MARCH 2017

ANNUAL PROGRESS REPORT 2015/16

PROVINCIAL STRATEGIC PLAN 2012-2016

LIMPOPO PROVINCAL AIDS COUNCIL

1. ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
APP	Annual Performance Plan
ART	Antiretroviral Therapy
ARV	Antiretroviral
CAPS	Curriculum and Assessment Policy Statement
CCMT	Comprehensive Care Management and Treatment
CFR	Case Fatality Rate
DAC	District AIDS Council
DHB	District Health Plan
DHIS	District Health Information System
DIP	District Implementing Plan
DOE	Department of Education
DOH	Department of Health
DOT	Directly Observed Treatment
DSD	Department of Social Development
EPWP	Expanded Public Works Programme
ETR	Electronic TB Register
FDC	Fixed Dose Combination
GBV	Gender Based Violence
HAST	HIV and AIDS STIs and TB
HCBC	Home Community Based Care
HCT	HIV Counselling and Testing
HCW	Health Care Worker
HDACC	Health Data Advisory and Co-ordination Committee
HIV	Human Immune-deficiency Virus
HSRC	Human Sciences Research Council
HTA	High Transmission Area
IACT	Integrated Access to Care and Treatment
ICT	Intensified Case Finding
IDP	Integrated Development Plan
IMR	Infant Mortality Rate
IMIS	Integrated Maintenance Information System
IPT	Isoniazid Preventive Therapy
ISHIP	Integrated School Health Policy
LAC	Local AIDS Council
LDoE	Limpopo Department of Education
LDoH	Limpopo Department of Health
LDSD	Limpopo Department of Social Development
LPT	Limpopo Department of Provincial Treasury
LPAC	Limpopo Provincial AIDS Council
MDG	Millennium Development Goal
MEC	Member of Executive Council
MTCT	Mother-to-Child Transmission

M & E	Monitoring and Evaluation
VMMC	Voluntary Medical Male Circumcision
MRC	Medical Research Council
NDOH	National Department of Health
NGOS	Non-Governmental Organizations
NIMART	Nurse Initiated and Managed Antiretroviral Therapy
NHLS	National Health Laboratory Service
NSDA	National Institute for Communicable Diseases
NSP	National Strategic Plan
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis
PLWHIV	People living With HIV
PMTCT	Prevention of Mother-to-Child Transmission
PSP	Provincial Strategic Plan
SAG	South African Government
SANAC	South African National AIDS Council
SRH	Sexual Reproductive Health
STATSA	Statistics South Africa
STIs	Sexually Transmitted Infections
TMC	Traditional Male Circumcision
TROA	Total Remaining on ART
TVEP	Thohoyandou Victim Empowerment Programme
TVET	Technical, Vocational and Educational Training
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health organisation

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EXECUTIVE SUMMARY

The Limpopo Provincial Government developed the Provincial Strategic Plan (PSP) 2012-2016 in line with the HIV, STIs and TB National Strategic Plan 2012-2016. Since the approval and implementation of the PSP in 2012; annual operational plans and annual reports were developed and approved by the Limpopo Provincial AIDS Council (LPAC). The Province made tremendous progress against the two epidemics i.e. HIV and TB with the implementation of PSP 2012-16. The PSP for Limpopo Province focused on achieving five main goals as guided by the NSP.

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

According to the Tembisa Model estimates, there was a decline in HIV incidence in Limpopo Province in all age groups. Young women between 15-24 years are more vulnerable to HIV-infection than males of the same age group. The Tembisa model indicates that HIV infection rates for females was estimated at 1.48% in 2012 and declined to 1.17% in 2016 while males estimated at 0.39% in 2012 and declined to 0.28% in 2016 in aged 15-24 group. HIV incidence in age group 15–49 years was estimated at 0.88% in 2012 and declined by 0.2% to 0.68% in 2016. The provincial reduction in incidence rates could be due to various interventions that were implemented. Limpopo Provincial HIV prevalence was estimated at 8.3% in men and women between 15-49 years in 2015/2016, the province is the third lowest HIV prevalence after Northern Cape (6.8%) and Western Cape (6.6%). The estimated prevalence rate revealed a decline during the 3 year period in the province and this could be attributed to the decreased numbers of new infections. Infant 1st PCR test positive around 6/10 weeks' rate remained a challenge in the province, fluctuated between 2.2% in 2014/15 and 2.1% in 2015/2016.

Goal 2: Initiate at least 80% of eligible patients on antiretroviral treatment (ART), with 70% of those alive and on treatment after 5 the years of initiation

It is worth noting that the province consistently achieved the above targets for the past three years, thus exceeding the targets of initiating patients on ART and increasing the number of patients retained on ART. The target for new patients put on ART was 58 693, an achievement by 4 390 initiates (63 083) in 2015/16. During the period under review, the province reported 260 893 506 as compared to 232 506 in 2014/15. However, the Province had a challenge in child retention in care; the performance was stable in at 69.6% in 2015/15and 69.5% in 2015/16. The success of the ART programme is the main driver for the significant increase in life expectancy of Limpopo residents. Remarkable scale up of antiretroviral therapy put the Limpopo Province on track to reach the target on aids-related deaths.

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

The Limpopo province reported a reduced 301/100 000 in new TB incidence against a target of 150/100 000 in 2015/16 the performance improved by approximately 26/100 000 from 2014-15. The province was ranked the lowest in TB incidence rates and below South African average of 520/100 000 new infections, followed by Gauteng province reported 330/100 000 TB new infections in 2015/16. The TB treatment success rate improved from 76.5% in 2014/15 to 81.4% in 2015/16 exceeding the target of 75%. The case fatality rate reduced from 11.1%in 2014/15 and exceeded the provincial target of <8% but declined to 6.8% (379/5582) in 2015/16 exceeding the target of <8%. According to ETR data TB programme was successful in the province.

Goal 4: Ensure an enabling and accessible legal framework to support implementation of the NSP.

The Limpopo province provided HIV and TB services of under-privileged communities, such as: informal settlement communities; Key Populations, sex workers, young women and girls.

Goal 5: Reduce self-reported stigma related to HIV and TB by 50%

Limpopo province conducted 554 campaigns on stigma and discrimination and the achievement exceeded the target by 234 totalling 320 in 2015/16. There was not much activity reported in this objective.

Assessment of progress made towards achieving PSP 2012 – 2016 Strategic Objectives

The province is on progression achieving targets of all **four objectives** i.e**. Strategic Objective 1: Social and Structural drivers of HIV, TB and STI, Prevention, Care and Impact**, **Strategic Objective 2**: **Preventing new HIV, TB and STI infections**, **Strategic Objective 3: Sustaining Health and Wellness and Strategic Objective 4: Ensuring protection of human rights and improving access to justice.** The percentage of registered TB patients who tested for HIV was 76.7% against the target of 100%. Number of newly diagnosed HIV positive and those who started on IPT for latent TB infection, reached 36 657, against a target of 43 186. The province needs to strengthen the activity on Pre-Exposure Prophylaxis (PEP) for sexual assaults. Objective 4, the province still requires much work to reach the target.

4. INTRODUCTION

5.1 OVERVIEW

The Limpopo Provincial Strategic Plan (PSP) 2012-2016 was developed in line with the National Strategic Plan (NSP) 2012-2016 in consultation with Government Departments, Private Sector, Civil Society sectors including people living with HIV at Provincial and District levels. The PSP 2012-2016 was approved for implementation by all Sectors in the Province, in April 2012. Since the approval and implementation of the PSP in 2012; annual Operational Plans and annual reports were developed and compiled, respectively and approved by the Provincial AIDS Council.

This Annual Report is to give progress on the status of the implementation of PSP-NSP in the province in 2015-2016 financial year. The report gives a background of the PSP, assessment of achievements made towards the goals and strategic objectives. A brief PSP 2012-2016 background is outlined below;

5.2 BACKGROUND OF THE PSP 2012 – 2016

The Limpopo Provincial AIDS Council (LPAC) is tasked to coordinate all HIV and TB interventions in the Province; with guidance from South African National AIDS Council (SANAC). The LPAC developed a Provincial HIV, STIs and TB Provincial Strategic Plan aligned to the NSP. The plan directed the provincial HIV and TB response, assisted in fulfilling the mandate of the LPAC in reporting to SANAC and assisted in costing the response during the five-year period. The LPAC developed this Provincial Strategic Plan (PSP) in consultation with all relevant stakeholders and was endorsed following all the necessary steps were taken. The vision of the plan as well as the strategic objectives was adopted from the global and national vision 2030.

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

- Zero new HIV and TB infections[1];
- Zero new infections due to vertical transmission [1]
- Zero preventable deaths associated with HIV and TB[1];
- Zero discrimination associated with HIV and TB[1].

The development of the PSP was heavily influenced and embeded within the broader national and international development instruments like the South African National AIDS Council (SANAC) the Joint United Nations Programme on AIDS (UNAIDS) which advocates for Zero new infections, Zero deaths associated with HIV and TB and Zero Stigma Discrimination and The United Nations General Assembly Special Session on HIV and AIDS. [1].The developmental approach recognised that HIV, TB and STIs is not just a health problem but a cross-cutting challenge for all sectors including the socio-structural, economic and politico-legal determinants of health as social drivers that increase risk and chances of vulnerability.

The PSP acknowledges the health challenges faced in the province and country as a while. It also acknowledges the various efforts by the South African Government (SAG) at national and provincial level to address those challenges. Some of the challenges include the quadruple burden of diseases (Communicable, Non-Communicable, Violence and Injury and HIV/AIDS and TB). Some of the efforts to address these challenges include the HIV counselling and Testing (HCT) Campaign launched by government in 2010, the introduction of the Nurse Initiated Management of ART (NIMART), the National Service Delivery Agreement (NSDA) and the changes in the eligibility criteria for ART initiation (CD4 below 350). Such an acknowledgment sets the tone and direction towards which efforts should be directed in order to arrest the epidemic.

The purpose of the strategic plan is:

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

The PSP for Limpopo focused on achieving five main goals as guided by the NSP (2012-2016). A detailed assessment of the progress made in the implementation of the PSP against the five main goals are outlined below. Subsequently, an assessment of the progress made towards achieving the four strategic objectives of the PSP are also discussed.

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

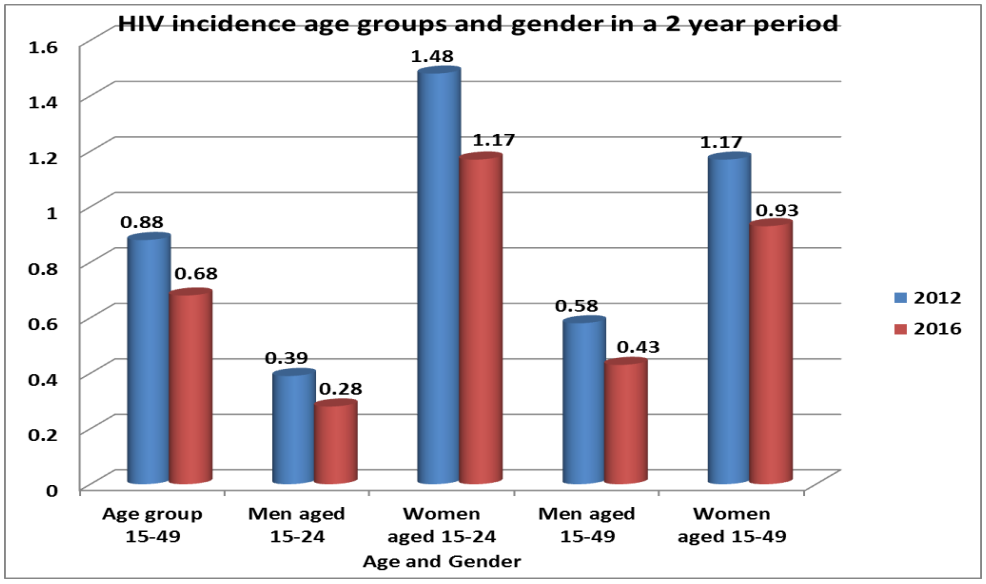
Goal 1

- **Reducing new HIV infections by at least 50% using combination prevention approaches**

Reduction in new HIV infections is pronounced mainly through measurement of the HIV incidence and prevalence. The Limpopo Province aimed to achieve a 50% reduction in HIV incidence over the period from 2012 – 2016 [2]. HIV -incidence measures were important because they provided insights into new infections in the Province. More importantly, they were the most direct means of assessing

the impact of HIV-prevention programmes that the Province had implemented [3]. A decline was estimated in HIV incidence in Limpopo province in all age groups. Young women between 15-24 years old were more vulnerable to HIV-infection than males of the same age [4]. The Tembisa Model estimated at 0.39% HIV incidence rate in 2012, which declined to 0.28% in 2016, in men aged between 15-24 years; while the rate in their female counterparts was estimated at 1.48% in 2012 and declined to 1.17% in 2016 [4]. HIV incidence in the age group between 15–49 years old were estimated at 0.88% in 2012 and declined by 0.2% to 0.68% in 2016 [4]. The HIV incidence in men aged between 15-49 years old was estimated at 0.58% in 2012 and declined to 0.43% in 2016; while in women it was 1.17% in 2012 which declined to 0.93% in 2016. Although estimates show a slight decline in new cases in the province, according to the Tembisa model estimates, this could be due to vigorous interventions that were implemented. The Province responded to these challenges by setting ambitious strategic targets to reduce new HIV infections by at least 50% using combined preventive approaches. However, problems remained with HIV prevention. Declines in new HIV infections among adults slowed, threatening further progress towards the end of the AIDS epidemic. The annual number of new infections among adults (15+) remained static since 2012. Figure 1 below shows the percentage of HIV incidence in different age groups in the Limpopo Province comparing 2012 and 2016.

