MARCH 2016

ANNUAL PROGRESS REPORT 2014/15

PROVINCIAL STRATEGIC PLAN 2012-2016

LIMPOPO PROVINCIAL AIDS COUNCIL

ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
APP	Annual Performance Plan
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASSA	Actuarial Society of South Africa
CCMT	Comprehensive Care Management and Treatment
CFR	Case Fatality Rate
CI	Confidence Interval
DAC	District AIDS Council
DHB	District Health Plan
DHIS	District Health Information System
DIP	District Implementing Plan
DOT	Directly Observed Treatment
ETR	Electronic TB Register
GBV	Gender Based Violence
HAST	HIV and AIDS STIs and TB
HCBC	Home Community Based Care
HCT	HIV Counseling and Testing
HCW	Health Care Worker
HDACC	Health Data Advisory and Co-ordination Committee
HIV	Human Immune-deficiency Virus
HSRC	Human Sciences Research Council
HTA	High Transmission Area
IACT	Integrated Access to Care and Treatment
ICT	Intensified Case Finding
IDP	Integrated Development Plan
IMR	Infant Mortality Rate
IMIS	Integrated Maintenance Information System
IPT	Isoniazid Preventive Therapy
ISHIP	Integrated School Health Policy
LAC	Local AIDS Council
LDoE	Limpopo Department of Education
LDoH	Limpopo Department of Health
LDSD	Limpopo Department of Social Development
LPT	Limpopo Department of Provincial Treasury
LPAC	Limpopo Provincial AIDS Council
MDG	Millennium Development Goal
MTCT	Mother-to-Child Transmission
MDR-TB	Multi Drug Resistant Tuberculosis
M & E	Monitoring and Evaluation
MMC	Male Medical Circumcision
MRC	Medical Research Council
NDOH	National Department of Health

NGO	Non-Governmental Organization
NHLS	National Health Laboratory Services
NIMART	Nurse-Initiated management of ART
NPO	Non- Profit Organization
NSDA	National Service Delivery Agreement
NSP	National Strategic Plan
NVP	Nevirapine
OVC	Orphan and Vulnerable Children
PCR	Polymerase chain reaction
PEP	Post- Exposure Prophylaxis
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-Child Transmission
PLWH	People Living With HIV
PSP	Provincial Strategic Plan
RMS	Rapid Mortality Surveillance
SAG	South African Government
SANAC	South African National AIDS Council
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UCT	University of Cape Town
UNAIDS	United Nations Joint Programmed on HIV & AIDS
UNGASS	United Nations General assembly Special Session
VEP	Victim Empowerment Program
VMMC	Voluntary Male Medical Circumcision
WHO	World Health Organisation

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BACKGROUND - PSP 2012 – 2016

The Limpopo Provincial AIDS Council (LPAC) which is tasked to coordinate all HIV and TB interventions in the Province took the guidance from South African National AIDS Council (SANAC) to develop a Provincial Strategic Plan (PSP) on HIV, STIs and TB aligned to the National Strategic Plan (NSP). The plan is meant to achieve the following: to direct the provincial HIV and TB response, to assist in fulfilling the mandate of the LPAC in reporting to SANAC as well as to assist in costing the response. The LPAC developed this PSP in consultation with all relevant stakeholders and this plan was endorsed after all the necessary crucial steps. The vision of the plan as well as the strategic objectives was adopted from the global and national vision 2030.

The Provincial Strategic Plan (PSP) 2012-2016 was developed in line with the National Strategic Plan (NSP) 2012-2016 in consultation with the Government Departments, Private Sector, Civil Society sectors including people living with HIV at Provincial and District levels. The PSP 2012-2016 was approved in April 2012 for implementation by all Sectors in the Province.

The PSP is a multi-sectoral plan aimed at addressing HIV, STIs and TB issues in an integrated and holistic manner. The PSP 2012-2016 adopted a long-term vision for the country with respect to the two epidemics which are as follows**:**

- Zero new HIV and TB infections;
- Zero new infections due to vertical transmission
- Zero preventable deaths associated with HIV and TB;
- Zero discrimination associated with HIV and TB.

The development of the PSP was heavily influenced and imbedded within the broader national and international development communities like the South African National AIDS Council (SANAC), which emphasises on a multi-sectoral approach, the Joint United Nations Programme on AIDS (UNAIDS) which advocates for Zero new infections, Zero deaths associated with HIV and TB and Zero Stigma Discrimination as well as the United Nations General Assembly Special Session on HIV and AIDS which responded to HIV and AIDS by involving all stakeholders. The developmental approach recognised that HIV, TB and STIs is not just a health

problem but a cross-cutting challenge for all sectors including the socio-structural, economic and politico-legal determinants of health as social drivers that increase the risk and chances of vulnerability.

From the outset the PSP acknowledges the health challenges that the country and the province is faced with. It also acknowledges the various efforts by the South African Government (SAG) at national and provincial level to address those challenges. Some of the challenges include the quadruple burden of diseases (Communicable, Non-Communicable, Violence and Injury and HIV/AIDS and TB). Some of the efforts to address these challenges include the HIV counselling and Testing (HCT) Campaign launched by the SAG in 2010, the introduction of the Nurse Initiated Management of ART (NIMART), the National Service Delivery Agreement (NSDA) and the changes in the eligibility criteria for ART initiation (CD4 below 350), among others. Such an acknowledgment sets the tone and direction towards the amount of efforts required to reduce the impact of the epidemic.

