MPAC

MPUMALANGA PROVINCIAL AIDS COUNCIL

developing an HIV free society

WHEN THE SUN RISES OUR ACTIONS COUNT

MPUMALANGA PROVINCIAL IMPLEMENTATION PLAN FOR HIV, TB AND STIs 2017 – 2022

MPUMALANGA

THE PLACE OF THE RISING SUN

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PREFACE TO THE PIP FOR HIV, TB AND STIs 2017 – 2022

Ms RM MTSHWENI, MPL
Premier: Mpumalanga Province

HIV, AIDS, STIs and TB remain the most serious health and developmental threats in South Africa, including in Mpumalanga. These epidemics are threatening to reverse the development gains that have been made since the advent of democracy in South Africa. They continue to ravage all human kind, especially the most vulnerable sectors of our society.

The development of the National Strategic Plan on HIV, STIs and TB 2017 – 2022 therefore affords us, as a country and a Province, an opportunity to reflect on what has been achieved during the implementation of the previous strategic cycles, in order to learn from the lessons and best practices to mitigate the impact of these epidemics. Accordingly, the Provincial Implementation Plan seeks to solidify and take forward our unfinished agenda of eradicating AIDS in our lifetime. For too long, we have been moping the floors, and it is about time that we start to fix the leaking taps.

This Plan makes a call to Action to reach all citizens of Mpumalanga, with a clear message – **No One will be left behind**. This is our endeavour to ensure that we reach the 90-90-90 UNAIDS Strategic goal. The goal is to test everybody who has not tested; ensure that all those who test HIV positive have access to treatment; and that those who are on treatment are virally suppressed. It is only through this Strategy that we will be able, as a Province, to increase the testing and treatment targets to reduce new infections.

Let me take this opportunity and express my sincere gratitude and appreciation to all who have contributed immensely, to the development of the Provincial Implementation Plan, as well as those who participated in the National consultative process for the development of the National Strategic Plan on HIV, STIs and TB for 2017 – 2022. This document is the roadmap for Mpumalanga to fight the spread of HIV, TB and STIs and to also mitigate its impact on our human capital.

The implementation of this Plan will assist us to move in unison in implementing the objectives of the National Development Plan and the Provincial Vision of ensuring an AIDS-free generation by 2030. The realisation of this dream is dependent on a very strong and militant multi-sectoral approach at all levels of leadership and management, within the public sector, civil society and the business sector. I am confident that this Plan will assist all the sectors in the development of their own sector-specific plans, in line with the Provincial Implementation Plan. I further believe the Integrated Service Delivery Model – *Operation Vuka Sisebente* – will assist the Province to deal with all programme implementation related activities at the coalface of service delivery – being at the ward level, where the rubber meets the road.

Once more, my utmost gratitude goes to formations and individuals who contributed and collaborated with us, in the development of this game-changing Plan, for the benefit of the people of Mpumalanga – *the Place of the Rising Sun*, South Africa, Africa and the global community at large. Let us start the journey towards the elimination of new HIV, STIs and TB infections in the Province with more determination and commitment.

Indeed, **when the Sun rises, we work hard** to reduce new HIV, STIs and TB infections, and take care of those already infected and affected.

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Ms RM MTSHWENI, MPL
Premier: Mpumalanga Province

Acknowledgement

The Mpumalanga Provincial Implementation Plan for HIV, TB and STIs for 2017 – 2022 is a product of a consultative process with different stakeholders who also directly and indirectly contributed to the development of the National Strategic Plan for HIV, STIs and TB 2017 – 2022.

The tireless efforts demonstrated by all those who were involved in this demanding and thought provoking exercise, have not gone unnoticed by the Provincial AIDS Council Secretariat that was charged with the responsibility to coordinate the development of the Provincial Implementation Plan.

Words of appreciation go the Chairperson of the Provincial AIDS Council – the Honourable Premier for her leadership and vision which is eloquently articulated in terms of future direction, on the fight against the spread of HIV, STIs and TB, especially among adolescent girls and young women.

The Mpumalanga Provincial AIDS Council (MPAC) Secretariat coordinated the development of the Provincial Implementation Plan (PIP) through the Provincial Steering Committee, which was appointed by the Director General, to facilitate the coordination of inputs from various stakeholders and role players. The contribution and support of the entire MPAC Secretariat staff to the Provincial Steering Committee has not gone unnoticed.

The valuable contribution made by all organisations represented in the Steering Committee through the provision of key information, which assisted in the development of this, inclusive and comprehensive multi-sectoral Plan is highly appreciated.

The inputs, contributions and guidance from the Technical Committees, Provincial Management Committee, Provincial AIDS Council and Provincial Executive Council have led to the successful completion of the Provincial Implementation Plan. We thank all the lead writers, AJW Management Consulting (Pty) Ltd who were responsible for the collation of information from various consultations and the development of this comprehensive and inclusive Plan for Mpumalanga Province.

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
ANC	Antenatal Care
ART	Anti-Retroviral Treatment
AYF	Adolescent and Youth Friendly
BCC	Behavioural Change Communication
CHC	Community Healthcare Centre
CSO	Civil society organisations
CD4	Cluster of Differentiation 4
CSVR	Centre for the Study of Violence and Reconciliation
CBO	Community-Based Organisation
CCMDD	Central Chronic Medicine Dispensing and Distribution
CDW	Community Development Workers
CNDC	Centre for National Diseases Control
CS	Civil Society
CSE	Comprehensive Sexuality Education
CTOP	Choice of Termination of Pregnancy
CSIR	Council for Science and Industrial Research
CXR	Chest X-Ray
CSW	Commercial Sex-workers
DAC	District AIDS Council
DCS	Department of Correctional Services
DHIS	District Health Information System
DM	District Municipality
DOH	Department of Health
DSD	Department of Social Development
DIP	District Implementation Plan
DoE	Department of Education
DoJ	Department of Justice
EAP	Employee assistance programme
EDM	Ehlanzeni District Municipality
EDAC	Ehlanzeni District AIDS Council
EHWP	Employee Health and Wellness Programme
ETR	Electronic TB Register
EXCO	Executive Committee
FAST	Finding, Actively, Separating, Treating
FBO	Faith Based Organisation
GBV	Gender Based Violence
GSDAC	Gert Sibande District AIDS Council
GCIS	Government Communication and Information Services
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HAART	Highly Active Anti-Retroviral Therapy
HAS	HIV, AIDS & STIs
HAST	HIV, AIDS, STIs and TB
HBC	Home Based Care
HCBC	Home and Community Based Care
HIVDR	HIV Drug Resistance
HSRC	Human Sciences Research Council

HTA	High Transmission Areas
HTS	HIV Testing Services
IEC	Information, education communication
IDU	Injecting Drug Users
IDP	Integrated Development Plan
IPT	Isoniazid Preventive Therapy
KP	Key Populations
LAC	Local AIDS Council
LGBTI	Lesbian, gay, bi-sexual, transgendered and intersex
LTFU	Loss to follow up
MARPs	Most At Risk Populations
MSM	Men who have sex with men
MTR	Mid-term review
MDIP	Multi-sectoral District Implementation Plan
MDR TB	Multi-drug-resistant tuberculosis
M&E	Monitoring and Evaluation
MPAC	Mpumalanga Provincial AIDS Council
MMC	Medical Male Circumcision
MOU	Memorandum of Understanding
MCSPs	Multiple Concurrent Sexual Partners
MSPs	Multiple Sexual Partners
MTCT	Mother To Child Transmission
MUS	Male Urethritis Syndrome
NSP	National Strategic Plan 2017 - 2022
NDAC	Nkangala District AIDS Council
NDP	National Development Plan
NHI	National Health Insurance
NIMART	Nurse Initiated Management of Anti-Retroviral Treatment
NGO	Non-Government Organisation
NYDA	National Youth Development Agency
OVC	Orphaned and Vulnerable Children
OVCY	Orphaned, Vulnerable Children and Youth
OTP	Office of the Premier
PIP	Provincial Implementation Plan
PHC	Primary Healthcare Centre
PCA	Provincial Council on AIDS
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PIC	Provincial Implementation Committees
PICT	Provider Initiated Counselling and Testing
PLHIV	People living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PTB	People with TB
PSP	Provincial Strategic Plan
PWID	People Who Inject Drugs
SANAC	South African National AIDS Council
STATS SA	Statistics South Africa
SHE	SHE Conquers Campaign
SWEAT	Sex Worker Education and Advocacy Taskforce
SALGA	South African Local Government Association
SANC	South African Nursing Council
SANCA	South African National Council on Alcoholism and Drug Dependence
SAPC	South African Pharmacy Council
SAPS	South African Police Service
SASSA	South African Social Security Agency

SO	Strategic Objective
SRHR	Sexual and Reproductive Health Rights
STI	Sexually Transmitted Infection
TB	Tuberculosis
TAC	Treatment Action Campaign
TVET	Technical and Vocational Education and Training
TWG	Technical Working Group
TST	Tuberculin Skin Tests
UNAIDS	Joint United Nations Programme on HIV/AIDS
VEP	Victim Empowerment Programmes
WBOTS	Ward Based Outreach Teams

Executive Summary

The Mpumalanga Provincial Implementation Plan for HIV, TB and STIs 2017 - 2022 (PIP) is the blueprint for action at provincial, district and local levels to operationalize the strategic direction that has been set by the NSP 2017 - 2022. Alignment of policy objectives between national and provincial underpins our commitment to work collectively and together to achieve the goals of the NSP. This document outlines the PIP and is the result of intensive stakeholder consultation. The document comprises the following sections:

The introduction provides the strategic context for the Mpumalanga Province PIP. It describes the HIV prevalence in Mpumalanga Province and leverages this as a call to urgency. It positions the strategic response of the PIP and outlines areas for strategic emphasis namely prioritising HIV prevention, accelerating the implementation of universal test-and-treat, an intensified focus on location, an intensified focus on populations disproportionately affected, a substantially stronger focus on adolescent girls and young women, prioritising service delivery, implementation of differentiated care, a strengthened multi-sectoral response, an expanded approach to financing and costing the response and strengthening strategic information

The Development of the Provincial Implementation Plan 2017 2022 was facilitated through a multisectoral consultative process. The epidemiological profile of Mpumalanga highlights the current status of HIV, TB and STIs in the Province, including the Province's status of ranking second in terms of HIV prevalence and the high rate of HIV prevalence amongst adolescent girls and young women. The epidemiology provides an overview of the status of TB infection in Mpumalanga Province, as well as the size and growth of the various components of key and vulnerable populations (including people living with HIV, migrants, sex workers, men who have sex with men, people who inject drugs, LGBTI, adolescent girls and young women, children, people living in informal settlements, people with disabilities, miners and long distance truck drivers). The packages provided to vulnerable populations are also described.

The section on Critical Enablers outlines the enablers required to achieve the eight goals of the PIP. These enablers will ensure the efficiency and effectiveness of the programme as it reaches its goals. The enablers are as follows:

- A focus on social and behaviour change communication (SBCC) to ensure social mobilization and increasing awareness;
- build strong social systems, including strengthening families and communities, to decrease risks of transmission and to mitigate the impact of the epidemics;
- effectively integrate HIV, TB and STI interventions and services;
- strengthen procurement and supply chain systems and
- ensure that there are sufficient, appropriately trained human resources where they are needed.

The PIP document outlines the goals of the NSP, including strategic context and strategic approaches. A table outlining goals, objectives and activities accompanies each goal. The goals of the PIP are as follows:

- **Goal 1: Accelerate prevention to reduce new HIV, TB and STI infections:** The strategic context of this goal includes the need for a comprehensive and combination approach to reduce new HIV, TB and STI infections, with a particular emphasis on adolescent girls and young women between the ages of 15-24. The importance of a multi-sectoral approach, which leverages community systems, is highlighted.

  We seek to reduce new HIV infections by more than 60% by 2022 across all three districts and to close the gap towards elimination of mother to child transmission; contributing towards South Africa potentially becoming the first country on the continent and the fifth country in the world to achieve this; to cut TB incidence by at least 30%; to significantly lower the incidence of gonorrhoea, syphilis and chlamydia, to achieve virtual elimination of congenital syphilis, and to maintain high coverage of HPV vaccination.

  This we will achieve by utilising proven prevention strategies, increasing prevention activities and targeting prevention efforts strategically to the locations and populations at greatest risk, thus accelerating prevention to reduce new HIV, TB and STI infections.

- **Goal 2: Reduce morbidity and mortality by providing treatment, care and adherence support to all:** The strategic context emphasised the fact that the Province is currently on-track with efforts to progress to reduce mortality and morbidity of HIV and TB. Areas of challenges included drug stock-outs, inadequate care provision and poor adherence models. To overcome these challenges, the Province will strive towards the 90-90-90 model adopted by UNAIDS. Collective action is essential to achieve the 90-90-90 targets for HIV and TB which was set by UNAIDS.

  Attaining these targets will lead to 607,000 of the estimate 675 000 PLHIV being identified and 547000 (including 31000 children) are on sustained antiretroviral therapy. It will also ensure that at 492000 PLHIV in Mpumalanga (including 28000 children) achieve HIV viral suppression, and attain at least a 90% treatment success rate for drug-sensitive TB and at least 65% treatment success rate for multi-drug resistant TB.

- **Goal 3: Reach all key and vulnerable populations with customised and targeted interventions:** This strategic goal highlights the need to provide appropriate care to key and vulnerable populations. The strategic approach will involve tailoring large-scale interventions at the same time as small-scale, targeted interventions. Tailoring services, sensitising healthcare providers and engaging communities in the development of programmes are all components of the strategic approach.

  In order to ensure that nobody is left behind, we will reach out prevention and treatment targets for key populations through intensified efforts peer-led and community-based support services that are tailored to meet the needs of key and vulnerable populations. Integral to this strategy is to build the capacity of service providers, implement and expand community and peer-led programming, and create enabling environments to reach key and vulnerable populations with comprehensive

and customised services and collectively advocate for their health and human rights and increase uptake of life-saving services.

- **Goal 4: Address the social and structural drivers of HIV, TB and STIs, and link these efforts to the NDP.** It is commonly understood that social factors deepen the disease burden of HIV and TB in the country. Factors such as poverty, unemployment, alcohol and drug abuse and gender-based violence are all contributors to the disease burden.

  In order to tackle these factors, the strategic approach will include reducing poverty through scaled-up social protection, strengthening outreach models to people at risk and changing gender norms to address-based violence. We require a multi-sectoral approach to address the social and structural determinants that increase risk and vulnerability to HIV, TB and STIs, with particular attention to adolescent girls and young women. The key is to work together and address the underlying and specific social and economic factors that drive HIV, TB and STI infections.

Goal 5: Ground the response to HIV, TB and STIs in human rights principles and approaches: External stigma is of great concern in the Province. Grounding the response to HIV, TB and STIs in human rights principles will help to combat the scourge of stigma. The strategic approach will include monitoring and responding to human rights abuses, and specific interventions to address the added vulnerability of key and vulnerable populations to stigma and discrimination and human rights abuse. We have a deepened commitment to equal treatment and social justice, including protection of human rights, increased access to justice as guided by our progressive Constitution. A particular focus for this goal is to provide legal redress and support to victims of stigma and discrimination and to reduce internalised and externalised stigma by at least 50%.

- **Goal 6: Promote leadership and shared accountability for a sustainable response to the HIV, TB and STI epidemics:** Collaboration and leadership will be key to achieving the goals set-out in this plan. A well-capacitated MPAC Secretariat, with strengthened AIDS Councils that commits to the values of transparency and dialogue will be critical. The strategic approach will include strengthening the capacity of AIDS Councils, civil society participation and leadership, strengthening private sector engagement and engaging organised labour.

  To ensure leadership and accountability for results and an expanded partnership to address HIV, TB and STIs, the strategic plan calls for the strengthening of AIDS Councils at all levels, improved cooperation and collaboration among government departments, deeper involvement of the private sector and capacitation of civil society sectors and community networks. Integral to leading this strategy is access to and sharing of essential information on the epidemics to enable inclusive and meaningful dialogues on our performance.

Goal 7: Mobilise resource to support the implementation of the goals of the NPS to sustain the response: For this PIP to be fully implemented, it is very important to ensure that resources are mobilised to support this plan. This multisectoral plan requires funding beyond government funding. The successful implementation of this plan will be dependent on funding of the activities that are not funded. The funding gap must be closed if we are to succeed in implementing this PIP. Funding the PIP is a challenge that will require maximising funding from existing sources, generation of new funding sources, improving spending efficiency of current resources by more effective planning, collaboration and ensuring that our interventions are underpinned by reliable and sound evidence.

- **Goal 8: Strengthening strategic information to drive progress towards achievement of NSP goals**: The theme of this goal is data driven action, which highlights the importance of accurate information in achieving meaningful change in this strategic cycle. The critical role of the Mpumalanga Provincial AIDS Council (MPAC) is highlighted. The strategic approach in this sector includes optimising the data that exists and aligning it with PIP strategic needs. Monitoring and Evaluation, surveillance and surveys, and research are the pillars of this strategic approach.

  The goals and targets of this plan will only be met through the generation and use of relevant and valid data. This allows us to monitor the epidemic, learn from others and furthermore understand trends, strategic directions and areas of new information. In essence, using information to our advantage to inform our interventions and share our findings.

Provincial actions and responsibilities:

This section outlines the roles and responsibilities of SANAC structures in implementing this PIP. The roles and responsibilities of the Mpumalanga Provincial AIDS Council (MPAC), District AIDS Councils (DACs), District AIDS Councils (DACs) and Ward Councils (LAC) are outlined.

Monitoring and Evaluation and success of the PIP

The monitoring and evaluation framework was developed that outlines the process of accountability on which the Mpumalanga's response to HIV, STIs and TB is built. Using baselines derived from previous performance, indicators to measure progress towards set targets on objectives and sub-objectives will be measured.

SECTION 1: Introduction

The Mpumalanga Provincial Implementation Plan for HIV, TB and STIs 2017-2022 (PIP) is the blueprint for action at provincial, district, local levels to operationalize the strategic direction that has been set by the NSP. Alignment of policy objectives between national and provincial underpins our commitment to work collectively and together to achieve the goals of the NSP.

The PIP is centred on a multi-sectoral approach to work towards the acceleration of the progress to reduce the morbidity and mortality associated with HIV, TB and STIs. The PIP will be augmented by the Multi-Sectoral District Implementation Plans (MDIPs) that will guide implementation at district and local levels.
This PIP will be the roadmap to guide the provincial response and represent all stakeholders. It includes targeted activities with measurable indicators, targets for each of the five years and the responsible sector or government department who will be held accountable for its achievement. Timelines and resource allocations for this plan are unpacked in Goal 7 for the period of the PIP.

Our focus however needs to remain unwavering in Gert Sibande and Ehlanzeni who are amongst the thirteen districts in South Africa with an unacceptably high HIV prevalence rate[1]. The focus of the national and provincial response over the last 16 years has seen some evolution. Access to treatment, extended psychosocial support and coordinating structures to monitor the response from a multi-sectoral perspective.

Section 2: Background

The Mpumalanga PIP was developed under the guidance of a multi-sectoral Steering Committee, in conjunction with the Mpumalanga Provincial AIDS Council (MPAC) Secretariat, which was responsible for overseeing all the elements included in its evolution. The following process outlines the key development phases:

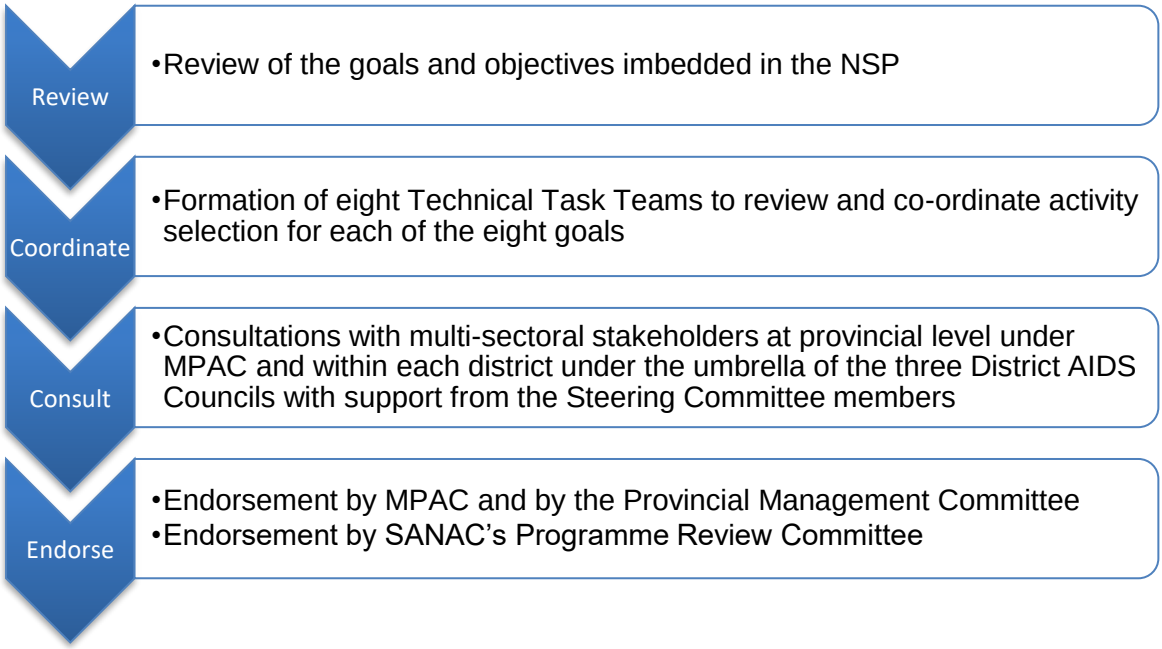

Figure 1 - Key development phases of the PIP 2017 - 2022

The Provincial Steering Committee led the development of the Provincial Implementation Plans and was appointed by the Director General. The Committee members were representative from the Office of the Premier, Department of Education, Department of Social Development, Department of Health, District Support Partners, Districts AIDS Councils, Civil Society Organizations and PEPFAR.

The role of the Steering Committee was to ensure that the PIP development process followed the multi-sectoral consultation approach for collective opinions on the PIP for adoption and ownership by HIV, STIs and TB stakeholders in the province. This was achieved through convention of consultative forums at all three Districts as well as at the Provincial level.

Aligned to the NSP, the Mpumalanga PIP 2017 - 2022 leverages lessons learned from public health successes, and takes into cognisance lessons learnt from unsuccessful endeavours, both nationally and provincially; that were learned under the NSP 2012-2016 and PSP 2012-2016 respectively. This PIP is the product of an extensive collaboration that involved provincial and local governments; civil society; the private sector; academics; multilateral institutions; developmental partners and communities.

Section 3: National contexts – Epidemiology

Mpumalanga Province is ranked second amongst the provinces of South Africa in terms of HIV prevalence, with a predicted prevalence rate for the whole population of 15.2% in 2016 and a total of 675,414 infections. The highest provincial HIV prevalence was recorded in KwaZulu-Natal (KZN), which increased from 37.4% in 2012 to 40.1% in 2013, an increase by 2.7%. Mpumalanga HIV prevalence increased from 35.6% in 2012 to 37.5% in 2013. These small increases fell within the expected sampling variability.

The provinces with 'lower' HIV prevalence estimates were: North West HIV prevalence decreased from 29.7% in 2012 to 28.2% in 2013 and in the Free State, it decreased from 32.0% in 2012 to 29.8% in 2013. The provincial HIV estimate were also within the expected sampling variability, which means that the HIV prevalence is stabilizing, but the statistical differences is significant in HIV prevalence's amongst provinces from a low of 17.5% in the Northern Cape to a high of 40.1% in Kwazulu-Natal.

Four out of the nine provinces have recorded HIV prevalence that is above the national average (Free State with 29.8%, Eastern Cape with 31.4%, Mpumalanga with 37.5% and KZN with 40.1%). According to the 2013 survey results four provinces, viz., Eastern Cape, KwaZulu-Natal, Mpumalanga and Western Cape show an HIV prevalence increase of between 1.8% to 2.7%, while Free State, Gauteng, Limpopo and North West show a slight HIV prevalence decrease of between 1.3% and 2.2%.

Section 4: Overview and profile of Mpumalanga

Geographical Profile

Mpumalanga lies in Eastern South Africa, bordering Swaziland and Mozambique. It constitutes 6.5% of South Africa's land area.

It shares borders with the South African provinces of Limpopo to the north, Gauteng To the west, the Free State to the southwest,
and KwaZulu-Natal to the south.

The Province has three districts: Gert Sibande, Ehlanzeni and Nkangala District Municipalities, which are further subdivided into 18 local municipalities.

Figure 2 - Map of South Africa, highlighting Mpumalanga Province

Gert Sibande District: Chief Albert Luthuli, Pixley Ka Isaka Seme, Mkhondo, Lekwa Dipaliseng, Msukalikwa and Govan Mbeki Local Municipalities. **Nkangala District:** Victor Khanye, EMalahleni, Steve Tshwete, EMakhazeni, Dr JS Moroka and Thembisile Hani Local Municipalities. **Ehlanzeni District:** City of Mbombela, Nkomazi, Thabachweu and Bushbuckridge Local Municipality.

Mpumalanga is South Africa's third most rural Province and many residents reside in the former homelands of Kwa-Ndebele, Ka-Ngwane and Lebowa.

Demographic profile

According to the Community Survey (2016), the total population in Mpumalanga was 4,335,964. This is an estimated 7.8% of the total population of South Africa. It increased annually with 1.6% since the Census 2011 (4,039,939). 50.7% of the population is female and 51.0% is <25 years.

The average life expectancy at birth for males increased from 51 to 55 years from 2011 to 2016, while it increased from 52.8 years to 60.6 years for females during the same period[i]. The mortality rate for infants is predicted to be 27.6 per 1,000 in 2016 and the under-five mortality rate, 43.2 per 1,000. The probability that a 16-year-old dies before the age of 60 was predicted to be 37% in 2016. According to Statistics South Africa there were 73,686 registrations. The fertility rate was predicted to be 2.52 in 2016.

Stats SA data indicates that 88% of the population relies on public health services. There are 350 health care facilities in the Province, with two tertiary hospitals and 3 regional hospitals. Gert Sibande had 95 facilities, and 24.7% of the primary healthcare facilities had performance agreements for staff. Ehlanzeni has a total of 143 facilities, with 9% of the staff employed at the Primary Health Care facilities. Nkangala has a total of 112 facilities, with 18% of staff at Primary Healthcare facilities with performance agreements.

Table 1: Health Care Facilities in Mpumalanga

District	Clinic	CHC	District Hospital	Regional Hospital	Tertiary Hospital	Other Hospitals	Total Facilities
Gert Sibande	54	22	8	1	0	6	91
Nkangala	68	22	7	1	1	6	95
Ehlanzeni	106	15	8	2	1	5	137

Socio-Economic Profile

The poverty headcount stood at 7.8% of households in Mpumalanga in 2016 (from 7.9% in 2011) and the intensity of poverty in Mpumalanga increased from 41.8% in 2011 to 42, 7% in 2016. Mpumalanga contributed 7% of the country's GDP in 2014. The major components of the economy are mining, manufacturing, agriculture (which includes forestry and fishing operations) and tourism.

Epidemiological profile of Mpumalanga's HIV, TB and STI epidemics

Mpumalanga Province is ranked second amongst the provinces of South Africa in terms of HIV prevalence, with a predicted prevalence rate for the whole population of 15.2% in 2016 and a total of 675,414 infections. HIV ranks 6th as an underlying cause of death in the Province in 2015, but it must be noted that many HIV deaths are misclassified as TB. In 2014, the estimated Years of Life Lost (YLL) due to HIV and TB was 33.9 in Gert Sibande and 36.0 in Ehlanzeni, ranking both districts amongst the worst in the country. In Nkangala the estimated YLLs due to HIV and TB was 25.0 in 2014.

There is a predicted prevalence rate in children <15 years of 2.7% in 2016 and of 9.8% in youth 15-24. The prevalence rate for young women is 15% whilst the prevalence rate for

males in the equivalent age bracket is 4.6%. The prevalence rate peaks at the 35-39 age bracket for both men (32.3%) and women (39.2%).

The HIV prevalence among pregnant women 15-49 years was 35.8% according to the antenatal care (ANC) survey 2014. The prevalence in Ehlanzeni (39.2%) and Gert Sibande (36.1%) is considerably higher than in Nkangala (29.9%).

The total number of new infections in the Province for 2016 was predicted to be 26,320. The incidence rate (rate of new infections) was 0.7% for the total population. The incidence rate was 1.70% among youth, with young women having a much higher rate compared to young men (1.23% versus 0.87%). The chance that a 15-year-old woman is infected before the age of 40 is predicted to be 40.44% whilst this is 27.75% for a man.

In Mpumalanga Province, the male condom distribution coverage (the number of male condoms distributed per male aged 15+) was 33.0 in 2015/16. In Gert Sibande this was 36.8 and in Ehlanzeni 35.3. Nkangala was one of the worst performing districts in terms of male condom distribution with a rate of 27.8.
HIV Counselling and Testing (HCT) is seen as an important gateway to care and treatment services. The HIV testing coverage (including ANC) was 34.5% in 2015/2016. It was 32.4 in the province, and 38.3% in Ehlanzeni, 29.9% in Gert Sibande and 27.0% in Nkangala.

The predicted ART coverage rate assuming that everybody who is HIV positive should be on ART is 55.3% in 2016. In total there are 373,360 patients who are predicted to be on ART including 17,910 children <15 years.

