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Retention in Care

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Decreasing Behaviours that put Men and Women aged 15-49 years at risk of HIV/AIDS, STI and TB
Infant Delivery rates for women under 18

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HIV and TB Screening
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Male Medical Circumcision
Sexually Transmitted Infection (STI)
Tuberculosis TB

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Acronyms

AGYW - Adolescent Girls and Young Women
ANC - Antenatal Care
CCG - Community Care Givers
DHP - District Health Plans
EMTCT - Eliminating Mother to Child Transmission
EPI - Expanded Programme on Immunization
HAST - HIV and AIDS, STI and TB
HIV - Human Immune Deficiency Virus
HTA - High Transmission Areas
MMC - Male Medical Circumcision
MSM - Men having Sex with Men
MTCT - Mother to Child Transmission
NDP - National Development Plan
NIMART - Nurse initiated and Managed Antiretroviral Therapy
NSP - National Strategic Plan
OVC - Orphans and Vulnerable Children
OSS - Operation Sukuma Sakhe
PCR - Polymerase Chain Reaction
PICT - Provide Initiated Counselling and Testing
PLHIV - People Living with HIV
PSP - Provincial Strategic Plan
PTWG - Provincial Technical Working Group
STI - Sexually Transmitted Infections
ROR - Rationalisation of Registers
UTT - Universal Test and Treat
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EXECUTIVE SUMMARY

Estimates indicate 1.7 million people living with HIV (PLHIV) in the province; this equates to about 26% of the estimated number of PLHIV in the country. According to the annual sentinel survey reports, the HIV prevalence among women attending ante-natal clinics in the province was consistently above the national average for a considerable period of time. This report details the performance and the activities for the period financial year 2015/2016.

Below is a summary of the provincial performance:

- **Orphans and Vulnerable Children:** Quarterly provincial revealed 49% of the estimated orphans and vulnerable children had been registered by March 2016 opposed to the targeted estimate of 35% 2014/15.
- **Prevention of mother to child transmission (PMTCT):** Significant progress in the reduction on infant positivity at around 6 weeks to 1.2% and the province is on course to eliminating mother to child transmission. This is coupled with progress on the HIV anti-body test rate at around 18 months, the initiating of eligible mothers on Highly Active Antiretroviral Therapy (HAART) and on early booking. Maternal and infant deaths remained a challenge.
- **Tuberculosis (TB):** Progress recorded on TB outcomes such as the TB cure rate, case finding registration and the fatality rate. Progress was made in early detection and initiating treatment and the integration of HIV/TB.
- **Medical Male Circumcision (MMC):** As per the last review in 2014/15, MMC coverage of 30% was low, however, there was five-fold increase in the number of males medically circumcised post baseline.
- **Condoms Distribution:** Numbers decreased in 2015/16, 54.5% were distributed as opposed to 92% in 2014/15 which could be attributed to the delay in appointment of district level service providers.

*Comprehensive Antiretroviral Therapy (ART) Services:* Provincial success recorded 1 084 712 patients remaining on ART by end of March 2016. The KZN DoH together with developing partners, invested in a number of ways such as capacity building for health care workers and human resources to improve access and the quality of TB, HIV and AIDS service provision. 60% where 89% of adults who

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1. Source: Provincial syntheses report 2015/16
2. Source: DHIS June 2016

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were aware of their HIV positive status are on ART. A large percentage of patients on ART were known to be on treatment after 12 months.

4. INTRODUCTION

OVERVIEW
This report reflects implementation of the PSP during the period 2015/16 where various stakeholders made interventions in response to the KZN PSP 2012-2016. The current report highlights: the provincial response to HIV and AIDS, Sexually Transmitted infections (STIs) and Tuberculosis (TB); an overview of the progress on the status of the implementation of the PSP during the period 2015-2016, and provides a snapshot of the performance on the PSP indicators aligned to the NSP indicators

Background of the KZN PSP 2012 – 2016
The KwaZulu-Natal Provincial HIV and AIDS, Sexually Transmitted Infections (STIs) and Tuberculosis (TB) Plan (PSP) 2012-2016 sets out the broad strategic direction for the multi-sectoral approach over the specified five-year period. The PSP is the framework within which multisectoral response initiatives are implemented by different stakeholders in the Province. The PSP forms the basis for measuring progress of the provincial response and also acts as a strategic plan for implementation. The provincial response to HIV and AIDS, STIs and TB is linked to the wider development efforts at international, national and provincial levels. For this reason, the KZN PSP 2012-2016 was developed in the context of a number of global, national and provincial developmental commitments. It is aligned to the NSP 2012–2016, the National Development Plan (NDP) vision 2030 and the KZN Provincial Growth and Development Strategy (PGDS).

The goal of the PSP is to provide strategic guidance to the provincial response to HIV and AIDS, STIs and TB is a framework within which various initiatives will be implemented by different stakeholders in the province. It forms the basis for measuring progress in the provincial response.

The strategic objectives of the plan are as follows:
• Addressing social and structural drivers of HIV, STIs and TB prevention,
• Prevention of new HIV, STIs and TB infections,
• Sustaining health & wellness,
• Ensuring protection of human rights and improving access to justice, and
• Coordination, monitoring & evaluation

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The four strategic objectives of the PSP are similar to those of the NSP. The fifth strategic objective contained in the PSP is coordination, monitoring and evaluation which specifically applies to the KZN province. Responding to the need to keep strengthening the coordination, monitoring and evaluation function, provincial stakeholders resolved to elevate this as a separate strategic objective in the PSP.

5. ASSESSMENT OF PSP PROGRESS AGAINST THE FIVE MAIN GOALS OF THE NSP/PSP

Goal 1
Reducing new HIV infections by at least 50% using combination prevention approaches - The PSP objectives for this goal are as follows:

- **To reduce risk of mother to child transmission (MTCT) of HIV to less than 1% by 2016** - This objective seeks to eliminate transmission of HIV from mother to child. This includes ensuring that all hard to reach populations such as the farm workers and migrants receive the full range of PMTCT services.

- **To scale up medical male circumcision (MMC) services to 80% of males aged 0 to 49 years by 2016** - The PSP proposes scaling up MMC in KZN as an additional intervention that can contribute positively to reducing the incidence and prevalence of HIV. This objective is intending to mobilise both men and parents to come forward or bring their children for MMC.

- **To ensure that 80% of STI infected men and women receive early and appropriate treatment by 2016** - The main strategies to be used in achieving the objective as creating community awareness on the need to seek early treatment for STIs, expanding access of STI services to key populations and improving the capacity of the health system to effectively carry out contact tracing and provide friendly services.

- **To ensure that 80% of men and women aged 15 to 49 years know their HIV status and receive TB screening by 2016** - The PSP indicates that implementation of HCT should be through the PHC package services by strengthening referrals and linkages between services (male circumcision, HIV/TB, PMTCT, mental health).

- **To increase access to early detection, diagnosis and early treatment of TB to 80% of exposed people by 2016** - This objective aims to improve prevention efforts to reduce new infections through reducing exposure, early case finding, treatment and case holding. One of the
intervention to this objective is Community outreach and mobilisation on TB. This intervention intends to create awareness on TB and HIV co-infection using the War Room and community field workers.