The purpose of the PSP is:

- To guide the development of an implementation plan for the response in the Province; with clear timeframes and indicators to measure progress
- To provide strategic direction in identifying practical interventions and the roles of the stakeholders that form part of the multi-sectoral response
- To guide costing and budgeting for HIV and AIDS, STI and TB interventions to ensure availability of resources and efforts for resource mobilization
- To mainstream HIV and AIDS, STI s and TB services in all sectors in the Province.
- To strengthen multi-sectoral collaboration with greater emphasis on implementation.
- To solicit support and commitment of all stakeholders involved in HIV and AIDS programmes.

The following is an outline of the strategic priorities for Limpopo as outlined in the PSP:

- Strategic Objective 1: Address Social and Structural drivers of HIV and TB Prevention, Care and Impact
- Strategic Objective 2: Prevention of new HIV and TB Infections
- Strategic Objective 3: Sustain Health and Wellness
- Strategic Objective 4: Protection of Human Rights and Promotion of Access to Justice

Under each of these strategic objectives are sub-objectives that focus on specific areas of interest and prioritised in the PSP development process based on the epidemiological profiling of the province. Additionally, each strategic objective has a summary of indicators against which the province is obliged to report routinely. Such an arrangement makes the collection, collation, analysis, reporting and usage of data much easier. It also makes it easy to track progress on specific soft issues that do not easily lend themselves to quantitative deductions and conclusion.

The goals of PSP guided by NSP

The following broad goals have been adopted by the Province:

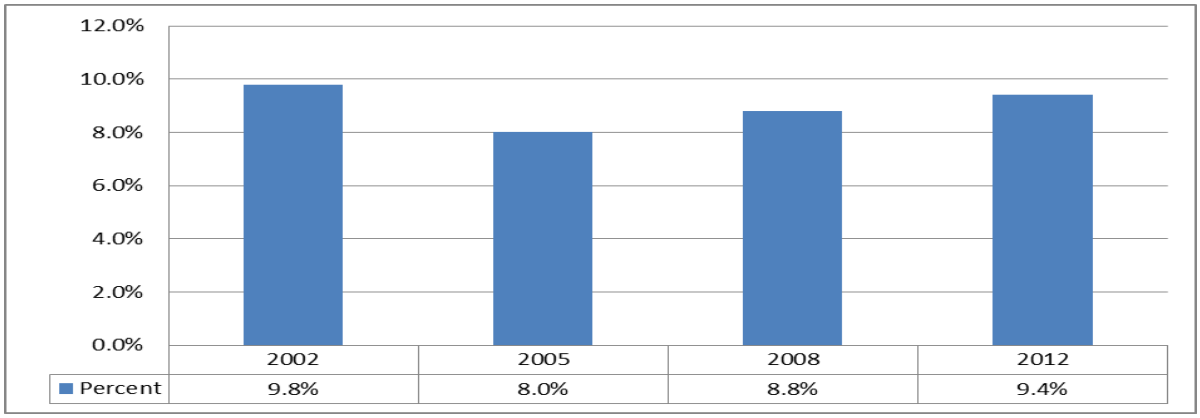
- Reduce new HIV infections by at least 50% using combination prevention approaches;
- Initiate at least 80% of eligible patients on antiretroviral treatment (ART), with 70% of those alive and on treatment after 5 years of initiation
- Reduce the number of new TB infections as well as TB deaths by 50%
- Ensure an enabling and accessible legal framework to support implementation of the NSP;
- Reduce self-reported stigma related to HIV and TB by 50%

ASSESSING PROGRESS MADE AGAINST THE FIVE MAIN GOALS OF PSP

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

According to Shisana et al, (2014), National HIV prevalence is estimated at 12.2% (95% CI: 11.4-13.1) in 2012. In 2008 prevalence was estimated at 10.6% indicating an increase of 1.6%. Limpopo recorded an HIV prevalence estimate of 9.2%; which was below the national estimate of 29.5%[1]. The province is the third with a low HIV prevalence after Northern Cape and Western Cape. The graph below presents the trends of HIV prevalence in Limpopo from 2002 to 2012.

Figure 1: HIV prevalence in Limpopo (2 years and older) 2002, 2005, 2008 and 2012



Source: Shisana et al., 2014

HIV prevalence for people 2 years and older in Limpopo decreased from 9.8% in 2002 to 8.0% in 2005 before it started to increase to 8.8% in 2008 and 9.4% in 2012. An increase in prevalence can either be caused by increased number of newly positives or an improved retention in care meaning that most people are living longer with the virus. Another explanation to the increase in prevalence from 2008 onwards could be a result of increased efforts by government and Non-Governmental Organisations (NGOs) of educating people about HIV is transmitted; which results in most people testing and receiving their HIV results. The province needs to identify the causes of an increase in prevalence and develop programmes to halt it if is a result of newly identified HIV positive people.

Percentage distribution of HIV prevalence by district in the Limpopo Province

The district level variations in the HIV prevalence over the past four years are depicted in Table 1 below. Waterberg district recorded the highest HIV prevalence rate of 27.3% in the Province. Capricorn and Mopani districts also recorded HIV prevalence rates of above 20% as well as above the provincial average of 20.3%. Sekhukhune and Vhembe districts[2] were the two areas in which the HIV prevalence rate was below the provincial average of 20.3%. For all the districts, prevalence rates have been fluctuating from year to year without a consistent pattern. Sekhukhune decreased with 5.1% and Vhembe districts with 2.8% between 2012 and 2013.

