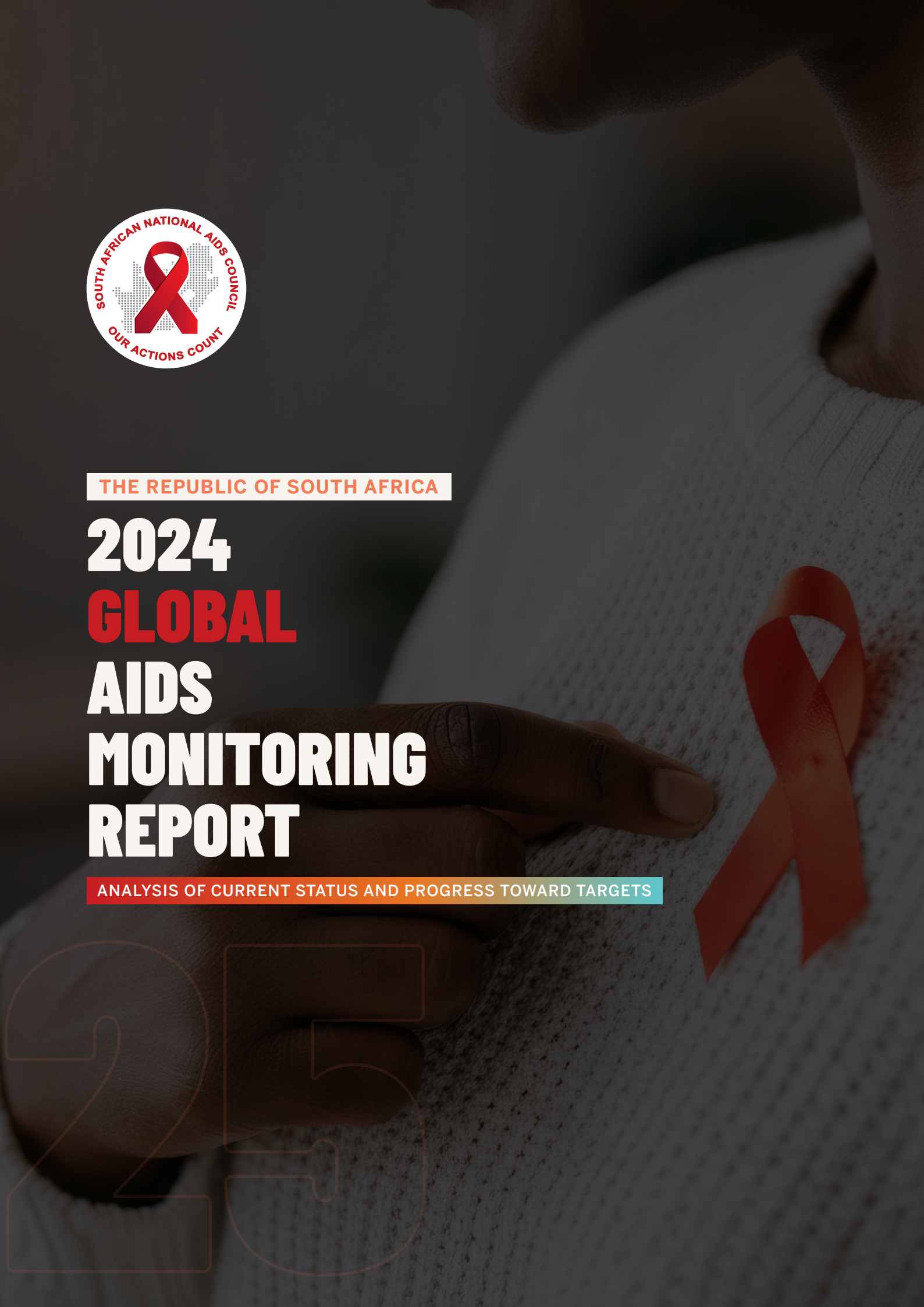

THE REPUBLIC OF SOUTH AFRICA

2024 GLOBAL AIDS MONITORING REPORT

ANALYSIS OF CURRENT STATUS AND PROGRESS TOWARD TARGETS

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REPORT PREPARATION BY NOVA GLOBAL SOLUTIONS TEAM

Professor Pedro T Pisa

Layout, design, and formatting: Tamuka Sanyika

SANAC TEAM

Billia Luwaca
Zwebuka Khumalo
Anthony Odama
Lifutso Motsieloa

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SANAC Trust

272 West Avenue, Diehoewes, Centurion, 0157 | 2nd Floor, Block B, Lakefield Office Park, South Africa

CONTACT

pppedropissa@gmail.com

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ABBREVIATIONS AND ACRONYMS

ABYM	Adolescent Boys and Young Men
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
AYP	Adolescents and Young People
CBO	Community-Based Organization
CCMDD	Centralized Chronic Medicines Dispensing and Distribution
CESAR	Centre for Statistical Analysis and Research
CHC	Community Health Center
CHW	Community Healthcare Worker
COP	Country Operational Plan
COSUP	Community-Oriented Substance Use Programme
COVID-19	Coronavirus Disease 2019
CSO	Civil Society Organizations
DBE	Department of Basic Education
DHET	Department of Higher Education and Training
DHIS	District Health Information System
DOJ&CD	Department of Justice and Constitutional Development
DSD	Department of Social Development
EID	Early Infant Diagnosis
eMTCT	Elimination of Mother-to-Child Transmission
FSW	Female Sex Workers
GAM	Global AIDS Monitoring
GBV	Gender-Based Violence
GDP	Gross Domestic Product
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
IBBS	Integrated Biological and Behavioural Studies
IPV	Intimate Partner Violence
LGBTI	People with Disabilities, Other Lesbian, Gay, Bisexual, Transgender and Intersex
M&E	Monitoring and evaluation
MDR-TB	Multi-drug-resistant TB
MMC	Medical Male Circumcision
MSM	Men who have sex with men
MTBPS	Medium Term Budget Policy Statement
MTCT	Mother-to-Child Transmission
MTEF	MTEF
MTEF	Medium Term Expenditure Framework
NACOSA	Networking HIV & AIDS Community of Southern Africa
NASA	National AIDS Spending Assessment
NDMP	National Drug Master Plan
NDoH	National Department of Health
NDP	National Development Plan
NGO	Non-Governmental Organization
NHI	National Health Insurance
NHLS	National Health Laboratory Service
NICD	National Institute of Communicable Diseases
NSP	National Strategic Plan for HIV, TB and STIs
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
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 provides a comprehensive assessment of South Africa's progress in responding to the HIV epidemic, drawing on the latest available data to evaluate performance against key national and global targets. It presents a structured analysis of achievements, the current legislative and regulatory environment, and persistent challenges that continue to hinder progress towards HIV commitments.

The report is aligned with the 2021 Political Declaration on HIV and AIDS and assesses progress across the core commitment areas through integrated analysis of epidemiological trends, programme performance, and policy implementation. It examines both the extent of progress made and the underlying factors influencing performance, including structural barriers, service delivery gaps, and inequities affecting priority populations.1

This report presents data for the period January to December 2024 and provides a critical assessment of South Africa's trajectory towards the 2025 HIV response targets. While notable progress has been achieved across several indicators, the analysis shows that most targets remain unmet, highlighting the need for accelerated and more targeted interventions. The scorecard analysis is structured to systematically evaluate performance across key commitments, with a focus on identifying trends, drivers of progress, and persistent bottlenecks.

It provides an in-depth examination of both programme effectiveness and structural constraints that continue to limit impact. By synthesizing achievements alongside ongoing challenges, the report offers a strategic, evidence-based foundation to inform policy refinement, programme prioritization, and resource allocation. It ultimately aims to support strengthened implementation and sustained momentum towards achieving epidemic control and ending AIDS as a public health threat by 2030.

2021 New UNAIDS Political Declaration on HIV and AIDS

Strengthening Accountability and Accelerating Progress

The 2021 Political Declaration on HIV and AIDS provides a comprehensive and time-bound framework for accelerating the global HIV response, with the goal of ending AIDS as a public health threat by 2030. Anchored within the Sustainable Development Goals and aligned to the Global AIDS Strategy, the declaration emphasizes the need to address persistent structural inequalities, strengthen health systems, and scale evidence-based interventions. Central to this approach is the prioritisation of equity, ensuring that populations most affected by HIV are reached through targeted and responsive programming, supported by high-quality data and continuous monitoring.

The Global AIDS Monitoring (GAM) framework serves as a critical accountability mechanism within this global architecture. It enables countries to systematically track progress against agreed targets, assess the effectiveness of national responses, and identify both achievements and persistent gaps. Through the integration of epidemiological data, programme performance indicators, and policy-level analysis, GAM provides a structured platform for evidence-based decision-making. The requirement for routine reporting further reinforces transparency and accountability, ensuring that national progress is continuously evaluated against global commitments and that corrective actions are identified in a timely manner.

In this context, this report plays a central role in assessing South Africa's response to the HIV epidemic. It provides a comprehensive analysis of progress across key commitment areas, examining not only the extent to which targets are being met, but also the underlying drivers of performance. This includes a detailed assessment of programme implementation, service delivery outcomes, and the broader enabling environment, including legal, policy, and regulatory frameworks. The analysis further interrogates persistent barriers—such as structural inequalities, access constraints, and system-level limitations—that continue to impede progress, particularly among priority and key populations. By combining quantitative trend analysis with qualitative insights, the report offers a nuanced understanding of South Africa's trajectory. It highlights areas of significant progress, while also identifying critical gaps that require intensified action. Importantly, the report moves beyond descriptive reporting to provide strategic interpretation of findings, linking observed outcomes to policy implementation, resource allocation, and programme design.

Key Focus Areas

The global HIV response, as articulated in the 2021 Political Declaration, is structured around eight interrelated priority areas that collectively define the scope of national and global action. These include combination HIV prevention, HIV testing and treatment, ending paediatric AIDS and eliminating vertical transmission, gender equality and empowerment, community leadership, human rights and stigma reduction, universal health coverage and service integration, and sustainable financing. These priority areas reflect a comprehensive and integrated approach to the HIV response, recognising that biomedical interventions alone are insufficient to achieve epidemic control. Instead, progress depends on the effective combination of biomedical, behavioural, and structural interventions, supported by enabling policies and sustained investments. The interdependence of these areas is critical; gaps in one domain—such as stigma, legal barriers, or financing—can significantly undermine progress in others. This report is therefore structured to assess progress across each of these areas, providing a detailed analysis of performance, trends over time, and the extent to which national strategies are effectively addressing the evolving dynamics of the epidemic.

Significance of the Report

This report provides critical insights into South Africa's progress in meeting its HIV response commitments, serving both as an accountability tool and as a strategic resource for programme improvement. It draws on national and subnational data sources to ensure a comprehensive and contextually relevant analysis, strengthening the accuracy of HIV estimates and enhancing the evidence base for decision-making. A key strength of the report lies in its focus on trend analysis, enabling the identification of patterns in performance over time and providing a clearer understanding of whether interventions are yielding the desired impact. By systematically assessing progress against established targets, the report highlights areas where South Africa is on track, as well as areas requiring accelerated action. In addition, the findings of this report are directly relevant to broader planning and resource mobilisation processes. The evidence generated supports the development and refinement of national strategies, informs the preparation of funding proposals and operational plans, and contributes to ongoing engagement with key stakeholders, including government, civil society, and development partners.

Policy and Programmatic Response

South Africa's response to HIV, tuberculosis (TB), and sexually transmitted infections (STIs) is guided by successive National Strategic Plans (NSPs), which provide a structured and multisectoral framework for implementation. These plans are designed to align national priorities with global commitments, ensuring that the country's response remains both contextually relevant and internationally comparable.

The NSP (2023–2028) represents a continuation and strengthening of previous efforts, with an increased emphasis on integration, equity, and sustainability. It outlines a comprehensive set of interventions aimed at reducing new infections, improving treatment outcomes, addressing social and structural determinants of health, and strengthening health systems. Central to this approach is the recognition that achieving epidemic control requires coordinated action across multiple sectors, including health, social development, education, and justice.

The South African National AIDS Council (SANAC) plays a critical role in coordinating this response, bringing together government, civil society, the private sector, and development partners within a unified governance framework. This collaborative model is essential for ensuring alignment of efforts, promoting accountability, and facilitating the effective implementation of interventions at scale. Despite this strong policy and institutional foundation, the magnitude and complexity of the HIV epidemic in South Africa continue to present significant challenges. Sustained political commitment, strategic resource allocation, and adaptive programme design remain essential to addressing persistent gaps and accelerate progress towards national and global targets.

Methods and Data Sources

A retrospective analytical approach was employed to assess progress across the political declaration commitments and corresponding frameworks, with a focus on measuring South Africa's performance against national and global HIV response targets. The methodology combined a comprehensive desktop review of key policy and programmatic documents—including legislation, strategies, guidelines, and technical reports—with quantitative comparative analysis of indicator data to assess trends over a five-year period. This mixed-methods approach enabled the triangulation of evidence, linking epidemiological outcomes with programme performance and the broader policy and implementation environment. Data used in this report were drawn from multiple validated national and international sources to ensure robustness and comparability. These included the Thembisa Model (Version 4.8), which provides the most comprehensive national estimates of HIV prevalence, incidence, and mortality; national policies, strategies, and guidelines governing the HIV, TB, and STI response; and data from national and biobehavioural surveys. Routine health system data were sourced from the District Health Management Information System (DHIS), complemented by programmatic data from implementing partners. Additional inputs were derived from scientific publications, peer-reviewed research, and global reporting frameworks and databases. By integrating these diverse data sources, the report provides a comprehensive and evidence-based assessment of South Africa's HIV response. The analytical approach enables not only the identification of progress and achievements, but also a deeper understanding of persistent gaps, emerging risks, and areas requiring strategic intervention to accelerate progress towards national and global targets.

Scorecard Analysis and Report Structure

This report is structured around a scorecard analysis of progress across each political declaration commitment, providing a systematic assessment of performance, trends, and gaps. Each section presents a detailed narrative that integrates epidemiological data, programme outcomes, and policy context, enabling a comprehensive evaluation of South Africa's response over time. In addition, the report provides an in-depth analysis of the HIV epidemic and response over the past five years, including:

- Trends in HIV prevalence, incidence, and AIDS-related mortality, as well as dynamics within key and priority populations
- Major achievements in scaling up treatment, prevention interventions, and policy and

programme innovations
- Persistent challenges, including uneven progress across populations and geographies, gaps in ART coverage and retention, structural inequalities, and health system constraints
- Strategic recommendations aimed at strengthening programme effectiveness, improving service integration, and ensuring sustainable financing

Overview of the epidemic in South Africa

While South Africa has made notable progress—particularly in achieving the first and third 95 targets, reducing mother-to-child transmission, and expanding prevention and treatment services—critical gaps remain. Persistent challenges include rising new infections among adolescent girls and young women, disparities in service access and outcomes among key populations, increasing STI burden, and ongoing health system pressures. These challenges are further compounded by emerging global and domestic financing constraints. Shifts in the global funding landscape in 2025, including reductions and uncertainties in external support from key partners such as PEPFAR and broader United States Government (USG) funding, have introduced additional pressures on programme sustainability. These changes have implications for service delivery continuity, workforce capacity, and the scale of prevention and treatment programmes, particularly those heavily reliant on donor support. As a result, there is an increased need for strategic prioritisation, improved efficiency, and strengthened domestic resource mobilisation to mitigate potential disruptions and sustain gains achieved to date.

As South Africa advances towards the 95-95-95 targets and broader epidemic control, there is a critical need for intensified, data-driven, and equity-focused interventions. Community-led approaches strengthened health system integration, and adaptive programme design will be essential to address remaining gaps. Sustained political leadership, coupled with resilient and diversified financing mechanisms, will be central to maintaining momentum. This report serves as a key accountability and strategic planning tool, tracking national progress while providing actionable insights to guide future interventions. By leveraging robust data, strengthening programme implementation, and responding proactively to emerging challenges—including shifts in the global funding environment—South Africa is positioned to accelerate progress towards ending HIV, TB, and STIs as public health threats by 2030.

SUMMARY OF PROGRESS TOWARDS POLITICAL DECLARATION AND FRAMEWORK TARGETS

Table 1 presents a consolidated scorecard analysis of South Africa's performance across the seven Political Declaration commitments (excluding Commitment 5), providing a structured assessment of national priorities, policy alignment, progress towards targets, and the likelihood of achieving these targets by 2025. The analysis demonstrates that all commitments remain high priorities for the country and are fully embedded within the National Strategic Plan (NSP) for HIV, TB, and STIs (2023–2028). However, despite this strong policy alignment, progress towards achieving most targets remains insufficient, with all commitments yet to be fully realized.

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 scorecard highlights a differentiated performance across commitment areas. South Africa is assessed as being on a positive trajectory towards achieving Commitment 2 (95–95–95 for HIV testing and treatment) and Commitment 7 (universal health coverage and integration), both of which are rated as "likely" to be achieved by 2025. For Commitment 2, substantial gains have been made in expanding HIV testing and achieving high levels of viral suppression, reflecting the maturity and scale of the national treatment programme. Nonetheless, gaps persist in the second 95—particularly in treatment initiation and retention—requiring continued focus on linkage to care, differentiated service delivery models, and adherence support. Similarly, progress under Commitment 7 reflects sustained investments in health system strengthening and service integration.

Ongoing reforms, including the advancement of the National Health Insurance (NHI) framework, signal a strong policy commitment to improving equitable access to comprehensive healthcare services. These efforts are beginning to translate into more integrated and people-centred service delivery models, although full realization of universal health coverage remains contingent on effective implementation and sustained financing.

In contrast, the remaining commitments, including combination prevention, pediatric HIV and vertical transmission, gender equality, human rights and stigma reduction, and sustainable financing—are all assessed as unlikely to meet their 2025 targets. These areas are characterized by persistent structural, behavioral, and system-level challenges, including uneven prevention coverage, ongoing gender and social inequalities, stigma and discrimination affecting service uptake, and increasing pressures on programme financing.

Overall, the scorecard underscores a critical disconnect between policy commitment and implementation outcomes. While South Africa has established a strong strategic and legislative foundation, accelerated and more targeted efforts are required to translate these commitments into measurable impact, particularly in prevention, equity, and sustainability domains.

Political Declaration and Framework 1: Combination HIV Prevention for All

South Africa has made measurable progress in reducing new HIV infections, with recent estimates indicating an overall decline of approximately 18%. However, this progress is uneven, with women aged 15+ and adults aged 50 and above experiencing slower declines, highlighting persistent prevention gaps. The national response, guided by the NSP 2023–2028, continues to emphasize combination prevention and structural interventions. Key policy and programmatic advances include the implementation of the National Drug Master Plan (NDMP), ongoing population size estimations, and Biological and Behavioural Surveys (BBS) to better inform programming for key populations. Community-led initiatives such as the Community-Oriented Substance Use Programme (COSUP) and SANPUD have strengthened harm reduction and advocacy for people who use drugs. Core prevention strategies—such as prevention of vertical transmission (PMTCT/VTP), voluntary medical male circumcision (VMMC), condom distribution, and expanded access to PrEP and PEP—continue to drive reductions in new infections. However, recent financing data National AIDS Spending Assessment+ (NASA+)-2021/22 to 2023/24 indicate that prevention remains underfunded relative to treatment, posing a risk to sustained incidence reduction.

Political Declaration and Framework 2: 95-95-95 for HIV Testing and Treatment

As of 2023/24, South Africa's HIV cascade stands at approximately 95-81-91, reflecting strong performance in HIV diagnosis and viral suppression but continued gaps in treatment coverage.

- 95% of people living with HIV (PLHIV) know their status
- 81% are on ART (below the 95% target)
- 91% of those on ART are virally suppressed

Recent programme data (2024) show continued improvements in viral suppression, supported by Direct Service Delivery (DSD) models and Multi Month Dispensing (MMD). However, the second 95 remains the key bottleneck, particularly among children and key populations. Addressing linkage to care, retention, and adherence remains critical to achieving full epidemic control.

Political Declaration and Framework 3: End Paediatric AIDS and Eliminate Vertical Transmission

South Africa has made strong progress in paediatric HIV and vertical transmission. By 2024, MTCT declined to approximately 2.63%, reflecting sustained success in PMTCT programmes. Thembisa Version 4.8 estimates indicate that approximately ~170,000 children (0–14 years) are living with HIV, with continued reductions in new infections.

Legal protections under the Children's Act (2010) ensure non-discrimination, while expanded early infant diagnosis and maternal ART coverage have improved outcomes. However, children still lag adults across the treatment cascade, requiring intensified efforts in early diagnosis, treatment initiation, and retention.

Political Declaration and Framework 4: Gender Equality and Empowerment of Women and Girls

South Africa maintains a strong legislative framework to address gender inequality and Gender Based Violence (GBV), including the Domestic Violence Act (1998), Sexual Offences Act (2007), and the National Strategic Plan on GBV and Femicide (2020–2030). Despite this, GBV remains a major driver of HIV risk. Approximately 29.1% of women aged 15–49 have experienced intimate partner violence (Simbayi et al., 2019), with increases observed during the COVID-19 period (Gill, 2021). Recent crime statistics show 53,773 sexual offences reported in 2023/24, reflecting persistent high levels of violence (SAPS, 2023/24). These trends underscore the need for stronger GBV prevention, survivor support, and integration of HIV and GBV services, particularly for Adolescent Girls and Young Women (AGYW) and vulnerable groups.

Political Declaration and Framework 5: Community Leadership

This framework was not required for reporting during the current review period. However, community-led responses remain central to the NSP 2023–2028, particularly for key populations and prevention programmes.

Political Declaration and Framework 6: Human Rights, Stigma, and Discrimination

South Africa continues to lead in legal protections, including constitutional safeguards against discrimination based on sex, gender, and sexual orientation, supported by the Promotion of Equality and Prevention of Unfair Discrimination Act (2000). However, stigma remains pervasive, particularly for MSM, sex workers, and people who use drugs, who continue to face discrimination in healthcare and communities (Ritcher, 2008; Parry et al., 2009; Lane et al., 2008; Scheibe et al., 2016). These barriers undermine service uptake and retention, highlighting the need for stronger enforcement, provider training, and community sensitisation.

Political Declaration and Framework 7: Universal Health Coverage and Integration

South Africa continues to advance toward Universal Health Coverage (UHC), with healthcare expenditure estimated at ~8.9% of Gross Domestic Product (GDP). The NSP 2023–2028 emphasizes integration of HIV, TB, STIs, and non-communicable diseases, including cervical cancer and HPV services. The UHC service coverage index improved from 36 (2000) to 67 (2020), reflecting strengthened health system performance. Ongoing reforms, including the rollout of National Health Insurance (NHI) and decentralised Multidrug-resistant tuberculosis (MDR-TB) care, support integrated and equitable service delivery.

Political Declaration and Framework 8: Investments and Resources

South Africa's HIV response is now largely domestically financed, with total HIV expenditure stabilising at approximately R38–39 billion annually NASA+ Report (2021/22–2023/24). Government contributes the majority share (~75–76%), while external partners—including PEPFAR, USAID, and the Global Fund—provide targeted support.

However, updated NASA+ findings highlight key risks:

- Over 70% of funding is allocated to treatment, with prevention underfunded
- Continued reliance on donor funding for key population and community programmes
- Potential risks associated with future USG funding reductions (post-2025)

While earlier projections suggested that scaling HIV programmes is financially feasible, recent fiscal pressures and budget constraints—alongside reductions in provincial allocations—may impact service delivery.

Overall Synthesis

South Africa has achieved substantial progress across all political declaration pillars, particularly in diagnosis, treatment scale-up, MTCT reduction, and domestic financing. However, the response is entering a critical phase where prevention gaps, funding imbalances, and structural barriers must be addressed. Sustained progress toward 2030 will require:

- Rebalancing investments toward prevention and key populations
- Strengthening ART coverage and retention (second 95)
- Managing donor transition risks, particularly USG funding
- Addressing GBV, stigma, and social determinants
- Enhancing integration and efficiency within the health system

By aligning financing, programming, and policy with epidemiological realities, South Africa remains well-positioned to achieve epidemic control by 2030.

OVERVIEW OF THE HIV/AIDS EPIDEMIC IN 2024

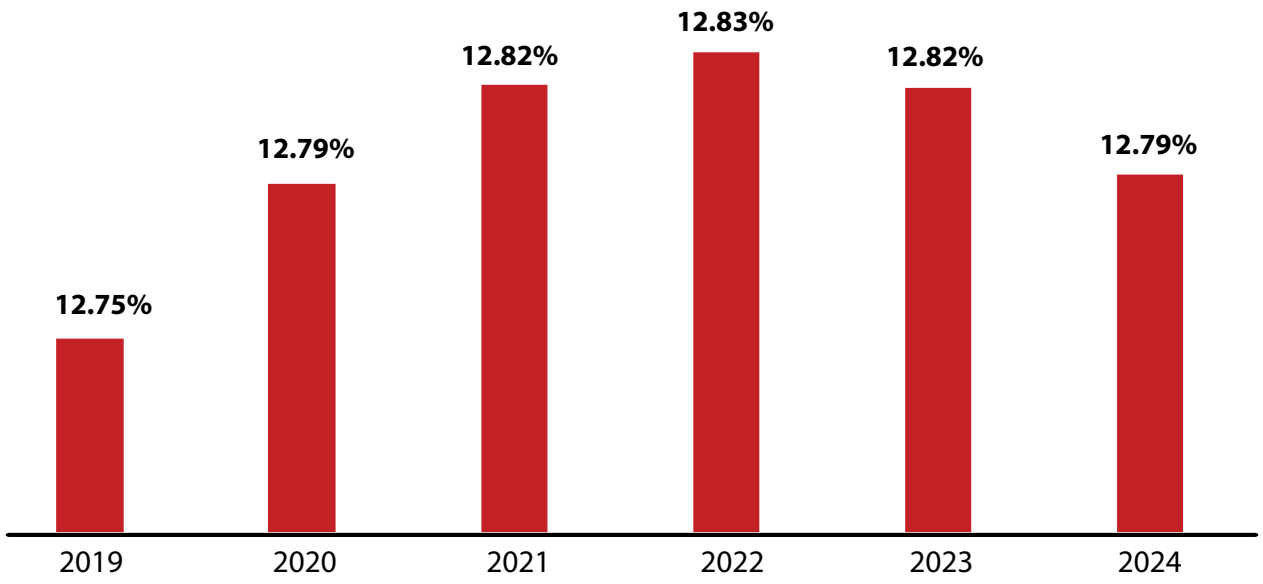
SOUTH AFRICA HIV PREVALENCE TRENDS

Achieving HIV epidemic control requires sustained reductions in new infections to levels below AIDS-related mortality, alongside high levels of population-wide viral suppression among people living with HIV (PLHIV). This dual objective remains central to South Africa's HIV response, where the scale and complexity of the epidemic continue to shape both national and global trajectories. South Africa remains the country with the largest HIV burden globally, accounting for a substantial share of both people living with HIV and new infections. As such, national trends in prevalence and incidence are critical indicators of progress towards epidemic control.

As illustrated in Figure 1, HIV prevalence in South Africa has remained relatively stable over the period 2019 to 2024, increasing slightly from 12.75% in 2019 to a peak of 12.83% in 2022, followed by a modest decline to 12.79% in 2024. This overall plateauing of prevalence reflects a maturing epidemic, where gains in treatment coverage and survival among PLHIV offset reductions in new infections. While the recent decline is encouraging, the relatively narrow fluctuation over time indicates that reductions in incidence have not yet translated into a substantial downward shift in overall prevalence. At the same time, the number of individuals accessing antiretroviral therapy (ART) has continued to expand significantly, increasing from approximately 5.1 million in 2019 to over 5.8 million in 2023, representing a sustained scale-up of the national treatment programme (Thembisa Model 4.8). This expansion has been critical in reducing AIDS-related mortality and improving viral suppression but also contributes to maintaining higher prevalence levels due to increased survival.

Reductions in HIV incidence over the same period have been driven by the continued scale-up of combination prevention strategies. These include the expansion of prevention of vertical transmission (PVT) services, voluntary medical male circumcision (VMMC), increased uptake of pre-exposure prophylaxis (PrEP) among high-risk populations, and improved access to post-exposure prophylaxis (PEP), particularly for survivors of sexual violence. The sustained rollout of ART has also played a central role in reducing onward transmission through viral suppression.

Figure 1: South Africa HIV prevalence (2019-2024)



Source: Thembisa Model ver. 4.8

Despite these gains, transmission dynamics remain uneven and concentrated within specific populations. In 2023, South Africa recorded approximately 181,376 new HIV infections, with women aged 15 years and older accounting for nearly 60% of these cases. Children under 15 years represented a smaller but still significant proportion of new infections. Individuals aged 15–49 years continue to account for most new infections, underscoring the ongoing vulnerability of the sexually active population. A key programmatic gap remains the second "95" target, relating to treatment coverage. While testing uptake and viral suppression rates are high, challenges in treatment initiation, retention in care, and adherence persist. These are influenced by a range of factors, including health system access barriers, socio-economic constraints, stigma, and psychosocial challenges, all of which contribute to interruptions in treatment and suboptimal outcomes.