To ensure that 100% of men and women aged 15 to 49 years have access to condoms by 2016 - This objective is to ensure that there is adequate access to and promotion of both male and female condoms. Advocate for access to condoms being improved and vigorously promoted.

The HIV prevalence rate amongst clients aged 15-49 years decreased from 13% (in 2013/14), 12.2% (in 2014/15) to 11.0% (in 2015/16). In the face of the epidemic, KwaZulu-Natal had consistently responded to HIV & AIDS, through numerous initiatives, namely: pronouncements, cabinet resolutions and implementation of policies and plans. The response to HIV & AIDS endured several programmatic transformations, to mainly keep abreast with the emerging issues aimed at eradicating HIV & AIDS and social ills. The response further shifted from being a purely health focussed initiative to being multi-sectoral with the inclusion of sexually transmitted infections, tuberculosis and social ills.

According to Thembisa model estimates, the percentage of HIV prevalence among men and women between aged 15-24 was 10.9% in the province, new cases were 1.81% in 2015. DHIS data indicated that the province was successful in eliminating mother to child transmission at 1.2% in this reporting period on MTCT rate around 6 weeks. During the period under review, KZN had the biggest treatment programme in the country. As per DHIS data 1 084 712 patients were alive and on treatment.

Table 1 below indicates the status on impact indicators during the reporting period 2015/2016

<table>
<thead>
<tr>
<th>Indicator</th>
<th>FY 2015/16 Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV prevalence among women and men aged 15-24</td>
<td>10.9%²</td>
</tr>
<tr>
<td>HIV prevalence in key populations</td>
<td>No data available</td>
</tr>
<tr>
<td>HIV Incidence</td>
<td>0.78%³</td>
</tr>
<tr>
<td>HIV mortality</td>
<td>32 683 ⁴</td>
</tr>
<tr>
<td>MTCT rate (around 6 weeks)</td>
<td>1.2⁵</td>
</tr>
<tr>
<td>Patients alive and on treatment</td>
<td>1 084 712⁶</td>
</tr>
</tbody>
</table>

¹ KZN Evaluation Report for the CCMT
² Source: Thembisa Model
³ Source: Thembisa Model
⁴ Source: EPI data
⁵ Source: DHIS 2015/16
⁶ Tier.Net 2016
Reducing the risk of mother to child transmission

One of the most successful interventions in the province was the decline in mother to child transmission from 1.3% in 2014/2015, to 1.2% in 2015/2016.\(^1\)

*Table* 2 below indicates a success rate of mother to child transmission rate during the period 2014/2015 to 2015/2016. The trend indicates that the province almost reached the set target of below 1% reduction of PMTCT; during the period under review. King Cetshwayo, uMkhanyakude and uThukela were the districts with rate reductions of below 1% in 2015/2016 Amajuba and uMgungundlovu were above the set target in 2015/2016 and both districts slightly increased the MTCT rate. The findings indicate that both districts require close monitoring.

*Table 2: Breakdown on District MTCT rate at 6 Weeks*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Amajuba</td>
<td>1.0</td>
<td>1.9</td>
</tr>
<tr>
<td>eThekwini</td>
<td>1.1</td>
<td>1.3</td>
</tr>
<tr>
<td>Harry Gwala</td>
<td>1.5</td>
<td>1.1</td>
</tr>
<tr>
<td>iLembe</td>
<td>1.5</td>
<td>1.2</td>
</tr>
<tr>
<td>King Cetshwayo</td>
<td>1.4</td>
<td>0.8</td>
</tr>
<tr>
<td>Ugu</td>
<td>1.6</td>
<td>1.4</td>
</tr>
<tr>
<td>uMgungundlovu</td>
<td>0.8</td>
<td>1.6</td>
</tr>
<tr>
<td>uMkhanyakude</td>
<td>1.2</td>
<td>0.5</td>
</tr>
<tr>
<td>UMzinyathi</td>
<td>1.2</td>
<td>1.2</td>
</tr>
<tr>
<td>uThukela</td>
<td>1.2</td>
<td>0.8</td>
</tr>
<tr>
<td>Zululand</td>
<td>2.4</td>
<td>1.5</td>
</tr>
<tr>
<td>Province</td>
<td>1.3</td>
<td>1.2</td>
</tr>
</tbody>
</table>

*Source: DHIS June 2016*

Goal 2

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

This goal focuses on both improving the quality of care and expanding access to those who need and are eligible for treatment. The PSP states the need to strengthen follow up, management of treatment failure and drug toxicities for better quality of care for those in need.

ART Coverage

KZN had the largest ART programme in the country during the period under review. A total of 772 health facilities (587 fixed PHC clinics, 22 CHCs, 60 hospitals and 103 mobiles)\(^1\) were rendering ART

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\(^1\) Source: DHIS June 2016
services in 2015/16, with an extensive decentralised ART program increased the coverage and adherence.

**ART Initiation**
Access to HIV care was reviewed and all facilities were provided with initiation targets to improve facility based accountability

**Retention in Care**
According to Tier.Net June 2015/2016, 71.2% of patients (adults and children) were known to be on ART treatment 12 months after initiation.

**Goal 3**
*Reducing the number of new TB infections, as well as the number of TB deaths by 50%. The main interventions designed to achieve goal 3 are as follows:*

- **Advocate for greater integration of HIV and TB services** - This intervention involves advocating to policy makers, programme managers and implementers within government, civil society organisations and community leaders to commit to TB/HIV services integration.

- **Ensuring adherence to DOTS strategy guidelines and expansion of access to TB/HIV services** - This entails expanding TB diagnosis; care and treatment services to a variety of settings in order to increase the coverage of TB and HIV integrated services. These settings may include tertiary education institutions, prisons, and NGO-funded facilities, workplaces and community settings.

- **Strengthening social mobilisation on TB/HIV co-infection** - This intervention calls for use of targeted communication and social mobilisation to increase knowledge on TB, and the links with HIV and to ensure that all TB patients have DOTS supporters.

- **Strengthening follow up of patients and expanding community management of MDR TB** - This intervention involves promoting facility-based and community adherence strategies to ensure patients remain on TB treatment, monitoring and maintain quality standards for TB care and treatment services, including quality standards for community-based care and support, enhancing referral from community setting to health facilities and on to higher-

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1 DOH Annual report 2015/16

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level facilities if need be and establishing community-based management teams for MDR TB and expanding MDR TB treatment centres.

Figure 1 below indicates provincial trends on TB incidence and TB/HIV co-infection rates from 2011 to 2015. TB co-infection rate increased to 64%\(^1\) in 2015 compared to 62% in 2014. The increase co-infection rate can be viewed as a positive result as there was intensified focus on TB/HIV integration and screening of TB at both HIV entry level and TB entry level. There was a decline of 678 / 100 000 population (60% per 100 000)\(^2\) of TB notification rate in 2015 compared to 808 / 100 000 population (62% per 100 000) in 2014. The TB notifications have declined by 130/ 100 000 during the reporting period. These are the trends experienced globally.

