Focus for Impact

Community profile
Catchment area for Shakaskraal Clinic
(Wards 7, 8, 21, 22, 23)

KwaDukuza local municipality
iLembe 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 7

1.3 POPULATION BY RACE 11

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 26

3.1.5 LUBRICANT 27

3.2 BEHAVIOUR THAT INFLUENCES 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 28

3.2.5 KEY AND VULNERABLE POPULATIONS 31

3.3 SOCIAL AND STRUCTURAL FACTORS THAT INFLUENCE HIV RISK 33

3.3.1 ORPHAN HOOD 33

3.3.2 CULTURAL AND RELIGIOUS NORMS 34

3.3.3 GENDER NORMS AND GENDER-BASED VIOLENCE 35

3.3.4 STIGMA 35

3.3.5 POVERTY 36

3.3.6 EMPLOYMENT 45
3.3.7 TYPES OF SETTLEMENTS 47
3.3.8 MIGRATION PATTERNS IN THE AREA 47
3.3.9 EDUCATION AND LITERACY 48
3.3.10 HATE CRIMES – XENOPHOBIC, HOMOPHOBIC, OTHER 48
3.3.11 DISABILITY 48
4. SERVICES IN THE LOCAL MUNICIPALITY 49
4.1 HEALTH FACILITIES 49
5. RECOMMENDATIONS FOR MULTI-SECTORAL INTERVENTIONS AND FOCUS ON KEY AND VULNERABLE POPULATIONS 50

APPENDIX A: SELECTING DATA FOR THE PROFILE 61
APPENDIX B: TERMS, DEFINITIONS AND CALCULATIONS 64
APPENDIX C: METHODOLOGY FOR STAKEHOLDER ENGAGEMENT TO EXPLORE LOCAL LEVEL DATA 71

Table of Figures

Figure 1: Local municipalities' iLembe district 5
Figure 2: Distribution of Wards in the KwaDukuza local municipality 6
Figure 3: Population Pyramid KwaDukuza local municipality 9
Figure 4: Dependency ratio KwaDukuza local municipality (Source Census 2011) 9
Figure 5: Population Pyramid Shakaskraal clinic catchment area (Source Census 2011) 10
Figure 6: Dependency ratio Shakaskraal clinic catchment area (Source Census 2011) 10
Figure 7: Population group distribution in KwaDukuza local municipality (Source Census 2011) 11
Figure 8: ANC client HIV 1st test positive rate iLembe district (Source: KZN DHIS 2015) 13
Figure 9: Infant 1st PCR test positive around 6 weeks rate iLembe district (Source: KZN DHIS 2015) 14
Figure 10: Infant rapid HIV test around 18 months positive rate iLembe district (Source: KZN DHIS 2015) 15
Figure 11: HIV test positive child 12-59 months rate iLembe district (Source: KZN DHIS 2015) 16
Figure 12: HIV test positive child 5-14 years rate iLembe district (Source: KZN DHIS 2015) 17
Figure 13: HIV prevalence amongst client tested 15-49 years rate iLembe district (Source: KZN DHIS 2015) 18
Figure 14: TB (pulmonary) case finding index iLembe district (Source: KZN DHIS 2015) 19
Figure 15: TB suspect sputum test rate iLembe district (Source: KZN DHIS 2015) 20
Figure 16: TB suspect smear positive rate iLembe district (Source: KZN DHIS 2015) 21
Figure 17: TB suspect treatment initiation rate iLembe district (Source: KZN DHIS 2015) 22
Figure 18: Male urethritis syndrome rate iLembe district (Source: KZN DHIS 2015) 24
Figure 19: Female condom distribution rate iLembe district (Source: KZN DHIS 2015) 29
Figure 20: Male condom distribution rate iLembe district (Source: KZN DHIS 2015) 30
Figure 21: Teenage Pregnancy rate iLembe district (Source: KZN DHIS 2015) 31
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, KwaDukuza local municipality 37
Figure 24: SAMPI (poverty Index) 2011 - ward level, KwaDukuza local municipality 39

Figure 25: SAMPI 2001 poverty headcount - ward level, KwaDukuza local municipality 41
Figure 26: SAMPI 2011 poverty headcount - ward level, KwaDukuza local municipality 43
Figure 27: Female and Male employment KwaDukuza local municipality (Source Census 2011) 45
Figure 28: Youth unemployment KwaDukuza local municipality (source Census 2011) 45
Figure 29: Female and Male employment Shakaskraal clinic catchment area (Source Census 2011) . 46
Figure 30: Youth unemployment Shakaskraal clinic catchment area (source Census 2011) 47
Figure 31: Distribution of health facilities in KwaDukuza local municipality 49
Figure 32: Data pyramid used for risk profiles 62
Figure 33: Factors influencing HIV associated risk and outcomes 63
Figure 34: Steps for development of HIV associated risk profile 72

List of Tables

Table 1: Population per age groups per ward, KwaDukuza local municipality 7
Table 2: Youth population per sex and five-year age groups per ward, KwaDukuza Local Municipality 8
Table 3: Ward level population distribution by Race in KwaDukuza local municipality 11
Table 4: Main cause of deaths in the iLembe District (Source STATSSA) 12
Table 5: HIV Positivity Rate (Antenatal 1st Test) iLembe district (Source: KZN DHIS 2015 report 26 June 2017) 13
Table 6: HIV Positivity Rate (6 weeks) iLembe district (Source: KZN DHIS 2015 report 26 June 2017) 14
Table 7: HIV Positivity Rate (18 months) iLembe district (Source: KZN DHIS 2015 report 26 June 2017) 15
Table 8: HIV Positivity Rate (12-59 months) iLembe district (Source: KZN DHIS 2015 report 26 June 2017) 16
Table 9: HIV Positivity Rate (5 - 14 years) iLembe district (Source: KZN DHIS 2015 report 26 June 2017) 17
Table 10: HIV Positivity Rate (15 - 49 years) iLembe district (Source: KZN DHIS 2015 report 26 June 2017) 18
Table 11: TB (pulmonary) case finding index iLembe district (Source: KZN DHIS 2015 report 26 June 2017) 19
Table 12: TB (Sputum Test Rate) iLembe district (Source: KZN DHIS 2015 report 26 June 2017) 20
Table 13: TB suspect smear positive rate iLembe district (Source: KZN DHIS 2015 report 26 June 2017) 21
Table 14: TB suspect treatment initiation rate iLembe district (Source: KZN DHIS 2015 report 26 June 2017) 22
Table 15: Male urethritis syndrome rate iLembe district (Source: KZN DHIS 2015 report 26 June 2017) 24
Table 16: Female condom distribution rate iLembe district (Source: KZN DHIS 2015 report 26 June 2017) 29
Table 17: Male condom distribution rate iLembe district (Source: KZN DHIS 2015 report 26 June 2017) 30
Table 18: Teenage Pregnancy rate iLembe district (Source: KZN DHIS 2015 report 26 June 2017) 31
Table 19: Key and vulnerable population groups 32
Table 20: Orphan hood for Census 2011 at Ward level in KwaDukuza local municipality 33

Table 21: Poverty measures for Census 2011 at Ward level in KwaDukuza local municipality 36
Table 22: SAMPI (poverty Index) 2001 - ward level, KwaDukuza local municipality 37
Table 23: SAMPI (poverty Index) 2011 - ward level, KwaDukuza local municipality 39
Table 24: SAMPI 2001 poverty headcount - ward level, KwaDukuza local municipality 41
Table 25: SAMPI 2011 poverty headcount - ward level, KwaDukuza local municipality 43
Table 26: Key and vulnerable populations as well as Priority interventions 51
Table 27: Recommended multi-sectoral service packages 52

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
LGBTI	Lesbian Gay Bisexual Transgender and Intersex
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
STD	Sexually Transmitted Disease
SRD	Social Relief of Distress (vouchers)
STI	Sexually Transmitted Infection
TB	Tuberculosis

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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 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*** is the most vulnerable populations?

(d) ***Which multi-sectoral interventions*** may be deployed in the high-burden area to reduce associated HIV and/or

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.

  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?"*

> **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

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 KwaDukuza local municipality under the iLembe 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 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 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 Shakaskraal Clinic, KwaDukuza local municipality is defined as KwaDukuza Wards 7, 8, 21, 22 and 23. For this specific profile, two stakeholder and community workshops held on 7 and 8 July 2017 in Inkobongo Hall, Shakaskraal. The workshops were attended by 145 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 KwaDukuza 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 Shakaskraal clinic catchment area:

- Key and vulnerable populations:
    - Youth, specifically young women and girls
    - Drug-users
    - Sex workers

- Interventions that address:
  - TB case finding
  - Alcohol and Substance Abuse that lead to unhealthy sexual practices and behaviours
  - Transactional Sex and poverty reduction, particularly keeping girls in school and out of risk
  - Inter-generational partners of which unequal gender relations and related risk behaviour
  - Parenting skills development and support, especially for teen mothers and families affected by poverty and domestic violence
  - Vulnerable groups such as the disabled and child-headed households
  - Stigma and discrimination, particularly disclosure and biomedical services

1. Socio-demographic profile

1.1 Demarcated boundaries

iLembe District is one of the 11 district municipalities of KwaZulu-Natal province. The KwaDukuza local municipality is one of the four local municipalities in iLembe district. The others are Maphumulo, Mandeni, and Ndwedwe local municipalities.

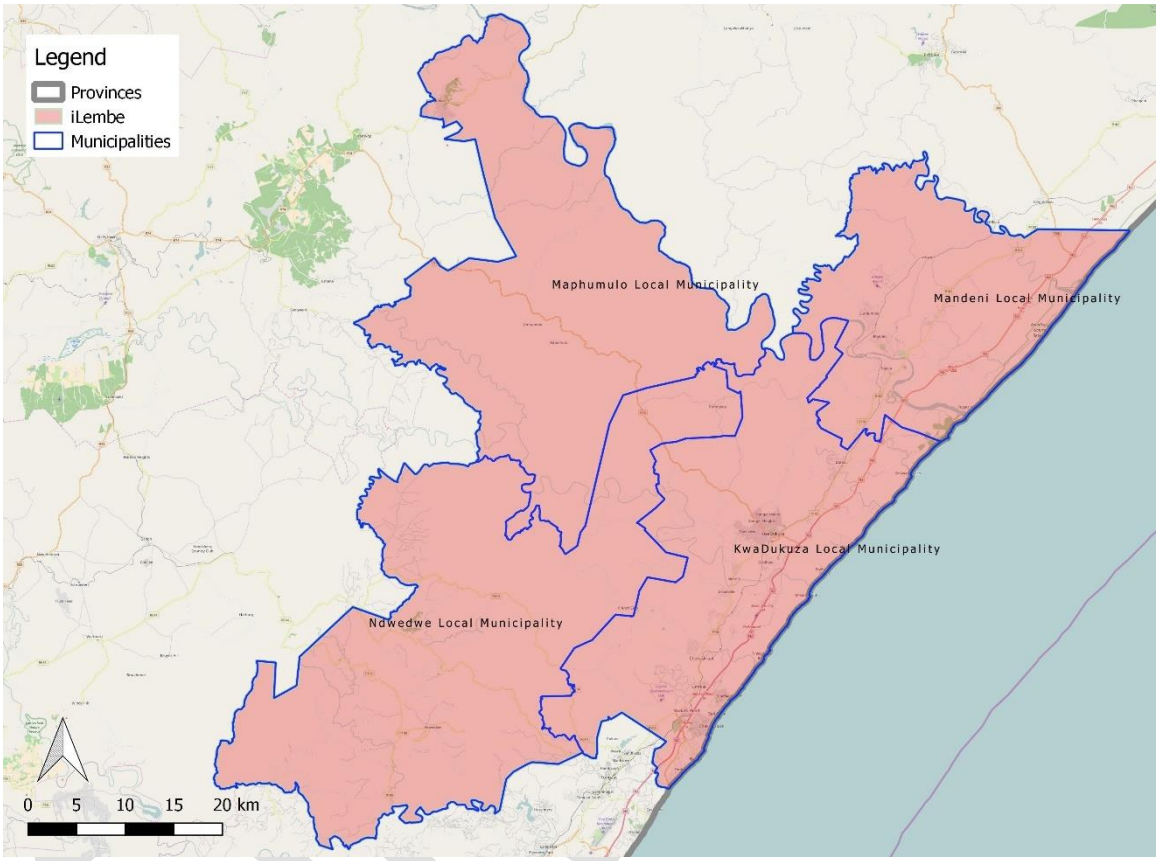

Figure 1: Local municipalities' iLembe district

The KwaDukuza local municipality constitute of 27 administrative wards (see Figure 2).

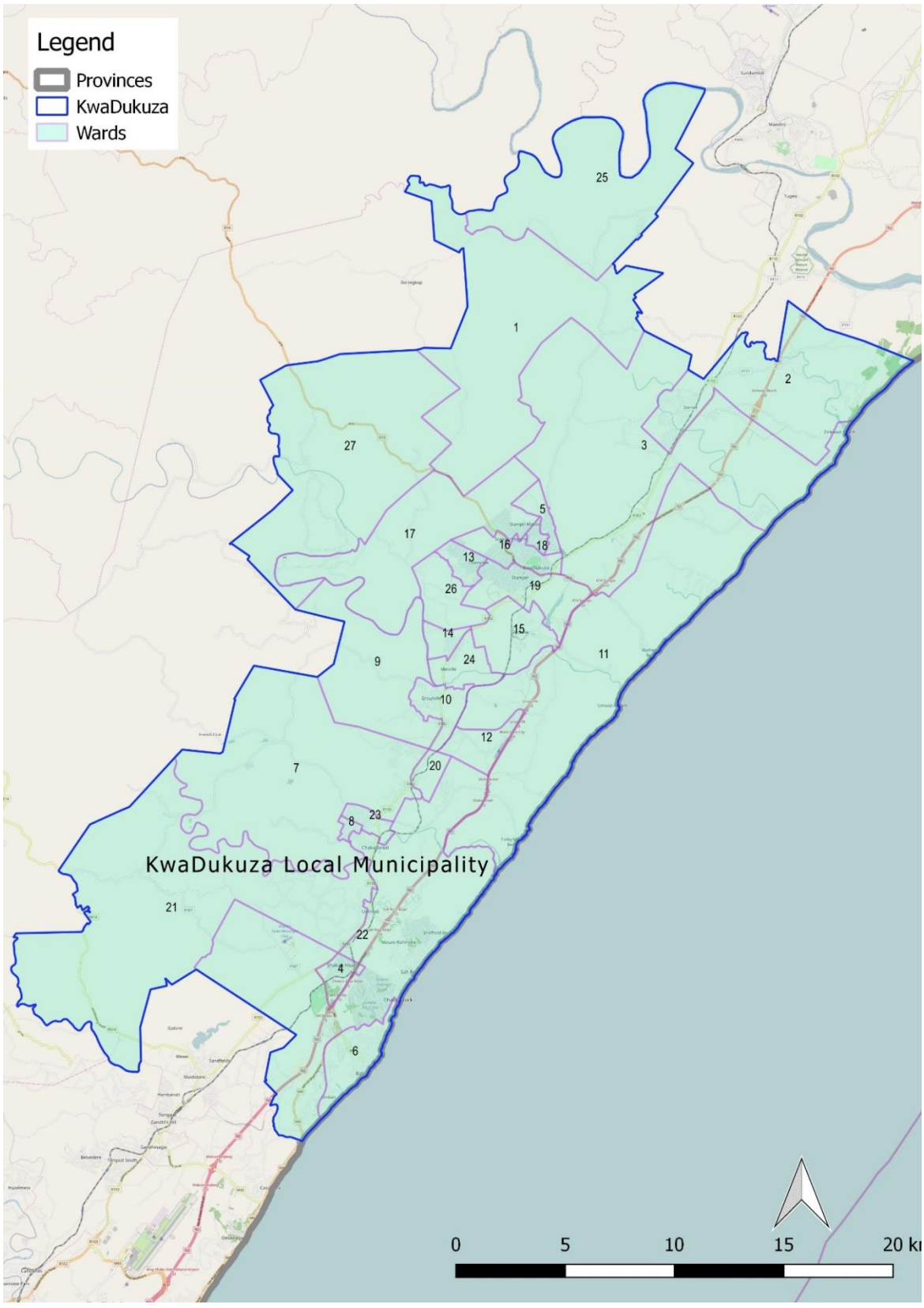

Figure 2: Distribution of Wards in the KwaDukuza local municipality

1.2 Population by sex and age

During the 2011 Census 231 144 people were counted in 27 wards. Table 1 summarises the age and sex per population in these wards. Females constitute 51% of population, compared to males 49%. The young people ≤ 25 years (49%) make up the majority of population in the local municipality. The detail for Wards 7, 8, 21, 22 and 23 that forms the catchment area for Shakaskraal Clinic, are highlighted in the table below.