Provincial status of Tuberculosis

TB was recorded as the leading underlying natural cause of death in the Province in 2015 with 7.9% of the deaths in the province attributed to TB (2,714 deaths). In 2015 the incidence was 449 per 100,000 in Ehlanzeni, 460 per 100,000 in Gert Sibande and 298 per 100,000 in Nkangala.
As there is a high correlation between HIV and TB, there has been a national push for TB patients to know their HIV status. In Nkangala, 96.8% of HIV patients know their status, and this was 94.3% in Ehlanzeni and 89.9% in Gert Sibande (one of the worst performing districts in the country).
In Ehlanzeni, 95.7% of co-infected patients with TB were on ART, in Nkangala 89.6% and in Gert Sibande 83.4%. The Provincial average was 90.6%, making it the second best performing province in the country Mpumalanga reported the highest treatment success rate across the provinces, increasing from 76.1% in 2013 to 84% in 2014.
In Ehlanzeni, the successful treatment rate was 86.1%, with a death rate of 5.5% and a lost to follow up rate of 3.3%. In Gert Sibande, the successful treatment rate was 79.7% with a death rate of 9.1% and a lost to follow up rate of 5.6%. In Nkangala, the successful treatment rate was 83.5% with a death rate of 6.9% and a lost to follow-up rate of 6.3%. In terms of Rifampicin resistant cases, Mpumalanga reported that 8.6% of the TB cases were rifampicin resistant.

Section 5: Focus for Impact

At the heart of the PIP 2017-2022, is the strategy to “focus for impact” (FFI) which is the use of geospatial mapping and consolidation of readily available data to identify high burden areas. Innovative data sources through the “focus for impact” helped identify the areas and populations more at risk as well as the high impact prevention and treatment services and

strengthened efforts to address the social and structural factors that increase vulnerability to infection.

To maximise the impact of efforts, the PIP introduces this more intensified, more strategic focus at provincial, district and ward levels. In Mpumalanga, all the three districts (Nkangala, Gert Sibande and Ehlanzeni) are among the 27 Districts with high HIV burden requiring intensified focus and response. Ehlanzeni district is among the 19 high TB burden which automatically makes Mpumalanga a priority province in South Africa. Thus, within the province's 3 districts, key and vulnerable populations most heavily affected by the epidemics will be empowered through improved service access and reduced barriers to service uptake.

To maximise impact the PIP advocates for more focus at district, sub-district and ward levels, with the multi-sectoral response tailor made to each person's needs, including loss to follow up among people who initiate care, while simultaneously implementing the new test and treat policy. Priority is given to ensuring that treatment programmes are holistic and address each person's health needs, including co-morbidities. Three levels of focus selected in the province that will accelerate implementation of the PIP and optimise its impact will include spatial location, population and community profiling and implementation of multi-sectoral interventions.

Level of Burden in District Municipalities

The table below indicates level of burden for the three districts using focus for impact data for the following 5 indicators namely (1) HIV Positivity Rate 15-49 years (2) TB Smear Positive Rate (3) Male Urethritis Syndrome (MUS) and (5) Deliveries in Facilities under 18 years.

Table 2: Level of Burden in District Municipalities

District Municipality	HIV positivity rate (15-49 years)	TB Smear positive rate	STI (MUS)	Deliveries in facilities under 19 years
Ehlanzeni	11.7%	7.8%	22.4%	8.6%
Gert Sibande	**12.7%**	**8.1%**	19.1%	**8.7%**
Nkangala	9.2%	6.9%	**24.4%**	6.1%

Source of data: District Focus for Impact Report (with DHIS 2015 Data) for Ehlanzeni, Gert Sibande and Nkangala 2017.

The table shows that Gert Sibande district municipality had the highest burden of HIV and TB and also a high rate of deliveries under 18 years when compared to the other districts. Ehlanzeni and then Nkangala followed it. Nkangala had the highest rate of STIs infection, followed by Ehlanzeni and Gert Sibande.
The province will focus intensity of activities in Gert Sibande (HIV and TB; and under 18 years deliveries), Ehlanzeni (HIV and STIs and deliveries under 18 years) and Nkangala (STIs).

Priority Districts and Local Municipalities (sub- districts)

The priority district and sub-districts will be selected based on the HIV, STIs and TB data for concentrated response from all relevant stakeholders. There is no doubt that Ehlanzeni will be the main focus on TB while, Gert Sibande and Nkangala will be considered second and third based on population and community profiling and implementation of multi-sectoral interventions. Interventions will also be based on various components of key and vulnerable populations that require tailor made requirements.

Table 3: Level of Burden in Ehlanzeni and its Local Municipalities

District	Local Municipality	HIV positivity rate (15-49 years)	TB Smear positive rate	STI (MUS)	Deliveries in facilities under 18 years
Ehlanzeni		**11.7%**	**7.8%**	**22.4%**	**8.6%**
	Bushbuckridge	7.80%	6.36%	21.24%	9.09%
	Thaba Chweu	12.84 %	4.46%	28.54%	5.36%
	Nkomazi	**12.89 %**	**8.30%**	**22.57%**	**10.58%**
	City of Mbombela	**14.65 %**	**8.95%**	**22.52%**	7.18%

Source of data: Ehlanzeni District Focus for Impact Report with DHIS 2015 Data

The table shows that, Nkomazi and City of Mbombela local municipalities had a high HIV, TB and STIs burden. Nkomazi local municipality, also had a high rate of deliveries under 18 years. Thaba Chweu had a high HIV burden while Bushbuckridge had a high rate of deliveries under 18 years. While the STIs rate was high in Thaba Chweu, the absolute numbers were low. Bushbuckridge had a low HIV positivity rate but had higher absolute numbers.
Intensity of activities for local municipalities in Ehlanzeni will be as follows; City of Mbombela and Nkomazi local municipalities (HIV, TB and STIs) and Thaba Chweu local municipality (HIV). Intensified activities will be required for Bushbuckridge and Nkomazi local municipalities in relation to the high rate of deliveries under 18 years.

From a province perspective, Gert Sibande had the highest burden of HIV and TB; and a high rate of deliveries under 18 years. The table below breaks it down further to local municipalities. Govan Mbeki local municipality had a high HIV, TB and STIs burden; and high rate of deliveries under 18 years. Msukaligwa local municipality had high HIV and TB burden. Mkhondo local municipality had a high burden of HIV. Chief Albert Luthuli and Mkhondo local municipalities had high rates of deliveries under 18 years.
Though the HIV positivity rates for Dr Pixley Ka Isaka Seme and Lekwa local municipalities were high, the corresponding absolute numbers were relatively low. This also applied to the TB and STIs rates for Lekwa local municipality and the TB rate for Mkhondo local municipality.

Table 4: Level of Burden in Gert Sibande and its Local Municipalities

District	Local Municipality	HIV positivity rate (15-49 years)	TB Smear positive rate	STI (MUS)	Deliveries in facilities under 18 years
Gert Sibande		**12.7%**	**8.1%**	**19.1%**	**8.7%**
	Chief Albert Luthuli	9.09%	4.3%	18.20%	9.36%
	Dipaliseng	10.62%	6%	17.26%	0.79%
	Dr Pixley Ka Isaka Seme	15.14%	6.49%	16.59%	10.71%
	Govan Mbeki	**12.88%**	**12.25%**	**23.50%**	**8.37%**
	Lekwa	19.80%	10.11%	36.32%	7.66%
	Mkhondo	16.01%	9.21%	15.63%	8.90%
	Msukaligwa	**13.0%**	**9.54%**	16.86%	8.16%

Source of data: Gert Sibande District Focus for Impact Report with DHIS 2015 Data.

As such, intensification of activities will be as follows; Govan Mbeki local municipality (HIV, TB and STIs and deliveries under 18 years); Msukaligwa local municipality (HIV and TB); Mkhondo local municipality (HIV) and Chief Albert Luthuli and Mkhondo local municipalities (deliveries under 18 years).
From a provincial viewpoint, Nkangala district municipality had a high burden of STIs. The table below shows further breakdown per local municipality. EMalahleni and Steve Tshwete local municipalities had high HIV, TB and STIs burden. In addition, EMalahleni local

municipality had a high rate of deliveries under 18 years. Thembisile Hani local municipality had high TB burden and a high rate of deliveries under 18 years.

Table 5: Level of Burden in Nkangala District and its Local Municipalities

District	Local Municipality	HIV positivity rate (15-49 years)	TB Smear positive rate	STI (MUS)	Deliveries in facilities under 18 years
Nkangala		**9.2%**	**6.9%**	**24.4%**	**6.1%**
	Dr JS Moroka	4.82%	4.51%	20.49%	5.58%
	EMakhazeni	8.05%	3.97%	23.74%	12.20%
	EMalahleni	**12.38%**	**7.07%**	**26.75%**	**6.01%**
	Steve Tshwete	**11.28%**	**11.26%**	**28.71%**	5.02%
	Thembisile Hani	8.46%	9.27%	19.35%	6.26%
	Victor Khanye	11.20%	9.89%	18.05%	7.82%

Source of data: Nkangala District Focus for Impact Report with DHIS 2015 Data

Though Dr JS Moroka local municipality had lower burden of HIV and TB as per the indicator rates, the absolute numbers were relatively high. On the other hand HIV and TB positivity absolute numbers for Victor Khanye local municipality were relatively low as were the absolute numbers of deliveries under 18 years. The STI absolute numbers for Thembisile Hani local municipality were high.

Therefore intensification of activities for the local municipalities in Nkangala will be as follows; EMalahleni and Steve Tshwete local municipalities (HIV, TB and STIs); EMalahleni local municipality (deliveries under 18 years) and Thembisile Hani local municipality (TB burden and deliveries under 18 years). Further there will be need to pay attention to Dr JS Moroka local municipality (HIV and TB) and Thembisile Hani local municipality (STIs).

Priority Populations

In Ehlanzeni district, community engagements were done in ward in the Eziweni clinic catchment area covering wards 2 and 29 in the city of Mbombela local municipality. The community identified the following as the key and vulnerable populations.

1. Adolescent girls and Young women
2. People who use drugs
3. Sex workers

In Gert Sibande district municipality, community engagements were done in wards 11, 12 and 14 Langverwaght extension 14 clinic catchment area in the Govan Mbeki Local Municipality. The community identified the following as the key and vulnerable populations.

1. Adolescent Girls and Young Women including sex workers
2. Youth
3. Orphaned and Vulnerable Children

For Nkangala district municipality, community engagements were done in Empumelelweni clinic catchment area ward 29 in EMalahleni local municipality**.** The community identified the following as the key and vulnerable populations.

1. Adolescent Girls and Young Women
2. Orphaned and Vulnerable Children
3. People who use drugs

The following population was identified as key and vulnerable for all the areas

1. People living with HIV
2. Household contacts of TB index patients
3. Children less than 5 years old
4. People living in informal settlements
5. Miners
6. Health care workers
7. Pregnant women

People living with HIV
The number of people living with HIV (PLHIV) in the Province is predicted to be 675,414 in the province, which shows a continuous increase due to survival of PLHIV on ART.

Migrants
According to Stats SA, there are an estimated 169 172 Mpumalanga Province residents who were born in Gauteng, 155 000 in who were born in Limpopo and 116 132 who were born outside South Africa. The total in-migration was 630 074 in 2016, but the out-migration was even higher at 668,341. A high percentage of Mpumalanga emigrants (both male and female) migrated to Gauteng (62,1% and 64,5% respectively), followed by Limpopo (13,4% and 12,7%
respectively). Migration is a driver of the HIV epidemic, although no data was found on the HIV prevalence specifically among migrants in the province. A study conducted in 2010 on commercial farms in Malalane found a HIV prevalence of 49.1%. The farm worker population in the area is roughly 60% South African, 24% Mozambican and 14% Swazi.

Sex Workers
A mapping exercise conducted in 2013 estimated that there are between 11,758 and 15,130 female sex workers in the Province. No data is available on the prevalence of HIV among sex workers in Mpumalanga, but it was found to be high in Johannesburg (71.8%), Durban (53.5%) and Cape Town (39.7%). Based on this data it can be deduced that HIV prevalence in MP is likely to be higher than general population. In particular, young female sex workers (under 25 years) carry a heavy HIV burden, highlighting the need for focused interventions for sex workers from an early age. Ehlanzeni and Gert Sibande districts mentioned sex workers as a priority population.

Men who have sex with men
Data on Men who have Sex with Men (MSM) for the province is available from the Mpumalanga Men's Study (MPMS) conducted in Gert Sibande and Ehlanzeni districts in 2012/13. HIV prevalence estimates are 28.3% in Gert Sibande, and 13.7% in Ehlanzeni. HIV Prevalence is significantly higher among MSM over age 25. Prevalence of previous HIV testing was 65.8% in Gert Sibande, and 69.3% in Ehlanzeni. Regular HIV testing was uncommon. Among HIV-positive participants, few knew their status (28.1% in Gert Sibande and 14.5% in Ehlanzeni), or were appropriately linked to care (18.2% and 11.3%, respectively), or taking antiretroviral therapy (13.6% and 9.6% respectively).
Successive surveys conducted up to 2015 found an incidence of 12.5/100 person-years.

People Who Inject Drugs
In South Africa, there is limited data on HIV prevalence among People Who Inject Drugs (PWID) and where it does exist it is based on small sample sizes. A cross-sectional survey among 450 PWID from five South African cities (in Gauteng, KwaZulu-Natal and Western Cape) in 2013 found a HIV prevalence of 14%. Furthermore, this study referenced a population estimate for PWID of 67 000 in South Africa. Neither population estimate nor HIV prevalence estimate is available for the province.

LGBTI
International evidence suggests that there is a high prevalence of HIV amongst Trans-gendered men. A key informant study performed in South Africa outlines some the challenges Transgendered people have when accessing services. Compared with MSM, transgendered women more frequently reported transactional sex, receptive anal intercourse without a condom, or more than five partners in the last 3 months.

As indicated limited data for gay and none for transgendered people is available for specifically Mpumalanga, but in general limited/no data is available for other LGBTI (Lesbian, Gay, Bisexual, Trans and intersex people) in the country.

Adolescent girls and young women

According to CS 2016, there are a total of 631,598 adolescent girls and young women in the Province. There are an approximate 207,192 girls and young women in the 10-14 age category, 210,042 in the 15-19 age category, 214,364 and in the 20-24 age category 2. The rate of teenage pregnancy that was found in the South Africa Demographics and Health Survey in 2016 found that 15,3% of women aged 15 – 19 have had a live birth and 2,8% are pregnant with their first child. As highlighted earlier, the predicted HIV prevalence in 2016 among young women is very high (15.0%) as well as the HIV incidence (2.63%).

A study conducted in seven HIV clinics across urban Gauteng (n=5) and rural Mpumalanga (n=2) found that HIV-infected adolescents and young adults between 15 and 24 years have poorer ART treatment outcomes in terms of virological response, LTFU, and virological failure than adults receiving ART. The sexual behaviour of girls between 15–24 years in Mpumalanga Province who had 2+ partners in the past 12 months were found to be 6,6% and 46,5% reported that they've had intercourse with a person who was neither their spouse or lived with them. 97,4% of women between 15-49 know where to get an HIV test in Mpumalanga Province and 2,6% tested, but never received their results.

Children

The 2012 national HIV survey estimated a prevalence of orphan-hood of 21.3% among children 0-18 years in Mpumalanga (16.9% nationally). According to CS 2016, Mpumalanga had a total number of 272 119 orphans, of which 162 288 were paternal orphans, 109 831 Maternal orphans and 33 760 were double orphans. Nationally the HIV prevalence among orphans was found to be higher compared to children that were not an orphan (6.2% versus 1.7%). There were 33,735 children on the foster care grant in 2016. Antenatal care from skilled service providers was found to be 91,7% in Mpumalanga Province with only 40,4% of live births protected against neonatal tetanus.

People living in informal settlements

In 2016, 135 039 households in the Province were living in informal dwellings, which is 10.9% of all households. Nationally, the HIV prevalence was 19.9% among those living in urban informal settlements and 13.4% among those in rural informal settlements. However, no province specific information is available.

People with disabilities

The Census 2016 found a disability prevalence of 7.5% in the Province, which would relate to about 325 000 people3. Nationally, the HIV prevalence among disabled people aged 15+ years was found to be 16.7% in 2012

With regards to disaggregation of persons with disabilities in the three districts in the province, Ehlanzeni has recorded the highest number (73 038) followed by Nkangala district at 67 661 and then Gert Sibande district at 64 581. However, when looking at the prevalence

[2] Statistics South Africa. Mid-year population estimates 2016. Statistical release P0302. Pretoria: Statistics South Africa, 2016.

Statistics South Africa. Community Survey 2016. Statistical Release P0301. Pretoria: Statistics South Africa, 2016.

The Profile of Persons with Disabilities in South Africa report compiled by Statistics South Africa in 2014 recorded a total number of 205 280 (7%) persons with disabilities in Mpumalanga. With regards to dis

of disabilities proportional to population size, Gert Sibande has the highest at 8.9%followed by Nkangala district (7.1%) and then Ehlanzeni district (5.8%) (refer to the table below).48a

Miners and long distance truck drivers
There were 103 000 mineworkers in 2014 (an increase from 53 500 in 2003), which represents 29% of national mine workers. The population of truck drivers is unknown, but they are thought to be an important driver of the HIV epidemic in Mpumalanga.

The N17 and other roads connecting Gert Sibande district to other districts and provinces, creates an opportunity for commercial sex work between unemployed women and long distance truck drivers. A study conducted in 2003/04 among 1900 long-distance truck drivers aged 18+ years in South Africa, found an HIV prevalence of 23.6% among 55 truck drivers currently living in Mpumalanga.

Priority Interventions

The packages of services being offered to vulnerable and key populations:

Orphans and Vulnerable Children
DSD, DoE and civil society organisations provides Service Delivery and Support for Families Caring for Orphans and Vulnerable Children.

Men Who Have Sex with Men
Project Boitato mobilises the MSM community of Gert Sibande through a multi-level approach to HIV risk reduction to improve HIV testing and treatment, condom and lubricant use, peer education (M-Groups) and distribute IEC Materials.

Miners, truck drivers
Workplace and community HIV prevention programmes in Mpumalanga Province and Masoyise has TB screening and HCT in mines.

Adolescent girls and young women & informal settlements
Rise Young Women's clubs in Nkangala are in the poorest areas, as well as high incidence areas. The curriculum that is covered includes gender inequality, and practical ways of helping each other in developing sustainable livelihoods, in supporting each other in preventing transactional sex, teenage pregnancy, and new HIV infections.

Inmates
The Department of Health has established formal partnership with the department of Correctional Services to offer comprehensive health care services including HIV, STIs and TB services to all inmates with the aim of improving the life expectancy of inmates during the period of incarceration.

Gender based violence
In a study in Nkangala District, 9% of pregnant women reported experiencing physical partner violence in the past 6 months. 26,4% of ever-partnered women 18 and older reported having experienced physical violence by any partner. These figures warrant a need for appropriate interventions to prevent and reduce GBV among women. Screening for GBV among pregnant women visiting antenatal health care facilities in South Africa may enable implementation of appropriate interventions among abused pregnant girls and women. A CSVR report highlights the lack of appropriate data on the incidence of Gender-Based Violence in South Africa.

Stigma
A 2014 Stigma index found that people living in Mpumalanga, the Free State and KwaZulu-Natal were more likely to experience external stigma than those in other provinces.

Section 6: The role of Provincial AIDS Council

The Provincial AIDS Council is a coordinating structure for a multisectoral response to HIV, STIs and TB in the province. This is highest body in the province to advise government. It contributes to an alliance building between various partners, building of members, building solidarity and thereby providing mutual encouragement, creating opportunities for cooperation and assessing progress made and identify problems areas and gaps in implementation.

The Provincial AIDS Council through its Secretariat will promote provincial-local intergovernmental relations in line with cooperative government principles enshrined in the South African constitution (Chapter 3). It will facilitate and advocate for the effective involvement of sectors and organizations in development of a Multisectoral District Implementation Plans, its implementation and monitoring at District and Local levels.

The Provincial AIDS Council will establish a Provincial Advisory Committee and Working Group on geospatial mapping to map high burden areas for both HIV and TB in the three districts in order to intensify targeted interventions at ward level. The Provincial AIDS Council will ensure that all sectors are supported to develop their sector specific plans.

The plans will be monitored through the District and Local AIDS Councils. Technical Task Teams will be established in all AIDS Councils to consolidate and verify all sector reports before they are presented to AIDS Council sitting for adoption. These Technical Task Teams will among others include the department of Health, Social Development, Education, Justice, Co- operative Governance and Traditional Affairs and Home affairs

The Provincial AIDS Council through its Secretariat will allocate managers to support each district in ensuring that the MDIPs are fully developed and implemented as planned. The findings on the geospatial mapping will be used to support the district to focus their attention and resources where they are needed the most. The Provincial AIDS Council will establish a Provincial Resource Mobilization Committee that will be chaired by Treasury. This committee will mobilize resources from all possible funders in and out of the province and allocate accordingly.

All funding proposal from Mpumalanga will be coordinated through the Resource Mobilization Committee before they are sent out to potential funders. The Provincial AIDS Council will ensure that Developmental Partners are allocated equitably to support the neediest communities to make maximum impact. This will be done through consultation with the relevant government departments and through Provincial Advisory Committee on geospatial mapping.

The Provincial AIDS Council will also establish working streams that will cover among others Prevention, Treatment Care and Support, Advocacy, Communication and Social Mobilization and Monitoring and Evaluation. These teams will meet quarterly to look at the progress made under each stream and recommend remedial action where there are challenges and underperformance.

SECTION 7: Provincial Implementation

GOAL 1: ACCELERATE PREVENTION TO REDUCE NEW HIV, TB AND STI INFECTIONS

Strategic Context

The NSP calls for a comprehensive and combination approach to prevention of HIV, TB and STIs in South Africa. HIV incidence rate in Mpumalanga and KwaZulu-Natal has been found to be the highest in the country. Although the data shows a decrease in incidence between 2011 (54 000), 2012 (44 000) and 2016 (26 320), there is more to do to ensure access to HTS and prevention methods such as PEP, PREP and TB preventive therapy. A strong focus will be placed on young women and girls between the ages of 15 – 24, which has been identified as the most at-risk population in dire need of intervention and support.

The province will address and meet this goal through information, education and communication (IEC). An attempt to address the structural and social drivers of the two epidemics will be put in place to change behaviour and reach underserved and vulnerable populations. Through education and information, citizens will be equipped with knowledge about HIV, TB and STIs and understand their risks.

The adoption of Operation Vuka Sisebente and the geospatial mapping will allow the province to use a multi-sectoral approach to addressing the key drivers of HIV, TB and STIs, and promote a combined effort between government departments to address biomedical and structural factors that drive HIV infection such as poverty, unemployment and inequality. There is a renewed commitment from government departments to scale up their health and wellness programmes and promotion of prevention, treatment and care programmes for their staff through internal mainstreaming programmes and campaigns.

This plan will assist the province to bring together government departments, civil society and the private sector to ensure a multi-sectoral approach in meeting the goals of the PIP. Progress will be monitored through performance on each of the set indicators per goal of the PIP. These indicators will be aligned to the provincial and national M&E framework of the NSP and PIP. Prevention of new HIV, STIs and TB infections remains at the centre of this PIP implementation.

Table with goal, objectives and activities

Table 2 - Goal 1: Table with Goal, Objectives and Activities

	GOAL 1: ACCELERATE PREVENTION TO REDUCE NEW HIV, TB AND STI'S INFECTIONS									
	Objective 1.1: Reducing new infections among youth from 1.2% to 0.7% and overall reducing new infections to below 100 000 by 2022									
	Sub-objective 1.1.1: Revitalize Information Education Communication (IEC) programmes in school, health, workplace and community settings									
Outputs		1. A revitalized IEC programs to reach all language and population groups as well as all people living with disabilities 2. Improved coverage of sensitive and age-appropriate Sexual and Reproductive Health services and Comprehensive Sexuality Education 3. Integrated and accessible combination prevention services at all health service points with focus on key and vulnerable populations 4. Access to Pre-Exposure Prophylaxis for all identified at-risk populations 5. Reduction of Mother to Child transmission of HIV to < 1.5 % and of congenital syphilis to 0%								
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Respo ble Secto
	Sub-objective 1.1.2: Implement targeted biomedical prevention services tailored to setting and population								
Educate leaners, educators, and parents/guardians/ care givers to use the B-Wise mobile website to access health information	Percentage of schools that are providing enhanced comprehensive sexuality education (CSE) life (National Indicator) (*national indicator*)	8	8	8	9	10	11	12	DOE
Routine provider-initiated facility and community HIV, STIs, TB screening for all populations and pregnancy screening of all females of child bearing age (All are *national indicator*)	Number of people tested for HIV	1 950 000	1 970 000	1 990 000	2 010 000	2 130 000	2 150 000	2 170 000	DOH
Implement targeted biomedical prevention services tailored to setting and population	MTCT rate at 10 weeks	1,6	1,5	1,4	1,3%	1,0%	0,8%	0,5%	DOH
	MTCT rate at 18 months	5%	4%	3%	2%	1,5%	1,0	0,5%	
	Number of health facilities accredited as AYF	2	6	12	18	24	30	36	

	Couple year protection rate	45%	55%	60%	65%	65%	65%	65%	
			(56622/ 102950)	(62548/ 104247)	(68588 /105519)	(68588/ 105519)	(68588/ 105519)	68588/ 105519)	
Sub-objective 1.1.3: Provide targeted services to reduce Mother to Child transmission of HIV and syphilis in the prenatal and postnatal period									
Mobilize multi-sectoral collaboration to improve early ANC bookings before 20 weeks	Number of ANC early bookings before 20 weeks	70%	72%	74%	75%	76%	78%	80%	DOH
			5408	54437	54793	55149	55505	56120	
Strengthen and monitor early infant diagnosis of HIV uptake and positivity rate, especially at 10 weeks and 18 months to detect mother to child transmission of HIV due to breastfeeding	Number of ANC HIV 1st test positive	19518	15329	13110	10687	8750	7175	6525	
	Number ANC clients initiated on ART	18727	14320	12820	10820	8820	7820	6343	
	Number of HIV exposed infants tested with PCR at 10 weeks	18177	15066	13504	12504	11504	10504	9504	
	Number of 1st PCR test positive around 10 weeks	289	226	190	163	115	94	78	DOH
Sub-objective 1.1.4: Provide sensitive and age-appropriate sexual and reproductive health services (SRH) and comprehensive sexuality education (CSE)									
Upscaling of coverage of the School Health Program to 100% to ensure access of scholars to prevention services	Number of grade 8 learners provided with SRHR and CSE	12522	17192	21490	25788	25788	26268	26268	DOH
Conduct youth dialogues targeting girls aged 15 – 24 years	Number of people reached	No baseline	500	700	1200	1700	2200	2700	
Conduct HTS campaigns for students in TVET colleges and Universities	Number of students in TVET and Universities reached through HTS campaigns	No baseline	500	800	1300	1600	1800	2000	
Provide school based events targeting tuberculosis	Number of advocacy and social mobilisation events including Tuberculosis	41 174	-	42 470	44 593	47 182	49 541	50245	DOE
Provide training to both educators and officials on CSE	Number of educators and officials trained on CSE	2 300	-	3 000	3150	3307	3472	35308	
Ensure that learners are the primary beneficiaries of the CSE services to retain them in school	Number of learners benefitting through the care and support programme (retention of learners in school; peer education)	2 300	-	24 500	25725	26 561	27889	28767	
Ensure that learners and educators are provided with support materials	Number of learner and teacher support materials distributed	5 300	-	8 300	8715	9150	10020	10 985	

on CSE									
	Sub-objective 1.1.5 Integrated and accessible combination prevention services at all health service points with focus on key and vulnerable populations								
Conduct community awareness campaigns and dialogues targeting high burden communities (e.g. High Transmission Areas) and key and vulnerable specific populations.	Number of community awareness campaign conducted on prevention	306	340	374	411	452	495		DOH
	Number of community conversations on HIV and AIDS responses	32	18	18	18	18	18	19	Civil Society
	Number community dialogues conducted	106	126	140	154	170	190	210	DOH
	Number of people reached through mobilization programmes	9 400	9 400	9 400	9 400	9 400	9 400	9400	
	Number of awareness campaigns on Health and Wellness Programme	27	27	27	27	27	27	27	
	Number of community dialogues conducted	106	126	140	154	170	190	210	
	Teenage pregnancy rate	7.7%	<6%	<5%	<4%	<3%	<3%	<2%	DOH
Re-engineer MMC demand creation by marketing of VMMC service and General Practitioners for provision of services	Number of public health facilities offering VMMC	64	70	75	80	85	85	85	
	Number of males of all ages who are circumcised under medical supervision	85 084 (204,405 cumulative)	79 007	72 929	66 852	60 852	60 852	60 852	
Train Traditional surgeons on Safe Traditional Male Initiation	Number of Traditional surgeons trained on Safe Traditional Male Initiation	-	45	60	60	60	60	60	DOH
Conduct comprehensive health screening of all prospective Initiates of the TMI	Number of initiates comprehensively screened	-	30 000	10 000	10 000	10 000	25 000	30 000	
Screen and issue certificate of compliance to Ingoma Schools	Number of certificates issued to compliant Ingoma schools	25	50	40	40	40	50	60	
	Objective 1.2: Significantly reduce T. Palladium gonorrhoea, syphilis and chlamydia infections to achieve the virtual elimination of congenital syphilis and maintain high coverage of HPV vaccination								
	Sub objective 1.2.1: Scale up and maintain high levels of HPV vaccination in 9 to 13 year target age group								
Outputs		1. Targeted HPV vaccine coverage of at least 95% among young girls aged 9-12 years 2. STI screening rate of 100% integrated into routine HIV/TB services as health screening package at all health facilities. 3. STI syndromic management algorithm implementation rate of 100% at all health facilities 4. Male and female condoms distributed to all sexually active males and females							

Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Respons e Sectors
Increase HPV coverage to reach at least 95% young girls aged 9-12 years	100% HPV Coverage	80%	85%	88%	90%	92%	94%	96%	DOH
Re-engineered advocacy, communication and social mobilization to increase uptake of HPV vaccines, female condoms and medical male circumcision	Percentage of HPV 1st dose coverage	80%	85%	88%	90%	92%	94%	96%	DOH
	Percentage of HPV 2nd dose coverage	80%	85%	88%	90%	92%	94%	96%	
	Percentage of cervical cancer screening coverage to women	70%	65%	75%	80%	80%	80%	80%	
			(609010/936932)	(724820/966431)	(796780/995971)	(796780/995971)	(796780/995971)	796780/995971)	
Increase access and distribution of female and male condoms at all distribution points, all the time	Number of Male condoms distributed from various sites	57 178 214	71 009 095	72 429 277	73 877 863	73 877 863	73 877 863	73 877 863	
	Number of Female condoms distributed from various sites.	1 315 607	3 737 321	3 812 067	3 888 209	3 908 222	3 908 222	3 908 222	
Sub objective 1.2.2:Scale up STI prevention by providing high quality health information and timely health services for persons at risk									
Upscale Male Urethritis Syndromic management and track performance.	Male Urethritis Syndrome treated - new episode	16 111	19 004	19 384	18 997	18 618	18 246	17 687	DOH
Train and mentor health workers to improve comprehensive STI screening, diagnosis, and proper management	Syphilis in pregnant female rate(sentinel sites)	4.1% From 2011 ANC survey	3%	3%	3%	2%	2%	2%	
1.2.3. Increase access to and provision of health services post exposure to HIV infections and other blood borne infections.									
Provide comprehensive medical services including PEP to survivors	Number of new sexual assault cases reported for medical intervention	3,502	4500	4800	5100	5400	5700	6000	DOH

of sexual assault to prevent HIV and other STI's infections	Number of new sexual assault cases provided with PEP	2 464	4500	4800	5100	5400	5700	6000	
Provide targeted and high-impact interventions including PEP for health care workers after occupational exposure to HIV and blood borne infections	Number of cases of occupational exposure to injuries seen	252	260	270	280	290	300	310	DOH
	Number of cases of occupational exposure to injuries provided with PEP	241	260	270	280	290	300	310	
	Objective 1.3 : Reduce TB incidence by at least 30% from 834/100 000 in 2017 to less than 584/100 000 by 2022								
Outputs		1 PHC TB screening rate of 100% at all health facilities 2 TB screening and diagnostic algorithm compliance in 100% of all health facilities 3.Isoniazid Preventative Therapy and Co-trimaxazole rate of 100% for eligible population 4. Increased Provincial coverage of Xpert MTB/RIF as the first-line diagnostic tool for TB cases							
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Respons e Sector
	Sub objective 1.3 Active TB case finding - increase TB screening among adult clinic attendees, including PLHIV and persons presenting with T symptoms								
Intensify TB Case Finding among all age groups including neonates and infants	Percentage of clients routine symptom screening for TB in health facilities	70 % screened for TB	90 %	90 %	90 %	100 %	100 %	100%	DOH
	TB symptom 5 years and older screened in facility rate	47.3%	70%	80%	90%	90%	90%	100%	
	TB suspect sputum test rate	95.2%	90%	90%	90%	90%	90%	95%	
	TB suspect smear positive rate	7.9%	(2 – 10%) <8	(2 – 10%) <8	(2 – 10%) <7	(2 – 10%) <7	(2 – 10%) <6	(2 – 10%) <5	
	Sub objective 1.3 B Improve case finding for neonatal and paediatric TB								
Provide support to Health Care workers to ensure 100% IPT and CPT uptake by eligible clients	TB symptom 5 years and older screened in facility rate	47.3%	70%	80%	90%	90%	90%	100%	DOH

	TB suspect 5 years and older test positive	7 703	7000	6300	5670	5103	4592	4120	
Sub objective 1.3 C Increased Provincial coverage of Xpert MTB/RIF as the first-line diagnostic tool for TB cases									
Undertake culture test for HIV+, Xpert-negative cases	Percentage of HIV+, Xpert-negative cases receive culture test	80%	90%	90%	90%	90%	90%	90%	DOH
	TB/HIV co-infected client on ART rate	100%	100%	100%	100%	100%	100%	100%	

Comprehensive package of services

Table 3 - Comprehensive package of services for general population

Comprehensive package of services for the general population, that will then be supplemented and customised to the age and population served
• Accessible, friendly, comprehensive service delivery and health education, customised to client needs • HIV screening, testing, treatment • STI screening, testing, treatment • TB screening, testing, treatment and contact tracing for DS- and DR-TB • Medical male circumcision, referral • Comprehensive SRH services (including: cervical cancer screening, Pap smears, access to emergency contraception, choice of termination of pregnancy) • Prevention of mother-to-child transmission (PMTCT) of HIV • Mental health screening and psychosocial support • Access to PEP and post-sexual assault support • Alcohol and drug-use screening, referral • Violence screening, referral • Condom promotion and provision • Targeted social and behaviour change communication

Table 4 - Comprehensive package of services targeted at specific population

Population	Services/Interventions/Approaches	Setting	Accountable parties
Children	• Child abuse screening • Age-appropriate HIV testing, treatment, adherence support • Support for disclosure of HIV status • HIV testing of household adult or adolescent index client • Contact tracing from adult, adolescent TB cases • Sputum induction for TB testing • Update hospital admission requirements for DR-TB treatment • Comprehensive sexuality education: Sexuality, puberty education, gender and empowerment, GBV, reproductive health, contraception, alcohol and drug use prevention, decision-making, self-esteem	• Health facility-based • School-based • Community-based • Mobile services	• DBE, DSD, DOH
PLHIV (adults, adolescents)	• Hearing and vision screening, referral, treatment • Partner HIV testing, disclosure support, treatment, adherence support • Hepatitis B and HPV vaccine where eligible • PMTCT and enhanced adherence support through pre- and post-natal period, including breastfeeding • Gender norms • Health and health rights literacy • Economic empowerment and health promotion • School retention • Accelerated nutritional and social grant support, if indicated • Targeted demand creation for services • Targeted, PLHIV-friendly IEC materials and SBCC, including social media and materials for those with vision and hearing impairment • Service delivery points in community, non-traditional	• Health facility-based • School-based • Community-based • Mobile services	• DBE, DSD, DOH

Population	Services/Interventions/Approaches	Setting	Accountable parties
	settings		
Persons with TB (adults, adolescents)	• TB contact tracing, testing and post-exposure management • Partner HIV testing, disclosure support, treatment, adherence support • Enhanced health education about HIV/TB co-infection, reinfection • Hearing and vision screening, referral, treatment • Hepatitis B and HPV vaccine where eligible • PMTCT and enhanced adherence support through pre- and post-natal period, including breastfeeding, if indicated • Mental health screening • Gender norms education • Health and health rights literacy • Economic empowerment and health promotion • School retention • Accelerated nutritional and social grant support, if indicated • Targeted, TB-friendly IEC materials and SBCC, including social media and materials for those with vision and hearing impairment • Service delivery and treatment delivery points in community, non-traditional settings	• Clinic-based • School-based • Community-based • Mobile services	• DBE, DOE, DSD, DOH
Discordant couples	• Partner HIV testing, disclosure support, treatment, adherence support • Hepatitis B and HPV vaccine where eligible • PMTCT and enhanced adherence support through pre- and post-natal period, including breastfeeding if pregnant and HIV-positive • Gender norms • Health and health rights literacy • Economic empowerment and health promotion	• Clinic-based • Community-based • Mobile services	• DSD, DOH

Population	Services/Interventions/Approaches	Setting	Accountable parties
	• Accelerated nutritional and social grant support, if indicated • Targeted demand creation for services		

GOAL 2: REDUCE MORBIDITY AND MORTALITY BY PROVIDING TREATMENT, CARE AND ADHERENCE SUPPORT TO ALL

Strategic Context

The mid-term review report found that the province was on track with progress to reduce mortality and morbidity of this strategic goal. The provincial challenges to address mortality and morbidity were largely linked to inaccessible TB treatment services due to drug stock outs, inadequate care provision and poor adherence models. These, in combination, caused high defaulting rates, increased levels of stigma and the sub-optimal management of TB patients' treatment, care and support led to the increase of MDR-TB.

During the previous strategic cycles, the province achieved timely enrolment of HIV positive clients onto ART and continued efforts to sustain treatment through a focus on adherence clubs and I-ACT strategies. With the successful implementation of Tier.net, the province has been able to improve its reporting mechanisms which led to better informed decision making and efficient allocation of resources that improve access to services and service uptake.

The high incidence of MDR-TB (8.6% of TB cases are Rifampicin resistant) is due to a high defaulting rate of TB treatment and subsequently affects the mortality rate of the province due to sub-optimal management of TB patients. Children below 15 years old have also been found to be missed and not enrolled onto TB treatment, retained into care nor provided with psychosocial support. Recommendations from the midterm review to achieve this goal were to improve the indicators that will allow a more streamlined process to monitor progress towards the strategic objective and to identify and target specific populations and community sites for TB programme implementation.

Efforts will be extended during this cycle to intensify TB case findings and get patients who test positive on treatment. The initiation of patients who are ready onto ART and the provision of psychosocial support to children and adolescents will be prioritised. Strategies informed by evidence will be used to improve retention into care and adherence of those on treatment, which will be complimented by sufficient and adequately allocated resourcing models. A key emphasis will be the alignment with the National Adherence Guidelines for Chronic Diseases and improved linages to HIV and TB care through strengthened patient tracking systems.

Strategic Approach

- The province is committed to the 90-90-90 goals of UNAIDS and, in harmony with SANAC, will apply this approach to its HIV, TB and STI programmes. In order to reach these goals, the province is introducing enhanced record keeping methods through a unique patient identifier for better tracking and monitoring of clients. Doing so will ensure a multi-sectoral approach to the management and service provision of HIV, TB and STI treatment and care programmes across sectors. Integrating TB screenings into HTS at service delivery level and expanding access through routine checks will ensure alignment of this strategy to the Road to Health Chart.
- Providing uninterrupted and continuous modes of care and treatment will address the high defaulting rate of ART and IPT clients. Clients can be initiated on treatment as soon as they are ready by ensuring that facilities do not experience stock-outs. Training and improving the capacity of WBOTS, CBOs and NGOs to retain clients on

ART after 12 months, monitoring drug stock-outs and being trained on adherence guidelines is essential to reduce mortality and drug resistance. Technical assistance to address stigma related to HTS will be provided to implementing partners to increase uptake of HTS and treatment services. Using M-health platforms that links to households (using the King Cetshayo Path in KZN as a benchmark) will ensure an effective method of information dissemination.

- To ensure that 90% of HIV positive patients are on a sustainable regimen of ART by ensuring no stock-outs at facilities (adherence to ART guidelines from National Department of Health) leading to quick initiation within two weeks if clients are ready for treatment. Other actions include training of WBOTS, CBOs and NGOs, retaining more than 90% of ART clients in care at/after 12 months and utilising an integrated Tier.net-ETR.net system for increased tracking and tracing of HIV, STs and TB positive clients for management. Also significant is monitoring drug stock outs to ensure uninterrupted ART drug supply for first, second and third line drugs; through M-health improve clients' adherence to treatment and link households [benchmark from King Cetshayo Path in KZN].
- The final 90% of the goal is to ensure that 90% of people who receive ART are virally suppressed through improved viral load monitoring mechanisms that will be deployed at district level by reporting on targets and promoting retention in care for PLHIV on ART through a fast track rollout of differentiated care models;
- Apply 90-90-90 for TB to reduce morbidity and mortality through easy access to treatment, care and support for all
    - Testing for TB will be intensified at facility level to amplify TB case findings in high burden areas such as mines, correctional services, mining communities, etc. A provincial drive to promote household symptom screening and the use of a combination of Xpert MTB/RIF and culture tests will be initiated. WBOTS will be used to initiate TB positive clients on IPT and track and trace TB contacts.
    - Treating TB with appropriate treatment regimes, especially targeted at key populations (pulmonary and DR-TB) through better coordination of TB management at all TB treatment sites (including private sector sites) will further increase TB treatment services.
    - To ensure treatment success rate, a key focus will be placed on monitoring TB drug availability at facility level and reducing lost-to-follow-ups, improving referral services and network directories and providing sufficient training to health care workers.

Table with goal, objectives and activities

Table 5 - Goal 2: Table with Goal, Objectives and Activities

	GOAL 2: REDUCE MORBIDITY AND MORTALITY BY PROVIDING EASY ACCESS TO TREATMENT CARE AND ADHERENCE SUPPORT FO ALL								
	Objective 2.1: implement the 90-90-90 strategy for HIV								
	Sub-objective 2.1.1: 90% of all people living with HIV know their HIV status								
Outputs		1. Unique patient identifier rolled out at 100% of the health facilities 2. Increased access to HTS 3. Reduced stigmatisation of children, adolescent girls/young women and other key populations at HTS service point 4. HIV status of every infant and child known and recorded in Road To Health Chart							
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sect
Expand health screening services through diversified approached and services i.e.: Provider-initiated routine and concurrent HIV, TB and STI screening and testing and increase access to underserved populations and high burden areas.	Number of HIV test client **15 years – 49 years** (excluding antenatal clients)	736 087	737007	622 307	622 307	622 307	622 307	622 307	DOH
	Number of HIV **test positive client 15 years – 49 years** (excluding antenatal clients)	80 439	79 233	78 045	76 875	75 722	74587	73 278	
	Total number of HIV **test clients excluding ANC**	756 892	777 884	777 884	777 884	777 884	777 884	777 884	
	Total number of HIV **test positive clients excluding ANC**	90 846	89 484	88 142	86 820	85 518	84 236	83014	
	Sub-objective 2.1.2: 90% of all people diagnosed with HIV infection receive sustained antiretroviral therapy								
Outputs		1. 100% of the facilities have Zero ARVs stock outs 2. More than 90% of ART clients retained in care at 12 months 3. Integrated Tier.net-ETR.net							
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sect
Ensure adherence to ART national guidelines on ART initiation, HIV, STI's and TB management to improve linkage to care and quick initiation on ART for all HIV positive people within two weeks and when they are ready for treatment.	TB/HIV co-infected clients on ART rate	100%	90% (13186/ 14651)	93% (13625/ 14651)	95% (13918/ 14651)	95% (13918 / 14651	100%	100%	DOH
	Naïve adults who started life-long ART	70 364	63 551	57 196	51 476	51 476	51 476	51 476	
	Naïve children under 15 years who started life-long ART	2 694	3 722	3 349	3 015	3 015	3 015	3 015	

	Total number clients new (adults & children) started on ART	73 058	67 272	60 545	54 491	54 476	54 476	54 476	
	People living with HIV viral load suppressed rate (VLS) at 6 months	80%	90%	90%	90%	90%	90%	90%	
	Number of children under 15 years remaining on ART at the end of the month	16 982	26 147	29 250	32 043	35 058	38 073	41068	
	Number of adults remaining on ART at the end of the month	316 023	428 835	479 736	525 547	580 033	634 509	688 985	
	Total number clients remaining on ART (adults & children)	318 232	454 982	508 986	557 590	557 590	557 590	557 590	
	Percentage of adults and children living with HIV known to be on ART 6 months after starting (Retention)	90%	90%	90%	90%	90%	90%	90%	
	Adult with HIV known to be on ART 6 months after starting (Retention)	74,9%	90%	90%	90%	90%	90%	90%	
	Child under 15 years with HIV known to be on ART 6 months after starting (Retention)	72,4%	90%	90%	90%	90%	90%	90%	
Upscale linkage of clients to care and support services and conduct follow-up care for the differentiated service delivered	Number of beneficiaries of adherence clubs / groups (I ACT) established for linkage to psychological support services	76 664	115 179	115 179	115 179	115 179	115 179	120 268	DOH
Sub-objective 2.1.3: 90% of all people receiving antiretroviral therapy are virally suppressed									
Outputs		1. More than 90% of Clients on ART are virally suppressed 2. More than 75% of stable ART clients receiving their ART through a differentiated ART delivery model							
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sect
Improve viral load monitoring through systems strengthening e.g. District Implementation Plan with targets set for reporting)	Adult with HIV viral load suppressed rate (VLS) at 6 months *(national indicator)*	88,4%	90%	90%	90%	90%	90%	90%	DOH
	Child under 15 year with HIV viral load suppressed rate (VLS) at 6 months *(national indicator)*	63,7% DOH	90%	90%	90%	90%	90%	90%	

	Goal 2: Reduce morbidity and mortality by providing easy access to treatment care and adherence support for all								
	Objective 2.2: Implement the 90-90-90 strategy for TB								
	Sub-objective 2.2.1: Find 90% of all TB cases and place them on appropriate treatment								
Outputs		1. More than 90% of TB suspects tested for TB 2. 100% of contacts of TB clients tested for TB							
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Intensify facility-level TB case-finding for all clients during consultation in health facilities and increase access in high burden areas (mines, mining community, correctional services, etc.).	TB client treatment initiation rate	100%	100%	100%	100%	100%	100%	100%	DOH
	Percentage of clients done routine symptom screening for TB in health facilities	47.3%	100%	100%	100%	100%	100%	100%	
Reduce initial loss to follow up for PTB and DR - TB cases on TB treatment by using WHBOTS	TB clients loss to follow up (defaulter) rate	5.4% (2015)	<5%	<5%	<5%	<5%	<5%	<5%	
	TB client death rate	4.7% (2015)	<5%	<5%	<5%	<5%	<5%	<5%	
	MDR-TB death rate	27.6%	16%	15%	14%	13%	12%	10%	
	Sub-objective 2.2.3: Treat successfully at least 90% of those diagnosed with TB (and 75% of those with DR TB)								
Outputs		1. All diagnosed TB patients commenced on treatment. 2. Integrated TB reporting by all TB treatment sites.							
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Ensure that 90% of Pulmonary TB confirmed cases are put on appropriate treatment with special focus on key and vulnerable population	Number of TB patients registered	15 921 (2016) All TB	15 500	15 000	14 500	14 000	13 500	13 000	DoH
	TB clients 5 years and older start on treatment rate	No baseline	70% (7000/10000)	80% (8000/10000)	90% (9000/10000)	90% (9000/10000)	90% (9000/10000)	90% (9000/10000)	
Co-ordinate TB management at all TB treatment sites	Number of DCS sites reporting on TB Treatment	3	3	3	3	3	3	3	
Ensure a 90% treatment success rate for	Improved TB Cure rate	85%	81%	82%	85%	85%	85%	90%	DOH

drug-sensitive (and at least a 65% treatment success rate for multi-drug resistant TB			(17458/21554)	(17674/21554)	(18320/21554)	(18320/21554)	18320/21554)	18320/24135)	
	TB client treatment success rate	>85%	87% (18752/21554)	89% (19183/21554)	90% (19399/21554)	90% (19399/21554)	90%	90%	
	TB MDR treatment success rate	58%	60% (694/1157)	62% (732/1182)	65% (781/1202)	65% (781/1202)	65% (781/1202)	65% (781/1202)	

GOAL 3: REACH ALL KEY AND VULNERABLE POPULATIONS WITH CUSTOMISED AND TARGETED INTERVENTIONS

Strategic Context

The NSP places special emphasis, and has a dedicated goal to address the health needs of key and vulnerable populations. It is essential to increase the access, support services and treatment options available to these high-at-risk populations and provide them with services that are sensitive to their needs, circumstances and underpinned social and human rights standards that supplement international and national efforts. The Province will use research and literature available on key and vulnerable population intervention targeting, size estimation and needs assessments to ensure that their activities align with the national policy directives such as the Sex Worker Strategy for HIV 2016–2020, the draft South African National LGBTI Framework for 2017–2022; and the NDoH Guidelines for the Management of HIV, TB and STIs in Correctional Facilities.

The large-scale programmes are supplemented by smaller programmes, which are tailored to address the specific needs of vulnerable groups. These programmes will be implemented in stages, starting with high-burden districts. Programmes are currently being developed to address the needs of men who have sex with men (MSM), sex workers, people who inject drugs (PWID), inmates, and adolescent girls and young women (AGYW). Certain social and structural factors that increase vulnerability among these groups must be strengthened for sustainability. Efforts to address these factors are described in Goal 4.

Strategic Approach

In order to provide specific support to key and vulnerable populations, specific strategies and accompanying packages tailored to their needs will be implemented. These strategies are described in table 9.3.3. To substantially reduce new infections, and the morbidity and mortality associated with HIV, TB and STIs among key and vulnerable populations, Mpumalanga will implement the following interventions in during the period 2017–2022:

Tailor health and social services and the mode of delivery. Tailored health service, social services and mode of delivery are vital in order to adequately address the needs of the target populations. In order to achieve this strategic objective, all provincial, district and local AIDS Councils will include at least one representative from a key and vulnerable population group. In order to understand the needs and make-up of the population, it will be important to map the provincial specific sector inclusions for key and vulnerable populations, significant actions include increasing the number of facilities providing specific key population friendly services and providing services to key populations in optimal times and locations. Other anticipated actions include the provision of mobile services with safety and health packs distributed to sex worker focussed service delivery sites.

Sensitise providers to address the needs of key and vulnerable populations. In order to sensitise providers to address the needs of key and vulnerable populations, rights-based components will be integrated in all health and integrate rights-based components in all social programmes to holistically serve key and vulnerable population clients and patients. Key activities include the provision of sensitisation workshops on sexual diversity to health care workers and SAPS in tandem with the provision of sensitization workshop, human right defence trainings for key and vulnerable populations.

Multi-sectoral engagement. Coordination between sectors and multi-sectoral engagements ensures that the needs of vulnerable and key populations are addressed in a holistic manner. The appointment of sector specific representatives for key and vulnerable populations at all levels of AIDS Council will ensure that the needs and voices of vulnerable populations are included in planning and implementation. In addition, provincial specific sectors will be established and supported to develop implementation plans.

Engage communities in the development and implementation of social and health support activities and build robust household and community capacity, engagement and inclusion: As these populations have specific needs and concerns, it is important to engage communities in the development and implementation of social and health support activities. Key actions include the adaptation of the national advocacy strategy for key and vulnerable populations on equal health and human rights. It will be critical to ensure that seasonal workers and contractors in farming communities are included in wellness, HIV, STI and TB programmes. Community networks will be leveraged to support key and vulnerable populations to build their capacity to advocate for equal health and human rights.

Provide peers with skills and education to involve peers in life skills empowerment programmes. Key and vulnerable population programmes should adopt a peer-led approach to implementation, as evidence shows that peer-led approaches support the specific needs of vulnerable populations. Strategic actions include rolling out the Focus for Impact Approach (mapping the key and vulnerable populations, their identified peers and the status of their peer programmes) and monitoring the development and implementation of the peer programmes. In order to build capacity in community structures for key and vulnerable populations to advocate for equal health and human rights**,** key and vulnerable population service providers will be provided with IEC materials and training and sexual history recordings. This will be provided in tandem with on-going capacity buildings and training of all healthcare, social development staff.

Eliminate stigma, discrimination and punitive laws that burden key and vulnerable populations Key and vulnerable populations are often highly marginalised, which diminishes their access to health information and deters them. The Mpumalanga Province will take action to implement validated anti-stigma initiatives, including broad and localised anti-stigma communications campaigns. Access to services will be monitored to identify any inequities or bottlenecks as they occur, and greater attention to implementation will help in improving service access. This is complemented by the interventions described in Goal 5, where there is a focus on monitoring the implementation of laws and policies, and identifying areas of improvement that influence key and vulnerable populations' access to services.

Strengthen strategic information for action on key and vulnerable populations. The provision of strategic health information greatly strengthens the Province's ability to provide tailored services to vulnerable and key populations. Over this strategic cycle, the Province will strengthen efforts to collect and promulgate strategic information. Specific actions include screening all inmates for TB, routine screening of all mine workers through occupational health services, tracking and tracing contacts of all HIV and TB clients diagnosed from above activities.

Conduct dialogues and awareness campaigns in the community and healthcare facilities. In order to fight stigma and ensure that vulnerable populations are aware of their

rights and health needs, rights-based components will be integrated into all health and social programmes. This will enable the Province to holistically serve key and vulnerable population clients and patients

Table with goal, objectives and activities

Table 6 - Goal 3: Table with Goal, Objectives and Activities

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									
Sub-objective 3.1.1: All provincial, district and local AIDS Councils will include at least one representative from a key and vulnerable population group									
Outputs	1. Improved awareness and sensitisation of service provision for key and vulnerable populations 2. Empowerment of key and vulnerable populations 3. Improved capacity through education and coordination of activities amongst implementing partners 4. Sustainability of developmental programmes which are donor funded								
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Appoint sector specific representatives for key and vulnerable populations at all levels of AIDS Councils	Proportion of representatives appointed to Provincial AIDS Council	1%	40%	70%	100%	100%	100%	100%	Sector Organisations
	Proportion of representatives appointed to District AIDS Council	10%	60%	80%	100%	100%	100%	100%	MPAC, DAC and NGO's
	Proportion of representatives appointed to Local AIDS Council	40%	70%	90%	100%	100%	100%	100%	DAC and NGO's
Sub-objective 3.1.2: Support key and vulnerable population to build their capacity to advocate for equal health and human rights through community networks.									
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Build capacity in community structures for key and vulnerable populations to advocate for equal health and human	Number of farm workers trained on advocacy for equal health and human	No baseline	40%	50%	70	90%	100%	100%	SAHRC, NGO's and Developmental

rights	rights								Partners
Sub-objective 3.1.3: All key and vulnerable population programmes should adopt a peer-led approach to implementation.									
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Roll out the Focus for Impact Approach (mapping the key and vulnerable populations, their identified peers and the status of their peer programmes)	Number of municipalities implementing Focus for Impact Approach	No Baseline	20%	30%	45%	70%	90%	100%	SALGA
Provide peers with skills and education to involve peers in life skills empowerment programmes	Number of candidates reached on life skills empowerment programmes	No Baseline	30%	50%	70%	80%	100%	100%	DOE
Monitor the development and implementation of the peer programmes	Number of peer education sessions on life skills empowerment conducted	No Baseline	20%	40%	70%	90%	100%	100%	DOE
Objective 3.2: To provide an enabling environment to increase access to health services by key and vulnerable populations									
Sub-objective 3.2.1: Enable increased access to tailored health services through differentiated service delivery approaches that are tailored for the populations served.									
Outputs	1. Building capacities of communities to improve inclusion and participation of health support activities 2. Providing communities with culturally appropriate leadership and sensitisation training 3. Create a Cadre of Risk Reduction Ambassadors								
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Increase the number of facilities accredited to providing service to specific key population friendly services Provide services to key populations in	Percentage (numbers) of specific key and vulnerable populations living with HIV who know their HIV status (1st 90) (*National Indicator)*	No baseline	30%	40%	50%	80%	100%	100%	DOH

optimal times and locations	Percentage (numbers) of specific key and vulnerable populations living with HIV receiving ART (2nd 90) *(National Indicator)*	No baseline	30%	40%	50%	80%	100%	100%	
	Percentage of specific key and vulnerable populations living with HIV who have suppressed viral loads (3rd 90) *(National Indicator)*	No baseline	30%	40%	50%	80%	100%	100%	
	Number of facilities providing key and vulnerable populations friendly services	39	49	59	69	79	89	99	
Screen all inmates for TB	Percentage of inmates screened for TB at different time points *(National Indicator)*	No baseline	20%	60%	70%	80%	100%	100%	
	Percentage of controlled mines providing routine TB screening at least once a year *(National Indicator) (Not sure if this is available at a Provincial level?) NO*	No baseline	30%	50%	70%	90%	100%	100%	DCS
Track and trace contacts of all HIV and TB clients diagnosed from above activities	Percentage of positive clients with contacts traced	20%	40	50	70	80	90	100	DOH
Provision of mobile services with safety and health packs distributed to sex worker focussed service delivery sites	Number of safety and health packages distributed to sex worker sites	10%	40%	50%	70%	90%	100%	100%	
Conduct dialogues and awareness campaigns in the community and healthcare facilities	Number of dialogues and awareness campaigns conducted in the community and healthcare facilities	250 (2016)	300	>300	>300	>300	>300	>300	
Sub-objective 3.2.2: Enable increased access to health information and social and behaviour change communication interventions									
Key Activities	Indicator	Baseline	Target	Target	Target	Target	Target	Target	Responsible

		(2016)	2017	2018	2019	2020	2021	2022	Sectors
Provide key and vulnerable population service providers with IEC materials and training on sexual history recordings	Number of service providers provided with IEC materials and training on sexual history recordings	No baseline	10%	30%	40%	60%	80%	100%	DOH; Implementing Partners and NGO's
Sub-objective 3.2.3: Further train and sensitise all service providers in the identification and delivery of appropriate services for key and vulnerable populations									
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
On-going capacity buildings and training of all healthcare, social development staff on identification and delivery of appropriate services for key and vulnerable populations	Number of officials trained per department	5%	30%	50%	70%	90%	100%	100%	Implementing Partners and DOH
Sub-objective 3.2.4: Provide psychosocial support services and safe spaces for key and vulnerable populations who experience internalized stigma									
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Sub-objective 3.2.5: Integrate rights-based components in all health and social programmes to holistically serve key and vulnerable population clients and patients									
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Provide sensitisation workshops on sexual diversity to health care workers and SAPS	Number of health care workers trained on medical ethics and human rights for key and vulnerable population clients	No baseline	30%	40%	60%	70%	90%	100%	DOH
	Number of SAPS members trained on SAPS ethics and human rights for key and vulnerable population clients	10%	60%	80%	90%	100%	100%	100%	SAPS
Sensitization workshop, human right	Number of defence force	5%	30%	40%	60%	70%	90%	100%	SANDF

defence trainings for key and vulnerable populations	members trained on SANDF ethics and human rights for key and vulnerable population clients								