![Figure 1: Trends in TB Incidence and TB/HIV co-infection rates](source: KZN DoH Programme Data/ETR March 2016)

**Goal 4**

*Ensuring an accessible legal framework that protects and promotes human rights in order to support implementation of the NSP.*

This goal deals with vulnerabilities due to factors that are influenced by human rights, policies, legal environment and social norms. Access to health care services is a fundamental right enshrined in the constitution of South Africa. These vulnerabilities include stigma and discrimination, gender inequality, gender violence, and other forms of discrimination, and

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\(^1\) Source: ETR.Net 2016  
\(^2\) Source: ETR.Net 2016
are amenable to changes in social norms; enforcement of laws and policies through proactive leadership.

KZN received a total amount of $31,676,308 (USD) from the Global Fund. The purpose of the funding was as to: implement prevention programmes for different populations such as adolescents and youth, in and out of school youth, sex workers and their clients, men who have sex with Men (MSM) and transgendered (TGs); this includes treatment, care and support and Community System Strengthening (CSS). Grant implementation was anticipated to commence by April 2016 following the signing of the grant. Organisations identified to work under the auspices of the global fund grant were: the NDoH, NGOs (Kheth’impilo, Soul City, NACOSA, AIDS Foundation of SA and Right to Care) and Right to Care.

The KZN Province was selected to implement the Determined, Resilient, Empowered, AIDS-free, Mentored and Safe (DREAMS Programme. The DREAMS Programme is a PEPFAR initiative, which has commenced in the following districts: eThekwini, UMgungundlovu and UMkhanyakude. These districts were identified for DREAMS intervention due to the high prevalence presented in the districts. The criteria for district selection used was: high incidence for females 10-24, population size and density for females 10-24, absolute number of PLHIV, teenage pregnancy rates for girls under 18, number of orphans, a combination of rural and urban areas, presence of informal settlements, level of migration, proximity of national transport routes, major trading centres, and economic hubs. The target population for the programme aimed at Adolescent Girls & Young Women (AGYW) identified through working with the existing structures and systems included local health and welfare services, community, non-governmental and faith-based organizations, as well as through schools. The province started working with districts and local partners to carry out size estimation and mapping activities to identify the target populations. Each province appointed a provincial coordinator for the programme.

Goal 5

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

This goal involves strengthening society at all levels to publicly promote the human rights and speak out against stigma, discrimination and related behaviours to create a more equal society.
Evidence suggesting strong political commitment and leadership towards equality for all, anti-marginalisation, anti-gender-based violence and elimination of all forms of stigma and discrimination was reported on, however, it also revealed an absence of advocacy package to promote human rights, positive societal values and norms that could be used by leaders for advocacy.

6. PROGRESS ASSESSMENT TOWARDS ACHIEVING PSP 2012-2016 STRATEGIC OBJECTIVES

Below is a summary of the status of Provincial Council on AIDS (PCA) key indicators. Data is derived from District AIDS Councils reports, submitted to the PCA secretariat. The summary also includes key NSP indicators, reported to SANAC by the PCA secretariat. The summary is categorized according to strategic objective and presentation of progress using graphs and tables to indicate the likelihood of the target being achieved or not.

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

Increasing access to quality of care and support

During the implementation of the KZN PSP (2012-2016); the province aimed at increasing access to quality care and support to at least 90% of its Orphans & Vulnerable Children (OVC). In order to achieve this, it was necessary that OVC were registered, linked to care and then tracked. Half (50%) 1 of the estimated OVC were registered during the reporting period. This implied that 21% more OVC were registered between the baseline 2011/12 and 2015/16 period. 55% 2 of the registered OVC were given care and support by 2015/16.

Child-Headed Households were supported through Learner Support Agents. Home visits were conducted, particularly for learners from child-headed households where they were checked for any conditions which needed immediate attention at their respective homes. They were then linked to local operation Sukuma Sakhe structures in order for these child-headed households to receive the necessary support.

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1 Provincial Multisectoral Annual syntheses report 2015/16
2 Provincial Multisectoral Annual syntheses report 2015/16
Table 3 below indicates, Harry Gwala; Amajuba and uMgungundlovu were the districts with the highest percentage of registered OVC; (over 50% of their estimated OVC). The remaining 8 districts registered less than 50% of their estimated OVC. During the current reporting period, Zululand, uMkhanyakude, eThekwini and uMzinyathi were the districts with the lowest registered OVC.

Table 3: Breakdown on number of OVC registered from 2012(start of new PSPS) to 2015/2016 (current reporting period)

<table>
<thead>
<tr>
<th>District</th>
<th>Estimated Number of OVC</th>
<th>Total Registered 2012-FY2014/2015</th>
<th>% Registered from 2012 - FY2015/2016</th>
<th>Total Registered 2012-FY2015/2016</th>
<th>% Registered from 2012 to FY2015/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amajuba</td>
<td>47186</td>
<td>26063</td>
<td>55%</td>
<td>42143</td>
<td>89%</td>
</tr>
<tr>
<td>eThekwini</td>
<td>322597</td>
<td>73372</td>
<td>23%</td>
<td>102011</td>
<td>32%</td>
</tr>
<tr>
<td>Harry Gwala</td>
<td>56815</td>
<td>46483</td>
<td>82%</td>
<td>55648</td>
<td>97%</td>
</tr>
<tr>
<td>iLembe</td>
<td>43335</td>
<td>13269</td>
<td>31%</td>
<td>17830</td>
<td>41%</td>
</tr>
<tr>
<td>King Cetshwayo</td>
<td>84742</td>
<td>34241</td>
<td>40%</td>
<td>36214</td>
<td>43%</td>
</tr>
<tr>
<td>Ugu</td>
<td>67409</td>
<td>24066</td>
<td>36%</td>
<td>25981</td>
<td>39%</td>
</tr>
<tr>
<td>uMgungundlovu</td>
<td>95335</td>
<td>48271</td>
<td>51%</td>
<td>77525</td>
<td>81%</td>
</tr>
<tr>
<td>uMkhanyakude</td>
<td>58741</td>
<td>7157</td>
<td>12%</td>
<td>10644</td>
<td>18%</td>
</tr>
<tr>
<td>uMzinyathi</td>
<td>48149</td>
<td>13019</td>
<td>27%</td>
<td>18381</td>
<td>38%</td>
</tr>
<tr>
<td>uThukela</td>
<td>62594</td>
<td>14089</td>
<td>23%</td>
<td>22377</td>
<td>36%</td>
</tr>
<tr>
<td>Zululand</td>
<td>74854</td>
<td>6615</td>
<td>9%</td>
<td>20606</td>
<td>28%</td>
</tr>
<tr>
<td>Province</td>
<td>961757</td>
<td>306645</td>
<td>35%</td>
<td>429360</td>
<td>49%</td>
</tr>
</tbody>
</table>

Source: Provincial Multisectoral report: June 2016

Survey based data on the following indicators was not available during the current reporting period since the last survey was done in 2012.

- Women and men aged 15 to 49 years with more than one sexual partner over a period of 12 months
- Women and men age 15 to 49 that had more than one sexual partner over a period of 12 months reporting use of condom during their last sexual intercourse
- The percentage of respondents aged 15 years and older who reported “using a condom every time“ with their most recent partner was 30.9%, those indicating “using a condom almost every time“ was 5%, while those who stated “using a condom sometimes“ was 13.9%. Those who reported that they never used a condom totaled 50%.
- Women and men aged between 15 to 24 years who correctly identified ways of preventing sexual transmission of HIV: 30% of women and men aged 15 to 24 years in 2008. The HSRC Behaviour Survey 2012 indicated this to be 24.4% in 2012. The PSP end term target was 90%.

