ANNUAL PROGRESS REPORT 2014/15
PROVINCIAL STRATEGIC PLAN 2012-2016

WESTERN CAPE PROVINCIAL AIDS COUNCIL
### ACRONYMS AND ABBREVIATIONS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANS</td>
<td>Antenatal Survey</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>DOTS</td>
<td>Directly Observed Treatment Short-Course</td>
</tr>
<tr>
<td>DR-TB</td>
<td>Drug-resistant Tuberculosis</td>
</tr>
<tr>
<td>FDC</td>
<td>Fixed-dose Combination</td>
</tr>
<tr>
<td>FET</td>
<td>Further Education and Training</td>
</tr>
<tr>
<td>FY</td>
<td>Financial Year</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender-based Violence</td>
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<tr>
<td>HCT</td>
<td>HIV Counselling and Testing</td>
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<tr>
<td>HIV</td>
<td>Human Immuno-deficiency Virus</td>
</tr>
<tr>
<td>HSRC</td>
<td>Human Sciences Research Council</td>
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<tr>
<td>IPC</td>
<td>Infection Prevention Control</td>
</tr>
<tr>
<td>IPT</td>
<td>Isoniazid Preventive Therapy</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
</tr>
<tr>
<td>MDR-TB</td>
<td>Multidrug-resistant Tuberculosis</td>
</tr>
<tr>
<td>MMC</td>
<td>Medical Male Circumcision</td>
</tr>
<tr>
<td>MSF</td>
<td>Médecins Sans Frontières</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with me</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<tr>
<td>NSP</td>
<td>National Strategic Plan</td>
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<tr>
<td>OVC</td>
<td>Orphaned and Vulnerable Children</td>
</tr>
<tr>
<td>PEP</td>
<td>Post-Exposure Prophylaxis</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
</tr>
<tr>
<td>PrEP</td>
<td>Pre-Exposure Prophylaxis</td>
</tr>
<tr>
<td>PSP</td>
<td>Provincial Strategic Plan</td>
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<tr>
<td>PWID</td>
<td>Persons Who Inject Drugs</td>
</tr>
<tr>
<td>SANAC</td>
<td>South African National AIDS Council</td>
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<tr>
<td>SAPS</td>
<td>South African Police Service</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>TAC</td>
<td>Treatment Action Campaign</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>XDR-TB</td>
<td>Extensively drug-resistant Tuberculosis</td>
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</table>
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1. INTRODUCTION

South Africa has the largest HIV and one of the largest tuberculosis (TB) epidemics in the world. The estimated HIV prevalence in the age group 15-49 years for the Western Cape is 5%\(^1\), which makes it the province with the lowest prevalence rate in the country. The highest HIV prevalence estimates are found amongst the 25-29 and 30-34 year age group\(^2\). There are also significant variations at district and sub-district level. Apart from mother to child transmission, the risk of acquiring HIV primarily involves the practice of unsafe sex, which is further exacerbated by patterns of high partner turnover and partner concurrency. Further drivers of the HIV epidemic include gender inequalities and the coercive nature of some sexual transactions. According to the Western Cape Burden of Disease Study\(^3\) other contributing factors driving the HIV and TB epidemics include poor levels of education, transactional sex, mobility, migration and the socio-economic clustering of poverty, unemployment and overcrowding. The HIV epidemic has led to an enormous increase in the number of TB cases and TB remains one of the key causes of mortality and morbidity in the Province. For reasons that are poorly understood, the Western Cape, relative to other parts of the country, has been particularly severely affected by TB. A century's worth of TB records in Cape Town shows that TB notification rates have always been very high - above 800/100,000\(^4\).

2. BACKGROUND TO THE PROVINCIAL STRATEGIC PLAN (PSP) 2012 – 2016

The Western Cape Provincial Strategic Plan on HIV/AIDS, STIs and TB (PSP) 2012 -2016 was developed in 2012 following the finalisation of the National Strategic Plan for HIV, TB and STIs 2012 – 2016 (NSP). A multi-sector approach was used to develop the provincial plan; particularly obtaining priority activities per sector and the NSP. The NSP was used as the framework for the PSP, which adopted the 4 key strategic objectives of the NSP as well as most of sub-objectives. The NSP was approved by cabinet in 2013.

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\(^1\) South African National HIV Prevalence, Incidence & Behaviour Survey, 2012 (HSRC)
\(^2\) Western Cape Provincial Strategic Plan 2012 - 2016
\(^3\) Western Cape Burden of Disease Reduction Project: Overview of the Report: Volume 1 (2007)
\(^4\) City of Cape Town TB records (2014)
3. GOALS OF THE PSP

In line with the twenty-year vision advocated by the Joint United Nations Programme on HIV and AIDS, the PSP 2012-2016 has the following broad goals.

- **Reduce new HIV infections by at least 50% using combination prevention approaches**
- **Initiate at least 80% of eligible patients on antiretroviral treatment (ART), with 70% of those alive and on treatment five years after initiation**
- **Reduce the number of new TB infections as well as deaths from TB by 50%**
- **Ensure an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the NSP**

4. OBJECTIVES OF THE PSP

The plan has four strategic objectives that will form the basis of the HIV, STI and TB response. These are:

- **Strategic Objective One**
  - Focus on social and structural approaches to HIV and TB prevention, care and impact

- **Strategic Objective Two**
  - Prevention of HIV and TB infections

- **Strategic Objective Three**
  - Sustain Health and Wellness

- **Strategic Objective Four**
  - Protection of Human Rights and Promotion of Access to Justice
5. ASSESSMENT OF PROGRESS AGAINST THE FIVE MAIN GOALS OF THE NSP

GOAL 1: Reducing new HIV infections by at least 50% using combination prevention approaches

The 2013 Western Cape Sero-prevalence HIV Antenatal Survey estimated that the HIV prevalence in the Western Cape participants of the Antenatal Survey was 17.1% (95% CI 16.4 to 18.0)\(^5\). Figure 1 compares national and provincial HIV prevalence trends over time. The age group which is specifically targeted in the MDG 6 Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS (Indicator 18: HIV prevalence among pregnant women aged 15-24 years); there seems to be a downward trend in the < 20 age group since 2010 and in the 20 to 24 age groups since 2009. In the 2013 findings, this trend continues. The two older age groups (30-34 and 35 and older) showed a clear increase. The prevalence of HIV is expected to increase over time with improved ART coverage. Increased ARV coverage increases life expectancy of HIV positive individuals as well as reduces deaths from HIV, thus increasing the number of people living with HIV in the population. See Figure 2.

