Isifundazwe SakwaZulu-Natali

Province of KwaZulu-Natal

Multi-Sectoral Response Plan for HIV, TB and STIs for KwaZulu-Natal Province 2017-2022

Foreword

The KwaZulu-Natal Provincial Multi-Sectoral HIV, TB and STIs Implementation Plan 2017-2022 cuts across all the seven strategic goals of the Provincial Growth and Development Strategy Vision 2035, but more specifically is aimed at contributing to strategic goal 3-Human and Community Development. It is the third plan developed by the province to guide stakeholders on the implementation of interventions within the multi-sectoral response to HIV, TB and STI. Through this plan, commitment to cementing the involvement of all stakeholders in the response continues. Government, non-government, business, civil society and traditional authorities all have a role in responding to the triple burden of HIV, TB and STIs.

We have made notable progress in responding to the epidemics. Data from our provincial Department of Health shows that mother to child transmission of HIV has drastically reduced. This means that we are saving many of people from HIV infection during the early stages of life. By the end of 2016, just above 1 million people were initiated on treatment translating into 61% coverage. Estimates from the Thembisa model also show that the total number of AIDS deaths have dropped by 39%. We attribute this reduction in part to the treatment efforts. The TB cure rate stands at 87% while the TB death rate is 3.0%, having been reduced by about 50% over the last five years. We continue to ensure single points of coordination of the response at the district level in the form of the AIDS Councils led by the Provincial Council on AIDS.

We are conscious of the fact that our infection rates remain high. A case in point is the high HIV infection rate among the youth with the adolescent girls and young women in the age group 15-24 years of age bearing the brunt. This in turn implies that the success we enjoy in reducing mother to child transmission is reversed as the children grow older into young adults. TB infection in the province is unacceptably high as is our sexually transmitted infection rates. We are aware that much more work must be done in reducing infection rates. To help us with this, we have embraced the relatively new methodology of Focus for Impact. This has allowed us to identify high burden areas along with the populations that are most at risk so that they are saturated with interventions. Five districts have been identified as having the triple burden of HIV, TB and STIs. Within these districts, we are targeting adolescent girls and young women, people living in informal settlements, sex workers, partners of sex workers, older men and farm workers. Critical to this is high intensity implementation of high impact interventions in the form of targeted social behaviour change communication interventions coupled with prevention efforts such as universal testing and immediately linking to treatment. This however, does not imply that the so called low burden districts will be neglected.

We are acutely aware that interventions must be concentrated at community level and that implementation must be as seamless as possible. The Operation Sukuma Sakhe platform, particularly the War Rooms will be central to this implementation. To this end, we are strengthening War Rooms to ensure that they have capacity to support implementation.

While most of the implementation falls within the domain of government departments, we are grateful to have benefited from the support of our partners such as the Global Fund to Fight AIDS TB and Malaria and the United States President Emergency Plan for AIDS relief.

Mr Thembinkosi Willies Mchunu
Premier of KwaZulu-Natal

Word of Support

Kwazulu-Natal (KZN) continues to be the epicentre of HIV/AIDS in South Africa. The epidemic has forced government and civil society to work together in curbing the spread of HIV/AIDS. Since April 2004, when the first patient was initiated on antiretroviral therapy (ART), KZN has made significant strides. We have saved many lives through the provision of ART to all those in need. KZN has given true meaning to Section 27 of the Constitution by guaranteeing access to life-saving medication. It is worth noting that a total of 1.2 million eligible people have so far been initiated on ART in KZN. This was not through luck, but rather the true evidence of strong collaboration, commitment and determination to save lives. The multi-sectoral approach led by the Provincial Council on AIDS (PCA) which is made up of government, civil society, development partners and all other community sectors in society, has demonstrated that the only way to succeed is to work together. KZN has the role of providing leadership to the rest of South Africa since we account for the largest share of the burden in the country. Operation Sukuma Sakhe (OSS) remains an instrumental vehicle in the fight against HIV/AIDS in the province.

The Provincial Multi-Sectoral HIV, TB and STIs Implementation Plan 2017-2022, gives an opportunity for KZN to even do more. KZN cannot afford complacency, but we should continue to have a sense of urgency in the response, until all the 90-90-90 targets are achieved. We have to ensure that 90% of all people living with HIV know their HIV status, 90% of all people living with HIV receive antiretroviral therapy and 90% of all people receiving antiretroviral therapy are virally suppressed to prevent new infections. The same applies for TB clients; 90% of all people living with TB being diagnosed, 90% of all TB diagnosed clients on TB treatment and 90% of all TB clients cured of TB. Youth, young girls, women, sex workers, truck drivers, LGBTI and injecting drug users remain at risk. This Provincial Multi-Sectoral HIV, TB and STIs Implementation Plan seeks to address and prioritize these key and vulnerable groups in our society which are highly exposed or are at risk of HIV/AIDS, TB and STI infection.

Civil society remains committed to supporting the implementation of the KwaZulu-Natal Provincial Multi-Sectoral HIV, TB and STIs Implementation Plan 2017-2022. We will continue to educate and mobilize our community through various sectors and advocate for the rights of every citizen in our province. We will continue to advocate for inclusive and non-discriminatory programming, ensuring that no group in our society is left out or left-behind in our response to HIV/AIDS, TB and STI.

Aluta Continua!

Mr Patrick Mdletshe
Provincial Council on AIDS (PCA) Deputy Chairperson and Civil Society Chairperson

Acknowledgements

The KwaZulu-Natal Provincial Multi-Sectoral HIV, TB and STIs Implementation Plan 2017-2022 was developed through an extensive consultative process with various stakeholders. This included Government Departments, Research Institutions, Development Partners, District and Local AIDS Councils, Non-Governmental Organizations, Civil Society Organisations and a cross section of sectors including the business sector.

The KwaZulu-Natal Provincial Council AIDS wishes to acknowledge all the individuals and organisations that participated in the consultative processes in many forms including those who submitted written inputs. The product of these processes is of course this important document.

Thank you all once again

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Table of Contents

Executive Summary

The province of KwaZulu-Natal is determined to achieve the vision 2035 of *"A KwaZulu-Natal Province that is free of new HIV, Tuberculosis and Sexually Transmitted Infections, free of deaths associated with HIV and free of discrimination where all infected and affected individuals enjoy a high-quality life"* through systematically responding to HIV, TB and STIs. This multi-sectoral response plan for HIV, TB and STIs 2017-2022 is the third plan developed by the province of KwaZulu-Natal. It provides the province's multi-sectoral stakeholders with implementation guidance of the response over the five year period of 2017-2022 and will further be used as a tool for implementation coordination, resource mobilisation and implementation accountability. In this regard, implementation of interventions will take place at the district level where this will be guided by multi-sectoral district implementation plans (MDIPs).

As was the case with the previous plans, its development is a product of a series of processes involving various stakeholder teams at national, provincial and district level. Its development was largely guided by the national process led by the South African National AIDS Council (SANAC). As a result, its contents are within the wider context of the national response as outlined in the National Strategic Plan for HIV, STIs and TB 2017-2022 (NSP 2017-2022). Deliberate effort has been made to align this plan with various provincial policy frameworks such as the Provincial Growth and Development Strategy (PGDS) 2035 and departmental and sector strategic plans to ensure that all stakeholders have a role to play in the response. The plan also presents an opportunity for alignment for those departments and sectors that may not have HIV, TB and STI activities reflected in their specific plans.

The plan continues on the path of the multi-sectoral response to HIV, TB and STIs and takes into account current developments such as the 90-90-90 strategy, prioritisation of implementation for maximum impact and; doubling the emphasis on tuberculosis (TB) and sexually transmitted infections (STIs). It also responds to the new bold national targets of ending AIDS as a public health threat by 2030 and takes into consideration acceleration of progress in reducing illness and deaths associated with HIV and TB.

The constitution of the country, as the supreme law guarantees specific rights to all those who reside in it, provides the overall framework for delivery of interventions and activities described in this plan. Other critical parameters in the delivery of interventions and activities for the province are political commitment, multi-sector participation, Operation Sukuma Sakhe (OSS), inclusion of and participation by key and vulnerable populations and observance of governance and accountability.

The province will continue cementing the "Three Ones" principle as demonstrated through the use of *single authorities* for coordination (i.e. AIDS councils), use of *one plan* to implement response activities and carrying out monitoring, evaluation and reporting using *one framework*. The province has a provincial council on AIDS, 11 district AIDS councils and 43 local AIDS councils which serve as the single authorities for coordination. It carries on to establish Ward AIDS committees with a view to ensuring that all its wards have these structures. Guidelines exist to support establishment and functioning of AIDS

councils. The province has enforced the use of a single plan through development of provincial multi-sectoral plans, ensuring that stakeholders use it as the main reference document. This will be the third single plan for the province whose use will be supported by the availability of multi-sectoral district implementation plans. The single monitoring and evaluation framework has been in place to provide single source guidance for monitoring and evaluation aspects of the response. A monitoring and evaluation framework document will be put in place with the facilitation of the PCA secretariat to provide guidance to the monitoring and evaluation function.

Acceleration, intensification, inclusivity, participation and efficiency in the provision of services will be hallmark of the interventions and activities of this plan given the dire situation of the epidemics in KZN and for the fact that it is considered the epicentre of the epidemic in the country. Towards this end the province adopted the *Focus for Impact* methodology to assist it pinpoint localities with the greatest burden with a view to targeting these with interventions and activities. The essence of the methodology is to deliver results that can provide the greatest impact with limited resources and highest value for money. Focus for impact results show that five of the province's eleven districts namely (1) eThekwini; (2) iLembe; (3) uThukela; (4) uMgungundlovu and (5) Ugu have a high triple burden of HIV, TB and STIs. Four of the eleven districts have a dual high burden as follows, (1) King Cetshwayo and (2) Zululand (high burden of HIV and TB), (3) Harry Gwala (high HIV and STIs burden) and (4) uMkhanyakude (high TB and STIs burden). Amajuba, on the other hand, has a high STIs burden.
It is important to note that the neighbouring districts of Gert Sibande (Mpumalanga province), Thabo Mofutsanyane (Free State Province) and Alfred Nzo (Eastern Cape Province) have been classified as high burden districts.

Community mobilisation will be the primary strategy for increasing awareness, effecting social behaviour change. In this regard, community mobilisation and social behaviour change communication (SBCC) interventions will be placed at the forefront of all interventions, encompass various age groups and all sections of the population. It will be implemented through the OSS platform. Political, cultural, community, religious leaders and policy-makers will be required to champion and support behaviour change efforts. A comprehensive provincial multi-media HIV, TB and STIs communication strategy will be developed to ensure widespread, intensified and coordinated reach. The PCA secretariat will be responsible for facilitating is development.

Operation Sukuma Sakhe, the province's integrated services delivery model will be the main platform for the community's involvement and participation in fighting HIV, TB and STIs. In this regard, there will be need to strengthen OSS within the community systems strengthening framework. War Rooms as focal points of community level OSS will be targeted with training and resourcing efforts to ensure full functionality. The training, targeting ward task team members will be based on the *OSS Operations Handbook*. Ward Task Team membership is composed of the following: the war room champion (ward

councillor); war room chairperson, deputy chairperson, secretary, deputy secretary, fieldworkers[1] and members from civil society, government departments among others. Resourcing on the other hand will involve providing furniture and equipment e.g. computers, printers to war rooms and exploring possibilities of internet connectivity of the war rooms. War rooms in the most deprived local municipalities as classified by Statistics South Africa multiple poverty index will be priority. The province will also be working towards integrating its fieldworkers so as to contribute to enhancing the delivery of integrated services at ward level.

The plan consists of 8 goals and 21 objectives and mainly reflect those of the NSP. Goal 1 is the primary goal and is geared towards accelerating prevention to reduce new HIV, TB and STI infections. It has 3 objectives that address reduction of new HIV infections, reduction of TB incidence and reduction of sexually transmitted infections. Each of the goals have ambitious targets demonstrating renewed commitment to controlling and eventually halting the epidemic.

In regard to reduction of HIV infections, the target is to reduce these to less than 20000 through combination prevention interventions from the estimated 65000. Interventions revolve around *expanded and intensified* provision of biomedical services, sexual and reproductive health and the provision of pre-exposure prophylaxis to high risk groups. The province is targeting reducing TB incidence by 50%. Currently TB incidence is way above the World Health Organisation threshold of 200 per 100 000 population. Earmarked interventions relate to increasing the *uptake* of TB preventive therapy using various strategies including mass screening. The target for reduction of sexually transmitted infections (STIs) is by 50%. Reaching this target will be supported by scaling up of STI prevention through *expansion and intensification* of contact tracing accompanied by treatment.

Goal 2 focusses on reducing morbidity and mortality by providing treatment, care and adherence support for all and has 2 objectives one of which is to have 90% of people living with HIV being put on treatment and remaining on treatment. The second objective is to have 90% of people diagnosed with TB getting treated and being TB negative. These objectives are aimed at achieving the 90-90-90 targets through interventions for *sustained provision* and *uptake* of ART and *intensification* of TB treatment.
Interventions for goal 1 and 2 are primarily the domain of the department of health. The spectrum of other government departments and civil society groups, however all have a role.

Goal 3 deals with reaching all key and vulnerable populations with customised and targeted interventions. Despite the province having made strides in inclusion of key and vulnerable populations in response activities, further opportunity exists to increase key and vulnerable population engagement,

[1] These are the community development workers, community caregivers, assistant extension officers, sports volunteers, social crime prevention volunteers and other volunteers e.g. those allocated by NGOs

collaboration and advocacy in the development and implementation of social and HIV, TB and STIs support activities and provide an enabling environment to increase access to HIV, TB and STIs services to key and vulnerable populations. This goal and its objectives calls for more inclusion, collaboration and participation. Interventions will revolve around *ensuring representation* of this population group in AIDS councils, *advocacy and support*, and *peer-led approach* to implementation of activities for key and vulnerable populations. In addition, *ensuring access to HIV, TB and STI services* and information in line with the Constitution will be a key intervention. The civil society forum and department of health will have the primary responsibility for implementing interventions in this goal and will be supported by government departments as per the province's multi-sectoral approach.

Goal 4 addresses the social and structural drivers of HIV, TB and STIs and consists of five objectives. The objectives are to (1) Implement social and behaviour change programmes to address key drivers of the epidemics and build social cohesion (2) Increase access to and provision of services for all survivors of sexual and gender-based violence (3) Scale up access to social protection for people at risk of and those living with HIV and TB (4) Implement and scale up a package of harm reduction interventions for alcohol and substance use and (5) Implement economic strengthening programmes with a focus on youth. Planned interventions will focus on *support* for the various population groups each of which may have different circumstances. Various strategies will be used in this support e.g. building resilience, social assistance, food security, improving access to sexual, gender-based violence services, anti-substance and drug abuse services. Goal 4 interventions will be the primary responsibility of various government departments such as the department of social development, department of education, department of agriculture and rural development and the department of sport, recreation, arts and culture. As per the multi-sectoral approach other government departments and civil society organisations working in the respective fields will provide the necessary support.

Goal 5 addresses grounding the response to HIV, TB and STIs in human rights principles and approaches with the objectives of reducing stigma and discrimination, facilitating access to justice, redress for people living with and vulnerable to HIV and TB; and promoting an environment that enables and protects human and legal rights; and prevents stigma and discrimination. Interventions to reduce stigma will mainly involve community mobilisation and awareness and advocacy against stigma and discrimination. Other interventions will be to do with legal literacy and ensuring accessibility to services. *Monitoring applications* of laws, regulations and policies relating to HIV and TB and *sensitising* law makers and law enforcement agencies will form part of the interventions. The primary responsibility of implementing these interventions will be the department of justice and constitutional development affairs, civil society organisations in the legal and human rights field and the office of the premier.

Goal 6 addresses promotion of leadership and shared accountability for a sustainable response to HIV, TB and STIs. Interventions for this goal will be under two objectives namely (1) To strengthen AIDS Councils to provide effective coordination and leadership to all stakeholders for shared accountability in the

implementation of the provincial plan and (2) To improve collaboration and co-operation between government, civil society, development partners and the private sector. Functional AIDS councils and a committed leadership are critical to the success of the response. Responsibility of implementing interventions for this goal will lie with the Office of the Premier and will revolve around *capacity building* of AIDS councils, *training* of community leaders, *facilitating inclusion* of stakeholders such as private sector, labour and *facilitating alignment* and development of plan e.g. MDIPs. The civil society forum will ensure that community groups plays a central role in the response.

Goal 7 revolves around mobilising resources to support the achievement of plan goals for a sustainable response. In the face of dwindling financial resources in an environment of competing demands, there is need to improve efficiency and mobilise sufficient resources to achieve the goals, objectives and targets of the provincial plan. The interventions earmarked are those of putting in place a *costed plan*, to enable the province have a clearer picture of funds available at its disposal and for which programmes. This will then set the base for better resource mobilisation. The office of the premier will be responsible for facilitating implementation of interventions for this goal.

Goal 8 deals with strengthening strategic information to drive progress towards achievement of provincial plan goals. The objectives are to (1) optimise routinely collected strategic HIV, TB and STIs information for data utilisation in decision making (2) rigorously monitor and evaluate implementation and outcomes of the plan and (3) strengthen strategic research activities to create validated evidence for innovation, improved efficiency and enhanced impact. The goals and objectives of the plan are in support for sustained availability of reliable and valid data critical to providing stakeholders with progress information and planning. Interventions will address *data collection systems* at service delivery points and development of an *information system*. The office of the premier will be responsible for facilitating implementation of interventions of this goal.

