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ANNUAL PROGRESS REPORT 2015/16

PROVINCIAL STRATEGIC PLAN 2012-2016

MPUMALANGA PROVINCAL AIDS COUNCIL

Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AFB	Acid Fast Bacilli
ANC	Antenatal care
ART	Antiretroviral treatment
CFR	Case fatality rate
CRDP	Comprehensive Rural Development Plan
CSOs	Civil Society Organisations
DAC	District AIDS council
DHA	Department of Home Affairs
DHIS	District Health Information Systems
DHB	District Health Barometer
DOE	Department of Education
DoH	Department of Health
DOJ	Department of Justice
DR-TB	Drug resistant tuberculosis
DSD	Department of Social Development
GBV	Gender Based Violence
GIZ	Gessellschaft Internationale Zusammenarbeit
HCT	HIV counselling and testing
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
IDP	Integrated Development Plan
LAC	Local AIDS Council
M&E	Monitoring and evaluation
MDGs	Millennium Development Goals
MDR-TB	Multi-drug resistant tuberculosis
MIET	Media in Education Trust
MMC	Medical male circumcision

MPAC	Mpumalanga Provincial AIDS Council
MPMEU	Mpumalanga Monitoring and Evaluation Unit
MSM	Men who have sex with men
MTCT	Mother-to-child transmission
MTR	Mid-term review
NDOH	National Department of Health
NGOs	Non-governmental organisations
NIMART	Nurse-initiated management of ART
NSDA	Negotiated Service Delivery Agreements
NSP	National Strategic Plan
OVC	Orphans and Vulnerable Children
PCR	Polymerase chain reaction
PHC	Primary health care
PEP	Post-exposure prophylaxis
PEPFAR	President's Emergency plan for AIDS Relief
PICT	Provided Initiated Counselling and Testing
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child HIV transmission
PrEP	Pre-exposure prophylaxis
PSP	provincial Strategic Plan
SA	South Africa
SAHRC	South African Human Rights Commission
SANAC	South Africa National AIDS Council
SAPS	South African Police Services
SMART	Specific Measurable Achievable Result Orientated & Time framed
SRH	Sexual and reproductive health
Stats SA	Statistics South Africa
STI	Sexual transmitted infections
SW	Sex workers
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV and AIDS

UNGASS	United Nations General Assembly Special Session on HIV & AIDS
UTT	Universal test and treat
VMMC	Voluntary medical male circumcision
WAC	Ward AIDS Council
WHO	World Health Organization
XDR-TB	Extremely drug resistant TB

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EXECUTIVE SUMMARY

One of the major achievements for Mpumalanga on Strategic Objective (SO) 1 for the period 2015/2016 was the mainstreaming of HIV, STIs and TB by all government departments (Mpumalanga Department of Health Annual Report, 2015/2016) internally and externally. Political commitments that were made led to the revamping of structures such as District AIDS Councils (DACs), Local AIDS Councils (LACs) and some Ward AIDS Councils (WACs) in some localities. A total number of 18 functional LACs, 3 DACs and 102 out of 132 WACs in Ehlanzeni District were reported to be functional during the period under review. (Ehlanzeni District Annual Report, 2015/2016).

Achievements in the implementation of outreach programs include the promotion of information, education and communication through community dialogues and community campaigns by government departments, civil society and other sectors. Programmes implemented were to empower men and women, to address inequities and gender based violence and also included programs for girls and young women such as: the ZAZI Campaign for young girls and young women, Soul Buddyz, Keeping Girls in Schools, community dialogues on responsible lifestyles and the Women Empowerment Sessions programme (Mpumalanga Department of Education Annual Report 2015/2016).

The multi-sectoral response in mitigating socio-economic drivers of HIV, STIs and TB by government departments was a major achievement e.g. the Department of Education (DoH) in collaboration with the Departments of Home Affairs (DHA) and Social Development (DSD) assisted Orphaned and Vulnerable Children through Coordinated Service Delivery campaigns promoting access to government services.

The Polymerase Chain Reaction (PCR) positivity rate decreased from 2% to 1.7% (Annual Report DoH 2015/2016) and the 100% baby Nevirapine uptake from 2013 including the review period; in the facilities offering the services. Implementation of prevention programmes targeting key populations for example provision of pre-exposure prophylaxis (PREP) and post-exposure (PEP) to sex workers was also administered in the province. The percentage of people eligible for Anti-Retroviral Treatment (ART) increased beyond the new set target of 90% due to the adoption of the Universal Test and Treat (UTT) policy which states that people are to be initiated

on treatment regardless of their CD4 count, (Mpumalanga DoH Annual Report 2015/2016).

The number of patients remaining on ART treatment increased for both children and adults. Adherence clubs were established and ensured adherence and retention in ART treatment after five years of ART initiation. The training of health professionals and non-professionals on HIV, STIs and TB management exceeded expectation (Mpumalanga DoH Annual Report 2015/16 where 2 980 doctors were trained on HIV&AIDS, STIs and TB out of a target of only 280. The TB new smear positive cure rate was a major achievement, reaching 86.5% in 2016, exceeding the provincial target of 80%. The TB defaulter rate provincial targeted at 6%, declined to 5.4% in 2016. At 4.1%, the TB death rate reached the set target of < 6% in 2016 (DHIS, 2015/2016).

Management of sexual assault cases including provision of Post Exposure Prophylaxis (PEP) and finalisation of cases through the setting up of Thuthuzela Care Centres for the management of survivors of sexual assault increased, with qualified personnel working closely with Department of Justice (DOJ), DSD and other sectors (Mpumalanga DSD Annual Report 2015/2016). Service sites for victims of crime and violence were established across the province and employee sessions that included human rights and Gender Based Violence (GBV) were conducted at workplaces especially in the government departments.

The challenges experienced during the period under review included sub-optimal reporting on activities conducted by civil society, lack of optimal and meaningful participation from other sectors and government departments in DACs and LACs and lack of representation by decision making officials at DAC and LAC meetings.

Many community members lost interest in HIV Counselling and Testing (HCT) initiatives (Mpumalanga DoH Annual Report 2015/2016). Male and female condom distribution and recording was sub-optimal with some of the data on male condom distribution missing. Voluntary Medical Male Circumcision (VMMC) uptake data was inconsistent in 2016 and excluded traditional circumcisions at provincial level.

Delays in PCR results reaching health facilities from the National Health Laboratory Services (NHLS) laboratories negatively affected the PMTC programme i.e. clinical

decision-making including paediatric ART initiation (Mpumalanga, Department of Health Annual Report 2015/2016).

The DR-TB regimen had many adverse effects resulting in DR-TB patient defaulting and death rate remaining high at 4.5% in 2016 (DHIS, 2015/2016). Inadequate capturing of HIV positive Antenatal (ANC) clients initiated on ART as per the new ART guidelines (Mpumalanga Department of Health Annual Report 2015/2016). Key populations were not adequately included in programmes and the definition of GBV was not clear to many, which led to incorrect reporting on GBV issues even with key departments such as the South African Police Services (SAPS).

In light of these challenges Mpumalanga Provincial AIDS Council (MPAC) recommended reintroduction and re-establishment of the Nerve Centres. Nerve centres will provide direction to all stakeholders, enhance communication and information sharing to strengthen the M&E activities. There is need to strengthen internal mainstreaming, especially workplace programs to reduce the number of employees becoming infected with HIV and TB. It was also recommended for the province to improve oversight, coordination and accountability on issues that involve both government and civil society sectors.