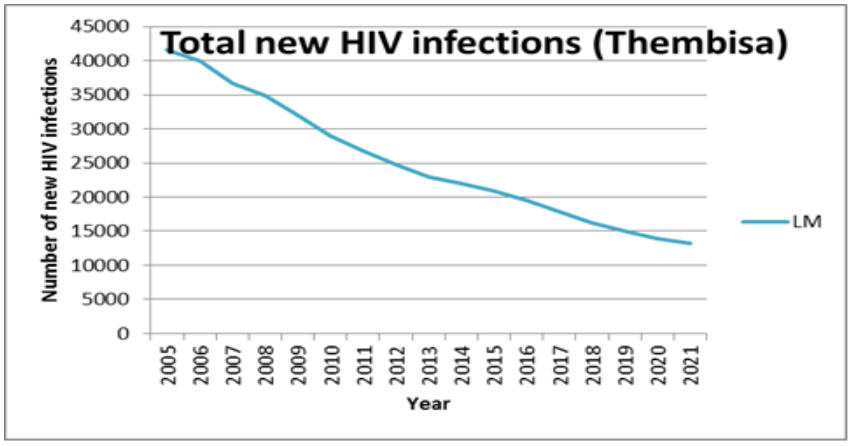
Figure 1: HIV incidence estimated Percentage in different age groups and gender



Source: Tembisa Model Estimates 2016 [4]

Figure 2 below shows a decline in HIV incidence in the province.

Figure: 2. Estimated HIV incidence in Limpopo province

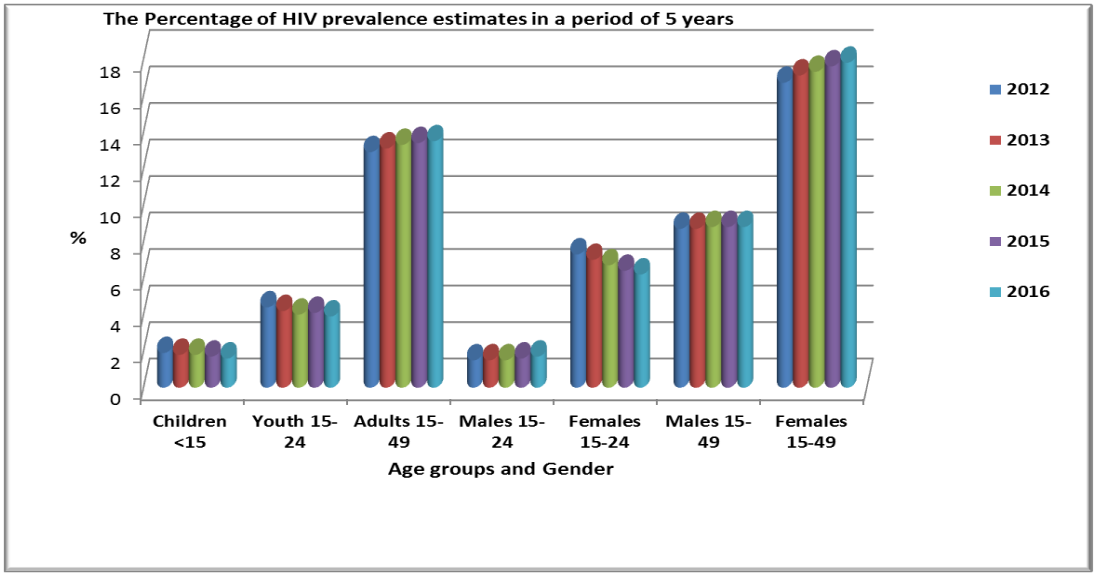


Source: Tembisa Model Estimates 2016 [4]

HIV Prevalence

Limpopo Provincial HIV prevalence was estimated at 8.3% in men and women between the ages15-49 years in 2015/2016. Limpopo Province remained the third lowest province in HIV prevalence; after Northern Cape (6.8%) and Western Cape (6.6%) [4]. The estimated prevalence rate showed a decline during a 3-year period in the province and this could be attributed to decreased numbers of new infections. HIV prevalence estimated vary in different age groups and gender. Children <15 years old HIV prevalence was estimated at 1.9% in 2012 and decreased to 1.8%for both 2013 & 2014. A further decrease of 1.7% was noted in 2015 while a decrease of 1.6% was noted in 2016 [4.] Estimates for HIV prevalence among youth between the ages 15-24 years decreased from 4.4% in 2012 to 3.9% in 2016. HIV prevalence estimates for dults the ages 15-49 years were at 12.9% in 2012 and increased to 13.5% in 2016. HIV prevalence estimates for males between the ages 15-24 years were at 1.5% for three consecutive years (2012, 2013 and 2014), and increased to 1.7% in 2016 while in the female counterparts ranked higher at 7.3% in 2012, reduced by 7% **in** 2013; 6.7% in 2014; 6.4% in 2015 and (6.2%) in 2016 [4]. HIV prevalence rate for males between the ages 15-49 years was estimated at 8.7% in 2012 and increased to 8.8% in 2016. The HIV prevalence rate for females between the ages 15-49 years was estimated at 16.7% in 2012 and increased to 17.8% in 2016 [4] **as depicted in Figure** 3 below:

Figure 3: Estimated HIV prevalence in age and gender



Source: Tembisa Model 2016 [4]

A trend analysis of HIV prevalence in the reproductive age population, in Limpopo Province indicates a significant increase in HIV prevalence in 2011 compared with 2010. Provincial HIV Prevalence among women attending ante-natal in public clinics increased slightly from 21.9% in 2010 to 22.1% in 2011, while a slight increase of 0.2% was observed in 2012 [5]. In 2013 a decline of 2% was observed in the Province. In districts ante-natal care (ANC) HIV prevalence varied, particularly in sub-districts. However, HIV prevalence remained high at 27.3% in the Waterberg district, followed by Mopani district with 24.6%, Capricorn district, being the third HIV prevalence district at of 21.1%, Sekhukhune district ranked second last at 17.1% and Vhembe district with lowest HIV prevalence of 14% in 2013. **Table 1: HIV prevalence among antenatal women by district, Limpopo, 2010 to 2013**

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

Source: NDoH Ante-Natal Survey 2014 [5]

Mother-To-Child Transmission

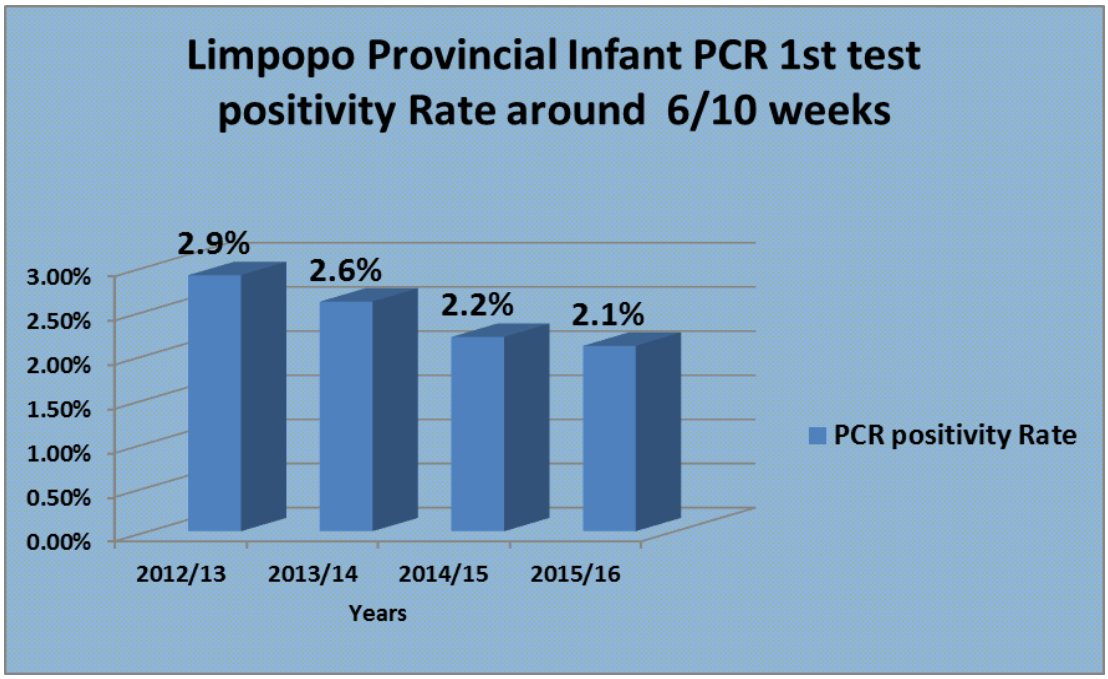
Women of childbearing age are particularly affected by the pandemic, resulting in large numbers of children being affected and infected by the transmission of HIV during pregnancy, delivery and also post-partum. HIV is the leading cause of death among women of reproductive age [6]. The reduction in the number of children newly infected with HIV and reduction in the transmission rate are key targets of the Global Plan. Prevention of Mother-to-Child Transmission (PMTCT) represents a unique and convenient entry point for HIV care and treatment services, not only for women and their infants but also for sexual partners and other family members. The success in improving South Africa's prevention of mother-to-child transmission (MTCT) programme has been widely documented. This has been achieved through progressive policy changes that have aimed to bring about widespread system transformation to improve the access and quality of PMTCT services in order to decrease mother-to-child transmission, and ultimately progress towards eliminating new HIV infections [7]. Indicators used to measure effectiveness of PMTCT programme are ANC 1st visit before 20 weeks, ART initiation, PCR uptake and infant PCR 1st test around six weeks' positivity rate [7].

Infant PCR 1st test around six weeks positivity rate

The indicator measures the percentage of HIV-exposed infants who receive an early HIV test (around 6 and 10 weeks of age). Children born from HIV positive women are at risk of being infected by their mothers at birth. According to NSP target, the PMTCT programme should reduce vertical transmission to less than 2% at 6-10 weeks of age by 2016 [7]. The provincial target for infant PCR 1st test around six weeks positivity rate was <2% in 2012/13 & 2013/14 financial years, Limpopo Province PCR positivity rate in 2012/13 was 2.9%, 2013/14 was 2.9% and was the lowest performing province in the country to reach the target of <2% [8]. The Provinces which managed to achieve the targets were Gauteng with 1.9%; followed by Kwa-Zulu Natal with 2%. During the period 2014/2015, performance declined by 0.8% to 2.2%. Limpopo Province ranked second last in the country followed by Northern Cape with 2.09% [9]. Infant 1st PCR positive test around 6/10 weeks remained a challenge in the province fluctuating between 2.2% in 2014/15 and 2.1% in 2015/2016. This could be due to changes on Early Infant diagnosis from 1st June 2015. The changes created much confusion because clinical interventions were not in line with program monitoring through the District Health Information System (DHIS). The changes also led to a low uptake of PCR test around 6/10 weeks. Contributing factors that put these groups at risk include lack of resources in rural settings,

socioeconomic deprivation, HIV positive mothers not adhering to treatment and high unemployment rate in the Limpopo Province. Some of the interventions implemented include strengthened drug literacy and mentor mother programmes[8]. Figure 4 below shows PCR positivity rate in the province between 2012--2016 reporting periods.

