HQA HEALTH QUALITY ASSESSMENT

T: +27 (0)82 453 5130
E: lj.botha@iafrica.com
W: www.hqa.co.za

PO Box 74960
Lynnwood Ridge
0040

Summary of the Industry Results Presentation and Clinical Quality Conference held 15th August 2025

Welcome

Health Quality Assessment, HQA, opened its 21st annual results presentation by restating its purpose: to measure and report on the quality of healthcare in South Africa. In the late 1990s there was a lot of information on cost and access, but very little on the quality of care. Formed in 2000 as a non-profit and public-benefit organisation, HQA aimed to address this gap and since then, HQA has built and refined a set of quality indicators, gathered data from across the sector and reported results so that patients receive better care and improvements are made from lessons learnt.

Participation in HQA is voluntary and broad. Funders, hospitals, clinicians, administrators, managed care and disease-management companies, pharmaceutical companies and other partners contribute to a shared effort. Data security is placed at the centre of this work. Individual results stay confidential, while industry trends and benchmarks are shared to drive improvement. The culture is "no name, no blame": a safe space for teams to test ideas, compare results and co-create better measures.

HQA's view of quality is practical and patient-centred: the right diagnosis, the right treatment, at the right time, in the right setting, at the right price, with the right outcome. Encouragingly, more organisations are now joining the mission of measuring quality, adding fresh insight and momentum to the national conversation.

Session 1: Artificial Intelligence (AI) in Healthcare

The keynote presentation was delivered by Prof Mihaela van der Schaar, a leading machine-learning scholar at the University of Cambridge and a widely recognised voice in AI for health care. Her core message was clear: AI should serve as a co-pilot, with clinicians firmly in the driver's seat. The goal is not to replace clinical judgement, but to support it with better tools.

Prof van der Schaar's lab builds those tools in close partnership with clinicians. They include methods to clean and harmonise messy clinical data; create risk scores and patient "phenotypes" over time; generate privacy-preserving data; and develop digital twins to explore likely patient trajectories. A major advance is the shift to secure, no-code "copilots" that allow clinicians to analyse data and build models through

natural-language prompts, without having to write code. One such platform, Climb, supports data quality checks, standard descriptive summaries, automated model building, patient-level explanations, and polished reports. Crucially, data remain private and encrypted; nothing is shared for external training and users can delete data at any time.

Prof van der Schaar's team's automated modelling framework, Auto Prognosis (now 2.0), assembles and fine-tunes full pipelines for prediction and time-to-event analysis, then explains the results in ways clinicians can interrogate - through simple equations, counterfactual "what-if" views and similar-patient comparisons. This interpretability helps users probe whether the model's reasoning matches clinical sense. The tools are designed to work even in low-data settings, making them relevant in resource-constrained contexts.

The lab's methods have supported practical tasks such as capacity planning during the COVID-19 pandemic and streamlined screening models in lung cancer work, and have appeared in publications, including *The Lancet*. The takeaway was optimistic and grounded: with clinicians leading and AI assisting, we can scale more consistent, equitable and efficient care, safely and at pace.

Session 2: Results 2024: what the data tells us

Dr Johann van Zyl presented this year's industry results, drawn from paid claims up to December 2024. The analysis covers 220 indicators across prevention and screening, antenatal and newborn care, chronic disease management, and hospital outcomes.

The dataset is large and representative: 7.5 million beneficiaries (about 81.5% of the medical scheme population), 19 schemes, 123 benefit options, and an average age of 35 years. Chronic disease remains common: overall prevalence sits near 28%, with around 15% of beneficiaries registered for hypertension and 6% for diabetes. There is wide variation in chronic disease registrations between schemes (with the lowest prevalence scheme at roughly 19% and the highest close to 60%), and a visible "step change" increase in 2021 as data collection improved - an HQA priority that continues.

Hospital use has normalised since Covid and now exceeds pre-pandemic levels: overall about 179 admissions per 1 000 beneficiaries, with 33 per 1 000 admitted more than once. Markers that suggest over-use or quality issues (e.g., high rates of spinal surgery) have been stable, as have average lengths of stay and readmission rates. Hip and knee replacement rates are back to pre-COVID levels; length of stay is edging down for knees. Interpretation is complicated by carve-outs and fixed-fee arrangements, which can blur whether a readmission is a redo, a complication, or a procedure on the opposite limb.

