



Focus for Impact

**Community profile
Catchment area for Emfundweni Clinic (Ward 11)**

**Dannhauser local municipality
Amajuba District
KwaZulu-Natal**

July 2017

Table of Contents

ABBREVIATIONS	V
ACKNOWLEDGEMENT	VI
FOCUS FOR IMPACT – UNDERSTANDING THE BACKGROUND	1
INTRODUCTION TO PROFILE	3
1. SOCIO-DEMOGRAPHIC PROFILE.....	5
1.1 DEMARCATED BOUNDARIES	5
1.2 POPULATION BY SEX AND AGE.....	6
1.3 POPULATION BY RACE.....	10
2. EPIDEMIOLOGICAL PROFILE.....	12
2.1 CAUSES OF DEATH.....	12
2.2 HIV	12
2.3 TB.....	19
2.4 STIS	23
3. ASSOCIATED RISK PROFILE	25
3.1 BIOMEDICAL PROFILE.....	25
3.1.1 HIV TESTING	25
3.1.2 CIRCUMCISION	25
3.1.3 ARV TREATMENT.....	26
3.1.4 PEP AND PREP	27
3.1.5 LUBRICANT.....	27
3.2 BEHAVIOUR THAT CAN INFLUENCE RISK FOR HIV INFECTION	27
3.2.1 HIV KNOWLEDGE.....	27
3.2.2 SEXUAL RISKY BEHAVIOURS	28
3.2.3 SUBSTANCE ABUSE.....	28
3.2.4 CONDOMS.....	29
3.2.5 KEY AND VULNERABLE POPULATIONS.....	32
3.3 SOCIAL AND STRUCTURAL FACTORS THAT INFLUENCE HIV AND TB RISK.....	34
3.3.1 ORPHAN HOOD	34
3.3.2 CULTURAL AND RELIGIOUS NORMS	35
3.3.3 GENDER NORMS AND GENDER-BASED VIOLENCE	35
3.3.4 STIGMA	35

3.3.5	POVERTY	36
3.3.6	EMPLOYMENT	41
3.3.7	TYPES OF SETTLEMENTS	43
3.3.8	MIGRATION PATTERNS IN THE AREA.....	43
3.3.9	EDUCATION AND LITERACY	43
3.3.10	HATE CRIMES – XENOPHOBIC, HOMOPHOBIC, OTHER	44
3.3.11	DISABILITY	44
4.	SERVICES IN THE LOCAL MUNICIPALITY	45
4.1	HEALTH FACILITIES	45
5.	RECOMMENDATIONS FOR MULTI-SECTORAL INTERVENTIONS AND FOCUS ON KEY AND VULNERABLE POPULATIONS.....	46
	APPENDIX A: SELECTING DATA FOR THE PROFILE	60
	APPENDIX B: TERMS, DEFINITIONS AND CALCULATIONS	63
	APPENDIX C: METHODOLOGY FOR STAKEHOLDER ENGAGEMENT TO EXPLORE LOCAL LEVEL DATA	70

Table of Figures

Figure 1: Local municipalities’ Amajuba district	5
Figure 2: Distribution of Wards in the Dannhauser local municipality.....	6
Figure 3: Population Pyramid Dannhauser local municipality	8
Figure 4: Dependency ratio Dannhauser local municipality (Source Census 2011)	9
Figure 5: Population Pyramid Emfundweni clinic catchment area (Source Census 2011)	9
Figure 6: Dependency ratio Emfundweni clinic catchment area (Source Census 2011)	10
Figure 7: Population group distribution in Dannhauser local municipality (Source Census 2011)	10
Figure 8: ANC client HIV 1st test positive rate Amajuba district (Source: KZN DHIS 2015)	13
Figure 9: Infant 1st PCR test positive around 6 weeks rate Amajuba district (Source: KZN DHIS 2015)	14
Figure 10: Infant rapid HIV test around 18 months positive rate Amajuba district (Source: KZN DHIS 2015)	15
Figure 11: HIV test positive child 12-59 months rate Amajuba district (Source: KZN DHIS 2015)	16
Figure 12: HIV test positive child 5-14 years rate Amajuba district (Source: KZN DHIS 2015)	17
Figure 13: HIV prevalence amongst client tested 15-49 years rate Amajuba district (Source: KZN DHIS 2015)	18
Figure 14: TB (pulmonary) case finding index Amajuba district (Source: KZN DHIS 2015).....	19
Figure 15: TB suspect sputum test rate Amajuba district (Source: KZN DHIS 2015)	20
Figure 16: TB suspect smear positive rate Amajuba district (Source: KZN DHIS 2015)	21
Figure 17: TB suspect treatment initiation rate Amajuba district (Source: KZN DHIS 2015).....	22
Figure 18: Male urethritis syndrome rate Amajuba district (Source: KZN DHIS 2015).....	24
Figure 19: Female condom distribution rate Amajuba district (Source: KZN DHIS 2015)	30
Figure 20: Male condom distribution rate Amajuba district (Source: KZN DHIS 2015).....	31
Figure 21: Teenage Pregnancy rate Amajuba district (Source: KZN DHIS 2015)	32

Figure 22: Total number of Orphans with percentage that are double orphans per ward (Source Census 2011).....	34
Figure 23: SAMPI (poverty Index) 2001 - ward level, Dannhauser local municipality.....	37
Figure 24: SAMPI (poverty Index) 2011 - ward level, Dannhauser local municipality.....	38
Figure 25: SAMPI 2001 poverty headcount - ward level, Dannhauser local municipality.....	39
Figure 26: SAMPI 2011 poverty headcount - ward level, Dannhauser local municipality.....	40
Figure 27: Female and Male employment Dannhauser local municipality (Source Census 2011).....	41
Figure 28: Youth unemployment Dannhauser local municipality (source Census 2011).....	42
Figure 29: Female and Male employment Emfundweni clinic catchment area (Source Census 2011).....	42
Figure 30: Youth unemployment Emfundweni clinic catchment area (source Census 2011).....	43
Figure 31: Distribution of health facilities in Dannhauser local municipality.....	45
Figure 32: Data pyramid used for risk profiles.....	61
Figure 33: Factors influencing HIV associated risk and outcomes.....	62
Figure 34: Steps for development of HIV associated risk profile.....	71

List of Tables

Table 1: Population per age groups per ward, Dannhauser local municipality.....	6
Table 2: Youth population per sex and five-year age groups per ward, Dannhauser local municipality.....	7
Table 3: Ward level population distribution by Race in Dannhauser local municipality.....	11
Table 4: Main cause of deaths in the Amajuba District (Source STATSSA).....	12
Table 5: HIV Positivity Rate (Antenatal 1st Test) Amajuba district (Source: KZN DHIS 2015 report 26 June 2017).....	13
Table 6: HIV Positivity Rate (6 weeks) Amajuba district (Source: KZN DHIS 2015 report 26 June 2017).....	14
Table 7: HIV Positivity Rate (18 months) Amajuba district (Source: KZN DHIS 2015 report 26 June 2017).....	15
Table 8: HIV Positivity Rate (12-59 months) Amajuba district (Source: KZN DHIS 2015 report 26 June 2017).....	16
Table 9: HIV Positivity Rate (5 - 14 years) Amajuba district (Source: KZN DHIS 2015 report 26 June 2017).....	17
Table 10: HIV Positivity Rate (15 - 49 years) Amajuba district (Source: KZN DHIS 2015 report 26 June 2017).....	18
Table 11: TB (pulmonary) case finding index Amajuba district (Source: KZN DHIS 2015 report 26 June 2017).....	19
Table 12: TB (Sputum Test Rate) Amajuba district (Source: KZN DHIS 2015 report 26 June 2017).....	20
Table 13: TB suspect smear positive rate Amajuba district (Source: KZN DHIS 2015 report 26 June 2017).....	21
Table 14: TB suspect treatment initiation rate Amajuba district (Source: KZN DHIS 2015 report 26 June 2017).....	22
Table 15: Male urethritis syndrome rate Amajuba district (Source: KZN DHIS 2015 report 26 June 2017).....	24
Table 16: Female condom distribution rate Amajuba district (Source: KZN DHIS 2015 report 26 June 2017).....	30

Table 17: Male condom distribution rate Amajuba district (Source: KZN DHIS 2015 report 26 June 2017)	31
Table 18: Teenage Pregnancy rate Amajuba district (Source: KZN DHIS 2015 report 26 June 2017) ..	32
Table 19: Key and vulnerable population groups	33
Table 20: Orphan hood for Census 2011 at Ward level in Dannhauser local municipality	34
Table 21: Poverty measures for Census 2011 at Ward level in Dannhauser local municipality.....	36
Table 22: SAMPI (poverty Index) 2001 - ward level, Dannhauser local municipality	37
Table 23: SAMPI (poverty Index) 2011 - ward level, Dannhauser local municipality	38
Table 24: SAMPI 2001 poverty headcount - ward level, Dannhauser local municipality	39
Table 25: SAMPI 2011 poverty headcount - ward level, Dannhauser local municipality	40
Table 26: Key and vulnerable populations as well as priority interventions identified.....	47
Table 27: Service packages Shakaskraal clinic catchment area	49

DRAFT

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CCG	Community Care Givers
CCMDD	Centralised Chronic Medicines Dispensing and Distribution
CDC	Centres for Disease Control and Prevention
CHC	Community Health Centres
DAC	District AIDS Council
DHIS	District Health Information System
HIV	Human Immunodeficiency Virus
HTS	HIV Testing Services
KZN	Kwa-Zulu Natal
LAC	Local AIDS Council
LGBTIQ	Lesbian Gay Bisexual Transgender, Intersex and Queer
MSM	Men Who Have Sex with Men
NDOH	National Department of Health
NHIRD	National Health Information Repository and Data warehouse
PEP	post-exposure antiretroviral prophylaxis
PLHIV	People living with HIV/AIDS
PrEP	Pre-exposure antiretroviral prophylaxis
PWID	People Who Inject Drugs
SAMPI	South Africa Multidimensional Poverty Index
SANAC	South Africa National AIDS Council
SRD	Social Relief of Distress (Vouchers)
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis

Acknowledgement

The initial work for the development of the Focus for Impact approach was funded through SANAC by the Centers for Disease Control and Prevention under Grant No CDC-RFA-GH13-1338 and in-kind contributions from the National Department of Health. Subsequent work is funded under the Global Fund.

Any opinions, findings, and conclusions or recommendations expressed in this material are those of the author(s) and do not necessarily reflect the views of the Funders.

DRAFT

Focus for Impact – understanding the background

At the heart of the NSP 2017-2022, is the strategy to “focus for impact” using the more detailed information and insights now available. While comprehensive prevention and care will be provided countrywide, intensified, concentrated efforts will be made in HIV and TB high burden areas. In these high-burden areas, redoubled efforts will draw on detailed, innovative data sources (such as geospatial mapping) to identify those most at risk. The purpose is saturation of high-impact prevention and treatment services and strengthened efforts to address the social and structural factors that increase vulnerability to infection. Nationally, but especially within these high-burden areas, key and vulnerable populations most heavily affected by the epidemics will receive intensified focus to empower them, improve service access and reduce barriers to service uptake. The “focus for impact” approach represents a new, transformative way to achieve reductions in the morbidity and mortality associated with HIV and TB and morbidity from STIs. In line with the evidence, there will be a substantially stronger focus on adolescent girls and young women and on key and vulnerable populations, not forgetting adolescent boys and young men.

The process for identifying high-burden areas for intensification of efforts dates back to September 2015, when the SANAC Secretariat established the Hotspot Mapping Advisory Committee. The Committee – including governmental and non-governmental epidemiological experts as well as international partners – was tasked with developing a transparent, multi-sectoral, locally informed and user-friendly approach to Focus for Impact.

An approach was developed that use geospatial mapping and risk profiling to allow stakeholders to have a more granular understanding of geospatial variations in HIV, TB and STI burden. The **model aims to answer four key questions:**

- (a) **Where** in a particular district **are the areas with the highest HIV and/or TB burden?**
- (b) **Why** does a **specific area** have a higher HIV and/or TB burden (i.e. what are the contributing/associated factors)?
- (c) **Who** are the most vulnerable populations?
- (d) **Which multi-sectoral interventions** may be deployed in the high-burden area to reduce associated HIV and/or TB risks?

To maximise the impact of efforts, the NSP introduces this more intensified, more strategic focus at provincial, district and ward levels. There will be a greater priority on primary prevention and on strategies to address the social and structural drivers of the three infections in a thoroughly multi-sectoral manner. South Africa’s recent success in scaling up prevention and treatment programmes will be complemented by an equivalent focus on improving service quality and on reducing loss to follow-up among people who initiate care, while simultaneously implementing the new “test and treat” policy. Recognising that different people require different prevention approaches, differentiated care models will be scaled up to tailor interventions to each person’s needs, including enhanced use of proven community-centred service delivery. Priority is given to ensuring that treatment programmes are holistic, addressing each person’s health needs, including co-morbidities. The need for innovative new sources of funding is identified. A higher priority is placed on the collection and timely use of high-quality data to guide and inform programmes and policies.

The ultimate success of the NSP 2017 – 2022, depend on effective implementation at the provincial, district and ward levels. From the national to the local context, three levels of focus will accelerate implementation of the Plan and optimise its impact:

- **Spatial location:** The NSP calls for steps to ensure the delivery of comprehensive services to all who need them, regardless of where they live. In cognisance of the marked geographic variation in disease burden, intensified action is required in localised areas of high burden for intensified action. In each of these high-burden areas:
 - 1) ambitious coverage targets will be set;
 - 2) current and new programmes will focus strategically on those in greatest need; and
 - 3) other strategies will be intensified to address the social and structural factors that increase individual and community vulnerabilities which contribute to the disease burdens.

This component links with the first question that the Focus for Impact model aims to answer: *“Where in a particular district are the areas with the highest HIV and/or TB burden?”*

- **Population and community profile:** The community profile is done once a high burden area is identified using secondary data from multiple sources (health, education, socio-economic) and the provision and utilisation of services is described. The engagement with the community is to identify priorities of the risks for HIV, TB and STIs in that specific area and gaps in service delivery to address these priorities.

In each of these high-burden areas, programmatic efforts will be strategically targeted towards the populations among whom the need is greatest, and where the impact of efforts will be most pronounced. Given the degree to which transmission among adolescent girls and young women is driving HIV across the country, every province, district and ward must take steps to intensify efforts to reduce new HIV infections and increase service access for adolescent girls and young women, including addressing the social and structural factors that increase their vulnerability. Guided by local data and circumstances from geospatial mapping and profiling, provincial and local responses should prioritise key and vulnerable populations.

This component links with the second question that the Focus for Impact model aims to answer: *“Why does a specific area have a higher HIV and/or TB burden (i.e. what are the contributing/associated factors)?”*

- **Multi-sectoral interventions:** Enhanced focus is also needed on the combination of interventions that are prioritised for scale-up. Priority will be placed on implementing the right mix of high-value, high-impact interventions that will maximise the number of new infections and deaths averted.

Multi-sectoral refers to deliberate collaboration among various stakeholder groups (e.g., government, civil society, and private sector) and sectors (e.g., health, environment, economy) to jointly achieve a common goal. In this case reducing the associated risks in high burden areas

This component links with the third question that the Focus for Impact model aims to answer: *“Which multi-sectoral interventions may be deployed in the high-burden area to reduce associated HIV and/or TB risks?”*

Introduction to Profile

This profile presents secondary (public and non-public) data on the HIV and TB epidemics and population demographic profile, enriched with information collected from the community identified associated risk factors, services and assets in this area in Dannhauser local municipality under the Amajuba district, KwaZulu Natal. The latest available ward level population data is that from Census 2011. This is used as the basis for the population data and aligned with boundaries within this report.

The profile is intended to give the AIDS Councils and any other planning groups a thorough understanding of the HIV, TB and STI related context within this district. By reflecting who is at risk of becoming HIV and/or TB infected and where they are within a specific location, the profile assists to identify the people who need prevention and care services, both those who are infected and those at risk of infection.

The profile highlights factors that influence the risks of HIV and/or TB infection. Such factors include the socio-economic status e.g. structural measures of poverty; sexual risk behaviours such as condom use, multiple sexual partnerships and transactional sex in a given population in a specific service area and/or administrative area. The same applies to data on exposure to psycho-active substances, report or history of sexually transmitted infections (STIs). Data is presented at the level that it is available. The risk factors are explored within the categories of the socio-demographic data (e.g., age, sex, race, educational status) at wards level.

The profile for this specific area includes two types of data: 1) secondary (public and non-public) data and 2) local knowledge and understanding of what influences the associated risk profile. Information that reflects the local knowledge and understanding of the associated risk profile for the area is collected through community engagement through stakeholder and community workshops in the specific catchment area. More detail on the approach is described in Appendix C: Methodology for stakeholder engagement to explore local level data.

For this profile, the catchment area for Emfundweni Clinic, Dannhauser local municipality is defined as Dannhauser Ward 11. To assist with the development of this profile, two stakeholder and community workshops held on 18 and 19 July 2017 in Emfundweni Community Hall, Emfundweni. The workshops were attended by 96 stakeholders and community members during these two days. As more local level profiles are completed within the local municipality, a richer picture of the context within Dannhauser local municipality will evolve. The same applies to more granular data that becomes available for this specific catchment area. This profile will be updated accordingly and should therefore be considered a living document.

During the workshops participants identified the following priorities for consideration during the implementation of multi-sectoral interventions and focus of key and vulnerable populations to reduce the HIV associated risk in the Emfundweni clinic catchment area:

- Key and vulnerable populations:
 - Young Women and Girls
 - Young Boys and Men
 - Unemployed Youth
- Interventions that address:
 - Poverty, especially livelihoods support, to mitigate transactional sex as a source of income
 - Keeping girls in school irrespective of pregnancy
 - Gender Norms and Gender-based Violence, particularly aspects of consent, reporting and GBV support coverage
 - Parenting Support to ensure consistent sexuality education messaging between school and home
 - Support to Teen mothers to enrol in and adhere to PMTCT, return to school and access services to support children
 - Youth unemployment to mitigate transactional sex as a source of income
 - Improved monitoring of and access to services for disabled persons to retain them care and support
 - Substance abuse, particularly among youth
 - Improved safety and security in open spaces and community education on child protection
 - Follow-up and counselling for VMMC, particularly management of adverse events and HIV prevention
 - Targeted location specific HIV prevention interventions with contract workers on big infrastructure projects
 - Community education, communication and linkage to support services for students at TVET colleges and other learning institutions

1. Socio-demographic profile

1.1 Demarcated boundaries

Amajuba District is one of the 11 district municipalities of KwaZulu-Natal province. The Dannhauser local municipality is one of the three local municipalities in Amajuba District. The others are Newcastle and Emadlangeni local municipalities.

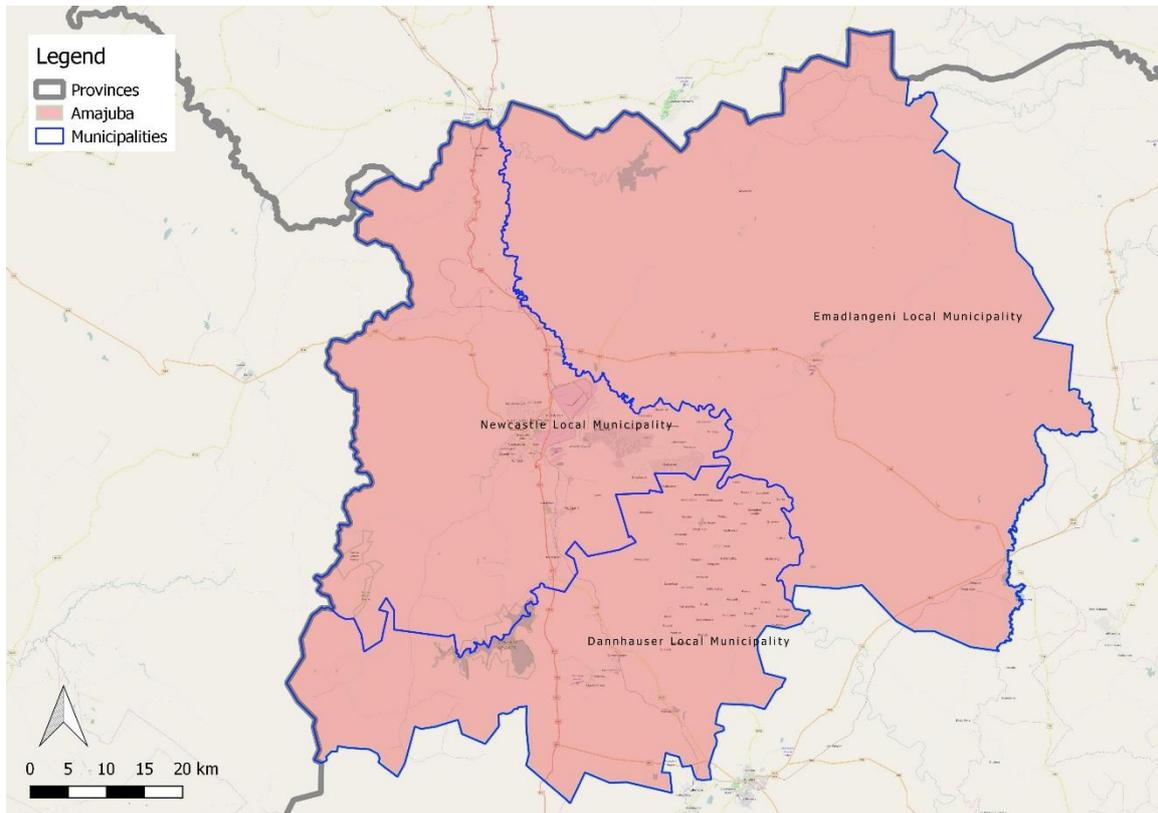


Figure 1: Local municipalities' Amajuba district

The Dannhauser local municipality constitute of 11 administrative wards (see Figure 2).