There was a need to ensure all HCT data from both public and private sector were captured. The DoH was recommended to promote collaboration with relevant stakeholders to establish behaviour change programmes targeting key populations such as TB patients to reduce the number of TB related deaths.

MPAC also recommended the development of strategies to ensure that data from traditional circumcision is recorded and reported together with the MMC data. Partnerships between government and the private sector need to be strengthened, to invest in HIV, STIs and TB programmes.

It was also recommended that Mpumalanga Province implement innovative approaches to improve DR-TB treatment outcomes including closing the diagnosis versus the treatment gap. The province was also recommended to develop and use the M&E plan across all sectors in the province by using the plan as a mechanism for supporting, coordinating and integrating multi-sectoral responses to HIV, STIs and TB.

INTRODUCTION

OVERVIEW

The Annual Progress Report assesses the provincial progress performance in response to the HIV, STIs and TB burden. The assessment focused on the progress of achieving the goals and objectives as set in the Mpumalanga Provincial Strategic Plan (PSP) for HIV, STIs and TB 2012-2016. The ***overall goal*** of the progress report of the PSP 2012-2016 is to give an overview of the PSP implementation progress, with emphasis on the highlights/achievements, gaps/challenges and emerging issues. The findings of the report provide recommendations for the remaining period of the PSP implementation. In addition, the recommendations inform the development of the next Provincial Implementation Plan (PIP), for the period 2017-2022.

The ***main objectives*** of the PSP annual progress report are:

- To assess progress made on the achievement of PSP goals.
- To review progress of PSP implementation against the strategic objectives including the indicators as per the indicator matrices.
- To identify gaps and challenges experienced in implementing the PSP.
- To assess the relevance and achievements of the focus on HIV, STIs and TB in relation to: increased coverage; improved quality, adaptation and combination of strategies.
- To assess and take into account epidemic dynamics and application of innovations.
- To identify PSP implementation lessons learned and document best practices.
- To put systems in place to collect and analyse data to measure the PSP indicators.

BACKGROUND OF THE MPUMALANGA PSP 2012-2016 ON HIV, STIS AND TB

In alignment with South Africa's (NSP) for (HIV), (STIs) and (TB) 2012-2016, which outlines the country's response to the HIV, STIs and TB epidemics, the Mpumalanga Provincial AIDS Council (MPAC) developed its Provincial Strategic Plan (PSP) for HIV, STIs and TB 2012-2016 with the aim of:

- Guiding the implementation of a provincial multi-sectoral and comprehensive HIV, STIs and TB response.
- Providing direction for the planning, coordination, implementation, monitoring and evaluation (M&E) of an evidence-based multi-sectoral provincial response to the three epidemics.
- Ensuring the availability of an investment and resource mobilisation framework on which provincial government, civil society, the private sector and development partners will provide technical and financial support at provincial, district and local levels.

In support of the NSP 2012-2016, the Mpumalanga Province adopted two of the **four Strategic Goals** of the NSP 2012-2016 and developed the other two which are contextual to the Mpumalanga Provincial AIDS Council (MPAC):

- ***Goal 1****:* Acceleration of prevention interventions in order to reduce the rate of new HIV and TB infections and deaths by 50%
- ***Goal 2:*** Improvement of access to comprehensive treatment, care and support services to 80% of all eligible people living with HIV, STIs and TB; 70% of them being alive 5 years following initiation of treatment.
- ***Goal 3****:* Mitigation of the socio-economic impacts of HIV, STIs and TB, especially among the most vulnerable groups such as orphans and children, PLHIV and their caregivers and/or families, and guarding against any form of discrimination and stigmatisation.
- ***Goal 4*****:** Strengthening the capacity of all sectors and the MPAC to respond effectively to the priority goals that have been established.

Similar to the NSP, the Mpumalanga PSP has four **Strategic Objectives** that guide the provincial HIV, STIs and TB response:

- ***Strategic Objective 1*:** Focuses on social and structural approaches to HIV and TB prevention, care and impact.
- ***Strategic Objective 2*:** Prevention of new HIV related, TB and STIs.
- ***Strategic Objective 3*:** Sustaining health and wellness of citizens.
- **Strategic Objective 4:** Ensuring protection of human rights and improving access to justice.

The PSP is aligned to the national and provincial vision of a society free from HIV, STIs & TB. This is informed by both local and international commitments such as the Negotiated Service Delivery Agreements (NSDA), the Millennium Development Goals (MDGs), the Strategy on Re-engineering of Primary Healthcare, the Comprehensive Rural Development Plan (CRDP), as well as the United Nations General Assembly Special Summit (UNGASS) declaration which calls for the commitment to the 'Three Ones' principles, namely: one coordinating entity, one strategic plan and one M&E framework for all HIV related interventions.

ASSESSMENT OF MPUMALANGA PROVINCIAL STRATEGIC PLAN 2012-2016 PROGRESS AGAINST THE FIVE MAIN GOALS OF THE NATIONAL STRATEGIC PLAN 2012-2016

Progress towards reaching the goals of the PSP 2012-2016

This overview highlights the progress made towards reaching each of the PSP 2012-2016 goals.

Goal 1: Acceleration of prevention interventions in order to reduce the rate of new HIV and TB infections and deaths by 50%.

As shown in ***Table 1*** below, the total HIV incidence rate in Mpumalanga decreased from 0.87% in 2013 to 0.70% in 2016. The total new HIV infections also decreased from 31 279 in 2013 to 26 320 in 2016. According to the Thembisa Model estimates, the incidence in the age group 15-49 years decreased from 1.53% in 2013 to 1.23% in 2016.

Mpumalanga Province adopted this goal based on the burden of HIV and TB in the province. The World Health Organisation (WHO) Spectrum Modelling estimates, and the drug resistant tuberculosis (DR-TB) treatment outcomes in 2011, revealed that Mpumalanga province constituted 24% of the 17.7% MDR-TB death rate and 69.2% of the 40.3% extremely drug resistant (XDR) TB.

Table 1: HIV incidence in Mpumalanga from 2013 to 2016

Year	Total HIV incidence rate (%)	Incidence in age group 15-49 (%)	Total new HIV infections
2013	0.87	1.53	31 279
2014	0.81	1.43	29 655
2015	0.76	1.33	28 052
2016	0.70	1.23	26 320

Source (THEMBISA Model, 2016)

HIV Prevalence

The 2012 to 2016 prevalence rates among different age groups are shown in ***Table 2*** below:

Table 2: Mpumalanga HIV Prevalence (%), 2012– 2016, by Age Group[i]

Age	2012	2013	2014	2015	2016
All age groups	14.9	15.0	15.0	15.1	15.2
Children (<15)	3.5	3.3	3.1	2.9	2.7
15-24 years	10.6	10.3	10.1	9.9	9.8
15-49 years	22.9	23.0	23.0	23.1	23.1
Females 15-24 years	16.5	16.1	15.7	15.3	15.0
Males 15-24 years	4.7	4.7	4.6	4.6	4.6
Females 15-49 years	27.2	27.5	27.8	28.0	28.2
Males 15-49 years	18.4	18.4	18.2	18.1	17.9

Source, THEMBISA Model, 2016

The highest prevalence rate of 28.2%, was identified in females aged 15-49years.The lowest prevalence of 2.7% was identified in children younger than 15 years in 2016 compared to 3.1% in 2014. Males aged 15-49 years had a prevalence rate of 17.9%. Based on the UNAIDS Spectrum Modelling, HIV prevalence for Mpumalanga age group 15-49years was 24.7% slightly lower than that recorded in the Thembisa Model in 2016.