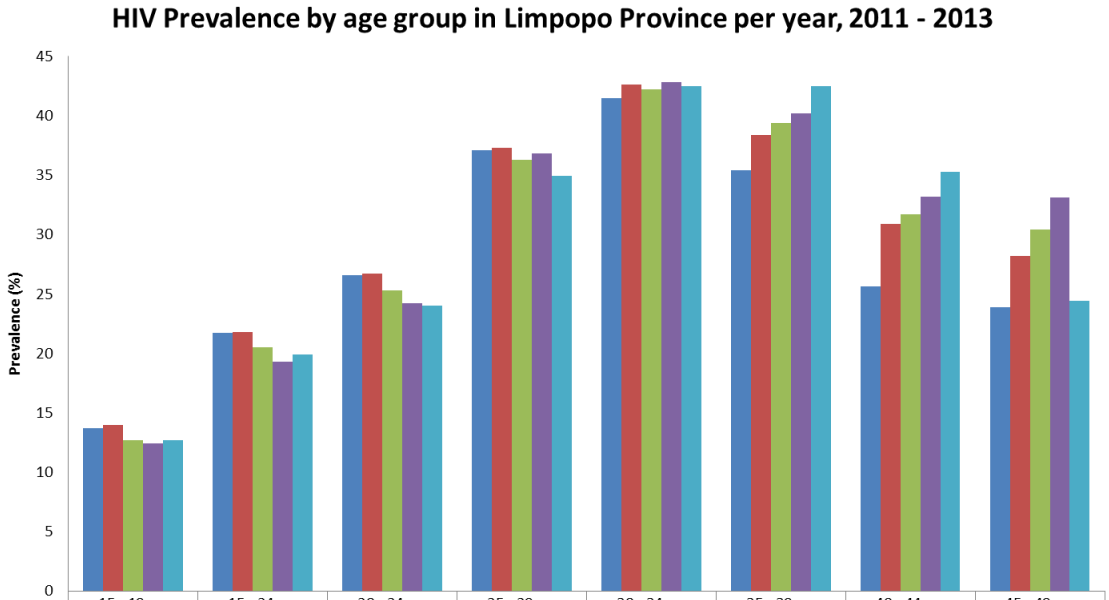
Table 1: HIV prevalence among antenatal women by district, Limpopo, 2010 to 2013[3]

	2010	2011	2012	2013
Provincial	21.9%	22.1%	22.3%	20.3%
Capricorn	23.7%	25.3%	22.4%	21.1%
Mopani	24.9%	25.2%	25.0%	24.6%
Sekhukhune	20.2%	18.9%	23.0%	17.9%
Vhembe	17.0%	14.6%	17.7%	14.9%
Waterberg	26.1%	30.3%	27.0%	27.3%

The 2013 HIV prevalence rate among 25-29 year old pregnant women increased from 36.3% in 2011 to 36.8% in 2012 but decreased from 36.8% in 2012 to 34.9% in 2013. The age group 30-34 recorded the highest HIV prevalence throughout the period under review followed by the age group 35-39 (Figure 2). Data in the figure below also shows that HIV prevalence for the age group 45-49 dropped in 2012 from 33,1% to 24.4% while 40-45 age group increased from 30.9% in 2010 to 35.3% in 2013.

[3] Department of Health. 2012. The 2011 National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa. Pretoria.

Figure 2: HIV prevalence among antenatal women by age group, Limpopo, 2010 to 2013[3]



	15 - 19 yrs	15 - 24 yrs	20 - 24 yrs	25 - 29 yrs	30 - 34 yrs	35 - 39 yrs	40 - 44 yrs	45 - 49 yrs
2009	13.7	21.7	26.6	37.1	41.5	35.4	25.6	23.9
2010	14	21.8	26.7	37.3	42.6	38.4	30.9	28.2
2011	12.7	20.5	25.3	36.3	42.2	39.4	31.7	30.4
2012	12.4	19.3	24.2	36.8	42.8	40.2	33.2	33.1
2013	12.7	19.9	24	34.9	42.5	42.5	35.3	24.4

Source: National Antenatal Sentinel HIV and Syphilis Prevalence Purvey in South Africa, 2013

HIV Incidence

The 2012 HSRC survey estimates that over the period mid-2011 to mid-2012 there were approximately 469 000 new infections (95% CI: 381 000–557 000) in the population aged 2 years and older. This translates to 1.1% estimated incidence for that period. It should be noted that the 2012 HSRC estimates of HIV incidence in adults by province, are the most recently published adult estimates. However, a number of earlier models have produced estimates of HIV incidence by province, and these estimates are summarised in Table 2 below. Differences in HIV incidence trends by province are important in identifying variations in changes in the epidemic, including potential influence of HIV prevention programmes. The earlier Spectrum, 2010-2011 and ASSA 2008 estimates of adult HIV incidence for Limpopo both suggested that incidence was among the lowest compared with other provinces.

TABLE 2: ESTIMATES OF HIV INCIDENCE BY PROVINCE[4]

Province	Spectrum 15-49 2010-11	ASSA2008 15-49 male 2007-08	ASSA2008 15-49 female 2007-08	SAPMTCTE 6-week perinatal acquired 2011-12[i]
Eastern Cape	1.30%	1.20%	2.20%	1.3% (0.7-1.8)
Free State	1.65%	1.23%	1.89%	1.2% (0.7-1.7)
Gauteng	1.30%	0.97%	1.39%	0.8% (0.3-1.2)
KwaZulu-Natal	2.22%	1.60%	2.47%	0.9% (0.4-1.5)
Limpopo	1.00%	0.62%	1.59%	0.8% (0.3-1.2)
Mpumalanga	2.15%	1.23%	2.45%	1.2% (0.8-1.7)
Northern Cape	0.69%	0.59%	1.19%	1.0% (0.4-1.6)
North West	1.58%	1.21%	1.90%	0.8% (0.4-1.2)
Western Cape	0.34%	0.41%	0.77%	0.4% (0.1-0.6)
Total	1.43%	1.11%	1.81%	0.9% (0.7-1.1)