Geographical disparities further highlight the heterogeneity of the epidemic. Provinces such as Mpumalanga continue to experience higher incidence rates, while the Western Cape reports comparatively lower levels. Over the longer term, KwaZulu-Natal has achieved the most substantial reductions in incidence, whereas provinces such as Western Cape, Limpopo, and Northern Cape have experienced slower rates of decline, indicating the need for more targeted and context-specific interventions. Key populations remain disproportionately affected by HIV, reflecting persistent structural and social vulnerabilities. HIV prevalence among female sex workers is estimated at approximately 54%, while prevalence among men who have sex with men (MSM) remains high at around 30%. Among women aged 25–49 years, prevalence is estimated at approximately 30%, significantly higher than among men and children. These disparities underscore the importance of targeted, differentiated, and rights-based approaches to prevention and treatment. Overall, while South Africa has made important progress in stabilizing the epidemic and expanding treatment coverage, the persistence of high prevalence levels and concentrated transmission among vulnerable populations highlights the need for intensified prevention efforts, improved treatment continuity, and a stronger focus on addressing structural drivers of the epidemic.

SOUTH AFRICA HIV PREVALENCE BY SEX AND AGE

Table 2 presents a detailed analysis of HIV prevalence by age and sex over the period 2019 to 2024, highlighting important demographic patterns and shifts in the epidemic. Overall, total HIV prevalence has remained stable at approximately 12.8% across the period, masking significant variations by age and sex. A consistent decline in HIV prevalence is observed among children and younger populations. Among children under 15 years, prevalence declined steadily from 1.6% in 2019 to 0.9% in 2024, reflecting sustained progress in prevention of vertical transmission and early infant diagnosis and treatment. Similarly, prevalence among youth aged 15–24 years decreased from 7.3% to 6.4% over the same period, with notable reductions among females in this age group (from 10.8% to 9.1%). These trends suggest that targeted prevention interventions for younger populations are yielding positive results, particularly those focused on reducing new infections and improving access to prevention services. Among the broader reproductive age group (15–49 years), HIV prevalence has also declined, from 18.8% in 2019 to 17.5% in 2024. This decline is evident for both males and females, although prevalence remains significantly higher among females. For females aged 15–49, prevalence decreased from 24.7% to 23.5%, while among males it declined more sharply from 12.7% to 11.5%. These patterns continue to reflect the disproportionate burden of HIV among women, particularly within the 25–49 age group, where prevalence remains high despite gradual reductions

over time. In contrast, HIV prevalence among adults aged 50 years and older has increased markedly over the review period, rising from 11.7% in 2019 to 16.0% in 2024. This upward trend is observed for both males and females, with prevalence among females aged 50+ increasing from 12.4% to 17.4%, and among males from 10.7% to 14.1%. This shift reflects the ageing of the HIV-positive population, driven by improved survival due to sustained access to antiretroviral therapy, as well as ongoing, albeit lower, levels of new infections within this age group.

At the aggregate level, HIV prevalence among individuals aged 15 years and older shows diverging trends by sex. Prevalence among males aged 15+ declined from 12.3% in 2019 to 12.0% in 2024, whereas prevalence among females aged 15+ increased slightly from 21.5% to 21.9% and has plateaued at this higher level since 2022. This pattern suggests that, despite overall gains in prevention and treatment, gender disparities in HIV burden persist, with women continuing to experience disproportionately higher prevalence. Overall, the data indicate meaningful progress in reducing HIV prevalence among younger populations and within key reproductive age groups, reflecting the impact of sustained prevention and treatment interventions. However, the continued high burden among women, coupled with the rapid increase in prevalence among older adults, highlights the need for more differentiated, age- and gender-responsive strategies. Addressing these dynamics will be critical to sustaining progress and ensuring that gains are equitably distributed across all population groups.

Table 2: HIV prevalence by age and sex (2019-2024)

INDICATOR	2019	2020	2021	2022	2023	2024
Total HIV prevalence	12,8%	12,8%	12,8%	12,8%	12,8%	12,8%
HIV prevalence in males aged 15+	12,3%	12,3%	12,3%	12,2%	12,2%	12,0%
HIV prevalence in females aged 15+	21,5%	21,7%	21,8%	21,9%	21,9%	21,9%
Prevalence in children (<15)	1,6%	1,4%	1,3%	1,2%	1,0%	0,9%
Prevalence in youth (15-24)	7,3%	7,2%	7,0%	6,8%	6,6%	6,4%
Prevalence in males aged 15-24	3,8%	3,8%	3,8%	3,8%	3,7%	3,7%
Prevalence in females aged 15-24	10,8%	10,5%	10,2%	9,9%	9,5%	9,1%
Prevalence in age group 15-49	18,8%	18,6%	18,4%	18,2%	17,9%	17,5%
Prevalence in males aged 15-49	12,7%	12,6%	12,4%	12,1%	11,8%	11,5%
Prevalence in females aged 15-49	24,7%	24,6%	24,4%	24,2%	23,8%	23,5%
Prevalence in age group 25-49	23,9%	23,7%	23,4%	23,0%	22,7%	22,3%
Prevalence in males aged 25-49	16,8%	16,5%	16,1%	15,7%	15,3%	14,9%
Prevalence in females aged 25-49	30,9%	30,8%	30,5%	30,2%	29,9%	29,5%
Prevalence at ages 25+	20,2%	20,3%	20,3%	20,4%	20,4%	20,4%
Prevalence in adults aged 50+	11,7%	12,5%	13,3%	14,2%	15,1%	16,0%
Prevalence in males aged 50+	10,7%	11,4%	12,1%	12,8%	13,5%	14,1%
Prevalence in females aged 50+	12,4%	13,2%	14,2%	15,3%	16,3%	17,4%

Source: Thembisa Model ver. 4.6

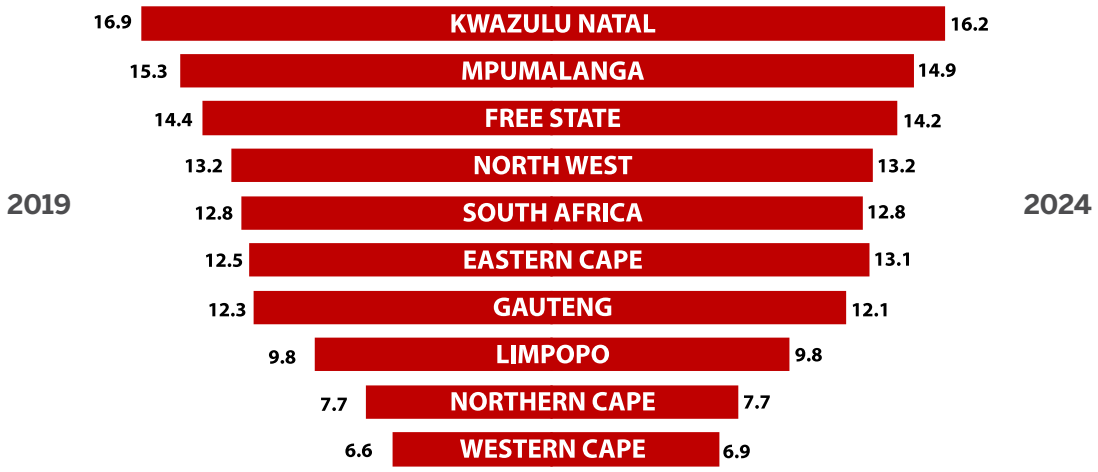
HIV PREVALENCE BY GEOGRAPHICAL AREAS

South Africa HIV prevalence trends by province

Figure 2 illustrates provincial variations in HIV prevalence between 2019 and 2024, highlighting both areas of progress and persistent disparities across regions. KwaZulu-Natal and Mpumalanga continue to report the highest HIV prevalence in the country, despite modest declines over the review period. KwaZulu-Natal's prevalence decreased from 16.9% in 2019 to 16.2% in 2024, while Mpumalanga declined from 15.3% to 14.9%. These provinces remain central to the national epidemic, reflecting a sustained high burden of HIV. Free State and North West also continue to report relatively high prevalence levels, with Free State showing a slight decline from 14.4% to 14.2%, while North West remained stable at 13.2% over the period. At the national level, HIV prevalence remained unchanged at 12.8%, reinforcing the broader trend of a stabilizing epidemic.

Provincial trends, however, are not uniform. The Eastern Cape is the only province demonstrating a notable increase in prevalence, rising from 12.5% in 2019 to 13.1% in 2024. In contrast, Gauteng experienced a slight decline from 12.3% to 12.1%. Limpopo and Northern Cape remained stable over time at 9.8% and 7.7%, respectively, indicating limited change in epidemic dynamics within these regions. The Western Cape, while maintaining the lowest HIV prevalence nationally, showed a slight increase from 6.6% to 6.9%. These variations reflect a complex interplay of epidemiological and programmatic factors, including differences in prevention coverage, testing uptake, treatment access and retention, as well as population mobility and demographic dynamics. Increases or stability in prevalence in certain provinces may also reflect improved survival due to expanded ART coverage, alongside enhanced case identification through broader testing strategies. Overall, the provincial analysis highlights the persistent geographic heterogeneity of the HIV epidemic in South Africa. While progress has been achieved in reducing prevalence in several high-burden provinces, the uneven pace of change and increases in specific regions underscore the need for more targeted, province-specific responses. Strengthening differentiated prevention strategies, improving treatment continuity, and tailoring interventions to local epidemic profiles will be critical to accelerating progress and reducing disparities across provinces.

Figure 2: South Africa HIV prevalence by province and year



Source: Thembisa Model ver. 4.8

South Africa HIV prevalence by district

Estimates from the Naomi Model (December 2024) highlight substantial variation in the distribution of people living with HIV (PLHIV) across South Africa's districts (Figure 3). The data demonstrates a highly concentrated epidemic, with a disproportionate share of the national burden located in a limited number of densely populated urban and peri-urban districts. These patterns underscore the continued importance of geographically targeted responses to maximize programme impact. The highest absolute numbers of PLHIV are concentrated in major metropolitan districts. Johannesburg (Gauteng) remains the district with the largest burden, followed by eThekwini (KwaZulu-Natal), both with estimated PLHIV populations exceeding 600,000.

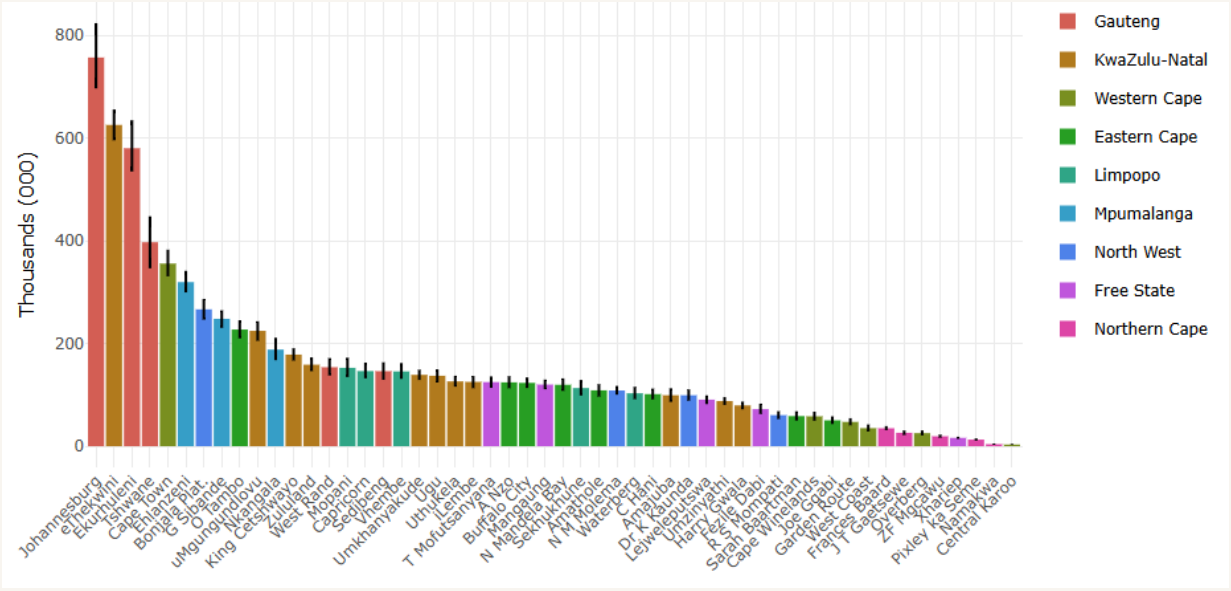
Other metropolitan districts—including Ekurhuleni and Tshwane in Gauteng, and Cape Town in the Western Cape—also contribute significantly to the national burden, each with large populations of PLHIV. Secondary urban centres such as Buffalo City (Eastern Cape) and districts within Mpumalanga and KwaZulu-Natal further reinforce the concentration of the epidemic in urbanized settings. At the provincial level, Gauteng accounts for the largest share of PLHIV, driven by its high population density and urban migration patterns, with Johannesburg, Ekurhuleni, and Tshwane collectively representing a substantial proportion of the national total. KwaZulu-Natal continues to carry a significant burden, with eThekwini and surrounding districts remaining key contributors.

Mpumalanga and Eastern Cape also contribute meaningfully, with districts such as Ehlanzeni and Buffalo City reflecting high absolute numbers relative to population size. In contrast, districts within provinces such as Limpopo, Northern Cape, and parts of the Free State report lower absolute numbers of PLHIV. While this partly reflects smaller population sizes, it may also indicate disparities in access to testing, diagnosis, and treatment services, particularly in more rural and hard-to-reach areas.

These findings have important implications for service delivery and resource allocation. The concentration of PLHIV in high-burden metropolitan districts supports a "focus for impact" approach, prioritizing intensified prevention, testing, and treatment interventions in these areas to maximize population-level outcomes. At the same time, sustained efforts are required to expand service access in lower-burden and rural districts to address potential gaps in case detection and continuity of care.

Differentiated service delivery models remain central to this approach, including community-based ART delivery, decentralized treatment services, and mobile outreach strategies to improve access among underserved populations. Strengthening linkage to care, retention, and adherence, particularly in high-mobility urban settings—will be critical to achieving sustained viral suppression at scale. Overall, the district-level distribution of PLHIV highlights the need for a dual strategy: intensifying interventions in high-burden urban districts while simultaneously strengthening equitable access to services in rural and underserved areas. A data-driven, geographically targeted response will be essential to accelerating progress towards epidemic control and achieving national HIV targets.

Figure 3: People living with HIV, age 15+, September 2024



Source: Naomi Model[3]

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

https://www.hivdata.org.za/[1]

LEGAL AND POLICY ENVIRONMENT

South Africa's legal and regulatory framework for HIV prevention has evolved significantly over time, reflecting a sustained commitment to reducing new infections through a comprehensive and multi-sectoral approach. Policy development has increasingly focused on addressing the needs of high-risk and priority populations, including adolescents and young people (15–24 years), children, pregnant women, and key populations. As illustrated in Figure 4, a range of national policies, strategies, and guidelines have been developed to support the scale-up of prevention, testing, and treatment services. Key national frameworks—including the National Strategic Plan (NSP) for HIV, TB, and STIs, the National Drug Master Plan (NDMP), and the National Sex Worker HIV Plan—have provided a strong foundation for the national response. These policies have enabled the expansion of HIV services and strengthened targeted interventions for key populations. Advocacy efforts have further supported improved inclusion of vulnerable groups within the national response, although gaps in equitable access and service coverage remain.

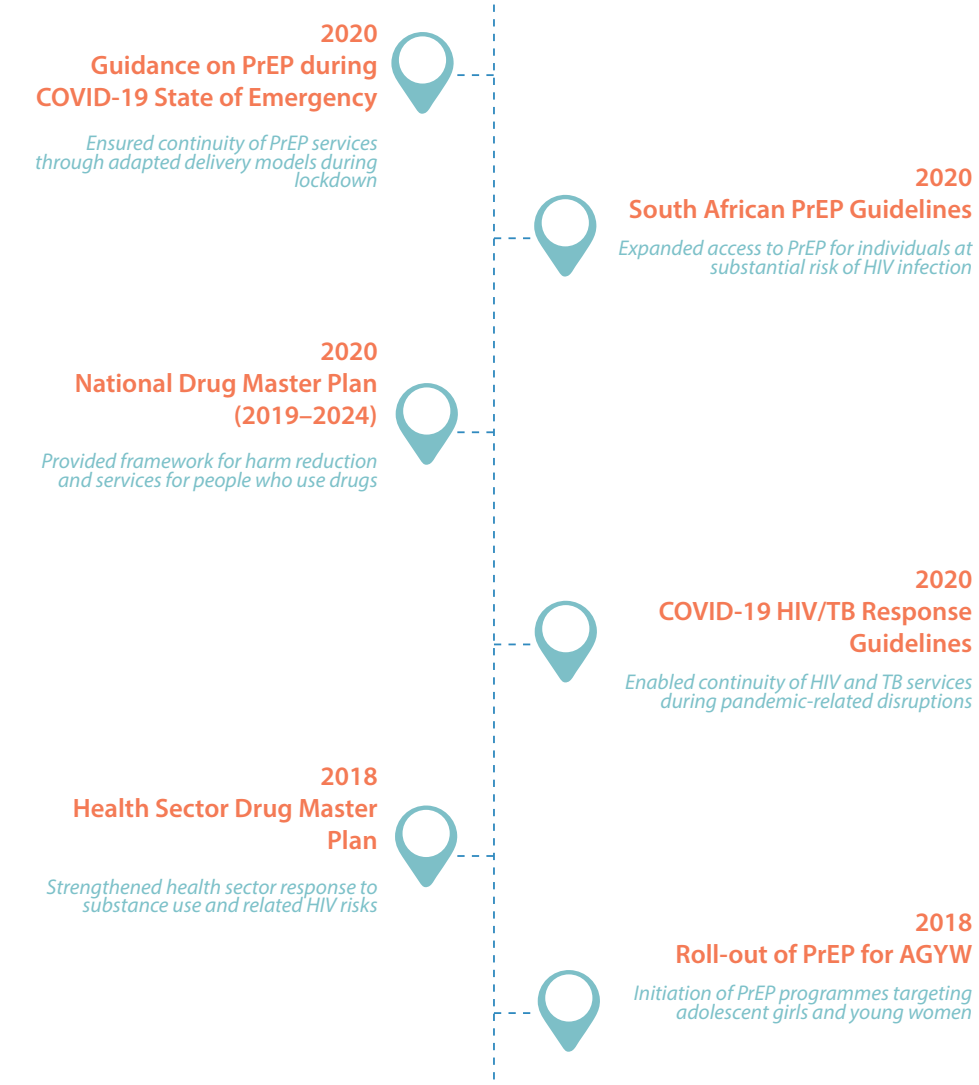
Progress has been particularly notable in harm reduction for people who use drugs (PWUD). The implementation of the National Drug Master Plan (2019–2024), supported by evidence from population size estimates and biological and behavioural surveys, has facilitated the introduction of targeted interventions. Community-led structures such as the South African Network of People Using Drugs (SANPUD), alongside programme platforms like Community Orientated Substance Use Programme (COSUP), have contributed to expanding access to harm reduction services, although scale-up remains uneven. South Africa has also strengthened its policy response to structural drivers of HIV, particularly gender-based violence (GBV) and intimate partner violence (IPV). The National Strategic Plan on GBV and Femicide (2020–2030) provides a framework for addressing these issues through improved legal protections, expanded survivor services, and strengthened multi-sectoral coordination.

The COVID-19 pandemic required rapid policy adaptation to maintain continuity of HIV and TB services. Emergency guidelines were introduced to support continued access to PrEP, ART, and other essential services, including the use of differentiated service delivery models. These measures mitigated the impact of service disruptions and reinforced the resilience of the health system. However, the policy and programmatic environment has been increasingly challenged

[1]https://www.hivdata.org.za/

by shifts in the global funding landscape. Overall, while South Africa has established a robust and progressive policy framework, challenges remain in ensuring consistent implementation, sustainable financing, and equitable access to services. Addressing these gaps will be essential to sustaining progress and accelerating efforts towards epidemic control.

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



Source: Authors

HIV INCIDENCE

Table 3 presents trends in new HIV infections in South Africa between 2019 and 2024, showing a sustained decline across most population groups. Total new HIV infections decreased from 212,690 in 2019 to 172,994 in 2024, representing an overall reduction of 19%. This decline reflects the continued impact of combination prevention strategies, expanded access to antiretroviral therapy (ART), and improvements in viral suppression, all of which contribute to reducing onward transmission. Reductions in new infections are observed across both sexes, although disparities persist. Among males aged 15 years and older, new infections declined by 23% over the period, compared to a 16% reduction among females. Despite this progress, females continue to account for a disproportionate share of new infections, with over 107,000 new infections recorded among women aged 15+ in 2024 alone.

This pattern underscores the ongoing vulnerability of women, particularly in the context of structural and socio-economic risk factors. Encouraging declines are also evident among younger populations. New infections among children under 15 years decreased by 21%, reflecting the continued success of prevention of vertical transmission programmes. Similarly, among youth aged 15–24 years, new infections declined by 16%, with reductions observed for both males (19%) and females (15%). However, young women continue to bear a significantly higher burden, accounting for many infections within this age group.

Among the broader 15–49 age group, which represents the core of the epidemic, new infections declined by 19%, from 191,090 in 2019 to 154,194 in 2024. The most substantial reductions were observed among males aged 25–49 years, where new infections declined by 26%, compared to a 19% reduction among females in the same age group. These trends suggest that prevention and treatment interventions targeting adult populations are having a measurable impact, although gender disparities remain evident. In contrast, progress among older adults has been limited. New infections among individuals aged 50 years and older declined by only 4% overall. Notably, infections among males aged 50+ decreased by 12%, while infections among females in this age group increased slightly by 1% over the period. This highlights an emerging gap in prevention efforts, as older women are not experiencing the same level of benefit from current interventions as other groups.

Trends among key populations further illustrate areas of concern. New infections among female sex workers (FSWs) declined modestly by 6%, while infections acquired by men through contact with FSWs decreased more substantially by 24%, suggesting some impact of targeted prevention efforts within transmission networks. However, new infections among men who have sex with men (MSM) remained relatively stable, with only a 4% decline over the period and a slight increase observed between 2023 and 2024. This indicates persistent gaps in reaching MSM with effective prevention and treatment services.

Overall, while the downward trend in new HIV infections is a positive indicator of progress, the rate of decline remains insufficient to achieve epidemic control within the targeted timeframe. Persistent disparities by sex, age, and population group highlight the need for more targeted, differentiated, and equity-focused interventions. Strengthening prevention efforts among adolescent girls and young women, expanding tailored services for key populations, and addressing emerging gaps among older adults will be critical to sustaining and accelerating reductions in HIV incidence.

Table 3: Number of new HIV infections and percentage change (2019-2024)

NUMBER OF NEW INFECTIONS IN SOUTH AFRICA BY SEX AND AGE	2019	2020	2021	2022	2023	2024	% CHANGE (2018-2022)
Total new HIV infections	212 690	201 637	192 926	185 013	178 355	172 994	-19%
New infections in males aged 15+	73 449	69 038	65 544	61 993	58 916	56 548	-23%
New infections in females aged 15+	127 575	121 501	116 792	112 874	109 779	107 231	-16%
New HIV infections in children <15	11 666	11 098	10 590	10 146	9 660	9 215	-21%
New HIV infections in 15-24 year olds	88 119	82 754	79 152	76 483	75 039	74 352	-16%
New HIV infections in 15-24 males	20 314	18 887	17 982	17 194	16 736	16 553	-19%
New HIV infections in 15-24 females	67 805	63 866	61 170	59 289	58 303	57 800	-15%
New HIV infections in 15-49 year olds	191 090	180 691	172 554	165 136	159 020	154 194	-19%
New HIV infections in 15-49 males	69 731	65 431	62 037	58 570	55 570	53 267	-24%
New HIV infections in 15-49 females	121 359	115 260	110 517	106 566	103 450	100 927	-17%
New HIV infections in 25-49 year olds	102 971	97 937	93 402	88 653	83 981	79 842	-22%
New HIV infections in 25-49 males	49 418	46 543	44 055	41 376	38 835	36 715	-26%
New HIV infections in 25-49 females	53 554	51 394	49 348	47 277	45 146	43 127	-19%
New HIV infections in adults aged 50+	9 934	9 849	9 782	9 731	9 675	9 585	-4%
New HIV infections in males aged 50+	3 718	3 608	3 507	3 423	3 345	3 281	-12%
New HIV infections in females aged 50+	6 216	6 241	6 275	6 309	6 330	6 304	1%
New HIV infections in FSWs	2 535	2 546	2 527	2 463	2 416	2 381	-6%
New HIV infections acquired by men from FSW contact	17 591	16 765	15 969	15 047	14 142	13 368	-24%
New HIV infections in MSM	5 910	5 760	5 712	5 616	5 590	5 647	-4%
New HIV infections in MSM	5,705	5,563	5,429	5,347		-9%	

Source: Thembisa Model ver. 4.8

ESTIMATES OF THE SIZE OF KEY POPULATIONS

Table 4 provides a comprehensive overview of key population dynamics in South Africa, including population size estimates (PSE), HIV incidence, HIV prevalence, testing coverage, condom use, and prevention programme reach. These data are critical for understanding the distribution of HIV risk and for informing targeted, high-impact interventions aimed at populations that continue to experience a disproportionate burden of infection.

HIV Incidence and Population Size Estimates

South Africa has achieved a sustained decline in HIV incidence over time, decreasing from 0.48% in 2018 to 0.28% in 2023, before rising slightly to 0.32% in 2024 (Thembisa Model 4.8). While the overall downward trend reflects the impact of national prevention and treatment strategies, the recent increase signals potential slowing of progress and highlights the need for renewed focus, particularly among key populations. Population size estimates for key populations have improved in recent years but remain uneven across groups. Estimates indicate a notable increase in key population sizes over time, with the number of sex workers rising from approximately 144,701 in 2020 to 165,472 in 2024, while estimates for men who have sex with men (MSM) grew from 382,737 to 416,381 over the same period. These increases likely reflect both improved estimation methodologies and a more accurate representation of the underlying population. In contrast, data for people who

inject drugs (PWID) and transgender populations remain outdated or incomplete beyond 2021, indicating persistent gaps in surveillance systems. The prison population has remained relatively stable, with over 156,000 individuals recorded in 2024, underscoring the continued importance of HIV services within correctional settings.

HIV Prevalence Among Key Populations

HIV prevalence remains significantly higher among key populations compared to the general population, although some improvements are evident. Among sex workers, prevalence declined from 63.2% in 2018 to 53.6% in 2023, but increased again to 57.8% in 2024, indicating ongoing vulnerability and potential service or prevention gaps. Among MSM, prevalence has shown a gradual decline from 32.1% in 2018 to 27.5% in 2024, although levels remain high relative to the general population. Data for other key populations are more limited and less consistent. Available estimates suggest high HIV prevalence among transgender individuals, reaching approximately 58% in 2024, although trend data are incomplete. Among prisoners, prevalence estimates vary significantly over time, with earlier estimates exceeding 19%, and a more recent estimate of 7% in 2024, suggesting possible differences in measurement approaches or improved treatment coverage within correctional services. For PWID, the absence of recent prevalence data continues to limit understanding of trends within this population.

HIV Testing and Service Coverage

HIV testing coverage among key populations shows mixed progress. Sex workers have historically achieved high testing coverage, reaching 95% of PLHIV diagnosed in 2021, but this declined significantly to 81% in 2024, indicating a concerning drop in case identification. Among MSM, testing coverage improved steadily to 90% in 2023, before declining to 86% in 2024, suggesting potential disruptions in service delivery or reduced access. Testing coverage for PWID and transgender populations remains highly variable and, in some cases, critically low. For example, programme data indicate extremely low levels of diagnosis among transgender individuals in 2022, with improvements observed in 2024 (89%), although inconsistencies in data sources limit comparability. Overall, these patterns point to ongoing barriers in access to testing and linkage to care for certain key populations.

Condom Use and Prevention Programme Coverage

Data on condom use and prevention programme coverage remain limited and outdated for most key populations. Available data from 2021 indicate that condom use was relatively high among sex workers (76%) and MSM (74%), with a more recent estimate for MSM of 71.8% in 2024. However, the absence of consistent and recent data across populations limits the ability to assess trends and programme effectiveness. Coverage of HIV prevention programmes remains uneven and generally low. The most recent available data (2021) indicate that only 31% of MSM, 21.8% of PWID, and 2.2% of transgender individuals were reached by prevention programmes. The absence of updated data beyond 2021 further highlights significant gaps in routine monitoring and reporting.

Implications

Despite overall progress in reducing HIV incidence at the population level, key populations continue to experience a disproportionately high burden of HIV, with persistent gaps in prevention, testing, and service coverage. Declines in testing coverage among sex workers and MSM, combined with limited data availability for PWID and transgender populations, raise concerns about potential reversals in progress.