Antenatal HIV prevalence

According to the National Department of Health Annual Report 2015/2016 improvements on HIV prevalence among antenatal women were a result of the revision of the Prevention of Mother to Child Transmission (PMTCT) guidelines. The PMTCT guidelines emphasised on the placement of all HIV+ ANC clients on treatment as well as the increased testing coverage of pregnant women at all ANC visits. ANC clients were also initiated on treatment irrespective of CD4 count. This in turn led to a drop on the mother-to-child transmission (MTCT) from <2% to 1.3%. (Mpumalanga Department of Health Annual Report-2015/16).

TB burden

According to the World Health Organisation (WHO) 2015 TB Report, South Africa's TB epidemic' co-infection rate of more than 60% is closely linked to HIV prevalence. According to the 2015/2016 Mpumalanga TB Control Programme Report, a total of 17 337 TB patients were registered, a decline from 21 493 registered in 2014/2015. Mpumalanga recorded a new smear positive TB patient's death rate of 4.1% in 2016 which declined from 4.5% in 2015, (NDoH, 2015/2016). There were forty-one cases of extremely drug resistant TB (XTB) recorded, with Mpumalanga having the highest proportion at 80.5%of XDR-TB /HIV co-infected patients nationally (NDoH, 2015/2016 report).

According to the 2015/2016 Mpumalanga PSP and the 2012-2016 Mid-term Review Report, (MTR) TB is the principal cause of death for people living with HIV (PLHIV) with an estimated rate of 134 per 100 000 populations. The results of the Mpumalanga MTR report also indicate that the PSP targets for goal one were not met, however, progress was made towards reaching the targets.

Goal 2: Improvement of access to comprehensive treatment, care and support services to 80% of all eligible people living with HIV, STIs and TB; 70% of them being alive 5 years following initiation of treatment.

Based on the number of infections in Mpumalanga, the province decided to adopt this goal in order to increase the number of people on ART.

Mpumalanga District Health Information System (DHIS) data revealed that of the 690 000 PLHIV in Mpumalanga, about 41% (283 932) were on ART at the end of 2016. During the period under review (2015/2016), the DHIS data, in Mpumalanga showed a total of 317 834 people (301 665 adults and 16 169 children) remaining on ART, at the end of March 2016.

Table **3** below indicates the trends in initiating both adults and children on ART from 2015 to 2016.

Table 3: New eligible HIV positive clients (both adults and children) initiated on ART in Mpumalanga

Indicator	2015	2016
New eligible HIV + adults initiated on ART	**73 383**	**34 009**
New eligible HIV+ children initiated on ART	**3189**	**1524**

Source Mpumalanga DHIS, 2015/2016

The above data indicates that the number of both adults and children initiated on ART declined According to the Mpumalanga DoH 2014/2015 annual report, the planned target for total clients remaining on ART was 309 071 but the province achieved 283 932. The deviation was due to the poor recording of results in facilities due to shortage of data capturers to update Tier.net, (Mpumalanga DoH Annual Report 2015/2016). The provincial rate (74.2%) of antenatal clients initiated on ART fell behind the provincial target of 90% (Mpumalanga DoH Annual Report, 2015/2016).

Table 4 below indicates the antenatal initiation on ART per district in Mpumalanga:

Table 4: Rate of antenatal clients initiated on ART by district Mpumalanga, 2015/2016

District	ART rate 2015/2016 (%)	HIV testing coverage (%)
Nkangala	100.2%	20.3
Gert Sibande	85.9%	21.2
Ehlanzeni	99.6%	30

Source, DHIS, 2015/2016

Table 4 above indicates that Nkangala had 100.2% (the highest) antenatal ART initiation rate followed by Ehlanzeni with 99.6% and lastly Gert Sibande 85.9%. HIV testing coverage in Ehlanzeni had the highest testing coverage of 30%, followed by Gert Sibande with 21.2% and Nkangala the lowest coverage of 20.3%. The piloting of e-Health National Project in Gert-Sibande and Ehlanzeni districts affected data submission in 30 facilities (high volume sites), interrupting routing data flow into the DHIS, resulting in Nkangala a district which had the highest ART initiation rate having the lowest HIV testing coverage, (Mpumalanga DoH, Annual Report 2015/2016).

Goal 3: Mitigation of the socio-economic impacts of HIV, STIs and TB, especially among the most vulnerable groups such as orphans and children, PLHIV and their caregivers and/or families, and guarding against any form of discrimination and stigmatisation

During the drafting of the Mpumalanga PSP 2012-2016 Mpumalanga opted to develop this goal and prioritise on mitigating the socio-economic impacts of HIV, STIs and TB to the most vulnerable populations in the province. The most vulnerable populations, defined by Mpumalanga, included orphans and children, PLHIV and care givers and/or families.

The NSP 2012-2016 recognises that HIV contributes to an increase in the number of Orphans and Vulnerable Children (OVC) in households. HIV also impacted care arrangements of children, and the vulnerability of children exposed them to the risk of acquiring HIV. The NSP 2012-2016 proposed scaled up initiatives at community level to reduce vulnerabilities, impact related to HIV and TB and to protect the rights of orphans and vulnerable children, including those in child headed households. Emphasis was placed on addressing mental health needs.

The Mpumalanga provincial Department of Social Development (DSD) was tasked to be the custodian of social services, well-being and resilience support through a number of interventions as part of their social services package, PSP 2012-2016 Examples of these interventions implemented in the period under review included, the provision of social assistance to 27 366 by DSD through the South African Social Security Agency (SASSA) OVC's in 2016, (Mpumalanga DSD Annual report 2015/16). Their work was complemented by other departments such as the DoH and DoE and other stakeholders.

Table 5 below shows some of the work completed towards addressing this goal:

Table 5: Data on OVC, PLHIV and psychosocial support for Mpumalanga Department of Social Development (DSD) 2015/16

Indicator	2015/16
Number of drop in centres funded to provide psycho-social support to Orphaned and Vulnerable Children (OVC)	105
Number of Isibindi sites funded to provide psycho-social support to OVC	38
Number of OVC provided with psycho-social support	2 474
Number of caregivers benefitting from the Expanded Public Works Programme (EPWP)	2568
Number of support groups established for PLHIV	112
Number of children supported through the Isibindi sites	9 992

Source, annual report Mpumalanga DSD 2015/16

Table 5 above indicates that Mpumalanga Province prioritised on OVC and PLHIV in most of the DSD programmes. A total of 38 sites were established through the Isibindi programme. The established sites provided psycho-social support to 9 992 children during the period under review. A total 9 585 out of the 9 992 were orphans and children were made vulnerable by HIV, (Mpumalanga DSD, annual report 2015/2016). A total of 105 drop-in centres were established as well as 112 support groups through DSD catering for OVC and PLHIV respectively. The National Department of Public Works (DPW) through the Mpumalanga DoH transferred funding amounting to R3 384 000 to nine (9) home based care organizations for the Expanded Public Works (EPW) programme, (Annual report Mpumalanga DoH, and 2015/16).

In an effort to mitigate the socio-economic impacts of HIV, STIs and TB, MPAC secretariat developed the “Operation Vuka Sisebente” a service delivery model that emphasised a multi-sectoral approach rolled out from 2015 and was operational in all sub-districts, during the 2015/2016 reporting period. This service delivery model was based on alleviating poverty, inequality and unemployment which were viewed as the drivers of the HIV pandemic. The model emphasised multiple sectors collaboration in creating employment, promoting gender balance in socio-economic issues and promoting economic growth in both rural and urban communities. Other impact mitigation activities implemented include the Department of Education’s ‘Child Care Jamborees’ for OVC and the ‘Keeping Girls’ in School initiative; DSD’s KeMoja

Project as well as other initiatives through the Positive Women's Network on reducing Gender Based Violence (GBV) and support groups for PLHIV.