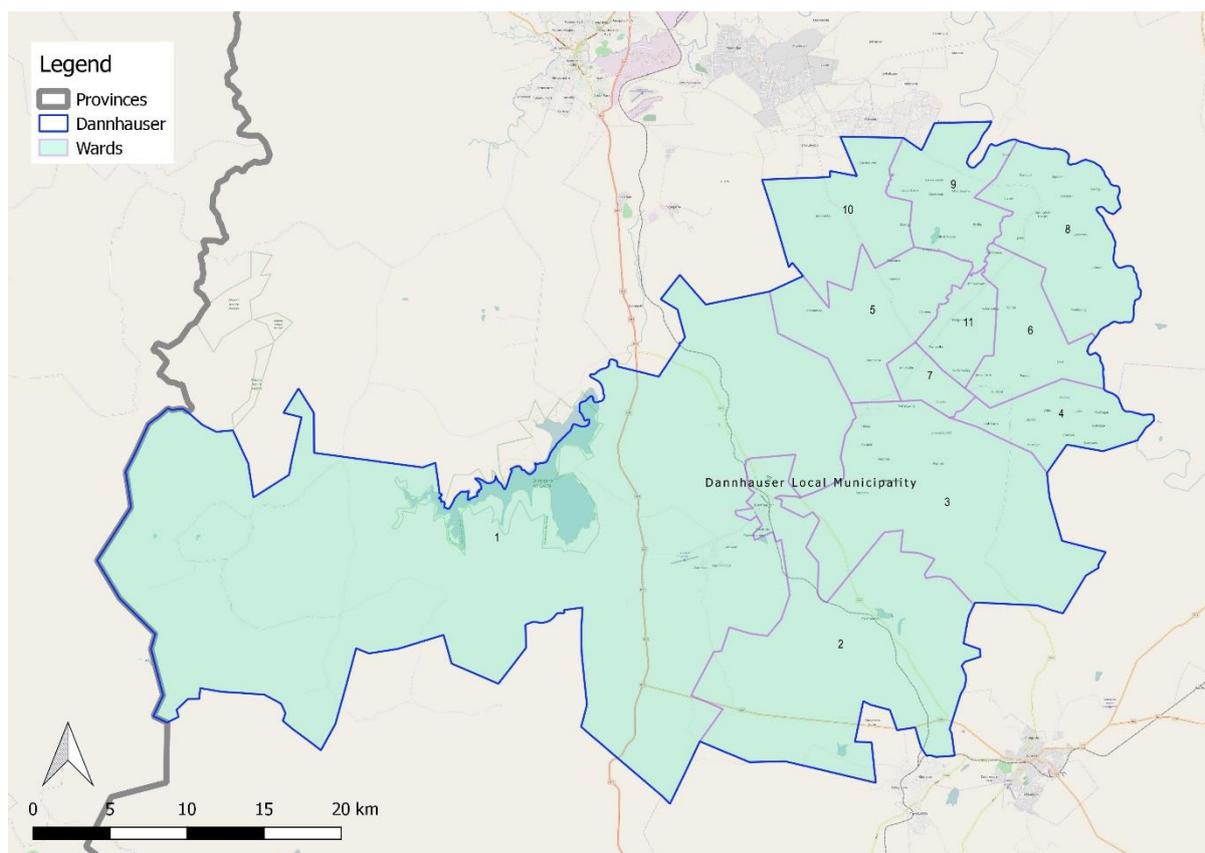


Figure 2: Distribution of Wards in the Dannhauser local municipality

1.2 Population by sex and age

During the 2011 Census 102132 were counted in the 11 wards. Table 1 summarises the age and sex per population in these wards. Females constitute 53% of population, compared to males 47%. The young people ≤ 25 years (61%) make up the majority of population in the local municipality. The detail for Ward 11 that forms the catchment area for Emfundweni Clinic, are highlighted in the table below.

Table 1: Population per age groups per ward, Dannhauser local municipality

Ward	Age						Sex			
	0-9	10-14	15-19	20-24	25-49	50+	Total	Female	Male	Total
Ward 001	2319	1206	1131	963	2853	1284	9756	5049	4707	9756
Ward 002	1647	885	774	879	2604	1320	8109	4149	3960	8109
Ward 003	2322	1089	1140	948	2247	1359	9105	4728	4377	9105
Ward 004	2538	1083	1212	891	2154	1332	9210	4776	4434	9210
Ward 005	1995	969	978	690	1686	1098	7416	3891	3525	7416
Ward 006	2553	1239	1227	936	2214	1350	9519	5034	4485	9519
Ward 007	2073	1023	1080	822	1929	1155	8082	4296	3786	8082
Ward 008	2562	1089	1233	942	2217	1398	9441	5034	4407	9441

Ward	Age							Sex		
	0-9	10-14	15-19	20-24	25-49	50+	Total	Female	Male	Total
Ward 009	2610	1206	1296	891	2295	1494	9792	5265	4527	9792
Ward 010	3144	1434	1416	1104	2823	1560	11481	6105	5376	11481
Ward 011	2748	1323	1377	978	2334	1461	10221	5424	4797	10221
	26511	12546	12864	10044	25356	14811	102132	53751	48381	102132
%	26%	12%	13%	10%	25%	15%		53%	47%	

Table 2 reflects the sex and age breakdown of the youth between 10 and 35 years for the same geographic area.

Table 2: Youth population per sex and five-year age groups per ward, Dannhauser local municipality

Ward	Female					Male					
	10-14	15-19	20-24	25-29	30-34	10-14	15-19	20-24	25-29	30-34	
Ward 001	570	573	441	396	306	636	558	522	405	270	4677
Ward 002	465	393	423	327	273	420	381	456	366	276	3780
Ward 003	546	552	468	357	270	543	588	480	324	258	4386
Ward 004	462	606	444	375	258	621	606	447	270	228	4317
Ward 005	429	459	357	252	225	540	519	333	240	165	3519
Ward 006	594	588	474	402	276	645	639	462	309	228	4617
Ward 007	495	534	432	336	243	528	546	390	297	192	3993
Ward 008	516	585	471	405	285	573	648	471	294	234	4482
Ward 009	618	624	483	384	273	588	672	408	297	228	4575
Ward 010	681	681	561	477	360	753	735	543	414	270	5475
Ward 011	672	690	510	390	312	651	687	468	339	228	4947
	6048	6285	5064	4101	3081	6498	6579	4980	3555	2577	48768

Figure 3 below reflects the population pyramid for Dannhauser local municipality. This figure visualises sex (male and female) and age in five-year age bands for this population. It is noted that the biggest group is in the age group 0-4, then 15-19 followed by 10-14 years old.

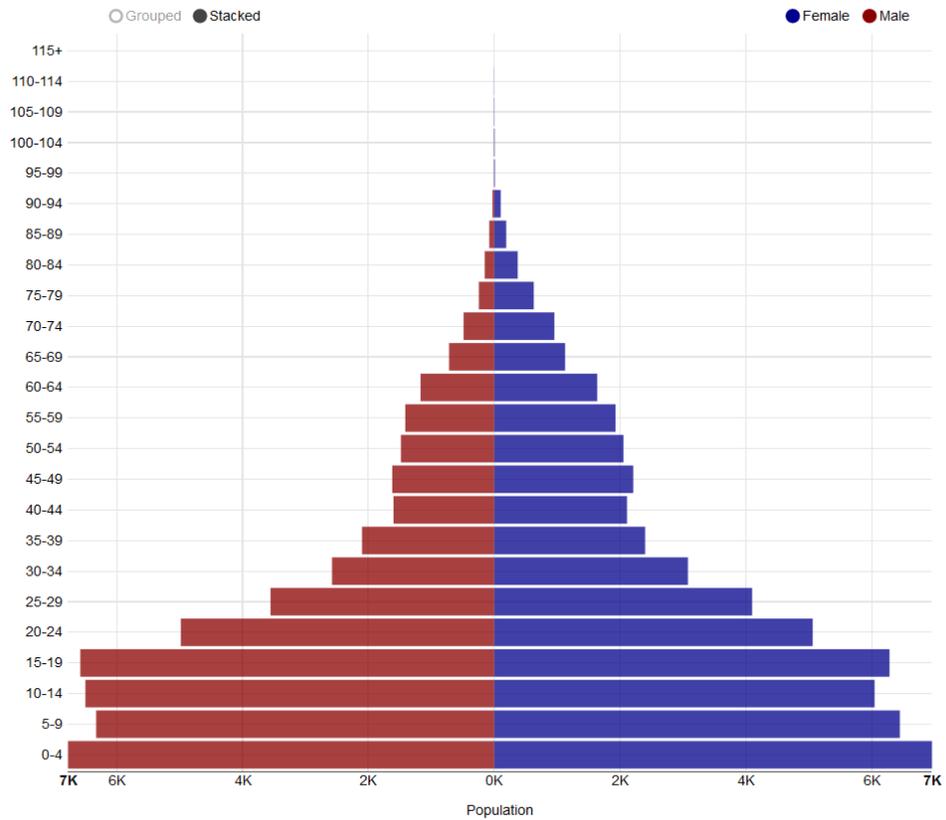


Figure 3: Population Pyramid Dannhauser local municipality

From this population, 38.2% children and 5% elderly are dependent on the 56.7% active population in the Dannhauser local municipality (Figure 4).

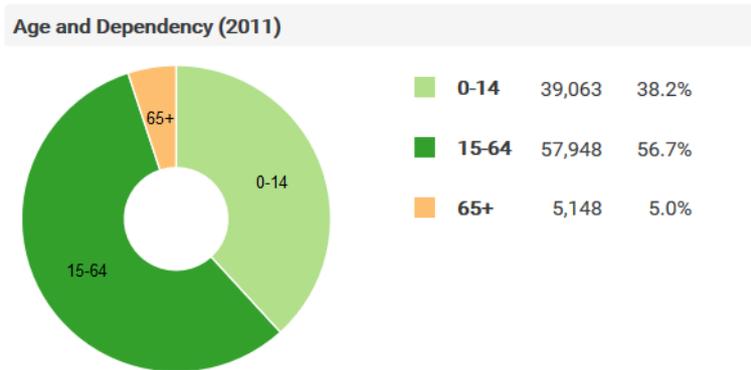


Figure 4: Dependency ratio Dannhauser local municipality (Source Census 2011)

In the catchment area for the Emfundweni Clinic (Dannhauser Ward 11) there is no significant variance in the population profile (Figure 5) and a different male to female distribution to that seen in the Dannhauser local municipality population pyramid in Figure 3.

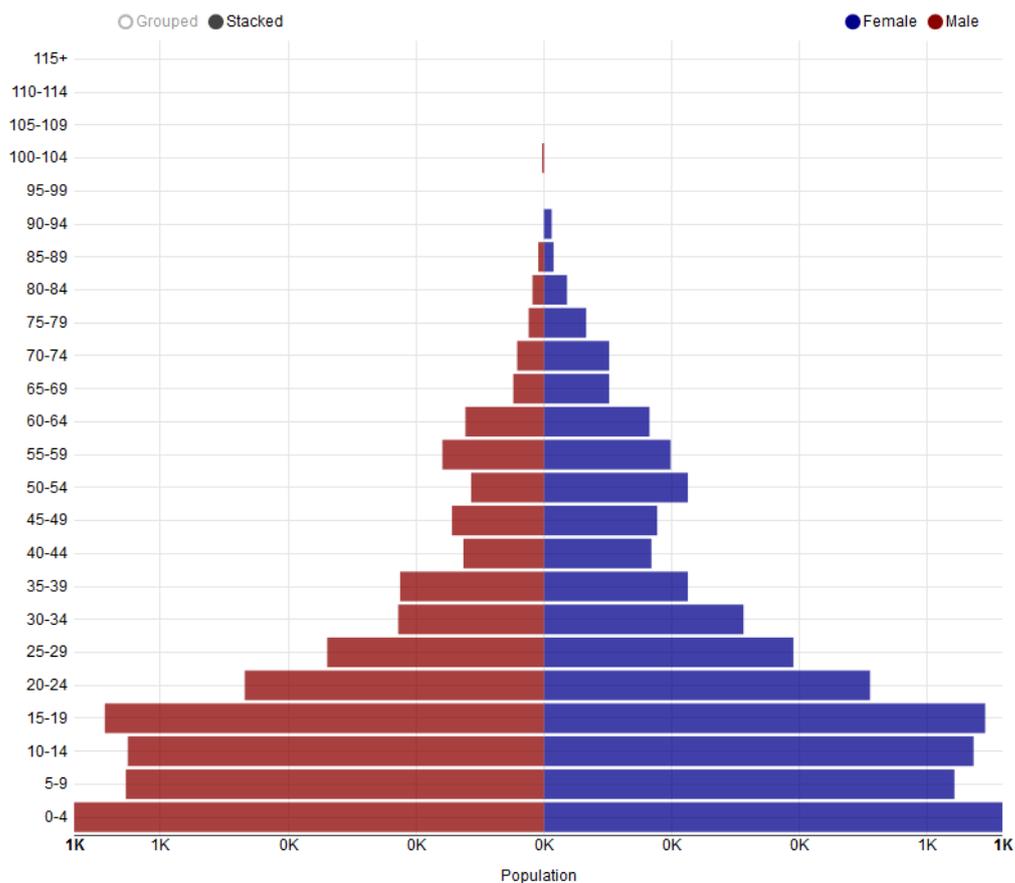


Figure 5: Population Pyramid Emfundweni clinic catchment area (Source Census 2011)

In the same catchment population, 39.8% children and 4.8% elderly are dependent on the 55.5% economically active population (Figure 6).

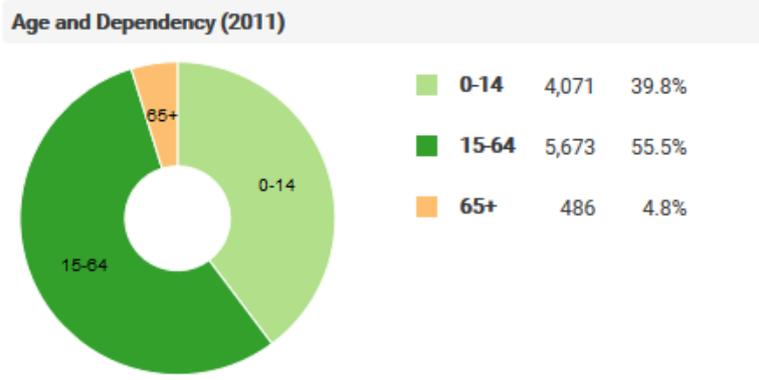


Figure 6: Dependency ratio Emfundweni clinic catchment area (Source Census 2011)

1.3 Population by race

The dominant population group in Dannhauser local municipality is Black African at 97.5% followed by Asian with 1.4% (detail in Figure 7 and Table 3).

**kz Dannhauser Local Municipality
2011**

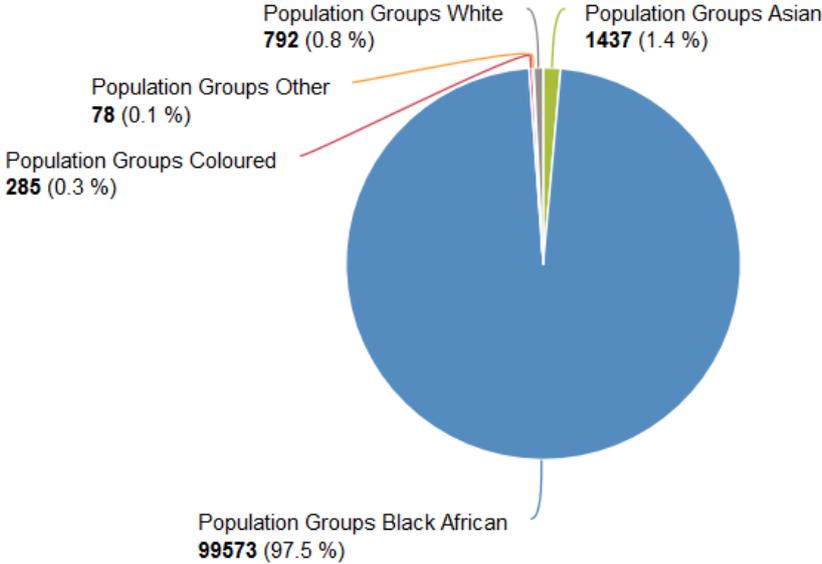


Figure 7: Population group distribution in Dannhauser local municipality (Source Census 2011)

The detail for Ward 11 that forms the catchment area for Emfundweni Clinic, are highlighted in the table below.

Table 3: Ward level population distribution by Race in Dannhauser local municipality

Ward	Asian	Black African	Coloured	Other	White	Total
Ward 001	156	9180	93	15	300	9744
Ward 002	1218	6291	132	42	414	8097
Ward 003		9033	18	9	42	9102
Ward 004		9195	6	6	6	9213
Ward 005		7413	6		6	7425
Ward 006		9531	6		3	9540
Ward 007		8091				8091
Ward 008	9	9417	6	3	6	9441
Ward 009	9	9774	3		6	9792
Ward 010	15	11466		3	3	11487
Ward 011	30	10182	15		6	10233
	1437	99573	285	78	792	102165

DRAFT

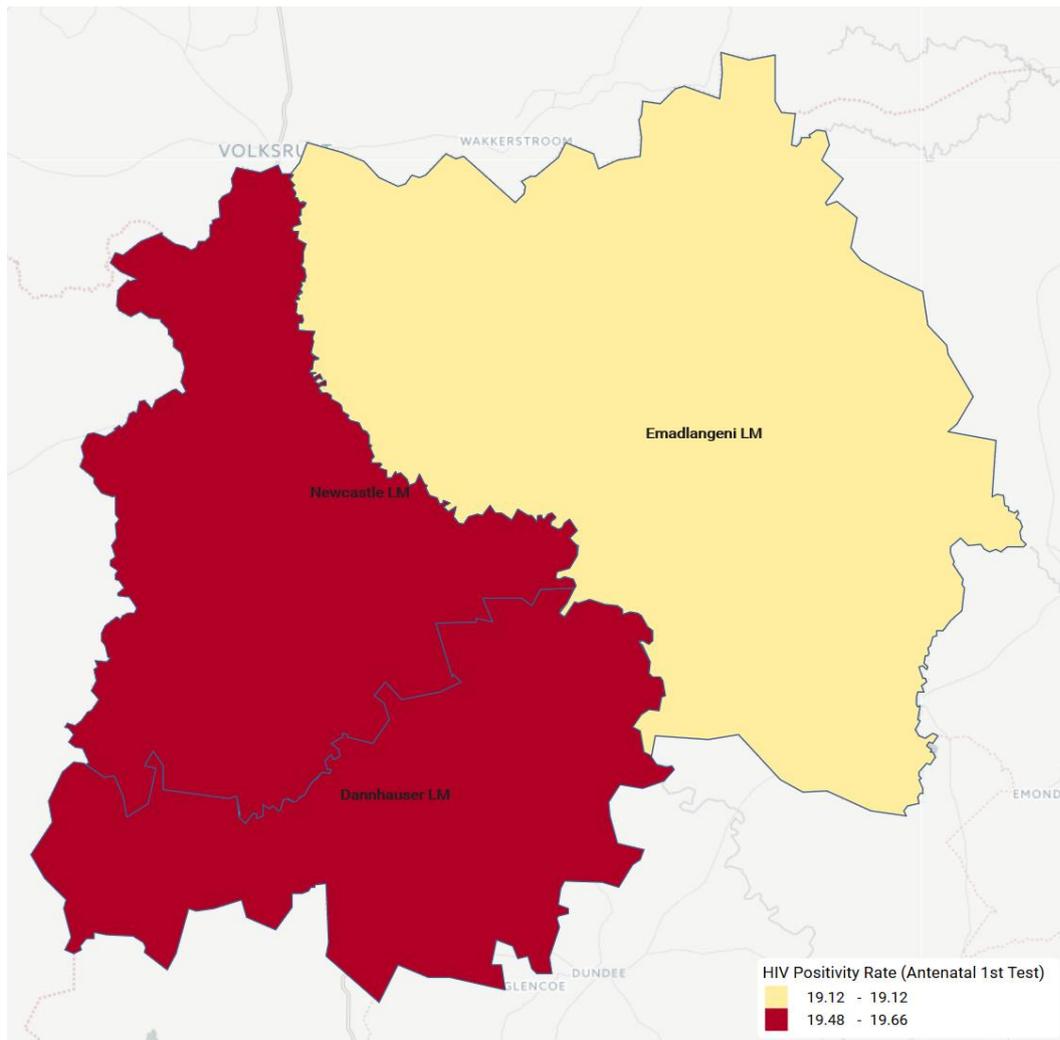


Figure 8: ANC client HIV 1st test positive rate Amajuba district (Source: KZN DHIS 2015)

Table 5: HIV Positivity Rate (Antenatal 1st Test) Amajuba district (Source: KZN DHIS 2015 report 26 June 2017)

KZ AMAJUBA DISTRICT MUNICIPALITY: 19.6 %								
	local municipality	2015 : HIV Positivity Rate (Antenatal 1st Test)					NUM %	DEN %
1	kz Emadlangeni local municipality	19.12	%	(91	/	476)	6.28 %	6.43 %
2	kz Dannhauser local municipality	19.48	%	(271	/	1391)	18.69 %	18.80 %
3	kz Newcastle local municipality	19.66	%	(1088	/	5533)	75.03 %	74.77 %

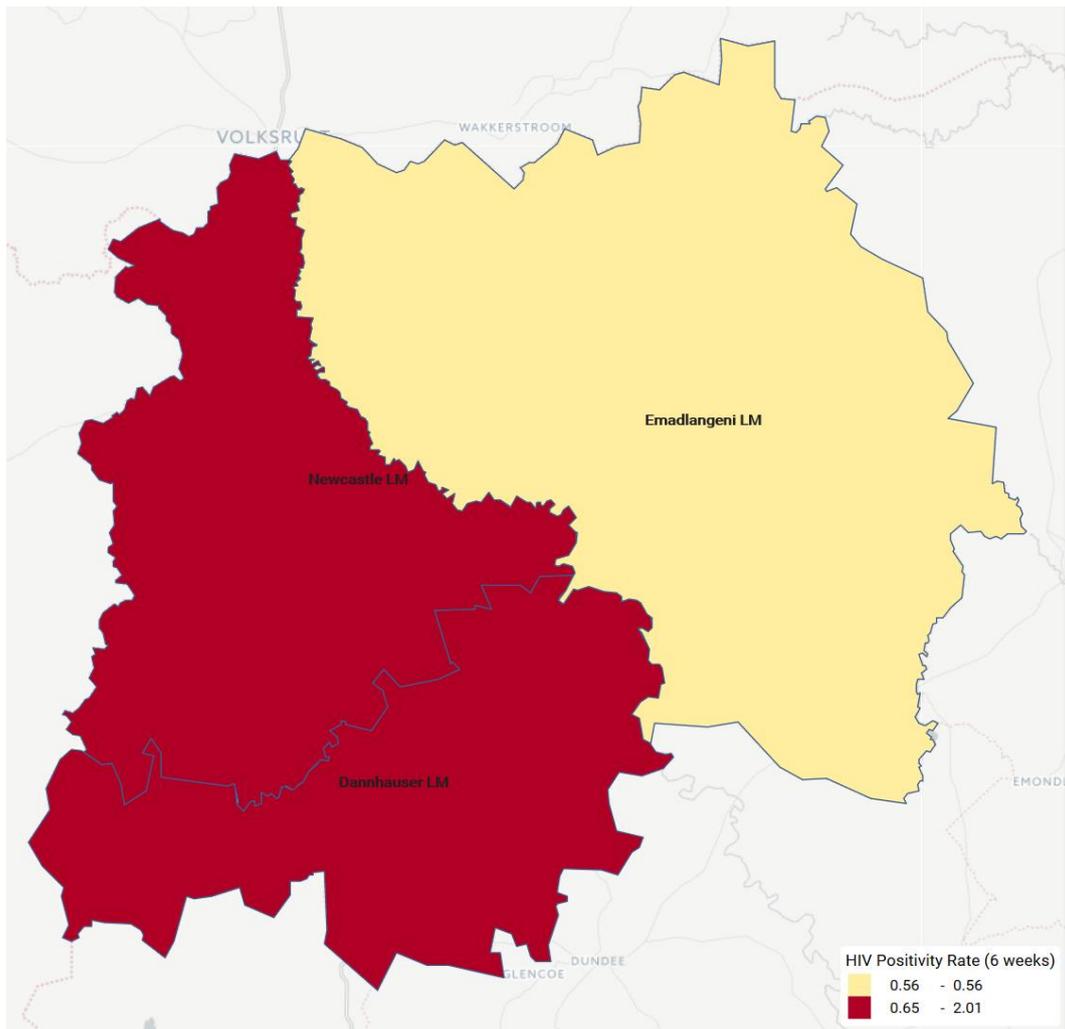


Figure 9: Infant 1st PCR test positive around 6 weeks rate Amajuba district (Source: KZN DHIS 2015)

Table 6: HIV Positivity Rate (6 weeks) Amajuba district (Source: KZN DHIS 2015 report 26 June 2017)

