

Global AIDS Monitoring 2017

Indicators for monitoring the 2016 United Nations Political Declaration on HIV and AIDS

National Commitments and Policy Instrument (NCPI) – SOUTH AFRICA

Overview

South Africa has a high prevalence generalised and heterogeneous HIV epidemic, with a tuberculosis (TB)/ human immunodeficiency virus (HIV) co-infection rate of over 60%ⁱ. In 2012, the population level HIV prevalence was 12.2%, with approximately 6.4-million people living with HIV (PLHIV)ⁱⁱ. The HIV epidemic is concentrated in several districts nationally, and provincial HIV prevalence ranges from 16.9% in KwaZulu-Natal to 5.0% in the Western Cape. HIV incidence is highest among young women aged 15-24 years. Concentrated sub-epidemics have also been observed among key populations including sex workers and men who have sex with men (MSM)ⁱⁱⁱ. With an estimated 7 million PLHIV in 2015^{iv}, South Africa had over 3.4 million people accessing antiretroviral therapy (ART) by end of 2015.

With respect to the development and implementation of policies, strategies and laws related to the HIV response, South Africa has made commendable strides towards achieving the 10 Fast-Track commitments and the expanded targets to end AIDS by 2030. The accomplishments were determined through the application of the National Commitment and Policy Instrument (NCPI) 2017 tool i.e. Part A and B as the findings are as follows: The country has fully adapted the recommendations from i) the World Health Organization (WHO) 2015 Consolidated Guidelines on HIV Testing Services (HTS) in a national process on testing guidelines, ii) the 2016 WHO Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV infection in a national process for i) Adult ART guidelines, ii) Prevention of mother-to-child transmission (PMTCT) guidelines, iii) Paediatric guidelines, and iv) Operational/ service delivery guidelines and; the 2016 WHO Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations are included in the national HIV policy and plans.

South Africa has laws and provisions to eliminate gender inequalities and end all forms of violence and discrimination against women, girls, PLHIV and key populations. Education policies that guide the delivery of life skills-based HIV and sexuality education in accordance with international standards are in place and there is an approved social protection strategy that is being implemented. There are safeguards in laws, regulations and policies that provide for the operation of civil society organizations (CSOs)/ community-based organizations (CBOs). Training and/or capacity building programmes for PLHIV and key populations to educate them and raise their awareness concerning their rights in the context of HIV are implemented but at varying degrees across the country.

Furthermore, there are training programmes on human rights and non-discrimination legal frameworks as applicable to HIV for health care workers at scale at national level whilst for the police and other law enforcement personnel it is at a small scale. Similarly, there are training programmes on preventing violence against women and GBV for i) police and other law enforcement personnel, ii) members of the judiciary, iii) elected officials and iv) healthcare workers at scale at national level. Mechanisms to document key human rights violations as well as monitor and enforce human rights have been put in place. HIV services are largely integrated with other health services across all health facilities.

Lastly, South Africa has a national strategy that guides the AIDS response and includes TB and STIs. The national HIV, TB and STIs strategy has been reviewed in the past two years and it explicitly addresses key populations and/ or vulnerable groups. The national strategy guiding the AIDS response in South Africa does the following i) Specifically includes explicit plans or activities that

address the needs of key populations, ii) Specifically includes explicit plans or activities that address the needs of young women and girls, iii) Draws on the most recent evidence about the national HIV epidemic and the status of the response, iv) Integrates inputs from a multisectoral process, including various government sectors as well as non-governmental partners and; comprises of gender-transformative interventions, including interventions to address the intersections of gender-based violence (GBV) and HIV. Accordingly, a national monitoring and evaluation (M&E) plan for HIV, TB and STIs is in place.

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

1.1 HIV Testing

South Africa acknowledges international trends and recommendations as described in the latest WHO guidelines. As reflected in the South African National HIV Testing Services Policy, 2016, the country has fully adapted the recommendations from the WHO 2015 Consolidated Guidelines on HIV Testing Services (HTS) in a national process on testing guidelines. The South African National HIV Testing Services Policy, 2016, provides that all forms of HTS adhere to the 5Cs: Confidentiality, Counselling, Consent, Correct results and Connection or linkage to care with all based within the human rights context.

Furthermore, South Africa puts emphasis on the use of a variety of HTS approaches to reduce the number of missed opportunities. The HTS approaches emphasized include client-initiated counselling and testing, provider-initiated counselling and testing (PICT), routine antenatal testing, infant and children counselling and testing, community-based testing and counselling, home testing, lay provider testing, and self-testing, in accordance with the revised WHO guidelines.

