ISIFUNDAZWE SAKWAZULU-NATALI
PROVINCE OF KWAZULU-NATAL

Multi-Sectoral Response to HIV & AIDS, STIs and TB Implementation Report

2012/2013

Table of Contents

Executive Summary

Introduction

This report details status of implementation of response interventions by the various stakeholders within in the multi-sectoral approach and services delivery integration set up as reflected by the KZNPSP 2012-2016 and the Sukuma Sakhe implementation model respectively.

The report structure is based on the provincial multi-sectoral strategic plan for HAST 2012-2016 broad strategic objectives as follows.

- Strategic Objective 1: Addressing Social and Structural Drivers of HIV & AIDS, STIs and TB Prevention
- Strategic Objective 2: Prevention of New HIV & AIDS, STI and TB Infections
- Strategic Objective 3: Sustaining Health and Wellness
- Strategic Objective 5: Coordination and Monitoring and Evaluation.

Strategic objective (SO) 4 on ensuring protection of human rights and improving access to justice has been omitted due to inadequate data.

Strategic Objective 1: Addressing Social and Cultural Drivers of HIV & AIDS, STIs and TB Prevention

Impact of OSS: The PSP objective is to reduce the impact of vulnerability to HAST transmission due to poverty, unemployment and gender inequality by 2016.

About 11% of the targeted households have been profiled and approximately 7% of the estimated number of households in the province reached with profiling. 5 % of the targeted households had established gardens translating into coverage of 3%.

Data on establishment of gardens in schools and health facilities was not sufficiently conclusive to determine progress made as was data seeking to establish the number of hectares under production and amount of produce realised out of cultivated land.

Trends in referrals and obtaining of vital registration documents was not steady, perhaps reflecting this to be a demand driven intervention and also one that depends on mobilisation and awareness. Those referred for these vital documents accounted for 2 % of the total population.

Those referred for and receiving HAST services accounted for about 12% of the population. This shows good effort on the part of field workers in mobilisation of the population towards accessing of services.

Data on other development indicators such as electricity, sanitation and piped was also not sufficiently conclusive to determine level of progress, as was that on number of support groups and the number of people in employment as a result of community oriented projects.

The following are the recommendations:

1. To allow for the household profiling exercise to be carried out with the requisite speed and completed within an acceptable time limit, the enabling environment within which household profiling is currently taking place (ranging from personnel, materials, financial resources to infrastructure) should be revisited. This will also apply to the establishment of household gardens.
2. Given that the goal of the "one home one garden" campaign is to enhance and maintain food security; the province should strategise on addressing sustainability of the established household gardens. Increasing household produce and organising households into cooperatives/teams that can create a platform for commercial sale of produce is one such option.

Community Mobilisation: The PSP objective is to decrease behaviours that put men and women aged 15-49 years at risk of HAST by 80% by 2016 through implementation of focussed programmes.

The province identified a range of key populations it intended to focus on over the next five years. These are people of reproductive age group, the youth, children under the age of 15 years, the poor, mobile worker populations, gays and lesbians and sex workers among others.

About 1% of the province's population was reached with information on prevention awareness, anti-gender based violence, sexual assault and any other information promoting positive values. Key populations such as gays & lesbians, sex workers, long distance truck drivers, farm workers, people living in informal settlements were either reached very minimally or not reached all together.

The recommendations are as follows:

1. As per the KZNPSP the province should develop one all-encompassing multi-sectoral community mobilisation and communication multi-media strategy/plan, spelling out stakeholders roles in community mobilisation and awareness activities. In the shorter term, all stakeholders involved in community mobilisation activities should submit

the work plans to respective district HIV & AIDS coordinator offices for consolidation.

Orphans and Other Vulnerable Children: The PSP objective is to increase access to quality of care and support to at least 90% of orphans and other vulnerable children by 2016. 56% of the targeted orphans and other vulnerable children were registered, with 28% reach of the estimated number in 2012/2013. Registration trends according to districts breakdown was steady but did not show sufficient rises for possibilities of having 90% of the OVC registered within the shortest time span. A high number of OVC remains to be registered and therefore not accounted for.

There are commendable percentages in the general area of care and support with 89% of those registered having been recorded to be in school. A similar percentage was receiving care and support and 76% had access to social grants. Coverage and reach of child headed households at both registration and support remains inadequate.

The following are the recommendations.

1. Gaps and weaknesses in the existing registration system should be addressed with a view to creating a speedy environment for accounting for orphans and vulnerable children.
2. Additional focus should also be directed to registration and support of child-headed households.

Life Skills: The PSP objective is to decrease behaviours that put men and women aged 15-49 years at risk of HAST by 80% through implementation of focussed programmes by 2016. According to the 2011 SNAP Survey Report for Ordinary Schools, there are 2841135 learners in just above 6000 schools in the province. This constitutes about 89% of those falling under the age group 5-19 years. All schools in the province offer life skills education. About 6% of the learners were reached with information through life skills focussed campaigns. 89% of those in the age group 5-19 years are in schools setting the platform where the majority of this age group can be reached.

The recommendation is as follows:

1. A plan for life skills focussed campaigns should be developed and thereafter incorporated into the communication and community mobilisation strategy/plan. In the shorter term, the department of education should submit a work plan of life skills focussed campaigns to the district HIV & AIDS coordinator offices.

Workplace Programmes The employee population in the province forms a large percentage of the population, in this sense, it is a key population. Data on workplace programmes was not reliable enough for a credible and informed analysis**.**

The recommendation is as follows:

1. There should be a workplace programme committee made up of both public and private sector representatives. This committee should then be cascaded down to the lower structures. The provincial council on AIDS and its lower level associated structures should then make workplace programme reporting a regular agenda item in the meetings to monitor progress.

Strategic Objective 2: Prevention of New HIV & AIDS, STI and TB Infections

Contraceptive Access: The PSP objective for this intervention is to reduce the risk of mother to child transmission to less than 1% by 2016.

About 41% of females 18 years and older accepted to use a family planning method for the first time in 2012/2013, an increased by about 7% when compared to the previous year. The percentage towards the target was 91%.

All districts except one showed a steady but slow increase in the number of new family planning acceptors, one district (eThekwini) showed a steady but slow declining trend. Nine of the eleven districts have totals that are more than their baseline indicating an improvement in the uptake of family planning methods.

The recommendation is as follows:

1. Strategies on maintaining new acceptors for reproductive health purposes should be devised. Community mobilisation coupled with messages on the need for family planning should be intensified; including messages promoting the use of condoms for family planning.

Prevention of Mother to Child Transmission: The PSP objective for this intervention is to reduce the risk of mother to child transmission to less than 1% by 2016.

There was a decline in the positivity rate (PCR) over the last two quarters after an initial increase between quarter one and quarter two. Most districts showed a positivity rate that is below the baseline 2012/2013. uMkhanyakude and uMgungundlovu showed a positivity rate marginally below the baseline. Based on a year on year comparison, Amajuba, uMzinyathi, uThungulu and eThekwini districts had the most improved decline.

Amajuba was the only district which showed a general steady quarter to quarter decline. The remaining districts had a fluctuating trend characteristic. uThungulu, despite its big improvement on reduction in the year on year comparison showed an increasing trend over the quarters in 2012/2013. Ugu, iLembe and Sisonke recorded increased rates in the fourth quarter.

There is an increase in the number of babies undergoing HIV anti-body test at around 18 months with the uptake rising from 33% to about 54% in the 2012/2013. In terms of the positivity rate at around 18 months, year on year comparison indicated a decline by slightly over 50%. The positivity rate was consistently below the baseline and by the fourth quarter was moving towards the targeted 2% or less. Quarter to quarter trends recorded a consecutive decline over quarters three and four but there was an increase evidenced from quarter one to quarter two.

District averages are all below the baselines. Amajuba, uMkhanyakude and uMzinyathi had rates inching towards the target of 2%. Amajuba, eThekwini, Ugu, uThungulu and Zululand all had large declines. uThungulu was the only district that showed a steady decline quarter to quarter. uMkhanyakude and Zululand had an increased rate in the fourth quarter.

There was a 5% increase for ANC booking before 20 weeks when compared to the previous year. Quarter to quarter trends in the reporting year showed a notable incline in the first and second quarter, a decline and then another incline in quarter four. More generally, the early booking quarterly trend increased by an average of 3.5%.

Amajuba and uThukela were the only districts whose early booking rate was marginally equal to the baseline. No district showed any steady increase over the four quarters.

There is a decline in the ante natal care first visit positivity rate and a notable declining trend over the four quarters. Those knowing their HIV positive status on first visit increased as compared to the last year possibly indicating an increased behaviour change towards testing and revealing their status. The decline in the number of ante-natal first visits is noted. At this stage of the plan implementation, it may be too early to determine whether this decline is related to programmatic interventions such as family planning methods uptake.

All districts except for two districts show a positivity rate below the baseline. The rates for the remaining two (Ugu and uMgungundlovu) are marginally equal to the baseline.

The recommendations are as follows:

1. Fluctuation of the district specific quarterly trends for the district PCR positivity rate is common to most districts. This indicates the possibility of the rate rising. Where a rise is noticed, immediate measures should be taken to investigate and

follow up with commensurate corrective action with a view to moving towards ensuring that the downward trend becomes the main characteristic. This should also apply other areas where fluctuation was noted viz; early booking rates and the ANC first visit positivity rate.

2. Consideration should be given to lowering the early booking period to e.g. as early as eight weeks.

Medical Male Circumcision: The PSP objective for this intervention area is to scale up male medical circumcision services to 80% of males aged 15-49.

There was an increase in the number of males undergoing medical circumcision by 19% in 2012/2013 when compared to the last reporting year. The province achieved 4% coverage in medical male circumcision during 2012/2013. Quarter by quarter analysis shows a general decline in the numbers of new cases circumcised per quarter. This is reflected in the district trends where all districts showed declining numbers in the fourth quarter. This fourth quarter pattern, largely contributes to a general declining trend for the total number circumcised. District specific totals show eThekwini, uMgungundlovu and uThungulu had the highest numbers of those undergoing circumcision.

The recommendations are:

1. Reasons behind the general downward trend among all the districts in the fourth quarter should be investigated and corrective action taken. Further, there should be sustained community mobilisation accompanied by correct messages on the benefits and myths associated with undergoing circumcision. This should contribute to both improving coverage and correcting undesirable beliefs on the abilities of circumcision.

Maternal, Child & Women's Health: The PSP objective for this intervention is to reduce the risk of mother to child transmission to less than 1% by 2016.

Despite data showing a reduction in the number of deliveries in public health facilities by 8%; this reduction has to be viewed against the lack of data submission by four districts. Generally, districts depicted a declining trend, which again could be attributed to the missing data from four districts. eThekwini and uMgungundlovu delivery totals were higher than their baselines.

Deliveries under the age of 18 increased by 6% and accounted for 10.8% of all the births. In 2011/2012, the percentage was 9%. Most births in this category were recorded in eThekwini and uMkhanyakude. Increasing quarter to quarter trends were noted in uMgungundlovu and uMkhanyakude while ILembe showed a declining trend.

Maternal deaths declined by about 5% when compared to the previous year. ILembe, Sisonke and uMzinyathi had relatively low numbers of maternal deaths while uThukela demonstrated an increasing trend. Maternal death totals for uMgungundlovu and uThukela exceeded that of their baseline.

Infant deaths increased by 6%. eThekwini, uMgungundlovu, uThungulu and Zululand all had totals exceeding their baselines, while the Amajuba total was significantly less than its baseline figure. None of the districts showed any steady quarter to quarter decline.

The recommendation is as follows:

1. Existing strategies to curb deliveries by those aged 18 years, infant and maternal deaths should be revisited to determine extent of effectiveness and/or implementation. Based on the emerging evidence, an effective process to arrest the situation should then be put in place.

Sexually Transmitted Infections: The PSP objective for this intervention is to ensure that 80% of the sexually transmitted infected men and women receive early and appropriate treatment by 2016.

8% of the sexually active population was treated for new STI cases as compared to the target of 5%. The data also indicated a 2% reduction on the number of new cases treated. At this point in time, it is unclear whether this reduction is as a result of interventions in place. Ugu, uMgungundlovu and uThungulu had totals that were above their baselines. Trends on a quarter to quarter basis illustrated a somewhat steady to increasing trend.

STI partner treatment was below target by 19% and below the baseline by 13%. eThekwini quarter to quarter trends showed a decline. The numbers for Amajuba, Sisonke, uThukela and Zululand were relatively low.

The recommendation is as follows:

1. Poor partner treatment figures could be due to a combination of factors that include denial, stigma, and secrecy leading to a tendency to seek treatment from alternative sources. Getting data from these alternative sources e.g. private practitioners and traditional health practitioners should be the first step towards a clearer picture on the numbers of partners treated. Engaging these groups is therefore necessary. Secondly tracking infected partners through use of field workers such as CCGs should be intensified.

HIV Counselling and Testing: The PSP objective for HIV testing and counselling is to ensure that 80% of men and women aged 15-49 years know their status and receive STIs and TB screening by 2016.

The number of HIV tests carried out increased by 5% and was towards the target by 55%. Numbers tested were marginally but consistently above the baseline over the four quarters. Testing coverage was at 21% as compared to 20% previously. Ugu, uMzinyathi and uThungulu had somewhat steady increases in the number of tests carried out. Generally however, district specific trends were mainly steady with insignificant increases or decreases.
The number of HIV positive cases has gone down by about 11%. District trends were mainly steady though trends for uMzinyathi and uThukela were increasing.
The recommendation is as follows:

1. HIV counselling and testing mobilisation campaigns should be a permanent fixture in implementation calendars annually and should involve multi-sector effort. Additionally HCT should be coupled with TB & STIs testing as part of efforts to contribute to increased numbers for those testing for both TB and STIs.

Condoms Distribution: The PSP objective for this intervention area is to ensure that 100% of sexually active men and women have access to condoms by 2016.
Condom distribution numbers were up by 58% and 44% towards the target. In this regard therefore, condoms distribution numbers were consistently above the baseline over the quarters; but showed a decline over the last two quarters. Ugu, eThekwini, uMgungundlovu and Amajuba accounted for the most distributed number of male condoms. uMgungundlovu and uMzinyathi showed steady increases on a quarter to quarter basis. On the other hand, Amajuba and eThekwini showed a decreasing trend.
Condoms distribution per male aged 15 years and older was 36 condoms as compared to 11 previously. iLembe, Sisonke and uMgungundlovu distributed the highest number of condoms per male while eThekwini, uThukela and Zululand distributed the least.
Female condoms distribution numbers were up by 37% as compared to the previous year and 65% towards the target. The quarterly trends steadily increased, however, district trends tended to illustrate an unsteady pattern. The number of female condoms distributed per female aged 15 years and older remains negligible.
The recommendation is as follows:

1. As stated in the PSP, a rapid assessment of multi-sector condoms distribution processes, development of mechanism and implementing system for condoms education and distribution should be put in place. Such a system should address access as measured by the number of condoms a client should get per year and the methodology for setting realistic targets and further address continued setting up of points for easy accessibility of condoms.

Prevention of HIV Transmission from Occupational Exposure & Sexual Violence: The PSP objective for this intervention is to reduce the risk of HIV transmission from occupational exposure, sexual violence and discordance by using ARV to less than 1% by 2016.

The numbers of new sexual assault cases decreased by 2.5% when compared to the last year. Despite this, quarterly trends increased over the last three quarters. Amajuba and iLembe showed increasing quarter trends. Amajuba, eThekwini and uMgungundlovu had the highest totals of sexual assault cases while Sisonke and uMkhanyakude recorded the lowest figures.

The trend for children under 12 sexually assault rate generally shows an increase of 7% between the quarters. Amajuba, eThekwini and uMgungundlovu recorded the highest averages while Sisonke, uThukela and uThungulu had the lowest rates. iLembe and uMkhanyakude quarterly trends demonstrated increases.

The recommendation is as follows:

1. There appears to be uncoordinated efforts in the fight against sexual violence. Coordination through for example, a coordination committee composed of relevant organisations in government, non-government, and civil society and development partners should be considered. Further community mobilisation and use of relevant messages should be intensified where the climax should be the holding of annual campaigns that should be made permanent fixtures in the calendar.

Strategic Objective 3: Sustaining Health & Wellness

Adults initiated on Antiretroviral Treatment: The PSP objective for this intervention is to ensure that at least 90% of the HIV infected people have access to treatment and support and remain adherent to treatment and maintain optimum health by 2016.

The number of adults on ART increased by 27% and a 95% achievement towards the target. eThekwini and uMgungundlovu districts had the most improved uptake illustrated by noticeable consistent upward quarterly trends. uThungulu was the only district to demonstrate a fluctuating trend.

Children initiated on Antiretroviral Treatment: The number of children on ART increased 13% with an achievement of 85% towards the target. Based on the data, 7% of eligible children are on ART, with the target being 9%. eThekwini, uMgungundlovu and Zululand had the most commendable consistent upward quarterly trends. uMkhanyakude and uMzinyathi showed fluctuating quarterly trends.

ART Patients De-registered due to Loss of Follow up: The number of patients de-registered due to loss of follow up reduced by 33% and was less the target by about 22%. Amajuba and uMzinyathi had considerably small amounts of people being lost to follow up while eThekwini, Zululand and uThukela had the highest number. Amajuba's total was however larger than its baseline. Sisonke and uMzinyathi were the only districts showing a steady quarterly trend. Sisonke, Ugu, uThukela and Zululand all achieved their targets as demonstrated by the total being below the target.

ART Patients De-Registered due to Death: The number of patients de-registered due to death reduced by 51% but was short of the target by 21%. The trend was consistently below the baseline and consistently above the target, indicating a failure to achieve the target. uThukela and uMzinyathi had the least number of deaths while eThekwini, uMgungundlovu and Ugu had the highest number of deaths. uMgungundlovu was the only district that showed a steadily declining trend in the numbers of deaths.

The recommendation is as follows:

1. Eliminating the quarterly fluctuations for both loss to follow up and deaths should be made possible through intensified use of community field workers.

Strategic Objective 5: Coordination, Monitoring & Evaluation

The PSP objectives of the strategic objective coordination, monitoring and evaluation are three fold namely:

1 To strengthen co-ordination and management for an effective provincial response by 2016

2 To strengthen the monitoring and evaluation systems at all levels and ensure that at least 90% of the sectors consistently report to coordination structures by 2016.

3 To strengthen the research component of the response by 2016.

District AIDS Councils Functionality: District AIDS Council (DAC) functionality was measured by a set of six data elements namely:

1. DAC meeting as scheduled
2. At least 70% of designated DAC members attended meeting
3. Meeting chaired by designated chairpersons
4. Submission of quarterly reports
5. Submission of DAC meeting minutes
6. DAC submission of LAC meetings

The district functionality score was 7.8 out of a possible 11. The score improved by about 3%. Submission of both DAC and LAC minutes to the PCA secretariat was a major challenge to the DACs.

Individual districts show no discernible consistently upward looking quarterly trends. Sisonke and uMkhanyakude were the only districts to achieve the perfect 1 score in the first two quarters but failed to maintain this in the next two subsequent quarters. Amajuba and uMgungundlovu maintained a uniform quarterly performance while uThungulu and iLembe showed an improvement in the last quarter. Zululand had a consistently upward trend for three quarters and Uthukela showed a decline in the last quarter.

Local AIDS Council Functionality: The local AIDS council functionality was measured as per the elements listed below

1. LAC meeting as scheduled
2. At least 70% of designated LAC members attended meeting
3. Meeting chaired by designated chairpersons
4. Submission of quarterly report
5. Submission of LAC meeting minutes
6. Submission of LAC meetings to DAC

The functionality score for the LAC was 26.2 out of a possible 50.

LAC functionality has improved by 26.2%. However, the general trend over the four quarters showed a decline in functionality by a score of 7.8. Challenges are evident in the elements of submission of quarterly reports and submission of minutes to the DAC.

Ugu was the only district to achieve a perfect score on the first two quarters while Zululand showed some consistent quarterly declines. Sisonke and uThungulu also had some declines especially in the last quarter.

Ward AIDS Committees Functionality: The Ward AIDS Committee functionality score was calculated as per the five elements listed below.

1. WAC meeting as scheduled
2. At least 70% of designated WAC members attended meeting
3. Meeting chaired by designated chairpersons
4. Submission of quarterly report to LAC
5. Submission of WAC meeting minutes

The functionality score for the WAC was 123.3 out of a possible 828. The score remained low, despite a functionality score increase by 19.80 points. The lowest functionality scores were witnessed in the elements of submission of reports and minutes to the LAC.

Some element of functionality was in Amajuba, Sisonke, Ugu, and uMzinyathi. Those in eThekwini, iLembe, uMgungunldovu and uMkhanyakude were totally non-functional.

The recommendations are as follows:

1. Districts should prepare for and hold regular training sessions in their respective localities. Such should span training the leadership and general membership of the DAC, LAC and the WAC.
2. Development of guidelines and toolkits on a range of topics such as planning, conducting meetings to writing of minutes among others should be done and applied uniformly across the DAC, LAC and WAC.
3. Districts should ensure that the terms of reference for DAC, LAC and WAC are fully disseminated and regularly distributed.
4. There should be sustained support from the respective designated chairpersons i.e. mayors, for the DAC, LAC and WAC for both the functions of these structures and the secretariat personnel i.e. the HIV & AIDS Coordinator.
5. All district municipalities, local municipalities and wards should have personnel fully dedicated to the coordination of HIV & AIDS activities.
6. More attention should be paid to promoting the research component at all levels.

Introduction

What the Report Details

This report details status of implementation of response interventions by the various stakeholders within in the multi-sectoral approach and services delivery integration set up as reflected by the KZNPSP 2012-2016 and the Sukuma Sakhe implementation model respectively. Compiled using data emanating from the Districts AIDS Councils (DAC) for the financial year 2012/2013, this report marks the end of the first year of implementation of the KZNPSP 2012-2016.

District AIDS Councils (DAC) are still facing difficulties in data collection and reporting. For this reason, it becomes difficult to measure the status for all the intervention areas of the response as per the strategic plan, which contains one hundred and thirteen intervention areas across the five strategic objectives that should be measured by a corresponding number of data elements. Data used in this report is however sufficient in providing an adequate picture of the status of the response thus far.

Report Organisation

The report structure is based on the provincial multi-sectoral strategic plan for HAST 2012-2016 broad strategic objectives as follows.

- Strategic Objective 1: Addressing Social and Structural Drivers of HIV & AIDS, STIs and TB Prevention
- Strategic Objective 2: Prevention of New HIV & AIDS, STI and TB Infections
- Strategic Objective 3: Sustaining Health and Wellness
- Strategic Objective 5: Coordination, Monitoring and Evaluation.

Strategic objective (SO) 4 on ensuring protection of human rights and improving access to justice has been omitted due to inadequate data.

The report is generally presented using graphs on an aggregate (provincial) level and thereafter district breakdown. This is accompanied by brief write-ups where amenable providing descriptive insights in the trends, key observations and recommendations. Thereafter a conclusion follows.

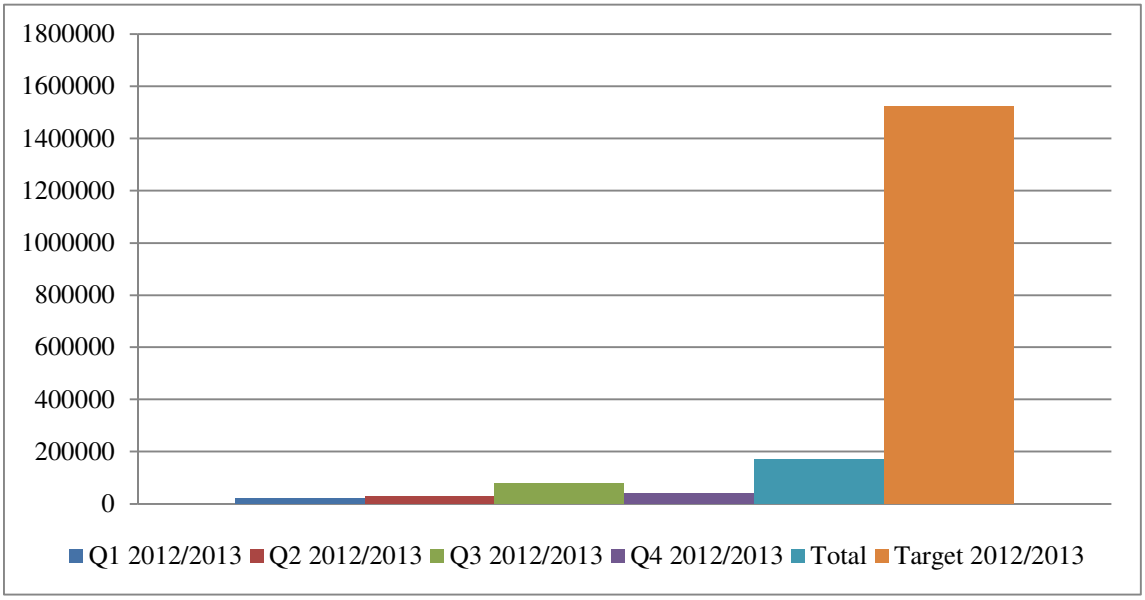
1. Strategic Objective 1: Addressing Social and Structural Drivers of HIV & AIDS, STIs and TB Prevention

1.1 Impact of OSS

This intervention area concentrates on activities revolving around household profiling for better services delivery and the establishment of gardens to enhance food security for every household. Household profiling therefore is a backbone to services delivery and is the first step to equipping the community, government and service providers with knowledge on the type of services required. These range from vital registration to health and other socio-economic and development services.