KZ AMAJUBA DISTRICT MUNICIPALITY: 1.6 %								
	local municipality	2015 : HIV Positivity Rate (6 weeks)					NUM %	DEN %
1	kz Emadlangeni local municipality	0.56	%	(1	/	178)	2.56 %	7.49 %
2	kz Dannhauser local municipality	0.65	%	(3	/	459)	7.69 %	19.31 %
3	kz Newcastle local municipality	2.01	%	(35	/	1740)	89.74 %	73.20 %

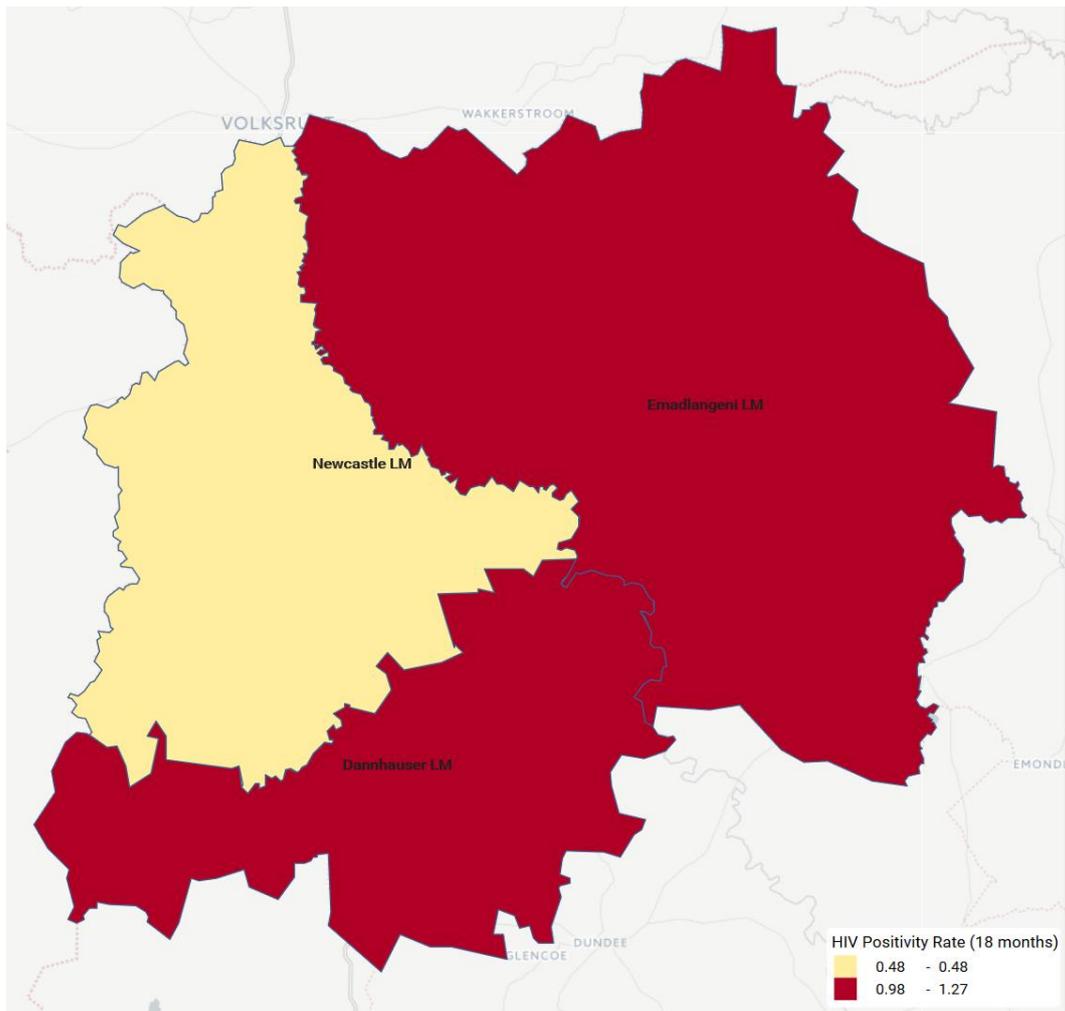


Figure 10: Infant rapid HIV test around 18 months positive rate Amajuba district (Source: KZN DHIS 2015)

Table 7: HIV Positivity Rate (18 months) Amajuba district (Source: KZN DHIS 2015 report 26 June 2017)

KZ AMAJUBA DISTRICT MUNICIPALITY: 0.7 %								
	local municipality	2015 : HIV Positivity Rate (18 months)				NUM %	DEN %	
1	kz Newcastle local municipality	0.48	%	(8	/	1656)	47.06 %	69.32 %
2	kz Emadlangeni local municipality	0.98	%	(1	/	102)	5.88 %	4.27 %
3	kz Dannhauser local municipality	1.27	%	(8	/	631)	47.06 %	26.41 %

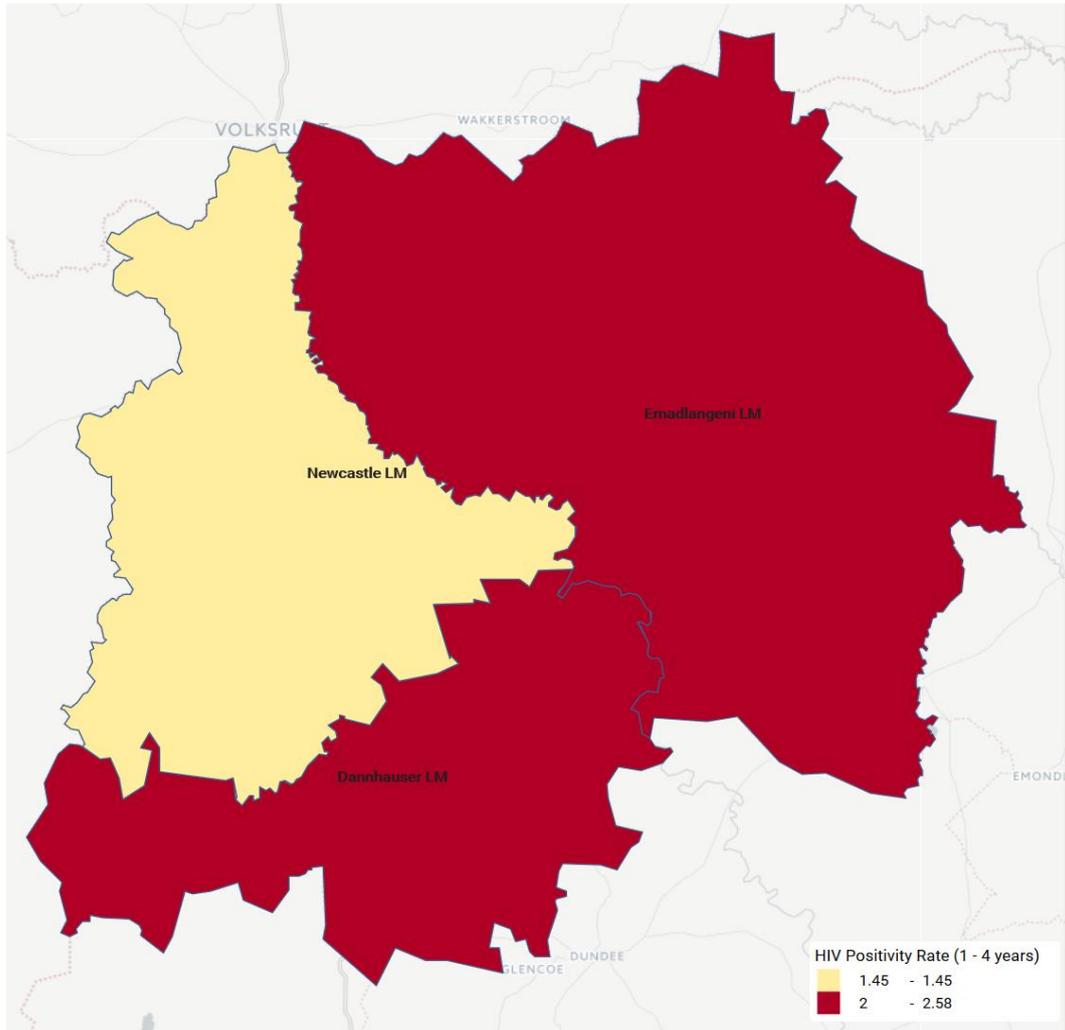


Figure 11: HIV test positive child 12-59 months rate Amajuba district (Source: KZN DHIS 2015)

Table 8: HIV Positivity Rate (12-59 months) Amajuba district (Source: KZN DHIS 2015 report 26 June 2017)

KZ AMAJUBA DISTRICT MUNICIPALITY: 1.8 %								
	local municipality	2015 : HIV Positivity Rate (1 - 4 years)				NUM %	DEN %	
1	kz Newcastle local municipality	1.45	%	(46	/	3181)	53.49 %	65.52 %
2	kz Emadlangeni local municipality	2	%	(11	/	549)	12.79 %	11.31 %
3	kz Dannhauser local municipality	2.58	%	(29	/	1125)	33.72 %	23.17 %

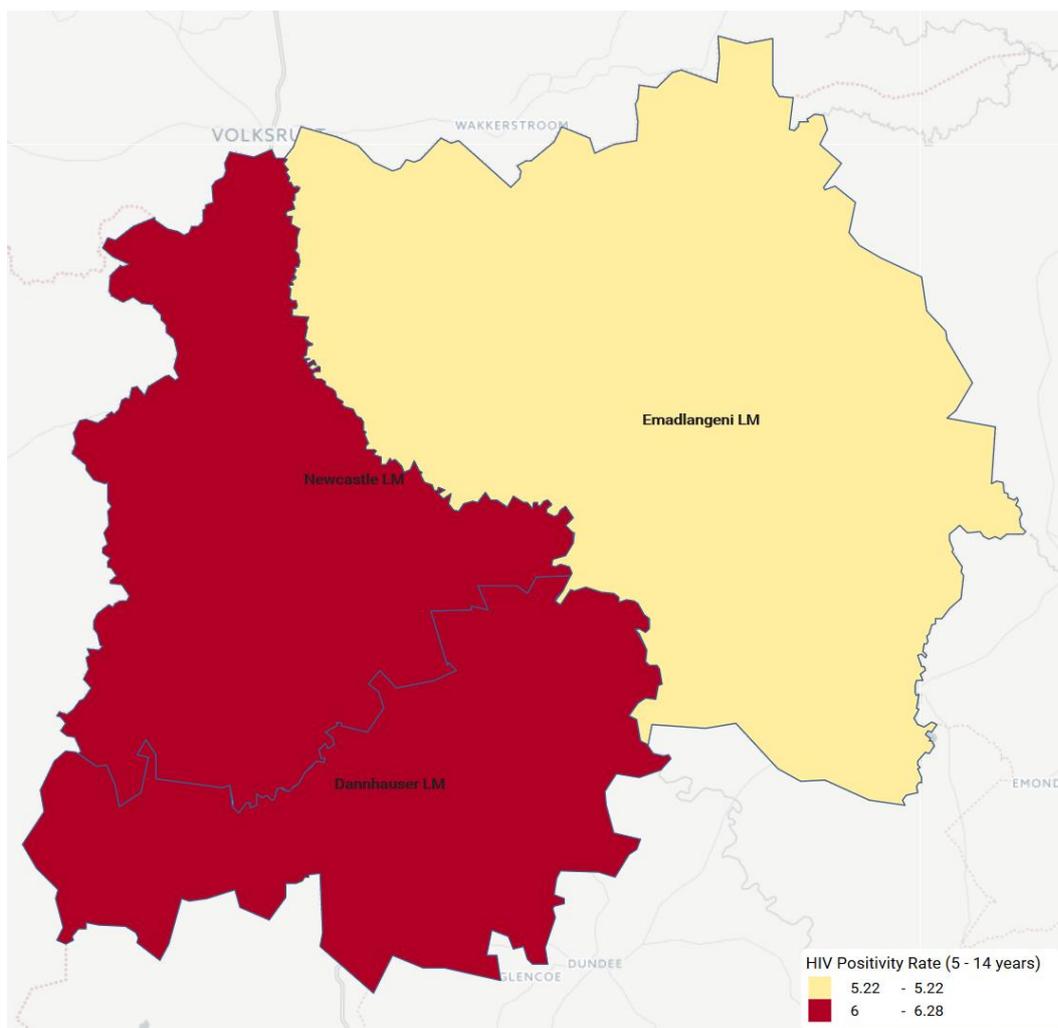


Figure 12: HIV test positive child 5-14 years rate Amajuba district (Source: KZN DHIS 2015)

Table 9: HIV Positivity Rate (5 - 14 years) Amajuba district (Source: KZN DHIS 2015 report 26 June 2017)

KZ AMAJUBA DISTRICT MUNICIPALITY: 6 %								
	local municipality	2015 : HIV Positivity Rate (5 - 14 years)				NUM %	DEN %	
1	kz Emadlangeni local municipality	5.22	%	(51	/	977)	19.77 %	22.74 %
2	kz Dannhauser local municipality	6	%	(31	/	517)	12.02 %	12.03 %
3	kz Newcastle local municipality	6.28	%	(176	/	2803)	68.22 %	65.23 %

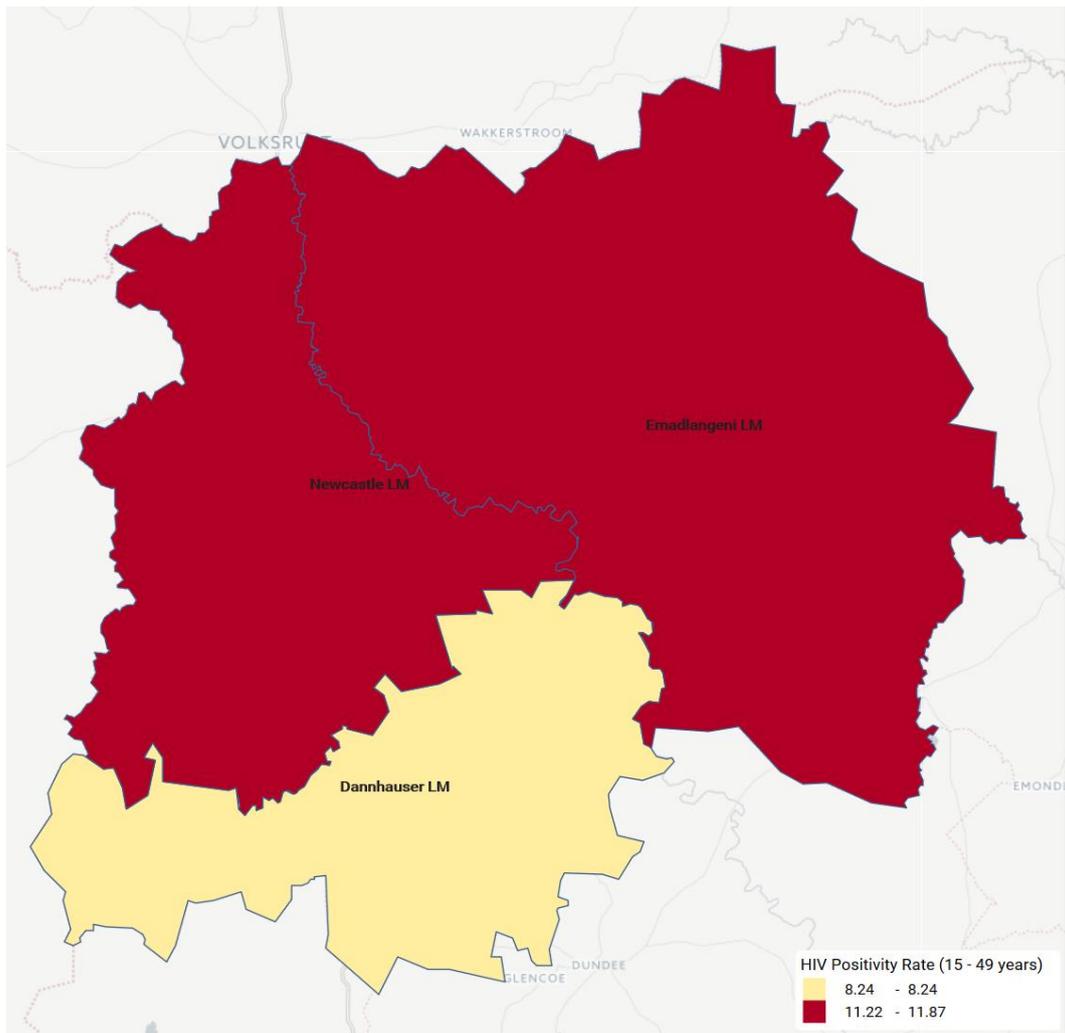


Figure 13: HIV prevalence amongst client tested 15-49 years rate Amajuba district (Source: KZN DHIS 2015)

Table 10: HIV Positivity Rate (15 - 49 years) Amajuba district (Source: KZN DHIS 2015 report 26 June 2017)

KZ AMAJUBA DISTRICT MUNICIPALITY: 11.2 %								
	local municipality	2015 : HIV Positivity Rate (15 - 49 years)				NUM %	DEN %	
1	kz Dannhauser local municipality	8.24	%	(1339	/	16253)	11.42 %	15.56 %
2	kz Emadlangeni local municipality	11.22	%	(1460	/	13015)	12.45 %	12.46 %
3	kz Newcastle local municipality	11.87	%	(8927	/	75177)	76.13 %	71.98 %

2.3 TB

The figures that follow reflects the TB burden based on the routine health data collected, collated and reported in health facilities under Amajuba district. The definitions for these indicators can be found in Appendix A.

Due to the small numbers at a local level, it is not included at ward level in this report. See note on small number in Annexure A.



Figure 14: TB (pulmonary) case finding index Amajuba district (Source: KZN DHIS 2015)

Table 11: TB (pulmonary) case finding index Amajuba district (Source: KZN DHIS 2015 report 26 June 2017)

KZ AMAJUBA DISTRICT MUNICIPALITY: 1.8 %								
	local municipality	2015 : TB (Identified)					NUM %	DEN %
1	kz Dannhauser local municipality	1.70	%	(3530	/	207086)	20.08 %	21.14 %
2	kz Newcastle local municipality	1.74	%	(12470	/	718533)	70.93 %	73.36 %
3	kz Emadlangeni local municipality	2.94	%	(1580	/	53825)	8.99 %	5.50 %

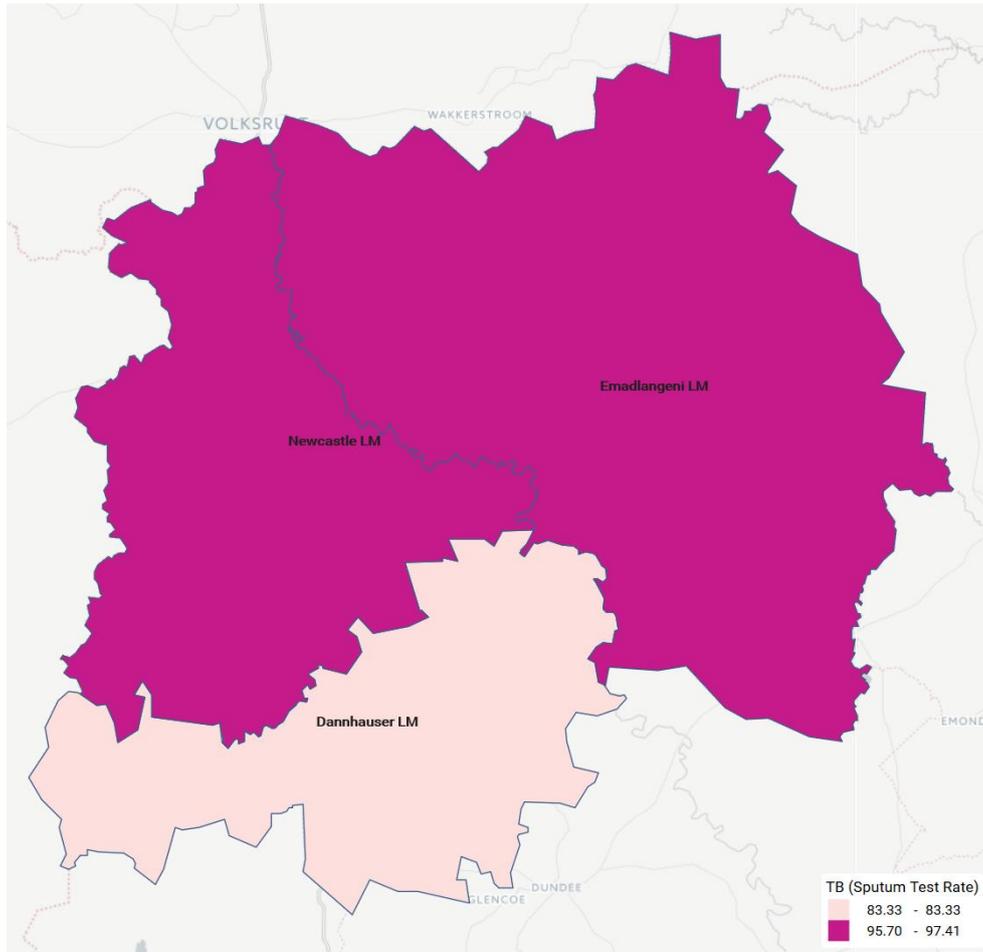


Figure 15: TB suspect sputum test rate Amajuba district (Source: KZN DHIS 2015)

Table 12: TB (Sputum Test Rate) Amajuba district (Source: KZN DHIS 2015 report 26 June 2017)

KZ AMAJUBA DISTRICT MUNICIPALITY: 94.1 %								
	local municipality	2015 : TB (Sputum Test Rate)					NUM %	DEN %
1	kz Dannhauser local municipality	83.33	%	(3530	/	4236)	20.08 %	22.67 %
2	kz Emadlangeni local municipality	95.70	%	(1580	/	1651)	8.99 %	8.83 %
3	kz Newcastle local municipality	97.41	%	(12470	/	12801)	70.93 %	68.50 %