HIV incidence in children

Mother to child HIV transmission is characterised by transmission occurring at or before the time of birth or after birth through breastfeeding. SANAC, 2014 report confirmed tremendous progress made in reducing HIV transmission through the PMTCT programme. Significant strides were noted in the PMTCT programme for the two years under review as more babies were born free from HIV infection. In Limpopo dramatic decline was shown in the prevention of Mother to child transmission between 2013/14 and 2014/15 where the response towards HIV born free infants at 6-8 weeks was found to be 2.3% and 2.2% respectively. The revised PMTCT Policy guideline which was first implemented in 2014/15 financial states that every pregnant woman must be initiated on ART regardless of CD 4cell count. In addition, the PMTCT Policy guideline states that HIV+ pregnant and breast feeding women will be initiated on ART irrespective of CD4 count (Option B+).

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

This goal is concerned about coverage, effectiveness and impact of the ART programme. Emanating from the country's NSP on HIV, STIs and TB 2012-2016, the

[4] South African National AIDS Council. Progress Report on the National Strategic Plan for HIV, TB AND STIs (2012 – 2016). Pretoria: South African National AIDS Council; November 2014.

Department's strategic objectives were to scale up combination prevention interventions. The purpose of scaling up combination prevention interventions was to reduce the rate of new infections, and to improve the quality of life of people living with HIV, by providing a comprehensive package of care, treatment and support services to at least 80% of people living with HIV and AIDS.

According to the LPAC and DOH province annual report for 2014/15, the total number of patients initiated on ART was 79, 524 against a target of 46,000. This represents 173% achievement for that year. In terms of the number of people on ART, the province reached 236 506 in 2014/15, which was an increase of 12 506 from the previous financial year 2013/14. The new ART revised guide states the following:

- Earlier initiation of ART at CD4 count ≤500 cells/mm^3
- Provision of ART for those with HBV co-infection, regardless of CD4 count or clinical staging
- Initiation of ART for all HIV/TB co-infected patients
- Provision of ART for all children under 5 years, regardless of CD4 count or clinical staging
- Earlier ART initiation for children ≥ 5 years at CD4 count ≤500 cells/mm^3 regardless of clinical staging

GOAL 3: Reducing the number of new TB infections, as well as the number of TB deaths by 50%

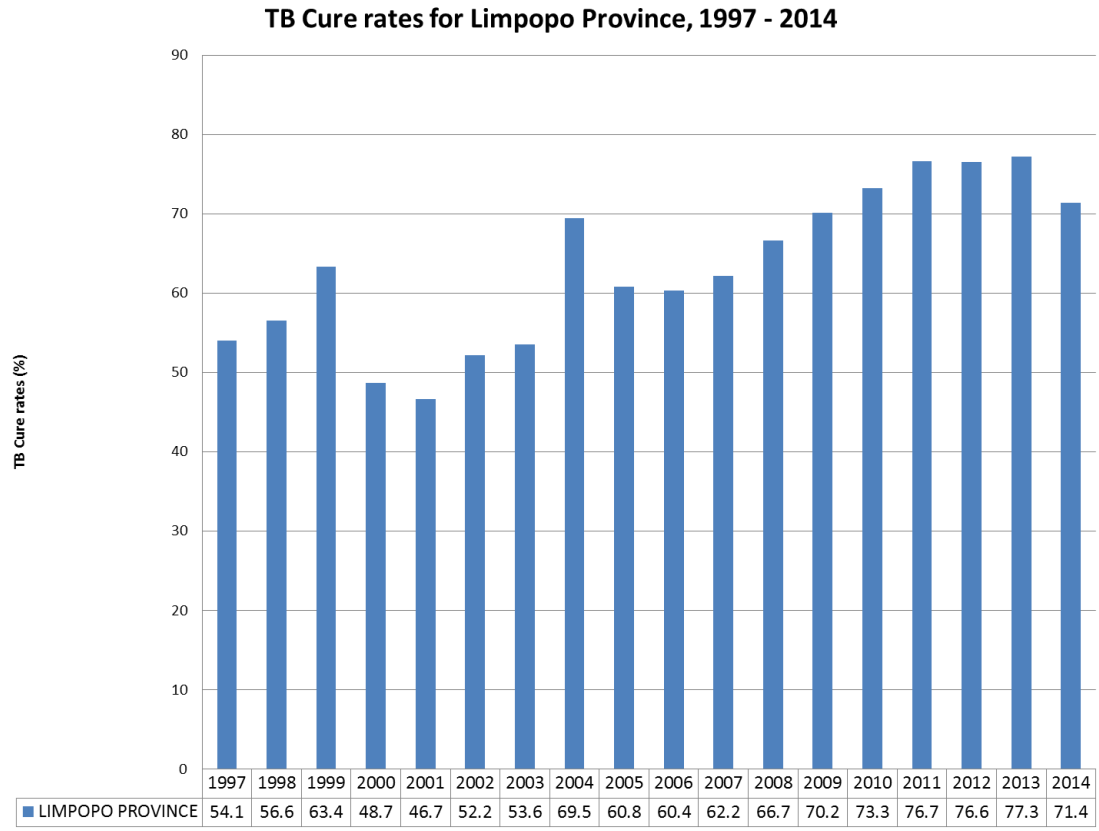
Limpopo's TB cure rate is estimated to be 75.3%, an achievement slightly above the national average of 74.2% in 2013 but reduced by 11.3% to 64.0 in 2014/15. Although TB remains the number one leading cause of death among South Africans (8.8% of all deaths), the death rate associated with TB decreased from 97 to 76 deaths per 100,000 population from 2000 to 2013. Those who died as a result of TB were at 11.1% in 2014/15 which puts Limpopo at second highest position across the country. Treatment success rate reached (77.5% ETR) (57.6% (DHB) and in the financial year 2014/15 the target for Limpopo Province was 77%. In the 2013/14 financial year 2013/14, the actual performance was 78.4%.