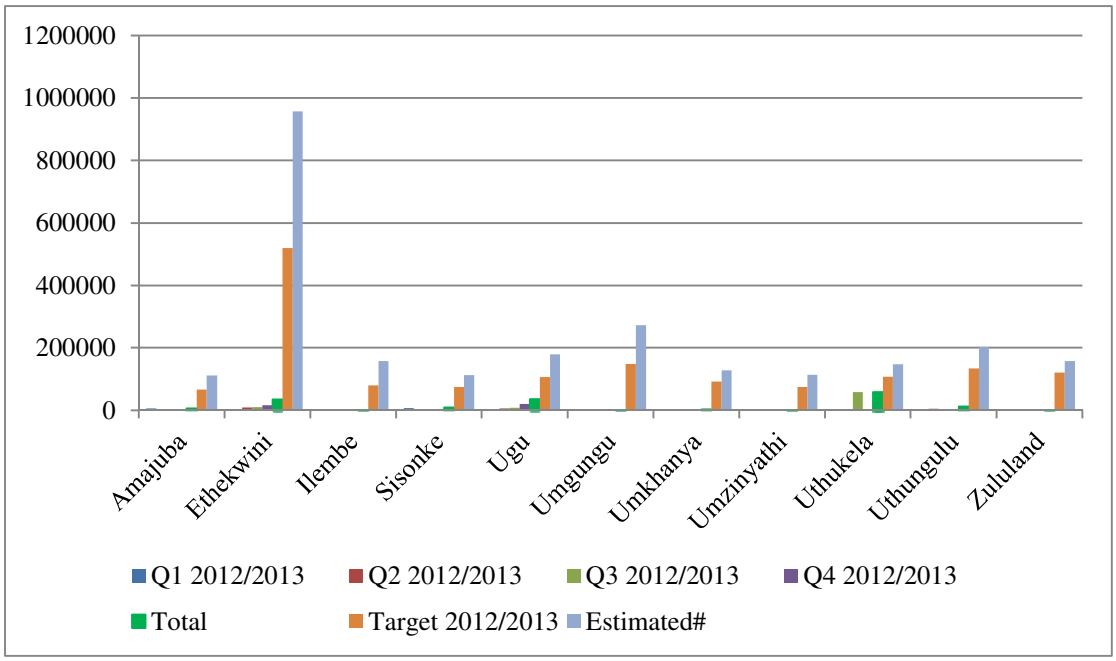
In the financial year 2012/2013, 168221 households were profiled of an estimated 2.5 million and a targeted 1523998. As the graph below shows, trends in profiling were generally within the 20000-42000 range except for the third quarter where close to 78000 households were profiled.

Figure 1.1: Trends and numbers of households profiled



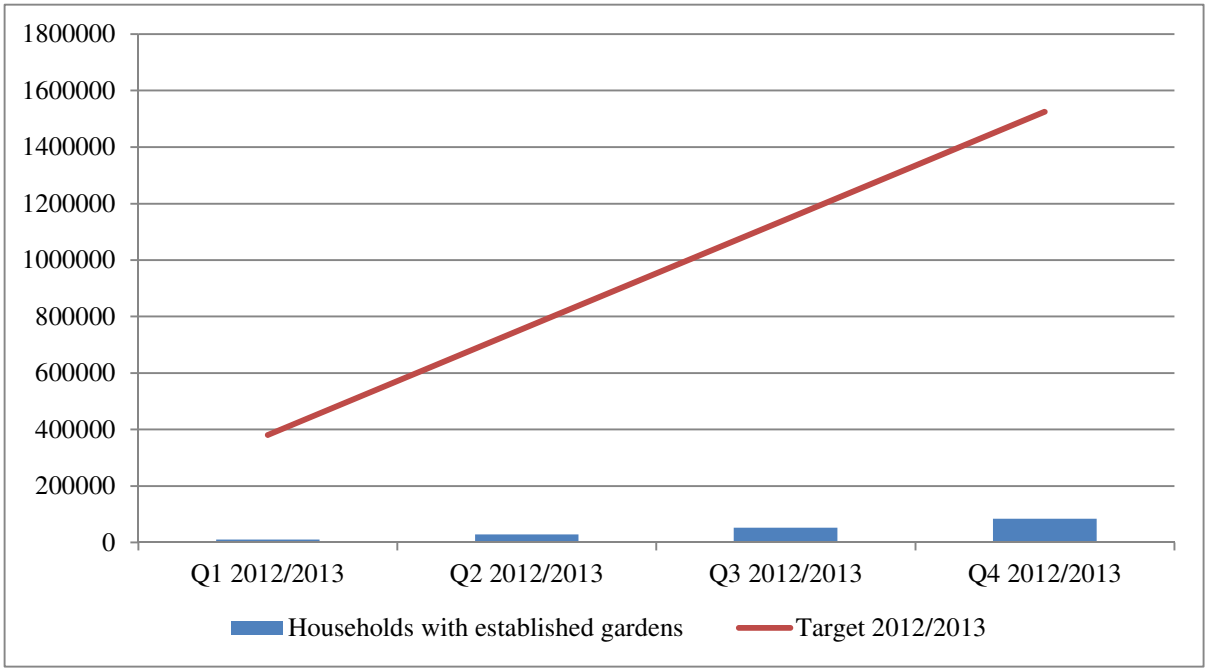
An average of 42010 households was profiled per quarter suggesting that each district was able to register an average of 3819 households per quarter. The districts breakdown is reflected by the graph below.

Figure 1.11: District breakdown and trends in households profiled



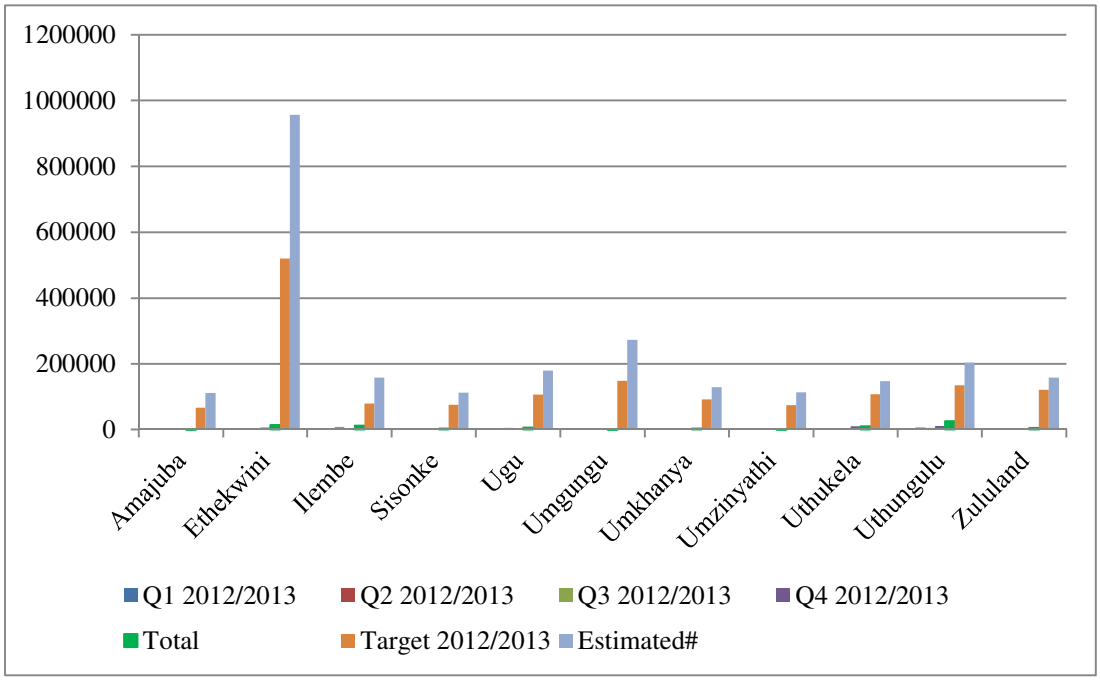
84022 households were recorded to have established gardens by the end of 2012/2013 out of a targeted 1523998 and a possible 2.5 million. The graph below provides the details.

Figure 1.12: Trends and numbers of households with established gardens



Each district was able to establish an average of 1890 household gardens per quarter. Figure 1.13 presents the graphical illustration of the district breakdown.

Figure 1.13: District breakdown numbers and trends of household gardens established



135851 people were referred for identity documents and 158677 people were recorded as having acquired the documents, indicating that an additional 20000 plus were self-referred. In regard to birth certificates, a total of 70578 were referred and 79827 were supplied with birth certificates also indicating that an additional 9000 were self-referred.

1819814 households were reported to be connected to a piped water source while 1766278 households of an estimated 2.5 million were connected to a sanitation service.

1.2 Community Mobilisation and Promotion of Positive Socio-Cultural Practices

Community mobilisation is aimed at increasing prevention awareness, and information on where to access services and to also contribute to behaviour and attitude change. Mobilisation should drive the community towards positive behaviour change, positive health seeking behaviour and taking personal responsibility to having a healthy lifestyle and a movement away from social ills.

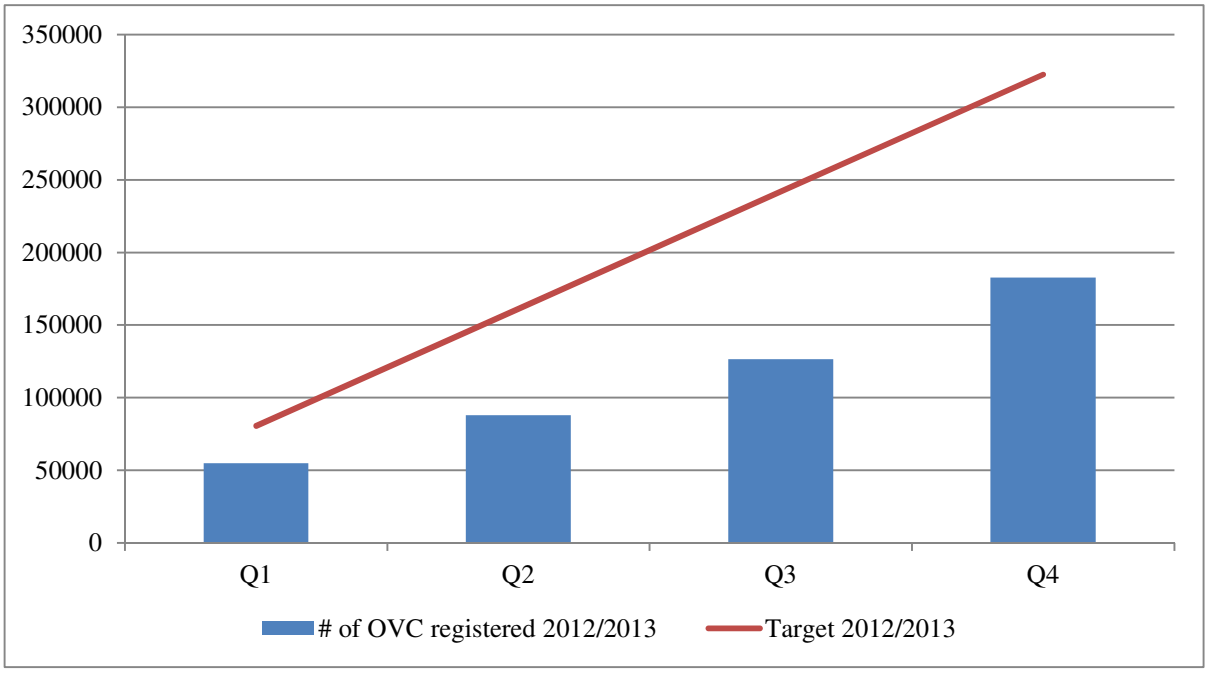
The province identified a range of key populations it intended to focus on over the next five years. These are people of reproductive age group, the youth, children under the age of 15 years, the poor, mobile worker populations, gays and lesbians and sex workers among others.

A total of 706969 people in the key population groups were reached. The age groups 25-49; 15-24 and children under 15 years covered the bulk of those reached.

1.3 Orphans and Other Vulnerable Children

A total of 182800 out of a targeted 322393 orphans and other vulnerable children (OVC) and out of an estimated 644781 were registered. The graph below provides the trends in OVC registration.

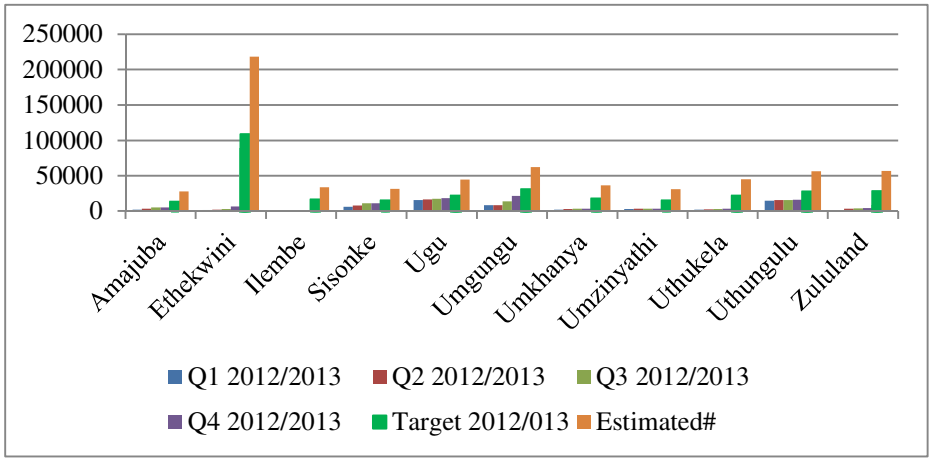
Figure 1.3: Trends and numbers of orphans and other vulnerable children registered



The province was able to register an average of 45700 OVC per quarter, translating into about 4155 children getting registered per district per quarter.

The graph below illustrates district breakdown in the registration efforts of OVC.

Figure 1.31: District breakdown numbers and trends of OVC registered



Of 182800 registered OVC, 162922 were in school and 164361 were receiving care and support. Graphs 1.32 and 1.33 below provide the illustrations over the four quarters.

Figure 1.32: Trends and numbers of OVC registered and numbers in school

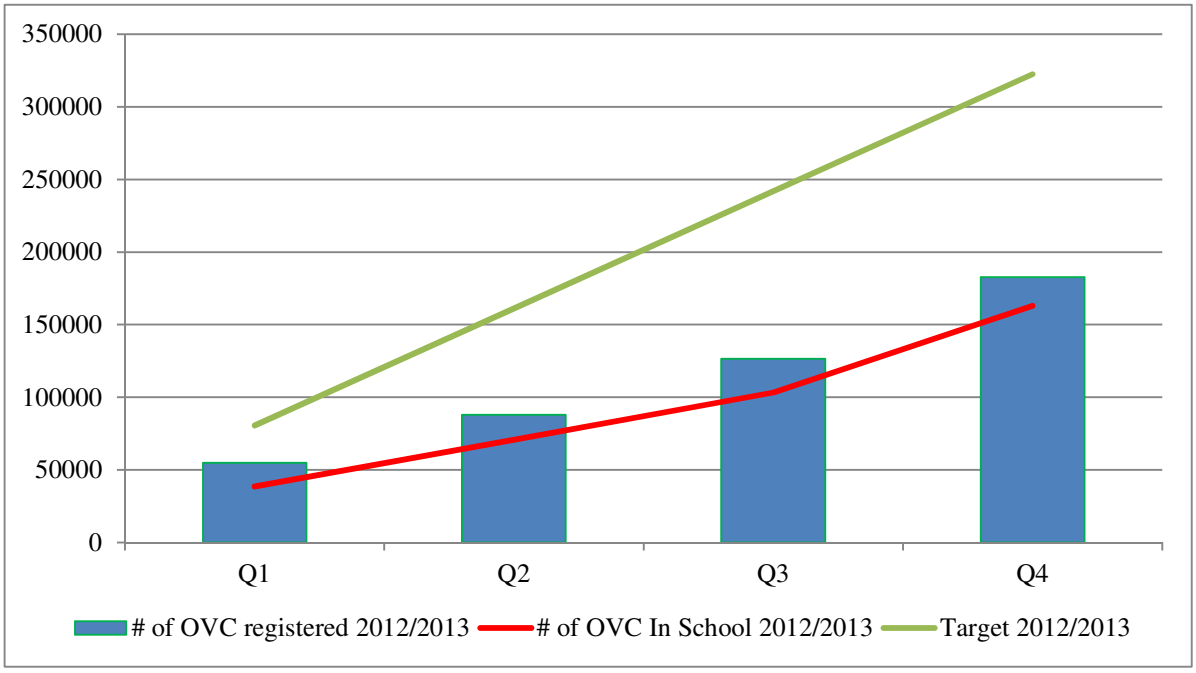
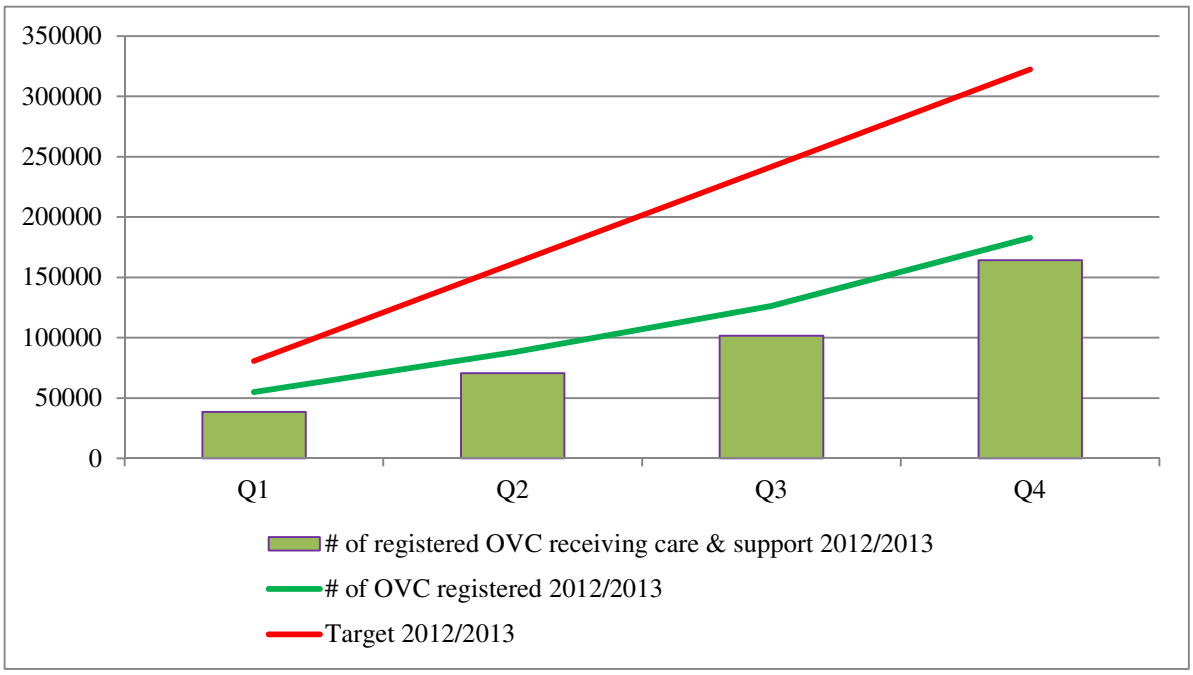


Figure 1.33.: Trends and numbers of OVC registered and receiving care and support



Based on the above graphs an average of 40731 registered OVC were in school per each quarter while an average of 41090 were receiving care and support in each quarter. An

average of 3703 registered OVC were in school per district and 3735 were receiving care and support per district.

District breakdown on the number of registered OVC in school and those receiving care and support are provided in the graphs 1.34 and 1.35 below.

Figure 1.34: District breakdown trends and number of registered OVC and number of OVC in schools

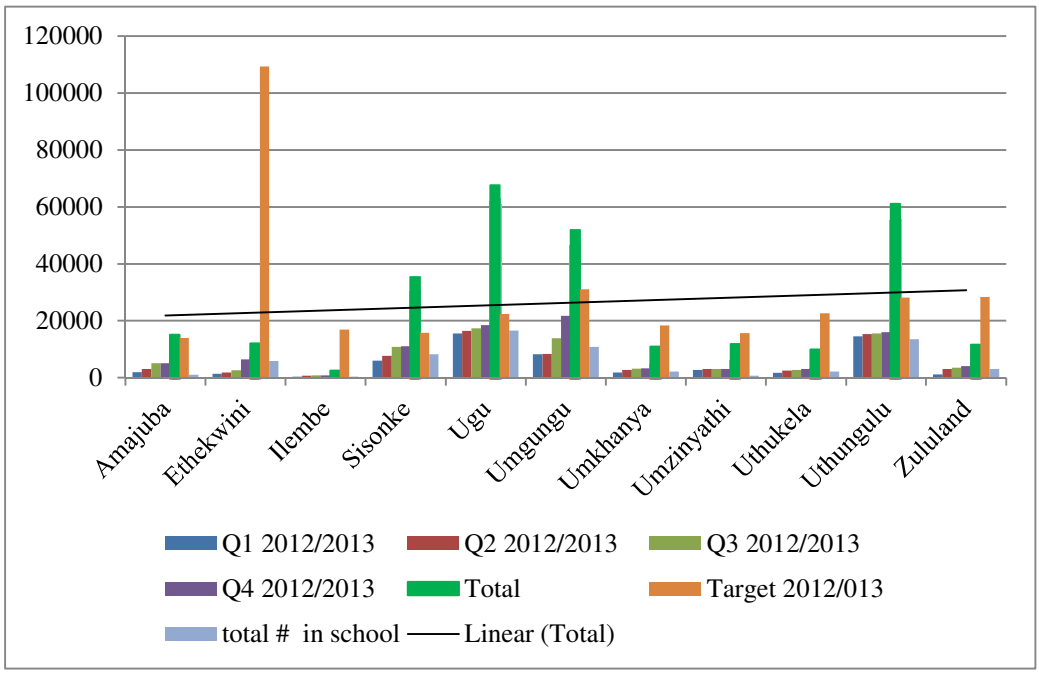
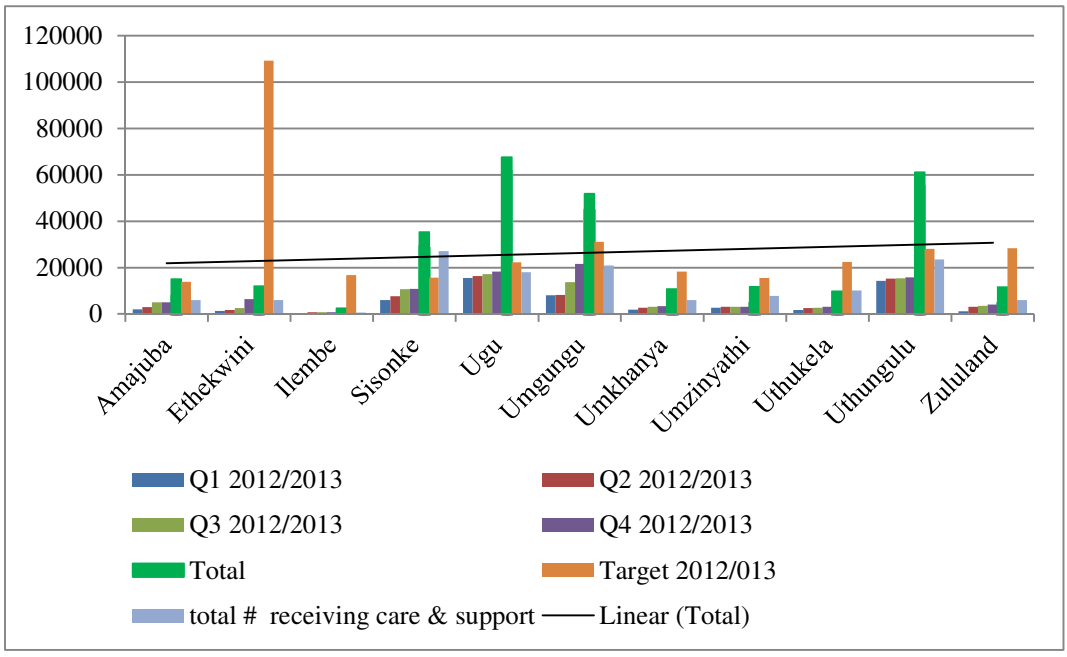


Figure 1.35: District breakdown trends and numbers of OVC registered and numbers receiving care and support

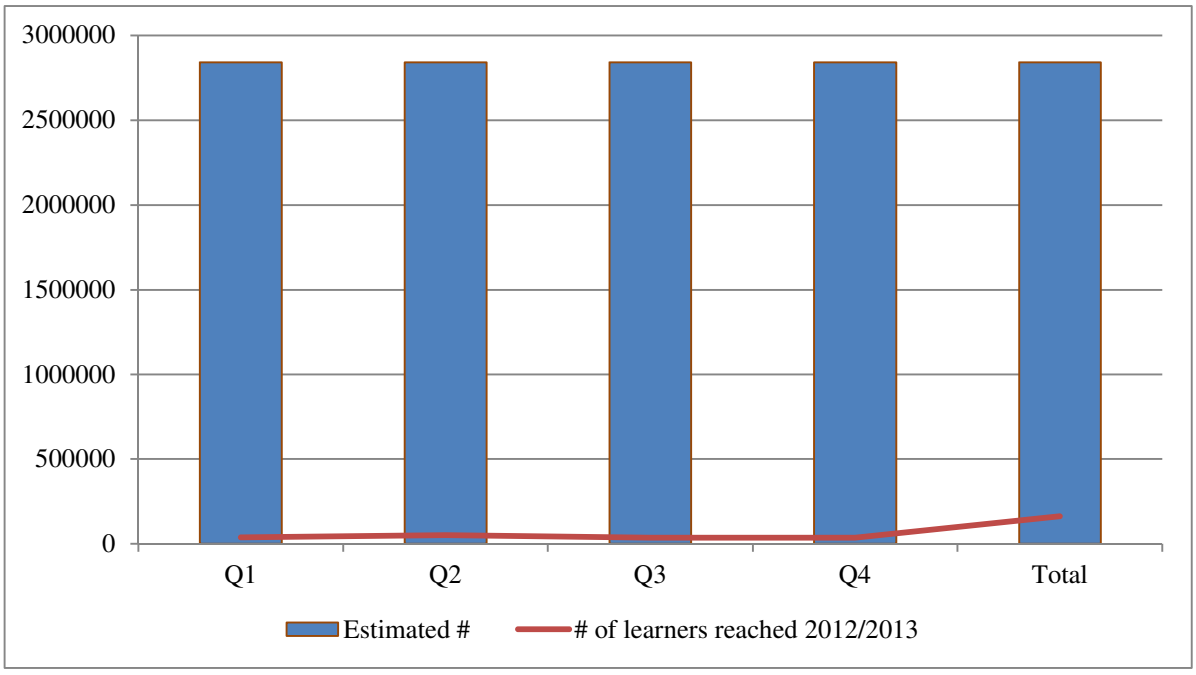


1.4 Life Skills

The life skills intervention area is designed to respond to learners falling in the key population age group 5-19 years. This population group constitutes 13% of the provincial population. According to the 2011 SNAP Survey Report for Ordinary schools, the number of schools in the province is just above 6000 with 2841135 learners. This constitutes about 89% of those falling under the age group 5-19 years. All schools in the province offer life skills education.