*Figure 1: South Africa national Antenatal HIV Prevalence compared to Western Cape over time*

<table>
<thead>
<tr>
<th>Year</th>
<th>National</th>
<th>Western Cape</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>23</td>
<td>5</td>
</tr>
<tr>
<td>2000</td>
<td>24</td>
<td>9</td>
</tr>
<tr>
<td>2002</td>
<td>26</td>
<td>12</td>
</tr>
<tr>
<td>2004</td>
<td>29</td>
<td>15</td>
</tr>
<tr>
<td>2006</td>
<td>29</td>
<td>14.5</td>
</tr>
<tr>
<td>2008</td>
<td>29.3</td>
<td>16.6</td>
</tr>
<tr>
<td>2010</td>
<td>30.2</td>
<td>17.3</td>
</tr>
<tr>
<td>2012</td>
<td>29.5</td>
<td>17.5</td>
</tr>
<tr>
<td>2013</td>
<td>29.5</td>
<td>17.1</td>
</tr>
</tbody>
</table>

\(^5\) National Antenatal HIV Prevalence Survey, South Africa: Western Cape 2013
It is important to note that there are major differences between districts and particularly sub-districts HIV prevalence. Kannaland in the Eden district has a HIV prevalence of 2% (with a wide confidence interval) compared to Khayelitsha in the City of Cape Town District with a HIV prevalence of 34%. See Table 1.

**Table 1: Western Cape Antenatal HIV Prevalence per district**

<table>
<thead>
<tr>
<th>District</th>
<th>Percentage HIV positive 2013 (95% confidence interval)</th>
<th>Percentage HIV positive 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cape Winelands</td>
<td>12.05 (10.56; 13.72)</td>
<td>14.1</td>
</tr>
<tr>
<td>Central Karoo</td>
<td>4.56 (2.13; 9.51)</td>
<td>12.2</td>
</tr>
<tr>
<td>City of Cape Town</td>
<td>19.66 (18.54; 20.83)</td>
<td>20.0</td>
</tr>
<tr>
<td>Eden</td>
<td>13.55 (11.81; 15.50)</td>
<td>14.3</td>
</tr>
<tr>
<td>Overberg</td>
<td>16.11 (13.33; 19.34)</td>
<td>16.6</td>
</tr>
<tr>
<td>West Coast</td>
<td>10.60 (8.64; 12.93)</td>
<td>10.9</td>
</tr>
<tr>
<td>Western Cape</td>
<td>17.11 (16.35; 17.95)</td>
<td></td>
</tr>
</tbody>
</table>

**GOAL 2: Initiating at least 80% of eligible patients on ART, with 70% alive and on treatment five years after initiation**

The Antiretroviral Treatment (ART) Programme at public health facilities in the Western Cape commenced early in 2001 with the support of Médecins Sans Frontières (MSF) in Khayelitsha and great progress was made in terms of saving lives, extending life expectancy and preventing mother to child transmission of HIV. See Figure 3. As Figure 4 illustrates that by the end of 2014, 169 547 People Living with HIV (PLHIV) in the Western Cape remained on ART treatment. This contributed to South Africa’s endeavour to reach the targets set by the Millennium Development Goals (MDG’s) in 2000, aimed at reducing maternal mortality and combating HIV/AIDS.

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6 Western Cape Department of Health Information Management System (Sinjane/Tier.net, 2015)
Figure 3: Western Cape Total Clients Started on ART: January 2005 - November 2015

Figure 4: Western Cape Total Clients Remaining in Care: January 2005 - November 2015

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7 Western Cape Department of Health Information Management System (Sinjane/Tier.net, 2015)
6.1.2 Acceleration of HIV Counselling and Testing Campaign

The Western Cape made significant progress in accelerating HIV counselling and testing since the South African National HIV Counselling and Testing Campaign was launched by President J.G Zuma on the 25 April 2010. The province also participated actively in planning and implementing the revitalisation of the HCT campaign on World AIDS Day 2013 by providing HCT services to all parliamentarians at Parliament. The province implemented the new national “Provider Initiated Counselling and Testing” model, expanded non-health HCT service points and implemented mobile HCT services. An HCT lottery was launched by the Premier in 2013 in select sub-districts to evaluate if a financial incentive encourages the public to come forward to be tested. Strong partnerships were established and maintained with NGOs, PEPFAR partners and the private sector. In the 2013/14 financial year 1,036,768\(^9\) people were tested for HIV.

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\(^8\) Western Cape Department of Health Information Management System (Sinjani)
\(^9\) Western Cape Department of Health Annual Report 2013/14
6.1.3 Implementation of ART fixed-dose combinations

The implementation of the National Department of Health’s policy of fixed-dose combinations (FDCs) in ART was implemented as from 01 April 2013. This cut down the daily pill burden of 3 - 5 pills to just 1 pill, hugely enhancing the chances of life-long adherence. It also considerably reduced the burden on clinic pharmacies to pre-pack or check pre-packs from the central dispensing service. By simplifying the first-line adherence regimen not only were adherence clubs made more possible but prevention of mother-to-child HIV transmission (PMTCT) treatment options were expanded.

6.1.4 ART Clubs

Médecins Sans Frontières (MSF) piloted ART adherence clubs in Khayelitsha in 2007, demonstrating improved adherence (and thus sustained virological suppression and immunological recovery) over mainstream care by a full 12%. Retention in care was 97% for those patients in ART Adherence Clubs compared to 85% for patients who remained in mainstream clinic care, despite qualifying for clubs (from January 2011 to August 2012). This paved the way for the Department of Health with the support of partners to commence the roll out of ART clubs. Groups of 30 stable patients met five times a year for about 45 minutes, during the period under review. The club was Lay Health-Care Worker led. Clients received pre-packed ART supply for 2 months and for 4 months over the end-of-year festive season. Each client had a clinician review once a year. Club patients were
entitled to send a ‘buddy’ to collect their treatment from their ART club. However, patients themselves attended every second club session, including the annual blood investigation and annual clinical consultation sessions.

The ART clubs reduced the patient load in mainstream care, enabling clinicians to better concentrate on new and relapsed patients. In addition, the ART clubs saved patients’ invaluable time and money. The collaboration between MSF, the Western Cape Department of Health and the Treatment Action Campaign (TAC) won a platinum award from the prestigious Impumelelo Social Innovations Centre and drew sustained applause when presented at the first-ever Southern African HIV Clinicians Society Conference in Cape Town late in 2015. This demonstrated the innovative manner in which ART Clubs improved adherence to treatment and facilitated continued access to treatment; as acknowledged by health leaders.

In 2013/14 894 clubs were established. There was a total of 1,215\textsuperscript{10} ART clubs in the province during the period under review.

