

National Commitments and Policy Instrument (NCPI) Narrative Report-South Africa 2019

Overview

Thembisa estimates indicate that South Africa has a generalised mature HIV epidemic, with about 7.5 million infected people. The epidemic is mostly heterosexually driven, and it is characterised by a high burden of tuberculosis (TB). Estimates indicate that the 2019 HIV prevalence was at 12.9% and has risen significantly in the past decade. The epidemic is heterogeneous across provinces, age groups and sex. Females continue to bear a disproportionate burden of the HIV epidemic, with an overall prevalence of 21.5% in females aged 15+ years and 13.1% in males of the same age group in 2019. Concerted national efforts in responding to the epidemic reflect a decline in incidence of infection in almost all groups. In 2019, the overall incidence rate was 0.39%, a 35% decline from the 0.74% reported in 2012. Concentrated sub-epidemics are evident among key populations including female sex workers and men who have sex with men (MSM). Although the burden of TB, fuelled by the HIV epidemic, remains high, the number of new cases of TB and deaths due to TB has started to decline. In 2017, there were 193,000 new TB cases occurring among people living with HIV, which is a 25% decline from the 258,000 cases reported in 2016.

South Africa has laws and provisions to eliminate gender inequalities and end all forms of violence and discrimination against women, girls, People Living with HIV (PLHIV) and key populations. An approved social protection strategy is in place. The National Strategic Plan (NSP) for HIV, TB and STIs guides implementation of all HIV, TB and STI activities in the country. Additionally, the mid-term review of the National Strategic Plan on HIV, TB and STIs is underway. Findings of the review will inform policy.

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

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. South Africa has more than 4 000 public health facilities offering provider-initiated counselling and testing (PICT) and client-initiated counselling and testing (CICT), routine antenatal testing, community-based testing and counselling, home testing, lay provider testing, self-testing, assisted partner notification/index testing, including social networking based testing. In addition, HTS is also available through non-medical sites and the private sector.

HIV self-testing is included in the 2016 National HTS Policy, 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. Partial implementation of HIV self-testing, as a pilot initiative in six out of the nine provinces (Eastern Cape, Free State, Gauteng, Kwa Zulu Natal, Mpumalanga and North West) is underway. The National Department of Health (NDoH) envisages the full implementation of the HIV self-testing in 2020. The NDoH will include the assisted partner notification/index testing approach in the national policy in 2020. Currently, social networking based testing is not included in the national HTS policy. The NDoH is making efforts to facilitate the inclusion of the approach in the national policy.

South Africa has strategies on linking HIV testing and counselling and enrolment with care. The national HTS policy subscribes to the 5Cs, namely, Consent, Confidentiality, Counselling, Correct test

results and Connection or linkage to care, as the foundation of effective HTS. This implies the linkage of counselled and tested clients to HIV prevention, treatment, care and support services and the provision of effective and appropriate follow-ups. Other strategies include i) streamlined interventions i.e. enhanced linkage, disclosure, tracing; ii) peer support and patient navigation approaches iii) and quality improvement approaches. The HTS policy does not necessarily encourage CD4 at point of care as the country does Test and Treat. The NDoH does not do CD4 count at diagnosis but does it to monitor clinical response and to give an idea of the non-response of the patient and to ART (which could be a sign of virological failure).

1.2 Antiretroviral Therapy (ART)

South Africa has adapted the recommendations from the *2018 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 1 September 2016, South Africa began implementing the WHO evidence-based guidelines of Universal Test and Treat (UTT), where there is no CD4 threshold (treat all regardless of CD4 count and clinical stage) for initiating ART in asymptomatic adults and adolescents. The NDoH implements the treat all regardless of CD4 count policy countrywide (>95% of treatment sites).

South Africa adopted the WHO 2017 Recommendation on rapid initiation of ART whereby all clients without contra-indications, initiation of ART occurs within 7 days and on the same day if possible. The NDoH implements the policy on rapid initiation of ART countrywide (>95% of treatment sites). 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 require routine adherence. CD4 testing for immunological staging is available in centralized laboratories and clients have access to testing and returning results countrywide (>95% of the sites).

Nurse-initiated ART (NIMART) has been policy in South Africa since 2010, to improve ART coverage and ensure the initiation of 90% of the HIV positive individuals on ART. 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 which is a pilot project implemented by partners in some of the provinces. South Africa defines the national criteria for “lost to follow-up” as a patient who has not received antiretroviral medicines within ninety days of their last missed drug collection appointment. Additionally, the country adopted the WHO 2017 recommendation to offer a package of interventions to all patients presenting with advanced HIV disease (defined by WHO as CD4<200) and implemented countrywide >95% of treatment sites. In South Africa, patients do not pay any routine user fees or charges for services when visiting a public sector health facility.