Addressing these challenges will require a strengthened, data-driven approach that prioritises:

- Improved and regular population size estimation and surveillance for all key populations
- Expanded and sustained access to HIV testing and prevention services, particularly for underserved groups such as PWID and transgender individuals
- Increased coverage of prevention interventions, including condom distribution, PrEP, and harm reduction services
- Strengthened programme monitoring systems to ensure timely and reliable data for decision-making

A focused and differentiated response, supported by improved data systems and targeted resource allocation, will be essential to reducing HIV transmission and ensuring equitable access to services 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	2024	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	0.28%	Thembisa Model V4.7	0.32%	Thembisa Model V4.8
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 Fransisco (2021) Consensus Cascades	155,546	Thembisa Model V4.8	160,588	Thembisa Model V4.8	165,472	Thembisa Model V4.8
MSM	No data	n/a	No data	n/a	309,686	JHU	309,686	University of California, San Fransisco (2021) Consensus Cascades	398,190	Thembisa Model V4.8	406,994	Thembisa Model V4.8	416,381	Thembisa Model V4.8
PWID	No data	n/a	No data	n/a	82,500	GI	82,500	University of California, San Fransisco (2021) Consensus Cascades	No data	n/a	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 Fransisco (2021) Consensus Cascades	No data	n/a	No data	n/a	No data	n/a
Prisoners	164,129	DCS	162,875	DCS	154,449	DCS	140,948	DCS Annual Report	143,223	DCS	157,056	DCS Annual Report	156,600	DCS Annual Report

INDICATORS	2018	DATA SOURCE	2019	DATA SOURCE	2020	DATA SOURCE	2021	SOURCE	2022	DATA SOURCE	2023	DATA SOURCE	2024	DATA SOURCE
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	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	No data	n/a
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	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	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	7%	UNAIDS Online tool
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	93.9%	Thembisa Model V4.7	81%	UNAIDS Online tool
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%	Thembisa Model V4.7	86%	UNAIDS Online tool
PWID	69.2%	KP Consensus Estimates	No data	n/a	No data	n/a	79.8%	UNAIDS Fact Sheet	30.4%	Programme Data	No data	n/a	No data	n/a
Transgender people	No data	n/a	96%	Botshelo Ba Trans	No data	n/a	no data	n/a	2.3%	Programme data (GF)	No data	n/a	89%	UNAIDS Online tool
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	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	71.8%	UNAIDS Online tool
PWID	No data	n/a	No data	n/a	No data	n/a	no data	n/a	No data	n/a	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	No data	n/a

INDICATORS	2018	DATA SOURCE	2019	DATA SOURCE	2020	DATA SOURCE	2021	SOURCE	2022	DATA SOURCE	2023	DATA SOURCE	2024	DATA SOURCE
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	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	No data	n/a
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	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	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 HIV response, given the heightened vulnerability of incarcerated populations. Table 5 highlights both progress and persistent gaps across key service areas, particularly in relation to prevention interventions. Prevention services within correctional facilities remain limited in scope. Notably, there has been no implementation of needle and syringe programmes or opioid agonist maintenance therapy across the reporting period, with zero coverage recorded from 2022 to 2024. This represents a significant gap in harm reduction services, particularly for populations at risk of injecting drug use within closed settings.

Condom distribution, one of the primary HIV prevention measures in correctional facilities, has shown variability over time. Following a decline between 2018 and 2020, distribution increased significantly in 2022 (over 2.5 million condoms), declined again in 2023, and partially recovered in 2024 to approximately 2.2 million. While this recovery is encouraging, the fluctuations indicate inconsistencies in prevention programme implementation, which may undermine sustained risk reduction efforts in these high-transmission environments. In contrast, HIV treatment services within prisons remain relatively strong. The number of people receiving antiretroviral therapy (ART) increased from 21,373 in 2023 to 27,347 in 2024, indicating recovery following a notable dip in 2023. When compared to the estimated number of people living with HIV in correctional settings (27,465 in 2024), this suggests a high level of treatment coverage. These trends reflect continued efforts to maintain access to HIV care and treatment within the correctional system.

HIV testing data, however, shows inconsistencies, with no reported data for 2023 and 2024. Earlier trends indicate significant fluctuations, with testing numbers dropping sharply in 2019, recovering in 2021, and declining again in 2022. The absence of recent data limits the ability to assess current case-finding performance and may signal gaps in routine monitoring and reporting systems. The burden of HIV within correctional facilities remains substantial, although recent data suggest some decline in prevalence. The proportion of people living with HIV in prisons decreased from 20% in 2023 to 17% in 2024, which may reflect improved treatment coverage, mortality trends, or changes in testing and reporting practices.

Tuberculosis (TB) continues to be a key co-morbidity within correctional settings. Encouragingly, the number and proportion of individuals diagnosed with TB or HIV/TB co-infection have declined over time, from 1,777 cases in 2018 to 312 cases (0.19%) in 2024. This suggests improvements in TB control, screening, and treatment within prisons. However, given the known risks associated with overcrowding and co-infection, sustained vigilance and integrated HIV-TB services remain essential. Data on hepatitis C and HIV/hepatitis C co-infections remain limited and inconsistent, further highlighting gaps in surveillance and service provision for co-morbid conditions within correctional settings.

Overall, while South Africa has made important progress in maintaining HIV treatment services and improving TB outcomes in prisons, significant gaps persist in prevention and harm reduction interventions. The absence of needle exchange and opioid substitution programmes, combined with inconsistent condom distribution and gaps in testing data, underscores the need for a more comprehensive and consistent approach.

Strengthening prevention services, improving routine data systems, and expanding integrated HIV, TB, and harm reduction interventions will be critical to reducing transmission and improving health outcomes in correctional settings.

Table 5: HIV prevention programmes in prisons

NUMBER OF NEW INFECTIONS IN SOUTH AFRICA BY SEX AND AGE	2018	2019	2020	2021	2022*	2023	2024
Number of clean needles distributed to people in prisons and other closed settings	No data	No data	No data	No data	0	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	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	2,198,242
Number of people in prisons and other closed settings receiving antiretroviral therapy	27,171	25,522	23,570	24,145	28,913	21,373	27,347
Number of people in prisons and other closed settings tested for HIV	158,257	57,027	93,333	140,743	66,723	No data	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%)	27,465 (17%)
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%)	No data
Number of people in prisons and other closed settings co-infected with HIV and hepatitis C virus	No data	No data	No data	3.3%	0	23,513 (20%)	130 (0.08%)
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%)	312 (0.19%)

Source: *DCS data, 2022; Programme data 2021 (multiple implementing partners); **UNAIDS Online tool; **Routine Programme data 2023 and 2024

SAFE INJECTING PRACTICES AMONG PEOPLE WHO INJECT DRUGS

South Africa's policy framework demonstrates strong alignment with global evidence on harm reduction, recognizing people who inject drugs (PWID) as a key population requiring targeted HIV prevention, treatment, and care services. The National Drug Master Plan (2019–2024) and the National Strategic Plan (NSP) for HIV, TB, and STIs (2023–2028) explicitly support the implementation of comprehensive harm reduction interventions, including opioid substitution therapy (OST) and needle-and-syringe programmes. These strategies are further reinforced by the National Guidelines for the Management of Viral Hepatitis (2019), which prioritize PWID for hepatitis B and C screening, prevention, and treatment (DoH, 2019).

Despite this strong policy foundation, implementation of harm reduction services remains limited and uneven. Recent data indicate significant gaps in programme coverage, with no reported national data for 2023 and 2024 on the number of individuals receiving OST or the number of needles and syringes distributed. This absence of routine data constrains monitoring of programme performance and suggests potential disruptions or stagnation in service delivery.

NEEDLES AND SYRINGES DISTRIBUTED PER PERSON WHO INJECTS DRUGS

supported by a strong global evidence base demonstrating their effectiveness in reducing HIV transmission among PWID. In South Africa, explicit policy support for NSPs is reflected in the NSP (2023–2028), the National Drug Master Plan (2019–2024), and the National Hepatitis Action Plan. However, implementation remains limited in scale. Historical data indicate that in 2019, NSPs distributed an average of 76 needles per person per year, with significant geographic variation—52 per person in Pretoria compared to 174 in Cape Town (Scheibe et al., 2019). By July 2020, NSPs were operational in nine health districts, reaching 7,316 individuals across key urban centres, including Pretoria, Johannesburg, Cape Town, Durban, and Port Elizabeth (Scheibe et al., 2020). Despite this progress, current coverage remains below international benchmarks required to effectively prevent HIV transmission. Furthermore, the absence of updated national data for 2023 and 2024 on needle and syringe distribution limits the ability to assess whether services have expanded, stabilized, or declined in recent years.

HIV BURDEN AND SERVICE COVERAGE AMONG PWID

Available programme data continue to highlight the high burden of HIV among PWID. As shown in Table 6, approximately 19.9% of PWID tested in 2022 were living with HIV, with similar prevalence among males (20.0%) and females (19.1%). Younger PWID (<25 years) showed a slightly higher prevalence (20.5%), indicating ongoing transmission among younger cohorts (Global Fund implementing partners programme data, 2022). Despite this burden, access to key services remains uneven. Coverage of OST and other harm reduction interventions remains limited, with no recent national data available to assess scale or reach. In addition, data on hepatitis B and C prevalence among PWID remain sparse, with available information largely derived from small-scale or programmatic studies.

IMPLICATIONS FOR HARM REDUCTION PROGRAMMING

The gap between policy commitments and implementation remains a critical challenge. While South Africa has established a supportive legal and strategic framework for harm reduction, the limited scale of needle-and-syringe programmes and OST, combined with weak and inconsistent data systems, continues to constrain the effectiveness of the response.
Addressing these gaps will require:

- Expansion of needle-and-syringe and OST services to achieve adequate population-level coverage
- Strengthening of routine surveillance and data systems for PWID
- Integration of HIV, TB, and viral hepatitis services within harm reduction platforms
- Increased investment in community-led and outreach-based service delivery models

Overall, scaling up evidence-based harm reduction interventions, supported by improved data and sustained financing, will be essential to reducing HIV transmission and improving health outcomes among PWID in South Africa.

COVERAGE OF OPIOID SUBSTITUTION THERAPY (OST)

In South Africa, opioid substitution therapy (OST) is provided as part of maintenance treatment for opioid dependence through a combination of private practitioners, self-funded programmes at selected tertiary hospitals, and initiatives led by universities and civil society organizations.

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

The policy environment strongly supports the integration of OST within broader HIV prevention and harm reduction efforts. Key frameworks—including the National Hepatitis Action Plan and Guidelines, the National Strategic Plan (NSP) for HIV, TB, and STIs (2017–2022), the Health Sector Drug Master Plan (2019–2025), and the National Drug Master Plan (2019–2024)—explicitly endorse the scale-up of OST as a core component of the national response. Despite this strong policy backing, access to OST remains extremely limited. Programme data from the Networking HIV & AIDS Community of Southern Africa (NACOSA) in 2019 indicate that among 6,827 opioid-dependent PWID in Johannesburg, only 60 individuals (0.9%) were receiving OST. Similarly, in Cape Town, only 30 out of 1,517 PWID (1.9%) were enrolled in OST programmes. These figures highlight the substantial gap between policy commitments and actual service coverage.

Further evidence from a 2019 harm reduction coverage study conducted in Pretoria, Durban, and Cape Town reinforces the limited reach of OST services. The study found that only 260 PWID were receiving OST, representing just 4% coverage across the three cities. Coverage varied markedly across locations, with no access reported in Port Elizabeth (0%), minimal access in Durban at 1% (n = 8), moderate coverage in Pretoria at 4% (n = 157), and relatively higher—though still limited—coverage in Cape Town at 8% (n = 55) (Scheibe et al., 2019). The same study also highlighted significant gaps in HIV service delivery among PWID. Only 24% (n = 1,773) of individuals were tested for HIV during the study period, indicating low overall testing coverage. Testing uptake varied geographically, with the lowest levels observed in Pretoria (15%) and Johannesburg (26%), and higher levels reported in Port Elizabeth (49%) and Cape Town (57%). 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.

Linkage to treatment among those diagnosed was also critically low. Only 20% of individuals diagnosed with HIV were initiated on antiretroviral therapy (ART). Substantial variation was observed across sites, with the lowest ART uptake recorded in Durban (6%) and the highest in Johannesburg (65%). These findings point to significant gaps not only in prevention and testing, but also in continuity of care and treatment initiation.

Overall, the evidence highlights profound limitations in the scale and accessibility of harm reduction services for PWID in South Africa. Extremely low coverage of OST, limited uptake

of HIV testing, and delayed ART initiation collectively undermine efforts to reduce HIV transmission within this high-risk population. Bridging these gaps will require urgent expansion of OST services, improved integration of HIV testing and treatment within harm reduction programmes, and intensified outreach to improve service uptake. Addressing structural barriers—including cost, stigma, and limited-service availability—alongside increased investment and stronger implementation of existing policies, will be critical to ensuring equitable access to comprehensive care for people who use drugs. Without accelerated scale-up of OST and related services, the potential for ongoing HIV transmission within this population remains high.

PEOPLE WHO RECEIVED PREP AND TRENDS

The scale-up of pre-exposure prophylaxis (PrEP) programmes in South Africa has expanded substantially over the past five years, reflecting increased prioritization of biomedical prevention within the national HIV response. The number of individuals accessing PrEP increased from 42,255 in 2019 to 803,171 in 2023, and further to 858,421 in 2024. This represents more than a 20-fold increase over the period, demonstrating significant progress in expanding access to HIV prevention services. Despite this growth, important disparities persist across population groups. Women continue to account for most PrEP users.

In 2023, 566,431 women accessed PrEP compared to 172,904 men, and in 2024, 530,757 women accessed PrEP compared to 162,656 men. This pattern reflects the continued prioritization of adolescent girls and young women (AGYW) and female sex workers (FSWs) within national prevention strategies. While this targeted approach is appropriate given the higher burden of HIV among women, it also highlights persistent gaps in reaching men and other underserved populations. Data on transgender individuals remain unavailable across both 2023 and 2024, limiting the ability to assess PrEP coverage within this group.

PrEP uptake varies significantly by age. In 2023, the highest number of users was recorded among individuals aged 25–49 years (333,806), followed by those aged 20–24 years (202,946) and 15–19 years (169,441). A similar pattern is observed in 2024, with 320,105 users aged 25–49 years, 189,711 aged 20–24 years, and 151,565 aged 15–19 years. These trends indicate strong uptake among sexually active and higher-risk age groups, particularly young women.

However, PrEP use among individuals aged 50 years and older remains low, with 25,928 users in 2023 and 25,272 in 2024, suggesting limited reach of prevention programmes within older populations. Encouragingly, the number of first-time PrEP users has remained high, indicating continued demand and programme expansion. First-time users increased from 333,944 in 2022 to 471,227 in 2023, before slightly declining to 440,471 in 2024. While this slight reduction may reflect programme stabilization or shifts in service delivery, it nonetheless indicates sustained uptake of PrEP as a prevention tool.

Overall, PrEP scale-up has been rapid, with the number of users more than doubling between 2022 (406,170) and 2023 (803,171) and continuing to grow in 2024. However, the data also highlights critical gaps in equitable access. Men, transgender individuals, and older adults remain underrepresented in PrEP programmes, and the absence of disaggregated data for certain populations limits the ability to fully assess programme reach and effectiveness.

To sustain progress and maximise impact, there is a need to expand PrEP access beyond traditionally targeted groups. This includes strengthening outreach to men, improving data collection for transgender populations, and tailoring interventions for older individuals. Continued investment in community-led approaches and differentiated service delivery models will be essential to ensure that PrEP programmes are inclusive, responsive, and effective in reducing new HIV infections across all population groups.

Table 7: Number of people who received any PrEP product (2019-2024)

	TOTAL	MALES	FEMALES	TRANSGENDER	GENDER UNKNOWN	FIRST TIME
2024						
All	858 421	162 656	530 757	No data	165 008	440 471
<15	6 760	1 303	5 456	No data		3 314
15-19	151 565	16 658	134 907	No data		70 426
20-24	189 711	29 754	159 957	No data		81 398
25-49	320 105	102 044	218 061	No data		113 044
50+	25 272	12 897	12 375	No data		7 281
Age unknown	165 008				165 008	165 008
2023						
All	803 171	172 904	566 431	No data	63 836	471 227
<15	6 787	1 523	5 260	No data	4	5 893
15-19	169 441	18 960	150 374	No data	107	119 681
20-24	202 946	32 264	170 678	No data	4	119 647
25-49	333 806	106 837	226 966	No data	3	151 619
50+	25 928	13 320	12 608	No data		10 124
Age unknown	64 263		545		63 718	64 263
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

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

Table 7: Number of people who received any PrEP product (2019-2024)

	TOTAL	MALES	FEMALES	TRANSGENDER	GENDER UNKNOWN	FIRST TIME
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 (2024)

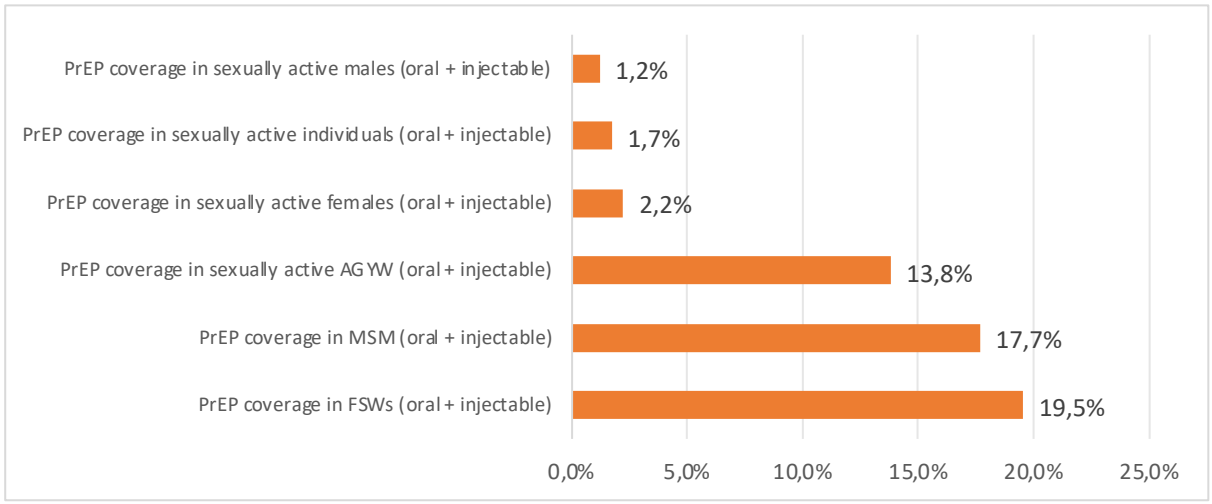
PrEP coverage estimates from the Thembisa Model (version 4.8) for 2024 reflect a highly differentiated pattern of uptake across population groups, with significantly higher coverage observed among key populations compared to the general population (Figure 5).

Female sex workers (FSWs) and men who have sex with men (MSM) demonstrate the highest levels of PrEP coverage, at 19.5% and 17.7%, respectively. Among adolescent girls and young women (AGYW), coverage is also relatively elevated at 13.8%, reflecting sustained prioritization of this group within national HIV prevention strategies.

In contrast, PrEP coverage among the broader sexually active population remains substantially lower. Coverage among sexually active females is estimated at 2.2%, while coverage among sexually active individuals overall is 1.7%, and even lower among males at 1.2%. These disparities highlight the targeted nature of PrEP programming in South Africa, where resources and interventions have been concentrated on populations at highest risk of HIV acquisition.

While this targeted approach has contributed to increased uptake among priority groups, the overall low coverage among the general population—particularly men—suggests missed opportunities for broader prevention impact. Expanding PrEP access beyond key populations, while maintaining focused interventions for high-risk groups, will be essential to achieving population-level reductions in HIV incidence.

Figure 5: PrEP coverage by population group (2024)

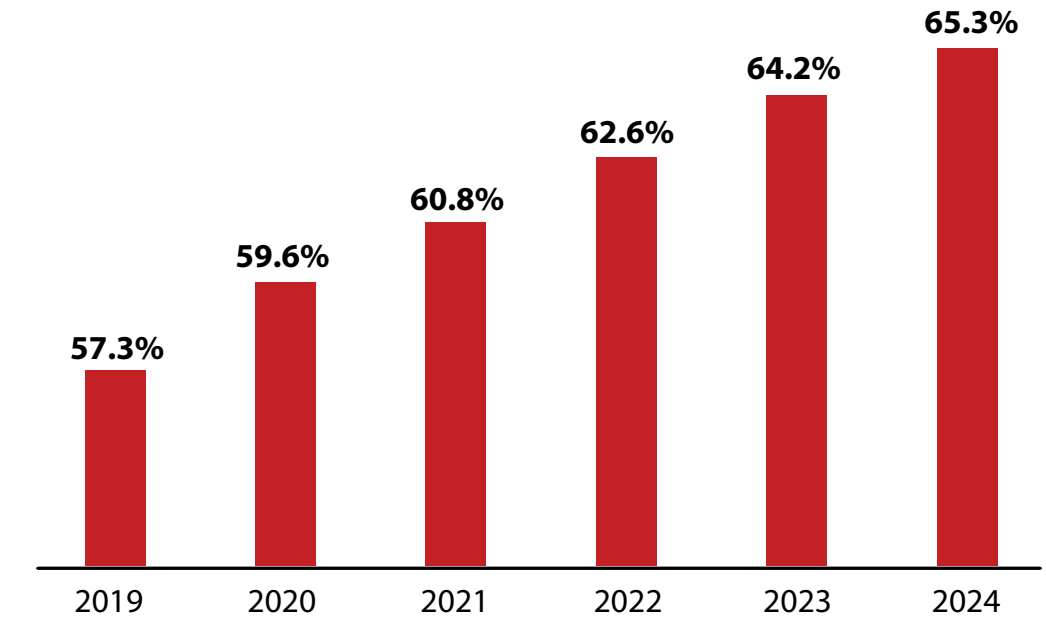


Source: Thembisa Model ver. 4.8

PREVALENCE OF VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC)

Voluntary medical male circumcision (VMMC) coverage among men aged 15–49 has increased steadily over time, rising from 57.3% in 2019 to 64.2% in 2023 and further to 65.3% in 2024 (Figure 6). This consistent upward trend reflects sustained investment in VMMC as a core component of combination HIV prevention, contributing to reduced female-to-male transmission risk.

Figure 6: Number of VMMCs conducted by age (2019-2024)



Source: Thembisa Model ver. 4.8

While the continued expansion is encouraging, the rate of increase has been gradual, suggesting the need for intensified efforts to reach remaining uncircumcised men, particularly in high-burden and underserved populations, to maximize the population-level prevention impact.

Data on the annual number of males voluntarily circumcised between 2019 and 2024 indicate a clear shift in programme performance across age groups (Table 8). The highest levels of coverage continue to be observed among males aged 10–14 years, who accounted for approximately 50% of all circumcisions in 2024, increasing from 43% in 2019. Despite a slight decline in absolute numbers over the period (from 205,733 in 2019 to 192,697 in 2024; -7%), this age group remains the primary focus of VMMC programmes.

In contrast, uptake among older age groups has declined both in absolute numbers and proportional contribution. Among males aged 15–19 years, circumcisions decreased from 45,207 in 2019 to 38,688 in 2024 (-17%), although their share increased slightly from 9% to 10%. More substantial declines are observed among males aged 20–24 years, where procedures fell from 36,336 in 2019 to 10,149 in 2024, alongside a reduction in proportional contribution from 8% to 3%. Similarly, among males aged 25–49 years, circumcisions declined from 123,297 to 75,841 (-63%), with their share decreasing from 26% to 20% over the same period. Among males aged 50 years and older, uptake remains minimal, with procedures decreasing from 5,325 to 3,728 (-43%) and consistently accounting for only 1% of total circumcisions.

Neonatal circumcision has shown modest growth, increasing from 62,655 in 2019 to 64,091 in 2024 (2%), with its proportional contribution rising from 13% to 17%. While this increase is gradual, it reflects growing integration of early infant male circumcision into routine health services.

The concentration of VMMC uptake among younger males is consistent with national and global prevention strategies aimed at achieving long-term reductions in HIV incidence. By prioritizing circumcision in early adolescence, the programme ensures that a larger proportion of males enter adulthood with reduced susceptibility to HIV infection. However, the declining uptake among older adolescents and adult men represents a missed opportunity for more immediate prevention impact, particularly given the higher risk of HIV acquisition within these age groups.

Overall, while progress in expanding VMMC coverage among younger populations is evident, the downward trend in uptake among older age groups highlights the need for more targeted and differentiated demand creation strategies. Strengthening outreach to sexually active adolescents and adult men, addressing barriers to uptake, and integrating VMMC services within broader sexual and reproductive health programmes will be critical to maximizing the population-level impact of this intervention.

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

	2019	2020	2021	2022	2023	2024	% CHANGE (2018-2022)	2019	2020	2021	2022	2023	2024
Number of neonatal MMC operations	62 655	62 745	63 021	63 394	63 755	64 091	2%	13%	32%	15%	15%	20%	17%
Number of MMC operations in males 10-14	205 733	70 900	205 105	215 429	152 970	192 697	-7%	43%	36%	48%	50%	48%	50%
Number of MMC operations in males 15-19	45 207	13 229	34 552	36 193	27 138	38 688	-17%	9%	7%	8%	8%	8%	10%
Number of MMC operations in males 20-24	36 336	9 669	19 734	16 324	9 574	10 149	-258%	8%	5%	5%	4%	3%	3%
Number of MMC operations in males 25-49	123 297	39 628	96 482	96 080	65 186	75 841	-63%	26%	20%	23%	22%	20%	20%
Number of MMC operations in males 50+	5 325	1 754	4 270	4 359	3 084	3 728	-43%	1%	1%	1%	1%	1%	1%

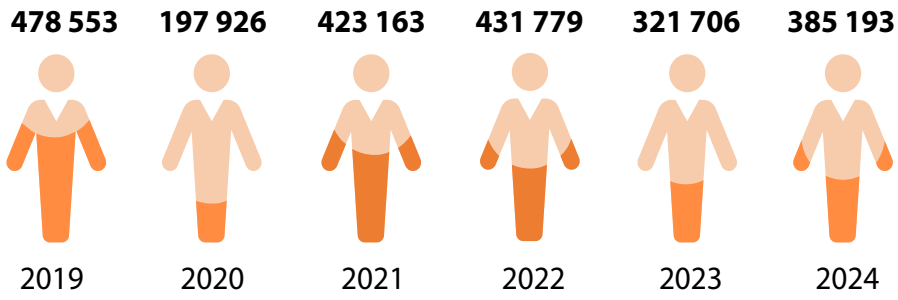
Source: Thembisa Model

ANNUAL NUMBER OF MALES VOLUNTARILY CIRCUMCISED

Figure 7 illustrates trends in the total number of voluntary medical male circumcisions (VMMCs) conducted between 2019 and 2024, highlighting fluctuations in programme performance over time. The number of VMMCs declined sharply from 478,553 in 2019 to 197,926 in 2020, reflecting the significant impact of COVID-19-related service disruptions. These disruptions were driven by lockdown measures, reduced access to health facilities, and the reallocation of resources towards the pandemic response. Following this decline, VMMC uptake recovered substantially, increasing to 423,163 in 2021 and peaking at 431,779 in 2022. This recovery demonstrates the programme's ability to rebound as restrictions eased and services resumed.

However, this upward trend was not sustained, with a subsequent decline observed in 2023 to 321,706 procedures. In 2024, the number of VMMCs increased again to 385,193, indicating partial recovery but not yet reaching pre-pandemic or peak levels. Overall, these trends reflect both the vulnerability of VMMC programmes to external shocks and their capacity for recovery. While the rebound in service delivery is encouraging, the fluctuations observed between 2022 and 2024 suggest the need for sustained programme stability and intensified implementation efforts.

Figure 7: Annual number of VMMCs conducted (2019-2024)



Source: Thembisa Model ver. 4.8

Ensuring consistent service delivery, particularly in high-burden areas and among priority age groups, will be critical to maintaining VMMC as a cornerstone of combination HIV prevention.