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

Ward	Age							Sex		
	0-9	10-14	15-19	20-24	25-49	50+	Total	Female	Male	Total
Ward 001	1926	816	804	771	2130	1002	**7449**	3900	3549	**7449**
Ward 002	1941	840	870	1002	3615	1023	**9291**	4782	4509	**9291**
Ward 003	1122	432	498	672	2379	1026	**6129**	2892	3237	**6129**
Ward 004	1575	447	606	1446	4164	483	**8721**	3816	4905	**8721**
Ward 005	1812	744	795	1092	2745	675	**7863**	4113	3750	**7863**
Ward 006	969	408	402	354	2796	2673	**7602**	4038	3564	**7602**
Ward 007	2604	1023	978	1248	4302	987	**11142**	5493	5649	**11142**
Ward 008	1890	711	663	1041	3066	507	**7878**	3927	3951	**7878**
Ward 009	1761	714	741	765	2646	849	**7476**	3792	3684	**7476**
Ward 010	2277	882	999	1209	3837	1005	**10209**	5253	4956	**10209**
Ward 011	2034	750	834	936	3414	1242	**9210**	4536	4674	**9210**
Ward 012	2634	1056	1107	1434	4263	966	**11460**	5901	5559	**11460**
Ward 013	1419	645	810	909	3246	1506	**8535**	4437	4098	**8535**
Ward 014	1920	822	798	966	3096	600	**8202**	4284	3918	**8202**
Ward 015	2466	951	1071	1410	4590	1224	**11712**	5742	5970	**11712**
Ward 016	1371	675	822	912	3609	2175	**9564**	4920	4644	**9564**
Ward 017	855	510	630	588	2592	1623	**6798**	3480	3318	**6798**
Ward 018	1638	708	774	1065	3093	792	**8070**	4254	3816	**8070**
Ward 019	1197	576	627	711	3291	1560	**7962**	4179	3783	**7962**
Ward 020	720	252	297	441	1365	420	**3495**	1653	1842	**3495**
Ward 021	1350	612	666	897	2550	924	**6999**	3429	3570	**6999**
Ward 022	1704	747	732	843	4692	2970	**11688**	5895	5793	**11688**
Ward 023	2673	1008	1026	1377	4296	762	**11142**	5583	5559	**11142**
Ward 024	2739	1053	1104	1482	4377	753	**11508**	5844	5664	**11508**
Ward 025	2187	984	1056	804	2193	987	**8211**	4413	3798	**8211**
Ward 026	1170	489	564	882	2445	591	**6141**	2991	3150	**6141**
Ward 027	1488	741	783	708	2028	939	**6687**	3462	3225	**6687**
Total	**47442**	**19596**	**21057**	**25965**	**86820**	**30264**	**231144**	**117009**	**114135**	**231144**
%	**21%**	**8%**	**9%**	**11%**	**38%**	**13%**		**51%**	**49%**	

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, KwaDukuza 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	399	426	381	324	219	417	378	390	285	189	**3408**
Ward 002	408	465	495	468	441	432	405	507	477	372	**4470**
Ward 003	204	264	318	288	204	228	234	354	408	285	**2787**
Ward 004	207	306	603	702	441	240	300	843	1035	648	**5325**
Ward 005	387	420	558	489	312	357	375	534	534	324	**4290**
Ward 006	201	201	189	294	339	207	201	165	219	279	**2295**
Ward 007	516	504	594	615	495	507	474	654	651	573	**5583**
Ward 008	363	333	513	534	333	348	330	528	606	411	**4299**
Ward 009	354	375	384	414	264	360	366	381	465	315	**3678**
Ward 010	417	513	627	627	459	465	486	582	651	450	**5277**
Ward 011	348	408	459	477	396	402	426	477	519	438	**4350**
Ward 012	516	576	726	711	516	540	531	708	804	543	**6171**
Ward 013	312	426	462	387	330	333	384	447	402	339	**3822**
Ward 014	402	420	507	504	372	420	378	459	525	393	**4380**
Ward 015	441	549	651	753	504	510	522	759	810	591	**6090**
Ward 016	315	414	474	432	366	360	408	438	459	366	**4032**
Ward 017	270	306	297	273	237	240	324	291	306	240	**2784**
Ward 018	348	399	522	504	384	360	375	543	528	345	**4308**
Ward 019	288	333	378	438	363	288	294	333	429	336	**3480**
Ward 020	120	144	201	189	138	132	153	240	267	174	**1758**
Ward 021	285	330	450	321	285	327	336	447	411	351	**3543**
Ward 022	372	366	402	537	468	375	366	441	534	489	**4350**
Ward 023	504	516	675	669	528	504	510	702	735	597	**5940**
Ward 024	519	594	786	711	513	534	510	696	792	549	**6204**
Ward 025	483	507	447	384	246	501	549	357	309	201	**3984**
Ward 026	237	303	426	375	258	252	261	456	495	363	**3426**
Ward 027	354	420	348	300	192	387	363	360	333	207	**3264**
	9570	**10818**	**12873**	**12720**	**9603**	**10026**	**10239**	**13092**	**13989**	**10368**	**113298**

Figure 3 below reflects the population pyramid for KwaDukuza 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 25-29, followed closely by the age group 20-24 years old.

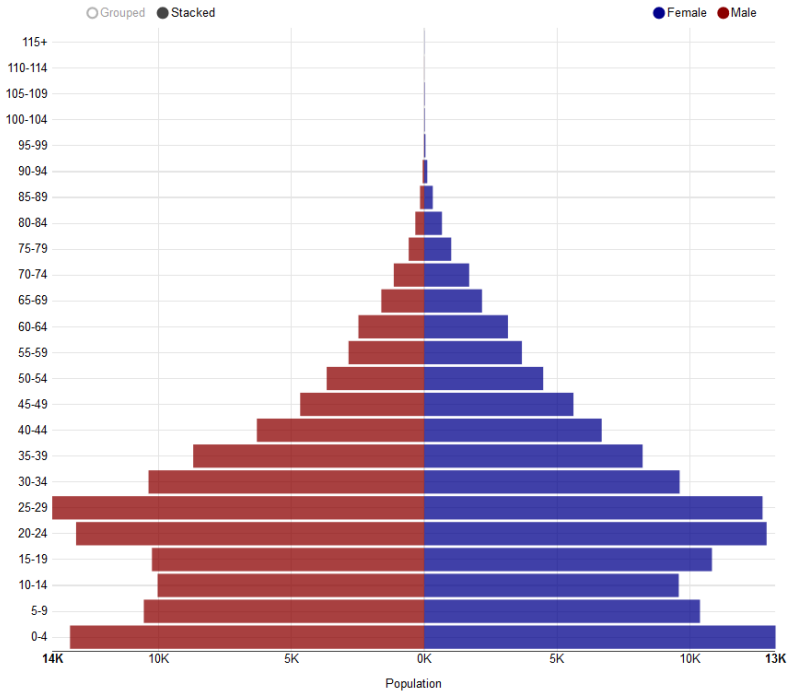

Figure 3: Population Pyramid KwaDukuza local municipality

From this population, 29% children and 4.3% elderly are dependent on the 66.7% economically active population of the KwaDukuza local municipality (Figure 4).

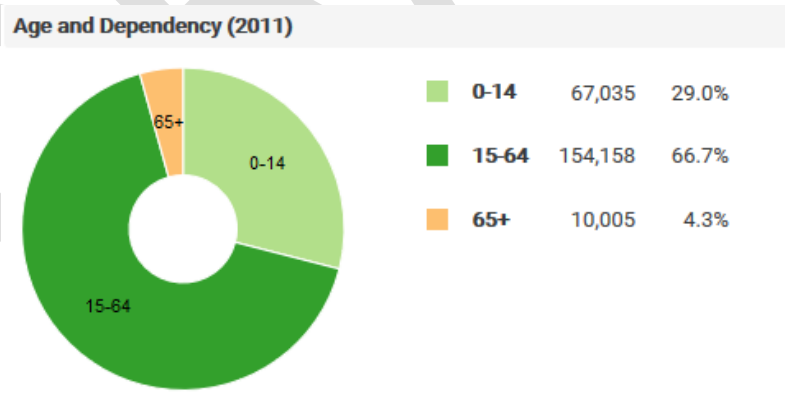

Figure 4: Dependency ratio KwaDukuza local municipality (Source Census 2011)

In the catchment area for the Shakaskraal Clinic (KwaDukuza Wards 7, 8, 21, 22 and 23) there is a slight change in the population profile (Figure 5) with a smaller 20-24 age group and different male to female distribution to that seen in the iLembe local municipality population pyramid in Figure 3.

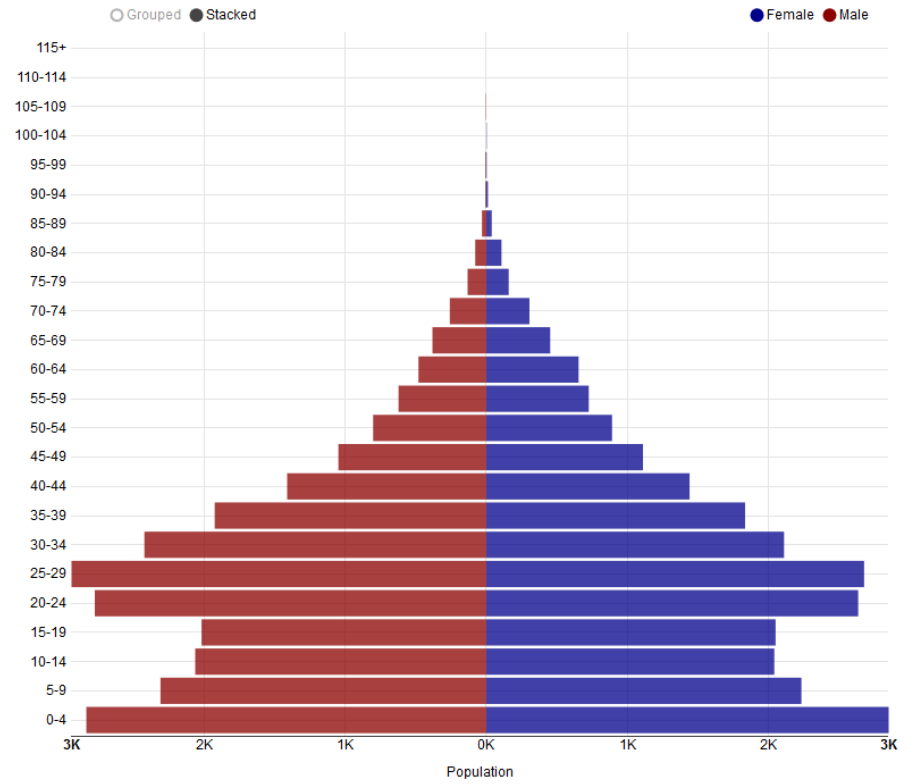

Figure 5: Population Pyramid Shakaskraal clinic catchment area (Source Census 2011)

In the same catchment population, 29.3% children and 4.1% elderly are dependent on the 66.6% economically active population (Figure 6).

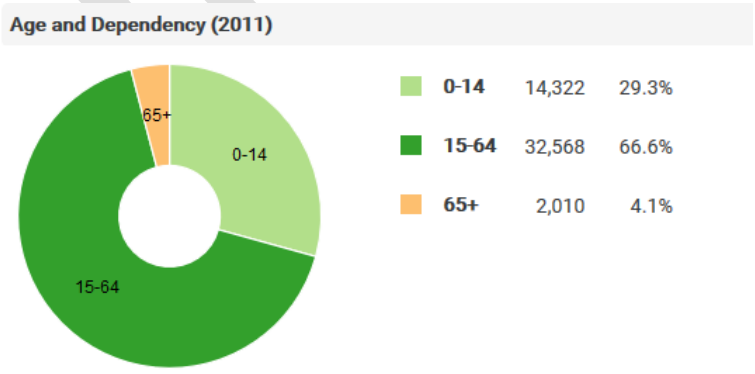

Figure 6: Dependency ratio Shakaskraal clinic catchment area (Source Census 2011)

1.3 Population by race

The dominant population group in KwaDukuza local municipality is Black African at 79% followed by Asian with 14.1% (detail in Figure 7 and Table 2).

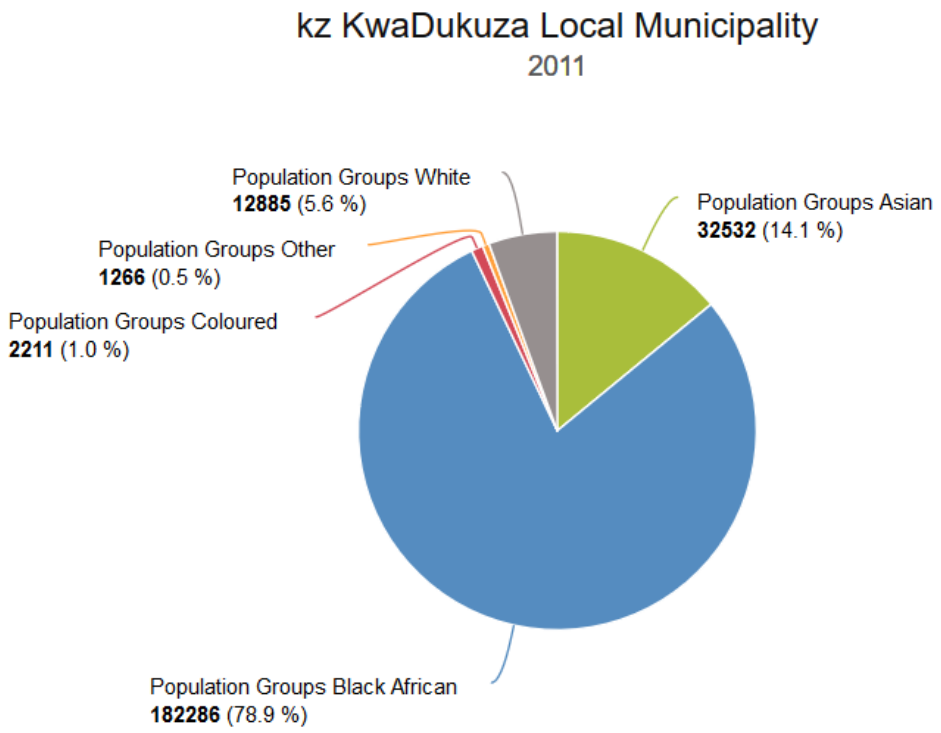

Figure 7: Population group distribution in KwaDukuza local municipality (Source Census 2011)

The detail for Wards7, 8, 21, 22 and 23 that forms the catchment area for Shakaskraal Clinic, are highlighted in the table below.

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

Ward	Asian	Black African	Coloured	Other	White	Total
Ward 001	252	7146	6	3	39	**7446**
Ward 002	1320	7710	60	27	168	**9285**
Ward 003	1059	4506	30	21	516	**6132**
Ward 004	372	7995	87	6	258	**8718**
Ward 005	207	7593	12	51	3	**7866**
Ward 006	567	1200	108	51	5685	**7611**
Ward 007	765	9957	267	51	120	**11160**
Ward 008	6	7836	42	9		**7893**
Ward 009	12	7443	9		9	**7473**
Ward 010	15	10179	18		6	**10218**
Ward 011	966	7584	87	21	537	**9195**
Ward 012	6	11322	21	93	9	**11451**
Ward 013	5316	2973	126	102	9	**8526**

Ward	Asian	Black African	Coloured	Other	White	Total
Ward 014	15	8058	21	114		**8208**
Ward 015	1011	10557	60	60	33	**11721**
Ward 016	6564	2796	150	33	24	**9567**
Ward 017	5058	1563	105	39	36	**6801**
Ward 018		7992	3	84	3	**8082**
Ward 019	4209	2928	543	39	246	**7965**
Ward 020	600	2832	69			**3501**
Ward 021	456	6300	21	45	168	**6990**
Ward 022	2841	3666	159	105	4920	**11691**
Ward 023	384	10704	57	12	6	**11163**
Ward 024	33	11391	45	27	6	**11502**
Ward 025	66	8025	39	57	24	**8211**
Ward 026	264	5619	15	213	18	**6129**
Ward 027	168	6411	51	3	42	**6675**
Total	**32532**	**182286**	**2211**	**1266**	**12885**	**231180**

2. Epidemiological profile

2.1 Causes of death

With the roll out of ART in South Africa, AIDS is now becoming a chronic disease since many people living with HIV are living longer. The main causes of death, the iLembe District is TB (XXX%) followed by HIV (XXX%) (Table 4). The profile would also show five-year series to show the trend of deaths over the past 5 years comparing AIDS related deaths and all-cause mortality at a local level.

Table 4: Main cause of deaths in the iLembe District (Source STATSSA)

Cause	Number of deaths	Percent deaths

2.2 HIV

The figures that follow below reflects the HIV positivity rate based on the routine health data collected, collated and reported in health facilities under iLembe District. The definitions for these indicators can be found in

Appendix B: Terms, Definitions and calculations.

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: Selecting Data for the Profile.

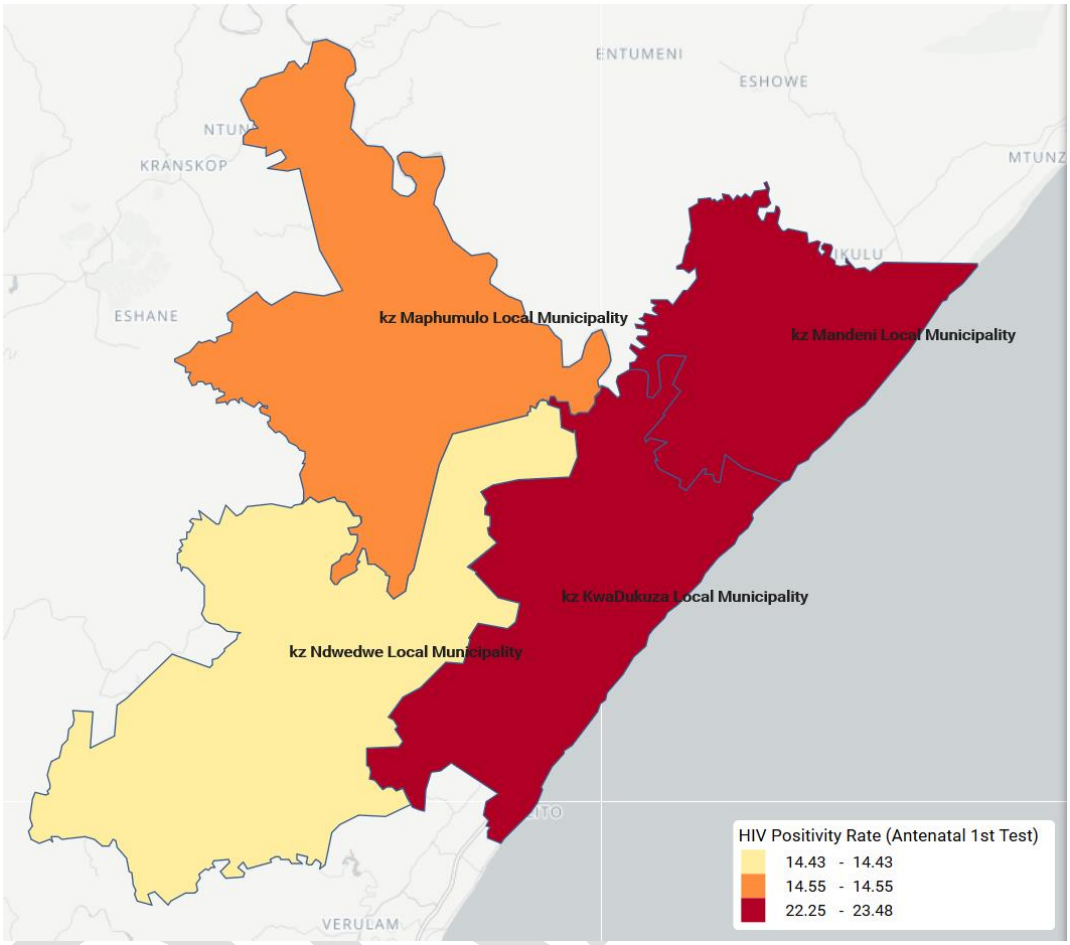

Figure 8: ANC client HIV 1st test positive rate iLembe district (Source: KZN DHIS 2015)