**Figure 7: Number of ART Clubs in Cape Metro District**

<table>
<thead>
<tr>
<th></th>
<th>Eastern</th>
<th>Khayelitsha</th>
<th>Klipfontein</th>
<th>M’Plain</th>
<th>Northern</th>
<th>Tygerberg</th>
<th>Southern</th>
<th>Western</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-14</td>
<td>106</td>
<td>247</td>
<td>120</td>
<td>118</td>
<td>73</td>
<td>71</td>
<td>54</td>
<td>88</td>
</tr>
<tr>
<td>Jan-15</td>
<td>160</td>
<td>345</td>
<td>164</td>
<td>155</td>
<td>76</td>
<td>101</td>
<td>75</td>
<td>139</td>
</tr>
</tbody>
</table>

**6.1.5 Use of GeneXpert in the Diagnosis of MDR-TB**

South Africa bears a large part of the global burden of individuals co-infected with HIV and tuberculosis. In 2011 the National Minister of Health, Minister Aaron Motsoaledi, in conjunction with National Health Laboratory Service (NHLS) took a decision to adopt the newly developed

\textsuperscript{10} Western Cape Department of Health Information Management System (Sinjani/Tier.net)
GeneXpert System (Cepheid) for TB diagnosis. The Xpert MTB RIF assay, a cassette-based cartridge, provides a rapid diagnosis of tuberculosis, while simultaneously providing a rapid screen for rifampicin (RIF) resistance. The assay is highly sensitive and specific for *M. tuberculosis* (MTB) infection and has received a strong recommendation from the World Health Organization in December 2010 as the initial test in individuals suspected of MDR-TB or those with HIV co-infection. The Western Cape started rolling out this technology at the end of 2011 and by 2013 access to Gene Xpert was available in all districts.

The main advantages of Xpert MTB RIF assay in the Western Cape were that 50% of suspects who had resistance were new and benefitted from DST testing at diagnosis\(^\text{11}\). No history of previous TB treatment was recorded for almost half of the cases for which rifampicin resistance was identified by Xpert, and this reinforced the importance of rapid resistance testing in patients with no history of TB and South Africa’s decision to screen all patients with presumptive tuberculosis with Xpert. In a study conducted by Dr Helen Cox and team in Khayelitsha in 2014 she showed that decentralised care and the rapid Xpert MTB/RIF test reduced the medium time to DR-TB treatment initiation from 42 days in 2009 to 7 days in 2013 for HIV positive clients\(^\text{12}\). This reduced time to treatment initiation interrupts MDR-TB transmission and thus significantly reduces morbidity and mortality.

### 6.2. Gaps/Challenges and Recommendations

#### 6.2.1 Ensuring continuity of care

HIV programs particularly those that were delivered at the community level, experienced disruptions in the continuum of HIV care, often in the pre-ART phase. Common challenges included loss-to-follow-up (LTFU) or attrition, poor retention, and limited attention to pre-ART services and clients. Distance to health care centres, transportation costs, male gender, younger age, unemployment, and lower levels of education contributed to attrition in pre-ART care. Another common barrier was stigma and fear of disclosure of HIV status. Guidelines and improved strategies to successfully link HIV-positive clients to care must be developed.

#### 6.2.2 Increased focus on HIV prevention

HIV prevention services need to be scaled up particularly focussing on young women and key populations. Social and Behaviour Change Communication Campaigns to be implemented focussing

\(^{11}\) GeneXpert MTB/RIF Version G4 for Identification of Rifampin-Resistant Tuberculosis in a Programmatic Setting

\(^{12}\) Reduced time to treatment initiation for drug-resistant TB with decentralised care and the rapid Xpert MTB/RIF test in Khayelitsha presented June 2014
on promoting condom use - which is declining in the Western Cape, and informing the public on HIV prevention. Plans for testing of hard-to-reach risk groups - migrants, homeless, PWIDs, MSMs should be developed and implemented. Male and female condom promotion and distribution including the distribution of lubrication must be expanded with a specific focus on targeting young people. Strategies to reach persons with disabilities and in particular persons with communication, intellectual and psychosocial disabilities with HIV prevention messaging must be developed. The uptake of PEP for victims of sexual assault was low mainly due to the fact that clients presented for services after 72 hours when PEP could no longer be provided. Community education programmes to address this should be embarked upon. PrEP should be adopted as policy for the country and rolled out in sex workers, MSM and young women. Management of STIs (sexually transmitted infections) needs to be strengthened and reconfigured to include greater focus on detection and treatment of asymptomatic infection. The business/private sector should contribute much more significantly to the response and should be mobilised.

6.2.3 Improve retention in care

Too many clients were lost to follow-up or default on treatment during the reporting period. As at 31 March 2015, 75% of clients initiated on treatment remained in care after 12 months. Strategies to effectively trace clients who drop out of treatment programmes must be developed. More resources into tracking defaulters are required. ART clubs should be continued to be rolled out and strengthened. Consideration can be given to integrate these clubs with chronic diseases clubs. Attention to the effective coordination of the clubs must be given as well as to drug delivery systems, information systems and adherence messaging. Cross-province migration issues must be addressed and the relationships between Western Cape and Eastern Cape Health Departments must be strengthened.

6.2.4 Improve TB prevention strategies

The Western Cape had successful TB cure rates but was not controlling the epidemic during the period under review (See Figure 6). There was a persistently high annual risk of TB infection (ARTI) in children of approximately 4% in the Western Cape13. Hospital surveillance of culture confirmed cases of TB in children demonstrated an increasing prevalence of drug-resistance in childhood TB. The TB epidemic was therefore not well controlled in the province and the programmatic response to childhood TB was inadequate.

13 Evidence to Inform South African TB Policies: Evisat Project: Stellenbosch University
Early identification and treatment of active TB cases is essential. Improved implementation of contact investigations to identify young household contacts and provide IPT or early TB diagnosis and appropriate treatment are required. Active case finding by household contact tracing is a key strategy in the programmatic response to childhood TB and should be a priority of the TB programme. TB infection prevention control (IPC) in the majority of South African health care facilities does not meet the minimal health care standards or legal requirements and should be strengthened. DR-TB outcomes are poor but slow progresses in improving outcomes were demonstrated. However strategies to improve treatment success rate in MDR-TB patients should be accelerated to prevent nosocomial transmission of MDR-TB.

6.2.5 Strengthen TB and HIV services in Correctional Facilities

People in prisons are at high risk for HIV/AIDS and TB. Most prisoners come from marginalised communities where there is a high prevalence of societal and structural risk factors that place individuals at high risk for HIV and TB, and incarceration may exacerbate existing health problems in prisoners with potential consequences for the communities to which they return. The donor funded programmes in correctional facilities must be sustained and expanded upon to reduce the impact of HIV and TB transmission in communities.

6.2.6 Accelerate the MMC programme

The Western Cape has not over the past few years met the national or provincial targets for medical male circumcision (MMC). New strategies must be implemented. These include involving more NGO partners in the programme and creating demand for these services.