Prevention and screening remain the weakest link. Coverage is low across most measures and has improved only slowly over the past 13 years. As a guide,

mammography hovers near 25%, cervical cytology (pap smears) near 30%, and colorectal screening close to 10%–12%, with colonoscopy and sigmoidoscopy favoured over faecal occult blood tests. HIV counselling and testing shows an upward trend, helped by wellness-day data now captured more consistently.

In chronic disease management, the picture is more positive and more consistent.

- **Hypertension:** Process measures (creatinine, ECGs, neuropathy screening, glucose, cholesterol) show steady improvement with small variation across schemes - evidence of more standardised practice taking hold. Stroke admissions are stable, with a COVID-era dip likely related to coding.
- **Diabetes:** Prevalence averages ~6% with wide scheme variance. Nearly all process measures are improving and increasingly standardised. Two new medicine-possession ratio (MPR) indicators show insulin MPR below 80%, which is a concern. Around 73% of people with diabetes had at least one HbA1c in the year; best practice is two tests, so the next push is to lift the "two-tests-per-year" rate. GP visits are trending down, which may reflect better self-management. Admissions (all-cause and diabetes-specific) are flat to declining.
- **Ischaemic heart disease:** Process coverage is improving and admissions are trending down. Yet stent rates are rising and bypass grafts up more modestly; variation stays large even after age and risk adjustment. Readmissions are stable at industry level but vary by scheme.
- **Respiratory disease (asthma/COPD):** Process coverage (flu jabs, lung function tests) is low, not improving, and varies widely. COPD carries very high comorbidity (~90%) and high admission rates. This is an area needing focused management.
- **Mental health:** Use of benzodiazepines rose after COVID-19 but is now reversing. Diagnosed depression and bipolar disorder show upward prevalence trends. Follow-up after admission is poor: for major depression, <30% had contact within 10 days and only ~30% within a month. For bipolar disorder, ~50% of patients/ beneficiaries had no follow-up within a month; for schizophrenia, >61% of patients/ beneficiaries had no follow-up at all.
- **HIV:** Regular ART use within schemes is rising, though prevalence varies widely between schemes. A decline in viral-load testing since COVID-19 is worrying and tracks with higher all-cause admissions for people living with HIV.

In antenatal care, most process measures are strong, but C-section rates keep rising, as do neonatal ICU admissions and low-birthweight admissions, despite declining births in the sector since 2016.

HQA also aggregates indicators to give a "big picture" view. Overall, average coverage for prevention/screening sits just under 16% and is inching up. Antenatal care

averages ~71.5% coverage. Chronic disease management (30 process measures across 8 conditions) has climbed from <35% to ~47% over 12 years. HIV management averages ~58.5% across its three process measures, broadly stable despite the viral-load dip. Importantly, there is no clear link between richer benefits (proxied by risk-adjusted contribution levels) and higher process-measure coverage. Performance seems to depend more on management focus and priorities than on budget alone.

In summary: the industry is getting better at the things it can standardise - especially diabetes and hypertension care - and is slowly improving on prevention and screening. The pressure points are clear: rising chronic disease (notably mental health), higher hospital use, higher C-section rates, very low respiratory process measure coverage, poor post-discharge follow-up in mental health, and falling viral-load testing in HIV. As Dr van Zyl put it, we manage what we measure. The gains we see in process measures show that measurement works, and show where the next round of efforts should go.

Q&A notes. Members asked whether a lull in public awareness campaigns may be part of the HIV viral load testing problem. Another question raised was of possible over-stenting in cardiovascular conditions; HQA has not yet studied this in detail, but it is a candidate for future work. A query confirmed a steady rise in all-cause readmissions from ~6–7% to just under 10% - a trend to watch. Dr van Zyl also noted that fixed-fee arrangements and carve-outs can distort spinal-surgery data and flagged the need to address data loss under alternative reimbursement models.