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

KZ ILEMBE DISTRICT MUNICIPALITY: 19.9 %								
	local municipality	**2015: HIV Positivity Rate (Antenatal 1st Test)**					**NUM %**	**DEN %**
1	kz Ndwedwe local municipality	14.43	%	(278	/	1926)	13.57 %	18.70 %
2	kz Maphumulo local municipality	14.55	%	(269	/	1849)	13.13 %	17.96 %
3	kz Mandeni local municipality	22.25	%	(535	/	2404)	26.11 %	23.35 %
4	kz KwaDukuza local municipality	23.48	%	(967	/	4118)	47.19 %	39.99 %

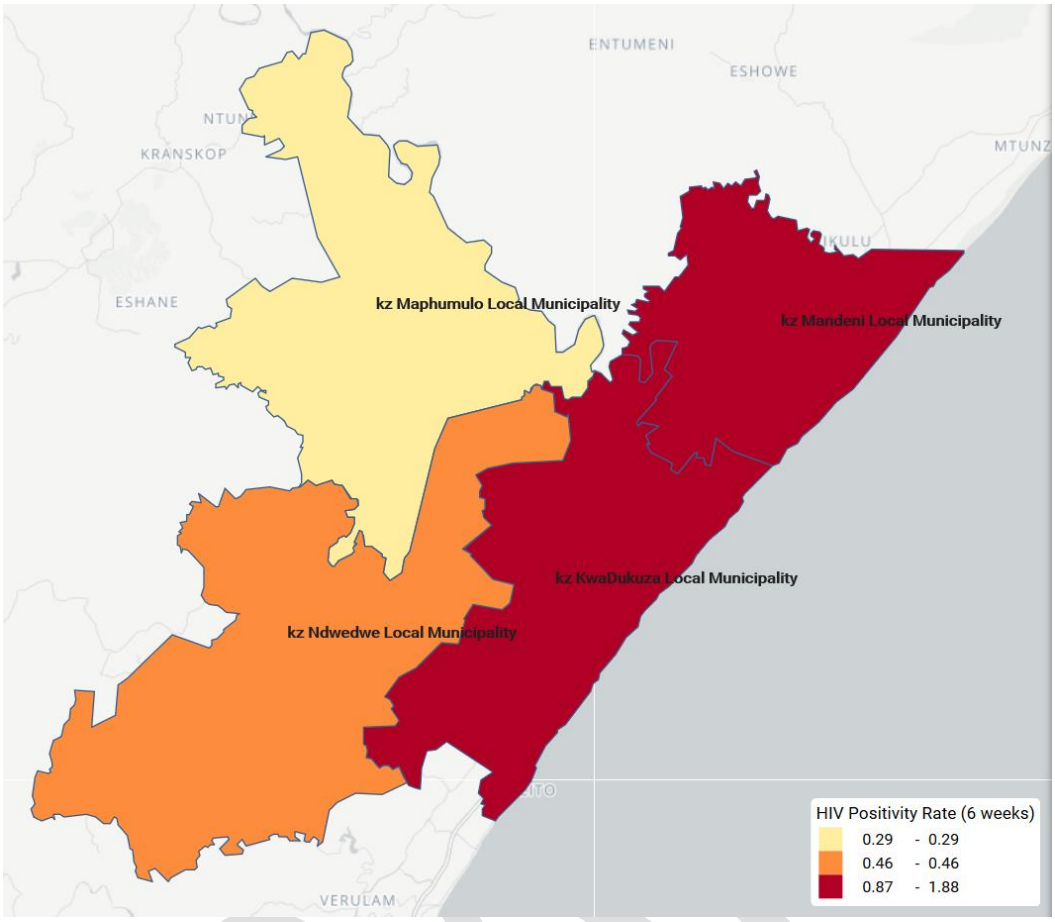

Figure 9: Infant 1st PCR test positive around 6 weeks rate iLembe district (Source: KZN DHIS 2015)

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

KZ ILEMBE DISTRICT MUNICIPALITY: **1.2 %**								
	local municipality	**2015 : HIV Positivity Rate (6 weeks)**					**NUM %**	**DEN %**
1	kz Maphumulo local municipality	0.29	%	(1	/	349)	2.63 %	11.21 %
2	kz Ndwedwe local municipality	0.46	%	(3	/	647)	7.89 %	20.79 %
3	kz Mandeni local municipality	0.87	%	(5	/	577)	13.16 %	18.54 %
4	kz KwaDukuza local municipality	1.88	%	(29	/	1539)	76.32 %	49.45 %

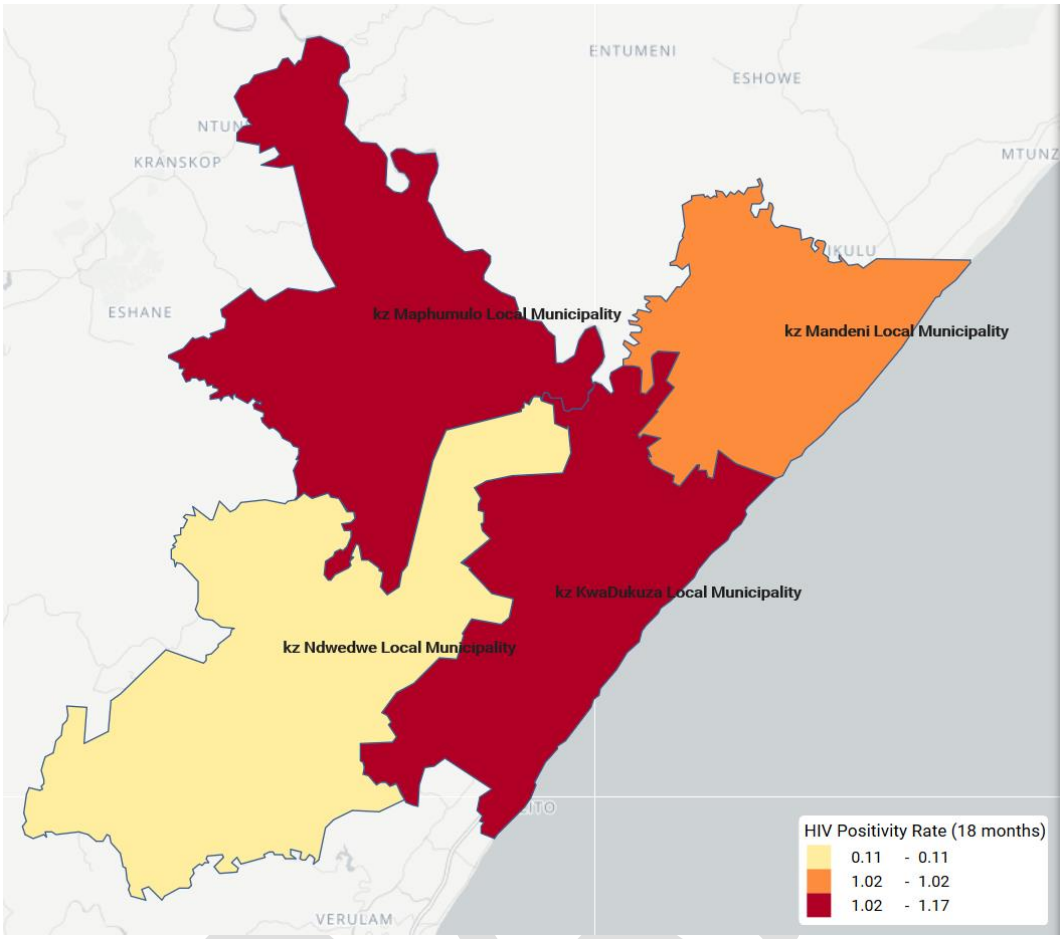

Figure 10: Infant rapid HIV test around 18 months positive rate iLembe district (Source: KZN DHIS 2015)

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

KZ ILEMBE DISTRICT MUNICIPALITY: **1 %**								
	local municipality	**2015 : HIV Positivity Rate (18 months)**					**NUM %**	**DEN %**
1	kz Ndwedwe local municipality	0.11	%	(1	/	951)	1.69 %	15.34 %
2	kz Mandeni local municipality	1.02	%	(11	/	1077)	18.64 %	17.37 %
3	kz Maphumulo local municipality	1.02	%	(13	/	1270)	22.03 %	20.49 %
4	kz KwaDukuza local municipality	1.17	%	(34	/	2901)	57.63 %	46.80 %

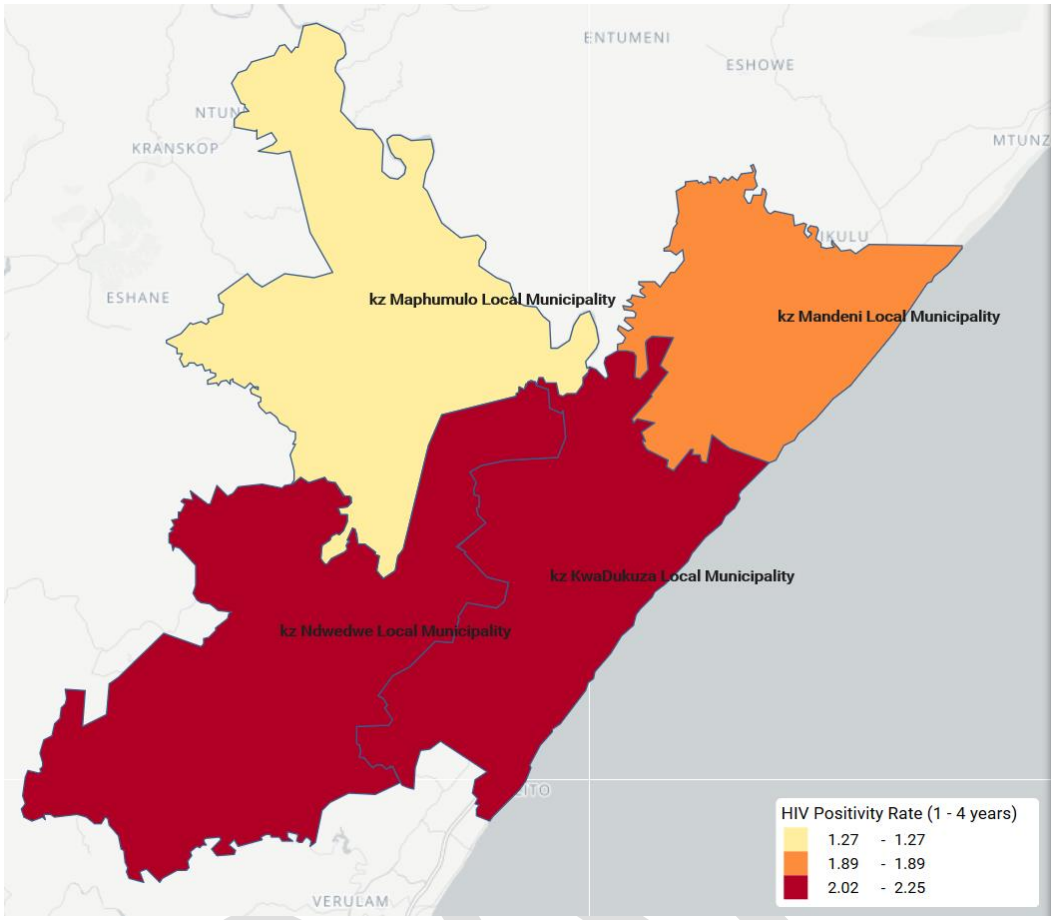

Figure 11: HIV test positive child 12-59 months rate iLembe district (Source: KZN DHIS 2015)

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

KZ ILEMBE DISTRICT MUNICIPALITY: **1.9 %**								
	local municipality	**2015 : HIV Positivity Rate (1 - 4 years)**					**NUM %**	**DEN %**
1	kz Maphumulo local municipality	1.27	%	(31	/	2436)	15.27 %	23.07 %
2	kz Mandeni local municipality	1.89	%	(32	/	1692)	15.76 %	16.03 %
3	kz Ndwedwe local municipality	2.02	%	(43	/	2126)	21.18 %	20.14 %
4	kz KwaDukuza local municipality	2.25	%	(97	/	4303)	47.78 %	40.76 %

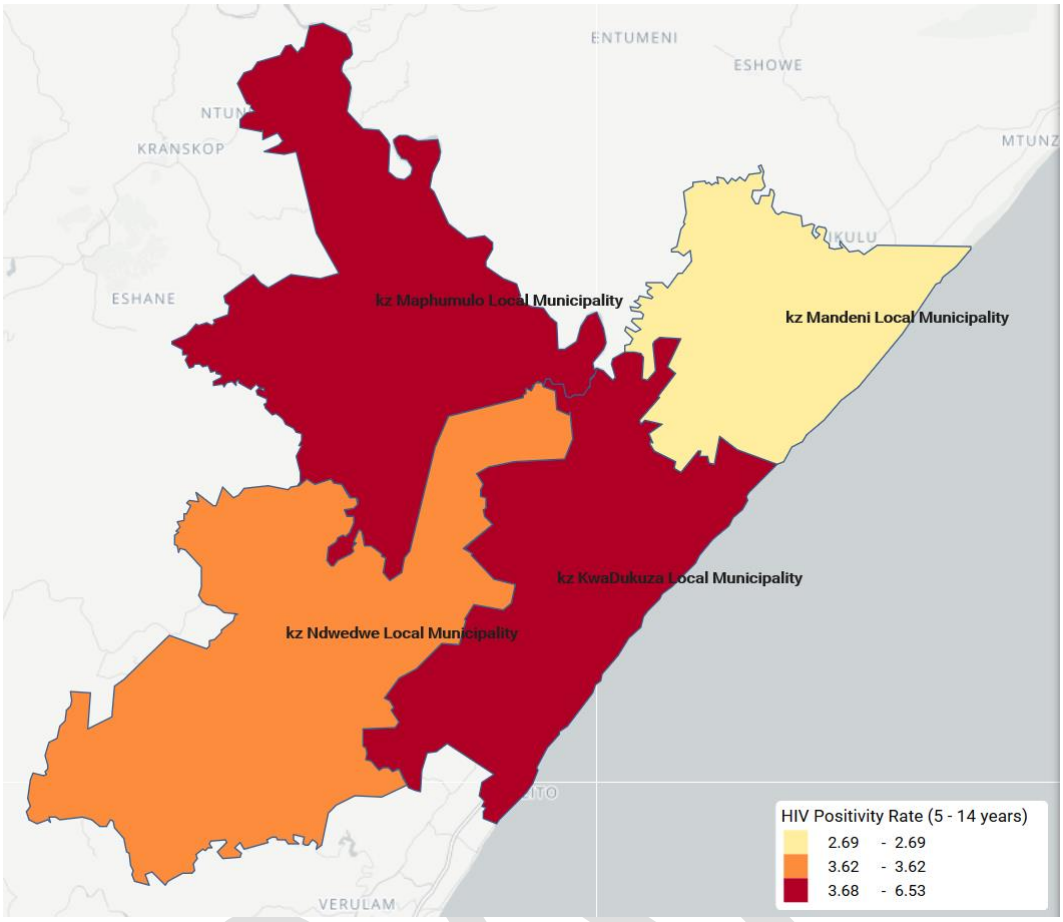

Figure 12: HIV test positive child 5-14 years rate iLembe district (Source: KZN DHIS 2015)

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

KZ ILEMBE DISTRICT MUNICIPALITY: **4 %**								
	local municipality	**2015 : HIV Positivity Rate (5 - 14 years)**					**NUM %**	**DEN %**
1	kz Mandeni local municipality	2.69	%	(34	/	1265)	14.59 %	21.93 %
2	kz Ndwedwe local municipality	3.62	%	(71	/	1963)	30.47 %	34.03 %
3	kz Maphumulo local municipality	3.68	%	(49	/	1332)	21.03 %	23.09 %
4	kz KwaDukuza local municipality	6.53	%	(79	/	1209)	33.91 %	20.96 %

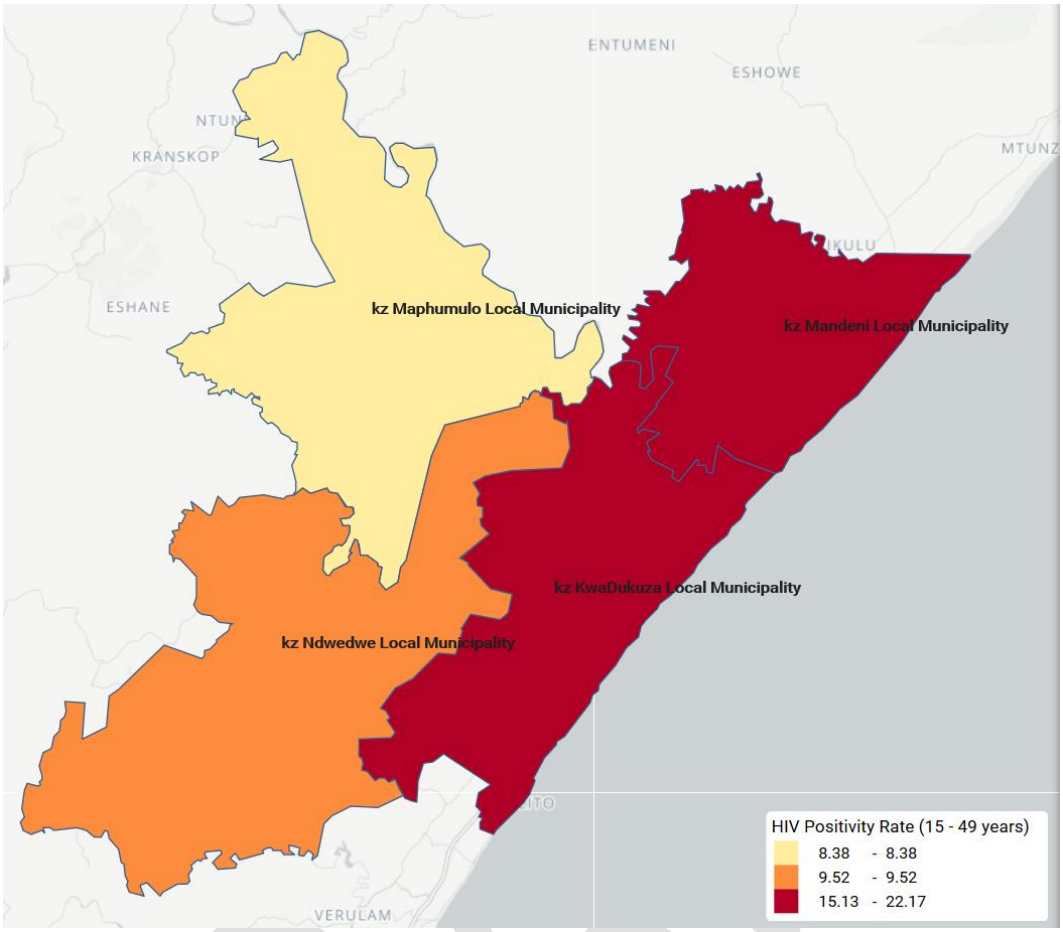

Figure 13: HIV prevalence amongst client tested 15-49 years rate iLembe district (Source: KZN DHIS 2015)

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

KZ ILEMBE DISTRICT MUNICIPALITY: **14.5 %**								
	local municipality	**2015 : HIV Positivity Rate (15 - 49 years)**					**NUM %**	**DEN %**
1	kz Maphumulo local municipality	8.38	%	(1565	/	18670)	11.10 %	19.25 %
2	kz Ndwedwe local municipality	9.52	%	(2238	/	23514)	15.87 %	24.24 %
3	kz Mandeni local municipality	15.13	%	(3989	/	26368)	28.29 %	27.18 %
4	kz KwaDukuza local municipality	22.17	%	(6309	/	28458)	44.74 %	29.34 %

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 iLembe District. The definitions for these indicators can be found in

Appendix B: Terms, Definitions and calculations.