Figure 4: Provincial performance on infant PCR positivity rate 2012-2016.



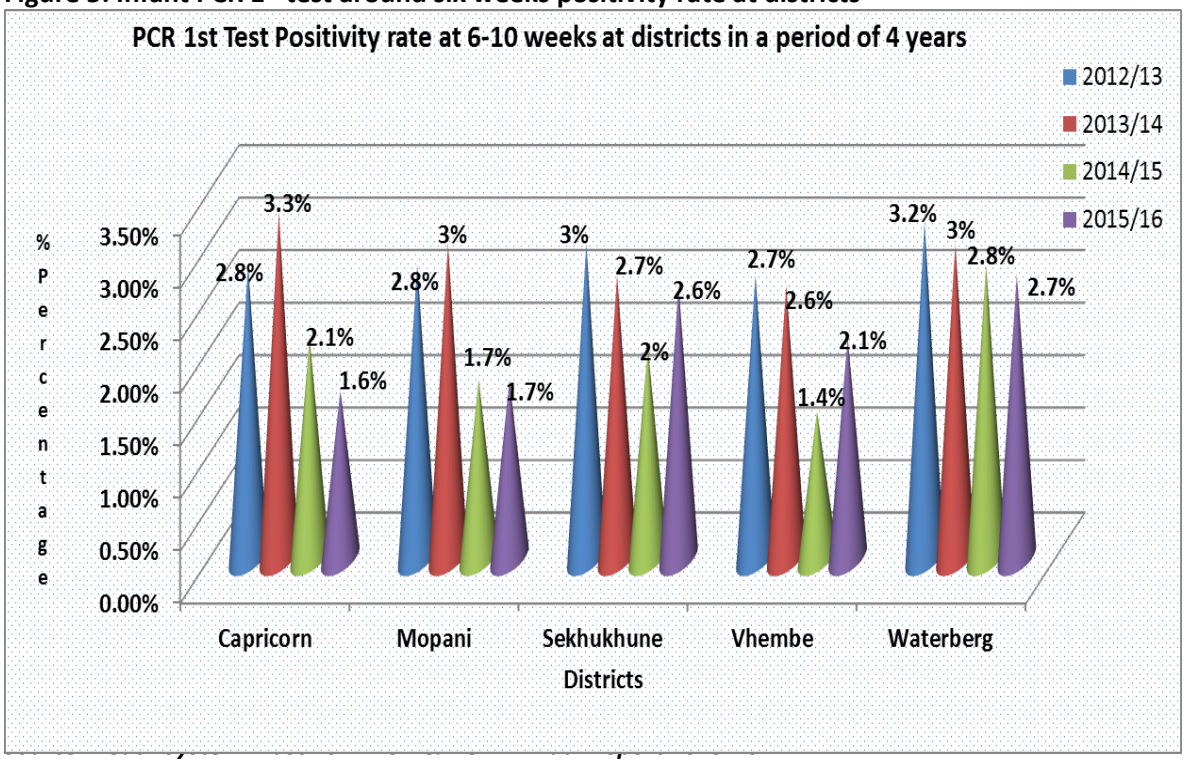
Source: Health System Trust 2014/15 [7] & DOH Annual Report 2015/16 [8].

Although the provincial infant PCR 1st test around six to ten weeks positivity rate declined from 2012/2013 to 2015/2016 reporting periods, the district performance varied, as depicted in Figure 5 below. In 2012/2013, Waterberg district had high PCR positivity rate at 3.2%, followed by Sekhukhune at 3% and both Capricorn and Mopani were at 2.8%, while Vhembe district was at (2.7%) [10]. In 2013/2014, Capricorn (3.3%) and Mopani (3%) increased by 0.5% and 0.2% respectively while Sekhukhune (0.3%), Vhembe (0.1%) and Waterberg (0.2%) managed to reduce slightly [10]. The province aimed to reach target of <1 infant PCR 1st test around six to ten weeks positivity rate in 2015/2016. During 2014/2015 reporting period; Capricorn district infant PCR 1st test around six to ten weeks positivity rate was at 2.1% and district performance was reduced by 0.4% to 1.6% in 2015/2016. Mopani district remained at 1.7% for 2014/2015 and 2015/2016 reporting periods. Sekhukhune district PCR positivity rate was 2% in 2014/2015 and increased to 2.6% in 2015-2016. Vhembe district also performed above the target of <2% in 2014/2015 but increased to 2.1% in 2015/2016. Although the provincial target was <1% in 2015/2016; Capricorn was at 1.6% and Mopani was at 1.7%, both districts managed to achieve a target <2%. It should be noted that three

districts, namely: Waterberg (2.7%), Sekhukhune (2.6%) and Vhembe (2.1%) contributed to an unmet provincial target of 2% during the period under review[10]. All the three districts received remedial intervention to reduce MTCT [8]. Figure 5 below indicates PCR 1st test around six-ten weeks positivity rate in the province over a four year period.

See graph below.

Figure 5: Infant PCR 1st test around six weeks positivity rate at districts



During the period under review, Limpopo Province reported the performance of 18 months HIV test positivity rate at 1.4% as compared to 2.04% in 2014/15. The province reached the target of <2%. The achievement could be attributed to the improvement interventions in a PMTCT programme [10].

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

ART initiation

The prevention and treatment efforts are both considered as critical components in fighting HIV/AIDS. The target for new patients put on ART was 58 693, an over achievement by 4 390 initiates, totalling 63 083 ART in 2015/2016 [11]. There was constant over achievement for ART initiation from the previous years 2014/15 to date where a target of 52 600 was exceeded by 61 346 in 2014-2015 and achieved 49 276 above the target of 48 244 in 2013-2014 financial years [8].

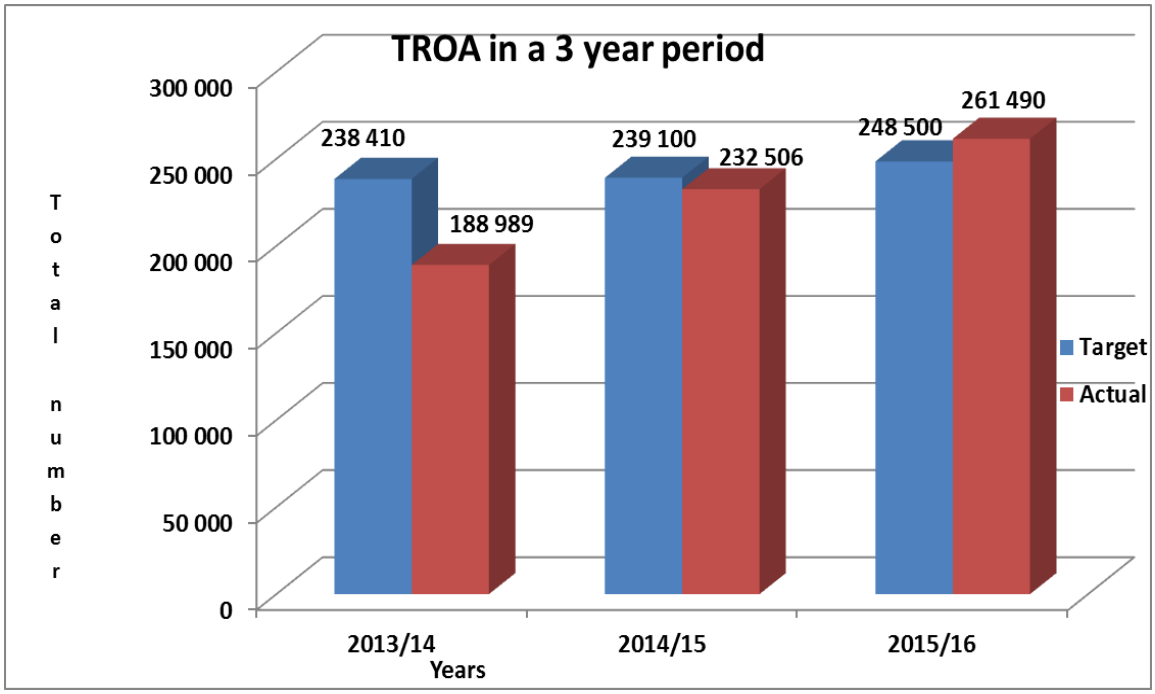
The Home Based Care (HBC) programme expanded significantly in one year with a significant number of patients receiving services. The implementation of the adherence strategy also improved

retention in care and adherence to ART, TB and chronic medications. Given the above cited progress in the implementation of Goal 2, the province is likely to meet its target.

Retention in care

Over the three year period of the review, there was an increase in the total remaining on ART at the end of the year. During the period under review, the province reported a total of 260 893 506 clients remaining on ART, compared to 232 506 in 2014/2015 [8]. The province was able to exceed its target of 248 500 by 12 343. A total number of 232 506 clients remained on ART during 2014/2015, of which the target was 239 100 [7]. The provincial performance in 2013/14 totalled 188 989 client on ART, of the targeted 238 410 [7]. The trend indicated that the province was below the target for 2 consecutive years but only reached the target of retention in care for the period under review. [8]. The performance improved due to the fact that all 8 869 home-based carers providing support to PLHIV and other chronic conditions received stipends to motivate them. There were 1 065 413 beneficiaries supported by home based care givers [11]. Figure 6 below shows the total number of clients remaining on ART in a period of 3 consecutive years.

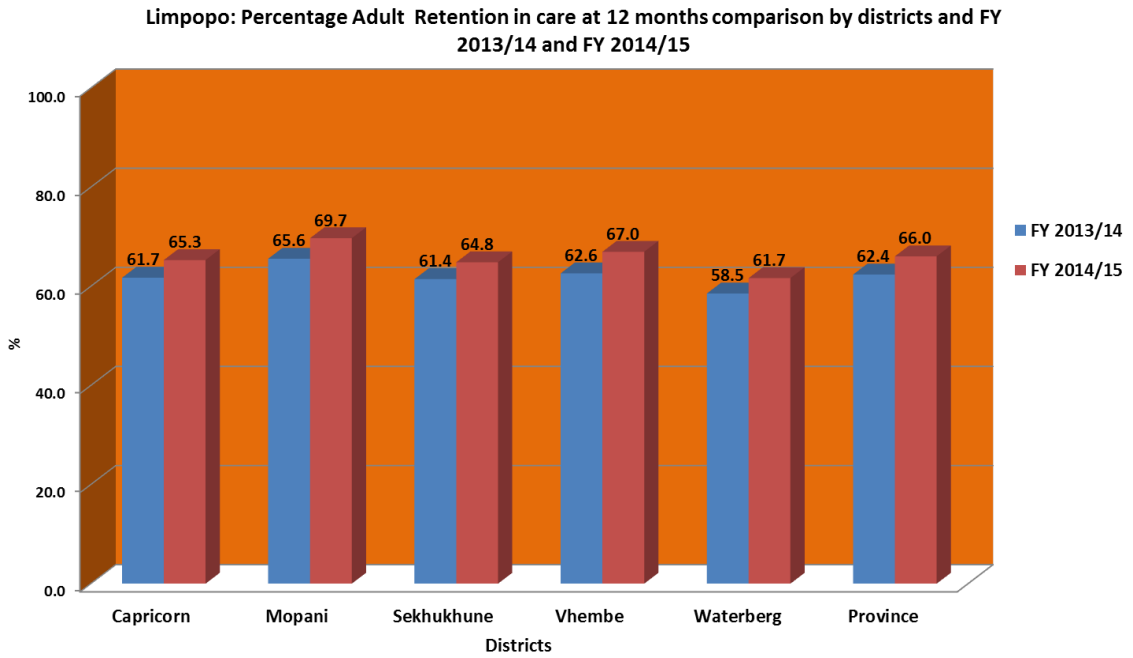
FIGURE 6: TOTAL CLIENTS REMAINING ON ART



Source: (DHIS) TIER.NET 2016 [10]

The districts increase in performance of adult retention in care in 2014/2015 as compared to 2013/2014. The province increased by 3.6% (62.4%) in 2013/2014 to (66.0%) [10].