The multi-sectoral response measures the number of learners reached with life skills focussed campaigns as an additional response to the life skills based education offered in schools. A total of 162628 learners were reached with life skills focussed campaigns. The graph below provides the illustration.

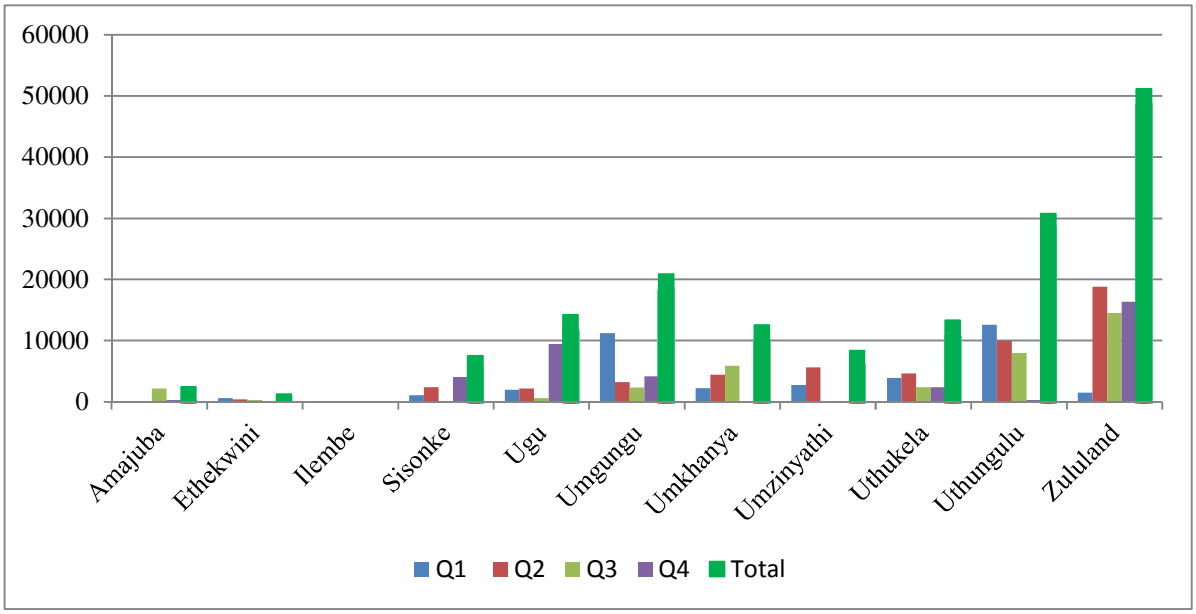
Figure 1.4: Trends and numbers of learners reached with life skills focused campaigns



The number indicates that an average of 40657 learners was reached per quarter; translating into a somewhat minimal number per school.

Districts breakdown of trends and numbers of learners reached with life focused campaigns is illustrated below.

Figure 1.41: Trends and numbers of learners reached with life skills focused campaigns



1.5 Observations

Impact of OSS: The PSP objective is to reduce the impact of vulnerability to HAST transmission due to poverty, unemployment and gender inequality by 2016.

About 11% of the targeted households have been profiled and approximately 7% of the estimated number of households in the province reached with profiling. 5 % of the targeted households had established gardens translating into coverage of 3%.

Data on establishment of gardens in schools and health facilities was not sufficiently conclusive to determine progress made as was data seeking to establish the number of hectares under production and amount of produce realised out of cultivated land.

Trends in referrals and obtaining of vital registration documents was not steady, perhaps reflecting this to be a demand driven intervention and also one that depends on mobilisation and awareness. Those referred for these vital documents accounted for 2 % of the total population.

Those referred for and receiving HAST services accounted for about 12% of the population; this showed good effort on the part of field workers in mobilisation of the population towards accessing of services.

Data on other development indicators such as electricity, sanitation and piped was also not sufficiently conclusive to determine level of progress, as was that on number of support groups and the number of people in employment as a result of community oriented projects.

Community Mobilisation: The PSP objective is to decrease behaviours that put men and women aged 15-49 years at risk of HAST by 80% by 2016 through implementation of focussed programmes.

About 1% of the province's population was reached with information on prevention awareness, anti-gender based violence, sexual assault and any other information promoting positive values. Key populations such as gays & lesbians, sex workers, long distance truck drivers, farm workers, people living in informal settlements have either been reached very minimally or not reached all together.

Orphans and Other Vulnerable Children: The PSP objective is to increase access to quality of care and support to at least 90% of orphans and other vulnerable children by 2016.

56% of the targeted orphans and other vulnerable children were registered, with 28% reach of the estimated number in 2012/2013. Registration trends according to districts breakdown was steady but did not show sufficient rises for possibilities of having 90% of the OVC registered within the shortest time span. A high number of OVC remains to be registered and therefore not accounted for.

There are commendable percentages in the general area of care and support with 89% of those registered having been recorded to be in school. A similar percentage was receiving care and support and 76% had access to social grants. Coverage and reach of child headed households at both registration and support remains in adequate.

Life Skills: The PSP objective is to decrease behaviours that put men and women aged 15-49 years at risk of HAST by 80% through implementation of focussed programmes by 2016.

89% of those in the age group 5-19 years are in schools setting the platform where the majority of this age group can be reached. About 6% of the learners were reached with information through life skills focussed campaigns.

1.6 Recommendations

Impact of OSS

1. To allow for the household profiling exercise to be carried out with the requisite speed and completed within an acceptable time limit, the enabling environment within which household profiling is currently taking place (ranging from personnel, materials, financial resources to infrastructure) should be revisited. This should also apply to the establishment of household gardens.

2. Given that the goal of the "one home one garden" campaign is to enhance and maintain food security; the province should strategise on addressing sustainability of the established household gardens. Increasing household produce and organising households into cooperatives/teams that can create a platform for commercial sale of produce is one such option.

Community Mobilisation

1. As per the KZNPSP the province should develop one all-encompassing multi-sectoral community mobilisation and communication multi-media strategy/plan, spelling out stakeholders roles in community mobilisation and awareness activities. In the shorter term, all stakeholders involved in community mobilisation activities should submit their work plans to respective district HIV & AIDS coordinator offices for consolidation.

Orphans and Other Vulnerable Children

1. Gaps and weaknesses in the existing registration system should be addressed with a view to creating a speedy environment for accounting for orphans and vulnerable children.
2. Additional focus should also be directed to registration and support of child-headed households.

Life Skills

1. A plan for life skills focussed campaigns should be developed and thereafter incorporated into the communication and community mobilisation strategy/plan. In the shorter term, the department of education should submit work plan of life skills focussed campaigns to the district HIV & AIDS coordinator offices.

Workplace Programmes

1. The employee population in the province forms a large percentage of the population, in this sense, it is a key population. Data on workplace programmes was not reliable enough for a credible and informed analysis which may be a sign of lack of coordinated efforts towards workplace responses. To drive these activities forward, there should be a workplace programme committee made up of both public and private sector representatives. This committee should then be cascaded down to the lower structures. The provincial council on AIDS and its lower level associated

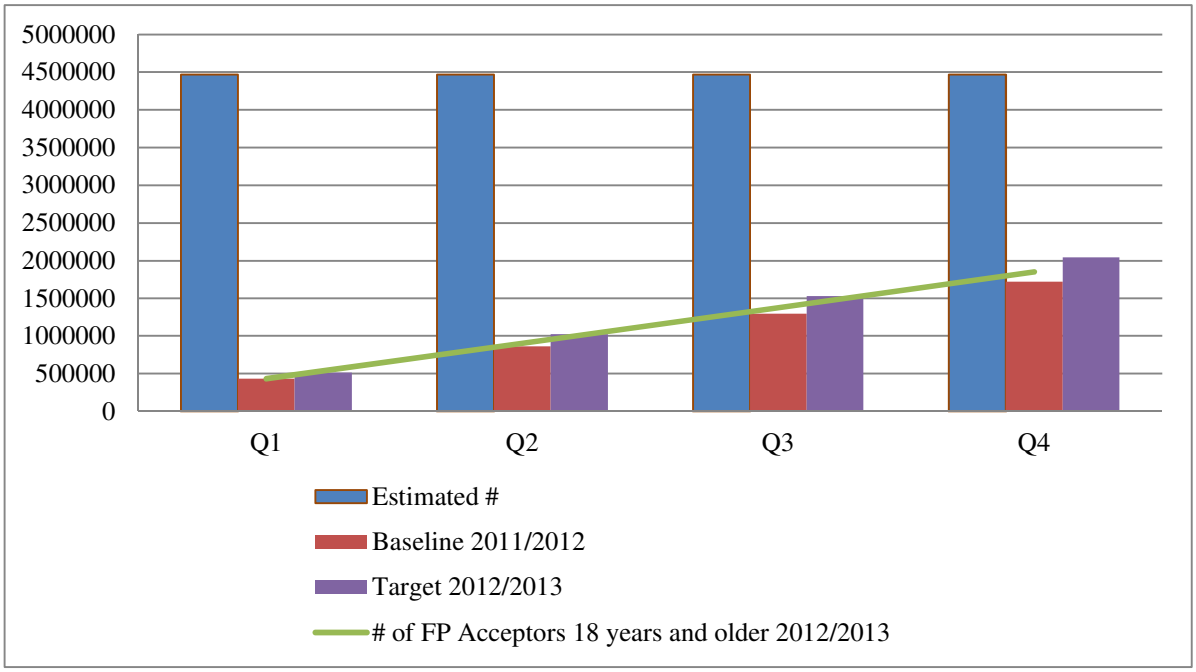
structures should then make workplace programme reporting a regular agenda item in the meetings to monitor progress.

2. Strategic Objective 2: Prevention of New HIV & AIDS, STI and TB Infections

2.1 Contraceptive Access

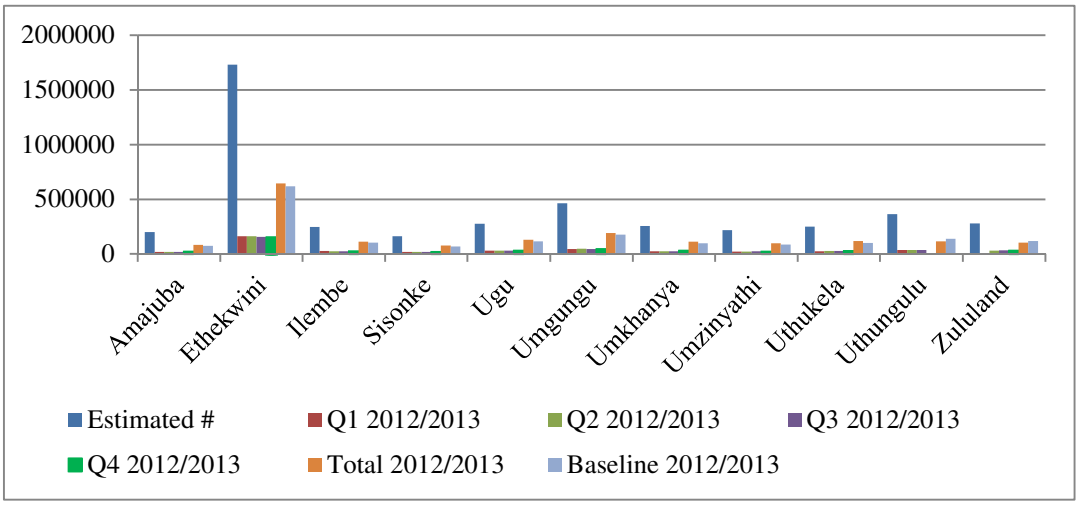
The KZNPSP advocates for access to comprehensive sexual and reproductive health services for all and especially to women as a way of effecting decisions on their reproductive choices. In this regard, the PSP measures this access through three data elements including the number of new clients aged 18 years and over accepting a family planning method for the first time. The number of family planning acceptors aged 18 years and older was 1850061 out of a targeted 2043394. The graph below illustrates trends in the number of women aged 18 years and above who decide to take up family planning method for the first time in 2012/2013.

Figure 2.1: Trends and numbers of new family planning acceptors aged 18 years and older



Based on these figures, an average of 462515 new clients accepted to use a method of family planning per quarter translating into about 42047 clients per district quarter. District trends are illustrated in the figure below.

Figure 2.11: District breakdown trends and numbers of new family planning acceptors aged 18 years and above

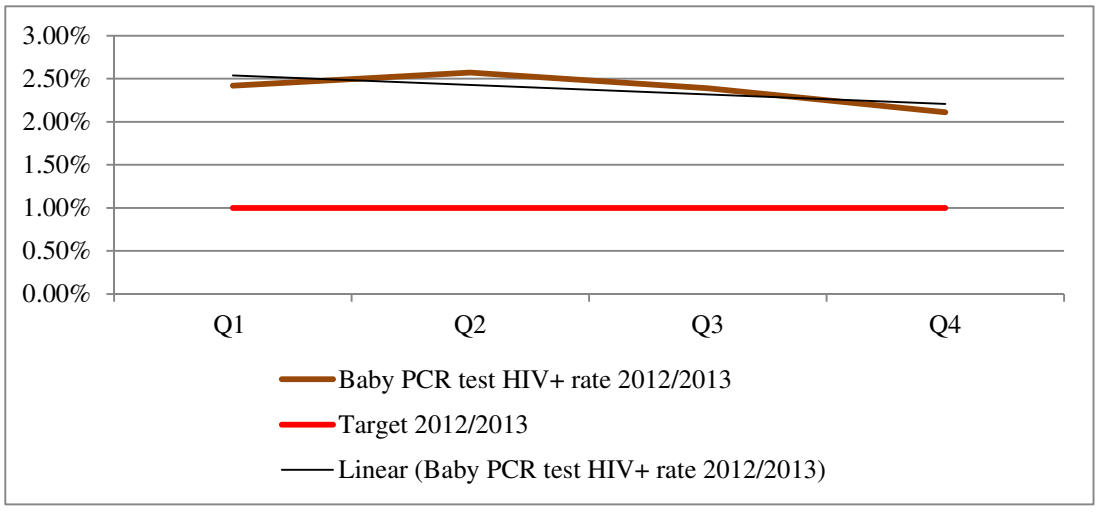


2.2 Prevention of Mother to Child Transmission

Scaling up access to HIV early diagnosis of HIV in babies born to HIV infected mothers is critical to increasing the chances for mother and infant leading healthy lives. The province has committed to ensuring that all mothers get tested early to inform timely interventions.

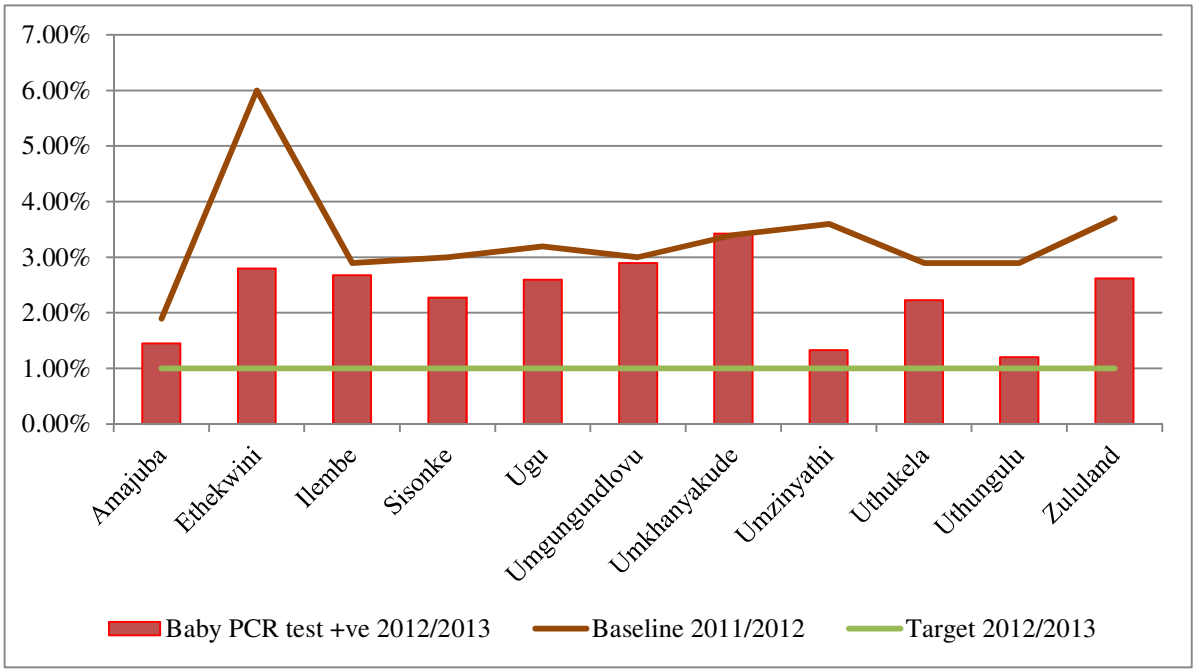
A total of 67750 infants were born to HIV positive mothers as compared to 68010 in the previous year. 77728 infants were PCR tested at around six weeks as compared to 73048 in the preceding year. 1945 tested positive as compared to 2883 the year before. The baby PCR test positive rate was 2.34% down from a baseline of 3.32%. The graph below provides an illustration of the positivity rates trends over the four quarters in 2012/2013. It shows a slight rise in quarter two before consecutive declines in the last two quarters.

Figure 2.2: Trends in baby PCR positive rate at around six weeks



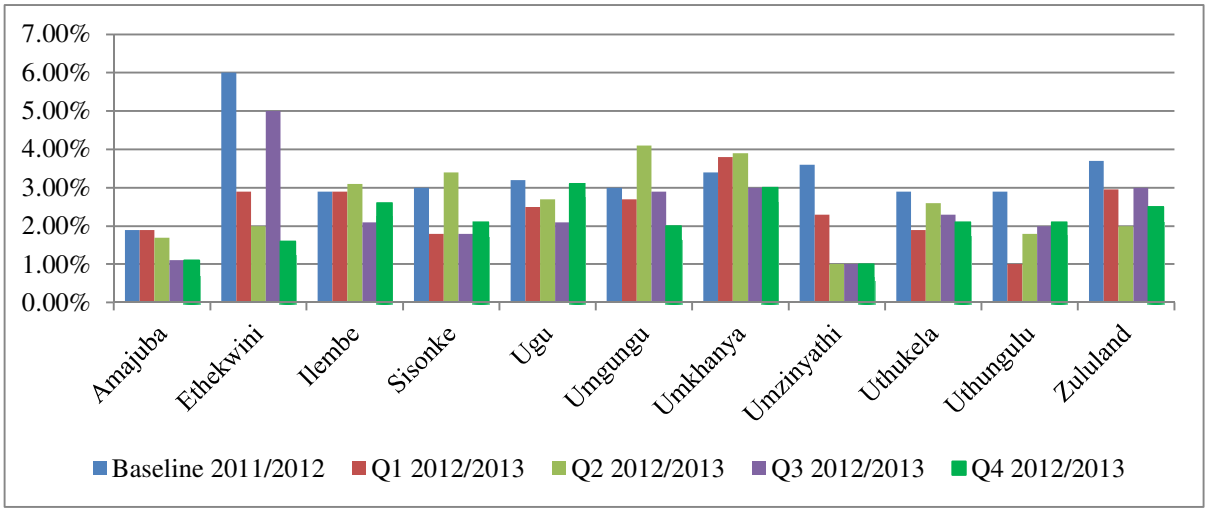
The graph below illustrates district breakdown on baby PCR tested positive at around 6 weeks.

Figure 2.21: District breakdown baby PCR tested positive rate at around six weeks



The figure below provides the district breakdown trends for baby PCR tested positive at around 6 weeks.

Figure 2.22: District breakdown and trends in baby PCR test positive rate at around six weeks



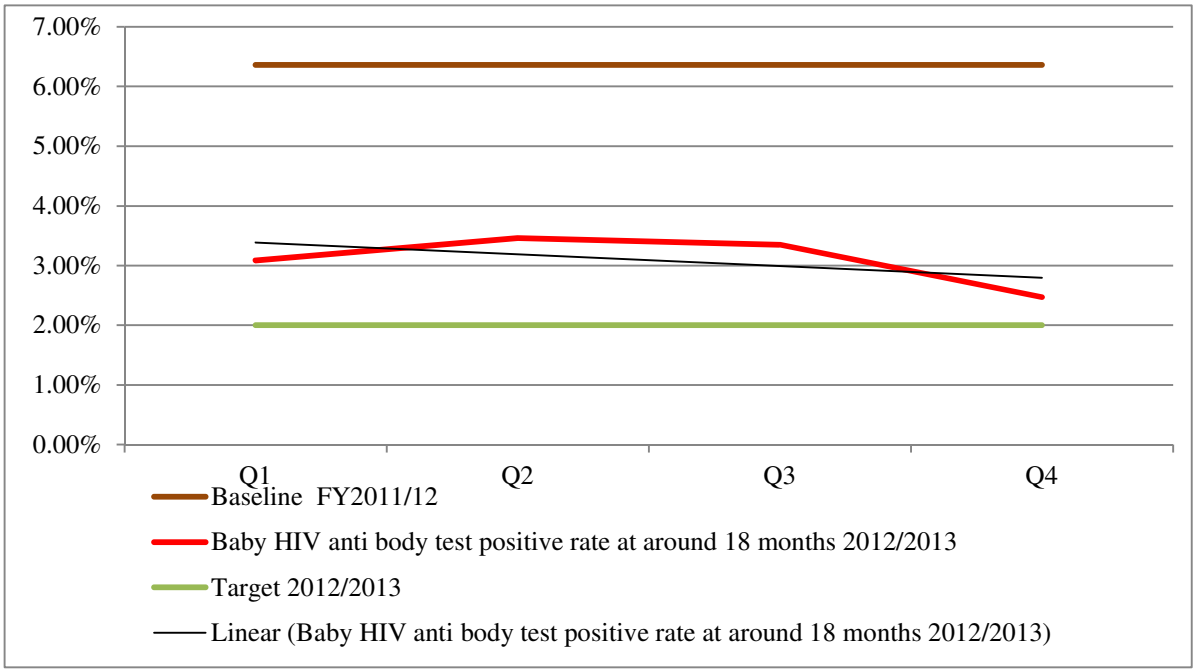
In regard to baby HIV antibody test at around 18 months, a total of 33394 babies underwent an HIV antibody test as compared to 22556 in the previous year. The table below presents information on the uptake.

Table 2.22: District breakdown on baby HIV antibody test at around 18 months

	Q1 2012/2013	Q2 2012/2013	Q3 2012/2013	Q4 2012/2013	Total
Amajuba	57.8%	64.9%	77.6%	96.2%	74.1%
eThekwini	27.0%	31.1%	43.0%	40.1%	35.3%
iLembe	55.5%	51.3%	72.4%	102.8%	70.5%
Sisonke	37.5%	40.9%	32.5%	71.6%	45.6%
Ugu	32.8%	60.8%	105.7%	118.8%	79.5%
uMgungundlovu	29.3%	45.3%	72.6%	81.2%	57.1%
uMkhanyakude	30.5%	33.6%	38.6%	40.7%	35.9%
uMzinyathi	42.2%	43.1%	57.8%	87.6%	57.7%
uThukela	18.3%	34.6%	71.0%	98.6%	55.6%
uThungulu	29.7%	21.5%	25.4%	39.2%	29.0%
Zululand	33.1%	28.2%	44.6%	46.2%	38.0%
Province	**35.8%**	**41.4%**	**58.3%**	**74.8%**	**52.6%**

Baby HIV antibody test at around 18 months was 3.10% whereas the previous year's rate was 6.36%. The figure below illustrates the trends in baby HIV anti-body test positive rate at around 18 months.

Figure 2.23: Trends in baby HIV anti-body test positive at around 18 months



The district breakdown for baby HIV anti-body test positive rate illustration is provided in the graph below while the district breakdown trends is shown in figure 2.25 .

