Total new HIV infections	181 376	170 807	163 906	157 676	149 277	-18%
New infections in males aged 15+	63 642	59 608	56 933	54 179	50 447	-21%
New infections in females aged 15+	107 508	101 618	97 848	94 751	90 589	-16%
New HIV infections in children <15	10 226	9 581	9 125	8 746	8 242	-19%
New HIV infections in 15–24-year-olds	69 913	64 507	61 507	59 324	57 231	-18%
New HIV infections in 15-24 males	16 394	14 929	14 165	13 527	12 925	-21%
New HIV infections in 15-24 females	53 519	49 578	47 342	45 797	44 307	-17%
New HIV infections in 15–49-year-olds	160 432	150 441	143 969	138 081	130 544	-19%
New HIV infections in 15-49 males	59 852	55 871	53 258	50 557	47 022	-21%
New HIV infections in 15-49 females	100 580	94 571	90 711	87 525	83 522	-17%
New HIV infections in 25–49-year-olds	90 519	85 934	82 463	78 757	73 313	-19%
New HIV infections in 25-49 males	43 458	40 942	39 094	37 030	34 097	-22%
New HIV infections in 25-49 females	47 061	44 993	43 369	41 727	39 216	-17%
New HIV infections in adults aged 50+	10 719	10 785	10 812	10 849	10 491	-2%
New HIV infections in males aged 50+	3 790	3 738	3 675	3 623	3 424	-10%
New HIV infections in females aged 50+	6 929	7 047	7 137	7 226	7 067	2%
New HIV infections in FSWs	4 062	4 016	3 968	3 858	3 691	-9%
New HIV infections acquired by men from FSW contact	15 580	14 933	14 457	13 843	12 844	-18%
New HIV infections in MSM	6 382	6 145	6 112	6 034	5 900	-8%

Source: Thembisa Model ver. 4.6

Estimates of the size of key populations

Table 4 presents critical data on population size estimates (PSE), HIV incidence, HIV prevalence, testing coverage, condom use, and prevention service coverage among key populations (KPs) in South Africa. These insights help inform targeted interventions and resource allocation to address the disproportionate HIV burden among high-risk groups.

HIV Incidence and Population Size Estimates

South Africa has seen a consistent decline in HIV incidence, dropping from 0.48% in 2018 to 0.28% in 2023, according to the Thembisa Model. This reduction reflects the success of national HIV prevention strategies, although key populations remain at significantly higher risk. Population size estimates remain inconsistent, with no new data for sex workers (SW), MSM, PWID, and transgender (TG) individuals beyond 2021. The prison population, however, has fluctuated over time, reaching 157,056 in 2023 according to the Department of Correctional Services (DCS), highlighting the need for ongoing HIV service provision in correctional facilities.

HIV Prevalence Among Key Populations

HIV prevalence remains alarmingly high among key populations:

- Sex workers: Prevalence has declined from 63.2% in 2018 to 53.6% in 2023, yet this group remains the most affected.
- MSM: HIV prevalence has remained relatively stable,

hovering around 30% between 2018 and 2023.

- PWID and transgender individuals: No recent prevalence data are available, highlighting gaps in surveillance and service provision.
- Prisoners: The last recorded estimate (2021) indicated a 19.6% prevalence, with no recent updates.

HIV Testing and Service Coverage

- Sex workers have the highest testing rates, with 95% of PLHIV diagnosed in 2021, though this dropped slightly to 93.9% in 2023.
- MSM testing rates have steadily improved, reaching 90% in 2023.
- PWID and transgender individuals have significantly lower testing rates, with only 2.3% of transgender individuals diagnosed in 2022—pointing to critical gaps in healthcare access for these groups.

Condom Use and Prevention Program Coverage

Despite the high HIV burden among KPs, there is a lack of new data on condom use and HIV prevention program coverage for most groups. The most recent estimates (2021) indicate that:

- 76% of sex workers and 74% of MSM reported using condoms.
- Coverage of HIV prevention programs remains extremely low, with only 31% of MSM, 21.8% of PWID, and 2.2% of transgender individuals reached in 2021.

While HIV incidence has declined, key populations continue to bear a disproportionately high burden.

Testing rates among MSM and sex workers are strong, but coverage among PWID and transgender individuals remains insufficient. Condom use and prevention program data gaps limit monitoring progress. To address these challenges, it is essential to:

- Expand surveillance efforts to obtain updated population size estimates and prevalence data for all key populations.
- Improve access to HIV testing and prevention services, especially for PWID and transgender communities.
- Increase condom distribution and targeted outreach efforts, ensuring that key populations are adequately covered.
- Enhance harm reduction strategies, particularly in correctional facilities and for PWID.

A sustained, data-driven approach is crucial for reducing HIV transmission and ensuring equitable access to care for South Africa's most vulnerable populations.

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 V4.7
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 V4.7
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 V4.7
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

The provision of HIV prevention, treatment, and care services within prisons and other closed settings remains a critical component of South Africa's response to the epidemic. While significant strides have been made in ensuring high levels of treatment coverage and viral suppression, recent data indicate gaps in prevention efforts, particularly in condom distribution.

Between 2022 and 2023, the number of condoms distributed in correctional facilities declined, signaling potential weaknesses in HIV prevention strategies within these settings. Given the heightened risk of HIV transmission in prisons due to overcrowding, sexual violence, and limited access to prevention tools, ensuring consistent condom availability remains essential for curbing infections.

Despite challenges in prevention, treatment outcomes among inmates living with HIV have remained strong. In 2023, approximately 91% (21,373 out of 23,513) of incarcerated individuals diagnosed with HIV were receiving

ART, reflecting continued efforts to ensure access to life-saving treatment. Additionally, the Department of Correctional Services (DCS) reported a viral load suppression rate of 97% among offenders on ART, reinforcing the effectiveness of treatment adherence programs in correctional facilities. Tuberculosis (TB) remains a major health concern in prisons, particularly among individuals co-infected with HIV.

In 2023, an estimated 386 inmates (1.64%) were diagnosed with TB or co-infected with HIV and TB, underscoring the need for continuous TB screening, early detection, and integrated HIV-TB treatment services. Encouragingly, TB cure rates in prisons have remained exceptionally high, with 96% of incarcerated individuals diagnosed with TB successfully completing treatment in the 2023/24 financial year.

These trends mirror the treatment outcomes recorded in 2022/23, where 97% of inmates on ART achieved viral load suppression and 97% of those with TB were cured

following treatment. Such high treatment success rates reflect the effectiveness of correctional healthcare services in managing HIV and TB within prisons. However, sustained efforts are needed to address gaps in prevention, particularly the declining availability of condoms. Moving forward, a comprehensive approach that strengthens HIV and TB screening, expands harm reduction initiatives, and ensures uninterrupted access to prevention tools will be essential to reducing transmission and improving health outcomes in correctional settings.

A review of available data indicates that hepatitis C reporting was only documented in 2021. During this period, seven prisoners were identified as having hepatitis C, while approximately 3.3% of incarcerated individuals were co-infected with both HIV and hepatitis C. This highlights the need for continued surveillance, routine screening, and integrated management of viral hepatitis and HIV within correctional facilities to ensure early detection and appropriate treatment interventions.

Table 5: HIV prevention programmes in prisons

Indicator	2018	2019	2020	2021	2022*	2023**
Number of clean needles distributed to people in prisons and other closed settings	No data	No data	No data	No data	0	0
Number of people in prisons and other closed settings receiving opioid agonist maintenance therapy	No data	No data	No data	No data	0	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	1,882,652
Number of people in prisons and other closed settings receiving antiretroviral therapy	27,171	25,522	23,570	24,145	28,913	21,373
Number of people in prisons and other closed settings tested for HIV	158,257	57,027	93,333	140,743	66,723	No data
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	23,513 (20%)
Number or percentage of people in prisons and other closed settings with hepatitis C	No data	No data	No data	7	No data	27 (2%)
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	23,513 (20%)
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%)	386 (1.64%)
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	No data

Source: *DCS data, 2022; Programme data 2021 (multiple implementing partners); **UNAIDS Online tool; ***Routine Programme data 2023

Safe injecting practices among people who inject drugs

South Africa's health policy framework supports evidence-based interventions for people who use drugs (PWUD), particularly those at high risk of HIV and hepatitis infections. The National Drug Master Plan (NDMP) (2019–2024) advocates for access to the WHO-recommended comprehensive package of HIV prevention, treatment, and care services for people who inject drugs (PWID). Similarly, the South African National Strategic Plan on HIV, TB, and STIs (2023–2028) emphasizes harm reduction strategies, including Opioid Substitution Therapy (OST) and needle-and-syringe programs, as critical components of the national HIV response.

Recognizing the increased vulnerability of PWID to hepatitis infections, the National Guidelines for the

Management of Viral Hepatitis (2019) target high-risk populations, including people who inject drugs, to improve hepatitis C virus (HCV) screening, prevention, and treatment (DoH, 2019). However, despite these policy commitments, no data was available for 2023 on the number of individuals receiving OST or the number of needles and syringes distributed.

Historical data from 2019 indicate that needle and syringe services distributed an average of 76 needles per person per year, with regional disparities—52 per person in Pretoria compared to 174 in Cape Town (Scheibe et al., 2019). However, data on Hepatitis B Virus (HBV) and HCV prevalence among PWID remain scarce, with available information limited to programmatic reports and small-scale, single-site studies. To strengthen harm

reduction efforts, there is an urgent need for enhanced data collection, expanded service provision, and greater investment in OST and needle exchange programs. Increasing access to integrated HIV, TB, and viral hepatitis services for PWID will be essential in reducing transmission risks and improving health outcomes for this vulnerable population.

Needles and syringes distributed per person who injects drugs

Harm reduction approaches and related interventions are backed by a large body of evidence, reinforcing their effectiveness in preventing HIV and other infectious diseases among people who inject drugs (PWID). Explicit support for needle-and-syringe services is outlined in the South African National Strategic Plan for HIV, TB,

and STIs (2023–2028), the National Drug Master Plan (2019–2024)—which serves as the overarching South African government policy on drug control and related interventions—as well as the National Hepatitis Action Plan. Between 14% and 21% of the estimated 75,000 PWID in South Africa are living with HIV, highlighting the urgent need for expanded harm reduction services. By July 2020, needle-and-syringe services were operational in nine South African health districts (Scheibe et al., 2020). During this period, a total of 7,316 people accessed needle and syringe programs, with 361 in Port Elizabeth, 541 in Durban, 700 in Cape Town, 1,365 in Johannesburg, and 4,349 in Pretoria (Ibid).

In 2022, data from Global Fund implementing partners reported that out of a sample of 6,599 PWID, 19.9% were living with HIV. Prevalence was slightly higher among males (20.1%) compared to females (19.1%), with younger PWID (<25 years) reporting a higher HIV burden (20.5%) compared to those over 25 years (19.9%) (Table 6). However, it is important to note that this data cannot be considered nationally representative, as it reflects only Global Fund-supported programs from selected districts.

These findings emphasize the need for comprehensive, nationally scaled harm reduction programs, including needle-and-syringe distribution, opioid substitution therapy (OST), and integrated HIV prevention and treatment services for PWID. Expanding these interventions will be crucial to reducing HIV transmission and improving health outcomes within this high-risk population.

Table 6: People who inject drugs living with HIV (2022)

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

Coverage of opioid substitution therapy (OST)

In South Africa, OST is provided as part of maintenance treatment for opioid dependence through private practitioners, self-funded programs at select tertiary hospitals, and university- and civil society-led initiatives. 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) all support the integration of OST into HIV prevention and harm reduction programming.

Despite this policy backing, access to OST remains extremely limited. Programme data from the Networking HIV & AIDS Community of Southern Africa (NACOSA) in 2019 reported that among 6,827 opioid-dependent PWID in Johannesburg, only 60 individuals (0.9%) were receiving OST. In Cape Town, 30 out of 1,517 PWID (1.9%) were enrolled in OST programs, demonstrating the critical gap in service coverage. A 2019 harm reduction coverage study conducted in Pretoria, Durban, and Cape Town further highlighted

the low uptake of OST. The study found that only 260 PWID were receiving OST, representing just 4% coverage across the three cities. Coverage varied significantly, with 0% access in Port Elizabeth, 1% in Durban (n = 8), 4% in Pretoria (n = 157), and 8% in Cape Town (n = 55) (Scheibe et al., 2019). Access to HIV testing among PWID was also inadequate, with only 24% (n = 1,773) of people tested for HIV over the study period. Testing coverage was lowest in Pretoria (15%) and Johannesburg (26%), while Port Elizabeth (49%) and Cape Town (57%) had the highest testing rates. Among those tested, 33% (598 out of 1,773) were diagnosed with HIV, with prevalence rates ranging from 3% in Cape Town to 45% in Johannesburg. Treatment initiation remained critically low, with only 20% of those diagnosed with HIV starting ART.

The lowest ART uptake was recorded in Durban (6%), while Johannesburg reported the highest at 65%. These findings underscore the urgent need for expanded access to OST, HIV testing, and treatment services for PWID in South Africa. The extremely low OST coverage, limited HIV testing uptake, and delayed ART initiation highlight significant gaps in harm reduction efforts. Expanding OST services, integrating HIV testing and treatment into harm reduction programs, and scaling up outreach efforts will

be essential in reducing HIV transmission and improving health outcomes for PWID. Policymakers and health service providers must prioritize removing structural barriers, increasing funding, and improving service accessibility to ensure comprehensive and equitable healthcare for people who use drugs.

People who received PrEP and trends

The expansion of PrEP programs in South Africa has led to a significant increase in uptake over the years, with the number of people accessing PrEP rising from 42,255 in 2019 to 803,171 in 2023. This 19-fold increase reflects the success of national HIV prevention efforts, particularly among women, who remain the largest group of PrEP users. However, gender disparities persist, with men and transgender individuals accessing PrEP at significantly lower rates, highlighting ongoing gaps in service delivery. In 2023, 566,431 women accessed PrEP, compared to 172,904 men, reinforcing the trend seen in previous years. This disparity is largely influenced by South Africa’s focus on key populations, particularly female sex workers (FSWs) and adolescent girls and young women (AGYW), who are at a higher risk of HIV infection. As a result, women dominated PrEP uptake across all age groups, while PrEP access among transgender individuals remains undocumented due to a lack of disaggregated data.

PrEP uptake also varied by age group, with the highest number of users recorded in the 25–49 age category (333,806 individuals), followed by 20–24 years (202,946) and 15–19 years (169,441). Encouragingly, the number of first-time PrEP users increased from 333,944 in 2022 to 471,227 in 2023, signaling growing awareness and

accessibility of PrEP as a critical HIV prevention tool. However, PrEP uptake among individuals aged 50 and older remains relatively low, with only 25,928 users

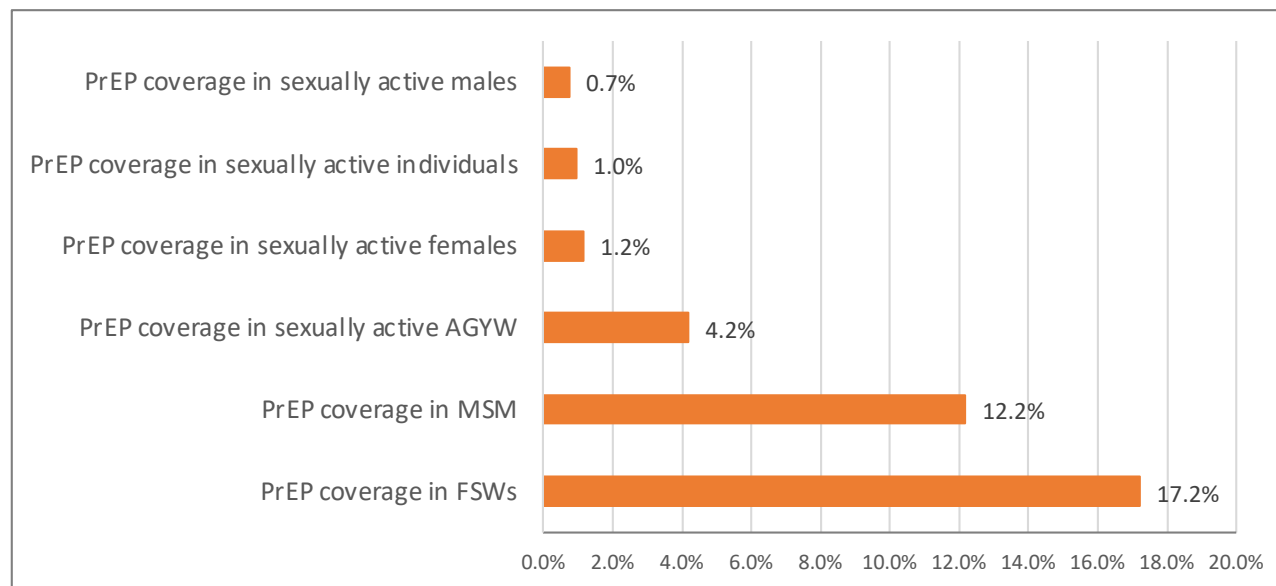
recorded in 2023, indicating the need for targeted outreach and education for older populations. Over the years, PrEP scale-up efforts have significantly expanded,

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

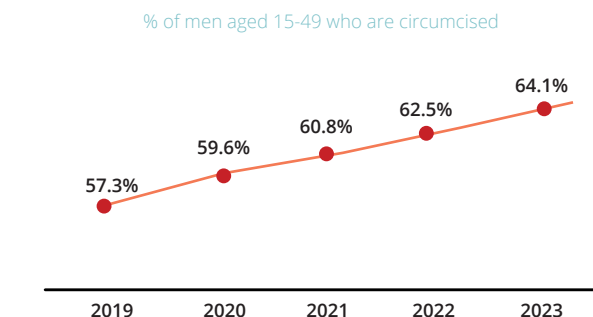
nearly doubling from 406,170 in 2022 to 803,171 in 2023. This growth highlights the country's commitment to HIV prevention, yet gaps remain in equitable PrEP access. Despite increasing numbers of users, men and transgender individuals remain underserved, with no recorded data on PrEP use among transgender populations in 2023. This lack of data presents a major challenge in evaluating the reach and impact of PrEP programs for gender-diverse populations. While South Africa has made tremendous progress in increasing PrEP availability, the unequal distribution of services among key populations suggests the need for a more inclusive approach. Expanding PrEP outreach to men, transgender

individuals, and older adults, as well as improving data collection on these groups, will be essential in ensuring equitable access to HIV prevention tools. Moving forward, targeted interventions, community-led outreach, and differentiated PrEP service delivery models will be critical in bridging existing gaps and further reducing new HIV infections across all populations.

Prevalence of Voluntary Medical Male Circumcision (VMMC)

VMMC coverage increased from 57.3% in 2019 to about 64.1% in 2023 (Figure 6). Data on the annual number of males voluntarily circumcised during the reporting period

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



Source: Thembisa Model 4.7

indicate an increase in VMMC coverage among the 10–14 age group, reaching 51%, while all other age groups either declined or maintained their previous levels of coverage (Table 8).

The rise in VMMC uptake among younger males aligns with global and national evidence demonstrating the long-term impact of circumcision on HIV prevention. By increasing coverage in this age group, a larger proportion of young males will reach adulthood with a reduced risk of HIV infection, contributing to broader epidemic control efforts.

However, the declining or stagnant performance among older age groups suggests the need for renewed strategies to sustain and expand VMMC services among adolescents and adults who may still benefit from the intervention.

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

	2019	2020	2021	2022	% change (2018-2022)	2018	2019	2020	2021	2022	2023
Number of neonatal MMC operations	62 740	62 821	63 150	63 561	63 967	2%	13%	32%	15%	15%	14%
Number of MMC operations in males 10-14	205 207	70 714	204 557	214 858	227 700	11%	43%	36%	48%	50%	51%
Number of MMC operations in males 15-19	45 227	13 242	34 600	36 254	40 800	-10%	9%	7%	8%	8%	9%
Number of MMC operations in males 20-24	36 486	9 723	19 880	16 469	14 509	-60%	8%	5%	5%	4%	3%
Number of MMC operations in males 25-49	123 701	39 764	96 872	96 482	97 728	-21%	26%	20%	23%	22%	22%
Number of MMC operations in males 50+	5 277	1 738	4 234	4 322	4 559	-14%	1%	1%	1%	1%	1%

Source: Thembisa Model ver 4.7

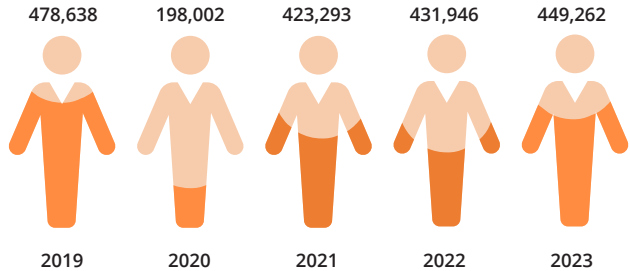
Annual number of males voluntarily circumcised

Figure 7 illustrates the total number of VMMC conducted between 2019 and 2023, highlighting key trends over this period. The data show a sharp decline in VMMC numbers from 2019 to 2020, followed by a steady and significant increase from 2020 to 2023.

The decline in 2020 reflects the impact of COVID-19-related service disruptions, which led to reduced access to VMMC services due to lockdowns, healthcare facility restrictions, and resource reallocation.

However, the subsequent rise in VMMC uptake from 2021 onward indicates a gradual recovery, as the program regains momentum. These findings highlight the resilience of VMMC programs and the importance of sustained efforts to further scale up services, ensuring that circumcision remains a key HIV prevention strategy.

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

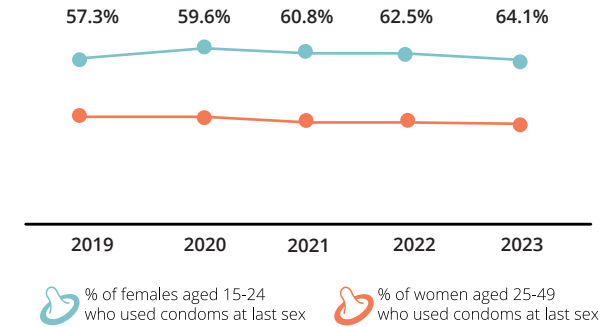


Source: UNAIDS Online tool (based on Department of Health Reports)

Condom use at last high-risk sex

Figure 8 compares condom use at last sex among young females aged 15–24 and women aged 25–49 from 2019 to 2023. The data indicate that condom use was consistently higher among women aged 25–49 compared to younger females. However, usage remained low across both age groups, with rates persistently below 30% throughout the period. Additionally, there has been a gradual decline in condom use over the years, signaling a potential reduction

Figure 8: Condom use at last sex (2019-2023)



Source: Thembisa Model ver. 4.7

in condom-based HIV prevention efforts or changing sexual behavior patterns. These trends highlight the need for renewed emphasis on condom promotion strategies, particularly among young women, who remain at higher risk of HIV acquisition. Expanding targeted awareness campaigns, improving access to condoms, and integrating condom distribution with other prevention interventions will be essential in addressing these low utilization rates.