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: Selecting Data for the Profile.

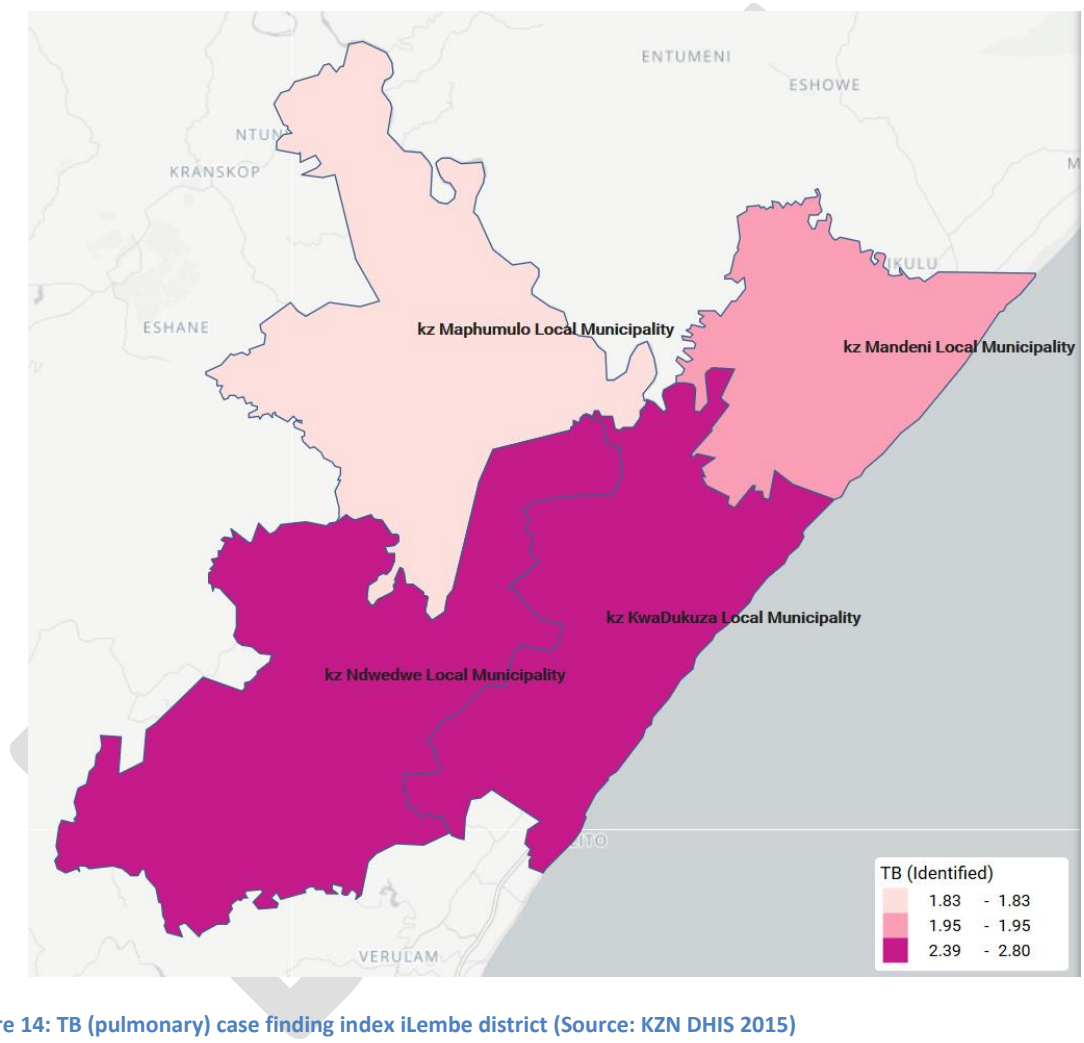

Figure 14: TB (pulmonary) case finding index iLembe district (Source: KZN DHIS 2015)

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

KZ ILEMBE DISTRICT MUNICIPALITY: **2.3 %**								
	local municipality	**2015 : TB (Identified)**					**NUM %**	**DEN %**
1	kz Maphumulo local municipality	1.83	%	(5289	/	288352)	13.84 %	17.13 %
2	kz Mandeni local municipality	1.95	%	(8606	/	441841)	22.51 %	26.24 %
3	kz KwaDukuza local municipality	2.39	%	(13751	/	575669)	35.97 %	34.19 %
4	kz Ndwedwe local municipality	2.80	%	(10579	/	377770)	27.68 %	22.44 %

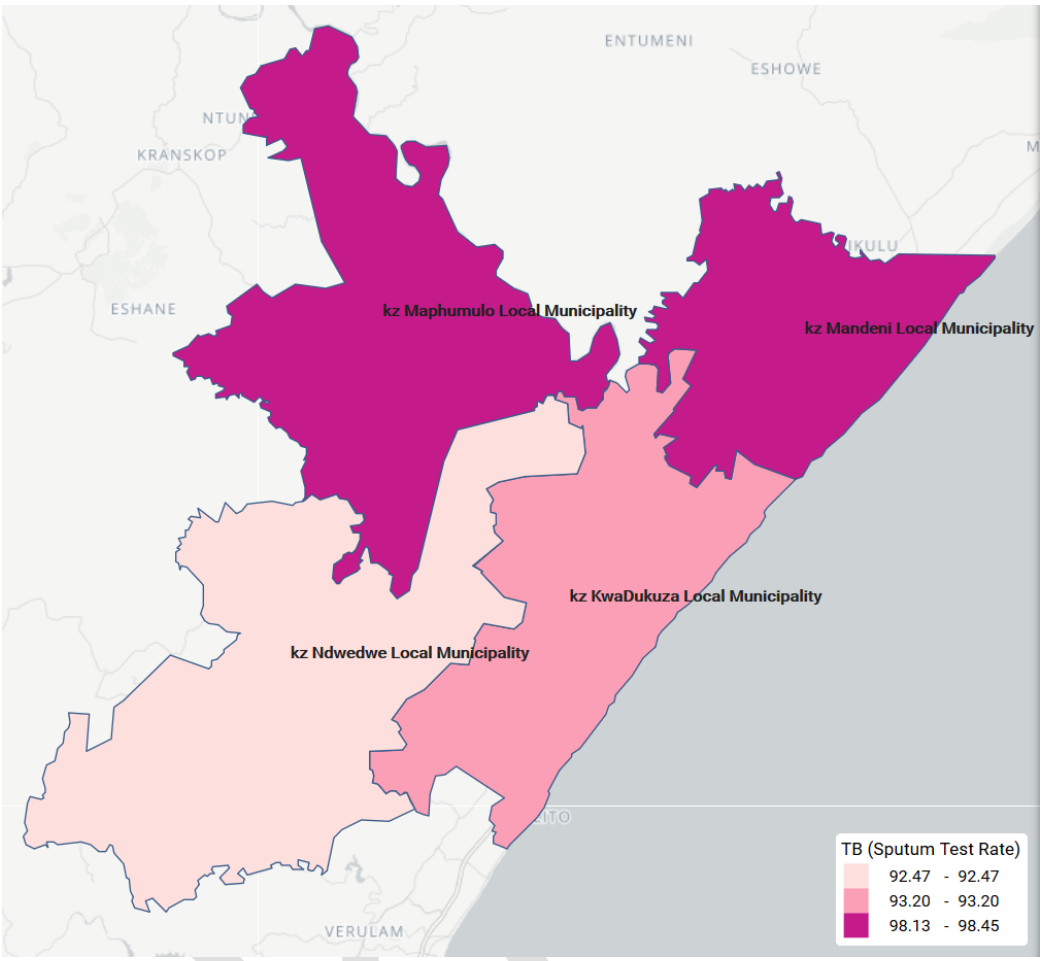

Figure 15: TB suspect sputum test rate iLembe district (Source: KZN DHIS 2015)

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

KZ ILEMBE DISTRICT MUNICIPALITY: **94.8 %**								
	local municipality	**2015 : TB (Sputum Test Rate)**					**NUM %**	**DEN %**
1	kz Ndwedwe local municipality	92.47	%	(10579	/	11441)	27.68 %	28.36 %
2	kz KwaDukuza local municipality	93.20	%	(13751	/	14755)	35.97 %	36.58 %
3	kz Mandeni local municipality	98.13	%	(8606	/	8770)	22.51 %	21.74 %
4	kz Maphumulo local municipality	98.45	%	(5289	/	5372)	13.84 %	13.32 %

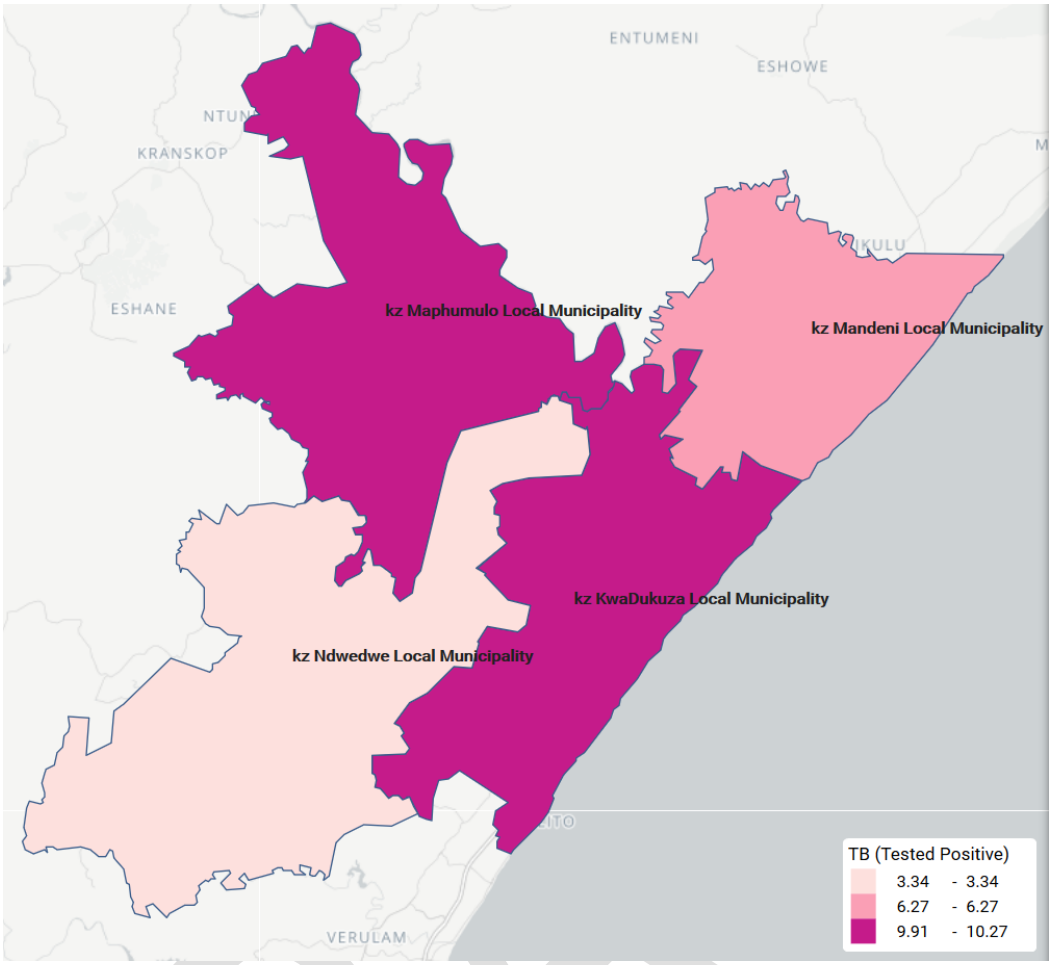

Figure 16: TB suspect smear positive rate iLembe district (Source: KZN DHIS 2015)

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

KZ ILEMBE DISTRICT MUNICIPALITY: **7.3 %**									
	local municipality	**2015 : TB (Tested Positive)**					**NUM %**	**DEN %**
1	kz Ndwedwe local municipality	3.34	%	(353	/	10579)	12.61 %	27.68 %
2	kz Mandeni local municipality	6.27	%	(540	/	8606)	19.29 %	22.51 %
3	kz KwaDukuza local municipality	9.91	%	(1363	/	13751)	48.70 %	35.97 %
4	kz Maphumulo local municipality	10.27	%	(543	/	5289)	19.40 %	13.84 %

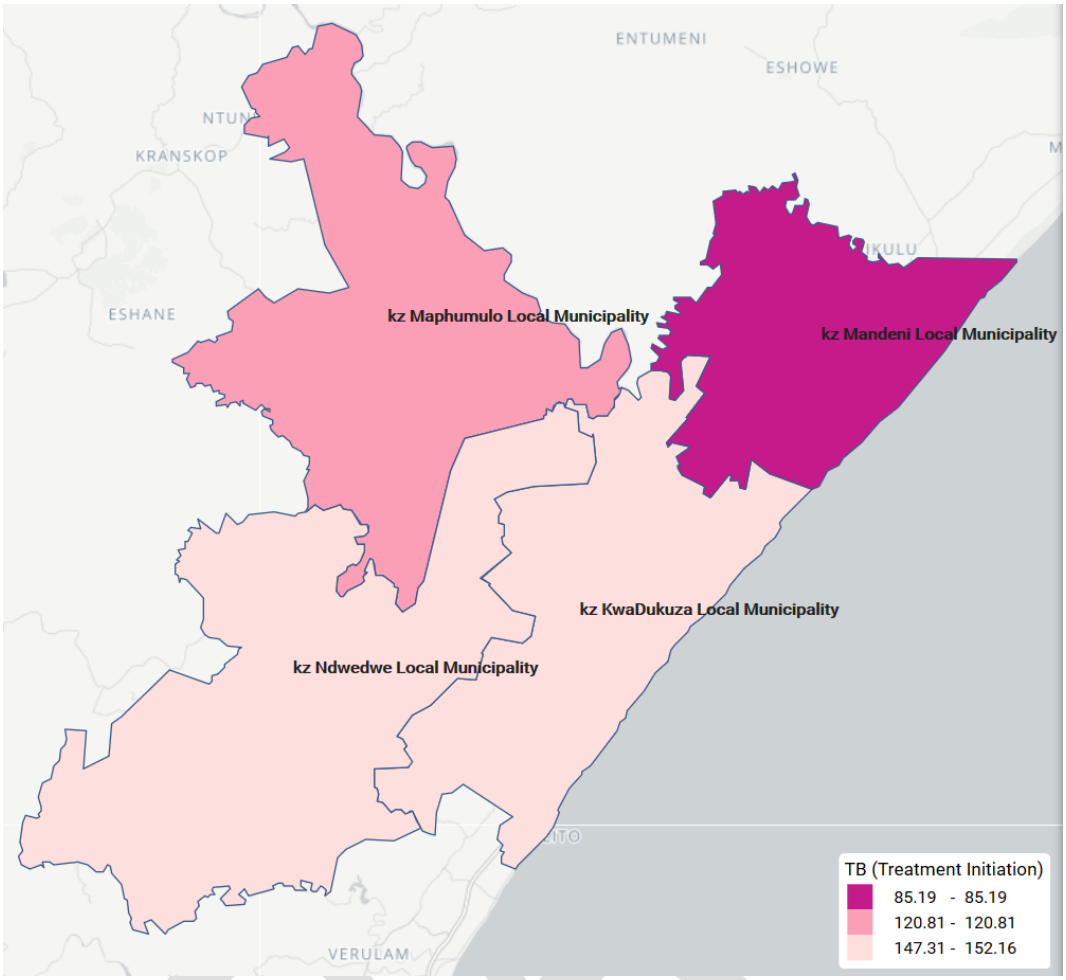

Figure 17: TB suspect treatment initiation rate iLembe district (Source: KZN DHIS 2015)

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

KZ ILEMBE DISTRICT MUNICIPALITY: **132.5 %**								
	local municipality	**2015 : TB (Treatment Initiation)**					**NUM %**	**DEN %**
1	kz Mandeni local municipality	85.19	%	(460	/	540)	12.40 %	19.29 %
2	kz Maphumulo local municipality	120.81	%	(656	/	543)	17.68 %	19.40 %
3	kz Ndwedwe local municipality	147.31	%	(520	/	353)	14.02 %	12.61 %
4	kz KwaDukuza local municipality	152.16	%	(2074	/	1363)	55.90 %	48.70 %

2.4 STIs

Sexually transmitted infections (STIs) are a major risk factor to the human immunodeficiency virus (HIV) epidemic[1]. 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 inflammation[23]. 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 syndrome[6] 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 iLembe 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: Terms, Definitions and calculations. 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: Selecting Data for the Profile.