Population-specific additions to the inclusive package of services described above are as follows:

Table 7:Special interventions that are specific to each population

HIV Key Population	Services
Inmates (also a key population for TB)	• Lubricants and condom options • PrEP • PEP • Integrated HIV, TB and STI prevention and treatment services • Entry, exit and biannual TB screening and regular offer to HIV testing • Detention and home contact-tracing for persons diagnosed or exposed to TB • Support groups for inmates living with HIV and TB • Peer education and support for HIV and TB programmes
Men who have sex with men	• Peer-led outreach • PrEP • Lubricant and condom options • Hepatitis B screening and immunisation • Rectal care and treatment
People who use drugs, including people who inject drugs	• Peer-led outreach • Harm reduction counselling • Linkage to rehabilitation centres • Case management to ensure a continuum of care • Needle and syringe programmes • Opioid substitution therapy • Accelerated nutritional and social grant support, if indicated • Hepatitis B screening and immunisations • Hepatitis C screening and treatment when policy is developed
Sex Workers	• Peer-led outreach • PrEP • Female and male condoms and lubricant • Intensified psychosocial support • Periodic presumptive treatment for STIs • Social mobilisation, use of formal/informal peer networks to create demand

HIV Key Population	Services
	• PMTCT • Hepatitis B screening and immunisations • Annual Pap smears • CTOP (choice of termination of pregnancy) • Screening for and protection from the sexual exploitation of children • Community empowerment
Transgendered persons	• Peer-led outreach • Specialised counselling support • PrEP • Female condoms and lubricant • Rectal car and treatment
Children <5 years	• Household TB and HIV screening, immediate linkage to treatment • Improved diagnostic and treatment capacity for paediatric TB • Promote activism for child-friendly TB formulations and introduce as soon as they are available • Improve sputum induction at PHC and hospital • Screening for and protection from the sexual exploitation of children
Healthcare workers	• Finalise and implement guidelines for TB • Institute regular TB screenings and offer HIV testing for all HCWs • Offer TB preventive therapy to all HCWs who are living with HIV • Develop a recoding and reporting system for TB and DR-TB in HCWs • Appoint a DOH-led task force to monitor implementation and further elucidate the effort-effect ration of screening all HCWs annually with symptoms screening and CXR, and to investigate the role of preventive therapy for HCWs • Implement the FAST model in facilities (finding cases actively by cough surveillance and rapid molecular sputum testing, separating safely and threating effectively, based on rapid drug susceptibility testing
Household contacts of TB index patients	• Develop simplified screening algorithms for TB-exposed children • Implement community education and mobilisation programmes to improve acceptance of contact investigations and to create awareness of the benefits of preventive therapy • Strengthen routine M&E for TB contact investigations, HIV testing, TB preventive therapy including outcomes, and pharmacovigilance
Minders (also a vulnerable	• Peer education and support for TB programme • specialised health education on risk of and vulnerability to TB, particularly regarding work and close-contact living

HIV Key Population	Services
population for HIV and STIs) and peri-mining communities	conditions • Routine TB screening and treatment with intensified contact-tracing at home, at the workplace and at workplace accommodation • Silica-exposed mine workers to receive TB preventive treatment per guidelines and screening which includes CXR • Improve linkage and access to cross-border care • Workplace HIV, TB and STI treatment services and the monitoring of these services for coverage, comprehensiveness and quality • Intensified psychosocial support • Education regarding annual benefit examinations and compensation for Occupational Lung Disease during life and post-mortem • Expand the focus on provision of services to miners who are not covered by wellness programmes • Expand the prevention, screening, diagnosis and linkage to care for HIV, TB and STIs in peri-mining communities • Improve the implementation of a holistic response to TB as set out in the 'TB in the mines' programmes being implemented across 10 countries in Southern Africa
People living in informal settlements (also a vulnerable population for HIV and STIs)	• Facilitate access and demand creation to increase community HIV, TB and STI service provision • Intensify GBV programmes and screening • Accelerate social support • Community education • Provide mobile services to improve accessibility • Infection control strategy for TB
People living with HIV	• Prompt ART initiation as a component of TB prevention • Adherence and psychosocial support • Peer education and support for TB prevention and treatment • Optimal uptake of preventive therapy for TB • Infection control in facilities, communities and households • TB symptom screening at each visit, linkages to treatment and care • HIV screening for household members, including partners and children • Cohort monitoring of HIV/TB co-infected patients • Support groups specifically addressing internalised stigma
Pregnant women	• Full access to PMTCT services

HIV Key Population	Services
with neonates	• Household TB and HIV screening, immediate linkage to treatment • Improve mother-child pair tracing and services • Improve TB screening testing among pregnant women to reduce congenital perinatal TB transmission • Improve diagnostic and treatment capacity for neonatal TB

Adolescent girls and young women	• Peer-led outreach
	• Youth-friendly sexual and reproductive health services in schools and community settings which include:
	  ○ PrEP (for over 18 years old)
	  ○ Complete two dose HPV vaccine (grade 4 learners)
	  ○ PMTCT
	  ○ Choice of termination of pregnancy
	  ○ Family planning services
	  ○ Male and female condom provision
	  ○ Sanitary towels
	• Programmes to keep girls in schools, including support for pregnant learners
	• Access to peer groups and clubs
	• Access to parenting programmes
	• Economic empowerment programmes
	• Increased access to further education opportunities
	• Increased access to mentorship and internships
	• Comprehensive sexuality and gender education
	• Provide reasonable accessibility for girls and young women with disabilities
	• Age specific support to HIV positive adolescents (support for disclosure and adherence)

Children and orphans and vulnerable children	• Health education, with a particular focus on sexual exploitation in the absence of primary caregivers
	• Accelerated nutritional and social grant support
	• Youth-friendly sexual and reproductive health services in schools and community settings which include:
	  ○ HPV vaccination
	  ○ Contraceptives including condoms
	  ○ Choice of termination of pregnancy
	• Comprehensive sexuality education in residential, school and non-school and youth-friendly settings
	• Intensive psychosocial support
	• Gender norms education, including risk reduction in relation to age-disparate relationships
	• School retention

HIV Key Population	Services
Mobile populations, migrants and other undocumented foreigners	• Mobile populations include those involved in big infrastructure and construction projects, agriculture and all four modes of transport, road, rail, civil aviation and maritime e.g. truck drivers, sea farers, long distance taxi drivers, pilots and cabin attendants • Provision of health services along the transport corridors • Flexible service delivery options including provision of condoms, HTS, provision of ART refills and TB treatment • Focused prevention messages and SBCC that addresses their specific challenges e.g. GBV, drug and alcohol use • Intensified psychosocial support • Cross border collaboration on HIV, TB and STI policy and programming • Utilise informal networks to raise awareness about services • Accelerated access to official papers to access services • Places of safety • Implementation of social impact plans that mitigate the impact of HIV,TB and STIs, for organisations involved in big infrastructure and construction projects e.g. building power stations, major roads
Other lesbian, gay, bisexual, transgendered and intersex (LGBTI) populations	• Peer-led outreach • Empowerment programmes including skills-building, ABET, and facilitation of post-school training and employment • Enhanced programmes for legal and counselling support
People with disabilities	• Peer-led or peer-supported outreach • Specialised health education regarding risk and vulnerability to HIV, STIs and TB, particularly regarding sexual exploitation • Accelerated nutritional and social grant support • Comprehensive sexuality education accessible to learners with disabilities • Intensive psychosocial support • Intensified TB screening, treatment and care due to increased exposure typically caused by confined living conditions • All people with disabilities have ready access to prevention services • Move to mainstreaming policy that sets a quota of 7% in all programmes so that 7% of all programmes target people with disabilities • PrEP available

The following table outlines the population that is considered high risk and key for specific disease interventions and prioritisation:

Table 8 - High risk, key and vulnerable population service package prioritisation

Key populations for HIV and STIs	**Key populations for TB**	**Vulnerable populations for HIV and STIs**
Sex Workers	People living with HIV	Adolescent girls and young women
Transgendered people	Household contacts of TB index patients	Children including Orphans & vulnerable children
Men who have sex with men	Health care workers	People living in informal settlements
People who use drugs	Inmates	Mine workers
Inmates	Pregnant women	Migrants and undocumented foreigners
	Children < 5 years	People with disabilities
	Diabetics	Other LGBTI populations
	People living in informal settlements	

GOAL 4: ADDRESS THE SOCIAL AND STRUCTURAL DRIVERS OF HIV, TB AND STIS, AND LINK THESE EFFORTS TO THE NDP

Strategic Context

The current understanding of HIV, TB and STIs, is that there are social and structural factors that deepen the disease burden in the country. South Africa currently confronts the linked challenges of poverty, inequality and long-term unemployment, with especially high jobless rates among young people. Other factors include Gender-based violence (GBV) and the harmful use of alcohol and drugs. 2,6% of women and 17,4% of men in Mpumalanga Province show signs of problem drinking by the CAGE test.

Factors which have a powerful impact on the risks of disease acquisition or transition, as well as on access to health services include: inadequate access to quality education, poor nutrition, migration, gender inequality, gender-based violence, and alcohol and drug use increase vulnerability to HIV, TB and STIs, the availability of safe and secure housing with good ventilation; the number of people in the household, the spatial location and distribution of health services; and access to and type of transportation. In order to address these structural issues, a multi-sectoral response is required.

Gender-based violence continues to impact upon HIV and STI risk. Whilst there are entrenched cultural practices and gender norms, which drive Gender-based violence, it is important to increase efforts to empower women and engage men and boys. As a component of strategic action for this issue, the current coverage of programmes and initiatives will be expanded and linked at local level to achieve sufficient scale. In response to an HSRC survey on addressing the social and structural factors that increase risk and vulnerability among adolescent girls and young women, 'She Conquers' will be implemented and strengthened. The multi-partner Dreams initiative will be implemented, as well and the Yolo and Zazi programmes of the Department of Social Development.

Alcohol and drug use increases HIV, hepatitis B and C, and TB risk and vulnerability, and also undermines adherence. Whilst the National Drug Master Plan deals with demand and supply issues, as well as a comprehensive approach to rehabilitation and harm reduction, interventions to prevent HIV, TB and STIs among young people who use drugs will be scaled up and harm reduction services will be expanded. These efforts will be supported by SBCC campaigns that include information about the harmful effects of alcohol and drug use. Targeted provision of condoms and other biomedical prevention commodities and, as appropriate, testing, screening, vaccination and treatment for HIV, TB, STIs and hepatitis B and C will be delivered. Linkage to services will include adherence and psychosocial support and rehabilitation services.

Strategic Approach

In the table below, a number of strategic actions and indicators are described to drive the battle against structural determinants of HIV, TB and STIs. The strategic focus is as follows:

Expansion of SBCC campaigns and programmes that build the resilience of individuals, parents and families. Health education will be a crucial component of this, with the provision of health education on risky behaviour to individuals, parents and families. Drop-in centres will be used to facilitate and support youth development programmes. A community capacity enhancement programme will be implemented as a sustained

methodology to empowering communities on community engagement. In addition, policies which build the resilience of individuals, parents and families will be monitored.

Reduce poverty and vulnerability through scaled-up social protection. Social grants are a critical component of the strategy to reduce poverty and vulnerability through scaled-up protection. As such, information about the process for accessing social grants will be integrated and disseminated through HIV, STI and TB community programmes. Increasing the availability of economic opportunities for young people will ensure that young people become economically empowered. Economic opportunities for young people will be provided through the improvement of the provision of skills development opportunities for youth, the promotion and development NYDA and SEDA programmes and the coordination of a response from the private sector through development of strategies that drive access to economic opportunities for youth. People living with disabilities are a vulnerable group of the population. Improving structural accommodation for people with disabilities and integrate the structural impediments in the workplace wellness programmes will help to tackle socio-economic vulnerability.

Scale up access to food security. Reliable access to nutritious food supports both HIV and TB treatment. In order to ensure reliable access to nutritious food for vulnerable portions of the population, it will be necessary to coordinate food schemes delivered by DSD, DOH and DoE.

Strengthening of outreach models to reach people at risk. Strengthening outreach models will require the implementation of a system to prevent, monitor and respond to human rights abuses and challenges and remove human rights barriers to accessing services. This includes a review of legal and policy frameworks and their implementation, with focus on drug use, mental health, domestic violence, sexual abuse of inmates and migration. Strengthening outreach models will require the sensitisation of healthcare, social cluster, professionals on rights to health for key and vulnerable populations. Advocacy plans for all key and vulnerable populations will need to be developed and implemented and supported by provincial and district media campaigns through print, radio and social networks.

Expand a comprehensive package of interventions through the 'She Conquers' campaign. The "She Conquers" campaign will target young women and girls with comprehensive education information on SRHR, prevention, MTCT.

Change gender norms and prevent and address gender-based violence. As discussed above, Gender-based violence (GBV) is closely correlated with HIV and STI infection. Thus a comprehensive strategy to inform gender based violence interventions; priorities and programme will be implemented. This will form part of a provincial gender based violence plan and follow through sensitisation workshops.

Better define and scale up harm reduction services. Harm reduction services support the mitigation of the effects of structural drivers of HIV, TB and STIs. An important priority is establishing support groups for PLWHIV (infected and affected) and strengthens and expands psychosocial support and mental health services in communities, schools, institutions of higher learning and health facilities. In order to manage harmful use of alcohol and other substances, it will be important to secure funding for rehabilitation and prevention

programs for alcohol and substance abuse at community level and within farming communities, scale up of rehabilitation facilities and human resources for in-patients, launch prevention and support campaigns at community level and conduct assessments to explore the drivers of substance abuse within communities. Education and awareness campaigns targeted at substance users will be formulated and launched.

Implement environmental interventions for TB control. As TB is air-borne, poor ventilation is associated with increased TB infections. Thus the improvement of ventilation and indoor air quality in congregate settings is of strategic importance. This will involve coordination with the CSIR to ensure the implementation of guidelines on ventilation and indoor air quality in congregate settings in conjunction with an advocacy campaign for health promotion specific to TB control.

Table with goal, objectives and activities

Table 9 - Goal 4: Table with Goal, Objectives and Activities

GOAL 4: ADDRESS THE SOCIAL AND STRUCTURAL DRIVERS OF HIV, TB AND STIS, INCLUDING HUMAN RIGHTS AND LINK THESE EFFORTS TO THE NDP DELIVERABLES									
Objective 4.1: Implement social and behaviour change programmes to address key drivers of the epidemic and build social cohesion									
Sub-objective 4.1.1: Reduce risky behaviour through the implementation of programmes that build resilience of individuals, parents and families.									
Outputs	1. Raise awareness of human rights access to HIV, TB and STI treatment, care and support, especially for vulnerable and key populations 2. Sensitize service providers and communities on social and structural drivers of HIV, TB and STIs 3. **PLHIV-led**, human rights based, 'prevention with people living with HIV' framework 4. **Holistic and comprehensive** approach to HIV prevention with people living with HIV 5. Emphasis on **supportive legal and policy** environments 6. **Primary goal:** Support PLHIV to achieve health **and** wellbeing								
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Provide health education on risky behaviour to individuals, parents and families.	Number of beneficiaries receiving DSD Social Behaviour Change programmes *(National indicator)*	205	309	420	510	605	680	760	DSD
	Number of beneficiaries reached through social and behavior change Programmes	1 524	5900	5900	5900	5900	5900	5900	
Facilitate and support youth development programmes through drop in centres.	Number of orphans and vulnerable children accessing services through drop-in centers	13 777	14 000	14 000	14 500	15 000	15 000	15 000	
	Number of youth reached through life skills workshops conducted	271	350	450	750	1000	1250	1500	
Sub-objective 4.1.2: Comprehensive and age-specific and appropriate support for learners and out-of-school youth.									
Key Activities	Indicator	Baseline	Target	Target	Target	Target	Target	Target	Responsible

		(2016)	2017	2018	2019	2020	2021	2022	Sectors
Establish campaigns that target young women and girls with education information on SRHR, prevention, MTCT	Number of campaigns targeting young girls with Education Information on SRHR and Prevention	4	6	10	14	20	30	40	DOE
	Number of young women and girls accessing comprehensive SBCC initiatives	No baseline	40%	60%	70%	80%	90%	100%	DOE
Monitor the implementation of policies already in place in the workplace	Number of visits to monitor the implementation of work place policies in place	4	8	8	8	8	8	8	DOE
Sub-objective 4.1.3: Strengthen the capacity of families and communities									
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Provide parenting programmes to families	Number of families participating in parenting programs	1962	2475	2600	4021	4100	4320	4400	DSD
Conduct social and behaviour change programmes	Number of beneficiaries reached through social and behavior change programs- Families Matter	No Baseline	4320	4320	4320	4320	4320	4320	
Sub-objective 4.1.4: Integrate strategies to address HIV, TB and STis into existing workplace policies and programmes									
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Monitoring the implementation of health and wellness policies	Number of monitoring sessions conducted on the full implementation of Health and Wellness policies	8	8	8	8	8	8	8	OTP
Objective 4.2: Increase access to and provision of services for all survivors of sexual and gender based violence									
Sub-objective 4.2.1: Increase access to provision of services for all survivors of sexual and gender-based violence.									

Outputs	1. A comprehensive strategy to inform gender based violence interventions, priorities and programmes								
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Develop and implement a provincial gender based violence plan and follow through sensitisation workshops	Number of funded VEP service sites	15	22	22	22	22	22	22	DSD
	Number of victims of crimes and violence receiving psychosocial support in VEP service sites	3274	3500	3500	4000	4000	4000	4000	
	Number of persons reached through prevention programs (GBV)	16 648	17 000	17 500	18 000	18 000	18 000	18 000	
Objective 4.3: Scale up access to social protection for people at risk of and those living with HIV and TB in priority districts									
Sub-objective 4.3.1: Ensure that all HIV- and TB-infected persons who are eligible, have access to social grants									
Outputs	1. Establishing support groups for PLWHIV (infected and affected) 2. Strengthen and expand psychosocial support and mental health services in communities, schools, institutions of higher learning and health facilities								
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Integrate and disseminate information on process for accessing social grants into HIV, STI and TB community programmes	No baseline	18	30	35	35	35	40	40	DSD HIV and AIDS Support Unit
Sub-objective 4.3.2: Scale up access to food security and nutritional support									
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Coordinate food schemes delivered by DSD, DOH and DoE	Number of beneficiaries provided with food	No Baseline	3700	3700	3700	3700	3700	3700	DSD Social Relief of

	parcels								Distress Unit
	Number of people accessing food through DSD programmes (centre based)	2 880	64 808	64 808	64 808	64 808	64 808	64 808	DSD Sustainable livelihood
Strengthening of outreach models to reach people at risk	Number of OVCY accessing services through Isibindi Program	9992	13 035	14 000	14 000	14 000	14 500	14 500	DSD Community Based Care Unit
Objective 4.4: Implement and scale up a package of harm reduction interventions for harmful use of alcohol and drugs in all districts									
Sub-objective 4.4.1: Scale up access and provision of in- and out-patient rehabilitation services for all who use alcohol and drugs									
Outputs	1. Provide comprehensive support to people living with alcohol and substance abuse 2. Targeted interventions at community level that is realistic 3. Awareness and education campaigns to inform people of risks								
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Secure funding for rehabilitation and prevention programmes for alcohol and substance abuse at community level and within farming communities	Number of funded NPO delivering services on prevention and treatment of substance abuse	6	8	8	8	8	8	8	DSD
	Number of service users who access in patients treatment services at funded treatment centres	400	224	224	274	324	324	324	DSD
	Number of service users who access out patients treatment services	1968	2200	2300	2400	2400	2400	2400	DSD
	Number of children 18 years and below reached through substance abuse prevention Programmes	70 735	72 000	75 000	80 000	80 000	80 000	80 000	DSD
	Number of people 19 years and above reached through	29 334	30 000	32 000	35 000	35 000	35 000	35 000	DSD

	substance abuse Programmes								
Sub-objective 4.5.1: Economically empower targeted groups of young people by increasing the availability of economic opportunities									
Outputs	1.								
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Improve the provision of skills development SBCC and create opportunities for youth to access socioeconomic benefits	Number of youth reached with SBCC and socioeconomic empowerment programmes	566	500	500	500	500	500	500	DSD
	Number of youth utilizing services delivered in Youth centres	126251	140000	140000	140000	140000	140000	140000	DSD
Promote and develop NYDA and SEDA programmes and its accessibility	Scale up National Youth Development interventions and targeting ages 15 – 24 years age cohorts	No Baseline	30%	40%	60%	80%	90%	100%	DSD SOE
Implement no-fee strategy to economically empower eligible learners in public schools	Number of learners offered no-fee education in public schools	No baseline	1500	1800	2000	2200	2500	2700	DOE
Objective 4.6: Address the physical building structural impediments for optimal prevention and treatment of HIV, TB and STIs.									
Sub-objective 4.6.1: Improve ventilation and indoor air quality in congregate settings									
Outputs	1. Ensure guidelines and plans are in place to manage and control TB								
	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Sub-objective 4.6.2: Develop advocacy campaign for health promotion specific to TB control									
Key Activities	Indicator	Baseline	Target	Target	Target	Target	Target	Target	Responsible

		(2016)	2017	2018	2019	2020	2021	2022	Sectors
Implement advocacy campaigns for health promotion specific to TB control through district support partners.	Number of TB specific health promotion campaigns conducted	4	6	8	10	12	16	20	DOE
Sub-objective 4.6.3: Improve structural accommodation for people with disabilities									
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Increase the number of workplaces that is certified friendly to people with disabilities	Number of workplaces certified	4	4	4	4	4	4	4	DSD
Objective 4.7: Implement a system to prevent, monitor and respond to human rights abuses and challenges and remove human rights barriers to accessing services									
Outputs	1. Documenting human rights violations for reporting purposes and advocacy 2. Educate communities on support for victims of human rights violations								
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Sensitisation of Department of Justice and SAPS officials	Number of human right and Legal Clinic conducted with communities	No baseline	30%	40%	50%	80%	90%	100%	DOJ n SAPS
Establish partnerships with Legal Aid to support communities with human rights violation cases	Number /proportion of trained Key Populations and PLHIV cadres on basic human rights and advocacy skilling	No baseline	30%	40%	60%	80%	90%	100%	DOJ and SAPS
Objective 4.8: Review legal and policy frameworks and their implementation, with focus on drug use, mental health, domestic violence, sexual abuse of inmates and migration									
Outputs	1. Develop drug and substance abuse mitigation strategies 2. Empower and raise awareness on the danger of drug and substance abuse around communities 3. Engage Key Stakeholders in the drug and substance abuse policy formulations 4. Improve cross border and migration services								
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Objective 4.10: Implementing advocacy campaigns and social transformation interventions									

Outputs									
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Launch provincial media campaigns through print, radio and social networks	Number of provincial media campaigns conducted	No baseline	2	3	5	7	9	10	OTP
Develop and implement advocacy plans for all key and vulnerable populations	Number of Ezabasha sessions conducted to promote SRHR	4	10	10	10	10	10	10	OTP

GOAL 5: GROUND THE RESPONSE TO HIV, TB AND STIS IN HUMAN RIGHTS PRINCIPLES AND APPROACHES

Strategic Context

The outcomes of the stigma index survey conducted in Mpumalanga showed that external stigma is a serious concern in the Province. Efforts to reduce the stigma associated with HIV, TB and STIs help to increase positive health outcomes as barriers to accessing healthcare are reduced. In addition, reduction of stigma experienced also reduces the mental health burden of those living with HIV, TB as STIs. The purpose of Goal 5 is to provide guidance to front-line workers and policy-makers on the provision of services in a manner that responds to the realities faced by people living with HIV and TB, including those who are most vulnerable. This approach is grounded in the principles of human rights, emphasizing the importance of equal rights, medical ethics and access for vulnerable populations such as Sex Workers and MSM.

Strategic Approach

Recognizing that the reduction of stigma and the promotion of human rights principles and approaches is critical, the following strategic approaches are being promoted.

Monitor and respond to human rights abuses: In order to monitor and respond to human rights abuses, it will be critical to utilize the robust legal and institutional frameworks the state currently fosters. Thus the Province will create awareness on availability of Legal Aid Services, and develop local directories of available legal services. The human rights accountability score card will be distributed and communities and other role players will be orientated, sensitized and trained on the score card. The Provinces will monitor activities implemented on the protection of human and legal rights and the prevention of stigma and discrimination. To strengthen the Province's ability to monitor human rights, the Province will collaborate with the SA Human Rights Commission, Public Protector and Section 27 on the monitoring of the implementation of laws, regulations and policies on HIV and TB and the identification of areas for reform. The Province will also develop and Implement an advocacy strategy with SA Human Rights Commission, Public Protector and Section 27 for areas of reform in laws, policy and regulations on HIV and TB.

Scale up SBCC initiatives to reduce stigma. In order to reduce stigma, community-based support groups will be revitalized to deal with internalised stigma. Stigma will be tackled through providing education to health care workers on reducing stigma in communities, as well as rolling out of the stigma reduction programme and stigma reduction training to religious and traditional health practitioners and leaders.

Invest in expanding training and sensitisation programmes to reduce stigma. The Province will initiate community dialogues on legal rights and literacy. Officials who are members of DSD, DOJ, SAPS and Municipal officials will be trained on human rights issues.

Specific interventions to address the added vulnerability of key and vulnerable populations to stigma and discrimination and human rights abuse. It is critical that key and vulnerable populations receive ethical and discrimination-free medical services at healthcare facilities. This will be achieved through the training of community health workers (CHWs) on human rights and medical ethics related to HIV and training health care workers in all healthcare facilities at all levels on human rights and medical ethics related to HIV. In

addition, healthcare managers at all levels will be trained to ensure alignment and sensitivity to human rights of SOP, health care policies and procedures.

Table with goal, objectives and activities

Table 10 - Goal 5: Table with Goal, Objectives and Activities

GOAL 5: GROUND THE RESPONSE TO HIV, TB AND STIS IN HUMAN RIGHTS PRINCIPLES AND APPROACHES									
Objective 5.1: Reduce stigma and discrimination among people living with HIV or TB by half by 2022									
Sub-objective 5.1.1: Revitalise community-based support groups to deal with internalised stigma									
Outputs	1. In healthcare settings, **educate and sensitize** Healthcare providers on stigma, discrimination and other Human Rights violations 2. **Familiarize & Empower** stakeholders, PLHIV, KPs and community on Stigma Index and Human Rights Count findings 3. Involvement in the development **Stigma Mitigation Interventions** 4. **Awareness** on legal services, e.g. *Legal Clinics* 5. **Document** Human Rights violations								
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Implement full disclosure programme and monitoring tool	Proportion of Key Populations ambassadors established	No baseline	30%	40%	60%	80%	90%	100%	DSD
Objective 5.1.2: Reduce stigma through community education									
Roll-out of the Stigma Reduction programme	Proportion of people reached through stigma reduction programmes	No baseline	30%	40%	60%	80%	90%	100%	MPAC
Roll out stigma reduction training to Religious and traditional health practitioners and leaders	Number of stigma reduction programmes targeting religious and traditional health practitioners conducted	No baseline	2	3	4	5	6	7	MPAC
Objective 5.2: Facilitate access to justice and redress for people living with and vulnerable to HIV and TB									
Sub-objective 5.2.1: Improve legal literacy about human rights and laws relevant to HIV and TB									
Outputs	1. Conduct HIV Basic Rights and Law Course for PLHIV's 2. Involvement of the Key Populations in the development of stigma mitigation interventions 3. Create awareness on available legal services 4. Create case findings on human right violations								
Key Activities	Indicator	Baseline	Targe	Target	Targe	Targe	Targe	Target	Responsible

		(2016)	t 2017	2018	t 2019	t 2020	t 2021	2022	Sectors
Improve legal literacy about human rights and national and local laws relevant to HIV and TB	Number of officials accessed HIV/AIDS, STI's, and TB and Human rights and access to justice information session.	1950	1950	1950	1950	1950	1950	1950	DOJ
Sub-objective 5.2.2: Make HIV-related legal services available and accessible									
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Create awareness on availability of Legal Aid Services DOJ	Number of PLHIV's capacitated on available legal services e.g. Legal Clinics	No baseline	30%	50%	60%	80%	90%	100%	DOJ
Develop local directories of available legal services DOJ	Legal services made user friendly and easily accessible to PHIV's and Key Populations	No baseline	40%	60%	80%	90%	100%	100%	DOJ
Objective 5.3: Promote an environment that enables and protects human and legal rights and prevents stigma and discrimination									
Sub-objective 5.3.1: Implement a human rights accountability scorecard									
Outputs	1. **Capacitate PLHIV's** on their rights 2. **Familiarize & Empower** stakeholders, PLHIV, KPs and community on Stigma Index and Human Rights Count findings 3. In healthcare settings, **educate and sensitize** Healthcare providers on stigma, discrimination and other Human Rights violations 4. **Document** Human Rights violations								
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Distribute the human rights accountability score card	Number of Human Rights Score cards distributed	No baseline	300	500	800	1000	1200	1500	MPAC
	Number of Key stakeholders capacitated on stigma and human right mitigation	No baseline	30%	40%	50%	80%	90%	100%	MPAC
	Develop the case compendiums/collection on Human Rights abuses		40%	70%	80%	100%	100%	100%	DOJ

Sub-objective 5.3.2: Monitor implementation of laws, regulations and policies relating to HIV and TB and identify areas for reform									
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Collaborate with the SA Human Rights Commission, Public Protector and Section 27 on the monitoring of the implementation laws, regulations and policies on HIV and TB and the identification of areas for reform.	Number of laws and policies reformed in line with HIV and TB	-	3	5	7	7	7	7	DOJ
Sub-objective 5.3.3: Sensitise law-makers and law enforcement agents									
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Train members of SAPS and Prosecutors on issues relating to reduction of stigma and rights relating to HIV and TBD	Number of Law enforcement agents trained on Stigma Reduction and Human Rights related to HIV and TB	-	200	400	600	800	1000	1200	DOJ
Sub-objective 5.3.4: Train healthcare providers on human rights and medical ethics									
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Train community health workers (CHWs) on human rights and medical ethics related to HIV	Number of Community Health Workers trained on human rights and medical ethics related to HIV	-	150	450	700	850	1000	1200	DOH, DOJ
Train health care workers in all healthcare facilities at all levels on human rights and medical ethics related to HIV	Number of health care workers trained on human rights related to HIV	-	300	600	1200	1800	2400	3000	DOH
Train healthcare managers at all levels to ensure alignment and sensitivity to human rights of SOPs , health care policies and procedures	Number of Health Care managers trained on human rights and health care policies	-	100	200	300	400	500	600	DOH

GOAL 6: PROMOTE LEADERSHIP AND SHARED ACCOUNTABILITY FOR A SUSTAINABLE RESPONSE TO THE HIV, TB AND STI EPIDEMICS

Strategic Context

Our implementation plan is aligned to the NSP of SANAC, partially to tap into leadership commitments from a national level, but also to ensure that we work collectively on a well-coordinated approach that is supported by the necessary political and subject experts to ensure conducive policy environments for implementation – which is key at a provincial and district level.