Figure 7: ART Adult Retention in care rate



Source: DHIS TIER.NET 2016 [10] **Child ART**

The mainstay of the WHO strategy is to increase access to paediatric treatment, access which lags behind that of adults, with paediatric ARVs representing less than 7% [13]. The Province experienced a challenge in child retention in care; the performance was stable in 2014/2015 with 69.6% and 69.5% in 2015/2016. [10]. This could be due to late identification of children who tested HIV positive or early diagnosis and missed opportunities during immunizations schedules. The district performance fluctuated with low improvement in child retention in care except for Capricorn district, which improved from 65.7% in 2013/2014 to 72.9% in 2014/2015 and Sekhukhune which improved from 68.3% in 2013/2014 to 69.8% in 2014/2015. Mopani decreased from 72.2% in 2013/2014 to 70.4% in 2014/2015. Vhembe district decreased from 70.6% to 68.1% in 2014/2015, while Waterberg decreased from 70% in 2013/2014 to (64.1%) in 2014/2015 [10]. The lifelong ART is recommended for all children living with HIV younger than five years of age, regardless of CD4 count. This should facilitate more rapid access to treatment for children diagnosed with HIV infection. Figure 8 below shows the ART child retention rate in Limpopo Province for 2013-2014 and 2014-2015 review periods. **Figure 8: ART child retention in care**

Source: DHIS TIER.NET 2016 [10]

Virological outcomes

The province had challenges concerning ART electronic monitoring system. The ART electronic monitoring system version had not yet been aligned to DHIS in 2013-2014 reporting period. This resulted in poor viral load (VL) data management. According to the 2013/2014 data, the Viral Load uptake was at 51.8% (14 951/28 861) while viral load suppression was at 79.3 % (11 862/14 951) in the same year. Although the 2014/2015 Cohort report had not yet been finalised the preliminary three quarters report showed an improvement in both viral load collection (62.2%) and viral load suppression (84.2%) [8]. The six months CD4 monitoring tests and viral load tests completed were above 100% of the target according to the National Health Laboratory Services (NHLS) report in 2014/15, which showed high numbers of VL load done, attributed to many factors amongst others – non suppressors, newly initiated who are collected twice within 12 months period, non-cohort aligned viral loads. There are 498 sites implementing ART monitoring system (Tier.net, 2016). A total 435 sites were on Phase 6 and 432 were reporting through DHIS quarterly [11]. **Impact of ART**

Life expectancy

The success of the ART programme is the main driver for the significant increase in life expectancy of Limpopo residents. The life expectancy at Limpopo Province was 58years in 2006-2011, and increased to 61.3years in 2011-2016 for males. Life expectancy for females was at 55.9 years in 2006-2011 and increased to 64.0 years in 2011-2016 [14]. The Provincial average life expectancy at birth for females in 2011-2016 of 64.0 years, ranked third in the country. Gauteng Province ranked second with 65.8 years and the highest ranking province was the Western Cape with 69.0 years [14]. The increased life expectancy indicated that interventions implemented in the province were effective and contributed to long and healthy lives.

The province reported a total of 167.4/100 000 live births maternal mortality in facility ratio, 2014/2015. The maternal mortality ratio in Capricorn district was reduced from 98 to 87 deaths per 100 000 in 2014/2015 and remained the second highest district in the country compared with absolute numbers of maternal deaths [7]. The province reported 140.1/100 000 live births (169 of 120 572) in 2015/2016 the performance was higher than provincial target of 182.6/100 000 death [8]. The improvement of 77% against the provincial target is a commendable achievement and it could be due to Training on Essential Steps in the Management of Obstetric Emergencies conducted to

improve health professional's skills in managing pregnant women and other effective strategies implemented in the province during 2015/2016 financial year [8].

The target for early neonatal death was 11.5/1000 and the province achieved 12.6/1000 (1521 of 120572) in 2015-2016. The provincial performance was below the target, possibly due to shortage of skilled health professionals in the management of neonates [8].

HIV Mortality rate-

Remarkable scale up of antiretroviral therapy has put the Limpopo Province on track to reach the target on aids-related deaths. The provincial target for adult clients who died after 12 months on ART was <5% while the performance was 3.1% (1775/57321) in 2015-16; in comparison with 5.5% for the period 2014/15 [10]. The province achieved 4.6% (119/2570) for the indicator on children under 15 years of age who died after 12 months on ART [10]. The effective Comprehensive Care Management and Treatment (CCMT) programme could be the possible cause of reduction in HIV mortality rate as compared with 2014/15 in HIV mortality in the province.

Goal 3

- **Reducing the number of new TB infections, as well as the number of TB deaths by 50%**

Individuals with the lowest socio-economic status are more vulnerable to HIV and TB infections. Those working in the informal sector had the highest HIV prevalence with almost a third of African informal workers being HIV positive. Among women, those with less disposable income had a higher risk of being HIV positive [15].

According to PSP 2012; similar to HIV, certain groups were considered key populations for TB. Taking into account the risk of TB infection, risk of progression from infection to TB disease and poor access to services the following groups should be prioritised for TB services in the Province:

- Household contacts of confirmed TB cases, including infants and young children especially in farming and mines areas.
- Healthcare workers, mine workers and farm workers;
- Children and adults living with HIV;
- Diabetics and people who are malnourished;
- Smokers, drug users and alcohol abusers;

• Mobile, migrant and refugee populations; and

• People living and working in poorly ventilated and overcrowded environments, including those living in informal settlements.

Within each strategic objective the populations are targeted with different and specific interventions to achieve maximum impact [2]

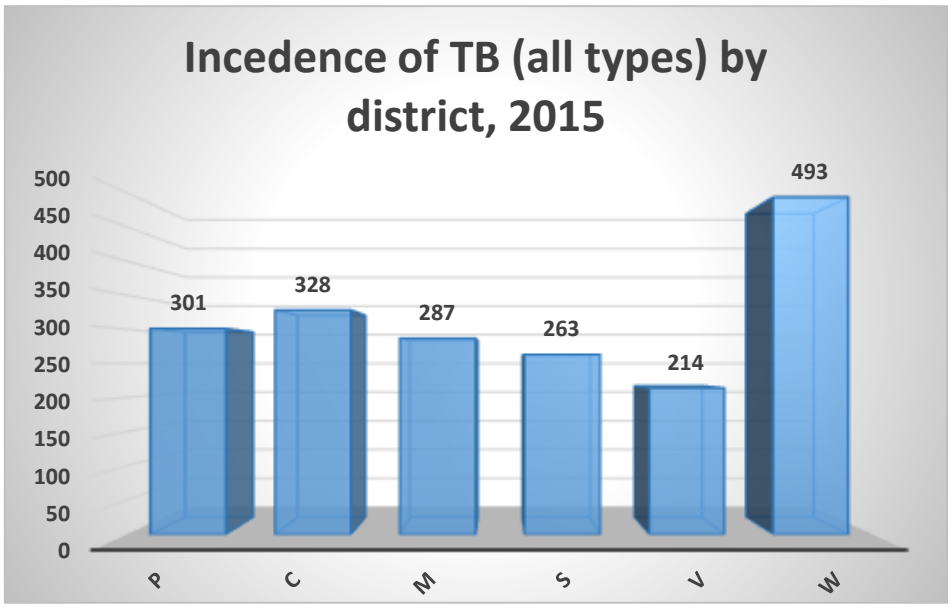
Control and management of Tuberculosis in the province

TB Incidence

TB is the leading cause of death among HIV-infected patients **which** can be measured in terms of incidence defined as the number of new and relapse cases of TB arising in a given time-period. (usually one year). TB prevalence is defined as the number of cases of TB at a given point in time. TB mortality is defined as the number of deaths caused by TB in a given time period, usually one year [16].

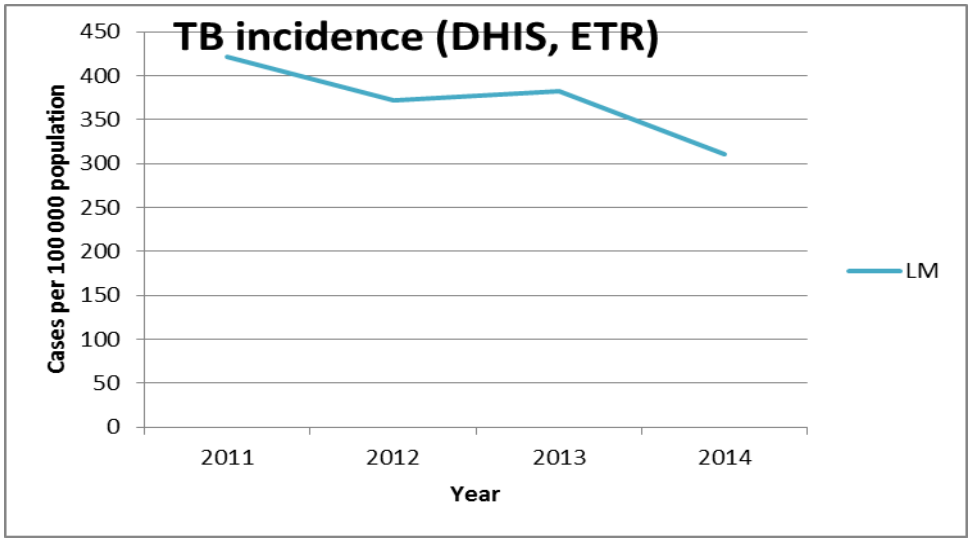
Limpopo Province ranked lowest in the country with TB incidence rate reported 301/100 000 in 2015/16 although was below the provincial target of 150/100 000 of new TB infections and followed by Gauteng province with 330/100 000 TB new infections[24]. According to the Tembisa Model 2016, Limpopo and Gauteng Provinces were the only provinces that managed to lower TB incidence below 400/100 000 in 2014. During the previous year 2014/2015 there were 327/100 000 new TB infections reported and this was below the target of 150/100 000 by 177/100 000 [24]. However, Waterberg district has the highest TB incidence rates in the province, with reported rates of 493 per 100 000, followed by Capricorn district with 328, Mopani with 287, Sekhukhune with 263 and Vhembe district with 214 per 100 000 new TB infections in 2015/16[24]. **See figure below**

Figure 9: TB incidence in the province



Source: Health System trust 2015/16 DHB[24]

Figure 10: TB estimates in Limpopo Province

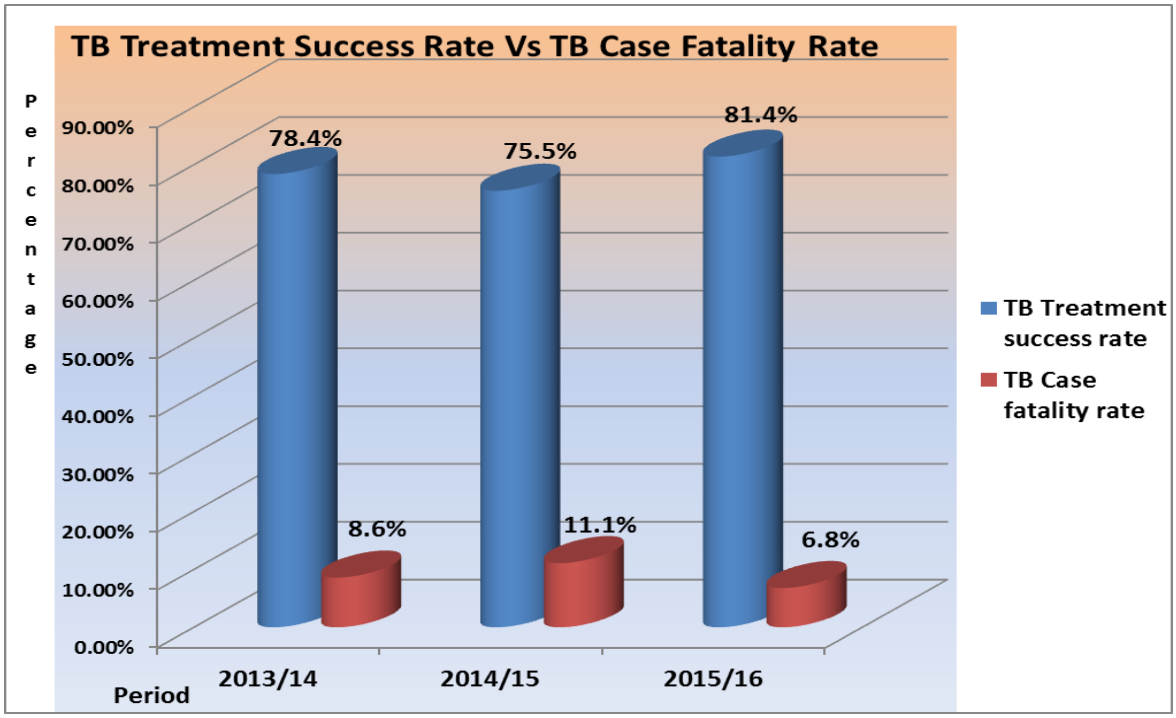


Source: Tembisa Model 2016 [4]

Based on data obtained from the ETR.Net system, the provincial TB programme was successful with steady progress in TB management, treatment success from 76.5% in 2014/2015 to 81.4% in 2015/2016, and 75% above the target [8].