Session 3: Understanding the clinical quality implications for mothers and babies comparing elective caesarean section and normal births, and how to measure this.

The programme moved into a panel on the differences in quality of care for mothers and babies, framed in HQA's "safe space" ethos: open discussion, shared learning, and collaboration to surface problems, measure progress, and drive improvement. The session was chaired by Dr Boshoff Steenekamp, a seasoned leader with a background in medicine, epidemiology, and medical scheme administration. The panel comprised Dr David Ngotho, Prof André van Niekerk, Dr Siviwe Mila and Dr Astrid Ellaya.

The central question was how to understand the clinical quality implications for mothers and babies when comparing elective caesarean section (C-section) and normal vaginal birth, and, crucially, how to measure that quality. HQA already tracks indicators across antenatal, pregnancy, delivery and neonatal care, including HIV and hepatitis B screening, teenage pregnancy, and the split between vaginal delivery and C-section. But the panel underscored real measurement limits: the system relies on tariff codes and financial claims rather than clinical data; it lacks true birth weights and conception dates; it cannot distinguish premature, early or full-term births or reliably risk-adjust on a mother's health status; it cannot cleanly identify reasons for C-sections; and neonatal records and screening data are incomplete, with clinical items such as Apgar scores,

birth trauma and parity often missing. Utilisation bias may also creep in where lower-cost options carry out-of-pocket expenses. Even so, HQA's data show a high and rising C-section rate in the private sector alongside fewer confinements, with neonatal admissions and low-birth-weight admissions also increasing.

From the paediatric perspective, Prof van Niekerk said South Africa's private sector sits at the very top of global C-section rates, a "pandemic of caesarean sections", and noting a rate of about 75% that is likely the highest in the world. He focused on elective C-sections done for non-medical reasons when both mother and baby are well. Babies delivered by elective C-section - at 37–39 weeks gestation - require more neonatal intensive care unit (NICU) care. He set out why: skipping labour can bypass organ maturity (spontaneous labour is the signal, which varies between 37 and 42 weeks of gestation), physiological readiness (the labour-related "shower of hormones" that primes feeding, glucose control and oxygenation), and the vaginal passage, which is "critically important" for the microbiome, gene expression, and successful breastfeeding. He stressed elective C-sections should not occur before 39 weeks gestation. Evidence cited included a 4 500-case elective cohort in which 1 in 5 babies required ICU; studies showing time spent in labour is inversely related to oxygen needs after birth; and a highly significant negative effect on breastfeeding after elective C-section. Planned C-section also entails prophylactic antibiotics - with about 75% of babies in South Africa receiving their first antibiotic dose at birth - and steroids are often used to prime the lungs, which affects gene transcription. Large-scale data (including a 2 million-baby study) link elective C-section with immune-related conditions (asthma, immune deficiency with more severe infections, systemic connective-tissue disorders, type 1 diabetes, inflammatory bowel disease), possible non-communicable disease risks, and neurodevelopmental concerns (learning difficulties tied to prematurity and higher rates of ADHD and autism). He was careful to say these are associations, not proven causation. He added that a "first C-section causes a ripple effect", making future C-sections more likely, and called for close monitoring of babies born electively, especially before optimal gestation.

From obstetrics, Dr Ngotho largely agreed on the infant risks and drew a clear line between emergency C-sections, the obstetrician's call in labour or for critical maternal conditions such as severe bleeding or hypertension, and elective cases. The mother's safety is paramount. He reiterated that C-sections should not be done before 39 weeks gestation but outlined the clinical exceptions: women with multiple prior C-sections (uterine rupture risk), presentations such as breech with a previous C-section, or diabetes and hypertension with risk of placental abruption. Peer review advises avoiding a first repeat C-section before 39 weeks, yet late booking can blur gestational dating, and some high-risk pregnancies may need delivery at 37–38 weeks gestation. He advocated for more vaginal deliveries, noting 70–80% vaginal -birth rates in the public sector. With normal births unpredictable events (e.g., shoulder dystocia) often trigger legal suits, while C-section cases tend to focus on mistakes like retained swabs

rather than outcomes. He favoured mediation models (as in Kenya), questioned the role of expert witnesses who have not practised modern obstetrics for many years, and stressed that while normal birth is the preferred route, private-sector obstetricians need strong support to withstand these pressures - especially as patients can legally refuse a vaginal birth.