Strengthening our AIDS Councils and providing them with the resources, support and mentorship, which they need to realise the activities of this plan, is at the core of our strategy. Using tools and information like the National Development Plan and the Sustainable Development Goals, we will ensure that the broader vision of a leadership approach is applied and informs our provincial priorities and strategies. Through well-represented civil society structures and putting those living with and affected by HIV, TB and STIs at the forefront of the dialogues to participate in programme prioritisation and design.

Strategic Approach

Strategic priorities, which will promote leadership and shared accountability for a sustainable response to the HIV, TB and STI epidemics are as follows:

Strengthen the MPAC, DAC & LAC and achievement of its goals and objectives. This will involve reviewing and revising the terms of reference for AIDS Councils. It will also be important to establish all civil society sectors that form part of AIDS councils at all levels and technical task teams in local and district AIDS councils. Strengthening capacity through developing capacity building programmes targeted at provincial, district and local AIDS councils will be important. In addition, the Province will develop an induction programme for councillors and management of district and local municipalities and implement the terms of reference for the Local, District and Provincial Councils on AIDS. All PCA activities will be guided by a costed budget.

Strengthen civil society participation and leadership and build local leadership. Civil society participation and leadership will be mapped by developing comprehensive stakeholder database within the province for ease of coordination. A resource mobilisation strategy will be developed to support civil society sectors with implementation of activities. In addition, 18 civil society sectors will be coordinated and supported and civil society forum terms of reference/procedural guidelines will be coordinated and implemented. Sector plans will be developed for the coordination of AIDS response at all levels.

Strengthen private sector engagement and engage organised labour. This will involve developing a close working relationship with SABCOHA and big business to ensure involvement and support in the activities of the Provincial Council on AIDs (PCA). It will be critical to develop close working relationship with non - business service providers (GPs, Private Hospitals etc.) to ensure involvement and support in the activities of the PCA.

Improve collaboration and cooperation among national and provincial government departments. Collaboration between national and provincial government departments will be improved though the establishment of government coordinating structures at provincial,

district and local levels. Platforms for multi-sectoral dialogues and engagement will also be provided.

Improve collaboration and cooperation between government, civil society and private sector and facilitate the development of an integrated and coordinated government programme on HIV, TB and STIs. In order to improve collaboration and cooperation, departmental representatives with decision making power will be appointed to a technical working group. To ease the coordination of provincial, district and local activities, a calendar of events will be developed.

Develop implementation plans. M&E task teams will be established at all AIDS council levels.

Increase cross-border co-operation: In order to increase cross-border cooperation, Collaboration with Mozambique and Swaziland on migration matters will be strengthened through a relationship with the IOM.

Table with goal, objectives and activities

Table 11 - Goal 6: Table with Goal, Objectives and Activities

GOAL 6: **PROMOTE LEADERSHIP AND SHARED ACCOUNTABILITY FOR A SUSTAINABLE RESPONSE TO THE HIV, TB AND STI EPIDEMICS**									
Objective 6.1: Strengthen MPAC, DAC &LAC provide effective co-ordination and leadership of all stakeholders for shared accountability									
Sub-objective 6.1.1: Formally establish the structures of AIDS Councils at district, local and ward level									
Outputs	1. Develop and implement Terms of Reference for AIDS Councils 2. Establish Civil Society Sectors 3. Establish Technical Task Teams in all AIDS Councils 4. Conduct inductions for AIDS Council members								
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Establish all civil society sectors that form part of AIDS councils at all levels	Number of Civil Society Sectors established	7	18	18	18	18	18	18	Civil Society
Establish technical task teams in local and district AIDS councils	Number of Technical Task Teams established	13	20	20	20	20	20	20	MPAC/DAC
Develop and conduct induction programme for councillors and management of district and local municipalities	Number of induction programmes conducted for District and Local AIDS Council	1	3	3	3	3	3	3	SALGA/ MPAC
Implement the terms of reference for the Local, District and Provincial Councils on AIDS	Number of Mayors who Chair AIDS Councils	20	20	20	20	20	20	20	MPAC
Develop a costed budget for all DACs and LACs activities	Number of DACs and LACs Secretariats that are allocated sufficient funds to	20	20	20	20	20	20	20	DACs

	coordinate the PIP								
Sub-objective 6.1.2: Ensure representation of all stakeholders in decision-making									
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Appoint departmental representatives with decision making power in technical working group	Number of Task Team Members appointed from government departments	-	1	1	1	1	1	1	MPAC
Develop a calendar of events for ease of coordinating provincial, district and local activities	Calendar of events developed	-	1	1	1	1	1	1	MPAC
Sub-objective 6.1.3: Strengthening the role of the private sector									
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Develop close working relationship with SABCOHA to ensure involvement and support in the activities of the PCA.	Participation of SABCOHA in all PCA activities	-	YES	YES	YES	YES	YES	YES	MPAC
Develop close working relationship with non - business service providers (GPs, Private Hospitals etc.) to ensure involvement and support in the activities of the PCA.	Partnership Pledge developed and signed by private health providers	-	-	1	1	1	1	1	MPAC
Sub-objective 6.1.4: Ensure a central role for civil society and community groups									
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Develop comprehensive stakeholder database within the province for ease of coordination	Provincial Database developed	-	1	1	1	1	1	1	MPAC
Develop a resource mobilisation strategy to support civil society sectors with implementation of activities	Resource Mobilization Strategy developed	-	1	1	1	1	1	1	MPAC
Adoption and implementation of the civil society forum terms of	Civil Society Terms of Reference	1	1	1	1	1	1	1	Civil Society

reference/procedural guidelines	adopted and implemented								
Sub-objective 6.1.5: Monitor annually the implementation of the accountability framework									
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Establish M&E task teams at all AIDS council levels	PCA, DACs and LACs Accountability performance score *(national indicator)*	-	20	20	20	20	20	20	MPAC
Objective 6.2: Improve collaboration between government, civil society, development partners and the private sector									
Sub-objective 6.2.1: Ensure that the plans of government and the non-government sector are aligned with the PIP									
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Establish a performance scorecard for Provincial and District AIDS Councils for accountability purposes	PCA and District AIDS Councils Accountability performance score: (5-year PIP aligned to the NSP, relevant PIP; representation)	-	4	4	4	4	4	4	MPAC
Sub-objective 6.2.2: Strengthen collaboration between and co-ordination of government departments									
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors
Establish government coordinating structures at provincial, district and local levels	Number of government forums at provincial, district and Local level.	1	20	20	20	20	20	20	MPAC/DAC
Sub-objective 6.2.3: Establish/strengthen regional collaboration									
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sectors

Strengthen collaboration with Mozambique and Swaziland on migration matters	Number of bilateral agreement with Swaziland and Mozambique	-	2	2	2	2	2	2	OTP
Develop provincial MOU with IOM	Provincial MOU with IOM developed	-	0	1	0	0	0	0	MPAC

SECTION 8: Monitoring and Evaluation - *'Data-Driven Action'*

GOAL8: Strengthening Strategic Information to drive progress towards achievement of the NSP and PIP

8.1 Strategic context

For the optimisation of strategic information, Mpumalanga Province uses and links with the various national government routine information systems in place (e.g. health, education, social development). The need exists within the province to harmonise and share components of these information systems that relates to the Mpumalanga PIP. This includes having clear aligned baselines and tracking progress for implementation for ***monitoring and evaluation*** purposes.

The need exists for the AIDS Councils at the different levels to generate or tap into provincial specific data that would assist and guide decision-making at the specific levels. This includes access to province specific ***survey*** data that is collected in the province during national surveys. In addition, access to provincial guided and generated research that answers provincial specific ***research*** questions remains a priority.

The Mpumalanga Provincial AIDS Council (MPAC) has the responsibility to coordinate the HIV, TB and STI response within the province. The provincial response, defined in the PIP, involves all sectors and organizations that implement programmes and strategies, create and strengthen partnerships for an expanded provincial response amongst all sectors, recommend appropriate research and mobilise resources for the implementation. Strategic information is a key programme activity of the PCS and its secretariat is tasked, amongst other things, with responsibility for developing a provincial monitoring and evaluation framework for the multi-sectoral responses.

8.2 Strategic approach

Building on existing strategic information structures and systems within the province, the priority would be on optimizing what exist and using this to realign with the PIP strategic information needs. This would include establishing special focus and multi-sectoral general technical working groups (TWGs) that focus on the different elements of strategic information, including identifying gaps are and weaknesses. The TWGs will be coordinated through the MPAC and links established with similar structures and a national level.

The latest Mid-term Review of the Mpumalanga PSP 2012-2016 on M&E conducted in 2015 and the Routine Data Quality Assessment in 2017 revealed that there is no sector-wide means for taking stock of what is being achieved by the private sector. It was also discovered that there is need to take stock of the impacts of HIV, STIs and TB on business and agriculture, but there has been limited research on this in the province. Most community level HIV, STIs and TB programmes being run by the civil society do not have basic indicators and monitoring systems for taking stock of the achievements of programme objectives, and have tended to rely on occasional retrospective evaluations or reviews. There are currently no M&E human resources employed at district and local level in the AIDS Councils. There are no M&E training programmes in any of the tertiary institutions in

the Province, and there is little HIV, STIs and TB programme specific support available for developing and implementing basic M&E systems at the local or provincial level.

8.2.1 Monitoring and evaluation

The main aim of Monitoring & Evaluation (M&E) has been to identify the gaps and needs in respect of information required for a more strategic and systematic approach to management of multi-sectoral responses to the HIV and AIDS epidemic and to promote and support a strategy aimed at addressing these. The Monitoring and Evaluation principles which advocate for one plan (the Mpumalanga PIP for HIV, STIs and TB 2017-2022), one coordinating body (the Mpumalanga Provincial AIDS Council) and one M&E system for monitoring and evaluating the PIP will guide the implementation of the PIP for the province. Linking with the existing national Focus for Impact web-application, a provincial instance will be developed that would assist with the consolidation of existing data sources and systems. This would:

- ***Strengthen and promote multi-sectoral ownership and accountability of the PIP M&E system*** by bringing together various information management systems and data sources, which are supported and maintained by various stakeholders. These stakeholders include public, private, civil society and development partner implementing agencies. The province aims to achieve a provincial HIV, STIs and TB programme that is coordinated across all sectors of the response and that is guided by and integrated monitoring and evaluation system linked to the national Focus for Impact system. This M&E system will reflect the dynamics of the changing epidemic and responses to it.

    - **Develop a provincial PIP M&E plan for 2017-2022:** A provincial five-year, costed M&E Implementation Plan will be developed to accompany the M&E Framework of this PIP. The Plan will detail the roles and responsibilities of all stakeholders and the reporting timelines and will define core indicators, data sources, collection tools and flow mechanisms. The MPAC will coordinate this at a provincial and sectoral levels. This will include capacity development, data quality assurance, resource mobilisation for M&E and data archiving. These activities will need to be fully funded and supported.

    - **Develop a uniform reporting template for all districts for data collection in all the three districts (Nkangala, Gert Sibande and Ehlanzeni):** Data on the core NSP and PIP indicators for HIV, STIs and TB will flow from the ward level to district level (to district AIDS Councils), to provincial AIDS councils, and then to the SANAC secretariat at national level, and will be returned back to the lowest level for feedback. While government and civil society sectors will report within their established structures at the different levels, they will also be required to feed into the AIDS council structures at the corresponding levels at the same time. This will help strengthen the multi-sectoral response at the different levels. To ensure a multi-sectoral ownership and accountability MPAC will implement the following:

    - ***Establish reporting channels for all national led government departments***. Mpumalanga Province will establish the Health Information Exchange (HIE) that is critical in collecting data from facility level to the

provincial data hub. In this regard the province will establish three district health information exchange forums. These forums will function as the technical working groups responsible for generating routine exception reports for action on patients failing to receive appropriate services.

- ***Strengthen capacity to generate and use available data effectively to monitor NSP and PIP performance****.* An overriding aim of the M&E Plan is to strengthen support to stakeholders to be effective in generating, interrogating and using data to adapt and improve programmes and service delivery on a continuous basis. This will be done at the different levels of implementation. The MPAC will facilitate support to sectors and localities that require it. The province will ensure that the health data collected is utilised at all levels hence there is need to capacitate data custodians through the development of computer and data analysis skills at all levels of the health system. The province will also develop a system that ensures automated quarterly facility cascade reports to District Implementation Teams (DITs). The province will also develop annual district and provincial HIV, STIs and TB reports.

  Given the lack of understanding of monitoring and evaluation and the need to develop systems for the same it is necessary to promote the recognition of needs for this and to gain the cooperation of organisations in developing integrated systems that will provide quality health data at local, district and provincial levels. Whereas MPAC has conducted a training programme on M&E there are many organisations that have little knowledge of M&E or capacity to engage with provincial M&E reporting needs at local, district and provincial levels and across sectors. In order to ensure data flow and quality at all levels the PIP prioritises the following:

  - Robust training of data custodians from organisations involved in reporting at local, district and provincial levels including the civil society sector leaders who are responsible for consolidating sector reports.

  - Establish District TWGs in all the three districts (Gert Sibande, Nkangala and Ehlanzeni).

  The province seeks to promote knowledge on HIV, STIs and TB to the public in an effort to promote public participation in the response. This will be done through the following activities:

  - Notification, publication on any media platforms and electronic distribution of recently released M&E and research publications of relevance to Provincial HIV and AIDS impact and responses.

  - consolidation and dissemination of HIV, STIs and TB related information in collaboration with all provincial stakeholders.

- ***Conduct independent reviews of progress****:* Aligning with NSP processes, independent evaluators will conduct robust and inclusive mid-term, end-term and programme evaluations of the PIP. The mid-term review, scheduled for 2019, will assess the implementation of the PIP against its goals and objectives. This review will allow for adjustments in programming and resource allocation for the second half

of the PIP and will also provide an opportunity for stakeholders to revise PIP targets. The final evaluation is scheduled to report in December 2021 and the findings will inform the development of the next NSP. The results of these reviews will be produced timeously and shared widely.

- ***Conduct the accountability scorecard annually****:* The province will participate in the development of the accountability scorecard as an important tool to support the leadership activities described in Goal 6. This will be conducted and published annually.

8.2.2 Surveillance and surveys

The PIP aims to enhance the ability to access and use national surveillance system and survey data to inform decision-making, including those that review quality of services. Aligned with the NSP this will include:

- ***Routine HIV, TB and STI surveillance among key and vulnerable populations****:* Integrated Bio-Behavioural Surveillance (IBBS) and population size estimation activities that generate size estimates and other strategic information about key populations, including MSM, people who use drugs, sex workers and transgendered people. In addition, special focus will be placed on characterising the vulnerabilities and burden of disease among adolescent girls and young women, healthcare workers and persons with disabilities.

- ***Support the implementation of facility- and laboratory-based surveillance activities to monitor HIV, TB and STI antimicrobial drug resistance****:* These activities are even more vital in view of the anticipated increased uptake of antiretroviral therapy under the Test and Treat approach, the expansion of adherence programmes, the expanded use of PrEP, the increase in person-to-person transmission of drug-resistant TB and emergence of STI-related anti-microbial resistance.

- ***Support the implementation of non-routine surveillance activities and surveys to monitor populations exposed to comprehensive prevention/treatment programmes****:* The province will actively participate and support special surveys, demographic surveillance systems and community-based survey activities will help monitor the burden of disease among specific populations, such as those exposed to comprehensive prevention and treatment programmes and those in high-burden areas. This links closely with the Focus for Impact approach for the province.

8.2.3 Research

Existing research related structures, systems and processes in the province would be optimized to facilitate HIV, TB and STI related operational research and evaluation, implementation science and investigations that build the evidence base for improved action. This includes service delivery optimisation to strengthen availability, access and adherence and optimisation of cost-effectiveness and efficiency. It is important to develop an understanding of research needs relating to provincial AIDS responses in all the different sectors. MPAC and the DoH will coordinate the development of provincial research needs and ensure rapid and widespread dissemination of research findings, and research efforts

that will adhere to best practices for community engagement and participation in research. Towards this end the following activities will be important:

- Publish a bibliographic database of research and M&E studies undertaken in the Province and periodically update this;
- Develop a costed and budgeted research agenda;
- Host annual research summits to attract research on HIV, STIs and TB;
- Develop research registry of ongoing research programmes and publish the results;
- Disseminate list of key research areas to Deans of Research of tertiary institutions and develop collaborative links with the research institutions through a multi-sectoral research committee; and
- The PIP will strengthen strategic and provincial specific research activities to create validated evidence for innovation, improved efficiency and enhanced impact.

- ***Develop, fully resource and implement a coordinated research agenda for the PIP****:* Enhance provincial research expertise by enhancing co-ordination, knowledge sharing, planning and implementation of all HIV, TB and STI research efforts. This will aid in identifying the provincial research priorities and gaps, mobilising resources for priority research projects and undertaking research across the province. The research TWGs will help build relationships and support co-ordination among diverse stakeholders and facilitate multi-disciplinary research. Specific efforts will be made to ensure rapid and widespread dissemination of research findings. Research will adhere to best practices for community engagement and participation, consistent with international guidelines on Good Participatory Practice in Research.

- ***Fill critical research gaps****:* The research agenda under the PIP will determine and address critical gaps in knowledge in order to accelerate progress towards achieving the Goals, objectives and targets of the NSP and PIP.
  - ***Social and anthropological research*** priorities will be link with the national inter-disciplinary Social Science Think Tank. Research priorities will include efficacy of anti-stigma interventions, piloting customised strategies for adolescent girls and young women and key and vulnerable populations, and validating additional social and behaviour change communication campaigns; and
  - ***Basic and clinical research*** activities, plans and findings will be reviewed and better disseminated to policy makers, health system managers, service providers and other stakeholders to enhance care and to encourage transparency and understanding of the full research portfolio in South Africa and Mpumalanga.

- ***Support implementation research and develop best practice models****:* The PIP seeks to catalyse implementation research for real-time learning and programme and service delivery improvements. Coordinated impact evaluations on implementation of perceived best practices will be undertaken and answers sought to priority research questions, with dissemination of findings to achieve implementation of best practices. Establish a link with the National Implementation Research Advisory Committee prioritised list of important implementation research questions, ranked by seven key

measures: impact, cost/cost-effectiveness, sustainability, scalability, available findings, resources and alignment. Experience from the intensified approaches undertaken in high-burden areas, particularly to address social and structural drivers, will be documented to inform efforts in the province. Communities will be consulted, engaged and fully informed of implementation research on HIV, TB and STIs.

Enable research: Steps will be taken to increase local research capacity, in close collaboration with national structures and processes. Communities will be involved to actively participate in research where relevant. Through revitalising research networks, scientific capacity will be mobilised for identified strategic information activities.

Table with goal, objectives and activities

Table 12 - Goal 8: Table with Goal, Objectives and Activities

GOAL 8: STRENGTHEN STRATEGIC INFORMATION TO DRIVE PROGRESS TOWARDS ACHIEVEMENT OF NSP AND PIP GOALS									
Objective 8.1 Optimize routinely collected strategic health information for data utilisation									
Outputs	1. Master patient index for use in all service delivery settings 2. Health information (HIE) exchanges for real-time data availability 3. Available data used for decision making and planning								
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sector
Sub-objective 8.1.1 Implement master patient index for use in all service delivery settings									
Roll-out the master patient index in health facilities	Percentage of health facilities utilising the master patient index	No baseline		100%	100%	100%	100%	100%	DOH
Link clinical, laboratory and pharmacy data	Linked provincial data fully functional	No baseline		1	1	1	1	1	DOH
Sub-objective 8.1.2 Establish health information (HIE) exchanges for real-time data availability									
Establish district health information exchange forums	Number of district health information exchange (HIE) forum meetings conducted annually	No baseline	3	3	3	3	3	3	DOH
Sub-objective 8.1.3 Increase data utilisation									
Consolidate annual LAC reports	Annual district HIV, TB and STI reports produced	No baseline	3	3	3	3	3	3	MPAC

Objective 8.2 Rigorously monitor and evaluate implementation and outcomes of the PIP	
Output	1. Multi-sectoral ownership and accountability of the PIP and DIP M&E systems 2. M&E capacity to monitor the PIP performance and HIV, TB and STI epidemics at all levels 3. Disseminate timely, relevant HIV, TB and STI information to the public

Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sector
Sub-Objective 8.2.1 Strengthen and promote multi-sectoral ownership and accountability of the PIP and DIP M&E systems									
Draft a provincial PIP M&E plan for 2017-2022	PIP five-year costed PIP M&E Plan	N/A	1	1	1	1	1	1	MPAC
Develop a uniform reporting template for all district stakeholders for data collection in the districts	Number of districts producing quarterly service coverage reports with data from civil society and the private sector	3	3	3	3	3	3	3	MPAC
Identify and collect data from all government departments in the province	Number of relevant provincial departments producing quarterly HIV, STIs and TB mainstreaming reports	12	12	12	12	12	12	12	MPAC
	Percentage of relevant provincial departments producing quarterly HIV, STIs and TB mainstreaming reports		80%	80%	100%	100%	100%	100%	MPAC
Sub-Objective 8.2.2 Strengthen M&E capacity to effectively use available data to monitor the PIP performance and HIV, TB and STI epidemics at all levels									
Develop district annual HIV, STIs and TB profiles	Number of districts with Annual HIV, TB and STI profiles	3	3	3	3	3	3	3	MPAC
Develop and track provincial indicators	Percentage of core PIP indicators	No baseline	80%	80%	100%	100%	100%	100%	MPAC

Objective 8.2 Rigorously monitor and evaluate implementation and outcomes of the PIP									
Output	1. Multi-sectoral ownership and accountability of the PIP and DIP M&E systems 2. M&E capacity to monitor the PIP performance and HIV, TB and STI epidemics at all levels 3. Disseminate timely, relevant HIV, TB and STI information to the public								
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sector
on the PIP 2017-2022	reported								
Sub-Objective 8.2.3 Ensure harmonised, timely and comprehensive routine systems to provide quality health data at provincial and district levels and across sectors.									
Establish three technical working groups in the three districts	Number of District Technical working groups established	3	3	3	3	3	3	3	MPAC
Sub-Objective 8.2.4 Disseminate timely, relevant HIV, TB and STI information to the public									
Consolidate HIV, TB and STIs reports for feedback	Number of HIV, TB and STI reports consolidated and published to the public	No baseline	1	1	1	1	1	1	
Sub-Objective 8.2.5 Generate and disseminate PIP Monitoring and Evaluation Reports to the public									
Conduct annual evaluations of the District Implementation Plans	Number of annual DIP evaluation reports conducted	3	0	3	3	3	3	3	MPAC,DAC
Conduct the Mid-term reviews of the DIPs 2017-2022	Number of Mid-Term Review reports for the DIPs 2017-2022 conducted	1	0	0	3	0	0	0	MPAC, DAC
Conduct the mid-term review of the PIP	PIP 2017-2022 Mid-term review	1	0	0	1	0	0	0	MPAC

Objective 8.2 Rigorously monitor and evaluate implementation and outcomes of the PIP									
Output	1. Multi-sectoral ownership and accountability of the PIP and DIP M&E systems 2. M&E capacity to monitor the PIP performance and HIV, TB and STI epidemics at all levels 3. Disseminate timely, relevant HIV, TB and STI information to the public								
Key Activities	Indicator	Baseline (2016)	Target 2017	Target 2018	Target 2019	Target 2020	Target 2021	Target 2022	Responsible Sector
2017-2022	Report								
Conduct an end of term evaluation of the PIP 2017-2022	PIP 2017-2022 End-of term evaluation Report	1	0	0	0	0	0	1	MPAC
Objective 8.4 Strengthen strategic research activities to create validated evidence for innovation, improved efficiency and enhanced impact									
Sub-Objective 8.4.1 Develop and coordinate research agenda for the PIP									
Develop a costed and provincial research agenda	Adoption of 5-year PIP HIV, TB and STI Research Agenda	1	1	1	1	1	1	1	MPAC
Select and conduct research on prioritised topics in the province	Number of research summits conducted	-	-	1	-	-	1	-	MPAC

SECTION 9: Critical Enablers

In order to maximise our response and impact for the achievement of the eight NSP goals with their objectives and targets within Mpumalanga, systems will be strengthened in the Province to ensure delivery of services and for programmes that are both effective and efficient. Critical enablers are those components that are vital to strengthen and align with the strategies outlined in the NSP and PIP.

Enabler 1: A focus on social and behaviour change communication (SBCC) to ensure social mobilization and increasing awareness

The province will develop a Provincial Social and Behaviour Change Communication Strategy under the leadership of the department of Social Development in order to assist individuals and communities to implement communication strategies that reduce HIV, TB and STI risk behaviours. This strategy will also assist in further facilitating positive health seeking behaviour and demand for services, assist people to remain engaged in HIV and TB services and to adhere to prescribed prevention and treatment regimens, appropriate to their specific settings.

This in turn provides a supportive environment, which will enable people to initiate, sustain and maintain positive and desirable behaviour outcomes. This process will extensive involve stakeholder engagement and participation focusing on capacity building for programmes, risk profiling of communities and the tailoring of key campaign messages to local communities.

The implementation of the SBCC Strategy will use multiple channels (e.g. advocacy, mass media both print and electronic); be scalable, sustainable, results-oriented and cost-effective; and recognise that social and behaviour change is seldom a linear process. Where possible, Mpumalanga Province will tap into national campaigns to ensure that a standardised message is used at a community and individual level and through the various channels.

In support of the SBCC intent of the NSP, the MPAC and district AIDS Councils will engage opinion leaders and influential individuals in local communities to support the campaign. Provincial and local leaders should ensure an enabling environment to support local actors in leveraging the campaigns. Community-based co-ordinating structures should be established in each community, with particular attention to high-burden areas to link to the Focus for Impact approach.

Enabler 2: Build strong social systems, including strengthening families and communities, to decrease risks of transmission and to mitigate the impact of the epidemics

Social systems are pivotal to the PIP's ambitions for key and vulnerable populations, for addressing social and structural drivers and for promoting and protecting human rights. Concerted efforts will be made to empower and strengthen households and parents or caregivers to build resilience in the communities.

Under the PIP, community-based responses will be strengthened through the implementation of a core package of multi-sectoral services to address the social, physical, educational and emotional needs of children and families. The role of parents and caregivers will be addressed in all prevention and early intervention programmes. Safe spaces will be provided for families or individuals who experience or are at risk of gender-based violence, including linkages to appropriate social support services.

Community engagement, dialogue and direct support will be prioritised to permit the most pressing needs of communities to be identified and addressed. Targeted risk assessments and measures to ensure early detection, treatment and adherence support will focus on reducing the vulnerability of children and families, with particular attention to adolescent girls and young women. Children, families and caregivers will be referred to screening for HIV, TB and STIs, and psychosocial support services will enable the uptake of testing. Existing platforms, institutions and structures will be fully leveraged to build strong, durable social systems for sex workers and other key and vulnerable populations.

The capacity, competencies and capabilities of government, civil society and NGO and CBO service providers will be increased to support the roll-out of quality HIV, TB and STI interventions and services. At the local level, improved community co-ordination forums and networks will strengthen integration and collaboration between health and social service providers.

Enabler 3: Effectively integrate HIV, TB and STI interventions and services

Service integration is a critical aspect of strengthening the HIV, TB and STI response in the province. Offering services and information in an integrated manner is more efficient and user friendly, as integrated systems require fewer service visits, reduce duplication and assist to diminish stigma.
Service integration will be optimised through enhanced coordination between different and multi-sectoral service providers at a community and district level. This would reduce duplication and optimize the use of available resources and service providers.