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

Condoms	2019	2020	2021	2022	2023
Male	635,981,213	558,190,486	577,572,000	403,740,579	548,365,152
Female	14,919,372	15,896,064	18,036,313	14,138,520	22,272,326
Total number of condoms distributed	650,900,585	574,086,550	595,608,313	417,879,099	570,637,478

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

Annual number of condoms distributed

Data from Table 9 indicates a consistent decline in condom distribution between 2019 and 2023, with the total number of condoms distributed dropping from approximately 650 million in 2019 to around 570 million in 2023. This downward trend raises concerns about South Africa's HIV prevention efforts, particularly as condom usage remains low across key populations.

The reduction in condom availability, coupled with already low uptake rates, may contribute to an increased risk of new HIV infections and other sexually transmitted infections (STIs). Strengthening supply chains, enhancing condom promotion campaigns, and improving accessibility through targeted distribution strategies will be critical in reversing this trend and reinforcing condom use as a key HIV prevention tool.

Young people: Knowledge about HIV prevention

The Sixth South African National HIV Prevalence, Incidence, and Behaviour Survey (SABSSM VI) was launched in November 2023, with key findings providing critical insights into HIV knowledge and awareness across different population groups. This section is based on the latest SABSSM VI (2022/23) report. A person's level of accurate knowledge about HIV transmission is essential for enabling effective HIV prevention practices. However, knowledge alone does not always translate into behavioral change or proactive efforts to prevent HIV infection. According to SABSSM VI (2022/23), only 25.7% of individuals aged 15 years or older demonstrated accurate knowledge about the sexual transmission of HIV, with no significant differences observed between males and females.

Interestingly, younger individuals displayed substantially higher levels of HIV transmission knowledge compared to adults aged 50 and older. This suggests that while educational efforts targeting younger populations have been somewhat effective, there is a critical need for enhanced awareness campaigns and knowledge dissemination among older age groups, who may remain less informed about HIV transmission and prevention strategies. Expanding community-based education, media campaigns, and targeted outreach efforts will be key in bridging these knowledge gaps and strengthening South Africa's HIV response.

Achievements

- The completion of the SABSSM VI provides timely and reliable data to guide HIV prevention, treatment, and care programs.
- PrEP uptake has consistently increased, particularly among key and priority populations, including female sex workers (FSWs), MSM, adolescent girls and young women (AGYW), and women in general. However, uptake remains lower among men.
- The development and adoption of the National Gender-Based Violence (GBV) and Femicide Strategy represent a major step toward addressing GBV and intimate partner violence (IPV) as critical factors contributing to HIV vulnerability.
- Combination prevention efforts—including Prevention of VTP, VMMC, increased condom use among young populations, higher PrEP uptake among key populations, and expanded access to Post-Exposure Prophylaxis (PEP) for survivors of sexual assault—have contributed to a reduction in new HIV infections (NDOH Annual Report, 2021).
- Despite setbacks due to Covid-19 disruptions, condom distribution has begun to recover since 2020, improving accessibility and HIV prevention efforts.
- Increased VMMC coverage among boys aged 10–14 years aligns with global evidence demonstrating that early circumcision reduces lifetime HIV risk, ensuring that more young males grow up with a lower risk of infection.

Key challenges

- South Africa continues to bear the highest HIV burden globally, struggling to significantly reduce new infections and achieve its target of a 50% reduction in incidence—currently only reaching an 18% decline.
- The COVID-19 pandemic negatively impacted the HIV response, leading to temporary suspension of research, diversion of key resources, disruptions in care and treatment services, and restricted patient access to healthcare facilities (Karim & Baxter, 2022).
- The continued criminalization of sex work increases the vulnerability of sex workers to HIV, limiting their access to prevention, treatment, and support services.
- Despite increased PrEP availability, knowledge and uptake remain low among key populations, particularly among sex workers, where uptake is still below 20%.
- The lack of updated data on harm reduction—due to the absence of integrated Biological and Behavioral Surveillance (BBS) surveys—limits evidence-based programming for key populations.

Recommendations

- Evaluate the implementation and impact of the National GBV and Femicide Strategy, ensuring its refinement to effectively reduce GBV and femicide as major contributors to HIV vulnerability.
- Given that long-acting injectable cabotegravir has been proven safe, acceptable, and highly effective in HIV prevention, South Africa should prioritize financial commitments and ensure access to the drug for all eligible and at-risk populations.
- With HIV incidence declining at a slower rate among individuals aged 50 and older, particularly among women, the country should conduct studies to investigate the factors influencing this trend and develop targeted interventions to address it.
- South Africa should prioritize and support the conduct of IBBS surveys, particularly for key populations, to enhance data-driven programming and improve service delivery for those most at risk.
- Harm reduction interventions, including OST, should be strengthened and expanded under the new National Strategic Plan (NSP) (2023–2028) to ensure greater accessibility and effectiveness in addressing HIV transmission among people who inject drugs (PWID).

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?	Unlikely

Legal and policy environment

Since the 2020 Global AIDS Monitoring (GAM) report, there have been no significant changes to South Africa’s policy and legal framework for HIV testing and treatment. The most recent treatment guidelines remain the 2019 ART Clinical Guidelines for the Management of HIV in Adults, Pregnancy, Adolescents, Children, Infants, and Neonates (Figure 10). These guidelines build upon the 2016 Universal Test and Treat (UTT) policy, which ensured that all people living with HIV (PLHIV) could access antiretroviral therapy (ART) regardless of their CD4 count.

The introduction of the 2017 ‘same-day initiation’ guidelines further aimed to reduce delays in treatment

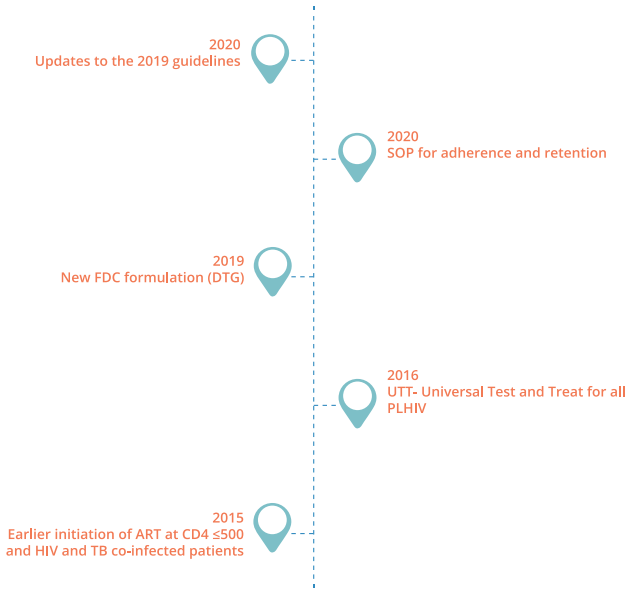
initiation, with a goal of starting ART within seven days of diagnosis.

Additionally, the 2020 GAM report highlighted the March 2020 NDoH updated Adherence Guidelines as a key advancement in supporting linkage to care, adherence, and retention. These guidelines introduced Standard Operating Procedures (SOPs), which serve as a minimum package of interventions designed to streamline patient support within the healthcare system.

The SOPs focus on standardized patient education and counseling, innovative approaches for repeat prescription collection, multi month dispensing, patient tracing, and re-engagement strategies for those who have fallen out of care.

The primary objective of these SOPs is to enhance differentiated service delivery (DSD) for stable HIV clients, ensuring efficient and patient-centered care within the health system. While the policy landscape remains largely unchanged, the implementation of these guidelines continues to shape HIV treatment strategies, reinforcing the country’s commitment to expanding access, improving adherence, and optimizing retention in care.

Figure 9: HIV testing and treatment legal and policy framework



Source: Bello et al, 2021

95-95-95. HIV testing and treatment

During the review period, South Africa’s performance against the UNAIDS 95-95-95 targets for HIV epidemic control stood at 95-81-91. As of December 2023, an estimated 95% of PLHIV were aware of their status, demonstrating significant progress in HIV testing and

diagnosis. However, only 81% of PLHIV were on ART, indicating a gap in treatment initiation and retention. Among those receiving ART, 91% achieved viral suppression at 12 months, reflecting strong adherence and treatment effectiveness (UNAIDS online tool)9.

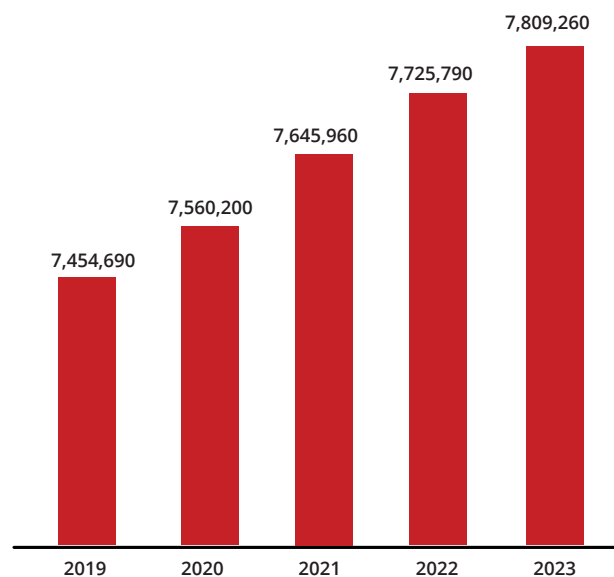
While South Africa has successfully met the first 95 target, efforts must be intensified to close the gap in ART coverage, ensuring that more diagnosed individuals are initiated and retained on treatment. Additionally, sustaining and improving viral suppression rates remains critical to preventing transmission and achieving long-term epidemic control.

People living with HIV who know their HIV status

South Africa is on the verge of achieving the first UNAIDS 95 target, with 95% of PLHIV now aware of their status. This milestone reflects significant advancements in HIV testing, diagnosis, and linkage to care. Figure 10 illustrates the steady increase in the estimated number of PLHIV between 2019 and 2023. Over this period, the number of PLHIV rose from 7,454,690 in 2019 to 7,809,260 in 2023, representing a 4.8% increase.

This growth can largely be attributed to the expansion of ART coverage, improved adherence, and enhanced retention in care, which have contributed to fewer AIDS-related deaths. As more individuals are initiated on ART and remain in treatment, life expectancy among PLHIV continues to improve, reinforcing the impact of sustained HIV care and treatment programs in South Africa.

Figure 10: Total HIV infections (2019-2023)



Source: Thembisa Model 4.7

People living with HIV on antiretroviral therapy

Expanding ART enrollment has been shown to reduce new HIV infections, if those on treatment achieve viral suppression, and to lower AIDS-related mortality through improved adherence and retention in care. However, South Africa has yet to reach the second UNAIDS 95 target, with ART coverage currently at 81% of PLHIV (UNAIDS AIDS info online tool: year?).

As of December 2023, like the first 95 target, females had a higher ART coverage rate than males, highlighting gender disparities in treatment initiation and retention. Strengthening targeted interventions—particularly among

men and other underserved populations—will be crucial in closing the gap and achieving the second 95% target.

People living with HIV who have suppressed viral loads

By 2023, South Africa was close to achieving the third UNAIDS 95 target, with 91% of people on ART achieving viral suppression across the total population. Among adults, 92% of males and 91% of females on ART were virally suppressed, indicating strong adherence and treatment effectiveness.

However, these figures must be interpreted in the context of the second 95 target, where ART coverage remains suboptimal at 77% (UNAIDS AIDS info online tool). While those on treatment are achieving high levels of viral suppression, the gap in ART initiation and retention highlights an urgent need to enroll more PLHIV in care to maximize the impact of viral suppression on epidemic control.

Advanced HIV disease and late HIV diagnosis

With South Africa's adoption of the Universal Test and Treat (UTT) policy and same-day ART initiation, the CD4 count at the time of ART initiation is often used as a proxy for late HIV diagnosis. Figure 11 presents data from the Thembisa Model, showing trends in the percentage of adults starting ART at different CD4 thresholds between 2019 and 2023.

Despite the UTT policy, a significant proportion of PLHIV continues to initiate ART at lower CD4 counts, indicating delayed HIV diagnosis or late treatment initiation. In

2023, approximately 68% of adults starting ART had a CD4 count below 500, a slight decline from 70% in 2019. Among them, 30% initiated ART with a CD4 count below 200, while 37% had CD4 counts between 200 and 349, suggesting ongoing challenges in early HIV detection and linkage to care.

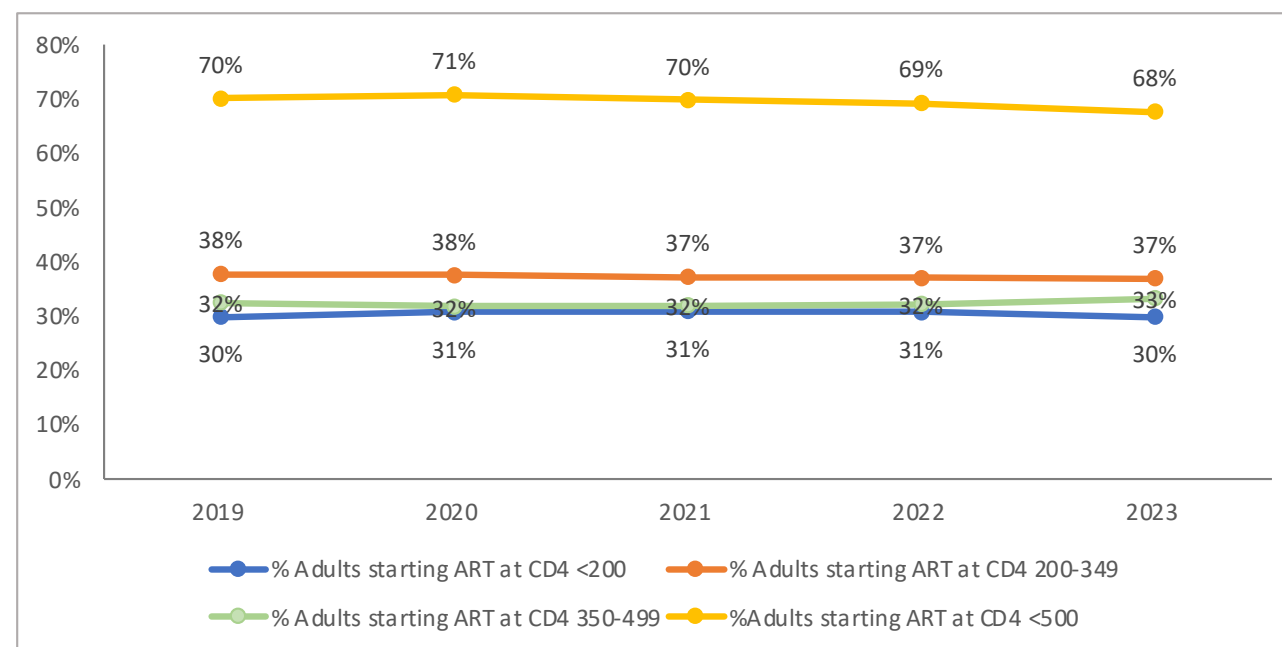
These trends highlight the need for intensified HIV testing strategies, earlier case identification, and improved linkage to treatment, ensuring that more individuals start ART at higher CD4 counts to optimize health outcomes and reduce HIV-related complications.

According to Thembisa model estimates, the proportion of people initiating ART with a CD4 count below 500 cells/mm³ declined slightly from 70% in 2019 to 68% in 2023. Despite this marginal decrease, the high percentage of late ART initiation remains a key indicator of delayed HIV diagnosis and treatment initiation. This trend suggests that many individuals are still being diagnosed at advanced stages of HIV infection or experiencing delays in linking to care after diagnosis. Strengthening early HIV detection, improving linkage-to-care interventions, and promoting immediate ART initiation will be critical in reducing late-stage diagnoses and improving treatment outcomes.

HIV testing volume and positivity

South Africa has seen a steady increase in HIV testing volume, rising from 18 million tests in 2019 to 19 million in 2023. This expansion reflects continued efforts to improve early detection and linkage to care. Figure 12 presents HIV testing positivity trends for both children and

Figure 11: Percentage of all people starting ART at CD4 <500 (2019-2023)



Source: Thembisa Model ver 4.7

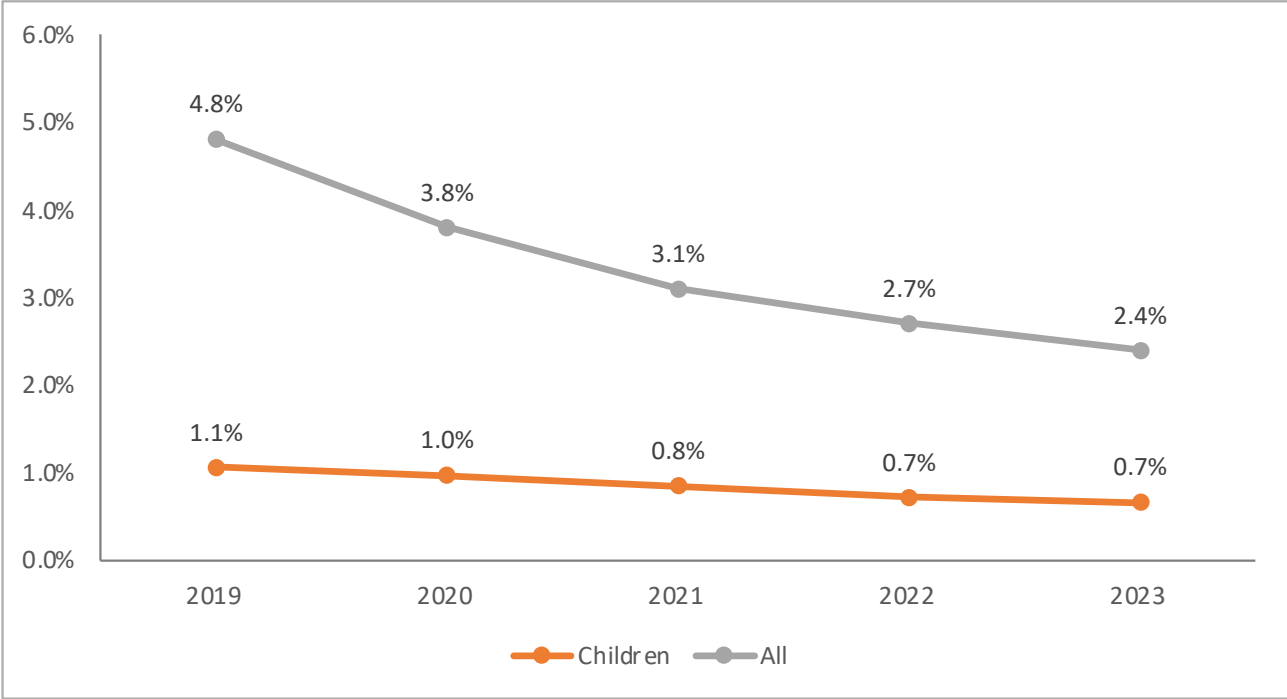
the general population. Among children, positivity rates declined from 1.1% in 2019 to 0.7% in 2023, while for the total population, positivity dropped from 4.8% in 2019 to 2.4% in 2023. This declining trend in positivity rates may suggest progress toward the first UNAIDS 95 target, with fewer undiagnosed people remaining. However, the remaining undiagnosed cases are likely concentrated among hard-to-reach populations, including individuals facing structural barriers to healthcare access. These findings underscore the need for targeted interventions to reach undiagnosed individuals, particularly in marginalized and high-risk populations. To enhance case detection, South Africa should invest in innovative and efficient HIV

testing strategies, such as index testing, community-based outreach, and differentiated testing services, ensuring that no one is left behind in the country's HIV response.

Antiretroviral therapy coverage among people living with HIV in key populations

Table 10 presents ART coverage data among key populations, highlighting disparities in treatment access compared to the general population. In 2023, overall, ART coverage for the general population stood at 75.1%. However, coverage varied significantly among key populations.

Figure 12: HIV testing positivity (2019-20223



Source: Thembisa Model ver. 4.7; UNAIDS Online Tool

MSM had lower ART coverage (61.8%), indicating gaps in treatment access and retention within this group.

- Incarcerated individuals had the highest ART coverage at 90.9%, reflecting structured healthcare provisions within correctional facilities.
- For people who inject drugs (PWID) and transgender (TG) individuals, the most recent available data from 2022 showed ART coverage at 77.5% and 83.6%, respectively.

These findings highlight ongoing disparities in ART access

among key populations, particularly for MSM and PWID, who face barriers such as stigma, discrimination, and limited healthcare engagement. Strengthening targeted ART programs, expanding harm reduction services, and improving linkage to care will be essential in ensuring equitable access to HIV treatment for all key populations.

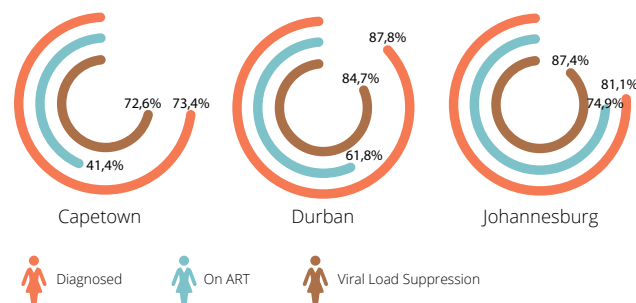
Although the IBBS studies have not been recently updated, the 2018 IBBS data for female sex workers (FSW) and men who have sex with men (MSM) remain the most recent city-level insights into the HIV 95-95-95 cascade. However, it is important to note that these figures differ from Thembisa Model estimates due to variations in methodology and data sources. According to the 2018 IBBS study, HIV status awareness among FSW ranged from 73.4% to 87.8%, underscoring gaps in testing and case identification in certain areas. Among those aware of their HIV-positive status, ART coverage varied significantly, ranging from 41.4% to 74.9%, reflecting disparities in treatment access and retention. Furthermore, among FSW on ART, viral load suppression rates ranged between 72.6% and 87.4% (Figure 13), indicating inconsistent treatment outcomes across different locations.

Table 10: ART coverage among key populations (2019-2023)

	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

These findings highlight the urgent need for updated BBS studies to provide current, city-specific data that can guide targeted HIV interventions. Strengthening HIV testing, linkage to care, and adherence support for FSW and MSM will be critical in addressing gaps in the HIV treatment cascade and advancing towards the UNAIDS 95-95-95 targets.

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



Source: South African Health Monitoring study, 2018

Female Sex Workers (FSWs)

Findings from the study indicate that progress toward achieving the UNAIDS 95-95-95 targets among female sex workers (FSWs) remains suboptimal, with none of the three targets being met across all surveyed cities. This highlights significant gaps in HIV testing, treatment initiation, and retention in care for this key population. One of the most concerning findings is the low proportion of FSW on ART, despite South Africa's Universal Test and Treat (UTT) policy, which ensures ART access for all people living with HIV. In Cape Town, less than half of HIV-positive FSW who were aware of their status were receiving ART,

indicating barriers to treatment linkage and uptake. These challenges reinforce the urgent need to strengthen HIV testing services, improve case-finding strategies, and enhance linkage-to-care mechanisms.