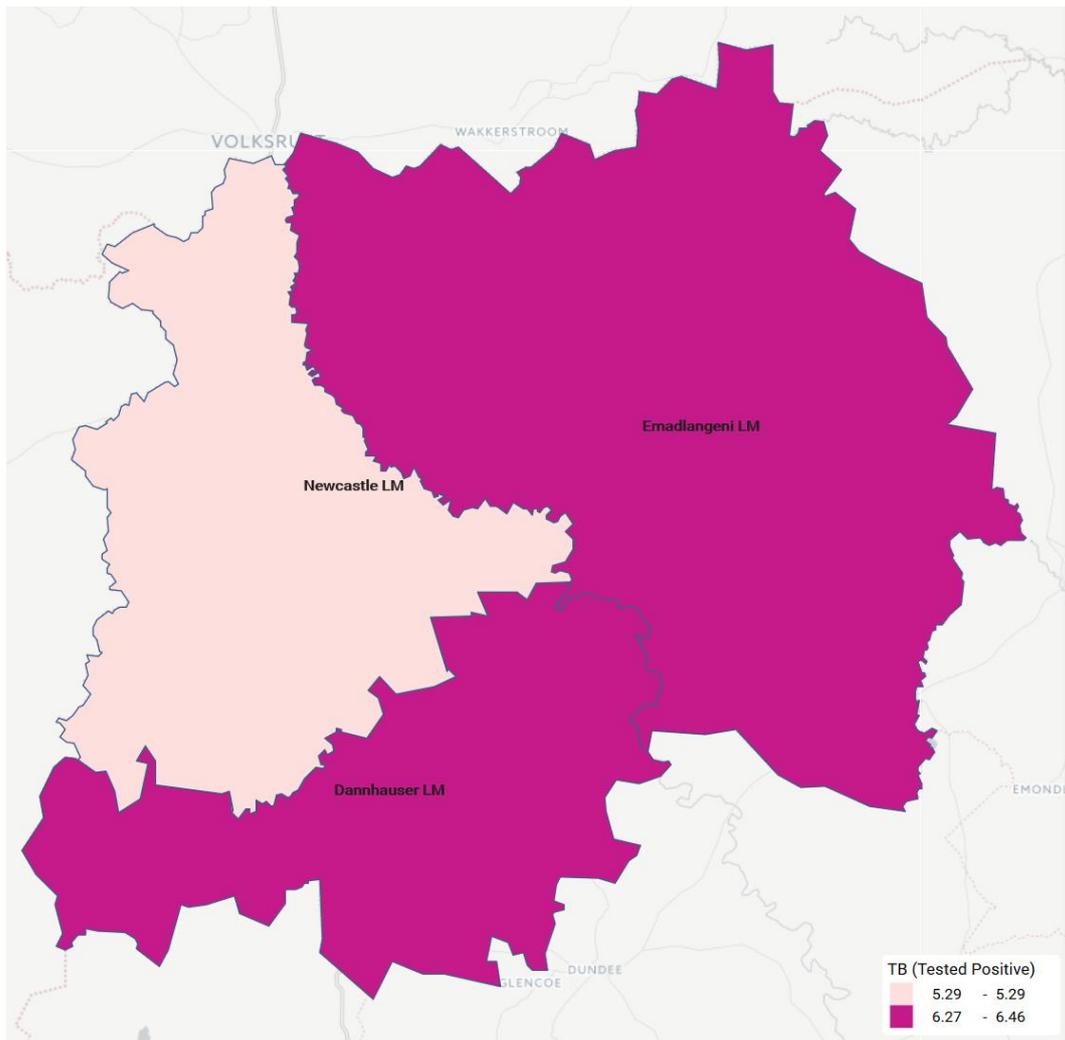


Figure 16: TB suspect smear positive rate Amajuba district (Source: KZN DHIS 2015)

Table 13: TB suspect smear positive rate Amajuba district (Source: KZN DHIS 2015 report 26 June 2017)

KZ AMAJUBA DISTRICT MUNICIPALITY: 5.6 %								
	local municipality	2015 : TB (Tested Positive)				NUM %	DEN %	
1	kz Newcastle local municipality	5.29	%	(660	/	12470)	66.87 %	70.93 %
2	kz Emadlangeni local municipality	6.27	%	(99	/	1580)	10.03 %	8.99 %
3	kz Dannhauser local municipality	6.46	%	(228	/	3530)	23.10 %	20.08 %

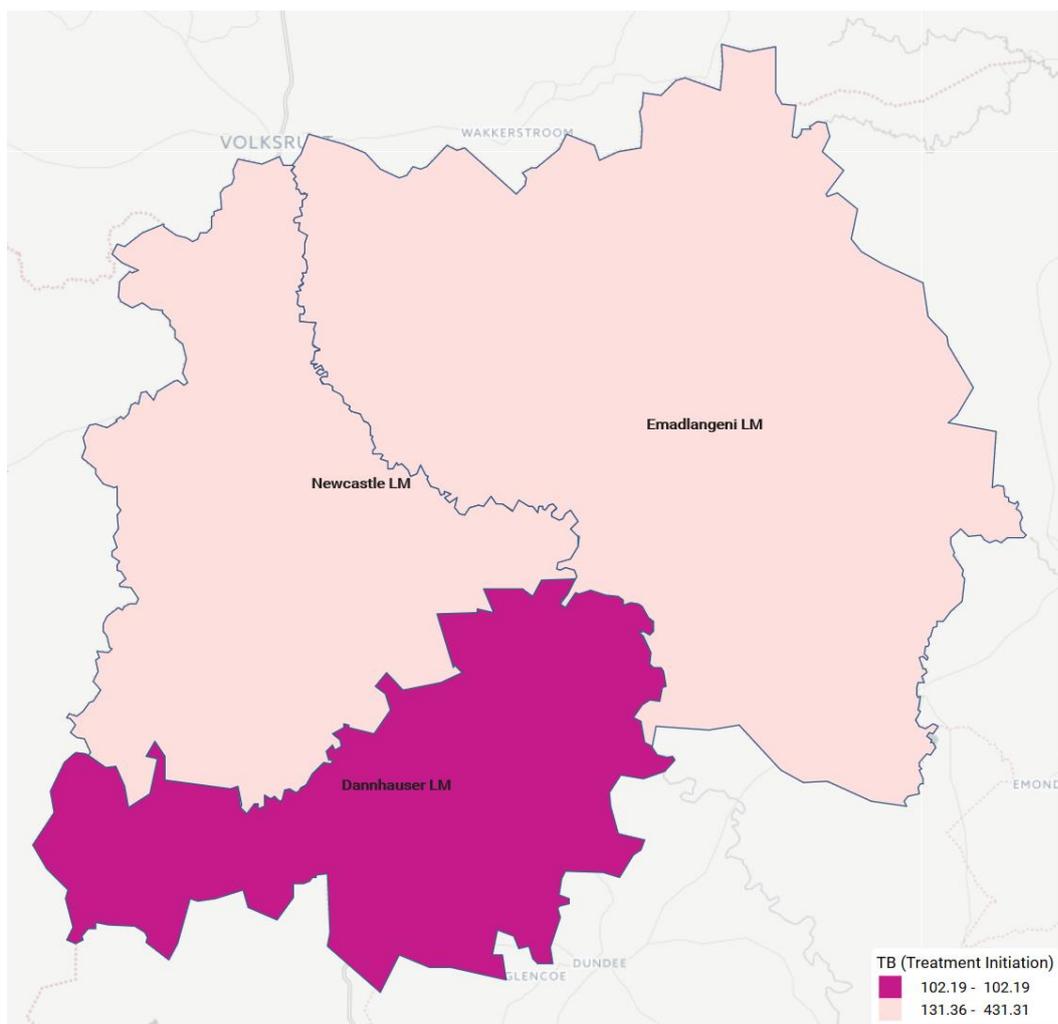


Figure 17: TB suspect treatment initiation rate Amajuba district (Source: KZN DHIS 2015)

Table 14: TB suspect treatment initiation rate Amajuba district (Source: KZN DHIS 2015 report 26 June 2017)

KZ AMAJUBA DISTRICT MUNICIPALITY: 154.7 %								
	local municipality	2015 : TB (Treatment Initiation)					NUM %	DEN %
1	kz Dannhauser local municipality	102.19	%	(233	/	228)	15.26 %	23.10 %
2	kz Newcastle local municipality	131.36	%	(867	/	660)	56.78 %	66.87 %
3	kz Emadlangeni local municipality	431.31	%	(427	/	99)	27.96 %	10.03 %

2.4 STIs

Sexually transmitted infections (STIs) are a major risk factor to the human immunodeficiency virus (HIV) epidemic¹. The presence of a sexually transmitted infection, such as syphilis, gonorrhoea, or herpes simplex virus infection, greatly increases the risk of acquiring or transmitting HIV infection (by two to three times, in some populations). The HIV-1 infected persons with STIs are at increased risk of transmitting HIV-1 because genital tract shedding of HIV-1 is elevated in the presence of genital tract inflammation²³. v. In 2014, HIV co-infection amongst STI patients remained relatively high with a HIV co-infection of 30.1%⁴⁵ among those with male urethritis syndrome, 40.3% among those with vaginal discharge syndrome and 46.3% among those with genital ulcer syndrome⁶ Location is also a factor. Ramjee et.al confirms the high prevalence and incidence of STIs among women living in rural and urban communities of KwaZulu-Natal. Therefore, STI control programmes need to be embedded in HIV care and treatment programmes and vice-versa in order to achieve optimal benefit in ameliorating the impact of HIV, AIDS and STIs.

The figure below reflects the STI burden based on the routine health data collected, collated and reported in health facilities under Amajuba district. At this point the most robust data is for Male urethritis syndrome rate. As the data quality for other STI routine health indicators improve, it will be included in updated profiles. The definitions for this indicator can be found in Appendix B. Due to the small numbers at a local level, it is not included at ward level in this report. See note on small number Appendix A.

¹ Naidoo, S., Wand, H., & Ramjee, G. (2014). High prevalence and incidence of sexually transmitted infections among women living in Kwazulu-Natal, South Africa. *AIDS Research and Therapy*, 11–31. <http://doi.org/10.1186/1742-6405-11-31>

² Cohen, M., Hoffman, I., Royce, R., Kazembe, P., Dyer, J., & Daly, C. (1997). Reduction of concentration of HIV-1 in semen after treatment of urethritis: implications for prevention of sexual transmission of HIV-1. AIDSCAP Malawi Research Group. *Lancet*, 349(9096), 1868–73.

³ Johnson, L., & Lewis, D. (2008). The effect of genital tract infections on HIV-1 shedding in the genital tract: a systematic review and meta-analysis. *Sex Transm Dis*, 35(11), 946–59.

⁴ Cohen, M., Hoffman, I., Royce, R., Kazembe, P., Dyer, J., & Daly, C. (1997). Reduction of concentration of HIV-1 in semen after treatment of urethritis: implications for prevention of sexual transmission of HIV-1. AIDSCAP Malawi Research Group. *Lancet*, 349(9096), 1868–73.

⁵ Johnson, L., & Lewis, D. (2008). The effect of genital tract infections on HIV-1 shedding in the genital tract: a systematic review and meta-analysis. *Sex Transm Dis*, 35(11), 946–59.

⁶ Naidoo, S., Wand, H., & Ramjee, G. (2014). High prevalence and incidence of sexually transmitted infections among women living in Kwazulu-Natal, South Africa. *AIDS Research and Therapy*, 11–31. <http://doi.org/10.1186/1742-6405-11-31>

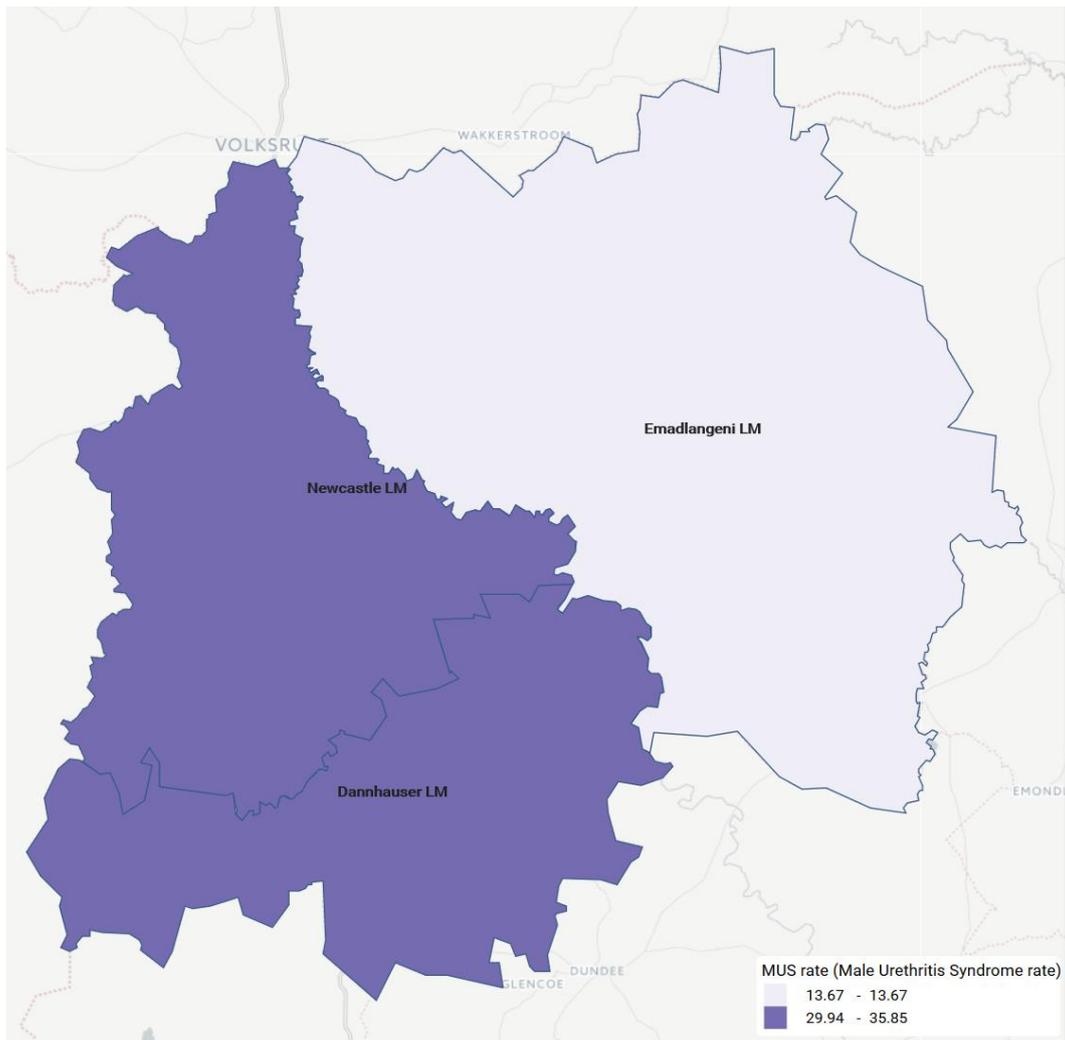


Figure 18: Male urethritis syndrome rate Amajuba district (Source: KZN DHIS 2015)

Table 15: Male urethritis syndrome rate Amajuba district (Source: KZN DHIS 2015 report 26 June 2017)

KZ AMAJUBA DISTRICT MUNICIPALITY: 29.8 %								
	local municipality	2015 : MUS rate (Male Urethritis Syndrome rate)					NUM %	DEN %
1	kz Emadlangeni local municipality	13.67	%	(150	/	1097)	3.08 %	6.70 %
2	kz Newcastle local municipality	29.94	%	(3794	/	12671)	77.83 %	77.43 %
3	kz Dannhauser local municipality	35.85	%	(931	/	2597)	19.10 %	15.87 %

3. Associated risk profile

3.1 Biomedical Profile

3.1.1 HIV Testing

Awareness of one's HIV status through HIV Testing Services (HTS) is pivotal to accessing prevention, care services, and ARV treatment which mitigate the impact of HIV⁷. It is therefore important to determine the success of routine HIV testing and counselling by the department of health. From the National 2013 HIV testing campaign, nearly two-thirds of respondents (65.5%) indicated that they had tested for HIV with females reporting higher rates of testing (71.5%) than of males (59%)⁸. 78% of adults aged 25–49 years reported testing compared to youth aged 15–24 years (50.6%) and the elderly (aged 50 years and older) (54.8%)⁹.

Stakeholder and community engagement workshops revealed the following about *HIV Testing Services* in the area:

- Testing is available at the clinic community awareness campaigns and multi-sectoral events where testing stations are available;
- Mostly women go to the clinic when they are pregnant and get tested;
- They also take their children to the clinic and end up getting tested;
- Men are not testing, they go to the clinic only when they are sick;
- Women above 25 years test, but women below 21 years are not ready to test;
- Men tend not to test preferring to know their status by the status of their partner; and
- Only men and young boys test when they go for circumcision and they feel it is mandatory as part of the procedure.

3.1.2 Circumcision

Voluntary medical male circumcision (VMMC) is being scaled up in the country because it has been shown to be partially effective in reducing HIV infection among males¹⁰. Nationally, there are reported about 46.4% circumcisions, with a significant lower percentage of men aged 15–19 years compared to all age groups. High percentage of black Africans (52.4%) reported that they were circumcised compared to the other three race groups¹¹.

⁷ Shisana, O., T. Rehle, et al. (2014). South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press.

⁸ *ibid*

⁹ *ibid*

¹⁰ SANAC. 2011. NSP 2012–2016

¹¹ Shisana, O., T. Rehle, et al. (2014). South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press.

Stakeholder and community engagement workshops revealed the following about **circumcision** in the area:

- There is high uptake of medical male circumcision in Emfundweni among young men and boys, cultural circumcision does not take place;
- Older men do not circumcise medically because they do not want to be attended to by women, sometimes younger than them. They also don't want to take instructions from the clinic;
- The young ones are collected from schools where Department of Health works hand-in-hand with the Department of Education;
- After circumcision, the boys have sex without condoms because they believe they cannot contract HIV; and
- Although patients are given a return date to come back to the clinic, those who do not return for follow-up, usually have complications.

3.1.3 ARV treatment

Stakeholder and community engagement workshops revealed the following about **ARV treatment** in the area:

- ARVs are available in the clinics and they never run out of stock;
- There are no barriers to ART, the patients receive SMS' and are also followed up by Community Care Givers (CCGs). Their medication can be picked up at a pickup point and even some have their medication delivered to their home;
- Everyone receiving treatment gets thorough counselling and HIV awareness. CCGs speak and teach about it in all their home visits;
- The problem is that people default and then go to other clinics so it looks like they are lost-to-follow-up;
- Some people do not have food to take with their treatment;
- Young girls who visit out of town do not bring their treatment with they are afraid that their boyfriend will see them;
- Patients are not disclosing that they are on treatment so they default when they try to hide their treatment;
- Adherence is not strong – people discard the tablets and pretend that they are taking when the CCG visits. They do this because they don't like the discipline of taking treatment every day;
- Patients also stop treatment when they feel they are strong and healthy;
- Peer pressure also plays a role – when they see their friend defaulting they follow her;
- Some people take their treatment with traditional medicine, alcohol and multivitamins - this is only acknowledged when their viral load is not suppressed;
- People who are initiated on treatment give wrong addresses to avoid follow-up, hence follow up becomes very difficult but CCG's continually follow up patients who are lost; and
- There has been a change over time in that the one tablet makes it easier to adhere and also there has been a decrease in OVC and AIDS-related deaths.

3.1.4 PEP and PrEP

The following was discussed around **post-exposure antiretroviral prophylaxis (PEP) and pre-exposure antiretroviral prophylaxis (PrEP)** during the stakeholder and community engagement workshops in the area:

- Health workers have knowledge that if you are raped there's medication that can be given so that you are not infected;
- CCG's refer candidates for PEP and also follow up on whether it was prescribed; and
- The health workers and the community have no knowledge of PrEP so they don't use it.

3.1.5 Lubricant

During the stakeholder and community engagement workshops it was noted that in general the community do not have access and do not know about **lubricants** except possibly for use by men who have sex with men and sex workers, although this was widely unknown.

3.2 Behaviour that can influence risk for HIV infection

The reported high incidence among young women aged 15–24 years (2.54; 2.04–3.04) approximately 116 000 new infections compared to young men (0.55; 0.45–0.65) approximately 26 000 new infections¹² calls for need to address the associated social factors such as age-disparate relationships, particularly at a much local level. However, data on factors influencing risk of HIV infection e.g. condom use, multiple sexual partnerships, intergenerational sex, transactional sex, risky sexual practices (anal sex) are not routinely collected. Such data are mostly obtained from independent behavioural surveys¹³, and are reported at provincial level which is much higher than district, local municipalities, and high burden areas. There is need for the department of health to devise approaches to routinely collect quantitative data on sexual risk behaviours in identified local levels and/or high burden areas.

3.2.1 HIV Knowledge

The following was discussed around **HIV knowledge** during the stakeholder and community engagement workshops in the area:

- The community knows about HIV, its spoken of everywhere regardless of what you attend the clinic for, the nurses still tell you about HIV, even the media always speaks of it;
- Life orientation in schools also talks about HIV;
- There is knowledge about HIV but it is uneven, inconsistent and sometimes incorrect:
 - At home, the parents and kids do not talk about HIV;
 - Knowledge is lacking among men, they do not come to awareness campaigns and they've got little and wrong information about HIV;
 - Men believe that ejaculating outside wont risk infection or infecting others;

¹² Shisana, O., T. Rehle, et al. (2014). South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press.

¹³ *ibid*

- There are still local areas that are under reached like next to the farms;
- Most women have lots of knowledge but the problem is they are dependent on men so they agree (not to use condoms) because they won't be given money;
- Our parents don't believe in using gloves when they look after us with HIV;
- At first there was lots of myths but now people are more knowledgeable about it;
- There are still myths about HIV in the Emfundweni community:
 - Condom make a rash;
 - To sleep with a disabled person will cure HIV;
 - Girls believe that snuff will make the size of their vagina smaller but instead that contributes to infection because of the inflammation;
 - If you sleep with a virgin you will be cured of HIV; and
 - The younger generation believes that skinnier girls have HIV and the more "meaty" ones do not have it.

3.2.2 Sexual risky behaviours

The following was discussed around **risky sexual behaviour** during the stakeholder and community engagement workshops in the area:

- Gay people practise unprotected anal sex;
- "Kudliwa Utshwala, kudliwa umuntu" – Girls expect to have group sex (Istimela) if they go to the tavern and they don't have money to drink; and
- The community debated whether Istimela is consensual or not. Some members of the community say the girls do consent before they drink, and by accepting drinks from many men they expect to have sex in return (even with multiple partners at the same time). But others felt that the influence of alcohol means you cannot consent so it must be termed "gang-rape".

3.2.3 Substance abuse

The following was discussed about **substance abuse** during the stakeholder and community engagement workshops in the area:

- There is a lot of substance abuse in the Emfundweni community, young people drink because they have nothing else to do;
- When young people drink they can't use condoms;
- Events like the Dundee July are frequented by young people who drink and then have sex afterwards;
- There are some injecting drug users in the community but not many;
- Istimela (group sex) is common with many boys and one girl after they have bought her drinks;
- The youth are mainly getting infected because they have sex under the influence of alcohol and can't make decisions, the 24-hour taverns make alcohol very accessible; and
- Drug users don't care about sex just about their next fix.

3.2.4 Condoms

Stakeholder and community engagement workshops revealed the following about **condoms use and availability** in the area:

- Male and female condoms are available at the clinics and CCG's also distribute them at homes, taverns and shops;
- Youth are afraid to take condoms at clinic, they fear adults seeing them taking a condom, afraid that their parents will know they are engaging in sexual activity;
- Women are more at risk - their partners refuse to use condoms but biologically women are recipients of HIV;
- The men do not want to use a condom. They ask if the partner wants to use a condom and she does not say yes;
- Women are scared of using female condoms in case they slip inside;
- Young boys don't want to use condoms after they have been circumcised;
- Condoms are used to hold up socks;
- There are burst condoms and expired condoms;
- People don't follow instructions on how to use condoms properly; and
- Some boys don't use condoms because they think a beautiful woman is not sick.

In Figure 19 and Figure 20 the condom distribution for females and males (annualised) are reflected at local municipality level in Amajuba district. The definitions for these indicators can be found in Appendix B. Due to the small numbers at a local level, it is not included at ward level in this report. See note on small number in Appendix A.