From the funder side, Dr Siviwe Mila confirmed the problem's scale and complexity. She proposed tracking the first five years of health and cost outcomes for children born by C-section. She also set out drivers: provider safety (a belief that C-section offers more control and less legal risk); maternal preference (from "snap-back" body goals and "mum influencers", to certain insurance incentives, avoidance of labour pain, or fear of tears and incontinence); and teenage pregnancies, where 55% of deliveries in the 10–19 age group are C-sections. She argued for value-based care models that reward normal vaginal births and for better litigation protection for clinicians.

From the hospital perspective, Dr Astrid Ellaya described operational and clinical strain as C-section rates rise: longer stays, more specialists, higher medicine use, and pressure on neonatal high-care and ICU. Deliveries before 39 weeks gestation, often elective, are linked to immature lungs, acute respiratory distress, and chronic problems such as asthma. She noted a decline in operative vaginal deliveries, which signals skill attrition and adds caution to labour management. Fear of malpractice shapes choices. Hospitals, she said, must back clinicians with clear guidelines, continuous training and multidisciplinary teamwork, keeping decisions patient-centred and balancing safety, indication and preference.

On data inside hospitals, Dr Ellaya highlighted highly variable data quality and coverage in the private sector. The Robinson classification for categorising C-sections - internationally endorsed - is not routinely used, hampering benchmarking and quality improvement. Outcome tracking has gaps, and poor documentation makes it hard to separate elective from emergency C-sections. She outlined Mediclinic initiatives: educating patients and providers on C-section risks and benefits; stronger clinical governance aligned to evidence; collaborative mother-and-baby reviews with paediatricians, obstetricians and nurses; the Mediclinic Baby app for comprehensive guidance; peer education and multidisciplinary training (e.g., ESMO drills) to rebuild confidence in vaginal birth; enhanced recovery after C-section; better data systems for real-time feedback; and collaboration with insurers and policymakers so financial incentives support best practice. While maternal preference matters, she cautioned that the high rate reflects a complex interplay of patient desire, provider recommendations, medicolegal pressure, and system factors. She argued for elective C-sections only after 39 weeks and for stronger partnerships across the system to deliver safe, respectful maternity care.

In discussion on what to measure and what to do, Dr Mila called for patient representation and sector-wide collaboration; Prof van Niekerk concluded by saying

data confirms a 76–78% rate versus a WHO ideal around 27%, implying two in three C-sections lack medical indication - so the levers lie outside the health system in the courts and public perception. Dr Ngotho echoed the litigation concern, suggested caps like Kenya's for specific complications, and questioned the influence of long-retired experts in court. Dr Ellaya argued that better data can change behaviour, starting with gestational-age capture, Robinson classification, and a national registry of maternal and neonatal outcomes. She also backed peer education by mothers who have experienced both delivery modes to help reshape preferences.

Session 4. Retaining access to data in a changing environment

The next session focused on the challenge of data loss in alternative reimbursement models (ARMs) and the implications for analytics and quality measurement. Chairing the discussion, Adam Lowe (NMG) reminded attendees that HQA's reporting is built mainly on data from medical schemes' administration systems, which is mostly transactional in nature: while this reflects the most complete dataset available today, gaps can emerge where ARMs aggregate information in those administration systems. He was joined by Ismail Rasool (Discovery Health), Craig Getz (Insight), Dr Wayne Riback (Medscheme) and Dr Nontuthuzelo Thomas (Momentum).