In a bold and progressive move, HIV self-testing is included in the 2016 National HTS Policy and the South African Pharmacy Council (SAPC) has approved over-the-counter distribution and use of HIV self-tests. All healthcare providers should support clients who have self-tested and provide them with counselling as needed after confirmation of diagnosis. Currently, assisted HIV partner notification is not included in the national HTS policy. Efforts are being made to facilitate the inclusion of assisted HIV partner notification in national policy in the future.

HIV testing is provided for free to all in all public health facilities. The HTS national policy specifies that clients have the right to refuse HIV testing without compromising their access to standard healthcare. In South Africa, mandatory HIV testing is provided for or carried out under specific circumstances namely, i) sexual offenders by court order, ii) pregnant women when starting ANC and, iii) at enlistment into the South African National Defence Force (SANDF). All HIV testing remains voluntary with informed consent, even when the services are initiated by the service provider. Specifically, HIV testing is not mandatory i) before marriage, ii) to obtain a work or residence permit and, iii) for certain groups. The only exception is in cases of sexual assault where the survivor requests the status of the perpetrator.

Lastly, South Africa has strategies on linking HIV testing and counselling and enrolment with care. As mentioned above, the national HTS policy subscribes to the 5Cs which include connection or linkage to care. This means clients who are counselled and tested are linked to HIV prevention, treatment, care and support services; and effective and appropriate follow-ups are provided. Other strategies include i) streamlined interventions i.e. enhanced linkage, disclosure, tracing; ii) peer support and patient navigation approaches iii) quality improvement approaches, and CD4 testing at point of care.

1.2 Antiretroviral Therapy (ART)

South Africa has adapted the recommendations from the *2016 WHO Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV infection* in a national process for i) Adult ART guidelines, ii) PMTCT guidelines, iii) Paediatric guidelines, and iv) Operational/ service delivery guidelines. Effective 1st September 2016, South Africa began implementing the WHO evidence-based guidelines of Universal Test and Treat (UTT) and the following criteria to start patients on lifelong ART apply:

- All HIV positive children, adolescents and adults regardless of CD4 count are offered ART including PLHIV:
 - With active tuberculosis (TB);
 - With hepatitis B and severe liver disease;
 - Identified as being in key populations regardless of CD4 cell count, and
 - HIV positive partners in sero-discordant couples
- Patients in the Pre-ART and Wellness Programme are considered for UTT.
- Willingness and readiness to start ART is assessed and patients who are not ready after assessment are kept in the Wellness Programme and continuous counselling on the importance of the early treatment and scheduled CD4 as per SA clinical guidelines continue at every visit.
- Baseline monitoring of CD4 count continues to be done as it is the key factor in determining the need to i) initiate opportunistic infection prophylaxis at CD4 equal or below 200, ii) identify eligibility for cryptococcal antigen (CrAg) test at CD4 equal or below 100, iii) prioritisation at CD4 equal or below 350 and iv) fast tracking at CD4 equal or below 200.

South Africa uses point-of-care CD4 technology and all primary health care (PHC) facilities in the country have access to CD4 cell count testing for their patients, whether on-site or nearby referral. For quality assurance, the CD4 count point of care testing has stringent calibration processes that need to be adhered to routinely.

To improve ART coverage and ensure 90% of the HIV positive individuals are initiated on ART, nurse-initiated ART (NIMART) has been policy in South Africa since 2010. Non-pregnant adults (men, women and transgender), pregnant women, adolescents (10-19 years old) and children younger than 10 years old are routinely initiated on ART by NIMART trained nurses at PHC level. As such, national policy promotes community delivery of ART.

In addition to NIMART, South Africa is implementing the Central Chronic Medicine Dispensing and Distribution (CCMDD), a pharmacy services system that allows stable patients on ART to pick-up their pre-packed ART at a community-based ART Pick-up Point (PUP) that is convenient and accessible to them – reducing the number of clinic visits. National policy stipulates that stable patients on ART must have six monthly clinical monitoring visits. Likewise, stable patients on ART pick-up their pre-packed ART every three months. The comprehensive and integrated ART service provision modalities are utilised in South Africa and these include the following:

- TB service providers provide ART in TB clinics.
- ART providers provide TB treatment in ART settings.
- Maternal, new-born and child health (MNCH) service providers provide ART in MNCH clinics.
- Nutrition assessment, counselling and support are provided to malnourished PLHIV.
- PHC providers provided ART in PHC settings.
- Patient support is provided.
- ART delivered in the community as part of a differentiated care model.
- ART providers carry out cardiovascular disease screening and management
- ART providers carry out mental health screening and treatment

1.3 ART Regimens

1.3.1 Adults

According to the latest national guidelines, TDF/3TC (or FTC)/EFV are the preferred first-line antiretroviral (ARV) combinations for treatment initiation in adults, adolescents and pregnant women. Dolutegravir (DTG), an integrase inhibitor, is registered with the South African Medicines Control Council (MCC), but is not yet in the national treatment guidelines. Furthermore, South Africa uses fixed-dose combinations (FDC) ART as the preferred first-line therapy – three drugs FDC taken once daily. AZT/3TC (or FTC)/ ATV/r (or LPV/r) is the preferred second-line ARV combination for adults and adolescents.

1.3.2 Children

The national guidelines specify that in children below three years of age with HIV, the preferred nucleoside reverse transcriptase inhibitor (NRTI) for treatment initiation is Abacavir (ABC). LPV/r based-regimens are the preferred treatment option for all infants and children below three years old, irrespective of NNRTI exposure. The national guidelines also stipulate that Efavirenz (EFV) is the preferred NNRTI for treatment initiation in children aged three and older and the recommended NRTI backbone for treatment initiation in children aged 3-10 years is ABC + 3TC (or FTC). Similarly, the recommended NRTI backbone for treatment initiation in adolescents > 35kg and at least 10 years of age.

1.4 Viral Load

South Africa has current national policy on routine viral load testing for ART and it is fully implemented for all i.e. adults, adolescents and children. Viral load testing for viral suppression is done both annually and episodically. In the public sector, viral load testing is freely available at all ART facilities through the National Health Laboratory Services (NHLS). Some non-government organizations (NGOs) have point of care PIMA machines in the mobile units they deployed in communities. The national policy also prioritizes viral load testing in selected populations and/ or situations i.e. pregnant women, infants, adolescents, as appropriate.

A system to monitor ARV drug resistance is in place and HIV drug resistance (HIVDR) surveillance was conducted in 2015, as per WHO protocols namely, i) Pre-treatment drug resistance survey ii) Acquired drug resistance survey among children. In 2014, a survey or routine monitoring of clinic performance was carried out using early warning indicators for HIV drug resistance in 1000 clinics. To date, HIV drug resistance among infants (<18 months) using early infant diagnosis has not been done.

1.5 ARV Drug Adverse Events

Besides passive pharmacovigilance approaches, South Africa makes ongoing systematic effort to monitor the toxicity of ARV medicines using approaches such as i) Sentinel sites report toxicity, ii) Pregnancy registry, and iii) Surveillance of birth defects

1.6 Adherence and Retention

South Africa has national policies and strategies on adherence support and the adherence support services available include peer counsellors, text messages, use of reminder devices, cognitive-behaviour therapy, behavioural skills training/ medication adherence training, FDC and once daily regimens, case management and peer navigation. National policies and strategies on retention in ART also exist and the retention support services available include community-based interventions as well as adherence clubs and peer support. Lastly, treatment literacy programmes are available for PLHIV and include information on side effects, drug resistance, etc.

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

2.1 Prevention of mother-to-child transmission (PMTCT)

South Africa has a national plan for the elimination of mother-to-child transmission (MTCT) of HIV. The current nationally recommended policy for preventing MTCT of HIV is to treat ALL pregnant women/ breastfeeding women for life and this is being implemented countrywide. The current nationally recommended first-line ART regimen for pregnant and breastfeeding women living with HIV is TDF/ 3TC (FTC) /EFV. On the other hand, the currently nationally recommended infant prophylaxis is Nevirapine (NVP) at birth, and then daily for six weeks, if the mother is on lifelong ART. If the mother did not get any ART before or during delivery and test HIV positive > 72 hours after delivery, started ART less than 4 weeks ago or is newly diagnosed within 72 hours of delivery, the infant must be given NVP as soon as possible and daily for 12 weeks (if the infant is breastfed).