The case fatality rate baseline of (8.6%) in 2013/2014 increased to (11.1%) in 2014/2015. and declined to 6.8% (379/5582) in 2015/2016, below the provincial target of <8%. The TB case fatality rate reduction of 4.3% could be attributed to the implementation of effective Directly Observed Treatment (DOT) strategy and issues with the surveillance system and data quality, (unless otherwise proven). These changes could have resulted in problems with data quality. The improved TB awareness campaign and intensified case finding could have also contributed to the performance. Figure 11 below indicates the increased TB treatment success rate which contributed to the reduction of TB Case fatality rate.

Figure 11: TB Treatment Success Rate Vs TB Case Fatality Rate in a period of three years



Source: DHIS ETR 2016 [10]

Goal 4

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

In line with the human rights provision of the Constitution of South Africa as well as strategic objective 4 of the PSP, Limpopo Province provided HIV and TB services to under-privileged communities, such as people staying in informal settlements, key population, young women and girls.

Key populations

The Province made steady progress in the establishment of High Transmission Areas (HTA), and focused on HTA by funding Non-Governmental Organisations (NPOs) to reach the hard to reach areas and key populations. There were 417 HTA intervention sites throughout Limpopo, monitored by 579 HTA peer educators. The Province completed capturing HTA sites on the web-based system using coordinates to see the location of each HTA and the activities at each site. The number of clients seen at HTA sites, (by headcount) was 676 269 in 2014/2015 and increased to 2 751 360 in 2015/2016 [11].

Programmes targeting key populations included sex workers, Men having Sex with Men (MSM) and prisoners were implemented across the province. The DoJ was supportive through in their contribution towards programmes that promoted human rights but much remains to be done to improve the status quo. The rape survivor programme was implemented to fight issues related to Gender Based Violence (GBV) which contributed to new HIV infections. Government departments included quarterly human rights issues in their reporting. The province targeted 110 000 people in the mobilization and advocacy for key populations and achieved a total of 55 562 in 2015/2016 [17].

The response in the country is built on the idea that human rights as pronounced in the South African Constitution must be upheld and considered when providing services to the public, especially PLWHIV and those with TB infection. While the PSP Strategic Plan (PSP) refers to the existence of the disability sector, the unavailability of relevant documents (in braille), and the lack of provision of sign language interpretation were noted as a great concern. The key populations include those with limited access to services; and risk of HIV infection and TB infection. Limpopo is an area exposed to truck routes especially in Waterberg, Capricorn, Vhembe and Mopani Districts with cross boarder transportation between South Africa, Zimbabwe and Zambia through the Beitbridge Boarder Post. This means that people living or working along national roads and highways are at greater risk of HIV and TB infection and transmission.

The agricultural sector reported one of the highest HIV prevalence and incidence rates due to illiteracy among farm workers, high mobility and vulnerability, resulting in a higher risk of HIV and TB transmission and infection at farms.

Orphans and vulnerable children (OVC) and youth were another key population for whom specific interventions were implemented to prevent HIV. The Department of Social Development (DSD) distributed 720 food parcels and uniforms in total against the target of 46 000 in 2015/2016 [18]. During the period under review, DSD established a Provincial Food Distribution centre, (a hub of food management and distribution to poor and vulnerable households) in the province [18]. The centre was functional and intensified campaigns of distributing food to needy families and individual as guided by the food for all programme. The feeding scheme provided food to a 76 619 people [18].

During 2014/2015 reporting period, 24 585 people were reached through social and behavioural change programmes while 135 community conversations on HIV & AIDS were held [18].

World AIDS Day (WAD) commemoration on 1st of December 2016 included activities of: food distribution and visits to wards by teams including Members of the Executive Committee (MECs), Executive and Local Mayors and Ward Counselors and senior managers, who visited five households

in each ward. Food parcels were distributed to different child/youth headed families at Tshikanoshi Village during the WAD commemoration event. Problems were identified in families visited and follow-ups done to ensure appropriate interventions [17].

Sex workers in South Africa faced high levels of stigma and discrimination and were restricted by the laws under which they work. A total of 15 000 Information, Education and Communication (IEC) materials were distributed to key populations in 2015/2016[17]. The number of sex workers seen at High Transmission Area (HTA) sites baseline was 3120 in 2014/2015, an increase of 2740 (5 860) in 2015/2016. Truck drivers seen at HTA were 5133 in 2014/2015, compared to 27 008 in 2015/2016. The number of Men who have sex with men (MSM) seen at HTA sites was 2448 in 2014/2015, increased to 6 193 in 2015/2016 [11]. Although the province had no target for the key population, the increase in numbers indicates the effectiveness of the community awareness campaigns. MSM found it difficult to disclose their sexuality to healthcare workers, based on traditional attitudes, limiting their access to HIV services. It should be noted that the province‘s performance in interventions for MSM took an upward trend on an annual basis.

The Limpopo province has poor data management on key population like LGBTI and sex worker’s community. The table below indicates estimations of the number of sex workers in the province.

TABLE 2: The estimate of the sex worker's population in Limpopo Province

Geography and population				*Number of sex workers*			
				Estimate 1	*Estimate 2*	*Estimate 3*	*Estimate 4*
Limpopo							
All Areas			*Female SWs*	*14 059*	*13 802*	*13 263*	*11 150*
Population 2011	*5 404 790*		*5% Male*	*703*	*690*	*663*	*558*
Adults females	*1 743 333*	*(32%)*	*4% Transgender*	*562*	*552*	*531*	*446*
			Provincial Total	*15 325*	*15 044*	*14 457*	*12 154*
As a % of adult female population				*0. 88%)*			
Urban>=100,000		*(9%)*		*15%*	*15%*	*13%*	*11%*
Adults females		*(34%)*					
Urban<100,000		*(44%)*		*60%*	*59%*	*60%*	*57%*
Adults females		*(33%)*					
Rural		*(47%)*		*24%*	*24%*	*25%*	*31%*
Adults females		*(32%)*					
All areas				*100%*	*100%*	*100%*	*100%*

Source: SANAC estimating the size of the sex worker population in South Africa, 2013 [19]

Young women and Girls

Young women and girls between the ages of 15 and 24 years are four times more likely to have HIV than males of the same age group. The risk is especially high among pregnant women between 15 and 24 years of age. On average young females become HIV-positive about five years earlier than males. Given the scenario in the Province, i.e. rural conditions, informal settlement, illiteracy, socio-economic deprivation and unemployment influence the spread of HIV & TB [6]. According to the 2012 survey found HIV prevalence among South African women was nearly twice as high as men [3]. Rates of new infections among women aged 15-24 were more than four times greater than that of men

the same age, and this age group accounted for 25% of new infections in South Africa [3]. Intergenerational relationships between older men and younger women are also seen to be increasing the rate of infections “blessors” & “”. Poverty, the low status of women and gender-based violence (GBV) have been cited as reasons for the disparity in HIV prevalence between genders, with GBV attributable to an estimated 20–25% of new HIV infections in young women.

Young people who are not attending school are at risk of HIV infections. Completing secondary schooling reduces the risk of infection to HIV, particularly for young girls due to acquired skills and knowledge. Men and women with tertiary education are significantly less likely to be HIV positive than those without tertiary education.

The importance of access to family planning and education is emphasised in order to further reduce the number of infant deliveries in women under the age of 18.

The uptake of the sub-dermal contraceptive implant by teenagers may play a role in changing trends.

At District Health Barometer (2014/15) (DHB) report workshops conducted in 2013 and 2014, reasons mentioned for a high delivery rate in facility under 18 years included:

- a failure or lack of education through school health programmes;
- cultural issues including that one should have a child before marriage; and
- Poverty [7]

Delivery rates for women under 18-NIDS

The proportion of under-18 deliveries in facilities in South Africa declined from 7.8% in 2013/2014 to 7.4% in 2014/2015 [5]. The highest proportions of under-18 deliveries were in the Northern Cape (NC) and Eastern Cape (EC) both with rates of 9.6% and in both provinces the rates declined from the 2013/2014 value in 2014/15 (DHB 2014/15) [5]. Limpopo Province declined by 0.4% from 2013/2014 to 2014/2015 and ranked fifth overall in the country. This could be mainly due to a number of interventions which were in place to manage teenage pregnancy in the province. Limpopo Province aimed at reducing under-18 years’ deliveries in facilities to <7%. However, the achievement was 7.1% in 2015/2016 and varied with districts [8]. Table 3 below shows that Vhembe district reported 7.8% the highest under 18 deliveries in the province followed by Mopani district at 7.2% and Waterberg at 7.0%. There were only two districts that were able to reach the target of <7%, namely: Capricorn (6.6%) and Sekhukhune (6.8%) in 2015/2016 [10]. **See Table 3 below**

Table 3: Delivery rate for women under 18 in Limpopo Province

	2012/13	2013/14	2014/15	2015/16
Capricorn	7.3%	7.4%	6.9%	6.6%
Mopani	8%	8.1%	7.9%	7.2%
Sekhukhune	7.6%	7.7%	7.2%	6.8%
Vhembe	8.3%	8.4%	7.9%	7.8%
Waterberg	8%	7.6%	7.4%	7.0%
Province	**7.9%**	**7.9%**	**7.5%**	**7.1%**

Source: DHIS 2016 [10]

The Department of Basic Education developed an integrated strategy on HIV, AIDS, STIs and TB, 2012 – 2016, in response to the NSP on HIV, TB and STIs. One of the key components of the strategy, is to increase HIV, STI and TB knowledge and skills among learners, educators and officials and decrease barriers to retention in schools, in particular, for vulnerable learners. The department introduced a Curriculum and Assessment Policy Statement (CAPS) for Life Orientation (LO) for grades 7 and 9 which include concepts, knowledge, values and attitudes that deal with sexual education and reproductive health [20]. The aim of LO lessons were to provide teaching and learning, to engage leaners on issues that encourage them to change their behaviours and their decisions around their sexual debut and, to provide them with support [20]. A total of of 1 217 children between the ages of 7-14 years and youth peer educators trained on SRH and overall life skills in 2015/2016 [17].

Goal 5

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

- **Implementation of stigma and discrimination in the Province**

  The National Stigma Index Survey results released in 2014 provided baseline information on stigma which are essential in tackling stigma and discrimination. When external and internal levels of stigma were measured, the results indicated that there was still a moderate level of stigma affecting about one-third of PLHIV who participated in the study. Unsurprisingly, the report revealed that internalized stigma is still a major challenge in South Africa with more than 40% of PLHIV expressing feelings of internalized stigma.