Beyond ART initiation, additional efforts are needed to support adherence and retention in treatment to ensure viral suppression. Sustained ART use not only improves individual health outcomes but also reduces the risk of onward HIV transmission. Addressing stigma, discrimination, and structural barriers that hinder FSW access to care will be crucial in closing the gaps in the HIV care cascade.

Men Who Have Sex with Men (MSM)

The South African Men's Health Monitoring Study (2019) similarly reported low HIV status awareness among MSM, with rates ranging from 62.9% in Mahikeng to 68.2% in Cape Town. Among those aware of their status, ART coverage varied widely, from 61.0% in Cape Town to 82.5% in Johannesburg, indicating disparities in treatment access between cities. Despite these gaps in testing and treatment initiation, viral suppression rates among MSM on ART were relatively high, ranging from 80.1% in Cape Town to 92.7% in Mahikeng (Figure 14).

This suggests that once MSM initiates treatment, adherence and retention rates are generally strong. However, closing the gap in testing and treatment uptake remains a priority to ensure that more MSM living with HIV are diagnosed, linked to care, and supported through the treatment cascade.

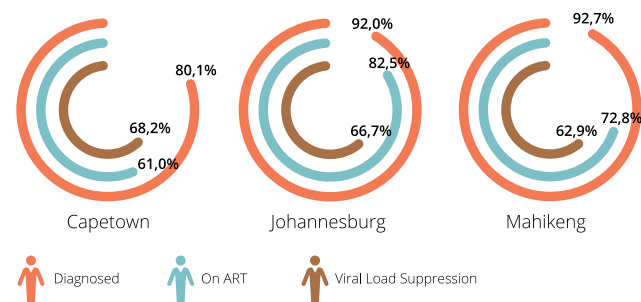
Key Priorities for Strengthening HIV Services for Key Populations

These findings underscore the critical need for tailored, community-led interventions to improve HIV testing, treatment uptake, and retention in care among FSW and MSM. Priorities should include:

- Scaling up targeted HIV testing services, including peer-led outreach and self-testing options, to reach more undiagnosed individuals.
- Strengthening linkage-to-care programs to ensure timely ART initiation following diagnosis, particularly among FSW.
- Expanding adherence and retention support, including differentiated service delivery models, to improve long-term treatment outcomes and viral suppression.
- Addressing stigma, legal barriers, and social determinants that hinder access to care for key populations.

By closing these gaps, South Africa can make meaningful progress toward achieving the 95-95-95 targets for FSW, MSM, and other key populations, ultimately reducing new HIV infections and improving health outcomes in these communities.

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

Challenges in Achieving the UNAIDS 95-95-95 Targets Among MSM and Transgender Populations

Men Who Have Sex with Men (MSM)

Findings from the study indicate suboptimal progress toward achieving the UNAIDS 95-95-95 targets among MSM across all three surveyed cities. Despite a combination of facility-based and community-based HIV testing strategies, less than 70% of MSM living with HIV were aware of their status, highlighting gaps in HIV testing coverage and case finding. Among those aware of their HIV-positive status, ART uptake remained low, with as few as 61.0% of MSM in some cities receiving treatment, despite South Africa's Universal Test and Treat (UTT) policy guaranteeing ART access for all PLHIV. This suggests barriers to treatment initiation, including stigma, discrimination, and structural challenges in accessing care.

Encouragingly, more than 90% of MSM on ART achieved viral suppression in Johannesburg and Mahikeng,

reflecting high-quality care and effective treatment adherence among those engaged in the health system. However, in Cape Town, further program evaluations may help identify specific barriers to adherence and retention in care, informing targeted interventions to improve treatment outcomes for MSM living with HIV.

Transgender Women (TGW) and Transgender Men (TGM)

HIV prevalence remains alarmingly high among transgender women (TGW) in South Africa, far exceeding that of the general population. While HIV prevalence across all ages in the general population is 12.7% (SABSSM, 2022), estimates for TGW are much higher—63% in Johannesburg and approximately 50% in Cape Town and Buffalo City (Cloete et al., 2019). Globally, HIV prevalence among transgender men (TGM) is estimated to be 10 times higher than in the general population (Schein et al., 2020); however, no national prevalence data exist for transgender men in South Africa. Population estimates suggest that South Africa is home to approximately 87,214 TGW, 28,065 TGM, and 66,076 gender non-conforming individuals, representing about 0.3% of the total population (Tshuma et al., 2021).

Despite the disproportionate HIV burden among TGW, engagement in HIV, STI, and TB prevention, treatment, and care remains challenging due to transphobic stigma in healthcare settings, low self-efficacy among transgender individuals, inadequate provider knowledge, and a lack of gender-affirming healthcare services (Scheibe et al., 2018). These barriers discourage healthcare-seeking behavior, contributing to late diagnosis, lower treatment

uptake, and poorer health outcomes among transgender individuals.

Addressing Barriers to HIV Services for MSM and Transgender Populations

To close the HIV treatment and prevention gaps for MSM, TGW, and TGM, South Africa must prioritize:

- Expanding targeted HIV testing programs, including peer-led outreach and self-testing, to increase case identification in key populations.
- Strengthening linkage-to-care initiatives, ensuring that MSM and transgender individuals diagnosed with HIV are immediately initiated on ART.
- Improving adherence and retention support, with differentiated service delivery models that cater to the specific needs of MSM and transgender individuals.
- Training healthcare providers on gender-affirming care to reduce stigma and discrimination in clinical settings.

Developing national HIV prevalence estimates for transgender men, enabling evidence-based programming and targeted health interventions.

AIDS mortality

Figure 15 illustrates the trends in AIDS-related deaths among adults and children in South Africa. Across all population and age groups, the data show a consistent decline over the review period, reflecting improvements in HIV treatment access, adherence, and overall disease management. AIDS-related mortality remains significantly

higher among adults compared to children, though both groups have experienced a downward trend. This reduction can be attributed to expanded ART coverage, improved early diagnosis, and enhanced HIV care programs, which have collectively contributed to longer life expectancy and lower HIV-related mortality rates. Continued investments in treatment accessibility, adherence support, and pediatric HIV interventions will be crucial in further reducing AIDS-related deaths across all age groups.

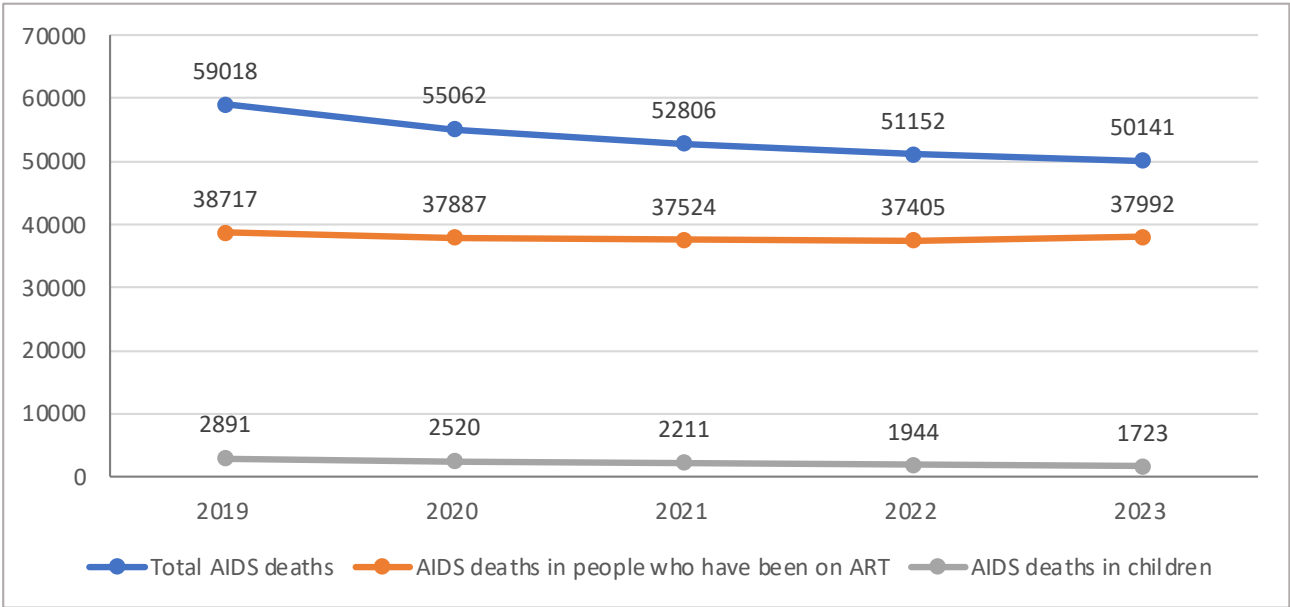
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The widespread availability of ART has significantly extended the lifespan of many individuals who might have otherwise succumbed to AIDS-related illnesses at an earlier age. This progress is reflected in the consistent decline in AIDS-related deaths in South Africa over recent years. However, the COVID-19 pandemic in 2021 posed a significant challenge to the healthcare system, disrupting HIV treatment and care services. During this period, an increase in AIDS-related deaths among patients on ART was observed, highlighting the pandemic’s impact on treatment adherence, healthcare accessibility, and overall patient outcomes. The strain on the health sector limited the ability to sustain life expectancy gains, emphasizing the need for resilient healthcare systems, integrated service delivery, and reinforced ART adherence support mechanisms to mitigate future disruptions in HIV care.

Figure 15: Trends in AIDS mortality among children and adults (2019-2023



Management of Cryptococcal Infection

Currently, no national data exist on the full management cascade for cryptococcal infection in South Africa. The World Health Organization (WHO) recommends flucytosine as a critical component of cryptococcal meningitis treatment. In 2018, WHO guidelines introduced a 1-week induction regimen combining amphotericin B deoxycholate and flucytosine as the preferred treatment approach. However, despite these global recommendations, South Africa’s Standard Treatment Guidelines continue to prescribe a 2-week induction course of amphotericin B deoxycholate and fluconazole for cryptococcal meningitis. Flucytosine was officially registered by the South African Health Products Regulatory Authority (SAHPRA) in December 2021, marking an important step toward expanding access to

this life-saving medication. However, its uptake remains limited within the public healthcare system.

A multi-center observational study conducted between 2018 and 2020 assessed the effectiveness of flucytosine-containing regimens in routine healthcare settings across South Africa. During the study period, 10,668 individuals aged 18 years or older were diagnosed with laboratory-confirmed cryptococcal meningitis or disseminated cryptococcosis nationwide. The findings revealed that in-hospital mortality among patients treated with flucytosine was significantly lower than among those receiving other regimens. Mortality outcomes were also comparable to those reported in 2022 clinical trials evaluating flucytosine-based treatments.

The study concluded that flucytosine combination therapy can be effectively implemented in routine care settings in resource-limited environments, offering substantial survival benefits. However, despite these findings, only a minority of South African patients with cryptococcal meningitis currently receive flucytosine, limiting its potential impact on reducing mortality. Urgent action is needed to expand access to flucytosine, as its wider availability could prevent thousands of avoidable deaths from cryptococcal meningitis each year in South Africa and across the broader African region (Mashau et al., 2022). Strengthening policy alignment, drug procurement, and healthcare provider training will be crucial in ensuring that all eligible patients benefit from WHO-recommended cryptococcal meningitis treatment protocols.

Achievements

- South Africa has successfully achieved the first UNAIDS 95 target, with 95% of people living with HIV (PLHIV) aware of their status. The country is also close to achieving the third 95 target, with 91% of individuals on ART achieving viral suppression. However, this progress must be interpreted with caution, as viral suppression depends on ART coverage (second 95), which remains suboptimal.
- AIDS-related deaths among children have consistently declined, dropping from 2,891 in 2019 to 1,723 in 2023, demonstrating improvements in pediatric HIV care and treatment access.

Challenges

- Children continue to lag adults across all three UNAIDS 95-95-95 targets, indicating gaps in pediatric HIV diagnosis, treatment, and viral suppression.
- ART coverage remains low, with only 75% of the general population on treatment, falling short of the 95% target.
- Late HIV diagnosis remains a concern, as over 60% of people initiating ART have a CD4 count below 500, while 28% of adults start ART with a CD4 count below 200, indicating advanced HIV disease at the time of treatment initiation.
- Key populations, like children, continue to lag in achieving the 95-95-95 targets, with Integrated Biological and Behavioral Surveillance (IBBS) data from 2018 highlighting ongoing gaps in HIV service coverage for these high-risk groups.

Recommendations

- Develop and implement targeted interventions to improve HIV diagnosis, treatment initiation, and viral suppression among children, addressing disparities in pediatric HIV care.
- Enhance ART initiation and retention strategies for the general population, ensuring that more individuals start and remain on treatment to increase overall ART coverage.
- Strengthen messaging around early HIV testing and rapid ART initiation, encouraging timely diagnosis and treatment uptake to prevent disease progression and reduce new infections.
- Increase data availability on key populations (KPs) and design evidence-based interventions to enhance HIV prevention, treatment access, and retention among KPs. These interventions should tackle stigma, expand harm reduction services, and improve healthcare accessibility for marginalized groups.
- Urgently address access to flucytosine for cryptococcal meningitis treatment, as only a minority of South Africans currently receive this life-saving medication. Expanding flucytosine availability has the potential to prevent thousands of avoidable deaths from cryptococcal meningitis each year.

**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

HIV continues to affect a significant number of children in South Africa. By the end of 2023, Thembisa Model estimates indicate that 172,868 children under the age of 15 were living with HIV. During the same year, an estimated 8,242 children acquired new HIV infections, highlighting ongoing challenges in pediatric HIV prevention. Furthermore, of the 50,141 AIDS-related deaths recorded in 2023, 3.4% were among children, underscoring the urgent need for enhanced treatment access and early intervention for this vulnerable group.

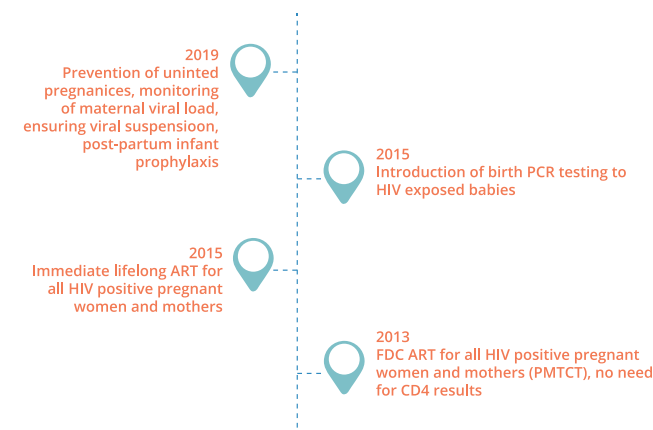
The impact of HIV and AIDS on children extends beyond infection, affecting their emotional, social, and economic well-being. Children living in HIV-affected households

often experience stigma and discrimination, assume caregiving responsibilities for sick parents, and endure financial hardships due to the loss of family income and medical expenses. This reality necessitates a comprehensive legal and policy framework to mitigate the effects of HIV on children and safeguard their rights.

South Africa has implemented several legal protections and policy strategies to address the needs of children affected by HIV. The Children's Act (2010) explicitly prohibits discrimination against children based on their health status (Section 6(2)(d)), ensuring that HIV is not treated as an exception but as part of broader health protections. Additionally, children 12 years and older can access contraceptives independently (Section 134, Children's Act, 2010), allowing them to exercise autonomy over their reproductive health. Figure 16 provides an overview of additional policy frameworks and interventions designed to prevent HIV transmission among children and ensure timely treatment for those diagnosed with HIV.

Strengthening these legal protections, expanding HIV prevention strategies, and enhancing pediatric treatment programs will be essential in reducing new infections and improving health outcomes for children affected by HIV and AIDS.

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



Source: Bello et al., 2021

HIV testing in pregnant women

The 2022 Antenatal Care (ANC) Survey Report, based on medical record review data, indicates high levels of HIV testing and treatment uptake among pregnant women attending ANC services. HIV testing was offered to 99.9% (35,498) of ANC attendees as part of routine care, and nearly all women (99.97%, 34,982) either accepted the test or already knew their HIV-positive status. Nationally, of the 10,726 participants who tested HIV-positive through enzyme immunoassay (EIA) testing, 96.0% (10,300) were already aware of their HIV status at the time of the survey. Among those who knew their status, and excluding 133

participants whose treatment status was not reported, 98.8% (10,166) had already been initiated on ART at the time of the survey (Figure 17).

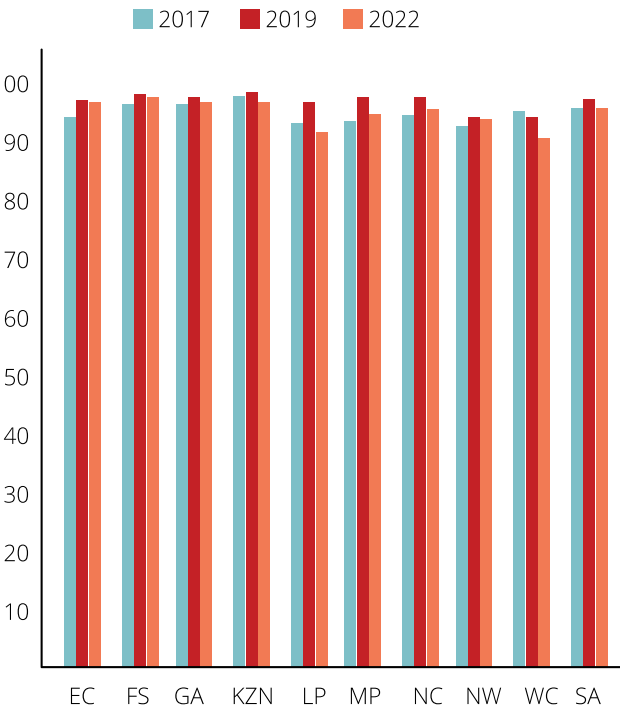
At the provincial level, the proportion of women who already knew their HIV-positive status ranged from 90.9% in the Western Cape to 97.8% in the Free State, reflecting strong but variable levels of HIV diagnosis awareness across provinces. ART initiation among those aware of their HIV status was highest in North West (99.4%) and lowest in the Western Cape (97.8%). Encouragingly, 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%), indicating progress in ensuring that more HIV-positive pregnant women are diagnosed and linked to treatment.

These findings highlight South Africa’s success in integrating HIV testing and treatment into antenatal care, while also emphasizing the need to address provincial disparities and further strengthen ART uptake among pregnant women to eliminate mother-to-child HIV transmission.

Early infant diagnosis

Early HIV diagnosis among HIV-exposed infants is critical for ensuring timely treatment initiation and improved health outcomes. South Africa's current HIV testing guidelines recommend that HIV-exposed infants undergo routine HIV Polymerase Chain Reaction (PCR) testing at birth (within the first seven days), at 10 weeks for those who tested negative at birth, and again at six months if they remain HIV-negative at 10 weeks, unless symptoms suggest earlier testing is required.

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



Source: ANC survey report, 2022

To monitor early HIV detection, HIV-PCR tests conducted at birth (within seven days) are used as a key indicator of program performance (Bello et al., 2021). In 2023, approximately 244,713 infants born to mothers living with HIV received an HIV virological test within two months of birth. Among these infants, 1,118 tested positive, representing a positivity rate of 0.5%.

These findings indicate that early infant HIV testing coverage remains strong, ensuring that most HIV-exposed infants receive timely testing and diagnosis. However, despite the low positivity rate, continued efforts to strengthen prevention of mother-to-child transmission (PMTCT) programs, enhance maternal ART adherence, and ensure immediate linkage to care for HIV-positive infants remain essential.

Expanding early infant diagnosis programs and reinforcing comprehensive follow-up services will be key in further reducing perinatal HIV transmission and improving infant survival rates.

Table 11: Early Infant Diagnosis (2018-2022)

	2018	2019	2020	2021	2022	2023
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%	No data
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	No data
Test result- Positive	1,555	1538	1381	1298	1,118	No data
Test result- Negative	252,163	259,367	266,866	269,485	No data	No data

Source: UNAIDS Online Tool

Vertical transmission of HIV

According to Thembisa model estimates (Table 12), the rate of mother-to-child transmission (MTCT) of HIV at or before birth in 2023 was 0.91%. Among HIV-diagnosed mothers, the MTCT rate at or before birth was slightly lower at 0.67%, reflecting the impact of effective prevention interventions and maternal ART coverage. For postnatal transmission, the MTCT rate up to 18 months from HIV-diagnosed mothers was 0.42%, indicating that postnatal ART adherence and infant prophylaxis programs are playing a significant role in reducing transmission during breastfeeding.

The 2020 GAM report highlights that Thembisa model estimates provide a more comprehensive national picture of MTCT rates, as they cover the entire country, whereas some other datasets may only reflect trends within public health facilities (Bello et al., 2021). These findings reinforce the effectiveness of South Africa's VTP while emphasizing the need for continued focus on early diagnosis, maternal ART adherence, and postnatal infant care to further reduce HIV transmission rates.

Preventing the vertical transmission of HIV

This indicator measures the number of pregnant women living with HIV who delivered in the past 12 months and received antiretroviral therapy (ART) to prevent mother-to-child transmission (MTCT) of HIV. According to the 2022 Antenatal Care (ANC) Survey Report, among HIV-positive women who were aware of their status before pregnancy and had their treatment status reported (7,296 participants), 6,173 (84.2%) had initiated ART prior to pregnancy. When considering all enzyme immunoassay

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

Indicator	2019	2020	2021	2022	2023
Mother-to-child transmission rate	2,72%	2,59%	2,50%	2,45%	2,39%
MTCT rate at/before birth	1,02%	0,99%	0,96%	0,95%	0,91%
MTCT rate at/before birth from HIV-diagnosed mothers	0,75%	0,73%	0,71%	0,70%	0,67%
Postnatal MTCT rate to 18 months, from HIV-diagnosed mothers	0,47%	0,44%	0,43%	0,42%	0,42%

Source: Thembisa Model ver. 4.7

(EIA) positive participants, 76.5% had already started ART before pregnancy, highlighting the progress in early ART initiation and treatment continuity.

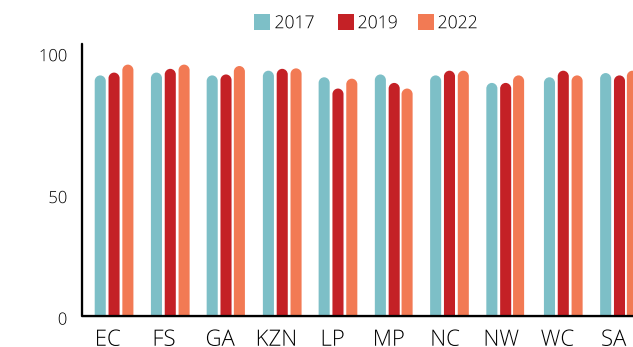
Encouragingly, knowledge of HIV-positive status before pregnancy significantly improved by 17.3% between 2017 and 2022, rising from 60.8% (95% CI: 59.9 – 61.7) in 2017 to 78.1% (95% CI: 77.3 – 78.8) in 2022. However, despite this improvement, the proportion of women initiating ART before pregnancy declined from 91.9% in 2017 to 84.2% in 2022, signaling a potential gap in early treatment uptake and retention in care. The data also reveal age-related disparities in ART initiation. Women aged 20–24 years had significantly lower ART initiation rates (80.5%) compared to older women aged 35–49 years (85.4%) (P-value = 0.000). These findings highlight the need for targeted interventions to improve ART uptake among younger women, ensuring that all pregnant women living with HIV receive timely and sustained treatment to further reduce MTCT risks.