For breastfeeding mother diagnosed with HIV, i) start the mother on a FDC immediately and, ii) give the infant NVP and AZT immediately. If the infant tests HIV PCR negative, stop AZT and continue with NVP for 12 weeks. If the mother has received 12 weeks of ART, then NVP can be stopped. If the infant tests HIV PCR positive, initiate ART immediately. For unknown maternal status for any reason, including orphans and abandoned children, i) give the infant NVP immediately and, ii) test infant with rapid HIV. If the infant is HIV positive, continue NVP for six weeks and if HIV negative, stop NVP. For a mother with latest viral load > 1000 copies/ml, give the infant dual ARV (NVP + AZT) for six weeks. Do HIV PCR at or shortly after birth and if negative, follow-up with an HIV PCR at 10 weeks. For non-breastfeeding mothers diagnosed with HIV, if more than 72 hours since birth, no infant NVP. Do HIV PCR and if positive, initiate ART.

Regarding infant feeding, South Africa recommends both breastfeeding and replacement feeding for HIV exposed infants – *it is left to individual choice and different settings*. If breastfeeding is recommended for HIV positive women and HIV-exposed infants, the duration is 24 months. Food and nutrition support is integrated within PMTCT and this is implemented nationwide.

Finally, there is a national strategy on interventions at delivery for women living with HIV who have not previously been tested for HIV and it is fully implemented nationally. Vertical transmission of HIV is not criminalized in South Africa.

2.2 Elimination of MTCT of Syphilis

South Africa has no national plan for the elimination of MTCT of syphilis but, has a national policy for routinely screening pregnant women for syphilis. Laboratory-based non-treponemal tests i.e. RPR/ VDRL are used.

2.3 Early Infant Diagnosis (EID)

National guidelines recommend that infants be tested for HIV at birth, two months and 18 months of age. In addition to the PMTCT setting, HIV testing of infants and children is carried out at other possible entry points namely, paediatric in-patient wards, nutrition centres, immunization clinics and outpatient clinics. National policy provides nucleic acid testing (DNA-PCR) for HIV-exposed infants at birth and at two months - EID. The final diagnosis HIV antibody test is done at 18 months of age or three months post cessation of breastfeeding. Point of care viral load testing policy for EID is available nationwide, through the NHLS.

All PHC health facilities in the public sector offer free PMTCT services and there are targeted interventions to ensure that any of the following human rights considerations are addressed as part of the PMTCT programme:

- Voluntary and informed consent as sole basis for testing and/ or treatment for HIV.
- Voluntary and informed consent as sole basis abortion, contraception and/ or sterilization of women with HIV.
- Confidentiality and privacy.
- Prevention of grave or systemic human rights abuses as part of the PMTCT programme.
- Due diligence to address any human rights abuses as part of the PMTCT programme.

There have been a few reports of i) lack of confidentiality and privacy, and ii) mandatory or coerced testing and/ or treatment for HIV and the South African Government (SAG) is carrying out due diligence in responding to these situations.

In the past 12 months, a meeting was held at national level to review South Africa's PMTCT progress. Community and civil society were represented at this national PMTCT review meeting. They were provided the opportunity to provide comments and their analysis was provided in a systematic manner. The analysis provided by community and civil society was documented and disseminated following the meeting. Women living with HIV are rarely given the opportunity to participate in the development of policies, guidelines and strategies relating to PMTCT.

2.4 Child ART

National guidelines recommend treating all infants and children living with HIV regardless of symptoms or age. In South Africa, a child who is initiated on ART is considered lost to follow up if he or she has not been seen for HIV care or pharmacy pick-up in three months. To reduce loss to follow up, South Africa has a plan to ensure that adolescents born with HIV are not lost to follow up as they transition into adult HIV care. Cohorts of children receiving ART are monitored in the national registers at 6-months and 12-months intervals, to ensure that these children are alive and receiving ART. Growth monitoring and nutrition programmes for children are integrated with HIV testing and treatment across all treatment sites in the country.

COMMITMENT 3: Ensure access to combination options including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people, especially young women and adolescent girls in high prevalence countries and key populations-gay men and other MSM, transgender, sex workers and their clients, people who inject drugs and prisoners.

In South Africa, the recommendations from the 2016 WHO Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations have been included in the national HIV policy and plans. Transgender people are not criminalized or prosecuted and cross-dressing is not criminalized. Laws penalizing same-sex sexual acts have been decriminalised/ never existed and same-sex marriage is legal in South Africa. However, selling and buying sexual services is still criminalized. The country does not have the death penalty in law for people convicted of drug-related offences but, drug use or consumption is a specific offence in law.

