MARCH 2017

ANNUAL PROGRESS REPORT 2015/16

PROVINCIAL STRATEGIC PLAN 2012-2016

NORTH WEST PROVINCAL AIDS COUNCIL

ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Treatment
ARV	Antiretroviral
ASSA	Actuarial Science Society of South Africa
DHIS	District Health Information System
DoE	Department of Education
DoH	Department of Health
DSD	Department of Social Development
GBV	Gender based violence
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
IPT	Isoniazid Preventive Therapy
M&E	Monitoring and Evaluation
MTCT	Mother to child transmission
NSP	National Strategic Plan
NW	North West
OVC	Orphans and vulnerable children
PLHIV	People living with HIV
PMTCT	Prevention of Mother to Child Transmission
PSP	Provincial Strategic Plan
RHR	Reconciliation Healing and Renewal
SAPS	South Africa Police Service
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	United Nations AIDS
WHO	World Health Organisation

TABLE OF CONTENTS

1. LIST OF TABLES

LIST OF FIGURES

EXECUTIVE SUMMARY

The report marks four years into the implementation of the North West Provincial Strategic Plan on HIV, STIs and TB, 2012-2016. It reflects progress made in 2015/2016 in the multi-sectoral response to HIV, STIs and TB in the North West Province.

The main findings of the report include:

- Approximately, 63% decline in the number of infants testing HIV positive at 6 weeks old from 2011 to 2015 is reported. This depicts the significant success of the Prevention of Mother to Child Transmission (PMTCT) programme. Mother to child transmission of HIV among 6 weeks old infants reduced from an incidence of 4% in 2011 to 1.5% in 2015/16.

- The Thembisa model estimates reduction in the number of new HIV infections (HIV incidence). A decline of 19% in the total population, 22% in the young people (15 -24 age group) and 23% in the 15-49 year age group was achieved in the province between 2011 and 2015 (Johnson et al, 2016). The decline in HIV incidence is however, not sufficient for the province to meet its 2016/2017 target.

- Viral suppression, intensified HIV counselling and testing (HCT), condom usage in short term sexual relationships, medical male circumcision, increased uptake of ART and reduction in partner age difference are some of the most important determinants of reducing new HIV infections in the province. Viral suppression and intensified HCT are the two most important predictors (Johnson et al, 2016).

- Approximately 13.3% (488 949) of individuals were estimated to be living with HIV in the province according to the 2014 population estimates.

- An estimated 204 184 individuals remained on ART in the public health care facilities by the end of March 2015/2016.

- Universal ART coverage estimated at 44% (Johnson et al 2016) against a target of 90% ART coverage during the period under review.

- TB continues to be the number one cause of death in the province with Dr Kenneth Kaunda having the highest proportion of TB deaths in the North West.

- High rate of loss to follow up, defaulter rate and non-compliance to TB guidelines were some of the challenges faced by the TB Control Programme.
- Internalised stigma was the most prevalent form of stigma among people living with HIV (PLHIV). Nearly a fifth (19.5%) of people living with HIV in the North West province (Dr Kenneth Kaunda and Ngaka Modiri Molema districts) experienced external stigma.

The report is a consolidation of the multi-sectoral response to HIV, STIs and TB in the North West as per available published data.

5. Introduction

OVERVIEW

Notable progress has been realized in the response to HIV, sexually transmitted infections (STIs) and Tuberculosis (TB) in the North West province since the beginning of the HIV/AIDS epidemic. This descriptive report highlights progress made in the multi-sectoral response to HIV, STIs and TB in the North West (NW) in 2015/2016. The data presented, highlights progress made as measured by the North West Provincial Strategic Plan (PSP) on HIV, STIs and TB (2012-2016) core Indicators. The report also presents challenges and gaps that still remain at provincial, district and local levels.

BACKGROUND OF THE NORTH WEST PROVINCIAL STRATEGIC PLAN ON HIV, STIs AND TB, 2012 – 2016

The North West Provincial Strategic Plan on HIV, STIs and TB, 2012-2016 was adapted from the National Strategic Plan (NSP) on HIV, STIs and TB, 2012-2016. Intensive consultations with provincial, district and community level stakeholders from government departments, civil society and development partners (funded by local and external funders) informed the development of the NW Provincial Strategic Plan (PSP). It built upon the successes and gaps of the previous PSP implemented between 2007 and 2011. The NW PSP provides a framework in which the multi-sectoral stakeholders work together in partnership to ensure that the goals and objectives of the PSP are achieved.

The goals of the NW PSP are:

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

The objectives are as follows:

- Address social and structural drivers of HIV, STI and TB prevention, care and impact.
- Prevent new HIV, STI and TB infections.
- Sustain health and wellness.
- Ensure protection of human rights and improve access to justice.

6. ASSESSMENT OF PSP PROGRESS AGAINST THE FIVE MAIN GOALS OF THE NSP

This section gives an overview of achievements, challenges and gaps related to the Strategic goals of the Provincial Strategic plan. Table 1 below outlines key PSP Impact indicators and related progress in 2015/2016. Well performing indicators are highlighted in green while those in red unlikely to meet the 2016/2017 target.

Table 1: Impact Indicators

Indicator	Baseline (2011)	Target (2016/17)	YR12/13 Status	YR13/14 Status	YR14/15 Status	YR15/16 Status	Comment
MTCT rate (@ 6 weeks & 18 months [mths])	4% (6 weeks)[1]	<2% (six weeks)	2.8%[2]	2.3% [3]	1.8% [4]	1.5%[5]	Target already reached for 6 weeks' positivity rate. Province will exceed 2016/17 target reach.
	No data	<5% (18 mths)	No data	No data	No data	No data	
HIV incidence: Total population	0.75%[6] (22 770)	0.375% (11385)	0.68%[6] (21177)	0.63%[6] (19 886)	0.63%[6] (19166)	0.56%[6] (18343)	Decline projected by Thembisa model though not sufficient to meet target.
HIV incidence: young people (15-24)	1.57%[7]	0.76%	1.46%[7]	1.36%[7]	1.29%[7]	1.21%[7]	Thembisa model predicts a decline though 2016/17 will not to be met.
HIV prevalence among women and men (15 – 24)	6.3%[8] **(CI**:3.3-11.6)	3.15%	8.2%[8] **(CI:**4.8-13.7)	-	-	-	30% increase in prevalence though not statistically significant. Target will not be met
HIV prevalence among pregnant women.	30.2%[9] **(CI:**28.2-32.4)		29.7%[9] **(CI:**27.5-32)	28.2%[9] **(CI:**26.3-30.2)			Decline may imply reduction in new infection or effect of deaths and or migration. Not statistically significant.

[1] Department of Health. 2011/12 Annual Report. North West Provincial Government.
[2] Department of Health. 2012/13 Annual Report. North West Provincial Government
[3] Department of Health. 2013/14 Annual Report. North West Provincial Government
[4] Department of Health. 2014/15 Annual Report. North West Provincial Government
[5] Department of Health. 2015/16 Annual Report. North West Provincial Government
[6] Johnson LF, et al. (2016) Prospects for HIV control in South Africa: a model-based analysis. Global Health Action. 9: 30314.
[7] Ibid
[8] Shisana O, Rehle T, Simbayi LC et al. (2009) South African National HIV Prevalence, Incidence and Behaviour Survey: A turning tide among teenagers? Cape Town: HSRC Press
[9] The National Antenatal Sentinel HIV Prevalence Survey, South Africa, 2011, National Department of Health.

Indicator	Baseline (2011)	Target (2017)	YR12/13 Status	YR13/14 Status	YR14/15 Status	YR15/16 Status	Comment
Patients alive and on treatment	Not set	12 months:94% 24 months:88% 36 months:82% 48 months:76% 60 months:70%					Significant increase in ART coverage. A total of 130 298 and 147 382 patients were on ART in 2012 and 2013 respectively. 191 612 individuals were on ART as of March 2015.[10] Data as per target is not available.
HIV mortality	36.2%[11] (2013)	18.1%	36.2%	36.3%	36.4%	-	Mortality predicted to remain high. 2016/17 target not to be met.
TB incidence (all types)	816.6 cases per 100 000	408.3 cases per 100 000	705.0 cases per 100 000	658.1 cases per 100 000	630.7 cases per 100 000	528.4 cases per 100 000	A decline in the number of reported cases of TB (all types)[12]. A decline has been experienced since 2012.
TB mortality	Not set	6% (is the target in NHI districts)[13]		10.2%	10.1%	-	High TB mortality with Kenneth Kaunda District having the highest mortality among NHI districts and second highest mortality rate in the country.
Stigma Index: External stigma	19.5% (2014)	-	-	-	19.5%	-	Baseline of 19.5% reported from sample from Dr Kenneth Kaunda and Ngaka Modiri Molema districts.