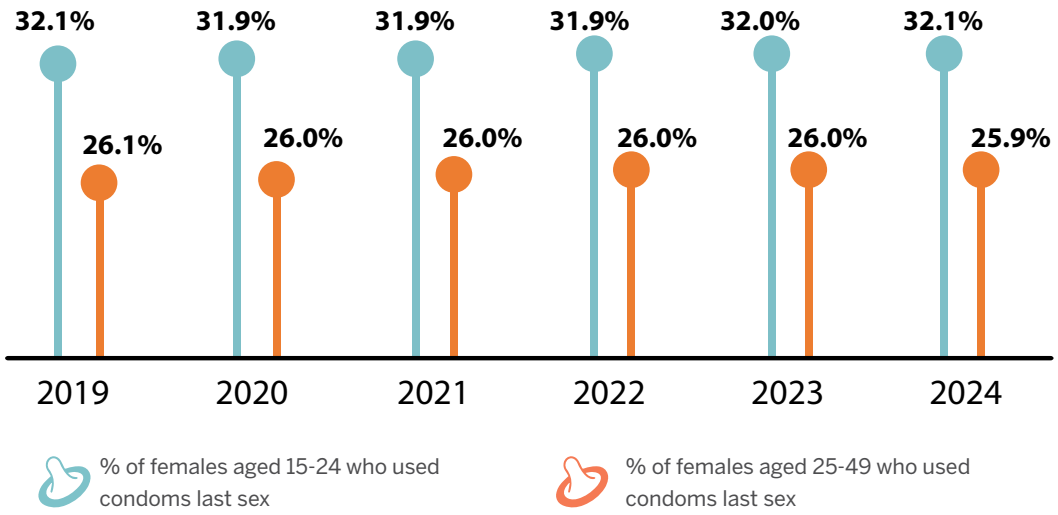
CONDOM USE AT LAST HIGH-RISK SEX

Figure 8 compares condom use at last sex among young women aged 15–24 and women aged 25–49 between 2019 and 2024. The data indicate that condom use is consistently higher among young women aged 15–24 compared to women aged 25–49 across all years. Among women aged 15–24, condom use remained relatively stable, fluctuating slightly from 32.1% in 2019 to 31.9% between 2020 and 2022, before increasing marginally to 32.0% in 2023 and 32.1% in 2024. In contrast, condom use among women aged 25–49 remained consistently lower and largely unchanged over the period, declining slightly from 26.1% in 2019 to 25.9%

in 2024. Across both age groups, condom use has remained persistently low, with rates below one-third of sexually active women, indicating limited reliance on condoms as a primary HIV prevention method.

Importantly, the data does not show a sustained decline over time but rather a pattern of stagnation, with minimal variation across the six-year period. This suggests that existing condom promotion strategies have not achieved meaningful increases in uptake, particularly among older women. The persistently low levels of condom use, especially in the context of high HIV incidence among women, remain a significant concern. These findings highlight the need to revitalize condom promotion efforts as part of combination prevention. Strengthening demand creation, improving consistent access to condoms, and integrating condoms use messaging within broader sexual and reproductive health services will be critical. Attention should be given to reinforcing condom use alongside other prevention tools, ensuring that it remains a central component of HIV prevention strategies across all age groups.

Figure 8: Condom use at last sex (2019-2024)



Source: Thembisa Model ver. 4.8

ANNUAL NUMBER OF CONDOMS DISTRIBUTED

Data from Table 9 indicates notable fluctuations in condom distribution over the period 2019 to 2024, rather than a consistent decline. The total number of condoms distributed decreased from 650,900,585 in 2019 to 417,879,099 in 2022, reflecting a significant drop during the COVID-19 period when service delivery and supply chains were disrupted. However, this decline was followed by a recovery, with distribution increasing to 570,637,478 in 2023 and further to 713,315,762 in 2024, surpassing pre-pandemic levels. This pattern is largely driven by trends in male condom distribution, which constitute most condoms supplied. Male condom distribution declined sharply from 635,981,213 in 2019 to 403,740,579 in 2022, before rebounding to

548,365,152 in 2023 and 691,720,160 in 2024. Female condom distribution, while substantially lower in volume, increased gradually over time, rising from 14,919,372 in 2019 to 21,595,602 in 2024, with a peak of 22,272,326 recorded in 2023.

While the recovery in condom distribution is encouraging, overall utilization remains a concern when considered alongside persistently low levels of condom use, particularly among sexually active populations. The earlier decline during the pandemic period may have contributed to gaps in prevention coverage, and although supply has improved, this does not necessarily translate into consistent or correct use. These findings highlight the need to not only maintain stable and sufficient condom supply chains, but also to strengthen demand creation and utilization. Enhancing condom promotion campaigns, improving access through community-based and targeted distribution strategies, and integrating condom use within broader combination prevention approaches will be critical to maximizing the impact of this intervention in reducing new HIV infections and other sexually transmitted infections (STIs).

Table 9: Annual number of condoms distributed (2019-2024)

CONDOMS	2019	2020	2021	2022	2023	2024
Male	635,981,213	558,190,486	577,572,000	403,740,579	548,365,152	691,720,160
Female	14,919,372	15,896,064	18,036,313	14,138,520	22,272,326	21,595,602
Total number of condoms distributed	650,900,585	574,086,550	595,608,313	417,879,099	570,637,478	713,315,762

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

YOUNG PEOPLE: KNOWLEDGE ABOUT HIV PREVENTION

The release of the Sixth South African National HIV Prevalence, Incidence, and Behaviour Survey (SABSSM VI) provides critical and updated insights into HIV knowledge, behaviours, and risk patterns across the population (SABSSM VI, 2022/23). The survey represents one of the most comprehensive sources of nationally representative data on HIV-related knowledge and behaviour, informing both policy and programme design. Accurate knowledge of HIV transmission remains a foundational component of effective prevention. However, findings from SABSSM VI (2022/23) indicate that levels of comprehensive knowledge remain low.

Only 25.7% of individuals aged 15 years and older demonstrated accurate knowledge about the sexual transmission of HIV, with no meaningful differences observed between males and females (SABSSM VI, 2022/23). This highlights a persistent gap in understanding that may limit the effectiveness of prevention efforts.

Age-disaggregated findings show that younger populations tend to have higher levels of HIV-related knowledge compared to older adults. This reflects the impact of sustained school-based education programmes, youth-focused interventions, and targeted awareness campaigns. However, individuals aged 50 years and older continue to exhibit lower levels of knowledge, suggesting that HIV prevention messaging has not adequately reached or resonated with older populations (SABSSM VI, 2022/23). Given the increasing HIV burden observed in older age groups, this gap represents a critical area for intervention. Importantly, the survey reinforces that knowledge alone is insufficient to drive behaviour change. While awareness of HIV transmission is necessary, it does not automatically translate into safer sexual practices,

uptake of prevention services, or reduced risk behaviours. Behavioural drivers—such as multiple sexual partnerships, age-disparate relationships, and low condom use—continue to shape HIV risk, highlighting the need for more comprehensive and behaviourally informed interventions (SABSSM VI, 2022/23). Overall, these findings underscore the need to strengthen HIV education and communication strategies beyond basic awareness. Expanding community-based education, leveraging mass media and digital platforms, and developing targeted interventions for older adults will be essential to improving knowledge levels across all age groups. Integrating HIV education with broader sexual and reproductive health services, and addressing the social and structural drivers of risk, will be critical to translating knowledge into sustained behaviour change and reducing new infections.

ACHIEVEMENTS

- The completion of the SABSSM VI provides robust, nationally representative data to guide HIV prevention, treatment, and care programming, strengthening evidence-based decision-making (SABSSM VI, 2022/23).
- PrEP uptake has expanded significantly over time, particularly among key and priority populations such as female sex workers (FSWs), men who have sex with men (MSM), adolescent girls and young women (AGYW), and women more broadly, although uptake among men remains comparatively low.
- The development and adoption of the National Strategic Plan on Gender-Based Violence (GBV) and Femicide represent a major step in addressing structural drivers of HIV risk, particularly among women and girls.
- Combination prevention interventions—including prevention of vertical transmission, VMMC scale-up, increased condom distribution, expanded PrEP access, and provision of post-exposure prophylaxis (PEP)—have contributed to observed declines in HIV incidence (NDoH Annual Report, 2021).
- Following COVID-19-related disruptions, condom distribution has recovered and surpassed pre-pandemic levels, improving access to a key prevention commodity.
- Increased VMMC coverage among boys aged 10–14 years aligns with global evidence demonstrating long-term reductions in HIV risk through early circumcision.

KEY CHALLENGES

- South Africa continues to bear the largest HIV burden globally, with progress in reducing new infections slower than required to meet national and global targets.
- The COVID-19 pandemic disrupted HIV service delivery, including testing, treatment, and prevention programmes, due to resource diversion and restricted access to healthcare services (Karim & Baxter, 2022).
- The continued criminalisation of sex work increases vulnerability among sex workers, limiting access to prevention, treatment, and support services.
- Despite expanded PrEP availability, uptake remains uneven, particularly among men and certain key populations, with overall coverage still below optimal levels.
- Persistent gaps in harm reduction data, including the absence of updated integrated biological and behavioural surveillance (IBBS) surveys, constrain evidence-based programming for key populations.
- Structural and behavioural drivers—including gender inequality, stigma, and socio-economic vulnerabilities—continue to fuel HIV transmission (SABSSM VI, 2022/23).

RECOMMENDATIONS

- Strengthen the implementation and evaluation of the National GBV and Femicide Strategy to ensure measurable reductions in GBV and its contribution to HIV vulnerability.
- Prioritise access to long-acting HIV prevention technologies, including injectable cabotegravir, through sustainable financing and integration into national programmes.
- Conduct targeted research and programme design for populations aged 50 years and older, where HIV incidence declines have been slower, particularly among women.
- Scale up integrated biological and behavioural surveillance (IBBS) surveys to improve data availability for key populations and inform targeted interventions.
- Expand and strengthen harm reduction interventions, including opioid substitution therapy (OST) and needle-and-syringe programmes, under the NSP (2023–2028).
- Enhance HIV education strategies to move beyond awareness, focusing on behaviour change, risk perception, and sustained prevention practices across all age groups (SABSSM VI, 2022/23).

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

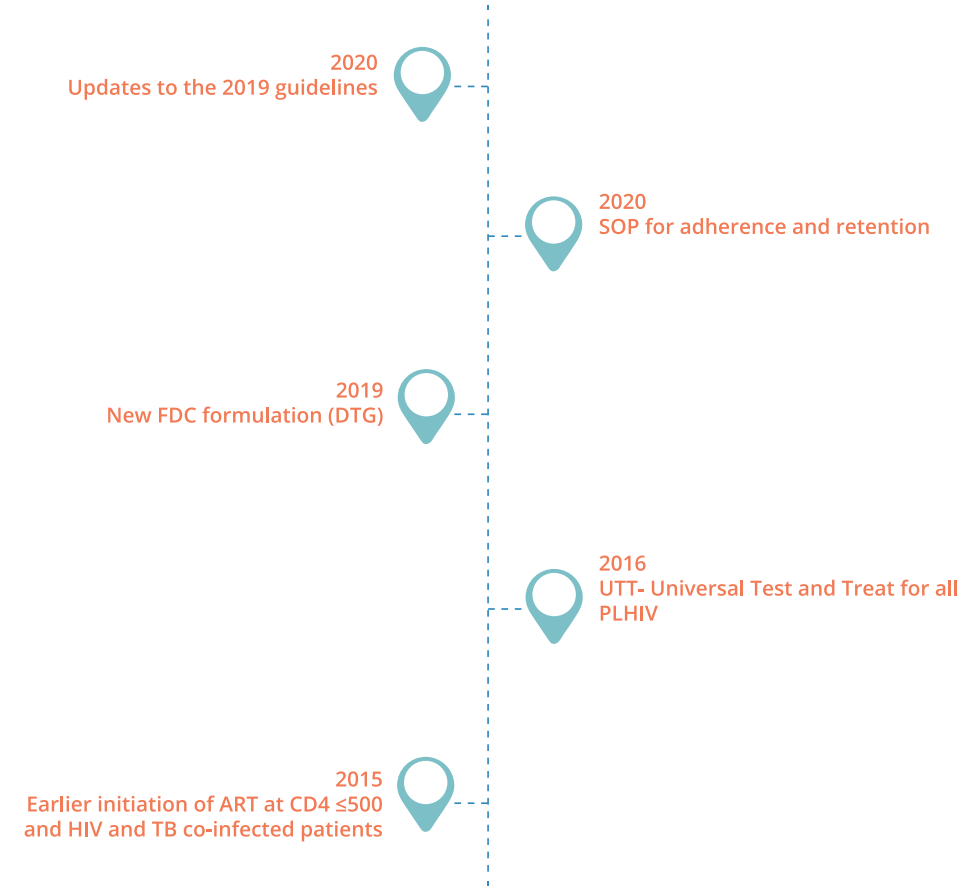
LEGAL AND POLICY ENVIRONMENT

Since the 2020 Global AIDS Monitoring (GAM) reporting cycle, South Africa's legal and policy framework for HIV testing and treatment has remained largely stable, with no major structural shifts in policy direction (Figure 9). The current framework continues to be anchored in the 2019 ART Clinical Guidelines for the Management of HIV in Adults, Pregnancy, Adolescents, Children, Infants, and Neonates, which remain the most recent comprehensive national treatment guidelines. These guidelines build on earlier transformative policy decisions, most notably the introduction of the Universal Test and Treat (UTT) strategy in 2016, which enabled all people living with HIV (PLHIV) to initiate antiretroviral therapy (ART) regardless of CD4 count. This marked a critical shift towards immediate treatment access and has been central to South Africa's progress in expanding ART coverage. Complementing this, the introduction of same-day initiation approaches further strengthened efforts to reduce delays in treatment initiation, aiming to ensure that individuals diagnosed with HIV are rapidly started on ART.

Subsequent policy refinements have focused on optimizing treatment outcomes rather than expanding eligibility. The introduction of the fixed-dose combination regimen containing dolutegravir (DTG) in 2019 represented a significant advancement in treatment efficacy and tolerability, supporting improved viral suppression outcomes. In addition, updates to the 2019 guidelines in 2020 further reinforced clinical management approaches in line with evolving evidence. A key programmatic advancement has been the release of the National Department of Health (NDoH) Adherence Guidelines in March 2020, which introduced Standard Operating Procedures (SOPs) to strengthen linkage to care, adherence, and retention. These SOPs provide a structured, minimum package of interventions designed to standardize patient support across the health system. Core components include enhanced patient education and counselling, multi-month dispensing of ART, streamlined repeat prescription collection, patient tracing, and re-engagement strategies for individuals who have interrupted treatment.

These interventions are closely aligned with differentiated service delivery (DSD) models, which aim to improve efficiency and patient-centred care, particularly for stable clients. By reducing the burden on both patients and the health system, DSD approaches have become a cornerstone of South Africa's HIV treatment strategy. Overall, while the policy framework has remained stable in recent years, its continued implementation and optimization have played a critical role in shaping HIV treatment outcomes. The focus has shifted from expanding access to strengthening quality of care, improving adherence, and ensuring long-term retention in treatment. Sustaining these efforts will be essential to achieving epidemic control and maintaining progress towards national and global HIV targets.

Figure 9: HIV testing and treatment legal and policy framework



Source: Bello et al, 2021

95-95-95- HIV TESTING AND TREATMENT

Based on 2024 estimates from the Thembisa model (version 4.8), South Africa's performance against the UNAIDS 95-95-95 targets is approximately 95-82-92.

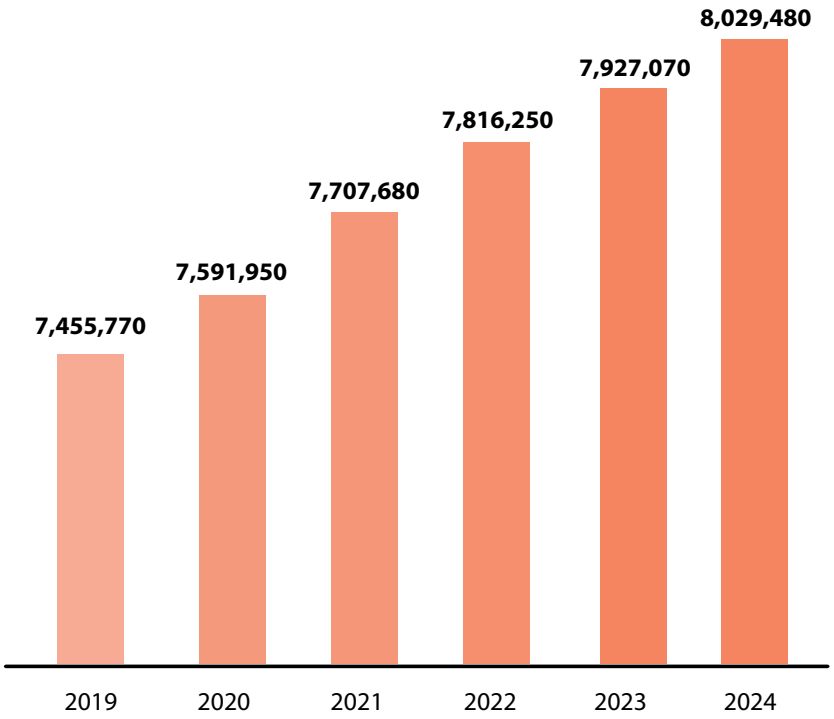
PEOPLE LIVING WITH HIV WHO KNOW THEIR HIV STATUS

Based on 2024 estimates from the Thembisa model (version 4.8), South Africa has effectively achieved the first UNAIDS 95 target, with approximately 95% of people living with HIV (PLHIV) aware of their HIV status. This reflects sustained progress in expanding HIV testing services, strengthening case-finding approaches, and improving linkage to care.
Figure 10 illustrates the steady increase in the total number of PLHIV in South Africa between 2019 and 2024. Over this period, the number of PLHIV rose from 7,455,770 in 2019 to 8,029,480 in 2024, representing an increase of approximately 7.7%. This upward trend is primarily driven by improved survival among PLHIV because of expanded access to antiretroviral therapy (ART), better adherence, and enhanced retention in care. The growth in the number of PLHIV reflects the success of the treatment programme rather than an increase in new infections. As more

individuals are diagnosed early and initiated on effective treatment, life expectancy continues to improve, leading to a larger population of people living with HIV over time. This highlights the importance of sustaining high levels of testing coverage to maintain achievement of the first 95, while ensuring that newly diagnosed individuals are promptly linked to care.

Despite this progress, maintaining the first 95 target will require continued efforts to reach undiagnosed individuals, particularly within populations that remain less engaged with testing services. Strengthening targeted and differentiated testing strategies will be essential to sustain gains and ensure that universal knowledge of HIV status is achieved and maintained.

Figure 10: Total HIV infections (2019-2024)



Source: Thembisa Model 4.8

PEOPLE LIVING WITH HIV ON ANTIRETROVIRAL THERAPY

Expanding antiretroviral therapy (ART) coverage remains one of the most critical components of South Africa's HIV response, given its dual impact on reducing HIV transmission and lowering AIDS-related mortality through sustained viral suppression. Based on 2024 estimates from the Thembisa model (version 4.8), approximately 82% of people living with HIV (PLHIV) who know their status are on ART, indicating that South Africa has not yet achieved the second UNAIDS 95 target. In absolute terms, an estimated 6.2 to 6.3 million people were receiving ART by the end of 2024, representing one of the largest treatment programmes globally. Despite this scale, a substantial treatment gap remains, with roughly one in five PLHIV not on treatment. This gap highlights ongoing challenges in treatment initiation and long-term retention in care.

Disparities in ART coverage persist across demographic groups. Among adults aged 15 years and older, women have higher treatment coverage (87%) compared to men (80%), reflecting continued gender differences in healthcare access, health-seeking behavior, and retention. The gap is even more pronounced among children aged 0–14 years, where only 63% of those diagnosed are on treatment, indicating significant lag in pediatric HIV care. Programme data also points to challenges with treatment continuity. In 2023/2024, an estimated 714,000 individuals restarted ART after previously discontinuing treatment, underscoring persistent issues with retention, adherence, and re-engagement in care.

These patterns suggest that, beyond initiation, sustaining individuals on lifelong treatment remains a key bottleneck in achieving the second 95 target. Overall, while South Africa has made substantial progress in expanding ART access, the second 95 target remains the weakest point in the cascade. Accelerated efforts to improve linkage to care, strengthen retention strategies, and implement differentiated service delivery models—particularly for men, children, and other underserved populations—will be essential to closing the treatment gap and maximizing the impact of the HIV response.

PEOPLE LIVING WITH HIV WHO HAVE SUPPRESSED VIRAL LOADS

South Africa is approaching achievement of the third UNAIDS 95 target, with an estimated 92% of individuals on ART achieving viral suppression in 2024 (Thembisa Model v4.8). This reflects strong treatment effectiveness, high levels of adherence among those retained in care, and the continued success of the national ART programme. Disaggregated data indicate relatively consistent viral suppression outcomes across adult populations, with 93% of women and 92% of men on treatment achieving viral suppression. These findings demonstrate that once individuals are successfully initiated and retained on ART, treatment outcomes are highly effective.

However, viral suppression among children remains substantially lower, with only 69% of children aged 0–14 years on treatment achieving viral suppression. This highlights persistent gaps in pediatric treatment adherence, regimen optimization, and continuity of care, requiring targeted interventions to improve outcomes in this vulnerable group. Importantly, the high level of viral suppression must be interpreted within the context of suboptimal ART coverage. While those on treatment are achieving strong outcomes, the overall population-level impact is constrained by the gap in treatment initiation and retention.

A significant proportion of PLHIV who are diagnosed are not on treatment, limiting the full prevention benefit of viral suppression at a population level. Overall, South Africa's progress towards the third 95 target demonstrates the strength of its treatment programme. However, achieving epidemic control will depend on closing the gap in the second 95, ensuring that more individuals are initiated on ART and sustained in care. Strengthening retention, improving re-engagement strategies, and addressing barriers to treatment access will be critical to maximizing the impact of viral suppression on reducing HIV transmission.

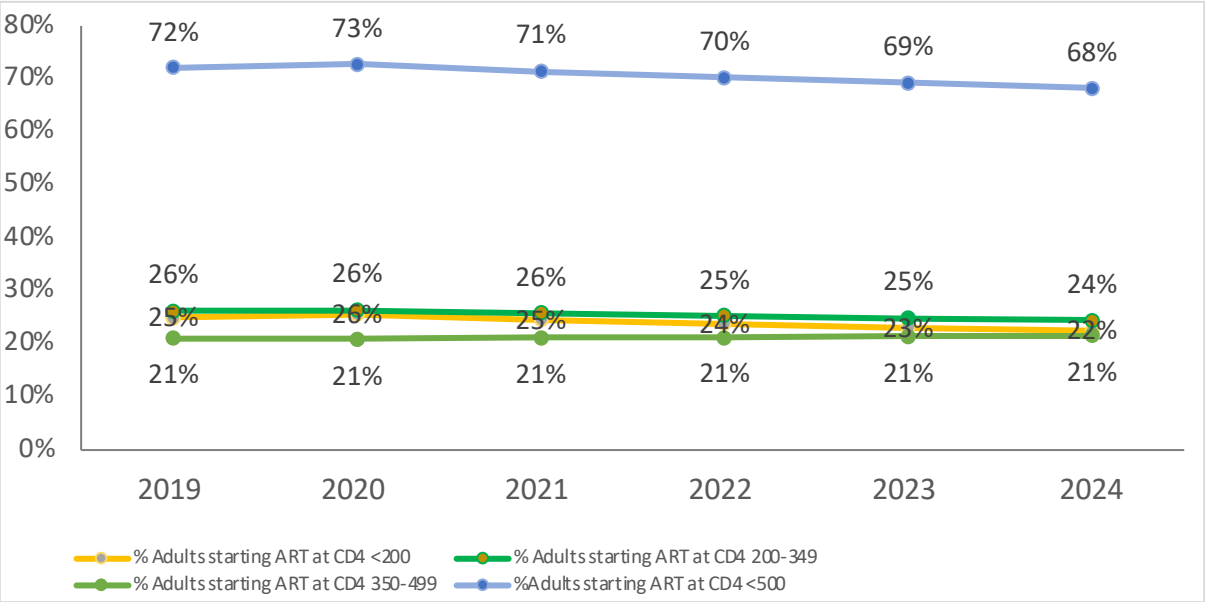
ADVANCED HIV DISEASE AND LATE HIV DIAGNOSIS

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 remains an important proxy for assessing the timeliness of HIV diagnosis and linkage to care. Figure 11 presents trends from the Thembisa Model (version 4.8) in the percentage of adults initiating ART across different CD4 thresholds between 2019 and 2024. Despite the policy shift towards immediate treatment regardless of CD4 count, a substantial proportion of individuals continue to initiate ART at lower CD4 levels, indicating ongoing delays in diagnosis and treatment initiation. The proportion of adults starting ART with a CD4 count below 500 declined modestly from 72% in 2019 to 68% in 2024, reflecting some progress in earlier diagnosis but still indicating that most patients are initiating treatment before reaching higher CD4 levels.

Disaggregated trends show relatively stable patterns across CD4 categories over time. The proportion of individuals initiating ART at CD4 counts below 200 decreased slightly from 25% in 2019 to 22% in 2024, suggesting a gradual reduction in very late presentation. Similarly, those initiating at CD4 counts between 200–349 declined from 26% to 24%, while the proportion initiating between 350–499 remained largely unchanged at approximately 21% throughout the period. While these shifts indicate incremental improvements, the persistently high proportion of individuals initiating ART at CD4 counts below 500 underscores ongoing challenges in early HIV detection and timely linkage to care.

The relatively small changes over time suggest that, despite expanded testing and treatment policies, a significant number of individuals are still being diagnosed at advanced stages of infection or are experiencing delays in accessing treatment after diagnosis. These findings highlight the need to further strengthen early HIV testing strategies, including targeted and community-based approaches, as well as interventions that improve rapid linkage to care. Expanding index testing, self-testing, and differentiated service delivery models will be critical to ensure that more individuals are diagnosed earlier and initiated on ART at higher CD4 counts, thereby improving clinical outcomes and reducing HIV-related morbidity and mortality.

Figure 11: Percentage of all people starting ART at CD4 <500 (2019-2024)



Source: Thembisa Model ver. 4.8

HIV TESTING VOLUME AND POSITIVITY

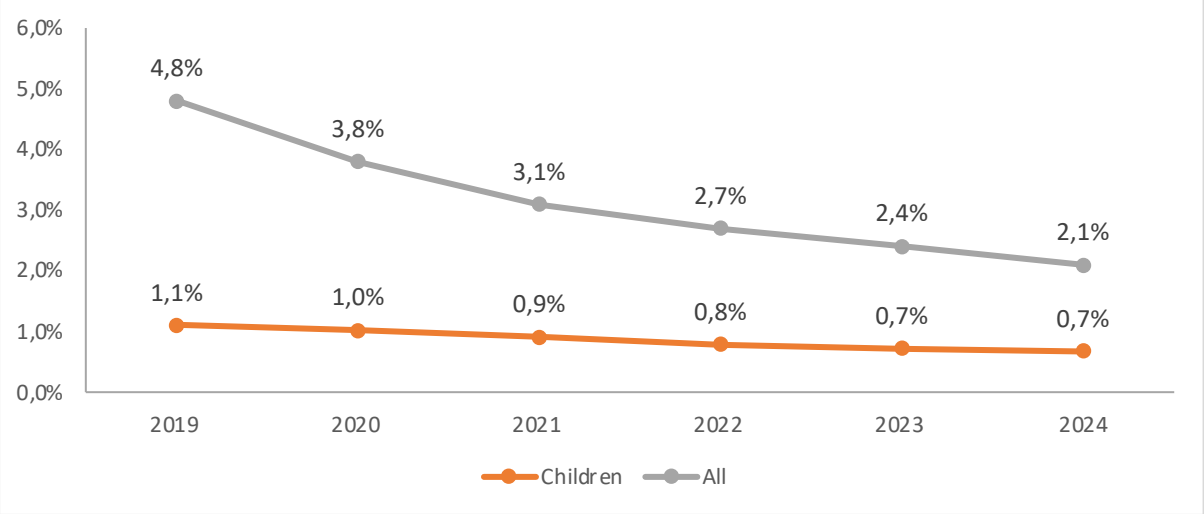
South Africa has continued to expand HIV testing services over time, with testing volumes increasing from approximately 18 million tests in 2019 to around 19 million in 2023. This sustained scale-up reflects ongoing efforts to improve early diagnosis, strengthen case-finding, and support linkage to care within the national HIV response. Figure 12 presents trends in HIV testing positivity between 2019 and 2024 for both children and the total population. Over this period, HIV positivity rates declined consistently across both groups. Among the total population, positivity decreased from 4.8% in 2019 to 2.1% in 2024, indicating a substantial reduction in the proportion of positive tests. Similarly, among children, positivity declined from 1.1% in 2019 to 0.7% in 2024, reflecting progress in early infant diagnosis, prevention of vertical transmission, and broader pediatric HIV interventions.

The declining positivity rates are indicative of progress in identifying and diagnosing a large proportion of people living with HIV, consistent with South Africa's achievement of the first 95 target. As testing programmes mature and reach saturation in higher-prevalent populations, a lower yield of positive results is expected. However, this trend also suggests that the remaining undiagnosed individuals are increasingly concentrated within hard-to-reach and underserved populations.

These populations may include men, adolescents, mobile populations, and individuals facing structural barriers such as stigma, geographic inaccessibility, and socio-economic constraints. As a result, further increases in testing volume alone are unlikely to substantially improve case detection without more targeted approaches. To enhance the efficiency and impact of HIV testing programmes, there is a need to shift towards more strategic, data-driven approaches. This includes scaling up index testing, expanding community-based and mobile testing services,

increasing the availability of HIV self-testing, and strengthening differentiated testing models tailored to specific population groups.