Syphilis among pregnant women

The 2022 Antenatal Care (ANC) Survey reported that maternal syphilis screening coverage at the national level reached 97.5%, reflecting a 1.1 percentage-point

increase from 96.4% in 2019 (Figure 18). Encouragingly, all provinces achieved syphilis screening coverage above 90%, demonstrating strong integration of syphilis testing within antenatal care services. However, syphilis screening data were missing for 2.5% of survey participants. If these missing responses are assumed to represent participants who did not receive a syphilis screening test, the adjusted national screening coverage would decrease to 95.0%. These findings highlight continued progress in maternal syphilis screening coverage, but also underscore the need for improved data completeness and strengthened efforts to ensure universal screening, thereby minimizing the risk of congenital syphilis and adverse pregnancy outcomes.

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



Source: 2022 Antenatal HIV sentinel survey

Syphilis Screening, Prevalence, and Treatment Coverage Among Pregnant Women

The 2022 Antenatal Care (ANC) Survey reported that among women who were screened for syphilis, 2.6% (992) tested positive, while 78.2% (27,677) tested negative. However, a significant proportion of results were pending (18.4%, 5,516) or missing from medical records (0.9%, 262). In total, 19.2% of screened participants had missing results, comparable to the 20.5% recorded in 2019.

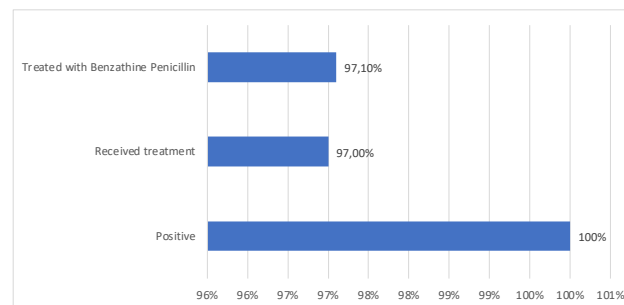
Provincial variations in missing syphilis test results were notable, with the Western Cape recording the lowest proportion of missing results (2.6%), while Gauteng had the highest (31.7%), indicating disparities in data management and reporting across regions. After excluding pending and missing results, the national syphilis prevalence among those with a recorded test result was 3.1% (95% CI: 2.9 – 3.3%). KwaZulu-Natal had the highest syphilis prevalence (4.4%, 95% CI: 4.0 – 5.0%), while Limpopo had the lowest (1.4%, 95% CI: 1.0 – 1.9%).

Syphilis Treatment Coverage

Among 941 participants who tested positive for syphilis and had documented treatment status, 97.0% (911) received treatment. Of those treated and with reported treatment type (847 participants), 97.1% (827) received at least one dose of Benzathine Penicillin (BPG). This translates to 85% treatment coverage with at least one dose of BPG among all syphilis-positive participants (Figure 19). If missing treatment data are assumed to indicate that participants did not receive treatment, syphilis treatment coverage would decrease from 97.0% to 92.2%, while BPG treatment coverage would decline from 97.1% to 89.1%.

These findings emphasize the need for strengthened syphilis screening, improved test result documentation, and enhanced access to timely treatment, ensuring that all syphilis-positive pregnant women receive appropriate care to prevent complications, including congenital syphilis.

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 classified as a Category 2 Notifiable Medical Condition (NMC) in South Africa, requiring all healthcare workers to report diagnosed cases within seven days using either paper-based or electronic Case Notification Forms (CNF). Healthcare providers follow a standardized NMC CNF to ensure timely and accurate reporting of CS cases.

According to the national case reporting system, in 2022, there were 965,543 live births, among which 832 cases of congenital syphilis (both live births and stillbirths) were reported, resulting in a CS prevalence of 0.1%. In

comparison, 373 cases were reported in 2020 out of 1,031,414 live births, and 160 cases were reported in 2021 out of 1,025,793 live births, reflecting 0% prevalence in those years.

Despite ongoing efforts to strengthen CS surveillance, several challenges persist. These include limited awareness among healthcare workers of the CS case definition, delays in paper-based notifications reaching the Notifiable Medical Condition Surveillance System (NMCSS), and difficulties in distinguishing between improved reporting and actual increases in disease burden (Morifi et al., 2021). Findings from the 2022 Antenatal Care (ANC) Survey further highlight an increase in maternal syphilis seroprevalence.

The proportion of women testing positive for syphilis increased from 2.6% to 3.1%, representing a 0.5 percentage-point increase between 2019 and 2022, and a 19% overall increase over this period. The syphilis seroprevalence estimate has risen by one percentage point since 2015, aligning with a sustained rise in congenital syphilis notifications (21), the increase in the number of Rapid Plasma Reagin (RPR)-positive infants since 2017 (22), and a growing contribution of syphilis to genital ulcer disease cases in recent years.

These findings underscore the need for intensified syphilis screening, improved case reporting mechanisms, and strengthened maternal syphilis treatment efforts to prevent congenital syphilis and its associated complications.

Hepatitis B Virus Among Pregnant Women Attending Antenatal Care Services

As of 2022, there was no available data for this indicator, with reporting expected to commence in 2023. However, a study conducted to assess HBV prevalence among pregnant women not living with HIV enrolled 1,194 HIV-seronegative pregnant women at their first antenatal visit (Davey et al., 2022). The study identified eight cases of HBV, confirmed through both point-of-care testing (POCT) and laboratory testing, resulting in an overall HBV prevalence of 0.67% (95% CI: 0.34–1.32%). Further analysis revealed a disparity in prevalence based on birth year and vaccination history:

- Among women born before 1995 (prior to the introduction of universal HBV vaccination in South Africa), eight out of 622 women tested positive for HBsAg, with a prevalence of 1.29% (95% CI: 0.65–2.52%).
- Among women born in 1995 or later (after the HBV vaccine was included in the Expanded Program on Immunization – EPI), none of the 572 women tested positive, indicating a prevalence of 0% (95% CI: 0.0–0.67%).

The study concluded that HBV prevalence among pregnant women not living with HIV was very low and was detected only among women born before the national HBV vaccination program was introduced. This finding underscores the success of routine HBV immunization in reducing infection rates among younger generations. However, no data were available on the number of pregnant women attending antenatal care (ANC) services with a positive HBsAg result who subsequently underwent

HBV DNA testing and/or HBeAg testing. Additionally, there was no data on the number of pregnant women in ANC who met eligibility criteria and received antiviral treatment for HBV. Moving forward, systematic data collection and reporting will be crucial to assess HBV screening, treatment eligibility, and antiviral therapy uptake among pregnant women in South Africa.

Achievements

Achievements

- **High HIV Status Awareness Among Pregnant Women:** Over 99% of women attending antenatal care (ANC) are aware of their HIV status, serving as a critical entry point to Prevention of Mother-to-Child Transmission (PMTCT) services. This high testing coverage presents a valuable opportunity to eliminate HIV transmission during pregnancy and breastfeeding.
- **Consistent Decline in Mother-to-Child Transmission (MTCT) Rates:** The MTCT rate has steadily declined, dropping from 3.29% in 2018 to 2.74% in 2022. This progress reflects improvements in maternal ART coverage, early infant diagnosis, and postnatal care interventions aimed at preventing perinatal HIV transmission.
- **Strong National Syphilis Screening Coverage:** With 95.0% of pregnant women receiving syphilis screening, South Africa has demonstrated a strong commitment to addressing maternal and neonatal health vulnerabilities, particularly for women living with HIV. This high coverage is essential in reducing congenital syphilis cases and ensuring early treatment for those diagnosed with syphilis during pregnancy.

Key challenges

- **Declining ART Initiation Before Pregnancy Despite Improved HIV Status Awareness:** While the proportion of women aware of their HIV-positive status before pregnancy increased significantly by 17.3% between 2017 (60.8%) and 2022 (78.1%), ART initiation before pregnancy declined from 91.9% in 2017 to 84.2% in 2022. This indicates gaps in preconception HIV care and retention in treatment, which may increase the risk of mother-to-child transmission (MTCT) during early pregnancy.
- **Lower ART Initiation Among Younger Women:** Among women who knew their HIV-positive status before pregnancy, ART initiation was significantly lower in younger women aged 20–24 years (80.5%) compared to older women aged 35–49 years (85.4%). This suggests the need for targeted interventions to improve treatment uptake and retention among younger women, who may face unique barriers such as stigma, lack of healthcare engagement, or socio-economic challenges.
- **Persistent Syphilis Prevalence Among Pregnant Women:** The prevalence of syphilis among those with test results remained stagnant at 2.6% in 2023, the same as in 2019, and higher than the 2.0% recorded in 2015. This trend indicates that syphilis prevalence is not declining, underscoring the need for enhanced prevention, screening, and treatment efforts to reduce adverse pregnancy outcomes related to maternal syphilis infection.

Recommendations

- **Enhancing Primary STI Prevention in Pregnant Women and Their Partners:** There is a critical need to strengthen STI prevention efforts among pregnant women and their partners. This includes routine symptom screening, rapid STI testing and treatment, partner notification, and referral for VMMC for uncircumcised partners, as circumcision has been shown to reduce STI transmission risk.
- **Exploring Doxycycline Post-Exposure Prophylaxis (PEP) for STI Prevention:** The potential use of doxycycline PEP—taken within 24 hours after unprotected sexual intercourse—should be investigated as an intervention to reduce STIs, including syphilis, in the general population. Evidence from the United States indicates that doxycycline PEP reduced new STIs by 66% among PrEP users and by 62% among PLHIV. If proven effective in the South African context, this intervention could have spill-over benefits for pregnant women by reducing syphilis transmission at the population level.
- **Promoting Male Circumcision and Condom Use for Syphilis Prevention:** The 2022 ANC Survey recommends further emphasis on male circumcision and condom use as primary prevention strategies for maternal and congenital syphilis. These interventions should be integrated into existing sexual and reproductive health programs to reduce syphilis transmission and adverse pregnancy outcomes.
- **Improving Rapid Syphilis Testing and Early Treatment Initiation:** With approximately 20% of women lacking syphilis test results in the 2022 ANC survey, there is a pressing need to scale up rapid syphilis testing to ensure same-day results and early treatment initiation. Introducing and expanding the use of dual and single rapid syphilis tests in ANC services nationwide, alongside a quality assurance program, will help improve detection and treatment coverage. These point-of-care tests will enable immediate identification of women with active syphilis, allowing for confirmatory testing and rapid treatment initiation, ultimately reducing the risk of congenital syphilis transmission.

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 has established a robust legislative and policy framework to combat gender-based violence (GBV) and promote gender equality, aligning with its commitments as a signatory to multiple international treaties. Several key laws provide the foundation for protecting women's rights and addressing gender-related violence, including the Domestic Violence Act (1998), the Sexual Offences Act (2007), and the Prevention and Combatting of Trafficking in Human Persons Act (2013).

These legislative measures are reinforced by the Bill of Rights in the South African Constitution, which explicitly enshrines gender equality as a fundamental principle, recognizing its role in addressing health,

social, and economic disparities linked to gender-based discrimination (DoJ, Bill of Rights, 1996). To operationalize gender equality, the South African government has introduced several national policy frameworks and acts of Parliament aimed at eliminating discrimination against women. Among these, the National Policy Framework for Women's Empowerment and Gender Equality (1996), commonly referred to as the Gender Policy Framework, provides a strategic direction for gender equity.

Additionally, the National Development Plan (NDP) Vision 2030 prioritizes gender equality as a national development goal, ensuring that women and marginalized groups are fully included in social and economic progress. The Gender Equality Amendment Act No. 17 of 2013 further strengthens institutional mechanisms for gender justice, reinforcing the government's commitment to eliminating gender-based discrimination (National Development Plan, 2013).

South Africa's legal framework also includes protections related to workplace equality and human rights, such as the Employment Equity Act No. 55 of 1998, which prohibits employers from requiring job applicants or employees to undergo HIV testing as a condition of employment (Employment Equity Act, 1998). Additionally, Chapter 9 of the Constitution affirms that people living with HIV/AIDS and their families have full and equal

rights under the Bill of Rights, ensuring their protection from discrimination and social exclusion (Human Rights Commission, 1996).

Institutional Accountability and National GBV Response
The South African Constitution sets the framework for an effective response to GBV, affirming principles of equality, human dignity, life, and personal security. The Commission on Gender Equality (CGE) plays a critical role in promoting women's empowerment and gender equity, a priority in South Africa's efforts to reach its 95-95-95 HIV targets.

Complementing this work, various statutory bodies contribute to monitoring, enforcement, and policy development to address gender-based violence and discrimination. In 2020, South Africa launched the National Strategic Plan on GBV and Femicide (NCGBVF) 2020–2030, which provides a coordinated national framework for responding to GBV and intimate partner violence (IPV). To support this initiative, the GBV and Femicide Response Fund was established, raising R128 million to address the needs of vulnerable groups.

This fund plays a critical role in supporting women of all ages, sexual orientations, and gender identities, including elderly women, women with disabilities, migrant women, and transgender women, ensuring that services

are accessible to those most affected by GBV and IPV. The progress made in policy development and the empowerment of women and girls is presented in Figure 20, highlighting key milestones in South Africa's gender equality and GBV response strategy.

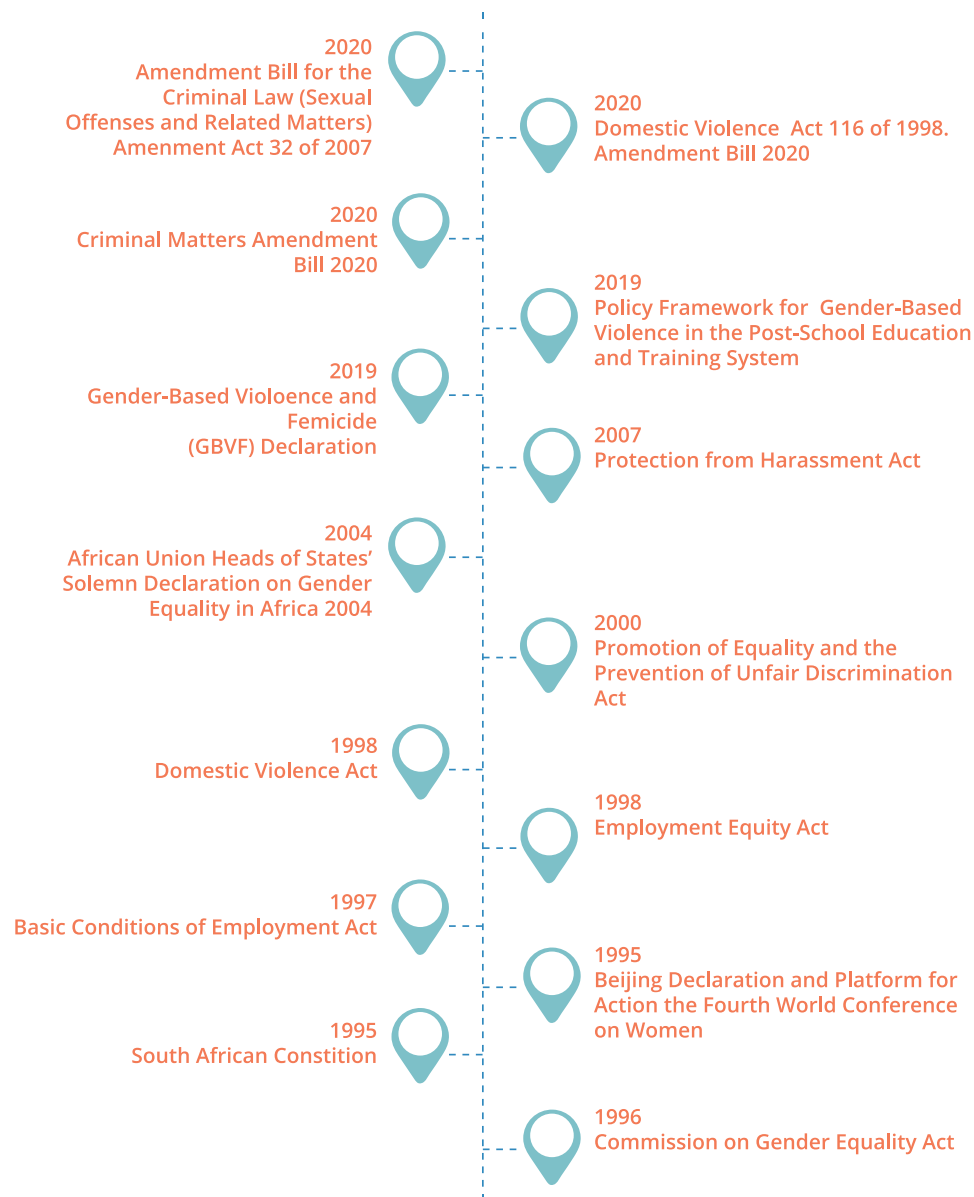
Structural Accountability and Program Implementation
The national gender program is housed within the Presidency, ensuring high-level oversight and accountability. This structure enables Provincial Offices on the Status of Women (OSWs) and departmental Gender Focal Points to report to both:

- Provincial leadership, including Premiers, Members of the Executive Committee (MECs), and Provincial Directors-General.
- National leadership, including Ministers, Directors-General, and the National OSW, ensure coordinated and cost-effective program delivery.

The country's legislative framework explicitly criminalizes multiple forms of gender-based violence, offering protections against physical, sexual, psychological, emotional, and economic violence, including marital rape. The law extends protection to former spouses and unmarried intimate partners, ensuring that all individuals affected by familial and intimate partner violence have legal recourse and protection.

Through strong policy frameworks, institutional accountability, and ongoing legislative advancements, South Africa continues to strengthen its response to GBV, promote gender equality, and uphold the rights of all individuals, particularly women and vulnerable populations.

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 established national protocols and guidelines for training personnel who handle cases of sexual abuse against children and other forms of GBV against women. These guidelines ensure that frontline responders, including healthcare providers, law enforcement officers, and social workers, are equipped to support survivors and facilitate access to justice and healthcare services.

In terms of protecting key populations and people living with HIV (PLHIV) from violence, the country has general criminal laws prohibiting violence alongside specific legal provisions that outlaw violence against individuals based on their HIV status or belonging to a key population. Additionally, there are targeted programs to address intimate partner violence, workplace violence, police abuse, and torture or ill-treatment in prisons.

South Africa's service delivery points integrate elements of comprehensive post-rape care, aligning with World Health Organization (WHO) guidelines. These services include:

- First-line support, psychological first aid, and psychosocial support
- Emergency contraception
- Sexually transmitted infection (STI) prophylaxis or treatment
- HIV post-exposure prophylaxis (PEP)
- Safe abortion services to the full extent of the law

Over 80% of health facilities in the country provide these services, ensuring widespread access to post-rape care (NCPI, 2021). Furthermore, women in South Africa

have access to free legal services in cases of violence. The Thuthuzela Care Centres, established within police stations, play a critical role in providing integrated legal and social support to survivors of GBV (SANAC NCPI Report, 2021).

Gender Disparities in HIV Prevalence and the Need for Targeted Interventions

While new HIV infections have been gradually declining, certain populations remain disproportionately affected. According to UNAIDS, AGYW aged 15–24 accounted for 19% of new HIV infections in 2017, with 80% of these cases occurring in sub-Saharan Africa (UNAIDS, 2019).

The gender disparity is particularly stark in South Africa, where HIV prevalence among AGYW aged 15–24 is four times higher than among males of the same age (Shishana et al., 2014).

In response, there is an urgent focus on empowering women and girls as a primary intervention to reduce HIV transmission and mitigate the impact of the epidemic. However, a coordinated, targeted approach across various stakeholders is needed to ensure that programs addressing HIV prevention, GBV, and stigma reduction are aligned and effectively implemented.

Challenges and Gaps in Addressing GBV and HIV Among Vulnerable Populations

As South Africa works toward achieving and sustaining progress in reducing new HIV infections, it is critical to scale up and optimize prevention efforts, stigma reduction initiatives, and GBV case identification strategies. These

efforts are particularly essential for children, adolescents, youth, men, and key populations at risk, where HIV incidence remains substantial (State Gov., 2022). These groups are especially vulnerable to acquiring HIV, as they are disproportionately affected by high rates of intimate partner violence and sexual violence. Additionally, they face significant barriers to accessing essential services, such as HIV testing, prevention, and post-exposure care.

Fluctuations in GBV and Sexual Offences Reports

Table 13 presents data from the South African Police Service (SAPS) on GBV and sexual offences recorded between 2019/20 and 2023/24. The data show fluctuations in reported cases, indicating that GBV remains a persistent challenge in South Africa. These patterns highlight the ongoing struggle to effectively address GBV, which remains a core determinant of HIV incidence.

Addressing this issue requires sustained efforts to strengthen GBV prevention, enhance survivor support, and improve access to justice for affected individuals. By strengthening multi-sectoral partnerships, expanding GBV response services, and reinforcing prevention strategies for HIV and violence, South Africa can make substantial progress toward reducing new HIV infections and eliminating gender-based violence.

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, 2024^{2,3}

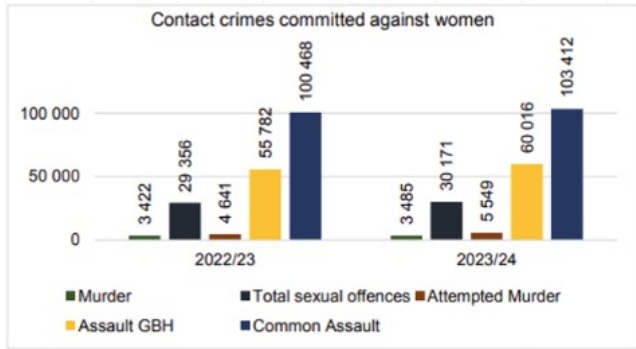
Gender-based violence (GBV) remains a significant challenge in South Africa, with intimate partner violence (IPV) being a major contributor. According to the South Africa National HIV Prevalence, Incidence, Behavior, and Communication Survey V, 29.1% of ever-married or partnered women aged 15–49 years experienced physical or sexual violence from a male intimate partner in the past 12 months (Simbayi et al., 2019).

However, this prevalence increased during the COVID-19 pandemic in 2020, with notable variations influenced by socioeconomic and structural factors (Gill, 2021). Despite ongoing national efforts to address GBV, crime reporting rates remain low. The Governance, Public Safety, and Justice Survey (GPSJS) recorded that in 2023/24, a total of 53,773 victims of sexual offences reported their cases to the South African Police Service (SAPS).