[10]Day C, Gray A. Health and Realted Indicators. In: Padarath A, King J, Mackie E, Casciola J, editors. 2016 South African Health Review 2016. Durban: Health Systems Trust; 2016.

[11] ibid

[12]Vanleeuw L & Loveday M. Tuberculosis. In: Massyn N, Peer N, English R, Radarath A, Day C, editors. 2016. District Health Barometer 2015/16. Durban: Health Systems Trust; 2016

[13] Massyn N, Peer N, Padarath A, Barron P, Day C, editors, 2015. District Health Barometer 2014/15. Durban.

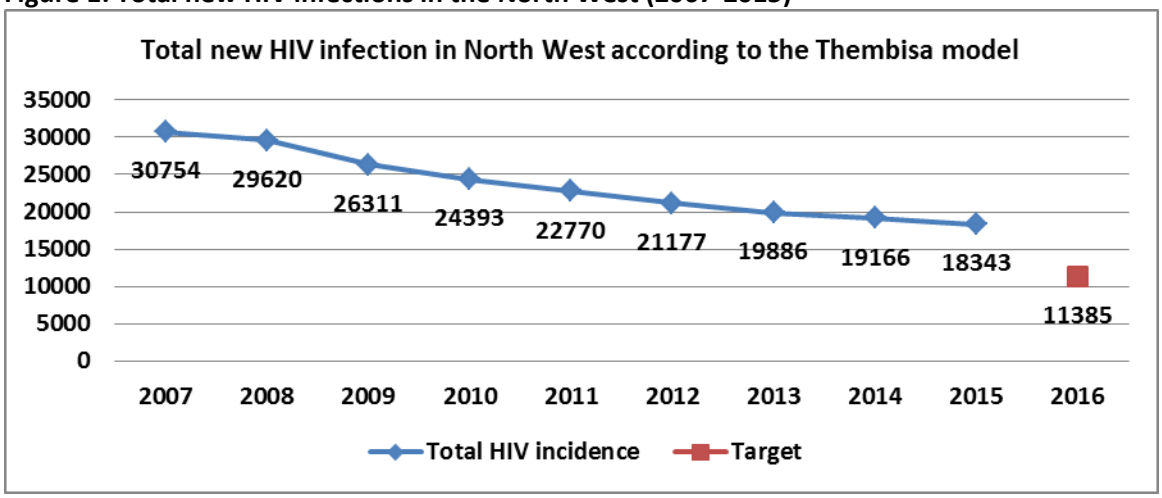
Goal 1: Reducing new HIV infections by at least 50% using combination prevention approaches

The North West province has succeeded in changing the trajectory of the AIDS epidemic since 2001. Combination prevention methods, namely biomedical, behavioural and structural interventions are used to reduce new HIV infections which are still largely due to sexual transmission.

Total new HIV infections in Bokone Bophirima Province of the North West

The Thembisa model (Johnson et al 2016) shows that HIV incidence in the general population has declined since 2007 though not fast enough to meet the 2016/2017 target.

Figure 1: Total new HIV infections in the North West (2007-2015)



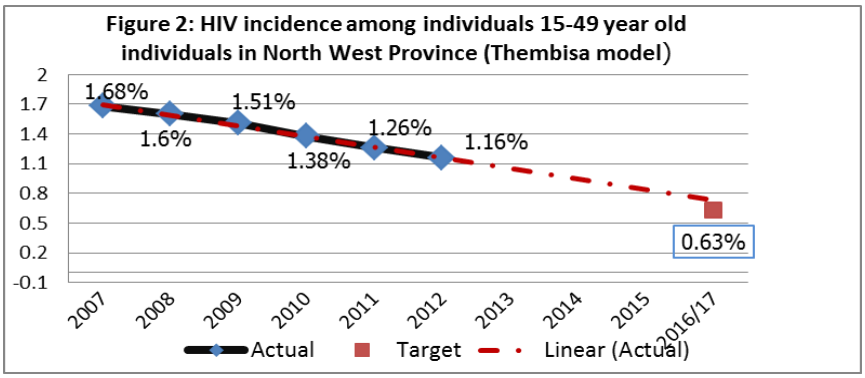
Source: (Thembisa model, Johnson et al, 2016)

Figure 1 indicates that the new infections have decreased from 22 770 in 2011 to 18 343 in 2015[14]. It is highly unlikely that the Province will meet its target of reducing HIV infection to below 11 385 as per the predictions of the Thembisa model (Johnson 2016). It still remains that there is greater need to intensify prevention interventions in the province to speed up the reduction of new HIV infections.

HIV incidence rate among 15-49 year old individuals

Figure 2 shows estimates of the Thembisa model (Johnson et al 2016) from 2007 to 2016 among the sexually active age group of 15-49 years. It was projected that a 23% decline would have occurred between 2011 and 2015/2016. The rate of new infections was projected to be 0.97% in 2015/2016. The decline is projected to reach an infection rate of 0.88% by the year 2016/2017 (Johnson et al, 2016)[15]. Hence, the province is unlikely to half the number of new HIV infections recorded in 2011 by the end of 2016/2017.

[14] Data from 2013 in the Thembisa model is to be treated with caution as it is based on model extrapolations of past trends for which no real data was available. The target is based on the 2011 as the baseline.
[15] ibid

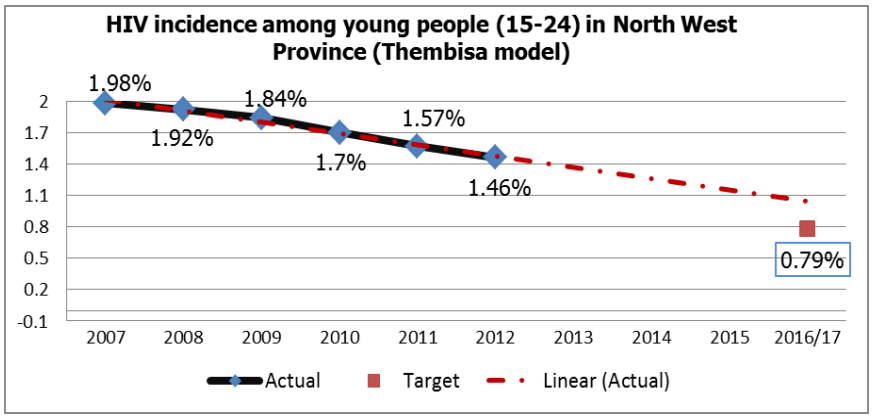


Source: (Thembisa model, Johnson et al, 2016)

HIV incidence rate among 15-24 year old individuals

Young people aged 15-24 years still make up the largest proportion of individuals newly infected by HIV in the Province, with young women at higher risk of infection when compared to their male counterparts.

Figure 3: HIV incidence among young people (15-24 years) in the North West Province



Source: Thembisa model (Johnson et al, 2016)

Figure 3 indicates that HIV incidence among young people aged 15-24 years has declined since 2007 based on estimation from the Thembisa model (Johnson et al 2016). It is also predicted that the province is unlikely to meet the 2016/2017 target (Johnson et al 2016). It is estimated that HIV incidence of 1.57% in 2011 was projected to decline to 1.11% in 2015. Despite the decline, HIV infection among the young people aged 15-24 continued to be unacceptably high and it accounted for the majority of new HIV infections.

The risk of being infected with HIV remains higher in young women when compared to young men in the 15-24 year age group. Intergenerational relationship especially with the male age cohort at least 10 years older, which had a high HIV prevalence, coupled with low condom usage predisposed the young women to HIV infection (Shisana et al 2014). Table 2 below indicates that despite a decline in HIV incidence in both sexes, young women were more likely to be newly infected with HIV than young men.

Table 2: HIV incidence among young women and men (15-24 age group)

	2010	2011	2012	2013	2014	2015	2016
Male (15-24)	0.96%	0.87%	0.77%	0.69%	0.64%	0.59%	0.53%
Female (15-24)	1.38%	1.26%	1.16%	1.08%	1.03%	0.97%	0.88%

In 2015, it was estimated that HIV incidence among young women aged 15-24 years was 0.97% compared to 0.59% among young men of the same age. Table 2 above, also indicates that a 32% decline was experienced among young men aged 15-24 years between 2011 and 2015 compared to a 23% decline among young women aged 15-24 years between 2011 and 2015. However, it is important to note that the estimates from the year 2013 are to be treated with caution as they are based on projections and not real data.

Mother to Child Transmission

The greatest achievement was the success of the Prevention of Mother to Child Transmission (PMTCT) programme with new infections among infants born to HIV positive mothers having fallen by approximately 63% since 2011 (baseline). Table 1 above, shows that the rate of infants born of mothers living with HIV who test HIV positive when 6 weeks old was estimated at 1.5% in 2015/2016. The previous year (2014/2015), it was estimated to be 1.8%.