Figure 2.24: District breakdown for baby HIV anti-body positive rate at around 18 months rate

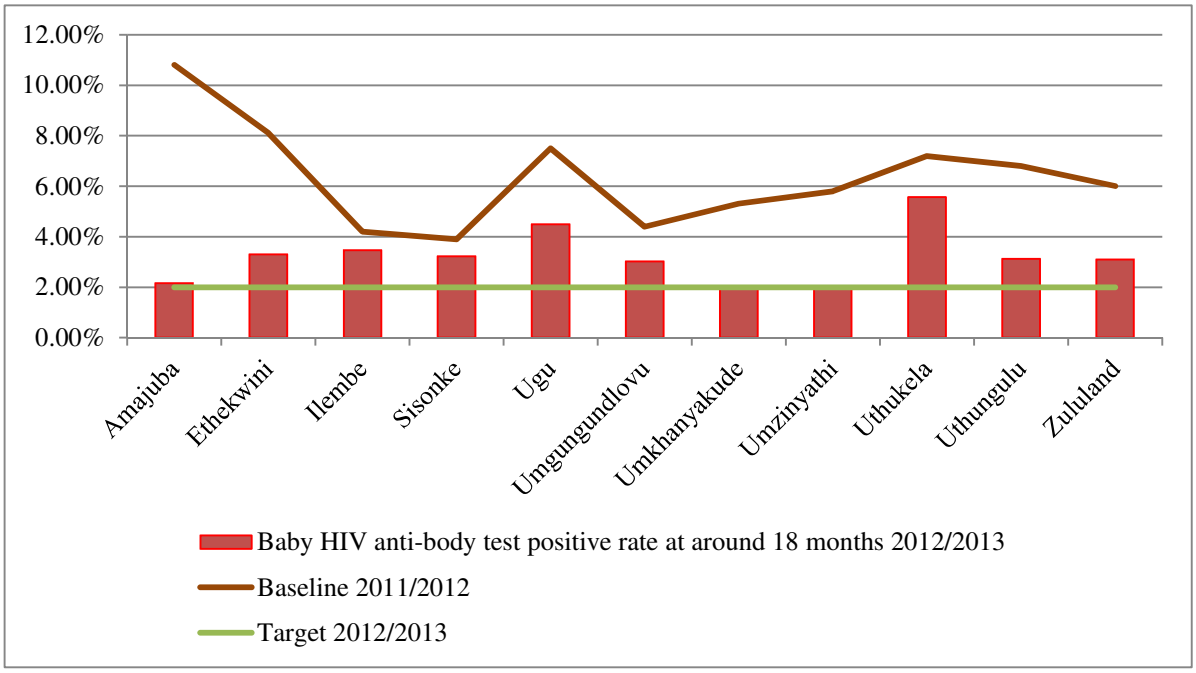
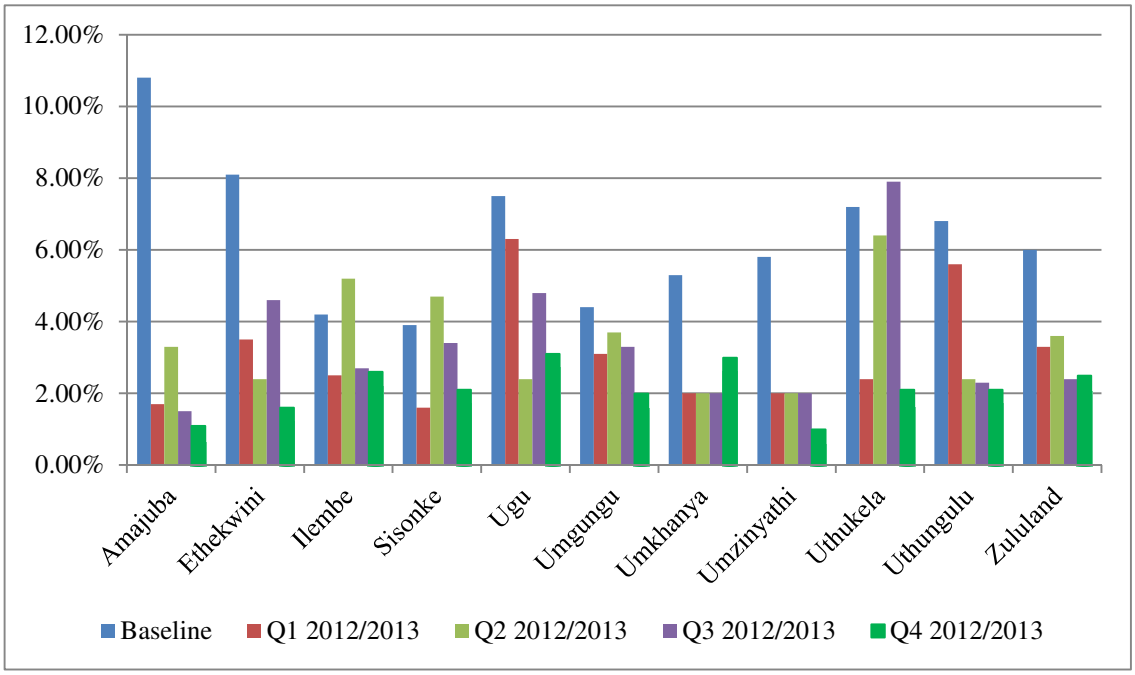
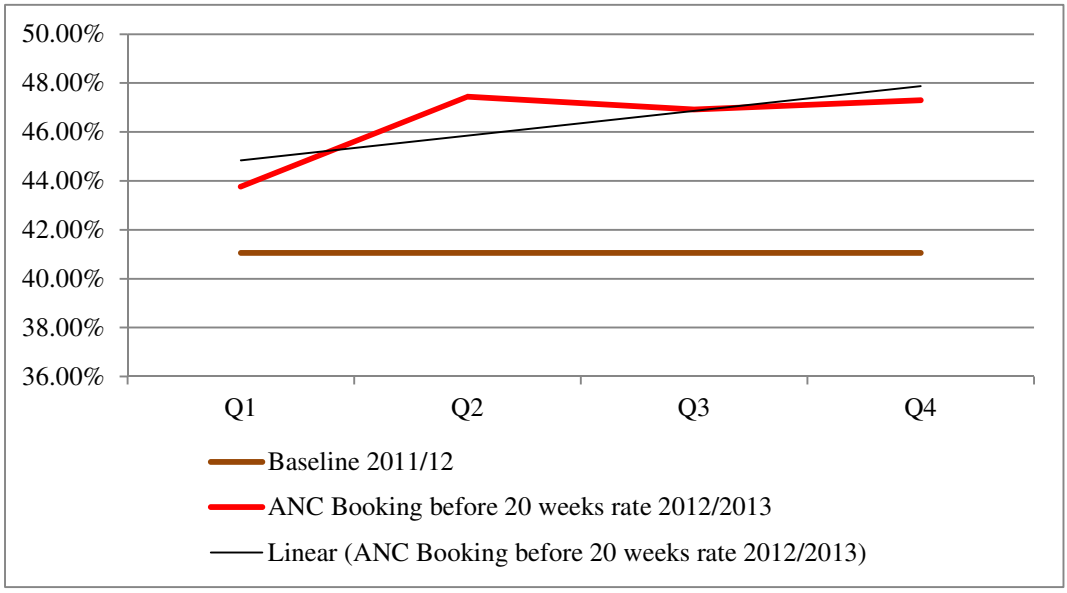


Figure 2.25: District breakdown on trends in baby anti-body test positive rate at about 18 months



Ante-natal clinic (ANC) first visit totaled 221740 as compared to 223146 in the preceding year. The number of ANC bookings before 20 weeks was 112372 as compared to 209326 in 2011/2012. ANC booking before 20 weeks rate was 46.35% higher as compared to 41.05% in the previous year. The graph below provides information on the trends for ANC booking before 20 weeks rate.

Figure 2.26: Trends in ANC booking before 20 weeks rate



District breakdown on ANC booking before 20 weeks is illustrated in the graph below while district breakdown on trends is illustrated in graph 2.27 while district breakdown on trends is shown in graph 2.28.

.

Figure 2.27: District Breakdown ANC booking before 20 weeks.

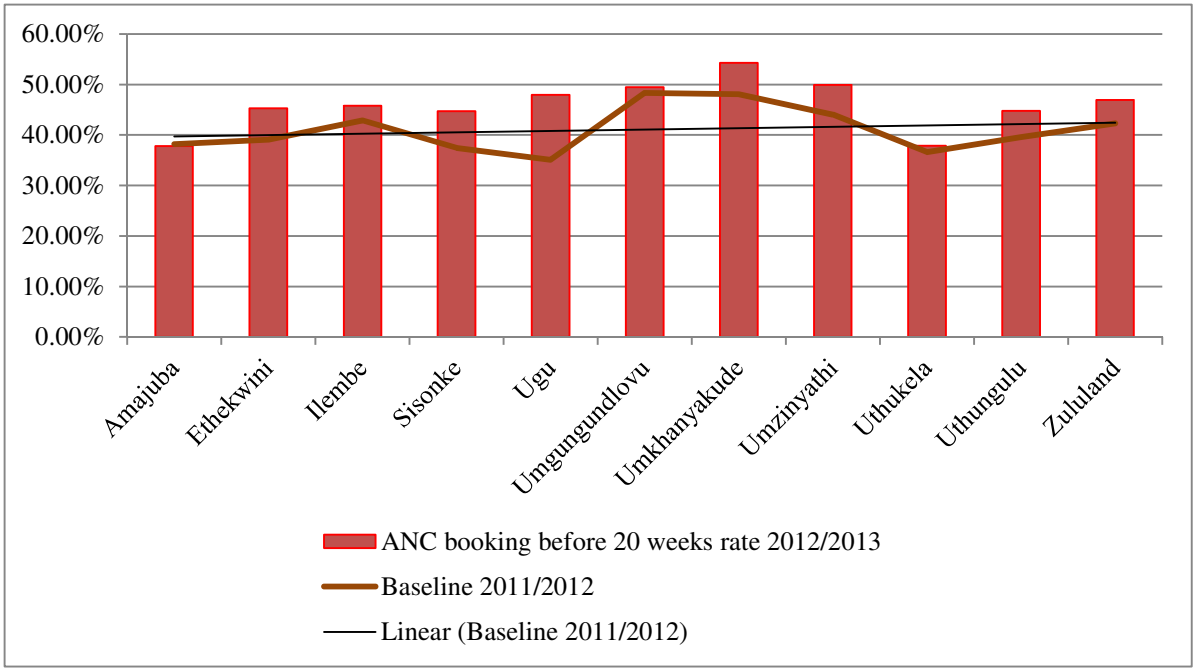
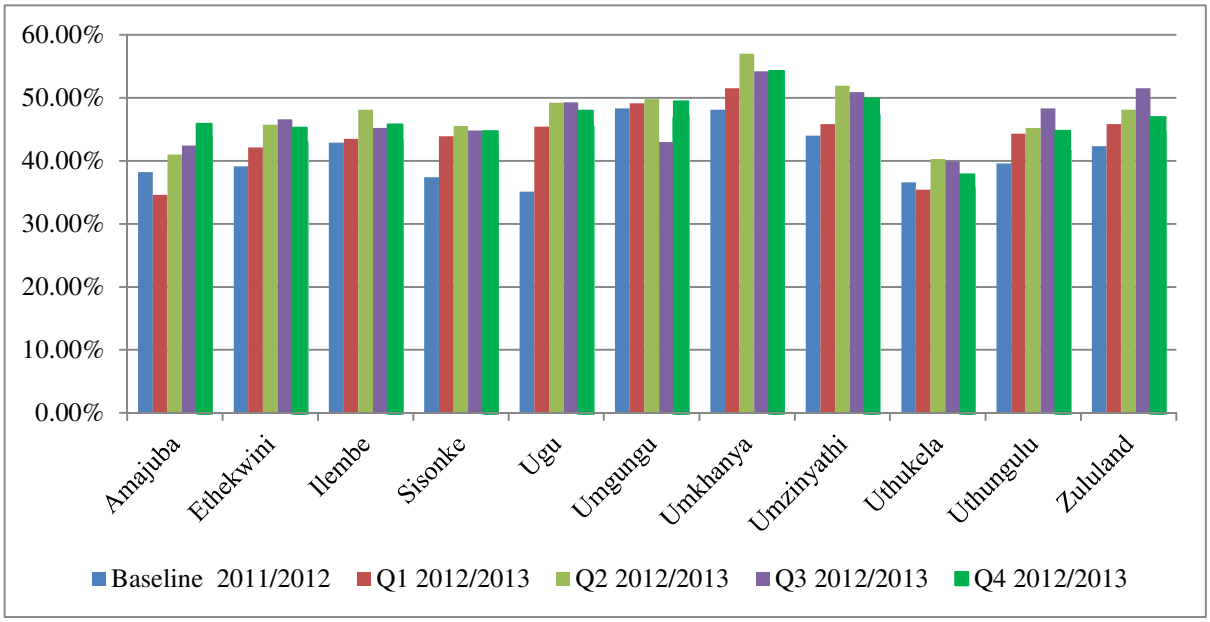
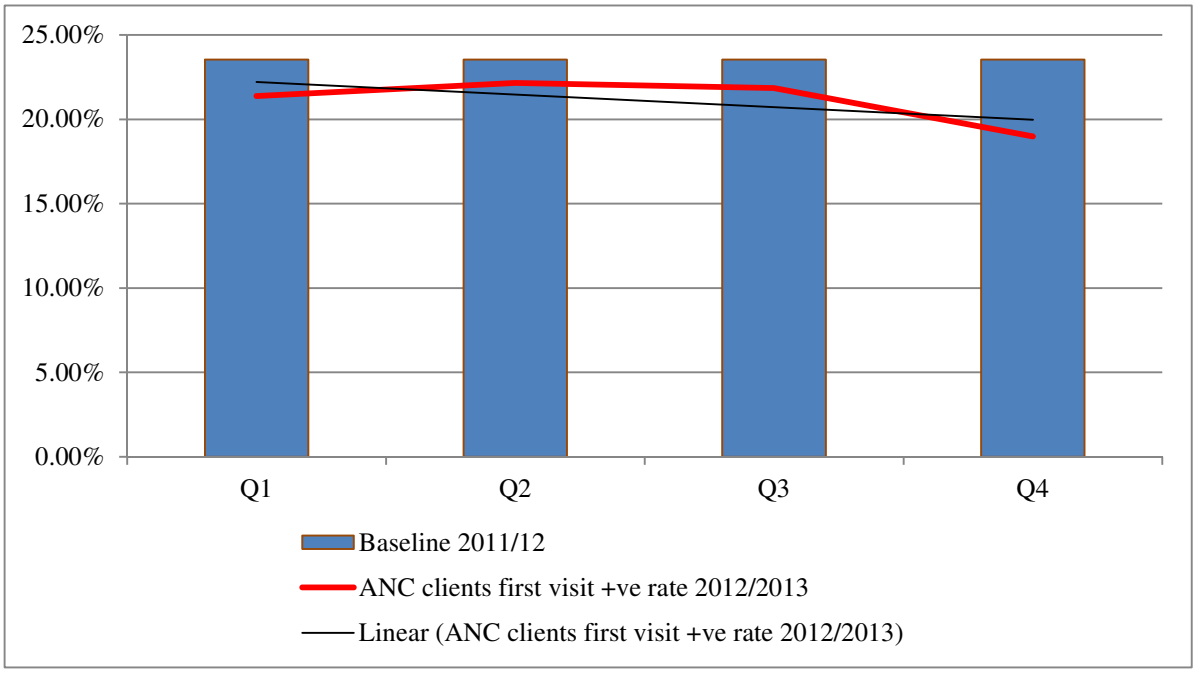


Figure 2.28: District breakdown on trends in ANC booking before 20 weeks rate



Of the 221740 ante natal clinic first visit clients, 46474 tested positive as compared to 223146 ANC first visits the previous year of which 55422 were positive. The ANC first visit positive rate was 21.09% while the preceding year's was 23.53%. Below is an illustration of trends on the ANC first visit positive rate trends.[1]

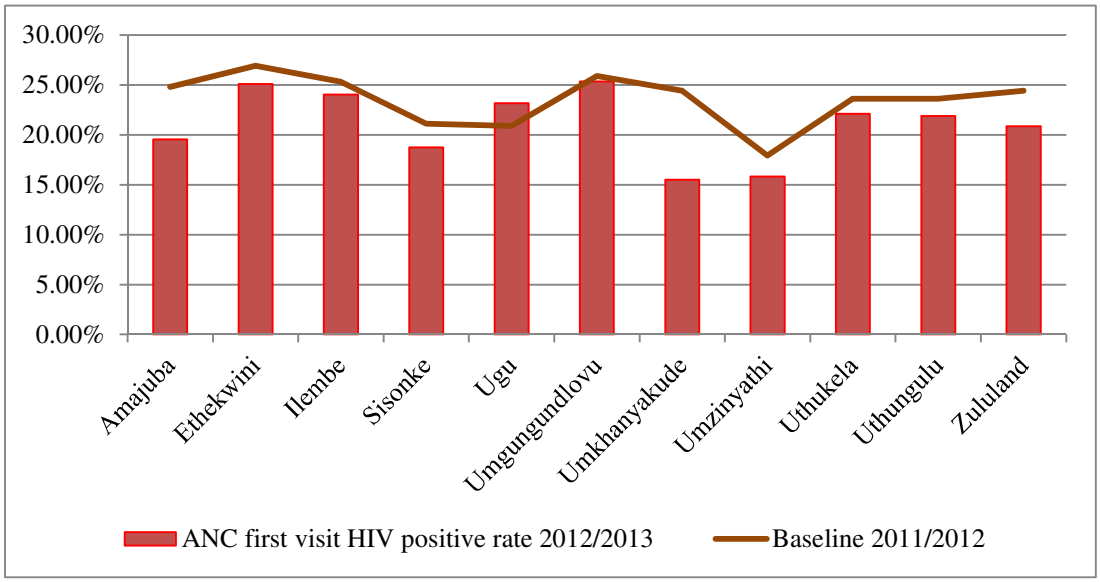
Figure 2.29: Trends on ANC first visit HIV positive rate



[1] Quarter 4 % lacks information for 1 district.

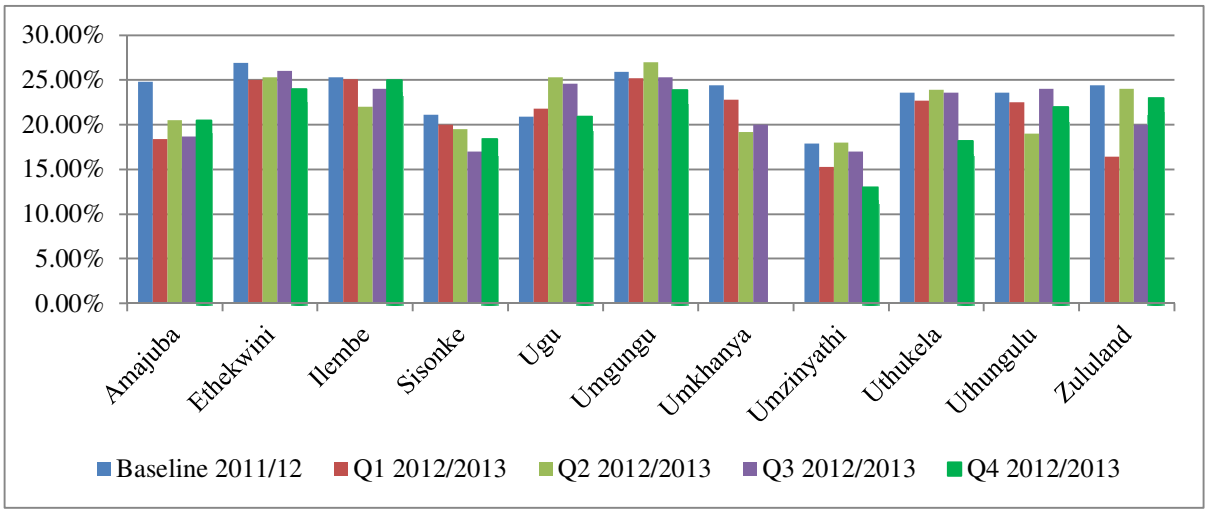
The graph below provides an illustration of district breakdown for ANC clients first visit positive rate.

Figure 2.210: District breakdown ANC clients first visit positive rate



The graph below provides an illustration of trends on ANC first visit HIV positive rate per district.

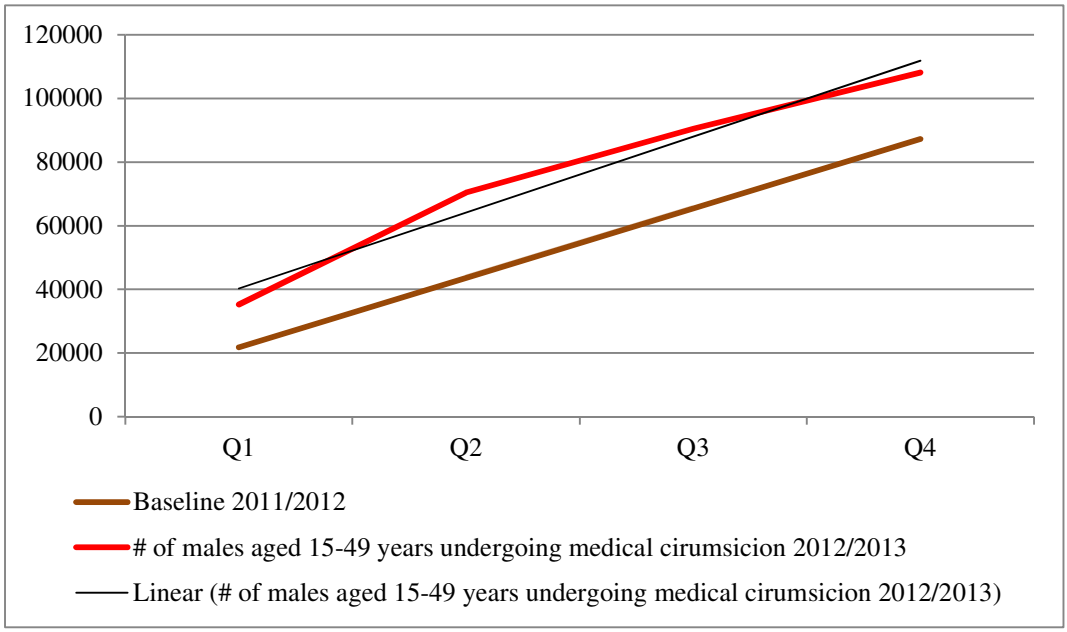
Figure 2.211: District breakdown trends ANC first visit positive rate



2.3 Medical Male Circumcision

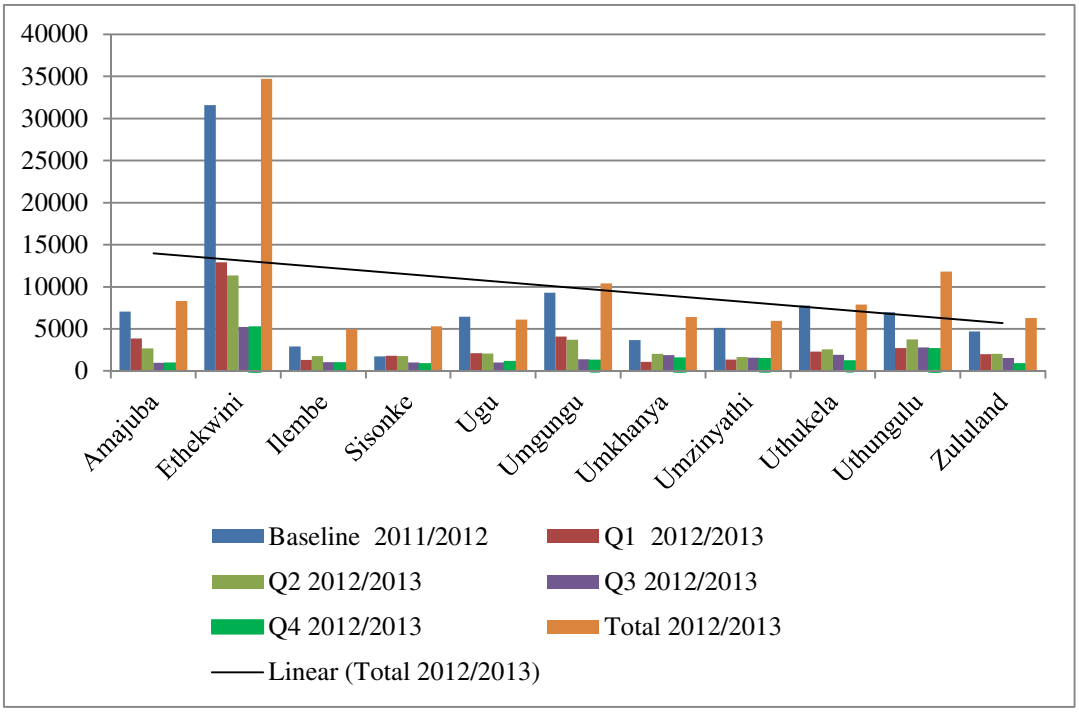
108108 males were medically circumcised in 2012/2013 as compared to 87233 in 2011/2012. The graph below illustrates the number of males aged 15-49 that have undergone medical male circumcision.

Figure 2.3 Numbers and trends of men aged 15-49 undergoing medical Male circumcision



Based on the above data, 27027 males underwent circumcision per quarter translating to about 2457 males per district per quarter. The graph below illustrates the district breakdown trends per quarter.

Figure 2.31: District breakdown on numbers and trends for males aged 15-49 years undergoing circumcision

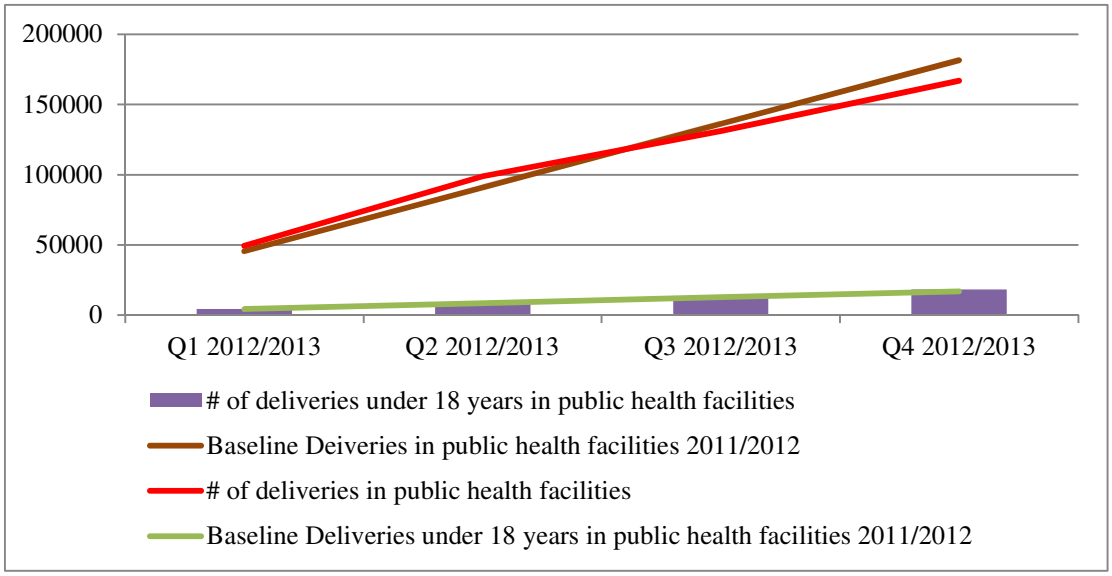


2.4 Maternal, Child & Women's Health

Births in public health facilities were recorded at 166793[2] as compared to 181585 in the previous year. Of the 166793 births, 18078 were deliveries less than 18 years. Previously this was 16914 against a total of 185585.

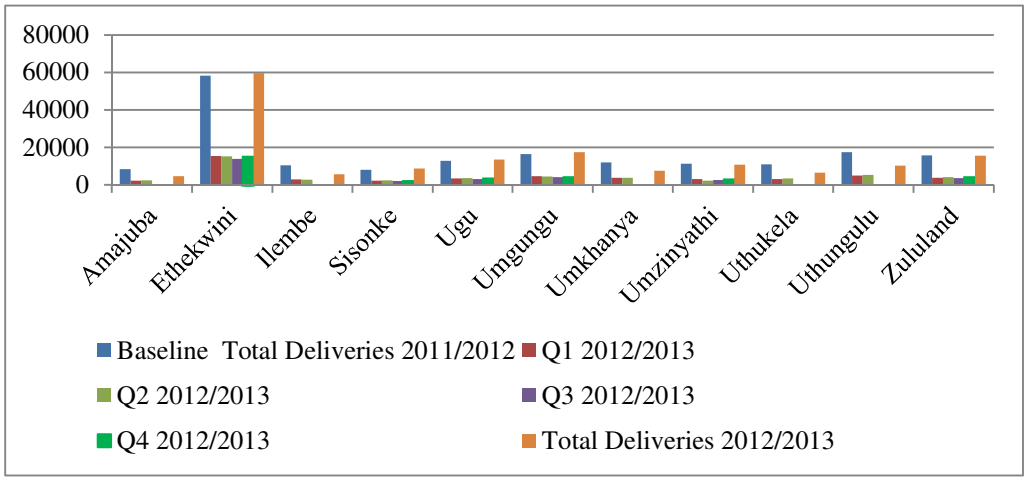
The graph below illustrates the number of deliveries in public health facilities and the number of deliveries recorded among 18 year olds and under.