This figure represents a slight decrease from 54,040 cases reported in 2022/23, resulting in an overall lower number of sexual offences reported in 2023/24 compared to the previous year (South African Police Service Report, 2022, 2023; Bello et al., 2021). While the decline in

reported cases may suggest improvements, evidence indicates a continued rise in GBV-related crimes and violence. Figure 21 highlights the increasing trend of GBV cases, underscoring the urgent need to strengthen GBV prevention strategies, improve survivor support services, and enhance reporting mechanisms to ensure greater protection, accountability, and justice for victims.

Figure 21: Selected contact crimes against women and children



Source: South African Police Service, 2024⁴

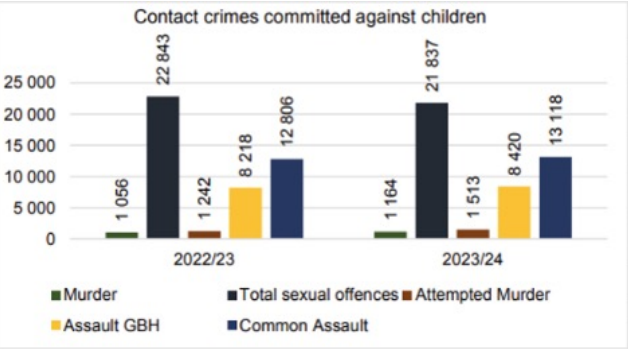
Physical and/or sexual violence experienced by key populations

Violence Against Key Populations in South Africa

There is currently no recent national data on the percentage of individuals in key populations who have experienced physical and/or sexual violence in the past 12 months. However, a literature review provides valuable insights into the extent and nature of violence faced by these populations, particularly female sex workers (FSWs) and LGBTQ+ individuals.

Violence and Barriers to Healthcare for Female Sex Workers (FSWs)

FSWs living with HIV often experience dual discrimination based on both their HIV status and their occupation. The criminalization of sex work and social stigma create barriers to accessing HIV treatment and prevention



services, including linkage to ART and retention in care (Baral et al., 2012). Additionally, HIV-related stigma has been linked to lower ART adherence, higher viral loads,

²https://www.saps.gov.za/services/downloads/2023-2024%20Annual_WEB.pdf
³https://www.saps.gov.za/about/stratframework/annual_report/2023_2024/SAPS_Annual%20Report_2023-24.pdf
⁴https://www.saps.gov.za/about/stratframework/annual_report/2023_2024/SAPS_Annual%20Report_2023-24.pdf

and poor mental and physical health outcomes (Zeng et al., 2020). A 2019 study (Jewkes et al., 2019) conducted as a multi-stage, community-based, cross-sectional survey among 3,005 FSWs across all nine provinces in South Africa found alarming rates of violence:

- 70.4% of FSWs had experienced physical violence
- 57.9% had been raped, with perpetrators including:
- Policemen (14.0%)
- Clients (48.3%)
- Other men (30.2%)
- Intimate partners (31.9%)

Sexual intimate partner violence (IPV) among FSWs was associated with food insecurity, childhood trauma, PTSD, alcohol use as a coping mechanism, increased sex work engagement, and partner-controlling behaviors (Jewkes et al., 2019). These findings are further supported by the 2016 Hands Off Needs Assessment Report, which concluded that 71% of sex workers in South Africa had experienced violence in 2015.

Legal Protections and Challenges Faced by LGBTQ+ Individuals

South Africa remains one of only twelve countries globally, and the only one in Africa, to provide explicit constitutional protection for LGBTQ+ individuals. The country banned discrimination based on sexual orientation in 1996, legalized same-sex adoption in 2002, and introduced marriage equality in 2005. Additionally, transgender South Africans have been able to attain legal gender recognition since 2003. Despite these progressive legal protections, LGBTQ+ South Africans continue to face systemic discrimination, violence, and barriers to full equality.

Reports highlight widespread violence, harassment, and even murder of LGBTQ+ individuals, alongside bullying and discrimination within public services such as healthcare and education. Local activists and human rights organizations emphasize that police responses to crimes against LGBTQ+ individuals remain slow and inadequate, leaving many survivors without justice or protection. While South Africa's legal framework is among the most progressive in the world, persistent social stigma and institutional failures continue to endanger the safety and rights of LGBTQ+ individuals.

Call for Action

The high prevalence of violence against FSWs and LGBTQ+ individuals underscores the urgent need for strengthened protection measures, improved law enforcement response, and expanded access to survivor-centered services. South Africa must bridge the gap between legal protections and lived realities, ensuring that key populations can access healthcare, legal recourse, and support services without fear of violence, stigma, or discrimination.

Attitudes towards violence against women

Data on societal attitudes toward intimate partner violence (IPV)—specifically, the percentage of women and men aged 15 to 49 years who believe a husband is justified in hitting or beating his wife under specific circumstances—is collected through population-based surveys. While a summary report on this indicator was produced in 2023, the full dataset has not yet been released. The most recent available data comes from the 2016 South African Demographic and Health Survey (DHS), which found that approximately 25% (2,930 out of

11,717 respondents) agreed that a husband is justified in hitting or beating his wife in certain situations. This statistic highlights the persistence of harmful gender norms and societal attitudes that normalize gender-based violence (DHS, 2016). The upcoming population-based survey results will provide updated insights into whether attitudes toward IPV have shifted over time. These findings will be critical in assessing progress in gender equality efforts and informing strategies to challenge and dismantle gender-based violence at the societal level.

Gender-responsiveness of HIV services

At the time of compiling this report, data on the percentage of health facilities providing gender-responsive HIV services were not available. However, most healthcare facilities, both public and private, integrate gender-sensitive approaches in service delivery, supported by government initiatives and international funding partners. Several programs demonstrate South Africa's commitment to addressing gender dynamics and intersectionality in HIV service provision. These include:

- DREAMS (Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe) initiative, which specifically targets AGYW to reduce HIV incidence through a multi-sectoral approach.
- Post-exposure prophylaxis (PEP) for survivors of gender-based violence (GBV), ensuring timely intervention and prevention of HIV transmission following sexual violence.
- A gendered approach to pre-exposure prophylaxis (PrEP) provisioning, ensuring high-risk populations, including women, have access to HIV prevention options tailored to their needs.

The private health sector has also played a crucial role in integrating gender-responsive healthcare services, including HIV prevention and treatment. For example, Mediclinic Southern Africa collaborates with community-based organizations (CBOs) to create supportive clinical environments for survivors of GBV, ensuring accessible and trauma-informed care (Figure 22).

While South Africa has made significant strides in gender-sensitive HIV programming, there remains a need for systematic monitoring and evaluation to ensure that all healthcare facilities consistently implement gender-responsive approaches in HIV prevention, treatment, and care.

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



Achievements

- In 2020, South Africa introduced the National Strategic Plan on GBV and Femicide (NCGBVF) 2020–2030, along with a targeted funding mechanism to provide a structured framework for addressing gender-based violence (GBV) and intimate partner violence (IPV). This initiative aims to enhance prevention, improve survivor support services, and strengthen accountability mechanisms.
- The active participation of private sector partners, such as Mediclinic Southern Africa, has played a crucial role in creating a more supportive and accessible environment for survivors of GBV. Through collaborations with community-based organizations (CBOs) and healthcare facilities, these efforts ensure comprehensive post-GBV services, including medical care, psychosocial support, and legal assistance.

Key challenges

- Cultural norms and attitudes that perpetuate gender-based violence (GBV) remain prevalent, as evidenced by 25% of women and men aged 15 to 49 years agreeing that a husband is justified in hitting or beating his wife for specific reasons. This statistic underscores the deep-rooted societal beliefs that continue to normalize and sustain GBV within communities.
- Female sex workers (FSWs) continue to experience multiple forms of violence, including sexual assault, physical abuse, and harassment by law enforcement agencies. These experiences not only violate their human rights but also increase their vulnerability to HIV infection, as violence and stigma create barriers to accessing essential HIV prevention and treatment services.

Recommendations

- Targeted interventions, including information and education initiatives at both facility and community levels, are crucial in challenging deep-rooted cultural norms, beliefs, and practices that perpetuate GBV and femicide. Strengthening community engagement, awareness campaigns, and behavioral change programs will be key to shifting societal attitudes and promoting gender equality.
- An evaluation of the National Council on Gender-Based Violence and Femicide (NCGBVF) strategy and its implementation is essential, given the rising cases of GBV reported by the South African Police Services (SAPS). Assessing the effectiveness of current interventions will help identify gaps, strengthen response mechanisms, and enhance accountability in addressing 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 Africa's statutory laws explicitly include measures to prevent unfair discrimination against people living with HIV (PLHIV). The South African Human Rights Commission, established under Chapter 9 of the Constitution, affirms 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 provides further protections, defining codes of good practice that prohibit employers from requiring employees or job applicants to undergo HIV testing as a condition of employment ("Employment Equity Act, 1998"). These legal safeguards ensure that PLHIV is not subjected to workplace discrimination based on their HIV status.

Additionally, South Africa remains the only African country to provide constitutional protection against discrimination based on sex, gender, and sexual orientation. The Promotion of Equality and Prevention of Unfair Discrimination Act No. 4 of 2000 ("Equality Act") was enacted to give effect to Section 9 of the Constitution, reinforcing the protection of individuals from unfair discrimination and harassment. A landmark case in 2011, *Lallu v Van Staden*, demonstrated the application of these protections.

In this case, the Equality Court ruled that verbal abuse directed at a transgender woman (TGW) by a neighbor constituted harassment, hate speech, and unfair discrimination. The court awarded damages for the infringement of the trans woman's dignity and ordered remedial psychological counseling to address the harm caused ("*Lallu v Van Staden*," 2011).

These legal frameworks affirm South Africa's commitment to human rights and anti-discrimination protections, ensuring that PLHIV and key populations receive legal recourse against stigma, harassment, and unfair treatment. However, continuous efforts are required to enforce these protections effectively and address persistent social barriers that undermine their implementation.

Discriminatory Attitudes Towards People Living With HIV

HIV-related stigma remains a key challenge in South Africa, despite progress in shifting public attitudes toward people living with HIV (PLHIV). A 2017 population-based cross-sectional household survey provided data for the Online UNAIDS tool, revealing that:

- 7.5% of surveyed individuals believed that children living with HIV should not attend school with HIV-negative children.
- 12.6% of respondents stated they would not buy vegetables from a vendor if they knew the vendor was HIV-positive.

While these figures indicate the persistence of HIV-related stigma, more recent data from the 6th South African National HIV Prevalence, Incidence, and Behaviour Survey (SABSSM VI) suggests a growing acceptance of PLHIV. The survey found that most respondents held positive attitudes towards PLHIV, with two-thirds stating they would keep a relative's HIV status confidential. This reflects an affirmation of human rights, dignity, and respect for family members living with HIV.

In the absence of continuous national data, the South African Stigma Index surveys provide valuable insights into HIV-related stigma trends. The 2020/21 Stigma Survey

reported that the proportion of PLHIV who experienced external stigma in the 12 months preceding the survey varied across regions:

- 10% in Thabo Mofutsanyane district (Free State province).
- 27.4% in eThekweni (KwaZulu-Natal province) (Cloete et al., 2022).

Encouragingly, both internalized and external stigma levels have declined over time. In 2020, internalized stigma was reported at 23%, while external stigma stood at 15%, a significant reduction from 2014 levels of 43% and 35%, respectively (Simbayi et al., 2015). These findings underscore progress in reducing HIV-related stigma and discrimination. However, targeted awareness campaigns, policy enforcement, and community engagement initiatives remain essential to further dismantle stigma and ensure full social inclusion for PLHIV.

Internalized stigma reported by people living with HIV

Despite progress in reducing HIV-related stigma, internalized stigma remains a persistent challenge for people living with HIV (PLHIV). At the time of reporting, there was no updated national data on the prevalence of internalized stigma among PLHIV. However, a 2022 study published in 2023 explored community perceptions of HIV-related stigma and discriminatory attitudes, revealing significant concerns around self-perception, guilt, and fears related to disclosure (Mokgatle & Madiba, 2023).

The study found that nearly half of respondents (44%) believed that PLHIV feel worse about themselves,

suggesting that self-devaluation and internalized stigma remain prevalent. Additionally, over one-third (37%) agreed that PLHIV experience guilt about their HIV status, highlighting the emotional and psychological burden associated with living with HIV.

One of the most striking findings was the high level of fear surrounding HIV disclosure. The study reported that:

- 73% of respondents viewed HIV status disclosure as risky, indicating a widespread concern about stigma, discrimination, or negative social consequences.
- 86.6% agreed that PLHIV are extremely cautious about who they disclose their status to, further emphasizing the deep-seated fears associated with openness about living with HIV.
- 41% of respondents expressed a preference to keep a family member's HIV status a secret, reflecting societal pressures to avoid potential stigma and discrimination.

These findings illustrate the continued presence of stigma and its impact on the mental well-being of PLHIV, which can create barriers to social acceptance, treatment adherence, and overall health outcomes. Addressing these challenges requires sustained efforts to promote HIV awareness, foster supportive environments for disclosure, and integrate mental health support into HIV care services.

Stigma and discrimination experienced by people living with HIV in community settings

At the time of reporting, data on the percentage of

people living with HIV (PLHIV) who experienced stigma and discrimination in the general community over the past 12 months was unavailable. However, a recent study aimed at examining community perceptions of stigma and discriminatory attitudes toward PLHIV, as well as concerns around disclosure, provides valuable insights into how these factors influence engagement with HIV prevention and disclosure interventions in South Africa (Mokgatle & Madiba, 2023).

The study highlighted that the willingness of the general HIV-negative population to engage with HIV prevention and disclosure interventions has not been fully established in South Africa. Findings revealed that the acceptability of HIV disclosure was relatively low, with only 60.2% of respondents agreeing that disclosure is acceptable, while 69.7% supported the idea that PLHIV should disclose their status. There was greater acceptance of disclosure within specific contexts, particularly when it involved:

- Sexual partners (81%)
- Children with perinatal HIV (84.5%)
- Parents disclosing their HIV status to their children (82.3%)

However, disclosure to non-family members was far less acceptable (48.8%), indicating persistent concerns about broader social stigma and discrimination. Despite reluctance toward non-family disclosure, 94% of respondents indicated that they would encourage participation in disclosure interventions, reflecting some level of support for structured HIV disclosure efforts. The study also revealed moderately high levels

of perceived stigma within communities, with 56.8% of respondents endorsing high levels of stigma and a mean perceived stigma score of 2.9 (SD = 1.8). Concerns around disclosure were significantly high, with 75% of respondents expressing fear or reluctance regarding HIV disclosure, and a mean disclosure concern score of 3.1 (SD = 1.2). In contrast, community discriminatory attitudes and internalized stigma were reported as relatively low, with both stigma scores averaging 1.5 (SD = 1.6). These findings suggest that while internalized stigma and overt discrimination may be declining, concerns about disclosure and broader social stigma remain significant barriers to full societal acceptance of PLHIV.

Implications

The study underscores the need for targeted interventions to address disclosure concerns and reduce perceived community stigma. While some progress has been made in shifting attitudes, continued efforts are required to create environments where PLHIV feel safe and supported in disclosing their status without fear of discrimination or social exclusion. Strengthening community education, stigma-reduction initiatives, and support systems for disclosure interventions will be critical in fostering an inclusive and non-discriminatory society.

Experience of HIV-related Discrimination in Health-care Settings

At the time of reporting, no new data was available on the percentage of people living with HIV (PLHIV) who reported experiences of HIV-related discrimination in healthcare settings. However, research presented at the 24th International AIDS Conference in Montreal highlighted that stigma in healthcare environments remains a significant

barrier to access, particularly for key populations and adolescents in Africa. The findings indicate that PLHIV, including healthcare workers themselves, often conceal their status due to fear of stigma and discrimination from colleagues. A South African qualitative study explored how HIV-related stigma manifests in clinical settings, focusing on key populations, sex workers, and LGBTQ+ individuals. Many participants, with a median age of 25, described experiencing discrimination and judgmental attitudes when seeking healthcare.

A report by the Human Sciences Research Council (HSRC) confirmed that key populations and youth face significant stigma in health facilities. A 34-year-old lesbian respondent shared her experience, stating:

"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."

Similarly, young people living with HIV encounter stigma when accessing sexual and reproductive health services. A 17-year-old female respondent described the judgment she faced when attempting to collect condoms:

"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.'"

Implications and Recommendations

These findings underscore the persistent discrimination and stigma within healthcare settings, which can discourage PLHIV, key populations, and adolescents from seeking essential health services. Addressing these

issues requires targeted stigma-reduction programs, sensitization training for healthcare workers, and stronger policy enforcement to ensure non-discriminatory practices in health facilities. By fostering inclusive and supportive healthcare environments, South Africa can improve health outcomes and treatment adherence for all PLHIV, especially those belonging to marginalized groups.

Stigma and Discrimination Experienced by Key Populations

Key populations, including men who have sex with men (MSM), injecting drug users (IDU), sex workers (SW), specific migrant sub-groups, prisoners, and transgender (TG) individuals, are present in all communities across South Africa (UNAIDS, 2011).

These groups face heightened vulnerability to HIV, STIs, and TB, alongside significant barriers to healthcare access and widespread discrimination. A key population is defined as any group that meets the following three criteria (Global Fund, 2013):

- Epidemiological risk – Faces an increased risk, vulnerability, and burden of at least one of the three diseases (HIV, STIs, TB).
- Limited access to services – Experiences significantly lower access to relevant healthcare services compared to the general population.
- Systematic discrimination and marginalization – Encounter frequent human rights violations, social and economic exclusion, disenfranchisement, and/or criminalization.

Research conducted in 2019 among 804 participants from

LGBTQ+ communities revealed substantial discrimination in healthcare settings. The study found that nearly one in four respondents had been denied healthcare, while 31% reported being insulted or called derogatory names by healthcare staff (Duby et al., 2018). Similarly, studies focusing on female sex workers (FSWs) documented high rates of stigmatization, where individuals reported experiencing shame, guilt, and a profound loss of dignity due to discriminatory treatment by healthcare providers and community members (Duby et al., 2018).

Addressing Stigma and Discrimination

These findings highlight the urgent need for systemic reforms to ensure inclusive, non-discriminatory healthcare environments for key populations. Addressing these challenges requires:

- Training healthcare providers on sensitivity, inclusivity, and non-discriminatory service provision.
- Strengthening legal protections to safeguard key populations from healthcare-related stigma and discrimination.
- Expanding outreach programs to bridge healthcare access gaps and encourage engagement with HIV prevention and treatment services.

By prioritizing equitable healthcare access and eliminating discrimination, South Africa can enhance health outcomes and reduce barriers to treatment for key populations disproportionately affected by HIV, STIs, and TB.

Avoidance of Health Care Among Key Populations Because of Stigma and Discrimination

Access to healthcare remains a significant challenge for key populations in South Africa, particularly for LGBTI individuals, FSWs, and MSM. While no specific data was available for this indicator as measured by UNAIDS, research provides valuable insights into where key populations seek care, their willingness to disclose sexual orientation and gender identity, and the barriers they face in healthcare settings. A 2019 study of 804 LGBTI individuals found that the majority (60%) sought healthcare services from NGOs, while only 25% accessed public healthcare facilities and 15% used private healthcare services (Müller, 2019).

This preference for NGO-led services suggests that many individuals feel safer and more supported in community-based organizations, which are often more inclusive and tailored to their needs. The study also revealed mixed attitudes towards disclosure of Sexual Orientation and Gender Identity Expression (SOGIE) in healthcare settings. While 64% of respondents felt comfortable disclosing their SOGIE to healthcare providers, 44% reported actively concealing SOGIE-related health concerns, likely due to fear of judgment, stigma, or mistreatment (Müller, 2019).

Similar concerns extend to other key populations, where stigma and discrimination remain significant barriers to accessing essential healthcare services. Studies have shown that:

- 30% of FSWs avoid seeking healthcare due to fear of stigma and discrimination from healthcare providers (Duby et al., 2018).
- 60% of MSM reported avoiding healthcare services for the same reasons (Mbede et al., 2020).

Overcoming Barriers to Healthcare Access

The reluctance of key populations to engage with formal healthcare systems underscores the urgent need to create inclusive, stigma-free healthcare environments. Strengthening training for healthcare providers on LGBTI sensitivity, non-discriminatory care, and key population-specific health needs is essential to building trust and ensuring equitable access to healthcare.

Additionally, expanding the reach of NGO and community-led health services can bridge the gap in care for key populations, offering safe spaces where individuals can access HIV prevention, treatment, and other health services without fear of discrimination. Policies that protect against healthcare-based discrimination and encourage safe disclosure through confidentiality measures will further promote a supportive and inclusive healthcare system for all.

People Living With HIV Seeking Redress for Violation of Their Rights

While no specific data is available on the proportion of people living with HIV (PLHIV) who have experienced rights abuses in the last 12 months and sought legal redress, South Africa has several legal mechanisms to address human rights violations, discrimination, and workplace inequalities.

The South African Human Rights Commission (SAHRC) has established Complaints Handling Procedures, outlining clear steps for investigating alleged human rights violations. In addition, the SAHRC has adopted specialized measures for addressing children's rights violations through the Child-Friendly Complaints Handling

Procedure. Both procedures are publicly available on the SAHRC website, ensuring accessibility for individuals seeking assistance.

To further promote access to justice, Equality Courts have been established to assist individuals facing unfair discrimination, hate speech, or harassment. These courts aim to simplify the legal process, ensuring that cases are resolved efficiently without the need for legal representation. Court officials are trained to guide individuals through the process, making it easier for the public, including PLHIV, to seek redress. Additionally, the SAHRC provides legal assistance for individuals bringing cases before the Equality Courts, reinforcing its commitment to protecting the rights of marginalized groups.

For workplace-related discrimination, the Commission for Conciliation, Mediation, and Arbitration (CCMA) assists employees and employers in resolving disputes, including those related to violations of the right to equality in the workplace due to unfair discrimination. As every Magistrates' Court serves as an Equality Court, individuals can approach either the SAHRC or their nearest Magistrates' Court to seek justice and protection from violations of rights. These legal frameworks provide accessible avenues for PLHIV and other vulnerable groups to challenge discrimination, seek justice, and uphold their fundamental rights. However, continued awareness-raising and legal support services remain essential to ensure that all individuals, particularly those facing stigma and discrimination, are empowered to use these mechanisms effectively.

Discriminatory Attitudes Towards People Living With HIV Among Health Facility Staff

At the time of reporting, no data was available on the percentage of healthcare facility staff who hold discriminatory attitudes toward people living with HIV (PLHIV). However, existing literature provides insight into the experiences of key populations in healthcare settings, highlighting ongoing stigma and discrimination. Studies indicate that fear of stigma remains a significant barrier to healthcare access, particularly for female sex workers (FSWs) and men who have sex with men (MSM). Research shows that:

- 30% of FSWs reported avoiding healthcare due to fear of stigmatization (Duby et al., 2018).
- 60% of MSM reported the same concerns, choosing not to seek medical care due to anticipated discrimination (Mbeda et al., 2020).

Additionally, stigma within healthcare environments extends to staff members living with HIV, as some healthcare workers conceal their HIV status for fear of being stigmatized by colleagues.¹⁴ This suggests that discriminatory attitudes within health facilities may not only affect patients but also impact HIV-positive healthcare providers, reinforcing the need for stigma-free workplace policies.