There was district variation in the MTCT at six weeks in 2015/2016. Bojanala district had the highest (1.8%) rate of infants at six weeks testing HIV positive followed by Ngaka Modiri Molema district (1.7%). In Dr Kenneth Kaunda, the HIV positivity rate was 1.1% and Dr Ruth S Mompati had the least at 0.8%.

Mother to child transmission is said to occur at or before birth and or after birth usually through breastfeeding. No data was available for the mother to child transmission of HIV for infants aged 18 months, during the period under review. This was a major gap as this data would shed more light on the number of infants being infected after the 6 weeks visit.

Johnson (et al 2016) of the Thembisa model suggested that the two most important factors to help in further reduction in HIV incidence in the next ten years in the province are viral suppression and intensified HIV counselling and testing (HCT), respectively. Other factors that will determine HIV incidence trends condom usage in short term sexual relationships, male medical circumcision, increased uptake of ART and reduction in partner age difference (Johnson et al 2016).

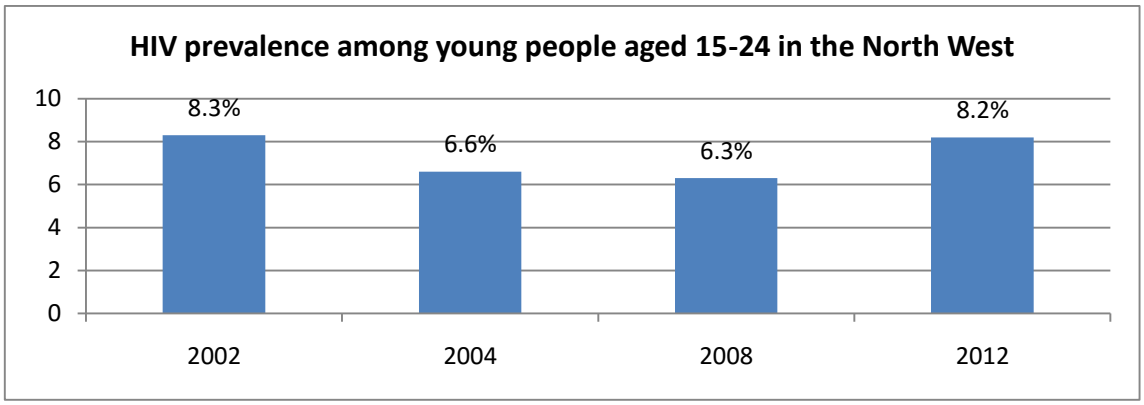
HIV prevalence

An HIV prevalence survey conducted in 2012 estimated that approximately 13.3% individuals were living with HIV in the North West (Shisana et al 2014). This translates to approximately 488 949 individuals when based on the 2014 population. HIV prevalence – a combination of new and old HIV infections among a particular population- depends upon the balance between incidence, HIV-associated mortality and migration[16]. Data on HIV prevalence among young people (15-24years) and among pregnant women (15-49 years) attending antenatal care in public health facilities is presented as the most sensitive indicators on HIV incidence trends in the province. HIV prevalence in older age groups represents the cumulative net effect of infection and attrition over a longer period of time and is; therefore, less able to detect recent changes in new HIV infections (Changalucha et al., 2002).

HIV Prevalence among young people aged 15-24 years old

Figure 4 below indicates a 30% increase in HIV prevalence from 6.3% in 2008 to 8.2% in 2012 among young people aged 15-24 years in the province in an HIV Prevalence survey (Shisana et al 2014). Results were interpreted with caution, as they are statistically insignificant. However, HIV prevalence among young people aged 15-24 years is more likely to reflect recently acquired HIV infections since the majority of the young people aged 15-24 years would become sexually active (Jackson et al., 1999).

Figure 4: HIV prevalence among young people (15-24), North West, 2002-2012



Source: Shisana et al, 2014

The increase in HIV prevalence could imply increased HIV infection in the age group especially when considering that HIV incidence rates (Johnson, et al 2016) are still remarkably high. Behavioural data showed that risky sexual behaviour was still relatively high. Early sexual debut significantly increased

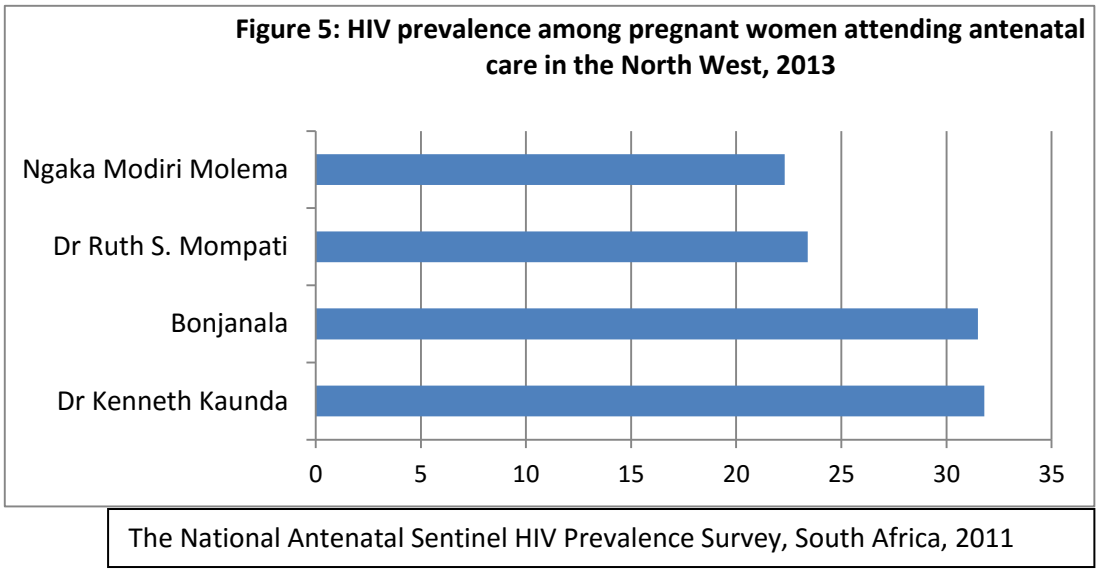
[16] http://www.who.int/hiv/pub/epidemiology/en/reducing_prev_young_people.pdf

the risk of HIV infection. About 8.5% (CI 4.8-14.7) of young people (15-24 years) had been sexually active before the age of 15 years (Shisana et al, 2014). This was compounded by the fact that a number engaged in age disparate relationships with partners in age groups with high HIV prevalence. At national level, data showed that more than a third (36%) of the female respondents aged 15-19 years had been involved in an age disparate relationship with a partner more than 5 years their senior. Condom usage with last sexual partner was estimated to be below 30% in both young women and men in the North West (Johnson 2016).

HIV prevalence among pregnant women accessing antenatal care

There was a moderate decrease in the HIV prevalence among pregnant women accessing antenatal care from 29.7% in 2012 to 28.2% in 2013 at provincial level in the national Antenatal Sentinel HIV prevalence Survey (National Department of Health 2013). Caution was exercised in interpreting the decline in prevalence. The increase could be attributed to the new HIV infections, migration and or the ART programme. ART programme has succeeded in significantly reduced mortality rate among the general population. Johnson (et al 2016) noted that the North West achieved the highest proportion of HIV-positive adults diagnosed and also achieved one of the highest rates of viral suppression in South Africa. Hence, a reduction in HIV prevalence among pregnant women may also be as the reduction of HIV incidence in recent years (Johnson et al 2016).

There is variation in the burden of HIV among pregnant women (15-49 years) in the survey. Figure 5 below shows that Dr Kenneth Kaunda had the highest burden of HIV with a prevalence of 31.8%. Bojanala District had the second highest HIV prevalence (31.5) with Ngaka Modiri Molema having the lowest. It is important to conduct further study to understand the dynamics of HIV prevalence in the province to enable allocation of appropriate interventions and investment.