[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

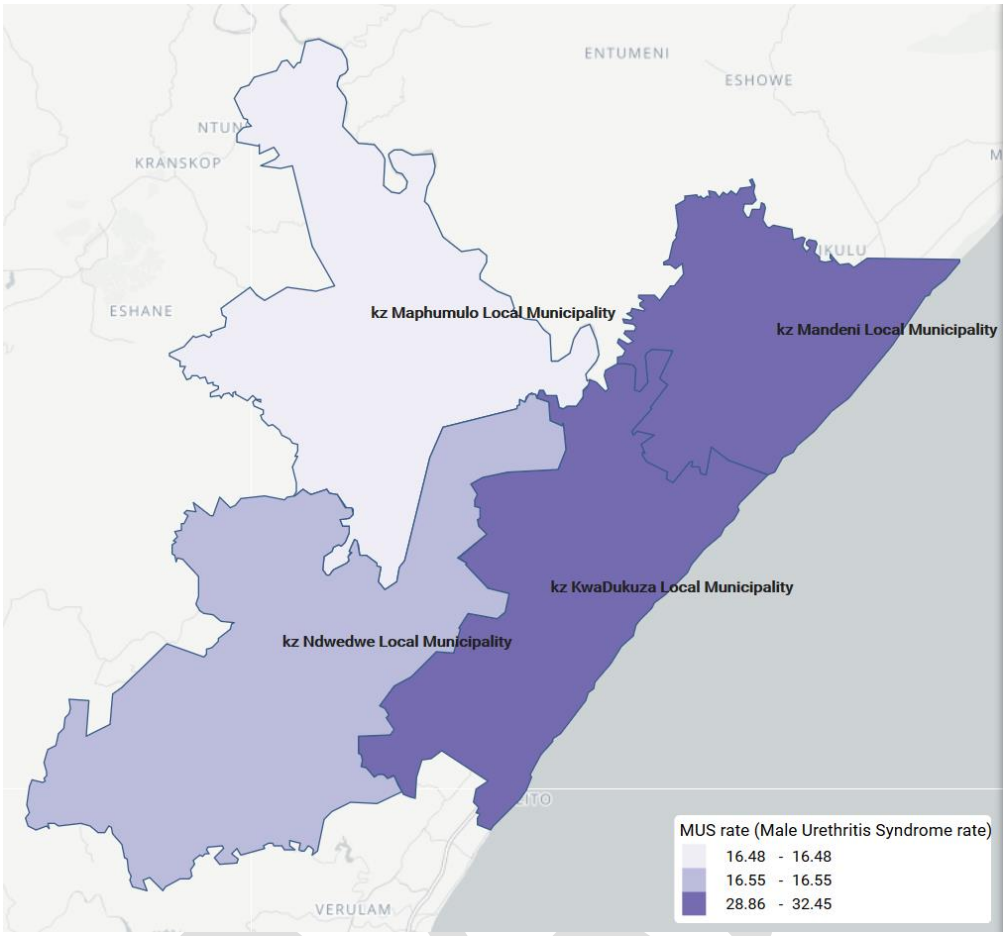

Figure 18: Male urethritis syndrome rate iLembe district (Source: KZN DHIS 2015)

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

KZ ILEMBE DISTRICT MUNICIPALITY: **27.9 %**								
	local municipality	**2015 : MUS rate (Male Urethritis Syndrome rate)**					**NUM %**	**DEN %**
1	kz Maphumulo local municipality	16.48	%	(504	/	3059)	7.12 %	12.04 %
2	kz Ndwedwe local municipality	16.55	%	(443	/	2676)	6.26 %	10.53 %
3	kz Mandeni local municipality	28.86	%	(2030	/	7034)	28.69 %	27.69 %
4	kz KwaDukuza local municipality	32.45	%	(4099	/	12633)	57.93 %	49.73 %

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 HIV [7]. 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

- Most community participants identified women in antenatal care and users of public health services as the main people who test for HIV for example boys who get medically circumcised;
- Men, especially young men under 25 years of age are very reluctant to test; and
- There is also a tendency to use a sexual partners' test results as a proxy for your own status.

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 males[10]. 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 groups[11].

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

- Medical circumcision is a "fashion" in KwaDukuza so there is high uptake among boys;
- Community members noted with concern the apparent high number of post-procedure complications and lack of adequate follow-up;
- There is a tendency for younger boys aged 10-21 to circumcise because the requirement of an HIV test presents a barrier to older men, above 22 years of age who don't want to test;

[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.

- Participants noted that cultural circumcision, which is not practised in this area, also comes with the benefit of teaching values and behaviour; and
- Medical circumcision is provided by a Mobile service offered by New Start, a HIV prevention programme managed by Society for Family Health (SFH); and
- An unintended consequence of medical circumcision is that when young men and boys have been medically circumcised they believe they are immune to HIV and don' use condoms.

3.1.3 ARV treatment

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

- Community members raised a concern that counsellors sell ARV scripts for R 500. This was mentioned numerous times and voted as the highest-ranking risk related to ART;
- Some community members felt ART is widely available and accessible. In particular, the Centralised Chronic Medicines Dispensing and Distribution (CCMDD) programme has provided an opportunity to collect treatment without the fear and stigma associated with clinic collections;
- Others felt ART is available at local clinics but there are still stigma-related barriers that limit patient retention, notably:
    - Fear of being seen carrying files as only HIV positive patients "carry files";
    - Shyness to go to the local clinic and seen by people that know them;
    - Fear of disclosure to intimate partner and family so inconsistent adherence;
- The mixing of ART and traditional therapies was identified as a challenge for adherence;
- There is a tendency by patients to deliberately default on ART in order to secure SRD vouchers, disability grants and other benefits;
- There is some concern related to counselling and support. Community members noted that patients do not adhere to the requirements of ART because counselling has not provided enough information or influenced their behaviour enough for ART to be successful;
- More education is needed regarding how to access ARV's when moving from one area to another or travelling; and
- Some churches do not support the use of ART by their congregants.

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:

- Some community members indicated they have no knowledge of PEP or PrEP;
- Others know PEP as a rape drug that must be taken within 72 hours of a rape and it can be accessed at the clinic;
- Some participants argued PEP can also be used for condom bursts and between discordant couples;
- Some participants indicated that PrEP can be taken to prevent HIV infection; and
- Some community members questioned whether PrEP leads to immunity from HIV.

3.1.5 Lubricant

This community had very little knowledge of lubricant, its purpose or where to access it. Only one participant indicated there is access to lubricants in the area.

3.2 Behaviour that influences risk for HIV infection

The reported high incidence among young women aged 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 infections[12] 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 surveys[13], and are reported at provincial level which is much higher that 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:

- Community members identified farm workers as having the least knowledge of HIV and access to health services;
- Traditional healers were also identified as role-players that could benefit from more education about HIV, especially about treatment;
- Traditional Healers can support testing and treatment;
- In general, ART patients need more education on Adherence;
- There was a strong view that behavioural messaging needed to focus on:
    - Condom negotiation skills;
    - Attitudes to sex – that it is something kept for committed monogamous relationships;
    - Self-esteem – sex is not the only way to get ahead;
    - Abstinence should be targeted at the very young but is not relevant to older children and adults;
- Parents are a key but absent role-player in educating their children about sex and HIV; and
- Community participants supported more social mobilisation, community dialogues, awareness campaigns, pamphleteering, door-to-door campaigns and support groups to improve HIV knowledge in the community.

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

3.2.2 Sexual risky behaviours

The only sexually risky behaviour identified by the community is girls who want to stay virgins practice anal sex, without the use of condoms.

3.2.3 Substance abuse

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

- Substance abuse was identified as the highest risk factor for HIV infection. Repeatedly participants indicated the pervasive use of alcohol among young people as the factor which prevents correct and consistent condom use, self-control, safety and protection;
- Alcohol is widely available in the many illegal shebeens as well as taverns and there is no control of consumption;
- Bluetoothing – the practice by injecting drug users to share blood – also contributes to HIV transmission in this area; and
- There is a concern that drug-use and alcohol abuse are on the rise in KwaDukuza – Dagga, Wonga and "pills" are very prevalent in the community as is alcohol abuse due to unemployment and dropping out of school.

3.2.4 Condoms

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

- The community confirmed the wide availability of male and female condoms but the correct and consistent use of condoms is low because of alcohol abuse and the inability of women to negotiate condom use;
- Some community members still felt condoms were not easily available;
- Some community members also raised concerns about aversion to government condoms and the preference for branded condoms;
- There is very little knowledge of the benefits of using lubricants with condoms to prevent infection;
- Female condoms are reported to be uncomfortable and interrupt the natural flow of sex; and
- The community reported that women believe condoms are for men to decide on.

In Figure 19 and Figure 20 the condom distribution for females and males (annualised) are reflected at local municipality level in iLembe District. The definitions for these indicators can be found in

Appendix B: Terms, Definitions and calculations.

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: Selecting Data for the Profile.

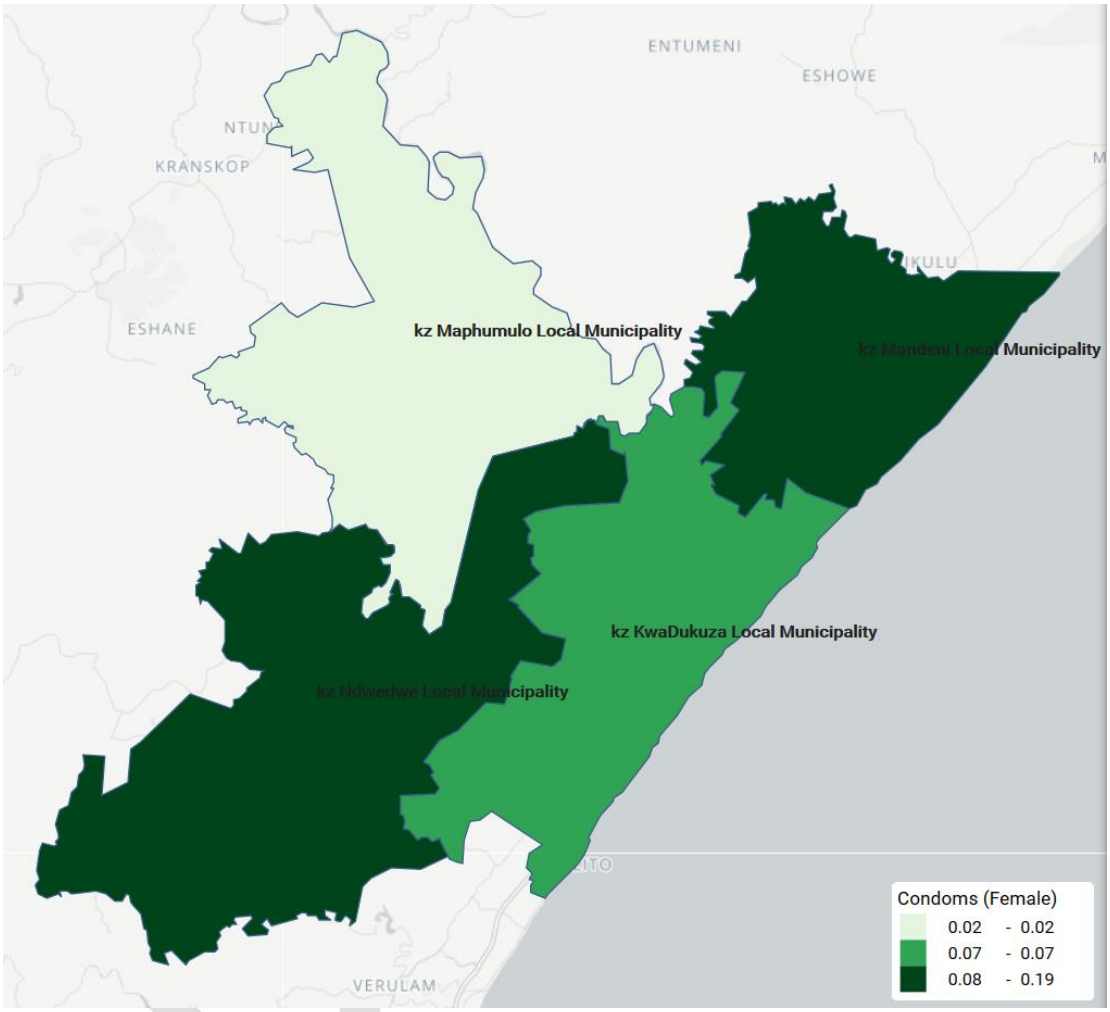

Figure 19: Female condom distribution rate iLembe district (Source: KZN DHIS 2015)

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

KZ ILEMBE DISTRICT MUNICIPALITY: **9.1 No**								
	local municipality	**2015 : Condoms (Female)**					**NUM %**	**DEN %**
1	kz Maphumulo local municipality	0.02	No	(8809	/	462732)	3.28 %	15.67 %
2	kz KwaDukuza local municipality	0.07	No	(78665	/	1149648)	29.30 %	38.94 %
3	kz Ndwedwe local municipality	0.08	No	(52002	/	661380)	19.37 %	22.40 %
4	kz Mandeni local municipality	0.19	No	(129036	/	678396)	48.06 %	22.98 %

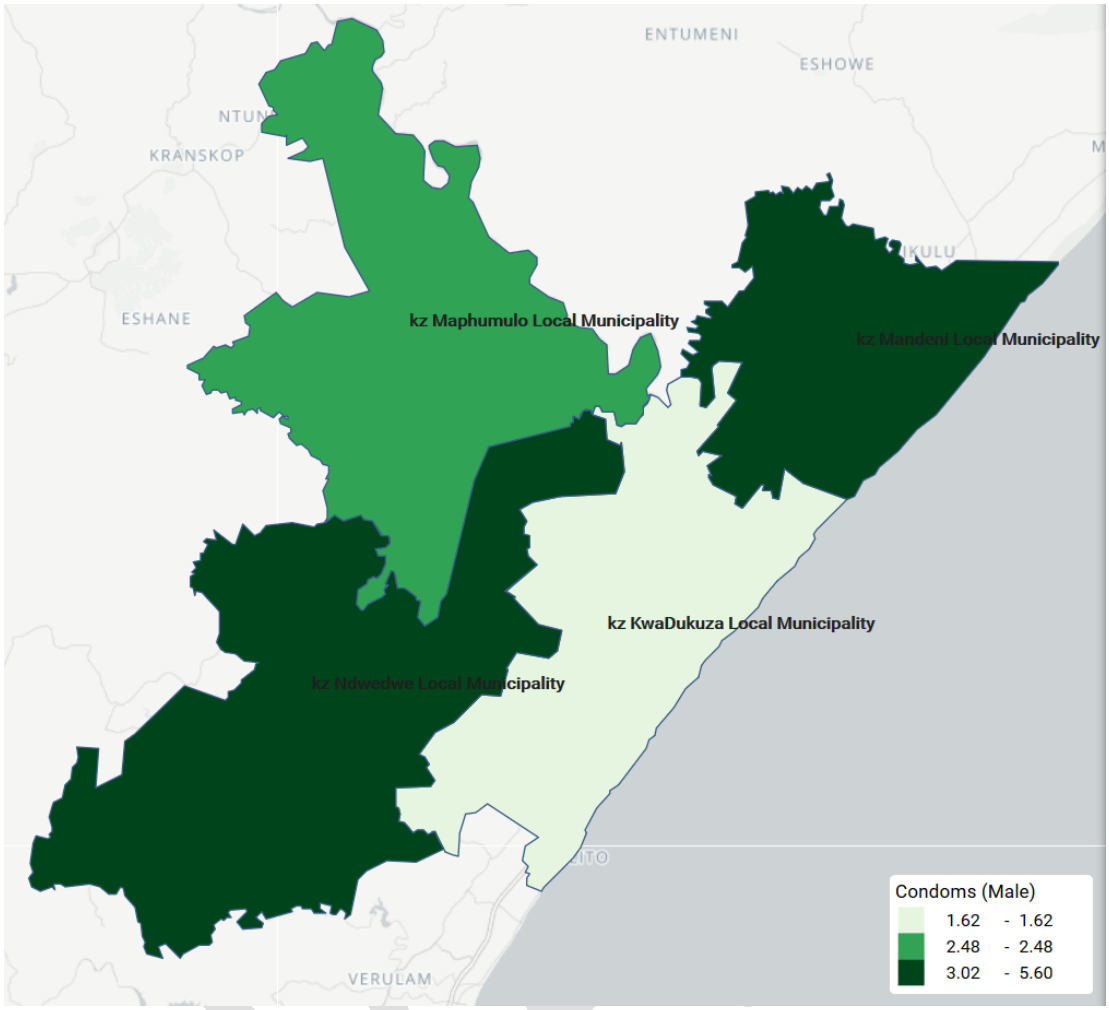

Figure 20: Male condom distribution rate iLembe district (Source: KZN DHIS 2015)

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

KZ ILEMBE DISTRICT MUNICIPALITY: **292.4 No**								
	local municipality	**2015 : Condoms (Male)**					**NUM %**	**DEN %**
1	kz KwaDukuza local municipality	1.62	No	(1787393	/	1103880)	24.34 %	43.95 %
2	kz Maphumulo local municipality	2.48	No	(759819	/	306240)	10.35 %	12.19 %
3	kz Ndwedwe local municipality	3.02	No	(1602470	/	530868)	21.82 %	21.14 %
4	kz Mandeni local municipality	5.60	No	(3193579	/	570768)	43.49 %	22.72 %

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: Terms, Definitions and calculations. 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: Selecting Data for the Profile.

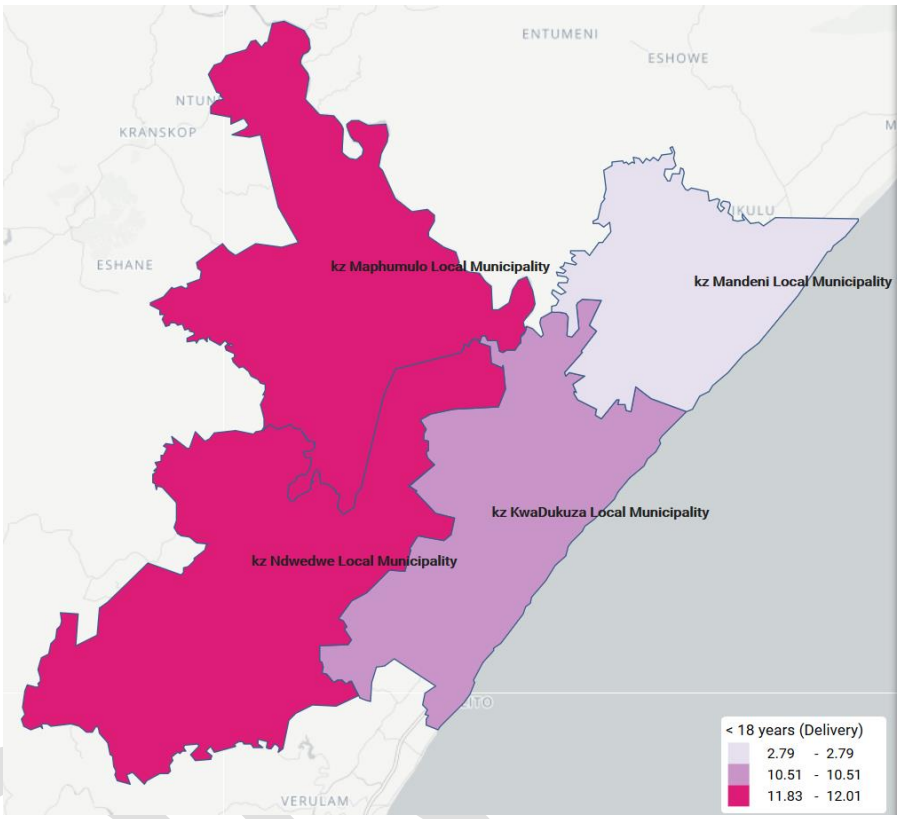

Figure 21: Teenage Pregnancy rate iLembe district (Source: KZN DHIS 2015)

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

KZ ILEMBE DISTRICT MUNICIPALITY: **10 %**									
	local municipality	**2015 : < 18 years (Delivery)**						**NUM %**	**DEN %**
1	kz Mandeni local municipality	2.79	%	(36	/	1289)		3.39 %	12.11 %
2	kz KwaDukuza local municipality	10.51	%	(669	/	6366)		62.99 %	59.81 %
3	kz Ndwedwe local municipality	11.83	%	(130	/	1099)		12.24 %	10.33 %
4	kz Maphumulo local municipality	12.01	%	(227	/	1890)		21.37 %	17.76 %

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	Young women, especially young girls affected by severe poverty that have dropped out of school, abuse alcohol which limits their ability to make healthy choices. They have survival and aspirational needs and therefore practice transactional sex with multiple partners. Their dependence on older men means that they cannot negotiate condom use.
Youth	Many youth, who drop out of school or are unemployed, abuse alcohol and drugs and cannot make healthy choices under these circumstances.
Sex workers	There are sex workers from the community who work closer to the N2 and in Stanger. Sex workers cannot negotiate condom use.
Orphans and vulnerable children	OVC, particularly the heads of child-headed households engage in transactional sex to meet the needs of the family. This is most urgent for over 18-year-olds who are not protected by the system any more. Grandmothers who look after HIV positive children are also at risk.
Drug users	Blue-toothers specifically contribute to HIV infection, but drug users in general make choices based on their need to secure drugs.
Disabled	Particularly people with intellectual disabilities are abused for their grants, and cannot negotiate safe sex. They also have multiple partners to meet their livelihood needs.