The panel mapped the main ARM types and their data implications. Capitation in dentistry, optometry and emergency care has long been in place and is less problematic for HQA because limited quality measures are available in those spaces, with a larger focus being placed on access to care. In the wellness space, bundled codes for wellness days and combined test sets make it hard to untangle information for process and screening indicators. Primary-care capitation, especially in lower-income options, shifts risk to provider groupings. Dr Thomas described Momentum's mature, 20-year model: data loss is a challenge, but they retrospectively collect line-item data, enforce standards through engagement and contracts, and use dispensing GPs to contain costs and guard against under-servicing. For disease-management capitation (e.g., CDE models), Mr Rasool noted that Discovery mitigates data gaps by drawing pathology results directly from laboratories, capturing absolute results for programmes such as diabetes. By contrast, fixed and global hospital fees (e.g., joint replacements, spinal surgery) are where HQA has the biggest current data challenge. The funder often only knows a procedure occurred, unless some fee-for-service items are still claimed. Dr Riback stressed the need for data-sharing agreements as the market shifts from fee-for-service to outcome-based models. Mr Getz outlined GEMS' multidisciplinary primary-care teams, funded via risk-based capitated fees; that creates real-time data loss, but GEMS backfills insights with post-hoc data from partners to understand what care was delivered.

Beyond HQA's quality measures, schemes need data for reporting to the Council of Medical Schemes (CMS) on claims that would have been paid under capitation

arrangements; ensuring members' access to care and preventing providers from denying services; and provider profiling and monitoring.

Potential strategies to manage such data loss, with three main approaches were discussed:

1. Virtual Arrangements (live claims are paid through regular claims systems and a retrospective reconciliation to the agreed ARM rates is performed):

Ismail Rasool: Discovery has applied this approach, having made a "decision decades ago not to lose the line level fee for service data". They use quarterly or annual reconciliations where claims are submitted fee-for-service, and settlements happen later. This approach minimises errors, provides detailed performance understanding, and requires close collaboration with providers.

Dr Wayne Riback: agreed, emphasising the crucial link between funders/administrators and providers to drive value-based models and contain data.

2. ARM payments are made upfront and the required data is recreated post-facto:

Dr Nontuthuzelo Thomas said that data is provided later through a "trust relationship" with "guard rails" outlined in contracts. Provider engagement consultants help manage compliance, and non-adherence can lead to disembarkation from agreements. This requires a very structured and partnered approach.

Craig Getz further noted that Government Employees Medical Scheme (GEMS) uses both real-time fee-for-service billing with retrospective reconciliation and direct ARMs with predefined data sharing after the fact, selecting the best approach for each arrangement.

3. Moving away from transactional data towards a focus on predefined clinical outcomes (Clinical Data):

Discovery is moving towards collecting more granular clinical data (e.g., blood results, blood pressure) for personalised and precise care. Their focus is on both short-term and long-term clinical outcomes, not just process measures.

This approach is seen as potentially "ideal" because it measures off clinical data rather than transactional data, but it faces challenges in data collection and quality. Data quality varies widely across the industry: schemes have transactional data, hospitals have transactional and some clinical data (for their patients), but provider data is a "mixed bag".

Dr. Wayne Riback highlighted that while registries are "invaluable" for collecting clinical data, they are costly and not easy to implement. He stressed the need to empower and support individual clinical practitioners in providing data, exploring various channels like electronic health records (EHRs), provider portals, and B2B engagements.

Data ownership, sharing, and future considerations: The panel discussed the complexities of data ownership and sharing:

The ideal would be a central electronic health record, but in its absence, collaboration among stakeholders is crucial.

AI models require vast amounts of data for training, raising future discussions about who can use what data.

Dr Wayne Riback emphasised the need for a "finite process, a very sound structured process and transparency" regarding data sharing agreements, ensuring compliance with regulations like POPIA while facilitating data exchange.

Craig Getz underscored the necessity of trust between providers and funders to prevent suspicion of data misuse.

Dr Nontuthuzelo Thomas highlighted that data governance must be "100% on point" due to sensitive member data and patient preferences for non-sharing. She also saw an opportunity for natural language processing (NLP) models to structure unstructured data and provide valuable, triangulated health risk assessment data back to GPs for better risk stratification.

A concern was raised that billing data might only reflect what a scheme will pay, not actual patient care. Dr. Thomas responded that Momentum tracks rejection data to inform providers of non-covered items, preventing unexpected out-of-pocket expenses for members. Dr. Riback added that standardisation of coding and billing information is critical for these models to work effectively.