Figure 12: HIV testing positivity (2018-2022)



Source: Thembisa Model ver. 4.8; UNAIDS Online Tool

Such approaches will be critical to identifying the remaining undiagnosed individuals and ensuring that South Africa sustains progress towards epidemic control.

ANTIRETROVIRAL THERAPY COVERAGE AMONG PEOPLE LIVING WITH HIV IN KEY POPULATIONS

Table 10 presents trends in ART coverage among the general population and key populations between 2019 and 2024, highlighting both overall progress and persistent disparities in treatment access. ART coverage in the general population increased steadily from 69.4% in 2019 to 77.7% in 2024, reflecting continued expansion of treatment services and improved linkage to care. Among key populations, coverage levels vary considerably. Female sex workers (FSWs) consistently demonstrate higher ART coverage than the general population, increasing from 72.3% in 2019 to 79.2% in 2024. This trend reflects sustained investment in targeted programmes for this group and relatively strong engagement in HIV services.

In contrast, men who have sex with men (MSM) continue to have substantially lower ART coverage, although gradual improvements are evident. Coverage increased from 52.6% in 2019 to 62.4% in 2024, remaining well below both the general population and other key populations. This gap points to ongoing barriers related to stigma, discrimination, and access to appropriate, inclusive health services. ART coverage among people who inject drugs (PWID) shows variability and data gaps over time. Coverage increased from 39.3% in 2019 to 40.5% in 2020, with a notable rise to 77.5% in 2022, followed by a reported level of 61.7% in 2024. The inconsistency in data availability and fluctuations in coverage highlight challenges in both service delivery and routine monitoring for this population. For transgender individuals, available data indicate relatively high ART coverage in reported years, with 68.8% in 2019 and 83.6% in 2022.

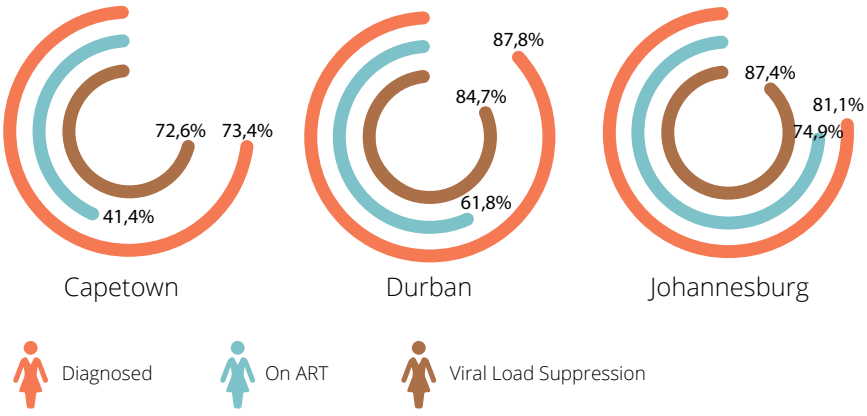
However, the absence of recent data limits the ability to assess current trends and programme performance for this group. Incarcerated populations consistently demonstrate the highest ART coverage across all groups, with levels above 98% in most years and reaching 99.6% in 2024. This reflects the structured nature of healthcare delivery within correctional facilities, where testing, treatment initiation, and adherence can be more systematically managed. Overall, while ART coverage has improved across most populations, significant disparities persist, particularly among MSM and PWID. These gaps are driven by structural barriers, including stigma, criminalization, and limited access to tailored services.

Table 10: ART coverage among key populations

	2019	2020	2021	2022	2023	2024	DATA SOURCE
ART coverage (General Population)	69,4%	72,0%	73,8%	75,4%	76,6%	77,7%	Thembisa Model 4.8
ART coverage in FSW (sex workers living with HIV)	72,3%	74,9%	76,4%	77,6%	78,4%	79,2%	Thembisa Model 4.8
ART coverage in MSM (men who have sex with men living with HIV)	52,6%	55,8%	58,0%	59,9%	61,3%	62,4%	Thembisa Model 4.8
ART coverage in PWID (people who inject drugs living with HIV)	39.3%	40.5%	No data	77.5%	No data	61,7%	UNAIDS Reporting Tool
ART coverage in TG (transgender people living with HIV)	68.8%	No data	No data	83.6%	No data	No data	UNAIDS Reporting Tool
ART coverage in inmates (prisoners living with HIV)	98.8%	99.1%	99.3%	No data	90.9%	99,6%	UNAIDS Reporting Tool

Addressing these inequities will require strengthening targeted and differentiated service delivery models, expanding harm reduction interventions, and improving data systems to ensure more consistent monitoring of key populations. Ensuring equitable access to ART across all populations will be critical to closing the treatment gap and maximizing the impact of South Africa's HIV response. Although Integrated Biological and Behavioural Surveillance (IBBS) studies have not been recently updated, the 2018 data remain the most recent city-level insights into the HIV 95-95-95 cascade among female sex workers (FSW), noting differences from Thembisa estimates due to methodological variations.

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



Source: South African Health Monitoring study, 2018

HIV status awareness ranged from 73.4% to 87.8%, ART coverage from 41.4% to 74.9%, and viral load suppression from 72.6% to 87.4% across cities (Figure 13). These findings highlight persistent gaps in testing, treatment uptake, and retention. Updated IBBS data and strengthened, targeted interventions for FSW and MSM are critical to improving cascade outcomes and advancing progress towards the 95-95-95 targets.

Female Sex Workers (FSWs)

Findings from the 2018 IBBS show that FSW have not met the 95-95-95 targets across cities, with key gaps across the cascade. ART coverage among those aware of their status remains low and variable (41.4%–74.9%), indicating barriers to treatment access despite UTT. Although viral suppression among those on ART is relatively high (72.6%–87.4%), gaps in testing, linkage, and retention limit overall impact. Strengthening targeted services and reducing structural barriers will be critical to improving outcomes for FSW.

Men Who Have Sex with Men (MSM)

Findings from the South African Men's Health Monitoring Study (2019) show suboptimal progress across the HIV cascade among MSM. HIV status awareness remains low, ranging from 62.9% in Mahikeng to 68.2% in Cape Town. ART coverage among those diagnosed varies widely (61.0%–82.5%), indicating disparities in treatment access. In contrast, viral suppression among those on ART is high (80.1%–92.7%), suggesting good adherence once treatment is initiated. These findings highlight the need to prioritize improved testing and linkage to care to strengthen cascade outcomes among MSM (Figure 14).

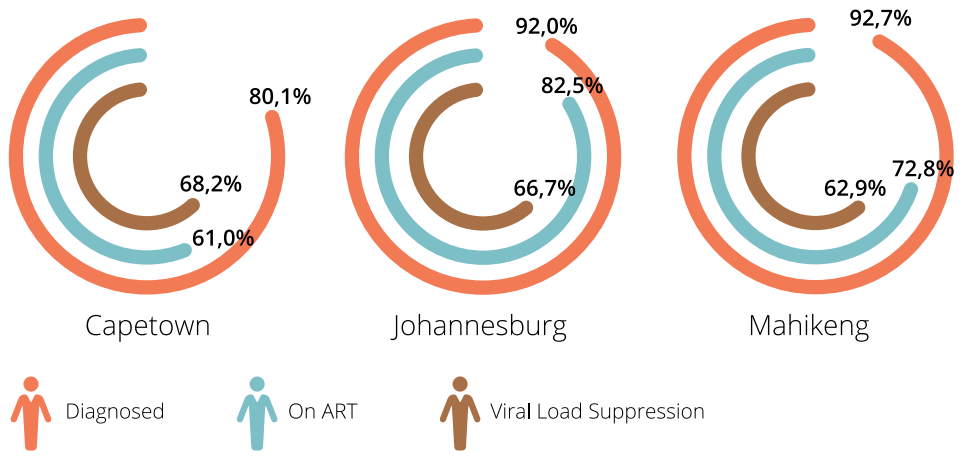
Key Priorities for Strengthening HIV Services for Key Populations

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:

- Scale up targeted and community-led HIV testing (including self-testing)
- Strengthen rapid linkage to ART, particularly for FSW and MSM
- Expand adherence and retention support through differentiated service delivery
- Address stigma, legal, and structural barriers limiting access to care

Strengthening these areas is essential to close gaps in the cascade and advance progress towards the 95-95-95 targets among key populations.

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)

Progress toward the 95-95-95 targets among MSM remains suboptimal across surveyed cities. Fewer than 70% of MSM living with HIV are aware of their status, indicating persistent gaps in testing and case finding. Among those diagnosed, ART coverage remains uneven and as low as 61.0% in some settings, despite the Universal Test and Treat (UTT) policy, pointing to barriers in treatment initiation and access. Viral suppression among MSM on ART is generally high—exceeding 90% in Johannesburg and Mahikeng—suggesting strong adherence among those engaged in care. However, performance is more variable in other settings, highlighting the need to strengthen retention and continuity of care.

Transgender Women (TGW) and Transgender Men (TGM)

HIV burden among transgender women remains disproportionately high. While national prevalence in the general population is approximately 12.7% (SABSSM, 2022), estimates among TGW are substantially higher, reaching 63% in Johannesburg and around 50% in Cape Town and Buffalo City (Cloete et al., 2019). Data for transgender men are limited, although global evidence suggests HIV prevalence may be significantly elevated compared to the general population (Scheim et al., 2020). In South Africa, population estimates indicate approximately 87,214 TGW, 28,065 TGM, and 66,076 gender non-conforming individuals (Tshuma et al., 2021). Despite this high burden, engagement in HIV services remains constrained by structural and health system barriers, including stigma and discrimination in healthcare settings, limited provider capacity, and a lack of gender-affirming services (Scheibe et al., 2018). These factors contribute to delayed diagnosis, lower ART uptake, and poorer health outcomes.

Priority Actions

- Expand targeted and peer-led HIV testing, including self-testing approaches
- Strengthen rapid linkage to ART for MSM and transgender populations

- Enhance adherence and retention through differentiated, client-centred models
- Improve provider training on gender-affirming care to reduce stigma
- Strengthen data systems, including generating national estimates for transgender men

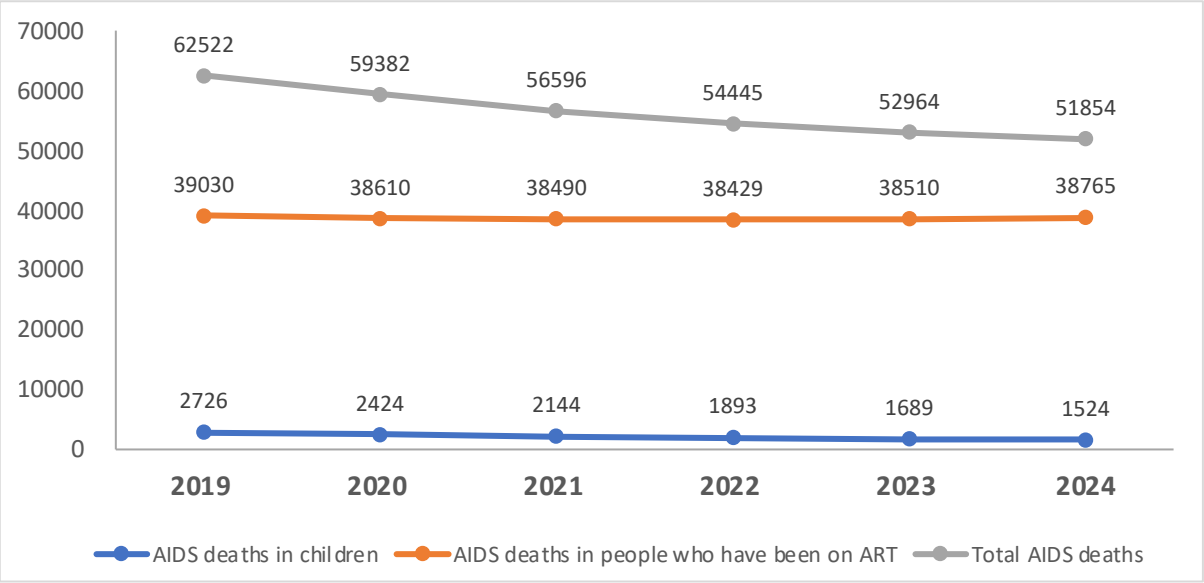
Addressing these gaps will be critical to improving cascade outcomes and advancing progress towards the 95-95-95 targets among key populations.

AIDS MORTALITY

Figure 15 shows a sustained decline in AIDS-related mortality in South Africa from 2019 to 2024. Total AIDS deaths decreased from 62,522 in 2019 to 51,854 in 2024, reflecting continued improvements in HIV treatment access and disease management. Among children, deaths declined steadily from 2,726 to 1,524 over the same period, indicating strong progress in paediatric HIV interventions. In contrast, AIDS-related deaths among individuals on ART remained relatively stable, fluctuating slightly from 39,030 in 2019 to 38,765 in 2024. This suggests that while treatment coverage has expanded, challenges with long-term adherence, late initiation, and co-morbidities persist among those already on treatment.

The overall downward trend underscores the impact of expanded ART coverage, earlier diagnosis, and improved retention in care. However, the slower decline among those on ART highlights the need to strengthen treatment quality, adherence support, and management of advanced HIV disease. Continued investment in resilient and integrated HIV services will be critical to sustaining and accelerating reductions in AIDS-related mortality.

Figure 16: Trends in AIDS mortality among children and adults



MANAGEMENT OF CRYPTOCOCCAL INFECTION

National data on the full management cascade for cryptococcal infection in South Africa remain limited. The World Health Organization (WHO) recommends flucytosine-based regimens, including a 1-week induction with amphotericin B deoxycholate and flucytosine (WHO, 2018). However, South Africa's Standard Treatment Guidelines still prescribe a 2-week induction with amphotericin B and fluconazole. Although flucytosine was registered by the South African Health Products Regulatory Authority (SAHPRA) in December 2021, its uptake in the public sector remains limited.

A multi-centre observational study (2018–2020) involving 10,668 adults with confirmed cryptococcal meningitis or disseminated cryptococcosis showed significantly lower in-hospital mortality among patients receiving flucytosine-containing regimens, with outcomes comparable to clinical trial findings (Mashau et al., 2022). Despite this evidence, only a minority of patients currently access flucytosine, limiting its potential to reduce mortality. Expanding access through improved policy alignment, procurement, and provider training is critical.

ACHIEVEMENTS

- South Africa has achieved the first UNAIDS 95 target (95% diagnosed) and is close to the third, with high viral suppression among those on ART, though dependent on suboptimal ART coverage.
- AIDS-related deaths among children declined substantially from 2,891 in 2019 to 1,723 in 2023, reflecting improved paediatric HIV care.

CHALLENGES

- Children lag adults across all three 95-95-95 targets.
- ART coverage remains below target, with approximately 75% of the general population on treatment.
- Late diagnosis persists, with over 60% initiating ART at CD4 <500 and 28% at CD4 <200.
- Key populations continue to show gaps in service coverage, as reflected in IBBS (2018) findings.

RECOMMENDATIONS

- Strengthen paediatric HIV diagnosis, treatment, and viral suppression interventions.
- Improve ART initiation and retention to close the treatment gap.
- Promote early testing and rapid ART initiation.
- Expand data and targeted interventions for key populations, addressing stigma and access barriers.
- Urgently scale up access to flucytosine for cryptococcal meningitis to reduce preventable mortality (Mashau et al., 2022).

POLITICAL DECLARATION AND FRAMEWORK 3: END PEDIATRIC AIDS AND ELIMINATE VERTICAL TRANSMISSION

SCORECARD ANALYSIS

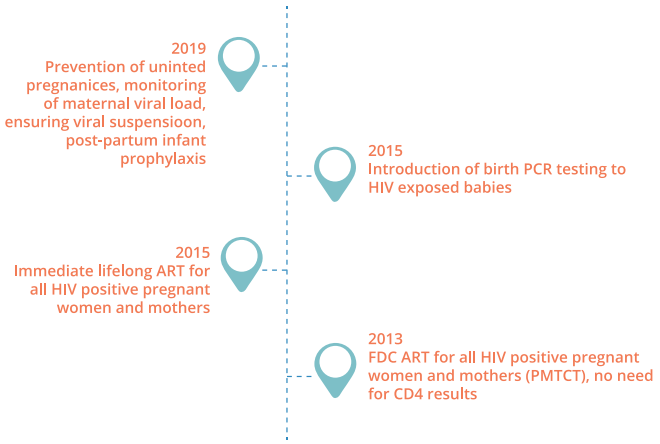
INDICATOR	RESULT
Is indicator/topic relevant?	YES
Is it addressed in the national strategic plan	Yes
Has the country reached the framework target?	No
How likely is the country to reach the target by 2025?	Unlikely

LEGAL AND POLICY ENVIRONMENT

HIV continues to place a significant burden on children in South Africa. By the end of 2024, Thembisa Model (version 4.8) estimates indicate that approximately 170,000–175,000 children under the age of 15 were living with HIV. During the same period, an estimated 9,215 new infections occurred among children, reflecting ongoing challenges in preventing vertical transmission. Of the 51,854 AIDS-related deaths recorded in 2024, approximately 1,524 (around 3%) occurred among children, underscoring persistent gaps in early diagnosis and timely access to treatment. Beyond the clinical burden, HIV continues to affect children's emotional, social, and economic well-being. Children in HIV-affected households often experience stigma and discrimination, assume caregiving responsibilities, and face financial hardship linked to illness and loss of household income. These realities highlight the need for a comprehensive, rights-based response that addresses both health and social vulnerabilities.

South Africa has established a strong legal and policy framework to protect children affected by HIV. The Children's Act (2010) prohibits discrimination based on health status (Section 6(2)(d)), ensuring equitable access to services. It also allows children aged 12 years and older to access contraceptives independently (Section 134), supporting autonomy in sexual and reproductive health. Additional policy frameworks and interventions (Figure 16) aim to prevent new infections and ensure timely treatment. Strengthening implementation, expanding prevention strategies, and improving pediatric treatment coverage will be critical to reducing new infections and improving outcomes for children affected by HIV and AIDS.

Figure 16: Legal and policy framework for ending pediatric HIV and eliminating vertical transmission



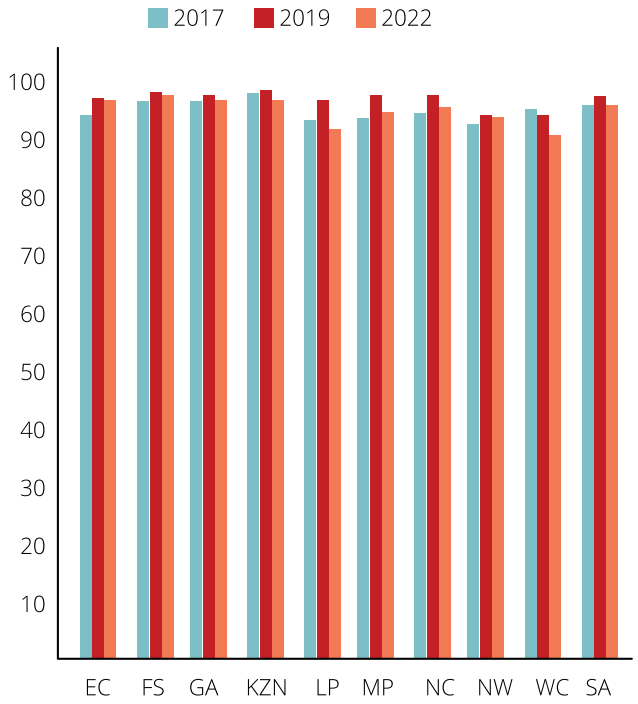
Source: Bello et al., 2021

HIV TESTING IN PREGNANT WOMEN

The 2022 Antenatal Care (ANC) Survey, based on medical record reviews, demonstrates near-universal HIV testing and strong treatment uptake among pregnant women attending ANC services. HIV testing was offered to 99.9% (35,498) of attendees, with almost all women (99.97%, 34,982) either accepting testing or already knowing their HIV status. Among the 10,726 women who tested HIV-positive through enzyme immunoassay (EIA), 96.0% (10,300) were already aware of their status. Of those aware, and excluding 133 with unknown treatment status, 98.8% (10,166) had been initiated on ART (Figure 17).

Provincially, knowledge of HIV-positive status ranged from 90.9% in the Western Cape to 97.8% in the Free State, indicating consistently high but uneven coverage. ART initiation among those aware of their status was similarly high, ranging from 97.8% in the Western Cape to 99.4% in North West. Notably, the proportion of HIV-positive women who knew their status and were on ART improved from 96% in 2019 to 98.8% in 2022, reflecting strengthened linkage to care. Overall, these findings highlight the success of integrating HIV testing and treatment within ANC services, while underscoring the need to address remaining provincial disparities and sustain high ART coverage to eliminate vertical transmission.

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



Source: ANC survey report, 2022

EARLY INFANT DIAGNOSIS

Early HIV diagnosis among HIV-exposed infants remains critical for timely treatment initiation and improved survival. National guidelines recommend routine HIV PCR testing at birth (within seven days), at 10 weeks for those testing negative at birth, and again at six months if still HIV-negative, unless earlier testing is clinically indicated (Bello et al., 2021). Data indicate consistently high early infant diagnosis (EID) coverage up to 2022, increasing from 94.1% in 2018 to 98.6% in 2022. In 2024, a total of 190,772 infants received a virological test within two months of birth, of whom 713 tested positive, reflecting a low positivity rate and continued progress in reducing vertical transmission. Earlier data show a steady decline in positive cases, from 1,555 in 2018 to 1,118 in 2022, reinforcing improvements in prevention of mother-to-child transmission (PMTCT).

While testing coverage remains strong, recent gaps in reporting (2023–2024) highlight the need for strengthened routine data systems. Continued efforts to improve maternal ART adherence, ensure early testing, and maintain rapid linkage to care for HIV-positive infants will be essential to sustain gains and further reduce pediatric HIV infections.

Table 11: Early Infant Diagnosis (2018-2024)

	2018	2019	2020	2021	2022	2023	2024
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	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	190,772
Test result- Positive	1,555	1538	1381	1298	1,118	No data	713
Test result- Negative	252,163	259,367	266,866	269,485	234,391	No data	No data

Source: UNAIDS Online Tool

VERTICAL TRANSMISSION OF HIV

According to Thembisa Model estimates (Table 12), South Africa has achieved steady declines in mother-to-child transmission (MTCT) of HIV over the period 2019–2024. By 2024, the overall MTCT rate had decreased to 2.63%, while transmission at or before birth declined to 0.91%. Among HIV-diagnosed mothers, the MTCT rate at or before birth was lower at 0.65%, reflecting the impact of improved maternal ART coverage and early intervention. Postnatal transmission up to 18 months among HIV-diagnosed mothers remained low and stable at 0.41% in 2024, indicating sustained effectiveness of postnatal ART adherence and infant prophylaxis during breastfeeding. The consistent downward trend across all MTCT indicators highlights the success of prevention of vertical transmission (VTP) programmes.

Thembisa Model estimates provide a comprehensive national perspective, capturing both public and private sector dynamics (Bello et al., 2021). While progress is evident, continued focus on early maternal diagnosis, sustained ART adherence, and strengthened postnatal follow-up will be critical to further reduce transmission and move towards elimination of mother-to-child transmission.

PREVENTING THE VERTICAL TRANSMISSION OF HIV

This indicator assesses the proportion of pregnant women living with HIV who receive ART to prevent mother-to-child transmission (MTCT). According to the 2022 ANC Survey, among HIV-positive women who knew their status before pregnancy and had reported treatment status (n=7,296), 84.2% (6,173) were already on ART prior to pregnancy. Across all EIA-positive participants, 76.5% had initiated ART before pregnancy, reflecting progress in early treatment initiation.

Table 12: Performance of MTCT indicators (2019-2024)

INDICATOR	2019	2020	2021	2022	2023	2024
Mother-to-child transmission rate	3,09%	2,95%	2,82%	2,74%	2,67%	2,63%
MTCT rate at/before birth	1,07%	1,02%	0,99%	0,96%	0,93%	0,91%
MTCT rate at/before birth from HIV-diagnosed mothers	0,74%	0,72%	0,69%	0,68%	0,66%	0,65%
Postnatal MTCT rate to 18 months, from HIV-diagnosed mothers	0,47%	0,45%	0,43%	0,42%	0,41%	0,41%

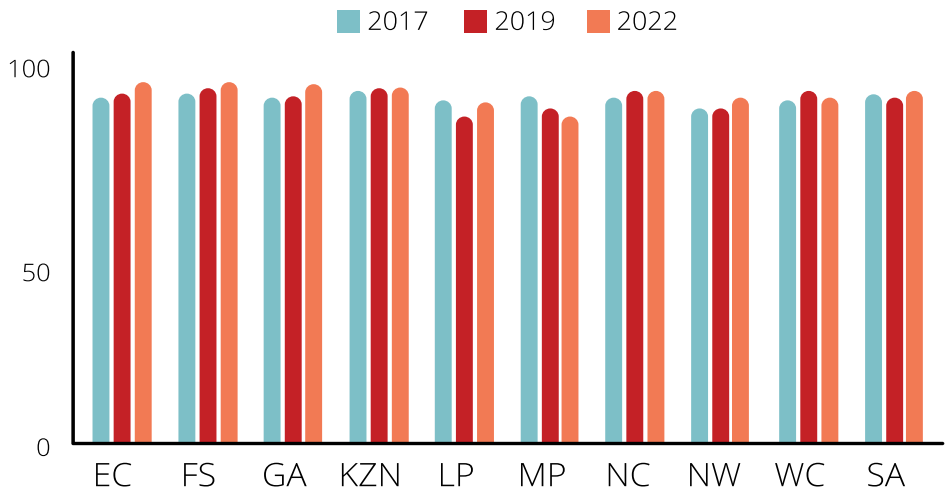
Source: Thembisa Model ver. 4.8

Knowledge of HIV-positive status before pregnancy improved substantially, increasing from 60.8% (95% CI: 59.9–61.7) in 2017 to 78.1% (95% CI: 77.3–78.8) in 2022. However, ART initiation before pregnancy declined from 91.9% in 2017 to 84.2% in 2022, indicating emerging gaps in early treatment uptake and continuity of care. Age disparities persist, with lower ART initiation among women aged 20–24 years (80.5%) compared to those aged 35–49 years (85.4%) (p=0.000), highlighting the need for targeted interventions for younger women.

SYPHILIS AMONG PREGNANT WOMEN

The 2022 ANC Survey shows high maternal syphilis screening coverage, reaching 97.5% nationally, an increase from 96.4% in 2019 (Figure 18). All provinces achieved coverage above 90%, reflecting strong integration of syphilis screening within antenatal care services. However, 2.5% of participants had missing screening data. Assuming these represent unscreened individuals, national coverage would decline to 95.0%. While progress is evident, improving data completeness and ensuring universal screening remain essential to prevent 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: 2019 Antenatal HIV sentinel survey

Syphilis Screening, Prevalence, and Treatment Coverage Among Pregnant Women

The 2022 Antenatal Care (ANC) Survey shows that among women screened for syphilis, 2.6% (992) tested positive and 78.2% (27,677) tested negative, while 18.4% (5,516) results were pending and 0.9% (262) were missing. Overall, 19.2% of results were incomplete, similar to 20.5% in 2019. Provincial disparities were evident, with missing results lowest in the Western Cape (2.6%) and highest in Gauteng (31.7%). Excluding missing and pending results, national syphilis prevalence was 3.1% (95% CI: 2.9–3.3%), highest in KwaZulu-Natal (4.4%) and lowest in Limpopo (1.4%).