3.3 Social and structural factors that influence HIV 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 KwaZulu-Natal had been associated with high proportion of orphans[14] , albeit at provincial level. The detail for the catchment area for Shakaskraal Clinic, are highlighted in the table below.

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

Ward	Maternal orphans			Paternal orphans			Double orphans		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Ward 1	55	57	112	233	215	448	98	96	194
Ward 2	49	55	104	219	238	458	55	76	131
Ward 3	33	24	58	105	115	221	26	30	56
Ward 4	31	46	77	129	140	270	58	39	97
Ward 5	39	54	93	236	252	487	80	109	189
Ward 6	8	5	13	28	35	63	14	12	26
Ward 7	73	63	137	261	278	538	73	79	152
Ward 8	43	51	94	189	231	420	67	79	145
Ward 9	57	56	113	191	207	398	75	87	162
Ward 10	52	39	92	328	268	596	86	92	177
Ward 11	48	47	95	219	218	438	80	62	142
Ward 12	60	58	118	311	296	607	99	118	217
Ward 13	14	24	38	124	132	255	28	32	60
Ward 14	65	56	121	245	261	506	74	114	188
Ward 15	50	51	101	286	275	560	107	100	207
Ward 16	15	9	24	107	130	237	16	23	39
Ward 17	6	21	26	62	44	106	12	12	24
Ward 18	54	37	90	226	208	435	68	74	142
Ward 19	9	15	24	75	84	158	17	24	41
Ward 20	13	13	26	76	64	140	23	20	43
Ward 21	34	39	74	141	158	299	67	71	138
Ward 22	12	24	36	109	92	202	30	30	60
Ward 23	53	55	108	323	275	598	80	103	183
Ward 24	79	74	153	275	302	578	92	92	183
Ward 25	60	69	130	368	335	704	129	106	236
Ward 26	19	43	62	166	151	317	51	70	121
Ward 27	52	48	100	275	276	552	101	98	199

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

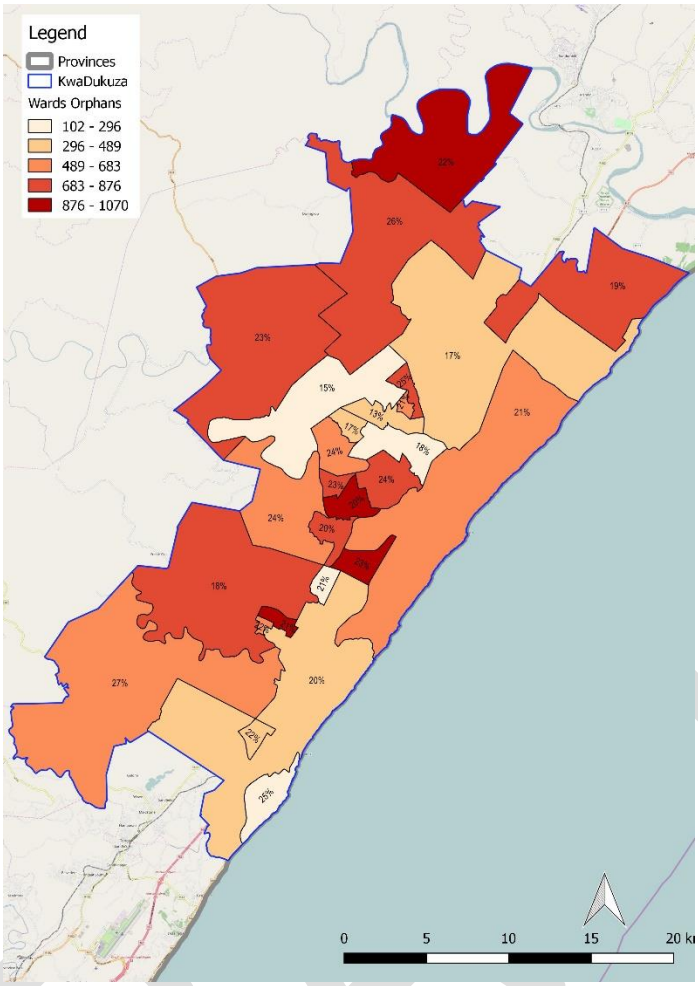

Figure 22: Total number of Orphans with percentage that are double orphans per ward (Source Census 2011)

The following was identified as associated risks for ***Orphans and vulnerable children***:

- Orphans are vulnerable to HIV because they cannot meet their needs except through transactional sex; and
- Particularly the head of child-headed households bears the responsibility to feed and clothe the younger ones and is forced into transactional sex or sex work.

3.3.2 Cultural and Religious Norms

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

- The community felt that Ukuhlolwa – being deemed not to be a virgin acts as a deterrent to unsafe sex;
- Ukupehlwa – a process that reduces sexual desire in boys can also be of use in this community;
- Ukuthwala - child abduction for forced marriage – this transmits HIV because the older man is a polygamist;
- The community raised concern about the use of blade-sharing for ukugcaba (ritual scarring) and taking blades home for cultural practices also increases HIV infection; and

- The community reported that many cultures do not support the use of condoms.

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:

- There is significant abuse in the households that contribute to HIV infection:
    - Sexual abuse by family members and step-fathers increases HIV infection;
    - Children run away to live with their older boyfriends who also abuse them;
    - Men impose their unwillingness to use condoms on their wives and girlfriends;
    - Children drop out of school and abuse substances - they cannot make healthy choices and are dependent on older men and women for survival; and
- There is a tendency of older men to seek out young women at sports tournaments.

3.3.4 Stigma

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

- After substance abuse, stigma was reported by the community as the second biggest risk factor for HIV infection;
- Stigma prevents people from going for HIV testing, especially people who know they are at risk due to their behaviour or circumstances;
- There is a tendency to add to stressors by PLHIV seeking out other facilities to avoid being recognised in their local facility. This contributes to the burden of accessing treatment and threatens adherence; and
- Disclosure and fear of disclosure remains a concern among PLHIV according to the community. This means that they take treatment secretly.

3.3.5 Poverty

Poverty is measured through the South Africa Multidimensional Poverty Index (SAMPI)[15]. The detail for the catchment area for Shakaskraal Clinic, are highlighted in the table below.

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

	Poverty Headcount (H)	Intensity of Poverty (A)	SAMPI (HxA)
kz KwaDukuza Ward 001	24.3	41.0	0.100
kz KwaDukuza Ward 002	2.4	39.5	0.009
kz KwaDukuza Ward 003	13.3	40.8	0.054
kz KwaDukuza Ward 004	7.1	40.7	0.029
kz KwaDukuza Ward 005	7.0	42.6	0.030
kz KwaDukuza Ward 006	0.1	35.5	0.000
kz KwaDukuza Ward 007	8.7	39.7	0.035
kz KwaDukuza Ward 008	9.3	41.6	0.039
kz KwaDukuza Ward 009	9.6	40.8	0.039
kz KwaDukuza Ward 010	6.3	41.8	0.026
kz KwaDukuza Ward 011	9.0	41.3	0.037
kz KwaDukuza Ward 012	7.4	41.6	0.031
kz KwaDukuza Ward 013	9.8	41.5	0.041
kz KwaDukuza Ward 014	9.6	40.2	0.039
kz KwaDukuza Ward 015	13.5	42.3	0.057
kz KwaDukuza Ward 016	4.3	41.4	0.018
kz KwaDukuza Ward 017	2.8	37.2	0.010
kz KwaDukuza Ward 018	8.5	47.5	0.040
kz KwaDukuza Ward 019	0.5	47.4	0.002
kz KwaDukuza Ward 020	21.7	42.7	0.093
kz KwaDukuza Ward 021	12.4	38.7	0.048
kz KwaDukuza Ward 022	1.8	39.8	0.007
kz KwaDukuza Ward 023	4.6	41.7	0.019
kz KwaDukuza Ward 024	10.6	41.8	0.044
kz KwaDukuza Ward 025	13.8	41.1	0.057
kz KwaDukuza Ward 026	21.5	40.1	0.086
kz KwaDukuza Ward 027	13.8	40.5	0.056
kz KwaDukuza	**9.4**	**41.1**	**0.039**

Ward 1 was the poorest Ward in KwaDukuza local municipality with close to a quarter of households (24.3%) being poor with the average intensity at 41.7% amongst these poor households (Table 21, Appendix B). Ward 6 had the lowest poverty head count at 0.1%. 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).

[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.

The Multidimensional Poverty Index for KwaDukuza local municipality changed between 2001 (Figure 23) and 2011 (Figure 24). In the catchment area for Shakaskraal clinic, the highest poverty index and poverty headcount is in ward 1 at 9.96% with an intensity of 15.54%. This is visible with the darker shading in Figure 26 for the SAMPI poverty headcount for the ward level.

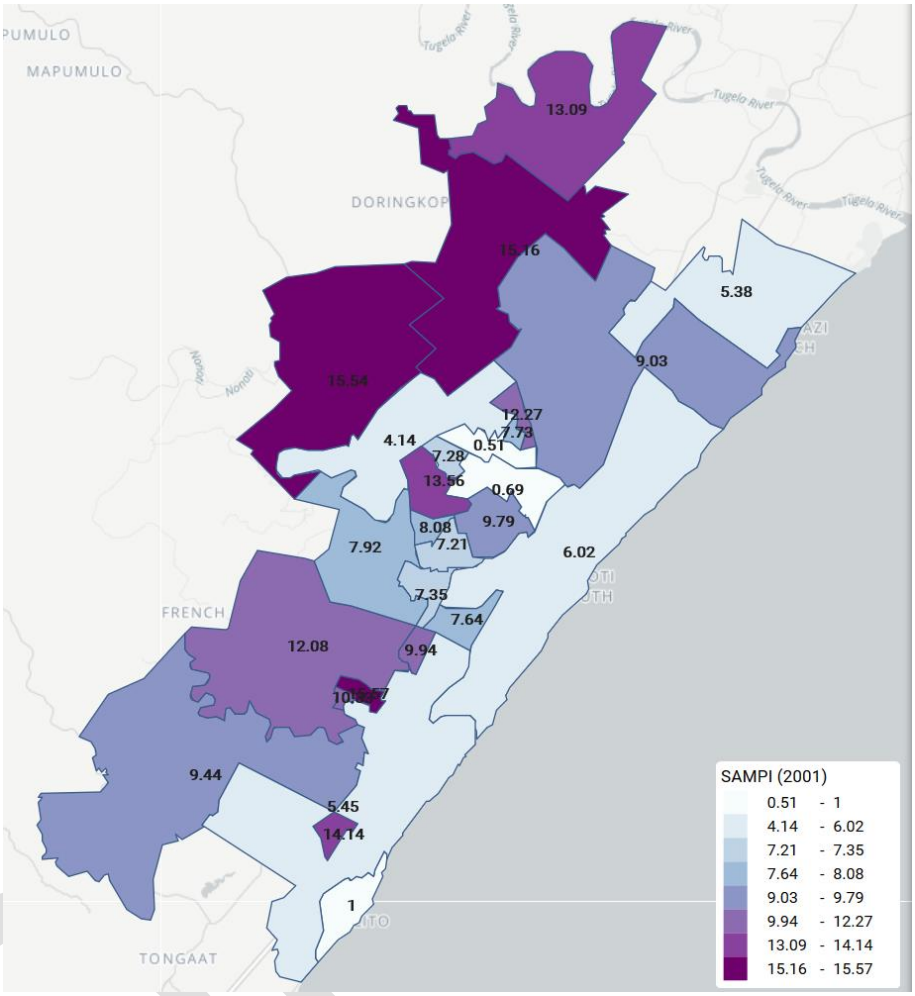

Figure 23: SAMPI (poverty Index) 2001 - ward level, KwaDukuza local municipality

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

KZ KWADUKUZA LOCAL MUNICIPALITY: **8.1 %**						
	Ward (2011)	**SAMPI (2001)**				
1	kz KwaDukuza Ward 016	0.51	%	(0.5	/	100)
2	kz KwaDukuza Ward 019	0.69	%	(0.7	/	100)
3	kz KwaDukuza Ward 006	1	%	(1	/	100)
4	kz KwaDukuza Ward 017	4.14	%	(4.1	/	100)
5	kz KwaDukuza Ward 002	5.38	%	(5.4	/	100)
6	kz KwaDukuza Ward 022	5.45	%	(5.5	/	100)
7	kz KwaDukuza Ward 011	6.02	%	(6	/	100)
8	kz KwaDukuza Ward 024	7.21	%	(7.2	/	100)
9	kz KwaDukuza Ward 013	7.28	%	(7.3	/	100)
10	kz KwaDukuza Ward 010	7.35	%	(7.3	/	100)

KZ KWADUKUZA LOCAL MUNICIPALITY: **8.1 %**						
	Ward (2011)	**SAMPI (2001)**				
11	kz KwaDukuza Ward 012	7.64	%	(7.6	/	100)
12	kz KwaDukuza Ward 018	7.73	%	(7.7	/	100)
13	kz KwaDukuza Ward 009	7.92	%	(7.9	/	100)
14	kz KwaDukuza Ward 014	8.08	%	(8.1	/	100)
15	kz KwaDukuza Ward 003	9.03	%	(9	/	100)
16	kz KwaDukuza Ward 021	9.44	%	(9.4	/	100)
17	kz KwaDukuza Ward 015	9.79	%	(9.8	/	100)
18	kz KwaDukuza Ward 020	9.94	%	(9.9	/	100)
19	kz KwaDukuza Ward 008	10.33	%	(10.3	/	100)
20	kz KwaDukuza Ward 007	12.08	%	(12.1	/	100)
21	kz KwaDukuza Ward 005	12.27	%	(12.3	/	100)
22	kz KwaDukuza Ward 025	13.09	%	(13.1	/	100)
23	kz KwaDukuza Ward 026	13.56	%	(13.6	/	100)
24	kz KwaDukuza Ward 004	14.14	%	(14.1	/	100)
25	kz KwaDukuza Ward 001	15.16	%	(15.2	/	100)
26	kz KwaDukuza Ward 027	15.54	%	(15.5	/	100)
27	kz KwaDukuza Ward 023	15.57	%	(15.6	/	100)

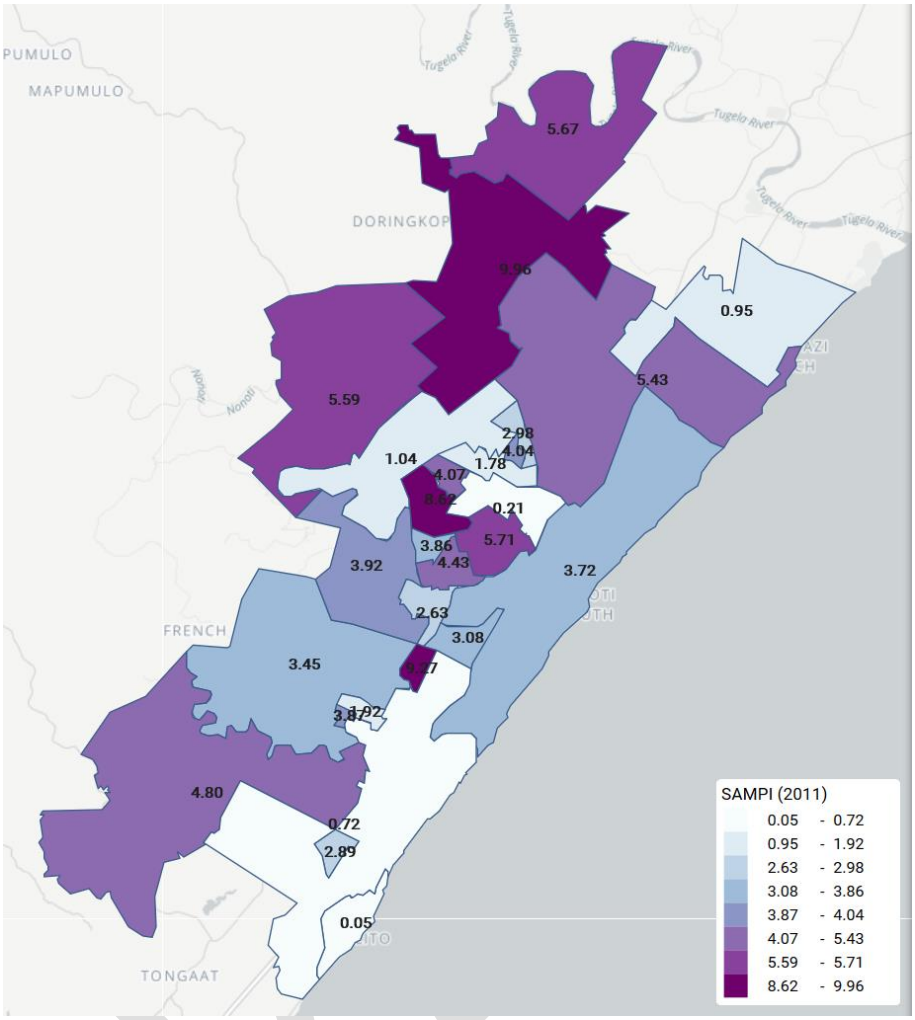

Figure 24: SAMPI (poverty Index) 2011 - ward level, KwaDukuza local municipality

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

KZ KWADUKUZA LOCAL MUNICIPALITY: **3.9 %**						
	Ward (2011)	**SAMPI (2011)**				
1	kz KwaDukuza Ward 006	0.05	%	(0.1	/	100)
2	kz KwaDukuza Ward 019	0.21	%	(0.2	/	100)
3	kz KwaDukuza Ward 022	0.72	%	(0.7	/	100)
4	kz KwaDukuza Ward 002	0.95	%	(0.9	/	100)
5	kz KwaDukuza Ward 017	1.04	%	(1	/	100)
6	kz KwaDukuza Ward 016	1.78	%	(1.8	/	100)
7	kz KwaDukuza Ward 023	1.92	%	(1.9	/	100)
8	kz KwaDukuza Ward 010	2.63	%	(2.6	/	100)
9	kz KwaDukuza Ward 004	2.89	%	(2.9	/	100)
10	kz KwaDukuza Ward 005	2.98	%	(3	/	100)
11	kz KwaDukuza Ward 012	3.08	%	(3.1	/	100)
12	kz KwaDukuza Ward 007	3.45	%	(3.5	/	100)
13	kz KwaDukuza Ward 011	3.72	%	(3.7	/	100)
14	kz KwaDukuza Ward 014	3.86	%	(3.9	/	100)