Abbreviations and Acronyms

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral (drugs)
CBO	Community-Based Organisation
CSO	Civil Society Organisation
DAC	District AIDS Council
DA&C	Department of Arts and Culture
DCS&L	Department of Transport, Community Safety and Liaison
DARD	Department of Agriculture and Rural Development
DEDT&EA	Department of Economic Development, Tourism and Environmental Affairs
DHS	Department of Human Settlements
DOE	Department of Education
DOH	Department of Health
DOJ&CD	Department of Justice and Constitutional Development
DS&R	Department of Sports and Recreation
DSD	Department of Social Development
ECD	Early Childhood Development
FBO	Faith-Based Organisation
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
HTS	HIV Testing Services
IEC	Information, Education and Communication
LAC	Local AIDS Council
MDIP	Multi-sectoral District Implementation Plans
MECs	Members of Executive Council (KZN)
M&E	Monitoring and Evaluation
MTCT	Mother-to-Child Transmission of HIV
NGO	Non-Governmental Organisation
OTP	Office of the Premier
OVC	Orphaned and Vulnerable Children
PCA	Provincial Council on AIDS
PEP	Post-Exposure Prophylaxis
PEMP	Poverty Eradication Master Plan
PLHIV	Person/People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PrEP	Pre-exposure Prophylaxis
SANAC	South African National AIDS Council
SAPS	South African Police Services

SBCC	Social Behaviour Change Communication
SRH	Sexual and Reproductive Health
STI/s	Sexually Transmitted Infection/s
TB	Tuberculosis

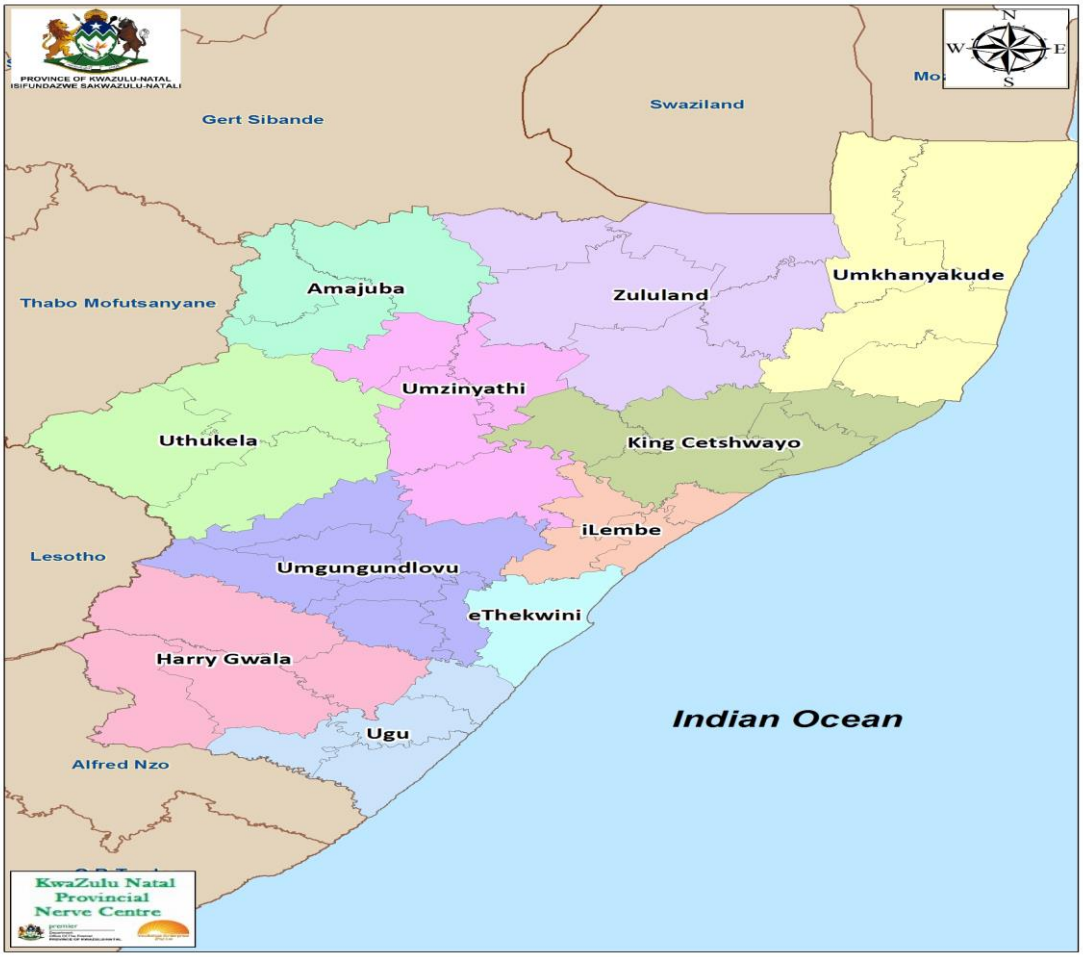
KwaZulu-Natal Province Map

Map developed by the KwaZulu-Natal Provincial Nerve Center

KwaZulu-Natal Province Demographic and Socio-economic Data						
Land Area	**Population**	**% young people aged less than 15 years**	**% young people aged 15-24 years**	**% of population below 35 years**	**% sexually active population**	**Households classified as low-income earners**
94 361 square kilometres	10.92 million (1)	34.8%	19.9%	71.5%	52%	48%
Human Development Index (2015)	**% in urban areas living in informal settlements**	**South African Multi-dimensional Poverty Index (2014)**	**% people classified as poor (2015)**	**% population below the food poverty line (2014)**	**Unemployment rate (2011)**	**Gini Co-efficient (2014)**
0.61(2)	10%	0.05	56.6% (2)	28.9%	35%	0.63[2]

[2] The gini co-efficient of 0.6 is indicative of wide income disparities in the province and is the second highest in the country.

KwaZulu-Natal Districts Map



Map developed by the KwaZulu-Natal Provincial Nerve Center

	District demographic and socio-economic data as percent share of province						
District	**Land Area**	**Population**	**Children below 15 years**	**Youth 15-24 years**	**Population less than 35 years**	**Population 15-49 years**	**Households**
Amajuba	7.4%	4.8%	5.1%	4.9%	4.9%	4.6%	4.8%
eThekwini	2.4%	33.1%	26.4%	32.9%	31.7%	37.2%	33.1%
Harry Gwala	11.2%	4.5%	5.3%	4.5%	4.7%	4.0%	4.5%
ILembe	3.5%	5.9%	6.2%	5.8%	6.0%	5.7%	5.9%
King Cetshwayo	8.8%	8.8%	9.6%	9.2%	9.2%	8.5%	8.8%
Ugu	5.4%	7.1%	7.3%	6.8%	6.9%	6.5%	7.1%
uMgungundlovu	10.3%	10.0%	8.9%	9.7%	9.5%	10.3%	10.0%
uMkhanyakude	13.7%	6.2%	7.6%	6.5%	6.3%	5.4%	6.2%
uThukela	12.1%	6.4%	7.5%	6.3%	6.7%	5.9%	6.4%
uMzinyathi	9.2%	5.0%	6.2%	4.9%	5.2%	4.2%	5.0%
Zululand	15.9%	8.1%	9.7%	8.1%	8.4%	6.9%	8.1%

Source of data: Municipal Finance 4th Quarter Review Close-Out Report 2015/2016

Multi-Sectoral Response for HIV, TB and STIs for KwaZulu-Natal Province

VISION 2035

A KwaZulu-Natal Province that is free of new HIV, Tuberculosis and Sexually Transmitted Infections, free of deaths associated with HIV and free of discrimination where all infected and affected individuals enjoy a high-quality life

MISSION

The people of the Province of KwaZulu-Natal commit themselves to continuing on the path of having a well-coordinated, managed and demonstrably effective response to HIV, TB and STIs informed by evidence and geared towards eliminating new infections and ensuring a high quality of life for the infected and affected

VALUES

Transparency and Accountability

Partnerships, Collaboration and Collective Accountability

Public Participation and Involvement

Upholding Human Rights and Equity

Ubuntu

Introduction

This plan was developed to provide implementation guidance to a broad range of province stakeholders on the multi-sectoral response to HIV, TB and STIs. It is a product of a series of processes involving various stakeholder teams and is therefore as inclusive as possible in charting the province's path to successfully responding to HIV, Tuberculosis (TB) and Sexually Transmitted Infections over the five years i.e. 2017-2022. It will also be used as a tool for implementation coordination, resource mobilisation and implementation accountability.

This document consists of a total of 4 chapters where chapter 1 is composed of the background information. Under various sub-sections it gives the contextual setting of the plan. These include sub-sections describing the province's historical aspects of responding to the epidemics; the process leading to the development of this plan; the context of delivering interventions; implementation and coordination arrangements; and monitoring and evaluation and research.

Chapter 2 discusses the situational analysis of the HIV, TB and Sexually Transmitted Infections (STIs) using selected indicators per epidemic. These are the number of new HIV infections, HIV prevalence, mother to child transmission rate, people on ART and ART deaths. Other indicators are TB incidence, TB death rate and STIs incidence. For each selected indicator, a comparison is made between the KwaZulu-Natal (KZN) province and other provinces in the country, the aim of which is to illustrate its positioning vis-à-vis other provinces; and therefore demonstrate magnitude of the situation. This is followed by descriptions of KZN's performance through a trends analysis to 2016 using data as far back as 2009 and projections data to 2022. Thereafter and where possible 2016 district specific analysis is provided to highlight the specific district's impact on the entire province.

Chapter 3 is entitled "Towards Implementation of the Plan" commences by describing the *Focus for Impact* as a basis for understanding the implementation direction of the current plan. The focus for impact methodology is used to identify high burden areas that can then be targeted with interventions and activities. The section also discusses community mobilisation and community systems strengthening as entry points to behaviour change, services uptake and sustainability of programmes.

Chapter 4 applies the logic framework approach in discussing the goals, objectives, interventions and activities. For each goal, a brief analysis of the response is provided, followed by a listing of corresponding objectives and a brief description of the rationale. Thereafter the interventions and activities are depicted in an implementation plan matrix presented in a table format. The matrix also shows lead agencies responsible for implementing the activities and collaborating agencies.

1 Background Information

Responding to HIV, STIs and TB

KwaZulu-Natal's commitment to systematically respond to HIV dates back to 1996. Over this twenty year period, the province has continued to demonstrate its commitment through leadership pronouncements, plans, programmes and various initiatives.

The province has so far implemented two 5 year multi-sectoral strategic plans for the periods 2007-2011 and 2012-2016 all of which were developed to respond to the epidemic based on emerging issues specific to these periods. This is the third multi-sectoral plan the province has developed. As in the previous plans it takes into account current developments such as the 90-90-90 strategy, rapidly expanding developments in science, the sustainable development goals, lessons learnt from reviews of both the preceding national and provincial plans, prioritisation of implementation for maximum impact and; doubling the emphasis on responding to tuberculosis (TB) and sexually transmitted infections (STIs). The plan responds to the new bold national targets of ending AIDS as a public health threat by 2030 and takes into consideration acceleration of progress in reducing illness and deaths associated with HIV and TB.

Development Process of the Plan

This plan was developed within the wider context of the national response as outlined in the National Strategic Plan for HIV, STIs and TB 2017-2022 (NSP 2017-2022) (3). Its development was largely guided by the national process led by the South African National AIDS Council (SANAC). SANAC provided guidance through documents, workshops, technical working groups, and other forms of consultative processes including feedback sessions/meetings and assigning to the province focal persons to support plan development.

The province used both existing structures and those it specifically set up to support the development of the plan. The structures it used were as follows; the provincial council on AIDS (PCA), the provincial executive council, province technical clusters, provincial plan executive committee, provincial plan steering committee and provincial plan thematic working groups.

The Context of Plan Delivery

Constitution of South Africa: As the supreme law of the Republic of South Africa; law or conduct inconsistent with the Constitution is invalid, and the obligations imposed by it must be fulfilled. Central to this are the civil, social, economic and cultural rights of which those who live in it are entitled to. In addition to providing the overall guiding framework for developing this plan, the constitution also sets out the parameters within which this plan will be implemented.

Political Commitment: The response to HIV, TB and STIs has over the years enjoyed consistent support and commitment from political leaders in the province. Political leaders have demonstrated commitment and support to the delivery of HIV, TB and STIs interventions through PCA meetings, provincial executive council meetings and other fora e.g. Operation Sukuma Sakhe meetings, at the province, district and community levels. During the State of the Province 2017 address, the Premier of the province noted progress made in combatting HIV and further expressed the need to focus on reducing infection among high risk groups thus setting the tone for this plan period.

Multi-Sector Participation: Multi-sectoral involvement in the provincial response has grown in strength over the years with implementing organisations placing more value to this approach, and in the process diminishing the commonly held view that responding to the epidemics falls purely within the health sector. Within the delivery environment of the response, each organisation will implement interventions based on its mandate and at the same time benefit from the comparative advantage of the other.
Government organisations, non-government organisations, civil society, the private sector, development partners, traditional leadership and the religious sector all have individual and complementary roles in implementing this plan and ensuring delivery.

Operation Sukuma Sakhe: Operation Sukuma Sakhe (OSS) is the province's community systems strengthening model designed to enhance integrated service delivery to the communities and to have communities mobilise and intervene on identified challenges. Stakeholders including the community use OSS as a vehicle in responding to HIV, TB and STIs, and in addressing social ills, for example, alcohol abuse, substance abuse, gender-based violence, sexual assaults and general crime, which more often are the predisposing factors for HIV infection (4).
Coordination of services delivery at the ward level is centred on the war room along with field worker teams dedicated to specific functions. The primary thrust of the OSS is the identification of community and household needs/challenges and then attending to those needs within stipulated time periods. All government departments are expected to integrate and mainstream OSS into their activities and assign officials to facilitate integrated delivery of services. Civil society organisations play a supportive, advocacy and accountability role.
District and local levels mayors are OSS champions at district and local municipality levels while the councillors are ward level champions. The province's leadership on the other hand provides oversight and support. The Premier, Members of the Executive Council (MECs) and Heads of Departments (HODs) are district OSS champions and oversee the implementation of OSS in their allocated districts.

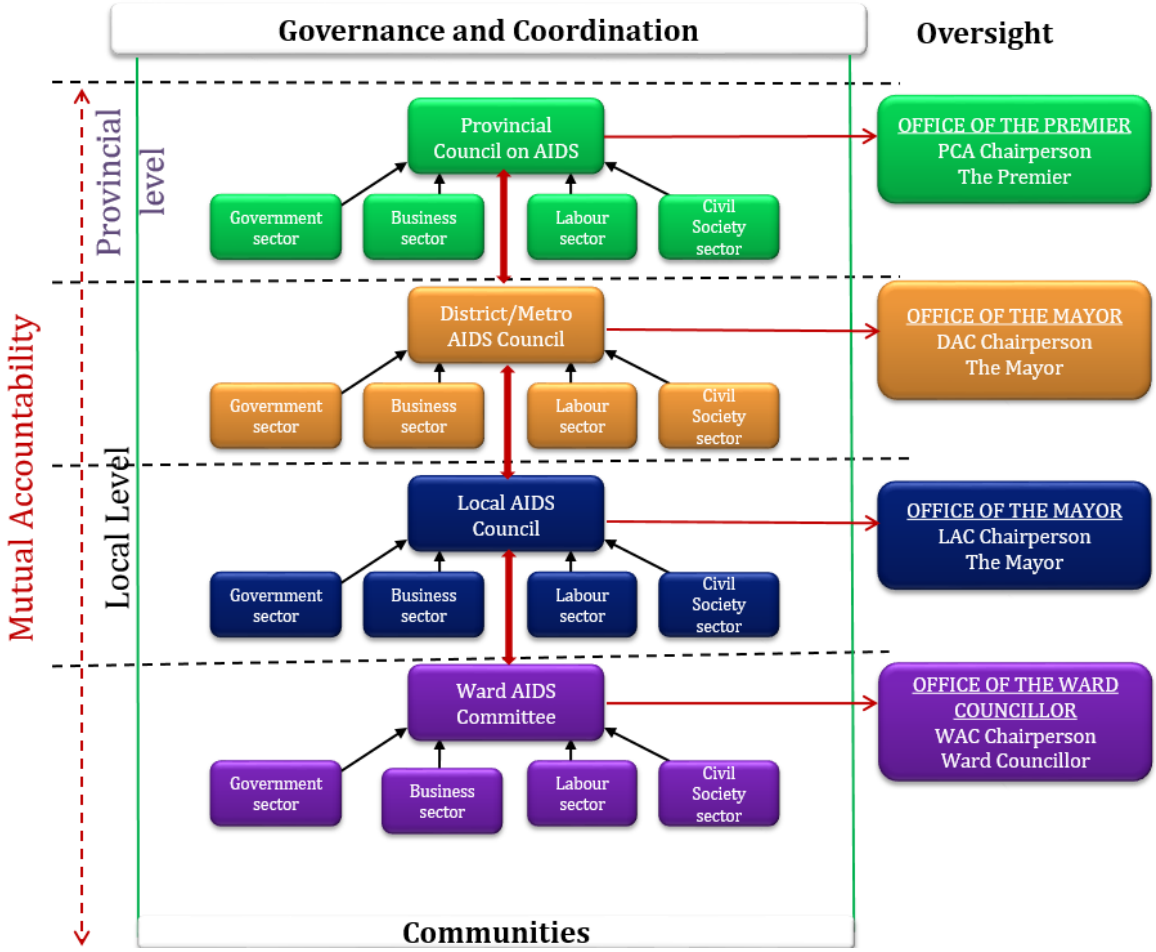
Key and Vulnerable Populations: As was the case with the preceding plan period, this plan continues targeting key and vulnerable populations with the focus being on ensuring that they have equal access to services. Generally the province is high burden across the board implying that the entire provincial citizenry broadly falls into the key and vulnerable population category as defined in the NSP. Based on the focus for impact methodology the province intends to target adolescent young girls and women, people

living in informal settlements, farm workers, sex workers and their male sex partners and older men. The province will also target people living with HIV; household contacts of TB index patients; health care workers; inmates; pregnant women; children <5 years old and diabetics.

Governance and Accountability: Executive Authority of the province is vested in the Premier who exercises this Authority along with the MECs. Likewise, the Executive Authority of each district and local municipality is vested in the mayor.

This Authority and oversight is manifest among others through the role of chairing of AIDS councils done by the Premier, the mayors and the Ward councillors. AIDS Council meetings held regularly at all levels are used as forums for reporting and accountability. The illustration below shows the governance and accountability arrangement of the multi-sectoral response.

Figure 1: Governance and Accountability of the Multi-sectoral Response



The PCA is supported by an HIV and AIDS Directorate located within the Office of the Premier. District and Local AIDS Coordinators located in the municipality support the district and local AIDS Councils respectively. The LACs further provide support to the ward AIDS committees. The PCA will ensure that the AIDS Councils are inclusive of and that there is coordination among all stakeholders including civil

society, the private sector, religious sector, government departments, and development partners among others. The PCA will also ensure that AIDS Councils that do not exist are established and that all the AIDS Councils are fully capacitated to perform their functions optimally.

Alignment with National and Provincial Policy Frameworks

This plan is aligned to various national and provincial policy frameworks to ensure its contribution to the overall development objectives and that participation by various stakeholders is increased. Key among these is the following:

The KZN Provincial Growth and Development Strategy 2035 (PGDS): The PGDS is the province's framework for accelerated economic growth and development designed to bring all stakeholders together in pursuit of the vision 2035 of *"a prosperous province with a healthy, secure and a skilled population, acting as a gateway to Africa and the World".* The PGDS states that "departmental strategic plans, integrated development plans and sector strategies and plans should cohere around the key goals and objectives of the PGDS" (5). This plan will contribute to all the seven strategic goals of the PGDS given the cross-cutting nature of the epidemics. In addition, the spatial development framework provided for in the PGDS is important to this plan in relation to the focus for impact and determination of the high burden areas and how they relate to the spatial framework.

Integrated Development Plans: All districts and local municipalities have in place integrated development plans (IDPs). All mention HIV as a development challenge and commit to reducing the burden of HIV, STIs and TB. The IDPs further mention priority areas most of which align with the interventions of this plan, this provides a basis for municipalities participation in the implementation of the plan.

Departmental Strategic Plans: These are department and sector specific plans that set out interventions to be implemented based on their mandate, goals and objectives that are to be achieved by respective departments. Departmental plans were reviewed to determine extent to which they support this plan. Below are the findings.

Table 1: Departmental Plan Areas Supporting this Plan

Department	Areas that Support this Plan
Agriculture & Rural Development	Food security, Expanded Public Works Programme (EPWP)
Arts, Culture, Sports and Recreation	Community mobilisation and awareness; EPWP; support to small and medium micro sized enterprises (SMMEs); youth and women development; elderly and people with disabilities; employee health and wellness
Co-operative Governance and Traditional Affairs	Support to OSS; public participation; EPWP and Community Works Programme (CWP), employee health and wellness

Table 1: Departmental Plan Areas Supporting this Plan (contd.)

Department	Areas that Support this Plan
Economic Development, Tourism and Environmental Affairs	Support to SMMEs; economic and employment opportunities for youth; women and people with disabilities; skills development for youth and women
Education	Universal access to early childhood development (ECD); inclusive education; curriculum support, promotion of sports & recreation in schools; life skills; learner alcohol and drug abuse; learner sexual and reproductive health; nutrition; no fee paying schools;
Health	HIV testing services, medical male circumcision, prevention of mother to child transmission, anti-retroviral treatment, tuberculosis prevention, sexually transmitted infections treatment, condoms distribution; sexual and reproductive health; EPWP
Human Settlements and Public Works	Housing; EPWP
Home Affairs	Birth registration; identity registration; identity cards issuance
Labour	Employer protection (occupational health; employee safety; employee protection) work seeker registration and placement; work and learning opportunities registration and placement; work seeker counselling
Office of the Premier	Governance and leadership; stakeholder coordination (OSS, HIV & AIDS); implementation of poverty eradication master plan, employee health and wellness.
South African Police Services	Crime reduction (general, women and children);partnership policing (community outreach; school safety programmes)
Social Development	EPWP; ECD; home based care, care and support (elderly, orphaned and vulnerable children, families) social behaviour change; child protection; social crime prevention and support; victim empowerment; substance abuse prevention and treatment
Social Security Agency of South Africa	Social assistance and support
Transport, Community Safety and Liaison	Support to learners (transport); community awareness; EPWP; youth, women and people with disabilities employment; community-based safety partnerships and initiatives; employee health and wellness

Information compiled with review of departmental plans listed

This plan has to the extent possible incorporated issues relating to HIV, TB and STIs as mentioned in other departmental and sector plans to enhance mainstreaming and multi-sector participation. It further presents a platform for participation in the response by departments and sectors that may not have HIV, TB and STIs activities in their current plan. They should use this plan as a reference document to inform

their implementation in line with the departmental mandate. The activities can then be incorporated into departmental strategic plans when the opportunity arises.
In addition all departments must have employee health and wellness activities that address the epidemic at the workplace.
The PCA through its secretariat will be required to facilitate the process of ensuring that all departmental plans support the goals and objectives of this plan.