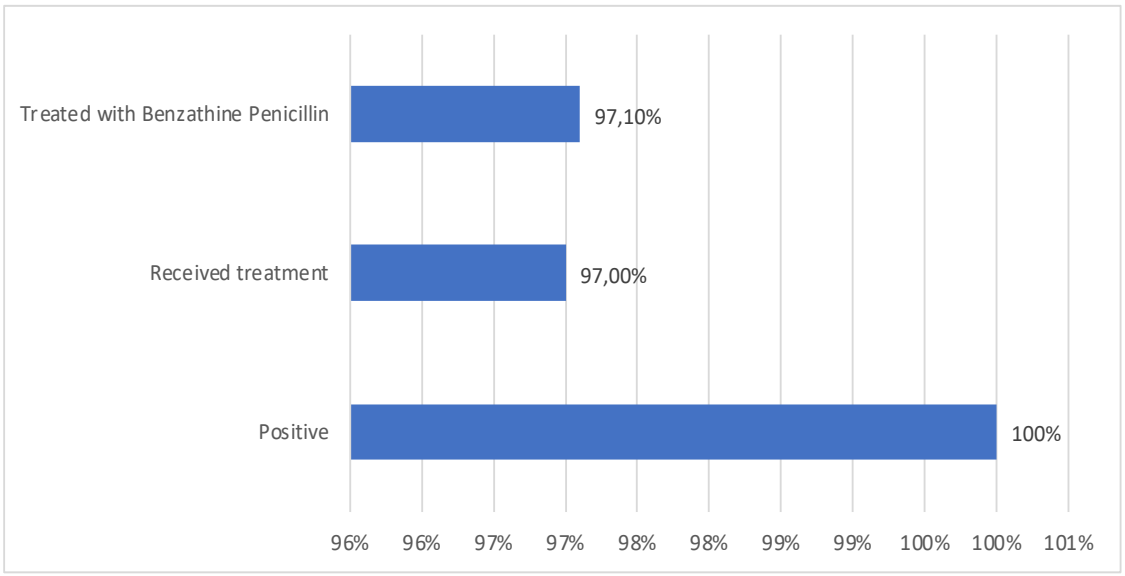
Syphilis Treatment Coverage

Among 941 syphilis-positive women with documented treatment status, 97.0% (911) received treatment. Of those with treatment type recorded (n=847), 97.1% (827) received at least one dose of Benzathine Penicillin (BPG), equivalent to 85% coverage among all positive cases (Figure 19). If missing data are treated as not treated, overall treatment coverage declines to 92.2% and BPG coverage to 89.1%. These findings highlight strong treatment uptake but underscore persistent gaps in test result documentation and completeness. Strengthening data systems, ensuring timely result capture, and maintaining universal access to treatment remain critical to preventing congenital syphilis.

HEPATITIS B VIRUS AMONG PREGNANT WOMEN ATTENDING ANTENATAL CARE

No routine national data were available for 2022. However, a study among 1,194 HIV-negative pregnant women found an overall HBV prevalence of 0.67% (95% CI: 0.34–1.32%) (Davey et al., 2022). Prevalence was 1.29% among women born before 1995 and 0% among those born after HBV vaccine introduction, demonstrating the impact of immunization. Data gaps remain on HBV DNA testing, treatment eligibility, and antiviral uptake, underscoring the need for improved routine surveillance.

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



Source: 2019 Antenatal HIV sentinel survey

ACHIEVEMENTS

- Over 99% of pregnant women know their HIV status, strengthening PMTCT entry points
- MTCT continued to decline, reaching 2.63% in 2024 (down from 3.29% in 2018) (Thembisa Model 4.8)
- Transmission at/before birth reduced to 0.91% in 2024, with postnatal MTCT stable at 0.41%, reflecting strong maternal ART and infant follow-up (Thembisa Model 4.8)
- Syphilis screening coverage remains high at approximately 95%, supporting early detection and treatment

KEY CHALLENGES

- ART initiation before pregnancy declined (91.9% in 2017 to 84.2% in 2022) despite improved HIV status awareness
- Lower ART uptake among younger women (20–24 years: 80.5% vs. 85.4% in older women)
- Persistent syphilis prevalence (~2.6–3.1%), indicating limited decline despite high screening coverage

RECOMMENDATIONS

- Strengthen early ART initiation before pregnancy, with targeted interventions for women of reproductive age, particularly adolescents and young women.
- Implement targeted strategies for younger women (20–24 years) to improve ART uptake and retention in care.
- Enhance maternal ART adherence and continuity of care throughout pregnancy and breastfeeding to further reduce vertical transmission.
- Improve early infant diagnosis (EID) data systems, including closing reporting gaps for 2023–2024 and ensuring complete, timely data capture.

- Strengthen linkage to care and rapid treatment initiation for HIV-positive infants to reduce paediatric morbidity and mortality.
- Maintain and expand high antenatal HIV and syphilis screening coverage, ensuring universal testing across all provinces.
- Improve data completeness for syphilis testing and results, particularly addressing high levels of missing and pending results in some provinces.
- Sustain and optimise syphilis treatment coverage, ensuring timely administration of Benzathine Penicillin for all positive cases.
- Strengthen surveillance and reporting systems for congenital syphilis, including improving case definition awareness and transitioning from paper-based to digital reporting.
- Expand routine screening and surveillance for Hepatitis B among pregnant women, including HBV DNA testing and treatment eligibility assessments.
- Integrate comprehensive maternal, child health, and HIV services, ensuring continuity from antenatal care through postnatal follow-up.
- Address social determinants affecting children in HIV-affected households, including stigma, poverty, and caregiving burden, through integrated social and health interventions.

POLITICAL DECLARATION AND FRAMEWORK 4: GENDER EQUALITY AND EMPOWERMENT OF WOMEN AND GIRLS


SENZENI NA? STOP KILLING US
WE FEEL THE PAIN ALWAYS
The Total Shut Down
STOP THE VIOLENCE

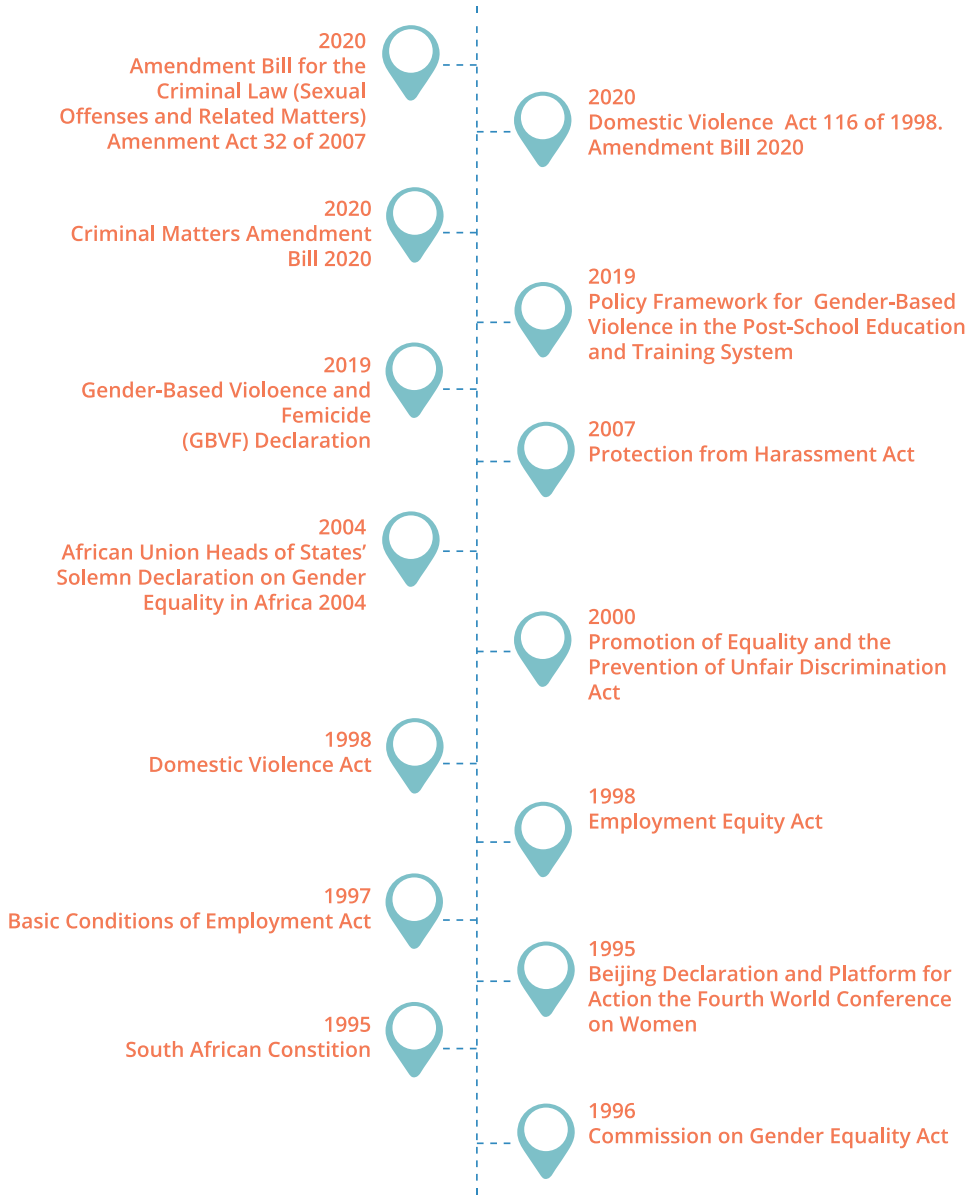
LEGAL AND POLICY ENVIRONMENT

South Africa has established a comprehensive legislative and policy framework to address gender-based violence (GBV) and promote gender equality, in line with its international commitments. Key laws underpinning this response include the Domestic Violence Act (1998), the Sexual Offences Act (2007), and the Prevention and Combating of Trafficking in Persons Act (2013). These are reinforced by the Bill of Rights in the Constitution, which enshrines gender equality and protection from discrimination as fundamental principles (DoJ, Bill of Rights, 1996). To operationalize these commitments, several national policy frameworks guide implementation. The National Policy Framework for Women's Empowerment and Gender Equality (1996) provide an overarching strategy for advancing gender equity, while the National Development Plan (NDP) Vision 2030 positions gender equality as central to inclusive development (National Development Plan, 2013). The Gender Equality Amendment Act No. 17 of 2013 further strengthens institutional mechanisms to advance gender justice and eliminate discrimination.

South Africa's legal framework also protects workplace and human rights. The Employment Equity Act No. 55 of 1998 prohibits mandatory HIV testing in employment settings (Employment Equity Act, 1998), while Chapter 9 institutions ensure that people living with HIV and their families enjoy full and equal rights under the Constitution (Human Rights Commission, 1996). The Constitution provides the foundation for institutional accountability in responding to GBV, emphasizing equality, dignity, and personal security. The Commission for Gender Equality (CGE) plays a central role in promoting women's rights and monitoring progress. In 2020, South Africa adopted the National Strategic Plan on GBV and Femicide (NCGBVF) 2020–2030, providing a coordinated framework to address GBV and intimate partner violence. This was supported by the establishment of the GBV and Femicide Response Fund, which mobilized R128 million to support vulnerable populations, including women with disabilities, migrant women, and transgender women.

Implementation is coordinated at the highest level, with the national gender programme located in the Presidency. Provincial Offices on the Status of Women and departmental Gender Focal Points report to both provincial leadership (Premiers, MECs, Directors-General) and national structures, ensuring alignment and accountability. South Africa's legal framework criminalizes multiple forms of GBV—including physical, sexual, emotional, psychological, and economic violence, as well as marital rape—and extends protection to former and unmarried partners. Through these legislative, policy, and institutional mechanisms, the country continues to strengthen its response to GBV, advance gender equality, and protect the rights of women and vulnerable populations.

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



Source: Bello et al., 2021

STATUS AND PROGRESS

South Africa has established national protocols and guidelines for training personnel who respond to cases of sexual abuse against children and gender-based violence (GBV) against women. These frameworks ensure that frontline responders, including healthcare providers, law enforcement officials, and social workers—are equipped to provide survivor-centred care, facilitate access to justice, and link individuals to appropriate health and psychosocial services. In addition to general criminal laws prohibiting violence, the country has specific legal protections that address violence against people living with HIV (PLHIV) and key populations,

alongside targeted programmes addressing intimate partner violence, workplace violence, police abuse, and ill-treatment within correctional settings.

Service delivery platforms in South Africa incorporate comprehensive post-rape care aligned with World Health Organization (WHO) guidelines. These services include first-line support and psychological care, emergency contraception, sexually transmitted infection (STI) prophylaxis or treatment, HIV post-exposure prophylaxis (PEP), and access to safe abortion services within the legal framework. More than 80% of health facilities provide these integrated services, reflecting broad national coverage (NCPI, 2021). In addition, survivors of violence have access to free legal services, with Thuthuzela Care Centres playing a pivotal role in delivering integrated medical, legal, and psychosocial support (SANAC NCPI Report, 2021).

Gender Disparities in HIV and the Need for Targeted Interventions

Despite overall declines in new HIV infections, significant gender disparities persist. Adolescent girls and young women (AGYW) remain disproportionately affected, accounting for 19% of new HIV infections globally in 2017, with 80% occurring in sub-Saharan Africa (UNAIDS, 2019). In South Africa, HIV prevalence among AGYW aged 15–24 is approximately four times higher than among their male counterparts (Shishana et al., 2014). These disparities underscore the need for intensified, gender-responsive interventions that address structural drivers of HIV risk, including GBV, economic vulnerability, and unequal power dynamics. Strengthening coordinated, multi-sectoral responses that integrate HIV prevention, GBV services, and stigma reduction remains critical.

Challenges and Gaps

While progress has been made, important gaps remain in addressing GBV and HIV among vulnerable populations. Efforts to scale up prevention, improve GBV case identification, and reduce stigma must be intensified, particularly for children, adolescents, youth, men, and key populations, where HIV incidence remains high (State Gov., 2022). These groups continue to face elevated exposure to intimate partner violence and sexual violence, alongside persistent barriers to accessing HIV testing, prevention services, and post-exposure care. Addressing these structural and service delivery barriers is essential to achieving sustained reductions in HIV transmission and improving health outcomes.

Fluctuations in GBV and Sexual Offences Reports

Table 13 presents South African Police Service (SAPS) data on reported GBV and sexual offences from 2019/20 to 2023/24, showing notable year-to-year fluctuations. These trends indicate that GBV remains a persistent and unresolved challenge, and a key structural driver of HIV incidence in South Africa. The variability in reported cases reflects both changes in reporting patterns and the continued burden of violence, underscoring the need for sustained and strengthened interventions. Addressing GBV requires a coordinated, multi-sectoral response that prioritizes prevention, expands survivor-centred services, and improves access to justice. Strengthening these efforts—alongside integrated HIV prevention strategies—will be critical to reducing new infections and advancing progress toward eliminating gender-based violence.

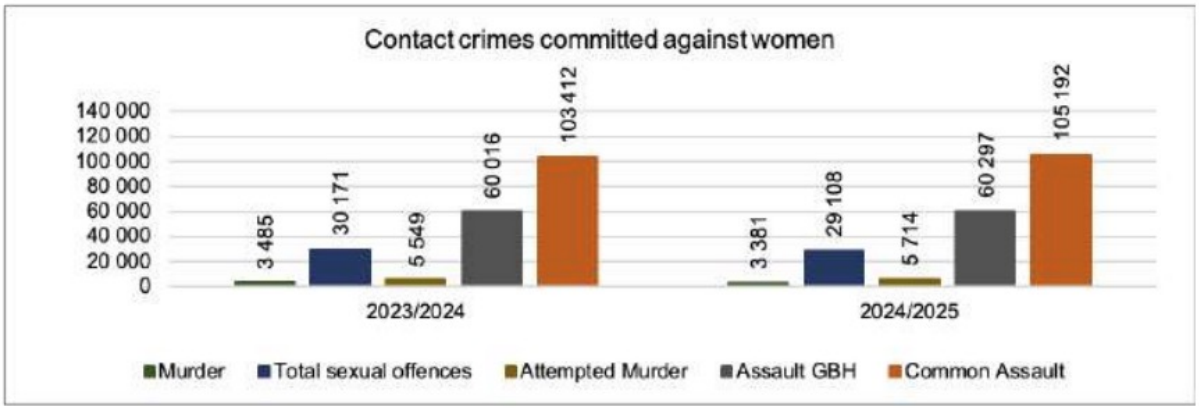
Table 13: Crime situation in South Africa

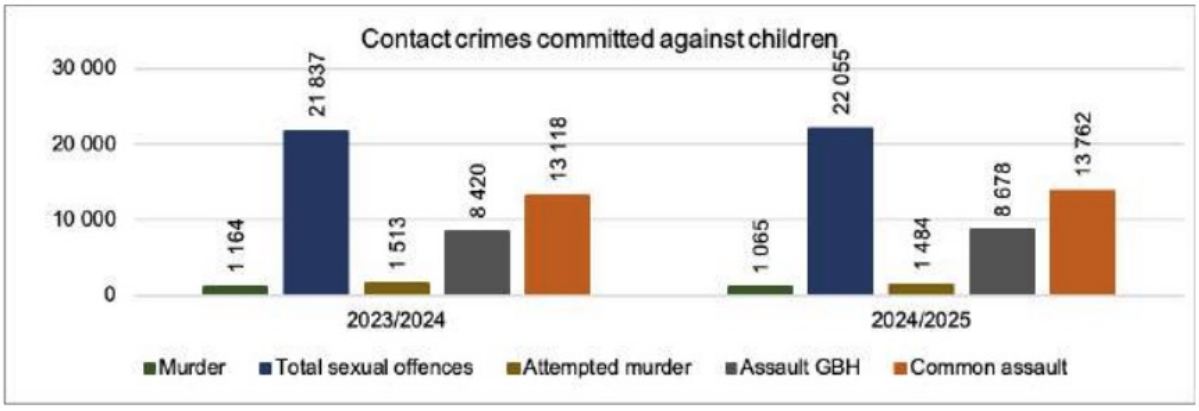
	2019-20	2020-21	2021-22	2022-23	*2023-24	*2024-25	% CHANGE
Rape	42 289	36 330	41 739	43 187	42 946	42 206	0%
Sexual assault	7 749	7 025	7 798	7 602	7 505	7 368	-5%
Attempted sexual offences	2 076	1 800	2 027	2 383	2 567	2 558	23%
Contact sexual offences	1 179	1 059	1 130	868	755	829	-30%

Source: South African Police Service, 2024-25[2] pg. 112

Gender-based violence (GBV) remains a major public health and social challenge in South Africa, with intimate partner violence (IPV) as a key driver. According to the South African National HIV Prevalence, Incidence, Behaviour and Communication Survey V, 29.1% of ever-married or partnered women aged 15–49 experienced physical or sexual violence from a male intimate partner in the past 12 months (Simbayi et al., 2019). This burden intensified during the COVID-19 pandemic in 2020, with variations shaped by underlying socioeconomic and structural factors (Gill, 2021).

Figure 21: Selected contact crimes against women and children





Source: South African Police Service, 2024-25[3] pg. 122

[2]https://www.gov.za/documents/annual-reports/south-african-police-service-annual-report-20242025-15-oct-2025

Despite ongoing national interventions, reporting of GBV remains limited. The Governance, Public Safety and Justice Survey (GPSJS) recorded 53,773 sexual offence cases reported to the South African Police Service (SAPS) in 2023/24, a slight decrease from 54,040 cases in 2022/23 (South African Police Service Report, 2022, 2023; Bello et al., 2021). While this decline may suggest progress, broader evidence indicates that GBV-related violence remains widespread and, in some contexts, increasing. As illustrated in Figure 21, the persistence and upward trends in GBV cases underscore the urgent need to strengthen prevention efforts, expand survivor-centred services, and improve reporting systems to ensure greater protection, accountability, and access to justice for victims.

PHYSICAL AND/OR SEXUAL VIOLENCE EXPERIENCED BY KEY POPULATIONS

Violence Against Key Populations in South Africa

There is limited recent national data on the proportion of key populations experiencing physical and/or sexual violence in the past 12 months. However, available literature highlights a substantial burden of violence, particularly among female sex workers (FSWs) and Lesbian, Gay, Bisexual, Transgender, Queer, and others (LGBTQ+) populations.

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

FSWs living with HIV face compounded stigma related to both HIV status and occupation, with criminalization further limiting access to prevention, treatment, and care services (Baral et al., 2012). HIV-related stigma is also associated with poorer ART adherence, higher viral loads, and adverse mental and physical health outcomes (Zeng et al., 2020). A national multi-stage survey of 3,005 FSWs reported extremely high levels of violence (Jewkes et al., 2019):

- 70.4% experienced physical violence
- 57.9% experienced rape, with perpetrators including clients (48.3%), intimate partners (31.9%), other men (30.2%), and police (14.0%)

Sexual IPV among FSWs was linked to food insecurity, childhood trauma, Post-Traumatic Stress Disorder (PTSD), alcohol use, and increased vulnerability within sex work contexts (Jewkes et al., 2019). These findings align with earlier evidence showing that 71% of sex workers experienced violence in 2015.

Legal Protections and Challenges for LGBTQ+ Populations

South Africa has one of the most progressive legal frameworks globally, including constitutional protection against discrimination (1996), same-sex adoption (2002), marriage equality (2005), and legal gender recognition (2003). Despite this, LGBTQ+ individuals continue to face widespread violence, harassment, and discrimination across communities and public services. Weak law enforcement responses and persistent stigma limit access to justice and protection.

Call for Action

The high burden of violence among FSWs and LGBTQ+ populations underscores the need to strengthen protection mechanisms, improve law enforcement responsiveness, and expand survivor-centred services. Bridging the gap between legal protections and lived realities remains critical to ensuring equitable access to healthcare, justice, and social support for key populations.

ATTITUDES TOWARDS VIOLENCE AGAINST WOMEN

Data on societal attitudes toward intimate partner violence (IPV)—measured as the proportion of women and men aged 15–49 who believe a husband is justified in hitting or beating his wife under certain circumstances—are collected through population-based surveys. The most recent available evidence from the South African Demographic and Health Survey (DHS) indicates that approximately 25% (2,930 of 11,717 respondents) endorsed such views (DHS, 2016), reflecting the persistence of harmful gender norms that normalize violence.

Forthcoming survey data will be critical to assess whether these attitudes have shifted over time and to inform targeted interventions aimed at challenging and transforming societal norms that perpetuate gender-based violence.

GENDER-RESPONSIVENESS OF HIV SERVICES

At the time of compiling this report, no national data were available on the proportion of health facilities providing gender-responsive HIV services. However, both public and private healthcare facilities increasingly integrate gender-sensitive approaches into service delivery, supported by national programmes and international partners. Several flagship initiatives demonstrate South Africa's commitment to addressing gender dynamics and intersectionality in HIV services.

The DREAMS (Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe) Partnership, implemented in South Africa since 2016, focuses on reducing HIV incidence among adolescent girls and young women (AGYW) through a comprehensive, multi-sectoral package of interventions. Complementing this, the She Conquers Campaign (2016–2022), led by the South African National AIDS Council (SANAC), aimed to empower AGYW through integrated HIV prevention, sexual and reproductive health services, education, and socio-economic support.

In addition, the health system provides post-exposure prophylaxis (PEP) for survivors of gender-based violence (GBV), ensuring timely access to HIV prevention following sexual assault. Gender-responsive pre-exposure prophylaxis (PrEP) programmes are also being scaled up to reach high-risk populations, particularly women and AGYW, with tailored service delivery models that address barriers related to stigma, access, and autonomy.

While these programmes reflect significant progress, the absence of systematic monitoring and national indicators on gender-responsiveness limits the ability to assess coverage and quality. Strengthening measurement frameworks and ensuring consistent implementation across facilities remain critical to advancing gender-equitable HIV services.

The private sector also contributes to gender-responsive care. For example, Mediclinic Southern Africa partners with community-based organizations provide trauma-informed services for GBV survivors, improving access to integrated HIV prevention and treatment services (Figure 22). Despite these advances, gaps remain in routine monitoring and evaluation. Strengthening data systems and accountability mechanisms will be essential to ensure consistent implementation of gender-responsive HIV services across all health facilities.

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

ACHIEVEMENTS

- In 2020, South Africa launched the National Strategic Plan on GBV and Femicide (NCGBVF) 2020–2030, supported by a dedicated funding mechanism, providing a structured framework to strengthen GBV and IPV prevention, enhance survivor support services, and improve accountability.
- Private sector engagement, including partnerships led by Mediclinic Southern Africa, has strengthened service delivery through collaboration with community-based organisations (CBOs), ensuring access to integrated post-GBV care, including medical, psychosocial, and legal support.

KEY CHALLENGES

- Harmful cultural norms persist, with 25% of women and men aged 15–49 agreeing that a husband is justified in beating his wife under certain circumstances, reflecting entrenched attitudes that sustain GBV.
- Female sex workers (FSWs) continue to face high levels of violence—including sexual assault, physical abuse, and harassment by law enforcement—which increases their vulnerability to HIV and limits access to prevention and treatment services.

RECOMMENDATIONS

- Scale up targeted information and education interventions at facility and community levels to challenge harmful norms and promote gender equality, supported by sustained community engagement and behaviour change programmes.
- Conduct a comprehensive evaluation of the NCGBVF strategy and its implementation considering rising GBV cases reported by the South African Police Service (SAPS), to identify gaps, strengthen response systems, and improve accountability.

POLITICAL DECLARATION AND FRAMEWORK 6: REALIZE HUMAN RIGHTS AND ELIMINATE STIGMA AND DISCRIMINATION

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 statutory framework includes explicit protection against unfair discrimination toward 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 reinforces these protections by prohibiting employers from requiring HIV testing as a condition of employment and by promoting codes of good practice that safeguard employees and job applicants from discrimination based on HIV status ("Employment Equity Act, 1998"). South Africa is also the only country in Africa with 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") gives effect to Section 9 of the Constitution, strengthening protections against discrimination and harassment. The application of these protections is illustrated in the landmark case of Lallu v Van Staden (2011), where the Equality Court found that verbal abuse directed at a transgender woman constituted harassment, hate speech, and unfair discrimination, awarding damages and ordering remedial psychological counselling ("Lallu v Van Staden," 2011). Together, these legal instruments demonstrate South Africa's strong commitment to human rights and anti-discrimination. However, despite this progressive framework, sustained efforts are required to strengthen enforcement and address persistent stigma and structural barriers that continue to limit the full realization of these rights.

DISCRIMINATORY ATTITUDES TOWARDS PEOPLE LIVING WITH HIV

HIV-related stigma remains a persistent challenge in South Africa, despite gradual improvements in public attitudes toward people living with HIV (PLHIV). A 2017 population-based cross-sectional household survey, reported through the UNAIDS online tool, found that 7.5% of respondents believed children living with HIV should not attend school with HIV-negative children, while 12.6% indicated they would not buy vegetables from an HIV-positive vendor. These findings highlight the continued presence of discriminatory attitudes. More recent evidence from the 6th South African National HIV Prevalence, Incidence, and Behaviour Survey (SABSSM VI) points to improving social acceptance, with most respondents expressing

positive attitudes toward PLHIV and approximately two-thirds indicating they would keep a relative's HIV status confidential. This reflects growing recognition of human rights, dignity, and respect for individuals living with HIV.

In the absence of continuous national data, the People Living with HIV Stigma Index 2.0 in Six Districts of South Africa (2020–2021) provides important and more recent insights into stigma trends. The findings indicate that external stigma experienced by people living with HIV (PLHIV) in the previous 12 months varied across districts, ranging from 10% in Thabo Mofutsanyane (Free State) to 27.4% in eThekwini (KwaZulu-Natal) (Cloete et al., 2022). Encouragingly, both internalized and external stigma have declined over time, with internalized stigma reported at 23% and external stigma at 15% in 2020, compared to 43% and 35% in 2014, respectively (Simbayi et al., 2015).

While these trends reflect measurable progress, the Stigma Index 2.0 findings also highlight persistent pockets of stigma and discrimination, particularly at community and service delivery levels. Sustained efforts are therefore required to further reduce stigma through targeted awareness campaigns, strengthened policy enforcement, and community-led interventions, to promote full social inclusion and improve health outcomes for PLHIV.

INTERNALIZED STIGMA REPORTED BY PEOPLE LIVING WITH HIV

Despite progress in reducing HIV-related stigma, internalized stigma remains a significant challenge for people living with HIV (PLHIV). At the time of reporting, no updated national estimates were available; however, a recent study examining community perceptions highlighted persistent concerns related to self-image, guilt, and disclosure (Mokgatle & Madiba, 2023). The study found that 44% of respondents believed PLHIV feel worse about themselves, while 37% agreed that PLHIV experience guilt about their status, underscoring the ongoing psychological burden associated with living with HIV. Fear of disclosure remains particularly pronounced. The study reported that 73% of respondents considered HIV status disclosure to be risky, 86.6% believed that PLHIV are highly selective about whom they disclose to, and 41% indicated they would prefer to keep a family member's HIV status secret. These findings reflect persistent concerns about stigma, discrimination, and negative social consequences. Overall, these patterns demonstrate that internalized stigma continues to affect mental well-being, social acceptance, and engagement in care. Addressing this requires sustained efforts to strengthen HIV awareness, promote safe and supportive disclosure environments, and integrate mental health services within HIV care (Mokgatle & Madiba, 2023).

STIGMA AND DISCRIMINATION EXPERIENCED BY PEOPLE LIVING WITH HIV IN COMMUNITY SETTINGS

Despite progress in reducing HIV-related stigma, internalized stigma remains a significant challenge for people living with HIV (PLHIV). At the time of reporting, no updated national estimates were available; however, a recent study examining community perceptions highlighted persistent concerns related to self-image, guilt, and disclosure (Mokgatle & Madiba, 2023). The study found that 44% of respondents believed PLHIV feel worse about themselves, while 37% agreed that PLHIV experience guilt about their status, underscoring the ongoing psychological burden associated with living with HIV. Fear of disclosure remains particularly

pronounced. The study reported that 73% of respondents considered HIV status disclosure to be risky, 86.6% believed that PLHIV are highly selective about whom they disclose to, and 41% indicated they would prefer to keep a family member's HIV status secret. These findings reflect persistent concerns about stigma, discrimination, and negative social consequences.