  The systems for data collection of the indicators still needs to be established and be reported.

Limpopo Province conducted 554 campaigns on stigma and discrimination and the achievement was 234 above the target of 320 in 2015/2016 [17].

6. 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

Social and structural determinants

Social and structural approaches address the social, economic, political, cultural and environmental factors that lead to increased vulnerability. As pointed out in the NSP, every government department at national, provincial and municipal levels has a critical role to play in addressing the structural factors driving HIV and TB.

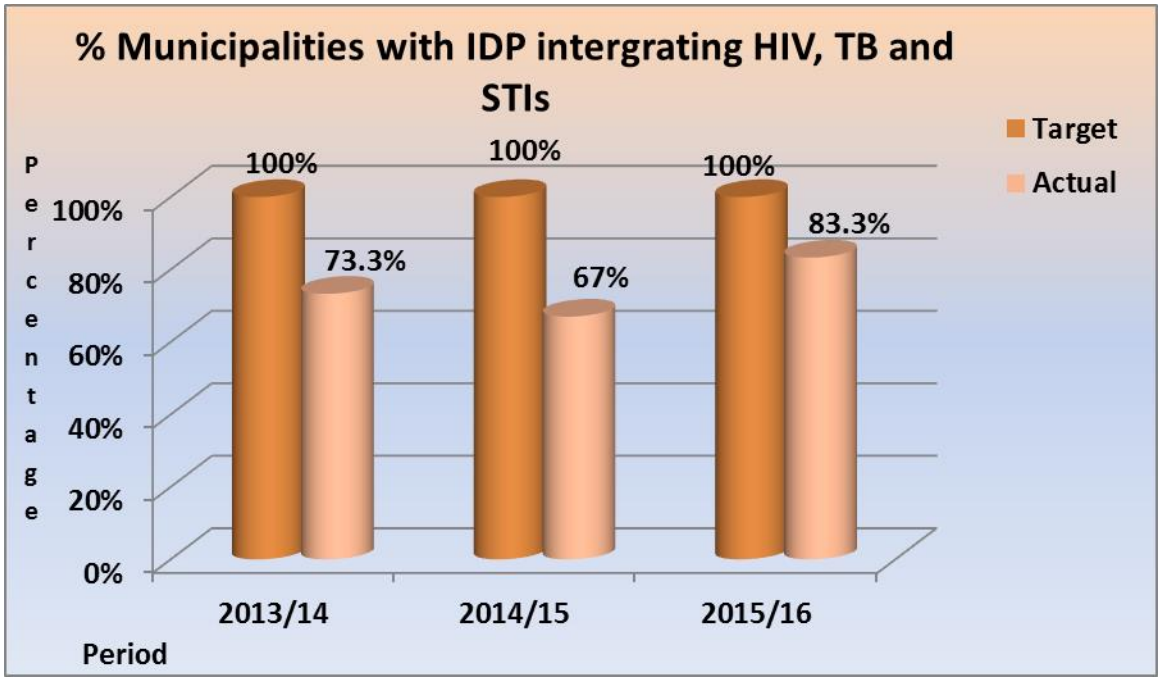
The key Social Drivers of the Epidemic in Limpopo identified as follows:

- Substance abuse,
- Mobility and migration,
- Multiple, concurrent and intergenerational sex,
- Cultural practices, stigma and discrimination,
- Unemployment and inequality in income and wealth [2].

Limpopo province aimed at reaching 100% (30) of government departments, municipalities and sectors with independent development plans (IDPs) integrating HIV, STIs, TB, gender and rights based dimensions. The province achieved 83.3% (25/30) in 2015/2016 [17]. Although the province did not meet the target of 100%, the performance increased by (16.3%) from the previous year's performance of 67%. 73.3% was achieved in 2013/2014. Most Departments had Employee Health and Wellness Programme with HIV, STI and TB management pillar that required the mainstreaming of HIV and AIDS STIs and TB (HAST) hence the 100% integrated plans in departments [17].

See Figure 12 below

Figure 12: Percentage of Municipalities integrated HIV, STIs and TB in Limpopo province



Source: LPAC Annual Report 2015/2015 [17]

Limpopo Province reported 100% on the number of municipalities with at least one informal settlement where targeted comprehensive HIV, STI and TB services were implemented in 2015/2016, as compared to 80% achievement of previous year. The province improved by 20% and met the target of 100% [17].

Current school attendance among orphans and among non-orphans aged 10 -14 years old

In terms of orphans and vulnerable children (OVC) school attendance in the province was at 55% in the 2012/2013 and achieved 100% school attendance among orphans and among non-orphans aged between 10 -14 years old (7267/7167) in 2014/2015 [21]. The performance decreased to 90.3% in 2015/2016 and the province did not reach the target of 100% but reached PSP target of 90%. The province decline in performance could be due to lack of integration between departmental sectors especially DOE and DSD (who are still working in silos).

HIV and TB Spend

Limpopo province target to spend for HIV and TB programmes by the DoH was 98% of the allocated budget in 2015/2016 and 98% of the allocated budget was used in the same year, in reaching the target. The performance increased from the previous year 2014/2015 at 96.4%. DSD used 98% of the allocated budget while the target was 100% and the performance remained the same as the previous year 2014/2015 at 98.1%. DOE improved the performance increased from 30% in 2014/15 to 90% of the allocated budget and the target of 90% was reached in 2015/2016 financial year. The

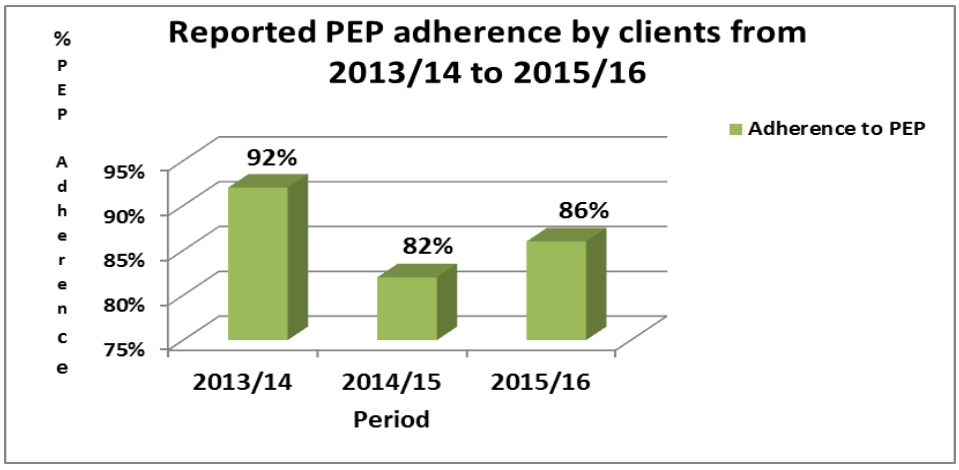
DoE performance improved following Provincial Treasury actively monitored the utilisation of budget DoE [17].

Number of women and children reporting gender-based violence (GBV) to the police in the last year

The province hosted 384 community dialogues and 327 campaigns addressing Gender Based Violence (GBV), during the 16 days of activism in 2015/2016, while a total of 18 campaigns were held in 2014/2015 and 227 community dialogues addressed social driver. The performance identified an increase in the number of campaigns in 2015/2016. Limpopo Province reported 18 495 people on the number of women and children reporting gender-based violence (GBV) to the police in 2015/16, while 10 547 were reported in 2014/15 [18]. The target of the current reporting period was 17 000 and was exceeded by 1 495. The increase in reporting GBV could be due to an increased number of community dialogues and campaigns addressing GBV conducted in the province and the high prevalence of GBV activities directed mostly to women and children during the reporting period.

Post Exposure Prophylaxis (PEP)

Limpopo Province reached 74% out of the target of 75% of those who were eligible for PEP in 2015/2016, there was an improvement of 0.6% compared to 73.8% reached in 2014/2015 [11]. Similarly, 72.6% of the target population were reached in 2013/2014 and the possible explanation of the province's failure of reaching the target could be caused by the poor reporting system of this p indicator. The challenge faced by clients was the completion of the regimen for complete prevention. See Figure 14 below sexual assault PEP adherence by clients. **Figure 13: PEP adherence at 2 Trauma centres, Vhembe distict Limpopo Province**



Source: TVEP Annual report 2015/16 [22]

Table 4: Strategic Objective 1 Social and Structural Drivers of HIV, TB and STI, 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	20 IDPs (66%) 11 APPs	100%	83%	The municipal elections, change of Political Leadership and dissolving of some of municipalities contributed in province not reaching the target of 100%
% municipalities with at least one informal settlement where targeted comprehensive HIV, STI and TB services are implemented	80%	100%	100%	Sustained
Provincial Inter-departmental Committee on HIV & TB is functional and meets regularly	No Baseline	100% (8/8) (4 LPAC TC & 4 LPAC meetings per annum)	100% (8/8) (4 LPAC TC & 4 LPAC meetings conducted	Reports were discussed and endorsed, Resolutions were taken with improvements plans
Current school attendance among orphans and among non-orphans aged 10 -14 (UNGASS 12; MDG Indicator)	7 267 (100%)	100%	90.3%	There is still a need for Department of Social Development and Department of Education to work together to improve reporting
Delivery rates for women under 18-NIDS	7.5% (9 599/128 587)	7%	7.1%	Although the performance improved from the previous year the target was not met. there was low utilization of reproductive services by youth
HIV and TB spend	DOE=31 083 (30%) DOH=99 503 (96%) DSD=98 154 (98.1%)	DOE DOH DSD	DOE= 90% DOH= 98% (HIV) & 76% (TB) DSD= 98%	Departments need monitoring in using budged allocated by Provincial treasury
Number of women and children reporting gender-based violence (GBV) to the police in the last year	10 547		18 495	Increased number of community dialogues and campaigns on GBV assisted in reaching the target
Proportion of women who have experienced physical or sexual violence in the last year	10 547		18 495	Increased number of community dialogues and campaigns on GBV assisted in reaching the target

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

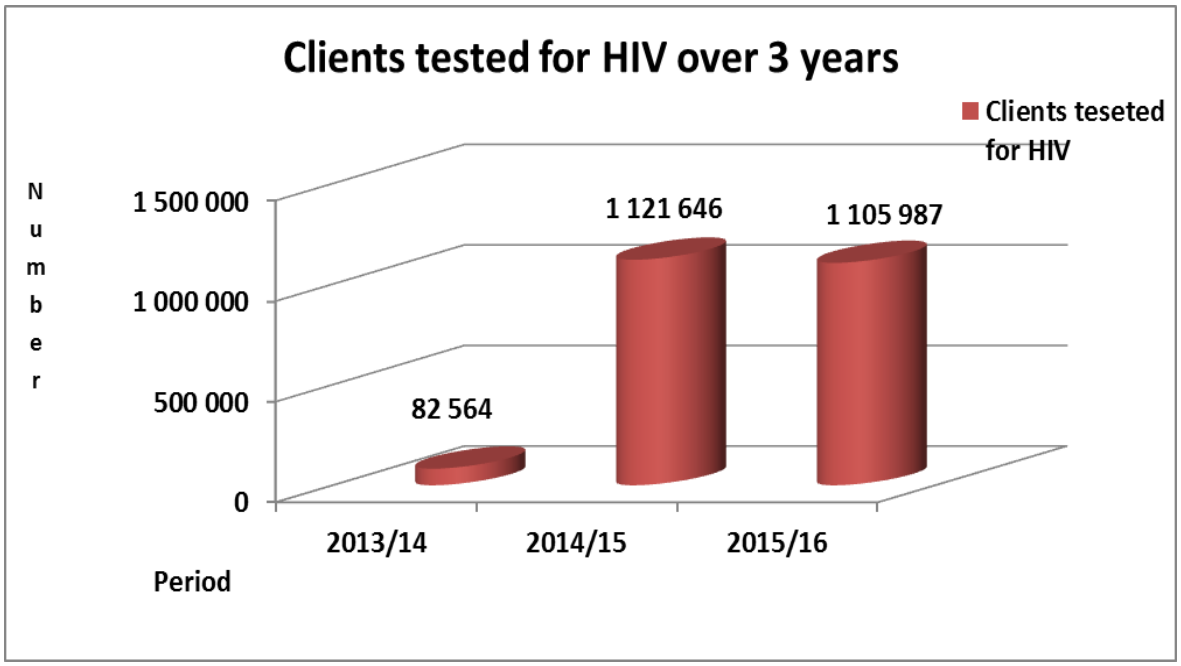
- ***HIV and TB screening***

The focus on prevention of new infections and improving the management of patients living with HIV was high. A total number of 1 105 987 people between 15-49 years old were tested for HIV to ensure that people knew their status as compared to 1 121 646 in 2014/2015 [8]. The province aimed at testing 999 342 and exceeded the target by 407 688 clients. Over achievement could have been complimented by the Province making an effort in availing these services in hard to reach areas as well as key populations [8]. There was a greater demand for HCT in all parts of the Province with sub-districts developing their own strategies and initiatives to get more people tested for HIV. The

employee wellness programs contributed with the HIV and TB screening of employees in different sector departments in the Province.