Enabler 4: Strengthen procurement and supply chain systems

This PIP requires ready, uninterrupted access to essential prevention, diagnostic and treatment commodities for HIV, TB and STIs. While existing procurement and supply chain system has largely functioned well in response to HIV, TB and STIs, the gaps that have sometimes occurred have undermined effective use of essential health commodities as well as adherence to prescribed prevention and treatment regimens, increasing the vulnerability of those already at risk of HIV, TB or STIs.

The steps to strengthen procurement and supply chain systems include linking provincial system with national level systems for stock monitoring system, supported by a rapid response system for shortages, to ensure consistent and adequate supplies of medicines, commodities and equipment.

Improved, transparent and up-to-date information systems will identify the causes of stock-outs. An early warning system will assist to identify impending shortages, and a distribution plan will respond in a timely manner. There will be a roll-out to all communities of a direct distribution system for medicines for chronic diseases (including HIV and TB) delivery in venues outside of health facilities through the Central Chronic Medicine Dispending and Distribution (CCMDD) Programme.

In addition, other approaches will be implemented to provide antiretroviral and TB medicines and other health supplies outside of health facilities, bringing HIV and TB treatment and services for other chronic diseases closer to where people live and work. This will include strengthening linkage with the private sector where possible to facilitate access to the employees in the workplace.

Tapping into the pricing and quality benefits of pool procurement, the benefit from the national linkages with the Medicines Control Council/SAHPRA to rapidly review for approval generic versions of medicines and new combinations and medicines that become available.

Enabler 5: Ensure that there are sufficient, appropriately trained human resources where they are needed

To ensure an appropriate response to HIV, TB and STI prevention, treatment and care is labour-intensive and requires diverse cadres of human resources from multiple disciplines in both the public and private for-profit and not-for-profit sectors. Human resources needs range from professionals to volunteers and from disease specialists to generalists.

Given the ambitious nature of the PIP's service targets and the imperative to expand efforts to address social and structural drivers, human resource needs under this PIP undoubtedly will grow and further diversify. This human resource cadre needs to be capacitated to render services in a caring, people-centred and competent manner to materialize and support the goals and objectives of this PIP.

The PIP requires an increase in the number of primary health care nurses who have the skills to administer antiretroviral therapy, manage drug-resistant TB, and address STIs beyond syndromic management, as well as a sufficient number of doctors to support services. Healthcare workers must be trained and proficient in occupational health and infection control standards and practices. Health and social development workers will benefit from training and technical support on working with key and vulnerable populations.

Linking with national processes that facilitate the formalization of community health workers as a cadre, appropriately trained and supported, and fully integrated into the various systems would be critical. Under this PIP, Mpumalanga will invest more resources and effort in the training and mobilisation of peer educators, lay counsellors and support personnel. Peers have an especially vital role to play in contributing to the response for young people and for other key and vulnerable populations. To play their optimal role, peer workers require standardised training, support and supervision as well as compensation.

SECTION 10: Financing of the Provincial Implementation Plan

This section is still to be finalised

PROVINCIAL ACTIONS AND RESPONSIBILITIES

The South African National AIDS Council (SANAC) makes provision for Provincial AIDS Councils (PCAs) and recommends that their structure and membership be similar to SANAC. In Mpumalanga, the Mpumalanga Provincial AIDS Council is administratively linked to the Mpumalanga Office of the Premier. The MPAC links directly with the three District AIDS Councils (DAC) in Ehlanzeni, Nkangala and Gert Sibande, for coordination of HIV, TB and STI activities in each of these districts. The DACs in turn coordinate with the various Local AIDS Councils (LACs) in their specific districts. Local AIDS Councils (WADs) coordinate activities within the various wards that they are linked to.

Mpumalanga Provincial AIDS Council (MPAC)

The MPAC act as advisory structure to the Executive committee of the Provincial Legislature and are also expected to provide province specific information and recommendations to SANAC. The MPAC is responsible for the coordination of the HIV, TB and STI response in line with the national strategic plan, and in response to direction received from District and Local AIDS Councils.

The focus is on implementation of programmes and strategies, creation and strengthening of partnerships for an expanded response, recommend appropriate research and mobilise resources for the implementation of HIV, STIs and TB programmes and monitoring of interventions between government, civil society, the private sector and development partners. This includes scaling up the use of the Focus for Impact approach as the key strategy within the NSP.

The objectives of MPAC is as follows:

- To act as an advisory structure to the executive committee of the provincial legislature on all policies related to HIV, STIs and TB;
- To advocate for the effective involvement of sectors and organisations in the implementation of programmes and strategies;
- To oversee the development of, and advocate for the PIP in line with the NSP;
- To provide support and oversight to District AIDS Councils;
- To oversee the mobilisation of resources for HIV, STI and TB programmes;
- To monitor the implementation of the PIPs, identify gaps and support the development of strategies to address these gaps;
- To collect regular reports on progress towards meeting the goals of the NSP and to submit these to SANAC; and
- Assess progress towards achieving the NSP goals, objectives and targets, as well as identify achievements, new opportunities and lessons learned across sectors and implementation levels (national, provincial and district).

District AIDS Councils (DACs)

Each District Municipality is expected to have its own AIDS Council. A DAC is an intermediary structure, responsible for providing the link between the MPAC and Local AIDS Councils (LACs). DACs are the highest decision-making structures for District Municipalities. Most DACs are district-level versions of SANAC and PCAs that are expected to advise District Municipalities on HIV, STI

and TB matters. DACs also co-ordinate, monitor and support the activities of the LACs. DACs are composed of District Municipal Councillors, officials from various district-level departments and representatives of LACs. Non-governmental organisations that operate in the district also participate. The structure of the District AIDS Council resembles that of the Provincial AIDS Council.

The DACs are responsible for carrying out the roles of the SANAC and the PCAs at District Municipality level and have as such adopted the roles and responsibilities of these. Generally, the objectives of DACs include:

- To act as an advisory structure to the executive committee of the District Mayoral Executive Council on all matters related to HIV, STIs and TB.
- To advocate for the effective involvement of sectors and organisations in the implementation of district programmes and strategies.
- To oversee the development of, and advocate for the DIP in line with the PIP,
- To provide support and oversight to Local AIDS Councils;
- To oversee the district-level mobilisation of resources for HIV, STI and TB programmes.
- To monitor the implementation of the provincial plans, identify gaps and support the development of strategies to address these gaps.
- To collect regular reports on progress towards meeting the objectives of the PIP and to submit these to the MPAC.
- Assess progress towards achieving the PIP goals, objectives and targets, as well as identify achievements, new opportunities and lessons learned across sectors.

The structure of most DACs is modelled from that of SANAC and PCAs. DACs are thus district-level versions of PCAs and their composition and structure, together with the roles of the different sub-structures are similar to those of SANAC and PCAs, with slight variations in line with the local context and realities.

Local AIDS Councils (LAC)

The LACS are set up in all municipalities in a district and should send representatives to the DAC so that there can be better coordination. DACs should help LACs to develop strategies, set up projects and access funding and resources.

Ward AIDS Councils (LAC)

Launched in 2013, WACs are responsible for helping collect ward-level data on HIV that will help inform not only provincial AIDS Council structures, but links closely with the implementation of the Focus for Impact approach that starts at a Ward level for risk profiling.

THE PROVINCIAL TARGETS (OVERVIEW)

The NSP 2017 - 2022 has ambitious goals and targets to guide the South Africa's HIV, TB and STI response. The current disease burden, latest research and evidence as well as national have informed these targets and international priorities set for HIV, TB and STIs. The national resource envelope to achieve these targets and the subsequent identification of the resource gap has been informed by these goals, objectives and targets.

Regarding the national targets, provinces are responsible to prioritise and focus on objectives and sub-objectives based on their specific provincial profile, disease burden and status. Mpumalanga Province followed a similar process to identify, prioritise and set targets for each activity that address each objective, sub-objective and goal. The process was informed and included a variety of stakeholders to ensure its multi-sectoral approach to its implementation and successful achievement. Key partners have been identified, however to ensure accountability and ownership of these targets and objectives, one specific partner will be the lead partner to coordinate the activities towards a specific target.

ANNEXURES

Annexure A: Glossary

Table 13 - Glossary

Term	Definition	Definition Source
Accountability	The key accountability principles outlined in the NSP are transparency and dialogue. Transparency involves access to meaningful data and analyses, representation on AIDS Councils, progress against targets set, budgeting and expenditure information and data on the community response. Dialogue includes engagement with diverse stakeholders in periodic reviews of the performance of the response to identify progress against targets, as well as gaps, weaknesses and emerging trends.	Customised for SA
Adolescent	Aged 10 to 19 years inclusive	National Consolidated Guidelines for PMTCT and the Management of HIV in Children, Adolescents, and Adults[4]
Adult	Older than 19 years of age	National Consolidated Guidelines for PMTCT and the Management of HIV in Children, Adolescents, and Adults
Antiretrovirals (ARVs)/ antiretroviral therapy (ART)/ HIV treatment	Antiretroviral therapy is highly active in suppressing viral replication, reducing the amount of the virus in the blood to undetectable levels and slowing the progress of HIV disease. ARV refers to antiretroviral medicines. It should only be used when	UNAIDS Terminology Guidelines[5]

[4] *National Consolidated Guidelines for PMTCT and the Management of HIV in Children, Adolescents, and Adults,*. 2015, National Department of Health: Pretoria.

[5] *UNAIDS Terminology Guidelines*. 2015, UNAIDS

Term	Definition	Definition Source
	referring to the medicines themselves and not to their use.	
ARV-based prevention	ARV-based prevention includes the oral or topical use of antiretroviral medicines to prevent the acquisition of HIV in HIV-negative persons (such as the use of pre-exposure prophylaxis or post-exposure prophylaxis) or to reduce the transmission of HIV from people living with HIV (treatment as prevention).	UNAIDS Terminology Guidelines
Behaviour change	The adoption and maintenance of healthy behaviours (with respect to particular practices) that reduce the chances of acquiring HIV	UNAIDS Terminology Guidelines
Behaviour change communication (BCC)	Behaviour change communication promotes tailored messages, personal risk assessment, greater dialogue and an increased sense of ownership of the response by the individual and the community. It is developed through an interactive process, and its messages and approaches use a mix of communication channels to encourage and sustain positive, healthy behaviours.	UNAIDS Terminology Guidelines
Biomedical factors	Biomedical factors relate to human physiology and its interaction with medicine.	UNAIDS Terminology Guidelines
Caregiver or carer	Carers are people who provide unpaid care for a family member, friend or partner who is ill, frail or living with a disability. This could include provision of unpaid care to a person living with HIV or TB.	UNAIDS Terminology Guidelines modified
Child	10 years of age and younger	National Consolidated Guidelines for PMTCT and the Management of HIV in Children, Adolescents, and Adults
Children, Adolescents, Youth, Young people	Children: According to Article 1 of the Convention on the Rights of the Child, “A child means every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier”.	Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations – 2016

Term	Definition	Definition Source
	Adolescents: Individuals between the ages of 10 and 19 years are generally considered adolescents. Adolescents are not a homogenous group; physical and emotional maturation comes with age, but its progress varies among individuals of the same age. Also, different social and cultural factors can affect their health, their ability to make important personal decisions and their ability to access services. Youth: This term refers to individuals between the ages of 15 and 24. Young people: This term refers to those between the ages of 10 and 24.	Update[6]
Client-initiated testing and counselling (CITC)	Client-initiated testing and counselling (CITC) involves individuals actively seeking HIV testing and counselling at a facility that offers such services. CITC is one of three principal modalities of HIV testing – the other two modalities being provider-initiated testing and counselling (PITC) and HIV self-testing (HIVST). CITC can be undertaken or carried out in community or special purpose settings.	UNAIDS Terminology Guidelines
Close contact	A person who has had prolonged, frequent or intense contact with a person with infectious TB. This group includes people who live together or spend a great deal of time together in close proximity. Close contacts, or household contacts, are more likely to become infected with tuberculosis than contacts who see the person with TB less often.	Global Plan to End TB 20–6-2020[7]
Combination HIV prevention	Combination HIV prevention seeks to achieve maximum impact on HIV prevention by combining human rights-based and evidence-	UNAIDS Terminology Guidelines

[6] *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations –2016 update*. 2016, World Health Organization: Geneva.

[7] *Global Plan to end TB. The paradigm shift 2016 - 2020*. 2015, Stop TB Partnership, UNOP

Term	Definition	Definition Source
	informed behavioural, biomedical and structural strategies in the context of a well-researched and understood local epidemic. Combination HIV prevention also can be used to refer to an individual's strategy for HIV prevention – combining different tools or approaches (either at the same time or in sequence), according to their current situation, risk and choices.	
Community response	Community response refers to a collective of community-led activities in response to HIV, TB or other issues. These activities are not limited to service delivery and can also include: advocacy by civil society and community networks for policies, programming and investments that meet the needs of communities; participation by civil society in monitoring and reporting on progress made in delivering the national HIV and TB response; and work by community systems on addressing inequalities and social drivers that are barriers to universal access. Service delivery by community systems could include community-led HIV testing and counselling , TB screening, peer-to-peer adherence support, home-based care, delivery of harm reduction services and service delivery by community networks to key populations.	UNAIDS Terminology Guidelines, modified
Community systems	There is no singular understanding of community systems, but one way of defining them is as "community-led structures and mechanisms used by communities, through which community members and community-based organisations and groups interact, co-ordinate and deliver their responses to the challenges and needs affecting their communities". Community systems can be informal and small-scale, or they can be extensive networks of organisations.	UNAIDS Terminology Guidelines
Community systems	Community systems are the structures, mechanisms, processes and actors through which communities act on the challenges and	Global Plan to End TB 2016–

Term	Definition	Definition Source
	needs that they face. They are made up of different types of entities: community members, formal and informal community organisations and networks, and other civil society organisations. Such systems are usually less formalised and less clearly defined than health systems. Entities that make up community systems have close links with communities; therefore, they are in a position to better understand the issues faced by those who are most affected and to find smart solutions.	2020[49]
Community systems strengthening (CSS)	Refers to initiatives that contribute to the development and/or strengthening of community-based organisations. This is done in order to increase knowledge of (and access to) improved health-service delivery, and it usually includes capacity-building of infrastructure and systems, partnership-building and the development of sustainable financing solutions. CSS promotes the development of informed, capable and co-ordinated communities and community-based organisations, groups and structures. It is the capacity-building and the actions that are needed to ensure that the community response can be delivered through community systems. CSS should reach a broad range of community actors, enabling them to contribute to the long-term sustainability of health and other interventions at the community level, including creating an environment in which these contributions can be effective. CSS should reach a broad range of community actors, enabling them to contribute to the long-term sustainability of health and other interventions at the community level, including creating an environment in which these contributions can be effective. As a systems approach, CSS aims to strengthen the role and effectiveness of key populations, community actors and organisations in the following areas: design, delivery, monitoring and evaluation of HIV and TB related services and activities;	UNAIDS Terminology Guidelines modified

Term	Definition	Definition Source
	advocacy and policy; organisational management and development; capacity strengthening; engagement in decision-making processes; and accountability and transparency.	
Comprehensive sexuality education	Sexuality education is defined as “an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic and non-judgmental information.” “Sexuality education provides opportunities to explore one’s own values and attitudes and to build decision-making, communication and risk reduction skills about many aspects of sexuality”. The term ‘comprehensive’ indicates “that this approach to sexuality education encompasses the full range of information, skills and values to enable young people to exercise their sexual and reproductive rights and to make decisions about their health and sexuality. It is important to understand that comprehensive sexuality education offers the full range of possibilities for young people to practice safer sex and does not just promote messages about abstinence”.	UNAIDS Terminology Guidelines
Comprehensive social protection	Comprehensive social protection addresses a range of measures for policy and programming, such as legal reforms to protect the rights of people living with HIV, women and key populations. It also includes economic empowerment programmes, referrals and linkages to maximise the impact of investments in (and across) sectors.	UNAIDS Terminology Guidelines, modified
Counselling	Counselling is an interpersonal, dynamic communication process between a client and a trained counsellor (who is bound by a code of ethics and practice) that tries to resolve personal, social or psychological problems and difficulties. In the context of an HIV diagnosis, counselling aims to encourage the client to explore important personal issues, identify ways of coping with anxiety and	UNAIDS Terminology Guidelines

Term	Definition	Definition Source
	stress, and plan for the future (such as keeping healthy, adhering to treatment and preventing transmission). When counselling in the context of a negative HIV test result, the focus is exploring the client's motivation, options and skills to stay HIV-negative.	
Counselling, follow-up	Follow-up counselling after post-test counselling helps clients to identify their concerns and supports them in addressing these. Follow-up counselling is of particular importance for supporting prevention of HIV transmission in serodiscordant couples and for linking women of reproductive age with HIV to programmes for the prevention of mother-to-child transmission (which are key to eliminating new HIV infections among children and keeping their mothers alive).	UNAIDS Terminology Guidelines, modified
Counselling, post-test	Post-test counselling is used to explain the result of the test. It provides additional information on risk-reduction measures – including prevention options for individuals who have tested negative – and it encourages people with high-risk practices or who may have been tested during the window period to come again for testing. The aim of post-test counselling for those who have tested HIV-positive is to help them cope psychologically with the result of the test and understand the services (including treatment and care options) that are available to them. This serves to encourage HIV-positive people to adopt prevention measures to avoid transmission of HIV to their partners and to begin a discussion about issues around disclosure and partner notification. Post-test counselling should be linked to onward referral to care and support services, including antiretroviral therapy, tuberculosis services and family planning (if applicable).	UNAIDS Terminology Guidelines, modified
Coverage rate	The coverage rate is the proportion of individuals accessing and receiving a service or commodity at a point in time. The numerator	UNAIDS Terminology Guidelines

Term	Definition	Definition Source
	is the number of people who receive the service and the denominator is the number of individuals who are eligible to receive the service at the same point in time. This is typically measured in surveys, but it also may be measured using service data (e.g. receiving clean needles or antiretroviral therapy).	
Critical enablers	Critical enablers are "activities that are necessary to support the effectiveness and efficiency of basic programme activities". Programmes that are critical enablers "should be primarily assessed in terms of their effectiveness in increasing the uptake, equitable coverage, rights-based delivery and quality of basic programme activities." Critical enablers also "overcome major barriers to service uptake, including social exclusion, marginalisation, criminalisation, stigma and inequity.	UNAIDS Terminology Guidelines
Early adolescent	Aged 10 to 15 years	National Consolidated Guidelines for PMTCT and the Management of HIV in Children, Adolescents, and Adults
Enabling environment	There are different kinds of enabling environment in the context of HIV. For instance, an enabling legal environment would not only have laws and policies against discrimination on the basis of sex, health status (including HIV status), age, disability, social status, sexual orientation, gender identity and other relevant grounds, but they would be enforced. In such an environment, people also would have access to justice – that is, a process and remedy if they are aggrieved. An enabling social environment is one in which social protection strategies (e.g. economic empowerment) are in place, and where social norms support knowledge, awareness and healthy behaviour choices.	UNAIDS Terminology Guidelines

Term	Definition	Definition Source
Epidemic (includes outbreak, pandemic, endemic)	An epidemic refers to a disease condition affecting (or tending to affect) a disproportionately large number of individuals within a population, community or region at the same time. The population may be all of the inhabitants of a given geographic area, the population of a school or similar institution or everyone of a certain age or sex (such as the children or women of a region). An epidemic may be restricted to one locale (an outbreak), be more general (an epidemic) or be global (a pandemic). Common diseases that occur at a constant but relatively high rate in the population are said to be endemic.	UNAIDS Terminology Guidelines
Epidemiology	Epidemiology is the scientific study of the causes, spatial and temporal distribution, and control of diseases in populations.	UNAIDS Terminology Guidelines
Extensively drug-resistant tuberculosis (XDR-TB)	Extensively drug-resistant tuberculosis occurs when the bacteria causing tuberculosis are resistant to isoniazid, rifampicin, fluoroquinolones and at least one injectable second-line drug. The emergence of XDR-TB underlines the necessity of managing tuberculosis programmes in a systematic way at all levels.	UNAIDS Terminology Guidelines[47]
Extrapulmonary TB	TB disease in any part of the body other than the lungs (for example, the kidney, spine, brain or lymph nodes)	Global Plan to End TB 2016-2020
Focus for Impact	The NSP uses the term ‘focus for impact’ to refer to intensified services, programmes, policies and interventions that will have the greatest impact. This includes implementing activities in locations with the highest burden of disease, with populations most affected and most at risk, and using evidence-informed interventions in the right combinations to maximise effect.	Customised for SA
Gender (2)	Gender “refers to the social attributes and opportunities associated with being male and female and the relationships between women	UNAIDS Terminology Guidelines

Term	Definition	Definition Source
	and men and girls and boys, as well as the relations between women and those between men. These attributes, opportunities and relationships are socially constructed and are learned through socialization processes. They are context-/time-specific and changeable. Gender determines what is expected, allowed and valued in a woman or a man in a given context. In most societies, there are differences and inequalities between women and men in responsibilities assigned, activities undertaken, access to and control over resources, as well as decision-making opportunities". Note that since many languages do not have the word 'gender', translators may have to consider alternatives to distinguish between the terms 'gender' and 'sex'.	
Gender equality	Gender equality – or equality between men and women – is a recognised human right, and it reflects the idea that all human beings, both men and women, are free to develop their personal abilities and make choices without any limitations set by stereotypes, rigid gender roles or prejudices. Gender equality means that the different behaviours, aspirations and needs of women and men are considered, valued and favoured equally. It also signifies that there is no discrimination on the grounds of a person's gender in the allocation of resources or benefits, or in access to services. Gender equality may be measured in terms of whether there is equality of opportunity or equality of results.	UNAIDS Terminology Guidelines
Gender identity	Gender identity refers to a person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth. It includes both the personal sense of the body – which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means – as well as other expressions of gender, including dress, speech	UNAIDS Terminology Guidelines

Term	Definition	Definition Source
	and mannerisms.	
Gender-sensitive	Gender-sensitive policies, programmes or training modules recognise that both women and men are actors within a society, that they are constrained in different and often unequal ways, and that consequently they may have divergent and sometimes conflicting perceptions, needs, interests, and priorities.	Global Plan to End TB 2016–2020[49]
Gender-based violence	Gender-based violence "describes violence that establishes, maintains or attempts to reassert unequal power relations based on gender." It encompasses acts that inflict physical, mental or sexual harm or suffering, threat of such acts, coercion and other deprivations of liberty. "The term was first defined to describe the gendered nature of men's violence against women. Hence, it is often used interchangeably with violence against women. The definition has evolved to include violence perpetrated against some boys, men and transgendered persons because they challenge (or do not conform to) prevailing gender norms and expectations (e.g. they may have a feminine appearance), or to heterosexual norms".	UNAIDS Terminology Guidelines
Harm reduction	The term 'harm reduction' refers to a comprehensive package of policies, programmes and approaches that seeks to reduce the harmful health, social and economic consequences associated with the use of psychoactive substances. The elements in the package are as follows: needle and syringe programmes; Opioid Substitution Therapy; HIV testing and counselling; HIV care and antiretroviral therapy for people who inject drugs; prevention of sexual transmission; outreach (information, education and communication for people who inject drugs and their sexual partners); viral hepatitis diagnosis, treatment and vaccination (where applicable); and tuberculosis prevention, diagnosis and treatment. For example, people who inject drugs are vulnerable to	UNAIDS Terminology Guidelines

Term	Definition	Definition Source
	blood borne infections (such as HIV) if they use non-sterile injecting equipment. Therefore, ensuring adequate supplies of sterile needles and syringes is a harm reduction measure that helps to reduce the risk of blood-borne infections.	
Health education	Health education is the provision of accurate and appropriately contextualised information on health (e.g. according to age, sex and culture) that is aimed at assisting individuals to make informed choices to improve their health.	UNAIDS Terminology Guidelines
Health sector	The health sector encompasses a number of related organisations and services. These include organised public and private health services (including those for health promotion, disease prevention, diagnosis, treatment and care), health ministries, health-related non-governmental organisations, health-related community groups and health specific professional organisations. It also includes institutions that provide direct input into the healthcare system, such as the pharmaceutical industry and teaching institutions.	UNAIDS Terminology Guidelines
Health system	A health system consists of all organisations, people and actions whose primary intent is to promote, restore or maintain health. It involves the broad range of individuals, institutions and actions that help to ensure the efficient and effective delivery and use of products and information to provide prevention, treatment, care and support for those who need such services.	UNAIDS Terminology Guidelines
Health systems strengthening	The term ‘health systems strengthening’ refers to a process that improves a health system’s capacity to deliver effective, safe and high-quality services equitably. Areas that require strengthening are typically the service delivery system, health workforce, health information system, systems to guarantee equitable access to health commodities and technologies, and health financing	UNAIDS Terminology Guidelines

Term	Definition	Definition Source
	systems. Leadership, governance and accountability also can be strengthened.	
HIV testing services (HTS)	HIV testing is the gateway to HIV treatment and care, and it is critical in the scale-up of universal access to HIV prevention, including in the context of medical male circumcision, elimination of new infections among children, and antiretroviral medicine-based prevention approaches (including pre-exposure prophylaxis or post-exposure prophylaxis). The term HIV testing services (HTS) is used to embrace the full range of services that should be provided together with HIV testing. HIV testing should be undertaken within the framework of the '5 Cs': consent, confidentiality, counselling, correct test results and connection/linkage to prevention, care and treatment.	UNAIDS Terminology Guidelines
Homophobia	Homophobia is the fear or rejection of (or aversion to) homosexuals and/or homosexuality. This often takes the form of stigmatising attitudes or discriminatory behaviour, and it occurs in many settings in all societies, often beginning as early as school.	UNAIDS Terminology Guidelines
Human rights	The South African Constitution guarantees a broad range of civil, political, cultural and socio-economic rights, including the rights to equality and non-discrimination, privacy, dignity, freedom and security of the person, access to health care and access to justice.	Customised for SA
Incidence	The number of new (HIV, TB or STI) infections over the number of people susceptible to infection in a specified time period	UNAIDS Terminology Guidelines
Infant	A child younger than one year of age	National Consolidated Guidelines for PMTCT and the Management of HIV in Children, Adolescents and Adults

Term	Definition	Definition Source
Intergenerational relationships, cross-generational relationships, age-disparate relationships	Terms that refer to relationships where there is a 10-year (or greater) age disparity between sexual partners	UNAIDS Terminology Guidelines
Key populations	The South African NSP defines key populations as those most at risk for HIV, TB, and STI. The NSP follows the UNAIDS and WHO definition of key populations for HIV and STI: gay men and other men who have sex with men, sex workers and their clients, transgendered people, people who inject drugs and prisoners and other incarcerated people as the main key population groups. These populations often suffer from punitive laws or stigmatising policies, and they are among the most likely to be exposed to HIV. Their engagement is critical to a successful HIV response everywhere – they are key to the epidemic and key to the response. Due to specific higher-risk behaviours, these groups are at increased risk of HIV irrespective of the epidemic type or local context. The key populations are important to the dynamics of HIV transmission. They are also essential partners in an effective response to the epidemic. In accordance with the Global TB plan, 'key populations' for TB are defined as people who are vulnerable, underserved or at risk of TB infection. These include people with increased exposure to TB due to where they live or work, people with limited access to quality TB services, and people at greater illness or risk due to biological or behavioural factors. The NSP defines key populations for TB as people living with HIV, household contacts of TB index patients, healthcare workers, inmates, pregnant women, children under five years of age, diabetics, and people living in informal settlements.	UNAIDS Terminology Guidelines 2015 Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations – 2016 Update
Late adolescent	Aged 15 to 19 years inclusive	National Consolidated Guidelines for PMTCT and the Management of HIV

Term	Definition	Definition Source
		in Children, Adolescents and Adults
Leadership	The NSP demands leadership from all spheres of government (national, provincial, local government) as well as communities, the private sector, organised labour, civil society, the general as well as key and vulnerable populations, academics, researchers, development partners and – most important of all – people living with HIV or infected with TB.	Customised for SA
Lost to follow-up	Someone who does not start or complete HIV, TB or STI treatment, generally because of poor quality health services or the lack of a patient-centred approach. Previously, people lost to follow-up were referred to as 'defaulters'. The term 'defaulters' should be avoided, however, as it unfairly places all the blame on patients.	Global Plan to End TB 2016–2020, modified
Men who have sex with men (MSM)	The term 'men who have sex with men' describes males who have sex with males, regardless of whether or not they also have sex with women or have a personal or social gay or sexual identity. This concept is useful because it also includes men who self-identify as heterosexual but who have sex with other men.	UNAIDS Terminology Guidelines
M-health	An abbreviation for 'mobile health', a term used for the practice of medicine and public health supported by mobile devices	Global Plan to End TB 2016–2020
Mobile workers/population	The term 'mobile worker' refers to a large category of persons who may cross borders or move within their own country on a frequent and short-term basis for a variety of work-related reasons. This is done without changing their primary residence or home base. Mobile work involves a range of employment or work situations that require workers to travel in the course of their work. Mobile workers usually are in regular or constant transit – sometimes in (regular) circulatory patterns and often spanning two or more countries – and	UNAIDS Terminology Guidelines