South Africa also implements 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 two 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, newborn 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 and adolescents

The NDoH revised the 2019 HIV clinical guidelines to include a new formulation of the fixed dose combination (FDC) of Tenofovir (TDF) 300 mg + Lamivudine (3TC) 300 mg + Dolutegravir (DTG) 50 mg (TLD) for all eligible adults, adolescents and children over the age of 10 years and weighing 35 kg or more. The 2019 revised HIV clinical guidelines introduced DTG as the first-line antiretroviral regimen in the country and initiation of procurement is in place. South Africa uses fixed-dose (FDC) antiretroviral therapy combinations as the preferred first-line therapy and patients take three drugs fixed-dose combination once a day. In the national guidelines, DTG-based regimen is the preferred second-line antiretroviral combination for adults and adolescents with HIV.

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, weighing less than 20kgs, irrespective of NNRTI exposure. The national guidelines also stipulate that DTG is the preferred NNRTI for treatment initiation in children aged three and older and weighing less than 20kgs. The recommended NRTI backbone for treatment initiation in children aged 3-10 years is ABC + 3TC (or FTC). DTG is recommended as the preferred second-line option for children weighing at least 20kgs, while LPV/r (or ATVr) is recommended as the preferred second-line option for children failing NNRTI-based regimens and weighing less than 20kgs. The 2019 HIV clinical guidelines do not recommend RAL as the preferred second-line option for children failing protease inhibiting-based regimens and weighing less than 20kgs.

1.4 Viral Load

The 2019 revised HIV clinical guidelines regard <50 copies/ml as the measured threshold at which viral load suppression in an individual is defined as a success. South Africa has a national policy on routine viral load testing for monitoring ART in adults, adolescents and children as stipulated in the revised 2019 HIV clinical guidelines and implementation of the policy is countrywide (>95%) of treatment sites.

Point-of-care viral load testing is not available at health facilities in the country. However, 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 revised policy does not recommend dried blood spot specimens for viral load testing. The national policy also prioritizes viral load testing in selected populations and/ or situations i.e. pregnant women, infants, adolescents, as appropriate. South Africa prioritizes viral load testing for pregnant and breastfeeding women as well as patients suspected of failing treatment.

1.5 HIV Drug resistance and toxicity monitoring

South Africa has a national plan that is in its development stages, and there is need to update this the plan considering that DTG is in place. Implementation of Early Warning Indicators (EWIs) in South Africa started in 2014 with the support of World Health Organisation (WHO). The plan covers the period 2014/2015 to 2017/2018. The country has not used World Health Organization (WHO)

protocols for HIV Drug Resistance (HIVDR) surveillance for pre-treatment drug resistance (PDR) survey in the year under review, due to complexity and cost. However, locally adapted surveys developed in conjunction with CDC are in place. The country uses WHO Protocols for HIVDR surveillance of Acquired Drug Resistance (ADR) in adult patients annually since 2019 and there are plans in place for 2020 – 2022. Similarly, the country uses WHO Protocols for HIVDR surveillance in children and a national survey took place in 2018. South Africa does not use WHO Protocols for HIVDR surveillance in infants <18 months and there are no plans. The country uses WHO Protocols for HIVDR surveillance for survey or routine monitoring of clinic performance using EWIs for HIV resistance and the most recent implementation was in 2019-2020. National Health Laboratory Services (NHLS) conducted routine monitoring of clinic performance in sample clinics. EWI survey in a sample of clinics provides data for the EWIs for HIV drug resistance.

South Africa has a national policy for HIV drug resistance testing for individual patients who fail second-line antiretroviral therapy. Additionally, the country makes an ongoing systematic effort to monitor the toxicity of antiretroviral medicines nationally, with the exclusion of passive pharmacovigilance approaches. South Africa uses the following approaches to monitor the toxicity of antiretroviral medicines: Routine toxicity monitoring as part of the national M&E system; Active toxicity monitoring/surveillance within cohorts in adults; Active toxicity monitoring/surveillance within cohorts in adolescents and children and Pregnancy registry and surveillance of birth defects. Additionally, the country has introduced, all of the above-cited toxicity monitoring approaches to monitor adverse drug reactions to DTG use. The country provides training to health-care workers on the management, capture and reporting of adverse drug reactions related to DTG.