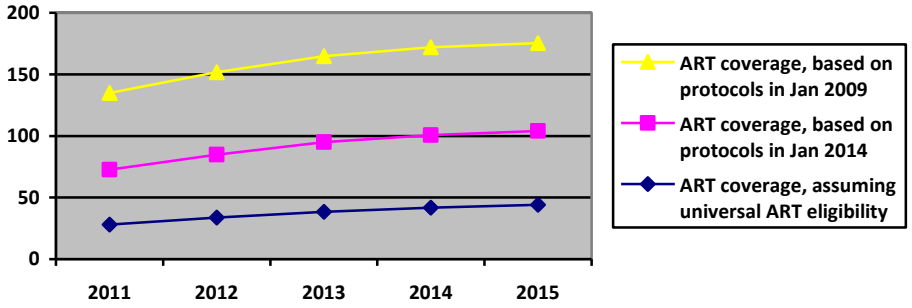
Goal 2: Initiating at least 80% of eligible patients on ART, with 70% alive and on treatment, five years after initiation

It is estimated that approximately 13.3% individuals are living with HIV in the province (Shisana et al 2014). Steady progress has been made in enrolling people living with HIV onto treatment. A little less than half of this estimate is reported to have remained on ART at the end of the 2015/2016 financial year (204 184).

ART Coverage

The eligibility criteria for enrolling people living with HIV onto ART changed several times during the implementation of the NW PSP. The 2013 World Health Organization (WHO) Treatment guidelines extended eligibility to CD4 T-cell count <500 cells/µl, with pregnant women, individuals infected with TB and infants being enrolled despite the CD4 count. The government of South Africa adopted the Test and Treat policy in 2015 which expanded eligibility to include all individuals living with HIV irrespective of CD4 count.

Figure 6: ART Coverage in the North West Province



Source: Johnson et al, 2016 (Thembisa model)

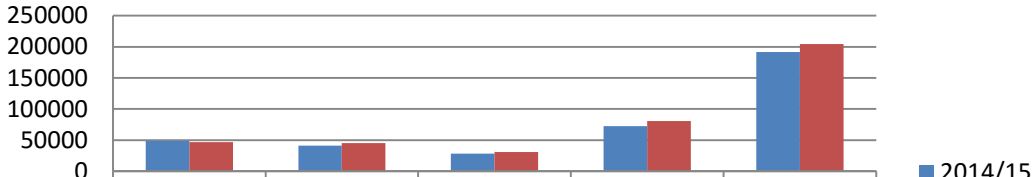
Figure 6 compares ART coverage estimates. The Thembisa model estimates that about 44% of all individuals living with HIV were enrolled onto ART in 2015 highlighting a gap of approximately 54% to be covered under the current Universal Test and Treat policy. Based on the then prevailing ART protocols of January 2014, approximately 60% of people living with HIV were enrolled onto ART in 2015. Figure 6 shows that irrespective of the guidelines the province did not meet its target of enrolling at least 80% eligible clients onto ART.

Clients remaining on ART

The province achieved a steady increase in the number of people living with HIV being enrolled onto ART. Figure 7 depicts the total number of adults and children remaining on ART in 2014/2015 and 2015/2016. The number of clients remaining on ART increased from 191 612 in 2014/2015 to 204 184 individuals in 2015/2016. About 42 092 new clients were reported to have been enrolled in the year 2015/2016. The data seems to imply that about 29 520 clients were lost in the system.

It is also interesting to note that Dr Kenneth Kaunda had the highest burden of HIV in the Province yet it was ranked 3rd in the number of individuals remaining on ART in 2014/2015 and 2015/2016 as per data in Figure 7.

Figure 7: Total number of clients remaining on ART



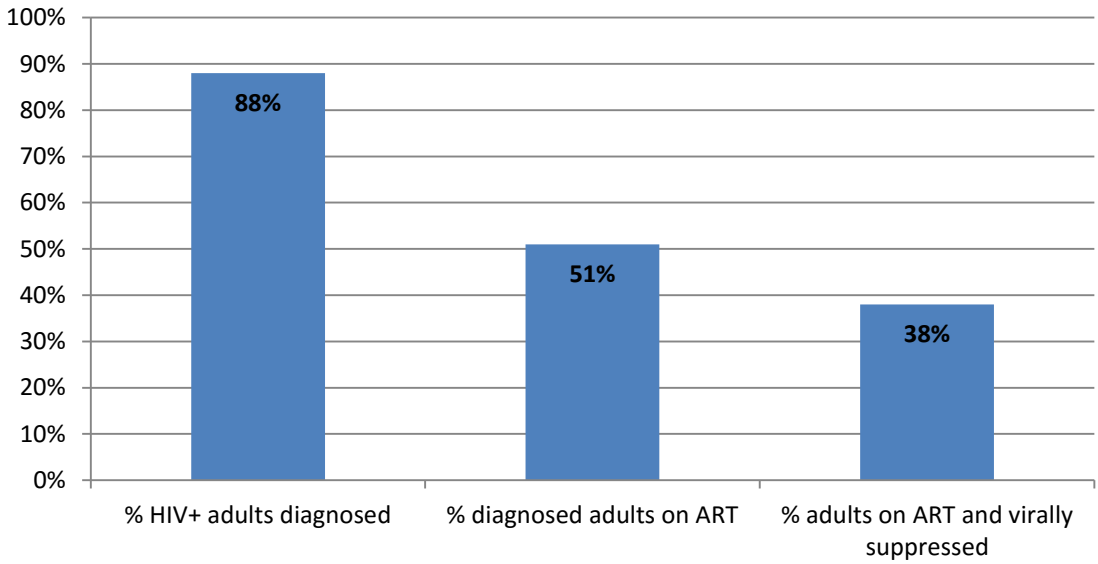
	Ngaka Modiri Molema DM	Dr K Kaunda DM	Ruth Segomotsi Mompati DM	Bojanala Platinum DM	North West Total
2014/15	48895	41493	28532	72692	191612
2015/16	46882	45428	30875	80999	204184

Source: District Health Information System (DHIS)

Adult HIV Treatment cascade for the North West

According to Johnson et al (2016), NW and KZN Provinces had the highest, percentages of adults diagnosed HIV positive nationally.

Figure 8: Adult HIV Treatment cascade for the North West, 2015



Source: Johnson et al, 2016 (Thembisa model)

Adopted from Johnson (2016), Figure 8 indicates progress towards the 90-90-90 targets, as at mid-2015. The North West has done remarkably well in nearly meeting the first 90 target. About 88% of HIV positive adults were diagnosed. However, nearly half (51%) of the adults diagnosed HIV positive were on ART. Of the diagnosed adults on ART approximately 38% are virally suppressed.

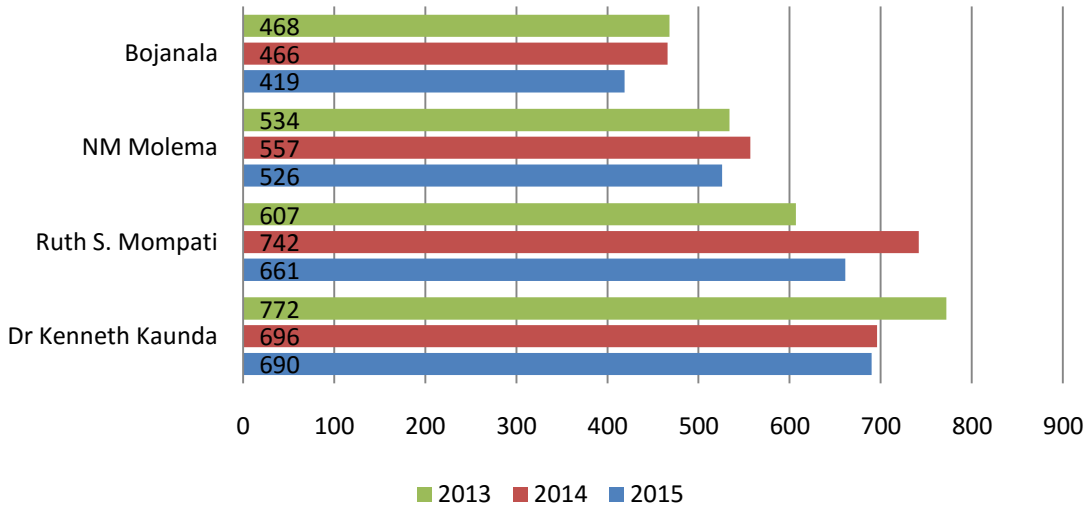
Goal 3: Reducing the number of new TB infections, as well as the number of TB deaths by 50%

TB incidence

The number of new TB cases has been declining in the province. Table 1 indicates that TB incidence (all types) declined from 630.7 cases per 100 000 population in 2014/2015 to 528.4 cases per 100 000 population in 2015/2016 (District Health Barometer 2015/2016).

TB incidence varies according to district.

Figure 9: TB incidence per 100 000 (all types) in the North West by district, 2013-2014



Source: District Health Barometer 2014/15

Figure 9 indicates that the district with the highest TB incidence (all cases) was Dr Kenneth Kaunda (690 cases /100 000 population) with Bojanala having the lowest incidence (419 cases/100 000 population) in 2015/2016.