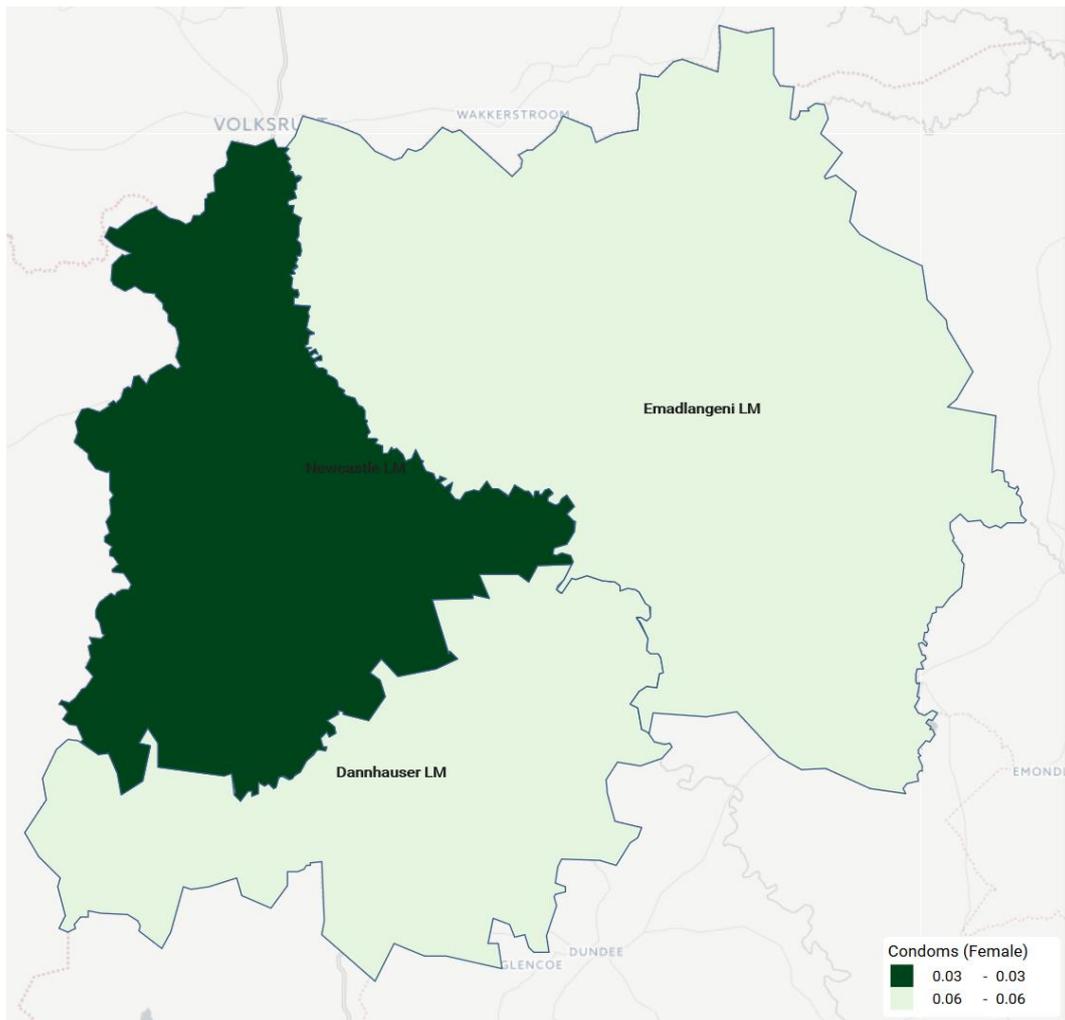


Figure 19: Female condom distribution rate Amajuba district (Source: KZN DHIS 2015)

Table 16: Female condom distribution rate Amajuba district (Source: KZN DHIS 2015 report 26 June 2017)

KZ AMAJUBA DISTRICT MUNICIPALITY: 3.7 No								
	local municipality	2015 : Condoms (Female)					NUM %	DEN %
1	kz Newcastle local municipality	0.03	No	(48663	/	1673112)	58.75 %	74.61 %
2	kz Emadlangeni local municipality	0.06	No	(7798	/	138528)	9.41 %	6.18 %
3	kz Dannhauser local municipality	0.06	No	(26374	/	430920)	31.84 %	19.22 %

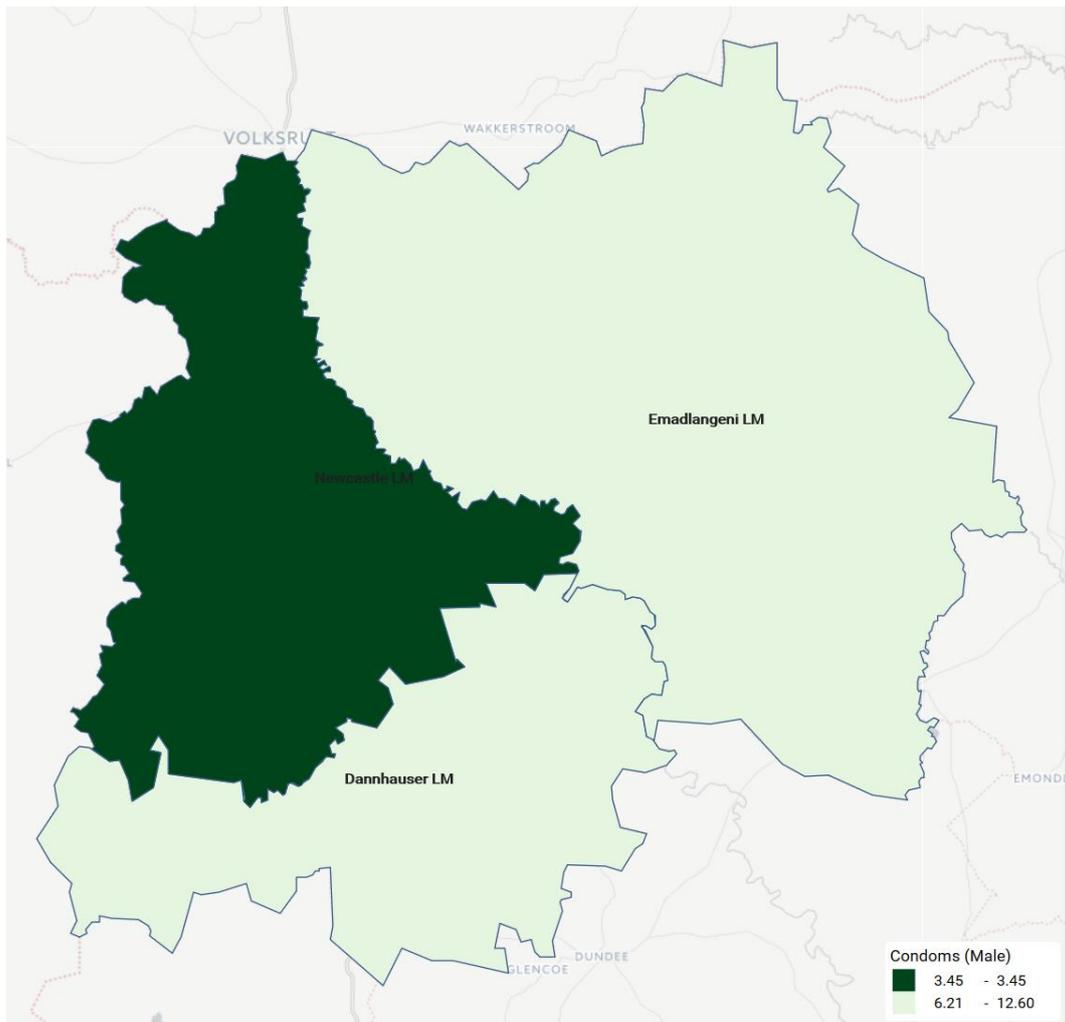


Figure 20: Male condom distribution rate Amajuba district (Source: KZN DHIS 2015)

Table 17: Male condom distribution rate Amajuba district (Source: KZN DHIS 2015 report 26 June 2017)

KZ AMAJUBA DISTRICT MUNICIPALITY: 462.3 No								
	local municipality	2015 : Condoms (Male)					NUM %	DEN %
1	kz Newcastle local municipality	3.45	No	(4953267	/	1435920)	55.39 %	74.24 %
2	kz Dannhauser local municipality	6.21	No	(2223905	/	358092)	24.87 %	18.51 %
3	kz Emadlangeni local municipality	12.60	No	(1764723	/	140088)	19.74 %	7.24 %

3.2.5 Key and vulnerable populations

Figure 21 is a reflection of under 18-year-old girls that deliver in facilities. This is a proxy for teenage pregnancies in the community. The indicator definition is included in Appendix B. Due to the small numbers at a local level, it is not included at ward level in this report. See notes on small numbers in Appendix A.

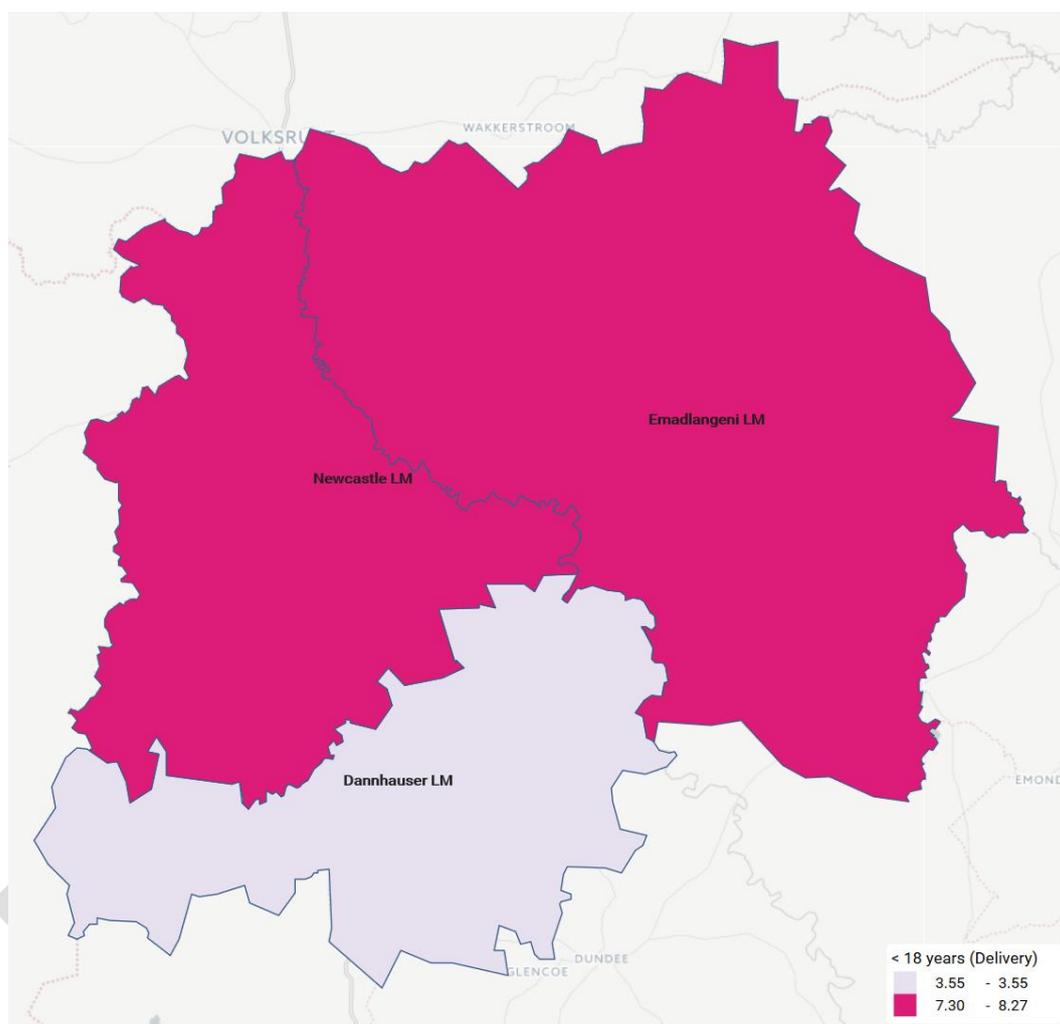


Figure 21: Teenage Pregnancy rate Amajuba district (Source: KZN DHIS 2015)

Table 18: Teenage Pregnancy rate Amajuba district (Source: KZN DHIS 2015 report 26 June 2017)

KZ AMAJUBA DISTRICT MUNICIPALITY: 8.1 %								
	local municipality	2015 : < 18 years (Delivery)					NUM %	DEN %
1	kz Dannhauser local municipality	3.55	%	(5	/	141)	0.68 %	1.56 %
2	kz Emadlangeni local municipality	7.30	%	(43	/	589)	5.87 %	6.54 %
3	kz Newcastle local municipality	8.27	%	(685	/	8280)	93.45 %	91.90 %

Table 19 reflects different discussions during the community engagement that relates to key and vulnerable populations specifically.

Table 19: Key and vulnerable population groups

Key and vulnerable population group	Stakeholder and community feedback
Young Women and Girls	Girls are the most vulnerable population in Emfundweni. They have no reason to stay in school and compete to have babies early. Having a baby early shows that you can bear children, you can get a grant and you don't have to finish school. Also, the boy's family support the child and the mother. Girls drink too much too early and have unprotected sex very young. They learn to use sex to get material things
Teen Mothers	Young girls don't use contraception and are forced by the society to leave school when they are pregnant. There are no opportunities so they rely on the grants and their families to raise their children.
Youth	Young people in Emfundweni have no opportunities to study or work so they drink and have sex. There is no access for Dannhauser people at the Newcastle TVET, it is too far and there is no money for fees and accommodation.
People Living with HIV (and their caregivers)	There is no status disclosure in families so PLHIV live in secrecy making it difficult for them to adhere to treatment. Also, when their elders do start looking after them the elders don't practice safety and get infected accidentally.
Disabled	Disabled children are not supervised and are exploited sexually by neighbours and other community members. They don't have facilities or programmes.
Contract workers	During infrastructure projects such as electrification and water and roads contract workers come in from other areas and exploit the poverty of young girls in Emfundweni.

3.3 Social and structural factors that influence HIV and TB risk

3.3.1 Orphan hood

In 2011, the proportion of orphans was especially high in the rural Wards. High level of HIV prevalence in KZN had been associated with high proportion of orphans¹⁴, albeit at provincial level. The detail for Ward 11 that forms the catchment area for Emfundweni Clinic, are highlighted in the table below.

Table 20: Orphan hood for Census 2011 at Ward level in Dannhauser local municipality

Ward	Maternal orphans			Paternal orphans			Double orphans		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Ward 1	89	74	163	338	322	660	107	119	226
Ward 2	49	54	104	157	198	355	44	71	115
Ward 3	95	107	202	334	310	644	168	169	336
Ward 4	115	96	211	314	288	602	148	130	278
Ward 5	91	83	174	252	281	533	118	103	220
Ward 6	138	117	255	355	321	676	163	140	303
Ward 7	97	84	181	342	284	626	128	152	279
Ward 8	115	106	221	288	328	617	172	140	312
Ward 9	128	139	267	290	325	615	156	162	318
Ward 10	169	150	319	402	371	773	149	149	299
Ward 11	89	121	210	356	394	750	186	141	327

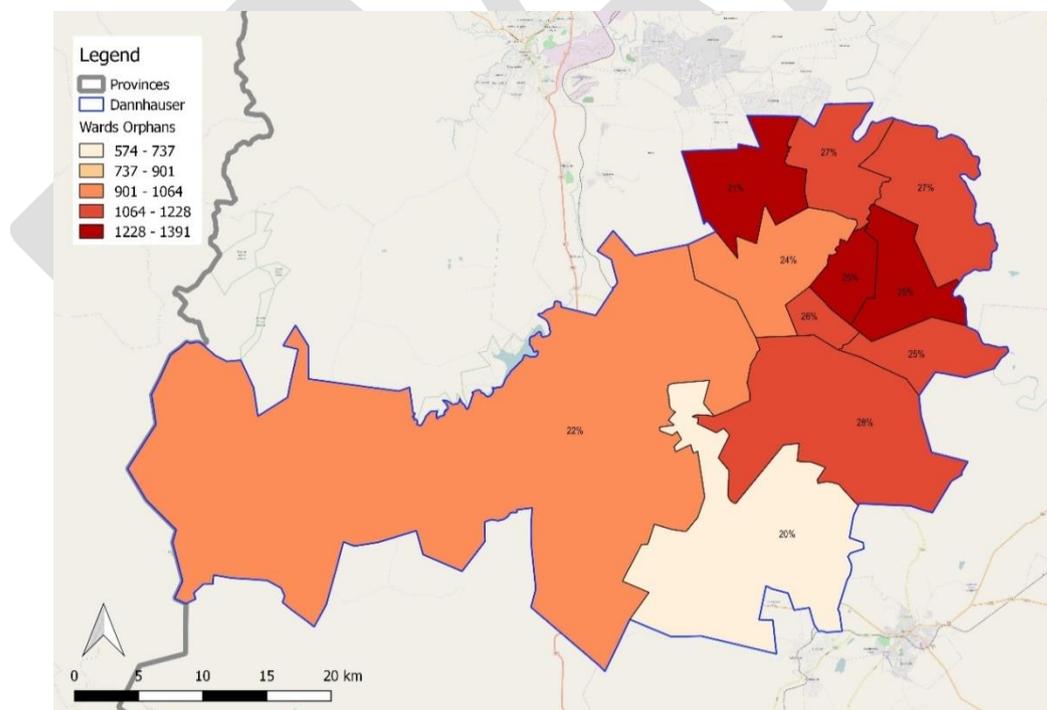


Figure 22: Total number of Orphans with percentage that are double orphans per ward (Source Census 2011)

¹⁴ Shisana, O., T. Rehle, et al. (2014). South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press.

Although there are not many or it is unknown how many orphans live in Emfundweni it is believed that **Orphans and vulnerable children** are taken advantage of because of their poverty

3.3.2 Cultural and Religious Norms

Stakeholder and community engagement workshops revealed the following about **cultural and religious norms**:

- The sharing of razors and blades for cultural practices spreads HIV;
- The Shembe church used to force young girls into marriage with older polygamous men but that practice is not applicable anymore; and
- Ukuluya or Muti murders do happen because there are areas that are not safe. This spreads HIV because HI positive people are killed and infection can happen.

3.3.3 Gender norms and gender-based violence

Stakeholder and community engagement workshops revealed the following about **gender norms and gender-based violence** in the area

- All women, young, old and wives cannot tell men to use condoms. The men decide what they want;
- Sugar daddies are infected but they don't know but they don't care because young girls cannot tell them to use condoms; and
- The traditional council in uMzinyathi is very good with gender-based violence but they don't consider HIV infection when they are sanctioning abusers.

3.3.4 Stigma

Stakeholder and community engagement workshops revealed the following about **stigma** and how this affects HIV in the area:

- Stigma in other facilities makes people come to Emfundweni because the clinic staff are open. This is especially for people who are not virally suppressed. This is a problem because these people default as they don't have money for transport always;
- Older people judge young people when they want to get condoms;
- Youth are scared to disclose they are sexually active because their parents won't approve;
- There is stigma against LGBTIQ so they don't test; and
- People disclose among themselves but they run away from the clinic because their neighbours and family members will recognise them.

3.3.5 Poverty

Poverty is measured through the South Africa Multidimensional Poverty Index (SAMPI)¹⁵. The detail for Ward 11 that forms the catchment area for Emfundweni Clinic, are highlighted in the table below.

Table 21: Poverty measures for Census 2011 at Ward level in Dannhauser local municipality

	Poverty Headcount (H)	Intensity of Poverty (A)	SAMPI (HxA)
kz Dannhauser Ward 001	4.9	39.2	0.0192
kz Dannhauser Ward 002	6.7	40.9	0.0274
kz Dannhauser Ward 003	15.5	43.3	0.0671
kz Dannhauser Ward 004	16.5	41.5	0.0685
kz Dannhauser Ward 005	14.5	40	0.0580
kz Dannhauser Ward 006	15.3	42.4	0.0649
kz Dannhauser Ward 007	12.8	41.2	0.0527
kz Dannhauser Ward 008	13	41.8	0.0543
kz Dannhauser Ward 009	10.6	41.7	0.0442
kz Dannhauser Ward 010	8.9	41.1	0.0366
kz Dannhauser Ward 011	12.9	41.7	0.0538
kz Dannhauser	12	41.3	0.0496

Ward 4 was the poorest Ward in Dannhauser local municipality with 16.5 being poor (Table 21, Appendix B). The greatest contributors to high poverty measures in KZN are health (measured by child mortality) and education (measured by years of schooling and school attendance). The Multidimensional Poverty Index for Dannhauser local municipality changed between 2001 (Figure 23) and 2011 (Figure 24). In 2001 the highest Poverty Index was 16.56. This reduced to 6.85 in 2011.

In the catchment area for Emfundweni clinic, the poverty headcount is at 12.9% with an intensity of 42%, making it the fifth highest in Dannhauser local municipality. This is visible with the darker shading in Figure 26 for the SAMPI poverty headcount for the ward level.

¹⁵ SAMPI is the product of the headcount (proportion of households defined as multi-dimensionally poor using the poverty cut-off) and intensity of poverty (average proportion of indicators in which poor households are deprived). The SAMPI constitutes weighted education, health, assets, and economic activity (unemployment rates) indicators.