KZ KWADUKUZA LOCAL MUNICIPALITY: **3.9 %**						
	Ward (2011)	**SAMPI (2011)**				
15	kz KwaDukuza Ward 008	3.87	%	(3.9	/	100)
16	kz KwaDukuza Ward 009	3.92	%	(3.9	/	100)
17	kz KwaDukuza Ward 018	4.04	%	(4	/	100)
18	kz KwaDukuza Ward 013	4.07	%	(4.1	/	100)
19	kz KwaDukuza Ward 024	4.43	%	(4.4	/	100)
20	kz KwaDukuza Ward 021	4.80	%	(4.8	/	100)
21	kz KwaDukuza Ward 003	5.43	%	(5.4	/	100)
22	kz KwaDukuza Ward 027	5.59	%	(5.6	/	100)
23	kz KwaDukuza Ward 025	5.67	%	(5.7	/	100)
24	kz KwaDukuza Ward 015	5.71	%	(5.7	/	100)
25	kz KwaDukuza Ward 026	8.62	%	(8.6	/	100)
26	kz KwaDukuza Ward 020	9.27	%	(9.3	/	100)
27	kz KwaDukuza Ward 001	9.96	%	(10	/	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 KwaDukuza was 35.80. This reduced to 24.30 in 2011.

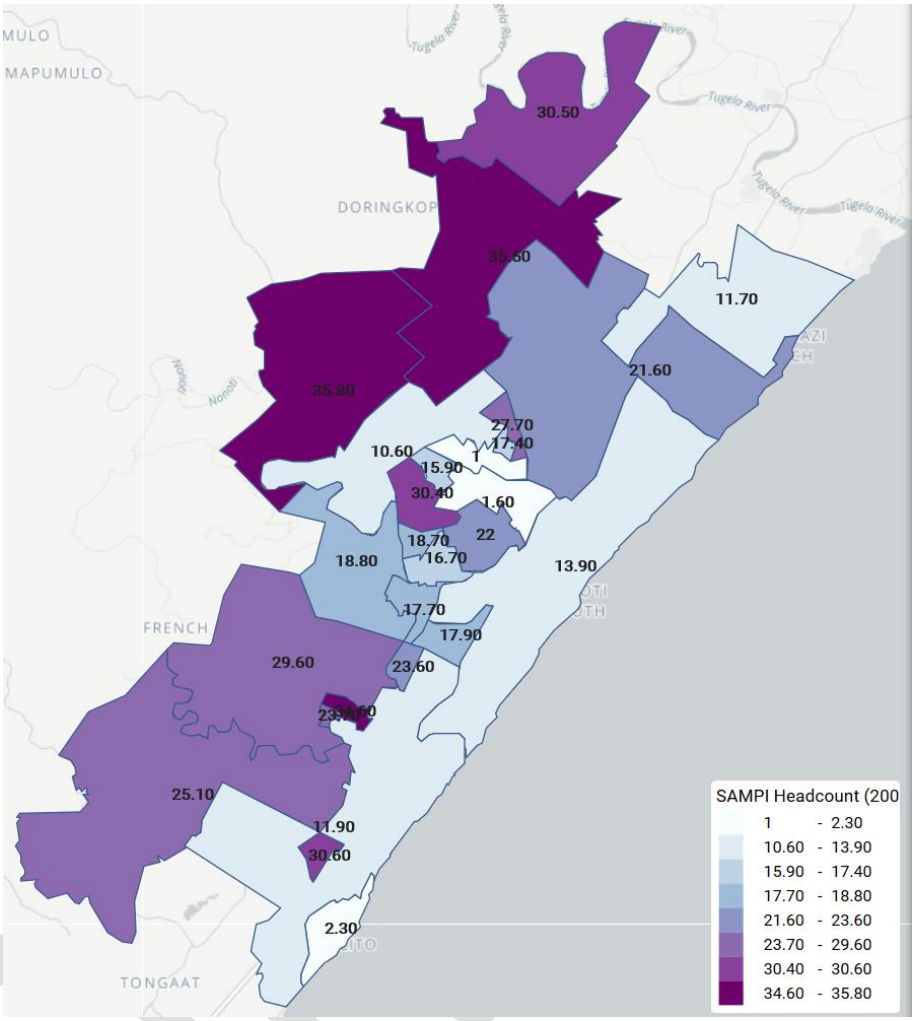

Figure 25: SAMPI 2001 poverty headcount - ward level, KwaDukuza local municipality

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

KZ KWADUKUZA LOCAL MUNICIPALITY: **18.8 %**						
	Ward (2011)	**SAMPI Headcount (2001)**				
1	kz KwaDukuza Ward 016	1	%	(1	/	100)
2	kz KwaDukuza Ward 019	1.60	%	(1.6	/	100)
3	kz KwaDukuza Ward 006	2.30	%	(2.3	/	100)
4	kz KwaDukuza Ward 017	10.60	%	(10.6	/	100)
5	kz KwaDukuza Ward 002	11.70	%	(11.7	/	100)
6	kz KwaDukuza Ward 022	11.90	%	(11.9	/	100)
7	kz KwaDukuza Ward 011	13.90	%	(13.9	/	100)
8	kz KwaDukuza Ward 013	15.90	%	(15.9	/	100)
9	kz KwaDukuza Ward 024	16.70	%	(16.7	/	100)
10	kz KwaDukuza Ward 018	17.40	%	(17.4	/	100)

KZ KWADUKUZA LOCAL MUNICIPALITY: **18.8 %**						
	Ward (2011)	**SAMPI Headcount (2001)**				
11	kz KwaDukuza Ward 010	17.70	%	(17.7	/	100)
12	kz KwaDukuza Ward 012	17.90	%	(17.9	/	100)
13	kz KwaDukuza Ward 014	18.70	%	(18.7	/	100)
14	kz KwaDukuza Ward 009	18.80	%	(18.8	/	100)
15	kz KwaDukuza Ward 003	21.60	%	(21.6	/	100)
16	kz KwaDukuza Ward 015	22	%	(22	/	100)
17	kz KwaDukuza Ward 020	23.60	%	(23.6	/	100)
18	kz KwaDukuza Ward 008	23.70	%	(23.7	/	100)
19	kz KwaDukuza Ward 021	25.10	%	(25.1	/	100)
20	kz KwaDukuza Ward 005	27.70	%	(27.7	/	100)
21	kz KwaDukuza Ward 007	29.60	%	(29.6	/	100)
22	kz KwaDukuza Ward 026	30.40	%	(30.4	/	100)
23	kz KwaDukuza Ward 025	30.50	%	(30.5	/	100)
24	kz KwaDukuza Ward 004	30.60	%	(30.6	/	100)
25	kz KwaDukuza Ward 023	34.60	%	(34.6	/	100)
26	kz KwaDukuza Ward 001	35.50	%	(35.5	/	100)
27	kz KwaDukuza Ward 027	35.80	%	(35.8	/	100)

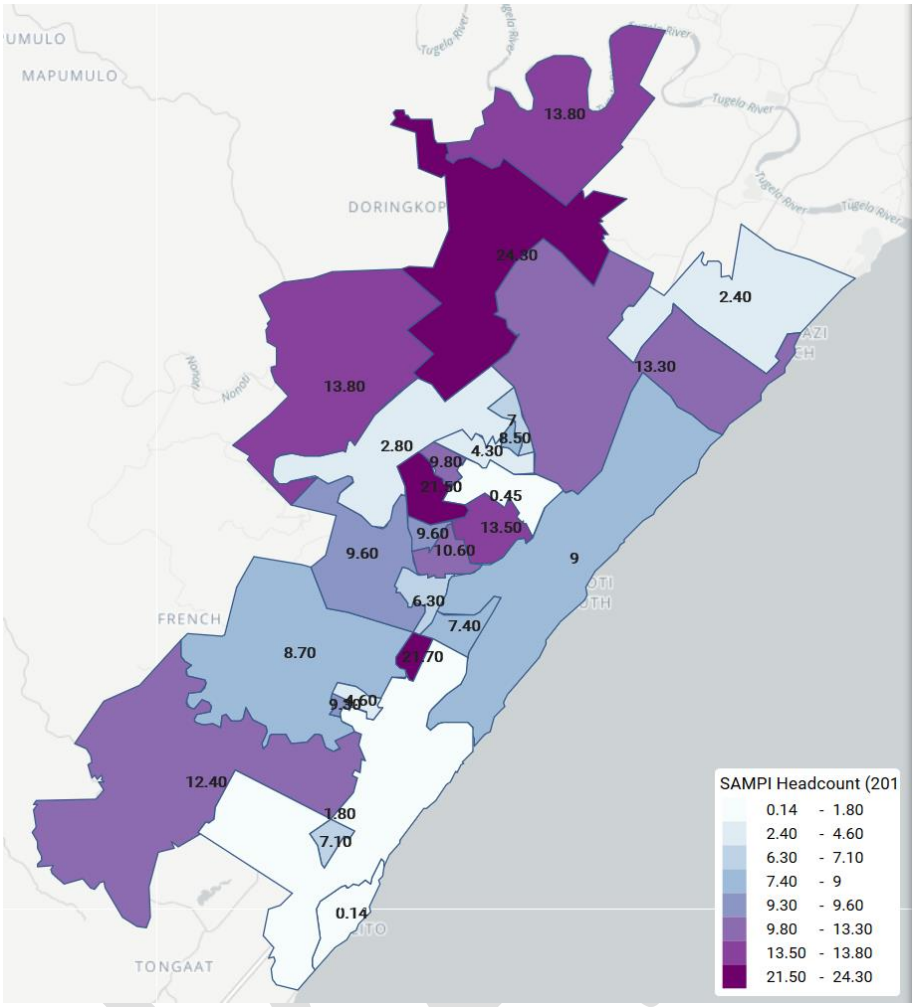

Figure 26: SAMPI 2011 poverty headcount - ward level, KwaDukuza local municipality

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

KZ KWADUKUZA LOCAL MUNICIPALITY: **9 %**						
	Ward (2011)	**SAMPI Headcount (2011)**				
1	kz KwaDukuza Ward 006	0.14	%	(0.1	/	100)
2	kz KwaDukuza Ward 019	0.45	%	(0.5	/	100)
3	kz KwaDukuza Ward 022	1.80	%	(1.8	/	100)
4	kz KwaDukuza Ward 002	2.40	%	(2.4	/	100)
5	kz KwaDukuza Ward 017	2.80	%	(2.8	/	100)
6	kz KwaDukuza Ward 016	4.30	%	(4.3	/	100)
7	kz KwaDukuza Ward 023	4.60	%	(4.6	/	100)
8	kz KwaDukuza Ward 010	6.30	%	(6.3	/	100)
9	kz KwaDukuza Ward 005	7	%	(7	/	100)
10	kz KwaDukuza Ward 004	7.10	%	(7.1	/	100)
11	kz KwaDukuza Ward 012	7.40	%	(7.4	/	100)
12	kz KwaDukuza Ward 018	8.50	%	(8.5	/	100)
13	kz KwaDukuza Ward 007	8.70	%	(8.7	/	100)
14	kz KwaDukuza Ward 011	9	%	(9	/	100)

KZ KWADUKUZA LOCAL MUNICIPALITY: **9 %**						
	Ward (2011)	**SAMPI Headcount (2011)**				
15	kz KwaDukuza Ward 008	9.30	%	(9.3	/	100)
16	kz KwaDukuza Ward 009	9.60	%	(9.6	/	100)
17	kz KwaDukuza Ward 014	9.60	%	(9.6	/	100)
18	kz KwaDukuza Ward 013	9.80	%	(9.8	/	100)
19	kz KwaDukuza Ward 024	10.60	%	(10.6	/	100)
20	kz KwaDukuza Ward 021	12.40	%	(12.4	/	100)
21	kz KwaDukuza Ward 003	13.30	%	(13.3	/	100)
22	kz KwaDukuza Ward 015	13.50	%	(13.5	/	100)
23	kz KwaDukuza Ward 025	13.80	%	(13.8	/	100)
24	kz KwaDukuza Ward 027	13.80	%	(13.8	/	100)
25	kz KwaDukuza Ward 026	21.50	%	(21.5	/	100)
26	kz KwaDukuza Ward 020	21.70	%	(21.7	/	100)
27	kz KwaDukuza Ward 001	24.30	%	(24.3	/	100)

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

- Community participants identified Poverty as the underlying reason for risky sexual behaviour such as transactional sex among young girls; and
- The community emphasises the vulnerability of child headed households and how poverty drives the children into unsafe transactional sex or sex work.

3.3.6 Employment

In KwaDukuza local municipality, 36% of the female population at economically active age is employed while 51% of the economically active males are employed. See Figure below.

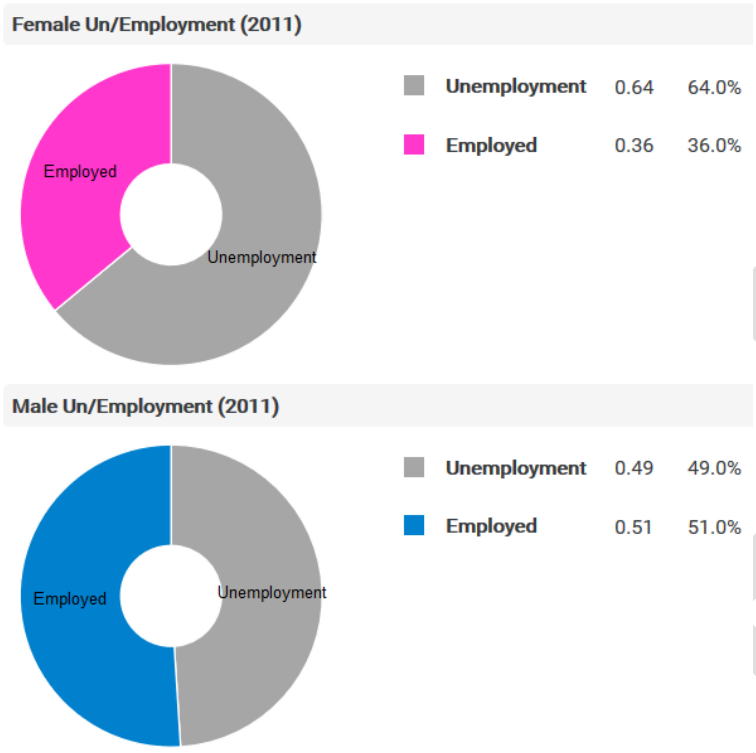

Figure 27: Female and Male employment KwaDukuza local municipality (Source Census 2011)

Unemployment of youth in KwaDukuza local municipality is at 60.5%. More than half of the youth in the area was therefore unemployed at the time of the Census.

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

In comparison with the KwaDukuza local municipality a slightly bigger percentage of females and males are employed from the total population in the Shakaskraal clinic catchment area. In this area 43% of the female population and 61% of the male population is employed (see Figure 29)

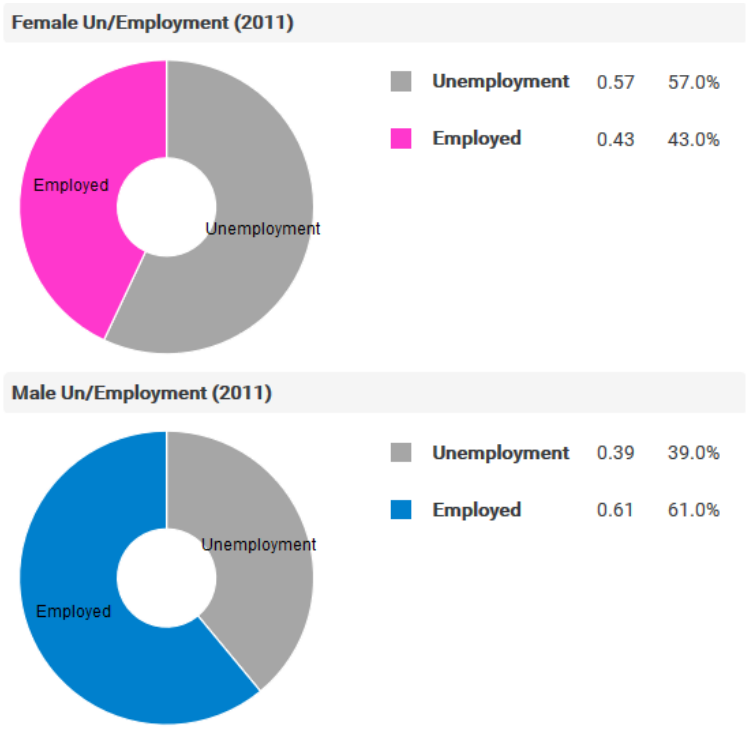

Figure 29: Female and Male employment Shakaskraal clinic catchment area (Source Census 2011)

Less youth (52.7%) are unemployed in the Shakaskraal clinic catchment area than the KwaDukuza local municipality (60.5%).