6.2.7 Gender-based violence

Access to human rights is not a lived reality even though the promotion and protection of human rights is entrenched in the SA Bill of Rights of the SA Constitution. Gender-based violence and gender inequality probably remains a key driver in the epidemic and more interventions aimed specifically at young women needs to be implemented. HIV Stigma and discrimination must be addressed through sustainable support. Conviction rates for perpetrators of sexual assault must be increased.
GOAL 3: Reducing the number of new TB infections, as well as the number of TB deaths by 50%

Tuberculosis and the combination of TB and HIV persisted as a public health problem of serious magnitude in the Western Cape Province and a leading cause of premature death. This placed an extraordinary burden of TB on those afflicted by the disease and their families. Significant progress in tuberculosis control has been made over the past decade with the implementation of the global TB DOTS Strategy and the provincial Enhanced TB Response Strategy.

Drug sensitive disease has had a provincial adult case-load in excess of 40,000 cases per annum for about the last decade, reaching a high of 50,000 in 2009\(^{14}\) and showing a gradual decrease between then and 2014 when a case load 43,042 was registered. Of this case-load about 1/3 are classified as new smear positive, about 1/3 as new but without a positive smear result and about 1/3 are re-treatment cases. Between 2003 and 2013 the cure rate for new smear positive cases increased from 65-70% to over 80%. The number of patients treated successfully was 85% - see Figure 6. Improvements of a similar magnitude were seen in completion rates of new cases with smear negative disease. Cure rates of re-treatment cases improved over the same period from around 50% to around 67%.

\(^{14}\) Western Cape Department of Health Information Management System (ETR.net, 2009)
About 45% of patients with TB were also infected with HIV during the period under review. The TB programme in 2014 commenced 83% of co-infected patients on ART. This has seen a reduction in death rates amongst HIV-infected people with TB from 7.2% in 2009 to 5.5% in 2013. In the short term, ART is likely to reduce the incidence of tuberculosis among the HIV-infected individuals receiving ART, although this effect may be less pronounced over time as ART increases life expectancy and may, thus, increase the cumulative lifetime risk of tuberculosis.
The growing emergence of multidrug-resistant TB (MDR-TB) and extensively drug-resistant TB (XDR-TB) was a major threat and highlighted the need for a strong robust TB prevention programme. DR-TB cases increased from 1,105 to 1,289 between 2009 and 2012 with much poorer outcomes. Treatment completion rates were below 40%\textsuperscript{15}.

\textsuperscript{15} Western Cape Department of Health Information Management System (EDR.net)
GOAL 4: Ensuring an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the NSP

South Africa’s response to HIV, STIs and TB, which recognises the centrality of constitutional values and human rights, is based on the understanding that the public interest is best served when the rights of those living with HIV and/or TB – or at risk of infection – are respected, protected and promoted. Not only is this globally accepted public policy, it is also in line with the rights entrenched in Chapter 2 of the Constitution and the obligations they impose on the state regarding their progressive realisation. Amongst others, these include the rights to equality, dignity, life, freedom and security of the person and privacy.

The PSP takes as a starting point the constitutional recognition that access to health care and other social services – which includes reproductive health care – is itself a fundamental right, with the state taking primary responsibility for ensuring access. The Western Cape Government’s Provincial Strategic Plan 2014-2019 set out five strategic goals that aim to achieve these objectives and aims to create an enabling environment for higher economic growth and increased jobs, improved education and health outcomes and better living environments for the citizens of this province. The Western Cape Province therefore seeks to create an enabling environment in which access to health services is improved.

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16 Western Cape Strategic Plan on HIV, STIs and TB 2012 - 2016
Over the past few years NACOSA and NGOs such as the AIDS Legal Network conducted district workshops to address issues such as the right to confidentiality. The AIDS Legal Network provided ongoing training aimed at building capacity and broadening the awareness and understanding of HIV and AIDS as a human rights issue.

Six Thuthuzela Care Centres under the management of the National Prosecuting Authority and the 34 health facilities managed by the Western Cape Department of Health provided 24-hour health and forensic services to survivors of rape and sexual assault and strived to ensure justice and protect the rights of survivors; during the reporting period.

Table 2: Western Cape Number of 24-hour forensic health services available per district for survivors of rape and sexual assault

<table>
<thead>
<tr>
<th>District</th>
<th>Public Health facilities</th>
<th>Thuthuzela Centres at Public Hospitals</th>
<th>Private Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Coast</td>
<td>6</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Cape Winelands</td>
<td>5</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Central Karoo</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Eden</td>
<td>9</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Overberg</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Metro</td>
<td>4</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>34</strong></td>
<td><strong>6</strong></td>
<td><strong>2</strong></td>
</tr>
</tbody>
</table>

These centres provided a 24-hour integrated and comprehensive service to rape and sexual assault survivors during the period under review. Thuthuzela Care Centres were established as a one-stop service as part of South Africa’s anti-rape strategy aiming to reduce secondary victimization, improve conviction rates and reduce the cycle time for finalisation of cases. According to the 2015 NACOSA Western Cape Provincial Report, 4,044 victims of sexual violence received services at Thuthuzela Care Centres in 2014/15.

The South African National Strategic Plan on HIV, STIs and TB (2012-2016) identifies Key Populations as groups of individuals who are more likely to be exposed to or to transmit HIV and/or TB and whose risk is influenced by prejudice and an inadequate protection of human rights. The Western Cape accelerated services to key populations and vulnerable groups and made efforts to reach these “hard-to-reach” groups. These services included mobile outreach services that expanded access to HCT, TB Screening, STI Screening and condoms for sex workers and MSM. During the period under

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17 Guidelines & Standards for the Provision of Support to Rape Survivors in the Acute Stage of Trauma
review, there were three fully functioning men’s clinics that aimed at increasing access to services for men who could not readily access health services. In all these programmes key populations were partners in the programmes to ensure an effective response to the epidemic. Programmes to sensitise health care workers to the health needs of key populations and to address health care attitudes were conducted in all districts in the province.

**GOAL 5: Reducing self-reported stigma and discrimination related to HIV and TB by 50%**

Stigma against people living with HIV or people with TB remains one of the central barriers to effective prevention and management of HIV and TB. Experiencing stigma (both received and internalised) can impact on a person’s ability to make positive choices about their health and their lives. The Western Cape participated in the SANAC/HSRC “People Living with HIV Stigma Index: South Africa 2014” survey. The survey showed that internalised stigma is still a major challenge in South Africa with more than 40% of PLHIV expressing feelings of internalised stigma. Overall moderate levels of HIV-related external and internalised stigma and discrimination were found as well as moderately high TB-related stigma. Programmes to address stigma in the province were implemented by NGOs such as TAC, MSF, NACOSA and Sonke Gender Justice, during the reporting period. These programmes included campaigns aimed at raising awareness of and increasing knowledge about HIV and TB as well as stigma reduction workshops targeted at health workers, law enforcement officers and other relevant stakeholders.