Addressing Stigma and Discrimination in Healthcare Facilities

The absence of comprehensive data on discriminatory attitudes among healthcare staff underscores the need for:

- Regular assessments of stigma and discrimination in healthcare settings, including surveys among healthcare workers.
- Targeted stigma-reduction training for healthcare providers, emphasizing non-discriminatory, patient-centered care for PLHIV and key populations.
- Support programs for healthcare staff living with HIV, ensuring a safe and inclusive work environment that protects against internal discrimination.

Discriminatory Attitudes Towards People From Key Populations Among Health Facility Staff

At the time of reporting, no data was available on the percentage of healthcare facility staff in South Africa who hold discriminatory attitudes toward key populations. However, existing research highlights significant levels of stigma, exclusion, and discrimination faced by men who have sex with men (MSM), sex workers, and people who use drugs (PWUD) in healthcare settings (Ritcher, 2008; Parry et al., 2009).

In South African communities, judgmental and moralizing attitudes toward sex work, same-sex relationships, and drug use remain prevalent. These negative perceptions are often reinforced within healthcare environments, where stigma from healthcare providers further marginalizes key populations and creates barriers to essential health services (Lane et al., 2008; Scheibe, Drame, & Shannon, 2016).

One of the contributing factors to these discriminatory attitudes is the lack of formalized training on key population health needs among healthcare professionals.

A review of undergraduate medical training at a South African medical school found that public-sector healthcare providers receive minimal professional education on how to effectively support key populations (Müller, 2013). Without adequate training, healthcare workers often lack the skills and knowledge necessary to provide competent and non-discriminatory care to MSM, sex workers, and PWUD (Müller et al., 2018).

Addressing Stigma in Healthcare Settings

To combat discrimination and exclusion within healthcare environments, it is essential to:

- Integrate comprehensive training on key population health needs into medical and nursing curricula.
- Implement stigma-reduction programs for healthcare workers, focusing on inclusive and patient-centered care.
- Develop policies that hold healthcare providers accountable for discriminatory practices, ensuring equitable access to healthcare for all individuals, regardless of sexual orientation, occupation, or substance use history.

Discriminatory Attitudes Towards People From Key Populations Among Police

Key populations in South Africa, including sex workers (SWs), people who use drugs (PWUD), MSM, women who have sex with women (WSW), and transgender (TG) individuals, frequently experience high levels of stigma, abuse, and discrimination. Disturbingly, evidence suggests that law enforcement officials—who are mandated to protect the public—are often the perpetrators of such abuses. This pattern of mistreatment reinforces

cycles of violence, heightens the risk of HIV infection, undermines prevention and treatment efforts, and violates constitutional mandates on human rights and police accountability. Reports indicate multiple forms of abuse by police officers toward key populations. Sex workers have documented harassment, physical assault, rape, extortion, and the confiscation of condoms by law enforcement officials.

Additionally, many have been denied access to essential medication, including HIV treatment, while in police custody (Sisonke Sex Worker Movement, 2011; Women's Legal Centre, 2012). Similarly, stigma and discrimination based on sexual orientation and gender identity are widespread in both communities and police facilities. Research confirms that LGBTQ+ individuals face systemic mistreatment by law enforcement officers, further marginalizing these groups and limiting their access to justice and healthcare (Breen et al., 2011).

For PWUD, negative interactions with law enforcement have been identified as a primary concern. During a national consultation in Cape Town, PWUD representatives highlighted hostile police encounters as their biggest barrier to safety and healthcare access (United Nations Office on Drugs and Crime, 2014).

This was further confirmed by a 2015 programmatic mapping study (Lambert, 2015) and a report on PWUD experiences in three cities with needle and syringe programs. The report documented instances of harassment, violence, confiscation and destruction of injecting equipment, and extortion by law enforcement officers (Step Up Project, 2015).

Addressing Police Abuse and Discrimination Against Key Populations

The criminalization and mistreatment of key populations by law enforcement not only violate human rights but also pose a direct threat to South Africa's public health goals, particularly in HIV prevention and treatment. To address these challenges, it is crucial to:

- Strengthen accountability mechanisms to ensure that law enforcement officers are held responsible for abuses against key populations.
- Implement human rights-based training programs for police officers to promote non-discriminatory practices and improve engagement with marginalized groups.
- Develop harm reduction approaches within law enforcement, ensuring that public health programs, such as needle and syringe programs, operate without police interference.
- Improve access to legal recourse for key populations, enabling them to report and challenge police abuse without fear of retaliation.

Achievements

- While systems for redress exist, their accessibility and efficiency need further evaluation to ensure that those experiencing rights violations can seek justice effectively.
- Levels of internalized (23%) and external (15%) stigma reported in 2020 were significantly lower than those recorded in 2014, which stood at 43% and 35%, respectively (Simbayi et al., 2015).
- Community-based key population networks, such as those established by the Sex Workers Education and

Advocacy Taskforce (SWEAT), have been instrumental in protecting the rights of sex workers, advocating for policy reforms, and providing legal and healthcare support at the community level.

- Between 85% and 92% of survey participants expressed accepting attitudes toward people living with HIV, marking a steady improvement across five waves of the SABSSM surveys (Simbayi et al., 2019).

Key challenges

- Nearly a quarter of LGBTI individuals have been denied healthcare, while 31% reported experiencing verbal abuse or insults from healthcare staff.
- LGBTQ+ issues are rarely included in healthcare worker training curricula, making it challenging to address the specific health needs of this population (Luvuno et al., 2019). The lack of national data on LGBTQ+ individuals further complicates efforts, as sexual orientation is not captured in routine health data systems.
- Female sex workers (FSWs) continue to experience high levels of stigma, often facing discrimination from healthcare providers and community members. This leads to feelings of guilt, shame, and a loss of dignity (Duby et al., 2018).
- Key populations continue to face significant stigma and discrimination in healthcare settings (Mbeda et al., 2020), which frequently results in limited or complete avoidance of healthcare services due to fear of mistreatment (Duby et al., 2018; Müller, 2019).

Recommendations

- To reduce clinical stigma, the Human Sciences Research Council (HSRC) recommends peer-driven delivery approaches, particularly for key populations and vulnerable groups. Additionally, healthcare workers should adopt a person-centered approach, ensuring that services are tailored to the specific needs of those accessing care.
- The relationship between law enforcement agencies and key populations needs urgent review and restructuring to facilitate appropriate, non-discriminatory responses and services. Evidence indicates that key populations continue to face harassment and abuse at the hands of law enforcement officials, further marginalizing these groups.
- Training and sensitization programs for judiciary and law enforcement officials are essential to enhance understanding of legal protections for key populations. These efforts would help reduce discrimination, stigma, and harassment, ensuring that law enforcement practices align with human rights and public health objectives.

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

South Africa's commitment to universal health coverage and integrated healthcare services is rooted in its Constitution, which guarantees access to healthcare for all (South Africa, 2015). The country's policy framework is designed to address key health challenges, including cancer prevention, cervical cancer control, and multi-drug-resistant tuberculosis (MDR-TB) management. The National Cancer Strategic Framework for South Africa (2017–2022) serves as a guiding document for the development, implementation, monitoring, and coordination of cancer-related policies and strategies. Additionally, the National Cervical Cancer Prevention and Control Policy provides a structured approach to cervical cancer screening and prevention. The policy recommends

screening for all women from age 30 at 10-year intervals until they reach 50 years (NDOH, 2017). However, for women living with HIV, the policy advises earlier and more frequent screenings, recognizing their higher risk for cervical cancer.

In the fight against tuberculosis, South Africa adopted a decentralized management policy for MDR-TB in 2019, aiming to enhance access to treatment and improve patient outcomes. These national policies are well aligned with regional and global health strategies, such as the Global Plan to End TB (2023–2030) (Stop TB Partnership, 2022). By integrating global best practices into national health policies, South Africa ensures a coordinated and evidence-based response to major public health challenges, strengthening its commitment to equitable healthcare access.

Viral hepatitis among key populations

Hepatitis B (HBV) and Hepatitis C (HCV) co-infections remain a significant public health concern among key populations in South Africa, particularly among people who inject drugs (PWID), sex workers (SW), and men who have sex with men (MSM). These populations face disproportionate risks of acquiring viral hepatitis and HIV, largely due to barriers in accessing healthcare, stigma, and high-risk behaviors such as injection drug use. In 2020, HBV and HCV co-infection rates among PWID

were particularly concerning. The prevalence of HBV co-infection with HIV was reported at 7.9% (18 out of 227 cases), while HCV co-infection with HIV was significantly higher at 65.2% (148 out of 227 cases). These findings highlight the urgent need for expanded screening and treatment efforts among PWID, given the high burden of co-infection within this group.

A 2019 study on viral hepatitis C, conducted among 3,443 individuals from key populations, provided additional insights into the overall prevalence of HBV, HIV, and HCV. The study found that 4% of the total cohort had HBV, 37% had HIV, and 13% had HCV. The distribution of these infections varied significantly by population group and region. HBV prevalence ranged between 3% and 5% across key populations, aligning with background prevalence levels in the broader South African population.

However, HIV prevalence was notably high among sex workers (47%) and MSM (43%), while it was relatively lower among PWUD at 13%. Regional disparities were also evident, with HIV prevalence among key populations varying widely across different locations. Among PWUD, HIV prevalence was as low as 3% in Cape Town but reached 80% among sex workers in Pietermaritzburg. HCV prevalence also differed significantly between subpopulations. PWID had the highest HCV prevalence at 45%, with substantial variation across regions—ranging

from 29% in Durban to 73% in Pretoria. Among PWUD, HCV prevalence was recorded at 7%, while 2% of MSM were found to be HCV-positive. Interestingly, many of the MSM who tested positive for HCV also reported having injected drugs in the past, suggesting a link between injection drug use and hepatitis transmission within this group (NICD, 2019).

Implications for Public Health and Prevention Strategies

The high burden of hepatitis co-infections among key populations underscores the urgent need for integrated healthcare approaches, including targeted screening, prevention, and treatment strategies. These findings emphasize the importance of:

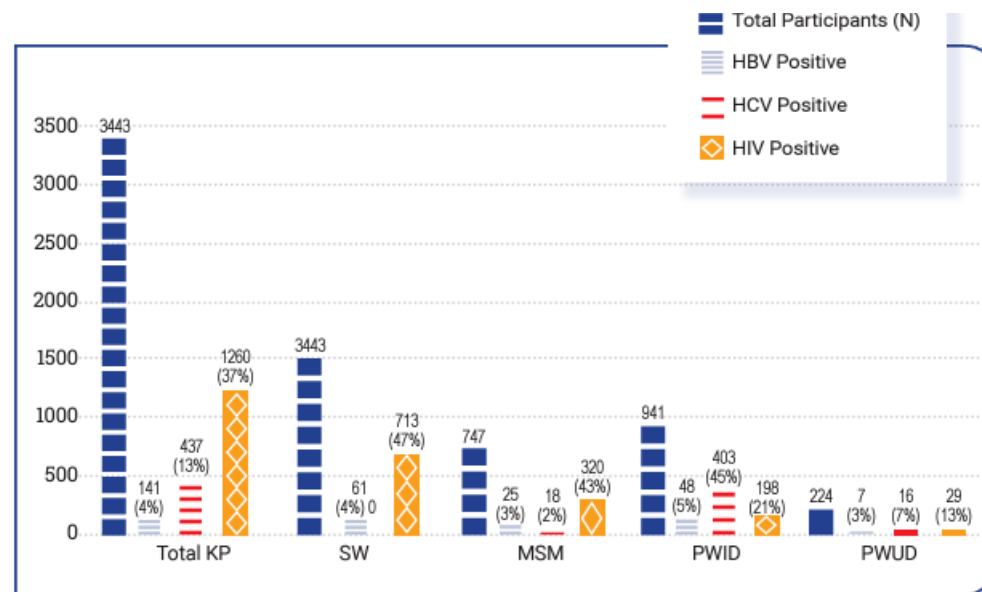
- Scaling up hepatitis screening and treatment programs, particularly for PWID, MSM, and sex workers, who remain highly vulnerable to co-infections.
- Expanding harm reduction services, such as needle and syringe programs and opioid substitution therapy, to reduce HCV transmission among PWID.
- Addressing regional disparities in HIV and hepatitis prevalence, ensuring that high-burden areas receive tailored public health interventions.
- Strengthening healthcare services to provide non-discriminatory, key population-friendly healthcare, allowing better access to HIV and hepatitis prevention and treatment programs.

The prevalence of HCV-HBV co-infection among the total study cohort was recorded at 0.7%, with variation across different key population groups. Prevalence rates ranged

between 0% and 2.4%, with the highest burden observed among people who inject drugs (PWID).

infection was less common, with an overall prevalence of 2.2%, showing consistent rates across all key populations.

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

This finding underscores the heightened vulnerability of PWID to multiple viral infections, likely due to needle-sharing practices and limited access to harm reduction services.

For HCV-HIV co-infection, the overall prevalence was 3.7%, with PWID experiencing the highest rate at 12.7%. Regional differences were evident, with Pretoria recording a notably high HCV-HIV co-infection prevalence of 29%. This elevated prevalence in Pretoria suggests a longer-established culture of injection drug use and higher HCV transmission rates among PWID in this area. HBV-HIV co-

Notably, triple co-infection with HIV, HBV, and HCV was rare and observed only among PWID, with a prevalence of less than 1%.

Public Health Implications

The high prevalence of HCV-HIV co-infection among PWID highlights the need for expanded hepatitis and HIV prevention efforts, particularly in areas with higher transmission rates, such as Pretoria. These findings reinforce the urgency of:

- Enhancing harm reduction interventions, such as needle and syringe programs and opioid substitution therapy (OST), to prevent further transmission.
 - Scaling up routine HCV and HBV screening and treatment, particularly for PWID, who remain at elevated risk of multiple co-infections.
 - Strengthening regional responses, ensuring that high-burden areas receive targeted interventions and resources to curb infection rates.
- 7.2 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 13 below presents data on the proportion of people starting antiretroviral therapy who were tested for hepatitis C virus (HCV).

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

According to programmatic data from Sediba Hope Medical Centre, which is based on clinical records from healthcare facilities, 94.4% (34 out of 36) of individuals co-infected with HIV and HCV initiated HCV treatment in 2020. However, no data was available for subsequent years, highlighting a gap in longitudinal tracking and reporting of HCV treatment outcomes among people living with HIV.

These findings emphasize the need for improved data collection and monitoring systems to assess treatment access, adherence, and outcomes for individuals

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)

co-infected with HIV and HCV over time. Expanding routine screening and treatment services for HCV in HIV care settings can further enhance integrated care and improve health outcomes for this vulnerable population.

Syphilis prevalence among key populations

This indicator assesses the prevalence of syphilis among key populations, including sex workers (SW), men who have sex with men (MSM), and transgender (TG) individuals. However, no data was reported for the period 2019 to 2023, indicating a gap in surveillance and monitoring efforts for sexually transmitted infections (STIs) within these populations. A 2019 South African prospective cohort study highlighted a high rate of recurrent STIs among MSM (van Liere et al., 2019). The study observed a median follow-up period of 55 days with a 78% retention rate among symptomatic MSM (n = 78).

During this period, the incidence rate of sexually transmitted infections was 188 per 100 person-years (95% confidence interval: 1.2–2.7).

The study further reported 16 newly acquired infections and 10 cases of persistent STI positivity, reinforcing concerns about high STI transmission rates among MSM. These findings underscore the urgent need to strengthen STI prevention efforts, particularly for key populations, by:

- Expanding syphilis screening and diagnostic services, especially in healthcare facilities serving key populations.
- Introducing and scaling up point-of-care diagnostic tools to ensure early detection and timely treatment of syphilis and other STIs.
- Enhancing access to comprehensive sexual health services, including prevention education, condom distribution, and STI treatment programs tailored to key populations.

Men With urethral discharge

Data from the District Health Information System (DHIS) indicates a gradual increase in the percentage of men reporting urethral discharge over the past four years. In 2019, the prevalence was 1.6%, followed by a slight

decline to 1.4% in 2020. However, cases began rising again, reaching 1.6% in 2021 and further increasing to 1.8% in 2022.

This upward trend suggests a potential increase in sexually transmitted infections (STIs) among men, warranting urgent public health interventions to prevent further transmission. The rising cases may reflect gaps in STI prevention and treatment services, barriers to healthcare access, or changes in sexual behaviors over time.

To address this concern, strengthening STI prevention, diagnosis, and treatment efforts is essential. This includes expanding routine screening for sexually transmitted infections, increasing public awareness campaigns on STI symptoms and prevention, and improving access to STI treatment services through integrated sexual and reproductive health programs. Given the steady increase in reported cases, implementing targeted STI interventions will be critical in curbing transmission rates and improving sexual health outcomes among men in South Africa.

Gonorrhoea among men

Between 2019 and 2022, there was no available data on the rate of laboratory-diagnosed gonorrhoea among men in countries with laboratory capacity for diagnosis. However, a study conducted in KwaZulu-Natal sought to measure the population prevalence of sexually transmitted infections (STIs) and explore the association between STIs, HIV, CD4 cell counts, and HIV viral load in a high HIV burden setting.

The study found that the prevalence of *Neisseria gonorrhoeae* among individuals aged 15–49 years was 2.8%, affecting both males and females. Additionally, the study identified a strong association between HIV viral load and gonorrhoea infection. Individuals with HIV viral loads ≥ 400 copies per mL had a significantly increased probability of having *N. gonorrhoeae* (adjusted prevalence ratio [aPR] = 1.91, 95% CI 1.36–2.70) (Kharsany et al., 2020). These findings highlight the importance of integrating STI screening and treatment within HIV care programs, particularly in high HIV burden areas. Strengthening routine surveillance for gonorrhoea and other STIs is critical to monitor trends, improve early diagnosis, and reduce transmission rates. Expanding accessible diagnostic services and public health interventions will be essential in curbing the dual burden of STIs and HIV in South Africa.

Co-management of Tuberculosis and HIV treatment

The integration of tuberculosis (TB) and HIV treatment remains a critical component of South Africa's healthcare response, as TB continues to be a leading cause of death among people living with HIV. Data on HIV-positive individuals diagnosed with TB who received treatment for both conditions is available for 2022 and has been systematically digitized in the patient information system across health facilities. In 2022, a total of 83,169 HIV-positive individuals who were either new TB cases or experiencing a TB relapse were initiated on TB treatment. These individuals were either already on antiretroviral therapy (ART) at the time of their TB diagnosis or started ART during TB treatment within the same year. Among those receiving TB-HIV co-treatment:

- 44,367 were male
- 38,802 were female
- 2,191 were children under 15 years old
- 80,978 were adults aged 15 and older

Comparatively, in 2021, the number of HIV-positive individuals receiving TB treatment was significantly lower, recorded at 58,017 cases (32,015 males and 25,912 females). A review of historical trends since 2018 shows fluctuations in TB-HIV treatment numbers, with a notable decline in 2021 from 97,506 cases recorded in 2018 (UNAIDS Online Tool). According to the Department of Health (DOH), the drop in 2021 was largely attributed to the COVID-19 pandemic, which disrupted routine healthcare services, reduced patient access to healthcare facilities due to lockdown restrictions, and negatively impacted TB screening and treatment initiation. These trends highlight the urgent need to strengthen TB-HIV integration efforts to prevent further disruptions in care. Priority actions should include:

- Expanding facility- and community-based TB screening among people living with HIV to improve early diagnosis.
- Ensuring wider access to TB preventive therapy (TPT) for individuals at risk of TB infection.
- Addressing healthcare system gaps that hinder consistent TB and HIV treatment services.
- Strengthening resilience in TB-HIV care programs to withstand future public health crises.

Given that TB remains the leading cause of mortality among people living with HIV, sustaining comprehensive

TB-HIV collaborative treatment programs is essential for reducing deaths and improving health outcomes for those affected by both diseases in South Africa.

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

In 2022, a total of 32,847 people living with HIV (PLHIV) who were newly enrolled on HIV treatment were diagnosed with tuberculosis (TB), representing 7% of newly initiated ART patients. This marks an increase from 2021, when 27,287 individuals (5.6%) were diagnosed with TB at the time of starting HIV treatment. The lower TB diagnoses in 2021 were attributed to the impact of the COVID-19 pandemic, which disrupted routine healthcare services and limited patient access to TB screening and diagnosis (DOH, 2022). These findings emphasize the need for strengthened TB screening protocols among newly diagnosed HIV patients to ensure early detection and treatment initiation.

Efforts to enhance TB prevention and treatment integration within HIV care services remain crucial to reducing TB-related morbidity and mortality among PLHIV. Strengthening facility- and community-based TB screening, improving access to TB preventive therapy (TPT), and ensuring uninterrupted ART and TB treatment services will be key strategies in mitigating the impact of TB-HIV co-infection in South Africa.

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

Data on the percentage of people on antiretroviral therapy (ART) who started tuberculosis preventive

treatment (TPT) from 2018 to 2023 reveals a fluctuating trend. The highest recorded performance occurred in 2020, while in other years, coverage remained below 70%. Given that TB remains one of the leading causes of death among people living with HIV (PLHIV) in South Africa, it is critical to review performance on this indicator to identify and address barriers to TPT uptake. Strengthening systematic TB screening, improving linkage to preventive therapy, and integrating TPT into routine HIV care services will be essential to enhancing coverage and reducing TB-related morbidity and mortality among PLHIV.

Table 15: Percentage of people on antiretroviral therapy who started tuberculosis preventive treatment (2018-2023)

Indicator	2018	2019	2020	2021	2022	2023
Percentage of people on antiretroviral therapy who started tuberculosis preventive treatment during the reporting period	65%	69.3%	93.1%	62.8%	61.8%	61.4%
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	261,684
Total number of people living with HIV newly enrolled on antiretroviral therapy	697,551	736,078	383,403	488,052	466,485	426,54

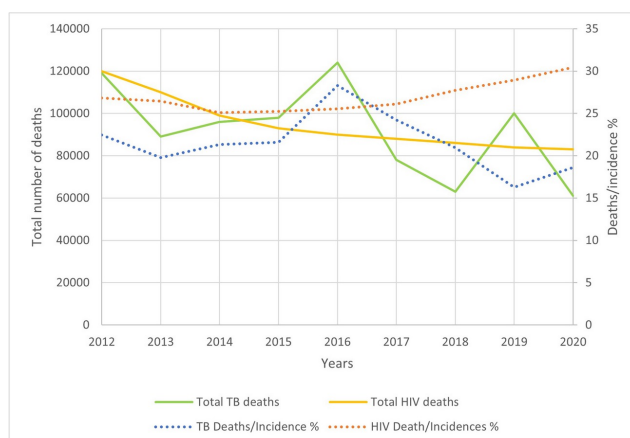
Source: UNAIDS Online Tool

South Africa's extensive genomic research on tuberculosis (TB) has identified genetic variations associated with increased TB susceptibility, providing critical insights into the disease's pathogenesis. This commitment extends to TB vaccine research, with the South African Tuberculosis Vaccine Initiative (SATVI) playing a pivotal role in global clinical trials aimed at developing effective TB vaccines (Visca et al., 2021). In terms of mortality trends, deaths attributed to HIV and TB have declined significantly over the past decade. In 2012, there were approximately 120,000 deaths due to HIV and TB combined, whereas

by 2020, HIV-related deaths had decreased to 83,000, and TB-related deaths had declined to 61,000 (Olivier et al., 2023). The data indicates that progress in reducing TB-related deaths has been more successful than efforts to reduce HIV-related mortality over the last eight years in South Africa. This is further illustrated in Figure 24, where the death-to-incidence ratio for TB shows a more substantial decline compared to HIV. By 2020, TB incidence had dropped to approximately 18%, while HIV incidence continued to rise steadily, reaching nearly 30%.