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2 HSRC Behaviour Survey 2012
3 HSRC Behaviour Survey 2012
Women and men aged between 15 to 24 years who had sexual intercourse before 15 years: women and men aged between 15 to 24 years was 4.9% at baseline (2009). The PSP end term target was less than 2.5%. The HSRC Behaviour Survey 2012 findings showed the figure to be 7.6%.

Decreasing Behaviours that put Men and Women aged 15-49 years at risk of HIV/AIDS, STI and TB.

According to Department of Basic Education (DoBE) provincial annual report 2015/16, the number of learner pregnancies remained high 10 201\(^1\) in KZN for the period 2015/2016 as compared to 2014 at 10 213 and 11 200in 2013. The issue of learner pregnancy is impacted by a host of contributing factors which are not restricted to the school context. Factors such as misrepresentation of traditional and religious practices and beliefs (amalawu, ukugaxa, ukuthwala, ukuboniswa) these are cultural beliefs where young girls are being forced by cultural beliefs. According to Thembisa model prevalence in females aged 15-24 in 2015 is 16.4\(^2\) and males aged 15-24 in 2015 is 5.4\(^3\)

Condom supply became a challenge in the KZN province, as a result of no contract being drawn up with condom distributors. Condoms at non-traditional sites (outside health facilities) were therefore limited e.g. taverns, spaza shops, non-governmental organisations and other departments. The process of adjudication and advertising of condom service providers’ contract was under way during the period under review. Commodities for various districts were ordered from suppliers nationally. Once the process of adjudication is finalised the service providers will have targets for distribution both in traditional (health facilities) and non-traditional outlets.

*Figure 2* below indicates the number of learner pregnancies per district from 2013 to 2015. The learner pregnancy increased over three years. Despite the programs implemented for learners on health education and sexuality such as My Life My future campaign, Peer Education Programme and Soul Buddies programme in 2015 there was no substantial improvement of learner pregnancy in 2015 as learner pregnancy was at 10 201

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1 DoBE Provincial Annual Report
2 Source: Thembisa Model
3 Source: Thembisa Model
Infant Delivery rates for women under 18

The percentage of infant deliveries under 18 years in public health facilities reduced by 0.2% between 2014/15 (8.9%) and 2015/16 (8.7%). The end term target was 8.5%. This target is likely to be achieved in the end term (2016/17) of the PSP, although there was minimal improvement in the performance of the previous reporting periods.

Strategic Objective 1: Addressing Social and Cultural Drivers of HIV, AIDS, STI Prevention, Care & Support

In the strategic objective 1 the PSP is aiming to increase access to quality care and support to at least 90% of the OVC by 2016. Also to decrease behaviours that put men and women aged 15 to 49 years at risk of HAST by 80% through implementation of focussed programmes by 2016.

Table 4 below provides progress on the strategic objectives 1 key indicators.

Table 4: Strategic Objective 1 indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Target 2016</th>
<th>FY 2015/16 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>Data not Available</td>
<td>Data not Available</td>
<td>Data not Available</td>
<td></td>
</tr>
</tbody>
</table>

1 Source: DHIS June 2016
<table>
<thead>
<tr>
<th>% municipalities with at least one informal settlement where targeted comprehensive HIV, STI and TB services are implemented</th>
<th>Data not Available</th>
<th>Data not Available</th>
<th>Data not Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current school attendance among orphans and among non-orphans aged 10 -14 (UNGASS 12; MDG Indicator)</td>
<td>Data not Available</td>
<td>Data not Available</td>
<td>Data not Available</td>
</tr>
<tr>
<td>Delivery rates for women under 18-NIDS</td>
<td>16886 (8.9%)</td>
<td>8.5%</td>
<td>8.7%</td>
</tr>
<tr>
<td>Strengthening of CCG’s in identifying pregnant women who do not attend ANC clinics and link them to care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learner Pregnancy</td>
<td>10213</td>
<td>Not available</td>
<td>10201</td>
</tr>
<tr>
<td>DoBE is working on strengthening the collaborative and committed efforts from all stakeholders.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV and TB spend</td>
<td>Target not available</td>
<td>11 529</td>
<td>No data available</td>
</tr>
<tr>
<td>Number of women and children reporting gender-based violence (GBV) to the police in the last year</td>
<td>Target not available</td>
<td>11 529</td>
<td>The number refers to sexual assault cases only</td>
</tr>
<tr>
<td>Proportion of women who have experienced physical or sexual violence in the last year</td>
<td>53 617</td>
<td>51,895</td>
<td>SAPS Report as Sexual offence cases include rape, compelled rape, sexual assault, incest, bestiality, statutory rape and sexual grooming of children. A decrease suggests that fewer people are reporting sexual offences. To strengthen community awareness and data use at all levels</td>
</tr>
<tr>
<td>% of OVC receiving care and support</td>
<td>44%</td>
<td>55%</td>
<td>Coordination and systems of reporting OVC in the province need to be strengthened and more effective way of accounting for the OVC to be implemented</td>
</tr>
</tbody>
</table>

Source: DHIS June 2016, District quarterly reports March 2015/16,

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

This strategic objective refers to adequate investment in prevention and scaling up access to high quality and effective interventions targeted at all the key populations. Interventions focuses on both sexual and vertical transmission of HAST geared towards key populations. This objective has interventions that are addressing the drivers of HIV, STI and TB infections among young people, as well as perceptions of personal risk and promoting risk avoidance.

---

1 Source: SAPS Report 2015/16
HIV and TB Screening

The total number of 2 367 331 males and females were tested for HIV in the 12 months ending March 2016, which represented an overachievement of 123% of the annual target for the Financial Year 2015/16.

Table 5 below indicates that 4 out of the 11 districts did not meet the HIV testing targets. However, 7 out of the 11 districts exceeded their targets in the current reporting period.

Table: 5 Status on key indicators (HIV Counselling and Testing) for strategic objective 2