The National Strategic Plan on HIV, TB and STIs (NSP) 2017-2022: The NSP 2017-2022 is the key reference document for all HIV, TB and STIs responses in the country, in this regard, this plan borrows from and is guided by the contents of the NSP. For instance, all the goals and objectives in the provincial plan have been adopted from the NSP. The province considers the NSP to be the link between the provincial plan and other policy frameworks at national and international level e.g. the National Development Plan, the Medium Term Strategic Framework and the Social Development Goals.

Implementation and Coordination Arrangements

The province will continue cementing the "Three Ones" principle as demonstrated through the use of *single authorities* for coordination, use of *one plan* to implement response activities and use of *one monitoring, evaluation and reporting framework* to guide monitoring, evaluation and reporting activities.

Co-ordination

Coordination of the response will be done by the AIDS councils i.e. the provincial council on AIDS, District AIDS councils (DACs) Local AIDS councils and Ward AIDS Committees. The province has developed the constitution/guidelines for each of the AIDS councils providing them with a basis for performing their functions. AIDS councils have membership spanning a cross-section of stakeholders including civil society, the private sector, religious sector, government departments, and development partners among others.

The PCA will provide overall coordination and oversight at a provincial level and will be supported by the DAC at the district level. The local AIDS council (LAC) will provide this support to the DAC at the local municipality level while the ward AIDS Committees will provide support to the local AIDS Councils.
Respective AIDS council secretariats at the provincial level, district and local municipality level will provide technical, secretariat and administrative support to the AIDS councils. AIDS council meetings which are held every quarter of the year will remain forums for reporting and accountability, unblocking any bottlenecks and making decisions to facilitate implementation.

Towards this, adequacy of resources (human, equipment and financial) within AIDS council secretariats and the functionality of AIDS councils will be critical. A review of human resource availability indicated that 6 districts and 21 local municipalities had AIDS coordinators that were exclusively assigned to HIV.

In order to support AIDS coordinators, the province recommended the formation of AIDS council secretariats that should be composed of the AIDS Coordinator and representatives from the key departments of education, health and social development and the civil society forum. The review also found that all AIDS coordinators were housed by the respective municipalities and afforded the resources e.g. furniture, computers, printers, internet connectivity, meeting spaces. 6 districts AIDS council coordinators and 15 local municipality counterparts indicated having a budget.

In regard to functionality of AIDS councils, a review noted that the provincial council on AIDS functionality was impressive. Based on a functionality composite calculation, district AIDS Council functionality was at 70.8% while that for the local AIDS councils was 45.6%. Ward AIDS Committee functionality was 19.1%.
The PCA will be required to strengthen AIDS councils commencing with the local AIDS council and ward AIDS committee through providing support to their establishment, facilitating their functionality and advocating for additional resources.

Implementation

Contrary to the preceding provincial plans, this plan goes a step further by suggesting activities for implementation. Attempts have also been made to ensure that this plan aligns as much as possible to stakeholder plans.

In striving to improve implementation, the province aims to ensure that all districts, local municipalities and wards use this plan as a guide to developing all-encompassing localised operational plans that respond to their respective needs. As an initial step to implementation, district AIDS councils will be required to develop district-level plans that take into account respective local specifics. This will then be cascaded to local municipalities and communities through Local AIDS Councils, Ward AIDS Committees (WACs) and OSS structures. The AIDS coordinators will be responsible for development of these plans with PCA secretariat facilitating and providing support. Acceleration, intensification, inclusivity, participation and efficiency in the provision of services will be hallmark of the interventions and activities in the plan

Implementation of activities in the plan will be done by government departments aided by community-based organisations and non-governmental organisations. Government departments and agencies have the responsibility of implementing activities based on their mandate. They will also be responsible for providing leadership, guidance, technical support, capacity building, resource mobilisation, setting standards, ensuring quality service delivery, monitoring and evaluation of activities performance against this plan.

In addition to implementing specific interventions, civil society's participation and networks are particularly critical due to their proximity to communities and their role in advocacy, communication awareness and mobilisation within communities.

Operation Sukuma Sakhe War Rooms

Besides being a platform for integration of services, OSS is also a vehicle for the community response through war rooms. War rooms have been established in all wards in the province and are the community platforms used by communities to mobilise and respond to challenges facing them. They are the initial reference points for communities to mobilise and respond to HIV & AIDS, STIs and TB and; social ills such as alcohol abuse, substance abuse, gender-based violence, sexual assaults and general crime among others. Interaction of community-based structures is done through the war rooms as depicted by the illustration below. This interaction allows for these structures to share information related to community needs and service delivery.

Figure 2: Interaction of key community-based structures involved in the war room

Illustration Adopted form OSS Operations Handbook

The province has developed guidelines[3] to support the operations of OSS.

Functionality of war rooms is made possible by the Ward task team (WTT) whose membership is composed of the war room champion (ward councillor); war room chairperson, deputy chairperson,

[3] See OSS Operational Handbook and OSS Monitoring & Evaluation Framework (2014-2019)

secretary, deputy secretary, fieldworkers[4] and members from civil society, government departments among others. The broad roles of the WTT are to facilitate public participation and community mobilisation, maintain a functional war room, plan, coordinate service delivery, conduct training, mobilise resources and monitor, evaluate and report.

There will be need to strengthen OSS within the community systems strengthening framework. War Rooms as focal points of community level OSS will be targeted with training and resourcing efforts to ensure full functionality. Training will be based on the *OSS Operations Handbook* with Ward Task Team members being targeted for training. Resourcing on the other hand will involve providing furniture and equipment (computers, printers) to War Rooms and exploring possibilities of War Room internet connectivity. War Rooms in the most deprived local municipalities according to classification of the Statistics South Africa multiple poverty index will be initially targeted. The province will also be working towards integrating its fieldworkers so as to contribute to enhancing the delivery of integrated services at ward level.

Monitoring, Evaluation and Reporting

The monitoring, evaluation and reporting (ME&R) system that is in place will be used to track progress and assess achievements. The system will be supported by an M&ER framework document aligned to the multi-sectoral plan 2017-2022. AIDS councils will use the system to assess implementation progress through the production of monitoring reports and use these as the foundation for discussion during AIDS councils meetings or any other relevant fora. The system will require further strengthening as outlined in Chapter 4 of this document.

Research

Research will play a critical part in the implementation of the plan. The research agenda will need to be revised to reflect the current situation. In addition the research committee will be re-established with a view to carrying forward the research agenda. Operations research, implementation evaluations and other forms of evaluations will be guided by the research committee. Additional detail is provided in Chapter 4 of this document.

[4] These are the community development workers, community caregivers, assistant extension officers, sports volunteers, social crime prevention volunteers and other volunteers e.g. those allocated by NGOs

2 Situation Analysis

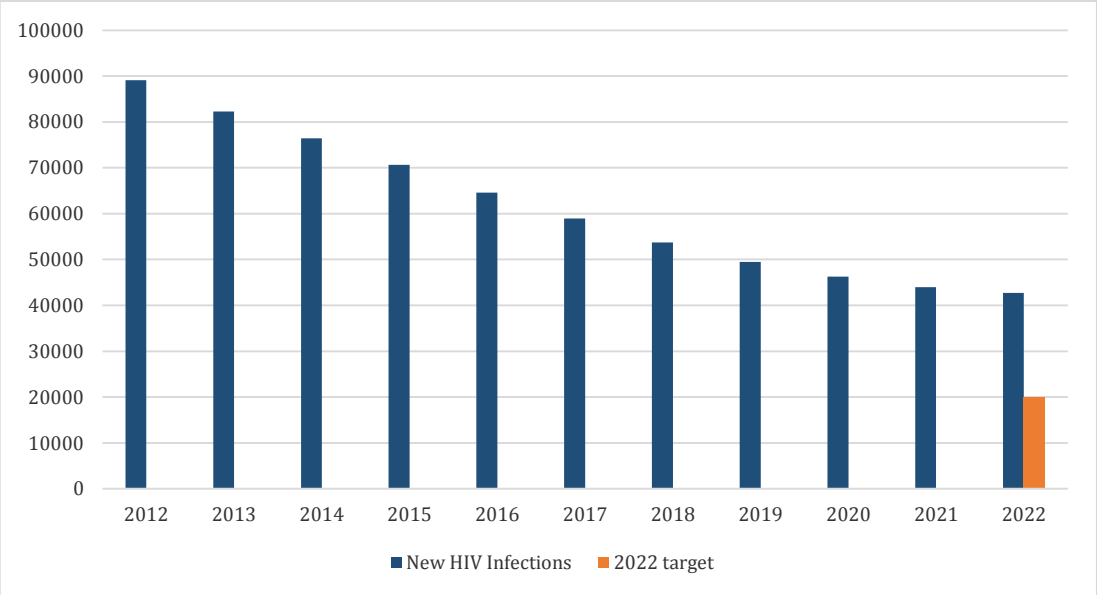
2.1 HIV

2.11 New HIV Infections

Total New Infections: According to estimates from the Thembisa model[5], new HIV infections for KZN in 2016 stood at just above 64600, the second highest among other provinces.

Using estimates data, the graph below illustrates two scenarios, scenario 1 is for the 2012-2022 period to depict progress over the last plan period (2012-2016) and while scenario 2 shows projections for the current plan period (2017-2022). Overall the graph indicates reducing numbers of new infections. Over the last plan period, new infections reduced by 27%. For the period 2017-2022, a 33% reduction is projected, translating into 43 000 new infections as opposed to the targeted less than 20000.

Figure 3: Trends in New HIV Infections 2012-2022 and 2022 Target



Graph developed with Estimates from Thembisa Model Output 3.2

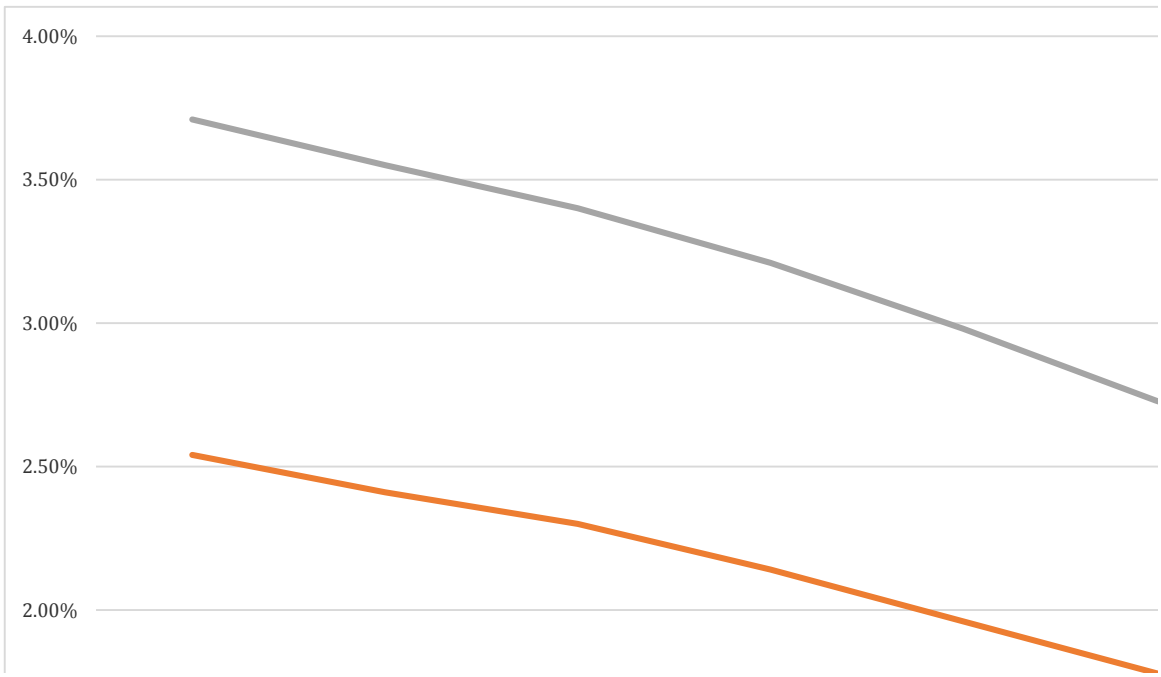
District estimates for 2016 showed eThekwini to have the highest number of new infections. Other districts with high new infection estimates uMgungundlovu, King Cetshwayo and Zululand. An estimated total of 39479 new infections occurred in these four districts thus accounting for 61% of estimated total new infections in the province.

[5] http://www.thembisa.org/downloads (Output 3.2)

New Infections 15-24 Years: Estimates showed that new infections within the 15-24 year age group was 34823, accounting for 53% of estimated total new infections in 2016. New infections among females in this age group was 24777 or 71% of estimated new infections within this age group.
32% of total new infections in this age group were accounted for by eThekwini. Females in this age group in eThekwini accounted for 22% of the provincial infections. Other high estimates were noted for uMgungundlovu, King Cetshwayo and Zululand accounting for 12% and 8.8% and 8.9% respectively.

HIV Incidence: The graph below illustrates trends in incidence based on the categories of total incidence, youth aged 15-24 years and by sex for the corresponding age. Incidence in all the categories generally show marginal decrease. Incidence among females aged 15-24 years is highest when compared to the other categories.

Figure 4: Trends in Total Incidence, Incidence youth 15-24 years and by Sex 15-24 years 2012-2022



Graph developed with Estimates from Thembisa Model Output 3.2

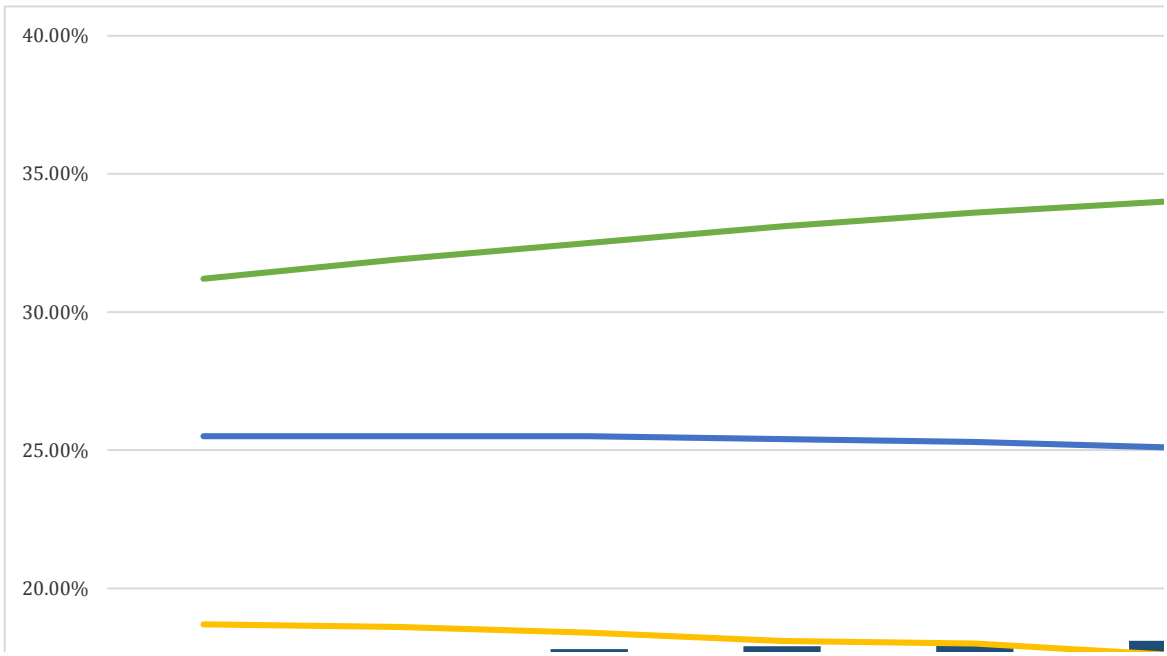
In 2016, district incidence ranged from 0.54% in ILembe to 0.69% uMgungundlovu. Other districts with high incidence rates were Zululand (0.64%); Ugu (0.62%) and Harry Gwala (0.57%).

2.1.2 HIV Prevalence

Total HIV Prevalence: Studies have shown that increased ART coverage with decreased mortality both contribute to an increased prevalence of HIV (6). Total HIV prevalence in 2016 was highest among all other provinces at 18.0 % having increased by 0.9% from 17.4% in 2012. As illustrated by graph 5, total HIV prevalence has generally been stable, a scenario that is likely to remain during the 2017-2022 period.

District specific total HIV prevalence for 2016 ranged from 16.1% in ILembe to 20.6% in uMgungundlovu. Other districts with relatively high prevalence rates were Zululand (19.2%), Ugu (18.5%) and King Cetshwayo (17.8%).

Figure 5: Trends in total HIV Prevalence, Age group and by Sex 2012-2022



Graph developed with Estimates from Thembisa Model Output 3.2

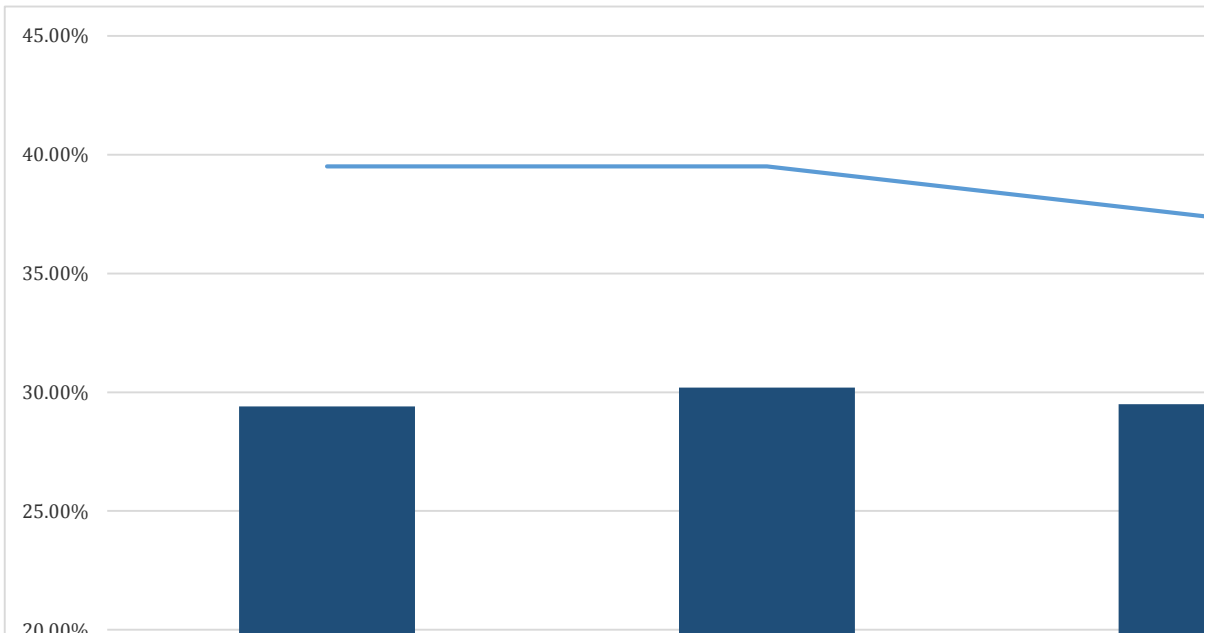
Prevalence by Age Group 15-24 years and by Sex: Prevalence in the age group 15-24 years ranged from 12.1% (2016) to 12.4% (2012) and recorded a 2.4% reduction. The projected estimates indicate a reduction of 3.2% between 2017 and 2022. Females in this age group had a higher prevalence, as shown by graph 5 where prevalence is slightly above the total prevalence in 2012 before more or less equalling total prevalence in 2016. Projections indicate that this will steadily but marginally go down between 2017 and 2022. Males in the age group 15-24 years had the lowest prevalence.