Goal 4: Strengthening the capacity of all sectors and the MPAC to respond effectively to the priority goals that have been established.

The Mpumalanga Provincial AIDS Council was set up to coordinate the multi-sectoral response to HIV, TB and STIs. This implies that the MPAC holds the overall responsibility of ensuring that there is optimal capacity to deliver on its mandate.

MPAC secretariat received support from development partners in capacity building, during the period under review. The Futures Group and the United States President's Emergency Plan for AIDS Relief (PEPFAR) funded development partners through their Sexual HIV Prevention Programme (SHIPP). SHIPP provided extensive support in capacity building in planning, implementation, monitoring and evaluation to ensure the MPAC secretariat delivers on the PSP. Some of the notable achievements include the development of the Mpumalanga PSP Operational, Monitoring and Evaluation Plans; and also a review of the Mpumalanga PSP 2012-2016 on HIV, STIs and TB.

MPAC also received support from Gessellschaft Internationle Zusammenarbeit (GIZ), who focused on capacity building and strengthening the functionality of the Provincial AIDS Council (PAC), District AIDS Councils (DACs) and Local AIDS Councils (LACs) as through training workshops and exchange programmes in civil society.

7. PROGRESS TOWARDS ACHIEVING THE STRATEGIC OBJECTIVES OF THE PSP

Strategic Objective 1: Focus on social and structural approaches to HIV and TB prevention, care and impact

South Africa has declared that HIV and AIDS is not a health issue alone but is driven by other social and economic factors hence the need to focus on the social and structural drivers of the epidemics. Analysis and measurement of progress in the response to HIV and TB has largely been on bio-medical interventions ignoring the impact of the structural and behavioural drivers of the twin epidemics. The NSP 2012 – 2016 placed emphasis on addressing social and structural drivers in multi-sectoral HIV, TB and STI response.

Mpumalanga Province adopted this strategic objective and placed, in their provincial response, the need to address the social, economic, political, cultural and environmental factors that lead to increased vulnerability. They included the following:

- Gender and gender-based violence
- Socio- economic drivers (poverty, unemployment and economic development activities)
- Stigma and discrimination
- Behaviour change communication

The main focus was to identify and address structural drivers that to be addressed within the 5-year period of the PSP. Sub-objectives of the PSP are:

- Mainstream HIV, STIs and TB, and the associated gender and rights based dimension into Provincial Government mandates and the mandates of all MPAC sectors.
- Address Behavioural and Socio-economic Drivers of HIV, STIs and TB.
- Empower Men and Women to Address Inequities and Gender-Based Violence.

A number of key structural drivers were identified in the Province including poverty, unemployment, inequality, informal settlements, high school drop-outs, sexual assault, gender inequality, gender based violence and alcohol and substance abuse. Behavioural factors included multiple sexual partnerships and condom use. The first priority for the province was to increase HIV awareness through all sectors especially high risk populations such as the youth with emphasis on young girls and migrant workers (mine and farm workers). Other interventions suggested were to strengthen MPAC, DACs and the LACs to promote multi-sectoral participation and approach to HIV, STIs and TB prevention, treatment, care and support.

Key Policy Issues

Mpumalanga Province adopted the Operation Vuka Sisebente (OVS) a new governance model aimed at improving service delivery, mainly targeted at unemployment, inequality and poverty which are all the drivers of HIV, STIs and TB in the province. The model was rolled out in all wards across the province and some "war rooms" were functional during the reporting period. The purpose of the "war rooms" was to discuss and resolve HIV, STI and TB related issues.

Government departments implemented both internal and external mainstreaming as guided by Departmental HIV&AIDS and TB management Policy and the Department of Public Service and Administration's HIV&AIDS Policy of 2009.

Indicator and Results

Table 6: Strategic Objective 1- Focus on social and structural approaches to HIV and TB prevention, care and impact

Indicator	Baseline	Target 2016	FY 2015/16 Status	Comment – progress towards target
% government departments and sectors with operational plans with HIV, TB and related gender and rights based dimension integrated	14 government departments	100%	100% DOH PSP (**Implementation Plan Annual Report 2015/16)**	All 14 government departments developed plans which incorporate HIV, TB and related gender and rights based dimensions
% municipalities with at least one informal settlement where targeted comprehensive HIV, STI and TB services are implemented		50% (provincial target)	100% (**Implementation Plan Annual Report 2015/16)**	The target was reached
Current school attendance among orphans and among non-orphans aged 10 -14 (UNGASS 12; MDG Indicator)		100%		Data for this indicator was not available during the period under review
Delivery rates for women under 18-NIDS	8.8%	<10%	0.8% (***Mpumalanga, DHIS 2015/16)***	Target reached
HIV and TB spend				Data not available during period under review.
Number of sectors with gender mainstreaming plans	100%	100%	100% ***(DOH PSP Implementation Plan Annual Report 2015/16)***	All government departments submitted their gender mainstreaming plans to MPAC as part of the Lekgotla resolutions
Number of women and children reporting gender-based violence (GBV) to the police in the last year	3274 (2014/15)	No target	4039 (***DSD Annual Report 2015/16)***	No set target for this indicator (but there was an increase of 765 cases
Number of non-professionals trained on HIV, STIs and TB issues	1 570	5 130	6334 (***DOH PSP Implementation Plan Annual Report 2015/16)***	Target exceeded due to new PMTCT guidelines introduced hence more training was required.
Number of community dialogues/campaigns on HIV, STIs and TB conducted	52	99	220 (***DOH PSP Implementation Plan Annual Report 2015/16)***	Overachievement of the target
Number of sports days held for government employees	8 sports days	12	11 sports days commemorated ***(DOH PSP Implementation Plan Annual Report 2015/16)***	Target not reached by 1 sports day commemoration. However, indicator needs to be reviewed in the next PIP to be directly linked to HIV, STIs and TB
Number of AIDS councils established	15	21	21	All 21 AIDS councils are functional (LACs & DACs)
Proportion of women who have experienced physical or sexual violence in the last year	2598	No target	3274 ***(DSD Annual Report 2015/16)***	There is no target for this indicator – Data available is not disaggregated by gender from SAPS.

Source: Mpumalanga, DHIS 2015/16, DOH PSP Implementation Plan Annual Report 2015/16, DSD Annual Report 2015/16

Key Achievements

- Internal and external mainstreaming of HIV, STIs and TB by all government departments. Some government departments focused on both employees and citizens in communities that provided services, example: The Department of Culture, Sports and Recreation went beyond internal mainstreaming by conducting Sports Days where condom distribution, counselling, HCT and TB screening were conducted as part of the day's activities.

- Firm commitments by political leadership to support HIV and AIDS programmes. Commitments led to the development of structures such as DACs and LACs and some WACs. A total number of 18 functional LACs, 3 DACs and 102 out of 132 WACs in Ehlanzeni District were functional during the period under review. (Ehlanzeni District Annual Report, 2015/2016).

- Implementation of outreach programs to promote information, education and communication through community dialogues and community campaigns by government departments, civil society and other sectors. Community dialogues on HIV, STIs and TB were overachieved by 121 dialogues.