**6. PSP PROGRESS REVIEW**

**6.1 Major Achievements**

**6.1.1 PMTCT Programme**

The prevention of mother–to-child-transmission (PMTCT) Programme remains one of the flagship HIV prevention programmes of the Western Cape. Significant progress was made to reduce morbidity and mortality in children. In 2011 the under-5 mortality rate was 24.1 per 100 000 live births\(^{18}\) in 2013 and the infant mortality rate to below 20 per 100 000 live births\(^{19}\). Mother-to-Child transmission was reduced to 1.9% in 2013/14\(^{20}\). The success of the programme was due to progressive provincial policies and successful partnerships with local authority health services,\(^{18}\) StatsSA 2011

\(^{19}\) Assessing the Impact of MDGs on Child Survival: The South African Context

\(^{20}\) Western Cape Department of Health Annual Report 2013/14
academic institutions and non-governmental organisations as well as dedicated managers and staff. In the 2013/14 financial year the Western Cape was the first province to adopt the Option B+ PMTCT policy. Lifelong ART was made available to all pregnant women as soon as they tested HIV positive, eliminating the need for infants to receive Nevirapine syrup for the duration of breastfeeding because they were now protected through their mothers taking ARVs.

**Figure 12: South Africa Under-5 years Mortality Rate by Province 2007 – 2009**

![Graph showing SA U5Y mortality rate by province 2007-2009](image)

**7. IMPACT INDICATORS**

Whilst prevalence of HIV is expected to increase over time with improved ART coverage as increased access to treatment of HIV increases life expectancy of HIV-positive individuals and reduces the number of deaths from HIV, the Western Cape Province saw a decline in prevalence rates among women and men aged 15 – 24 years (from 12.7% in 2011/12 to 10.2% in 2014/15). The Prevention of Mother-to-Child Transmission rate continued to show improvements with the province reporting a 1.4% transmission rate at 6 weeks in 2014/15.

HIV was ranked the second leading underlying natural cause of death in the Western Cape amongst both sexes of all ages and the leading underlying natural cause of death amongst the age group 15 – 44 years (StatsSA). TB incidence in the Western Cape remained high at 710 per 100,000 but StatsSA reports that in 2014 the Western Cape Province had the lowest proportion of deaths due to tuberculosis at 5.6%.
Table 3: NSP/PSP Impact Indicators, 2014/15

<table>
<thead>
<tr>
<th>Indicator</th>
<th>FY 2014/15 Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV prevalence among women and men aged 15-24</td>
<td>10.2%&lt;sup&gt;21&lt;/sup&gt;</td>
</tr>
<tr>
<td>TB incidence</td>
<td>710 per 100 000</td>
</tr>
<tr>
<td>TB Mortality</td>
<td>3.8%</td>
</tr>
<tr>
<td>HIV mortality (Percentage of adult mortality due to HIV)</td>
<td>5.8%&lt;sup&gt;22&lt;/sup&gt;</td>
</tr>
<tr>
<td>MTCT rate</td>
<td>1.4% (at 6 weeks)&lt;sup&gt;23&lt;/sup&gt;</td>
</tr>
<tr>
<td>Stigma Index</td>
<td>Provincial data not available</td>
</tr>
<tr>
<td>Patients alive and on treatment</td>
<td>180,769 (TROA)&lt;sup&gt;24&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>21</sup> Western Cape Department of Health Annual Report 2014/15  
<sup>22</sup> Statistics South Africa, Mortality and Causes of Death in South Africa 2014  
<sup>23</sup> Western Cape Department of Health Annual Report 2014/15  
<sup>24</sup> Western Cape Department of Health Annual Report 2014/15
8. PROGRESS TOWARDS ACHIEVING PSP 2012 – 2016 STRATEGIC OBJECTIVES

Strategic Objective 1: Social and Structural Drivers of HIV, STIS and TB

HIV prevention efforts cannot succeed in the long term without addressing the underlying social and structural drivers of HIV risk and vulnerability. The evidence about understanding the pathways through which different factors, such as gender inequality and lack of economic opportunity, influence HIV risk is weak. The PSP identified some key focus areas under this strategic objective, which include providing a comprehensive package of services to migrant populations, reducing alcohol and substance abuse, improving access to HIV and TB services for orphaned and vulnerable children (OVCs), improving school completion rates and implementing interventions to address gender-based violence.

Table 4: Strategic Objective 1 Social and Structural Drivers of HIV, STIS and TB

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Target 2016</th>
<th>FY 2014/15 Status</th>
<th>Comment – progress towards target</th>
</tr>
</thead>
<tbody>
<tr>
<td>% government departments and sectors with operational plans with HIV, TB and related gender and rights based dimension integrated</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>% municipalities with at least one informal settlement where targeted comprehensive HIV, STI and TB services are implemented</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Information not available</td>
</tr>
<tr>
<td>Current school attendance among orphans and among non-orphans aged 10 -14 (UNGASS 12; MDG Indicator)</td>
<td>98%</td>
<td>100%</td>
<td>98.1%</td>
<td>School attendance amongst children aged 7 – 15 years</td>
</tr>
<tr>
<td>Delivery rates for women under 18-NIDS</td>
<td>6.8%</td>
<td></td>
<td>6.1%</td>
<td></td>
</tr>
<tr>
<td>HIV and TB spend</td>
<td>R1.014 billion(^{27})</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
</tr>
</tbody>
</table>

\(^{25}\) Department of Basic Education, Education for All 2014 Country Progress Report

\(^{26}\) Western Cape Department of Health 2014/15 Annual Report

\(^{27}\) Western Cape Spending Assessment Report 2011
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Target 2016</th>
<th>FY 2014/15 Status</th>
<th>Comment – progress towards target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of women and children reporting gender-based violence (GBV) to the police in the last year</td>
<td>9,179</td>
<td>Not available</td>
<td>7,369(^{28})</td>
<td>Total number of sexual offences reported to the SAPS</td>
</tr>
<tr>
<td>Proportion of women who have experienced physical or sexual violence in the last year</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Information not available</td>
</tr>
</tbody>
</table>

**Major Achievements**

**Migrant Populations**

The following projects were implemented in the Western Cape Province to address the needs of migrant populations during the current reporting period:

- There were two Trucking Wellness Clinics in the province; (one in Beaufort West and one in the Cape Metro). The trucking wellness clinics were placed at busy truck stops where truckers, sex workers and the surrounding communities were able to access HIV prevention and treatment services.