Figure 2.4: Number of deliveries in public health facilities and Number of deliveries under 18 years of age



It can be deduced from the data that an average of 41698 births occurred per quarter translating to a district average of 3791 per quarter. Graph 2.41 shows district breakdown trends in number of deliveries per quarter.

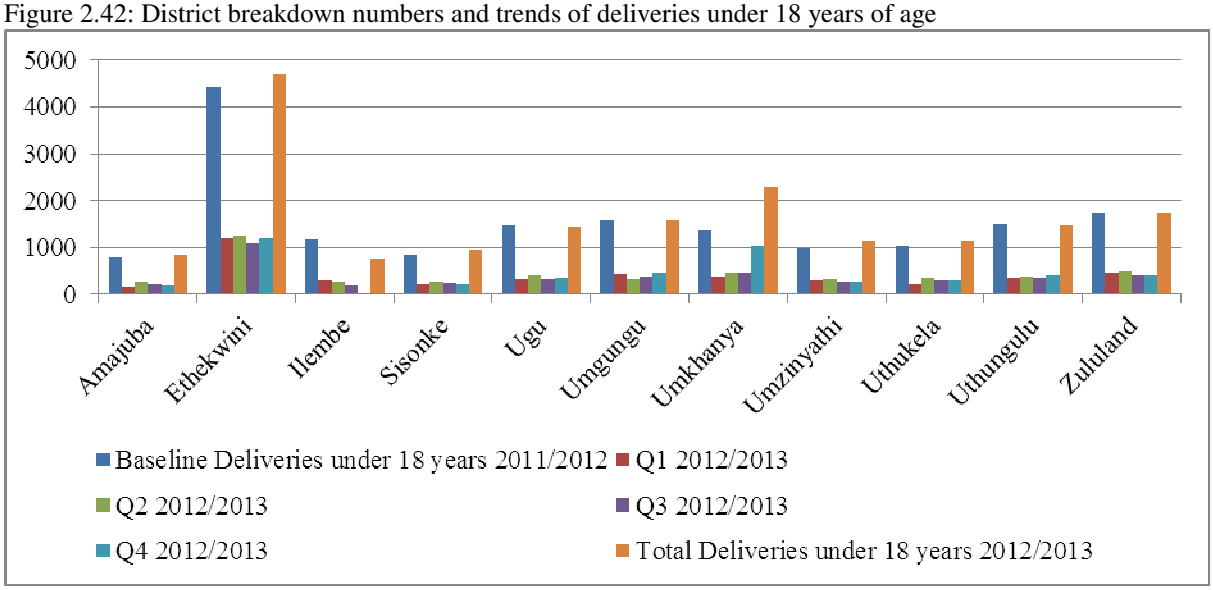
Figure 2.41: District breakdown on number and trends of deliveries per quarter



[2] Quarter 4 data for 4 districts missing.

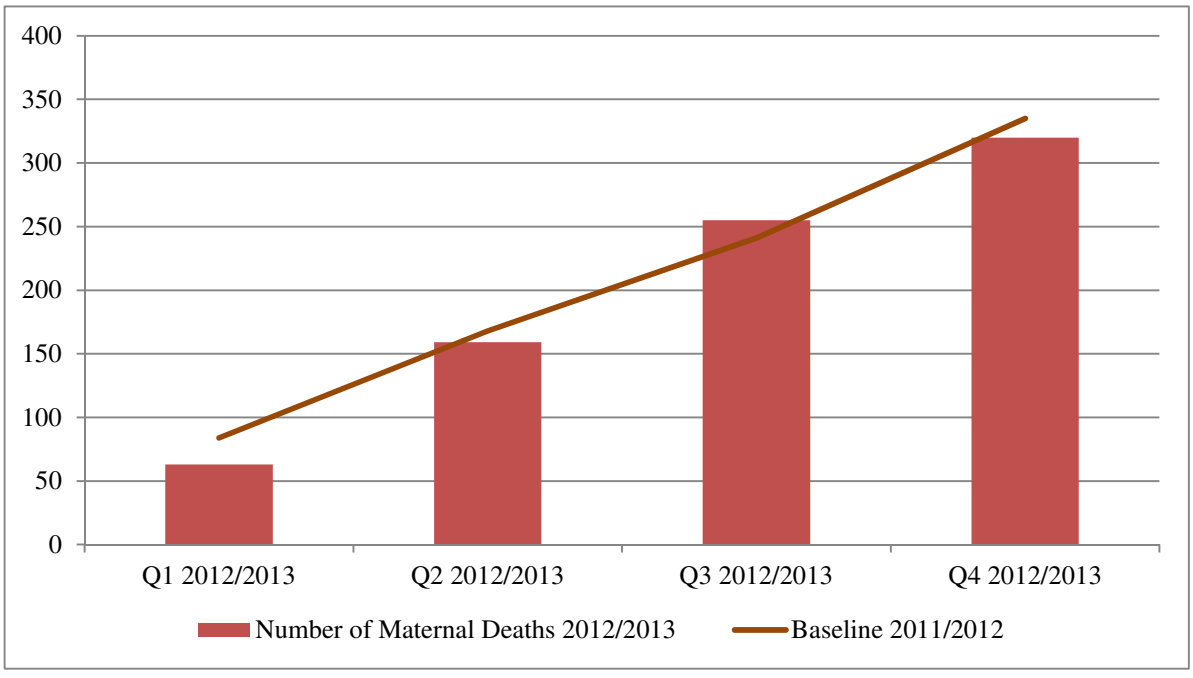
Graph 2.42 illustrates district breakdown and trends for total number of deliveries 18 years and under.

Figure 2.42: District breakdown numbers and trends of deliveries under 18 years of age



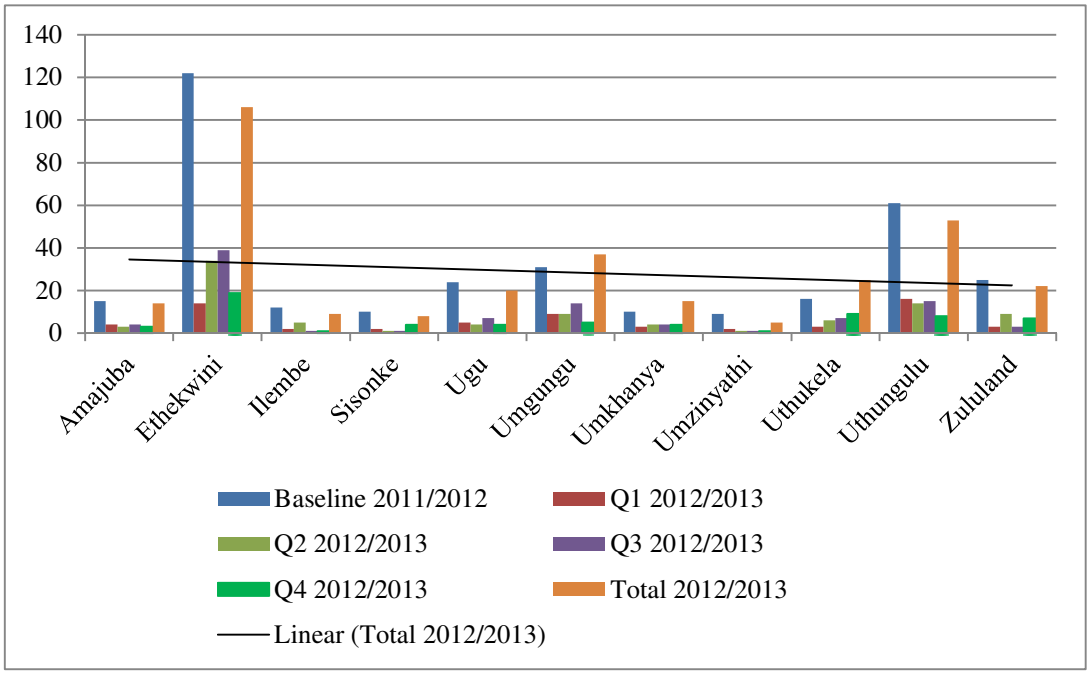
There were 320 maternal deaths in 2012/2013 as compared to 335 in the year 2011/2012. The graph below shows the trends in maternal deaths per quarter.

Figure 2.43: Number and trends in maternal deaths per quarter



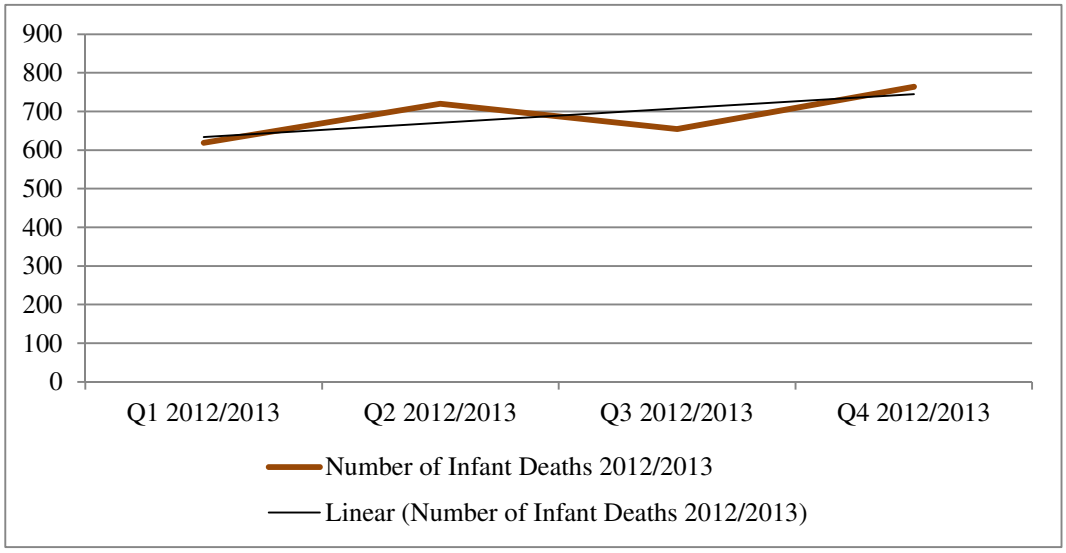
Average maternal deaths were 80 per quarter translating into about 8 deaths per district per quarter. The graph below provides information on district breakdown on the number of maternal deaths.

Figure 2.44: District breakdown in trends and numbers of maternal deaths



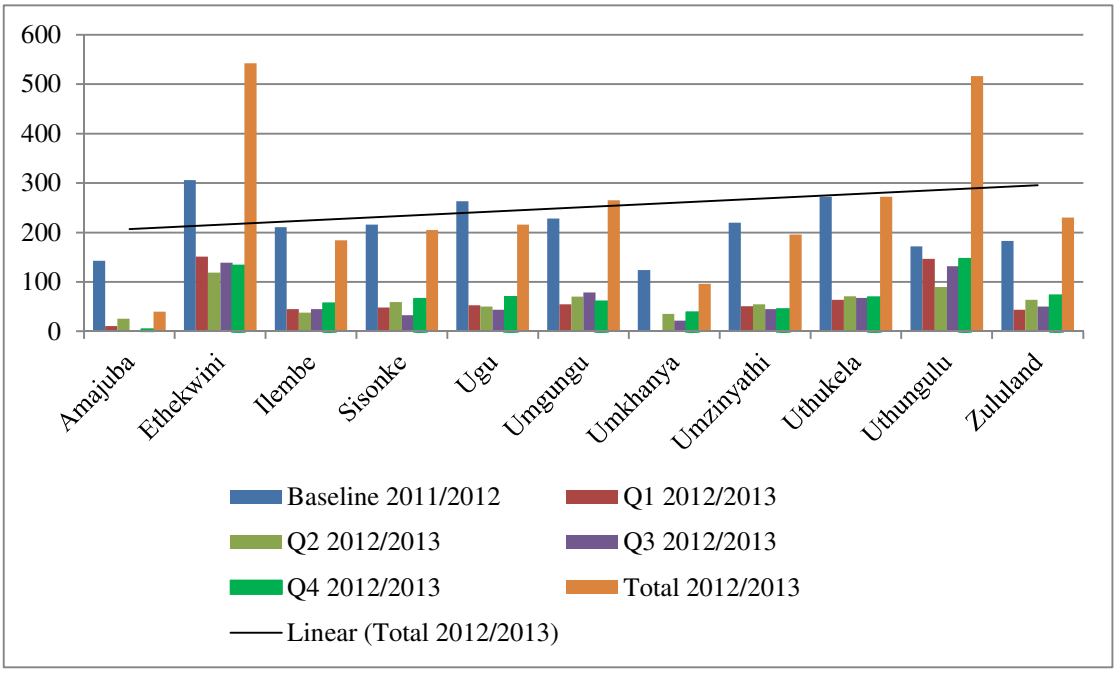
Infant deaths totaled 2757 as compared to 2338 previously. The graph below illustrates the number trends in the number of infant deaths.

Figure 2.45: Trends and numbers in infant deaths per quarter



An average of 689 infant deaths occurred per quarter showing that about 63 infant deaths were recorded per district per quarter. The graph below provides information on infant deaths per district.

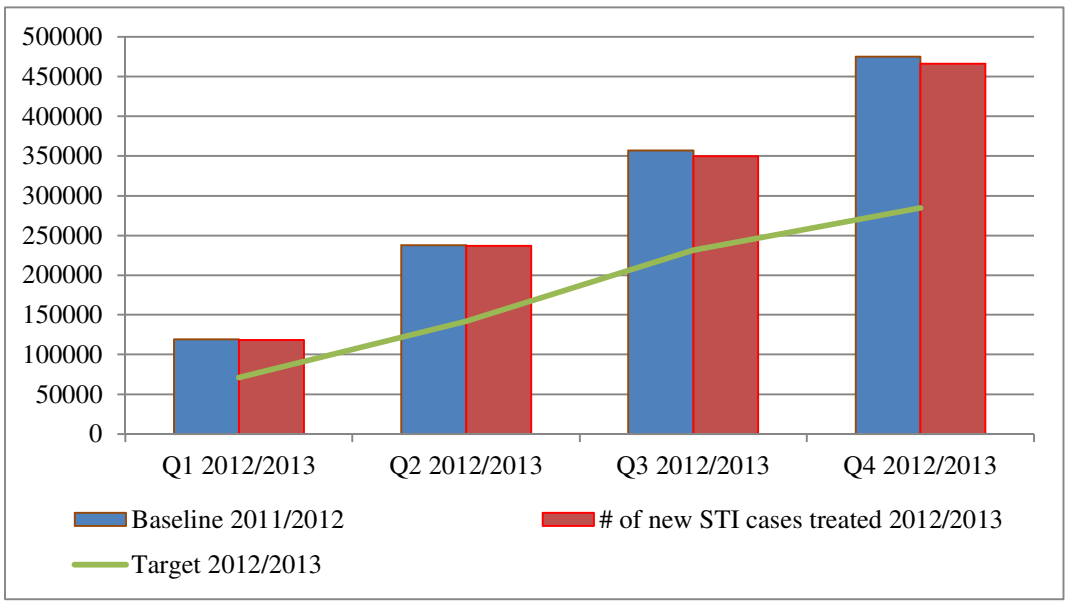
Figure 2.46: District breakdown in trends and numbers of infant deaths



2.5 Sexually Transmitted Infections

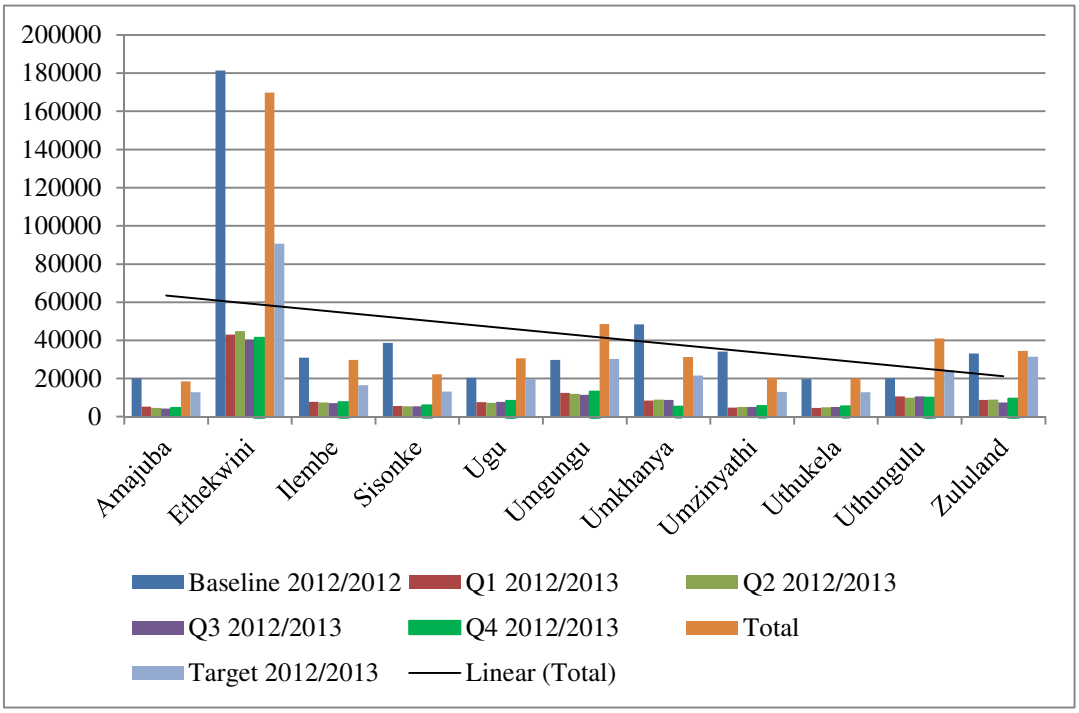
465949 new cases of sexually transmitted infections were treated in 2012/2013 as compared to 475766 in the previous year. The province hoped to reduce treatment of new STI episodes to 302504. The graph below provides information on the number of new sexually transmitted infections treated per quarter.

Figure 2.5: Number of new sexually transmitted infections treated per quarter



116487 new STI cases were treated per quarter, translating into about 10590 cases per district per quarter. The graph below presents the district breakdown in the number of new sexually transmitted cases treated.

Figure 2.51: District breakdown trends and number of new STI cases treated



The number of new sexually transmitted infection partners was 85274 as compared to 98616 in the previous year. Below is the graphical illustration.

Figure 2.52: Number of new STI cases partners treated

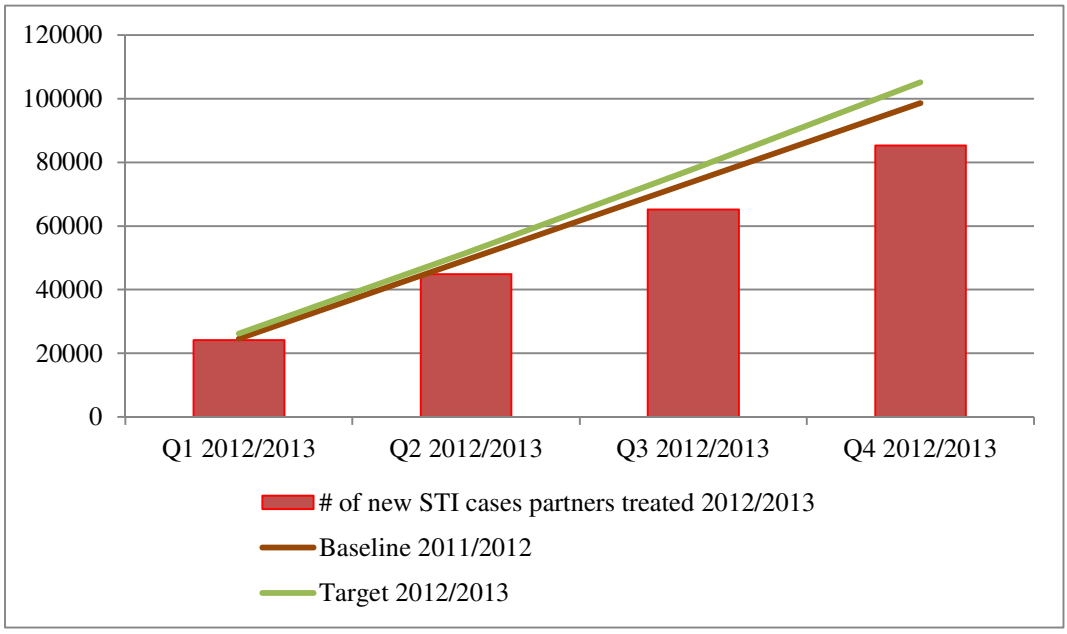
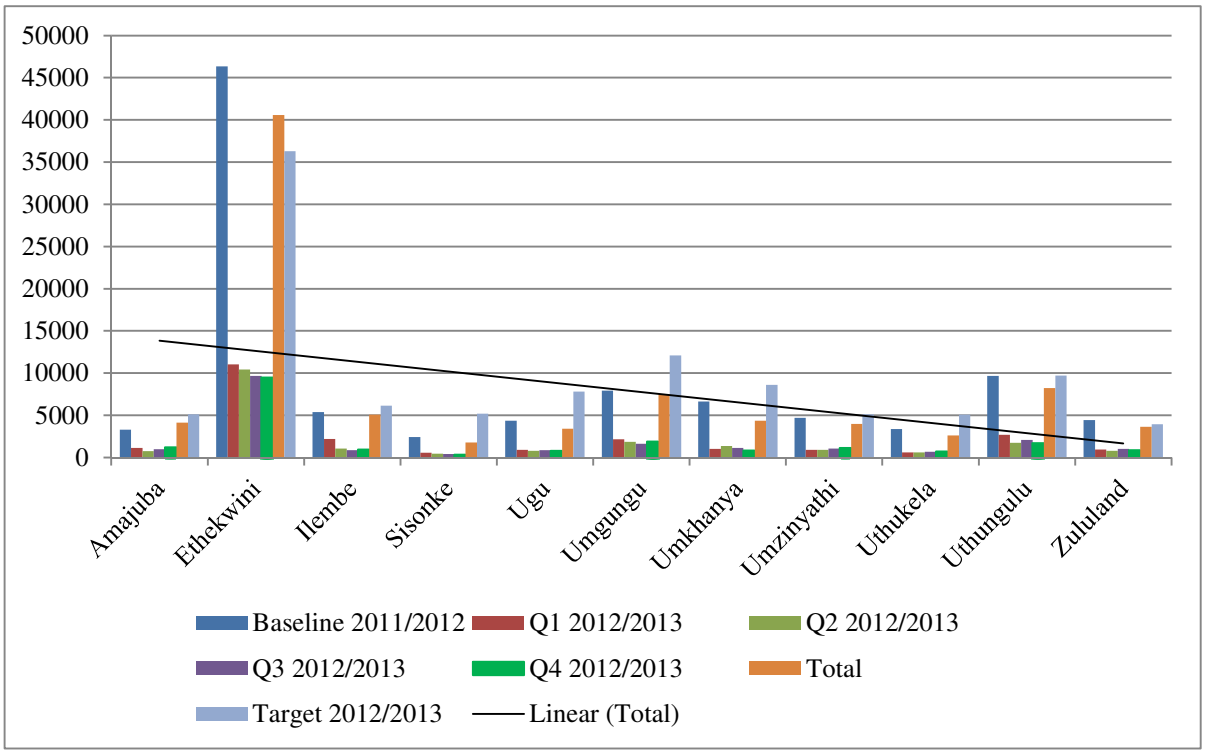


Figure 2.53 presents information on district breakdown on the number of new STI partners treated.

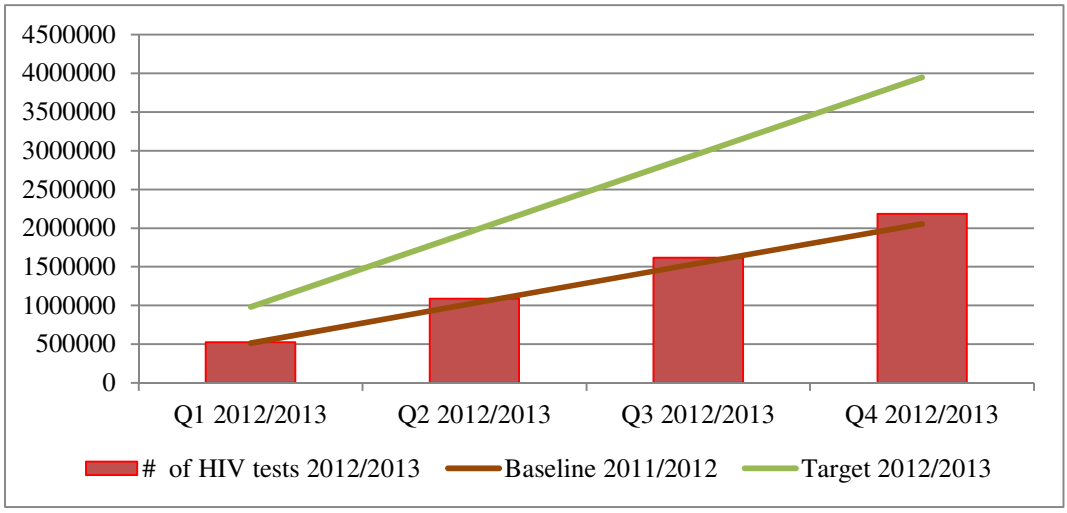
Figure 2.53: District breakdown trends and numbers of new STI cases partners treated



2.6 HIV Counselling and Testing

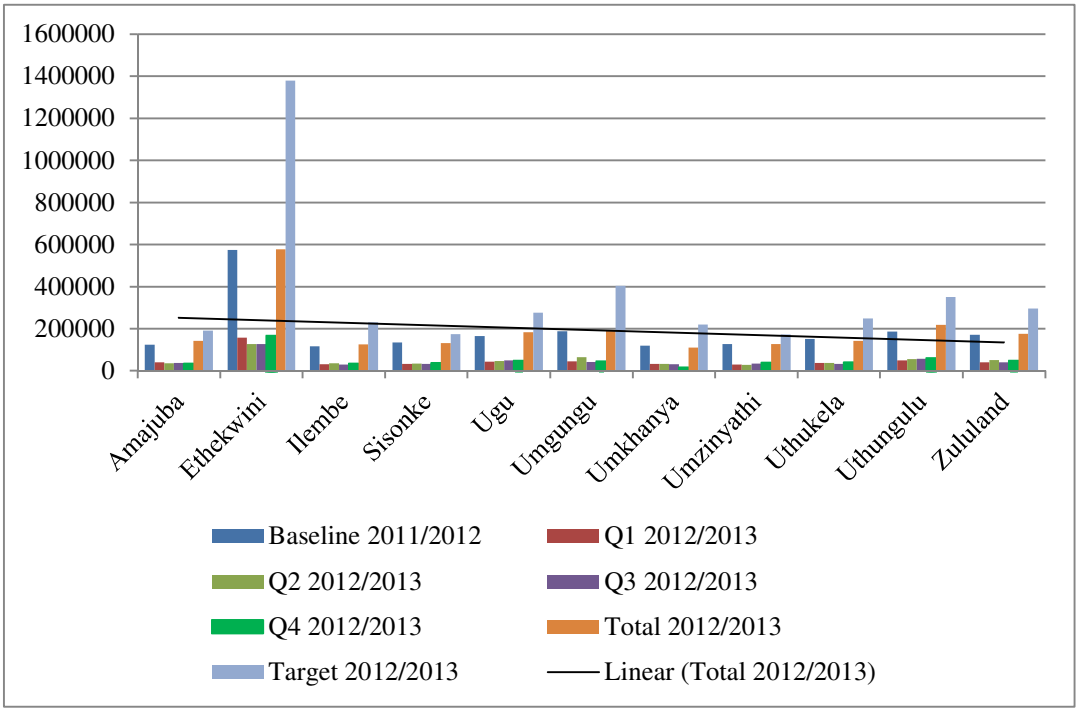
2186302 HIV tests were carried out as compared to 2055935 in 2011/2012. The graph below provides an illustration.