- Programs to empower men and women to address inequities and gender based violence including programs for girls and young women were in existence. The following key programs were implemented in line with SO1 objectives: The ZAZI Campaign for young girls and young women, Soul Buddyz, Keeping Girls in Schools, community dialogues on responsible lifestyles and the Women Empowerment Sessions programme.

- Multi-sectoral response in mitigating socio-economic drivers of HIV, STIs and TB by government departments e.g. the DoE in collaboration with the DHA and DSD assisted OVC through Coordinated Service Delivery campaigns promoting access to government services. These services included applications for identity documents, accessing child grants, screening of minor ailments and psychosocial support. DoE implemented a "Keeping Girls in Schools Programme" which was implemented by an NGO, Media in Education Trust (MIET). The programme was implemented in 59 Schools

including: 39 Ehlanzeni and 20 in Gert-Sibande targeting schools with high teenage pregnancy, (Mpumalanga DoE and DSD annual reports 2015/2016).

- Establishment of support Groups for PLHIV and GBV interventions through the Positive Women's Network.
- The different civil society sectors in the DACs and LACs also implemented interventions on addressing social and structural barriers to TB, HIV and STI including behaviour change interventions.
- Setting up structures at DACs and LACs for example the launch of the Disability Forum in Nkangala on the 6th of November 2015, (3rd Nkangala District AIDS Council Report 2015/16).

Gaps and Challenges

The PSP 2012-2016 MTR identified the following gaps and challenges:

- A lack of optimal and meaningful participation of other sectors and government departments in DACs and LACs, e.g. participating in other initiatives such as "Operation Vuka Sisebente", war rooms etc.
- Representation comprised of junior officials with no decision making powers, poor coordination and reporting skills.
- The reporting on activities aligned to this sub-objective amongst civil society was sub-optimal.
- Mainstreaming and integration of HIV in government and sectoral plans was done but some were sub-optimal. Lack of balance between internal and external mainstreaming.
- Lack of resources and access to other key populations such as farmworkers and mine workers due to resistance by owners of farms and mines in implementing HIV, STIs and TB programmes, (2nd Quarter Sibande AIDS Council Report October to December 2015/2016. Indicators were not adequately linked to performance for this strategic objective.

Recommendations

- Re-introduction and re-establishment of the Nerve Centres to provide direction to all stakeholders, enhance communication and sharing of information and strengthening of the M&E activities.
- Review of all the sub-objectives of SO1 and development of SMART indicators aligned to activities as per the sub-objectives;
- A need for the Province to develop a comprehensive behaviour change strategy and implement it in the Province;
- While there is a strong focus on structural drivers, the lack of emphasis on social drivers underpinning behavioural risk needs to be addressed for inclusion in the forthcoming period.
- Strengthening of internal mainstreaming, especially workplace programs to reduce the number of employees becoming infected with HIV and TB;
- Optimal participation of Private Sector in the implementation of key interventions for addressing social and structural factors – Business Sector;
- The MPAC secretariat requires oversight improvement, coordination and accountability on issues that involve both government and civil society sectors.

***Strategic Objective 2 (SO2)*: Prevention of new HIV, STI and TB Infections**

SO2 Overview

Strategic Objective 2 focused on the key strategies for preventing sexual and vertical transmission of HIV and STIs and; preventing and mitigating TB. Preventing HIV, TB and STIs requires combination prevention interventions. Recognizing that no single prevention intervention can address the HIV and TB epidemics at population level, the combination prevention approaches applied should integrate biomedical, behavioural, social and structural interventions to have maximum impact on lowering the spread and susceptibility to HIV, STIs and TB. In addition, assorted prevention interventions and combinations are vital to support the focus on key populations with a view of achieving the long-term vision of zero new HIV and TB infections.

SO2 is critical to the fight against the HIV and AIDS epidemic. In Mpumalanga, SO2 is to be achieved through increasing HIV awareness across all sectors, especially in high risk populations such as the youth and the farm workers. The use of combination prevention strategies to maximise HIV prevention and intensifying HIV case identification through HCT campaigns and Provider Initiated Counselling and Testing (PICT) are key interventions also used to achieve SO2. The PSP aims to address SO2 through three sub-objectives:

1. Reduce new HIV, STIs and TB infections
2. Prevent vertical transmission of HIV to reduce MTCT to less than 2% at 6 weeks and less than 5% at 18 months by 2016.
3. Universal screening and testing for HIV, STIs and TB at all consultations.

These sub-objectives are to be achieved through various interventions including HIV and TB community dialogues to promote behaviour change, involvement of community-based stakeholders (e.g. traditional leaders, faith-based organizations, etc.) in HIV, STIs and TB awareness initiatives and, intensified HIV, STIs and TB case finding

In 2013, the National TB plan was updated and replaced with the new national TB guidelines and published 2014. The 2014 TB guidelines placed emphasis on: 1) Reducing transmission of infection; 2) Diagnosing drug-sensitive/susceptible (DS)

and drug resistant (DR) TB early; 3) Initiating treatment in all patients diagnosed with TB early; 4) Retaining patients in treatment and care until completion of treatment; 5) Preventing TB in PLHIV by initiating all eligible HIV positive individuals on ART and isoniazid preventive therapy (IPT), to address the high HIV and TB related morbidity and mortality in South Africa.

In accordance with international good practice, the national PMTCT guidelines were revised in December 2014 and the key changes included 1) Initiation of life-long ART for pregnant women regardless of CD4 count or clinical stage as well as PCR testing for all HIV exposed neonates/infants. HCT offered to all pregnant and breastfeeding mothers with unknown HIV status or those who tested HIV negative in the preceding three months. Pregnant women who test negative included in the PMTCT programme were routinely offered HIV testing throughout their pregnancy, labour and breastfeeding stages (re-testing)**.** The guidelines also recommended integration of TB and syphilis screening and treatment for all HIV infected pregnant women.

To address the HIV, STI and TB prevention needs and gaps in services, research, and support for key populations, the NDoH developed an Operational Framework for Key Populations, HIV, STIs and TB Programmes in South Africa in 2012. The Framework was intended to assist health planners to develop, plan, implement, monitor and evaluate programmes in order to achieve the targets for key populations as set out in this NSP. Several recent studies conducted in collaboration with DoH provide an overview of the current situation in relation to key populations including issues influencing their susceptibility to HIV.

Indicator and Results

Increasing HIV awareness in all sectors especially high risk populations such as the youth and farm workers; the use of combination prevention strategies to maximize HIV prevention and; intensifying HCT campaigns and testing in clinical settings through Provider Initiated Counselling and Testing (PICT) were identified as key priorities under SO2 of the PSP.