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Amajuba</td>
<td>125141</td>
<td>159 497</td>
<td>127%</td>
<td>101 691</td>
<td>128 392</td>
<td>126%</td>
</tr>
<tr>
<td>eThekwini</td>
<td>890 662</td>
<td>749 466</td>
<td>84%</td>
<td>743 471</td>
<td>863 322</td>
<td>116%</td>
</tr>
<tr>
<td>Harry Gwala</td>
<td>116 645</td>
<td>151 479</td>
<td>130%</td>
<td>89 341</td>
<td>128 335</td>
<td>144%</td>
</tr>
<tr>
<td>iLembe</td>
<td>151 346</td>
<td>143 553</td>
<td>95%</td>
<td>130 095</td>
<td>107 648</td>
<td>83%</td>
</tr>
<tr>
<td>King Cetshwayo</td>
<td>232 733</td>
<td>237 091</td>
<td>102%</td>
<td>176 072</td>
<td>130 949</td>
<td>74%</td>
</tr>
<tr>
<td>uGu</td>
<td>181 416</td>
<td>225 600</td>
<td>124%</td>
<td>140 050</td>
<td>160 993</td>
<td>115%</td>
</tr>
<tr>
<td>uMgungundlovu</td>
<td>261 459</td>
<td>263 405</td>
<td>101%</td>
<td>222 509</td>
<td>402 362</td>
<td>181%</td>
</tr>
<tr>
<td>uMkhanyakude</td>
<td>148 330</td>
<td>149 079</td>
<td>101%</td>
<td>118 225</td>
<td>802 94</td>
<td>68%</td>
</tr>
<tr>
<td>uMzinyathi</td>
<td>115 231</td>
<td>201 551</td>
<td>175%</td>
<td>96 569</td>
<td>146 197</td>
<td>151%</td>
</tr>
<tr>
<td>uThukela</td>
<td>164 023</td>
<td>152 446</td>
<td>93%</td>
<td>132 126</td>
<td>90 175</td>
<td>68%</td>
</tr>
<tr>
<td>Zululand</td>
<td>197 444</td>
<td>218 131</td>
<td>110%</td>
<td>157 701</td>
<td>128 664</td>
<td>82%</td>
</tr>
<tr>
<td>Province</td>
<td>258 4430</td>
<td>2 651 298</td>
<td>103%</td>
<td>2 107 850</td>
<td>2 367 331</td>
<td>112%</td>
</tr>
</tbody>
</table>

Source of Data: June 2016

Ensuring that 100% of men and women aged 15-49 had access to condoms

The province achieved 85% of the distribution targets for male condoms and above 100% (167%) for female condoms.

Figure 3 indicates provincial performance of male condoms distributed against set targets. The province was not able to reach the set target during reporting period. The lower than expected output was mainly due to delays with approval of a new contract for the procurement of condom distributors.

---

1 Source: DHIS June 2016
2 Source: DHIS 2016
3 Source: DHIS June 2016
Figure 3: Provincial Male Condoms Distributed in 2015/2016

Figure 4 indicates provincial performance of female condoms distributed against set targets, the province achieved 167% of the set targets target. The targets are viewed as low than the sexually active population this concern was raised with the National Department of Health (NDoH) however, targets remained unchanged as they are a given from NDoH

Figure 4: Provincial Female Condoms Distributed in 2015/2016

1 Source: DHIS June 2016
Male Medical Circumcision
The Province did not reach the targets set for the MMC indicator. Performance was at 23% ¹ of the target; indicating no improvement in performance compared to 23% performed in 2014/2015. The Province developed the Medical Male Circumcision (MMC) turnaround strategy in an attempt to improving MMC. Isibaya Samadoda continued to integrate behaviour modification in HIV prevention. The coverage involved local government structures and Amakhosi together with traditional councils. Greater stakeholder engagement was achieved whereby all partners recommitted to provide support for improving MMC in the province.

The stakeholder engagement further committed to quality MMC by partaking in the establishment of Provincial Technical Working Group (PTWG) that identified all MMC issues in the province. Massive camps and men friendly services have been initiated they are expected to explore further areas of improving MMC uptake. Development partners supported Community Based HIV Testing Services and offered a door to door personal testing service.

In an MMC hosted stakeholders’ meeting in January 2016, aimed at shifting MMC service delivery from provincial level to the local level (ward); through the involvement of medical managers and facility managers at ward level. All circumcised males are inaugurated (Ukubuthwa) annually by His Majesty, the King. The inauguration ceremony was part of behaviour change for young men who will graduated to manhood. About 1 700 males attended uMkhosi Woselwa in December 2015. UMkhosi Woselwa is the inauguration ceremony whereby males, (especially young men) that have been circumcised attend as part of celebrations and are then taught on lifestyle issues and behavioural change.

Figure 5 indicates performance of the province against the set targets in the two reporting periods. It should be noted that, there was no improvement in the performance for both periods (2014/15 and 2015/16) in which an achievement of 23% of the set targets was evident.

¹ Source: DHIS June 2016
Sexually Transmitted Infection (STI)

The STI incidence remained high in the province as depicted by the high number of new STI treated episodes. A total of 418 758\(^1\) new STI’s were treated in 2015/16. The STI incidence (STI treated new episode incidence (annualised) remained high at 57.4/1000\(^2\). This indicator was important to monitor the spread, identification and treatment of STIs as it measured the percentage of the population 15 years and older treated for a new episode of an STI in public health facilities.

Tuberculosis TB

TB new client treatment success rate was consistent against the set target of 85% with a performance of 84.5%\(^3\) in 2015/2016 and 85.3% in 2014/15. The province has improved in clinical management and compliance with TB MDR policies and guidelines.

Table 6 below indicates the performance for the reporting period 2015/16 looking at the trends of performance compared with baseline and targets

---

1. Source: DHIS June 2016
2. Source: DHIS June 2016
Table 6: Strategic Objective-2 indicators

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number (and percentage) of men and women 15–49 counselled and tested for HIV</td>
<td>2 005 920</td>
<td>2 659 268</td>
<td>2 627 796 (incl. ANC)</td>
<td>98% towards achievement.</td>
</tr>
<tr>
<td>HIV prevalence amongst client tested 15-49 years rate (%)</td>
<td>13.0%</td>
<td>No target available</td>
<td>1 893 689(excl. ANC) 12.2%</td>
<td>Improved results compared to 2014/15 can be ascribed to scaling up of HIV integrated services at community level</td>
</tr>
<tr>
<td>Number and percentage of people screened for TB</td>
<td>3 437 595/23 085 064</td>
<td>35%</td>
<td>6 491 562/25 561 315</td>
<td>Improved results compared to 2014/15 can be ascribed to intensified focus on TB prevention and screening as part of the 90-90-90 Strategy implementation.</td>
</tr>
<tr>
<td>TB symptom 5 years and older screened rate</td>
<td>15%</td>
<td>25%</td>
<td>20%</td>
<td>Reporting at facility level improved with reviewed TB data flow</td>
</tr>
<tr>
<td>Number of newly diagnosed HIV positive people started on IPT for latent TB infection (HIV positive new client initiated on IPT rate)</td>
<td>148 983</td>
<td>214 069</td>
<td>101 903</td>
<td>48% towards target</td>
</tr>
<tr>
<td>Number of newly diagnosed HIV positive people started on IPT for latent TB infection (HIV positive new client initiated on IPT rate)</td>
<td>65.4%</td>
<td>No target available</td>
<td>79.7%</td>
<td>Intensified approach on TB/HIV integration</td>
</tr>
<tr>
<td>Infant 1st PCR test positive around 6 weeks rate (%)</td>
<td>1.3%</td>
<td>&lt; 1.4%</td>
<td>1.2%</td>
<td>Change of indicator to “PCR test positive around 10 weeks” mid-year (NDOH directive) influenced capturing of the indicator negatively. This has since been corrected.</td>
</tr>
<tr>
<td>Infant rapid HIV test around 18 months positive rate (%)</td>
<td>1.1%</td>
<td>&lt;1.4%²</td>
<td>0.9%</td>
<td>The target was achieved but this data does not give the correct picture as universal testing is done for all children at 18 months, including those who were not HIV exposed</td>
</tr>
<tr>
<td>Percentage men and women aged 15–24 reporting the use of a condom with their sexual partner at last sex</td>
<td>Data not available</td>
<td>Data not available</td>
<td>Data not available</td>
<td>Data not available</td>
</tr>
<tr>
<td>Male condom distribution</td>
<td>195 852 357 (92%)</td>
<td>212 000 008 (61.8%)</td>
<td>184 431 641 (54.5%)</td>
<td>The process of adjudication and advertising of condom service provider’s contract was under way. This was expected to eliminate the shortage condoms in districts.</td>
</tr>
<tr>
<td>Male condoms distributed per male</td>
<td>55</td>
<td>52</td>
<td>Coverage was expected to increase in 2016/17 as condom distributors were to be appointed at district levels</td>
<td></td>
</tr>
</tbody>
</table>