Expanded programmes of monitoring TB patients and initiating them early on treatment to improve patient outcomes are required in Limpopo. The lost to follow-up rate is the lowest across the country. Lost to follow up is an important indicator in ensuring early diagnosis, timely initiation on treatment, and adherence to treatment. Although Limpopo Province is slowly approaching the national target of 82%, considerable effort will be needed to assist National efforts in achieving the international target of 85% as set by the WHO, and the target of 90% approved by the following countries': Brazil, Russia, India, China and South Africa (BRICS) ministers of health in December 2014.

The BRICS ministers also agreed to cooperate on scientific research and innovations on diagnostics and treatment, including drug resistance and service delivery of TB. On the commemoration of World TB day on 24 March 2015, the Deputy President Cyril Ramaphosa launched "the largest tuberculosis screening campaign yet seen in South Africa"; as a first step towards this ambitious strategy. In its first year, TB screening campaign will focus on six priority districts, which are linked to mines and peri-mining communities: Sekhukhune and Waterberg in Limpopo Province (LP). In addition, at least 135 000 inmates in correctional facilities and up to half a million mineworkers will be screened in the first year.

With the widespread roll-out of GeneXpert diagnostic machines through the country, many patients are diagnosed as having DR-TB at their first clinic visit. This not only enables the early initiation of appropriate therapy, but has exposed the increasing burden of DR-TB, which may have contributed slightly to the decline in number of patients with drug-sensitive TB.

Figure 3: TB Cure rate for Limpopo Province 1997-2014



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
LIMPOPO PROVINCE	54.1	56.6	63.4	48.7	46.7	52.2	53.6	69.5	60.8	60.4	62.2	66.7	70.2	73.3	76.7	76.6	77.3	71.4

GOAL 4: Ensuring an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the NSP

Chapter 2 of the South African Constitution makes provision for the protection and promotion of human rights and obliges the state to ensure the realisation of such rights particularly for specific vulnerable groups. These rights include amongst others, the rights to equality, dignity, life, freedom, privacy and security of the person, irrespective of sexual orientation. In line with this provision, the Limpopo province emphasised the need for implementing intervention which are targeted at key populations such as truck drivers, farm workers, and commercial sex workers, among others.

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

The stigma index is the indicator for measuring this goal. The stigma index indicator was not tracked by the DHIS in the Province; during the period under review. The Province through the guidance of SANAC was driving efforts to implement the stigma index with the aim of monitoring efforts to reduce stigma and discrimination. Government Sectors, Civil Society and Local government departments continued to implement stigma and discriminating reduction programmes in line with the PSP goals and objectives.

Table 3: NSP/PSP Impact indicators, 2013/14 - 2014/15

Indicator	FY 2014/15 Status
HIV prevalence among women and men aged 15-24	3.1%
HIV prevalence in key populations	
HIV Incidence	20.3%
TB incidence	327/100 000[5] (ETR 340/100 000)
TB Mortality	11.1%[6]
HIV mortality	5.5%
MTCT rate ***(6 weeks and 18-months)***	6 Weeks 2.02% [7] 18 Months 2.04%
Stigma Index	
Patients alive and on treatment	(Increase 12 506) 232 506)[7]

[5] Naomi Massyn et al. District Health Barometer 2014/15. South Africa: Health system Trust. 2015
[6]Limpopo Department of Health TB Annual report 2014/15 (Unpublished)
[7]Limpopo Department of Health HIV and Sexually Transmitted Infections (HAS) annual report 2014/15 (Unpublished).

ASSESSING PROGRESS MADE TOWARDS ACHIEVING PSP 2012 – 2016 STRATEGIC OBJECTIVES

Strategic objective 1: Address social and structural drivers of HIV, STI and TB prevention, care and impact

Social and structural approaches address the social, economic, political, cultural and environmental factors that lead to increased vulnerability. As pointed out in the NSP, every government department at national, provincial and municipal levels has a critical role to play in addressing the structural factors driving HIV and TB. With a cumulative total of 22 independent development plans (IDPs) developed by different sectors mainstreaming HIV, TB and STIs, Limpopo province is on track to meet its target by 2016. In line with the human rights provision of the Constitution of South Africa as well as strategic objective 4 of the PSP, the Limpopo province also reached out to under-privileged communities in informal settlements providing HIV and TB services. By the end of 2014/15 year, the province had reached its target of 100% which was sustained from previous financial year 2013/14.

In terms of orphans and vulnerable children (OVC) school attendance, the province was at 55% by 2012/13 year and managed to achieve 100% (7267/7167) in 2014/15. Spending on HIV/TB was also on track for the province. The province achieved 94% on HIV and 76% on TB Department of Health (DOH) spending for 2014/15, 99% Department of Social Development (DSD) and 33% Department of basic Education (DOE). Provincial Treasury developed a strategy to assist and monitor DOE on HIV spending.

In 2014/15, 10547 women and children versus a target of 17 000 reported gender-based violence (GBV) against them to the police.