South Africa does not have other punitive laws affecting lesbian, gay, bisexual, transgender and intersex (LGBTI) people and the following legal protections apply for transgender people i) Constitutional prohibition of discrimination based on gender diversity, ii) Prohibitions of discrimination in employment based on gender diversity, iii) A third gender is legally recognized and, iv) Other non-discriminatory provisions specifying gender diversity. Though sex work is not recognised as work in South Africa, there is legal protection for sex workers through the

constitutional prohibition of discrimination based on occupation. In addition, there are laws and provisions specifying protections based on grounds of sexual orientation namely, i) Constitutional prohibition of discrimination based on sexual orientation, ii) Hate crimes based on sexual orientation considered an aggravating circumstance, iii) Incitement to hatred based on sexual orientation is prohibited, and iv) Prohibition of discrimination in employment based on sexual orientation. Furthermore, South Africa has specific antidiscrimination laws or provisions that apply to people who use drugs and there is explicit supportive reference to harm reduction in national policies.

3.1 HIV prevention for sex workers

South Africa has a national prevention strategy to reduce new infections among sex workers and provide services to sex workers and their clients. The strategy includes:

- Community empowerment and capacity building for sex worker organisations.
- Community-based outreach and services for sex workers and their clients.
- Distribution of condoms for sex workers and their clients.
- Clinical services for sex workers and their clients.
- Actions to address GBV.
- Actions to reduce stigma and discrimination in the health setting.

3.2 HIV prevention for MSM

South Africa has a national prevention strategy to reduce new infections among and provide services to gay men and other MSM. The strategy includes:

- Community empowerment and capacity building for MSM organisations.
- Community-based outreach and services for MSM.
- Distribution of condoms and condom-compatible lubricants
- Sexually transmitted infections (STIs) prevention, screening and treatment services.
- Clinical services for MSM.
- Psychological counselling and/ or mental health services
- Legal support services.
- Actions to address homophobic violence.
- Actions to reduce stigma and discrimination.

3.4 HIV prevention for people who inject drugs (PWID)

National policies do not exclude people who are currently using drugs from receiving ART. Needle and syringe programmes are operational in South Africa and possession of a needle or syringe without a prescription cannot be used as evidence of drug use or cause for arrest. Opioid substitution therapy (OST) programmes are operational and other non-opioid drug dependence treatment interventions are also implemented. Naloxone (used to reverse opioid overdose) is not available through community distribution channels.

3.5 HIV prevention services for prisoners

South Africa has neither needle and syringe nor OST programmes operational in prisons. Condoms and lubricants are available in prisons. HIV testing is carried out with informed consent of the prisoners and is free of charge and confidential. HIV testing is equally accessible to all prisoners and available at any time during detention, accompanied by relevant and accessible information as well as confidential pre- and post-test counselling. Lastly, ART is available to all prisoners living with HIV.

3.6 Participation of key populations in the national response

In South Africa, MSM, sex workers, PWID, transgender people and former/ current prisoners participate in the development of policies, guidelines and strategies relating to their health.

3.7 Services for people affected by humanitarian emergencies

In South Africa, people affected by humanitarian emergencies (including but not limited to non-displaced people, refugees and asylum seekers, internally displaced people and migrants), have access to the following services: HTS, PMTCT, HIV treatment, TB screening and treatment, preventing and treating STIs, services for key populations, services for survivors of sexual and gender-based violence and, food and nutrition support.

3.8 Pre-exposure Prophylaxis (PrEP)

PrEP is available in South Africa and is provided in various ways namely, i) provided as national policy, ii) provided as part of a pilot project, iii) available through research and iv) available through private providers. Currently, PrEP is recommended for Gay men and other MSM, sex workers, PIWD, transgender people, serodiscordant couples and young women. A training programme on PrEP is provided to healthcare personnel.

3.9 Condoms

South Africa has a national condom strategy that explicitly addresses the needs of and target condom programming for PLHIV, sex workers (male and female), MSM, PWID, young people (15-24 years old), people with STIs, prisoners and the general public. The strategy includes the free distribution to key populations, condom promotion through mass media and private sector sales. National condom needs have been estimated and there are no restrictions on distributing condoms in public places. No individual can be prosecuted or punished for carrying condoms but there are age restrictions for accessing condoms. The country has not experienced any condom stock-outs at national or local level in the last 12 months. Below are the condoms and lubricants that were distributed (that left the central or regional warehouses for onward distribution) in the previous calendar year:

Table 1: Condom Distribution in the Previous Calendar Year

Sector	Male Condoms	Lubricants
Public	839,000,000	996,000
Private	-	-
NGOs	-	-
Total	839,000,000	996,000

1.10 Voluntary Male Medical Circumcision (VMMC)

South Africa has a national VMMC strategy which refers to a specific age group i.e. 15-49 years old. A target has been set for the number of men in this age group to be reached. The target number or proportion of men in the age group 15-49 years old for the year 2016/17 is 700,000. Male medical circumcision (MMC) is offered free of charge in public health facilities and the MMC methods recommended/ approved by the national programme are i) Conventional surgical methods (dorsal slit, forceps guided, sleeve resection) and ii) WHO pre-qualified device method approved for use.