In the North West, HIV and mining were two of the main risk factors for the TB epidemic. In 2014, the national TB screening campaign included the mining districts of Bojanala and Dr Kenneth Kaunda among the six national priority districts[17]. Prioritising the TB Programme has seen a steady improvement in the proportion of successfully treated patients from 65.8% in 2013 to 70.2% in 2014.

[17] DHB 2014/15

TB mortality

TB remains the leading cause of death in the province[18]. There has been a marginal decrease in TB death rates (all types of TB) in the province. Table 1 indicates that TB death rate declined from 10.2% in 2013 to 10.1% in 2014.

Dr Kenneth Kaunda continues to have the highest proportion of TB related deaths in the province. In 2013, TB death rate was recorded at 14.1% in Kenneth Kaunda. Bojanala had the second highest TB death rate of 8.9%. The NW DOH 2015/2016 Annual report attributed the high death rate to high rates of loss to follow up, defaulter rate, non-compliance to TB protocols and a very low screening rate of TB can be attributed to the high death rate.

Goal 4: Reducing self-reported stigma and discrimination related to HIV and TB by 50%

As the HIV/AIDS epidemic has matured nationally, progress has been made in the extent of stigma and discrimination. A study called the People Living with HIV Stigma Index was conducted in 18 districts of South Africa to explore the extent of HIV and TB related stigma and discrimination among people living with HIV.

Of the three forms of stigma (external, internal and anticipated stigma), internalised stigma was more prevalent among PLHIV who took part in the national survey.

The study found that internalized stigma was prevalent with nearly a forth (43%) of the respondents reporting feeling ashamed, guilty, and having blamed themselves or others and or were suicidal. Among the people living with HIV who experienced internalized stigma, the majority (31%) blamed them for being infected with HIV, whilst 29% felt ashamed and 28% were guilty. The people who were more likely to feel internalized stigma included young people (15-24), newly infected (0-1 year), cohabiting or those living separately from spouse or partner, respondents with no formal education and those with tertiary education.

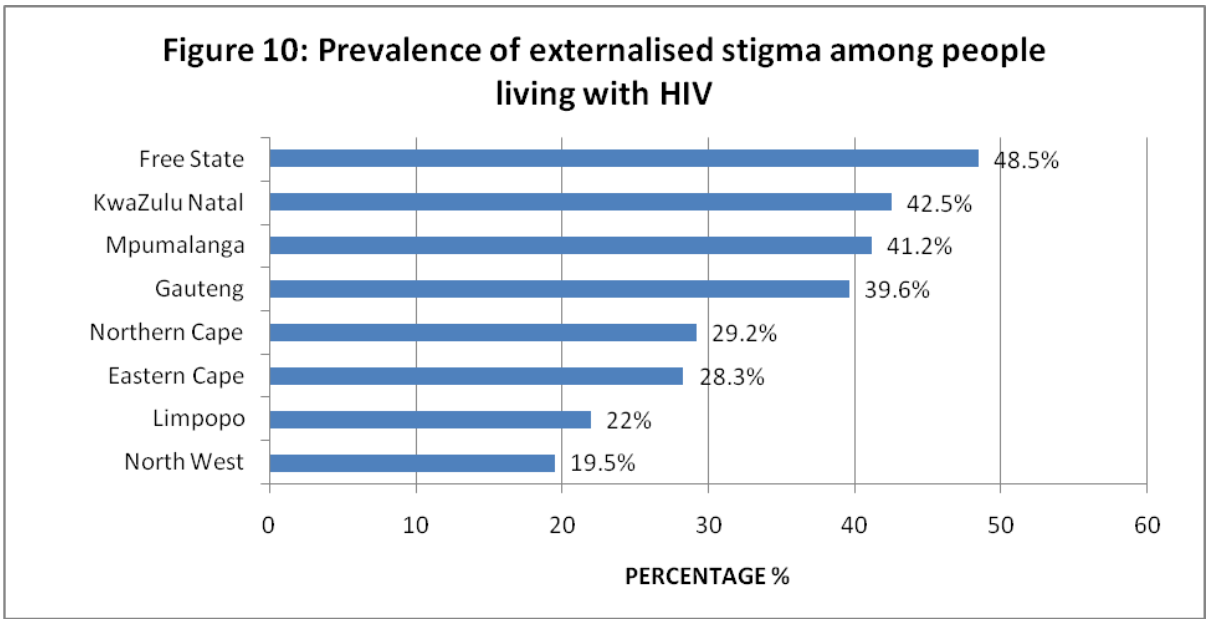
Over a third (36%) of respondents reported that they had been teased, insulted, or sworn at because of their TB status with over a forth (41%) reporting being gossiped about their TB status.

About 36% of the respondents reported that they had experienced external stigma. Being gossiped about (42%), discrimination (37%) and verbal assault and harassment (35%) were the main forms of external stigma experienced. Young people (15-24), married, cohabiting or living separately from

[18] Statistics South Africa. Mortality and causes of death in South Africa, 2014: Findings from death notification. Pretoria: StatsSA;2015.

spouse or partner, female respondents and those who had lived with an HIV diagnosis for 2-4 years were more likely to experienced external stigma.

In the North West, Dr Kenneth Kaunda and Ngaka Modiri Molema districts participated in the survey. Figure 10 shows extent of external stigma according to province.



Approximately 19.5% of respondents in the North West reported experiencing external stigma. It was commended that the North West has the lowest levels of external stigma when compared with other provinces.

The study also found that at national level, the country had succeeded in addressing stigma and discrimination experienced by PLHIV at especially the health care facilities. It was recommended that despite this great achievement, there was still urgent need for a Stigma mitigation campaign to address the internal and external forms of stigma which were prevailing (Cloete et al, 2014).

7. ASSESSMENT OF PROGRESS MADE TOWARDS ACHIEVING PSP 2012 – 2016 STRATEGIC OBJECTIVES

STRATEGIC OBJECTIVE 1: SOCIAL AND STRUCTURAL DRIVERS OF HIV, TB AND STI, PREVENTION, CARE AND IMPACT

This strategic objective addresses socio-economic and structural issues that fuel HIV, STIs and TB through interventions that address societal norms and behaviours across all sectors.

The sub objectives of Strategic Objective 1 are:

- Mainstream HIV and TB and its gender and rights based dimensions into the core mandates of all government departments and all SANAC sectors.
- Address social, economic and behavioural drivers of HIV, STIs and TB.
- Implement interventions to address gender inequalities and gender based violence as drivers of HIV and STIs.
- Mitigate the impact of HIV and TB on orphans, vulnerable children and youth.
- Reduce the vulnerability of young people to HIV infection by retaining them in school as well as providing post school education and work opportunities.
- Reduce HIV and TB related stigma and discrimination.
- Strengthen community systems.
- Support efforts aimed at poverty alleviation and enhancing food security programmes.

Remarkable progress was achieved in addressing Strategic Objective One. Data presented in Table 3 (below) highlights some of the achievements, challenges and gaps. Below are some of the key achievements of 2015/16:

- Launch of the 'Keeping Girls in School' programme for secondary female students by the Department of Education and Sports Development to reduce school drop outs and risky behaviours and encourage academic excellence.
- Increased visibility of government service providers addressing socio-economic and structural challenges in the communities through the Fifth Administration concretes such as Setsokotsane.
- All government departments had operational plans with mainstreaming of gender and rights based dimensions of HIV and TB.
- Strategic partnerships between government departments and implementing partners in implementing Social Behaviour Change programmes.
- Increased support given to orphans and vulnerable children.

Table 3 below indicates that, in 2015/2016 as in the previous year, all government departments continued to mainstream gender and rights based dimensions related to HIV, STIs and TB. Some government departments facilitated the provision of non-health HIV testing services, stigma and discrimination mitigation for their employees for whom some represent the hard to reach population. No data was available on operational plans submitted by the civil society.

Residence in informal settlements and hard to reach areas was identified as one of the socio-economic and structural determinants of HIV, STIs and TB transmission[19]. No data was available to confidently state the proportion of municipalities with at least one informal settlement where targeted comprehensive HIV, STI and TB services are implemented. However, the Honourable Premier of the North West launched the Setsokotsane and RHR unit to deal specifically with societal issues. The two units seek to facilitate the availability and accessibility of comprehensive social services to previously disadvantaged localities in particular.

In 2015/2016, there were approximately 830 529 students in 1 527 ordinary public schools[20]. No data was available to measure the proportion of orphans versus non-orphans in school. However, in 2015/16, the Department of Education and Sports Development launched a 'Keeping Girls in School' programme which aims to reduce school drop outs and risky behaviours and encourage academic excellence. Through the Care and Support for Teaching and Learning Programme, vulnerable learners who included survivors of sexual abuse and other forms of abuse and from child headed families were referred for care and support to relevant government departments. No data was available on the orphans and non-orphan's attendance of formal schooling. The Peer Education Programme facilitated peer education camps for secondary school learners who were capacitated to deal with sexual reproductive health issues including their overall rights.