District estimates for 2016 showed prevalence for this age group ranging from 13.8% in uMgungundlovu to 8.6% in uMzinyathi. Besides uMgungundlovu, other districts with high prevalence were eThekwini (13.5%), King Cetshwayo (11.7%), Ugu (10.9%) and Zululand (10.7%). District estimates for females ranged from 20.3% in uMgungundlovu to 12.8% in uMzinyathi. Other high prevalence rates were noted in eThekwini (19.8%), King Cetshwayo (16.9%), Ugu (16.7%) and Zululand (15.8%).

Prevalence by Age Group 25+ years and by Sex: As illustrated by graph 5, prevalence in the age group 25 years and above for females was highest of the depicted categories standing at 33.6% in 2016. This was highest among other provinces. The graph shows an always rising trend, with a 1.8% increase between 2012 and 2016 and a projected increase for 2017 to 2022 by 0.8%. Prevalence for males in this age group was 25.5% in 2012, decreasing to 25.3% in 2012. In the 2017-2022 period, a marginal reduction is expected.

Prevalence among Women attending Antenatal Clinics: According to the 2013 National Antenatal Sentinel HIV Prevalence Report, HIV prevalence among women attending antenatal clinics in KZN was 40.1%, in comparison to the national figure of 29.7%. Over the 2009-2013 period, prevalence has been high, but generally stable going down in 2011 and maintaining the same figure in 2012 before going up to the highest level in 5 years in 2013. Below is an illustration.

Figure 6: Trends in HIV prevalence of Women attending Antenatal clinic 2009-2013

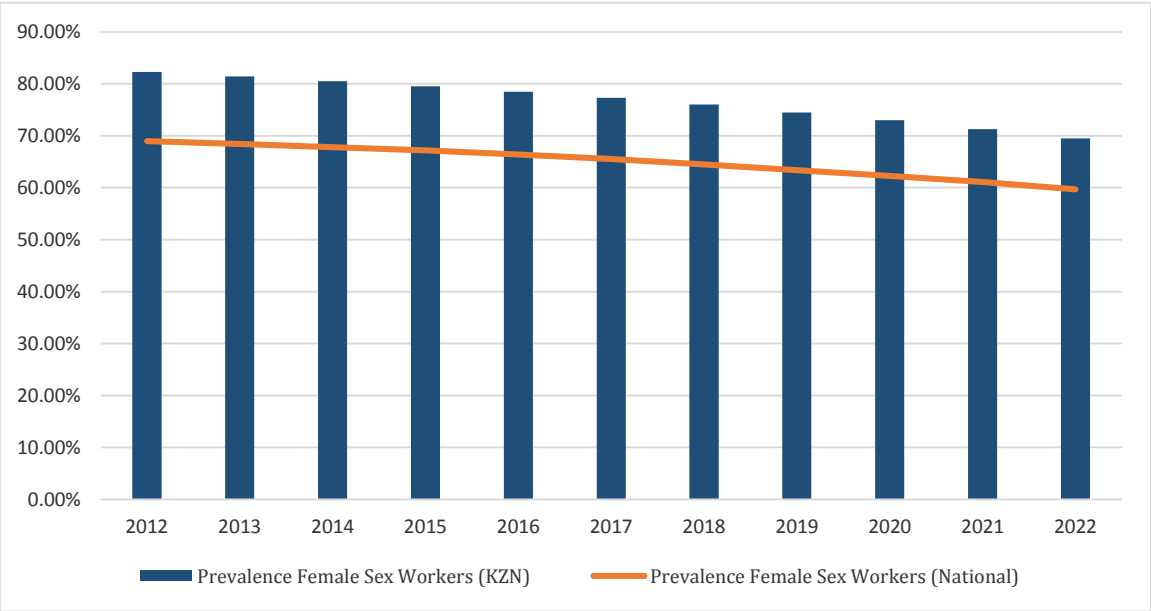


Graph developed with data from National Antenatal Prevalence Survey 2009-2013 publications

Districts specific rates ranged from 45.1% in iLembe to 31.4% in Amajuba. Six of the eleven districts had ANC prevalence rates of 40% and above.

HIV Prevalence among Key and Vulnerable Populations: The National HIV Prevalence, Incidence and Behaviour Survey (2012) reported high HIV prevalence among key and vulnerable populations. For example, in eThekwini, sex workers between the ages of 16 and 24 years had a prevalence of 29.4% whereas the rate was 71.2% among sex workers aged 25 years and older(7). Estimates from the Thembisa model shows sex workers prevalence in KZN ranging from 82.30% (2012) to 69.50% (2022) and was consistently above the national average. Figure 7 illustrates that the 2012-2016 period witnessed a reduction of 4.6%, the projected reduction for the period 2017-2022 is 10%.

Figure 7: Trends in HIV prevalence among Sex Workers 2012-2022



Graph developed with Estimates from Thembisa Model Output 3.2

Further, the National HIV Prevalence, Incidence and Behaviour Survey (2012) study indicated that HIV prevalence was higher among women especially those whose economic situation was classified as "not having enough money to buy basic things like food and clothes "(8) indicating that economic situation of the individual sexual influenced behaviour. The same study indicated that HIV prevalence among orphaned children was 7.4% as compared to 1.5% among non-orphaned children. The prevalence among double orphaned children was 15.2% (7).

2.1.3 Mother to Child Transmission of HIV

The province has made significant progress in reducing the rate of mother to child transmission of HIV (MTCT) as shown by figure 8 where in 2009, the MTCT rate was 10.3% going down to 1.1% in 2016. There was a variation of this rate across districts with King Cetshwayo, uMgungundlovu and uMkhanyakude having rates of 1% or less while uThukela and Zululand had relatively high rates at 2% each[6]. While it will be important that these variations be addressed, it is worthwhile noting that eliminating infection at MTCT level is a reality, the high infection rates among the older age groups remains a threat. An individual who turns HIV negative due to an MTCT intervention has a high risk of getting infected at the later stages of their life.

[6] District Health Information System (DHIS) Provincial Data

Figure 8: Trends in MTCT rates 2009-2016

Graph developed with data from Provincial DOH annual Reports 2009-2016.

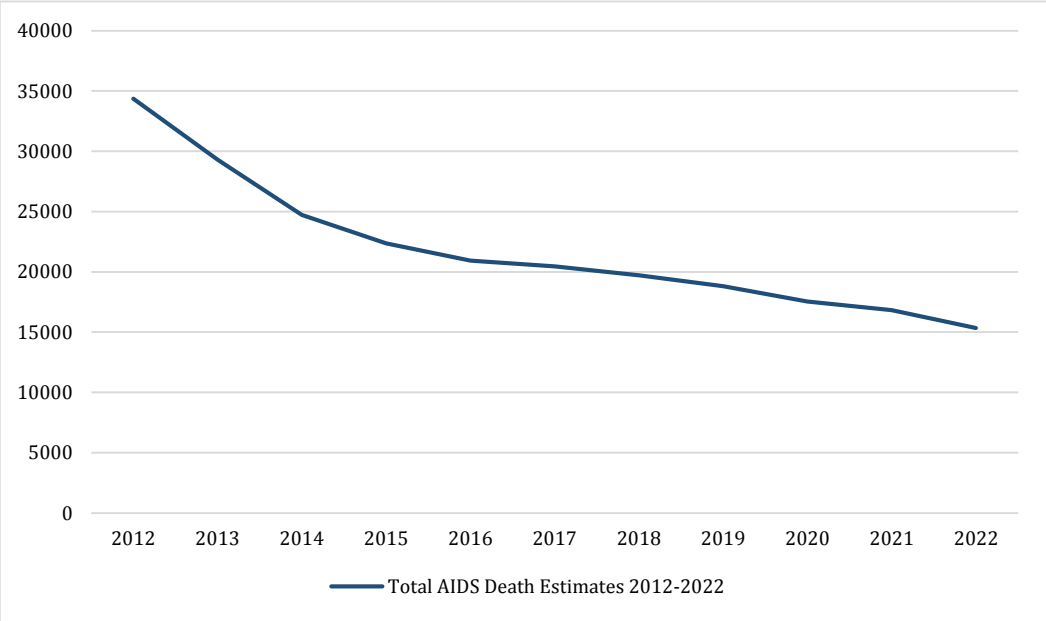
2.1.4 Anti-retroviral Treatment

Estimates from Thembisa model show that the number of people living with HIV (PLHIV) in the province is 1 934 126, representing 27% of the total number of PLHIV in the country. The number of children 15 years and less living with HIV was 108419 (about 6 % of PLHIV in the province). eThekwini has the highest concentration of people living with HIV (28.71%) followed by uMgungundlovu (12.53%)(9).

By 2016, 1 179 901 patients had been initiated on ART, translating into 61% ART coverage. District specific ART coverage ranged from 45% in Harry Gwala to 94 % in uMkhanyakude.

Total AIDS deaths estimates for the province in 2016 was just above 20000. These were the second highest deaths among other provinces. Figure 9 shows a generally downward trend as total AIDS deaths declined by 39% between 2012 and 2016. Projections show these will decline by 24% over the period between 2017 and 2022.

Figure 9 Trends in total AIDS deaths 2012-2022



Graph developed with Estimates from Thembisa Model Output 3.2

2.2 Tuberculosis

2.2.1 Tuberculosis Incidence

The incidence of TB in the province was 642.5/100 000 population (10) as compared to 1 902/100 000 in 2011(11) and remains well above the World Health Organisation threshold of 200 000/100 000. District specific TB notifications rates ranged from 1 081/100 000 in Zululand to 352/100 000 in uThukela.

The province remains concerned about the steady decline in the number of new TB cases per year which according to the province's TB crisis plan is due to failure to actively find suspects within the community. The estimated rate of TB screening at primary health care (PHC) level (i.e. the percentage of PHC attendees 5 years and older who underwent screening for TB) in 2016 was 25.3%.

A cumulative total of 16 173 MDR cases have been diagnosed from 2012 to 2016. MDR numbers increased by 95% from 1 854 (2012) to 3 621 (2014) and then declined by 0.75% between 2015 and 2016 to 3 234 cases. 2016 cases recorded accounted for 20% of the cumulative cases since 2012, the highest during the 2012-2016 period, reinforcing that MDR cases are increasing.

TB/HIV co-infection has increased from 55.9% in 2011 to 63.9% in 2015. District specific co-infected rates on ART ranged from 59.6% in Harry Gwala to 72.6% in uThukela. Seven districts namely Amajuba, uMgungundlovu, uThukela, uMzinyathi, uMkhanyakude and Zululand had co-infection rates higher than the provincial average. 85.1% of the co-infected patients had been put on ART as compared to 25.6% in 2011.

2.2.2 Tuberculosis Deaths

The TB death rate declined from 6.2% in 2011 to 3.0% in 2015 reflecting a 51% decline. District specific death rates ranged from 6.8% in uMzinyathi to 0.6% in King Cetshwayo. 6 of the 11 districts namely Amajuba, Harry Gwala, uMgungundlovu, uMzinyathi, uThukela and Zululand recorded TB death rates above the provincial average (10).

In regard to MDR TB, the percentage of MDR deaths rose from 15.7% in 2011 to 17.9% in 2015. Zululand (27%) and uMzinyathi (23%) recorded the highest percentage of MDR deaths in the province[7].

2.3 Sexually Transmitted Infections

2.3.1 Sexually Transmitted Infections Incidence

The annual STI incidence in the province was 57.4 per 100 000 population. Annual STI incidence was highest in uMkhanyakude at 75.4; followed by Harry Gwala (69) King Cetshwayo (63.4) and Zululand (61.1).

A study conducted in KwaZulu-Natal by Abdool Karim et al. (2014) among high school learners 15-18 years, with a median age of 16 years, found the prevalence of HSV-2 for males and females to be 2.6% and 10.7% respectively (12). This study also found that HIV infection was almost synonymous with the sexual debut for female learners. A pilot study of an on-site sexual and reproductive health (SRH) clinic in a rural setting in KZN amongst youths aged 15-19 years found that about 40% of the referrals to the local clinics were for the management of STIs with majority (78.4%) of referrals being for female learners (13). These findings raise, among others concerns about the prevalence of STIs, especially HSV-2 in relation to increased risk of transmission of HIV (14).

2.4 Key Gaps and Challenges

KwaZulu-Natal's situation of the epidemics has a significant impact (both positive and negative) on the situation in the entire country particularly with the province being considered the epicentre of the epidemics. The province has the unenviable tag of being leader in most HIV, TB and STIs data. New HIV infections based on all categories i.e. total new infections and by age groups and sex are highest in the country. The TB incidence is roughly five times higher than the World Health Organisation threshold of 200 000/100 000 and TB multi-drug resistance cases have increased close to double fold between 2012 and 2016. The TB/HIV co-infection has also increased. Sexually transmitted infections incidence is high and data showed that a cumulative 31% of the sexually active population had been treated for new STI episodes between 2012 and 2016.

[7] Data Source: ETR.net from Department of Health

At the same time, there has been laudable progress in the area of prevention of mother to child transmission with the 2016 rate of about 1.1% demonstrating the province's strategy has been on the whole successful. The province has put slightly above 1 million of the 1.9 PLHIV on treatment. ART coverage stands at about 61% and is a positive sign towards achieving universal treatment.

Prevention efforts remain key to eliminating infections. The NSP 2012-2016 review indicated that meeting the target of reducing new HIV infections was not likely especially due to sexual transmission as opposed to the success noted in PMTCT. The PSP review 2012-2016 report noted that the province did not meet its targets in many of its HIV, TB and STIs prevention programmes and that coverage efforts for these prevention programmes were generally low. While the province achieved its condoms distribution targets, these were not adequate when calculated at number of condoms per eligible male. Sexually transmitted infections were also high while reduction of pregnancies for females under 18 years has generally been slow.

The HSRC Behaviour Survey (2012) findings showed poor sexual behaviour outcomes for the province by stating that (a) 11% of women and men aged 15-49 years reported having had more than one sexual partner in the past 12 months; (b) only 21% of the women and men aged 15-49 years who had had more than one sexual partner in past 12 months reported use of condom during their last sexual intercourse and; (c) just 24% of people in the province rejected misconceptions about transmission of HIV, TB and STIs. The 2016 South Africa demographic and health survey stated that 50% of women and 58% of men reported having had sex with a person who was neither their spouse or was living with them in the past 12 months. This suggests that reach of information, education and communication (IEC) programmes to the population to effect positive behaviour change has not been adequate despite an abundance of platforms to convey sustained messages. Both the NSP review and PSP review noted an absence of a communication strategy to be used in implementing adequate and sustained behaviour change messages.

The province has made commendable progress in the inclusion and facilitating participation of key populations with civil society becoming active with in AIDS councils. More effort will be required to cement this inclusion and participation e.g. through having civil society organise themselves further and step up advocacy and implementation.

Good functionality of AIDS councils crucial to effective coordination and management of the response. While functionality of the PCA was impressive, that of AIDS Councils at the other spheres of government was generally poor especially, at local municipality and ward level. In some cases ward AIDS Committees were non-existent. More broadly all AIDS councils face the challenge of effective stakeholder participation with few stakeholders from different departments, organisations and civil society participating in AIDS councils. This affects governance and mutual accountability of the response.

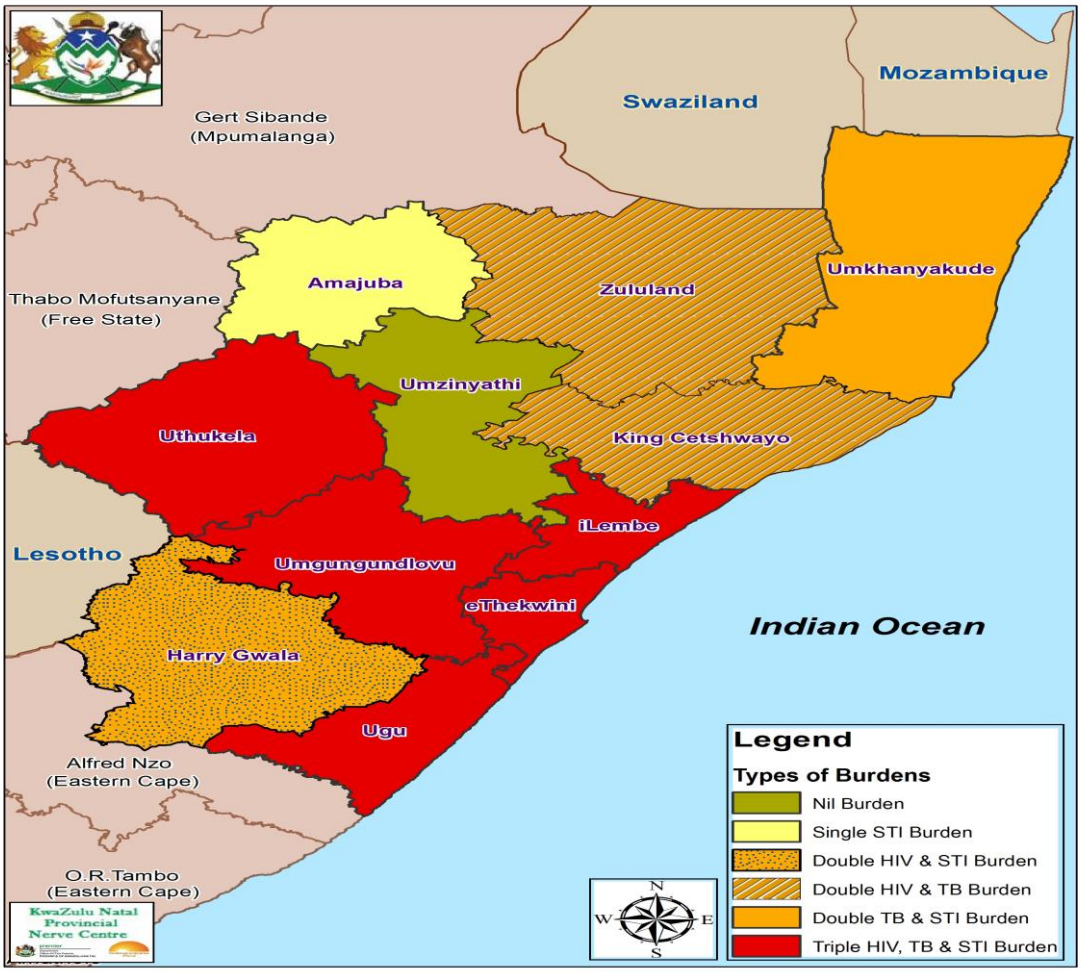
3 Towards Implementation over 2017-2022 Period

3.1 Focus for Impact

The NSP 2017-2022 states that Focus for Impact is a fundamentally new "way of doing business" as South Africa works to achieve a decisive transition from disease control to eliminating HIV, TB and STIs as public health threats. *Focus for Impact* methodology promotes localised responses and moves away from the assumption that the epidemic is uniformly distributed and all areas require 'a one fits all' set of interventions. The essence of the methodology is to deliver services/interventions that can provide the greatest impact with limited resources and highest value for money. The province has adopted this approach and is using it in prioritising interventions based on the burden of the epidemics per specific district.

The map below presents an illustration of the level of burden per district.