COMMITMENT 4: Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020.

4.1 Violence

South Africa may not have a national plan or strategy to address GBV and violence against women that includes HIV but, has legislation on domestic violence and it covers physical, sexual, emotional and economic violence. In addition, the legislation covers i) explicit criminalization of marital rape, ii) protection of former spouses and, iii) protection of unmarried intimate partners. The following provisions related to domestic violence are implemented in South Africa:

- Court injunctions to ensure the safety and security of survivors.
- Protection services for survivors of domestic violence, such as legal services or shelters.
- Services for the person perpetrating violence.

Likewise, there are criminal penalties for domestic violence and there have been prosecutions in the past two years.

To protect key populations and PLHIV from violence, South Africa has: i) General criminal laws prohibiting violence, ii) Specific legal provisions prohibiting violence against people based on their HIV status or belonging to a key population, iii) Programmes to address intimate partner violence and workplace violence and, iv) Interventions to address police abuse as well as torture and ill-treatment in prisons.

South Africa has service delivery points that provide appropriate medical and psychological care and support for women and men who have been raped and experienced incest in accordance with the recommendations of the 2013 WHO guidelines, *responding to intimate partner violence and sexual violence against women*. The services include the following:

- First-line support or what is known as psychological first aid.
- Emergency contraception for women who seek services within five days.
- Safe abortion if a woman becomes pregnant because of rape in accordance with national law.
- Post-exposure prophylaxis (PEP) for STIs and HIV (within 72 hours of sexual assault) as needed.

4.2 Child marriage

The legal age of marriage for boys and girls in South Africa is 18 years of age. Child marriage or informal union before the age of 18 is void and prohibited.

4.3 Stigma and discrimination

Policies requiring healthcare settings to provide timely and quality health care regardless of gender, nationality, age, disability, ethnic origin, sexual orientation, religion, language, socio-economic status, HIV or other health status, or because of selling sex, using drugs, living in prison or any other grounds exist and they are consistently implemented. However, incidents of inconsistent implementation have been reported. There are interventions targeting health care workers to i) build their human rights competencies, ii) address stigma and GBV, and these are implemented at scale. South Africa does not have laws that criminalize the transmission of, non-disclosure of or exposure to HIV transmission but prosecutions exist based on general criminal laws. Lastly, there are no laws or policies that restrict the entry stay and residence of PLHIV.

4.4 Parental and spousal consent for accessing services

South Africa has laws requiring parental consent for adolescents younger than 14 years to access sexual and reproductive health services including HIV testing and treatment. Laws requiring spousal consent for married women to access sexual and reproductive health services or HIV testing do not exist.

COMMITMENT 5: Ensure that 90% of young people have skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services

by 2020, to reduce the number of new HIV infections among adolescent girls and young women to 100 000 per year.

South Africa has education policies that guide the delivery of life skills-based HIV and sexuality education in accordance with international standards in primary school, secondary school and teachers' training. Young people (15-24 years old) also participate in the development of policies, guidelines and strategies relating to their health and these include the following decision-making spaces in the national response:

- Technical teams for the development, review and update of national AIDS strategies and plans.
- Technical teams for the development or review of programmes that relate to young people's access to HIV testing, treatment, care and support services.
- National AIDS Coordinating Authority or equivalent, with a broad based multi-sector mandate.
- Global Fund Country Coordinating Mechanism.
- Civil society coordination spaces of populations most affected by HIV.
- Other national or civil society-led campaigns e.g. the "She Conquers" Campaign

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

South Africa has an approved social protection strategy that is being implemented. The strategy refers to HIV and recognizes PLHIV, key populations (i.e. sex workers, gay men and other MSM, PIWD, transgender people, prisoners), adolescent girls and young women and, people affected by HIV (children and families) as key beneficiaries. The strategy also addresses the issue of unpaid care work in the context of HIV. There is a social protection coordination mechanism/ platform and it includes representatives of the National AIDS Programme or equivalent. At present, there is no cash transfer for young women aged 15-24 years being implemented in South Africa.