Table 3 also indicates a marginal decline in the delivery rate among young women under the age of 18 in public health facilities. Approximately 6.3% of all deliveries in 2015/2016 were of young women under the age of 18 years, a decline from 6.9% in 2014/2015. This indicator is a proxy for early sexual debut and unprotected sex among young women. There is evidence that delaying sexual debut significantly reduces the risk of HIV infection per sexual act in women. The decline in delivery rates could imply the success of the multi-sectoral interventions targeting young women in school and in the community. The indicator is treated with caution however, due to the possibility of under reporting and street abortions.

[19] North West Provincial Strategic Plan on TB, HIV and AIDS (2012-2016).
[20] Annual Report 2015/16. North West Department of Education and Sport Development

Table 3: Social and Structural drivers of HIV, TB and STIs, Prevention, Care and Impact

Indicator	Baseline 2011	Target 2016/17	FY2014/15	FY2015/16 Status	Comment – progress towards target
% government departments and sectors with operational plans with HIV, TB and related gender and rights based dimension integrated.	-	100%	100%	100%	Target reached in government departments. No data for SANAC sectors.
% municipalities with at least one informal settlement where targeted comprehensive HIV, STI and TB services are implemented.	-	-	-	-	No data for the indicator.
Current school attendance among orphans and among non-orphans aged 10 - 14 (UNGASS 12; MDG Indicator).	-	-	-	-	No data for the indicator.
Delivery rates for women under 18-NIDS.	7.2%	-	6.9%	6.3%	Marginal decline.
HIV and TB spend (R'000) [1] DSD [2] DoH [3] DoE		-	R77 877	R 101 985[1]	Government spending on HIV/AIDS and TB increased in 2015/16.
		-	R 936 937 996	1 002 075[2]	
		-	R 17 388	R 22 325[3]	
Percentage/Number of OVC aged 0-17 whose households received free basic external support in caring for the child:	-	-	105 244	107 720	Indicator reported is number of OVC receiving psychosocial support services through home base care and community care.
Number of women and children reporting gender-based violence (GBV) to the police in the last year	-	-	4 164	4 585	9.2% decline is of concern because of underreported. Data does not include other forms of GBV nor is it aggregated by neither sex nor age.
Proportion of women who have experienced physical or sexual	-	-	2,897	2801	Marginal decline.

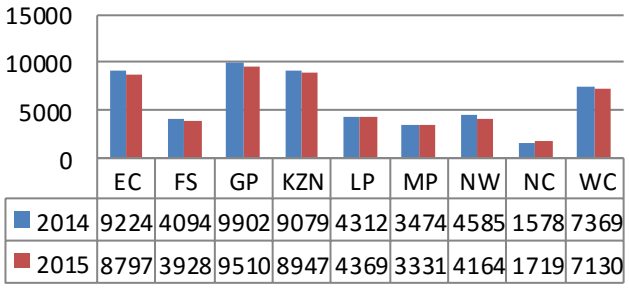
violence in the last year					

The South Africa Investment Case determines the cost, impact and cost effectiveness of different HIV and TB interventions. This rationalises the approach to the epidemics from an economic point of view. It was envisaged that this would enable prioritised spending through delivering basic sets of HIV and TB programmes at limited expenditure but for greater impact (Meyer-Rath, et al 2016). The prioritised spending would be done through geo-spatial mapping to identify areas of high HIV and TB burden for a targeted response. Data reported on HIV and TB spend in Table 3 above is limited to only three departments, namely the Department of Education and Sports Development (DoE), Department of Health (DoH) and Department of Social Development (DSD). The Department of Social Development spent R 101 985 000 under the HIV/AIDS Prevention, Care and Support Services Sub Programme. Under the Comprehensive HIV& AIDS Conditional Grant, DoH spent R1 002 075 000 in 2015/2016 whilst the DoE spent R 22 325 000. The limitation of the indicator was that investment done from private and donor or implementation partners was not available. However, all multi-sectoral stakeholders need to adopt the 90-90-90 strategy as it seeks to achieve maximum impact on investment being done in the HIV and TB epidemics.

Remarkable effort was put in the province to reduce vulnerability of young people and orphans and vulnerable children (OVC). The DSD Annual report 2015/2016, estimates that approximately 107 720 OVC households received free basic external support in caring for the OVC in 2015/16. The reach surpassed the annual target set for 2015/16.

The association between HIV and gender based violence is well documented in literature. It is difficult to measure the true extent of gender based violence in the province due to a variety of factors including secrecy surrounding it. Gender based violence is defined as physical, emotional, financial and sexual abuse. However, data from the South Africa Police Services (SAPS) measures extent of reported sexual assault cases on the general population. According to the SAPS, there was a 9.2% decline in the number of reported cases of sexual assault in the province[21]. According to Figure 11, it is reported that sexual offenses declined from 4 585 in 2014/2015 to 4 164 in 2015/2016. Research shows that gender based violence has always been underreported, thus a decline in the 2015/16 statistics may not necessarily imply a decline in the crime itself. About 2 801 cases of sexual abuse were reported in public health care facilities in 2015/16. Of these, about 1 970 cases were given Pre-exposure prophylaxis.

Figure 11: Sexual Offences by Province



	EC	FS	GP	KZN	LP	MP	NW	NC	WC
2014	9224	4094	9902	9079	4312	3474	4585	1578	7369
2015	8797	3928	9510	8947	4369	3331	4164	1719	7130

Source: Crime Situation in South Africa.

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

Guided by the objective, the North West Province uses a combination of structural, behavioural and biomedical approaches in preventing new infections. Strategic partnerships and ability to adapt responses to the dynamic nature of the epidemics through the use of evidenced based scientific innovations are emphasised.

The sub-objectives to Strategic Objective 2 are:

- Maximise opportunities to ensure everyone in Bokone Bophirima, Province of North West, tests voluntarily for HIV and screened for TB at least annually, and subsequently enrolled in relevant wellness and treatment, care and support programmes
- Make accessible a package of sexual and reproductive health services
- Prevent transmission of HIV to reduce Mother to child transmission to at least 2% at six weeks and to less than 5% at 18 months by 2016/17
- Implement a comprehensive national social and behavioural change communication (SBCC) strategy with particular focus on key population.

[21] Crime Situation in South Africa. Accessed http://www.saps.gov.za/services/final-crime-stats-release-02september2016.pdf

- Prepare for the potential implementation of future innovation, scientifically proven HIV, STI and TB prevention strategies.
- Prevent TB infection and disease
- Address sexual abuse and improve services for survivors of sexual assault.

Remarkable progress was made in addressing Strategic Objective One. Data presented in Table 4 below highlight some of the achievements, challenges and gaps. Below are some of the key achievements of 2015/2016:

- Reduction by about 63% from 2011 estimate of the mother to child transmission of HIV.
- Strategic partnerships between government departments and implementing partners in implementing Social Behaviour Change programmes such as between the Department of Social Development and NACOSA and with PACT SA respectively.
- Increase in the number and capacitation of community based organisations in Social Behaviour Change Programmes through departments such as the Department of Social Development.
- Improved HIV counselling and testing due to target setting at facility level as per the 90-90-90 strategy.

It is established that HIV counselling and testing (HCT) is the gateway to appropriate treatment, care and support. As such, the NW DoH, assisted by various stakeholders including implementing/development partners and community based organisations intensified provision of routine HIV testing. Table 4 below indicates that approximately 760 379 individuals of the sexually active age group (15-49 years) were tested for HIV. The urgency of fast tracking ending of the AIDS epidemic motivated a paradigm shift by setting ambitious targets of the 90-90-90 strategy. As such, target setting at facility level resulted in the department surpassing its annual target. However, comparison of the HIV testing coverage of 2014/15 and 2015/16 shows that the proportion of individuals aged 15-49 declined.

HIV is well documented as driving the TB epidemic. The risk of TB infection increases by approximately ten times in individuals living with HIV. About 64 612 HIV positive individuals were screened for TB in 2015/16 which is a reduction from about 85 080 HIV positive individuals screened in 2014/15. No data was available for the numbers of people (HIV positive and HIV negative individuals) who were screened in for TB in the province. Approximately 21 146 newly diagnosed HIV positive individuals received Isoniazid Preventive Therapy (IPT), a treatment for latent TB infection, in 2015/16.