Table 7 below shows SO2 indicator matrix and results achieved for the period under review:

Table 7: Strategic Objective 2 Indicator Matrix

Indicator	Baseline	Target 2016	FY 2015/16 Achieved	Comment
Number (and percentage) of men and women 15–49 counselled and tested for HIV	1 103 335	882 714 90%	868 897 ***(Mpumalanga DHIS, 2015/2016)***	Target was achieved in the province
Number and percentage of people screened for TB	90%	90%	84% ***(Mpumalanga DHIS, 2015/2016)***	6% below provincial target
Number of newly diagnosed HIV positive people started on IPT for latent TB infection	81.9%	90% of newly enrolled on HIV care	60% ***(Mpumalanga DHIS, 2015/2016)***	Performance was lower than the set target by the provincial government.
Percentage men and women aged 15–24 reporting the use of a condom with their sexual partner at last sex	66%	100%	66% ***(Mpumalanga DHIS, 2015/2016)***	There is no provincial target thus national target applied. This indicator needs to be reviewed for the next PSP due to the difficulty in acquiring the data.
Percentage young women and men aged 15–24 who had sexual intercourse before age 15 (age at sexual debut)	10%	<5%	7.7% ***(Mpumalanga DHIS, 2015/2016)***	The age at sexual debut rate improved from baseline but has not reached the target. This impact indicator is difficult to measure routinely in the absence of a survey on behaviour change communication
Percentage women and men aged15–49 years who have had sexual intercourse with more than one partner in the last 12 months	7%	<5%	7% ***(Mpumalanga DHIS, 2015/2016)***	This indicator remained constant since 2012 but needs to be reviewed for the Province as it is was difficult to collect data on this indicator.
Male condom distribution	96 718 307	64 685 251	47 579 965 ***(Mpumalanga DHIS, 2015/2016)***	Target was not reached and data mopping was reported that affected the accuracy of data on condom distribution.
Female condom distribution	512 900	1 238 630	1 825 571 ***(Mpumalanga DHIS, 2015/2016)***	Female condom distribution is notably above the 2016 target
Number of men medically circumcised	42 776 (2014/15)	210 535	38 439 ***DoH PSP (Implementation Plan Annual Report 2015/2016)***	Still below the anticipated target
Number of people reached by prevention communication at least twice a year	3 953 (2012/13)	(99%)No provincial target set		There was no data for this indicator during the drafting of this report.

Source: Mpumalanga DHIS, 2015/2016 and DoH PSP Implementation Plan Annual Report 2015/2016

Achievements and Highlights

In an effort to prevent new HIV and TB infections, the province made concerted efforts through province wide HCT and achieved the goals set with the following results:

- The PCR positivity rate decreased from 2% to 1.7% (annual report DoH 2015/2016.
- 100% uptake of Baby Nevirapine from 2013 to the period under review; in the facilities offering the services.
- Implementation of prevention programmes targeting key populations, for example, provision of pre-exposure prophylaxis (PReP) and post-exposure (PEP) to sex workers.
- 7 487 TB cases were identified and 7 152 of them were initiated on treatment. The 2015/2016 DHIS data reveals that the number of Acid-Fast Bacilli (AFB) positive cases is declining.

Gaps and Challenges

- Many community members lost interest in HCT initiatives (Mpumalanga DoH Annual Report 2015/2016).
- Health facilities were non-compliant in reporting and managing the HCT data leading to poor HCT data quality (Mpumalanga DoH Annual Report 2015/2016).
- Male and female condom distribution and recording remained sub-optimal with some of the data on male condom distribution missing.
- VMMC uptake was inconsistent over the years and no record included traditional circumcisions at provincial level.
- Delays in PCR results reaching health facilities from the National Health Laboratory Services (NHLS) laboratories negatively affected the PMTC programme that is, clinical decision-making including paediatric ART initiation (Mpumalanga, DoH Annual Report 2015/2016).

- Though the number of programmes targeting key populations for HIV prevention services increased, few resulted in TB related deaths with the province recording a 4.5% TB death rate in 2016 (DHIS 2015/2016).

Recommendations

- Ensure that all HCT data from both public and private sector are captured - create organisational units within DHIS to adequately capture non-public sector HCT activities.
- Strengthened partnerships between government and the private sector, especially the mining and agricultural sectors employing majority of key populations affected by TB and HIV.
- Key population programming must focus on saturation of high HIV incidence/prevalence districts and communities, with an appropriate package of interventions. Hot spots in these communities need to be mapped and M&E and reporting strengthened.
- Collaborate with relevant stakeholders to establish behaviour change programmes that target key populations such as TB patients to reduce the number of TB related deaths.
- Develop strategies that will ensure that data from traditional circumcision is recorded and reported together with the MMC data.

***Strategic Objective 3*: Sustain health and wellness of citizens**

Overview

The PSP sets out to achieve SO3 through increasing *access to care treatment and support for HIV, STIs and TB.* The primary focus of SO3 in the Mpumalanga PSP was: to significantly reduce death and disability as a result of HIV, STIs and TB infection through universal access; affordable and good quality diagnosis and; treatment and care services. The 2007–2011 PSP review established that Mpumalanga rated as one of the highest hospital bed occupancy rate attributed to late presentation and management of HIV and TB cases, which led to a host of severe opportunistic infections which required prolonged hospital admission. As a result, the core principles that underpinned SO3:

- Improved early diagnosis of HIV, STIs and TB
- Improved access to timely, appropriate and user-friendly treatments (including rehabilitation) and retention in treatment and care.

The review of the PSP 2007-2011 provided insight on HIV, STIs and TB to the Mpumalanga province, which expanded access to HAART through Nurse Initiated Management of Anti-Retroviral Treatment (NIMART) and Primary Health Care (PHC) re-engineering which focussed on community based services, (District Health Barometer, 2013/2014). The community based services were critical in improving access, wellness and quality of health care thus the Mpumalanga strategy was intended to help address the HIV, STIs and TB gaps identified in 2011 (UN Spectrum Modelling 2013).

Key policy issues

South Africa is committed to sustaining the health and wellness of children, adolescents and adults living with HIV by keeping up with the latest new policy developments based on the latest local and international scientific developments in sustaining PLHIV. Based on this background, South Africa subscribes to the ‘2011 UN Political Declaration’ and has endorsed the UNAIDS 90-90-90 targets to be achieved by 2020. Mpumalanga Province adopted the 90-90-90 strategy (i.e. 90% of people living with HIV knowing their HIV status, 90% of people living with HIV who

know their status and on ART, and 90% of people on treatment having suppressed viral loads that also applies to TB).

In December 2014, South Africa revised the March 2013 national HIV and AIDS management guidelines –in line with international good practice. The key changes include: 1) increased CD4 threshold for ART initiation from 350 to 500 cells per cubic millimetre; 2) Viral load monitoring prioritization; 3) Lifelong HAART for pregnant women; 4) Birth PCR. The Universal Test and Treat (UTT) was adopted and implemented in September 2016 advocating for the initiation of clients on ART regardless of their CD4 count.

Indicator and results

Maintaining and sustaining health and wellness of all citizens, intensifying case finding and follow-up through screening for HIV, STIs and TB were identified as key priorities under this SO3 of the PSP. Proposed interventions included: 1) implementation of targeted programmes for key populations and 2) increasing the number of sites offering treatment for HIV, STIs and TB.

Table 8: Strategic Objective 3: Sustain Health and Wellness of the citizens.