Table 4: NSP Strategic Objective 1: Address social and structural drivers of HIV, STI and TB prevention, care and impact

Indicator	Baseline	Target 2016	FY 2014/15 Status	Comment – progress towards target
% government departments and sectors with operational plans with HIV, TB and related gender and rights based dimension integrated	22 IDPs 5 APPs	30 IDPs 12 APPs (100%)	20 IDPs 11 APPs	There are sectors that are not active
% municipalities with at least one informal settlement where targeted comprehensive HIV, STI and TB services are implemented	100%	100%	80%	One district did not respond to this indicator
Current school attendance among orphans and among non-orphans aged 10 -14 (UNGASS 12; MDG Indicator)	6 469	100%	7 267 (100%)	There is still a need of Department of Social Development and Department of Education to work together to improve reporting
Delivery rates for women under 18- NIDS	7.9	7%	7.5% (9 599/128 587)	Low utilization of reproductive services by youth
HIV and TB spend	90 DOH	DOH 98% DSD 100% DOE 90%	DOH 96.4% (HIV 94% & TB 76%) DSD 98.1% DOE 30.1%)	Provincial Treasury to assist Department of Education to utilize the budget appropriately
Number of women and children reporting gender-based violence (GBV) to the police in the last year	6 423	17 000	10 547	There is incidence of non-reporting by victims in the Province
Proportion of women who have experienced physical or sexual violence in the last year	6 423	17 000	10 547	SAPS still need more support for reporting by LPAC

Gaps and Challenges

- Sexual assault survivors not completing ARV prophylaxis, however, the Province is collaborating with the Department of Social Development to manage the situation.
- The Province has few Thuthuzela centres to manage victims comprehensively. Some victims of sexual assault not reporting the incidences

Table 5: PSP Strategic Objective 1: Address social and structural drivers of HIV, STI and TB prevention care and impact

INDICATOR	TARGET	PROGRESS	CHALLENGES	INTERVENTIONS
Number of GBV Action Plans developed.	**30 Municipalities**	**15** **50%**	Lack of capacity to develop GBV Action plans at municipality level.	SALGA to provide support to Municipalities.
Number of government officials trained on GBV.	**12 000**	**213** **1.8 %**	Poor coordination due to lack of Secretariat unit.	AIDS Council Secretariat unit established in the Office of the Premier to strengthen coordination.
Number of victims of crime accessed VEP services at sites.	**17 000**	**10 547** **62%**	Poor coordination due to lack of Secretariat unit.	AIDS Council Secretariat unit established in the Office of the Premier to strengthen coordination.
Number of children and peer education groups trained.	**2 700**	**984** **36.4%**	Poor coordination due to lack of Secretariat unit.	AIDS Council Secretariat unit established in the Office of the Premier to strengthen coordination.
Number of key populations reached.	**100 000**	**58 508** **58.5%**	Poor coordination due to lack of Secretariat unit.	AIDS Council Secretariat unit established in the Office of the Premier to strengthen coordination.

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

"Targeted, evidence-based combination prevention is needed to achieve the long-term goal of zero new HIV, STI and TB infections. Focusing prevention efforts in high transmission areas and on key populations is likely to have the greatest impact, whilst simultaneously sustaining efforts in the general population[5]." A Combination Prevention approach acknowledges that no prevention intervention on its own 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[6].

As indicated in the introductory section of this report; a combination of factors including the HCT campaign launched in 2010 and outreach programmes targeted at specific vulnerable populations contributed to the achievements under this indicator. With a target of reaching 1 118 126 people with HCT services by the end of 2016, the province reached 2 873 346 people who were counselled and 2 833 827 out of 2 873 346 people counselled were tested. This implies that the target was achieved by 257% by the end of 2014/15 year. The Province targeted 70% (2000 000) for the number of people screened for TB, and 6 671 850 people were screened for TB during the reporting period. It should be noted that there is an integration of health services in the province.

Reach of HCT Programme and TB Screening in the province

HIV treatment guidelines state that all HIV positive but TB negative people should be initiated on IPT to prevent them from developing active TB disease. Limpopo Province set a cumulative target of 60,000 on this indicator for the period under review, and 54 436 (90%) people were initiated on IPT in 2014/15. Condom use among the age group 15-24 remained low in the province. An achievement of 39.3%

[5] SANAC. National strategic plan on HIV, STIs and TB 2012-2016. Pretoria: SANAC; 2011.

[6] SANAC. National strategic plan on HIV, STIs and TB 2012-2016. Pretoria: SANAC; 2011.

is below the baseline value of 40%. This is an area where the province needs to improve on. This trend in performance is observed again for indicators on young women and men having sexual intercourse before the age of 15 and having multiple sexual partners. Performance on these indicators remained below the baseline values[7].

Reach of male condom distribution

In terms of male condom distribution, the province targeted to distribute 79 530 000 condoms by the end of 2015/16 financial year but managed to distribute 72 983 620 by 2014/15. This was over targeting by National Dept. of Health; hence the National Dept. of Health needs to review and set realistic targets. It should be noted that there was a shortage of male condoms supplied by service providers. However, the province distributed 1 838 720 of female condoms during the 2014/15 financial year.

Reach of Male medical circumcision

The Voluntary Male Medical Circumcision (VMMC) Policy of South Africa indicates that there is a need to upscale this programme and reach more men as this is regarded as one of the effective strategies to reduce HIV transmission amongst men by 60%. By the end of 2014/15 67 205 (cumulative) males were medically circumcised.

A total of 70,000 people were reached with prevention communication at least twice a year against a target of 20,000; during the period under review. This indicates that the province was effective in increasing its reach to the target population; which may explain it's over achievement in most of its indicators. The province reached 157 449 people with prevention communication by the end of 2014/15 financial year.