A number of High Transmission Areas (HTA) was established across the Province. There was a greater demand for HCT in all parts of the Province with sub-districts developing their own strategies and initiatives to get more people tested for HIV [11]. The province exceeded the target since 2014/2015. See Figure 15 below

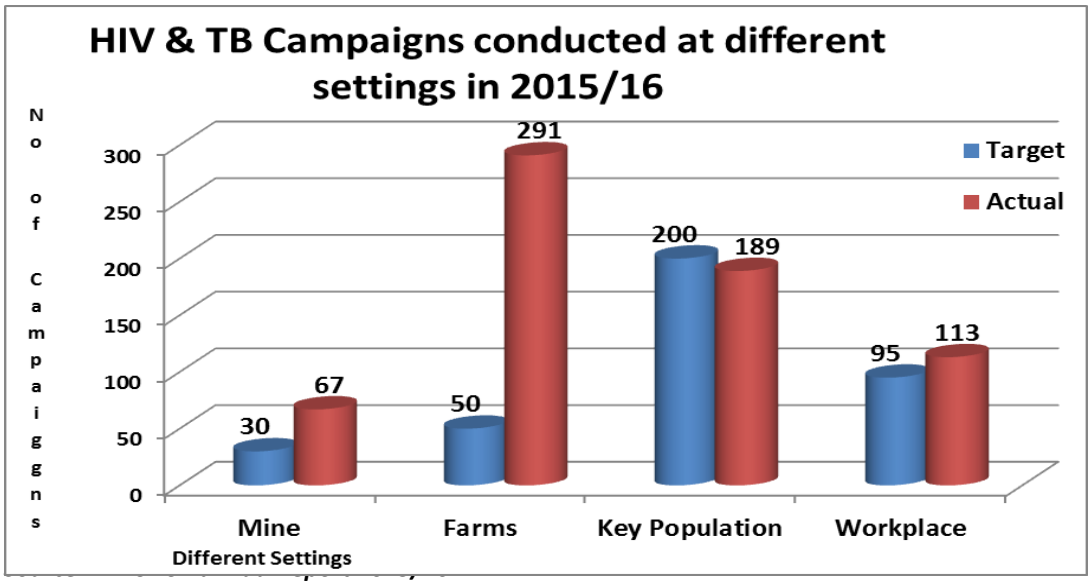
Figure 14: Clients Tested for HIV Limpopo Province



Source: DHIS 2016 [10]

Different campaigns were conducted at different settings in 2015/2016. Limpopo Province reported 67 mine campaigns conducted as compared to 34 campaigns conducted in 2014/2015. [10]. The province reported 291 campaigns conducted at farms while the target was 50 farm campaigns, 241 above target [10.] for campaigns on farms which contributed to the provincial success. Campaigns for key populations increased from 180 in 2014/2015 to 189 in 2015/2016 compared to the target of 200 campaigns. This implies that the province did not reach its target for key population campaigns. The employee wellness programs conducted a total of 113 HIV and TB screenings of workplace programs, as compared to the target of 95 workplace programs. The target was low in comparison with a baseline of 187 workplace programs conducted in 2014/15 [17]. Figure 16 below shows the performance in campaigns conducted at different settings in Limpopo, during the period under review.

Figure 15: HIV and TB Campaigns at different settings



VMMC

Voluntary Medical Male Circumcision is a priority programme for South Africa. The Province strives to contribute to the national target by implementing large scale MMC programmes. The VMMC programme has grown tremendously with the provincial DoH establishing partnerships with Developmental Partners, traditional leaders and community leaders. MMC include Traditional, Circumcisions that are supported by contracted General Practitioners (GPs). The province conducted 90 969 MMC, out of a target of 62 000 in 2015/2016 [11]. MMC performance increased from 67 205 in 2014/2015 to 90 969 in 2015/2016 which increased by 23 764 [11]. The NDoH set a higher target of 123 077 in 2015/2016 despite the 2012 Human Science Research Council report (HSRC) indicating that out of 10 males in Limpopo 7 are already circumcised [11]. The province performed above the target of 50 000 for 2 years, with actual MMC conducted at 68 516 in 2013/2014 and 67 205 in 2014/2015 [8].

TB

Prevention of new infections of Mycobacterium tuberculosis and the progression to tuberculosis (TB) disease is critical to reduce the burden of disease and death caused by TB, and to achieve the End TB Strategy targets set for 2030 [16]. TB screening assisted in Intensify Case Finding to identify more TB cases.

The actual provincial performance reached on the indicator for the rate of TB symptoms 5 years and older screened was at 70.1% (7 941 859/11 333 492) against a target of 70% in 2015/2016 compared to 63% during the previous reporting period [8]. The performance increased by 7.1%, despite the increase the province still needed to intensify TB screening.

The province successfully integrated HIV with TB in its programming. From the TB entry point, the percentage of TB patients tested for HIV was 92.3% in 2013/2014 and increased to 94% in

2014/2015 which was above a target of 90% [11]. This shows a positive result in the implementation of HIV and TB co-infection strategy.

Condom distribution

Limpopo Province male condom distribution rate was 51.2% targeted (36%) in 2015/16. The male condom distribution increased from 66 315 475 in 2014/2015 to 90 573 253 in 2015/2016 which translated into 51.2% male condom coverage. There were 2 401 397 female condoms distributed against the target of 1 728 28 in 2015/2016 [11]. The female condom distribution target was exceeded by 673 117. There were 51 664 469 male condoms and 1 400 142 female condoms distributed at High Transmission Areas [11].

Antenatal 1st visit before 20 weeks rate

Registration for antenatal care services is the initial step in the PMTCT service cascade and is a critical step for pregnant women to access HIV testing and subsequent services e.g. Early presentation during pregnancy provides an earlier opportunity to initiate the cascade of PMTCT services, and has also been shown to be an important predictor for being on ART at the time of delivery, which in turn reduces risk of MTCT [7].

Limpopo Province Antenatal 1st visit before 20 weeks rate was 42.3% in 2012/2013 which increased to 45.8% in 2013/2014. The increase of 4.9% was also observed in 2014/2015 financial year. The provincial target was 46% and achieved 60.7% in 2015/2016. The performance improved due to maternal health summits conducted in all districts with communities to create awareness on the importance of early booking [11].

The province implemented the National Consolidated Guidelines for PMTCT, and the management of HIV in children, adolescents and adults in this current year. 25% of ANC booking at 1st visits book already on ART, therefore the target of 24 000 to be initiated on ART has been above the number to be initiated [11].

Substance Abuse

DSD aimed to conduct substance abuse campaigns targeting 165 000 children below the age of 18 years. A total of 167 574 was reached and it was above the target, 18 the province achieved above the target of 2 574 children below the age of 18 years campaigns on Substance Abuse. A total of 125 843 people aged 19 years and above were reached through drug prevention programmes, out of the target 125 000 in 2015/2016 [18] and the target exceeded with 843 people aged 19 years and above reached on drug prevention programmes in 2015/2016 [18]. Provincial commemoration of International Day against drug abuse and illicit trafficking was held in Bela-Bela on 30 July 2015. The DoE in consultation with the South African Police Services identified eleven hotspots (problematic schools), which required special attention and remedial action plans from different stakeholders in the Province. [18]. During 2015/2016 financial year 24 585 people were reached through social and behavioural change programme while 135 community conversations on HIV & AIDS were held [18].

There were 298 drop-in centres out of a target of 365 School Nutrition Programmes which benefitted under the reporting period A total of 1 365 Secondary schools were targeted and 1 369 benefitted [17]. The target for the number of schools providing learners with meals as per the National School Nutrition Programme (NSNP) in Limpopo Province was 8 854 and a total of 3 845 participated in the NSNP. The target was not met due to the fact that special schools withdrew from the programme [20].

HIV education is in the package of the Integrated School Health Programme (ISHP), which aim to make youth-friendly, sexual and reproductive health (SRH) services accessible in school, enrich HIV prevention efforts and support young people who tested HIV negative to remain so. However, the percentage of schools implementing the ISHP in Limpopo Province increased from 13.2% in 2014/2015 to 14% in 2015/2016 [10]. The impact of the ISHP, which promotes use of contraception among youth and also sought to address teenage pregnancy through supporting peer education and health promotion in schools, should be prioritised by an integration of interventions by DOH, DSD and DOE in the province. The provincial target was 81 871, though the province managed to reach 50 710 learners in 2014/2015 and dropped significantly to 49 700 learners in 2015/2016 [10].

Table 5: Strategic Objective 2 Preventing new HIV, TB and STI infections

Indicator	Baseline	Target 2016	FY 2015/16 Achieved	Comment – progress towards target
Number (and percentage) of men and women 15–49 counselled and tested for HIV	999 678	999 342	1 516 487	Target exceeded by 407 688
Number and percentage of people screened for TB	6 67 1 850	90 000 (70%)	99 514 (70.1%)	Sustained TB screening
Number of newly diagnosed HIV positive people started on IPT for latent TB infection	54 436	43 186	36 657	Deviation of 6 529 towards target
Percentage men and women aged 15–24 reporting the use of a condom with their sexual partner at last sex	39.3% (HSRC) National HIV Prevalence, Incidence and Behaviour Survey 2012	-	39.3% (HSRC) National HIV Prevalence, Incidence and Behaviour Survey 2012	The indicator is only measured after surveys are conducted
Percentage young women and men aged 15–24 who had sexual intercourse before age 15 (age at sexual debut)	11.8% (HSRC) National HIV Prevalence, Incidence and Behaviour Survey 2012	-	11.8% (HSRC) National HIV Prevalence, Incidence and Behaviour Survey 2012	The indicator is only measured after surveys are conducted
Percentage women and men aged15–49 years who have had sexual intercourse with more than one partner in the last 12 months	13.1% (HSRC) National HIV Prevalence, Incidence and Behaviour Survey 2012	-	13.1% (HSRC) National HIV Prevalence, Incidence and Behaviour Survey 2012	The indicator is only measured after surveys are conducted

Male condom distribution	72 983 620	79 528 444	90 573 253	Exceeded target by 11 044 809 male condoms distributed
Female condom distribution	1 838 720	1 728 280	2 401 397	Target exceeded by 673 117 Female condoms distributed
Number of men medically circumcised	67 205	62 000	90 969	Target exceeded by 28 969 MMC
Number of people reached by prevention communication at least twice a year	157 449	-	136 660	No target for 2015/16 and there was a deviation of 20 789

Strategic Objective 3: Sustaining Health and Wellness

The thrust for the government was to ensure that people who were affected and infected with HIV and TB were provided relevant services to ensure a change in their quality of life. (PSP 2012-2016).

Ante-Retroviral Therapy Coverage

There were significant achievements in universal access to antiretroviral therapy in Limpopo since 2012. During the reporting period, the province had 500 facilities offering ART services. About 492 facilities were public health while 8 were non-public health facilities. The public health facilities offering ART increased from 488 in 2014/2015 to 500 in 2015/2016 [8]. This shows an increment in ART coverage which allowed communities to access life-long ART treatment nearer to their homes.