Indicator	Baseline	Target 2016	FY 2015/16 Achieved	Comment – progress towards target
Proportion (%) of people per year becoming eligible who receive ART	**7884 62.7%**	**90%**	**95% *(Mpumalanga DHIS 2015/16)***	The 2016 target was surpassed due to the Universal Test and Treat (UTT) introduced in the province.
TB case registration rate	**570/100 000**	**354/100 000**	**583/100 000 *(Mpumalanga DHIS 2015/16)***	2016 target surpassed
TB case detection rate	**93% (2015)**	**80%**	**86.5% *(Mpumalanga DHIS 2015/16)***	2016 target surpassed
% smear positive TB cases that are successfully treated	**90%**	**>85%**	**81.8% *(Mpumalanga DHIS 2015/16)***	Target not reached
TB case fatality rate (CFR)	**6% (2015)**	**<5%**	**4.1% (*Mpumalanga DHIS 2015/16)***	The target was achieved.
CFR HIV-positive = CFR HIV-negative	**54%**			There is no provincial target set for this indicator
Number and % of registered TB patients who tested for HIV	**17 781 (2015) 90.2%**	**100%**	**16 700 (tier,.net)**	FY 2015/16 was not achieved

Number of all newly registered TB patients who are HIV-positive, expressed as a proportion of all newly registered TB patients	**12 582 63.8%**	**No target**	**No data available**	Data will be updated once available
MDR-TB treatment success rate	**47%**	**55%**	**36% *(Mpumalanga DHIS 2015/16)***	Target not met
New smear positive PTB patients lost to follow up	**4% (2015)**	**<5%**	**3.9% *(Mpumalanga DHIS 2015/16)***	Target reached
TB MDR confirmed treatment start rate	**95.3%**	**90%**	**99.6 *(Mpumalanga DHIS 2015/16)***	
Number of facilities offering ART services		**No target**	**312 *(DoH PSP Implementation Plan Annual Report 2015/2016)***	No provincial target set

Source; Mpumalanga DHIS 2015/16, DoH PSP Implementation Plan Annual Report 2015/2016 and Tier.net

Achievements and highlights

Based on ***Table 8*** above the achievements in Mpumalanga are:

- The TB Case Fatality Rate (CFR) dropped from 6% to 4.1% an indication of those initiated on treatment are living longer.
- The percentage of people eligible for ART increased going beyond the new set target of 90% due to the adoption of the UTT policy which calls for people to be initiated on treatment regardless of their CD4 count.
- Those remaining on ART treatment both children and adults took an upward trend from 2014 to 2016. A total of 354 991 clients remained on ART treatment out of a projected 189 481 for the period under review.
- The training of health professionals and non-professionals on HIV, STIs and TB management was overachieved reaching 6 334 due to the new ART guidelines.
- The introduction of adherence clubs in Mpumalanga proved to be effective in improving adherence to ART. Considering the adoption the UNAIDS 90-90-90 strategy, with the second 90 speaking to a new target of 90% of all HIV

positive clients initiated on ART, adherence clubs will continue to have a critical role in ensuring patients initiated on ART adhere to treatment and are retained in care after five years of ART initiation.

- Development partners, NGOs and Civil Society Organisations were working in collaboration to strengthen the HIV programmes.
- The provision of combination prevention service packages which include the distribution of condoms and facilitation of focus group discussions on HIV, STIs and TB programmes.
- The TB new smear positive cure rate was a major achievement, reaching 86.5% in 2016 -higher than the provincial target of 80%. The number of laboratories confirmed MDR-TB patients started on treatment was above the provincial annual target from 2012. The TB defaulter rate also fell below the provincial target of <6% - at 5.4% in 2016. At 4.1%, the TB death rate reached the set target of < 6% in 2016.

Gaps and challenges

Some of the challenges identified on this strategic objective include:

- The increase in a number of TB cases was a challenge during the period under review.
- MDR-TB increased and can be attributed to poor management of drug-sensitive TB patients.
- TB data management was identified as a challenge - creating gaps in TB programme reporting. This was partly caused by lack of data capturers in Ehlanzeni and Nkangala districts; which created data capturing backlog in the two districts.
- The DR-TB regimen had many adverse effects resulting in DR-TB patient defaulting and death rate remaining high at 4.5% in 2016 (DHIS, 2015/2016).
- Inadequate capturing of HIV positive ANC clients initiated on ART as per the new ART guidelines - in some instances, ANC clients on ART were recorded

as PEP affected the credibility of the DHIS data (Mpumalanga DoH Annual Report 2015/2016).

Recommendations

The province may consider the following recommendations based on the data and results of the third strategic objective:

- Evidence-based strategies to improve retention in care and adherence to treatment should be prioritised for improvement and financial resources allocated accordingly, in line with the National Adherence Guidelines for Chronic Diseases (HIV, TB and NCDs).
- Implementation of innovative approaches to improve DR-TB treatment outcomes including closing the diagnosis versus the treatment gap.
- Encouragement of all government departments to collaborate in implementing combination prevention programmes and ensure maximum impact in preventing new HIV and TB infections.

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

The South African freedom charter recognises the right to freedom for individuals as mirrored in the 1996 South African Constitution. Similarly, the NSP 2012-2016 is based on an understanding that protecting the rights of people affected by HIV, STIs and TB is not only in keeping with the Constitutional values of the country, but also integral to promoting an effective national response. As a result, there was need to address the impact of stigma, discrimination and human rights violations on access to services for HIV, STIs and TB in South Africa. It aimed to ensure that rights are not violated when interventions are implemented, and that discrimination on the basis of HIV and TB was not only reduced, but ultimately eliminated.

There was much to be done regarding addressing of legal and human rights interventions, therefore MPAC focused on strengthening mechanisms for monitoring abuses. Strengthening mechanisms were achieved through empowering communities to guard against human rights violations as an intervention. Mpumalanga recognised the need to protect PLHIV by making sure that the rights of

those living with HIV and TB, and at greatest risk of infection, were respected, protected and promoted. This is in alignment with the Bill of Rights as enshrined in Chapter 2 of the South African Constitution which includes the rights to equality, dignity, life, freedom, privacy and security of the person irrespective of sexual orientation. This was to be measured against reporting and resolutions of all human rights violations as reported in the Province.

Key Policy Issues

The NSP identifies a number of priorities to the protection of human and legal rights which were not all adopted in the Mpumalanga PSP but in principle, applied to the Province. The NSP identified the following priorities;

1. Conduct a review and assessment of remaining laws and policies that may impact negatively on the response to HIV, STIs and TB in an attempt to address any barriers and shortcomings that could undermine the rights of individuals.

2. Ensure that the provision of services for HIV, STIs and TB is done in a manner that upholds the dignity of individuals especially those living with HIV and have TB infection.

3. Address the support of women and young girls' sexual and reproductive health and rights, including the right to access comprehensive services and the right to reproduce.

4. Continue deliberations on the decriminalisation of sex work.

5. Address the importance of collaborative, national campaigns to address unfair discrimination in the workplace, public amenities and communities in general.

6. Address the need for strengthening workplace responses to HIV and TB in all sectors of the economy, especially the vulnerable sectors such as domestic and farm workers

Indicator and results

Table 9: Data on sexual assault and occupational exposure to injuries

Indicator	Baseline 2012	2015/16
Sexual assault cases new	**3835**	**4039**
Sexual assault cases provided with post-exposure prophylaxis (PEP)	**2565**	**2277**
Cases of occupational exposure to injuries seen	**no target**	**358**
Cases of occupational exposure to injuries provided with PEP	**no target**	**305**

Source: DoH PSP Implementation Plan Annual Report 2015/2016

Table 9 above indicates that the sexual assault cases totalled 4039 in 2016 and those provided with 2277 PEP interventions. Cases of exposure to injuries evident in 358 individuals while those provided with PEP were 305 indicating a small difference between the two which is a positive response to occupational health.

Key achievements and highlights

- Mpumalanga Province participated in the National Stigma Index Survey which set the baseline data for stigma and discrimination. However, the province rated highest on both internal and external HIV related stigma.
- Civil society organisations provided advocacy on the key issues affecting key populations such as the Sex Worker Sector. It should be noted that the Sex Worker Sector advocated for the decrimalisation of sex work and provided education on GBV at community level during the period under review;
- Increased management of sexual assault cases including provision of PEP and finalisation of cases;
- The province set up Thuthuzela Care Centres for the management of survivors of sexual assault with qualified personnel working closely with DOJ, DSD and other sectors;
- DoE implemented workshops in Secondary Schools on gender based violence sensitization and civil society organisations also supported the initiative.
- The DoJ was supportive in the programmes related to Gender Based Violence (GBV) at sub-district level, but much remains to be done to improve the status quo.