These findings emphasize the need to sustain and enhance TB prevention efforts, while intensifying HIV prevention and treatment strategies to reverse the upward trajectory of new HIV infections. Strengthening integrated HIV and TB interventions, expanding vaccine research, and optimizing preventive treatment coverage will be essential to further reducing the burden of both diseases in South Africa.

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>

While significant progress has been made, reaching the ambitious "End TB" and "End HIV" targets set by the World Health Organization (WHO) for 2030 remains a complex challenge. Persistent socio-economic disparities, healthcare system constraints, and political dynamics continue to hinder efforts to fully control these epidemics (Olivier et al., 2023).

Addressing these barriers will require sustained investment in health infrastructure, targeted interventions for vulnerable populations, and strengthened political commitment to ensure comprehensive and equitable access to prevention, treatment, and care services.

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 provides data on the percentage of people living with HIV (PLHIV) currently on antiretroviral therapy (ART) who initiated and completed tuberculosis (TB) preventive treatment in 2023. The findings indicate that only 48.6% of PLHIV on ART who started TB preventive therapy successfully completed the course, based on the 2022 cohort.

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	96,966	1,487	3,710	145,146	264,010	No data

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

However, disaggregated data for transgender individuals, specific TB preventive therapy regimens,

and monotherapy were not available, highlighting gaps in routine reporting and monitoring. These findings underscore the need for strengthened adherence support, improved treatment monitoring, and enhanced access to TB preventive therapy to ensure higher completion rates and better TB prevention outcomes among PLHIV. A study conducted in South Africa (Jarrett et al., 2020) provides valuable insights into the challenges associated with TB preventive therapy (TPT). The study assessed adoption, fidelity, acceptability, and sustainability of TPT interventions and found that while adoption,

fidelity, and acceptability were moderately high, significant barriers to sustainability remained. A key challenge identified was that nurses felt unable to sustain the increased prescriptions of isoniazid preventive therapy (IPT) over time. Additionally, although many patients intended to inquire about IPT, very few did, citing power imbalances in patient-provider interactions as a major deterrent.

The study further emphasized that complex guidelines, a lack of adequate oversight, and ineffective patient-provider communication could hinder the successful implementation and scale-up of TB preventive treatment. Addressing these barriers will require simplified guidelines, improved healthcare provider training, and strengthened communication strategies to enhance patient engagement and adherence to TPT.

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

In South Africa, women living with HIV are recommended to undergo cervical cancer screening every three years, starting immediately after HIV diagnosis, as outlined in the national policy on cervical cancer screening (Denny and Kuhn, 2017). Studies have shown that women living with HIV face a higher prevalence of HPV infection than their HIV-negative counterparts, primarily due to immune suppression caused by HIV and increased susceptibility to persistent HPV infections (Hopkins et al., 2021; Ntuli et al., 2020). Despite public awareness campaigns and health promotion efforts aimed at increasing screening rates, uptake remains low across the country. However, data from the National Health Laboratory Services (NHLS)

and programme data from implementing partners indicate a significant increase in cervical cancer screening among women living with HIV. The number of screenings conducted in the past 12 months using any screening method rose from 134,338 in 2020 to 336,174 in 2022.

While this progress is promising, further efforts are needed to enhance screening coverage, integrate cervical cancer prevention into routine HIV care, and address barriers to access. Expanding HPV vaccination, improving treatment pathways for precancerous lesions, and strengthening linkages between HIV and reproductive health services will be critical in reducing the burden of cervical cancer among women living with HIV in South Africa.

Cervical precancer treatment in women living with HIV

The Department of Health's (DOH) Cervical Cancer Prevention and Control Policy¹⁵ underscores the need for secondary prevention measures to complement primary prevention efforts, particularly for women who may not fully benefit from the HPV vaccination programme. According to the policy, secondary prevention will remain necessary for at least two decades after the introduction of HPV vaccination. This involves routine screening for early detection of high-risk precancerous lesions and timely treatment to prevent progression to cervical cancer. As a national priority, cervical cancer screening continues to be offered free of charge by the public healthcare system to all eligible women. However, data on the percentage of women living with HIV who screened positive for cervical precancerous lesions and subsequently received treatment within

the past 12 months was not available at the time of reporting. Ensuring comprehensive screening, prompt treatment, and strengthened follow-up mechanisms is critical for reducing the burden of cervical cancer among women living with HIV. Further efforts are needed to improve data collection, monitor treatment uptake, and integrate cervical cancer prevention into routine HIV care to enhance early intervention and long-term health outcomes.

Treatment of invasive cervical cancer in women living with HIV

At the time of reporting, data on the percentage of women diagnosed with invasive cervical cancer who received treatment within the last 12 months was not available. However, South Africa's national cervical cancer prevention and control policy ensures that all women with detected cervical abnormalities following a positive screening test receive appropriate clinical management based on their screening results. For most cases, precancerous cervical lesions can be effectively treated on an outpatient basis using minimally invasive procedures. The available treatment methods include ablation therapy, electrocoagulation diathermy (ED), cryotherapy, laser cauterization (vaporization), and excision procedures such as the large loop excision of the transformation zone (LLETZ). These interventions are used for managing Cervical Intraepithelial Neoplasia (CIN), including CIN2, CIN3, and adenocarcinoma in situ, as outlined in the Department of Health's (DOH) Cervical Cancer Prevention and Control Policy (2017).

Ensuring that screened women with cervical abnormalities are linked to timely and appropriate treatment remains

critical in preventing progression to invasive cervical cancer. Strengthening screening-to-treatment pathways, expanding access to treatment services, and enhancing follow-up mechanisms are essential in improving early intervention outcomes, particularly for women living with HIV, who remain at higher risk of HPV-related cervical cancer.

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

Data on the proportion of people living with HIV (PLHIV) currently on antiretroviral therapy (ART) who receive multi-month dispensing (MMD) of antiretroviral medicine is available up to 2022. According to the Central Chronic Medicines Dispensing and Distribution (CCMDD) system, approximately 25% of PLHIV on ART received less than a three-month supply of antiretroviral medication in 2022. This reflects a significant decrease from 74% in 2021, indicating a positive shift towards increased adoption of multi-month dispensing.

Expanding MMD strategies plays a crucial role in enhancing ART adherence, reducing healthcare facility congestion, and improving patient retention. Continued efforts to optimize and scale-up multi-month dispensing will be essential in ensuring uninterrupted ART access, particularly for key and vulnerable populations who may face barriers to frequent healthcare visits.

Coverage of differentiated service delivery antiretroviral therapy models among

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

enhance the responsiveness of HIV treatment programs by tailoring services to meet the individual needs of people on antiretroviral therapy (ART). These models are designed to improve treatment outcomes, increase retention in care, and enhance the quality of life for people living with HIV. At the time of reporting, there was no available data on the percentage of people enrolled in DSD models among all individuals on ART.

However, a study assessing the expansion of the Central Chronic Medicines Dispensing and Distribution (CCMDD) system toward national scale (Liu et al., 2021) provides valuable insights into the growth of DSD models in South Africa. Between March 2016 and October 2019, the number of health facilities offering DSD increased significantly, from 972 to 3,436, representing 94.6% of all healthcare facilities in the participating districts. Concurrently, the number of external pick-up points (PuPs) expanded 12-fold, rising from 164 to 2,037. As a result of this scaling up, the number of patients served by CCMDD increased more than eightfold, with 2,993,044 registered patients and 2,069,039 active patients (69.1% of those registered) by October 2019.

Between November 2018 and October 2019, there was a shift in patient reliance on different ART collection methods. The proportion of active patients using clinic-based fast lanes decreased from 55% to 52%, while those collecting ART from external PuPs increased from 31% to 35% ($p < 0.001$). By the end of the study period, 734,005 active CCMDD patients were collecting their medication from external PuPs, reflecting a 73% increase in patient volume at these locations within a year. These findings highlight the successful expansion of DSD models through

decentralized ART delivery, reducing the burden on healthcare facilities and improving access to life-saving HIV treatment. Continued investment in scaling up external pick-up points and strengthening DSD models will be essential to further enhance treatment adherence, reduce facility congestion, and ensure long-term retention in HIV care.

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

At the time of reporting, data on the percentage of people living with HIV (PLHIV) engaged in differentiated service delivery (DSD) antiretroviral therapy (ART) models who achieved virological suppression was not available. However, a study assessing the impact of South Africa's Central Chronic Medicines Dispensing and Distribution (CCMDD) program on clinical outcomes (Wang et al., 2024) provides insight into virological suppression and retention in care among PLHIV enrolled in DSD models.

The study, which analyzed 390 PLHIV participating in CCMDD, found that viral load (VL) suppression and retention in care were similar between CCMDD-eligible patients who participated in the program and those who did not (adjusted relative risk [aRR]: 1.03; 95% CI 0.94–1.12). When assessing virological suppression alone, results remained comparable (aRR: 1.02; 95% CI 0.97–1.08), as did retention in care alone (aRR: 1.03; 95% CI 0.95–1.12). These findings suggest that while CCMDD provides an alternative ART distribution model, it does not significantly impact virological suppression or retention outcomes when compared to standard ART service delivery. Future research and programmatic evaluations

should focus on understanding patient experiences, adherence challenges, and possible enhancements to DSD models to further optimize virological suppression and long-term treatment success.

Achievements

- Universal HCV Testing for ART Patients: Despite challenges associated with HIV-HCV co-infection rates, it is encouraging that 100% of patients initiating ART through implementing partner programs undergo HCV testing, ensuring early detection and appropriate management.
- Decline in HIV and TB-Related Deaths: Mortality due to both HIV and TB has shown a steady decline, decreasing from approximately 120,000 deaths in 2012 to around 83,000 for HIV and 61,000 for TB in 2020.
- Increased Cervical Cancer Screening for Women Living with HIV: The number of women living with HIV screened for cervical cancer using any screening method in the past 12 months more than doubled, increasing from 134,338 in 2020 to 336,174 in 2022.
- Improvement in Multi-Month Dispensing of ART: In 2022, approximately 25% of people living with HIV on ART received less than a three-month supply of antiretroviral medicine, reflecting a significant decrease from 74% in 2021. This shift suggests an improvement in the implementation of multi-month dispensing strategies, which can enhance treatment adherence and reduce healthcare facility congestion.

Challenges

- HCV-HIV Co-Infection Prevalence: The overall HCV-HIV co-infection prevalence was 3.7%, with people who

inject drugs (PWID) experiencing the highest burden at 12.7%. This was primarily driven by the 29% co-infection rate observed in Pretoria, likely reflecting both a high prevalence of HCV infections and a longer history of injecting drug use in this group.

- HIV and Tuberculosis (TB) Co-Infection: In 2022, 32,847 people living with HIV (PLHIV) newly enrolled on ART were diagnosed with active TB disease, accounting for 7% of new ART initiations. This represents an increase from 27,287 cases (5.6%) in 2021.
- Rising Trends in Sexually Transmitted Infections (STIs): There is a notable increase in STI infections, with urethral discharge prevalence rising from 1.6% in 2019 to 1.8% in 2022. Additionally, curable STIs remain most prevalent among younger populations, the same demographic experiencing a peak in HIV incidence, emphasizing the interconnected risks between STIs and HIV transmission.
- **Challenges in TB Preventive Treatment (TPT) Implementation:**
 - The percentage of people on ART who started TB preventive treatment remains relatively low at 61.8%, highlighting a gap in prevention efforts.
 - Completion rates for TB preventive therapy are also suboptimal at 49.3%, raising concerns about treatment adherence and the overall effectiveness of TB prevention programs.
 - Complicated Isoniazid Preventive Therapy (IPT) guidelines, coupled with insufficient oversight and limited patient-provider communication, present barriers to successful TB preventive treatment implementation.
- STIs as a Barrier to HIV Epidemic Control: The

persistent high burden of STIs in South Africa, particularly among key populations and younger age groups, threatens progress toward achieving HIV epidemic control. Strengthening integrated HIV and STI prevention strategies is critical in mitigating these risks.

Recommendations

- Enhancing STI Testing and Treatment: There is a critical need to educate clinical professionals on the importance of intensifying STI testing among PLHIV and promoting STI treatment among key and vulnerable populations to reduce HIV transmission risks.
- Strengthening TB Preventive Therapy (TPT) Completion: Community-based support mechanisms should be established to encourage PLHIV to complete TB preventive therapy. This should be complemented by enhancing TPT initiation within health facilities, ensuring that eligible patients are started on preventive treatment as early as possible.
- Expanding HCV Screening and Treatment Access: Given the high prevalence of HCV and the low uptake of referrals, there is a pressing need for expanded, community-based HCV screening, diagnosis, and treatment, particularly targeting people who inject drugs (PWID).
- Integrating HIV and HCV Prevention Services: Strengthening harm reduction initiatives such as needle and syringe programs, opioid substitution therapy (OST), and integrated HIV-HCV prevention services is essential, as both infections share the same transmission route.
- Increasing HCV Awareness and Counselling: HCV

education and awareness campaigns should be expanded, ensuring that post-test counselling provides clients with a clear understanding of their HCV status, the risks of delaying treatment, and the benefits of timely care. Incorporating psychosocial support can further encourage individuals to seek and complete HCV treatment.

- Investigating HCV Prevalence Among PWUD: The higher-than-expected HCV prevalence among PWUD (7%) requires further investigation and targeted interventions to implement appropriate harm reduction and treatment services.
- Enhancing STI Surveillance and Control: The high prevalence of STIs highlights the need for enhanced STI surveillance and comprehensive control strategies, ensuring early detection and timely treatment.
- Improving Isoniazid Preventive Therapy (IPT) Guidelines: Future IPT guidelines should include clear, comprehensive instructions addressing patient eligibility, potential medication stockouts, and treatment duration. These guidelines should be simplified and accompanied by visual aids, such as decision trees, to facilitate implementation.
- Evaluating Multi-Level Interventions for IPT: More research is needed to assess the effectiveness and sustainability of multi-level interventions, including nurse and patient education on IPT, text message-based support for nurses, district-level monitoring, and patient-centered communication strategies.
- Enhancing IPT Implementation and District-Level Support: National IPT guidelines should be unambiguous, easy to implement, and require minimal training. Additionally, nurse-patient

interactions should be empowering, and district-level monitoring and support systems should be strengthened to improve adherence and sustainability.

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

South Africa's Constitution places a strong emphasis on ensuring socio-economic rights, including the right to affordable and quality healthcare for all citizens (South Africa, 2015). This commitment is reflected in the National Strategic Plan (NSP) 2017–2022, which outlines a multi-sectoral strategy to address the HIV and TB epidemics. One of the core objectives of the NSP is to mobilize resources that support the achievement of its goals and ensure a sustainable response to HIV, TB, and STIs. This strategic focus reaffirms South Africa's commitment to ending HIV, TB, and STIs as public health threats by 2030 through the provision of adequate and targeted funding to key stakeholders involved in the national response. The

NSP 2023–2028 aligns closely with South Africa's National Development Plan (NDP): Vision 2030 (South African Government, 2012), which envisions a health system that is inclusive, efficient, and capable of reducing the national disease burden. Additionally, South Africa remains committed to the global health agenda, specifically Goal 3 of the Sustainable Development Goals (SDGs), which aims to ensure healthy lives and promote well-being for all. A critical component of this goal is the elimination of AIDS and tuberculosis epidemics by 2030 (UNAIDS, 2022a).

In line with these commitments, South Africa's National Health Insurance (NHI) policy is designed to achieve equitable health financing (Health, 2019). Approved by the Cabinet in 2019, the NHI remains under ongoing review. Once fully implemented, it is expected to provide universal access to quality healthcare for all South Africans, as enshrined in the Constitution.

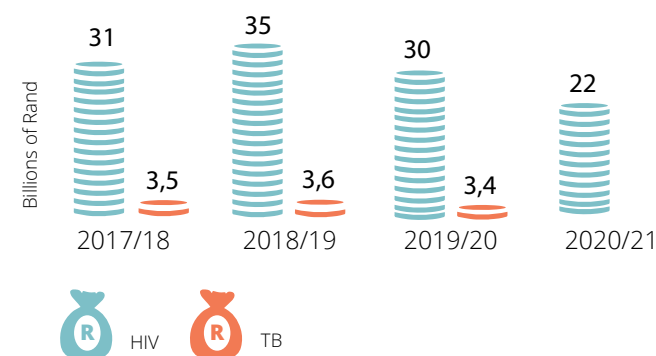
The NHI framework is also anticipated to incorporate HIV financing, ensuring that HIV prevention, care, and treatment services are included as part of the comprehensive benefits package. However, no new data was available on investment and resource allocation during the current reporting period. The most recent data available is up to 2021, and further analysis will be required to assess funding trends and sustainability efforts in subsequent years.

Status and recent trends

Domestic Public Budget on HIV

For the period up to 2021, total HIV expenditure in South Africa declined significantly, decreasing from R30.6 billion in 2017/18 to R21.6 billion in 2020/21 (Figure 25). This represents an overall reduction of 40% in HIV-related spending over the period. In contrast, expenditure on tuberculosis (TB) remained relatively stable, hovering at approximately R3 billion (UNAIDS, 2022b). The decline in HIV funding raises concerns regarding sustaining critical prevention, treatment, and care interventions, particularly in the context of South Africa's high HIV burden.

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, findings from the 2017–2020 report indicate that the largest share of HIV funding—at least two-thirds—was allocated to HIV care and treatment (Table 16). Total expenditure on HIV care and treatment increased from R19.7 billion in 2017/18 to R26.7 billion in 2019/20 (NASA, 2021). Despite the prevention benefits associated with expanding HIV treatment access, a declining investment in HIV prevention was observed, both in nominal and proportional terms.

Prevention expenditure dropped from 11% to 8% of the total HIV budget during this period, raising concerns about the sustainability of efforts aimed at reducing new infections (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)

Antiretrovirals: Unit Prices and Volume

Table 12 shows expenditure on ART accounted for most of the NDoH’s expenditure on HIV programs. The NDoH

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	22,174,807,439	23,715,850,996	26,039,000,179	72%	68%	69%
PEPFAR	5,875,239,835	8,101,197,101	9,131,899,608	19%	23%	24%
Global Fund	992,612,830	1,582,377,302	650,911,799	3%	5%	2%
Other bilateral funding entities	37,597,640	24,906,829	9,063,637	0.1%	0.1%	0.0%
Other multilateral funding entities	84,022,352	128,771,599	182,621,861	0.3%	0.4%	0.5%
INGOs and Foundations	407,180,825	412,768,984	355,258,335	1.3%	1.2%	0.9%
Other International entities	135,925,855	116,637,361	82,765,950	0.4%	0.3%	0.2%
Medical insurances	879,902,138	1,009,827,415	1,101,371,508	2.9%	2.9%	2.9%
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)

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 South African government leads the national response to HIV, TB, and STIs, contributing the largest share of domestic funding, while external donors such as PEPFAR, USAID, the Global Fund, and the private sector provide additional support (NASA, 2021). Although government expenditure on HIV increased from R22.2 billion in 2017/18 to R26.0 billion in 2019/20, its relative share of total HIV spending declined from 72% to 69% (Figure 25). Meanwhile, donor commitment to South Africa’s HIV response remained strong over the years. PEPFAR funding increased by 55%, rising from R5.8 billion

in 2017/18 to R9.1 billion in 2019/20. However, Global Fund spending declined during this period, indicating shifts in external funding priorities.

Achievements

Sustained Increase in HIV/AIDS Budget and Expenditure

South Africa has made significant strides in securing consistent funding for HIV programs, leveraging both domestic resources and international donor support. During the review period, financial investments in HIV programs increased, reflecting the country's commitment to addressing the epidemic. The R7 billion increase in total funding over three years is a notable achievement, demonstrating a strong political and financial commitment to sustaining and expanding the HIV response.

Prioritizing of ART Programs

The South African government's HIV expenditure trends indicate a strong focus on providing treatment for people living with HIV (PLHIV). This prioritization aligns with efforts to achieve the 95-95-95 targets, ensuring that more individuals are diagnosed, initiated on treatment, and achieve viral suppression. Additionally, investing in ART is cost-effective in the long term, as it reduces HIV-related health burdens, prevents new infections, and significantly improves life expectancy.

Key challenges

Insufficient TB Funding

TB remains one of the leading causes of natural deaths in South Africa, yet funding for TB services remains inadequate. To effectively control TB and improve health outcomes, it is critical to increase financial investments to

ensure TB services are widely available, accessible, and of high quality. Strengthening TB prevention, diagnosis, and treatment efforts requires consistent and sufficient funding, particularly given the high burden of TB co-infection among people living with HIV.

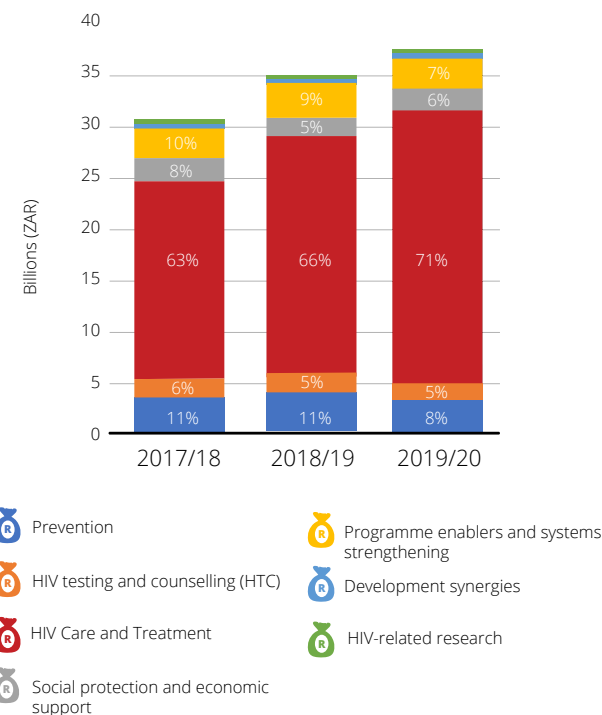
Decreasing investments in HIV prevention

The decrease in HIV prevention funding is a cause for concern, particularly as South Africa continues to experience high HIV incidence rates. According to UNAIDS recommendations, at least 25% of the total HIV budget should be allocated to HIV prevention interventions. However, the National AIDS Spending Assessment (NASA) report indicates a decline in prevention funding, dropping from 11% in 2017/18 to 9% in 2019/20. Given the ongoing HIV transmission risks, there is a critical need to invest in research to identify the primary drivers of new infections and scale up evidence-based prevention strategies with adequate resource allocation.