- Measures were put in place to mitigate the challenges of the provision of health services faced by seasonal farm workers in the West Coast District. The district was able to implement a programme that specifically targeted this vulnerable group to improve HIV and TB outcomes by strengthening referral pathways, improving communication and partnerships with stakeholders and improving monitoring systems.

**School Attendance**

- School attendance amongst children aged 7 - 15 years remained consistent at approximately 98%. Keeping young people in school beyond this age and ensuring that they complete Grade 12 was a priority for the Western Cape Education Department.

- Steps which aimed at keeping learners in school included the following: attention to subject-selection at the end of Grade 9, better advice about career options and choices, and strengthening of the academic support given at high school level.

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\(^{28}\) SAPS 2014/15 Crime Stats (total sexual offences reported)
Figure 13: Percentage of Learners Staying in School for Grades 10 - 12

Orphans and Vulnerable Children (OVC)

- According to the South African Child Gauge, in 2014, 24,000 children in the province were maternal orphans. A further 115,000 were paternal orphans, and 24,000 children are double orphans. Psycho-social support services were provided to OVCs primarily through the organisations funded by the Western Cape Department of Social Development. An evaluation of these programmes found that the provision of psycho-social support services improved the confidence and self-esteem of OVCs and also had a positive impact on school attendance during the period under review.

Gaps, Challenges and Recommendations

Alcohol and Substance Abuse

Whilst addressing alcohol and substance abuse was a priority for the Western Cape Government during the reporting period, substance abuse trends in the province continued to escalate as illustrated by the 181% increase in drug related crime between April 2004 and March 2014. Methamphetamine was the primary substance of abuse in the province, followed by cannabis and alcohol; during the year under review.

In addition, there were limited facilities available for in-patient and out-patient treatment services for substance abuse. Furthermore, referral and retention in care for people who abuse substances remained the biggest challenge. Inter-departmental collaborations to strengthen referral mechanisms is needed as well as strategies to ensure clients are retained in care and are able to successfully participate in treatment programmes.

29 Western Cape Education Department Annual Report 2014/15
30 An Outcome Evaluation of Psychosocial Services Provided to OVC in the Western Cape, Department of Social Development, August 2015
31 Western Cape Department of Social Development 2014/15 Annual Report
32 Western Cape Department of Social Development 2014/15 Annual Report
**Gender-based violence**

Gender-based violence information and statistics remained difficult to collect due to the complexities related to this particular indicator. However, the number of sexual offences reported to the South African Police Service in the Western Cape decreased steadily from a reported 9,179 cases in 2010/2011 to 7,369 cases in 2014/15. Sexual offences, as recorded by the SAPS, include several crimes (ranging from sex work to rape). Increases or decreases in such a broad category therefore tell us very little about the extent of the offences contained in them.

**Mainstreamed Operational Plans**

All provincial government departments reported to DPSA that operational plans with HIV, TB and related gender rights-based dimensions were developed. It was, however, not possible to determine the extent to which these plans were successfully implemented during the reporting period.

**Strategic Objective 2: Preventing new HIV, TB and STI infections**

The approach of combination prevention recognises that no single prevention intervention can adequately address the HIV and TB epidemics at the population and individual levels. Combination prevention uses a mix of structural, social, behavioural and biomedical interventions that, when implemented simultaneously, will have the greatest power to reduce transmission, as well as mitigate individuals’ susceptibility and vulnerability to infection.

**Table 5: Strategic Objective 2 Preventing new HIV, TB and STI infections 2014/15**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Target 2016</th>
<th>FY 2014/15 Achieved</th>
<th>Comment – progress towards target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number (and percentage) of men and women 15–49 counselled and tested for HIV</td>
<td>904,699</td>
<td>Not set</td>
<td>33.7%</td>
<td>On track to meet target</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1,151,571</td>
<td></td>
</tr>
<tr>
<td>Number and percentage of people screened for TB</td>
<td>-</td>
<td>3.1%</td>
<td>2.5%</td>
<td>On track to meet target</td>
</tr>
<tr>
<td>Number of newly diagnosed HIV positive people started on IPT for latent TB infection</td>
<td>5,021</td>
<td>30,000</td>
<td>21,937</td>
<td>On track to meet target</td>
</tr>
</tbody>
</table>

33 Western Cape Department of Health Annual Report 2014/15

34 Western Cape Department of Health Annual Performance Plan 2015/16
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Target 2016</th>
<th>FY 2014/15 Achieved</th>
<th>Comment – progress towards target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage men and women aged 15–24 reporting the use of a condom with their sexual partner at last sex</td>
<td>34.8%</td>
<td>-</td>
<td>24.3%(^{35})</td>
<td></td>
</tr>
<tr>
<td>Percentage young women and men aged 15–24 who had sexual intercourse before age 15 (age at sexual debut)</td>
<td>9.3%</td>
<td>-</td>
<td>14.2%(^{36})</td>
<td></td>
</tr>
<tr>
<td>Percentage women and men aged 15–49 years who have had sexual intercourse with more than one partner in the last 12 months</td>
<td>9.9%</td>
<td>-</td>
<td>10.1%(^{37})</td>
<td>On track to meet target</td>
</tr>
<tr>
<td>Male condom distribution</td>
<td>102,346,532</td>
<td>130,893,367(^{38})</td>
<td>123,416,309(^{39})</td>
<td>On track to meet target</td>
</tr>
<tr>
<td>Female condom distribution</td>
<td>1,863,238</td>
<td>3,167,181(^{40})</td>
<td>3,063,347(^{41})</td>
<td>On track to meet target</td>
</tr>
<tr>
<td>Number of men medically circumcised</td>
<td>2,047</td>
<td>22,899(^{42})</td>
<td>15,498(^{43})</td>
<td>On track to meet target</td>
</tr>
</tbody>
</table>

**Major Achievements**

*Isoniazid Preventive Therapy (IPT)*

Isoniazid Preventive Therapy (IPT) is the administration of Isoniazid (INH) to individuals with latent TB infection in order to prevent progression to active TB disease. The Province prioritised IPT and actively engaged with all stakeholders to drive an increase in the uptake of this service. This saw an increase from approximately 5,000 HIV-positive individuals started on IPT for latent TB infection in 2012/13 to more than 20,000 in 2014/15.