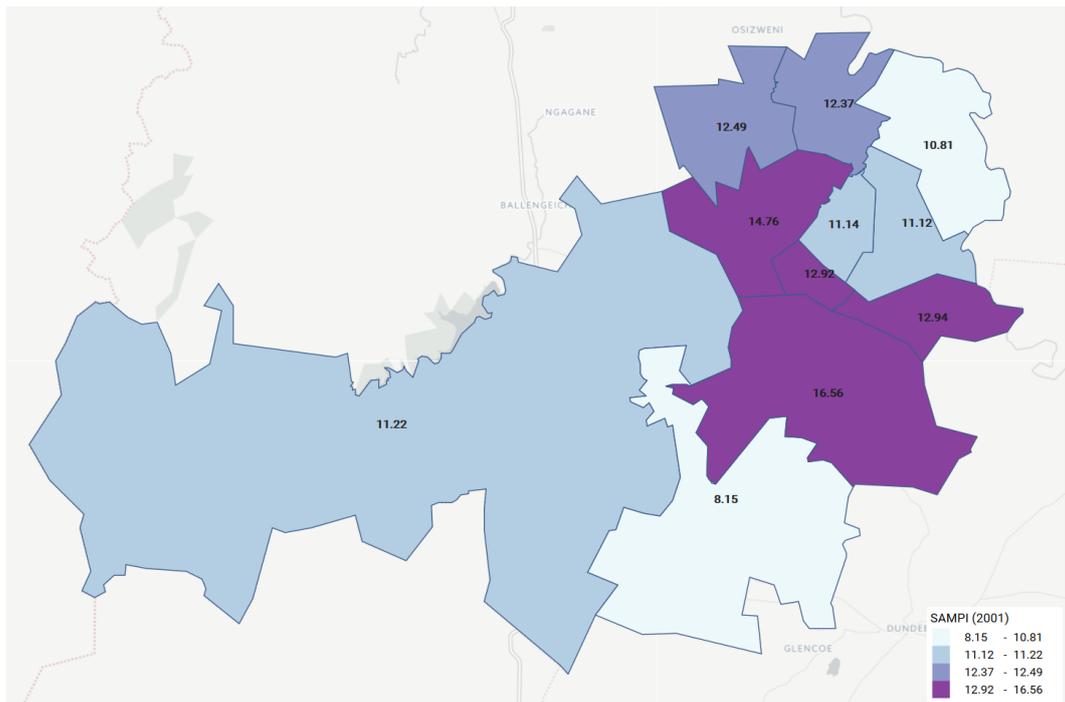


Figure 23: SAMPI (poverty Index) 2001 - ward level, Dannhauser local municipality

Table 22: SAMPI (poverty Index) 2001 - ward level, Dannhauser local municipality

KZ DANNHAUSER LOCAL MUNICIPALITY: 12.4 %					
	Ward (2011)	SAMPI (2001)			
1	kz Dannhauser Ward 002	8.15	%	(8.2	/ 100)
2	kz Dannhauser Ward 008	10.81	%	(10.8	/ 100)
3	kz Dannhauser Ward 006	11.12	%	(11.1	/ 100)
4	kz Dannhauser Ward 011	11.14	%	(11.1	/ 100)
5	kz Dannhauser Ward 001	11.22	%	(11.2	/ 100)
6	kz Dannhauser Ward 009	12.37	%	(12.4	/ 100)
7	kz Dannhauser Ward 010	12.49	%	(12.5	/ 100)
8	kz Dannhauser Ward 007	12.92	%	(12.9	/ 100)
9	kz Dannhauser Ward 004	12.94	%	(12.9	/ 100)
10	kz Dannhauser Ward 005	14.76	%	(14.8	/ 100)
11	kz Dannhauser Ward 003	16.56	%	(16.6	/ 100)

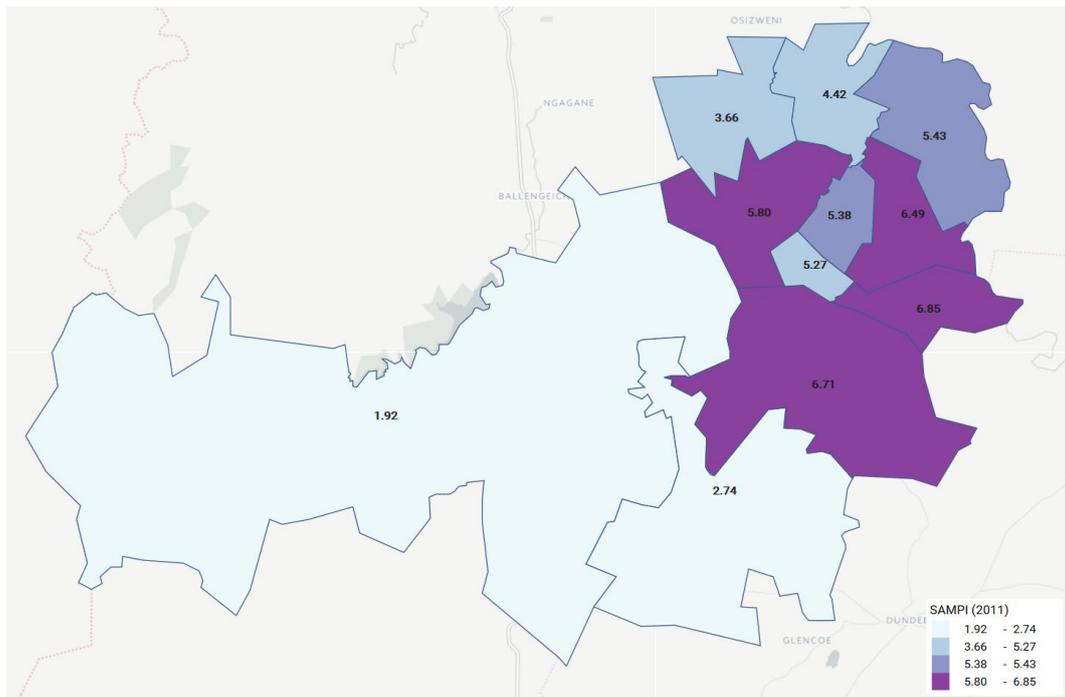


Figure 24: SAMPI (poverty Index) 2011 - ward level, Dannhauser local municipality

Table 23: SAMPI (poverty Index) 2011 - ward level, Dannhauser local municipality

KZ DANNHAUSER LOCAL MUNICIPALITY: 5.4 %					
	Ward (2011)	SAMPI (2011)			
1	kz Dannhauser Ward 001	1.92	%	(1.9	/ 100)
2	kz Dannhauser Ward 002	2.74	%	(2.7	/ 100)
3	kz Dannhauser Ward 010	3.66	%	(3.7	/ 100)
4	kz Dannhauser Ward 009	4.42	%	(4.4	/ 100)
5	kz Dannhauser Ward 007	5.27	%	(5.3	/ 100)
6	kz Dannhauser Ward 011	5.38	%	(5.4	/ 100)
7	kz Dannhauser Ward 008	5.43	%	(5.4	/ 100)
8	kz Dannhauser Ward 005	5.80	%	(5.8	/ 100)
9	kz Dannhauser Ward 006	6.49	%	(6.5	/ 100)
10	kz Dannhauser Ward 003	6.71	%	(6.7	/ 100)
11	kz Dannhauser Ward 004	6.85	%	(6.8	/ 100)

It is important to note that changes between the 2001 (Figure 25) and 2011 (Figure 26) for SAMPI at ward level. In 2001 the highest headcount amongst the wards in Dannhauser was 37.9. This reduced to 16.5 in 2011.

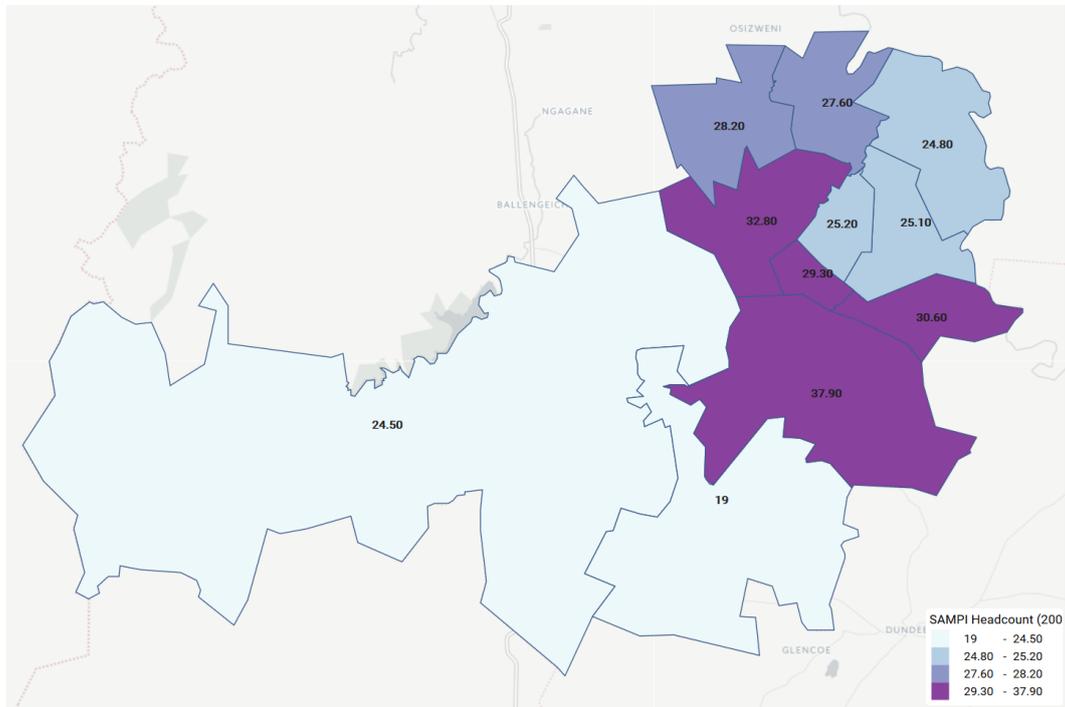


Figure 25: SAMPI 2001 poverty headcount - ward level, Dannhauser local municipality

Table 24: SAMPI 2001 poverty headcount - ward level, Dannhauser local municipality

KZ DANNHAUSER LOCAL MUNICIPALITY: 27.6 %			
	Ward (2011)	SAMPI Headcount (2001)	
1	kz Dannhauser Ward 002	19	% (19 / 100)
2	kz Dannhauser Ward 001	24.50	% (24.5 / 100)
3	kz Dannhauser Ward 008	24.80	% (24.8 / 100)
4	kz Dannhauser Ward 006	25.10	% (25.1 / 100)
5	kz Dannhauser Ward 011	25.20	% (25.2 / 100)
6	kz Dannhauser Ward 009	27.60	% (27.6 / 100)
7	kz Dannhauser Ward 010	28.20	% (28.2 / 100)
8	kz Dannhauser Ward 007	29.30	% (29.3 / 100)
9	kz Dannhauser Ward 004	30.60	% (30.6 / 100)
10	kz Dannhauser Ward 005	32.80	% (32.8 / 100)
11	kz Dannhauser Ward 003	37.90	% (37.9 / 100)

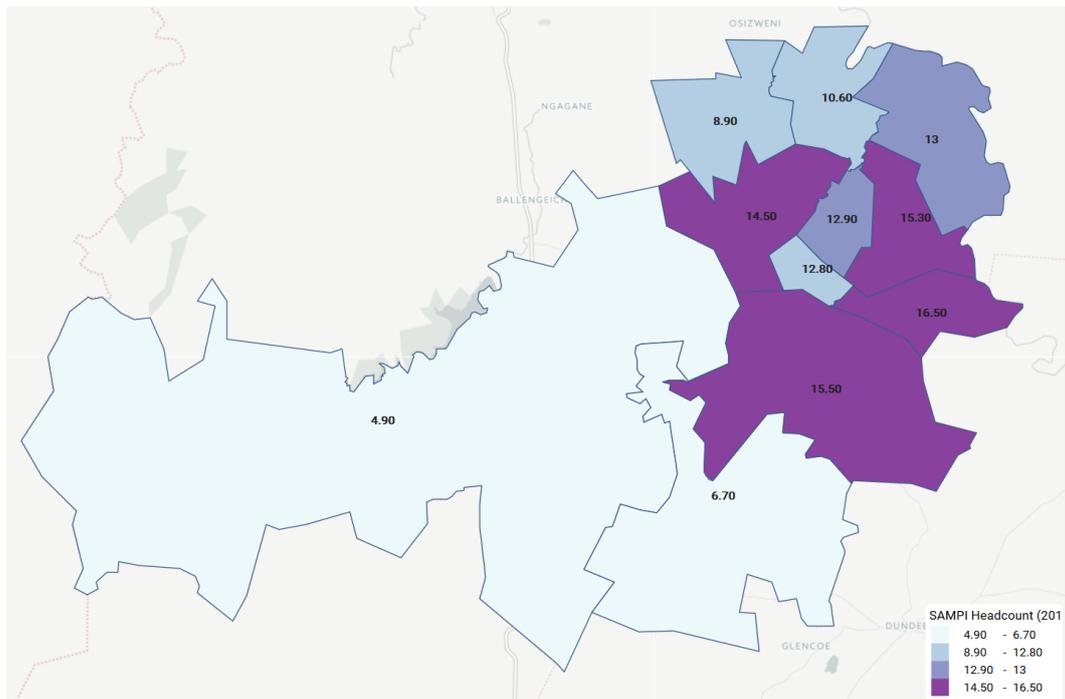


Figure 26: SAMPI 2011 poverty headcount - ward level, Dannhauser local municipality

Table 25: SAMPI 2011 poverty headcount - ward level, Dannhauser local municipality

KZ DANNHAUSER LOCAL MUNICIPALITY: 12.9 %						
	Ward (2011)	2015 : SAMPI Headcount (2011)				
1	kz Dannhauser Ward 001	4.90	%	(4.9	/	100)
2	kz Dannhauser Ward 002	6.70	%	(6.7	/	100)
3	kz Dannhauser Ward 010	8.90	%	(8.9	/	100)
4	kz Dannhauser Ward 009	10.60	%	(10.6	/	100)
5	kz Dannhauser Ward 007	12.80	%	(12.8	/	100)
6	kz Dannhauser Ward 011	12.90	%	(12.9	/	100)
7	kz Dannhauser Ward 008	13	%	(13	/	100)
8	kz Dannhauser Ward 005	14.50	%	(14.5	/	100)
9	kz Dannhauser Ward 006	15.30	%	(15.3	/	100)
10	kz Dannhauser Ward 003	15.50	%	(15.5	/	100)
11	kz Dannhauser Ward 004	16.50	%	(16.5	/	100)

Stakeholder and community engagement workshops revealed the following about **poverty** and how this affects HIV in the area:

- PLHIV heads of households cannot provide so they have unprotected sex because they can't negotiate condoms;
- Young people have sugar daddies and mama's because they don't have food and other material things; and
- Orphans and child headed households are forced into having sex for money.

3.3.6 Employment

In Dannhauser local municipality, 16% of the female population at economically active age is employed while 21% of the economically active males are employed. See Figure 27 below.



Figure 27: Female and Male employment Dannhauser local municipality (Source Census 2011)

Unemployment of youth in Dannhauser local municipality is at 86.2%. The majority of the youth in the area was therefore unemployed at the time of the Census.

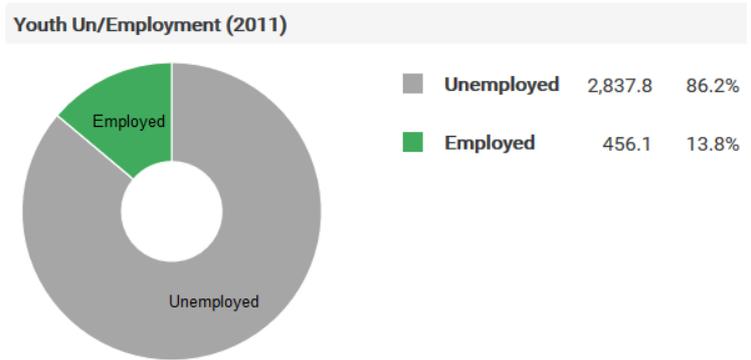


Figure 28: Youth unemployment Dannhauser local municipality (source Census 2011)

In comparison with the Dannhauser local municipality a bigger percentage of females and males are unemployed from the total population in the Emfundweni clinic catchment area. In this area 89% of the female population and 86% of the male population is unemployed (see Figure 29)



Figure 29: Female and Male employment Emfundweni clinic catchment area (Source Census 2011)

Less youth (8.5%) are employed in the Emfundweni clinic catchment area than the Dannhauser local municipality (13.8%).

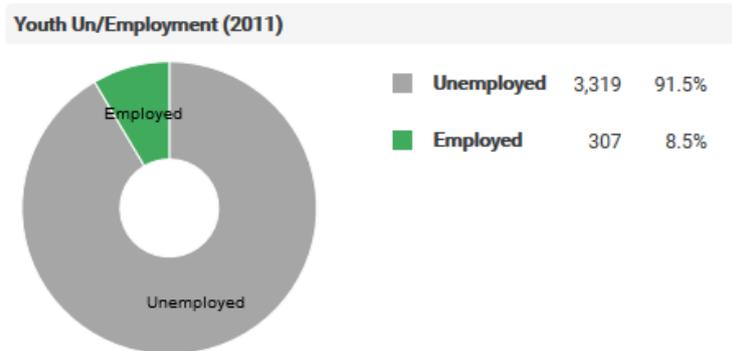


Figure 30: Youth unemployment Emfundweni clinic catchment area (source Census 2011)

During the stakeholder and community engagement workshops the following was said about **employment** and how this affects HIV and TB in the area:

- When you finish matric there is no jobs, no hope. The only jobs are in town at the post office and library and so being blessed is the only route to income; and
- When people look for work they hike to Newcastle and must pay for their lift with sex often without condom.

3.3.7 Types of settlements

Stakeholder and community engagement workshops felt that the **types of settlements** have the following influences in the area:

- We have lots of space there is no impact of space on HIV but it is unsafe to live so far apart; and
- The farm areas are not safe for children they get raped and murdered (ukuluya) because there are no shops and the distance to shops is far.

3.3.8 Migration patterns in the area

The community reported very low levels of internal and external migration. References were made to Somali shop owners forming relationships with young girls and the role played by infrastructure contract workers but there seemed to be little impact of migration on HIV according to the community.

3.3.9 Education and literacy

The community noted some concerning patterns in school completion and further education and training:

- Children drop out of school in grade 10/11 because they want to work for their families but they only get piece work;

- When girls fall pregnant they leave school. The boy also leaves school to go to work to provide for the baby;
- Drugs like Wonga stop children from finishing school;
- The FET's are full and the youth from Emfundweni are excluded in Newcastle because they don't see the adverts and can't afford the transport to Newcastle; and
- There is no special school for disabled children so they drop out.

3.3.10 Hate crimes – xenophobic, homophobic, other

The community acknowledged a high level of tolerance to foreign nationals but also confirmed significant intolerance for people from the LGBTIQ community to the extent that one person acknowledged that “gay men (but not lesbian women) get beaten and raped”

3.3.11 Disability

Stakeholder and community engagement workshops felt that the *people with disability* have an increased risk of HIV infection because:

- Disabled people get raped because there is no adult supervision when they are left at home in the day;
- Intellectually disabled people can't access Department of Social Development programmes;
- Because there is no special school for disabled children they are uneducated and live at home with no stimulation or supervision (they get exploited); and
- The community further noted that CCG's are pivotal in reporting and supporting disability that is hidden.

4. Services in the local municipality

4.1 Health facilities

There are 11 health facilities in Dannhauser local municipality. See Figure 31 below for distribution of these facilities.

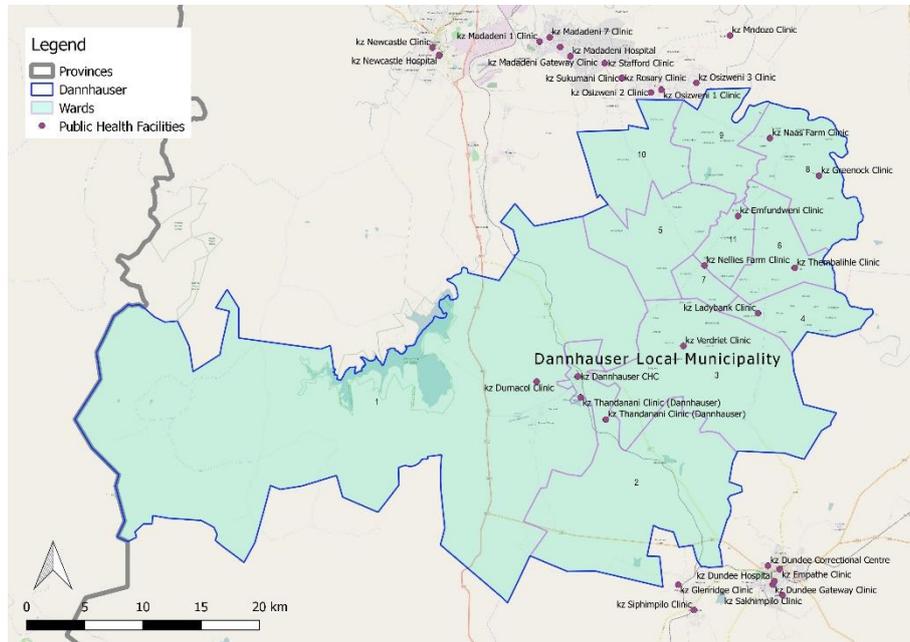


Figure 31: Distribution of health facilities in Dannhauser local municipality

5. Recommendations for multi-sectoral interventions and focus on key and vulnerable populations

Based on the priorities identified in the profile for high burden areas, a mechanism needs to be put in place to coordinate the multi-sectoral response at the various levels. This is to ensure a comprehensive approach and to build sustainability of the response with local ownership.

Coordination of the multi-sectoral interventions at the level of implementation would result in:

- increased access to available resources;
- more efficient use of resources;
- enhancement of accountability;
- development of innovative implementation strategies and modalities;
- broadened awareness about the priorities highlighted in the risk profile;
- development of new partnerships to render services;
- sustainable development of activities;
- broadened sharing of responsibility for different, yet related activities;
- stronger ownership by stakeholders;
- use of strengths of different partners; and
- sharing of new knowledge and lessons learnt.

Process for development and implementation of multi-sectoral HIV, TB and STI intervention packages through existing multi-sectoral coordination structures e.g. AIDS Councils, OSS war rooms:

1. Update community profiles with directory of existing services e.g. rendered by government, NGO, donor funded organisations. This will be used to determine resources and programmes already available to address the priorities in the community profile as well as resource and programme gaps that exist;
2. Communicate and validate the profiles through meetings with government, private and civil society organisations in the specific geographical area;
3. Present the profile findings and recommendations for multi-sectoral interventions to the multi-sectoral structure for validation of findings, prioritization of programmatic gaps and linkage with existing resources (final decision on resource allocation should be requested through appropriate channels, e.g. government processes, Global Fund etc.);
4. For gaps prioritised, identify possible service providers and interventions that can address the needs following the relevant government or donor processes and procedures (depending on source of funding);
5. Provincial, district and local coordination structures to coordinate an implementation plan with clear activities, timelines and responsible stakeholders that aligns with the profile. This will form the foundation for tracking performance and progress against the implementation plan; and

6. Further and focused engagement to be done with the Young women and girls group identified as the priority population in this area to have a detailed understanding of their specific risks.

Considering the priorities identified during the stakeholder and community workshops as well as the general profile, the following service delivery packages are recommended in line with the National Strategic Plan for HIV, TB and STIs (2017 to 2022) and other relevant strategic documents. These service delivery packages need to be unpacked and included in the implementation plan referred to above based on the existing resource envelop in the District and local municipality . Priority is given to the key and vulnerable populations identified, followed by other interventions identified in the NSP. Table 26 summarises the key and vulnerable populations as well as priority interventions identified during the development of the community profile. Due to the importance of TB as the main cause of death in the district, it is included in the priority interventions.