Overall, these patterns demonstrate that internalized stigma continues to affect mental well-being, social acceptance, and engagement in care. Addressing this requires sustained efforts to strengthen HIV awareness, promote safe and supportive disclosure environments, and integrate mental health services within HIV care (Mokgatle & Madiba, 2023).

Implications

The findings highlight the need for targeted interventions to address disclosure-related concerns and reduce perceived community stigma. Although attitudes have improved, many PLHIV still do not feel safe to disclose their status due to fear of discrimination and social exclusion. Strengthening community education, scaling up stigma-reduction programmes, and expanding support systems for safe disclosure will be essential to creating more inclusive and supportive environments for PLHIV.

EXPERIENCE OF HIV-RELATED DISCRIMINATION IN HEALTH-CARE SETTINGS

At the time of reporting, no updated nationally representative estimate was available on the proportion of people living with HIV (PLHIV) experiencing discrimination in healthcare settings. However, multiple community-led and programmatic data sources provide important insights into the persistence of stigma within health facilities. Evidence from the Ritshidze Community-Led Monitoring (CLM) dashboard and related CLM reports highlights systemic challenges within public health facilities, including negative staff attitudes, breaches of confidentiality, long waiting times, and inconsistent service quality. These findings indicate that stigma and discrimination remain significant barriers to accessing HIV services, particularly for key populations and young people. Data from Situation Room dashboards further reinforce these trends, showing that service delivery gaps—often linked to provider behaviour and facility conditions—continue to undermine patient trust and engagement in care.

These findings are consistent with qualitative evidence presented at the 24th International AIDS Conference, which showed that PLHIV, including healthcare workers, may conceal their status due to fear of stigma and discrimination. Additional South African studies confirm that stigma is frequently experienced in clinical settings, particularly among sex workers and (LGBTQ+) individuals.

Community-level evidence also highlights lived experiences of discrimination. A 34-year-old lesbian respondent noted:

> "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, adolescents reported judgmental attitudes when accessing sexual and reproductive health services. A 17-year-old respondent stated:

> "YOU KNOW, WE CANNOT EVEN COLLECT CONDOMS... THEY BE LIKE, 'SO THIS ONE IS ALREADY DOING THE NASTY BUSINESS."

Overall, while policies promoting non-discriminatory care are in place, CLM and Ritshidze findings demonstrate persistent gaps between policy and practice. Addressing these challenges will require strengthened accountability mechanisms, ongoing sensitization of healthcare workers, and continued investment in community-led monitoring systems to improve the quality and inclusiveness of HIV services.

Implications and Recommendations

These findings highlight persistent stigma and discrimination within healthcare settings, which deter PLHIV, key populations, and adolescents from accessing essential services. Addressing this requires targeted stigma-reduction interventions, healthcare worker sensitization and training, and strengthened enforcement of non-discriminatory policies. Creating inclusive and supportive healthcare environments will be critical to improving service uptake, treatment adherence, and overall health outcomes among PLHIV, particularly within marginalized groups.

STIGMA AND DISCRIMINATION EXPERIENCED BY KEY POPULATIONS

Key populations—including men who have sex with men (MSM), people who inject drugs (PWID), sex workers (SW), migrant sub-groups, prisoners, and transgender (TG) individuals—are present across all communities in South Africa and bear a disproportionate burden of HIV, STIs, and TB (UNAIDS, 2011). These groups face heightened vulnerability, compounded by limited access to healthcare services and pervasive discrimination. A key population is defined as a group that meets three criteria: elevated epidemiological risk, reduced access to services compared to the general population, and systemic discrimination or marginalization, including exposure to human rights violations and criminalization (Global Fund, 2013).

Evidence highlights persistent discrimination in healthcare settings. A 2019 study among 804 LGBTQ+ participants found that nearly one in four had been denied healthcare, while 31% reported verbal abuse or derogatory treatment by healthcare providers (Duby et al., 2018). Similarly, female sex workers reported high levels of stigma, including experiences of shame, guilt, and loss of dignity resulting from discriminatory treatment by both healthcare providers and communities (Duby et al., 2018). These findings are reinforced by Ritshidze Community-Led Monitoring (CLM) data, which document ongoing challenges within public health facilities, including negative provider attitudes, breaches of confidentiality, and differential treatment of key populations. Ritshidze findings indicate that stigma and discrimination continue to undermine access to HIV prevention, testing, and treatment services, particularly for marginalized groups. Together, these data sources demonstrate that despite strong legal protections, healthcare-related stigma remains a significant barrier to equitable access, underscoring the need for strengthened accountability, provider sensitisation, and community-led monitoring interventions.

These findings underscore the need for systemic reforms to ensure inclusive and non-discriminatory healthcare environments. Addressing these barriers requires strengthening healthcare worker training on sensitivity and inclusivity, reinforcing legal protections against discrimination, and expanding targeted outreach programmes to improve access to HIV prevention and treatment services. Advancing equitable healthcare access and eliminating stigma will be critical to improving health outcomes among 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 major challenge for key populations in South Africa, particularly LGBTI individuals, female sex workers (FSWs), and men who have sex with men (MSM). Although no specific UNAIDS indicator data were available, existing research provides insight into care-seeking patterns, disclosure practices, and barriers within health systems. A 2019 study of 804 LGBTI individuals found that 60% accessed services through NGOs, compared to 25% using public facilities and 15% private providers, suggesting a strong preference for community-based services perceived as safer and more inclusive (Müller, 2019). Disclosure of sexual orientation and gender identity (SOGIE) remains complex. While 64% of respondents reported feeling comfortable disclosing to healthcare providers, 44% concealed SOGIE-related health concerns due to fear of stigma, judgment, or mistreatment (Müller, 2019).

Similar barriers are observed across other key populations. Evidence shows that 30% of FSWs avoid healthcare due to anticipated stigma (Duby et al., 2018), while 60% of MSM report avoiding services for similar reasons (Mbeda et al., 2020). These patterns highlight the urgent need to strengthen inclusive, stigma-free healthcare environments. This requires enhanced training of healthcare providers on LGBTI sensitivity and non-discriminatory care, alongside expansion of community- and NGO-led services that provide safe and accessible entry points for care. Strengthening policies that protect against discrimination and promote confidential, safe disclosure will be critical to improving equitable access to HIV prevention, treatment, and broader health services for key populations.

PEOPLE LIVING WITH HIV SEEKING REDRESS FOR VIOLATION OF THEIR RIGHTS

While no recent data are available on the proportion of people living with HIV (PLHIV) who have experienced rights violations and sought legal redress, South Africa has established multiple mechanisms to address human rights abuses, discrimination, and workplace inequalities. The South African Human Rights Commission (SAHRC) provides formal Complaints Handling Procedures, including a Child-Friendly Complaints Process, which outline clear steps for investigating alleged violations and are publicly accessible to ensure ease of use. Equality Courts further strengthen access to justice by addressing cases of unfair discrimination, hate speech, and harassment through simplified procedures that do not require legal representation. Court officials are trained to assist individuals throughout the process, and the SAHRC offers legal support for cases brought before these courts, enhancing access for marginalized groups, including PLHIV. For workplace-related discrimination, the Commission for Conciliation, Mediation, and Arbitration (CCMA) facilitates resolution of disputes, including those related to violations of equality rights. As all Magistrates' Courts function as Equality Courts, individuals

can seek redress either through the SAHRC or their nearest court. Together, these mechanisms provide accessible pathways for PLHIV and other vulnerable populations to challenge discrimination and uphold their rights. However, continued awareness-raising and strengthened legal support are essential to ensure that these protections are effectively utilized, particularly by those most affected by stigma and discrimination.

DISCRIMINATORY ATTITUDES TOWARDS PEOPLE LIVING WITH HIV AMONG HEALTH FACILITY STAFF

At the time of reporting, no national data were available on the proportion of healthcare facility staff who hold discriminatory attitudes toward people living with HIV (PLHIV). However, existing evidence highlights persistent stigma within healthcare settings, particularly affecting key populations. Fear of discrimination remains a major barrier to accessing care: 30% of female sex workers (FSWs) report avoiding healthcare due to anticipated stigma (Duby et al., 2018), while 60% of men who have sex with men (MSM) report similar avoidance (Mbeda et al., 2020). Stigma also affects healthcare workers living with HIV, many of whom conceal their status due to fear of discrimination from colleagues. This suggests that discriminatory attitudes within health facilities impact both patients and providers, underscoring the need for stigma-free and supportive workplace environments.

Addressing Stigma and Discrimination in Healthcare Facilities

The lack of comprehensive data highlights the need to:

- Conduct regular assessments of stigma and discrimination within healthcare settings, including among healthcare workers
- Strengthen targeted stigma-reduction training focused on non-discriminatory, patient-centred care for PLHIV and key populations
- Implement support systems for healthcare workers living with HIV to ensure safe, inclusive, and non-discriminatory work environments

Addressing these gaps will be critical to improving healthcare access, quality of care, and health outcomes for PLHIV and key populations.

DISCRIMINATORY ATTITUDES TOWARDS PEOPLE FROM KEY POPULATIONS AMONG HEALTH FACILITY STAFF

At the time of reporting, no data were available on the proportion of healthcare facility staff in South Africa who hold discriminatory attitudes toward key populations. However, existing evidence points to persistent stigma, exclusion, and discrimination affecting men who have sex with men (MSM), sex workers, and people who use drugs (PWUD) within healthcare settings (Ritcher, 2008; Parry et al., 2009).

Broader societal attitudes—often judgmental and moralizing toward sex work, same-sex relationships, and drug use—are frequently mirrored within health facilities, where provider stigma further marginalizes these groups and limits access to essential services (Lane et al., 2008; Scheibe, Drame, & Shannon, 2016). A key driver of these attitudes is the limited formal training on key population health needs among healthcare professionals. Evidence from South

Africa shows that undergraduate medical training provides minimal preparation for engaging effectively with key populations (Müller, 2013), resulting in gaps in provider competence and the delivery of non-discriminatory care (Müller et al., 2018).

Addressing Stigma in Healthcare Settings

Reducing discrimination requires a systemic response, including:

- Integrating comprehensive key population health training into medical and nursing curricula
- Implementing targeted stigma-reduction programmes that promote inclusive, patient-centred care
- Strengthening accountability mechanisms to address discriminatory practices and ensure equitable access to healthcare

These actions are essential to creating inclusive health systems that effectively serve key populations and improve overall HIV, STI, and TB outcomes.

DISCRIMINATORY ATTITUDES TOWARDS PEOPLE FROM KEY POPULATIONS AMONG POLICE

Key populations in South Africa—including sex workers (SWs), people who use drugs (PWUD), men who have sex with men (MSM), women who have sex with women (WSW), and transgender (TG) individuals—continue to experience high levels of stigma, abuse, and discrimination. Evidence indicates that, in some instances, law enforcement officials—who are mandated to protect the public—are themselves perpetrators of abuse, reinforcing cycles of violence, increasing HIV risk, undermining prevention and treatment efforts, and violating constitutional human rights protections.

Sex workers report multiple forms of abuse by police, including harassment, physical assault, rape, extortion, and confiscation of condoms, as well as denial of access to essential medication such as HIV treatment while in custody (Sisonke Sex Worker Movement, 2011; Women's Legal Centre, 2012). Similarly, LGBTQ+ individuals face systemic discrimination within communities and police settings, with evidence documenting widespread mistreatment by law enforcement that further limits access to justice and healthcare (Breen et al., 2011). For PWUD, hostile interactions with law enforcement remain a major barrier. National consultations and programmatic studies highlight experiences of harassment, violence, confiscation and destruction of injecting equipment, and extortion by police (United Nations Office on Drugs and Crime, 2014; Lambert, 2015; Step Up Project, 2015).

Addressing Police Abuse and Discrimination

The criminalization and mistreatment of key populations undermine both human rights and public health goals. Addressing these challenges requires:

- Strengthening accountability mechanisms for law enforcement abuses
- Implementing human rights-based training for police to promote non-discriminatory engagement
- Protecting harm reduction programmes (e.g., needle and syringe services) from police interference

- Expanding access to safe legal recourse for affected populations

ACHIEVEMENTS

- Redress mechanisms exist, though their accessibility and effectiveness require further strengthening
- Internalized stigma declined to 23% and external stigma to 15% in 2020, compared to 43% and 35% in 2014 (Simbayi et al., 2015)
- Community-led organisations, including SWEAT, continue to play a key role in advocacy, rights protection, and service delivery
- Between 85% and 92% of respondents reported accepting attitudes toward PLHIV across SABSSM survey waves (Simbayi et al., 2019)

KEY CHALLENGES

- Nearly one in four LGBTI individuals have been denied healthcare, with 31% reporting verbal abuse by healthcare staff
- Limited inclusion of LGBTQ+ health in training curricula constrains provider capacity (Luvuno et al., 2019)
- Female sex workers continue to experience stigma, discrimination, and loss of dignity (Duby et al., 2018)
- Stigma in healthcare settings leads to avoidance of services among key populations (Mbeda et al., 2020; Duby et al., 2018; Müller, 2019)

RECOMMENDATIONS

- Expand peer-led, community-based service delivery models to reduce stigma (HSRC recommendations)
- Strengthen person-centred care approaches within healthcare systems
- Reform relationships between law enforcement and key populations to eliminate abuse and improve service access
- Scale up sensitisation and training for judiciary and law enforcement to align practices with human rights and public health priorities


ZERO
STIGMA

POLITICAL DECLARATION AND FRAMEWORK 7: UNIVERSAL HEALTH COVERAGE AND INTEGRATION

7

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 commitment to universal health coverage and integrated healthcare is grounded in its Constitution, which guarantees access to healthcare for all (South Africa, 2015). This commitment is operationalized through a comprehensive policy framework addressing major public health priorities, including cancer prevention, cervical cancer control, and multi-drug-resistant tuberculosis (MDR-TB). The National Cancer Strategic Framework for South Africa (2017–2022) provides strategic guidance for the development, implementation, monitoring, and coordination of cancer-related interventions. Complementing this, the National Cervical Cancer Prevention and Control Policy outline a structured screening approach, recommending routine screening for all women from age 30 at 10-year intervals until age 50, with earlier and more frequent screening for women living with HIV due to their elevated risk (NDOH, 2017).

In tuberculosis control, South Africa introduced a decentralized MDR-TB management policy in 2019 to expand access to treatment and improve patient outcomes. These national strategies are aligned with global and regional priorities, including the Global Plan to End TB (2023–2030) (Stop TB Partnership, 2022). Through this alignment, South Africa continues to strengthen a coordinated, evidence-based response to key health challenges, reinforcing its commitment to equitable and accessible healthcare.

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 people who inject drugs (PWID), sex workers (SW), and men who have sex with men (MSM). These groups face a disproportionate risk of viral hepatitis and HIV, driven by structural barriers to healthcare access, stigma, and high-risk practices such as injection drug use. In 2020, co-infection rates among PWID were notably high: HBV/HIV co-infection was 7.9% (18/227), while HCV/HIV co-infection reached 65.2% (148/227), underscoring the urgent need for expanded screening and treatment within this population.

A 2019 study involving 3,443 individuals from key populations further highlights the burden of infection. Overall prevalence was 4% for HBV, 37% for HIV, and 13% for HCV (NICD, 2019). While HBV prevalence (3–5%) aligned with national background levels, HIV prevalence was

substantially higher among sex workers (47%) and MSM (43%), compared to 13% among PWUD. Marked regional variation was observed, with HIV prevalence ranging from 3% among PWUD in Cape Town to as high as 80% among sex workers in Pietermaritzburg.
HCV prevalence showed even greater disparities. PWID had the highest burden at 45%, with geographic variation from 29% in Durban to 73% in Pretoria. Among PWUD, HCV prevalence was 7%, while 2% of MSM were HCV-positive. Notably, many MSM with HCV reported a history of injecting drug use, suggesting overlapping risk networks and transmission pathways (NICD, 2019).

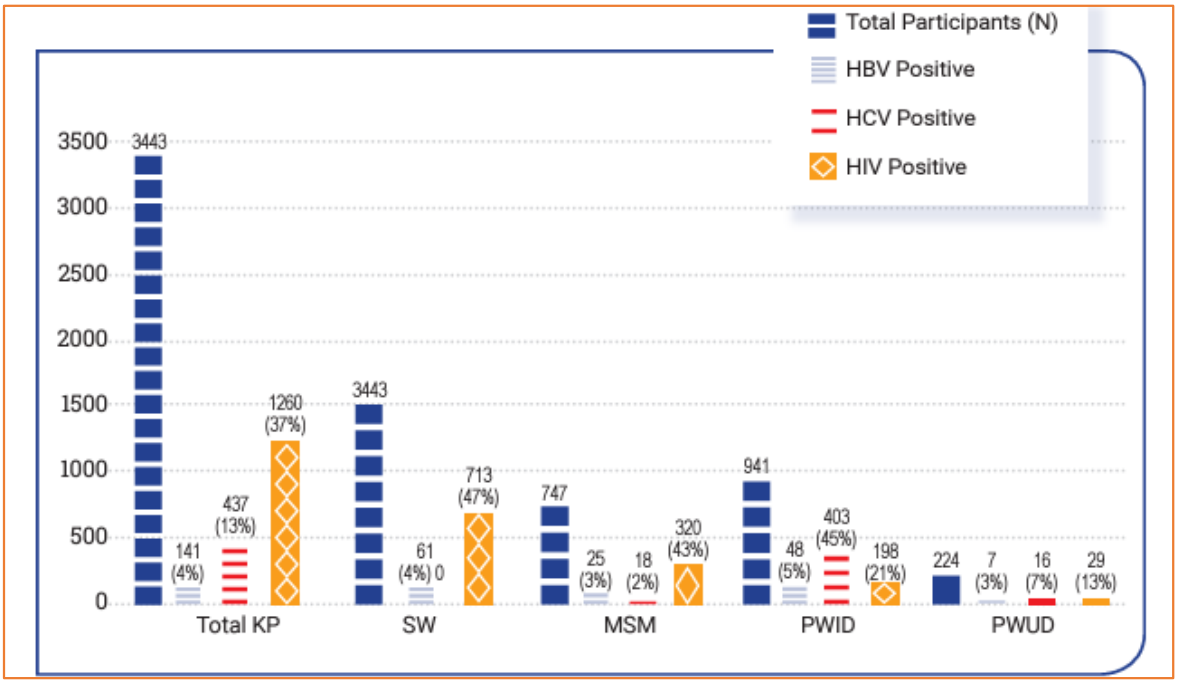
Implications for Public Health and Prevention Strategies

The high burden of hepatitis co-infections among key populations highlights the need for integrated and targeted responses. Priority actions include:

- Scaling up hepatitis screening and treatment, particularly for PWID, MSM, and sex workers
- Expanding harm reduction services, including needle and syringe programmes and opioid substitution therapy, to reduce HCV transmission
- Addressing regional disparities through targeted, high-burden interventions
- Strengthening non-discriminatory, key population-friendly health services to improve access to integrated HIV and hepatitis care

A coordinated, data-driven approach will be essential to reducing co-infection rates and improving health outcomes among these vulnerable 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

The prevalence of HCV–HBV co-infection in the total study cohort was 0.7%, with variation across key population groups. Rates ranged from 0% to 2.4%, with the highest burden observed among people who inject drugs (PWID), reflecting their increased vulnerability to multiple infections due to needle-sharing practices and limited access to harm reduction services. HCV–HIV co-infection had an overall prevalence of 3.7%, with PWID disproportionately affected at 12.7%. Marked regional variation was evident, with Pretoria reporting a particularly high prevalence of 29%, suggesting more established injection drug use networks and higher transmission dynamics in this setting. HBV–HIV co-infection was less common, with an overall prevalence of 2.2% and relatively consistent rates across key populations. Triple infection (HIV, HBV, and HCV) was rare, occurring in less than 1% of cases and observed only among PWID.

Public Health Implications

The elevated burden of HCV–HIV co-infection among PWID highlights the need for intensified, targeted interventions, particularly in high-prevalence settings such as Pretoria. Key priorities include:

- Expanding harm reduction services, including needle and syringe programmes and opioid substitution therapy (OST)
- Scaling up routine HBV and HCV screening and treatment for high-risk populations
- Strengthening geographically targeted responses to address regional disparities in infection burden

A focused, integrated approach will be essential to reduce co-infections and improve health outcomes among vulnerable populations.

HEPATITIS C TESTING

Data on the proportion of individuals initiating antiretroviral therapy (ART) who were tested for hepatitis C virus (HCV) were available only for 2020. It is important to note that these data were not derived from routine ART initiation services, but from a hepatitis C treatment programme implemented by a non-profit organization (NPO) in Tshwane. Table 13 presents the available data on HCV testing among individuals starting ART.

Table 14: Proportion of people starting antiretroviral therapy who were tested for hepatitis C virus (HCV) (2020)

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

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

PEOPLE COINFECTED WITH HIV AND HEPATITIS C VIRUS STARTING HEPATITIS C VIRUS TREATMENT

According to programme data from Sediba Hope Medical Centre, based on clinical records, 94.4% (34/36) of individuals co-infected with HIV and HCV initiated HCV treatment in 2020. However, no data is available for subsequent years, indicating a gap in longitudinal monitoring and reporting of treatment outcomes among people living with HIV. These findings highlight the need to strengthen data collection and monitoring systems to better track access, adherence, and outcomes for HIV–HCV co-infected individuals. Expanding routine HCV screening and integrating treatment within HIV care services will be critical to improving continuity of care and overall health outcomes for this population.

SYPHILIS PREVALENCE AMONG KEY POPULATIONS

This indicator assesses syphilis prevalence among key populations, including sex workers (SW), men who have sex with men (MSM), and transgender (TG) individuals. However, no data were reported for the period 2019–2023, highlighting a significant gap in STI surveillance and monitoring for these populations. Evidence from a 2019 South African prospective cohort study among MSM demonstrates a high burden of recurrent STIs (van Liere et al., 2019). Among symptomatic MSM (n = 78), followed for a median of 55 days with 78% retention, the incidence of STIs was 188 per 100 person-years (95% CI: 1.2–2.7). The study identified 16 new infections and 10 cases of persistent STI positivity, indicating ongoing transmission and reinfection risks within this population. These findings underscore the need to strengthen STI prevention and control efforts among key populations through:

- Expanded syphilis screening and diagnostic services in facilities serving key populations
- Scale-up of point-of-care diagnostic tools for early detection and timely treatment
- Improved access to comprehensive sexual health services, including prevention education, condom distribution, and tailored STI treatment programmes

Addressing these gaps is critical to reducing STI transmission and improving overall sexual health outcomes among vulnerable groups.

MEN WITH URETHRAL DISCHARGE

Data from the District Health Information System (DHIS) show a gradual increase in the proportion of men presenting with urethral discharge over recent years. Prevalence declined slightly from 1.6% in 2019 to 1.4% in 2020, before rising again to 1.6% in 2021 and reaching 1.8% in 2022. This upward trend suggests a growing burden of sexually transmitted infections (STIs) among men, pointing to potential gaps in prevention, access to care, and treatment services, as well as possible shifts in sexual behaviours.

These findings highlight the need to strengthen STI prevention and control efforts. Priority actions include expanding routine STI screening, increasing awareness of symptoms and prevention strategies, and improving access to timely treatment through integrated sexual and reproductive health services. Targeted interventions will be essential to curb transmission and improve sexual health outcomes among men in South Africa.

GONORRHEA AMONG MEN

Between 2019 and 2022, no data were available on the rate of laboratory-diagnosed gonorrhoea among men in settings with diagnostic capacity, indicating a gap in routine STI surveillance. However, a study conducted in KwaZulu-Natal provides important insights into STI prevalence and its relationship with HIV in a high-burden context.

The study reported a prevalence of Neisseria gonorrhoeae of 2.8% among individuals aged 15–49 years, affecting both males and females. It also found a strong association between HIV viral load and gonorrhoea infection: individuals with viral loads ≥400 copies/mL had nearly double the likelihood of infection (adjusted prevalence ratio [aPR] = 1.91, 95% CI 1.36–2.70) (Kharsany et al., 2020). These findings underscore the importance of integrating STI screening and treatment within HIV care programmes, particularly in high-burden settings. Strengthening routine surveillance, expanding access to diagnostic services, and scaling up targeted public health interventions will be critical to reducing 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 central to South Africa's health response, as TB continues to be a leading cause of mortality among people living with HIV. Data for 2022, digitized through patient information systems, indicates that 83,169 HIV-positive individuals with either new or relapsed TB were initiated on TB treatment. These individuals were either already on antiretroviral therapy (ART) at diagnosis or initiated ART during TB treatment in the same year. Of those receiving TB–HIV co-treatment, 44,367 were male, 38,802 females, 2,191 were children under 15 years, and 80,978 were adults aged 15 and older.

This represents a substantial increase from 2021, when only 58,017 HIV-positive individuals received TB treatment (32,015 males and 25,912 females). Historical trends since to date show fluctuations, also largely attributed to disruptions caused by the COVID-19 pandemic, including reduced healthcare access, service interruptions, and declines in TB screening and treatment initiation (UNAIDS Online Tool).

These trends underscore the need to strengthen TB–HIV integration to ensure continuity of care. Priority actions include expanding facility- and community-based TB screening among people living with HIV, increasing access to TB preventive therapy (TPT), addressing systemic gaps in service delivery, and building more resilient TB–HIV programmes capable of withstanding future public health disruptions. Sustained, integrated TB–HIV care remains essential to reducing mortality and improving outcomes for co-infected individuals 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) newly initiated antiretroviral therapy (ART) were diagnosed with tuberculosis (TB), accounting for 7% of ART initiates. This represents an increase from 2021, when 27,287 individuals (5.6%) were diagnosed with TB at

ART initiation. The lower figures in 2021 are attributed to COVID-19-related disruptions, which affected access to TB screening and diagnostic services (DOH, 2022). These trends highlight the importance of strengthening TB screening at the point of HIV treatment initiation to ensure early detection and timely management.

Enhancing TB–HIV integration remains critical to reducing morbidity and mortality among PLHIV. Key priorities include expanding facility- and community-based TB screening, increasing access to TB preventive therapy (TPT), and ensuring continuity of both ART and TB treatment services to effectively manage co-infection in South Africa.

PEOPLE LIVING WITH HIV ON ANTIRETROVIRAL THERAPY, WHO STARTED TUBERCULOSIS PREVENTIVE TREATMENT

Data on the proportion of people on antiretroviral therapy (ART) who initiated tuberculosis preventive treatment (TPT) between 2018 and 2024 show notable fluctuations. Coverage increased from 65% in 2018 to 69.3% in 2019, peaking at 93.1% in 2020, before declining to 62.8% in 2021, 61.8% in 2022, and 61.4% in 2023. Encouragingly, performance improved again to 78.3% in 2024. In absolute terms, the number of newly enrolled on ART who also initiated TPT decreased from 509,762 in 2019 to 261,684 in 2023, before slightly increasing to 270,523 in 2024. Over the same period, the total number of newly initiated people on ART declined from 736,078 in 2019 to 345,675 in 2024 (UNAIDS Online Tool).

Given that tuberculosis remains a leading cause of death among people living with HIV (PLHIV) in South Africa, these trends highlight gaps in consistent TPT uptake. Strengthening systematic TB screening, improving linkage to preventive therapy, and fully integrating TPT into routine HIV care will be essential to sustain gains and reduce TB-related morbidity and mortality among PLHIV.

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

INDICATOR	2018	2019	2020	2021	2022	2023	2024
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%	78.3%
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	270,523
Total number of people living with HIV newly enrolled on antiretroviral therapy	697,551	736,078	383,403	488,052	466,485	426,540	345,675

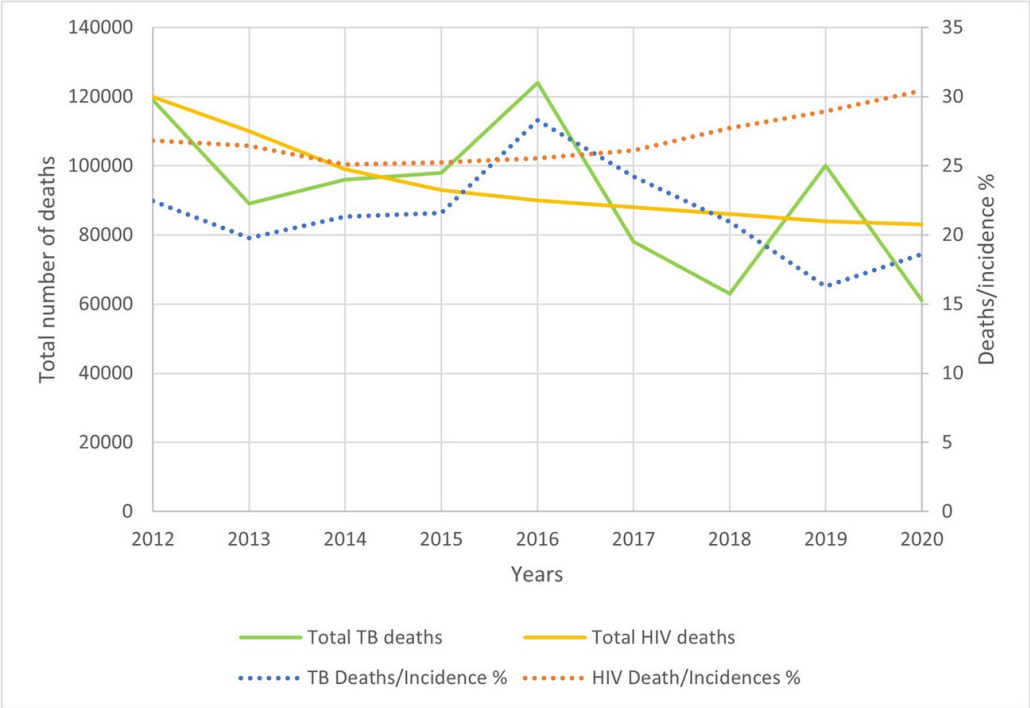
Source: UNAIDS Online Tool

South Africa's extensive genomic research on tuberculosis (TB) has identified genetic variations linked to increased susceptibility, advancing understanding of TB pathogenesis. This commitment is complemented by ongoing vaccine research, with the South African Tuberculosis Vaccine Initiative (SATVI) playing a key role in global clinical trials aimed at developing effective TB vaccines (Visca et al., 2021). Mortality trends show substantial progress over the past decade. In 2012, approximately 120,000 deaths were attributed to HIV and

TB combined. By 2020, HIV-related deaths had declined to 83,000, while TB-related deaths decreased to 61,000 (Olivier et al., 2023).