- Service sites for victims of crime and violence were established across the province
- Employee sessions that include human rights and GBV were conducted at workplaces especially in the government departments.
- According to the Mpumalanga Department of Education (DoE) 2015/2016 Annual Report, some workshops were being conducted in secondary schools on gender issues. Some gender sensitisation community awareness behaviour campaigns were also being conducted across the province with assistance from civil society.
- Government departments conducted gender based violence workshops and policies were developed to guard against unfair discrimination due to disability, HIV or TB status.

Gaps and challenges

- Capacity and financial resources among key service providers for implementing programmes in the area were inadequate, given the challenges that needed to be addressed.
- During the period under review; programmes did not adequately include Key Populations
- There was a lack of coordinated monitoring and evaluation of HIV and TB-related human rights violations, and no indicators for measuring progress of SO4
- While being recognised as existing, the disability sectors the unavailability of strategic documents such as plans and Integrated Development Plans (IDP) and the lack of provision of sign language interpretation was noted as a great concern.
- There is still lack of data on this strategic objective and monitoring GBV proves to be a challenge across the province. The definition of Gender Based Violence is not clear to many, leading to inaccurate reporting on GBV issues even with key departments such as the South African Police Services (SAPS).

Recommendations

- Develop a centralised mechanism, for tracking all sectoral plans and human rights indicators to ensure ongoing M&E of human rights violations and responses in terms of SO4, at Provincial level.

- Focus on Gender Based Violence especially its definition for improved data collection.
- Develop key indicators for this strategic objective and routinely track;

  The Province implemented some activities to ensure realisation of human rights and promotion of access to justice but requires more on the development of indicators and routinely collecting the data to assess performance.

8. Monitoring and evaluation

Overview

The Monitoring and Evaluation Plan for the Mpumalanga Multi-Sectoral Strategic Plan on HIV, STIs and TB, 2012-2016, which advocated for one strategic plan (the Mpumalanga PSP for HIV, STIs and TB 2012-2016), one coordinating body (the Mpumalanga AIDS Council) and one M &E system for monitoring and evaluating the PSP was developed. The main aim of M&E plan was to identify the gaps and needs information required for a strategic and systematic approach to the management of a multi-sectoral response to the HIV and AIDS epidemic and to promote and support a strategy aimed at addressing these.

Key Achievements and Highlights

- The province was committed to implementing M&E at all levels of its response to HIV, STIs and TB and in doing so, the M&E system for the PSP was strengthened at provincial level.
- M&E systems were put in place to identify gaps and areas of opportunities at sub-district and district levels with reports developed for programme implementers to make informed decisions from provincial level.
- The PSP 2012-2016 M&E reviews were conducted at district level and presented to the DACs prior to the development of their annual AIDS strategies.
- A uniform reporting template was developed and data was collected from sub-district level to the provincial level with feedback reports on all reports received.
- The M&E technical assistance workshops in the three districts (Ehlanzeni, Gert Sibande and Nkangala) were conducted with training on uniform reporting, including all the data custodians from government departments, NGOs and AIDS councils.

- The Mid-term review of the PSP 2012-2016 was conducted, spearheaded by the provincial M&E unit in the Mid-term review process.
- Civil society organisations were provided with M&E tools such as reporting templates and indicators. Civil society organizations were provided with general technical assistance on reporting their activities.
- The functional DAC technical working groups also received technical assistance (T/A) to verify data before the DAC meetings were held.

Gaps and challenges

- No existing integrated plan for monitoring of HIV, STIs and TB response in most stakeholders, with the exception of a few well-developed workplace programmes there was little evidence of M&E activity.
- Non-availability of private sector data resulted in gaps in the implementation of HIV, STI and TB programmes.
- There was limited research on the impact of HIV, STIs and TB on business and agriculture.
- Most community level HIV, STIs and TB programmes implemented by the civil society did not have basic indicators and monitoring systems for monitoring achievements of programme objectives. These programmes relied on retrospective evaluations or reviews.
- The M&E systems at district and sub-district level were neglected, with only the provincial ones still functional further complicating the tracking of progress on the response from local and district level.

Remedial action

- The development and use of a M&E plan across all sectors in the province by using the plan as a mechanism for supporting, coordinating and integrating multi-sectoral responses to HIV, STIs and TB, within and between provincial government, local government, civil society and the private sector.
- There is a need to align provincial priorities with national strategies as well as developing indicators that are aligned to the provincial interventions.
- There is need to conduct periodic provincial surveillance and research to determine outcomes and impacts as well as optimisation of existing resources and structures to implement M&E.

- There is also urgent need to utilise a four-step results chain based on inputs including activities and processes, outputs, outcomes and impacts. Training of data custodians and political leadership on the importance of HIV, STIs and TB programmes is also critical.
- There is need to bring other critical stakeholders on board such as the business sector and the NGOs and integrate their M&E systems with those of MPAC in order to share data on the various programmes on HIV, STIs and TB being implemented.

9. OVERVIEW OF GAPS AND CHALLENGES IN ACHIEVING THE STRATEGIC OBJECTIVES

According to the PSP 2012-2016 MTR report, there were gaps and challenges experienced in achieving the strategic:

- The Alignment of the PSP to the NSP – MPAC successfully developed a PSP that has a multi-sectoral approach to the HIV response but there are a few areas that need improvement as the review and development of the new one commences. The PSP 2012-2016 was not completely aligned to some of the NSP goals and objectives and the indicators in the PSP are not all Specific Measurable Achievable Result oriented and Time framed (SMART). This made tracking the progress against set national targets impossible. Whilst the Province has autonomy to develop a context specific PSP, it is important to adopt the national goals and objectives as a way of contributing to the national HIV, TB and STI response.
- Representation in the AIDS Council was adequate but the main challenge was inconsistency in attendance by senior government officials who were represented by junior officials who were unable to make decision at these meetings. They would prefer taking issues back to their principals and this had a very long turn-around time to get issues resolved;
- The lack of commitment amongst local leaders to participate in the DAC and LAC meetings which reduced the levels of political support that was so critical in the response to HIV, STIs and TB. Lack of this critical political leadership warranted non-functionality of some local structures;
- Private/Business Sector representation was sub-optimal;

- MPAC did not manage to realise its target of the four AIDS Council sittings due to unavailability of the political leadership to chair the meetings which presented gaps in the functionality of the AIDS council.
- There was lack of capacity amongst civil society to optimally deliver on their mandate in the AIDS council although capacity building was consistently provided by the Secretariat through development partners such as GIZ;
- Resolutions were not always implemented at all levels of the AIDS Council;

10. CONCLUSION AND RECOMMENDATIONS

MPAC as a Provincial Chapter of the South Africa National AIDS Council is founded on SANAC principles and has the overall role of coordinating the Provincial Multisectoral Response to TB, HIV and STIs as guided by the PSP on HIV, TB and STI 2012 – 2016. The PSP as a strategic guide to the HIV, STIs and TB response has to a greater success achieved in the response as well as to a lower extent failed to address the key issues as planned. Key achievements established; one (1) functional Provincial, three (3) District and eighteen (18) Local AIDS councils. These structures managed to coordinate the response by addressing social and structural drivers of HIV, STIs and TB; enrolment of HIV and TB clients on treatment; as well as sustaining their health and wellness. However, some of the human rights and social justice issues related to HIV, STIs and TB were not addressed thoroughly which calls for improved strategies to successfully achieve the intended goals.

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