Figure 10: KwaZulu-Natal Focus for Impact Districts



Map developed by the KwaZulu-Natal Provincial Nerve Centre with data from the SANAC focus for impact methodology

Identification of level of burden was done using HIV positivity rates, TB smear positive rates and male urethritis syndrome rates from 2015 DHIS data. Five of the province's eleven districts have the highest proportion of HIV, TB and STIs. These are (1) eThekwini; (2) iLembe; (3) uThukela; (4) uMgungundlovu;

and (5) Ugu. King Cetshwayo and Zululand have a high HIV and TB burden while Harry Gwala has a high HIV and STIs burden. uMkhanyakude district has a high TB and STIs burden. Amajuba, on the other hand, has a high STIs burden. It is important to note that the neighbouring districts of Gert Sibande (Mpumalanga province), Thabo Mofutsanyane (Free State Province) and Alfred Nzo (Eastern Cape Province) have been classified as high burden districts.

An analysis of the 2016 TB case load laboratory data indicated that an estimated 70% of the new TB cases occurred in 4 districts namely (1) eThekwini (2) uMgungundlovu (3) King Cetshwayo and (4) Ugu. Within local municipalities (1) Newcastle (2) eThekwini (3) KwaDukuza (4) Hibiscus Coast (5) Msunduzi (6) Big 5 Hlabisa (7) Alfred Duma (8) uMhlathuze (9) uMlalazi and (10) Abaqulusi were the 10 out of 51 accounted for 70% of the TB case load in the province.

In regard to STIs 5 districts namely (1) eThekwini (2) uMgungundlovu (3) King Cetshwayo (4) uMkhanyakude and (5) Zululand accounted for 72% of those diagnosed with Male Urethritis Syndrome in 2015. 16 local municipalities accounted for 42% of the STIs burden, namely: (1) Newcastle, (2) Greater Kokstad, (3) Mandeni, (4) uMhlabuyalingana, (5) Jozini, (6) Mtubatuba, (7) Alfred Duma (8) uPhongolo, (9) Nongoma, (10) Abaqulusi, (11) Msunduzi, (12) KwaDukuza, (13) uMhlathuze,(14) uMlalazi (15) KwaDukuza and (16) Hibiscus Coast.

3.2 Community Mobilisation

The province is concerned about risky sexual behaviour e.g. multiple and concurrent sexual partners, low condom use, increasing early sexual debut and age-disparate sexual relations that put its population at risk of infection. Data shows that young people especially young females are most vulnerable to HIV infections(15). Equally, the province is concerned at the level of uptake of prevention and treatment services viz; HIV testing, contraception, early booking, treatment of sexually transmitted infections and medical male circumcision.

Community mobilisation will be the primary strategy for increasing awareness, effecting social behaviour change increasing uptake of prevention and treatment services and addressing stigma and discrimination. There will be need to intensify existing community mobilisation efforts already in place e.g. using OSS platform and ward based outreach teams, hlola manje campaigns and mobilisation efforts targeting key populations. Increasing the number and coverage of peer mobilisers targeting youth at institutions of higher education will enhance uptake of medical male circumcision (MMC) (9). Other flagship campaigns and programmes spearheaded by various government agencies such as Baby not Now; Soul buddyz (DOE); Kemoja; Healthy Lifestyles (DSD); Happy Hour; Zazi; Anti-Sugar Daddy Campaign; Isibaya Samadoda (DOH), Young Maidens (DA&C); and Safe Schools (DCS&L) among others will require coordinated implementation so that they contribute to intensified mobilisation efforts.

In this regard, social behaviour change communication (SBCC) interventions will be put at the forefront of all other interventions. The interventions will; (a) target specific age groups and different risk groups; (b) employ sustained multi-pronged approaches aimed at achieving different behavioural outcomes (c) promote supportive social norms and values at different levels in society (for example, families, social and sexual networks, institutions, and entire communities); (d) be at a sufficient scale and intensity to have

effects and (e) respond to the structural dimensions of HIV infection that shape people's response to circumstance and increase tolerance of risk(9).

There will be need to employ the use of a mix of channels and embrace new technologies to ensure wide reach and coverage. For example, use of information and communication technology (ICT) for various populations groups will be critical. These platforms allow consumers to receive and access information anonymously, privately and conveniently and can also improve coverage to key populations, who may not utilise routine communication settings because of issues of stigma. ICT accessibility keeps increasing and offers a major source of information. Research has shown that social marketing can promote positive health behaviours on a wide variety of health issues, with diverse populations and in diverse settings (16-20). A community-based study in 2012 found that there was widespread exposure to multimedia programmes in the community, with about 78% of the respondents reporting exposure to five of more HIV prevention media programmes as opposed to face-to-face communication exposure (21).

Political, cultural, community, religious leaders and policy-makers will be required to commit to champion community mobilisation and support behaviour change efforts through making public statements and other forms of advocacy.

This plan proposes the following community mobilisation and awareness activities, implementation of which will be facilitated by the Provincial Council on AIDS secretariat. These activities are aimed at changing behaviour and creating demand for HIV, TB and STI services.

1. **Communication Strategy:** A comprehensive provincial multi-media HIV, TB and STIs communication strategy will be developed to ensure widespread and coordinated reach. Office of the Premier will be responsible for the delivery and coordination of this strategy.

2. **Posters/billboards:** Posters and billboards on various IEC messages will be developed and placed at strategic locations and community settings. Messages to be conveyed will include those on sexual reproductive health (SRH), sexuality, HIV testing, condoms use, anti-gender-based violence (GBV), sexual harassment, TB treatment and adherence to treatment, sexually transmitted infections, ART treatment and adherence, HPV, social and behaviour change messages targeting key and vulnerable populations, alcohol and drug abuse, anti-stigma and legal literacy relevant to HIV and TB.

3. **Brochures and Information Packs:** Brochures/information packs on various IEC messages will be developed and directed to various target groups. The various messages will be on SRH, sexuality, HIV testing, condoms use, MMC, GBV, sexual harassment, TB, ART, STIs, HPV, inclusion of key and vulnerable populations, anti-stigma and discrimination and accessibility of health services for key and vulnerable populations. They will be distributed using various outlets to different target groups.

4. **Conducting Awareness Activities:** Awareness activities will be conducted in the form of campaigns, dialogues, advocacy and peer led education and will be directed to various targets groups. Awareness topics will mirror those conveyed through billboards, brochures and information packs.

3.3 Community Systems Strengthening

The Operation Sukuma Sakhe model is the province's platform to the community's involvement and participation in development programmes in general but more specifically in improving the social, economic and health profiles of communities. As an integrated services delivery model, OSS advocates for communities assisting Government in responding to their challenges through self-mobilisation and seeking solutions to these challenges. This means that OSS is the platform for mobilisation, services scale up, services uptake by the community and services delivery by all stakeholders.

War rooms will be used by all implementing stakeholders across the spectrum of all goals and objectives in contributing to uptake of services through identifying and linking community members to services. For example, intensifying HIV, TB and STIs education and act as the linkage to testing, screening and treatment or identifying eligible women and link to both short-term and long-term empowerment programmes e.g. victim empowerment forums

According to the Community Systems Strengthening (CSS) Framework document developed by the Global Fund, the goal of CSS is "to develop the roles of key affected populations and communities, community organisations and networks, and public or private sector actors that work in partnership with civil society at the community level, in the design, delivery, monitoring and evaluation of services and activities aimed at improving health". This goal largely fits into the province's aspirations of strengthening OSS and its community-based actors but with a much broader aim of alleviating poverty, fighting disease particularly HIV, TB and STIs and fighting social ills such as sexual assaults, general crime, alcohol and substance abuse among others. Evidence suggests that CSS has been a powerful strategy for engaging people at high risk for HIV infection, like people who inject drugs (23) to come up with solutions.

War rooms are the focal points of community level OSS and the province embarked on ensuring that war rooms are led by people drawn from the community. Towards this end, these war room leaders will need to be trained and regularly orientated to ensure effective leadership. The main reference document for these trainings and orientations will be *OSS Operations Handbook*- a document developed by the province with the aim of using it to strengthen OSS *war rooms* and its other structures for full functionality. The province recently commenced on resourcing the *war rooms* with furniture and equipment including computers. Priority is being extended to *war rooms* in the most deprived municipalities. During this plan period there will be need scale up this resourcing and explore possibilities of internet connectivity of the war rooms.

The province is committed to scaling up treatment through complementing facility-based services with non-facility based approaches. Interventions are underway to intensify implementation of task shifting in clinical settings and improving the capacity of community caregivers. Existing initiatives focus on training

community care givers and other outreach workers such as peer educators. Evidence suggests that trained fieldworkers have expanded access to HIV services among sex workers, men who have sex with men and transgender people, thereby increased community buy-in for the multi-sectoral HAST response(22). Sex workers and MSM programmes have commonly used peer led approaches in the community with good effect to tackle the structural constraints of health, human rights and wellbeing (24-26). Training fieldworkers in a range of areas that include services delivery to key populations, human rights and legal literacy will potentially contribute to accelerating progress in scaling up HIV, TB and STIs treatment and improving treatment outcomes. As part of expanding participation and inclusivity, there will be need to target key populations with this training.

As part of enhancing and laying the foundation for smarter service delivery, the province is working towards integrating its fieldworkers.

4 Goals, Objectives and Interventions

This section plan applies the logical framework approach structured around the eight goals, along with corresponding objectives, intervention areas and activities. This approach will be the basis for measurement and determining results.

4.1 Goals

This plan has the following eight goals in line with the NSP 2017-2022 goals

1. Goal 1: Accelerate prevention to reduce new HIV, TB and STI infections
2. Goal 2: Reduce morbidity and mortality by providing treatment, care and adherence support for all
3. Goal 3: Reach all key and vulnerable populations with customised and targeted interventions
4. Goal 4: Address the social and structural drivers of HIV, TB and STIs
5. Goal 5: Ground the response to HIV, TB and STIs in human rights principles and approaches
6. Goal 6: Promote leadership and shared accountability for a sustainable response to HIV, TB and STIs
7. Goal 7: Mobilise resources to support the achievement of plan goals and ensure a sustainable response
8. Goal 8: Strengthen strategic information to drive progress towards achievement of plan goals

4.1.1 Goal 1: Accelerate prevention to reduce new HIV, TB and STI infections

Prevention remains the primary goal of reversing new infections of HIV, TB and STIs and enabling total elimination as envisaged in the provincial vision. Despite gains made in reducing HIV, TB and STI infections, additional and concerted efforts for further gains and in meeting the targets set forth is required. *Acceleration* should be aided by the focusing on impact, the 90-90-90 strategy and targeting populations who will contribute to making the most impact. SBCC will be critical to the reduction of HIV, TB and STI disease. In the case of HIV, SBCC to encourage safer sexual practices constitutes a primary prevention tool in the absence of a single bio-medical prevention technology, SBCC can also create higher demand for bio-medical prevention interventions, such as MMC and significantly enhance infection control to prevent TB.

This goal has the following three objectives

1. Objective 1.1: Reduce new HIV infections to less than 20000 by 2022 through combination prevention interventions
2. Objective 1.2: Reduce TB incidence to 321/100 000 population by 2022
3. Objective 1.3: Reduce incidence of sexually transmitted infections (STIs) to 50/100 000 or less by 2022

Goal 1 Objectives Implementation Matrix

Objective 1.1: Reduce new HIV infections to less than 20000 by 2022 through combination prevention interventions: In as much as the province witnessed declining HIV infections in the 2012-2016 period, it was not able to meet its set target of reducing new HIV infections by 50%. New HIV infections remain high and projections show that they will reduce but the set target may not be achieved. According to the 2016 district estimates, new infections in the province are concentrated mainly in eThekwini which carries 32% of the provincial total, followed by uMgungundlovu (11.7%) Zululand (8.9%), King Cetshwayo (8.9%) and Ugu (7.2%). These five districts account for 68.7% of new infections in the province and will need to be the focus locations for the plan period.

Table 1: 2016 District new HIV infections estimates and 2022 targets

Rank	District	Total Population	New HIV Infections	Proportion of New Infections	2022 Targets
1	eThekwini	3702232	20718	32%	5180
2	uMgungundlovu	1095861	7543	11.7%	1886
3	Zululand	892309	5722	8.9%	1431
4	King Cetshwayo	971133	5766	8.9%	1442
5	Ugu	753337	4642	7.2%	1161
6	uThukela	706589	3939	6.1%	985
7	Harry Gwala	510868	2920	4.5%	730
8	uMzinyathi	554883	3106	4.8%	777
9	uMkhanyakude	689086	3857	6.0%	964
10	Amajuba	531325	2879	4.5%	720
11	iLembe	657611	3531	5.4%	883

Source:

Due to unavailability of local municipality estimates, priority local municipalities will be selected using positivity numbers in the focus for impact analysis which uses 2015 DHIS data.

Available studies show that transmission of HIV in the province is mainly through heterosexual relationships. Females especially those in the age bracket 15-24 years are most affected. A cross-section study conducted by Abdool Karim at al. (2014) on high school learners confirmed HIV, HSV-2 and pregnancy as indicators of high-risk sexual behaviour in the youth (12). Hence, in reaching this goal, learners in school, students at a tertiary education level, educators and staff within the Department of Education as well as youth out of school should be reached with key prevention interventions applicable to their age and context.

High uptake for condoms use, medical male circumcision (MMC), HIV testing, STIs treatment could be determinant to a rapid reduction of the infection rates. Globally, male and female condoms remain the only approved multipurpose prevention technology (MPT) that simultaneously offers protection against, HIV, STI and pregnancies. A recent study by Crankshaw, Smit and Beksinska (2016) discusses the rationale for placing contraception at the centre of the HIV prevention agenda and then endorses dual method contraception methods (28). Given that this is a low-cost intervention it would be prudent to promote consistent use of condoms.

The innovative programmes that will be implemented in the province embrace multiple prevention strategies, as proposed under the 2017 HIV Prevention 2020 Roadmap which South Africa has committed to achieving by reducing new infections by 75% (22). These include including comprehensive sexuality education, TB awareness, access to sexual reproductive health and TB services; integrated school health programme, First Things First, HPV campaign, knowledge, values, skills and attitudes to develop and adopt behaviour that might protect them from being infected, and to support people being infected and affected.

Goal 1 Objective 1 Implementation Matrix

Goal 1: Accelerate Prevention to reduce new HIV, TB and STI infections		
Objective 1.1: Reduce new HIV infections to less than 20000 by 2022 through combination prevention interventions		
Priority districts: 1-eThekwini; 2-King Cetshwayo; 3-uMgungundlovu; 4-Zululand and 5-Ugu		
Priority local municipalities: 1- eThekwini; 2-Msunduzi; 3-Newcastle; 4-Hibiscus Coast; 5-uMhlathuze; 6-KwaDukuza; 7-Abaqulusi and 8-Alfred Duma		
Intervention Area: Information education and communication (IEC) and Comprehensive Sexuality Education		
Activities	**Responsibility**	**Collaborating Agencies**
Expand comprehensive sexuality education (CSE) in schools including training of life orientation educators to implement SRH and TB programmes for learners	DOE	DOH; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in the field of IEC and messaging; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; \ Municipal Authorities.
Reach learners with peer education programmes e.g. Soul Buddyz clubs	DOE	DOH; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in the field of IEC and messaging; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities.

Intervention Area: Provision of biomedical prevention services		
Activities	**Responsibility**	**Collaborating Agencies**
Expand provision of comprehensive HIV testing services (HTS) to using a mix of channels	DOH	DOE; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in the field of IEC and messaging and HTS; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities.
Intensify provision of HTS services in health facilities	DOH	DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in the field of HTS; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities.
Expand provision of male medical circumcision (MMC) services using a different mix of channels	DOH	DOE; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in the field of MMC; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities.
Conduct voluntary MMC for male infants and boys under 15 years	DOH	DOE; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in the field of MMC; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities.
Expand distribution of male and female condoms using a different mix of channels	DOH	DOE; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in the field of condoms distribution; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Private Sector; Municipal Authorities.
Intervention Area: Provision of sexual and reproductive health services		
Expand age-appropriate sexual and reproductive health services (SRH) in schools	DOH	DOE; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in the field of IEC and messaging and youth; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities.
Expand coverage of dual method contraceptive services to the sexually active population with special focus of AGYW	DOH	DOE; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in the field of family planning; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities.

Intervention Area: Provision of pre-exposure prophylaxis (PrEP)		
Activities	**Responsibility**	**Collaborating Agencies**
Provide PrEP as part of prevention package for the general population and key population groups e.g. sex workers	DOH	DOE; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in the field of prevention; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities.
Expand availability of PrEP to settings e.g. tertiary institutions and other institutions of higher learning	DOH	DOE; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in the field of PrEP; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities.
Provide regular follow-up and adherence support to PrEP clients	DOH	DOE; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in the field of PrEP; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities.
Intervention Area: Prevention of MTCT of HIV		
Increase uptake of services to prevent MTCT of HIV and syphilis in the prenatal and postnatal period using community settings/structures e.g. Phila Mntwana centres, war rooms	DOH	DOE; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in the field of prevention; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities.

Objective 1.2: Reduce TB incidence to 321/100 000 population by 2022: The KZN TB crisis plan notes the severity of TB by stating among others that "KwaZulu-Natal remains the battleground for TB and HIV in the country". The plan further notes a number of challenges associated with fighting TB one of which is that TB suspects in the community are not being traced at the required rate. It also cites stigma, treatment adherence and reluctance for TB patients to accept supporters as some of the factors contributing to the spread of TB within communities. In addition, MDR-TB and mortality rates among MDR-TB/HIV co-infected patients are high thus compounding to an already immense problem.

The need for greater emphasis on education and awareness of the signs and symptoms of TB to enable the community to come forward for testing and treatment and ways to prevent the spread of TB in the community is underscored.

Goal 1 Objective 2 Implementation Matrix

Goal 1: Accelerate Prevention to reduce new HIV, TB and STI infections		
Objective 1.2: Reduce TB incidence to 321/100 000 population by 2022		
Priority Districts: 1-King Cetshwayo 2-iLembe 3-eThekwini 4-Ugu 5-Zululand and 6-uMgungundlovu.		
Priority local municipalities: 1-Newcastle; 2-eThekwini; 3-KwaDukuza; 4-Hibiscus Coast; 5-Msunduzi; 6-Big 5 Hlabisa; 7-Alfred Duma; 8-uMhlathuze; 9-uMlalazi and 10-Abaqulusi.		
Intervention Area: Uptake of TB preventive therapy		
Conduct systematic mass screening for active TB in different settings	DOH	DOE; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in TB; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Intensify contact tracing for people with TB including children and key populations and in communities e.g. informal settlements,	DOH	DOE; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in TB; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities

1.3: Objective 1.3: Reduce the incidence of sexually transmitted infections (STIs) incidence to 50 per 100 000 or less by 2022: An 11% reduction was recorded in the incidence of STIs between the periods 2012 to 2016. In 2016 5.2% of the sexually active population were treated for new STI episodes. Over the five year period, 31% of the sexually active age group have been treated for new STIs. High transmission is being attributed to factors that include a low rate of condom use, challenges in partner tracing and a host of other behavioural factors.

Goal 1 Objective 3 Implementation Matrix

Goal 1: Accelerate Prevention to reduce new HIV, TB and STI infections		
Objective 1.3: Reduce incidence of sexually transmitted infections (STIs) incidence to 50 per 100 000 or less by 2022		
Priority Districts: 1-King Cetshwayo 2-eThekwini 3-Zululand 4-uMkhanyakude and 5-uMgungundlovu 6-Amajuba		
Priority local municipalities: (1) Newcastle, (2) Greater Kokstad, (3) Mandeni, (4) uMhlabuyalingana, (5) Jozini, (6) Mtubatuba, (7) Alfred Duma (8) uPhongolo, (9) Nongoma, (10) Abaqulusi		
Intervention Area: Scale Up STI prevention		
Activities	**Responsibility**	**Collaborating Agencies**
Expand STI treatment services e.g. mobile outreach services to schools and institutions of higher learning	DOH	DOE; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in the field of IEC and Messaging and STIs prevention; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Intensify STIs contact tracing identification and treatment	DOH	DOE; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in STIs prevention; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams
Intervention Area: Scale up HPV vaccination		
Maintain high coverage of HPV vaccination in targeted public schools	DOH	DOE; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in school health; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities.