Figure 2.6: Number of HIV tests conducted



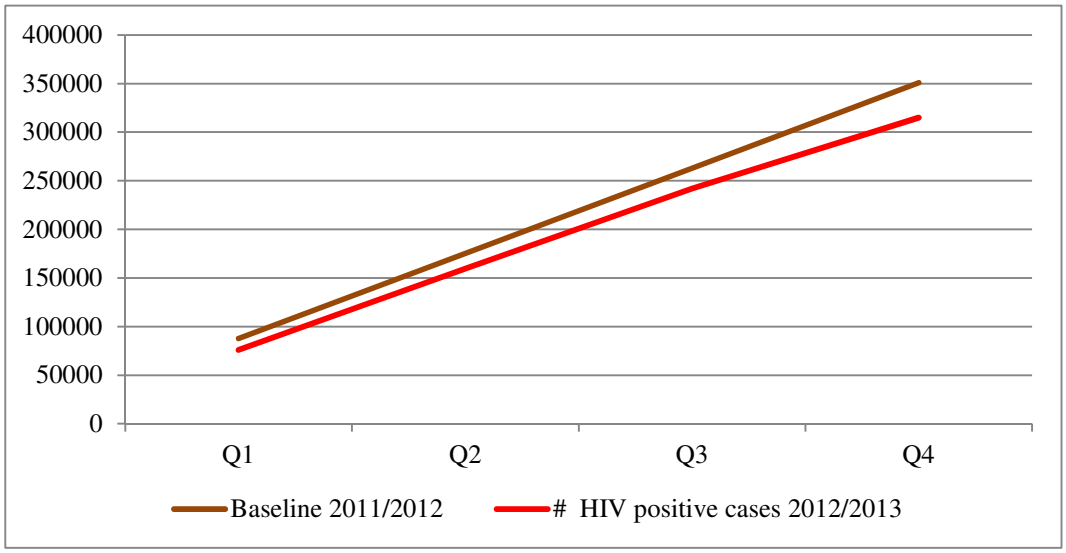
The province was able to carry out an average of 546575 tests per quarter, indicating that the district average was 4517 cases a quarter. The district breakdown on trends in the number of HIV tests conducted is illustrated in the graph below.

Figure 2.61: District breakdown trends and numbers of HIV tests conducted



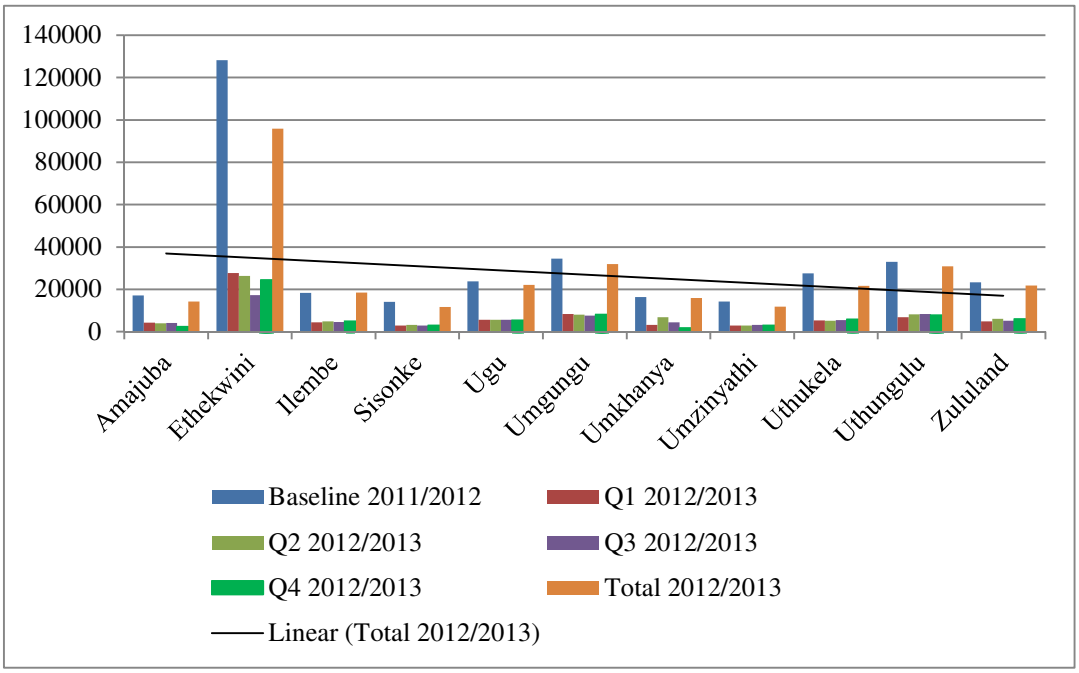
314826 HIV positive cases were found as compared to 350734 in the year 2011/2012. The graph below depicts the number of HIV positive cases.

Figure 2.62: Number of HIV positive cases



Below is the district breakdown.

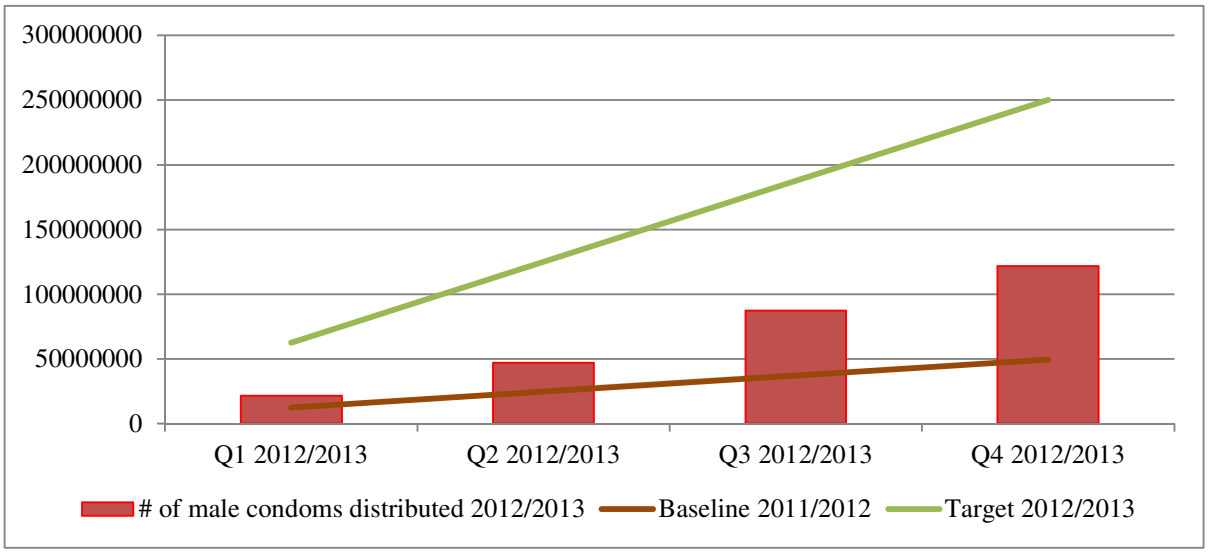
Figure 2.63: District breakdown trends and numbers of HIV positive cases



2.7 Condoms Distribution

A total of 121808957 male condoms[3] were distributed by both health and non-health facilities. The previous year's distribution was 49441045. The graph below provides an illustration.

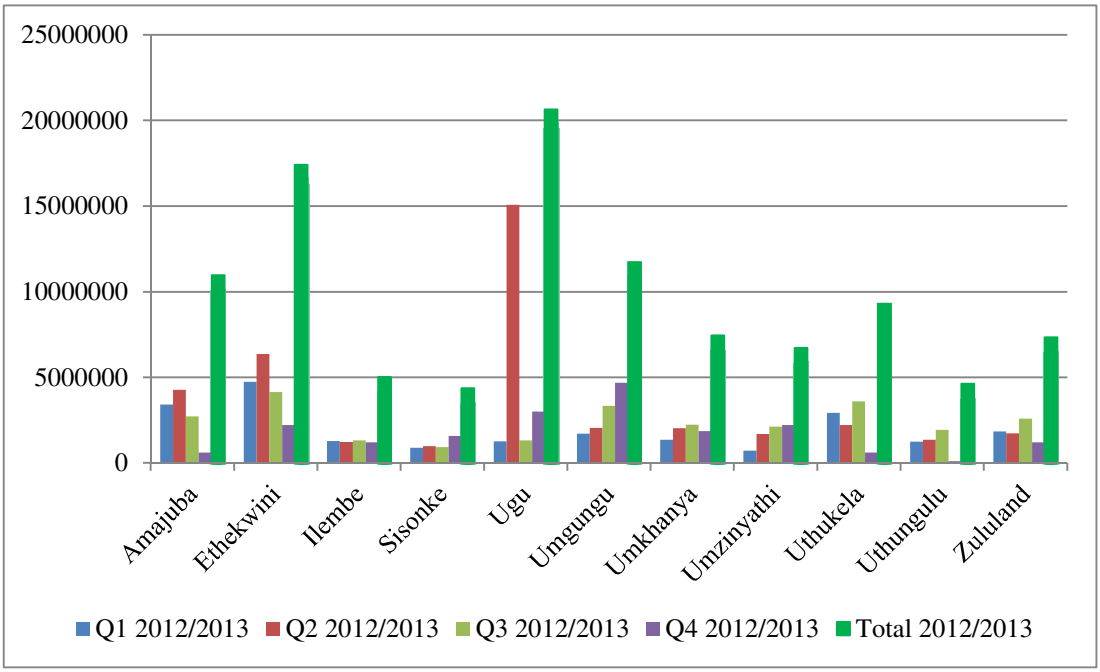
Figure 2.7: Number of male condoms distributed



[3] Data for 2 districts missing for 2 separate quarters including baseline data

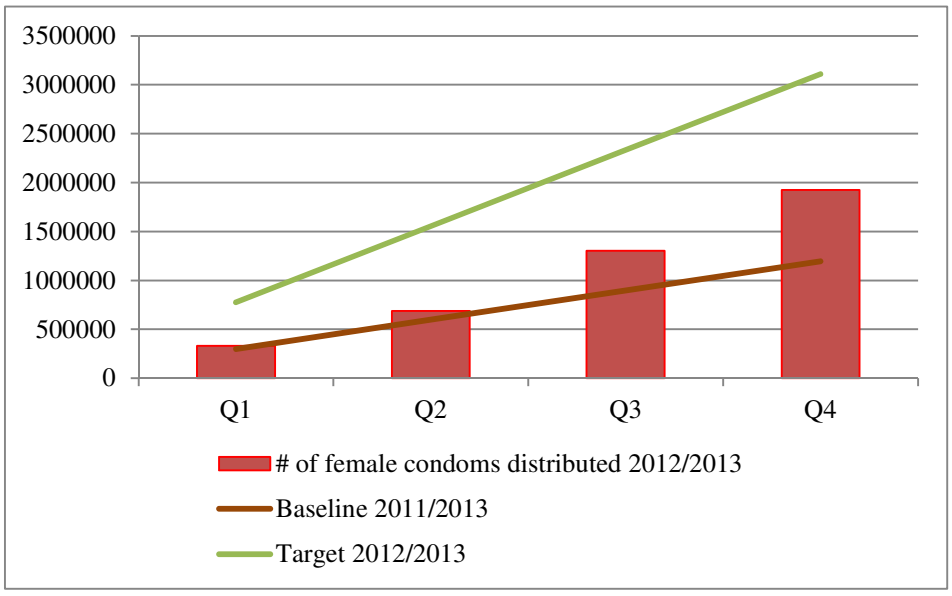
An average of 30452239 pieces of male condoms was distributed per quarter translating into 2768385 pieces per district per quarter. Below is the district breakdown.

Figure 2.71: District breakdown trends and number of male condoms distributed



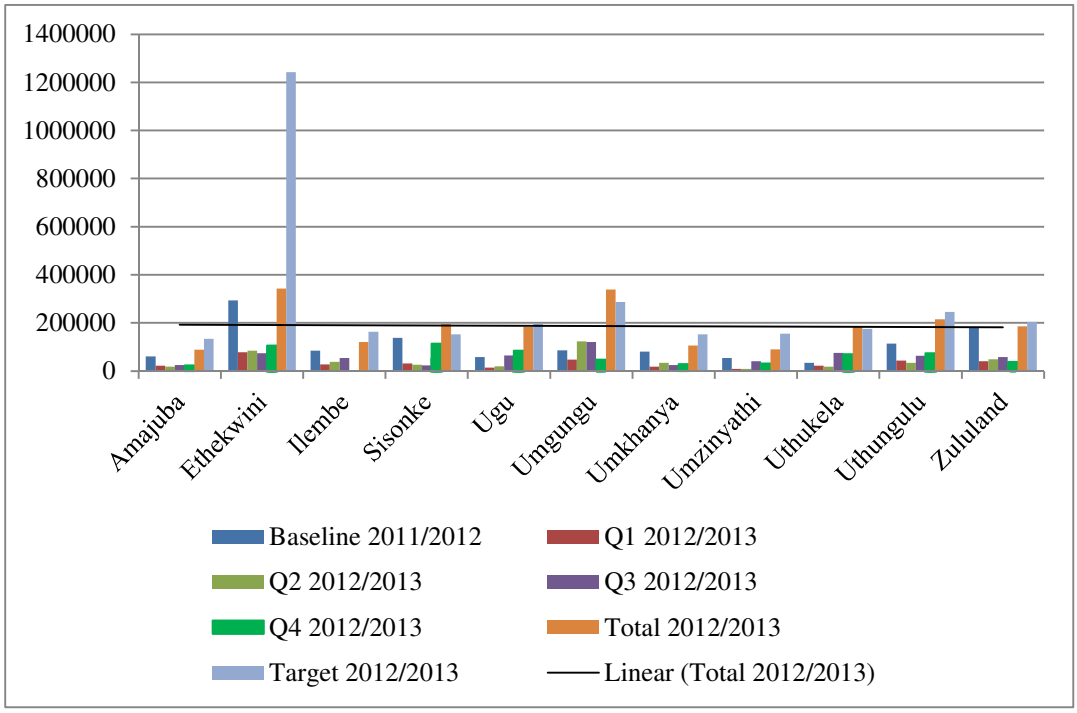
1925106 female condoms were distributed as compared to 1196054 in the preceding year. The graph below provides further information.

Figure 2.72: Number of female condoms distributed



An average of 481277 pieces of female condoms was distributed per quarter in the province, making it 43752 pieces per district per quarter. The graph below shows district breakdown.

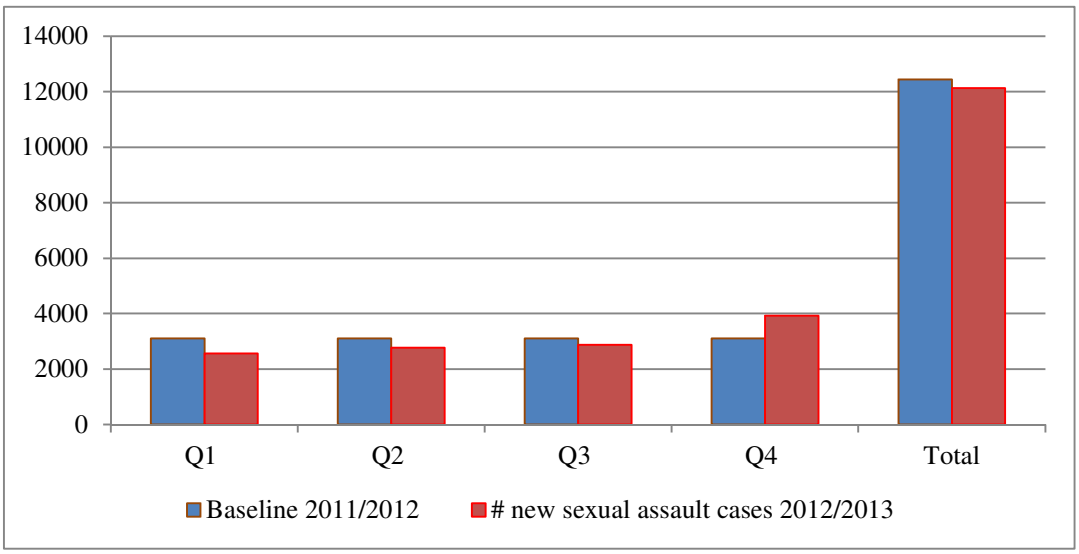
Figure 2.73: District breakdown trends and numbers of female condoms distributed per quarter



2.8 Prevention of HIV Transmission from Occupational Exposure & Sexual Violence

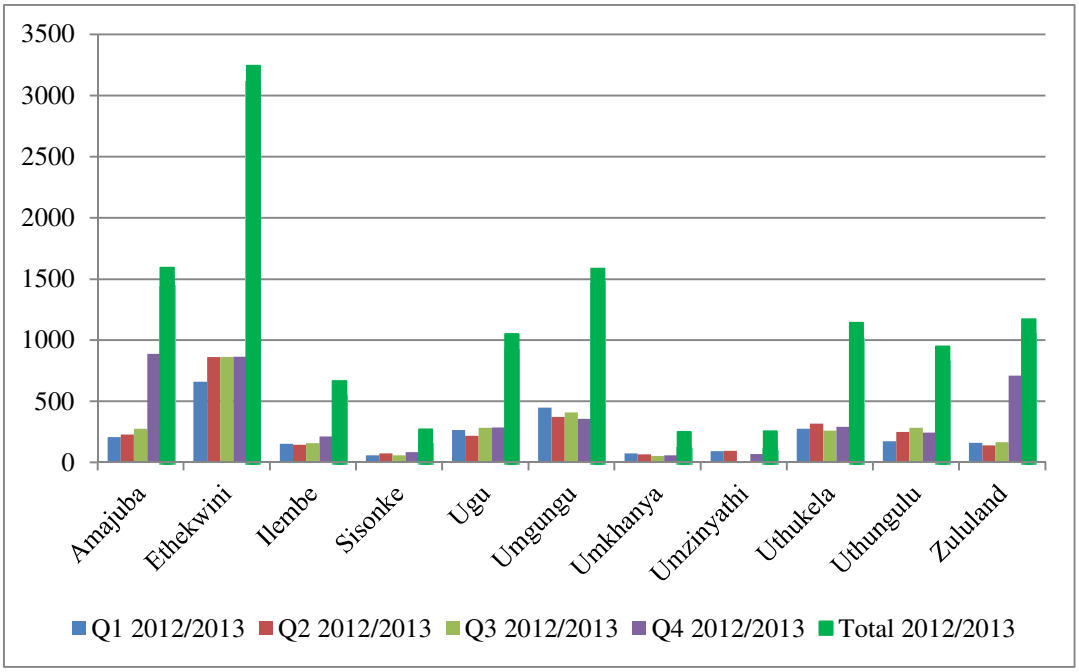
There were a total of 12131 cases of new sexual assault cases reported as compared 12435 in the previous year.

Figure 2.8: Number of sexual assault cases



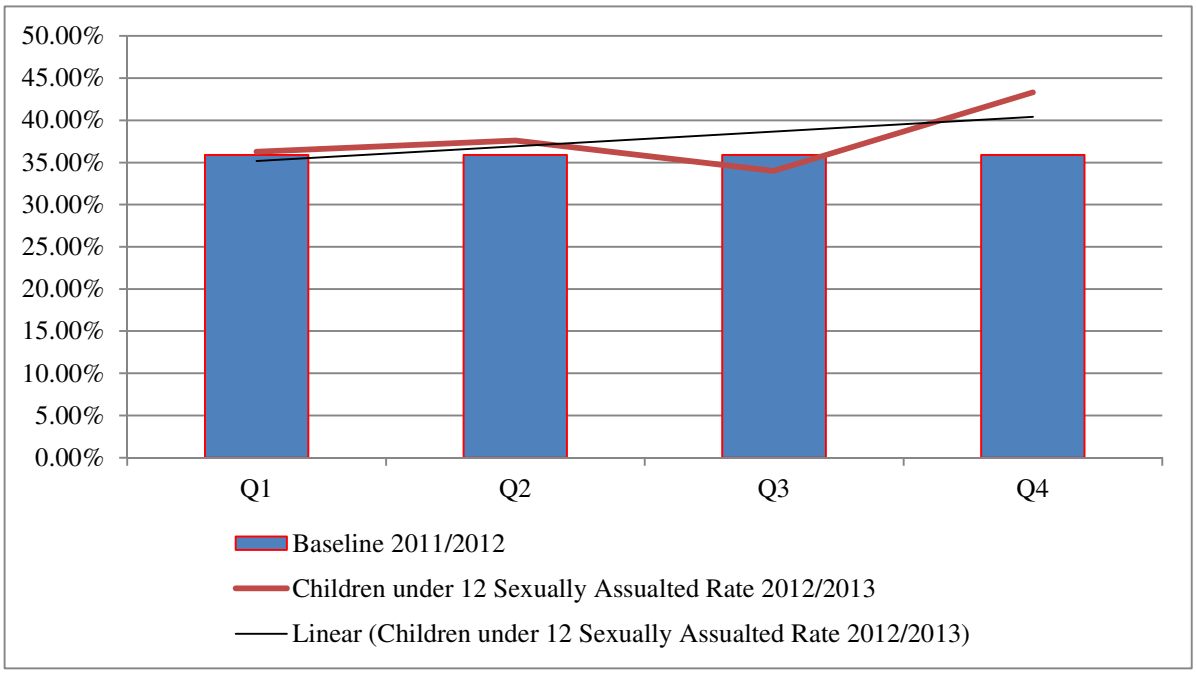
There was an average of 3033 new sexual assault cases per quarter translating into 275 cases per quarter per district. The illustration below provides information on the district breakdown trends for new sexual assault cases.

Figure 2.81: District breakdown trends and numbers of new sexual assault cases



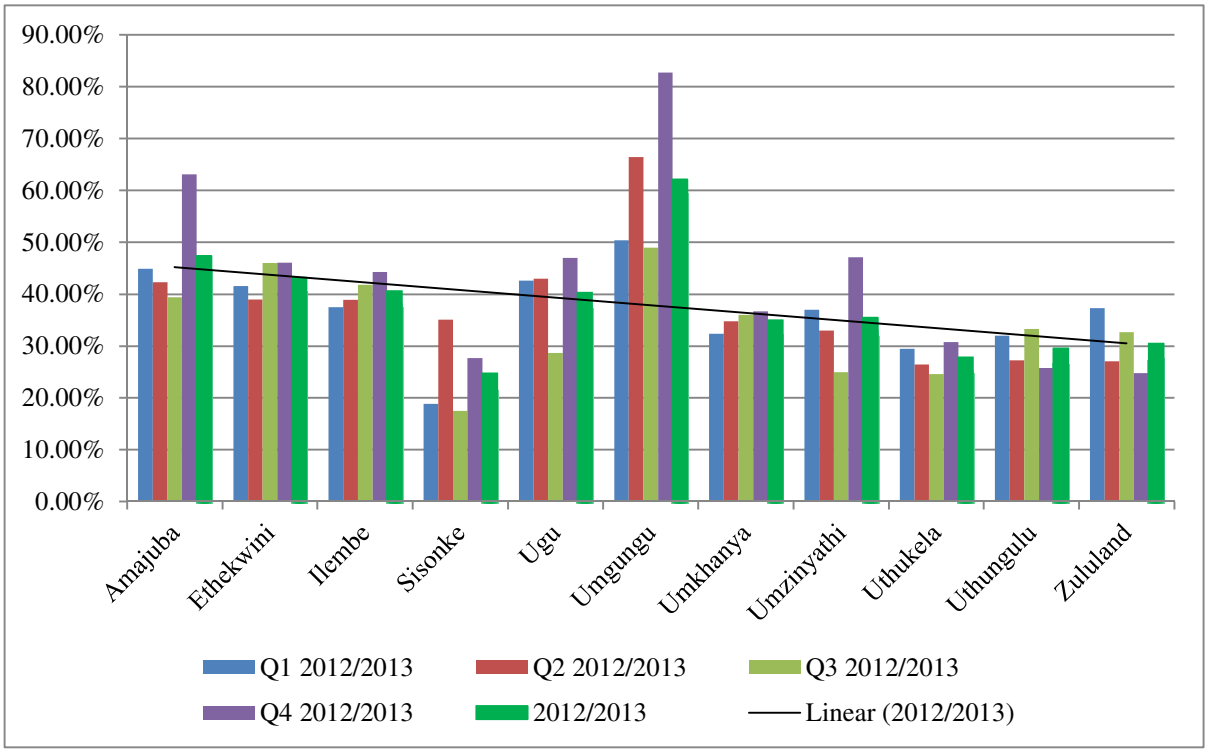
Data on children less than 12 years of age sexually assaulted indicated the rate to be 38.29% as compared to 35.91% in 2011/2012. The illustration below provides the trends.