1 DOH PIDS/NIDS element name is HIV test client 15-49 years
2 90 90 90 Target
Female Condom Distribution

<table>
<thead>
<tr>
<th></th>
<th>5 594 474</th>
<th>3 539 954</th>
<th>5 770 644</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance above target viewed as a positive result.</td>
<td></td>
<td></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>Data not available</td>
<td></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>Data not available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New STI episodes treated</td>
<td>442 568</td>
<td>435 790</td>
<td>418 758</td>
</tr>
<tr>
<td>STI Incidence</td>
<td>61.7/1 000</td>
<td>60/1 000</td>
<td>57.4/1000</td>
</tr>
<tr>
<td>Scaling up of HIV/AIDS prevention initiatives by identifying missed opportunities for STI assessment at facility level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance below target can be viewed as a positive result.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensified identifying of missed opportunities for STI assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of men medically circumcised</td>
<td>133 172</td>
<td>187 618¹</td>
<td>124 086</td>
</tr>
<tr>
<td>66% towards target.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of people reached by prevention communication at least twice a year</td>
<td>Data not available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of sexually assault cases</td>
<td>11 611</td>
<td>12 450</td>
<td></td>
</tr>
<tr>
<td>To strengthen data use at levels especially Wards Levels and War Rooms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children under 12 Sexually Assaulted Cases</td>
<td>Data not available, indicator of number of sexually assaulted cases is inclusive of children under 12</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Strategic Objective 3: Sustaining Health and Wellness

**Comprehensive ART services:** The objective is to ensure that at least 90% of HIV infected people had access to treatment and support, remained adherent to treatment and maintained optimum health. The expected outcome was that 100% of all eligible HIV-positive people had access to appropriate ART treatment by 2016 and 90% of all HIV-positive people on ART remain adherent by 2016. 97.6% of eligible antenatal women were initiated on ART during the reporting period; increasing from 82.7% in 2014/15.
According to Tier.Net data 2015/16 the total number of patients remaining in care (as at end of March 2016) was 1 084 712. Patients known to be on treatment 12 months after ART initiation was at 71.2% and 27.5% \(^1\) were lost to follow up.

Table 7 below illustrates the performance of districts in the last two reporting periods 2014/2015 and 2015/2016 on the total adults and children who remained in care. UMgungundlovu district followed by King Cetshwayo District reported the highest numbers towards achieving annual targets.

Table 7: Breakdown on District performance on Total ART Patients Remaining in Care – Adults and Children

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Amajuba</td>
<td>38 903</td>
<td>41272</td>
<td>106</td>
<td>57 290</td>
<td>45739</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>eThekwini</td>
<td>297 530</td>
<td>309119</td>
<td>104</td>
<td>380 650</td>
<td>346253</td>
<td>91</td>
<td></td>
</tr>
<tr>
<td>Harry Gwala</td>
<td>39 423</td>
<td>41540</td>
<td>105</td>
<td>57 830</td>
<td>46655</td>
<td>81</td>
<td></td>
</tr>
<tr>
<td>iLembe</td>
<td>47 908</td>
<td>51406</td>
<td>107</td>
<td>71 140</td>
<td>59354</td>
<td>83</td>
<td></td>
</tr>
<tr>
<td>King Cetshwayo</td>
<td>89 508</td>
<td>91013</td>
<td>102</td>
<td>102 450</td>
<td>98366</td>
<td>96</td>
<td></td>
</tr>
<tr>
<td>uGu</td>
<td>64 362</td>
<td>67432</td>
<td>105</td>
<td>95 560</td>
<td>76414</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>uMgungundlovu</td>
<td>97 645</td>
<td>121135</td>
<td>124</td>
<td>142 730</td>
<td>141667</td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>uMkhanyakude</td>
<td>62 369</td>
<td>66359</td>
<td>106</td>
<td>94 770</td>
<td>71510</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>uMzinyathi</td>
<td>42 452</td>
<td>44194</td>
<td>104</td>
<td>96 630</td>
<td>49497</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>uThukela</td>
<td>51 829</td>
<td>55769</td>
<td>108</td>
<td>76 880</td>
<td>63318</td>
<td>82</td>
<td></td>
</tr>
<tr>
<td>Zululand</td>
<td>72 349</td>
<td>78268</td>
<td>108</td>
<td>100 270</td>
<td>85939</td>
<td>86</td>
<td></td>
</tr>
<tr>
<td><strong>Province</strong></td>
<td><strong>904 278</strong></td>
<td><strong>967507</strong></td>
<td>107</td>
<td><strong>1 276 200</strong></td>
<td><strong>1084712</strong></td>
<td>85</td>
<td></td>
</tr>
</tbody>
</table>


Improved access to ART was made possible through the Nurse initiated and Managed Antiretroviral Therapy (NIMART). There was a total of 1 332 nurses who were initiating ART at PHC level but still waiting for certification during the period under review. The target for Antiretroviral treatment initiation for 2015/16 was 237 646, and the province initiated a total of 204 104. This was made up of 197 961 adults and 6 143 children. The new ART initiating guidelines came into effect in the last quarter of 2014/15. This resulted in an upward trend in the last quarter as compared to the previous quarters as reflected in Figure 6 below.

\(^1\) Source: Tier.Net 2016
Figure 6: Total ART new initiations – Adults and Children

![Total ART New Initiations in 2015/16](image)

Source: Tier.Net

**Table 8** The table has key indicators for strategic objectives 3, which was Sustaining health and wellness. The table indicates performance for the current reporting period 2015/16 looking at the trends of performance compared with baseline which was 2014/15 and targets for the reporting period.