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, Fixed Dose Combination (FDC) and once daily regimens, case management and peer navigation. Partners implement adherence support interventions of text messages and case management. National policies and strategies on retention in ART also exist and the retention support services available as differentiated care models include community-based interventions as well as adherence clubs and peer support. Treatment literacy programmes are available for PLHIV and include information on side effects, drug resistance, etc. Retention in ART enhancement is through external pick up points, for example, flexible pick up times for men who are part of the men forum programmes.

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 policy on retesting HIV-negative women during pregnancy, at delivery and post-partum/breastfeeding. Additionally, 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 implementation of the plan is countrywide (>95%) of maternal and child health sites. The current nationally recommended first-line ART regimen for pregnant and breastfeeding women living with HIV is TDF/3TC/DTG, recommended since 2019. On the other hand, the currently nationally recommended infant prophylaxis is Nevirapine (NVP) at birth, and then daily for six weeks, for low risk if the mother is on lifelong ART. If the mother did not get any ART before or during delivery and tests HIV positive > 72 hours after delivery, started ART less than 4 weeks ago or is newly diagnosed within 72 hours of delivery; (high risk); the infant

must be given AZT as soon as possible, and daily for 12 weeks, (if the infant is breastfed) and until mother is virally suppressed.

South Africa regards breastfeeding as a national recommendation on infant and young child feeding for HIV-exposed infants. The country recommends breastfeeding for 24 months for HIV-positive and HIV-exposed infants. Food and nutrition support is integrated within PMTCT programmes and implemented countrywide (>95%) of maternal and child health sites. The country fully implements a national strategy on interventions at delivery for women living with HIV not previously tested for HIV. Vertical transmission of HIV is not criminalized in South Africa.

2.2 Elimination of MTCT of Syphilis

South Africa has a national plan, which is integrated with HIV or other elimination initiative(s) for the elimination of MTCT of syphilis. Additionally, the country 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, six months and 18 months of age. National guidelines also recommend additional tests at the end of breastfeeding. The final diagnosis HIV antibody test is done at 18 months of age or three months post cessation of breastfeeding. 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, immunization clinics, outpatient clinics and TB clinics. National policy provides nucleic acid testing (DNA-PCR) for HIV-exposed infants at birth. National policy recommends routine testing for HIV-exposed infants at birth, 10 weeks, 6 months, 18 months and three months from cessation of breastfeeding. The country does not have a policy for point of care early infant diagnosis (EID).

2.4 Community engagement in the prevention of mother-to-child transmission of HIV

All Primary Health Care (PHC) health facilities (4 377) in the public sector offer free PMTCT services. There are no health facilities with community mechanisms providing PMTCT service, although there are clinic committees with no data on the saturation. 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 for abortion, contraception and/ or sterilization of women with HIV.
- Confidentiality and privacy.

In the past 12 months, the NDoH held a national level meeting to review South Africa's PMTCT progress. The attendees of the meeting were members of the Technical working group, not representative of civil society and community members and women living with HIV.

2.4 Child ART

National guidelines recommend treating all infants and children living with HIV regardless of symptoms or age. The treat all policy regardless of age is implemented countrywide (>95% of treatment sites). 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 implementation is countrywide (>95% of treatment sites).

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.

3.1 Participation of key populations in the national response

In South Africa, Men who have sex with men (MSM), sex workers, People who inject drugs (PWID), transgender people and former/current prisoners participate in the development of policies, guidelines and strategies relating to their health. Participation of key populations is evident in the development of strategies such as National Sex workers strategy for HIV, TB and STIs and the Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) strategic plan for HIV, TB and STIs.

3.2 Pre-exposure Prophylaxis (PrEP)

South Africa developed PrEP guidelines and implementation is taking place as part of comprehensive combination prevention, drawing on implementation and research evidence and WHO recommendations. Currently, PrEP is recommended for all high risk populations, including : Gay men and other Men who have sex with men (MSM), sex workers, People who inject drugs (PWID), transgender people, serodiscordant couples and young women. Doctors and nursing cadre (e.g. midwives, nurse practitioners and registered nurses have the authority to prescribe PrEP in accordance with the national PrEP guidelines. PrEP is available in South Africa and is provided in public facilities, private providers and selected educational institutions with capacity. Private providers implement PrEP routinely.