Recommendations

- **Developing a Sustainable Funding Model:** With HIV expenditure showing a declining trend between 2017 and 2021, the government and stakeholders must explore innovative ways to increase domestic funding, particularly by leveraging private sector investment in the national HIV response.
- **Prioritizing HIV Prevention for Long-Term Impact:** While expanding access to HIV treatment has proven benefits in reducing transmission, there is a critical need for increased investments in prevention programs to effectively curb new HIV infections.
- **Adopting a "spend now to save later" approach** will be instrumental in reducing future healthcare costs and

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



Source: NASA report (2017-2020)

- ensuring long-term sustainability of the HIV response.
- **Enhancing Domestic Investment in HIV Research:** HIV-related research has received relatively low budget allocations, with most funding coming from international agencies. This creates a sustainability risk as donor funding declines. To ensure the continuity of critical research efforts, the government and stakeholders must mobilize domestic resources to support data-driven, evidence-based decision-making for the national HIV response.

Conclusion

Advancing South Africa's HIV Response Towards 2030: Progress, Challenges, and the Path Forward

South Africa remains at the forefront of the global fight against HIV and AIDS, aligning its efforts with the Sustainable Development Goals (SDGs), particularly Goal 3, which seeks to ensure good health and well-being for all. In June 2021, the country reaffirmed its commitment by adopting a political declaration on HIV and AIDS, joining other nations in accelerating progress towards ending the epidemic as a public health threat by 2030. While there have been significant achievements, the challenges remain substantial, and the nation must adapt its strategies to address emerging barriers effectively.

Key Achievements in South Africa's HIV Response

South Africa's HIV prevention and treatment efforts have resulted in measurable progress across several critical areas:

Declining HIV Incidence and Expanded ART Coverage

Over the past five years, new HIV infections have steadily declined, reflecting the impact of combination prevention strategies such as PMTCT, VMMC, PrEP expansion, and condom distribution. The country has also made notable progress in ART scale-up, bringing it closer to achieving universal treatment coverage. By 2023, South Africa had achieved the first (95% diagnosis rate) and third (91% viral suppression) UNAIDS 95-95-95 targets, underscoring the effectiveness of treatment programs and adherence support interventions.

Significant Reduction in Mother-to-Child Transmission (MTCT)

A major public health success has been the consistent decline in MTCT rates, highlighting the effectiveness of strong PMTCT interventions and improved antenatal care services. South Africa's commitment to early diagnosis and ART initiation during pregnancy has played a pivotal role in reducing HIV transmission to infants.

Decline in AIDS-Related Mortality

Efforts to scale up ART, TB prevention and treatment, and differentiated service delivery models have contributed to a steady decline in AIDS-related deaths. By 2020, the country recorded a decrease in HIV and TB-related mortality, demonstrating that effective treatment and care programs are saving lives.

Strengthening of Social Protection Programs

The integration of gender-responsive, rights-based, and community-led approaches into HIV programming has enhanced equity in service delivery. South Africa has also prioritized social protection measures, particularly for AGYW, key populations, and vulnerable communities, ensuring that those at the highest risk receive tailored support.

Persistent Challenges and Barriers to Reaching 2030 Goals

Despite commendable progress, several barriers continue to hinder South Africa's ability to fully achieve its HIV response targets:

High HIV Incidence Among Adolescents and Young Women

While overall incidence has declined, AGYW continue to bear the brunt of new infections. Low risk perception, declining condom use, and barriers to PrEP uptake contribute to their vulnerability, highlighting the urgent need for gender-transformative prevention strategies.

Suboptimal ART Coverage Among Children and Key Populations

Although ART coverage has expanded, children, MSM, FSW, transgender individuals, and people who inject drugs (PWID) experience lower ART initiation and retention rates. Stigma, discrimination, and systemic barriers continue to limit access to life-saving treatment among these populations.

Rising HIV Incidence Among Women Aged 50+

An emerging concern is the increasing HIV incidence among older women, which suggests missed prevention opportunities and limited tailored interventions. The lack of targeted messaging and services for this demographic needs to be addressed.

Disruptions to Health Services Due to COVID-19

The COVID-19 pandemic significantly impacted HIV and TB services, affecting testing, ART initiation, retention in care, and TB treatment coverage. Although the country has made efforts to restore service delivery, health system disruptions remain a challenge.

Declining Investment in HIV Prevention

A worrying trend is the decline in funding for HIV prevention programs, despite persistently high HIV incidence rates. According to UNAIDS recommendations, 25% of the HIV budget should be allocated to prevention, yet South Africa's prevention spending has decreased, dropping from 11% in 2017/18 to 9% in 2019/20. Without reinvestment in prevention, the country risks reversing the gains made by reducing new infections.

The Path Forward: Strengthening Community-Led and Health System Innovations

To accelerate progress towards the 2030 targets, South Africa must expand and refine its HIV response strategies. The following priorities will be critical to ensure continued progress:

Expanding Targeted Prevention Strategies

Increasing access to PrEP, condoms, and voluntary medical male circumcision (VMMC), alongside evidence-based risk reduction programs, will help curb new infections. Special focus should be placed on adolescents, AGYW, older adults, and key populations who remain at high risk.

Improving ART Coverage and Retention in Care

Efforts must be intensified to increase ART coverage among children and key populations by reducing barriers to treatment, expanding differentiated service delivery models, and ensuring uninterrupted ART access through multi-month dispensing (MMD) and decentralized ART pick-up points.

Strengthening HIV and TB Service Integration

Given the high burden of TB among PLHIV, there is an urgent need to scale up TB preventive therapy (TPT), improve early diagnosis, and enhance linkage to TB treatment to reduce co-infection mortality.

Enhancing Data Systems & data utilization for Evidence-Based Decision-Making

Strengthening routine data collection, surveillance, and research initiatives will ensure that policymakers and program implementers have access to real-time, high-quality data to guide their response efforts.

Ensuring Sustainable HIV Financing

Given declining international donor support, South Africa must increase domestic investments and explore private sector partnerships to secure long-term HIV financing. A sustainable funding model will be key to maintaining treatment and prevention programs.

Addressing Stigma, Discrimination, and Gender-Based Violence (GBV)

The elimination of stigma and discrimination must remain a top priority. Strengthening gender-transformative approaches, increasing GBV case identification and response, and ensuring equal access to healthcare for key populations are essential steps towards achieving inclusive and equitable HIV services.

The COVID-19 pandemic significantly impacted HIV and TB services, affecting testing, ART initiation, retention in care, and TB treatment coverage. Although the country has made efforts to restore service delivery, health system disruptions remain a challenge.

In conclusion, South Africa has made significant strides in its HIV response, achieving high levels of diagnosis and viral suppression while expanding access to treatment and prevention services. However, critical challenges persist, including high HIV incidence among AGYW, suboptimal ART coverage among children and key populations, funding gaps, and ongoing stigma and discrimination. To meet the 2030 goal of ending AIDS as a public health threat, the country must embrace innovative, community-led solutions, strengthen health systems, and reinvest in prevention programs. By prioritizing person-centered, equity-driven approaches, South Africa can sustain its progress and move closer to achieving an HIV-free future.

References

1. Morifi, M., Malevu, N., Odayan, S., McCarthy, K., & Kufa, T. (2021). Congenital Syphilis Case Surveillance in South Africa 2017-19: Experience, Challenges and Opportunities. *Journal of tropical pediatrics*, 67(4), fma079. <https://doi.org/10.1093/tropej/fma079>
2. Joseph Davey, D., Hsiao, Ny., Wendy Spearman, C. et al. Low prevalence of hepatitis B virus infection in HIV-uninfected pregnant women in Cape Town, South Africa: implications for oral pre-exposure prophylaxis roll out. *BMC Infect Dis* 22, 719 (2022). <https://doi.org/10.1186/s12879-022-07697-5>
3. Msomi N, Naidoo K, Yende-Zuma N, Padayatchi N, Govender K, Singh JA, Abdool-Karim S, Abdool-Karim Q, Mlisana K. High incidence and persistence of hepatitis B virus infection in individuals receiving HIV care in KwaZulu-Natal, South Africa. *BMC Infect Dis*. 2020 Nov 16;20(1):847. doi: 10.1186/s12879-020-05575-6. PMID: 33198649; PMCID: PMC7670610.
4. van Liere, Geneviève A.F.S; Kock, Marleen M. PhD; Radebe, Oscar MBBCh; Struthers, Helen E. PhD; Morre, Servaas PhD; McIntyre, James A. FRCOG; Peters, Remco P.H. MD, PhD. High Rate of Repeat Sexually Transmitted Diseases Among Men Who Have Sex With Men in South Africa: A Prospective Cohort Study. *Sexually Transmitted Diseases* 46(11):p e105-e107, November 2019. | DOI: 10.1097/OLQ.0000000000001041
5. Kharsany ABM, McKinnon LR, Lewis L, Cawood C, Khanyile D, Maseko DV, Goodman TC, Beckett S, Govender K, George G, Ayalew KA, Toledo C. Population prevalence of sexually transmitted infections in a high HIV burden district in KwaZulu-Natal, South Africa: Implications for HIV epidemic control. *Int J Infect Dis*. 2020 Sep;98:130-137. doi: 10.1016/j.ijid.2020.06.046. Epub 2020 Jun 17. PMID: 32562845; PMCID: PMC7484252.
6. Olivier, C., Luies, L. WHO Goals and Beyond: Managing HIV/TB Co-infection in South Africa. *SN Compr. Clin. Med*. 5, 251 (2023). <https://doi.org/10.1007/s42399-023-01568-z>
7. Visca D, Ong C, Tiberi S, Centis R, D'ambrosio L, Chen B, et al. Tuberculosis and COVID-19 interaction: a review of biological, clinical and public health effects. *Pulmonology*. 2021;27(2):151–65
8. Jarrett BA, Woznica DM, Tilchin C, Mpungose N, Motlhaoleng K, Golub JE, Martinson NA, Hanrahan CF. Promoting Tuberculosis Preventive Therapy for People Living with HIV in South Africa: Interventions Hindered by Complicated Clinical Guidelines and Imbalanced Patient-Provider Dynamics. *AIDS Behav*. 2020 Apr;24(4):1106-1117. doi: 10.1007/s10461-019-02675-6. PMID: 31549265; PMCID: PMC7085432.
9. Denny L, Kuhn L. Cervical cancer prevention and early detection from a South African perspective. *South African Health Review*. 2017 Dec 1;2017(1):189–95
10. Hopkins KL, Jaffer M, Hlongwane KE, Otjombe K, Dietrich J, Cheyip M, et al. Assessing national cervical cancer screening guidelines: results from an HIV testing clinic also screening for cervical cancer and HPV in Soweto, South Africa. *PLoS One*. 2021 Jul 30;16(7):e0255124.
11. Ntuli ST, Maimela E, Skaal L, Mogale M, Lekota P. Abnormal cervical cytology amongst women infected with human immunodeficiency virus in Limpopo province, South Africa. *Afr J Prim Health Care Fam Med*. 2020 Oct 6;12(1):e1–e4
12. Liu, L., Christie, S., Munsamy, M. et al. Expansion of a national differentiated service delivery model to support people living with HIV and other chronic conditions in South Africa: a descriptive analysis. *BMC Health Serv Res* 21, 463 (2021). <https://doi.org/10.1186/s12913-021-06450-z>
13. Wang M, Violette LR, Dorward J, Ngobese H, Sookrajh Y, Bulu E, Quame-Amaglo J, Thomas KK, Garrett N, Drain PK. Delivery of Community-based Antiretroviral Therapy to Maintain Viral Suppression and Retention in Care in South Africa. *J Acquir Immune Defic Syndr*. 2023 Jun 1;93(2):126-133. doi: 10.1097/QAI.0000000000003176. Erratum in: *J Acquir Immune Defic Syndr*. 2024 Feb 1;95(2):e1. PMID: 36796353; PMCID: PMC7614548.
14. Baral S, Beyrer C, Muessig K, Poteat T, Wirtz AL, Decker MR, et al. Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysis. *Lancet Infect Dis*. 2012;12(7):538–49
15. Zeng C, Li X, Qiao S, Yang X, Shen Z, Zhou Y. Anticipated stigma and medication adherence among people living with HIV: the mechanistic roles of medication support and ART self-efficacy. *AIDS Care*.

- 2020;32(8):1014–22.
16. Mokgatle M, Madiba S. Community Perceptions of HIV Stigma, Discriminatory Attitudes, and Disclosure Concerns: A Health Facility-Based Study in Selected Health Districts of South Africa. *Int J Environ Res Public Health*. 2023 Jul 18;20(14):6389. doi: 10.3390/ijerph20146389. PMID: 37510621; PMCID: PMC10379360.
 17. Sisonke Sex Worker Movement. Cape Town: Sisonke; 2011. Submission to the Global Commission on HIV and the Law from sex workers in South Africa.
 18. Women's Legal Centre, SWEAT, Sisonke. Cape Town: Women's Legal Centre; 2012. "Stop harassing us! Tackle real crime!": a report on human rights violations by police against sex workers in South Africa
 19. Breen D, Nel J. South Africa – a home for all: the need for hate crime legislation. *S Afr Crime Q*. 2011;38:33–43
 20. United Nations Office on Drugs and Crime, Centers for Disease Control, TB HIV Care Association, OUT LGBT Wellbeing. Pretoria: United Nations Office on Drugs and Crime; 2014. "Hello Mr President, it's time to take notice of the harm reduction movement". Draft report from the national people who inject drugs community consultation.
 21. Lambert A. Harm reduction in South Africa. Presentation. HIV and Drug Use Pre-Conference; 2015 June 9; Durban. 2015.
 22. Step Up Project, TB/HIV Care Association, Mainline, OUT LGBT Wellbeing. Cape Town: TB/HIV Care Association; 2015. Human rights report. 15 August to 15 November 2015.
 23. Richter M. Erotic labour in Hillbrow: Sex work, Johannesburg's 'den of iniquity' and HIV/AIDS. Health Systems Trust, 2008; p. 1–24.
 24. Parry CDH, Dewing S, Petersen P, et al. Rapid assessment of HIV risk behavior in drug using sex workers in three cities in South Africa. *AIDS Behav*. 2009 Aug 29;13(5):849–859. <https://doi.org/10.1007/s10461-008-9367-3>
 25. Lane T, Mogale T, Struthers H, McIntyre J, Kegeles SM. 'They see you as a different thing': The experiences of men who have sex with men with healthcare workers in South African township communities. *Sex Transm Infect*. 2008 Nov 1;84(6):430–433. <https://doi.org/10.1136/sti.2008.031567>
 26. Scheibe A, Drame FM, Shannon K. HIV prevention among female sex workers in Africa. *SAHARA*. 2012 Dec 6;9(3):167–172. <https://doi.org/10.1080/17290376.2012.743809>
 27. Muller A. Teaching lesbian, gay, bisexual and transgender health in a South African health sciences faculty: Addressing the gap. *BMC Med Educ*. 2013 Dec 28;13(174):1–7. <https://doi.org/10.1186/1472-6920-13-174>
 28. Müller A, Spencer S, Meer T, Daskilewicz K. The no-go zone: A qualitative study of access to sexual and reproductive health services for sexual and gender minority adolescents in Southern Africa. *Reprod Health*. 2018 Jan 24;15(12):1–15. <https://doi.org/10.1186/s12978-018-0462-2>
 29. Mashau, R. C., Meiring, S. T., Quan, V. C., Nel, J., Greene, G. S., Garcia, A., Menezes, C., Reddy, D. L., Venter, M., Stacey, S., Madua, M., Boretta, L., Harrison, T. S., Meintjes, G., Shroufi, A., Trivino-Duran, L., Black, J., Govender, N. P., & GERMS-SA (2022). Outcomes of flucytosine-containing combination treatment for cryptococcal meningitis in a South African national access programme: a cross-sectional observational study. *The Lancet. Infectious diseases*, 22(9), 1365–1373. [https://doi.org/10.1016/S1473-3099\(22\)00234-1](https://doi.org/10.1016/S1473-3099(22)00234-1)
 30. Bello B, Ndagurwa P, Omogiate S, Luwaca B, Motsieloa L. . 2021. "Republic of South Africa: 2020 Global AIDS Monitoring Report (2021)." In. Johannesburg: CESAR.
 31. Cloete, Allanise, Musawenkosi Mabaso, Goitseone Maseko, Sean Jooste, Jacque Mthembu, Leickness Simbayi, Khangelani Zuma, Nompumelelo Zungu, T. Schmidt, Philisiwe Ndlovu, Pelagia Murangandi, Jason Bedford, Nuha Naqvi, and and Committee. 2022. The People Living with HIV Stigma Index 2.0 in Six Districts of South Africa 2020 – 2021.
 32. Commission;, South African Human Rights. 2017. "HIV/AIDS and Human Rights." In, edited by South Africa Human Rights Commission. Pretoria.
 33. Duby, Z., B. Nkosi, A. Scheibe, B. Brown, and L. G. Bekker. 2018. "Scared of going to the clinic": Contextualising healthcare access for men who have sex with men, female sex workers and people who use drugs in two South African cities', *South Afr J HIV Med*, 19: 701.
 34. "Employment Equity Act, 1998." In. 1998. South Africa.
 35. Fund, Global. 2013. "Key Populations Action Plan 2014-2017." In, edited by Global Fund. Geneva, Switzerland: The Global Fund.
 36. Gupta, V., and V. K. Sharma. 2019. 'Syndromic management of sexually transmitted infections: A critical appraisal and the road ahead', *Natl Med J India*, 32: 147-52.
 37. Health., Department of. 2019. 'National Health

- Insurance', Department of Health. <https://www.health.gov.za/nhi/>.
38. Kularatne, R. S., R. Niit, J. Rowley, T. Kufa-Chakezha, R. P. H. Peters, M. M. Taylor, L. F. Johnson, and E. L. Korenromp. 2018. 'Adult gonorrhea, chlamydia and syphilis prevalence, incidence, treatment and syndromic case reporting in South Africa: Estimates using the Spectrum-STI model, 1990-2017', *PLoS ONE*, 13: e0205863.
 39. "Lallu v Van Staden." In. 2011. Roodepoort Equality Court.
 40. Luvuno, Z. P., G. McHunu, B. Ncama, H. Ngidi, and T. Mashamba-Thompson. 2019. 'Evidence of interventions for improving healthcare access for lesbian, gay, bisexual and transgender people in South Africa: A scoping review', *Afr J Prim Health Care Fam Med*, 11: e1-e10.
 41. Mbeda, C., A. Ogendo, R. Lando, D. Schnabel, D. A. Gust, X. Guo, V. Akelo, K. Dominguez, R. Panchia, Y. Mbilizi, Y. Chen, and W. Chege. 2020. 'Healthcare-related stigma among men who have sex with men and transgender women in sub-Saharan Africa participating in HIV Prevention Trials Network (HPTN) 075 study', *AIDS Care*, 32: 1052-60.
 42. Müller, A., Daskilewicz, K. and the Southern and East African Research Collective on Health. 2019. "Are we doing alright? Realities of violence, mental health, and access to healthcare related to sexual orientation and gender identity and expression in South Africa: Research report based on a community-led study in nine countries." In. Amsterdam: COC Netherlands.
 43. NASA. 2021. "NATIONAL AIDS SPENDING ASSESSMENT plus (NASA+) HIV and TB SPENDING IN SOUTH AFRICA: 2017/18 – 2019/20." In.
 44. NDOH. 2018. "The First National TB Prevalence Survey: South Africa." In.
 45. NICD. 2020. 'Impact-of-Covid-19-interventions-on-TB-testing-in-SouthAfrica', Accessed 12 December pdf. <https://www.nicd.ac.za/wp-content/>.
 46. Orazulike, N., J. B. Sharma, S. Sharma, and O. U. J. Umeora. 2021. 'Tuberculosis (TB) in pregnancy - A review', *Eur J Obstet Gynecol Reprod Biol*, 259: 167-77.
 47. SANAC. 2020. "GAM Online Reporting Tool: South Africa, 2020." In.
 48. Sekoni, A. O., N. K. Gale, B. Manga-Atangana, A. Bhadhuri, and K. Jolly. 2017. 'The effects of educational curricula and training on LGBT-specific health issues for healthcare students and professionals: a mixed-method systematic review', *J Int AIDS Soc*, 20: 21624.
 49. Simbayi, Leickness, Khangelani Zuma, Allanise Cloete, Sean Jooste, Zimela S, Sipiwe Blose, Njeri Wabiri, Maduna V, Davids A, Musawenkosi Mabaso, Jacque Mthembu, Mashologu Y, Gladys Matseke, and Goitseone Mafoko. 2015. The people: living with HIV sti gma index: South Africa 2014: summary report.
 50. Simbayi, Leickness, Khangelani Zuma, Nompumelelo Zungu, Sizulu Moyo, Edmore Marinda, Sean Jooste, Musawenkosi Mabaso, Alicia North, Johan Zyl, Neo Mohlabane, Cheryl Dietrich, Inbarani Naidoo, and Sabbssm Team. 2019. South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2017.
 51. South Africa. 2015. "The Constitution of the Republic of South Africa, 1996: as adopted on 8 May 1996 and amended on 11 October 1996 by the Constituent Assembly." In, edited by & Department of Justice and Constitutional Development South Africa. Pretoria: Republic of South Africa.
 52. South African Government. 2012. 'National Development Plan 2030: Our Future - Make it Work:' Accessed 2 December <https://www.gov.za/documents/national-development-plan-2030-our-future-make-it-work>.
 53. Stone, J., C. Mukandavire, M. C. Boily, H. Fraser, S. Mishra, S. Schwartz, A. Rao, K. J. Looker, M. Quaife, F. Terris-Prestholt, A. Marr, T. Lane, J. Coetzee, G. Gray, K. Otworld, M. Milovanovic, H. Hausler, K. Young, M. McInanga, M. Ncedani, A. Puren, G. Hunt, Z. Kose, N. Phaswana-Mafuya, S. Baral, and P. Vickerman. 2021. 'Estimating the contribution of key populations towards HIV transmission in South Africa', *J Int AIDS Soc*, 24: e25650.
 54. Stop TB Partnership. 2022. 'GLOBAL PLAN TO END TB 2023-2030', UNOPS, Accessed 12 December.
 55. UNAIDS. 2011. "Terminology Guidelines." In. Geneva: UNAIDS. ———. 2022a. 'Ensure healthy lives and promote well-being for all at all ages', Accessed 2 December <https://sdgs.un.org/goals/goal3>. ———. 2022b. "Welcome to AIDS Spending Tool." In.
 56. WHO. 2021. 'WHO recommends DNA testing as a first-choice screening method for cervical cancer prevention', WHO, Accessed 2 December. <https://www.who.int/europe/news/item/11-09-2021-who-recommends-dna-testing-as-a-first-choice-screening-method-for-cervical-cancer-prevention>.
 57. Oosthuizen, A. (ed). (2024) HSRC Review 22(4). December: 1-59. Cape Town: HSRC Press. <http://hdl.handle.net/20.500.11910/23783>