**Table 8: Strategic Objectives-3 indicators**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline 2014/2015</th>
<th>Targets 2015/2016</th>
<th>Achieved FY 2015/16</th>
<th>Comments – progress towards targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion (%) of people per year becoming eligible who receive ART</td>
<td></td>
<td></td>
<td></td>
<td>Data not available</td>
</tr>
<tr>
<td>HIV positive adult (15 years and older) patients eligible for ART starting ART rate (%)</td>
<td>110.1</td>
<td>180 323</td>
<td>204 104</td>
<td>There was Sub-optimal tracking and linkage of eligible patients to care after the Policy change for initiation of patients on ART with CD4 count 500 and below.</td>
</tr>
<tr>
<td>HIV positive children under 15 years eligible for ART starting ART rate (%)</td>
<td>90.3%</td>
<td>90.0%</td>
<td>93.3%</td>
<td>Special focus on paediatric care for children under the age of 15 years was receiving particular focus.</td>
</tr>
<tr>
<td>Patients alive and on treatment (Total Remaining on ART)</td>
<td>949 339</td>
<td>1 273 724</td>
<td>1 059 193</td>
<td>All 11 districts submitted monthly reports detailing poor performing facilities and remedial actions.</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>---------</td>
<td>-----------</td>
<td>-----------</td>
<td>------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>TB case registration rate</td>
<td>87 518</td>
<td></td>
<td>73318</td>
<td>TB Case registration was in absolute numbers not a rate</td>
</tr>
<tr>
<td>TB case detection rate</td>
<td>808</td>
<td></td>
<td>678</td>
<td>To increase the number of TB tracing teams at community level</td>
</tr>
<tr>
<td>% smear positive TB cases that are successfully treated</td>
<td>85.3%</td>
<td>85%</td>
<td>84.5%</td>
<td>To strengthen and improve clinical management and compliance with TB MDR policies and Guidelines.</td>
</tr>
<tr>
<td>TB case fatality rate (CFR)</td>
<td></td>
<td></td>
<td></td>
<td>TB programme indicated that this indicator is not measured. TB programme monitor death rate as a proxy indicator</td>
</tr>
<tr>
<td>CFR HIV-positive = CFR HIV-negative</td>
<td></td>
<td></td>
<td></td>
<td>TB Programme reported that the indicator is not collected</td>
</tr>
<tr>
<td>Number and % of registered TB patients who tested for HIV</td>
<td>61.8%</td>
<td></td>
<td>63.9%</td>
<td>The indicator available is TB Co-infected patients for 1 year behind reporting (Q2/2013 – Q1/2014 and Q2/2014 – Q1/2015)</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></td>
<td></td>
<td></td>
<td>TB programme indicated that this indicator is not measured. TB programme monitor Proportion of all TB patients known to be HIV positive</td>
</tr>
</tbody>
</table>

Source: TIER.Net and ETR.Net June 2016
Strategic Objective 4: Ensuring protection of human rights and improving access to justice

Ensuring Protection of Human Rights and Access to Justice was mostly unavailable thus making determination of progress difficult. This does not imply that this strategic objective was not implemented but less attention was placed on its implementation relative to the other strategic objectives.

The sector for People Living with HIV and AIDS was launched in 9 districts and the sector submitted the implementation plan in the PCA. The plan was well received, the PCA Chairperson urged all stakeholders to support this sector in implementing the plan.

Religious Leaders and Traditional Healers were trained on HIV and AIDS.

Women’s sector representatives participated in the ring study focus group discussions, sponsored by SANAC women’s sector. The women’s sector in eThekwini received a donation of 5 000 sanitary towels for distribution to young girls in schools. The donation will be scaled up to cover other municipalities in the next financial year. The sector placed the orders through the PCA deputy chair and chairperson of civil society.

Civil society was involved in various protests and remained vigilant, for example, in uThungulu district they protested against a person who was arrested for selling ARVs. The suspect was ordered to appear in court and received R7000 bail. Civil Society also protested when 27 children were raped by a teacher in the Ilembe District, and marched to court in order to voice their concerns for the growing crisis of young children being sexually assaulted. They also protested for those cases that were not finalized some with dockets that had gone missing.

The National World AIDS Day (WAD) event was hosted in UGU District which was a huge success through collaboration by all stakeholders as well as the use of the OSS approach.
8. MONITORING AND EVALUATION

8.1 Overview of the Provincial M&E system

Coordination of the response towards the three epidemics rested with the Office of the Premier, an office whose mandate includes governance and coordination of all government programmes in the Province. The directorate is responsible for among others ensuring that coordination of the response is realised through the following structures: The Provincial Council on AIDS (PCA), the district and local municipalities AIDS councils (DACs & LACs) and the Ward AIDS Committees (WACs). During the period under review, the province had 890 AIDS councils.

The HIV and AIDS directorate which falls under Priority programmes in the Office of the Premier collaborated with a number of partners in the province. The purpose of the collaboration was to strengthen M&E particularly in improving multisectoral data collection and the utilization at local level to improve program performance.

*Strengthening coordination and management & monitoring & evaluation systems*

The HIV and AIDS directorate with the Provincial AIDS guidance has put systems in place for information management such as the multi sectoral standard operation procedure for reporting and the standardised multisectoral reporting tool. These tools were established to ensure that submitted data was of good quality and could be used to make decisions based on the multisectoral response towards meeting the NSP targets.

Coordination, monitoring and evaluation at the lower level coordinating structures remained generally poor, during the period under review. Only 44% (22/50) Local AIDS Councils met the requirement of reporting to District AIDS Councils. Likewise, 19% of the Ward AIDS Committees reported to Local AIDS Councils as generally poor.

8.2 CHALLENGES IN THE IMPLEMENTATION OF THE PROVINCIAL M&E SYSTEM

The province experienced challenges which made it difficult for the HIV and AIDS directorate to timeously submit quality and complete data to the national office. Some of the challenges faced during the period under review were: data quality issues (data inconsistency), discrepancy in district quarterly reports (from different sources such as DHIS, ETR, TIER.Net etc.), as well as late reporting by districts, local AIDS council and Ward AIDS councils. Poor data verification and validation at different levels of data collection and reporting was evident.
Poor synchronization of data from the High Transmission Areas (HTA) intervention sites that were led by developmental partners. General observation by the Provincial Council on AIDS was non-participation in district meetings by Local Mayors and Councillors in LAC and DAC. The other challenge across most districts was poor reporting by sectors/departments and lack of reporting on learner pregnancies to the DAC by the department of education.

8.3 Remedial Action
There was a need to strengthen the effectiveness of the information system for community based data as this posed a challenge in appropriate analysis of value for money and impact of community based services on health and social ills services and outcomes. For example, the health data for the reporting period was incomplete and not linked with specific health facility catchment populations to inform trend analysis per catchment area and impact of outreach on specific communities.

There was a need for the provincial data management for health to create an ORG. Unit (which allows capturing data sets in the DHIS) for HTA data set. The ORG Unit will allow for outreach data generated by development partners on key populations to be captured in the system. There was a need to strengthen monitoring and reporting at all levels of care to inform evidence-based planning and decision-making.

To ensure that the Member of Executive Council (MEC) champions for each district are informed Mayors and Councillors in districts who were not leading the DAC and LAC meetings so that the relevant MEC Champion could monitor their respective districts in taking the lead in LAC’s and DAC’s meetings.

There was a need for the province to fast rack the process of implementing a multi-sectoral web-based information system that would be accessible to all interdepartmental spheres of government.

There was a need to improve the new key policy development such as the 90-90-90 Strategy for HIV, AIDS and TB. The strategy makes provision for new global targets. Implementation plans have been developed for all districts and the implementation plans need to be closely monitored at all levels on monthly bases (as low as facility level).
9. OVERVIEW OF GAPS AND CHALLENGES IN ACHIEVING THE STRATEGIC OBJECTIVES

9.1 Main findings
To further improve antenatal visits before 20 weeks, the Province rolled out pregnancy testing by Community Care Givers (CCGs) at household level in all districts. Orientation of CCGs on how to do testing was in progress during the period under review. Pregnant women and new mothers were linked to CCG’s to ensure follow up and support. This programme was still in infancy stage it will be further rolled out in the next financial year.