Overall, reductions in TB-related mortality have outpaced progress in reducing HIV-related deaths. This is reflected in the more pronounced decline in the TB death-to-incidence ratio compared to HIV, as illustrated in Figure 24. By 2020, TB incidence had decreased to around 18%, while HIV incidence remained higher, approaching 30%. These trends underscore the need to sustain gains in TB control while intensifying HIV prevention and treatment efforts. Strengthening integrated HIV–TB interventions, expanding vaccine research, and improving coverage of preventive therapies will be critical 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 notable progress has been achieved, attaining the ambitious "End TB" and "End HIV" targets set by the World Health Organization (WHO) for 2030 remains challenging. Persistent socio-economic inequalities, health system constraints, and complex political dynamics continue to impede full epidemic control (Olivier et al., 2023).

Overcoming these barriers will require sustained investment in health systems, targeted interventions for vulnerable populations, and strengthened political commitment to ensure 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 presents data on the proportion of people living with HIV (PLHIV) on antiretroviral therapy (ART) who initiated and completed tuberculosis (TB) preventive treatment in 2023. The results show that only 48.6% of PLHIV on ART who started TB preventive therapy completed the course, based on the 2022 cohort. Disaggregated data by transgender status, specific TB preventive therapy regimens, and monotherapy were not available, indicating gaps in routine monitoring and reporting. These findings highlight the need to strengthen adherence support, improve treatment tracking systems, and expand access to TB preventive therapy to increase completion rates and enhance TB prevention outcomes among PLHIV.

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 2022	STARTED ART PRIOR TO 2022	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	48.6%	43%	62.2%	52%	57.3%	45.6%	50.2%	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)	226,722	142,326	84,396	1,303	3,304	76,621	145,494	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)	466,297	330,621	135,676	2,504	5,770	167,925	290,098	No data

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

South Africa's extensive genomic research on tuberculosis (TB) has identified genetic variations linked to increased susceptibility, advancing understanding of TB pathogenesis. This commitment is complemented by ongoing vaccine research, with the South African Tuberculosis Vaccine Initiative (SATVI) playing a key role in global clinical trials aimed at developing effective TB vaccines (Visca et al., 2021). Mortality trends show substantial progress over the past decade. In 2012, approximately 120,000 deaths were attributed to HIV and TB combined. By 2020, HIV-related deaths had declined to 83,000, while TB-related deaths decreased to 61,000 (Olivier et al., 2023).

Overall, reductions in TB-related mortality have outpaced progress in reducing HIV-related deaths. This is reflected in the more pronounced decline in the TB death-to-incidence ratio compared to HIV, as illustrated in Figure 24. By 2020, TB incidence had decreased to around 18%, while HIV incidence remained higher, approaching 30%. These trends underscore the need to sustain gains in TB control while intensifying HIV prevention and treatment efforts. Strengthening integrated HIV–TB interventions, expanding vaccine research, and improving coverage of preventive therapies will be critical to further reducing the burden of both diseases in South Africa.

NUMBER OF WOMEN LIVING WITH HIV WHO WERE SCREENED FOR CERVICAL CANCER USING ANY SCREENING TEST

In South Africa, national policy recommends that women living with HIV undergo cervical cancer screening every three years, starting immediately after HIV diagnosis (Denny and Kuhn, 2017). Evidence shows that women living with HIV have a higher prevalence of HPV infection than HIV-negative women, largely due to immune suppression and increased susceptibility to persistent HPV infection (Hopkins et al., 2021; Ntuli et al., 2020). Despite ongoing public awareness and health promotion efforts, screening uptake remains suboptimal. However, data from the National Health Laboratory Services (NHLS) and implementing partners indicate notable progress, with the number of screenings conducted in the previous 12 months increasing from 134,338 in 2020 to 336,174 in 2022.

While encouraging, these gains need to be sustained and expanded. Strengthening integration of cervical cancer screening into routine HIV care, addressing access barriers, scaling up HPV vaccination, improving management of precancerous lesions, and enhancing linkages between HIV and reproductive health services will be critical to 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 Policy[15] emphasizes the importance of secondary prevention to complement primary prevention efforts, particularly for women who may not fully benefit from HPV vaccination. The policy notes that secondary prevention will remain essential for at least two decades following the introduction of the HPV vaccine. This includes routine screening to detect high-risk precancerous lesions early and ensure timely treatment to prevent progression to cervical cancer. Cervical cancer screening remains a national priority and is provided free of charge in the public healthcare system to all eligible women. However, at the time of reporting, no data were available on the proportion of women living with HIV who screened positive for precancerous lesions and received treatment within the past 12 months.

Strengthening screening coverage, ensuring timely treatment, and improving follow-up systems are critical to reducing cervical cancer burden among women living with HIV. In addition, improving data systems, monitoring treatment uptake, and further integrating cervical cancer services into routine HIV care will be essential to support early detection and improve long-term health outcomes.

TREATMENT OF INVASIVE CERVICAL CANCER IN WOMEN LIVING WITH HIV

At the time of reporting, no data were available on the proportion of women diagnosed with invasive cervical cancer who received treatment within the past 12 months. However, South Africa's national Cervical Cancer Prevention and Control Policy ensure that all women with abnormal screening results are managed according to standardized clinical guidelines. Most precancerous cervical lesions can be effectively treated on an outpatient basis using minimally invasive procedures, including ablation therapy, electrocoagulation diathermy (ED), cryotherapy, laser cauterization, and excision methods such as large loop excision of the transformation zone (LLETZ). These approaches are used to manage Cervical Intraepithelial Neoplasia (CIN2, CIN3) and adenocarcinoma in situ, in line with Department of Health (DOH) guidelines (2017). Ensuring timely linkage from screening to treatment remains critical to preventing progression to invasive cervical cancer. Strengthening referral pathways, expanding access to treatment services, and improving follow-up systems will be essential, particularly for women living with HIV who face a higher risk of HPV-related cervical disease.

PEOPLE LIVING WITH HIV RECEIVING MULTI-MONTH DISPENSING OF ANTIRETROVIRAL MEDICINE

Data on the proportion of people living with HIV (PLHIV) on antiretroviral therapy (ART) receiving multi-month dispensing (MMD) are available up to 2022. According to the Central Chronic Medicines Dispensing and Distribution (CCMDD) system, about 25% of PLHIV on ART received less than a three-month supply of medication in 2022, a substantial improvement from 74% in 2021. This shift reflects increased uptake of MMD approaches.

The expansion of MMD is critical for improving ART adherence, reducing facility congestion, and strengthening retention in care. Continued scale-up and optimization of MMD will be essential to ensure uninterrupted access to treatment, particularly for key and vulnerable populations who 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 are designed to improve the responsiveness of HIV treatment programmes by tailoring services to the needs of people on antiretroviral therapy (ART), with the aim of enhancing treatment outcomes, retention in care, and quality of life. At the time of reporting, no national data were available on the proportion of ART patients enrolled in DSD models. However, evidence from the scale-up of the Central Chronic Medicines Dispensing and Distribution (CCMDD) system provides important insights (Liu et al., 2021). Between March 2016 and October 2019, the number of facilities offering DSD increased from 972 to 3,436, covering 94.6% of facilities in participating districts. External pick-up points (PuPs) expanded twelvefold, from 164 to 2,037. Over the same period, CCMDD enrolment grew more than eightfold, reaching 2,993,044 registered patients, of whom 2,069,039 (69.1%) were active by October 2019.

Patterns of ART collection also shifted. Between November 2018 and October 2019, the proportion of patients using clinic-based fast lanes declined from 55% to 52%, while those collecting medication from external PuPs increased from 31% to 35% ($p<0.001$). By the end of the period, 734,005 active patients were using PuPs, representing a 73% increase in one year. These trends demonstrate the successful expansion of decentralized ART delivery through DSD models, reducing pressure on health facilities and improving access to treatment. Sustained investment in scaling up external pick-up points and strengthening DSD approaches will be essential to further improve adherence, reduce congestion, and support long-term retention in HIV care.

VIRAL SUPPRESSION AMONG PEOPLE LIVING WITH HIV ENGAGED IN DIFFERENTIATED SERVICE DELIVERY MODELS

At the time of reporting, no national data were available on the proportion of people living with HIV (PLHIV) enrolled in differentiated service delivery (DSD) antiretroviral therapy (ART) models who achieved virological suppression. However, evidence from an evaluation of South Africa's Central Chronic Medicines Dispensing and Distribution (CCMDD) programme provides important insights into treatment outcomes (Wang et al., 2024). The study, which included 390 PLHIV, found that virological suppression and retention in care were comparable between patients enrolled in CCMDD and those receiving standard ART services. Combined outcomes of viral suppression and retention showed no significant difference (adjusted relative risk [aRR]: 1.03; 95% CI 0.94–1.12). Similarly, virological suppression alone (aRR: 1.02; 95% CI 0.97–1.08) and retention in care alone (aRR: 1.03; 95% CI 0.95–1.12) were also comparable between the two groups. These findings indicate that DSD models such as CCMDD are effective in maintaining treatment outcomes while improving access and convenience of ART delivery.

ACHIEVEMENTS

- Sustained treatment outcomes under DSD models: Virological suppression and retention in care among CCMDD patients are comparable to standard ART delivery (Wang et al., 2024).
- Expanded access to ART services: DSD models have improved convenience and reduced the burden on health facilities, supporting continuity of care.
- Improved patient-centered care: CCMDD enables decentralized ART access, enhancing patient experience and reducing barriers to treatment collection.

CHALLENGES

- Lack of national DSD outcome data: Absence of routine, disaggregated data on virological suppression within DSD programmes limits comprehensive evaluation.
- Adherence and retention variability: While overall outcomes are comparable, underlying adherence challenges and patient-level barriers remain insufficiently understood.
- Limited differentiation by population groups: Data do not adequately capture outcomes across key populations, age groups, or geographic areas.

RECOMMENDATIONS

- Strengthen routine monitoring systems: Develop national indicators to track virological suppression and retention specifically within DSD models.
- Enhance patient-centered support: Address adherence barriers through counselling, digital support tools, and differentiated follow-up mechanisms.
- Expand and optimize DSD models: Continue scaling up CCMDD and similar models while refining service delivery based on patient needs and outcomes.
- Conduct implementation research: Generate evidence on long-term effectiveness, patient experience, and cost-efficiency of DSD approaches to inform policy and scale-up.

POLITICAL DECLARATION AND FRAMEWORK 8: INVESTMENT AND RESOURCES

8

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 constitutional framework strongly affirms the right to access quality and equitable healthcare, forming the foundation of the national response to HIV, tuberculosis (TB), and sexually transmitted infections (STIs) (South Africa, 2015). This commitment is operationalized through successive National Strategic Plans (NSPs), with the current National Strategic Plan for HIV, TB and STIs 2023–2028 building on the achievements and lessons of the NSP 2017–2022. The NSP 2023–2028 adopts a renewed, equity-focused and multi-sectoral approach, prioritizing populations left behind, strengthening integration of services, and addressing structural drivers such as inequality, gender-based violence, and mental health. A central pillar of the NSP is sustainable financing and efficient resource allocation. Evidence from the National AIDS Spending Assessment Plus (NASA+) 2025 indicates that South Africa has maintained a relatively stable HIV and TB expenditure envelope of approximately ZAR 42–43 billion annually between 2021/22 and 2023/24, with government contributing the majority share (up to 76% by 2023/24). This reflects strong domestic ownership of the response and alignment with NSP priorities. However, while treatment continues to dominate expenditure (over 70%), prevention and key population programming remain comparatively underfunded, highlighting areas requiring strategic rebalancing.

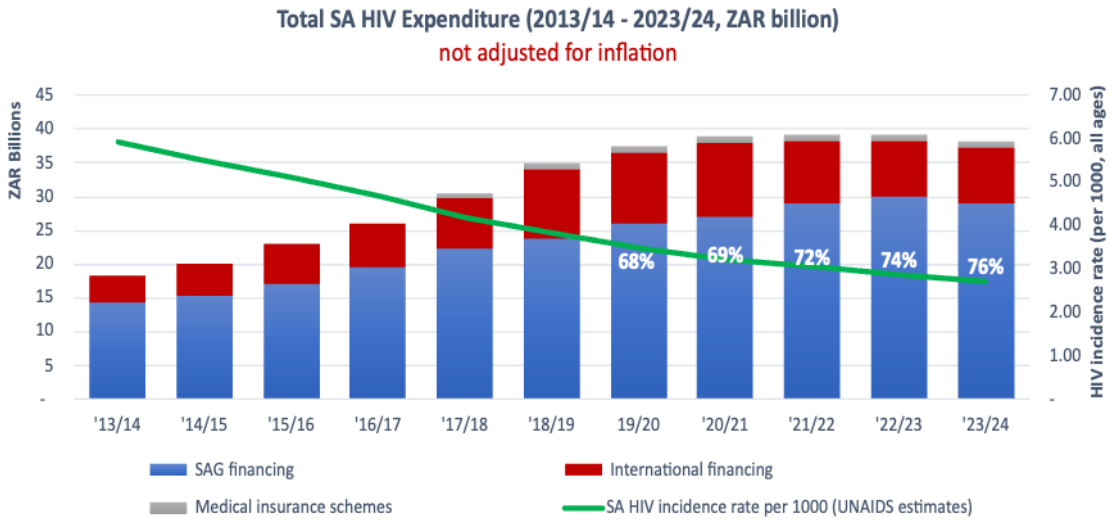
The NSP 2023–2028 is closely aligned with the National Development Plan Vision 2030 (South African Government, 2012), which envisions an inclusive, efficient, and sustainable health system capable of reducing the national burden of disease. It also aligns with global commitments, including Sustainable Development Goals Goal 3, which aims to end the AIDS and TB epidemics by 2030 (UNAIDS, 2022a). The NSP further reinforces a whole-of-society approach, engaging government, civil society, private sector, and development partners in a coordinated national response. In parallel, South Africa's National Health Insurance policy South Africa remains a critical reform aimed at achieving universal health coverage through equitable health financing (Health, 2019). Once fully implemented, the NHI is expected to integrate HIV, TB, and STI services into a comprehensive benefits package, ensuring sustained access to prevention, treatment, and care services. Despite these advances, the NASA+ findings highlight ongoing challenges related to sustainability, efficiency, and equity. While the overall funding gap relative to NSP targets is relatively small, there are notable misalignments—particularly underinvestment in prevention and key populations, rising input costs, and continued reliance on external funding for specific interventions. Furthermore, limitations in private sector reporting and incomplete expenditure tracking constrain a full understanding of total resource flows.

Overall, South Africa demonstrates strong political commitment and financing leadership in its HIV and TB response. Sustaining progress toward the 2030 targets will require continued domestic investment, improved efficiency in resource allocation, strengthened prevention funding, and enhanced integration of services within broader health system reforms.

Status and recent Expenditure trends

The updated expenditure trends (Figure 25) indicate that, contrary to earlier declines observed up to 2020/21, total HIV spending in South Africa has stabilized and increased over the longer term. HIV expenditure rose steadily from approximately R18 billion in 2013/14 to around R38–39 billion by 2022/23, before a slight decline to about R38 billion in 2023/24. This reflects a sustained expansion of the national HIV response, largely driven by increased domestic (SAG) financing, which now constitutes the majority share of total expenditure. In contrast to earlier concerns about declining investment, these updated trends suggest that South Africa has maintained a strong and relatively stable funding base for HIV programmes in recent years. While tuberculosis (TB) expenditure remains comparatively smaller—at approximately R3–4 billion annually—it has also remained relatively stable over time (UNAIDS, 2022b).
Overall, the current trajectory demonstrates improved financial commitment and sustainability of the HIV response. However, the plateauing of expenditure in recent years underscores the importance of ensuring efficient resource allocation, particularly toward prevention and key populations, to sustain progress in reducing HIV incidence in a high-burden setting.

Figure 25: Total expenditure on HIV



Source: NASA report (2021/22 – 2023/24)

Updated findings from the latest National AIDS Spending Assessment Plus (NASA+) 2025 provide a more current picture of HIV resource allocation. Total HIV expenditure remained relatively stable in recent years, amounting to R39.2 billion in 2021/22, R39.3 billion in 2022/23, and R38.3 billion in 2023/24 (Table 17). Consistent with earlier trends, the largest share of HIV funding continues to be directed toward care and treatment, accounting for most of the total expenditure. While this reflects South Africa's strong commitment to sustaining

treatment coverage and improving health outcomes, it also highlights ongoing imbalances in resource allocation. Evidence from the NASA+ analysis indicates that prevention programmes remain comparatively underfunded relative to their importance in reducing new infections and achieving long-term epidemic control. These trends underscore the need to optimise resource allocation by maintaining investments in treatment while strengthening funding for prevention, particularly for key and vulnerable populations. Ensuring a more balanced and efficient distribution of resources will be critical to sustaining progress toward the NSP 2023–2028 targets and achieving epidemic control.

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)

Antiretroviral Expenditure: Unit Prices and Volume

Updated findings from the National AIDS Spending Assessment Plus (NASA+) 2025 confirm that antiretroviral therapy (ART) continues to account for the largest share of HIV programme expenditure in South Africa. Recent data indicate that treatment-related costs—driven primarily by antiretroviral medicines—consume over 70% of total HIV spending, reflecting the scale of the national treatment programme and the large number of people on ART. While earlier estimates (UNAIDS, 2022b; NASA, 2021) reported ART expenditure at R14.2 billion in 2019/20 with an average unit cost of approximately R2,850 (around USD 98), the latest NASA+ analysis suggests that overall, ART expenditure has increased in line with programme expansion. However, this increase has been partially offset by improved procurement efficiencies, price negotiations, and the transition to cost-effective regimens, which have helped stabilize or reduce unit costs over time. These trends highlight South Africa's success in achieving economies of scale in ART procurement while sustaining one of the largest HIV treatment programmes globally. Continued focus on cost-efficiency, optimized regimens, and supply chain management will be critical to maintaining affordability and ensuring long-term sustainability of ART provision.

Total HIV Expenditure by Source and Key Programs

Updated findings from the National AIDS Spending Assessment Plus (NASA+) 2025 confirm that the South African government continues to play a dominant role in financing the national HIV response, contributing the largest share of total funding. Total HIV expenditure remained stable at approximately R39.2 billion in 2021/22, R39.3 billion in 2022/23, and R38.3 billion in 2023/24 (Table 18).

Domestic public financing accounts for most resources, reflecting strong government ownership and commitment to sustaining HIV, TB, and STI programmes. External partners—including PEPFAR, USAID, and the Global Fund—continue to provide important complementary support, particularly for targeted programmes and key populations. However, recent trends indicate a gradual shift toward increased reliance on domestic funding, with donor contributions becoming more targeted and, in some cases, stabilizing or declining relative to total expenditure.

These patterns highlight South Africa's progress toward financing sustainability, while also underscoring the need to optimize resource use. Continued strategic alignment between domestic and external funding will be critical to ensure that priority areas—especially prevention and key population programmes—are adequately resourced to achieve NSP 2023–2028 targets.

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

HIV FUNDING ENTITIES (ZAR)	2021/22	2022/23	2023/24	% 2021/22	% 2022/23	% 2023/24
Government of South Africa	29,068,994,920	29,974,849,507	29,074,644,515	74%	76%	76%
PEPFAR	8,216,515,262	7,470,234,250	7,162,583,331	21%	19%	19%
Global Fund	926,399,287	681,020,602	933,509,576	2%	2%	2%
Other bilateral funding entities	6,495,978	12,406,659	18,087,000	0.0%	0.0%	0.0%
Other multilateral funding entities	77,658,964	96,374,350	54,450,972	0.2%	0.2%	021%
INGOs and Foundations	3,005,662	504,057	486,476	0.0%	0.0%	0.0%
Medical insurances	889,346,480	1,043,107,979	1,026,902,624	2.3%	2.7%	2.7%
Private sector/domestic corporations	432,706	423,706	523,694	0.0%	0.0%	0.0%
Total HIV (ZAR)	**39,188,849,259**	**39,278,930,110**	**38,275,188,187**	**100%**	**100%**	**100%**

Source: NASA report (2021/22 – 2023/24)

Overall Insights and Conclusions from the NASA+ Analysis

The National AIDS Spending Assessment Plus (NASA+) 2025 highlights a mature and largely domestically sustained HIV financing landscape in South Africa, with total annual expenditure stabilising at approximately R38–39 billion between 2021/22 and 2023/24. This stability reflects strong government commitment and fiscal prioritisation of the HIV response, with domestic public resources accounting for the majority share (up to ~75–76%) of total funding.

A key finding is the continued dominance of treatment expenditure, which absorbs over 70% of total HIV spending. This reflects the scale and success of South Africa's ART programme, now serving over 6 million people. However, this allocation pattern also reveals a structural imbalance, with prevention—particularly for key and vulnerable populations—remaining underfunded relative to its strategic importance in reducing new infections.

The analysis further indicates that while overall funding levels are relatively stable, there are emerging pressures on sustainability. Rising input costs, increasing patient volumes, and the need to expand differentiated and integrated service delivery models place additional demands

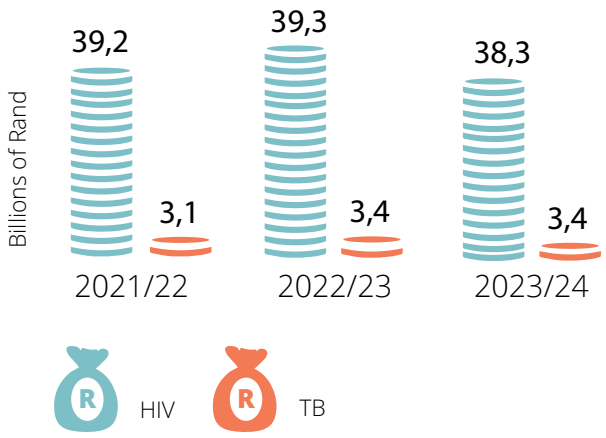
on the system. At the same time, inefficiencies in resource allocation and gaps in expenditure tracking—particularly in the private sector and non-clinical interventions—limit optimal planning and accountability.

Another critical insight is the uneven alignment between spending and epidemiological need. Despite the disproportionate burden of HIV among key populations and priority districts, funding for targeted interventions remains limited. This misalignment risks slowing progress toward epidemic control, particularly in the context of persistent incidence among adolescents, young women, and key populations.

Figure 26 illustrates total national expenditure on HIV and tuberculosis (TB) in South Africa from 2021/22 to 2023/24, highlighting both the scale and relative distribution of funding between the two programmes. Over the three-year period, HIV expenditure remained consistently high and stable, at approximately R39.2 billion in 2021/22, R39.3 billion in 2022/23, and R38.3 billion in 2023/24. In contrast, TB expenditure was substantially lower, ranging from R3.19 billion in 2021/22 to R3.38 billion in 2022/23, and slightly decreasing to R3.38 billion in 2023/24.

This trend demonstrates that HIV continues to dominate health spending within the combined HIV/TB response, accounting for most of the total programme expenditure. While this reflects the scale of South Africa's HIV epidemic and the large treatment programme, it also highlights the comparatively lower level of investment in TB, despite its status as a leading cause of mortality among people living with HIV. Overall, the figure underscores a stable financing environment for both programmes but also points to the need for continued attention to TB resource allocation. Strengthening investment in TB prevention, diagnosis, and treatment—alongside sustained HIV funding—will be essential to address the dual burden of HIV and TB and achieve integrated epidemic control.

Figure 26: Total HI/TB spending by programme area (2017-2020, ZAR)



Source: NASA report (2021/22 – 2023/24)

CONCLUSION

Advancing South Africa's HIV Response Towards 2030: Progress, Sustainability, and Strategic Priorities

South Africa continues to demonstrate strong leadership in the global HIV response, underpinned by a robust constitutional commitment to health, alignment with the Sustainable Development Goals (SDG 3), and implementation of the National Strategic Plan (NSP) 2023–2028. The country has made substantial progress toward epidemic control, but the latest evidence—including updated programme, epidemiological, and financing data—highlights the need for a strategic recalibration to sustain and accelerate gains.

Key Achievements

South Africa has achieved notable success across the HIV cascade. The country has effectively reached the first (95% diagnosis) and is close to the third (viral suppression ~91%) UNAIDS targets, reflecting strong testing coverage and treatment effectiveness. ART coverage has continued to expand, supported by differentiated service delivery (DSD) models and multi-month dispensing (MMD), which have improved retention and patient convenience. Significant progress has also been made in reducing mother-to-child transmission (MTCT), with rates steadily declining to approximately 2.63% in 2024, alongside high levels of antenatal HIV testing and treatment coverage. Early infant diagnosis remains strong, and paediatric AIDS-related mortality continues to decline. From a financing perspective, South Africa has transitioned to a largely domestically funded HIV response, with total annual expenditure stabilising at approximately R38–39 billion between 2021/22 and 2023/24. Government now contributes the majority share of funding, demonstrating sustainability and national ownership.

Persistent Challenges

Despite these achievements, several structural and programmatic challenges persist. HIV incidence, while declining overall, remains disproportionately high among adolescent girls and young women (AGYW) and continues to affect key populations such as MSM, FSW, and PWID. ART coverage and retention remain suboptimal among children and key populations, driven by stigma, discrimination, and structural barriers to care. A critical concern emerging from the latest NASA+ analysis is the imbalance in resource allocation, with over 70% of funding directed toward treatment, while prevention—especially for key populations—remains underfunded. This misalignment risks slowing progress in reducing new infections.

Health system disruptions from COVID-19 have had lingering effects, particularly on TB and HIV service integration, early diagnosis, and treatment initiation. TB remains a leading cause of death among people living with HIV, yet TB funding remains significantly lower than HIV expenditure, highlighting gaps in integrated programming. In addition, stigma, gender-based violence (GBV), and discriminatory practices continue to limit access to services, particularly for vulnerable and marginalized populations. Data gaps—especially for key populations and programme outcomes within DSD models—further constrain evidence-based planning.

Financing Risks and Sustainability

While South Africa's HIV programme is largely domestically funded, the analysis highlights emerging sustainability risks, particularly in the context of potential reductions in US Government (USG/PEPFAR) funding from 2025. Donor funding continues to play a critical role in supporting prevention, community-based services, and key population programmes. Any reduction in external support could disproportionately affect these high-impact interventions. At the same time, rising programme costs, increasing patient volumes, and the need to expand integrated and person-centred services place additional pressure on available resources. These dynamics underscore the importance of efficiency, prioritisation, and strategic resource allocation.

The Path Forward

To sustain progress and achieve the goal of ending AIDS as a public health threat by 2030, South Africa must prioritise the following:

- Rebalance investments toward prevention, particularly for AGYW and key populations, to reduce new infections
- Strengthen ART coverage and retention, especially among children and underserved groups
- Enhance TB-HIV integration, including expanded TB preventive therapy and early diagnosis
- Institutionalise and optimise DSD models, ensuring quality outcomes while improving efficiency
- Strengthen health system resilience, including workforce integration and service continuity
- Improve data systems and expenditure tracking to support real-time, evidence-based decision-making
- Address structural drivers, including stigma, discrimination, and GBV, through rights-based and community-led approaches

Final Reflection

South Africa's HIV response stands as one of the most advanced globally, characterised by strong political commitment, large-scale treatment success, and increasing financial sustainability. However, the next phase of the response will require strategic shifts—toward prevention, equity, efficiency, and sustainability. By aligning resources with epidemiological need, strengthening integrated service delivery, and proactively managing funding transitions, South Africa is well-positioned to sustain its progress and move decisively toward achieving the 2030 targets.

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