Ismail Rasool offered a broader perspective, stating that South African data, despite challenges, is "not bad" globally, and often a "better product relative to the price we're paying" compared to other markets.

Virtual versus face-to-face consultations: Regarding virtual consultations, Adam Lowe noted a surge during COVID-19 (mostly telephonic) that receded post-pandemic, suggesting it was a "needs must basis". Dr. Wayne Riback agreed that while virtual medicine has a definite role in improving access, the South African private sector still largely prefers physical, face-to-face consultations. He acknowledged that "a lot of work" is needed to overcome this traditional preference and fully leverage virtual care.

Session 5: Measuring quality of HIV management, the trends, and challenges

The final session, chaired by Professor Jacqui Miot, focused on "Are we making progress in the quality of HIV care?" in the private sector and whether current measurement approaches are adequate.

HQA HIV data overview

- Prevalence: Measured by beneficiaries with more than one ARV claim per year (excluding PREP and PEP). HQA data shows higher prevalence in females than males, with most of the population in the 25-49 years and 50+ year age groups. Overall prevalence in HQA data is 4.56%, compared to 12.8% in South Africa's general population.
- Comorbidities: Over 50% of people living with HIV aged 50 and above have at least one other chronic condition, adding complexity to care.
- Medicine Possession Ratio (MPR): beneficiaries living with HIV and on ART claim around 80% of the time, with higher MPR in older populations. However, in HIV, defaulting treatment poses a significant risk for increased viral load and transmission.
- Viral load coverage: This is a major concern, showing a "steady decline" across the industry. For 15-24-year-olds, it is below 70%, which is "way behind" the national South African data where 94-95% of people on ART have had a viral load test, and 75% are virally suppressed.
- Admissions:
    - Single all-cause admissions for people living with HIV declined but are now ticking up, with more admissions for women than men.
    - HIV-related admissions are relatively stable.
    - Multiple HIV-related admissions (more than once a year) are more prevalent in males across all age groups 15 years and up, suggesting a need for nuanced management.

Measurement challenges and data limitations:

- Reliance on ARV claims for identification, leading to missing data for those on disease management programs or registered for chronic medicine benefits.
- Lack of clinical detail on viral suppression status (suppressed, unsuppressed, low-level viremia) or newly initiated on ART.
- Admissions data based on potentially unreliable tariff codes.
- Utilisation bias where patients might switch between public and private sectors. Prof. Miot concluded that viral load coverage is a "major concern," emphasising that "we can't take our foot off the pedal" regarding HIV management, especially as focus shifts to non-communicable diseases. She also highlighted the potential future impact of US government funding cuts on HIV management.

Life Sense Disease Management Perspective (Zella Young):

Zella Young provided insights from a disease management organisation, stressing the importance of patient education and addressing stigma.

- Prevalence: She noted an alarming increase in SA's HIV population from 4.1 million in 2002 to 8.1 million in 2025, an increase of about 4.7%. She questioned the notion that "Africa's got AIDS under control" if prevalence continues to rise.
- Gender Disparity: This increase is driven by the female population, with significantly more women living with HIV than men.
- Teenage Pregnancies: She highlighted the "very scary" data of 90,000 girls aged 10-19 being pregnant between March 2021 and April 2022, questioning if HIV screening is being missed in this vulnerable group.
- Viral Load Testing: HQA data showed an impressive increase in viral load tests from 2010-2019, followed by a 3.6% decrease to 2024. Young stressed, "You cannot manage what you don't measure".
- Patients in Disease Management Programs: Life Sense's patient base is 60% female to 40% male, with an average age of 45 years, indicating an aging HIV-positive population.
- Pregnant Females: While Life Sense has never had an HIV-positive baby born to a mother in their disease management program in 26 years, they find that some pregnant women living with HIV are only diagnosed in their second or third trimester, raising questions about early screening practices.
- Challenges with patient engagement:
    - Detectable viral loads: These patients are often medicine-experienced but non-adherent, possibly due to denial, lost-to-follow-up, or trauma. A lack of centralised patient records complicates their management.
    - Refusing treatment: Patients may refuse due to misperceptions about side effects (despite newer, single-tablet regimens with minimal side effects) or the lack of positive messaging about living with HIV.
    - Opting for state facilities: Some patients choose state care to avoid claims appearing on their medical aid records (fearing disclosure to the main member) or are in denial and may not be taking treatment, thus not being captured by HQA data.
- Key Issues: Medication claims do not equate to adherence; viral load outcomes are the true measure of adherence. There is an issue of "doctor hopping" due to a lack of centralised records. Life Sense observes a high percentage of admissions (65-75%) for detectable viral load patients, as well as increases in TB, malignancies, and mental health conditions among individuals living with HIV.