Data projections from the Thembisa model (Johnson 2016) indicates that condom use declined among young people (15-24 years) since 2011. The data also shows that more young women (15-24 years) than young men of the same age group used condoms in their last sexual act. It is forecasted that nearly a quarter of these young men (24.7%) and young women (26.9%), used a condom at their last sexual encounter in 2014/2015. A reduction in condom usage is predicted as about 23.8% of young men and 26% of young women use condoms at their last sexual encounter in 2015/2016.

Proportion of men and women aged 15-49 years engaging in multiple and concurrent sexual partnerships in the North West still sustained the high infection rate. Sexual networks promote rapid transmission of the HIV virus especially during the early phase of infection. A nationally representative HIV survey conducted in 2011 shows that approximately 13% of sexually active individuals aged between 15 and 49 years of age had had more than one sexual partner in the 12 months preceding the survey (Shisana et al 2014). It is well documented that transmission of HIV is high in these sexual networks especially when the sexual networks are characterised by low condom usage and low levels of male circumcision (Leclerc-Madlala 2009; Jana 2008). Jana 2008 estimates that transmission rate is about eight times higher in long term concurrent relationships.

Table 4: Preventing new HIV, TB and STI infections

Indicator	Baseline 2011	Target 2016/17	FY2014/15 status	FY 2015/16 Status	Comment-progress toward target
Number (and percentage) of men and women 15–49 counselled and tested for HIV		-	- 32,2% (testing coverage)	760 379 27%(testing coverage)	2015/16 reach surpassed annual NW DoH target.
Number and percentage of people screened for TB	-	-	-	-	No data. However, 85 080 HIV positive were screened for TB in 2014/15 and 64,612 in 2016.
Number of newly diagnosed HIV positive people started on IPT for latent TB infection	-	-	38926	21 146	Decrease in number started of IPT
Percentage men and women aged 15–24 reporting the use of a condom with their sexual partner at last sex	28.6% (men)	-	24.7%[22]	23.8%[18]	Segregated data by sex from Thembisa model. Reduction in condom use projected.
	30.6% (women)	-	26.9%[18]	26%[18]	

[22] This is projected data taken from Thembisa model (Johnson 2016), which is to be treated with caution.

Percentage young women and men aged 15–24 who had sexual intercourse before age 15 (age at sexual debut)	8.5% (4.8-14.7) 2008 survey data	-	9.8% (6.6-14.5) 2012 Survey data	-	An increase in the number of young people engaged in sex before the age of 15.
Percentage women and men aged15–49 years who have had sexual intercourse with more than one partner in the last 12 months	12.9% (9.2-17.7)[23]	-	13%(9.1-18.1) 2012 survey data	-	Marginal increase which is statistically not significant.
Male condom distribution	-	-	37,924,713	32,184,899	Reduction due to poor condom management at Primary Delivery sites (PDS)
Female condom distribution	-	-	980,549	1,211,666	Affected by poor condom management at Primary Delivery sites (PDS).
Indicator	**Baseline 2011**	**Target 2016/17**	**FY2014/15**	**FY 2015/16 Status**	**Comment – progress towards target**
Number of men medically circumcised	2,116	-	46970	38 816	Reduction in MMC due to withdrawal of implementing partners.
Number of people reached by prevention communication at least twice a year	-	-	-	-	-

About 32 million male condoms were distributed in 2015/2016. However, condom distribution is reported to have been affected by poor management at Primary Delivery sites (PDS). Approximately 1.2 million female condoms were distributed in 2015/2016, an increase from 980 549 female condoms distributed in 2014/2015.

The North West succeeded in scaling up medical male circumcision (MMC) it increased from 2 116 in 2011 (baseline value) to 38 816 in 2015/16. However, Table 4 also shows that despite this achievement, MMC declined from 46 970 in 2014/15 to 38 816 in 2015/16. Among other reasons, this was due to the reduction in number of implementing partners offering the service in the

[23]Shisana, O., Rehle, T., Simbayi, L., Zuma, K., Jooste, S., Zungu, N., Labadarios, D., Onoya, D., et al. (2014) South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town: HSRC Press.

province. A model called Decision Makers Program planning Toolkit found that scaling up circumcision among men aged between 15 and 34 years would have the greatest impact in reducing HIV transmission to men as well as being cost effective (Kripke et al 2016). The study concluded that there is greater need to encourage circumcision among young men.

According to a nationally representative survey conducted in 2012, there was an increase from 8.5% in 2008 to 9.8% in 2012 in the proportion of young people aged 15-24years engaging in sexual intercourse before the age of 15years (Shisana et al 2014). However, the increase is not statistically significant. Research has shown that early sexual debut significantly increases the risk of HIV infection by increasing the period of exposure. Individuals who have sex earlier were more likely to engage in risky sexual intercourse due to lack of capacity to demand for safe sex. Shisana (et al 2014) argues that young women tend to have age-disparate relationships with older men, which has been shown to significantly increase the risk of HIV infection among the young women.

Remarkable effort has been put in offering treatment, care and support for survivors of gender based violence especially sexual assault. Though data from the NW DoH only is presented in Table 4 (above), it shows on average, 70% of the sexual assault cases presented at health care facilities were given Post exposure prophylaxis for preventing HIV infection. Again, it is important to note that research has shown that there is underreporting of sexual assault cases. This may just represent the tip of the iceberg.

Strategic Objective 3: Sustaining Health and Wellness

This objective supports the implementation of wellness programmes by ensuring that there is access to high-quality treatment, care and support for people with TB, STIs and HIV.

The following are the sub-objectives of Objective 3:

- Reduce disability and death resulting from HIV, STIs and TB through universal access to HIV and TB screening, diagnosis, care and treatment.
- Ensure that people living with HIV, TB and STIs remain within the health care system, are adherent to treatment and maintain optimal health and wellness.
- Ensure that systems and services remain responsive to the needs of people living with HIV, STIs and TB.

The province succeeded in reducing deaths and disabilities which result from HIV, STIs and TB by providing universal access to affordable, accessibility and good quality diagnosis, treatment and care. Major achievements under Objective 3 include the following:

- The North West province has the highest proportion of HIV-positive adults diagnosed in the country (Johnson et al 2016).
- The province also had the highest rates of viral suppression in HIV positive adults on ART in South Africa (Johnson et al 2016).
- Increasing implementation of the Central Chronic Dispensing and Distribution Programme in especially high volume Community Health Centres in all sub-districts. This is part of the decanting strategy which seeks to decongest health care facilities whilst ensuring that all patients adhere to their treatment.
- TB new clients' treatment success rate increased.
- Increased life expectancy at birth for women and males. Projected to be 57.5% for males and 65.5% for females in 2015 by the Thembisa model (Johnson et al 2016).
- Increased enrolment of eligible individuals onto ART. The ART programme succeeded in reducing AIDS related mortality in the province.

Table 5 below indicates that assuming universal eligibility as per the Test and Treat policy; approximately 44% of eligible HIV positive individuals were receiving ART in 2015/16. This is an increase from 41.8% coverage of 2014/2015.

Table 5: Sustaining Health and wellness.

Indicator	Baseline (2011)	Target 2016	FY 2014/2015	FY 2015/16 Achieved	Comment – progress towards target
Proportion (%) of people per year becoming eligible who receive ART	28.1%	90%	41.8%	44%	The new policy on test and treat has everyone being eligible for ART
TB case detection rate	24,930	-	-	-	The indicator measures case finding.
% smear positive TB cases that are successfully treated	70.8%	85%	70.4%	-	Below target. Intensified TB programme can reach target.
TB death rate	-	No target	10.1%		High lost to follow up and defaulter rate results in high TB death.
CFR HIV-positive = CFR HIV-negative	-	-	-	-	No data
Number and % of registered TB patients who	-	-	-	-	HIV/TB co-infection rate

tested for HIV					

The TB Control Programme in the province struggled with loss to follow up, non-compliance to TB policies and high defaulter rate. The proportion of smear positive TB cases that were successfully treated is below the 85% target. About 70.4% of smear positive TB cases were successfully treated in 2014/2015. According to the 201520/16 Annual Report from DoH, the TB new clients' treatment success rate increased from 76.2% in 2014/15 to 82.1% in 2015/16. Despite, being below the annual target of 85%, the increase is a significant achievement.

TB death rate in this report measures the proportion of TB patients who died while on treatment. In 2014/2015, the provincial average death rate of 10.1% was reported for TB patients on treatment.

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

The PSP recognises that access to health care and other social services is a fundamental right to all. Thus, the objective addresses violations of human rights, gender inequality, discrimination and stigma.

The sub-objectives include:

- Identify and address laws and policies that undermine implementation of all PSP interventions or increase vulnerability to HIV and or TB infection.
- Ensure that rights are not violated when interventions are implemented and establish mechanism for monitoring abuses and exercising rights.
- Reduce unfair discrimination in access to services.