[7] LPAC & LDoH Annual report 2014/15

Table 6: NSP Strategic Objective 2: Prevention of new HIV and TB Infections

Indicator	Baseline	Target 2016	FY 2014/15 Achieved	Comment – progress towards target
Number (and percentage) of men and women 15–49 counselled and tested for HIV	Counselled= 1 161 960	Number (and percentage) of men and women 15–49 counselled and tested for HIV	Counselled= 1 161 960	Number (and percentage) of men and women 15–49 counselled and tested for HIV
Number and percentage of people screened for TB	5 627 509	2000 000 (70%)	6 67 1 850	TB screening at mines, farms, correctional services and schools is the area of concern
Number of newly diagnosed HIV positive people started on IPT for latent TB infection	33 464	43 188	54 436	Although target is reached there is a need to strengthen reporting by facilities e.g hospitals
Male condom distribution	52 166 855	79 530 000	72 983 620	Shortage of male condoms supply by service provider
Female condom distribution	1 499 593	1 728 000	1 838 720	Under-target with multiple suppliers of female condoms
Number of men medically circumcised	48 784	250 000	67 205	Shortage of male condoms supply
Number of people reached by prevention communication at least twice a year	70 447	55 000	157 449	The Province exceeded target

Table 7: PSP Strategic Objective 2: Prevention of new HIV and TB Infections

INDICATOR	TARGET	PROGRESS	CHALLENGES	INTERVENTIONS
Number of campaigns conducted in farming communities.	350	**270** **77.1%**	Poor coordination due to lack of Secretariat unit.	AIDS Council Secretariat unit established in the Office of the Premier to strengthen coordination.
Number and percentage of Grade 8 learners benefiting from ISHP.	19 753 / 98 768 20%	**10 175 / 98 768** **52%**	Shortage of School health teams at District level.	Department of Health to work in collaboration with Department of Education to maximize the utilisation of resources.
Number of male condoms distributed.	105 000 000	**72 983 620** **69.5%**	Insufficient supply of male condoms by service providers.	Male condoms have been supplied by the service providers.
Percentage of HIV exposed babies tested for HIV at 18 months.	**100%**	**64.4%**	Patients not adhering to follow-up sessions.	Intensify campaigns and encourage patients to adhere to follow-up sessions.
Number of newly diagnosed HIV positive clients who are given IPT for latent TB infections.	121 292	54 436 45%	Poor coordination due to lack of Secretariat unit.	AIDS Council Secretariat unit established in the Office of the Premier to strengthen coordination.

Major Achievements

There are 326 HTA intervention sites in Limpopo. The HTA are monitored by 397 HTA peer educators. Health promotion and education, together with male and female condoms and materials are distributed at the HTA sites and hot spots areas. During the period under review,

- A total of 1 499 593 female condoms were distributed and these exceeded the target.
- About 23 595 babies were given Nevirapine within 72 hours after birth and exceeded the target by giving 95% of babies, this influenced the programme outcome of reducing mother to child transmission to 2.2%.
- A total number of 16 745 ANC clients were initiated on life-long ART and this exceeded the target by 11 745:
- A total of 123 901 women volunteered for HIV test.

Gaps and Challenges

Not all contracted condom suppliers were willing to register on the Limpopo Province data base and this caused a delay in placing orders. In addition, condom usage is not measured frequently which could also assist in determining the protection rate.

Strategic objective 3: Sustaining health and wellness

As part of their contribution to the work of Health Data Advisory and Co-ordination Committee (HDACC), the Medical Research Council (MRC) of South Africa and the School of Actuarial Sciences at the University of Cape Town (UCT), released data from the Rapid Mortality Surveillance (RMS) System on four key outcome indicators for South Africa in August 2012. The data reflected that the life expectancy of South Africans increased from 56.5 years in 2009 to 60 years in 2011 and the status was at 61.5 years in 2014. The Infant Mortality Rate (IMR) decreased from 40 deaths per 1000 live births in 2009 to 30 deaths per 1000 live births in 2011 and further reduced to 23.6 in 2013; and the Under-5 Mortality Rate decreased from 56 deaths per 1000 live births in 2009 to 42 deaths per 1000 live births in 2011, 37.5 in 2012 and reduced to 34.3 2013. These achievements far exceeded the targets set for 2014 in the NSDA of the Health Sector for 2010 to 2014 but the province was still far from reaching MDG goal target of 20 by 2015.

Control and management of Tuberculosis in the province

Based on data obtained from the ETR.Net system, the Limpopo Province TB programme has been largely successful. Inter-sectoral collaboration is very crucial towards winning the battle against the scourge of HIV and AIDS, TB and STI. At sub-national level this need to be elevated for the purpose of monitoring and evaluation of HIV and TB programmatic activities as well as reducing infection rates and the related burden of diseases affecting our communities. For the percentage of people per year becoming eligible who receive ART, the province attained 90% towards the 2016 target of 188,410. TB case registration rate provincial target was 90% (19 000). The province is also on track to reach a target of 19,000 TB case detection by 2016 as the province reached over 94% (17 837) of the target 2014/15 financial year.

The Province made steady progress with regards to TB management. Table 8 below also shows that the smear positive successfully treated cases have been consistent at around 76% (4475/5907), an achievement above the baseline values. However, the case fatality increased from a baseline of 8.6% to the highest of 11.1%. The causes of deaths related to

TB need to be investigated so that appropriate and targeted interventions can be developed and implemented for improved patient outcomes.

Data in table 8 also supports an earlier observation made in the province, through successful integration of HIV and TB in its programming. From the TB entry point, the percentage of TB patients testing for HIV was 92.3% in 2013/14 and increased to 94% in 2014/15 which is above the target of 90%. This also indicates the integration in implementation of HIV and TB co-infection strategy.