**Distribution of Male and Female Condoms**

The Western Cape Province developed a Condom Distribution Strategy and ensured the distribution of condoms to non-traditional sites such as taverns/shebeens, night clubs and work places. The Western Cape Province successfully distributed the newly launched grape-scented condom to all

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\(^{38}\) Western Cape Department of Health Annual Performance Plan 2015/16
\(^{39}\) Western Cape Department of Health Annual Report 2014/15
\(^{40}\) Western Cape Department of Health Annual Performance Plan 2015/16
\(^{41}\) Western Cape Department of Health Annual Performance Plan 2015/16
\(^{42}\) Western Cape Department of Health Annual Performance Plan 2015/16
\(^{43}\) Western Cape Department of Health Annual Report 2014/15
Further Education and Training (FET) Colleges and key population groups, including sex workers in the province during 2015. Services to Key Populations

The 2013 rapid population size estimate reported that there were around 153 000 sex workers in South Africa. Female sex workers comprised the majority, followed by male sex workers and transgender sex workers. The rapid populations size estimation also found that the number of sex workers varied by region, with the highest concentration of sex workers in Gauteng (22%), KwaZulu-Natal (16%) and the Western Cape (11%). HIV prevalence among sex workers and their clients today is commonly 10–20-fold higher than among the general population. In South Africa, the 2013 IBBS estimated that HIV prevalence among female sex workers was 71.8% (95% confidence interval [CI]: 56.5%-81.2%) in Johannesburg; 39.7% (95% CI 30.1%-49.8%) in Cape Town, and 53.5% (95% CI 37.5%-65.5%) in Durban.

Through donor funding TB/HIV Care Association implemented comprehensive mobile health services for sex workers in the Cape Town Metro district and this programme increasingly reached the hard to reach sex worker community of Cape Town. SWEAT, with support of Global Fund funding through NACOSA, delivered a risk reduction programme which included HCT and peer education services to sex worker in all the major towns of the Western Cape. ANOVA Health4Men, with PEPFAR and other funding sources, provided services to MSM’s and also had three dedicated health clinics for men in Cape Town, during the period under review.

Youth Focus

Figure 14: Percentage Testing and Screening per TVET College in 2015, Western Cape
Prevention efforts that target young people included the roll-out of the Higher Education AIDS programme (HEAIDS) to all Technical Vocational Education and Training (TVET) Colleges in the Western Cape. This programme, in partnership with the Western Cape Department of Health and other stakeholders, ensured access to key prevention services directly to young people. These services included HIV Counselling and Testing, TB Screening, condom distribution and STI screening.

**Gaps, Challenges and Recommendations**

**Medical Male Circumcision**

Uptake of Medical Male Circumcision (MMC) in the Western Cape remained well below target despite several efforts at improving this, during the year under review. Dedicated MMC teams were allocated to all districts and the Department of Health partnered with NGOs to assist in scale-up activities, including social mobilisation for MMC and mobile MMC services.

**Behaviour Change Communication**

Although condom distribution was high in the Western Cape, the South African National HIV Prevalence, Incidence and Behaviour Survey, 2012 (HSRC) confirmed the following findings: a decrease in self-reported condom usage; an increase in the number of individuals aged 15 – 24 years who report having sexual intercourse before the age of 15 years and a slight increase in the percentage of individuals who reported having more than one sexual partner in the last 12 months. These findings highlight the need for a concerted effort at targeting key populations and vulnerable groups with behaviour change interventions aimed at lowering the risk of HIV acquisition.

In the context of increased access to ART and the persisting perception amongst some that they are not at risk of HIV infection, there is a need to design programmes that are able to effectively communicate the risks of acquiring HIV through the personalisation of information. Health promotion campaigns aimed at educating the public and raising awareness about the basics of HIV and TB prevention should be considered.
**Strategic Objective 3: Sustaining Health and Wellness**

The core strategies for this objective relate to early and improved diagnosis of TB and HIV and improved access to appropriate and user friendly treatment services. Achievement of this objective will contribute towards reducing disability and death resulting from TB and HIV through ensuring that people living with HIV and TB are retained in care, are adherent to treatment and maintain optimal health.

**Table 6: Strategic Objective 3: Sustaining Health and Wellness**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Target 2016</th>
<th>FY 2014/15 Achieved</th>
<th>Comment – progress towards target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion (%) of people per year becoming eligible who receive ART</td>
<td></td>
<td>90%</td>
<td>89.1%</td>
<td></td>
</tr>
<tr>
<td>TB case registration rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB case detection rate</td>
<td>National Department of Health discourages calculations at provincial level due to variability. National detection rate applies to all provinces.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% smear positive TB cases that are successfully treated</td>
<td>81.5%</td>
<td>84.6%</td>
<td>82.7%</td>
<td></td>
</tr>
<tr>
<td>TB case fatality rate (CFR)</td>
<td></td>
<td>2.7%</td>
<td>3.8%</td>
<td></td>
</tr>
<tr>
<td>CFR HIV-positive = CFR HIV-negative</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number and % of registered TB patients who tested for HIV</td>
<td>88%</td>
<td>100%</td>
<td>95.6%</td>
<td></td>
</tr>
<tr>
<td>Number of all newly registered TB patients who are HIV-positive, expressed as a proportion of all newly registered TB patients</td>
<td>39%</td>
<td></td>
<td>37.5%</td>
<td></td>
</tr>
</tbody>
</table>

**Major Achievements**

**Expanding the ART Programme**

The ART programme in the Western Cape has expanded rapidly over the last years, almost doubling the total number of clients remaining on ART from 105,748 in 2011 to 193,746 in 2015. The province successfully implemented ART Adherence Clubs as a means of providing patient-friendly access to treatment for clients who are stable. This not only reduced the burden on the healthcare facilities but also facilitates easier and quicker access to a continued ART supply for patients.

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**TB Treatment Success**

Since 2008/09, each year fewer people are treated for TB in the Western Cape (Figure 5) and there was a steady increase in the cure rate of new smear positive TB cases (66.5% in 1995 to 75.7% in 2006 to 82.7% in 2014). These are welcome trends in the TB Control Programme.

**Gaps, Challenges & Recommendations**

**TB/HIV Integration**

The extent of the combined TB and HIV epidemics has created operational challenges for a health service that has traditionally run separate programmes for TB and HIV, with treatment delivered by different healthcare staff, often in separate facilities. This is particularly problematic for TB/HIV co-infected patients who need to access both services. Whilst policies and strategies are in place to support TB/HIV integration, integration at the facility level needs to be enhanced.

**Strategic Objective 4: Ensuring protection of human rights and improving access to justice**

Ending the HIV and TB epidemics requires not only increasing prevention and treatment services but also protecting and promoting human rights within the response. In the context of HIV, accessing justice is related to ensuring that rights are not violated when interventions are implemented, and that discrimination on the basis on HIV and TB is eliminated.

Eliminating of HIV-related stigma and discrimination in various sectors, such as health care and employment, and encouraging law enforcement officials to be supportive of key populations’ access to services are actions that can contribute towards the achievement of this strategic objective.