4.1.2 Goal 2: Reduce morbidity and mortality by providing treatment, care and adherence support for all

The high burden of HIV the province faces is reflected in part by the 1.9 million people living with HIV residing in KZN. Progress has been made in expanding access to ART with ART coverage now standing at 61%, on the other hand, deaths related to HIV have decreased from 35000 in 2012 to 21000 in 2016.

In regard to TB, stigma, treatment adherence and reluctance for TB patients to accept supporters are but some of the challenges that have been mentioned as contributing to the spread of TB within communities. As such, SBCC remains a key factor in treatment of HIV and TB as it will be used to create the awareness necessary for successful screening and testing, building treatment literacy and facilitate establishment of treatment support groups.

In 2014, the country adopted the UNAIDS 90-90-90 targets for 2020 which provide that:

1. 90% of all people living with HIV will know their HIV status
2. 90% of all people with an HIV diagnosis will receive sustained antiretroviral therapy and
3. 90% of all people receiving antiretroviral therapy will achieve viral suppression.

The thrust of the provincial plan will be to move towards attaining these targets with interventions focused on the high burden locations and tailored for the specific populations as follows:`

The objectives of this goal are as follows:

1. Objective 2.1: To increase the proportion of people living with HIV who know their status to 90% by 2022
2. Objective 2.2: To increase the proportion of people living with HIV on ART and remain on treatment to 90% by 2022
3. Objective 2.3: To increase the proportion of people on ART with suppressed viral load to 90% by 2022
4. Objective 2.4: To treat successfully at least 90% of those diagnosed with DS TB (and 75% for those with DR TB) by 2022

Goal 2 Objectives Implementation Matrix

Objective 2.1.1: To increase the proportion of people living with HIV who know their status to 90% by 2022.

The focus will be on closing the testing gaps among young men 25-34 years, older adults above 45 years and key population groups. Core interventions will include: increasing access to HIV testing services by providing community-based testing services, focusing on locations and venues conducive for men and older adults, making testing facilities key-population friendly, facilitating HIV self-screening testing for people unable or unwilling to access HTS otherwise, demand creation and community mobilisation for the health screening campaign and strengthening the training of health care providers and procurement and logistics system for testing commodities.

Goal 2 Objective 1 Implementation Matrix

Goal 2: Reduce morbidity and mortality by providing treatment, care and adherence support for all		
Objective 2.1: To increase the proportion of people living with HIV who know their status to 90% by 2022		
Priority districts: 1-eThekwini 2-King Cetshwayo 3-uMgungundlovu 4-Zululand and 5-Ugu		
Priority local municipalities: 1-eThekwini; 2-Msunduzi; 3-Newcastle; 4-Hibiscus Coast; 5-uMhathuze; 6-KwaDukuza; 7-Abaqulusi and 8-Alfred Duma		
Intervention Area: Scale up HIV Testing Services with focus on closing the gaps among young men 25 – 34, older adults above 45 and key population groups		
Activities	**Responsibility**	**Collaborating Agencies**
Expand HIV screening services through diversified approach including self-screening testing, community-based testing and provider-initiated testing	DOH	DOE; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in the field of adherence; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities.
Conduct community mobilisation events to educate the public and generate demand for HIV testing services	DOH	DOE; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in the field of adherence; Civil Society Forum; Traditional authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities.
Proficiency training for health care providers on proper screening to improve quality of screening	DOH	DOE; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in the field of adherence; Civil Society Forum; Traditional authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities.
Strengthen procurement and supply chain management to reduce stock-out of test kits	DOH	Private Sector

Objective 2.2: To increase the proportion of people living with HIV on ART and remain on treatment to 90% by 2022: Good progress has been made in putting clients on ART. The percentage of adults and children under 15 years known to be on treatment after six months of initiation was 80.4 % and 89.5% respectively.

While the health facilities remain the backbone for monitoring ART clients, a significant proportion of adherence support rests with community health systems. The role of non-clinical caregivers, non-clinical facilities and counselors, functionality of war rooms will need to be enhanced and additional attention paid to programmes such as the CCMD in order to improve access and coverage of ART at community

level. Currently, 558 facilities, which participate in the Centralised Chronic Medicine Dispensing and Distribution (CCMDD) programme, with 49106 clients enrolled onto the programme(9).

Core interventions will include: active linkage of people tested positive especially through community based HTS to HIV care facilities, implementing universal test and treat in all facilities and provide training and facilitating same-day initiation of ART after successful linkage. Scaling up differentiated model of care (adherence support, fast lane and CCMDD) and increasing the role of PLHIV and communities in linkage to care, treatment literacy and adherence support and effective tracking of people from testing to HIV care and treatment and follow up.

Goal 2 Objective 2 Implementation Matrix

Goal 2: Reduce morbidity and mortality by providing treatment, care and adherence support for all		
Objective 2.2: To increase the proportion of people living with HIV on ART and remain on treatment to 90% by 2022		
Priority districts: 1-eThekwini; 2-King Cetshwayo; 3-uMgungundlovu; 4-Zululand and 5-Ugu.		
Priority local municipalities: 1-eThekwini; 2-Msunduzi; 3-Newcastle; 4-Hibiscus Coast; 5-uMhathuze 6-KwaDukuza; 7-Abaqulusi and 8-Alfred Duma		
Intervention Area: Sustained provision and uptake of ART		
Activities	**Responsibility**	**Collaborating Agencies**
Promote and expand same day- initiation of those diagnosed HIV positive	DOH	DOE; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in the field of adherence; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities.
Provide pre-ART care package for those not ready for same-day initiation to ensure prompt linkage to care	DOH	DOE; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in the field of adherence; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities.
Facilitate the setting up of support groups; adherence clubs and link with war rooms	DOH	DOE; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in the field of adherence; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities.

Intervention Area: Sustained provision and uptake of ART		
Activities	**Responsibility**	**Collaborating Agencies**
Train community members/structures in the setting up and management of support groups; adherence clubs	DOH	DOE; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in the field of adherence; Civil Society Forum; Traditional authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities.
Expand the Centralised Chronic Medicines Dispensing and Distribution (CCMDD) model	DOH	DOE; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in the field of adherence; Civil Society Forum; Traditional authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities.

Objective 2.3: To increase the proportion of people on ART with suppressed viral load to 90% by 2022: As the province steps up efforts to have PLHIV on treatment, focus turns to the suppression of the viral loads, as this is a critical measure to determining the number of PLHIV leading a healthy life. The percentage of adults and children under 15 years living with HIV viral load suppressed rate (VLS) was 90.5 %. While VLS is commendable, information indicated that only 55.7% of those on ART had viral loads done (VLD). There will be need to facilitate viral load testing, returning the results, strengthen drug resistance surveillance

Goal 2 Objective 3 Implementation Matrix

Goal 2: Reduce morbidity and mortality by providing treatment, care and adherence support for all		
Objective 2.3: To increase the proportion of people on ART with suppressed viral load to 90% by 2022		
Priority districts: 1-eThekwini 2-King Cetshwayo 3-uMgungundlovu 4-Zululand and 5-Ugu.		
Priority local municipalities: 1-eThekwini; 2-Msunduzi; 3-Newcastle; 4-Hibiscus Coast; 5-uMhathuze 6-KwaDukuza; 7-Abaqulusi and 8-Alfred Duma		
Intervention Area: Viral Suppression of People Living with HIV on ART		
Activities	**Responsibility**	**Collaborating Agencies**
Improve viral load monitoring through systems strengthening	DOH	DOE, DSD, PLHIV Organisations, Civil society organisations, FBOs
Strengthen monitoring of drug resistance	DOH	PLHIV, NGOs
Strengthen data quality assurance	DOH	NGOs, PLHIV

Objective 2.4: To treat successfully at least 90% of those diagnosed with DS TB (and 75% for those with DR TB) by 2022: As described in the Global Plan to end TB 2016-2020, the 90-90-90 targets for TB provide that 90% of all people who need TB treatment are diagnosed and receive appropriate therapy as required; that 90% of people in key and vulnerable populations are diagnosed and receive appropriate therapy; and that treatment success is achieved for at least 90% of people diagnosed with TB through affordable treatment services, adherence to correct and complete treatment, and social support. The key push of this strategy is to find the missing TB patients through active targeted and systematic screening for TB.

The TB treatment success rate has been in the 80 percentage points' zone over the past 5 years and is a demonstration that TB can successfully be cured. Data also shows TB deaths to have reduced. MDR-TB, on the other hand, is high, as is the rate of MDR-related deaths. This goal requires that treatment is successful and that deaths due to TB are reduced.

Goal 2 Objective 4 Implementation Matrix

Goal 2: Reduce morbidity and mortality by providing treatment, care and adherence support for all		
Objective 2.4: To treat successfully at least 90% of those diagnosed with DS TB (and 75% for those with DR TB) by 2022		
Priority districts: 1-eThekwini 2-iLembe 3-King Cetshwayo 4-uMgungundlovu 5-Zululand and 6-Ugu		
Priority local municipalities: 1-Newcastle; 2-eThekwini; 3-KwaDukuza; 4-Hibiscus Coast; 5-Msunduzi; 6-Big 5 Hlabisa; 7-Alfred Duma ; 8-uMhlathuze; 9-uMlalazi and 10-Abaqulusi		
Intervention Area: Intensify TB treatment		
Activities	**Responsibility**	**Collaborating Agencies**
Scale-up of decentralization of quality MDR TB treatment services including Bedaquiline (BDQ) based regimens and 9 –months short treatment regimens (STR) for MDR TB	DOH	DOE; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in the field of IEC and messaging and TB; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities.
Conduct high quality DR TB services – through ensuring a minimum package of care – testing for ototoxicity etc.	DOH	DOE; DSD; DS&R; DA&C; DCS&L; SAPS; CBOs, NGOs & FBOs working in the field of IEC and messaging and TB; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities.

4.1.3 Goal 3: Reach all key and vulnerable populations with customised and targeted interventions

Inclusivity and participation of key and vulnerable populations in decision-making, designing and implementing programmes coupled with accelerating and intensification services provision should ensure adequate reach for key and vulnerable populations. Available size estimates suggest sizable numbers of key and vulnerable populations which reinforces the need to target this population group. For example, KZN is host to 16% of the estimated 153000 sex workers in the country.[8] Estimates from the Thembisa model shows sex workers prevalence in KZN for 2016 at 78.5%. According to the DSD Annual Performance Plan 2016/2017, people with disabilities in the province make up 4.3 % of the total population.

The Integrated Biological and Behavioural Surveillance Study done in 2012, showed that rates of new infections among women aged 15-24 were more than four times greater than that of men of the same age. An analysis of 2016 district estimates indicate that each week, 475 new HIV infections occur among adolescent girls and young women aged 15- 24 years, making this the most vulnerable population.

The province will implement the national multi-sectoral She Conquers HIV prevention campaign for adolescent girls and young women. The campaign will seek to decrease teenage pregnancies (by 30%), decrease new HIV infections in young women (by 30%), reduce sexual and gender-based violence (by 10%), increase retention of girl learners in school (by 20%), and increase economic opportunities for young people (by 10%) will be co-branded and identified as a component of the She Conquers campaign and report into programme reporting on the campaign at the provincial level.

The She Conquers package will deliver biomedical, socio-behavioural and structural interventions to increase access to information, services and support for adolescent girls and young women. The campaign will be implemented through broad-based collaboration and engagement of multiple sectors at the provincial level, including government departments, civil society and the private sector. In addition, SBCC will have play a strongly informative character and the power to build self-efficacy and resilience. The PCA will ensure an optimally coherent and holistic response to adolescent girls and young women in the province by coordinating and monitoring the implementation of the She Conquers campaign.

A core package of interventions customised for each key and vulnerable population for HIV include: comprehensive sexuality education; service delivery in non-traditional settings, including after-hours and weekends; STI screening, treatment, targeted SBCC, economic empowerment, PrEP, condom and lubricant promotion, VMMC, mental health screening and psychosocial support.

For TB, the key and vulnerable populations identified are: people living with HIV; household contacts of TB index patients; health care workers; inmates; pregnant women; children <5 years old; diabetics; people living in informal settlements A core package of interventions will be offered to these populations are: index and contact testing, health information customised to client needs; HIV screening, testing and

treatment; TB screening, treatment (including preventive therapy) and contact tracing for DS- and DR-TB, human rights protection and SBCC.

To ensure that orphaned and other vulnerable children (OVCs) are not left behind, schools have an important role to play as they have relatively easy access to this target group in addition to having a duty to provide services, care and support to these children. Interventions applicable to OVCs should facilitate access to psycho-social services, nutritional support, education, safe schools and school transport, as well as the protection of their human rights.

SBCC plays a significant role in increasing access to HIV, TB and STI programmes for vulnerable and key populations. The key is outreach to groups who are often stigmatised and difficult to reach, as well as providing information that is custom-made for their specific needs and circumstances.

Objectives of goal 3 are as follows

1. Objective 3.1: Increase engagement, collaboration and advocacy of key and vulnerable populations in the development and implementation of social and HIV, TB and STI support activities
2. Objective 3.2: Provide an enabling environment to increase access to HIV, TB and STI services by key and vulnerable populations

Goal 3 Objectives Implementation Matrix

Objective 3.1: Increase engagement, collaboration and advocacy of key and vulnerable populations in the development and implementation of social and HIV, TB and STI support activities: In efforts to increase engagement, the KZN PCA has facilitated the formation of the provincial civil society organisation (CSO) forum and supported the provincial forum to establish similar forums at district level. Through this objective, these and other support efforts are set to continue so that key and vulnerable populations are represented in all AIDS councils structures and other related structures.

Goal 3 Objective 1 Implementation Matrix

Goal 3: Reach all key and vulnerable populations with customised and targeted interventions		
Objective 3.1: Increase engagement, collaboration and advocacy of key and vulnerable populations in the development and implementation of social and health support activities		
Priority districts: 1-eThekwini 2-iLembe 3-King Cetshwayo 4-uMgungundlovu 5-Zululand and 6-Ugu		
Priority local municipalities: 1-Newcastle; 2-eThekwini; 3-KwaDukuza; 4-Hibiscus Coast; 5-Msunduzi; 6-Big 5 Hlabisa; 7-Alfred Duma ; 8-uMhlathuze; 9-uMlalazi and 10-Abaqulusi		
Intervention Area: AIDS councils representation for key and vulnerable populations		
Activities	**Responsibility**	**Collaborating Agencies**
Facilitate the establishment of key and vulnerable population forums	Civil Society Forum	DOH; DOE; DSD; DS&R; DA&C; CBOs, NGOs & FBOs working with key and vulnerable populations; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Capacitate key and vulnerable population forums on their roles in AIDS councils	Civil Society Forum	DOH: DOE; DSD; DS&R; DA&C; CBOs, NGOs & FBOs working with key and vulnerable populations; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Select representatives of key and vulnerable populations to sit in AIDS councils	Civil Society Forum	DOH: DOE; DSD; DS&R; DA&C; CBOs, NGOs & FBOs working with key and vulnerable populations; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Facilitate having all AIDS councils select deputy chairs from CSO forum	Civil Society Forum	DOH: DOE; DSD; DS&R; DA&C; CBOs, NGOs & FBOs working with key and vulnerable populations; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams
Intervention Area: Advocacy and support for key and vulnerable populations		
Conduct a mapping exercise for key and vulnerable populations	Civil Society Forum	DOH: DOE; DSD; DS&R; DA&C; CBOs, NGOs & FBOs working with key and vulnerable populations; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Facilitate networking among community groups including key and vulnerable population forums	Civil Society Forum	DOH: DOE; DSD; DS&R; DA&C; CBOs, NGOs & FBOs working with key and vulnerable populations; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities

Intervention Area: AIDS councils representation for key and vulnerable populations		
Activities	**Responsibility**	**Collaborating Agencies**
Train key and vulnerable population forums on networking and community involvement in response activities	Civil Society Forum	DOH: DOE; DSD; DS&R; DA&C; CBOs, NGOs & FBOs working with key and vulnerable populations; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Social mobilisation on DBE policy to enhance participation and shift norms and values on SRH and TB	DOE	DOH: DSD; DS&R; DA&C; CBOs, NGOs & FBOs working with key and vulnerable populations; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Intervention Area: Peer educator-led approach to implementation of key and vulnerable population programmes		
Activities	**Responsibility**	**Collaborating Agencies**
Develop standardised life skills training for peer educators	Civil Society Forum	DOH: DOE; DSD; DS&R; DA&C; CBOs, NGOs & FBOs working with key and vulnerable populations; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Conduct training for peer educators	Civil Society Forum	DOH: DOE; DSD; DS&R; DA&C; CBOs, NGOs & FBOs working with key and vulnerable populations; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Conduct peer education activities for key and vulnerable populations	Civil Society Forum	DOH: DOE; DSD; DS&R; DA&C; CBOs, NGOs & FBOs working with key and vulnerable populations; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities

Objective 3.2: Provide an enabling environment to increase access to HIV, TB and STI services by key and vulnerable populations: High transmission area (HTA) sites and a limited number of specialist NGOs have been involved in the provision of services for this population group.

Based on the department of health data, HTA sites number 81 and had served a total of 27435 clients. Anecdotal evidence suggests that a smaller number accesses services from what may be classified as "traditional" service outlets. Stigma, discrimination, exclusion and non-availability of customised services have been cited as some of the reasons that make it difficult for these populations to access services.

Goal 3 Objective 2 Implementation Matrix

Goal 3: Reach all key and vulnerable populations with customised and targeted interventions		
Objective 3.2: Provide an enabling environment to increase access to HIV, TB and STI services by key and vulnerable populations		
Priority districts: 1-eThekwini 2-iLembe 3-King Cetshwayo 4-uMgungundlovu 5-Zululand and 6-Ugu		
Priority local municipalities: 1-Newcastle; 2-eThekwini; 3-KwaDukuza; 4-Hibiscus Coast; 5-Msunduzi; 6-Big 5 Hlabisa; 7-Alfred Duma ; 8-uMhlathuze; 9-uMlalazi and 10-Abaqulusi		
Intervention Area*: *Access to HIV, TB and STI services and information for key and vulnerable populations		
Activities	**Responsibility**	**Collaborating Agencies**
Expand provision of mobile and community based health Services including HTS, TB screening, STI screening, post violence care, ART initiation and TB treatment customised to the needs of each population	DOH	DOH: DOE; DSD; DS&R; DA&C; CBOs, NGOs & FBOs working with key and vulnerable populations; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Develop appropriate social and behaviour change messages and disseminate using a mix of channels	Civil Society Forum	DOH: DOE; DSD; DS&R; DA&C; CBOs, NGOs & FBOs working with key and vulnerable populations; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities

4.1.4 Goal 4: Address the social and structural drivers of HIV, TB and STIs

Improvement of socio-economic status, eradication of poverty, fighting social ills and changing negative societal norms are necessary parts of reducing infections and sustaining health and wellness. The PGDS sets the out broad parameters to attaining development encompassing interventions to be implemented by the various stakeholders. To reduce vulnerability factors that impact on health seeking behaviour including gender inequality, gender-based violence and alcohol and drug use must be addressed through the school curriculum and appropriate and quality learning and teaching support (including material for learners with barriers to learning).

The poverty eradication master plan (PEMP) sets out the province's blueprint to accelerated eradication of poverty. The plan advocates for acceleration of poverty alleviation commencing with the most deprived wards spread across the five local municipalities in uMzinyathi, uMkhanyakude, iLembe, Ugu and King Cetshwayo. The approach underscores the province's commitment to targeting communities through the lowest administrative structures.