Table 26: Key and vulnerable populations as well as priority interventions identified

Key and vulnerable populations for TB	Priority interventions
<ul style="list-style-type: none"> • People living with HIV • Household contacts of TB index patients • Health care workers • Pregnant women • Children < 5 years old • Diabetics • People living in informal settlements 	<ul style="list-style-type: none"> • TB contact tracing, testing and post-exposure management • Enhanced health education about HIV/TB co-infection, reinfection • Service delivery and treatment delivery points in community, non-traditional settings
Key and vulnerable populations for HIV	Priority interventions
<ul style="list-style-type: none"> • Young Women and Girls • Young Boys and Men • Unemployed Youth 	<ul style="list-style-type: none"> • Poverty, especially livelihoods support, to mitigate transactional sex as a source of income • Keeping girls in school irrespective of pregnancy • Gender Norms and Gender-based Violence, particularly aspects of consent, reporting and GBV support coverage • Parenting Support to ensure consistent sexuality education messaging between school and home • Support to Teen mothers to enrol in and adhere to PMTCT, return to school and access services to support children • Youth unemployment to mitigate transactional sex as a source of income • Improved monitoring of and access to services for disabled persons to retain them care and support

Key and vulnerable populations for TB	Priority interventions
	<ul style="list-style-type: none"> • Substance abuse, particularly among youth • Improved safety and security in open spaces and community education on child protection • Follow-up and counselling for VMMC, particularly management of adverse events and HIV prevention • Targeted location specific HIV prevention interventions with contract workers on big infrastructure projects • Community education, communication and linkage to support services for students at TVET colleges and other learning institutions

DRAFT

Table 27: Service packages Shakaskraal clinic catchment area

Inclusive package of services for all key and vulnerable populations that will be customised to age and population served	Multi-sectoral partner
<ul style="list-style-type: none"> • Service delivery in non-traditional settings, including after-hours and weekend hours • Health information, customised to client needs • Sexual and reproductive health services • HIV screening, testing and treatment • STI screening, treatment • TB screening, treatment (including preventive therapy) and contact tracing for DS- and DR-TB • Mental health screening and psychosocial support • Access to PEP and post-sexual assault support • Alcohol and drug use screening and referral to harm reduction services • Violence screening and referral to psychosocial and other support services • Condom and lubricant promotion and provision • Targeted social and behaviour change communication • Core rights-based programme components: <ul style="list-style-type: none"> ○ Human rights and constitutional protection ○ Health empowerment ○ Economic empowerment ○ Gender norms and equality ○ Justice ○ Principles of universal design and accommodation that enables reasonable access for persons with disabilities 	<ul style="list-style-type: none"> • NGOs • DoH • DSD • DBE • NPA • PCA, DAC, LAC • SAPS • DOT
HIV and STI vulnerable populations	
Adolescent girls and young women	<ul style="list-style-type: none"> • Peer-led outreach • Youth-friendly sexual and reproductive health services in schools and community settings which include: <ul style="list-style-type: none"> ○ PrEP (for over 18 years olds) ○ Complete two dose HPV vaccine (Grade 4 learners) ○ PMTCT ○ Choice of termination of pregnancy

Inclusive package of services for all key and vulnerable populations that will be customised to age and population served		Multi-sectoral partner
	<ul style="list-style-type: none"> ○ Family planning services ○ Male and female condom provision in school ○ Sanitary towels ● Programmes to keep girls in schools, including support for pregnant learners ● Access to peer groups and clubs ● Access to parenting programmes ● Economic empowerment programmes ● Increased access to further education opportunities ● Increased access to mentorship and internships ● Comprehensive sexuality and gender education ● Provide reasonable accessibility for girls and young women with disabilities ● Age-specific support to HIV-positive adolescents (support for disclosure, adherence) 	
Children and orphans and vulnerable children	<ul style="list-style-type: none"> ● Health education, with a particular focus on sexual exploitation in the absence of primary caregivers ● Accelerated nutritional and social grant support ● Youth-friendly sexual and reproductive health services in schools and community settings which include: <ul style="list-style-type: none"> ○ HPV vaccination ○ Contraceptives including condoms ○ Choice of termination of pregnancy ● Comprehensive sexuality education in residential, school and non-school and youth-friendly settings ● Intensive psychosocial support ● Gender norms education, including risk reduction in relation to age-disparate relationships ● School retention 	<ul style="list-style-type: none"> ● DSD ● DBE ● DoH
TB key populations		
Household contacts of TB index	<ul style="list-style-type: none"> ● Implement simplified screening algorithms for TB-exposed children 	<ul style="list-style-type: none"> ● DoH

Inclusive package of services for all key and vulnerable populations that will be customised to age and population served		Multi-sectoral partner
patients	<ul style="list-style-type: none"> • Implement community education and mobilisation programmes to improve acceptance of contact investigations and to create awareness of the benefits of preventive therapy • Strengthen routine M&E for TB contact investigations, HIV testing, TB preventive therapy including outcomes, and pharmacovigilance 	<ul style="list-style-type: none"> • NGOs
People living with HIV	<ul style="list-style-type: none"> • Prompt ART initiation as a component of TB prevention • Adherence and psychosocial support • Peer education and support for TB prevention and treatment • Optimal uptake of preventive therapy for TB • Infection control in facilities, communities and households • TB symptom screening at each visit, linkages to treatment and care • HIV screening for household members, including partners and children • Cohort monitoring of HIV/TB co-infected patients • Support groups specifically addressing internalised stigma 	<ul style="list-style-type: none"> • DoH
Pregnant women and neonates	<ul style="list-style-type: none"> • Full access to PMTCT services • Household TB and HIV screening, immediate linkage to treatment • Improve mother–child pair tracing and service delivery • Improve TB screening and testing among pregnant women to reduce congenital and perinatal TB transmission • Improve diagnostic and treatment capacity for neonatal TB 	<ul style="list-style-type: none"> • DoH • NGOs • DSD

Comprehensive package of services for the general population, that will then be supplemented and customised to the age and population served	Multi-sectoral partner
<ul style="list-style-type: none"> • Accessible, friendly, comprehensive service delivery and health education, customised to client needs • HIV screening, testing, treatment • STI screening, testing, treatment • TB screening, testing, treatment and contact tracing for DS- and DR-TB • Medical male circumcision, referral • Comprehensive SRH services (including: cervical cancer screening, Pap smears, access to emergency contraception, choice of termination of pregnancy) • Prevention of mother-to-child transmission (PMTCT) of HIV • Mental health screening and psychosocial support • Access to PEP and post-sexual assault support • Alcohol and drug-use screening, referral • Violence screening, referral • Condom promotion and provision • Targeted social and behaviour change communication 	<ul style="list-style-type: none"> • All implementing agencies • DoH • DSD • NPA • DBE • NGOS • PCA and DAC

Population	Services/Interventions/Approaches	Setting	Multisectoral partner
Children	<ul style="list-style-type: none"> • Child abuse screening • Age-appropriate HIV testing, treatment, adherence support • Support for disclosure of HIV status • HIV testing of household adult or adolescent index client • Contact tracing from adult, adolescent TB cases • Sputum induction for TB testing • Update hospital admission requirements for DR-TB treatment • Comprehensive sexuality education: Sexuality, puberty education, gender and empowerment, GBV, reproductive health, contraception, alcohol and drug use prevention, decision-making, self-esteem 	<ul style="list-style-type: none"> • Health facility-based • School-based • Community-based • Mobile services 	<ul style="list-style-type: none"> • DoH • DBE • DSD • CBOs • NGOs • Private employers • Private healthcare providers
PLHIV (adults, adolescents)	<ul style="list-style-type: none"> • Hearing and vision screening, referral, treatment • Partner HIV testing, disclosure support, treatment, adherence support • Hepatitis B and HPV vaccine where eligible • PMTCT and enhanced adherence support through pre- and post-natal period, including breastfeeding • Gender norms • Health and health rights literacy • Economic empowerment and health promotion • School retention • Accelerated nutritional and social grant support, if indicated • Targeted demand creation for services • Targeted, PLHIV-friendly IEC materials and SBCC, including social media and materials for those with vision and hearing impairment • Service delivery points in community, non-traditional settings 	<ul style="list-style-type: none"> • Health facility-based • School-based • Community-based • Mobile services 	<ul style="list-style-type: none"> • DoH • DBE • DCS • DSD • CBOs • NGOs • Private employers • Private healthcare providers
Persons with TB (adults, adolescents)	<ul style="list-style-type: none"> • TB contact tracing, testing and post-exposure management • Partner HIV testing, disclosure support, treatment, adherence support • Enhanced health education about HIV/TB co-infection, reinfection • Hearing and vision screening, referral, treatment • Hepatitis B and HPV vaccine where eligible 	<ul style="list-style-type: none"> • Clinic-based • School-based • Community-based • Mobile services 	<ul style="list-style-type: none"> • DoH • DBE • DCS • DSD • CBOs

Population	Services/Interventions/Approaches	Setting	Multisectoral partner
	<ul style="list-style-type: none"> • PMTCT and enhanced adherence support through pre- and post-natal period, including breastfeeding, if indicated • Mental health screening • Gender norms education • Health and health rights literacy • Economic empowerment and health promotion • School retention • Accelerated nutritional and social grant support, if indicated • Targeted, TB-friendly IEC materials and SBCC, including social media and materials for those with vision and hearing impairment • Service delivery and treatment delivery points in community, non-traditional settings 		<ul style="list-style-type: none"> • NGOs • Private employers • Private healthcare providers
Discordant couples	<ul style="list-style-type: none"> • Partner HIV testing, disclosure support, treatment, adherence support • Hepatitis B and HPV vaccine where eligible • PMTCT and enhanced adherence support through pre- and post-natal period, including breastfeeding if pregnant and HIV-positive • Gender norms • Health and health rights literacy • Economic empowerment and health promotion • Accelerated nutritional and social grant support, if indicated • Targeted demand creation for services 	<ul style="list-style-type: none"> • Clinic-based • Community-based • Mobile services 	<ul style="list-style-type: none"> • DoH • DCS • DSD • CBOs • NGOs • Private employers • Private healthcare providers

Generic HIV, TB and STI prevention, management and care		
Focus	Activities	Multi-sectoral partner
Promote retention in care for all PLHIV on ART	<p>This will be supported and strengthened by:</p> <ul style="list-style-type: none"> • Increased efforts to implement the test and treat policy at facility level through the DIP process • Increased quality assurance to promote adherence to guidelines 	<ul style="list-style-type: none"> • DoH • DoT • Dept. of Agriculture • Private Sector

Generic HIV, TB and STI prevention, management and care		
Focus	Activities	Multi-sectoral partner
	<ul style="list-style-type: none"> • Expansion of implementation strategies to include community based ART initiation demonstration projects for well patients, including the use of GPs • Prioritise rapid and same day ART initiation • Implement extended hours services for working people and adolescents • Use PLHIV in health facilities and communities to encourage linkage to care • Explore innovative ways to improve patients' linkage to services • Differentiated ART delivery for stable patients, including a minimum of 3 months drug supply and optimised prescription periods to meet the needs of key and vulnerable populations and improve adherence • Ensure a functional fast lane for collection of repeat drug prescriptions at all pharmacies • Use of approved patient representatives to collect ART refills • Expand of the Central Chronic Medicine Dispensing and Distribution programme • Implementation of a return friendly system in all facilities • Track and improve the management of chronic diseases and their complications, as the population on ART ages 	<ul style="list-style-type: none"> • Civil society (PLHIV sector)
Improve adherence support	<ul style="list-style-type: none"> • Implementation of a comprehensive and age appropriate psychosocial package to enhance adherence • Promoting the establishment of peer-led differentiated support groups for new and stable patients • Ensuring their linkages to psychosocial support. 	<ul style="list-style-type: none"> • DSD • DoH • Private Sector
Intensified facility-level TB case-finding	<ul style="list-style-type: none"> • Passive case-finding (test individuals presenting with symptoms of TB • Routine symptom screening for all adult clinic attendees • Undertaking Xpert MTB/RIF test for symptomatic individuals not tested for TB in the last 3 months and undertaking culture test for HIV+, Xpert-negative cases 	<ul style="list-style-type: none"> • DoH • Private healthcare providers
Improve laboratory diagnostics to deliver optimal DS and DR-TB services	<ul style="list-style-type: none"> • Universal implementation of Xpert MTB/RIF as initial diagnostic tests • Monitoring and optimising implementation of all existing algorithms • Implementing robust reflex testing for samples found to be Xpert RIF resistant • Developing a platform for introduction of new diagnostics 	<ul style="list-style-type: none"> • DoH

Generic HIV, TB and STI prevention, management and care		
Focus	Activities	Multi-sectoral partner
	<ul style="list-style-type: none"> • Prepare and train on guidelines and algorithms in advance of Xpert Ultra introduction • Upgrade the laboratories to ensure sufficient second line LPA coverage to ensure optimal implementation of MDR-TB short regimen • Implement lessons learnt from Xpert rollout • All labs doing second line LPA should be either able to conduct phenotypic second line drug sensitivity testing or have easy referral to a lab that has this capability. 	
Active case-finding for key and vulnerable populations	<ul style="list-style-type: none"> • Screening of household contacts under 5 years of age • Intensified TB screening and access to appropriate treatment in correctional facilities, mines, informal settlements and antenatal clinics and for diabetics, PLHIV, health care workers and all household contacts • Contact tracing for all household members of TB index cases • Routine screening for health care workers • TB screening and testing among pregnant women to reduce congenital and perinatal TB transmission • Improved paediatric sputum induction at PHC and hospital level. 	<ul style="list-style-type: none"> • DoH • NGOs and CBOs working in this area • DBE • DSD • Private healthcare providers
Reduce initial loss to follow-up rates for DS and DR TB cases	<ul style="list-style-type: none"> • Retrain staff and implement on-going clinical governance using QI approach • Establish initial loss to follow-up rate as a management priority as part of the DIP process • Reduce duration and number of visits from symptom onset to treatment initiation. 	<ul style="list-style-type: none"> • DoH • Districts • Facilities • Development partners
Provide standard care for DS-TB cases	<ul style="list-style-type: none"> • Provision of adherence support and retention of patients in care for treatment duration including referral for psychosocial support as needed • Bacteriological monitoring of treatment outcomes and implementation of recommendations from reviews • National research priority studies to determine what health facility and programme management interventions impact on treatment outcomes, whether alternative drug dispensing strategies affect adherence and patient 	<ul style="list-style-type: none"> • DoH • Civil society (PLHIV, PTB sectors) • NGOs

Generic HIV, TB and STI prevention, management and care		
Focus	Activities	Multi-sectoral partner
	<p>outcomes and what clinical management and adherence support strategies improve treatment outcomes?</p> <ul style="list-style-type: none"> The multi-sectoral TB Think Tank using the findings to timeously review and update policies. 	
Scale up short-course MDR-TB treatment and provide decentralised MDR-TB care	<ul style="list-style-type: none"> Training and mentoring of staff on these at PHC level and referral centres Adaptation of the EDR to accommodate new regimens Monitoring the initiation rate of patients on the new regimen as part of the DIP process to optimise uptake Provision of psychosocial support to patients who need it. 	<ul style="list-style-type: none"> DoH
Implement a quality improvement (QI) initiative to close gaps in the TB care cascade and improve programme outcomes.	<ul style="list-style-type: none"> Development of DoH capacity to undertake QI (district and sub-district teams established; leadership and QI skills developed; tools and guidelines developed; learning networks established) with demonstration sites for QI established All implementing partners to implement TB QI projects Then undertake district baseline assessments and set targets for national scale-up based on successful models including nurse initiated care. 	<ul style="list-style-type: none"> DoH Support partners
Implement the National STI National Framework guidance on the detection and treatment of asymptomatic STIs	<ul style="list-style-type: none"> Developing, testing and validation of the sexual history tool for different populations and different ages as the basis for screening tests and / or presumptive treatment Building capacity of health workers on the use of the tool and integrating it into all customised delivery sites. Improved ACSM in high burden districts through targeted STIs messages. Using the sexual history tool to screen and treat priority populations (pregnant women, AGYW and SW) for asymptomatic STIs . 	<ul style="list-style-type: none"> DoH, NICD ,NHLS Dept. of Transport Civil society (key population sectors) District Management Teams Private health sector
Appropriate syndromic management of STIs	<ul style="list-style-type: none"> Ensuring appropriate management of cases non-responsive to the syndromic approach The use of mobile outreach services for men with extended hours Implementation of strategies to strengthen partner notification and contact tracing especially for key populations Training and re-training of HCWs on syndromic management 	<ul style="list-style-type: none"> DoH DHET/HEAIDS Private health sector

Generic HIV, TB and STI prevention, management and care		
Focus	Activities	Multi-sectoral partner
	<ul style="list-style-type: none"> Quality assurance programmes and advanced level STI management in secondary hospitals and CHCs with the necessary tools and training. 	
Screening of all pregnant women for syphilis at first ANC visit	<ul style="list-style-type: none"> Screening for syphilis at birth for all infants born to Syphilis positive women or to women who were unbooked or untested Linking all children diagnosed with congenital syphilis to care and ensuring they receive treatment; Intensified notification process Routine congenital syphilis monitoring and tracing and management of confirmed syphilis clients. 	<ul style="list-style-type: none"> DoH Private health sector
Promote integration of STI prevention care and treatment into HIV, TB, ANC, sexual and reproductive health services	<ul style="list-style-type: none"> Strengthened ART initiation at STIs services or linkage to ARV services 	<ul style="list-style-type: none"> DoH Private health sector

Addressing social and structural drivers	Service	Multi-sectoral partner
Strengthened and scaled-up community based one-stop Khuseleka Centres	<ul style="list-style-type: none"> Integrate community support programmes in one-stop centres 	<ul style="list-style-type: none"> DSD SAPS DoH DOJ
Strengthened and scaled-up community-based 'white-door' shelters	<ul style="list-style-type: none"> Provide short-term (72-hour) places of safety and shelter within communities and referral/integration with HIV/TB/STI services 	<ul style="list-style-type: none"> DSD SAPS DoH DOJ
Identify and speedily allocate social grants to all who are eligible	<ul style="list-style-type: none"> Link PLHIV, TB clients to social security programmes for access to social relief distress grants 	<ul style="list-style-type: none"> DSD Civil society including NGOs

Addressing social and structural drivers	Service	Multi-sectoral partner
Scaled-up provision of food parcels, and nutritional supplementation to all eligible PLHIV and PTB	<ul style="list-style-type: none"> • Strengthen capacity of HIV/TB providers to screen for food insecurity • Ensure access to sufficient food in particular for PLHIV and PWTB • Expand drop-in centres especially in high-burden districts • Expand access through Isibindi model 	<ul style="list-style-type: none"> • DSD • NGOs • SANAC sectors
Expand inpatient and outpatient rehabilitation facilities	<ul style="list-style-type: none"> • Develop adolescent-friendly practices • Sensitise and capacitate HCWs to screen for and refer and provide interim support for people with harmful use of alcohol and drugs • Expand availability of inpatient rehabilitation facilities 	<ul style="list-style-type: none"> • DSD • DoH • DBE • NGOs
Implementation of harm reduction services to identify and support people who use substances and alcohol	<ul style="list-style-type: none"> • The Drug Master Plan harm reduction interventions including the provision of Opioid Substitution Therapy • Needle and syringe exchange programmes by NGOs • Identify for referral to in- and out-patient rehabilitation services 	<ul style="list-style-type: none"> • DSD • DoH • NGOs • DBE • DHET
Community awareness and advocacy programmes	<ul style="list-style-type: none"> • Implement programmes to increase awareness of services 	<ul style="list-style-type: none"> • DSD • Civil society including NGOs
Combination socio-economic programmes	<ul style="list-style-type: none"> • Strengthen economic capacities through support to access further education, training, job placements and entrepreneurial activities, including for PWDs 	<ul style="list-style-type: none"> • DSD • Private sector • DHET • Civil society including NGOs
Training for adolescent girls and young women	<ul style="list-style-type: none"> • Empower young women, such as through SABCOHA's BizAIDS programme, to start and improve their own businesses • Encourage companies to support the programme through co-funding and job opportunities 	<ul style="list-style-type: none"> • SABCOHA and other private sector • Organised labour • DOT

Appendix A: Selecting Data for the Profile

It is important to note that the quality of an HIV epidemic and risk profile depends on the quality of secondary data used. The following are considerations for reviewing data and data sources to be used in the epidemiologic profile:

- **Completeness of the data:** How well do the prevalence of HIV and the associated factors represent the true number of persons living with HIV in the selected service and/or administrative area?
- **Representativeness of the data:** How well do the characteristics from a data source correspond to the characteristics of the overall population? For example, data from a hospital-based sample may not represent all HIV-infected persons or all HIV-infected persons in care in the area covered by the survey.
- **Age of the data:** For example, a behavioural survey conducted in 2000 might not provide data that are sufficiently up-to-date for current prevention activities.
- **Timeliness of the data:** if dealing with administrative data, how long is the reporting delay between the diagnosis of HIV and associated socio demographic characteristics recorded and reported to relevant departments?
- **Surrogate, or proxy, markers:** A proxy variable can be used as a marker for other variables when what we really want to measure is too difficult to measure directly. For example, some areas may use STI data as a proxy when data on sexual behaviours are not available.
- **Reliability of the data:** How accurate and complete are the data? For example, how well was information e.g. age, recorded whether in a survey or in administrative records and transcribed to the case report from the medical record.
- **Small numbers:** Small numbers of cases need to be interpreted with caution because small absolute changes in the number of cases can produce large relative or proportionate changes in rates that may be misinterpreted by end users. Rates calculated from numerators smaller than 10 should be denoted in a footnote as unreliable.

Data assumptions and limitations

The National Department of Health collects routine HIV data. The data is captured in the National Health Information Repository and Data warehouse (NIRDS), through the provincial and district health information systems (DHIS). The data are mostly obtained through routine service delivery by providers e.g. health facilities, and PHC clinics and consist of reports of confirmatory HIV tests, viral loads and CD4 counts. Additionally, the system captures case reports and interview data that might include information on socio-demographics e.g. age, race, sex. Data on socio demographics rely heavily on patient and provider reporting. In most cases data of this nature may be obtained from independent cross-sectional and bio-behavioural surveys and only reported at much higher geographical levels than local levels or high burden areas. The bio-behavioural surveys also provide data on sexual risk behaviours.

Age breakdown of routine indicators are limited to predefined indicators, with no sex breakdown available at Provincial and National Dataset level. No key population specific data can be segregated from any of the available datasets. Given the importance of key populations in understanding of the local context, this is considered a serious limitation in available routine data. Data on HIV risk exposure or mode of transmission require disease specialists and willingness of patient to participate is also not available at national and/or local level. Mobile clinic data is reported under the point where mobile is working from and is not segregated by service delivery point. This skews the picture when data is projected geospatially. Sexual risk data not part of routine data collected, secondary data available from surveys are included for this yet this is only available at District level. Figure 32 below reflects on the source of various levels of data for the profile. Data is presented at the level that it is available.

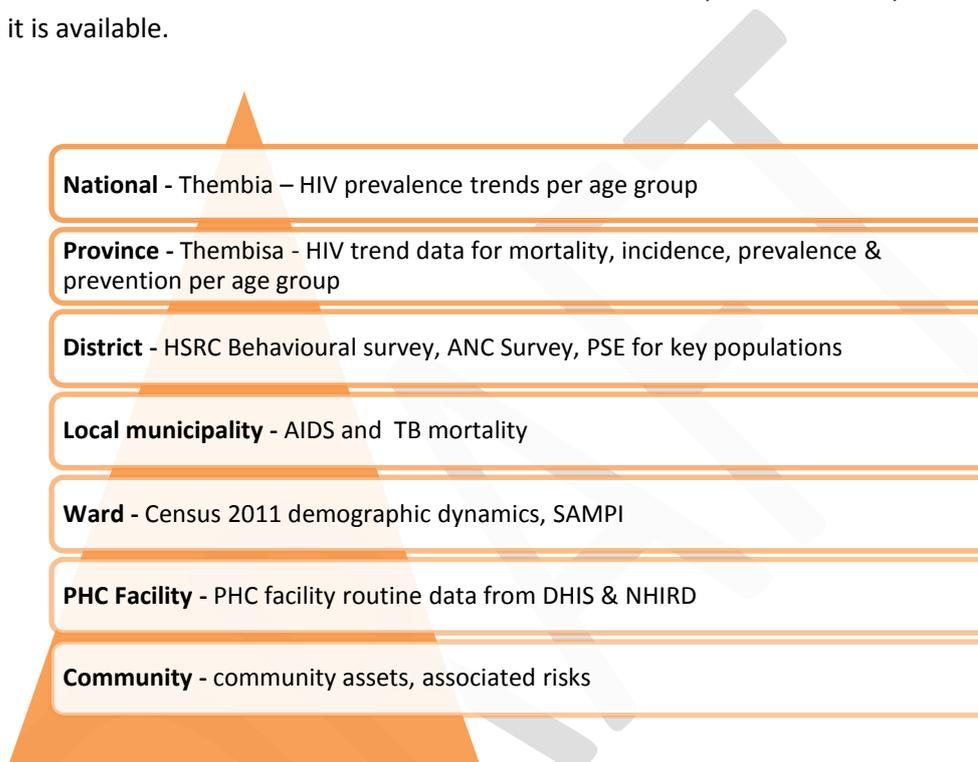


Figure 32: Data pyramid used for risk profiles

Care is also taken to avoid reporting on small number of cases without caution. Definitions and outlines of calculations are provided in

Catchment area and catchment populations

The catchment population is different from a catchment area, whereby the population is not simply just a count of the total number of people that are resident within that geographical boundary, but is rather an estimate of the estimated population that could access that specific facility.

Agreement on a health-care facility’s catchment area is an important component in the Focus for Impact approach for defining the soft boundary for associated risk profiling within the catchment population linked to a specific HIV high burden area, estimate population-based rates of HIV, TB and STI as well as other important analyses.

For the purpose of the Focus for Impact approach demographic data for the population is derived from the Census 2011 data linked to a specific ward within the agreed catchment areas.