3.3 Condoms

South Africa has a national condom strategy that explicitly estimates the national needs for condoms. The estimated number of male condoms needed for the period 2020/2021 is 850 million, while the estimate number of female condoms for the same period is 40 million. The methods used to estimate the number of condoms needed are as follows: General population (condoms per sexually active man/year) and Demand-based (Based on past condom usage rates, such as using the GOALS model). The target for male condoms for the year under review is less than the target (953 152 462) for the previous year because of the use of the demand-based method. The country did not experience national and local condom stockouts in the past 12 months.

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

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- 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.
- Community advisory body for hospitals, clinics and/or research projects
- 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 implements an approved social protection strategy. The National Development Plan (NDP), vision 2030 is the countrywide approved policy. NDP Chapter 11: Social Protection addresses income poverty and developmental services to vulnerable groups such as those infected and affected by HIV, older persons, women, children, adolescent girls, young women and persons with disabilities. The country implement social protection at national, provincial and local levels. The Social Protection Strategy does not recognise any key populations (sex workers, gay men and other men who have sex with men, people who inject drugs, transgender people or prisoners) as key beneficiaries. Additionally, the Social Protection Strategy does not address the issue of unpaid care work in the context of HIV.

There is a social protection coordination mechanism or platform, but it does not include any representatives of the National AIDS Programme or equivalent. Government adopted the outcomes approach to implement the Social Protection Programme. The Outcome 13 aligns with the NDP: Chapter 11 on Social Protection. The Outcome 13 (“herein referred as the Social Protection”) comprises of the Departments of Social Development, Health, Education, Transport, Labour, Cooperative and Traditional Affairs and Human Settlement. The Social Protection Programme provides income support and services to citizen, permanent residents and refugees. These target groups include those infected and affected by HIV/AIDS. The Department of Social Development coordinates the activities of the Social Protection Programme and submits reports to the Department of Planning, Monitoring and Evaluation (DPME). DPME supports the Ministers when they present progress report to Parliament. Therefore, the coordination mechanism or platform is at the Government level.

The country does not implement cash transfer programmes for young women aged 15-24 years. The existing cash transfer programme is a constitutional right paid to everyone, those infected and affected by HIV/AIDS who satisfy the set criteria and the means test.

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; which include the following: Social contracting or other mechanisms allowing for funding of service delivery by communities from domestic funding; from international donors; both from domestic funding and international donors and require a certain percentage of government funding for CSOs/CBOs.

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 programmes on human rights and non-discriminatory legal frameworks as applicable to HIV, at scale, at the national level for the following groups: police and other law enforcement personnel, members of the judiciary and health care workers. Plans are underway to conduct training for the police and other law enforcement personnel in the near future. However, the country did not conduct the above-cited training for elected officials (lawmakers/parliamentarians).

Similarly, there are training programmes on preventing violence against women and Gender Based Violence (GBV) for i) police and other law enforcement personnel, (at scale at the national level) ii) members of the judiciary, (at scale at the national level) (iii) elected officials (at small scale) and iv) healthcare workers (at scale both at national and sub-national levels). Lack of funding is the only barrier to providing training and/or capacity building activities.

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.

South Africa recommends cervical cancer screening and treatment for women living with HIV 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
- Co-trimoxazole prophylaxis therapy (CPT)
- Hepatitis B screening and management in ART clinics
- Hepatitis C screening and management in ART clinics

Clinics conduct Hepatitis C screening and tertiary institutions focus on the management and treatment of HIV/Hepatitis C co-infected patients

10.1 Sexually Transmitted Infections (STIs)

South Africa has national STIs treatment guidelines, last updated in 2019. Furthermore, there is a national strategy or action plan for the prevention and control of STIs. The country conducts Gonococcal antimicrobial-resistance monitoring every second year. The national definition for congenital syphilis includes stillbirths.

10.2.1 Strategy

South Africa has a national health strategy that guides and integrates the AIDS response and it includes TB and STIs. The review of the national HIV, TB and STIs strategy occurred 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) and transgender people.

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. HIV M&E is integrated in a broader health M&E strategy or plan. The M&E plan is due for an update and will integrate gender-sensitive indicators.

10.2.3 Information system

South Africa has a functional health information system (District Health Information System-DHIS) that is both electronic and paper-based. The health information system includes routinely available patient-level viral load testing results and treatment cascade data at district level.

10.2.4 Surveillance

The country carries out surveillance in the following special populations:

Table 1: Sentinel Surveillance in Special Populations

Population	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?
Sex workers	Yes	2-3 years	2018	
MSM	Yes	2-3 years	2017	
PWID	Yes			
Transgender	Yes (HSRC)	-	2019	
In prisons and other closed settings	No (UNODC)	New	Ongoing	
Other (please specify-----)				

South Africa uses data from antenatal clinic attendees on the number of women who tested positive for HIV and the number of women already known to be HIV-positive to monitor trends in HIV prevalence.