Goal 4 objectives are as follows:

1. Objective 4.1: Implement social and behaviour change programmes to address key drivers of the epidemics and build social cohesion
2. Objective 4.2: Increase access to and provision of services for all survivors of sexual and gender-based violence
3. Objective 4.3: Scale up access to social protection for people at risk of, and those living with HIV and TB
4. Objective 4.4: Implement and scale up a package of harm reduction interventions for alcohol and substance use
5. Objective 4.5: Implement economic strengthening programmes with a focus on youth

Below is the implementation matrix of Goal 4 objectives.

Goal 4 Objectives Implementation Matrix

Objective 4.1: Expand social and behaviour change programmes and campaigns that build the resilience of individuals, parents and families: Social and behaviour change programmes are a major part of cushioning against the effects of HIV and TB and therefore reducing the vulnerability of the affected populations by creating resilience and cohesion of individuals and families. The province has made worthy strides in areas of providing care and support to orphans and other vulnerable children and lessening the burden of the vulnerable through several programmes.

Goal 4 Objective 1 Implementation Matrix

Goal 4: Address the social and structural drivers of HIV, TB and STIs		
Objective 4.1: Expand social and behaviour change programmes and campaigns that build resilience of individuals, parents and families		
Priority districts: 1-eThekwini 2-iLembe 3-King Cetshwayo 4-uMgungundlovu 5-Zululand and 6-Ugu		
Priority local municipalities: 1-Newcastle; 2-eThekwini; 3-KwaDukuza; 4-Hibiscus Coast; 5-Msunduzi; 6-Big 5 Hlabisa; 7-Alfred Duma ; 8-uMhlathuze; 9-uMlalazi and 10-Abaqulusi		
Intervention Area: Building resilience of individuals, parents, families and communities		
Activities	**Responsibility**	**Collaborating Agencies**
Conduct life skills and parenting skills sessions and workshops	DSD	DOE; DOH; DS&R; DA&C; CBOs, NGOs & FBOs working in the field of education, youth and counselling; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Conduct marriage and family counselling sessions	DSD	DOE; DOH; DS&R; DA&C; CBOs, NGOs & FBOs working in the field of counselling; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Reach male parents with fatherhood programmes	DSD	DOE; DOH; DS&R; DA&C; CBOs, NGOs & FBOs working in the field of counselling; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Conduct protective workshops for people with disabilities	DSD	DOE; DOH; DS&R; DA&C; CBOs, NGOs & FBOs working people with disabilities; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Intervention Area: Provision of comprehensive age-specific and appropriate support for learners and out-of-school youth		
Facilitate the establishment of clubs e.g. Zazi, Soul Buddyz and Rise Clubs	DOE	DSD; DOH; DS&R; DA&C; CBOs, NGOs & FBOs working with youth; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Expand life skills education in schools	DOE	DSD; DOH; DS&R; DA&C; CBOs, NGOs & FBOs working with youth; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities

Objective 4.2: Increase access to and provision of services for all survivors of sexual and gender-based violence: Sexual and gender-based violence remains a challenge as demonstrated by findings from the South African Demographic and Health Survey 2016 which indicated that in KZN, 14% of women had ever experienced partner violence and 3% of women aged 18 years and older had ever experienced sexual violence. Sexual crimes data from the South African Police Service (SAPS) showed that 5345 of these crimes had been reported over the 9 month period of 2016, i.e. April 2016 to December 2016. Sexual crimes data generally reduced during the 2012-2016 period but not at a desirable pace.

Goal 4 Objective 2 Implementation Matrix

Goal 4: Address the social and structural drivers of HIV, TB and STIs		
Objective 4.2: Increase access to and provision of services for all survivors of sexual and gender-based violence		
Priority districts: 1-eThekwini 2-iLembe 3-King Cetshwayo 4-uMgungundlovu 5-Zululand and 6-Ugu		
Priority local municipalities: 1-Newcastle; 2-eThekwini; 3-KwaDukuza; 4-Hibiscus Coast; 5-Msunduzi; 6-Big 5 Hlabisa; 7-Alfred Duma ; 8-uMhlathuze; 9-uMlalazi and 10-Abaqulusi		
Intervention Area: Provide support for survivors of sexual assault		
Activities	**Responsibility**	**Collaborating Agencies**
Improve access to services and coverage for sexual and gender-based violence survivors	DSD	DOE; DS&R; DOH; DA&C; SAPS; DOJ&CD CBOs, NGOs & FBOs working in the field of abuse; IEC and messaging; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities

Objective 4.3: Scale up access to social protection for people at risk of and those living with HIV and TB: Provision of social protection to alleviate suffering in the face of poverty and other harsh socio-economic conditions contribute to improving the quality care of those living with HIV and in cushioning those at risk. According to the DSD, the province has the highest expenditure in social grant payments when compared to other provinces and also has the highest number of children receiving child support grants as well as foster care grants. This reflects the severity of poverty and other socioeconomic conditions in the province.

Goal 4 Objective 3 Implementation Matrix

Goal 4: Address the social and structural drivers of HIV, TB and STIs		
Objective 4.3: Scale up access to social protection for people at risk of and those living with HIV and TB		
Priority districts: 1-eThekwini 2-iLembe 3-King Cetshwayo 4-uMgungundlovu 5-Zululand and 6-Ugu		
Priority local municipalities: 1-Newcastle; 2-eThekwini; 3-KwaDukuza; 4-Hibiscus Coast; 5-Msunduzi; 6-Big 5 Hlabisa; 7-Alfred Duma ; 8-uMhlathuze; 9-uMlalazi and 10-Abaqulusi		
Intervention Area: Scaling up access to social grants		
Activities	**Responsibility**	**Collaborating Agencies**
Link eligible social grantees with development programmes e.g. income generating projects and other employment opportunities	DSD	DOE; DS&R; DOH; DA&C; SAPS; DCS&L; CBOs, NGOs & FBOs working in the field of social support; IEC and messaging; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Intervention Area: Scaling up access to food security and nutritional support		
Use of different mix of channels to distribute food parcels to those eligible	DSD	DOE; DSD; DS&R; DOH; DA&C; SAPS; DCS&L; DEDT&EA; CBOs, NGOs & FBOs working in the field of agriculture;;IEC and messaging; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Intensify the establishment of the household gardens	DAERD	DOE; DSD; DS&R; DOH; DA&C; SAPS; DCS&L; DEDT&EA; CBOs, NGOs & FBOs working in the field of agriculture;;IEC and messaging; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Support the establishment of household gardens through provision of inputs, equipment, training, education	DAERD	DOE; DSD; DS&R; DOH; DA&C; SAPS; DCS&L; DEDT&EA; CBOs, NGOs & FBOs working in the field of agriculture;;IEC and messaging; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Expand nutritional support to Learners, Orphans and other vulnerable children	DOE	DOE; DSD; DS&R; DOH; DA&C; SAPS; DCS&L; DEDT&EA; CBOs, NGOs & FBOs working in the field of agriculture;;IEC and messaging; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities

Objective 4.4: Implement and scale up a package of harm reduction interventions for alcohol and substance use: The 2016 South Africa Demographic and Health Survey findings showed that in KZN, the percentage

of men who ever drank alcohol was 56%, while those who drank alcohol in the past 12 months was 46%. 14% showed signs of a drinking problem. The National Drug Master Plan quoting Dada et al. suggested that alcohol tended to be the leading substance of abuse and was the cause of admissions to treatment centres of people younger than 20 years. 26.8% of the population admitted to treatment centres in KZN comprised of youth. Studies show positive results in targeting alcohol and substance abuse with interventions. For example, findings from a study on factors that influence condom use by males in a rural setting in KZN by Manyaapelo et al. (2017) suggest that participants who had strong intentions to reduce harmful substance use were more likely to avoid engaging in risky sexual encounters (29).

Goal 4 Objective 4 Implementation Matrix

Goal 4: Address the social and structural drivers of HIV, TB and STIs		
Objective 4.4: Implement and scale up a package of harm reduction interventions for alcohol and substance use		
Priority districts: 1-eThekwini 2-iLembe 3-King Cetshwayo 4-uMgungundlovu 5-Zululand and 6-Ugu		
Priority local municipalities: 1-Newcastle; 2-eThekwini; 3-KwaDukuza; 4-Hibiscus Coast; 5-Msunduzi; 6-Big 5 Hlabisa; 7-Alfred Duma ; 8-uMhlathuze; 9-uMlalazi and 10-Abaqulusi		
Intervention Area: Scaling up access and provision in- and out-patient rehabilitation services		
Activities	**Responsibility**	**Collaborating Agencies**
Link rehabilitated alcohol and drug abuse victims to support programmes, e.g. income generation projects	DSD	DOE; DS&R; DSD; DOH; DA&C; SAPS; DCS&L; DEDT&EA; DARD; CBOs, NGOs & FBOs working in the field of social support, alcohol and drug abuse; IEC and messaging; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Provide psychosocial support to victims of alcohol and drug abuse	DSD	DOE; DS&R; DSD; DOH; DA&C; SAPS; DCS&L; DEDT&EA; DARD; CBOs, NGOs & FBOs working in the field of social support, alcohol and drug abuse; IEC and messaging; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Establish recreational activities spaces in the communities and intensify activities	DS&R	DOE; DS&R; DSD; DOH; DA&C; SAPS; DCS&L; DEDT&EA; DARD; CBOs, NGOs & FBOs working in the field of social support, alcohol and drug abuse; IEC and messaging; Civil Society Forum; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities

Objective 4.5: Implement economic strengthening programmes with a focus on youth: Data on HIV incidence, unemployment and other socio-economic parameters show that the youth are the most affected group. As a result deliberate strategies have been and are being put in place for youth to improve their well-being and reduce their vulnerability. Using the community mobilisation campaigns existing community structures will be used to identify youth requiring economic empowerment who will then be linked to the relevant programmes. Target districts will be 1-eThekwini 2-iLembe 3-King Cetshwayo 4-uMgungundlovu 5-Zululand and 6-Ugu.

4.1.5 Goal 5: Ground the response to HIV, TB and STIs in human rights principles and approaches

Human rights are universal legal guarantees protecting individuals and groups against actions and omissions that interfere with fundamental freedoms, entitlements and human dignity. Human rights are inherent for all human beings and are founded on respect for the dignity and worth of each person. The country's constitution guarantees specific rights to all people who reside in it. These include rights to services and non-discrimination of any form. Ensuring access to HIV, TB and STI services requires that interventions are implemented on the backbone of the Constitution and in a manner that addresses the specific needs and barriers to access to health services by key and vulnerable populations. The school curriculum and appropriate learner and teacher support material will play a major role in addressing stigma, discrimination and human rights abuses against individuals and their families infected and affected by HIV and/or TB.

The PSP mid-term review noted strong political commitment to human rights and acknowledged efforts made thus far.

Goal 5 objectives are as follows

1. Objective 5.1: Reduce stigma and discrimination by 50% by 2022 among people living with HIV or TB
2. Objective 5.2: Facilitate access to justice and redress for people living with and vulnerable to HIV and TB
3. Objective 5.3: Promote an environment that enables and protects human and legal rights and prevents stigma and discrimination

Implementation of this goal will require broad-based collaboration and engagement of multiple sectors at the provincial level, including government departments, civil society and the private sector.

Goal 5 Objectives Implementation Matrix

Objective 5.1: Reduce stigma and discrimination by 50% by 2022 among people living with HIV or TB:
Stigma can be described as a dynamic process of devaluation that significantly discredits an individual in the eyes of others. When stigma is acted upon, it results in discrimination. Discrimination is a human rights violation. (UNAIDS Terminology Guidelines [55]).

Stigma and discrimination are a single most known cause to inaccessibility to services by key and vulnerable populations. The SANAC stigma and discrimination study showed that PLHIV experienced relatively high levels of both external and internal stigma. Activities for this objective will revolve around community mobilisation and will target 1-eThekwini 2-iLembe 3-King Cetshwayo 4-uMgungundlovu 5-Zululand and 6-Ugu

Key interventions include:

1. Improving access to HIV, TB and STI services by addressing the specific needs of key and vulnerable populations and barriers to access

2. Develop community mobilization strategy for reduction of stigma at all levels (including family, community, facility and society) and internalized stigma, as well as discrimination (*e.g. HIV and TB Stigma Reduction for Social Change Programme)*
3. Improving access to quality legal and advice services
4. Promote an environment that enables and protects human and legal rights and prevents stigma and discrimination

*Objective 5.2: Facilitate access to justice and redress for people living with and vulnerable to HIV and TB***:** Key and vulnerable populations face challenges related to stigma and discrimination that include psychological and physical abuse, violence, assault and exclusion. Actions to reduce stigma and discrimination should be complemented by those that elevate access to justice and seek redress for people living with HIV.

Goal 5 Objective 2 Implementation Matrix

Goal 5: Ground the response to HIV, TB and STIs in human rights principles and approaches		
Objective 5.2: Facilitate access to justice and redress for people living with and vulnerable to HIV and TB		
Priority districts: 1-eThekwini 2-iLembe 3-King Cetshwayo 4-uMgungundlovu 5-Zululand and 6-Ugu		
Priority local municipalities: 1-Newcastle; 2-eThekwini; 3-KwaDukuza; 4-Hibiscus Coast; 5-Msunduzi; 6-Big 5 Hlabisa; 7-Alfred Duma ; 8-uMhlathuze; 9-uMlalazi and 10-Abaqulusi		
Intervention Area: Legal literacy about human rights and laws relevant to HIV and TB		
Activities	**Responsibility**	**Collaborating Agencies**
Empower key and vulnerable populations to recognise and deal with human rights violations	DOJ&CD	DOE; DSD; DS&R; DOH; DA&C; SAPS; DCS&L; CBOs, NGOs & FBOs working in the field of human rights; IEC and messaging; Traditional Authorities; Civil Society forum; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Interventions Area: Availability and accessibility of HIV-related legal services		
Activities	**Responsibility**	**Collaborating Agencies**
Establish networks between community structures and legal services organisations	Civil Society Forum	DOE; DSD; DS&R; DOH; DA&C; SAPS; DCS&L; CBOs, NGOs & FBOs working in the field of human rights; IEC and messaging; Traditional Authorities; Civil Society Forum; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities

Objective 5.3: Promote an environment that enables and protects human and legal rights and prevents stigma and discrimination: An enabling legal and policy environment creates room for a robustness in the response through ensuring that access to services are all encompassing including key and vulnerable populations participation in the response. Social behaviour change communication (SBCC) is key for stigma reduction. SBCC embraces both people living with HIV and TB, who may have "internalised" negative beliefs about themselves, and the broader society. Fear is a strong driver of stigma and a major them of anti-stigma communication is to replace myths and superstition with facts about HIV and TB.

Goal 5 Objective 3 Implementation Matrix

Goal 5: Ground the response to HIV, TB and STIs in human rights principles and approaches		
Objective 5.3: Promote an environment that enables and protects human and legal rights and prevents stigma and discrimination		
Priority districts: 1-eThekwini 2-iLembe 3-King Cetshwayo 4-uMgungundlovu 5-Zululand and 6-Ugu		
Priority local municipalities: 1-Newcastle; 2-eThekwini; 3-KwaDukuza; 4-Hibiscus Coast; 5-Msunduzi; 6-Big 5 Hlabisa; 7-Alfred Duma ; 8-uMhlathuze; 9-uMlalazi and 10-Abaqulusi		
Intervention Area: Monitor application of laws, regulations and policies relating to HIV and TB		
Activities	**Responsibility**	**Collaborating Agencies**
Conduct training for frontline services delivery staff on human rights	DOJ & CD	DOE; DSD; DS&R; DOH; DA&C; SAPS;DCS&L; CBOs, NGOs & FBOs working in the field of human rights; IEC and messaging; Traditional Authorities; Civil Society Forum; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Facilitate the use of toll-free helpline to report human rights abuses	OTP	DOE; DSD; DS&R; DOH; DA&C; DOJ & CD SAPS;DCS&L; CBOs, NGOs & FBOs working in the field of human rights; IEC and messaging; Traditional Authorities; Civil Society Forum; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Report regularly to AIDS councils on human rights	DOJ & CD	DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; CBOs, NGOs & FBOs working in the field of human rights; IEC and messaging; Traditional Authorities; Civil Society Forum; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities

Intervention Area: Monitor application of laws, regulations and policies relating to HIV and TB		
Activities	**Responsibility**	**Collaborating Agencies**
Intervention Area: Sensitise lawmakers and law enforcement agents		
Conduct sensitisation sessions with law enforcement agencies	DOJ& CD	DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; CBOs, NGOs & FBOs working in the field of human rights; IEC and messaging; Traditional Authorities; Civil Society Forum; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Intervention Area: Sensitise those in authority to human rights and stigma		
Hold workshops/seminars and training sessions on human rights and stigma for various leaders	DOJ&CD	DOE; DSD; DS&R; DOH; DA&C; DOJ&CD; SAPS; DCS&L; CBOs, NGOs & FBOs working in the field of peer education; IEC and messaging; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Intervention Area: Sensitise those in authority to human rights and stigma		
Activities	**Responsibility**	**Collaborating Agencies**
Promote public speaking against stigma and discrimination by leaders (political, cultural, religious)	Civil society Forum	DOE; DSD; DS&R; DOH; DA&C; DOJ&CD; SAPS; DCS&L; CBOs, NGOs & FBOs working in the field of peer education; IEC and messaging; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Hold/provide human rights update sessions with the provincial leadership	DOJ & CD	DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; CBOs, NGOs & FBOs working in the field of human rights; IEC and messaging; Traditional Authorities; Civil Society Forum; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities
Intervention Area: Reduce stigma through community education		
Develop sensitisation packages for leaders on promoting human rights	Civil society Forum	DOE; DSD; DS&R; DOH; DA&C; DOJ&CD; SAPS; DCS&L; CBOs, NGOs & FBOs working in the field of peer education; IEC and messaging; Traditional Authorities; AIDS Council Secretariats; AIDS Councils; OSS Task Teams; Municipal Authorities

4.1.6 Goal 6: Promote leadership and shared accountability for a sustainable response to HIV, TB and STIs

Political leadership and commitment to the response continue to be strong. This is demonstrated through various fora, the most regular of which is the holding and chairing of AIDS council meetings by designated chairpersons at the various levels.

Community leadership is promoted through OSS with war rooms being led by members drawn from the community. Additionally, communities are afforded leadership through a platform of self-mobilising and acting on their challenges. Community level leadership is supplemented by the concept of OSS champions where the province's political principals are assigned districts as OSS champions.

The province is ensuring that all its AIDS councils have a representative from the civil society forum as deputy chairs as part of cementing inclusiveness and shared responsibility.

The key roles of the PCA to facilitate implementation of the plan are:

Advocacy: The oversight role of the PCA will ensure that advocacy for the PIP and MDIPs is continually entrenched in all platforms. The PCA will facilitate and advocate for the effective involvement of sectors and organizations in the implementation and monitoring of the PIPs and MDIPs. The AIDS Councils at all levels will advocate for the plans to be a standing agenda item or discussion point in various provincial, district and local platforms. The councils will also work with their key stakeholders including Civil Society to create demand for key interventions such as condoms, ARV's and HTS

Resource Mobilisation: While most of the programmatic work in the PIPs and MDIPs will be funded through government departments and partners, the PCA will work to develop a provincial resource mobilization strategy to ensure additional funding for coordination.

Monitoring (Strategic Information): The PCA will ensure ongoing monitoring of the implementation of the plans and in regular intervals provide strategic information with regards to latest information pertaining to the HIV and TB response from all levels of implementation. The PCA will continually advocate for the use of strategic information for decision making and programme planning.

The NSP places strong emphasis on accountability, therefore it is essential for the AIDs Councils to prioritise accountability as a key mandate for implementing the PIPs and MDIPs to achieve outcomes outlined in the plans. The AIDS Councils will work with SANAC to develop an accountability framework and accountability scorecards for this purpose.

Objectives of goal 6 are as follows:

1. Objective 6.1: Strengthen AIDS Councils to provide effective coordination and leadership of all stakeholders for shared accountability in the implementation of the provincial plan.
2. Objective 6.2: Improve collaboration and co-operation between government, civil society, development partners and the private sector.