Figure 2.82: Children under 12 sexually assaulted rate



The graph below presents an illustration of district trends.

Figure 2.83: District trends children under 12 years sexually assaulted rate



2.9 Observations

Contraceptive Access: The PSP objective for this intervention is to reduce the risk of mother to child transmission to less than 1% by 2016.

Based on the data provided about 41% of females 18 years and older accepted to use a family planning method for the first time in 2012/2013. When compared to the previous year, this number increased by about 7%. The percentage towards the target was 91%.

All districts except one show a steady but slow increase in the number of new family planning acceptors, one district (eThekwini) shows a steady but slow declining trend. Nine of the eleven districts have totals that are more than their baseline indicating an improvement in the uptake of family planning methods.

Prevention of Mother to Child Transmission: The PSP objective for this intervention is to reduce the risk of mother to child transmission to less than 1% by 2016.

There was a decline in the positivity rate (PCR) over the last two quarters after an initial increase between quarter one and quarter two. Most districts show a positivity rate that is below the baseline 2012/2013. uMkhanyakude and uMgungundlovu show a positivity rate marginally below the baseline. Based on a year on year comparison, Amajuba, uMzinyathi, uThungulu and eThekwini districts had the most improved decline.

Amajuba was the only district which showed a general steady quarter to quarter decline. The remaining districts had a fluctuating trend characteristic. uThungulu, despite its big improvement on reduction in the year on year comparison showed an increasing trend over the quarters in 2012/2013. Ugu, iLembe and Sisonke recorded increased rates in the fourth quarter.

There is an increase in the number of babies undergoing HIV anti-body test at around 18 months with the uptake rising from 33% to about 54% in the 2012/2013. In terms of the positivity rate at around 18 months, year on year comparison indicated a decline by slightly over 50%. The positivity rate was consistently below the baseline and by the fourth quarter was moving towards the targeted 2% or less. Quarter to quarter trends recorded a consecutive decline over quarters three and four with an increase evidenced from quarter one to quarter two.

District averages are all below the baselines. Amajuba, uMkhanyakude and uMzinyathi had rates inching towards the target of 2%. Amajuba, eThekwini, Ugu, uThungulu and Zululand all had large declines. uThungulu was the only district that showed a steady decline quarter to quarter. uMkhanyakude and Zululand had an increased rate in the fourth quarter.

There was a 5% increase\d for ANC booking before 20 weeks when compared to the previous year. Quarter to quarter trends in the reporting year showed a notable incline in the first and second quarter, a decline followed by an incline in quarter four. More generally, the quarterly trend increased by an average of 3.5%.

Amajuba and uThukela were the only districts whose early booking rate was marginally equal to the baseline. No district showed any steady increase over the four quarters.

There is a decline in the ante natal care first visit positivity rate and a notable declining trend over the four quarters. Those knowing their HIV positive status on first visit increased as compared to the last year possibly indicating an increased behaviour change towards testing and revealing their status. The decline in the number of ante-natal first visits is noted. At this stage of the plan implementation, it may be too early to determine whether this decline is related to programmatic interventions such as family planning methods uptake.

All districts except for two districts show a first ANC visit positivity rate below the baseline. The rates for the remaining two (Ugu and uMgungundlovu) are marginally equal to the baseline.

Medical Male Circumcision: The PSP objective for this intervention area is to scale up male medical circumcision services to 80% of males aged 15-49.

There was an increase in the number of males undergoing medical circumcision by 19% in 2012/2013 when compared to the last reporting year. The province achieved 4% coverage in medical male circumcision during 2012/2013. Quarter by quarter analysis shows a general decline in the numbers of new cases circumcised per quarter. This is reflected in the district trends where all districts showed declining numbers in the fourth quarter. This fourth quarter pattern, largely contributes to a general declining trend for the total number circumcised. District specific totals showed eThekwini, uMgungundlovu and uThungulu with the highest numbers of those undergoing circumcision.

Maternal Child and Women's Health: The PSP objective for this intervention is to reduce the risk of mother to child transmission to less than 1% by 2016.

Despite data showing a reduction in the number of deliveries in public health facilities by 8%; this reduction has to be viewed against the lack of data submission by four districts. Generally, districts depicted a declining trend, which again could be attributed to the missing data from four districts. eThekwini and uMgungundlovu delivery totals were higher than their baselines.

Deliveries under the age of 18 increased by 6% and accounted for 10.8% of all the births. In 2011/2012, the percentage was 9%. Most births in this category were recorded in eThekwini and uMkhanyakude. Increasing quarter to quarter trends were noted in uMgungundlovu and uMkhanyakude while ILembe showed a declining trend.

Maternal deaths have declined by about 5% when compared to the previous year. ILembe, Sisonke and uMzinyathi had relatively low numbers of maternal deaths while uThukela demonstrated an increasing trend. Maternal death totals for uMgungundlovu and uThukela exceeded that of their baseline.

Infant deaths increased by 6%. eThekwini, uMgungundlovu, uThungulu and Zululand all had totals exceeding their baselines, while the Amajuba total was significantly less than its baseline figure. None of the districts showed any steady quarter to quarter decline.

Sexually Transmitted Infections: The PSP objective for this intervention is to ensure that 80% of the sexually transmitted infected men and women receive early and appropriate treatment by 2016.

8% of the sexually active population was treated for new STI cases as compared to the target of 5%. The data also indicated a 2% reduction on the number of new cases treated, at this, it is unclear whether this reduction is as a result of interventions in place.

Ugu, uMgungundlovu and uThungulu had totals that were above their baselines. Trends on a quarter to quarter basis illustrated a somewhat steady to increasing trend.

STI partner treatment was below target by 19% and below the baseline by 13%. eThekwini quarter to quarter trends showed a decline. Amajuba, Sisonke, uThukela and Zululand numbers were relatively low.

HIV Counselling & Testing: The PSP objective for HIV testing and counselling is to ensure that 80% of men and women aged 15-49 years know their status and receive STIs and TB screening by 2016.

The number of HIV test carried out increased by 5% and was towards the target by 55%. Numbers tested were marginally but consistently above the baseline over the four quarters. Testing coverage was at 21% as compared to 20% previously.

Ugu, uMzinyathi and uThungulu had somewhat steady increases in the number of tests carried out. Generally however, district specific trends were mainly steady with insignificant increases or decreases.

The number of HIV positive cases has gone down by about 11%. District trends were mainly steady though trends for uMzinyathi and uThukela were increasing.

Condoms Distribution: The PSP objective for this intervention area is to ensure that 100% of sexually active men and women have access to condoms by 2016.

Condom distribution numbers were up by 58% and 44% towards the target. In this regard therefore, condoms distribution numbers were consistently above the baseline over the quarters; but showed a decline over the last two quarters. Ugu, eThekwini, uMgungundlovu and Amajuba accounted for the most distributed number of male condoms. uMgungundlovu and uMzinyathi showed steady increases on a quarter to quarter basis. On the other hand, Amajuba and eThekwini showed a decreasing trend.

Condoms distribution per male aged 15 years and older was 36 condoms as compared to 11 previously. iLembe, Sisonke and uMgungundlovu distributed the highest number of condoms per male while eThekwini, uThukela and Zululand distributed the least.

Female condoms distribution numbers were up by 37% as compared to the previous year and 65% towards the target. The quarterly trends steadily increased though district trends demonstrated an unsteady pattern. The number of female condoms distributed per female aged 15 years and older remains negligible.

Prevention of HIV Transmission from Occupational Exposure & Sexual Violence: The PSP objective for this intervention is to reduce the risk of HIV transmission from occupational exposure, sexual violence and discordance by using ARV to less than 1% by 2016.

The numbers of new sexual assault cases decreased by 2.5% when compared to the last year. Despite this, quarterly trends increased over the last three quarters. Amajuba and iLembe showed increasing quarter trends. Amajuba, eThekwini and uMgungundlovu had the highest totals of sexual assault cases while Sisonke and uMkhanyakude recorded the lowest figures.

The trend for children under 12 sexually assault rate generally shows an increase of 7% between the quarters. Amajuba, eThekwini and uMgungundlovu recorded the highest averages while Sisonke, uThukela and uThungulu had the lowest rates. iLembe and uMkhanyakude quarterly trends demonstrated increases.

2.10 Recommendations

Contraceptive Access

1. Strategies on maintaining new acceptors for reproductive health purposes should be devised. Community mobilisation coupled with messages on the need for family planning should be intensified; including messages promoting the use of condoms for family planning.

Prevention of Mother to Child Transmission

1. Fluctuation of the district specific quarterly trends for the district PCR positivity rate is common to most districts. This indicates the possibility of the rate rising. Where a rise is noticed, immediate measures should be taken to investigate and follow up with commensurate corrective action with a view to moving towards ensuring that the downward trend becomes the main characteristic. This should also apply other areas where fluctuation was noted viz; early booking rates and the ANC first visit positivity rate.
2. Consideration should be given to lowering the early booking period to e.g. as early as eight weeks.

Medical Male Circumcision

1. Reasons behind the general downward trend among all the districts in the fourth quarter should be investigated and corrective action taken. There should be sustained community mobilisation accompanied by correct messages on the benefits and myths associated with undergoing circumcision. This should contribute to both improving coverage and correcting undesirable beliefs on the abilities of circumcision.

Maternal Child and Women's Health

1. Existing strategies to curb deliveries by those aged 18 years, infant and maternal deaths should be revisited to determine extent of effectiveness and/or implementation. Based on the emerging evidence, an effective process to arrest the situation should then be put in place.

Sexually Transmitted Infections

2. Poor partner treatment figures could be due to a combination of factors that include denial, stigma, and secrecy leading to a tendency to seek treatment from alternative sources. Getting data from these alternative sources e.g. private practitioners and traditional health practitioners should be the first step towards a clearer picture on the numbers of partners treated. Engaging these groups is therefore necessary. Secondly tracking infected partners through use of field workers such as CCGs should be intensified.

HIV Counselling & Testing

1. HIV counselling and testing mobilisation campaigns should be a permanent fixture in implementation calendars annually and should include multi-sector effort. Additionally, HCT should be coupled with TB testing to contribute to increased numbers for those testing for TB.

Condoms Distribution

1. As stated in the PSP, a rapid assessment of multi-sector condoms distribution processes, development of mechanism and implementing system for condoms education and distribution should be put in place. Such a system should address access as measured by the number of condoms a client should get per year and the methodology for setting realistic targets and further address points for easy accessibility of condoms.

Prevention of HIV Transmission from Occupational Exposure & Sexual Violence

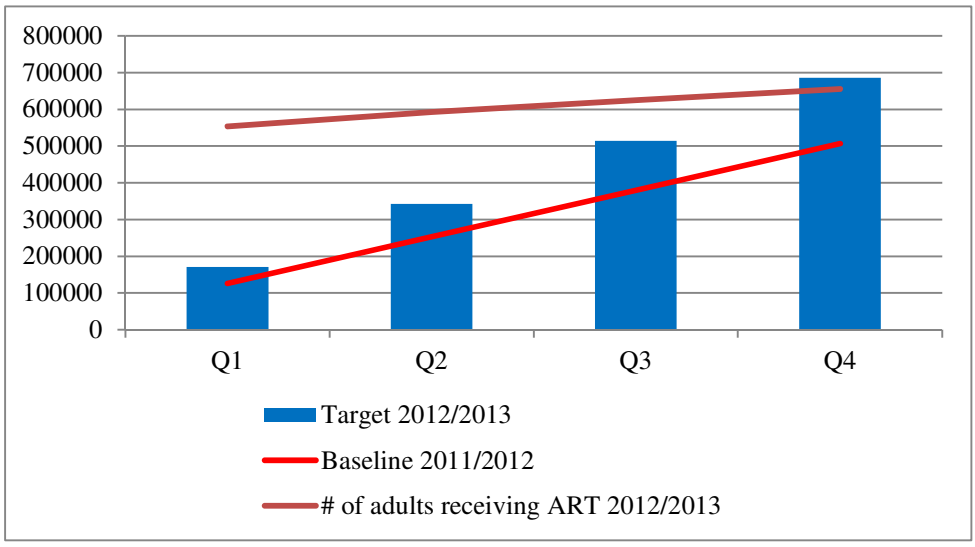
1. There appears to be uncoordinated efforts in the fight against sexual violence. Coordination through for example, a coordination committee composed of relevant organisations in government, non-government, civil society and development partners should be considered. Further community mobilisation and use of relevant messages should be intensified where the climax should be the holding of annual campaigns.

3 Strategic Objective 3: Sustaining Health & Wellness

3.1 Adults initiated on Antiretroviral Treatment

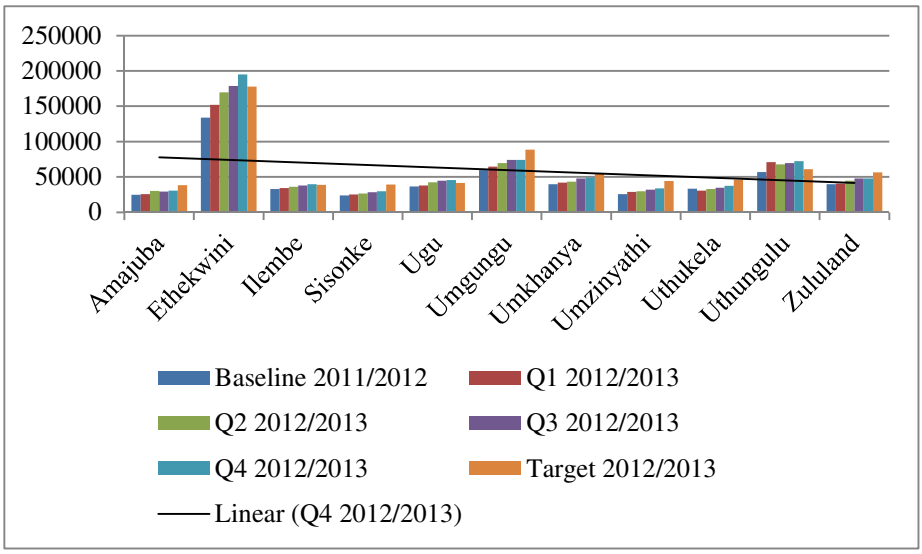
A total of 654986 adults were on antiretroviral treatment (ART) as compared to 506333 in the preceding year. The graph below provides an illustration.

Figure 3.1: Number of adults on ART



This illustrates that the province was able to have an average of 163747 patients per quarter. In this regard, districts were able to initiate an average of 14886 clients per quarter. The graph below provides the illustration on district breakdown trends.

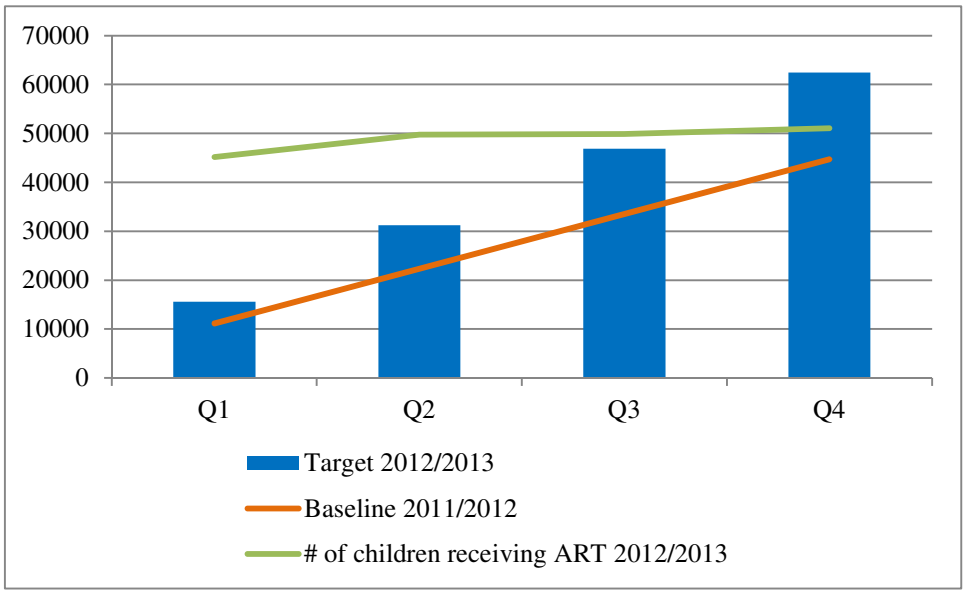
Figure 2.1 District breakdown trends and numbers of adults on ART



3.2 Children initiated on Antiretroviral Treatment

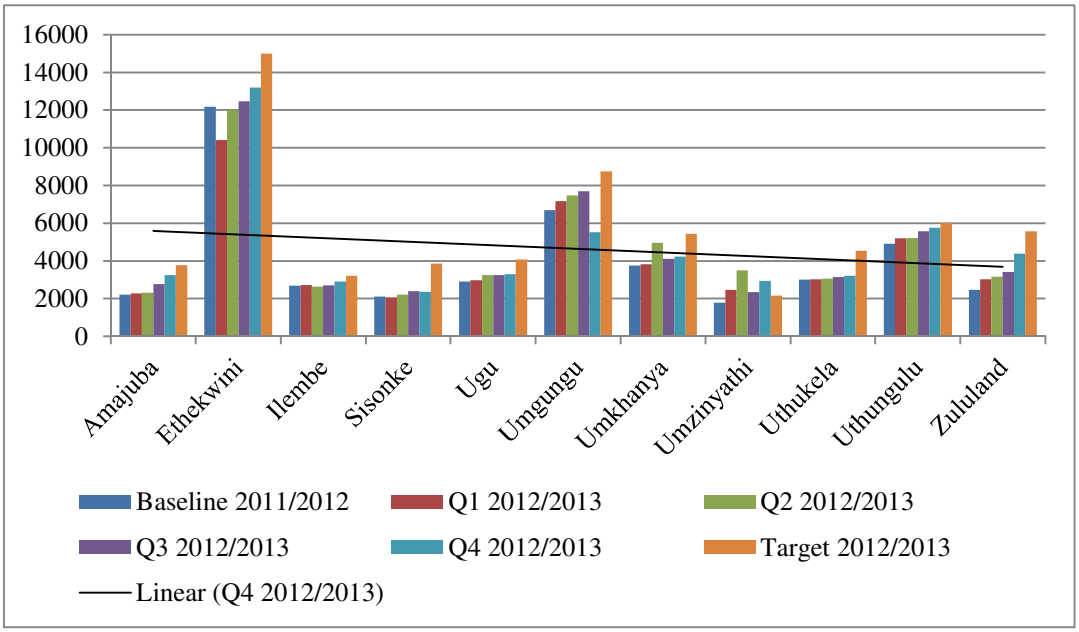
A total of 51094 children were on ART as compared to 44682 in the previous year. The graph below provides the trends.

Figure 3.2 Trends and number of children on ART



On average, of 12774 children were initiated on ART per quarter and therefore an average 1161 children per district. The graph below presents information on the district breakdown.

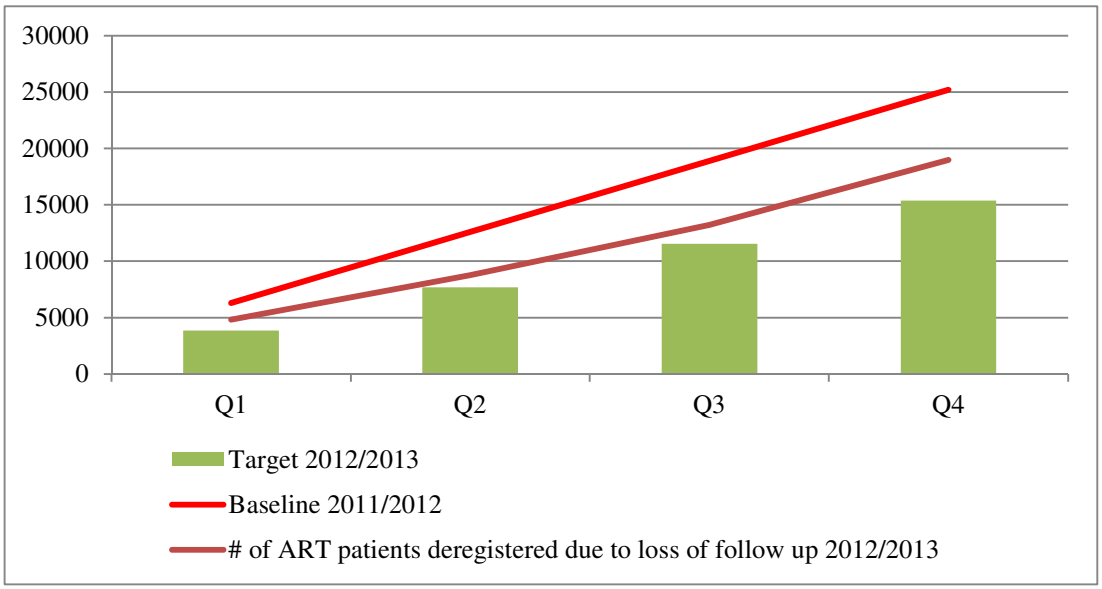
Figure 3.21: District breakdown trends and numbers of children on ART



3.3 ART Patients De-registered due to Loss of Follow up

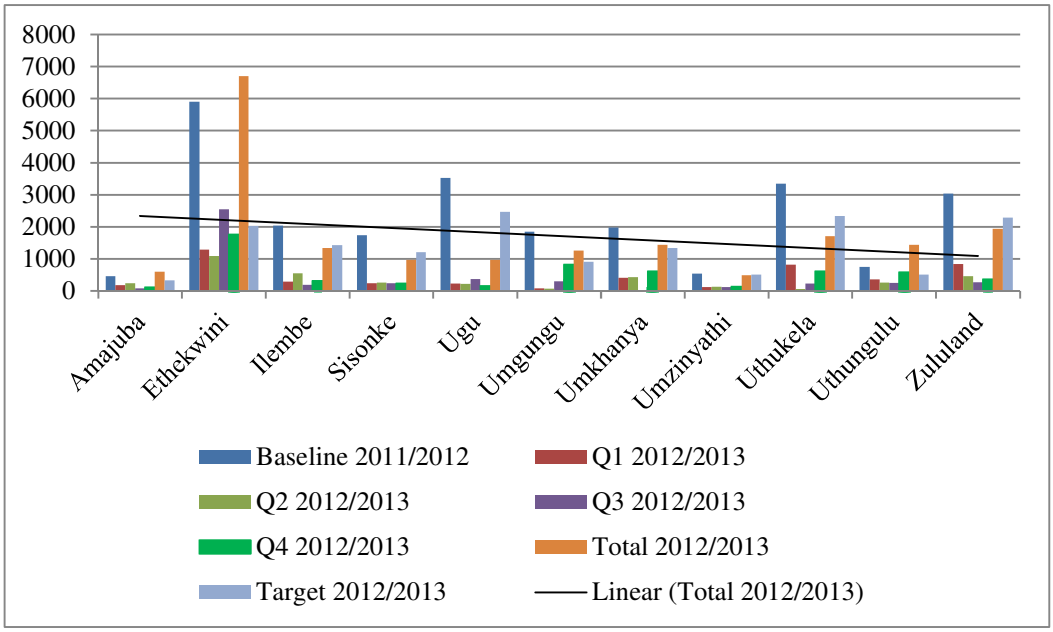
18915 patients on ART were de-registered due to loss of follow up. In 2011/2012, the number was 25198. The graph below provides an illustration.

Figure 3.3: Number of ART patients de-registered due to loss of follow up



4743 patients were lost to follow up per quarter on the average translating into 431 clients per district per quarter. The graph that follows provides information on the district breakdown on trends of number of ART patients de-registered due to loss of follow up.

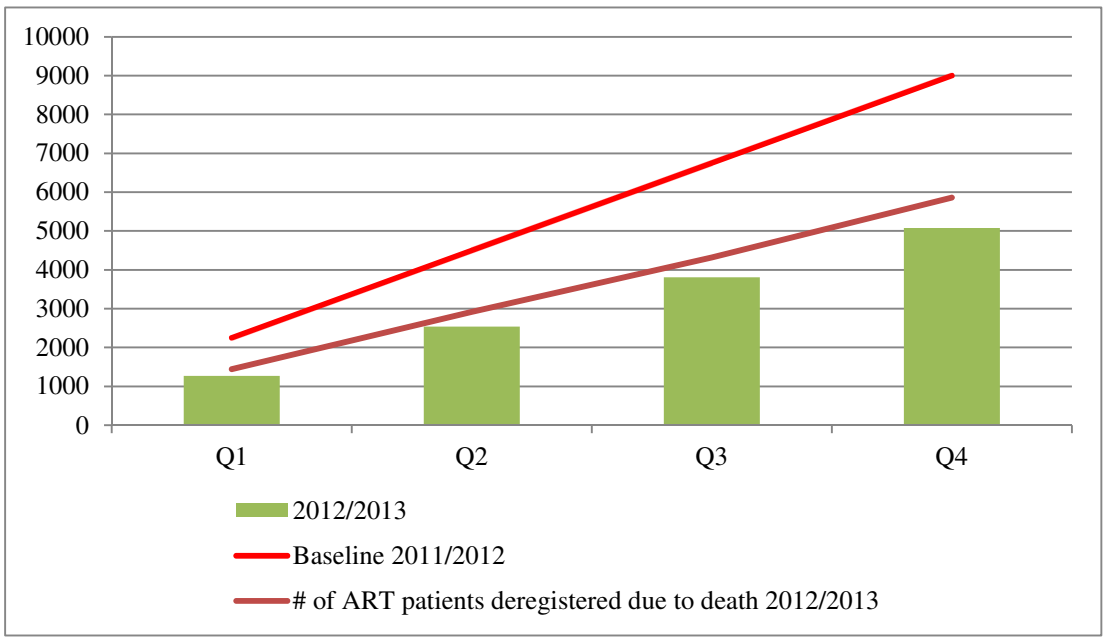
Figure 3.31: District breakdown trends on ART patients de-registered due to loss of follow-up



3.4 ART Patients De-Registered due to Death

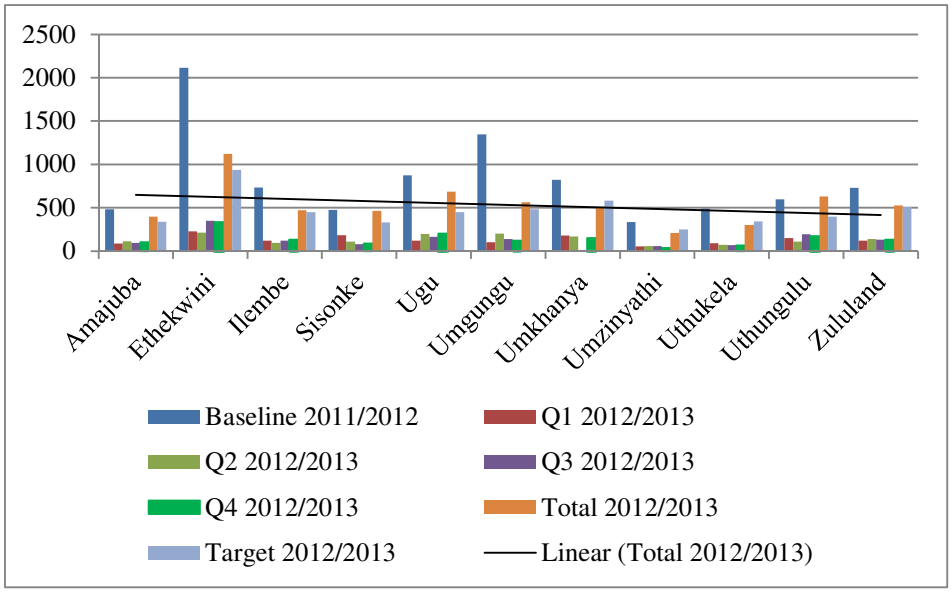
The graph below illustrated information on the number of ART patients that were deregistered due to death. 5861 patients were deregistered as compared to 8998 in the preceding year.