Table 8: Strategic Objective 3: NSP Sustaining health and wellness

Indicator	Baseline	Target 2016	FY 2014/15 Achieved	Comment – progress towards target
Proportion (%) of people per year becoming eligible who receive ART	47 612	50 000	79 524	Exceeded Target
TB case registration rate			7.4% (18 367/247 759)	
TB case detection rate	17 713 not in rate	19 000	48% (8 795/18 367)	Need fast tracking
% smear positive TB cases that are successfully treated	78.4	77%	77.5%	Target to be reach by end of PSP 2016/17
TB case fatality rate (CFR)	8.4	8%	11.1% (2 159/18 499) (ETR & DHB)	
CFR HIV-positive = CFR HIV-negative			6278/11 176=448/1566 (ETR)	
Number and % of registered TB patients who tested for HIV	92.3	92%	94% (ETR & DHB)	Exceeded target
Number of all newly registered TB patients who are HIV-positive, expressed as a proportion of all newly registered TB patients			11299/18 367 (61.5%) (ETR)	Need to be fast tracked

Table 9: Strategic Objective 3: PSP Sustaining health and wellness

INDICATOR	TARGET	PROGRESS	CHALLENGES	INTERVENTIONS
TB incidence rate	150/100 000	327**/100 000**	Survey not conducted to identify the causes of incidence rate in Waterberg, Sekhukhune and Vhembe Districts due to lack of funds.	Conduct the survey in the next financial year 2015/16.
Number of households visited by Home Community Based Carers (HCBC) with referrals made to clinics.	**1 855 000**	1 371 544 74%	insufficient coordination due to lack of Secretariat unit.	AIDS Council Secretariat unit established in the Office of the Premier to strengthen coordination.

Gaps and Challenges

- Physical structures of various public health facilities are inadequate to conduct HCT and integrate CCMT into Primary Health Care (PHC) facilities.

- Limited clinic space in some PHC facilities limit the implementation of quality comprehensive HIV, TB and STIs programme

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

The constitution of South Africa is founded on the realisation of rights to equality, dignity, life, freedom, privacy and security of a person. The primary area of focus for the Province is to ensure that HIV and TB infected patients gain access to health services and that people's rights are not violated when interventions are being implemented. This objective upholds the rights of people living with HIV in making choices related to fertility, decriminalisation of sex work, access to sexual and reproductive health for women and girls, provision of quality health care services to patients regardless of HIV status, gender and sexual orientation.

Gaps and Challenges

- Under-reporting of activities conducted on reducing HIV and TB discrimination in the workplace and communities by sectors.
- Stigma index is not measured on monthly basis

MONITORING AND EVALUATION

Lessons learnt from previous plans are that strategic plans are implemented over years and monitoring and evaluation must form part of the process to provide reports on progress as needed. The M&E function has to be embedded in the Plan to ensure continuous monitoring, which influences data driven decision making.

Monitoring and Evaluation of the PSP

The implementation of the PSP is being tracked and thus, a detailed Provincial monitoring and evaluation framework for PSP was developed. This document is providing the necessary steps for effective tracking of progress and it also guides the development of district and local monitoring and evaluation systems. The coordination of M&E activities is a central function of the Limpopo Provincial AIDS council and its channels to ensure compliance with standardised policies and guidelines.

All activities and initiatives arising from the PSP are subjected to rigorous monitoring and evaluation to ensure effectiveness, accountability and mutual learning. There is need to have clarity on the following:

- Reporting level and data flow
- The roles and responsibilities of stakeholders in HIV/TB M&E

- The roles and responsibilities of LPAC,DAC and LAC
- The roles and responsibilities of District M&E focal person
- The roles and responsibilities of Government Department and other public Institutions /Organization's Focal person
- The roles and responsibilities of other Stakeholders

Major Achievements

- Functional M & E unit at LPAC Secretariat unit
- All sectors are reporting using a specified tool

Gaps and Challenges

- During the current reporting period, the Province did not have the sub-district HIV, AIDS, STIs and TB (HAST) structure both health and local municipalities.
- The HAST programme was still regarded as a purely health concern rather than a developmental issue and departments were working in silos. This practice led to minimal participation of some government departments and key figures in the Department of Health.
- The Provincial AIDS Council was fully functional however, District and Local AIDS councils were not fully functional and need capacity development in order to provide strategic leadership to HAST programme.
- There was poor capacity among local structures for implementation and monitoring of the HIV & STIs and TB strategies outlined in the PSP.
- Programme ownership was still a challenge and HIV, STI & TB was seen as a vertical programme by most sectors.
- An under-developed sub-district information management system compromised the quality of data received from facilities e.g. incompleteness of data and lack of information management system from Social Development.
- There was a challenge to develop a system in place to collect HAST related data from the private sector.
- Political change caused a negative impact to the implementation of HAST programme at Municipalities
- The Province was unable to conduct Provincial Strategic Plan for HIV, STI and TB Mid-Term review to identify gaps and challenges

Recommendations

- A number of indicators need to be reviewed to ensure that they are measurable; namely:
    - Proportion of Women experienced sexual assault
    - Current school attendance among orphans and among non-orphans aged 10 -14 years in order to be measurable.
    - Ensuring protection of human rights and improving access to justice
- To increase reporting on stigma and discrimination, there is need to sensitize departments. In addition, community awareness at public launches, local media etc. should be intensified and supported by Political Leaders to improve knowledge about stigma and discrimination activities.
- There is a need for the development of a central data management system for LPAC to access data from all sectors, districts and locals to ensure comprehensive reporting in a timely manner.

OVERALL CONCLUSION

- Multisectoral response should form part of performance area of all government structures including municipalities
- The creation of LPAC which is a Strategic Directorate in the Province has enhanced HAST Programme Management, Coordination, monitoring and reporting