Working closely with the KZN DoH, the DoH used a geospatial approach to allocate each ward in KZN to the closest health facility. For the purposes of the Focus for Impact approach only the catchment area of fixed PHC facilities were used. Please keep in mind that multiple PHC facilities (fixed and mobile) refer to a specific Hospital and therefore relates to a larger catchment area that might overlap with several PHC facility catchment areas.

It is acknowledged that this approach does not take into consideration the topography of the area or preferences of the health facility users. It is therefore suggested that the catchment area be used as a starting point and that the approach be refined to determine the catchment population as better data becomes available e.g. through the scale up of the Health Patient Registration System (HPRS) where more granular patient level data will become available.

HIV associated risks

The HIV associated risk profile is a tool to assist decision-makers to design appropriate and sustainable interventions for HIV prevention. The diagram below illustrates factors affecting HIV associated risk. Data in this profile links with the different variables identified below (as far as it is available).

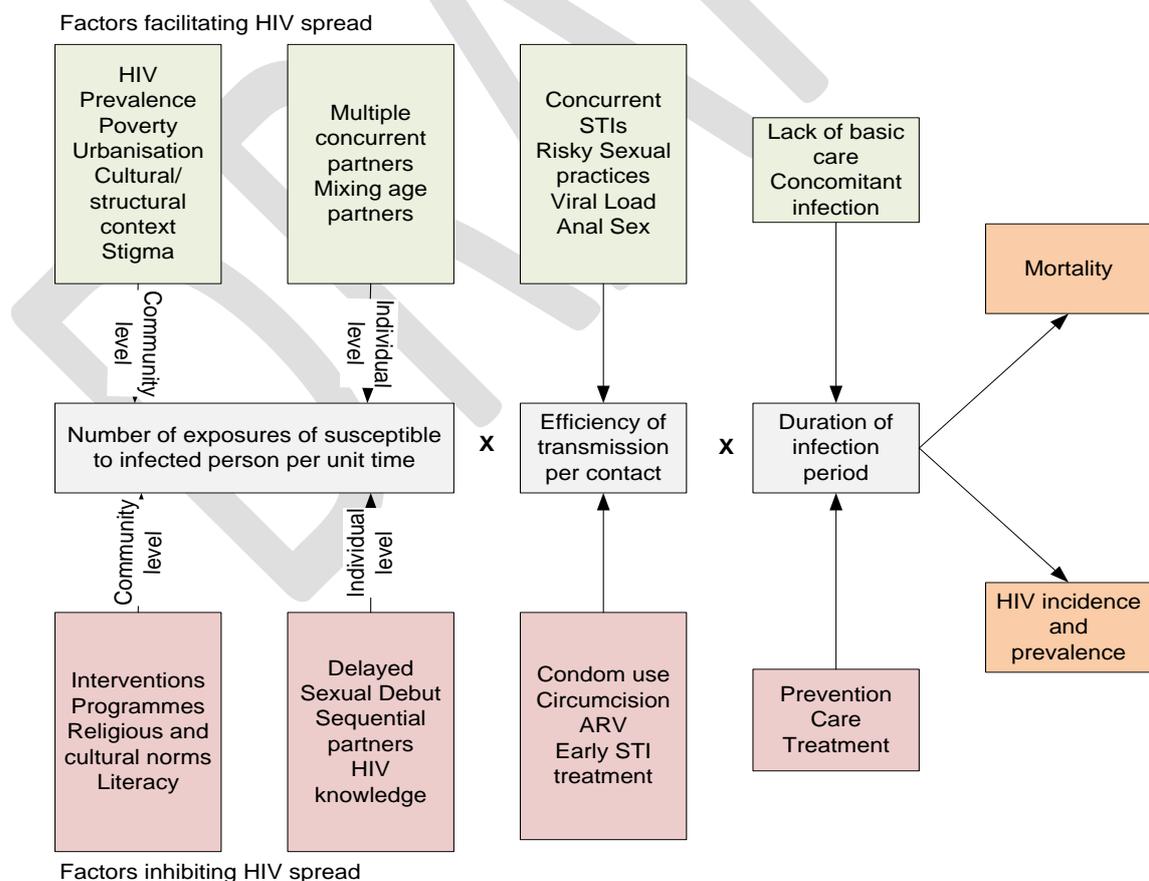


Figure 33: Factors influencing HIV associated risk and outcomes

Appendix B: Terms, Definitions and calculations

ANC client HIV 1st test positive rate (routine health indicator DHIS 2015)	<p>Short Name - ANC HIV 1st test pos rate</p> <p>Numerator - Antenatal client HIV 1st test positive</p> <p>Denominator - Antenatal client HIV 1st test</p> <p>Indicator Type - %</p> <p>Definition - Antenatal clients tested HIV positive as proportion of antenatal clients HIV tested for the first time during current pregnancy</p>
Antenatal client HIV re-test positive rate (routine health indicator DHIS 2015)	<p>Short Name - ANC HIV re-test pos rate</p> <p>Numerator - Antenatal client HIV re-test positive</p> <p>Denominator - Antenatal client HIV re-test</p> <p>Indicator Type - %</p> <p>Definition - Antenatal clients re-tested positive for HIV as proportion of antenatal clients re-tested for HIV</p>
Behavioral data	Data collected from studies of human behavior that is relevant to disease risk. Relevant behaviors for HIV risk may include sexual activity, substance use, needle sharing, condom use, or responses to primary and secondary prevention messages, knowledge of HIV transmission and prevention
Data	Raw, unprocessed numbers
Delivery in facility under 18 years rate (routine health indicator DHIS 2015)	<p>Short Name - Delivery 18 rate</p> <p>Numerator - Delivery under 18 years in facility</p> <p>Denominator - Delivery in facility - total</p> <p>Indicator Type - %</p> <p>Definition - Deliveries to women under the age of 18 years as proportion of total deliveries in health facilities</p>
Dependency ratio	The dependency ratio is an indicator of potential dependency burden of children and the elderly on those who are of economically productive ages in a population. Source Census 2011
Epidemiologic profile	A document that describes the distribution of HIV in various populations and identifies characteristics both of HIV-infected and HIV-negative persons in defined geographic areas. It is composed of information gathered to describe the effect of HIV on an area in terms of socio-demographic, geographic, behavioral, and clinical characteristics. Identifies characteristics of the general population and of populations who are living with, or at high risk for HIV infection in the pre-defined geographic areas in need of primary and secondary prevention or care services; and also identifies social, behavioral, cultural, factors driving local HIV infection. This providing information required to conduct needs assessments and gap analyses to complete the local HIV profile
Female condom distribution coverage	<p>Short Name - Fem condom dist cov</p> <p>Numerator - Female condoms distributed</p>

(routine health indicator DHIS 2015)	Denominator - Female population 15 years and older Indicator Type - % Definition - Female condoms distributed from a primary distribution site to health facilities or points in the community (e.g. campaigns, non-traditional outlets, etc.)
HIV prevalence amongst client tested 15-49 years rate (routine health indicator DHIS 2015)	Short name - HIV test 15-49y pos rate Numerator - HIV test positive 15-49 years, excl ANC Denominator - HIV test 15-49 years, excl ANC Indicator Type - % Description - Proportion of clients on whom an HIV test was done who tested positive for the first time
HIV test positive child 12-59 months rate (routine health indicator DHIS 2015)	Short Name - HIV+ 12-59 rate Numerator - HIV test positive 12-59 months Denominator - HIV test 12-59 months Indicator Type - % Definition - Children 12 to 59 months who tested HIV positive as a proportion of children who were tested for HIV in this age group
HIV test positive child 5-14 years rate (routine health indicator DHIS 2015)	Short Name - HIV+ 5-14 rate Numerator - HIV test positive 5-14 years Denominator - HIV test child 5-14 years Indicator Type - % Definition - Children 5 to 14 years who tested HIV positive as a proportion of children who were tested for HIV in this age group
Incidence	The number of new infections in a defined population during a specific period, often 1 year, which can be used to measure disease frequency. There is an important difference between HIV incidence and a new diagnosis of HIV infection: HIV incidence refers to persons newly infected with HIV, whereas persons newly diagnosed with HIV may have been infected years before the diagnosis. Population-based incidence estimates include new infections that have been diagnosed as well as new infections that have not been diagnosed. HIV incidence data may be used to monitor emerging trends and guide prevention activities
Indicators	A quantitative or qualitative variable that provides a simple and reliable measurement of one aspect of performance, achievement or change in a program or project
Infant 1st PCR test positive around 6 weeks' rate (routine health indicator DHIS 2015)	Short Name - PCR at 10w pos rate Numerator - Infant PCR test positive around 6 weeks Denominator - Infant PCR test around 6 weeks Indicator Type - % Definition - Infants tested PCR positive for follow up test as a proportion of Infants PCR tested around 6 weeks
Infant rapid HIV test around 18 months positive rate (routine	Short name - HIV test 18m pos rate Numerator - HIV test positive around 18 months Denominator - HIV test around 18 months

health indicator DHIS 2015)	Indicator Type - % Description - Infants tested positive for HIV antibodies around 18 months after birth as the proportion of Infants tested for HIV antibodies around 18 months
Information	Processed or analyzed data that adds context through relationships between data to allow for interpretation and use
Intensity of poverty	The average proportion of indicators in which poor households are deprived. Example, an intensity of 44% in 2011 means the average intensity of poverty was 44% amongst the 20% poor households
Male condom distribution coverage (routine health indicator DHIS 2015)	Short Name - Male cond dist cov Numerator - Male condoms distributed Denominator - Male population 15 years and older Indicator Type - % Definition - Male condoms distributed from a primary distribution site to health facilities or points in the community (e.g. campaigns, non-traditional outlets, etc.)
Male urethritis syndrome rate (routine health indicator DHIS 2015)	Short Name - MUS rate Numerator - Male Urethritis Syndrome treated - new episode Denominator - STI male - new episode Indicator Type - % Definition - Male Urethritis Syndrome new episodes treated as a proportion of total males with STI new episodes treated
Modes of HIV transmission or mode of HIV exposure	Heterosex (or heterosexual contact with a partner who is HIV positive or at increased risk for HIV. Often this level of knowledge about sexual partners (anonymous, casual, or exclusive) may be unknown; Men who have sex with men (MSM); People who Inject Drugs (PWID); Joint risk of MSM/PWID; and Other mode of exposure including (transplant, hemophilia, transfusion or mother with HIV or HIV risk (PMTCT)
Morbidity	The presence of illness in the population.
Mortality	The total number of persons who have died of the disease of interest. Usually expressed as a rate, mortality (total number of deaths over the total population) measures the effect of the disease on the population as a whole
Percentage	A proportion of the whole, in which the whole is 100. Example: Assume that 10 of the 40 cases of AIDS in a given year in a Ward occurred in men. $(10 \div 40) \times 100 = 25\%$
Poverty Headcount	The proportion of households defined as multi-dimensionally poor using the poverty cut-off. Example a headcount of 20% in 2011, based on 2011 census, means that 20% of households in South Africa were poor.
Prevalence	The proportion of cases of a disease in a population at risk, measured at a given point in time (often referred to as point prevalence). Prevalence can also be measured over a period of time (e.g., a year; known as period

	<p>prevalence). Prevalence does not indicate how long a person has had a disease. It can provide an estimate of risk for a disease at a specific time. Prevalence data provide an indication of the extent of a condition and may have implications for services needed in a community. For HIV surveillance, prevalence refers to living persons with HIV disease, regardless of time of infection or date of diagnosis.</p>
Qualitative data	<p>Information from sources such as narrative behaviour studies, focus group interviews, open-ended interviews, direct observations, ethnographic studies, and documents. Findings from these sources are usually described in terms of common themes and patterns of response rather than by numeric or statistical analysis. Qualitative data often complement and help explain quantitative data</p>
Quantitative data	<p>Numeric information (e.g., numbers, rates, and percentages).</p>
Rate	<p>Measure of the frequency of an event compared with the number of persons at risk for the event. When rates are being calculated, it is usual for the denominator to be the general population rather than the population potentially exposed to HIV infection by various high-risk behaviours. The size of the general population is known from data from the U.S Census Bureau, whereas the size of a population at high risk is usually not known.</p> $\frac{\text{number of HIV diagnoses}}{\text{Population}} \times 100000 = \text{population rate of HIV diagnosis}$ <p>Calculated for a given period. The multiplier (100,000) is used to convert the resulting fraction to number of cases per 100,000 populations. Although arbitrary, the choice of 100,000 is standard practice.</p> <p>Example: Assume that 200 cases of HIV disease were diagnosed during 2014 in a Ward X and that 400,000 persons lived in the Ward X in 2014 Rate: $200 \div 400,000 \times 100,000 = 50$ per 100,000</p>
Routine health service based information	<p>In terms of the National Health Act (Act 61 of 2003) the National Department of Health (NDoH) is required to facilitate and coordinate the establishment, implementation and maintenance of health information systems at all levels. The District Health Management Information System (DHMIS) Policy 2011 defines the requirements and expectations to provide comprehensive, timely, reliable and good quality routine evidence for tracking and improving health service delivery. The strategic objectives of the policy are to strengthen monitoring and evaluation (M&E) through standardization of data management activities and to clarify the main roles and responsibilities at each level for each category of staff to optimize completeness, quality, use, ownership, security and integrity of data.</p> <p>In 2000 the District Health Information System (DHIS) was adopted as the official South African routine health information system for managing aggregated routine health service based information. This information is</p>

	<p>defined as specific indicators and used in Focus for Impact to ensure standardization of indicators across the different geographical areas.</p> <p>Source: Department of Health. 2015. NDOH Data Directory. Available online from http://dd.dhmis.org/index.html</p>														
Service area	The jurisdictions of service areas or planning regions of respective planning groups. Example Health districts, sub- districts, wards or health facility catchment areas														
Socio-demographic factors	Background information about the population of interest (e.g., age, sex, race, educational status, income, geographic location). These factors are often thought of as explanatory because they help us to make sense of the results of our analyses														
Socio-economic status (SES)	A measure of social and economic factors that helps to describe a person's standing in society (e.g., income level, relationship to the national poverty line, educational achievement)														
South Africa Multidimensional Poverty Index (SAMPI ¹⁶) (StatSSA, 2014)	<p>The SAMPI is based on the global Multidimensional Poverty Index (MPI) which is an international measure of acute poverty. The MPI “complements traditional income/ expenditure-based poverty measures by capturing the severe deprivations that each person or household faces with respect the following dimensions: - education (measured by years of schooling and school attendance indicators), health (measured by nutrition and child mortality indicators), and living standards (measured by indicators such as cooking fuel, Sanitation, water, electricity, floor, and assets).</p> <p>The MPI creates a comprehensive picture of who and where people are that are living in poverty... [and it also] permits comparisons within countries by population group, settlement type, as well as other key household and community characteristics.</p> <p>The SAMPI includes an additional dimension –the economic activity indicated by adult unemployment</p> <table border="1"> <thead> <tr> <th>Dimension</th> <th>Indicator</th> <th>Deprivation cut-off</th> </tr> </thead> <tbody> <tr> <td>Health</td> <td>Child mortality</td> <td>If any child under the age of 5 has died in the past 12 months</td> </tr> <tr> <td rowspan="2">Education</td> <td>Years of schooling</td> <td>If no household member aged 15 or older has completed 5 years of schooling</td> </tr> <tr> <td>School attendance</td> <td>If any school-aged child (aged 7 to 15) is out of school</td> </tr> <tr> <td>Standard of</td> <td>Fuel for lighting</td> <td>If household is using</td> </tr> </tbody> </table>	Dimension	Indicator	Deprivation cut-off	Health	Child mortality	If any child under the age of 5 has died in the past 12 months	Education	Years of schooling	If no household member aged 15 or older has completed 5 years of schooling	School attendance	If any school-aged child (aged 7 to 15) is out of school	Standard of	Fuel for lighting	If household is using
Dimension	Indicator	Deprivation cut-off													
Health	Child mortality	If any child under the age of 5 has died in the past 12 months													
Education	Years of schooling	If no household member aged 15 or older has completed 5 years of schooling													
	School attendance	If any school-aged child (aged 7 to 15) is out of school													
Standard of	Fuel for lighting	If household is using													

¹⁶ StatSSA. (2014). *The South African MPI: Creating a multidimensional poverty index using census data*. Pretoria, South Africa.

living		paraffin/candles/nothing/other
	Fuel for heating	If household is using paraffin/wood/coal/dung/other/none
	Fuel for cooking	If household is using paraffin/wood/coal/dung/other/none
	Water access	If no piped water in dwelling or on stand
	Sanitation type	If not a flush toilet
	Dwelling type	If an informal shack/traditional dwelling/caravan/tent/other
	Asset ownership	If household does not own more than one of radio, television, telephone or refrigerator and does not own a car
Economic activity	Unemployment (all adults)	If all adults (aged 15 to 64) in the household are unemployed

SAMPI is the product of the headcount (proportion of households defined as multi-dimensionally poor using the poverty cut-off) and intensity of poverty (average proportion of indicators in which poor households are deprived)

Example - If the headcount poverty was 20% in 2011 (i.e. 20% of all households were poor in 2011), and the average intensity of poverty amongst the poor households was 44%. Then the SAMPI equals 0.09(=20% X 44%)

In an extremely poor society where all households are poor and are deprived in all dimension indicators, the SAMPI score would be 1, 0. However, in an impoverished society where 50% of households are poor and experienced deprivation on 50% of all dimensions, the SAMPI score would be 0.25.

TB (pulmonary) case finding index (routine health indicator DHIS 2015)	<p>Short name - PTB case finding index</p> <p>Numerator - TB suspect 5 years and older sputum sent</p> <p>Denominator - PHC headcount 5 years and older</p> <p>Description - Proportion of clients 5 years and older, who were identified as TB suspects and for whom sputum was sent to the laboratory</p> <p>Growth-Sentiment - negative (high values are negative, low values are ideal: positive)</p>
TB suspect smear positive rate (routine health indicator DHIS 2015)	<p>Short name - TB suspect smear pos rate</p> <p>Numerator: TB suspect 5 years and older test positive</p> <p>Denominator: TB suspect 5 years and older sputum sent</p> <p>Indicator Type - %</p> <p>Description - Proportion of TB suspects with smear positive sputum results</p>

	Growth-Sentiment: negative (high values are negative, low values are ideal: positive)
TB suspect sputum test rate (routine health indicator DHIS 2015)	<p>Short name - TB susp sputum test rate</p> <p>Numerator - TB suspect 5 years and older sputum sent</p> <p>Denominator - TB suspect 5 years and older identified</p> <p>Indicator Type - %</p> <p>Description - Proportion of TB suspects with sputum sent to the laboratory for testing</p> <p>Growth-Sentiment: positive (low values are negative, high values are ideal: positive)</p>
TB suspect treatment initiation rate (routine health indicator DHIS 2015)	<p>Short name - TB suspect treatment rate</p> <p>Numerator - TB suspect 5 years and older initiated on treatment</p> <p>Denominator - TB suspect 5 years and older test positive</p> <p>Indicator Type - %</p> <p>Description - Proportion of smear positive TB suspects initiated on treatment</p> <p>Growth-Sentiment - positive (low values are negative, high values are ideal: positive)</p>
Triangulation	Synthesis of data to compare and contrast the results of different kinds of research that address the same topic

Appendix C: Methodology for stakeholder engagement to explore local level data

The feedback from the community brings a local intelligence and ownership to the process that not only facilitates buy-in for HIV programming, but also brings about an opportunity for advocacy and accountability at this level. This gives new meaning to ‘nothing about us, without us’. There is internal validation and triangulation of the data through this process, as stakeholders should be from various sectors/departments and types of organisations. Groups within the workshop validate the information before it is documented. In addition, the same information is tested with a community group (that should include members of key populations) and additions made with consensus.

Figure 34 below describes the various steps followed to develop this risk profile. A detailed guideline is available from SANAC that can be used by stakeholders and partners to ensure a standardised approach in the development and updating of the risk profile.

DRAFT

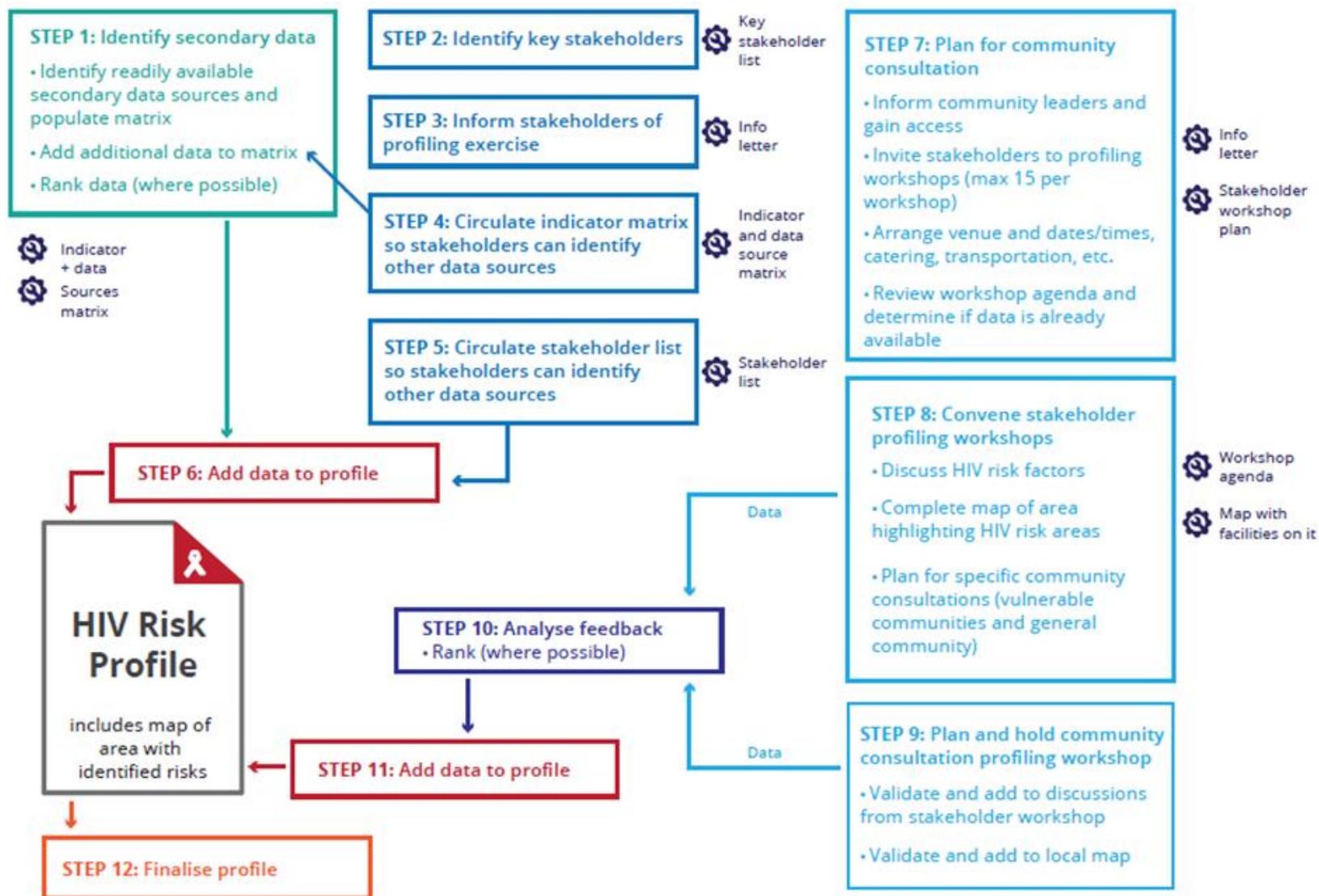


Figure 34: Steps for development of HIV associated risk profile