- Recommendations: Better collaboration among schemes and wellness organisations, integration across chronic disease management programs (for comorbidities), centralised patient records, and lobbying for positive public messaging like "Undetectable = Untransmittable".

SANAC's view: Dr Nkhensani Nkhwashu

Dr Nkhwashu emphasised South Africa's unique position as the country with the "highest number of people on the ART HIV program" globally, while also facing persistent challenges at local levels.

- Current Challenges: Finances, retaining men and adolescents on treatment, prevention of vertical HIV transmission, losing children after initial monitoring, managing TB/HIV co-infection (54% of individuals infected with HIV developing TB), and addressing the needs of key populations (MSM, drug users, transgender people) who often face poor treatment in public clinics.
- National Strategic Plan (NSP) for HIV, TB & STI (2023-2028): This plan guides the national response, involving government, private sector, and civil society. Its focus is on human rights and integrated service delivery.
- Four Goals of the NSP:
    1. Breaking down barriers to HIV/STI solutions (human rights, social drivers, gender-based violence).
    2. Biomedical interventions (PREP, condoms, injectable medicine, Treatment as Prevention like U=U, and new breakthroughs like the twice-yearly injectable Lenacapavir).
    3. Building resilient systems (supply chain, human resources, learned from COVID-19).
    4. Accountability and financing (estimated R270 billion needed over 5 years, with a R40 billion gap; South Africa finances 74% of its own response).
- Goal 2 targets (95-95-95): The NSP aims for 95% of key populations reached, 95% on treatment, and 95% with viral load suppression (defined as <50 copies). Similar targets exist for TB and continuous cervical cancer screening for HIV-positive women.
- National Campaigns:
    - "Close the Gap": Aims to achieve the 95-95-95 targets, like Eswatini and Botswana. Strategies include reducing visit frequency (e.g., 3-month, moving to 6-month ART supply for patients meeting clinical stability criteria), improving the paediatric cascade (where children are often lost), increasing efficiencies in the public sector, and enhancing monitoring and evaluation.

- "Global Alliance": Focused on eliminating AIDS in children and mothers, as paediatric treatment cascades are notably lagging.

Preliminary results: While South Africa has reached the first 95 target (95% diagnosed), it is still behind on the second 95 (95% on treatment), with a gap of approximately 148,322 individuals, and the third 95 (95% virally suppressed) is also behind, with only 72% of viral loads done by late July. Dr. Nkhwashu described the challenge as a "leaky bucket": gains are made in putting people on ART (75,027 recently) but losses occur due to deaths, disengagement (7.2%), transfers to other countries (34,000), and unknown whereabouts. She called for the private sector to participate in campaigns to identify and re-engage these individuals lost to care. Preliminary data for Gauteng showed 96-82-97 for the 95-95-95 targets, indicating that the second 95 (on treatment) remains a challenge.

Conclusion:

In closing the conference, Louis Botha highlighted several key questions for future consideration:

- Are we doing enough with the generated data in the healthcare sector?
- How effectively can South Africa apply emerging AI tools, given the quality, storage, and digitalisation levels of current data?
- How can more "headline awareness" be created among healthcare consumers about the importance of prevention, screening, and adherence to disease management protocols?
- How can consumers be better reached regarding the consequences of their lifestyles and healthcare choices?

'Coming together is a beginning, staying together is progress, and working together is success.' Henry Ford

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