Child-Headed Households were supported through Learner Support Agents. Home visits were conducted, particularly for learners from child-headed households where they were checked for any conditions which needed immediate attention at their respective homes. They were then linked to local operation Sukuma Sakhe structures in order for these child-headed households to receive the necessary support.

The target for HIV Testing for 2015/16 was 2 107 815, and the performance was 2 627 796. Some of the strategies which could have led to the province reaching targets were: testing taking place outside health facilities, testing targeting most vulnerable groups’ e.g. key populations, including in institutions of higher learning, and services that include testing at taxi ranks. The province enhanced efforts to increase HIV testing through a number of initiatives. These included promotion of HCT services using community radio talk shows and taxi rank activations.

The PCR testing guidelines were changed in 2015/2016 from 6 weeks to 10 weeks. This increased the positivity rate. There were 893 (2%) positive PCR around 10 weeks out of 55 307 PCRs done at 10 weeks. High MTCT rate was noted amongst the high-risk category babies tested at 14 weeks at 3.1% (350/10977) compared to the 1.1% (521/44400) for the PCR at 10 weeks. The high-risk babies were to have been given NVP for 12 weeks and were part of this indicator. The major challenges were: late ANC booking, unbooked clients, client’s sero-converting during labour or delivery, non-adherent clients and unsafe infant feeding practices. Another challenge was that the reporting system was not able to segregate new PCR tests to confirmatory PCR tests. The system of cohort monitoring and use of unique patient identifier systems has been implemented as per EMTCT Last Mile Plan for South Africa in the next reporting period.

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1 Source: DHIS June 2016
2 Source: DHIS June 2016
3 Source: DHIS June 2016
The province embarked on innovative ways of dealing with increasing numbers of patients and addressing issues of congestion and waiting times. This was specifically to address the ever-increasing numbers of ART patients including other conditions like diabetes mellitus, hypertension etc. There were 445 active clubs during the reporting period.

The performance on percentage of people screened for TB is ascribed to intensified focus on TB prevention and screening in health facilities as part of the implementation of the 90-90-90 Strategy. Reporting at facility level improved with the TB data flow that was revised to allow for the capturing of TB screening data in the new Rationalisation of Registers (ROR) Tool at facility level.

9. 2 Challenges and Gaps
Although interventions for learners were in place, learner pregnancy was not reduced as anticipated. The issue of learner pregnancy was impacted factors which were not restricted to the school context factors, such as emergent culture of consumerism & materialism (blessers, misrepresentation of traditional and religious practices and beliefs (amalawu, ukugaza, ukuthwala, ukuboniswa) etc.

Learner pregnancy data source and reliability is a challenge as there is possible under-reporting due to the fact that DoE reported only statistics where learners had disclosed the pregnancy. There was however a possibility that many cases were not reported. The DoH reported all teenagers who were in and out of school, but who had attended Primary Health Care facilities. Learner pregnancy data needed to be triangulated with under 18 infant deliveries and school attendance among females to determine the extent of under-reporting.

There was high loss to follow up on ART which was mainly caused by cross boarder movement where patients moved in and out from other provinces to access treatment. The province is bordered by Mozambique, Swaziland, and Lesotho. There was also movement across provinces such as Eastern Cape, Mpumalanga, Free State and Gauteng.

Challenges relating to late ANC booking, unbooked clients, clients sero converting during labour or delivery, non-adherent clients and unsafe infant feeding practices. Segregating confirmatory PCR from the first PCR test was still a challenge during the period under review.

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1 DoH Annual Report 2015/16
10. CONCLUSION AND RECOMMENDATIONS

10.1. Recommendations

The Province had to intensify Universal voluntary counselling and testing followed by immediate initiation on ART for all those diagnosed HIV positive (UTT). It was envisaged that this approach had the potential to reduce HIV incidence dramatically. Testing and Treating all those who are HIV positive has the potential of a huge reduction in HIV incidence and reducing HIV related morbidity and mortality, could potentially eliminate HIV as a crisis in the province. The Province needs to ensure the decentralization of chronic clubs to community level where access will be brought even closer to the patients is fast tracked.

It was recommended that strategies on improving reporting and coordination systems for OVC within the DSD and its stakeholders be implemented to allow the province to have a more effective means of accounting for its OVC. Additionally, the department could consider strengthening its reporting systems for all its interventions as spelt out in the PSP.

The Provincial secretariat had to ensure that there was a political buy-in and a well-coordinated collaboration of influential people at all levels for prevention programs. Different approaches should be put in place, targeting males in non-medical sites to curb the spread of STI, HIV and AIDS. It was recommended to closely monitor districts performance towards their sets targets on 90-90-90 strategy for HIV, AIDS and TB in 2015/16.

The province needs to embark on massive campaigns and ensure that there are men friendly services focusing on exploring further areas of improving MMC uptake in the province. The Province needs to ensure a greater engagement with OSS structures to include MMC as a standing item in war room meetings.

The process of adjudication and advertising the condom service provider’s contract needs to be processed timely to avoid condoms stock out in the province.

There was a need to strengthen surveillance and enhance knowledge of STI epidemiology. This will be done through identifying and targeting key populations for STI control which are adolescents, younger populations and high risks groups.
There was a need to fast track geospatial mapping of infections and viral load of PLHWHIV in the province, to gain a better understanding of where the cases of infections are occurring. This will also help in knowing the prevalence of HIV by ward and understand if interventions are working for the province to allocate resources accordingly. Geospatially mapping will result in evidence-based prioritisation and a better understanding of drivers and risk at a local level. Approaches and interventions can be customised appropriately for local epidemic.

10.2. Conclusion
Implementation of progressive policies played a positive role on PMTCT. There was significant progress in the reduction of infant positivity at around 6 months and the province could be on course to eliminating mother to child transmission. This is coupled with the progress on the HIV antibody test rate at around 18 months, the initiation of eligible mothers on HAART and early booking, however, maternal and infant deaths remained a challenge.

The PSP noted that the ART programme recorded major successes over the five years period 2012-2015. ART programme recognised the challenges and issues that needed to be addressed in order to improve the quality of care of those on treatment. This included an addition to the already large number of patients on treatment due to revised eligibility criteria leading to e.g. challenges in effective follow-up.

Adherence clubs proved to be a success in dealing with facility decongestion as all stable patients were grouped voluntarily for routine check-ups and repeat collections were managed by a Lay Health Worker.

The province made positive strides in developing its coordination, monitoring and evaluation function. This was built upon what the province started years back through instituting the first ever review of its PSP, followed by development of a new PSP, in which its implementation was supported by developing a monitoring and evaluation system. This further complemented effective functionality of the Provincial Council on AIDS. From a provincial perspective, overall functionality of AIDS councils was reduced by 0.12%. Functionality was most poor among Ward AIDS Committees. Reporting is yet to fully trickle down to Local AIDS councils and Ward AIDS committees in the next financial year.

1 Source: Provincial annual syntheses report 2015/16
The province was not able to establish the entire ideal baseline data required within the PSP due to a number of factors including: the issue of alignment with implementing partner plans. However, the Province made considerable efforts in monitoring implementation of the PSP.
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