Figure 3.4 Number of ART patients deregistered due to death



In this regard, 4320 clients were lost due to death per quarter and about 393 per district per quarter. Graph 3.41 illustrates district breakdown information on trends of ART patients deregistered due to death

Figure 3.41: District breakdown of numbers and trends on ART patients de-registered due to death



3.5 Observations

Adults on ART: The objective for this intervention is to ensure that at least 90% of the HIV infected people have access to treatment and support and remain adherent to treatment and maintain optimum health by 2016.

The number of adults on ART increased by 27%. There was a 95% achievement towards the target. This was corroborated by the uptake trend being consistently above the baseline. eThekwini and uMgungundlovu districts had the most improved uptake illustrated by noticeable consistent upward quarterly trends. uThungulu was the only district to demonstrate a fluctuating trend.

Children on ART: The number of children on ART increased 13% with an achievement of 85% towards the target. Based on the data 7% of eligible children are on ART, with the target being 9%. eThekwini, uMgungundlovu and Zululand had the most commendable consistent upward quarterly trends. uMkhanyakude and uMzinyathi showed fluctuating quarterly trends.

Patients lost to Follow Up: The number of patients de-registered due to loss of follow up reduced by 33% and was less the target by about 22%. Amajuba and uMzinyathi had considerably small amounts of people being lost to follow up while eThekwini, Zululand and uThukela had the highest number. Amajuba's total was however larger than its baseline. Sisonke and uMzinyathi were the only districts showing a steady quarterly trend. Sisonke, Ugu, uThukela and Zululand all achieved their targets as demonstrated by the total being below the target.

Patients Lost to Death: The number of patients de-registered due to death reduced by 51% but was short of the target by 21%. The trend was consistently below the baseline and consistently above the target, indicating a failure to achieve the target. uThukela and uMzinyathi had the least number of deaths while eThekwini, uMgungundlovu and Ugu had the highest number of deaths. uMgungundlovu was the only district that showed a steadily declining trend in the numbers of deaths.

3.6 Recommendation

2. Eliminating the quarterly fluctuations for both loss to follow up and deaths should be made possible through intensified use of community field workers.

4 Strategic Objective 5: Coordination Monitoring & Evaluation

4.1 District AIDS Coordination Functionality

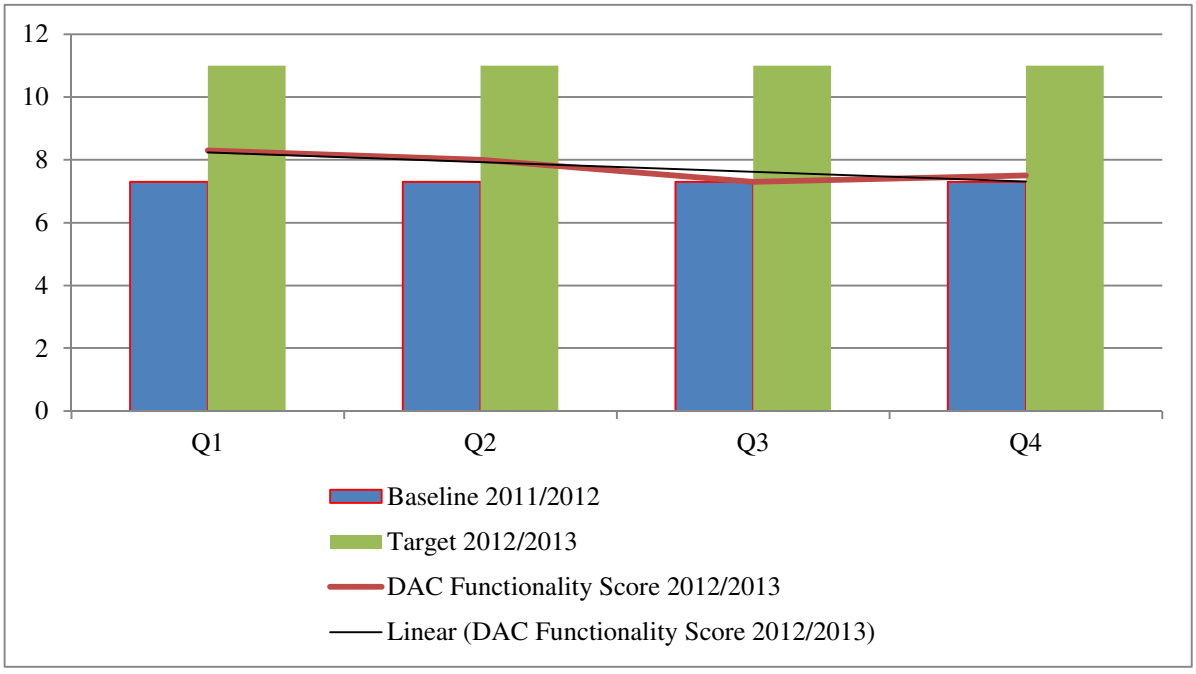
District AIDS Council (DAC) coordination functionality was measured by a set of six data elements as shown in table 4.1. The table provides a breakdown of the functionality of the DAC while figure 4.1 depicts the same information graphically.

Table 4.1: District AIDS Councils functionality

		Q1	Q2	Q3	Q4	Ave.
1	DAC meeting held as scheduled	11	10	9	10	10
2	At least 70% of designated DAC members attended meeting	11	10	9	10	10
3	Meeting chaired by designated chairperson	11	10	8	8	9
4	Submission of quarterly report	11	11	11	11	11
5	Submission of DAC meeting minutes	3	4	4	3	4
6	DAC submission of LAC minutes	3	3	2	3	3
	Functionality Score	8.3	8.0	7.3	7.5	7.8

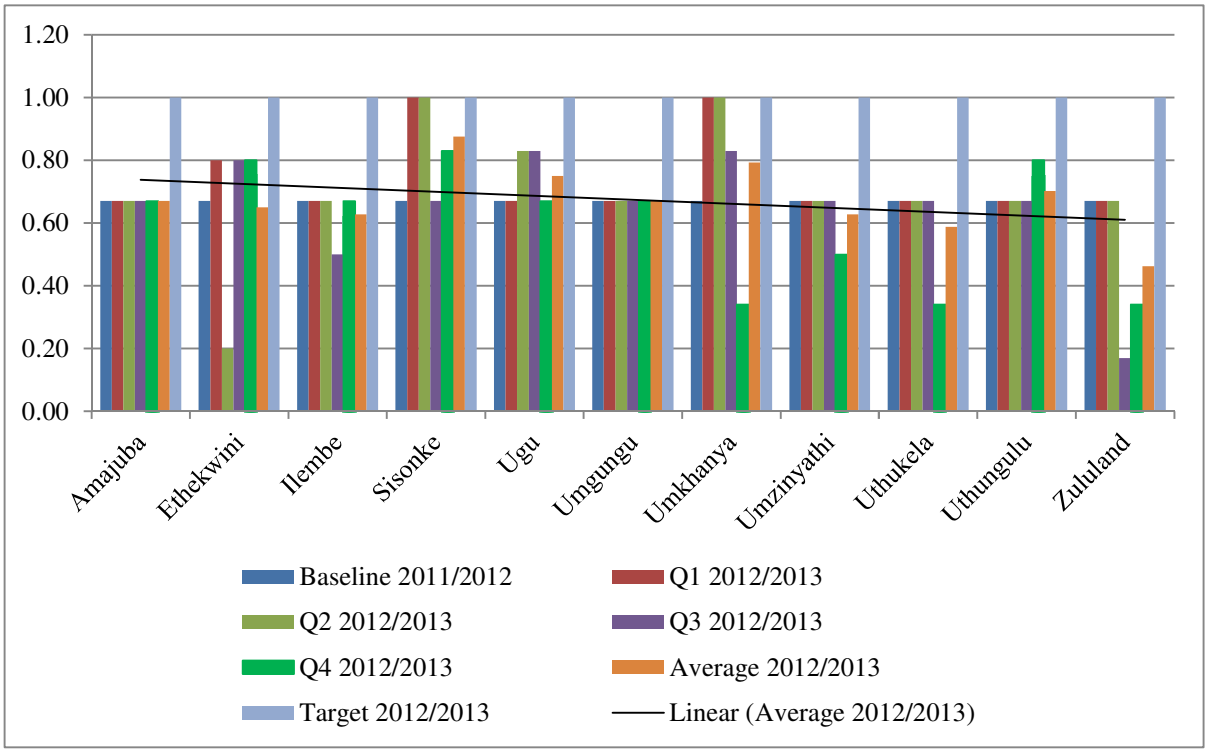
Figure 4.1 provides a graphical illustration of the findings as per table 4.1.

Figure 4.1: Trends in district AIDS council functionality



The graph below provides information on the functionality score per district.

Figure 4.12: District breakdown of trends on District AID Councils functionality



4.2 Local AIDS Council Functionality

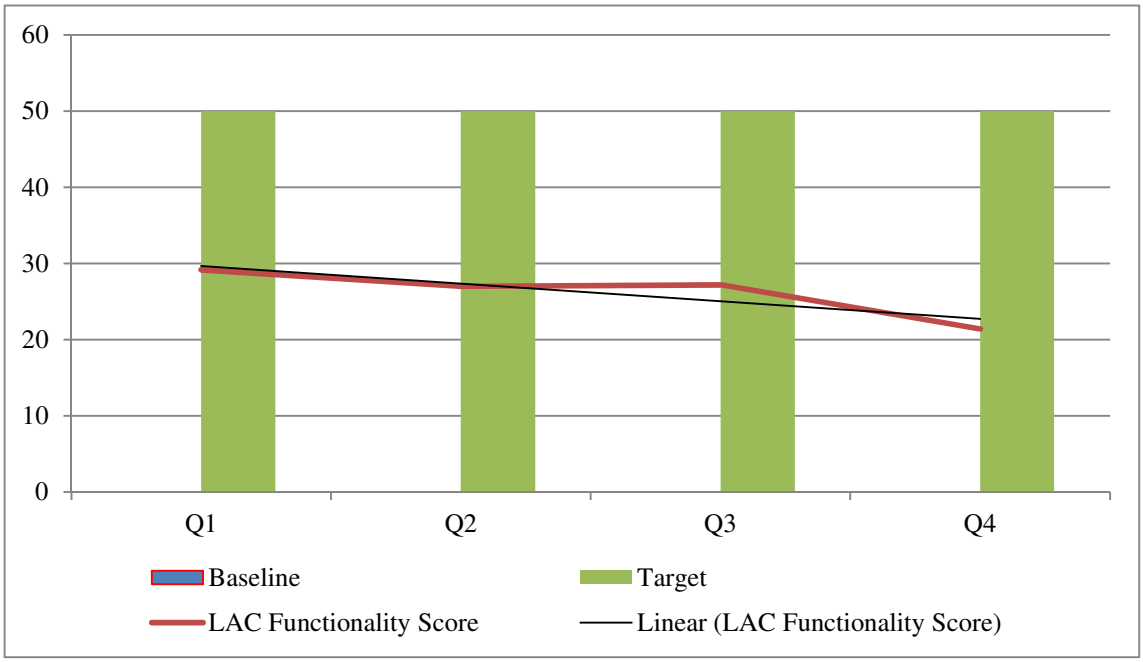
The table below measures local AIDS council functionality as per the elements listed on the table.

Table 4.2: Local AIDS Councils functionality

		Q1	Q2	Q3	Q4	Ave.
1	LAC meeting held as scheduled	38	33	30	23	31
2	At least 70% of designated LAC members attended meeting	37	33	30	23	30
3	Meeting chaired by designated chairperson	35	33	30	21	29
4	Submission of quarterly report to DAC	18	24	22	22	21
5	Submission of LAC meeting minutes to DAC	18	12	19	18	16
	Functionality Score	29.2	27.0	27.2	21.4	26.2

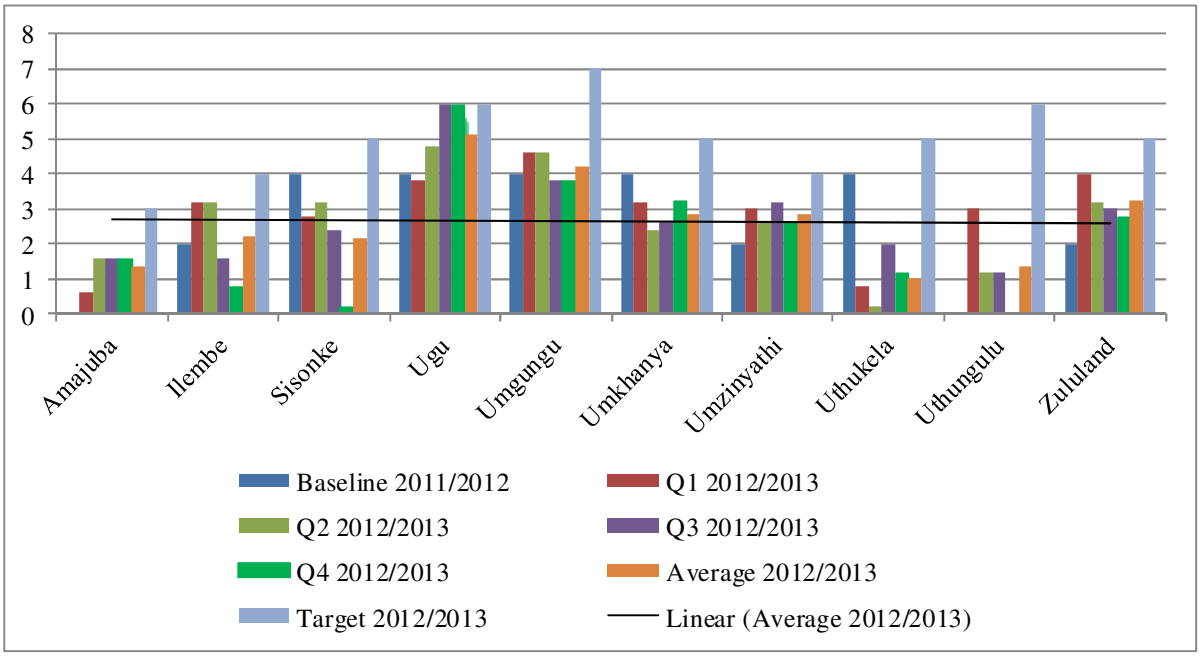
The figure below illustrates the trends in LAC functionality based on the scores in table 4.2 above.

Figure 3.2 Trends in local AIDS council functionality



The graph below provides information on the functionality score for local municipalities per district.

Figure 4.21 Districts breakdown of trends on Local AIDS Councils functionality



4.3 Ward AIDS Committees Functionality

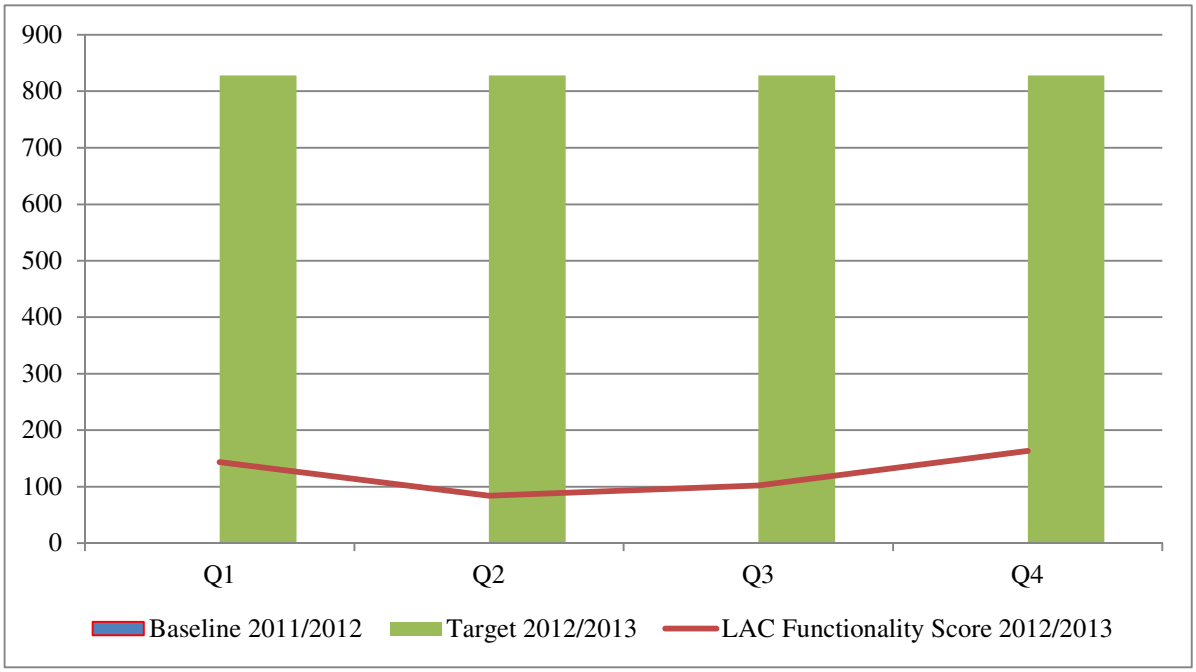
The table below provides information on the Ward AIDS Committee functionality as per the five elements listed there in.

Table 4.3: Trends in Ward AIDS Committee functionality

		Q1	Q2	Q3	Q4	Ave.
1	WAC meeting held as scheduled	194	157	211	211	193.3
2	At least 70% of designated WAC members attended meeting	184	150	185	185	176.0
3	Meeting chaired by designated chairperson	196	114	114	197	155.2
4	Submission of quarterly report to LAC	83	0	0	110	48.3
5	Submission of WAC meeting minutes to LAC	61	0	0	114	43.8
	Functionality Score	143.6	84.2	102.0	163.4	123.3

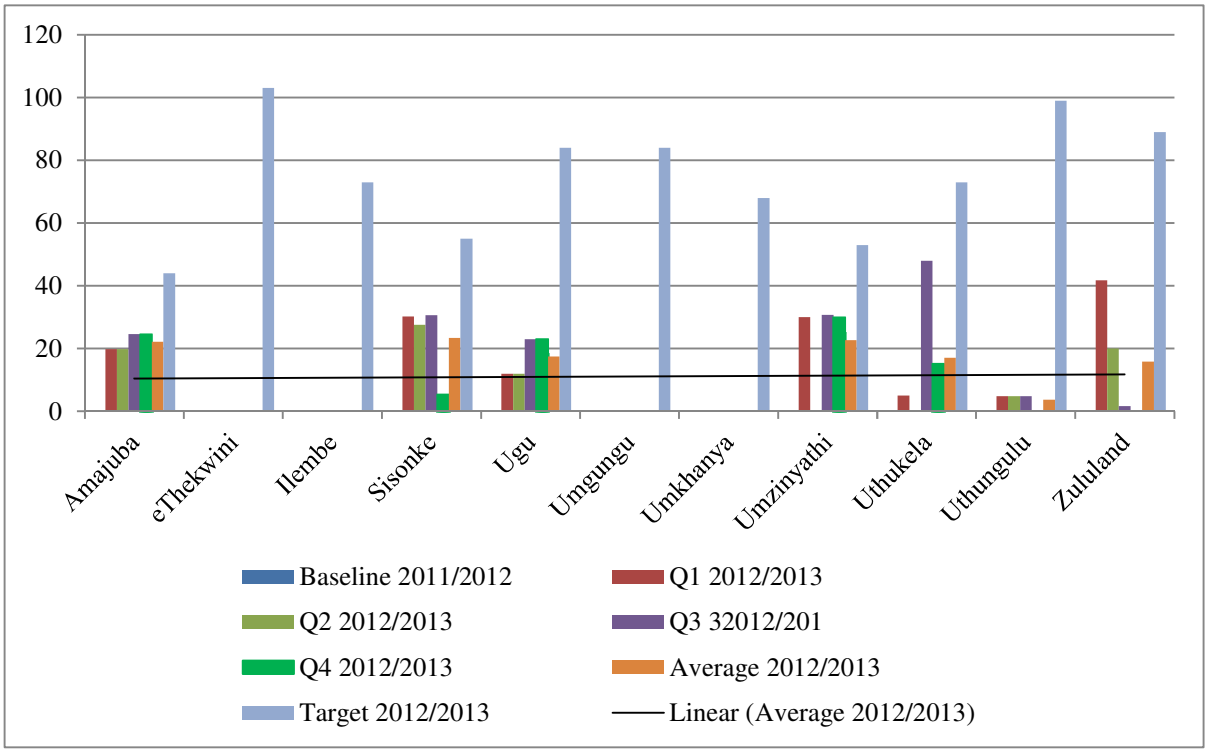
The figure below illustrates the graphical version of the tabulated information above.

Figure 4.3: Ward AIDS Committee functionality



The district breakdown of WAC functionality is provided in figure 4.31 below.

Figure 4.31: District breakdown of trends in Ward AIDS Committee functionality



4.4Observations

The PSP objectives of the strategic objective coordination, monitoring and evaluation are three fold namely:

4 To strengthen co-ordination and management for an effective provincial response by 2016

5 To strengthen the monitoring and evaluation systems at all levels and ensure that at least 90% of the sectors consistently report to coordination structures by 2016.

6 To strengthen the research component of the response by 2016

DAC Functionality: DAC functionality improved by about 3% as corroborated by the 1.2 increase in functionality points. Submission of both DAC and LAC minutes to the PCA secretariat was a major challenge to the DACs. This showed a weakness in DAC coordination and a lack of support provided to LACs despite the chairing and attendance score being notably commendable. Likewise the lack of submission of DAC minutes to the PCA secretariat is an indication that that the entire DAC secretariat is unable to effectively support the DAC.

Individual districts show no discernible consistently upward looking quarterly trends. Sisonke and uMkhanyakude were the only districts to achieve the perfect 1 score in the first two

quarters but failed to maintain this in the next two subsequent quarters. Amajuba and uMgungundlovu maintained a uniform quarterly performance while uThungulu and iLembe showed an improvement in the last quarter. Zululand had a consistently upward trend for three quarters and uThukela showed a decline in the last quarter.

LAC Functionality: LAC functionality has improved by 26.2%. However, the general trend over the four quarters showed a decline by a functionality score of 7.8. Challenges are evident in the elements of submission of quarterly reports and submission of minutes to the DAC. This indicates a weakness in coordination and lack of/or inadequate support by the various stakeholders to ensure the LACs function.

Ugu was the only district to achieve a perfect score on the first two quarters while Zululand showed some consistent quarterly declines. Sisonke and uThungulu also had some declines especially in the last quarter.

WAC Functionality: The functionality score remained low, despite a functionality score increase by 19.80 points. The lowest functionality scores were witnessed in the elements of submission of reports and minutes to the LAC.

Some element of functionality was in Amajuba, Sisonke, Ugu, and uMzinyathi. Those in eThekwini, iLembe, uMgungunldovu and uMkhanyakude were totally non-functional.

4.5 Recommendations

1. Districts should prepare for and hold regular training sessions in their respective localities. Such should span training the leadership and general membership of the DAC, LAC and the WAC.
2. Development of guidelines and toolkits on a range of topics such as planning, conducting meetings to writing of minutes among others should be done and applied uniformly across the DAC, LAC and WAC.
3. Districts should ensure that the terms of reference for DAC, LAC and WAC are fully disseminated and regularly distributed.
4. There should be sustained support from the respective designated chairpersons i.e. Mayors for the DAC, LAC and WAC for both the functions of these structures and the secretariat personnel i.e. the HIV & AIDS Coordinator.
5. All district municipalities, local municipalities and wards should have personnel fully dedicated to the coordination of HIV & AIDS activities.
6. More attention should be paid to promoting the research component at all levels.

5 Conclusion

The report provided information on the status of implementation of the HAST multi-sectoral response in 2012/2013. Referring to the objectives for each intervention area as they appear in the KZNPSP 2012-2016 allowed for focus in providing of an emerging picture.

Moving forward, it will be necessary that consideration be given to adoption and implementation of the recommendations herein some of which appear in the KZNPSP but have yet to be implemented. There will be need to direct more attention to strategic objective one, four and five in that order. Further, addressing the fluctuating trends for most of the intervention areas will be necessary in order to ensure emergence of predictive patterns which can be vital to planning.

As the province moves into the second year of implementation, efforts to support improvement of data collection and reporting continue. Preparing and sending district specific feedback reports, hosting of DAC/LAC secretariat meetings and DAC meeting feedback sessions are all part of this support. This support further reinforces the provincial emphasis of empowering districts and lower level structures in the monitoring of the response and use of data at the lower levels.