**Major Achievements**

**Stigma Reduction**

- Whilst no baseline information on stigma was available at the start of the NSP/PSP period, the first national stigma index survey was conducted by SANAC in 2015. The survey report shows the levels of internalised stigma to be relatively high with 40% of persons living with HIV expressing feelings of internalised stigma.
**Services for Key Populations**

- With the aim of raising awareness of the health needs of different groups, and specifically sex workers and MSM, a number of interventions were implemented in health facilities targeted at health care workers. These interventions provide participants with the knowledge and skills necessary to successfully engage with key populations in a health setting.
- Training was provided to health workers in all districts.
- ANOVA Health4Men deemed several health facilities to be “MSM competent”.

**Gaps, Challenges & Recommendations**

Stigma and discrimination related to HIV and TB continued to persist in many communities and settings. There remains a need for concerted efforts to be made to address this challenge. Programmes aimed at reducing discrimination in the workplace and also in reducing discrimination in access to services are needed.
9. MONITORING AND EVALUATION

Monitoring and evaluation of the multi-sectoral response requires greater coordination of all sectors (public, private, civil society and development partners). In the absence of a national M&E framework and M&E Plan for the NSP, the Western Cape relied on existing M&E systems that are implemented by key stakeholders in the response to HIV and TB to monitor and report on the implementation of the PSP.

Despite the PSP being a strategy to guide the multi-sector response to HIV and TB, many indicators contained in the PSP are health-related (especially under Strategic Objectives 2 and 3) and were tracked through data that is routinely recorded and reported on by the Western Cape Department of Health. Indicators related to addressing the social and structural barriers and also those related to human rights (Strategic Objectives 1 & 4) are not adequately defined and were difficult to track and report on during the period under review.

In the absence of District AIDS Councils and Local AIDS Councils in the Western Cape, there were no mechanisms for ensuring data flow from the local level through to the district level and then to the Provincial AIDS Council. Where sectors are able to report on the implementation of activities in a coordinated manner, this reporting was done directly to the Provincial AIDS Council.

Notwithstanding these challenges, the Western Cape Provincial AIDS Council is confident that was able to track progress towards the achievement of the goals of the PSP through existing information management and M&E systems; during the current reporting period.
10. **OVERALL CONCLUSION**

The first annual PSP Progress Report did not adequately capture all available data and HIV and TB programmes in the Western Cape. This was particularly the case with respect to NGOs and the private sector and was mainly due to the fact that an information framework and systems were not in place to capture the data. It is envisaged that these gaps will be addressed when developing the new NSP and PSP for 2017-2021. The Western Cape and its donors however invested considerable resources in addressing HIV and TB in the Province and the HIV prevalence is starting to decline women aged 15-24 years. There was a downward trend in the < 20 age group since 2010 and in the 20 to 24 age groups since 2009. As the report shows significant progress was made in reducing HIV transmission in infants through the PMTCT programme, increasing HIV counselling and testing, increasing condom distribution, and placing and retaining eligible clients on ART. TB incidence was also on the decline during the period under review. However drug-resistant tuberculosis is an emerging epidemic. The high TB mortality rates and high TB infection rates in children are indications that TB was by no means under control and much more needs to be done.

11. **OVERALL RECOMMENDATIONS**

1. It is recommended that as from 2015/16 the Province adopts, as recommended by the National Department of Health, the UNAIDS 90-90-90 global targets for HIV and the Stop TB Partnership 90-90-90 targets for TB. These are as follows:

<table>
<thead>
<tr>
<th>ART Targets</th>
<th>Tuberculosis Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 90% of all people living with HIV <strong>will know their HIV status</strong></td>
<td>- 90% of <strong>vulnerable groups/key population screened for TB</strong>: PHC count, inmates, miners, and people living in informal settlements-screen contacts of index cases</td>
</tr>
<tr>
<td>- 90% of people with diagnosed HIV <strong>infection will receive sustained ART</strong></td>
<td>- 90% of people with <strong>TB diagnosed and treated</strong></td>
</tr>
<tr>
<td>- 90% of all people receiving ART <strong>will have viral suppression</strong></td>
<td>- 90% of TB <strong>treatment success rate</strong></td>
</tr>
</tbody>
</table>

2. The MMC programme needs to be accelerated with the implementation of new strategies which promote uptake of MMC.

3. The drug-resistant TB programme must be strengthened.
12.  **FAST TRACKING PROGRESS PLAN ---2015/16**

_The following are the priority programs to reach set targets by end 2016 by each Strategic Objective_ 

**Strategic Objective 1: Focus on Social and Structural Approaches to HIV and TB Prevention, Care and Impact**

I. Implementation of the “Cash and Care” Grant for young women will commence.

II. Commence “hot spot” mapping to target vulnerable high burden communities with HIV prevention interventions.

III. Implement the People who inject drugs (PWID) project in Cape Town Metro District.

IV. Implement harm reduction programmes for sex workers.

V. Sustain services to survivors of rape and sexual assault through the Thuthuzela and other care centres.

VI. Implement the provincial ‘Alcohol Harm Reduction Initiative’ project.

**Strategic Objective 2: Prevention of HIV, STI and TB Infections**

I. Expand HCT services to key populations and vulnerable groups such as adolescents.

II. Reduce HIV transmission to mother-to-child to 1,3%.

III. Promote condom usage with the introduction of scented condoms and lubricants as part of the government condom programme.

IV. Implement PrEP in select research sites for young women as part of a comprehensive sexual services package.

V. Intensify TB case finding as part of the 90 90 90 strategy.

VI. Increase uptake of MMC.

**Strategic Objective 3: Sustain Health and Wellness**

I. Increase viral load completion rate in HIV positive clients on ART to increase the number of clients that are virally suppressed.

II. Improve the treatment outcomes for drug-resistant TB clients.

III. Expand ART/Chronic clubs to enhance adherence to ART.

**Strategic Objective 4: Protection of Human Rights and Promotion of Access to Justice**

I. Work with relevant organizations and NGOs to protect human rights, promote access to justice and reduce stigma and discrimination (NPA, SAP, Human Rights Commission, Sonke Gender Justice, AIDS Legal Network etc.)
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7. National Antenatal HIV Prevalence Survey, South Africa: Western Cape 2013. Investigator: Dr Bart Willems Registrar Public Health Medicine: Community Health, Stellenbosch University Faculty of Medicine and Health Sciences: June 2014

8. Reduced time to treatment initiation for drug-resistant TB with decentralised care and the rapid Xpert MTB/Rif test in Khayelitsha presented June 2014: Helen Cox, Jennifer Hughes, Sizulu Moyo, Johnny Daniels, Vivian Cox, Mark Nicol and Virginia Azevedo


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13. Western Cape Department of Health Annual Report 2014/15

14. Western Cape Spending Assessment Report 2011

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