The rapid expansion of the ART programme was attributed to the HCT campaigns and supported by innovative policies such as the training of nurses in the initiation and management of patients on ART (NIMART) in early 2014/2015, as well as the introduction of the fixed-dose combination (FDC) for patients in April 2013.

Over the three-year period under review, annual increases were evident in the total remaining on ART. During the period under review, the province reported 260 893 506 in 2015/2016 as compared to 232 506 in 2014/2015. The province was able to exceed its target of 248 500 by 12 343 total remaining on ART at the end of the year. The Limpopo Province previous year 2014/2015 performance was 232 506 with the target of 239 100. The provincial performance in 2013/2014 was 188 989 under a target of 238 410. The trend shows that the province under performed for 2 consecutive years but only reached the target of retention in care in 2015/2016[8]. The performance improved due to all 8 869 home-based carers providing support to PLHIV and other chronic conditions were paid stipends. 1 065 413 beneficiaries supported by home based care givers.

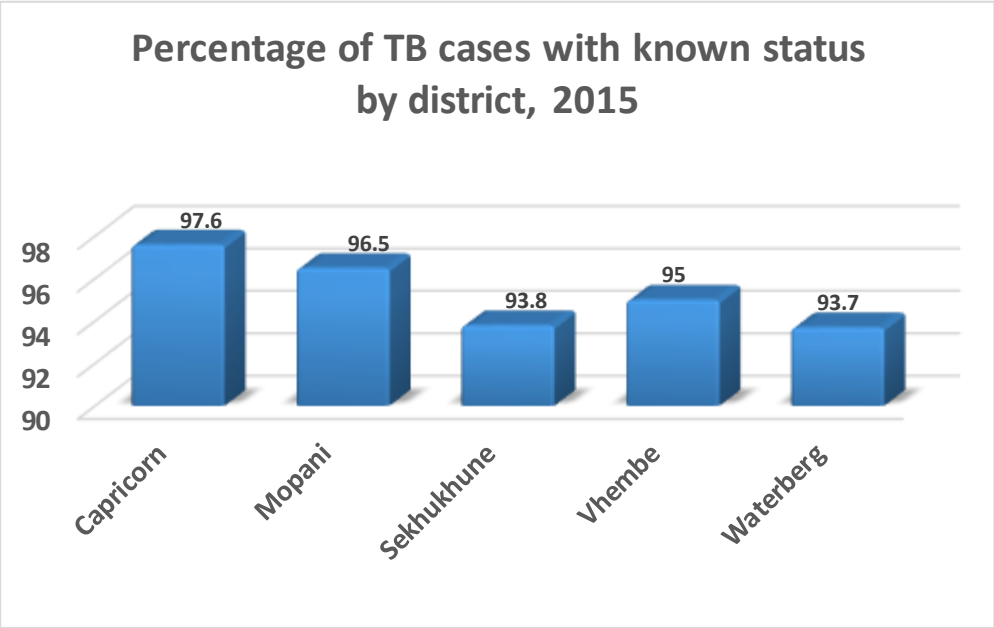
The Home Based care programme was one of the biggest programmes in Limpopo funded through the conditional grant, despite the fact that it was given a smallest portion of the Equitable Share budget. The success of the implementation of the programme was achieved through the partnership between the provincial DOH and the NPOs providing HBC in the Province and in cooperation with Expanded Public Works Programme (EPWP). The number of home-based carers providing support to PLHIV and received stipend reduced from 8 914 in 2014/2015 to 8 869 in 2015/2016. There was no replacement for resigned care givers as the Province was reduced cadres.

HIV and TB Co-infection

The HIV epidemic in Limpopo Province fueled the TB epidemic because people living with HIV were at a higher risk of developing TB due to their weakened immune system. The integration of TB and HIV services is a necessary and critical step to prevent new infections, more effectively manage

existing infections and combat this devastating co-epidemic. The number of HIV positive clients screened for TB was 99 514, compared to the target of 90 000 [11]. Despite progress in providing TB preventive treatment to people living with HIV, much more remains to be done. The number of HIV positive clients initiated on IPT was 36 657 against the target of 43 186 in 2015/2016 [11]. The IPT initiation was below the target by 6 529 and the performance low. The remedial actions were being implemented to achieve the target. Capricorn district reported 97.6% of TB cases with known status in 2015/16, followed by Mopani with 96.5% while other three districts Sekhukhune, Vhembe and Waterberg reported 95% and below. **See figure below**

FIGURE 16: Percentage of TB cases with known HIV status



Source: Health System Trust 2015/16 DHB [24]

World Health Organisations (WHO) EWIs piloted in Mopani District and rolled out to remaining Distracts from August 2015 to improve ART clinical outcomes

Patients piloted in 6 facilities and rolled out to 40 facilities and other Districts in the Province to improve quality of HIV testers to avert HIV false positive and negative test results

Walk in services were extended to 16 Technical, Vocational and Educational Training (TVET) colleges to improve access to HCT and SRH services to students.

Adherence strategy within the care and Support sub-programme was piloted in Mopani District and rolled out to other Districts to improve adherence and retention to HIV and TB treatment [11].

In the year under review, 18 913 orphans and vulnerable children receiving psychosocial services were reached and the number increased due to intensified campaigns in the areas with high levels of illnesses [18].

Table 6: Strategic Objective 3 Sustaining Health and Wellness

Indicator	Baseline	Target 2016	FY 2015/16 Achieved	Comment – progress towards target
Proportion (%) of people per year becoming eligible who receive ART	79 524	58 693	63 083	Sustained- increase byh 4 390
TB case registration rate				**This indicator was not targeted for by the province or was not measured in the previous financial years because the TB provincial team do not understand what the indicator intends to measure. Alternatively the provincial TB team tracks the indicator for TB case detection rate.**
TB case detection rate	(18 416/3 035 49) 6.0%		(17 993/269337) 6.6%	
% smear positive TB cases that are successfully treated	77.5.%	76.5%	82.2% (4173/5122)	Increase of 5.7% sustain the performance
TB case fatality rate (CFR)	11.1% (2 159/18 499) (ETR & DHB)	8%	6.8% (379/5582/)	Decrease 1.2% improved awareness campaigns
CFR HIV-positive = CFR HIV-negative	678=448 (ETR)	-	252= 71 (Unknown=56)	The indicator was not targeted for 2015/16 financial years
Number and % of registered TB patients who tested for HIV	94% (ETR & DHB)	100%	76.7%	The performance declined from (17.3%) 94% from previous year 2014/15 as compared to 2015/16
Number of all newly registered TB patients who are HIV-positive, expressed as a proportion of all newly registered TB patients	11 299/18 367 (61.5%) (ETR)	-	11 059/17 993 (61.4%)	The indicator was not targeted for 2015/16 financial years

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

The Constitution of South Africa is founded on the realisation of rights to equality, dignity, life, freedom and security of a person and privacy. The primary area of focus for the Province was to ensure that HIV and TB infected patients gained access to health services and that people's rights were not violated when interventions were implemented. This objective upholds the rights of people living with HIV in making choices related to fertility, decriminalisation of sex work, access to sexual and reproductive health for women and girls, provision of quality health care services to patients regardless of HIV status, gender and sexual orientation. All Provincial departments aligned their departmental HIV, STIs and TB policies to address discrimination in the workplaces.

MEC for Health conducted a community dialogue with approximately 30 Sex worker communities on World TB day. The main focus was on the human rights violation of sex workers and to develop strategies of integration with South African Police Services.

The number of children, youth, women and men educated on human and legal rights was 15 393 in 2015/2016 out of a target of 7 500. The province 's performance was 7 893 above target [17]. Although the target on educating the community about legal rights was reached, there was still a lot to be done in the province through multisectoral responses to ensure protection of human rights and improving access to justice.

7. MONITORING AND EVALUATION

8.1 Overview of the Provincial M&E system

In November 2015, a Monitoring and Evaluation (M&E) Committee was established for the purpose of leading and guiding the monitoring and evaluation of the PSP. The committee held quarterly meetings in which the terms of reference (TOR) were developed. The purpose of the TOR was to guide the operations of the provincial, district and local M&E committees within the AIDS Councils. The establishment of M&E a steering committee involved members being appointed by the Premier. The committee was also responsible for quality assurance of reports.

The standardised reporting tool was distributed to Sector Departments, District Municipalities for reporting. Collation, analysis and reporting giving was done quarterly and feedback was given during sector meetings.

Limpopo Provincial AIDS Council Technical Committee (LPAC TC) had all 4 targeted meetings in which an operational plan, quarterly and annual reports were checked for quality and relevance, prior presentations at LPAC meetings. All reports were endorsed by LPAC.

The following documents were developed to identify the gaps and needs in respect of information required for a more strategic and systematic approach in the management of a multi-sectoral response to the HIV and AIDS epidemic: Limpopo Monitoring and Evaluation Plan 2012-2016 and the Provincial and District Coordinator Narrative Quarterly Reporting Template. Furthermore, the developed documents promote support a strategy aimed at improving the status of M&E in the province. Limpopo province monitoring and evaluation plan was developed and was awaiting approval by SANAC.

An investigation into the functionality of the provincial, district and local AIDS councils in Limpopo Province was conducted in May-July 2015 at all 5 district and 25 local municipalities. The study revealed that AIDS councils were semi-functional in some districts and local municipalities. The capacity of AIDS Councils varied. Some of the challenges that hindered functionality of AIDS Councils include: absence of dedicated AIDS Secretariats, weak capacity of HIV & AIDS Co-ordinators, competing priorities and irregularly meetings held. Various strategies were identified to deal with the challenges [23]. The study was also accepted as a Poster presentation at the International AIDS Conference which was held in Durban in July 2016.

Limpopo Province conducted a research day where studies done on health issues including HIV, STIs, TB and social drivers were presented as a way of giving updates; identifying gaps and proposing recommendations. The Provincial HAST directorate participated in provincial and district quarterly reviews that are conducted regularly.

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

There was no dedicated AIDS Secretariat at district and local municipalities, Co-ordinators were also responsible for other programs, which resulted in competing priorities that compromised the submission and quality of reports.

The HAST programme was seen as a purely health concern rather than a developmental issue and evidence of departments who worked in silos. Minimal participation and reporting of activities undertaken by various departments was an outcome of this practice.

The Province under performed in reaching targets in some of the indicators such as PEP, PCR 1st test positivity rate around 6-10 weeks, viral load outcome.

8.3 Remedial Action

Plan for capacity building workshops on HIV, STIs and TB issues to district and local AIDS Council secretariat. Sector Departments, Civil Society and Developmental Partners are to actively engage in multi-sectoral intervention and strategies to solve problems

The Province embraced the development of District Implementation Plans (DIP) for 90 90 90 strategy as the vehicle to focus at the ground level where action happens. The 2015/2016 DIPs remedial plans were developed in consultation with the districts where three tracer indicators were monitored, followed by 2016/2017 DIPs where twelve tracer indicators were monitored up to facility level on a monthly basis to address HIV and TB epidemics. The 2016/2017 DIP informed the 2016/2017 HIV & AIDS Conditional Grant. The DIP processes empowered district and facility managers to analyse the situation (in the specified review period) and develop remedial action using the available information. The Provincial and District Technical Working groups were appointed and met as planned. The DIP encouraged participation and ownership amongst officials at all levels of care.

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

9.1 Main findings

Based on the progress discussed, Limpopo province performed well in implementation of PSP.

9. 2 Challenges and Gaps

Monitoring and evaluation of HIV, STIs AND TB prevention services was challenging given the lack of systems for recording and reporting data, and the involvement of multiple service providers at other Sector Departments.

There was no system in place to collect HAST related data from the private sector.

9. CONCLUSION AND RECOMMENDATIONS

The Limpopo Province succeeded in implementing PSP on HIV, STIs 2012-2016; however social drivers need to be taken into considerations

Multisectoral response need to be strengthen and focusing on capacity building on the comprehensive HIV and AIDS and STI's programme with its key strategic components of prevention, treatment, care and support

The province still need to strengthen and focus more on multispectral response, community mobilisation and behaviour change interventions

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