10.2.5 Patient monitoring systems

South Africa has partially updated the patient monitoring system indicators and tools using the 2017 WHO Consolidated guidelines on person-centred HIV patient monitoring and case surveillance. Ninety-five percent of health facilities have electronic systems for patient-level longitudinal data capture such as electronic and medical records.

10.2.6 Unique identification codes for patients

South Africa has methods to identify and remove duplicate health information for patients within and between clinics, such as linking records using unique identifiers and/or personal identifiable information for the services illustrated in Table 2 below.

Table 2: Methods to identify and remove duplicate health information

	Methods to identify and remove duplicate health information	If yes, please specify how data are linked
Treatment services	Yes, nationally harmonized	National unique personal identifier. Combination of routinely collected personal identifying information.
Laboratory services	Yes, nationally harmonized	National unique personal identifier. Combination of routinely collected personal identifying information. Patient information matching processes.

South Africa does not have methods to identify and remove duplicate health information for patients within and between clinics for the following key populations and services:

- Testing services,
- HIV prevention services designed for any key population group to track combination prevention uptake,
- Gay men and other men who have sex with men,
- Sex workers,
- Transgender people
- People who inject drugs.

That said, their data does form part of the national treatment dataset, and is included in national processes to attend to duplicate health information. These processes are not specific to the referenced key population.

10.2.7 Case surveillance

In South Africa, HIV is not a nationally notifiable condition by law and the country does not have an HIV case surveillance system. This implies non-reporting of sentinel events such as diagnosis, result of first CD4 cell count at diagnosis, ART initiation, results of first and follow-up viral load test and deaths.

10.2.8 90-90-90

South Africa uses modelling as a source of data on the number of people who know their HIV status that is available for indicator 1.1 for 2018. Programme data, primarily reported in aggregate serves as the sources of data for the number of people living with HIV who are on ART for indicator 1.2 for 2018.

The NDoH conduct routine data quality reviews to determine the accuracy of national-level numbers of people reported to be on treatment. The NDoH conducts Facility Technical support at selected facilities by all levels and inbuilt parameters within WebDHIS.

Every year, the NDoH submits data to Thembisa Modellers for use in adjusting the numbers of people on treatment. The source of data of the number of PLHIV who are virally suppressed for indicator 1.4 is proxy from Tier.Net for people on treatment for 12 months who received a viral test.

10.2.9 TB/HIV

South Africa recommends TB screening and TB preventative treatment for PLHIV in national strategies, policies, plans or guidelines related to TB and/or HIV. South Africa also adopted the 2015 WHO policy update on the use of lateral flow urine liporabinomannan assay (LF-LAM) for diagnosis and screening of active tuberculosis in PLHIV.

South Africa recommends the following regimens for TB preventive treatment in national guidelines:

12 months of daily isoniazid monotherapy (12H) for adults living with HIV and 6 months of daily isoniazid monotherapy (6H) and 3 months of rifapentine plus isoniazid weekly (3HP) as preferred regimens if the adults are using more than one regimen.

6 months of daily isoniazid monotherapy (6H) and 3 months of rifapentine plus isoniazid weekly (3HP) for children living with HIV and the same regimens as preferred regimens if children are using more than one regimen.

Tuberculin skin test or interferon-gamma release assay (IGRA) test and X-rays are not required in national guidelines prior to initiating TB preventive treatment. South Africa never had stock-outs of Isoniazid, Vitamin B6 and other nationally recommended TB preventive therapy drugs in the last reporting period.

South Africa has a countrywide (>95%) of health facilities coverage of integration of the following HIV/TB services:

- WHO-recommended rapid molecular diagnostics (e.g. Xpert MTB/RIF) are collocated
- People living with HIV who have TB received antiretroviral medicines at the same place as they receive their TB treatment
- Antiretroviral therapy is initiated by the same health-care worker providing TB treatment for people living with HIV who have TB
- Antiretroviral therapy and TB treatment for people living with HIV who have TB are monitored by one health-care worker

10.2.10 Universal Health Insurance

South Africa has a universal health insurance scheme based on a draft bill and policy on National Health Insurance (NHI), which is not yet law due to consultation funding. The NHI scheme will benefit every citizen of South Africa. The package of the benefits of the universal health insurance scheme include antiretroviral medicine and pre-exposure prophylaxis.