As reported under Goal 4, a stigma and discrimination national study reported that in the two sampled districts of North West; approximately 19.5% of PLHIV have experienced some form of external stigma.

The survey also reports that discrimination in access to services especially health care services is relatively low at national level. However, it was acknowledged that stigma and discrimination at health facility level despite being low needs to be addressed.

The Employee Health and Wellness unit under the Office of the Premier continued to provide Stigma and discrimination mitigation services to government employees.

8. MONITORING AND EVALUATION

8.1 Overview of the Provincial M&E system

The NW PSP acknowledges that monitoring and evaluation (M&E) is one of the key enablers. The goal is to establish a comprehensive, well-coordinated and simple information management and reporting system for effective implementation, monitoring and evaluation of impact.

In 2014/2015, the former Provincial AIDS Council and associated local AIDS Councils were dissolved and a new structure, the Reconciliation, Healing and Renewal (RHR) Directorate under the Office of the Premier was established. Hence forth, the Monitoring and Evaluation unit was transferred to the RHR directorate. With the establishment of RHR Forums from ward level to Provincial level, it is anticipated that data will flow in that pathway to the Provincial M&E unit.

The M&E unit uses secondary data in monitoring and evaluation. It depends on the multi-sectoral implementers availing quality real data in a timely manner for effective evidenced informed decision making. Routine data as in programmatic data and non-routine data (research data) is required. Currently, data flows from stakeholders at the provincial level to the M&E Unit.

8.2 Challenges in the implementation of the Provincial M&E system

- Poor data quality which compromises the quality of reporting.
- Lack of M&E capacity at local levels to monitor and evaluate the multi-sectoral response to HIV, STIs and TB.
- Lack of local level structures to facilitate upward (from ward level to provincial level) flow of data relating to the multi-sectoral response to HIV, STIs and TB.
- Late or no reporting from multi-sectoral stakeholders makes it difficult to compile quarterly feedback reports.
- No reports from other structures or stakeholders such as civil society including private and business stakeholders.
- There is no dedicated evaluation and research agenda. No platforms exist for all stakeholders to learn and share knowledge and information as a Province.
- Lack of 2016/17 yearly targets for some targets make it difficult to make judgement on progress reached. Government departments have targets that change of a yearly basis.

8.3 Remedial Action

- Establishment of RHR forums at local levels and at Provincial level with coordination, monitoring and evaluation of HIV, STI and TB as a key agenda.
- Signing of Memorandum of understanding with government departments to enable reporting of data to the RHR Directorate.
- Strengthening of role of the RHR Directorate on coordination, monitoring and evaluation of the PSP through the RHR forums and associated structures.
- Selection of indicators that sectors can report on.

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

9.1 Main findings

The year 2015/2016 means that there is one year left to the end of the NW PSP on HIV, STIs and TB, 2012-2016. The financial year of 2016/2017 marks the end of the five-year implementation period. Data presented in the report shows that much progress was made by the province. However, the province experienced challenges which impede the reaching of a number of identified targets for the NW PSP objectives

The following are the main findings from the Strategic objectives:

- Anecdotal evidence from research shows that risky sexual behaviour among sexually active age group continues to fuel the spread of new HIV infection. High rate of early sexual debut, decreasing trend in condom usage, and a high proportion of individuals engaging in multiple and concurrent partnership are some of the behavioural drivers.
- Mother to child transmission of HIV to infants at six weeks old declined from 1.8% in 2015/2016 to 1.5% in 2015/2016.
- Intensified efforts towards HIV testing, saw 760 379 individuals being tested in 2015/2016, surpassing the annual target of 541 499.
- The number of people living with HIV enrolled and remaining on ART increased to 204 184 by March 2016.
- Under the universal access to ART, the province had about 44% of eligible adults enrolled onto ART. The target for 2020 being 90%.

- Internalised stigma was the most prevalent form of stigma among people living with HIV (PLHIV). Nearly a fifth (19.5%) of people living with HIV in the North West province (Dr Kenneth Kaunda and Ngaka Modiri Molema districts) experienced external stigma.

- The number of individuals benefiting from social relief of distress increased through the intensification of services provision through the Setsokotsane (NW DSD Annual report 2015/2016).

9. 2 Challenges and Gaps

The following are some of the main challenges and gaps in the Strategic Objectives:

- Risky sexual behaviour among sexually active age group continued to fuel the spread of new HIV infection. High rate of early sexual debut, decreasing trend in condom usage, and a high proportion of individuals engaging in multiple and concurrent partnership were some of the behavioural drivers.
- Poor reporting due to incomplete records at facility level continued to affect data quality.
- Not all clients enrolled onto ART remained in care by the end of the year. Poor reporting at facility level and increased loss to follow up were experienced during the reporting period.
- A 33% gap exists between the targeted number of MMC to be performed (58 366) and the reach (38 816) in 2015/16.
- Withdrawal of development partners supporting the Department of Health in the MMC Programme resulted in a decline in the number of MMC performed.
- Poor condom management at Primary Delivery sites negatively affected condom distribution.
- Poor performance by the TB Control Programme. It was characterised by poor adherence to TB protocol, high rate of loss to follow up and defaulter rate among TB patients. The 2015/16 NW DoH Annual Report reports that some TB patients provide wrong demographic information which impedes tracing of patients.
- Low levels of reporting to gender based violence crimes to the SAPS and to public health care facilities. Anecdotal evidence shows that a decline in the number of reported GBV cases does not necessarily imply success in the programme. It may imply high levels of non-disclosure or reporting.
- Lack of data on key population such as sex workers, men who have sex with men (MSM) and the Lesbian Gay Bisexual Transgender and Intersex (LGBTI).

10. CONCLUSION AND RECOMMENDATIONS

The 2015/2016 Annual report is a consolidation of the efforts of the multi-sectoral response to HIV, STIs and TB as per the selected key indicators in the PSP.

The province achieved its desired target in reducing mother to child transmission (MTCT) at 6 weeks after birth. The target for 2016/2017 is that less than two percent of all infants born to HIV positive mothers should test HIV positive at 6 weeks after birth. The provincial reach in 2015/2016 was 1.5%. The national MTCT rate at 6 weeks also significantly declined to 1.7% in 2015/2016. This implies a huge success in the PMTCT programme nationally and provincially.

Despite a decline in HIV incidence as per Thembisa model (Johnson et al 2016), the HIV incidence was still unacceptably high in the province, during the period under review. The province is unlikely to meet its target of halving new HIV infections. Young women aged 15-24 years continued to be the most susceptible to HIV infection. HIV was predominantly transmitted through sexual contact. This is supported by research which shows that risky sexual behaviour is still prevalent in the province. The national survey shows that there is an increase in early sexual debut among 15-24 years old, multiple and concurrent partnerships and of age disparate relationships among young women and men 5 years or older (Shisana et al 2016). The risky sexual behaviour happens in circumstances of low condoms usage.

HIV prevalence decreased among pregnant women aged 15-49 years attending antenatal care in public health facilities. Caution is exercised in interpreting this decline. There is need for further in-depth study to explore the reason for the decline. However, data from Johnson et al (2016) suggests some significant reduction in HIV incidence which may be attributed to the decline.

The expansion of the ART programme resulted in improved health hence increased life expectancy. Just as in the rest of the country, the proportion of females on the ART programme was higher than the males (Shisana et al 2016).

The results also show that not all clients who were enrolled onto ART (both newly enrolled and those remaining on ART) in 2015/2016 remained on ART. This shows that there is need for systems to be put in place to encourage clients to remain in care.

The TB Control Programme saw an increase in TB cases successfully treated. However, TB death rate is remarkably high especially when TB is curable and treatment is freely available. The province faced challenges regarding adherence to TB protocol, loss to follow up and high rate of defaulters.

Thus, despite the achievements, much still remains to be done for the province to fast track to a generation of zero new HIV infections.

Recommendations

Below are the main recommendations:

- Once the RHR Forums at provincial and lower levels have been formed, there is need to capacitate the new structures on coordination of the HIV, STIs and TB response
- The province needs to strengthen and scale up programmes aimed at achieving the 90-90-90 targets for HIV and TB. There is need for intensifying guidelines as per the HIV Testing Services policy. The HIV Testing Services policy seeks to promote scaling up of universal testing, early linkage and retention in care treatment and support.
- There is need to strengthen the TB Control programme in the province through increased capacity building, TB prevention, case finding and treatment interventions.
- The HIV prevention strategy needs to scale up interventions that tackle determinants of transmission such as concurrency, age disparate relationships and low condom usage, early sexual debut and gender based violence.
- There is need for the province to adopt the Investment Case Model approach. This will promote allocation of resources to localities of high burden for a more focused response which yields high impact.

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