Lastly, several barriers that limit access to social protections programmes have been identified and these include i) Lack of information available on programmes, ii) Complicated procedures, iii) Fear of stigma and discrimination has been identified as a barrier, iv) Laws or policies that present obstacles to access and, v) High related out-of-pocket expenses.

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

There are safeguards in laws, regulations and policies that provide for the operation of CSOs/ CBOs in South Africa and these include the following:

- Registration of HIV CSOs is possible.
- Registration of CSOs/CBOs working with key populations is possible. HIV services can be provided by CSOs/CBOs.
- Services to key populations can be provided by CSOs/ CBOs.
- Reporting requirements for CSOs/ CBOs delivering HIV services are streamlined.

Moreover, there are laws, policies or regulations that enable access to local and international funding for CSOs/ CBOs. In conclusion, South Africa has neither restrictions to registration and operation of CSOs/ CBOs that affect HIV service delivery nor regulatory barriers to community-led service delivery.

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

Health care financing is the responsibility of the SAG and there is a move to improve health equity through the National Health Insurance (NHI) initiative. Currently, SAG funds HIV programmes through the conditional grant and the equitable share from National Treasury, and other external sources including the Global Fund, PEPFAR and other developmental partners.

COMMITMENT 9: Empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violations of human rights.

South Africa has had training and/or capacity building programmes for PLHIV and key populations to educate them and raise their awareness concerning their rights (in the context of HIV) in the last two years, and implementation varies from i) once-off activities, ii) at a small scale, to iii) at scale at sub-national level across the country. In addition, there are training programmes on human rights and non-discrimination legal frameworks as applicable to HIV for i) health care workers at scale at national level, ii) police and other law enforcement personnel at a small scale, iii) once-off for members of the judiciary and, iv) none for elected officials (lawmakers or parliamentarians). Similarly, there are training programmes on preventing violence against women and GBV for i) police and other law enforcement personnel, ii) members of the judiciary, iii) elected officials and iv) healthcare workers at scale at national level. Barriers to providing training and/or capacity building programmes for PLHIV and key populations to educate them and raise their awareness concerning their rights have been reported and these include i) Lack of funding, Lack of capacity for delivery of trainings and, ii) Barriers that hinder the target audience to access such trainings or capacity-building.

Efforts to document key human rights violations have been put in place. The High Court, Equality Court, Labour Court and Legal Aid South Africa are mechanisms/platforms that are in place to record and address cases of HIV-related discrimination based on perceived HIV status and/ or belonging to any key population. The Stigma Index, a research study conducted annually, is one other mechanism used to monitor and document HIV related stigma and discrimination. In summary, South Africa has accountability mechanisms in relation to discrimination and violations of human rights in the healthcare settings and these include i) Complaints procedures, ii) Mechanisms of redress and accountability and, iii) Procedures or systems to protect and respect patient privacy or confidentiality. However, barriers to accessing accountability mechanisms exists and these include the following i) Awareness or knowledge of how to use such mechanisms is limited, ii) Affordability constraints for people from marginalized and affected groups and, iii) Mechanisms not always sensitive to HIV.

South Africa has human rights monitoring and enforcement mechanisms which include i) Existence of independent functional national institutions for the promotion and protection of human rights, including human rights commissions (i.e. South African Human Rights Commission), law reform commissions, and ombudspersons which consider HIV-related issues within their work. Likewise, there is oversight for implementation of concluding observations and recommendations from treaty monitoring bodies and UPR. Lastly, South Africa also has mechanisms to promote access to justice and these include i) Legal aid systems applicable to HIV casework, ii) Pro bono legal services provided by private law firms, iii) Legal services provided by university-based legal clinics and, iv) Community paralegals. Nonetheless, there are documented barriers to access to justice for key populations and PLHIV i.e. because sex work remains criminalised in South Africa, sex workers are not afforded the opportunity to access justice for sex work related human rights abuses.

COMMITMENT 10: Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for TB, cervical cancer and hepatitis B and C.