Term	Definition	Definition Source
	they can be away from their habitual or established place of residence for varying periods of time.	
Multidrug-resistant tuberculosis (MDR-TB)	MDR-TB is a specific form of drug-resistant tuberculosis, due to a bacillus resistant to at least isoniazid and rifampicin, the two most powerful anti-tuberculosis drugs.	UNAIDS Terminology Guidelines
Needle and syringe programme	The term 'needle and syringe programme' is increasingly replacing the term 'needle exchange programme' because the exchange of needles has been associated with unintended negative consequences compared with distribution. Both terms refer to programmes aimed at increasing the availability of sterile injecting equipment.	UNAIDS Terminology Guidelines
Opioid Substitution Therapy	Opioid Substitution Therapy is the recommended form of drug dependence treatment for people who are dependent on opioids. It has proved to be effective in the treatment of opioid dependence, in the prevention of HIV transmission and in the improvement of adherence to antiretroviral therapy. The most common drugs used in OST are methadone and buprenorphine.	UNAIDS Terminology Guidelines
Patient-centred approach to TB care	A patient-centred approach considers the needs, perspectives and individual experiences of people affected by TB, while respecting their right to be informed and receive the best quality of care based on individual needs. It requires the establishment of mutual trust and partnership in the patient–care provider relationship, and creates opportunities for people to provide input into and participate in the planning and management of their own care. A patient-centred approach improves treatment outcomes, while respecting human dignity.	Global Plan to End TB 2016-2020
People affected by TB and/or	This term encompasses people who are ill with TB and/or HIV and	Global Plan to End TB 2016–2020,

Term	Definition	Definition Source
HIV	their family members, dependents, communities and healthcare workers who may be involved in caregiving or are otherwise affected by the illness.	modified
People who inject drugs	Refers to people who inject psychotropic (or psychoactive) substances for non-medical purposes. These drugs include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypno-sedatives and hallucinogens. Injection may be through intravenous, intramuscular, subcutaneous or other injectable routes. People who self-inject medicines for medical purposes – referred to as 'therapeutic injection' – are not included in this definition. The definition also does not include individuals who self-inject non-psychotropic substances, such as steroids or other hormones, for body-shaping or improving athletic performance. While these guidelines focus on people who inject drugs because of their specific risk of HIV transmission due to the sharing of blood-contaminated injection equipment, much of this guidance is relevant also for people who inject other substances.	Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations – 2016 Update
Population and location	In the context of HIV, population and location or local epidemic is a concept that is used to help prioritise programme activities within the HIV response. It refers to the need to focus on specific areas and specific populations where there is high HIV prevalence or incidence. The result of using a population and location approach will be a more efficient HIV response based on a more distilled knowledge of the HIV epidemic in the country .	UNAIDS Terminology Guidelines
Post-exposure prophylaxis (PEP)	Post-exposure prophylaxis refers to antiretroviral medicines that are taken after exposure (or possible exposure) to HIV. The exposure may be occupational (e.g. a needle stick injury) or non-occupational (e.g. condom less sex with a seropositive partner). The latter is sometimes referred to as non-occupational post-	UNAIDS Terminology Guidelines

Term	Definition	Definition Source
	exposure prophylaxis (N-PEP).	
Pre-exposure prophylaxis (prep)	Pre-exposure prophylaxis (PrEP) refers to antiretroviral medicines prescribed before exposure (or possible exposure) to HIV. Several studies have demonstrated that a daily oral dose of appropriate antiretroviral medicines is effective in both men and women for reducing the risk of acquiring HIV infection through sexual or injection transmission.	UNAIDS Terminology Guidelines
Prevention of mother-to-child transmission (PMTCT) and mother-to-child-transmission (MTCT) of HIV	MTCT is the abbreviation for 'mother-to-child transmission'. PMTCT, the abbreviation for prevention of mother-to-child transmission, refers to a four-pronged strategy for stopping new HIV infections among children and keeping their mothers alive and families healthy. The four prongs are: helping reproductive-age women to avoid HIV (prong 1); reducing unmet need or family planning (prong 2); providing antiretroviral medicine prophylaxis to prevent HIV transmission during pregnancy, labour and delivery, and breastfeeding (prong 3); and providing care, treatment and support for mothers and their families (prong 4).	UNAIDS Terminology Guidelines
Provider-initiated testing and counselling (PITC)	Provider-initiated testing and counselling (PITC) refers to HIV testing and counselling that is recommended by healthcare providers to people attending healthcare facilities as a standard component of medical care. It is offered routinely to all people attending a service (such as pregnant women attending antenatal care) and is recommended as an opt-out approach; that is, it remains voluntary and the decision not to take the test is left with the patient. The purpose of provider-initiated testing and counselling is to enable specific clinical decisions to be made (or specific medical services to be offered) that would not be possible without knowledge of the person's HIV status. It also helps to identify unrecognised or unsuspected HIV infection among people	UNAIDS Terminology Guidelines

Term	Definition	Definition Source
	attending healthcare facilities.	
Psychosocial support	Psychosocial support addresses the on-going psychological and social problems of HIV infected individuals, their partners, families and caregivers.	WHO, 2017
Reproductive health	Reproductive health "is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. It implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility that are not against the law , and the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant".	UNAIDS Terminology Guidelines
Reproductive rights	Reproductive rights "embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future	UNAIDS Terminology Guidelines

Term	Definition	Definition Source
	children and their responsibilities towards the community".	
Risk	Risk is defined as the risk of exposure to HIV or the likelihood that a person may acquire HIV. Behaviours, not membership of a group, place individuals in situations in which they may be exposed to HIV, and certain behaviours create, increase or perpetuate risk. Avoid using the expressions groups at risk or risk groups – people with behaviours that may place them at higher risk of HIV exposure do not necessarily identify with any particular group.	UNAIDS Terminology Guidelines, modified
Second-generation surveillance	Second-generation surveillance for HIV is the regular and systematic collection, analysis, interpretation, reporting and use of information to track and describe changes in the HIV epidemic over time. In addition to HIV surveillance and AIDS case reporting, second-generation surveillance includes behavioural surveillance to track trends in risk behaviours over time in order to identify or explain changes in levels of infection and the monitoring of sexually transmissible infections in populations at risk of acquiring HIV. These different components achieve greater or lesser significance depending on the surveillance needs of a country, as determined by the nature of the epidemic it is facing.	UNAIDS Terminology Guidelines
Sex (see also gender)	The term 'sex' refers to biologically determined differences that are used to label individuals as males or females. The bases for this classification are reproductive organs and functions.	UNAIDS Terminology Guidelines
Sex worker	Female, male and transgendered adults (18 years of age and older) who receive money or goods in exchange for sexual services, either regularly or occasionally. Sex work is consensual sex between adults, can take many forms, and varies between and within countries and communities. Sex work also varies in the degree to which it is more or less 'formal', or organised. As defined	Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations – 2016 Update

Term	Definition	Definition Source
	in the Convention on the Rights of the Child (CRC), children and adolescents under the age of 18 who exchange sex for money, goods or favours are 'sexually exploited' and are not defined as sex workers.	
Sexual and reproductive health package	Programmes, supplies and multi-integrated services to ensure that people are able to have not only a responsible, satisfying and safer sex life, but also the capability to reproduce and the freedom to decide if, when and how often to do so. It is particularly important that this decision be free of any inequality based on socio-economic status, education level, age, ethnicity, religion or resources available in their environment. A sexual and reproductive health package aims to guarantee that men and women are informed of (and to have access to) the following resources: safe, effective, affordable and voluntary acceptable methods of birth control; access to appropriate healthcare services for sexual and reproductive care, treatment and support; and access to comprehensive sexuality education. A package also includes (but is not limited to): pregnancy-related services (and skilled attendance and delivery), as well as emergency obstetric and post-abortion care; STI and HIV prevention, diagnosis and treatment; prevention and early diagnosis of breast and cervical cancers; and prevention of gender-based violence and care for survivors of gender-based violence.	UNAIDS Terminology Guidelines
Sexual and reproductive health programmes and policies	Sexual and reproductive health programmes and policies include, but are not restricted to, the following: services for family planning; infertility services; maternal and new-born health services; prevention of unsafe abortion and post-abortion care; prevention of mother-to-child transmission of HIV; diagnosis and treatment of sexually transmitted infections, including HIV infection, reproductive	UNAIDS Terminology Guidelines

Term	Definition	Definition Source
	tract infections, cervical cancer and other gynaecological morbidities; promotion of sexual health, including sexuality counselling; and prevention and management of gender-based violence.	
Sexual and reproductive health services	This includes services for family planning; infertility services; prevention of unsafe abortion and post-abortion care; diagnosis and treatment of sexually transmitted infections, including HIV infection, reproductive tract infections, cervical cancer and other gynaecological morbidities; and the promotion of sexual health, including sexuality counselling.	NSP 2012-2016, UNAIDS Terminology Guidelines
Sexual rights	Sexual rights embrace a "human right that already are recognised in many national laws, international human rights documents and other consensus statements: the right of all persons to the highest attainable standard of sexual health, free of coercion, discrimination and violence. This includes the following: accessing sexual and reproductive healthcare services; seeking, receiving and imparting information related to sexuality; obtaining sexuality education; enjoying respect for bodily integrity; choosing a partner; deciding to be sexually active or not; participating in consensual sexual relations; engaging in consensual marriage; determining whether or not (and when) to have children; and pursuing a satisfying, safe and pleasurable sexual life" (19).	UNAIDS Terminology Guidelines
Sexually transmitted infection (STI)	The transfer of organisms spreads STIs from person to person during sexual contact. In addition to the traditional STIs (syphilis and gonorrhoea), the spectrum of STIs also includes: HIV, which causes AIDS; chlamydia trachomatis; human papillomavirus (HPV), which can cause cervical, penile or anal cancer; genital herpes; and cancroid. More than 20 disease-causing organisms and	NSP 2012-2016, UNAIDS Terminology Guidelines

Term	Definition	Definition Source
	syndromes are now recognised as belonging in this category.	
Social drivers	The NSP highlights complex and multi-dimensional social drivers from factors such as poverty, inequality, inadequate access to education, poor nutrition, migration, gender inequality and gender-based violence, and alcohol and substance abuse that increase vulnerability to HIV, TB and STIs; deter individuals from seeking needed services early; and interfere with the ability of individuals to receive services and to adhere to prescribed regimens.	Customised for SA
Social protection	Social protection has been defined as "all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance social status and rights of the marginalised; with the overall objective of reducing the economic and social vulnerability of the poor, vulnerable and marginalised groups" (20). Social protection involves more than cash and social transfers; it encompasses economic, health and employment assistance to reduce inequality, exclusion and barriers to accessing HIV prevention, treatment, care and support services.	UNAIDS Terminology Guidelines, modified
Sputum	Phlegm coughed up from deep inside the lungs. Sputum is examined for TB bacteria using smear microscopy, culture or molecular tests.	Global Plan to End TB 2016–2020
Stigma and discrimination	Stigma is derived from a Greek word meaning a mark or stain, and it refers to beliefs and/or attitudes. Stigma can be described as a dynamic process of devaluation that significantly discredits an individual in the eyes of others, such as when certain attributes are seized upon within particular cultures or settings and defined as discreditable or unworthy. When stigma is acted upon, the result is discrimination. Discrimination refers to any form of arbitrary	UNAIDS Terminology Guidelines

Term	Definition	Definition Source
	distinction, exclusion or restriction affecting a person, usually (but not only) because of an inherent personal characteristic or perceived membership of a particular group. It is a human rights violation. In the case of HIV, this can be a person' s confirmed or suspected HIV-positive status, irrespective of whether or not there is any justification for these measures. The terms stigmatisation and discrimination have been accepted in everyday speech and writing, and they may be treated as plural.	
Strategic approach	The NSP highlights a strategic approach for each goal. This includes the use of data to identify locations and populations in need of intensified responses, as well as the customisation of responses to the local context. Further, strategic approaches include the scale up of high-impact interventions, assurance of co-ordinated multi-sectoral approaches, and continuous monitoring of results to determine any needed corrective actions.	Customised for SA
Strategic information	For the purposes of the NSP, 'strategic information' includes three key components: monitoring and evaluation, surveys and surveillance, and research.	Customised for SA
Structural drivers	Structural drivers are factors in the physical, legal and social environment that influence individual and group behaviour.	UNAIDS Terminology Guidelines, modified
Structural interventions	Structural interventions are those that seek to alter the physical, legal and social environment in which individual behaviour takes place. They also can aim to remove barriers to protective action or to create constraints to risk-taking.	UNAIDS Terminology Guidelines
Surveillance	Public health surveillance is the continuous systematic collection, analysis and interpretation of health-related data that are needed for the planning, implementation and evaluation of public health	UNAIDS Terminology Guidelines

Term	Definition	Definition Source
	practice.	
TB disease	An illness in which TB bacteria multiply and attack a part of the body, usually the lungs. The symptoms of active TB disease include weakness, weight loss, fever, loss of appetite and night sweats. Other symptoms of TB disease depend on where in the body the bacteria are growing. If TB disease is in the lungs (pulmonary TB), the symptoms may include a bad cough, pain in the chest and coughing up blood. A person with pulmonary TB disease may be infectious and spread TB bacteria to others.	Global Plan to End TB 2016–2020
TB infection	Also called 'latent tuberculosis infection'. This is a condition in which TB bacteria are alive but inactive in the body. People with latent TB infection have no symptoms; they do not feel sick, cannot spread TB bacteria to others, and usually test positive for infection – positive to a tuberculin skin test or a special test called IGRA test. In the Global Plan, people referred to as 'infected with TB' are people having such latent TB infection.	Global Plan to End TB 2016–2020
TB prevention and care	The efforts of healthcare workers to provide TB services to the communities they serve. These terms are preferred over 'TB control', which may create the perception that TB experts are in full control of all aspects of prevention, treatment and care of people with TB. It is useful to examine the term 'control' critically so as to avoid neglecting community and patient resources and capacities.	Global Plan to End TB 2016–2020
Transgendered persons	'Transgendered' is an umbrella term to describe people whose gender identity and expression does not conform to the norms and expectations traditionally associated with their sex at birth. Transgendered people include individuals who have received gender reassignment surgery, individuals who have received gender-related medical interventions other than surgery (e.g.	UNAIDS Terminology Guidelines, modified

Term	Definition	Definition Source
	hormone therapy) and individuals who identify as having no gender, multiple genders or alternative genders. Transgendered individuals may self-identify as transgendered, female, male, transwoman or transman, trans-sexual or one of many other transgendered identities, and they may express their genders in a variety of masculine, feminine and/or androgynous ways. Due to this diversity, it is important to learn and use positive local terms for transgendered people, and to avoid derogatory terms.	
Voluntary medical male circumcision (VMMC)	Voluntary medical male circumcision (VMMC) is the surgical removal of the foreskin, the tissue covering the head of the penis where cells highly receptive to the Human Immunodeficiency Virus are located. There is compelling evidence that circumcision can significantly reduce the risk of HIV transmission. Conventional surgery or more recently, the use of male circumcision devices, is methods of MMC. It should always be offered as part of a combination package of HIV prevention services that includes: active detection of symptomatic sexually transmitted infections and their treatment; provision and promotion of male and female condoms; safer sex and risk-reduction counselling; and HIV testing and (if the individual is found to be HIV-positive) linkage to antiretroviral therapy.	UNAIDS Terminology Guidelines
Vulnerability, vulnerable populations	'Vulnerability' refers to unequal opportunities, social exclusion, unemployment or precarious employment (and other social, cultural, political, legal and economic factors) that make a person more susceptible to TB, STIs and/or HIV infection and developing AIDS. The factors underlying vulnerability may reduce the ability of individuals and communities to avoid HIV, TB or STI risk, and they may be beyond their control. These factors may include: lack of the knowledge and skills required to protect oneself and others; limited	UNAIDS Terminology Guidelines, modified, The Global TB Plan

Term	Definition	Definition Source
	accessibility, quality and coverage of services; and restrictive societal factors, such as human rights violations, punitive laws or harmful social and cultural norms (including practices, beliefs and laws that stigmatise and disempower certain populations). The South African NSP defines vulnerable populations for HIV, TB and STIs as: adolescent girls and young women; children, including orphans and vulnerable children, people living in informal settlements, mine workers, migrants and undocumented foreigners, people with disabilities, and other LGBTI populations.	

PROVINCIAL IMPLEMENTATION PLAN M&E FRAMEWORK ON HIV, TB and STIs (APRIL 2017 – MARCH 2022) CORE INDICATORS

GOAL 1: ACCELERATE PREVENTION TO REDUCE NEW HIV, TB AND STI INFECTIONS														
	INDICATOR	**TYPE**	**CALCULATION**	**DISAGGREGATION**	**DATA SOURCE**	**BASELINE VALUE**	**TARGET**						**REPORTING FREQUENCY**	**RESPONSIBLE**
							FY 2017	***FY2018***	***FY2019***	***FY 2020***	***FY2021***	***FY2022***		
Objective 1.1 Reduce new HIV infections to less than 100,000 per year by 2022 through combination prevention interventions														
1.	Number of people tested for HIV	Output	**Numerator**: Number of people tested for HIV **Denominator:**	Geographic area	Programme reports								Quarterly	
2.	1. Mother-to-Child transmission rate at 10 weeks Impact	Impact	**Numerator**: Infant PCR test positive around 10 weeks **Denominator**: Total Infant PCR test around10 weeks	Geographic area DHIS	DHIS PMTCT	1.6 % (2015/16)	1.5% (PMTCT Last Mile Plan 2016 – 2021)	1.4%	1.3%	1.0%	0.8%	<0.8%	Quarterly PDOH	PDOH
3.	Mother-to-Child transmission rate at 18 months	Impact	Children born to HIV-positive women who tested positive for HIV antibodies around 18 months after birth	Geographic area	DHIS	18 months: 5%	4%	3%	2%	1.5%	1.0%	<1.0%	Quarterly	PDOH
4.	Couple year protection rate	Outcome	**Numerator:** Women protected against pregnancy by using modern contraceptive methods **Denominator:** Population females 15–49 years	Geographic area	DHIS	45% (205/16) (PDOH APP 2017/18-2019/2020)	55%	60%	65%	65%%	>65%	>65%	Annual	NDOH
5.	**Sub-objective 1.1.3: : Provide targeted services to reduce Mother to Child transmission of HIV and syphilis in the prenatal and postnatal period**													

6.	ANC early bookings before 20 weeks rate	Outcome	**Numerator:** Number of ANC bookings before 20 weeks **Denominator:** Total number of all ANC bookings	Geographic area	DHIS (ANC Survey)	*70%*	72%	74%	75%	76%	78%	>78%	Quarterly	DOH
7.	Number of ANC 1st test positive	Output	**Numerator:** Number of ANC 1st test positive **Denominator:** N/A	Geographic area	DHIS DOH annual report	19 518	15 329	13 110	10 687	8 750	7 175	>7 175	Quarterly	DOH
8.	Number of ANC clients initiated on ART	Output	**Numerator:** Number of ANC clients initiated on ART **Denominator:**	Geographic area	DHIS	18 727	14 320	12 820	10 820	8 820	7 820	<7 820	Quarterly	DOH
9.	Number of HIV exposed infants tested with PCR at 10 weeks	Output	**Numerator:** Number of HIV exposed infants tested with PCR at 10 weeks **Denominator:** N/A	Geographic area	DHIS	18 177	15 061	13 504	12 504	11 504	10 504	<10 504	Quarterly	DOH
10.	Number of 1st PCR test positive around 10 weeks	Outcome	**Numerator:** number of 1st PCR test positive around 10 weeks **Denominator:** total number of **HIV exposed infants tested with PCR at 10 weeks**	Geographic area	DHIS	289	226	190	163	115	94	<94	Quarterly	DOH
11.	**Sub-objective 1.1.4: Provide sensitive and age-appropriate sexual and reproductive health services (SRH) and comprehensive sexuality education (CSE)**													
12.	Number of grade 8 learners provided with SRHR and CSE	Output	**Numerator:** number of grade 8 learners provided with SRHR and CSE **Denominator:** Total number of all grade 8 learners	Geographic area	DOE quarter and annual reports Programme reports	No baseline	17 192	21 490	25 788	TBD			Quarterly	DOE
13.	Number	Output	**Numerator:**	Geographic	DHE	No baseline	1 200			2 200			Quarterly	DHE

	of girls aged 15-24 years reached through dialogues on HIV, STIs and TB prevention		number of girls aged 15-24 years reached through dialogues on HIV, STIs and TB prevention	area	annual and quarter reports Programme reports (SHE Conquers)									
14.	Number of students in TVET and universities reached through HTS campaigns	Output	**Numerator:** number of students in TVET and universities reached through HTS campaigns	Geographic area	DHE annual and quarter reports Programme reports	No baseline	500	800	1300	1 600	1 800	>1 800	Quarterly	DHE
15.	Number Schools reached with School Health programme	Output	**Numerator:** number of schools reached with School Health programme **Denominator:** Total number of schools	Geographic area	DOE annual and quarter reports	910	1000	1000	1000	1000	1000	1000	Quarterly	
16.	**Sub-objective 1.1.5 Integrated and accessible combination prevention services at all health service points with focus on key and vulnerable populations**													
17.	Number of community awareness campaigns conducted on HIV, STIs and TB prevention in high burden communities	Output	**Numerator:** number of community awareness campaigns conducted on HIV, STIs and TB prevention in high burden communities **Denominator: N/A**	Geographic areas	DOH quarter and annual reports Programme reports (registers)	147	150	153	156	159	162	>162	Quarterly	DOH
18.	Number	Output	**Numerator**:	Geographic	DOH	32	18	18	18	18	18	18	Quarterly	DOH

	of community conversations on HIV and AIDS responses		number of community conversations on HIV and AIDS responses **Denominator: N/A**	area	quarter and annual reports Programme reports (registers)									
19.	Number of people reached through mobilization programmes	Output	**Numerator:** number of people reached through mobilization programmes **Denominator:** N/A	Geographic area	DOH quarter and annual reports Programme reports (registers)	9 400 Target not changing (Advice from SANAC) Dept indicated no changes coming	9 400	9400	9400	9 400	9400	9400	Quarterly	DOH
20.	Number of public health facilities offering VMMC	Outputs	**Numerator:** number of public health facilities offering VMMC **Denominator:** N/A	Geographic area	DOH annual and quarter reports Programme reports	64	71	75	80	85	85	>85	Quarterly	DOH
21.	Number of medical male circumcisions performed	Output	**Numerator:** number of male medical circumcisions performed **Denominator:** N/A	Geographic area	DHIS	85 084 (204 405 cumulative)	79 007	72 929	66 852	60 852	60 852	TBD	Quarterly	DOH
22.	Number of prospective Traditional male initiates (TMI) comprehensively screened	Output	**Numerator:** number of prospective traditional male initiates (TMI) comprehensively screened	Geographic area	DOH quarter and annual reports	No baseline	30 000	10 000	10 000	10 000	25 000	TBD	Quarterly	DOH
23.	Number of Ingoma schools issued with	Output	**Numerator:** number of Ingoma schools issued with compliant certificates	Geographic area	DOH annual and quarter reports	25	50	40	40	40	50	TBD	Quarterly	DOH

	compliant certificates		**Denominator: N/A**											
24.	**Objective 1.2: Significantly reduce T. Palladium gonorrhea, syphilis and chlamydia infections to achieve the virtual elimination of congenital syphilis and ma coverage of HPV vaccination**													
25.	HPV coverage	Output	**Numerator:** number of girls 9 years and older that received HPV dose **Denominator:** number of grade 4 learners≥ 9 years	Geographic area, sex, age	DHIS	HPV 1st dose-80% 2nd dose-80%	HPV 1st dose 90% HPV 2nd dose 90%	HPV 1st dose 90% HPV 2nd dose 90%	HPV 1st dose 90% HPV 2nd dose 90%	HPV 1st dose 90% HPV 2nd dose 90%	HPV 1st dose 90% HPV 2nd dose 90%	HPV 1st dose 90% HPV 2nd dose 90%	HPV 1st dose 90% HPV 2nd dose 90%	MPDOH
26.	Percentage of cervical cancer screening coverage to women	Output	**Numerator:** number of girls 9 years **Denominator:** total number of screened for	Geographic area, sex	DHIS DOH quarter and annual reports	70%	65%	75%	80%	80%	80%	TBD	Quarterly	DOH.
27.	Number of male condoms distributed	Output	**Numerator:** number of male condoms distributed **Denominator:** N/A	Geographic area, sex, age	DHIS	57 178 214	71 009 095	72 429 277	73 877 863	73 877 863	>73 877 863	TBD	Quarterly	DOH
28.	Number of female condoms distributed	Output	**Numerator:** number of female condoms distributed **Denominator:** N/A	Geographic area, sex, age	DHIS	1 315 607	3 737 321	3 812 067	3 888 209	3 908 222	3 908 222	TBD	Quarterly	DOH
29.	**Sub objective 1.2.2:Scale up STI prevention by providing high quality health information and timely health services for persons at risk**													
30.	New male urethritis syndrome episodes treated rate	Output	**Numerator:** male urethritis syndrome treated-new episodes **Denominator:** male population 15-49 years	Geographic are, sex, age	DHIS	16 111	19 004	19 384	18 997	18 618	18 246	TBD	Annual	NDOH
31.	Syphilis in pregnant	Output	**Numerator:** syphilis in pregnant	Geographic area, sex, age	DHIS ANC survey	4.1%	3%	3%	3%	3%	2%	2%	Quarterly	DOH

	females rate (sentinel sites)		females tested **Denominator:** total number of pregnant females screened for syphilis											
32.	**1.2.3. Increase access to and provision of health services post exposure to HIV infections and other blood borne infections.**													
33.	Number of new sexual assault cases reported for medical attention	Output	**Numerator**: New sexual assault cases reported for medical attention **Denominator:** N/A	Geographic area, sex	DHIS	3 502 (2016 MPDOH annual report)	4500	< 4500	< 4500	< 4500	< 4500	< 4500	Quarterly	DOH
34.	Number of sexual assault cases provided with PEP	Output	**Numerator:** Number of sexual assault cases provided with PEP **Denominator:** N/A	Geographic area, sex	DHIS	2 464 (2016 MPDOH annual report)	< 4500	< 4500	< 4500	< 4500	< 4500	< 4500	Quarterly	DOH
35.	Number of cases of occupational exposure to injuries seen	Output	**Numerator:** Number of cases of occupational exposure to injuries seen **Denominator:** N/A	Geographic area	DHIS	252 (2015/16 MPDOH annual report	260	<260	<260	<260	<260	TBD	Quarterly	DOH
36.	Number of cases of exposure to injuries provided with PEP	Output	**Numerator:** Number of cases of exposure to injuries provided with PEP	Geographic area	DHIS MPDOH Annual report	241 (2015/16 MPDOH Annual report)	260	<260	<260	<260	<260	<260	Quarterly	MPDOH
37.	**Sub objective 1.3 Active TB case finding - increase TB screening among adult clinic attendees, including PLHIV and persons presenting with TB symptoms**													
38.	Percentage of clients routine symptom screening for TB in health	Output	**Numerator:** Number of clients routine symptom screened for TB in health facilities **Denominator:**	Geographic area	DHIS DOH quarter reports	47.3% (2015/16 Annual report)	70%	80%	90%	95%	97%	TBD	Quarterly	DOH

	facilities		**T**otal number of clients seen in health facilities											
39.	TB suspect sputum test rate	Output	**Numerator:** TB suspect sputum test rate **Denominator:**	Geographic area	DHIS	95.5% (2015/16 MPDOH-TB annual report)	95.5%	>95.5 %	>95.5%	>95.5%	>95.5%	>95.5%	Quarterly Annual	DOH
40.	TB suspect smear positive rate	Output	**Numerator:**	Geographic area	DHIS	7.9% (2015/16 MPDOH-TB annual report)	<7.5%	<7%	<6.5%	<6%	<5.5%	<5%	Quarterly	DOH
41.	**Sub objective 1.3 B Improve case finding for neonatal and pediatric TB**													
42.	TB suspect 5 years and older identified	Output	**Numerator:**	Geographic area	DHIS	107 507	112 257	118 882	123 632	129 007	129 007	TBD	Annual	MPDOH
43.	TB suspect 5 years and older sputum sent	Output	**Numerator:** TB suspect 5 years and older sputum sent **Denominator:** Total number of TB suspect 5 years and older identified	Geographic area, age	DHIS	102 351	107 469	112 587	117 705	122 833	122 833	TBD	Annual	MPDOH
44.	TB suspect 5 years and older test positive	Output	**Numerato**r: TB suspect 5 years and older test positive **Denominator:** Total number of TB suspect 5 years and older sputum sent	Geographic area, age	DHIS	7 703	7 000	6 300	5 670	5103	4393	<4 393	Quarterly	DOH
45.	**Sub objective 1.3 C Scale up and maintain high levels of HPV vaccination in 9 to 13 years target group**													
46.	HPV coverage	Output	**Numerator:** Number of girls9 years and older that received HPV dose **Denominator:** Number of grade 4 learners ≥ 9 years	Geographic area, age, Type of dose	DHIS	HPV 1st dose – 85%HPV 2nd dose - 63.8% (NDOH Annual Report 2015/16)	HPV1st dose: 90%			90% nationally 80% in every district			Annual	MPDOH
GOAL 2: REDUCE MORBIDITY AND MORTALITY BY PROVIDING HIV, TB AND STI TREATMENT, CARE AND ADHERENCE SUPPORT FOR ALL														

	INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET						REPORTING FREQUENCY		RESPONSIBI
							FY 2017	*FY 2018*	*FY 2019*	*FY2020*	*FY 2021*	*FY2022*			
Sub-objective 2.1.1:90% of all people living with HIV know their HIV status															
1.	Number of HIV test client 15 years – 49 years (excluding antenatal clients)	Output	**Numerator:** Number of HIV test client 15-49 years (excluding antenatal) **Denominator:** total population 15-49 years	Geographic area, age, sex	DHIS	736 087 (2016)	736 400	736 100	736 800	736 700	736 400	737 300	TBD	Quarterly	DOH
2.	Number of HIV test positive client 15 years – 49 years (excluding antenatal clients)	Outcome	**Numerator:** Number of HIV test positive clients 15-49 years excluding antenatal clients **Denominator:** total number of HIV test clients 15-49 years (excluding antenatal clients)	Geographic area, age, sex	DHIS	80 439 (2015/16 MPDOH annual TB report	78 233	78 0 45	76 875	76 722	75 722	<75 722		Quarterly	DOH
3.	Total number of HIV test clients excluding ANC	Output	**Numerator:** Total number of HIV test clients excluding ANC **Denominator:** total number of people (men and women) excluding ANC	Geographic area, age, sex	DHIS	756 892 (2015/16 MPDOH Annual report)	777 884	777 884	777 884	777 884	777 884	777 84	777 884	Quarterly	DOH
4.	Total number of HIV test positive clients excluding ANC	Output	**Numerator: T**otal number of HIV test positive clients including ANC **Denominator:** total number of HIV test clients excluding ANC	Geographic area, age, sex	DHIS	90 846 (2015/16 MPDOH Annual report)	89 484	88 142	86 820	85 518	85 518	<85 518	TBD	Quarterly	DOH
5.	**Sub-objective 2.1.2: 90% of all people diagnosed with HIV infection receive sustained antiretroviral therapy**														
6.	Naïve adults who started	Outcome	**Numerator:** Naïve adults who started lifelong ART	Geographic area, age	DHIS	70 364 (2015/16 MPDOH)	63 551	57 196	51 476	44 663	37 850	31 037	<31037	Quarterly	DOH

	lifelong ART		**Denominator:** N/A												
7.	Naïve children under 15 years who started lifelong ART	Outcome	**Numerator:** Naïve children under 15 years who started lifelong ART Denominator: all children under 15 years tested and diagnosed as HIV positive	Geographic area, age	DHIS ART register survey	2 694 (MPDOH 2015/16 Annual report)	2 694	3 722	3 349	3 015	**TBD**	-	-	Annual Quarterly	DOH
8.	Number of children under 15 years remaining on ART at the end of the month	Outcome	**Numerator:** Number of children under 15 years remaining on ART at the end of the month **Denominator**: total number of children under 15 years who were initiated on ART	Geographic area, age, sex	DHIS ART register	16 982 (2015/16 MPDOH Annual report)	26 147	29 250	32 043	35 058	38 073	-	-	Annual Quarterly	DOH
9.	Number of adults remaining on ART at the end of the month	Outcome	**Numerator:** Number of adults remaining on ART at the end of the month **Denominator:** Total number of adults started on ART	Geographic area, age, sex	DHIS	316 023 (MPDOH 2015/16 annual report)	428 835	479 736	525 547	580 033	634 509	TBD	TBD	Annual Quarterly	DOH
10.	Total number of clients remaining on ART (children & adults)	Outcome	**Numerator:** Total number of clients remaining on ART (children and adults) **Denominator:** Total number of clients initiated on ART (children and adults)	Geographic area, age, sex	DHIS	318 232 (Thembisa model)	454 982	508 986	557 590	>557 590	**TBD**			Annual	NDOH
11.	**Sub-objective 2.1.3: 90% of all people receiving antiretroviral therapy are virally suppressed**														
12.	Adults	Outco	**Numerator:**	Geographic	DHIS	88.4%	90%	91%	93%	95%	97%	>97%	TBD	Annual	NDOH

	with HIV viral load supressed rate at 12 months	me	Adults on ART clients viral load under 400 cps/ml **Denominator:** ART viral load done at intervals	area, age, sex		(MPDOH Annual report 2015/16)									
13.	Child under 15 years with HIV viral load supressed rate (VLS) at 12 months	Outcome	**Numerator:** Child on ART clients viral load under 400 cps/ml **Denominator:** ART viral load done at intervals	Geographic area, age	DHIS	63.7%	90%	91%	93%	95%	97%	>97%	TBD	Annual	NDOH
14.	**Sub-objective 2.2.1: Find 90% of all TB cases and place them on appropriate treatment**														
15.	TB client treatment initiation rate	Outcome	**Numerator:** Number of TB clients started on TB treatment **Denominator:** Total number of TB clients diagnosed	Geographic area, age	DHIS	97.1% (2015/16 WHO annual TB report)	>90%	>90%	>90%	>90%	>90%	>90%	>90%	Annual	NDOH
16.	Percentage of clients done routine symptom screening for TB in health facilities	Output	**Numerator:** Clients done routine symptom screening for TB in health facilities **Denominator:** Total clients seen in health facilities	Geographic area, age, sex	TB Programme report	47.3% (WHO TB annual report 2015/16)	70% (TB strategy)	80%	90%	95%	97%	>90%	TBD	Quarterly	DOH
17.	TB clients loss to follow up rate	Outcome	**Numerator:** TB clients lost to follow up **Denominator:** TB clients started on treatment	Geographic area, Drug resistant TB	DHIS	5.4% (MPDOH 2015/16 Annual TB report)	<5%	<5%	<5%	<5%	<5%	<5%	<5%	Quarterly	DOH
18.	TB client death rate	Outcome	**Numerator:** TB client death during treatment **Denominator:** TB client start	Geographic area	DHIS	4.7% (WHO TB report 2015/16, MPDOH Annual TB report, 2015/16	<5%	<5%	<5%	<5%	<5%	<5%	<5%	Quarterly	DOH

			on treatment												
19.	MDR-TB death rate	Outcome	**Numerator:** MDR-TB client death during treatment **Denominator:** MDR-TB client start on treatment	Geographic area, MDR-TB	DHIS	30.6% (2015/16 MPDOH TB report) WHO TB report 2016)	27.6%	16%	15%	14%	13%	<13%	TBD	Annual	DOH
20.	**Sub-objective 2.2.3: Treat successfully at least 90% of those diagnosed with TB (and 75% of those with DR TB**														
21.	Number of TB patients registered	Outcome	**Numerator:** Number of TB patients registered **Denominator:**	Geographic area, sex,age	DHIS	15 921 (All TB) (MPDOH TB report 2016)	15 500	15 000	14 500	14 000	13 500	<13 500	TBD	Quarterly	DOH
22.	TB clients 5 years and older started on treatment rate	Outcome	**Numerator:** Number of TB clients 5 years and older started on treatment **Denominator:**	Geographic area, Age: <5, 5 years and older	DHIS	No baseline	70%	80%	90%	90%	90%	90%	90%	Annual	NDOH
23.	Number of DCS sites reporting on TB treatment	Output	**Numerator:** number of DCS sites reporting on TB treatment	Geographic area	DOH TB Programme report	3 (2016)	3	3	3	3	3	3	3	Quarterly	DOH
24.	TB cure rate	Outcome	**Numerator:** Number of TB clients successfully treated **Denominator:** TB clients on treatment	Geographic area	DHIS	75% (2016 WHO TB report,)	77%	79%	81%	83%	85%	87%	89%	Annual	NDOH
25.	TB client treatment success rate	Outcome	**Numerator:** TB patients cured and completed treatment **Denominator:** Total TB be patients initiated on treatment	Geographic area, drug sensitive, drug resistant TB	DHIS (WHO TB report)	>85% (2016)	87%	89%	90%	90%	90%	90%	90%	Annual	NDOH
26.	MDR-TB treatment success rate	Outcome	**Numerator:** MDR-TB patients cured and completed treatment **Denominator:**	Geographic area, Age, drug sensitive	DHIS	45% (2015/16)	60%	62%	65%	>65%	>65%	TBD	Annual Quarterly	NDOH	

			Total MDR-TB patients initiated on treatment											
GOAL 3: REACH ALL KEY AND VULNERABLE POPULATIONS WITH COMPREHENSIVE, CUSTOMIZED AND TARGETED INTERVENTIONS														
	INDICATOR	**TYPE**	**CALCULATION**	**DISAGGREGATION**	**DATA SOURCE**	**BASELINE VALUE**	**TARGET**						**REPORTING FREQUENCY**	**RESPONSIBLE**
							FY 2017	***FY2018***	***YY 2019***	***FY2020***	***FY2021***	***FY2022***		
1.	**Sub-objective 3.1.1: All provincial, district and local AIDS Councils will include at least one representative from a key and vulnerable population group**													
2.	Proportion of key and vulnerable population representatives appointed to District AIDS Council (DAC)	Output	**Numerator:** number of key and vulnerable population representatives in District AIDS Council (DAC) **Denominator:** total number of all district AIDS Council representatives	Geographic area	DAC reports	No baseline	100%	100%	**TBD**				Quarterly	DAC
3.	Proportion of key and vulnerable population representatives appointed in Local AIDS Council (DAC)	Output	Numerator: number of key and vulnerable population representatives in local AIDS Councils (LAC) **Denominator:** total number of all Local AIDS Council representatives	Geographic area	LAC reports	No baseline	100%	100%	**TBD**				Quarterly	LAC
4.	**Sub-objective 3.1.3: All key and vulnerable population programmes should adopt a peer-led approach to implementation.**													

5.	Number of municipalities implementing focus for impact approach	Output	**Numerator:** municipalities implementing the focus for impact approach **Denominator:** All municipalities in the province	Geographic area	LAC reports DAC reports	No baseline	20%	30%	45%	70%	90%	100%	Quarterly	SALGA
6.	Number of peer candidates trained on life skills empowerment programmes	Output	**Numerator:** number of peer candidates trained on life skills empowerment programmes **Denominator:** total number of all candidates	Geographic area, sex, age	Programme reports Registers	2300 (2016)	3000	4000	5000	6000	7000	8000	Quarterly	DOE
7.	Number of peer education sessions on life skills empowerment conducted	Output	**Numerator:** number of peer education sessions on life skills empowerment conducted	Geographic area, sex, age	Programme reports	60 (2016)	60	100	150	180	200	210	Quarterly	DOE
8.	**Sub-objective 3.2.1: Enable increased access to tailored health services through differentiated service delivery approaches that are tailored for the populatio served.**													
9.	Percentage of inmates screened for TB at different time points	Output	**Numerator:** Number of inmates screened for TB at different time frames **Denominator**: Total number of inmates at different time frames	Geographic area, sex,	DCS report	No baseline	20%	60%	70%	80%	100%	100%	Quarterly	DCS
10.	**Sub-objective 3.2.5: Integrate rights-based components in all health and social programmes to holistically serve key and vulnerable population clients and p**													

11.	Number of SAPS members trained on SAPS ethics and human rights for key and vulnerable population clients	Output	**Numerator:** Number of SAPS members trained on SAPS ethics and human rights for key and vulnerable population clients	Geographic area, sex, age	SAPS reports	No baseline	350	400	450	500	550	600	Quarterly	SAPS
GOAL 4: ADDRESS SOCIAL AND STRUCTURAL DRIVERS OF HIV, TB AND STIS NCLUDING HUMAN RIGHTS, AND LINK THESE EFFORTS TO NDP DELIVERABLES														
	INDICATOR	**TYPE**	**CALCULATION**	**DISAGGREGATION**	**DATA SOURCE**	**BASELINE VALUE**	**TARGET**						**REPORTING FREQUENCY**	**RESPONSIBI**
							FY 2017	***FY2018***	***FY2019***	***FY2020***	***FY2021***	***FY2022***		
Sub-objective 4.1.1: Reduce risky behaviour through the implementation of programmes that build resilience of individuals, parents and families.														
1.	Number of beneficiaries receiving DSD Social Behaviour change programmes	Output	**Numerator:** Number of beneficiaries receiving DSD Social behaviour change programmes **Denominator:** N/A	Geographic area, sex	DSD Programme report	1 524	5 900	5 900	5 900	5 900	5 900	5 900	Quarterly	DSD
2.	Number of orphans and vulnerable children (OVC) accessing services through drop-in centres	Output	**Numerator:** number of OVC accessing services through drop-in centres	Geographic are, age, sex	DSD Programme report	13 777	14 000	14 000	14 500	15 000	15 000	15 000	Quarterly	DSD

3.	Number of youths reached through "Life Skills" workshops conducted	Output	**Numerator:** number of youths reached through Life Skills workshops **Denominator:** N/A	Geographic area, sex, age	DSD Programme report	No baseline	180	185	190	195	200	200	Quarterly	DSD
4.	**Sub-objective 4.1.2: Comprehensive and age-specific and appropriate support for learners and out-of-school youth.**													
5.	Number of campaigns targeting young girls with Education information on SRHR and prevention	Output	**Numerator:** Number of campaigns targeting young girls with Education Information on SRHR and prevention **Denominator:** N/A	Geographic area, sex, age	DOE Programme reports Registers	4 (2016)	6	10	14	20	30	40	Quarterly	DOE
6.	Percentage of young women and girls accessing comprehensive SBCC initiatives	Output	**Numerator:** Number of young women and girls accessing comprehensive SBCC initiatives **Denominator:** Total number of young women and girls	Geographic area, sex, age	DOE Programme reports	No baseline	40%	60%	70%	80%	90%	100%	Quarterly	DOE
7.	Number of visits to monitor the implementation of workplace policies	Output	**Numerator:** number of visits to monitor the implementation of workplace policies	Geographic area	DOE Programme reports, registers	4 m (2016)	8	8	8	8	8	8	Quarterly	DOE
8.	**Sub-objective 4.1.3: Strengthen the capacity of families and communities**													

9.	Number of families participating in parenting programmes	Output	**Numerator:** number of families participating in parenting programmes **Denominator:** N/A	Geographic area	DSD Programme reports, registers	1962 (2016)	2 475	2 600	4 021	4100	4v320	4400	Quarterly	DSD
10.	Number of beneficiaries reached through the Families Matter programme (SBC)	Output	**Numerator:** number of beneficiaries reached through the Families matter programme **Denominator:** total number of families in an area	Geographic area	DSD Programme reports Registers	No baseline (2016)	4320	4320	4320	4320	4320	4320	Quarterly	DSD
11.	Number of monitoring sessions conducted on the full implementation of Health and Wellness policies	Output	**Numerator:** Number of monitoring sessions conducted on the full implementation of health and Wellness policies **Denominator:** N/A	Geographic area	OTP Programme reports	8 (2016)	8	8	8	8	8	8	Quarterly	OTP
12.	**Sub-objective 4.2.1: Increase access to provision of services for all survivors of sexual and gender-based violence.**													
13.	Number of funded VEP service sites	Output	**Numerator:** VEP sites funded **Denominator:** N/A	Geographic area	DSD programme report	15 (2016)	22	22	22	22	22	22	Quarterly	DSD

14.	Number of victims of crime and violence receiving psycho-social support in VEP service sites	Output	**Numerator:** number of victims of crime and violence receiving psycho-social support in VEP service sites **Denominator:** N/A	Geographic area, gender, Age	DSD programme report	3 274 (2016)	3 500	3 500	4 000	4 000	4 000	4 000	Quarterly	DSD
15.	Number of people reached through Gender Based Violence (GBV) prevention programmes	Output	**Numerator:** People reached through GBV prevention programmes	Geographic area, gender,	DSD programme report	16 648 (2016)	17 000	17 500	18 000	18 000	18 000	18 000	Quarterly	DSD
16.	**Sub-objective 4.3.2: Scale up access to food security and nutritional support**													
17.	Number of beneficiaries provided with food parcels		**Numerator:** people receiving food parcels from the department Denominator: total population	Geographic area, age, gender	DSD programme report	No baseline (2016)	3 700	3 700	3 700	3 700	3 700	3 700	quarterly	DSD
18.	Number of people accessing food through DSD programmes (centre based)	Output	**Numerator:** Number of people accessing food through DSD programmes **Denominator:**	Geographic area, gender, age sex	DSD programme report	2 880	64 808	64 808	64 808	64 8 0	64 808	64 808	Quarterly	DSD

19.	Number of OVCY accessing services through Isibindi programme	Output	**Numerator:** Number of OVCY accessing services in Isibindi sites **Denominator:** Total number of OVCY	Geographic area, sex, age	DSD report	9 992 (2016)	13 035	14 000	14 000	14 500	14 500	14 500	Quarterly	DSD
20.	**Sub-objective 4.4.1: Scale up access and provision of in- and out-patient rehabilitation services for all who use alcohol and drugs**													
21.	Number of funded NPO delivering services on prevention and treatment of substance abuse	Output	**Numerator:** Funded NPOs providing services on prevention and treatment of substance abuse **Denominator:** N/A	Geographic area	DSD report	6 (2016)	8	8	8	8	8	8	Quarterly	DSD
22.	Number of users who access in-patient treatment services at funded treatment centres	Output	**Numerator:** Number of users accessing in-patient treatment services at funded treatment centres **Denominator:** N/A	Geographic area	DSD report	400 (2016)	224	224	274	324	324	324	Quarterly	DSD

23.	Number of children 18 years and below reached through substance abuse prevention programmes	Output	**Numerator:** Number of children 18 years and below reached through substance abuse prevention **Denominator: N/A**	Geographic area, age	DSD report	70 737	72 000	75 000	80 000	80 000	80 000	80 000	Quarterly	DSD
24.	Number of people 19 years and above reached through substance abuse programmes	Output	**Numerator:** number of people 19 years and above reached through substance abuse prevention programmes **Denominator:** N/A	Geographic area, age	DSD report, registers	29 334	30 000	32 000	35 000	35 000	35 000	35 000	Quarterly	DSD
25.	**Sub-objective 4.5.1: Economically empower targeted groups of young people by increasing the availability of economic opportunities**													
26.	Number of youths reached with SBCC and socio-economic empowerment programmes	Output	**Numerator:** Number of youth reached with SBCC and socio-economic empowerment programmes	Geographic area, age	DSD report, attendance registers	566 (2016) DSD annual report	450	500	500	500	500	500	Quarterly	DSD
27.	Number of youth utilizing services delivered in youth centres	Output	**Numerator:** Number of youth utilizing services delivered in youth centres	Geographic area, age	DSD report, registers	126 251 (2016) DSD annual report	108 000	108 000	108 000	108 000	108 000	108 000	Quarterly	DSD

28.	Number of learners offered no fee education in public schools	Output	**Numerator:** number of learners offered no-fee education in public schools **Denominator:** N/A	Geographic area, age, gender	DOE reports	1582 (DOE annual report 2016)	1740	1914	2105	2315	2546	2800	Quarterly	DOE

GOAL 5: GROUND THE RESPONSE TO HIV,TB, AND STIs IN HUMAN RIGHTS PRINCIPLES AND APPROACHES													
INDICATOR	**TYPE**	**CALCULATION**	**DISAGGREGATION**	**DATA SOURCE**	**BASELINE VALUE**	**TARGET**						**REPORTING FREQUENCY**	**RESPONSIBLE**
						FY 2017	***FY2018***	**FY 2019**	**FY 2020**	**FY2021**	**FY 2022**		
Objective 5.1: Reduce stigma and discrimination among people living with HIV or TB by half by 2022													
Sub-objective 5.1.1: Revitalize community-based support groups to deal with internalized stigma													
Number of local municipalities with the Stigma reduction programme	Output	**Numerator:** Number of local municipalities with the Stigma Reduction programme **Denominator:** N/A	Geographic area	Programme report	No baseline	2	4						MPAC
Sub-objective 5.3.1: Implement a human rights accountability scorecard													
Number of Human Rights scorecards distributed	Output	**Numerator:** Number of human rights scorecards distributed **Denominator:** N/A	Geographic area	Programme report MPAC annual progress report	No baseline	300	500	800	1000	1 200	1500	Quarterly	MPAC
Sub-objective 5.3.2: Monitor implementation of laws, regulations and policies relating to HIV and TB and identify areas for reform													
Sub-objective 5.3.3: Sensitize law-makers and law enforcement agents													
Sub-objective 5.3.4: Train healthcare providers on human rights and medical ethics													
Number of doctors	Output	**Numerator:** Number of	Geographic area	MPDOH annual	No baseline	TBD						Quarterly	DOH

trained on TB and TB-DR management including initiation of TB and TB-MDR treatment		doctors on TB and DR-TB management including initiation of TB and TB-MDR **Denominator:** N/A		report, 2015/16									
Number of **professional nurses** trained on TB and TB-DR management including initiation of TB and TB-MDR treatment	Output	**Numerator:** number of professional nurses trained on TB and TB-DR management including initiation of TB and TB-MDR treatment **Denominator:** N/A	Geographic area	MPDOH annual report	142 (MPDOH 2015/16 annual report	172	189	208	229	142	TBD	Quarterly	DOH
Number of **non-clinicians** trained on TB and TB-DR management	Output	**Numerator:** Number of non-clinicians trained on TB and TB-DR management **Denominator:** N/A	Geographic area	MP DOH Programme report	546 (2015/16 DOH annual report)	601	661	727	800	880	546	Quarterly	DOH

GOAL 6: MOBILISE LEADERSHIP AND COORDINATION AT ALL LEVELS AND PROMOTE SHARED ACCOUNTABILITY FOR A SUSTAINALE RESPONSE TO HIV, STI and TB													
INDICATOR	**TYPE**	**CALCULATION**	**DISAGGREGATION**	**DATA SOURCE**	**BASELINE VALUE**	**TARGET**						**REPORTING FREQUENCY**	**RESPONSIBLE**
						FY 2017	***FY2018***	**FY 2019**	**FY 2020**	**FY2021**	**FY 2022**		
Objective 6.1: Strengthen MPAC, DAC &LAC provide effective co-ordination and leadership of all stakeholders for shared accountability													
Sub-objective 6.1.1: Formally establish the structures of AIDS Councils at district, local and ward level													
Terms of reference for AIDS councils adopted and implemented	Output	**Numerator:** Terms of reference for AIDS councils adopted and implemented **Denominator:** N/A	Geographic area	MPAC annual report	1 2016 MPAC annual report	1	-	-	-	-	-	Annual	MPAC
Number of	Output	**Numerator:**	Geographic	Civil	7	10	12	14	16	17	18	Quarterly	MPAC

civil society sectors established		Number of civil society sectors established **Denominator:** N/A	area, name of the sector	society report									
Number of District and local AIDS councils inducted on their roles and responsibilities	Output	**Numerator:** Number of AIDS Councils inducted on their roles and responsibilities **Denominator:** N/A	Geographic are	MPAC annual report MP annual progress report on HIV, STIs and TB	20 SALGA 2016 induction report	-	-	-	-	-	20	Every 5 years	MPAC/SALGA
Number of Technical Task teams established in local and district AIDS Councils	Output	**Numerator:** Number of technical task teams established in all AIDS Councils **Denominator:** N/A	Geographic area	DAC and LAC reports	13	20	-	-	-	-	-	Quarterly	DAC/LAC
Number of Mayors who chaired the AIDS Councils	Output	**Numerator:** Number of Mayors who chaired AIDS council meetings **Denominator:** N/A	Geographic area	DAC/LAC reports	20 MP Annual progress report on HIV, STIs and TB	20	20	20	20	20	20	Quarterly	DAC/LAC
Number of MPAC meetings chaired by the Premier	Output	**Numerator:** Number of MPAC meetings chaired by the Premier **Denominator:** N/A	Geographic area	MPAC quarterly reports	1	4	4	4	4	4	4	Quarterly	MPAC
Number of LAC and DAC Secretariats sufficiently funded to implement the 2017-2022 PIP on HIV, STIs and TB	Output	**Numerator:** Number of LACs and DAC secretariats sufficiently funded to implement the 2017-2022 PIP on HIV, STIs and TB **Denominator:** N/A	Geographic area	DAC and LAC reports	17	20	20	20	20	20	20	Annual	DAC LAC
Sub-objective 6.1.2: Ensure representation of all stakeholders in decision-making													
Calendar of events developed and adopted	Output	**Numerator**: Calendar of events developed and adopted	Geographic area	MPAC annual progress report on	No baseline	1	1	1	1	1	1	Quarterly	MPAC

		Denominator: N/A		HIV, STIs and TB									
Sub-objective 6.1.3: Strengthening the role of the private sector													
Partnership pledge developed and signed by private health providers	Output	**Numerator:** Partnership pledge developed and signed by private health providers **Denominator:** N/A	Geographic area	MPAC annual progress report on the 2017-2022 PIP on HIV, STIs and TB	No baseline	-	1	-	-	-	-	Annual	MPAC
Sub-objective 6.1.4: Ensure a central role for civil society and community groups													
Provincial database developed	Output	**Numerator**: Provincial database developed **Denominator: N/A**	Services provided, stakeholders	MPAC annual progress report on the 2017-2022 PIP on HIV, STIs and TB	No baseline	1	-	-	-	-	-	Annual	MPAC
Resource mobilisation strategy developed and adopted	Output	**Numerator:** Resource mobilisation strategy developed and adopted **Denominator:** N/A	Geographic area	MPAC annual progress report on the 2017-2022 PIP on HIV, STIs and TB	No baseline	1	-	-	Revie wed	-		Annual	MPAC
Sub-objective 6.2.2: Strengthen collaboration between and co-ordination of government departments													
Number of government forums at provincial, district and Local level	Output	**Numerator:** Number of government forums at provincial, district and local level **Denominator:** N/A	Geographic area, type of AIDS Council	MPAC report	No baseline	1	-	-	-	-		Annual	MPAC
Sub-objective 6.2.3: Establish/strengthen regional collaboration													
Number of bilateral agreements with Swaziland and Mozambique	Output	**Numerator:** Number of bilateral agreements signed with Swaziland and Mozambique **Denominator:** N/A	Geographic area	MPAC report	No baseline	-	2	-	-	-	-	-	OTP International Relations

GOAL 8: STRENGTHEN STRATEGIC INFORMATION TO DRIVE PROGRESS TOWARDS ACHIEVEMENT OF NSP GOALS													
INDICATOR	**TYPE**	**CALCULATION**	**DISAGGREGATION**	**DATA SOURCE**	**BASELINE VALUE**	**TARGET**						**REPORTING FREQUENCY**	**RESPONSIBLE**
						FY 2017	***FY2018***	**FY 2019**	**FY 2020**	**FY2021**	**FY 2022**		
Objective 8.1 Optimize routinely collected strategic health information for data utilization													
Sub-objective 8.1.1 Implement master patient index for use in all service delivery settings													
Number of district health information exchange (HIE) forum meetings conducted annually	Output	**Numerator:** Number of district health information exchange (HIE) forum meetings conducted annually **Denominator:** N/A	Geographic area	DAC reports	No baseline	3	3	3	3	3	3	Quarterly	DAC
Annual district HIV, TB and STI reports produced	Output	**Numerator:** annual district HIV, STIs and TB reports produced **Denominator:** N/A	Geographic area	DAC reports	3 2015/16 District annual reports	3	3	3	3	3	3	Annual	MPAC
Objective 8.2 Rigorously monitor and evaluate implementation and outcomes of the PIP													
Sub-Objective 8.2.1 Strengthen and promote multi-sectoral ownership and accountability of the PIP and DIP M&E systems													
5 year costed M&E plan adopted	Output	**Numerator:** 5 year costed M&E plan adopted **Denominator**: N/A	N/A	M&E Plan	1 2012-2016	1	-	-	-	-	-	Annual	MPAC
Number of districts producing quarterly service coverage reports with data from civil society and the private sector	Output	**Numerator:** Number of district producing quarter reports with data from CS and the private sector **Denominator: N**/A	Geographic area	DAC reports	3 2016	3	3	3	3	3	3	Quarter	DAC

Percentage of relevant national led government departments active in the province producing quarterly HIV, STIs and TB service coverage reports	Output	**Numerator**: National led departments producing quarterly HIV, STIs and TB service coverage reports **Denominator:** Total number of national led departments in the province	National, province	DAC reports	No baseline	20%	30%	40%	50%	60%	70%	Quarter	DAC
Number of relevant provincial departments producing quarterly HIV, STIs and TB reports.	Output	**Numerator:** number of relevant provincial departments producing quarterly HIV, STIs and TB mainstreaming reports	Province	MPAC quarter report	12 (2015/16 MP Annual progress Report)	12	12	12	12	12	12	Quarter	MPAC
Sub-Objective 8.2.2 Strengthen M&E capacity to effectively use available data to monitor the PIP performance and HIV, TB and STI epidemics at all levels													
Percentage of core PIP indicators reported	Output	**Numerator:** Number of PSP core indicators reported **Denominator:** Total number of PSP core indicators	According to PIP Goals and Objectives	PCA M&E reports	80% (2016 PCA Annual report)	80%	85%	90%	95%	100%	100%	Quarter Annual	MPAC
Sub-Objective 8.2.5 Generate and disseminate PIP Monitoring and Evaluation Reports to the public													
Number of annual DIP evaluations conducted	Output	**Numerator:** number of annual DIP evaluations conducted **Denominator:** N/A	Province, district	DAC reports	3 (2016)	3	3	3	3	3	3	Annual	MPAC DAC
PIP 2017-2022 Mid-term review and end-of term Report	Output	**Count**	National, Province	PIP reports	2 (1 mid-term, 1 end-of term)			1 (Pip mid-term) evaluation			1 end-of-term PIP evaluation	Annual	SANAC MPAC
Objective 8.4 Strengthen strategic research activities to create validated evidence for innovation, improved efficiency and													

enhanced impact													
Sub-Objective 8.4.1 Develop a coordinate research agenda for the PIP													
Adoption of 5-year PIP HIV, TB and STI Research Agenda	Output	Count	N/A	Research agenda	None	1	-	-	-	-	-	Annual	MPAC

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