Goal 6 Objectives Implementation Matrix

Objective 6.1: Strengthen AIDS Councils to provide effective coordination and leadership of all stakeholders for shared accountability in the implementation of the provincial plan: The province has largely established AIDS councils at all levels to provide coordination and leadership. The functionality of AIDS councils is critical in ensuring sustained leadership and regular accountability of the response.

The SANAC AIDS councils' functionality report[9] confirmed good PCA functionality while the PSP mid-term review report showed DAC[10] to be 70.8%. LAC functionality and WAC functionality on the other hand was 45.6% and 19.1% respectively.

Goal 6 Objective 1 Implementation Matrix

Goal 6: Promote leadership and shared accountability for a sustainable response to HIV, TB and STIs		
Objective 6.1: Strengthen AIDS Councils to provide effective coordination and leadership of all stakeholders for shared accountability in the implementation of the provincial plan		
Priority districts: 1-eThekwini 2-iLembe 3-King Cetshwayo 4-uMgungundlovu 5-Zululand and 6-Ugu		
Priority local municipalities: 1-Newcastle; 2-eThekwini; 3-KwaDukuza; 4-Hibiscus Coast; 5-Msunduzi; 6-Big 5 Hlabisa; 7-Alfred Duma ; 8-uMhlathuze; 9-uMlalazi and 10-Abaqulusi		
Intervention Area: Strengthen AIDS Councils and War Rooms		
Activities	**Responsibility**	**Collaborating Agencies**
Conduct an audit of LACs, WACs and war rooms	OTP	AIDS Councils Secretariats; Civil Society Forum; OSS Task Teams; Municipal Authorities; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L: DOJ & CD
Launch/Re-activate LACs, WACs and war rooms	OTP	AIDS Councils Secretariats; Civil Society Forum; OSS Task Teams; Municipal Authorities; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L;DOJ&CD
Conduct capacity building sessions for LACs, WACs and war rooms	OTP	AIDS Councils Secretariats; Civil Society Forum; OSS Task Teams; Municipal Authorities; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD

[9] SANAC 2015: Report on the Functionality of the Provincial Council on AIDS in South Africa. The report is based on self-assessment findings and external validation findings. Criteria used to rate functionality was as follows-existence of the PCA, chairs and co-chairs, secretariat support, participation of civil society, M&E, staffing, involvement & participation by government departments, involvement & participation of DACs and leadership from the Office of the Premier

[10] Composite functionality calculated from a set of elements that define functionality as follows- AIDS council meeting held as scheduled, 70% of designated members attending AID council meetings, AIDS councils chaired by designated chairpersons and AIDS councils submitting reports.

Intervention Area: Strengthen AIDS Councils and War Rooms		
Activities	**Responsibility**	**Collaborating Agencies**
Conduct refresher sessions for the PCA and DACs	OTP	AIDS Councils Secretariats; Civil Society Forum; OSS Task Teams; Municipal Authorities; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD
Intervention Area: Ensure representation of all stakeholders in decision-making structures at all levels		
Facilitate inclusion of all stakeholders in all AIDS councils	OTP	AIDS Councils Secretariats; Civil Society Forum; OSS Task Teams; NGOs, CBOs and FBOs; Municipal Authorities; Private Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD
Interventions Area: Strengthen the role of political leaders at community level to address the response		
Conduct training sessions for political leaders/community leaders at ward level	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; OSS Task Teams; Municipal Authorities; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD
Interventions Area: Strengthen the role of the private sector and labour in AIDS Councils		
Engage with private sector and labour sector on formation of district level forums	OTP	AIDS Councils Secretariats; Civil Society Forum; OSS Task Teams; Private Sector; Labour Sector; Municipal Authorities; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD
Conduct training sessions for private sector and labour sector	OTP	AIDS Councils Secretariats; Civil Society Forum; OSS Task Teams; Private Sector; Labour Sector; Municipal Authorities; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD
Interventions Area: Strengthen Accountability		
Facilitate monitoring and reporting by stakeholders through the PCA, DAC and LAC	OTP	Civil Society Forum, DOH, DSD, DOE, DBE, Municipal Authorities, SAPS, CDS&L, DOJ&CD, private sector, labour sector,
Build M&E and data utilisation capacity of stakeholders	OTP	AIDS Councils Secretariats; Civil Society Forum; OSS Task Teams; Private Sector; Labour Sector; Municipal Authorities; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD
Interventions Area: Ensure a central role for civil society and community groups		
Conduct training sessions for civil society and community groups	Civil Society Forum	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams
Facilitate formation of civil society forums and sectors at all levels	Civil Society Forum	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams

Interventions Area: Ensure a central role for civil society and community groups		
Activities	**Responsibility**	**Collaborating Agencies**
Facilitate representation of civil society forum in AIDS councils	Civil Society Forum	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams

Objective 6.2: Improve collaboration and co-operation between government, civil society, development partners and the private sector: Effective implementation and corresponding positive results can be made possible through improved collaboration by all stakeholders. Collaboration between various stakeholders will enhance the multi-sectoral approach to implementation, provide support, facilitate mainstreaming and ensure participation and accountability.

Goal 6 Objective 2 Implementation Matrix

Goal 6: Promote leadership and shared accountability for a sustainable response to HIV, TB and STIs		
Objective 6.2: Improve collaboration and co-operation between government, civil society, development partners and the private sector		
Priority districts: 1-eThekwini 2-iLembe 3-King Cetshwayo 4-uMgungundlovu 5-Zululand and 6-Ugu		
Priority local municipalities: 1-Newcastle; 2-eThekwini; 3-KwaDukuza; 4-Hibiscus Coast; 5-Msunduzi; 6-Big 5 Hlabisa; 7-Alfred Duma ; 8-uMhlathuze; 9-uMlalazi and 10-Abaqulusi		
Intervention Area: Alignment of government and non-government sector plans with the provincial plan		
Activities	**Responsibility**	**Collaborating Agencies**
Facilitate establishment of joint planning and budgetary committee	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams
Facilitate alignment of government and non-government sector plans	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams

Intervention Area: Alignment of government and non-government sector plans with the provincial plan		
Activities	**Responsibility**	**Collaborating Agencies**
Facilitate the development of district operational plans	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams
Support the development of local municipality operational plans and ward AIDS activities	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams
Intervention Area Strengthen collaboration between and coordination of government departments		
Facilitate inter-governmental department meetings (Nerve centre meetings) at all levels to discuss response	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams
Interventions Area: Establish/ strengthen regional collaboration		
Facilitate holding of exchange visits between AIDS councils in the province and other AIDS councils and other stakeholders outside the province	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams
Participate in national/regional international conferences and meetings	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams

4.1.7 Goal 7: Mobilise resources to support the achievement of plan goals and ensure a sustainable response

Shrinking financial resources to fight the epidemics has resulted in new thinking about the smart use of available funds. Several studies done in this field have, for example, specified strategies that are least cost-effective yet show most impact while others have argued for the need to spend now and save later. The South Africa Investment Case Report is one such study that provides various response scenarios and their corresponding costs. The report found that maximizing prevention efforts (specifically condom provision, VMMC and social and behaviour change communication) were more cost-effective than treatment, and that an approach that combines treatment and prevention is necessary to achieve the 90-90-90 targets (30).

In 2017, the country adopted the global prevention roadmap which calls for a quarter of the HIV budget to be allocated to prevention. However, given the constrained fiscal space, government has levelled funding for many services, and future rising HIV and TB treatment costs are projected to consume an increasing share of the budget allocation. This is reflected in the department of health 2017/18 allocation of HIV conditional grant whereby 69% was earmarked for antiretroviral treatment. For sustainability, technical and allocative efficiencies of domestic resources is required to optimise impact within available resources.

As an initial step, the province will need to examine its own funding outlay, take into consideration recommendations from the investment case report and other reports of similar nature and determine how best the available funding outlay will be used. This should inform the mobilisation of additional external resources critical to filling in the funding gaps.

The objective of this goal is as follows:

1. Objective 7.1: Improve efficiency and mobilise sufficient resources to achieve the goals, objective and targets of the provincial plan

Below is the implementation matrix

Goal 7 Objective Implementation Matrix

Objective 7.1: Improve efficiency and mobilise sufficient resources to achieve the goals, objective and targets of the provincial plan: Improving efficiency calls for ensuring that funds for the response are put into the best possible use resulting in maximum impact. Avoiding expenditure that will not demonstrate value for money is critical. Funding for HIV, TB and STIs has mainly been confined to budget lines of the implementing agencies, with very little in the way of having one central budget reference point. This may have resulted into possibilities of similar activities being funded from different sources. Towards this end, aligning of funding will be necessary.

Goal 7 Objective 1 Implementation Matrix

Goal 7: Mobilise resources to support the achievement of PIP goals and ensure a sustainable response		
Objective 7.1: Maximise the funds available for implementation of the plan and the impact of these funds		
Intervention Area : Costing the Plan and Resource Mobilisation		
Activities	**Responsibility**	**Collaborating Agencies**
Facilitate the development of an all-encompassing stakeholders costed plan	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams
Intervention Area : Costing the Plan and Resource Mobilisation		
Facilitate the development and implement resource mobilisation strategy	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams
Conduct sensitisation sessions with implementing stakeholders on resource alignment and mobilisation	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams
Conduct advocacy for corporate social spending on HIV, AIDS, TB and STIs	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams

4.1.8 Goal 8: Strengthen strategic information to drive progress towards achievement of provincial plan goals

The province has in place a monitoring and evaluation system it uses to track implementation of the response. The system has provided AIDs councils meetings with data it has used to make implementation and strategic decisions. Further, a range of M&E information systems owned by stakeholders, developed to meet their specific needs exist in the province. Aligning these systems will be necessary in order to maximise the use of available strategic information avenues and work towards ensuring adequate utilisation of the ensuing products.

Goal 8 objectives are as follows:

1. Objective 8.1: Optimise routinely collected strategic HIV, TB and STIs information for data utilisation in decision making
2. Objective 8.2: Rigorously monitor and evaluate implementation and outcomes of the plan
3. Objective 8.3: Strengthen strategic research activities to create validated evidence for innovation, improved efficiency and enhanced impact

Below is the implementation matrix for Goal 8 objectives.

Goal 8 Objectives Implementation Matrix

Objective 8.1: Optimise routinely collected strategic health information for data utilisation in decision making: The provincial multi-sectoral response M&E system has provided fairly adequate support to the province in collecting and reporting on the response on a routine and regular basis.

An M&E framework and plan will be developed to meet the needs of this plan. The M&E framework will set out the modalities of data collection, data flow, analysis, presentation, reporting and feedback. The plan, on the other hand, will specify areas of strengthening; the resource needs and provide of interventions that will be implemented to strengthen ME&R.

Goal 8 Objective 1 Implementation Matrix

Goal 8: Strengthen strategic information to drive progress towards achievement of provincial plan goals		
Objective 8.1: Optimise routinely collected strategic HIV, TB and STIs information for data utilisation in decision making		
Intervention Area: Strengthen data collection systems at service delivery points		
Activities	**Responsibility**	**Collaborating Agencies**
Assess data collection systems at service delivery points including feasibility of single identifiers	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams

Intervention Area: Strengthen data collection systems at service delivery points		
Activities	**Responsibility**	**Collaborating Agencies**
Assess data collection systems at service delivery points including feasibility of single identifiers	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams
Facilitate revision/revamping of data collection systems at service delivery points based on assessment results	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, Task Teams; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams
Facilitate conducting training on data collection systems for points of service delivery staff	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams
Facilitate establishment of data collection systems for civil society organisations	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams
Facilitate conducting training on data collection systems for civil society organisations	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams
Intervention Area : Strengthen Information System		
Establish and maintain a functional web-based information repository within OTP	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams
Develop and maintain an early warning system to track plan indicators to enable timely intervention	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams
Generate quarterly provincial plan performance dashboard reports	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams
Improve access to quarterly performance reports by uploading them onto the information repository website at OTP	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams

Objective 8.2: Rigorously monitor and evaluate the plan: The province has made commendable progress in monitoring and evaluating its response, having developed a routine monitoring system, produced annual reports and commissioned a mid-term review. This period will be dedicated to improving monitoring and evaluation capacity and creating a culture of M&E for all stakeholders.

Goal 8 Objective 2 Implementation Matrix

Goal 8: Strengthen strategic information to drive progress towards achievement of provincial plan goals		
Objective 8.2: Rigorously monitor and evaluate implementation and outcomes of the plan		
Intervention Area: Strengthen and promote multi-sectoral ownership and accountability of the M&E system		
Activities	**Responsibility**	**Collaborating Agencies**
Facilitate establishment of monitoring & evaluation technical working group (TWG) at province and district level	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams
Facilitate the holding of M&E TWG meetings at all levels	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams
Intervention Area: Strengthen M&E capacity at all levels		
Activities	**Responsibility**	**Collaborating Agencies**
Conduct M&E capacity assessment at all levels	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams
Provide capacity building based on capacity assessment results	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams

Intervention Area: Generate and disseminate plan monitoring and evaluation reports		
Activities	**Responsibility**	**Collaborating Agencies**
Develop M&E reports dissemination plan	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams
Conduct periodic reviews-annual, mid and end-term review	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams
Package M&E information for various audiences and disseminate periodically using various forums and mix of channels	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams

Objective 8.3: Strengthen strategic research activities to create validated evidence for innovation, improved efficiency and enhanced impact: Some advances have been made in the development and growth of the research component. A multi-sectoral provincial research forum and research agenda are in place and will require strengthening in addition, there will be need to coordinate research activity being carried out to ensure that it fully serves the province.

Goal 8 Objective 3 Implementation Matrix

Goal 8: Strengthen strategic information to drive progress towards achievement of provincial plan goals		
Objective 8.3: Strengthen strategic research activities to create validated evidence for innovation, improved efficiency and enhanced impact		
Intervention Area : Develop a coordinated research agenda		
Activities	**Responsibility**	**Collaborating Agencies**
Facilitate the revamping of the multi-sectoral research forum	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams

Intervention Area : Develop a coordinated research agenda		
Activities	**Responsibility**	**Collaborating Agencies**
Revise research agenda	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams
Develop and mechanisms for dissemination of research results	OTP	AIDS Councils Secretariats; AIDS Councils; Civil Society Forum; NGOS, CBOs and FBOs; Development Partners; Private Sector; Labour Sector; DOE; DSD; DS&R; DOH; DA&C;SAPS;DCS&L; DOJ&CD; Municipal Authorities; OSS Task Teams

5. REFERENCES

1. Statistics South Africa. 2015 Mid-year population estimates. Pretoria; 2015 11 July 2016. Report No.: P0302.
2. Statistics South Africa. The South African MPI: Creating a multidimensional poverty index using census data. 2014a 2014. Report No.: 03-10-08.
3. SANAC. The South African National Strategic Plan on HIV, TB and STIs 2017-2022. 2017 2017.
4. Kwazulu-Natal Office of the Premier. Operation Sukuma Sakhe - KZN Service Delivery Model. 2013.
5. KwaZulu-Natal Planning Commission. Provincial Growth and Development Strategy 2016. Pietermaritzburg; 2016.
6. Zaidi J, Grapsa E, Tanser F, Newell M, Bärnighausen T. Dramatic increases in HIV prevalence after scale-up of antiretroviral treatment: a longitudinal population-based HIV surveillance study in rural Kwazulu-Natal. AIDS (London, England). 2013;27(14):2301.
7. Shisana O, Rehle, T, Simbayi LC, Zuma, K, Jooste, S, Zungu N, Labadarios, D, Onoya, D Et Al. South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. 2014. Report No.: 978–0-7969–2456-8.
8. Coates TJ, Richter L, Caceres C. HIV Prevention 3: Behavioural strategies to reduce HIV transmission: how to make them work better. The Lancet. 2008;372(9639):669-84.
9. KwaZulu Natal Department of Health. Annual Performance Plan 2016/17 - 2018/19. Pietermaritzburg; 2016a 2016.
10. KwaZulu Natal Department of Health. The 2015/2016 Annual Report - Vote 7. Pietermaritzburg; 2016 2016.
11. Massyn N, Peer N, English R, Padarath A, Barron P, Day C. District Health Barometer 2015/16. Durban: Health Systems Trust; 2016.
12. Karim QA, Kharsany ABM, Leask K, Ntombela F, Humphries H, Frohlich JA, et al. Prevalence of HIV, HSV-2 and pregnancy among high school students in rural KwaZulu-Natal, South Africa: a bio-behavioural cross-sectional survey. Sexually transmitted infections. 2014:sextrans-2014-051548.
13. Frohlich JA, Mkhize N, Dellar RC, Mahlase G, Montague CT, Karim QA. Meeting the sexual and reproductive health needs of high-school students in South Africa: Experiences from rural KwaZulu-Natal. SAMJ: South African Medical Journal. 2014;104(10):00-.
14. Wald A, Link K. Risk of human immunodeficiency virus infection in herpes simplex virus type 2–seropositive persons: a meta-analysis. Journal of Infectious Diseases. 2002;185(1):45-52.
15. Cluver L, Boyes M, Orkin M, Pantelic M, Molwena T, Sherr L. Child-focused state cash transfers and adolescent risk of HIV infection in South Africa: a propensity-score-matched case-control study. The Lancet Global Health. 2013;1(6):e362-e70.
16. Wakefield MA, Loken B, Hornik RC. Use of mass media campaigns to change health behaviour. The Lancet. 2010;376(9748):1261-71.

17. Evans WD, Blitstein J, Hersey JC, Renaud J, Yaroch AL. Systematic review of public health branding. Journal of Health Communication. 2008;13(8):721-41.
18. Abroms LC, Maibach EW. The effectiveness of mass communication to change public behavior. Annual Review of Public Health. 2008;29:219-34.
19. Vu L, Nieto-Andrade B, DiVincenzo A, Rivas J, Firestone R, Wheeler J, et al. Effectiveness of Behavior Change Communications for Reducing Transmission Risks Among People Living with HIV in 6 Countries in Central America. AIDS and Behavior. 2015;19(7):1203-13.
20. Kerrigan D, Moreno L, Rosario S, Gomez B, Jerez H, Barrington C, et al. Environmental–structural interventions to reduce HIV/STI risk among female sex workers in the Dominican Republic. American journal of public health. 2006;96(1):120-5.
21. Peltzer K, Ramlagan S, Chirinda W, Mlambo G, McHunu G. A community-based study to examine the effect of a youth HIV prevention programme in South Africa. International Journal Of STD & AIDS. 2012;23(9):653-8.
22. UNAIDS. HIV Prevention 2020 Roadmap. Accelerating HIV prevention to reduce new infections by 75% Geneva, Switzerland. 2017.
23. Spratt K. STIGMA Foundation. Empowering drug users to prevent HIV in Indonesia. 2010.
24. Blankenship KM, Bray SJ, Merson MH. Structural interventions in public health. Aids. 2000;14:S11-S21.
25. Sweat MD, Denison JA. Reducing HIV incidence in developing countries with structural and environmental interventions. Aids. 1995;9:S251-7.
26. UNAIDS. UNAIDS Guidance Note on HIV and Sex Work. 2009.
27. World Health Organization. Priority HIV and sexual health interventions in the health sector for men who have sex with men and transgender people in the Asia-Pacific Region: Manila: WHO Regional Office for the Western Pacific; 2010 2010.
28. Crankshaw TL, Smit JA, Beksinska ME. Placing contraception at the centre of the HIV prevention agenda. African Journal of AIDS Research. 2016;15(2):157-62.
29. Manyaapelo T, Nyembezi A, Ruiter R, Borne B, Sifunda S, Reddy P. Understanding the Psychosocial Correlates of the Intention to Use Condoms among Young Men in KwaZulu-Natal, South Africa. International Journal of Environmental Research and Public Health. 2017;14(4):339.
30. South African National AIDS Council (SANAC). South African HIV and TB Investment Case: Summary Report Phase 1. SANAC; 2016 2016.