HIV services are integrated with other health services across all health facilities in South Africa:

Full integration

- HIV counselling and testing (HCT) is fully integrated with sexual and reproductive health.
- HIV treatment and care is fully integrated with sexual and reproductive health.
- HCT is fully integrated in TB services.
- TB screening is fully integrated in HIV services.
- ART and TB treatment are fully integrated.
- HCT and chronic non-communicable diseases are fully integrated.
- ART and chronic non-communicable diseases are fully integrated.
- HCT is fully integrated with general outpatient care.
- ART is fully integrated with general outpatient care.
- HCT is fully integrated in cervical cancer screening and treatment services.
- Cervical cancer screening is fully integrated in HIV services.
- PMTCT is fully integrated with antenatal care/ maternal and child health (MCH).
- HIV treatment and care is fully integrated with nutrition support.

Partial integration

- HIV and hepatitis C treatment are integrated in some health facilities.
- Violence screening and mitigation are integrated with HIV services in some of the health facilities.
- HIV testing is fully integrated with child health services including growth monitoring, nutrition and immunization in some of the health facilities.

No integration

- HIV and harm reduction services are delivered separately.

Cervical cancer screening and treatment for women living with HIV is recommended in the national strategy, policy, plan and guidelines for cervical cancer or the broader response to non-communicable diseases (NCDs), in the national strategic plan governing the AIDS response, and in the national HIV treatment guidelines.

Co-infection policies are in place for adults, adolescents and children and include the following:

- Isoniazid preventive therapy (IPT) or latent TB infection (LTBI) prophylaxis for PLHIV.
- Intensified TB case finding among PLHIV.
- TB infection control in HIV health-care settings
- Cotrimoxazole prophylaxis therapy (CPT)
- Hepatitis B screening and management in ART clinics
- Hepatitis B vaccination provided at ART clinics
- All TB patients offered CPT

10.1 Sexually Transmitted Infections (STIs)

South Africa has national STIs treatment guidelines, last updated in 2015. Furthermore, there is a national strategy or action plan for the prevention and control of STIs. Gonococcal antimicrobial-resistance monitoring is conducted annually.

10.2 National HIV strategy and monitoring and evaluation

10.2.1 Strategy

South Africa has a national strategy that guides the AIDS response and it also includes TB and STIs. The national HIV, TB and STIs strategy was reviewed in the past two years and it explicitly addresses the following key populations or vulnerable groups: adolescent key populations, MSM, people in prisons and other closed settings, PWID, sex workers (male and female), transgender people, refugees and migrants and asylum-seekers.

The national strategy guiding the AIDS response does the following:

- Specifically includes explicit plans or activities that address the needs of key populations.
- Specifically includes explicit plans or activities that address the needs of young women and girls.
- Draws on the most recent evidence about the national HIV epidemic and the status of the response.
- Integrates inputs from a multisectoral process, including various government sectors as well as non-governmental partners.

The national strategy guiding the AIDS response also comprises of gender-transformative interventions, including interventions to address the intersections of GBV and HIV.

10.2.2 Monitoring and evaluation (M&E)

South Africa has a national M&E plan or strategy for HIV, which like the national strategy for the AIDS response includes TB and STIs. The M&E plan was updated in the past two years and does integrate gender-sensitive indicators. There are multiple unharmonised or parallel information systems that various entities manage and operate separately.

Currently, South Africa has no national method to de-duplicate key data such as people being diagnosed with HIV or people seeking ART i.e. unique identifier. However, sentinel surveillance is carried out in the following special populations, see table 2 below:

Table 2: Sentinel Surveillance in Special Populations

	Sentinel surveillance conducted	How often is it conducted (in years)?	What year was the most recent survey conducted?	In what number of sites was the surveillance conducted?
Antenatal clinic attendees	Yes	1	2013	48
Sex workers	Yes	-	2014	3
MSM	Yes	-	2012/13	3
PIWD	Yes	-	2014	3

Lastly, a nationally-representative data quality assesment that provides information about the accuracy of facility-level data of the number of people reported to be on ART has been conducted during the reporting period.

ⁱ UNAIDS HIV estimates with uncertainty bounds, 1990-2012. Source: UNAIDS 2013, UNAIDS Report on the Global AIDS Epidemic - 2013 [Excel file]

ⁱⁱ Shisana, O, Rehle, T, Simbayi LC, Zuma, K, Jooste, S, Zungu N, Labadarios, D, Onoya, D et al. (2014) South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press.

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- ⁱⁱⁱ Shisana, O, Rehle, T, Simbayi LC, Zuma, K, Jooste, S, Zungu N, Labadarios, D, Onoya, D et al. (2014) South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press.
- ^{iv} <http://www.unaids.org/en/regionscountries/countries/southafrica>