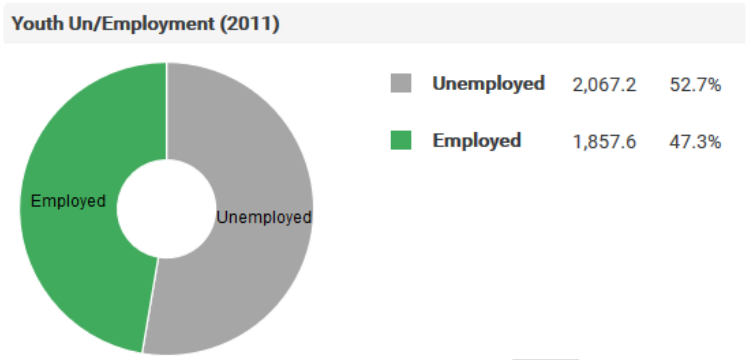

Figure 30: Youth unemployment Shakaskraal clinic catchment area (source Census 2011)

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

- Unemployment is seen by the community as the leading reason for the high rate of alcohol abuse and drug-use;
- There is also a sense that the lack of recreational facilities or activities for youth out of school contributes to the high rate of substance abuse leading to unsafe sex; and
- The community sees the low skill levels among young people as a contributing factor to high unemployment.

3.3.7 Types of settlements

There was significant concern raised by the community that both the way in which settlements are planned and resourced as well as the structure of individual homes contributes to HIV infection:

- New RDP settlements don't think of long distances to schools which means children drop out of school or transact with taxi drivers to pay for school transport with unprotected sex;
- Because new homes do not account for privacy of adults, sexual activities take place in close proximity to children who role-model their parents; and
- New houses are far away from clinics making it difficult to get treatment.

3.3.8 Migration patterns in the area

The following was identified as implications of ***migration patterns*** in the area on the associated risk of HIV:

- There is a view that internal migration contributes to HIV infection in the area. Participants noted the risks posed by construction workers; and
- Participants also noted that many young girls have relationships with shopkeepers who are foreign nationals because they have money. These are concurrent partnerships on both sides which leads to higher risk of HIV infection.

3.3.9 Education and literacy

- There is an overwhelming view in the community, that the rate of dropping out of school is very high. This is attributed to the lack of parental supervision, poverty, and long distances to school.
- There is also a sense that there are low skill levels for employment in the KwaDukuza community because so many people are being hired from outside of the community.

3.3.10Hate crimes – xenophobic, homophobic, other

The community was unable to reflect on hate crimes, they do not know of them.

3.3.11Disability

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

- Notably the most significant issue for the community around disability is the vulnerability of intellectually disabled persons who are exploited for their grants by their sexual partners who are also in concurrent partnerships with others; and
- There is concern that intellectually disabled community members are unable to practice safe sex and also engage in transactional sex to meet their needs.

4. Services in the local municipality

4.1 Health facilities

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

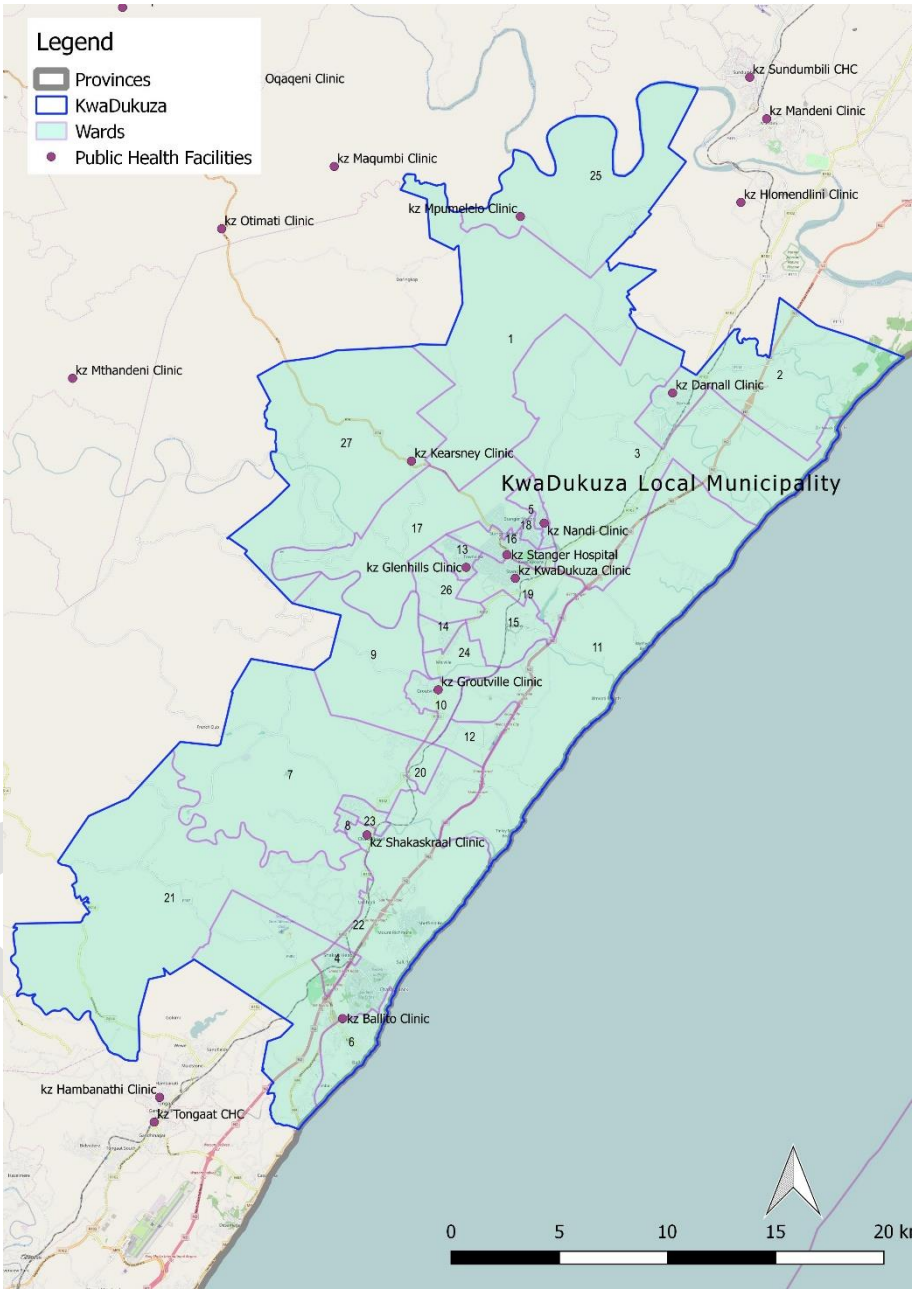

Figure 31: Distribution of health facilities in KwaDukuza local municipality

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); and
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. 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

Key and vulnerable populations for TB	**Priority interventions**
• People living with HIV • Household contacts of TB index patients • Health care workers • Pregnant women • Children < 5 years old • People living in informal settlements	• 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**
• Youth, specifically young women and girls • Drug-users • Sex workers	• Alcohol and Substance Abuse and unhealthy sexual practices and behaviours that emanate from this • Transactional sex and poverty reduction, particularly keeping girls in school and out of risk • Mixing (age) Partners of which unequal gender relations and related risk behaviour is a key focus • Vulnerable groups such as the disabled and child-headed households • Stigma and discrimination, particularly disclosure and biomedical services

Table 27: Recommended multi-sectoral service packages

Inclusive package of services for all key and vulnerable populations that will be customised to age and population served		Multi-sectoral partner

• 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:
  ○ 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
		• NGOs
		• DoH
		• DSD
		• DBE
		• NPA
		• PCA, DAC, LAC
		• SAPS
		• DOT

Adolescent girls and young women	• Peer-led outreach
	• Youth-friendly sexual and reproductive health services in schools and community settings which include:
	  ○ PrEP (for over 18 years olds)
	  ○ Complete two dose HPV vaccine (Grade 4 learners)
	  ○ PMTCT
	  ○ Choice of termination of pregnancy
	  ○ 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
		• DBE
		• DHET
		• DoH
		• DSD
		• NGOs
		• DoL
		• Private sector

Inclusive package of services for all key and vulnerable populations that will be customised to age and population served		Multi-sectoral partner
	• 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)	
People who use drugs, including people who inject drugs	• Peer-led outreach • Harm reduction counselling • Linkage to rehabilitation centres • Case management to ensure a continuum of care • Needle and syringe programmes • Opioid Substitution Therapy • Accelerated nutritional and social grant support, if indicated • Hepatitis B screening and immunisation • Hepatitis C screening and treatment when policy is developed	• DoH • NGOs • DSD
Sex workers	• Peer-led outreach • PrEP • Female and male condoms and lubricant • Intensified psychosocial support • Periodic presumptive treatment for STIs • Social mobilisation, use of formal/informal peer networks to create demand • PMTCT • Hepatitis B screening and immunisation • Annual Pap smears • CTOP (Choice of Termination of Pregnancy) • Screening for and protection from the sexual exploitation of children • Community empowerment	• DoH • DSD • NGOs
TB key populations		
Children <5 yrs	• Household TB and HIV screening, immediate linkage to treatment • Improved diagnostic and treatment capacity for paediatric TB • Promote activism for child-friendly TB formulations and introduce as soon as they are available	• DoH • NGOs • Civil Society • DSD

Inclusive package of services for all key and vulnerable populations that will be customised to age and population served		Multi-sectoral partner
	• Improve sputum induction at PHC and hospital level • Screening for and protection from the sexual exploitation of children	
Healthcare workers	• Implement guidelines for TB in HCWs • Institute regular TB screening and offer HIV testing for all HCWs • Offer TB preventive therapy to all HCWs who are living with HIV • Develop a recording and reporting system for TB and DR-TB in HCWs • Appoint a DoH-led task force to monitor implementation and further elucidate the effort–effect ratio of screening all HCWs annually with symptom screening and CXR, and to investigate the role of preventive therapy for HCWs • Implement the FAST model in facilities (finding cases actively by cough surveillance and rapid molecular sputum testing, separating safely, and treating effectively, based on rapid drug susceptibility testing)	• DoH • DoH
Household contacts of TB index patients	• Implement simplified screening algorithms for TB-exposed children • Implement community education and mobilisation programmes to improve acceptance of contact investigations and to create awareness of the benefits of preventive therapy • Strengthen routine M&E for TB contact investigations, HIV testing, TB preventive therapy including outcomes, and pharmacovigilance	• DoH • NGOs
People living in informal settlements (also a vulnerable population for HIV and STIs)	• Facilitate access and demand creation to increase community HIV, TB and STI service provision • Intensify GBV programmes and screening • Accelerate social support • Community education • Provide mobile services to improve accessibility • Infection control strategy for TB	• DoH • DSD • NGOs
People living with HIV	• Prompt ART initiation as a component of TB prevention • Adherence and psychosocial support • Peer education and support for TB prevention and treatment • Optimal uptake of preventive therapy for TB • Infection control in facilities, communities and households • TB symptom screening at each visit, linkages to treatment and care • HIV screening for household members, including partners and children • Cohort monitoring of HIV/TB co-infected patients	• DoH

Inclusive package of services for all key and vulnerable populations that will be customised to age and population served		Multi-sectoral partner
	• Support groups specifically addressing internalised stigma	
Pregnant women and neonates	• 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	• DoH • NGOs • DSD

Addressing social and structural drivers	Service	Multi-sectoral partner
Community awareness and advocacy programmes	• Implement programmes to increase awareness of services	• DSD • Civil society including NGOs
Training for adolescent girls and young women	• 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	• SABCOHA and other private sector • Organised labour • DOT
Combination socio-economic programmes	• Strengthen economic capacities through support to access further education, training, job placements and entrepreneurial activities, including for PWDs	• DSD • Private sector • DHET • Civil society including NGOs
Expand inpatient and outpatient rehabilitation facilities	• 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	• DSD • DoH • DBE • NGOs
Implementation of harm reduction services to identify and support people who use substances and alcohol	• 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	• DSD • DoH • NGOs • DBE • DHET

Addressing social and structural drivers	Service	Multi-sectoral partner
Strengthened and scaled-up community based one-stop Khuseleka Centres	• Integrate community support programmes in one-stop centres	• DSD • SAPS • DoH • DOJ
Strengthened and scaled-up community-based 'white-door' shelters	• Provide short-term (72-hour) places of safety and shelter within communities and referral/integration with HIV/TB/STI services	• DSD • SAPS • DoH • DOJ
Identify and speedily allocate social grants to all who are eligible	• Link PLHIV, TB clients to social security programmes for access to social relief distress grants	• DSD • Civil society including NGOs
Scaled-up provision of food parcels, and nutritional supplementation to all eligible PLHIV and PTB	• 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	• DSD • NGOs • SANAC sectors
Expand inpatient and outpatient rehabilitation facilities	• 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	• DSD • DoH • DBE • NGOs
Community awareness and advocacy programmes	• Implement programmes to increase awareness of services	• DSD • Civil society including NGOs
Combination socio-economic programmes	• Strengthen economic capacities through support to access further education, training, job placements and entrepreneurial activities, including for PWDs	• DSD • Private sector • DHET • Civil society including NGOs

Comprehensive package of services for the general population, that will then be supplemented and customised to the age and population served			Multisectoral partner
• 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			• All implementing agencies • DoH • DSD • NPA • DBE • NGOS • PCA and DAC
Population	**Services/Interventions/Approaches**	**Setting**	**Multisectoral partner**
PLHIV (adults, adolescents)	• Hearing and vision screening, referral, treatment • Partner HIV testing, disclosure support, treatment, adherence support • Hepatitis B and HPV vaccine where eligible • PMTCT and enhanced adherence support through pre- and post-natal period, including breastfeeding • Gender norms • Health and health rights literacy • Economic empowerment and health promotion • School retention • Accelerated nutritional and social grant support, if indicated • Targeted demand creation for services • Targeted, PLHIV-friendly IEC materials and SBCC, including social media and materials for those with vision and hearing impairment • Service delivery points in community, non-traditional settings	• Health facility-based • School-based • Community-based • Mobile services	• DoH • DBE • DCS • DSD • CBOs • NGOs • Private employers • Private healthcare providers
Persons with TB (adults, adolescents)	• TB contact tracing, testing and post-exposure management • Partner HIV testing, disclosure support, treatment, adherence support • Enhanced health education about HIV/TB co-infection, reinfection • Hearing and vision screening, referral, treatment	• Clinic-based • School-based • Community-based • Mobile services	• DoH • DBE • DCS • DSD

Population	Services/Interventions/Approaches	Setting	Multisectoral partner
	• Hepatitis B and HPV vaccine where eligible • PMTCT and enhanced adherence support through pre- and post-natal period, including breastfeeding, if indicated • Mental health screening • Gender norms education • Health and health rights literacy • Economic empowerment and health promotion • School retention • Accelerated nutritional and social grant support, if indicated • Targeted, TB-friendly IEC materials and SBCC, including social media and materials for those with vision and hearing impairment • Service delivery and treatment delivery points in community, non-traditional settings		• 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	This will be supported and strengthened by: • Increased efforts to implement the test and treat policy at facility level through the DIP process • Increased quality assurance to promote adherence to guidelines • 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	• DoH • DoT • Dept. of Agriculture • Private Sector • Civil society (PLHIV sector)

Generic HIV, TB and STI prevention, management and care		
Focus	**Activities**	**Multi-sectoral partner**
	• 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	
Improve adherence support	• 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.	• DSD • DoH • Private Sector
Intensified facility-level TB case-finding	• 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	• DoH • Private healthcare providers
Active case-finding for key and vulnerable populations	• 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.	• DoH • NGOs and CBOs working in this area • DBE • DSD • Private healthcare providers
Appropriate syndromic management of STIs	• 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 • Quality assurance programmes and advanced level STI management in secondary hospitals and CHCs with the necessary tools and training.	• DoH • DHET/HEAIDS • Private health sector
Screening of all pregnant women for syphilis at first ANC visit	• 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	• DoH • Private health sector

Generic HIV, TB and STI prevention, management and care		
Focus	**Activities**	**Multi-sectoral partner**
	receive treatment; • Intensified notification process • Routine congenital syphilis monitoring and tracing and management of confirmed syphilis clients.	
Promote integration of STI prevention care and treatment into HIV, TB, ANC, sexual and reproductive health services	• Strengthened ART initiation at STIs services or linkage to ARV services	• DoH • Private health sector

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.

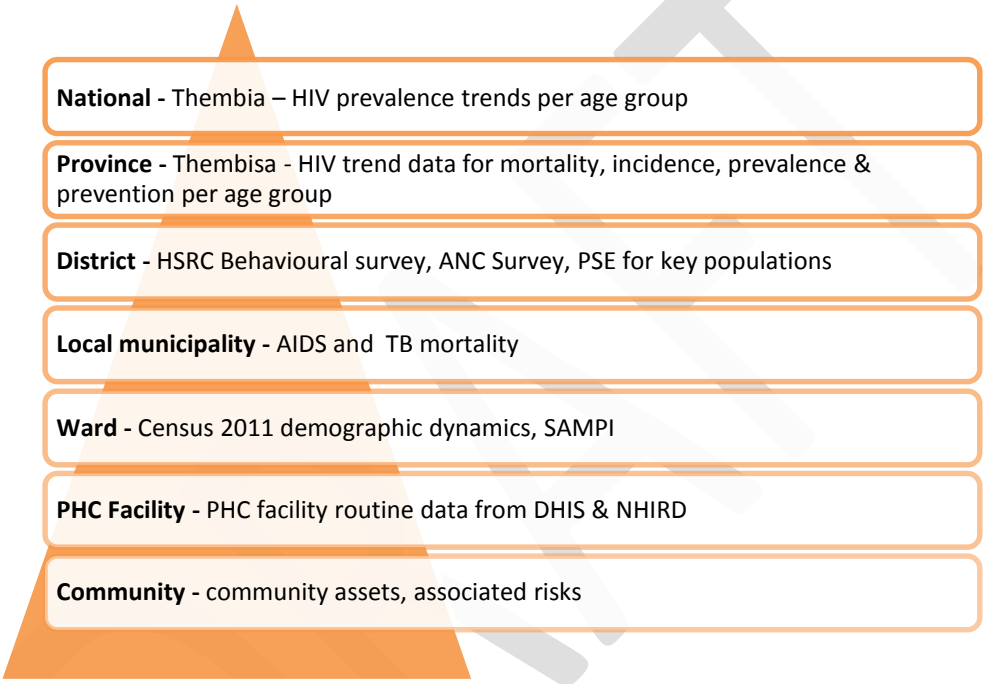

Figure 32: Data pyramid used for risk profiles

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 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 relate 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).

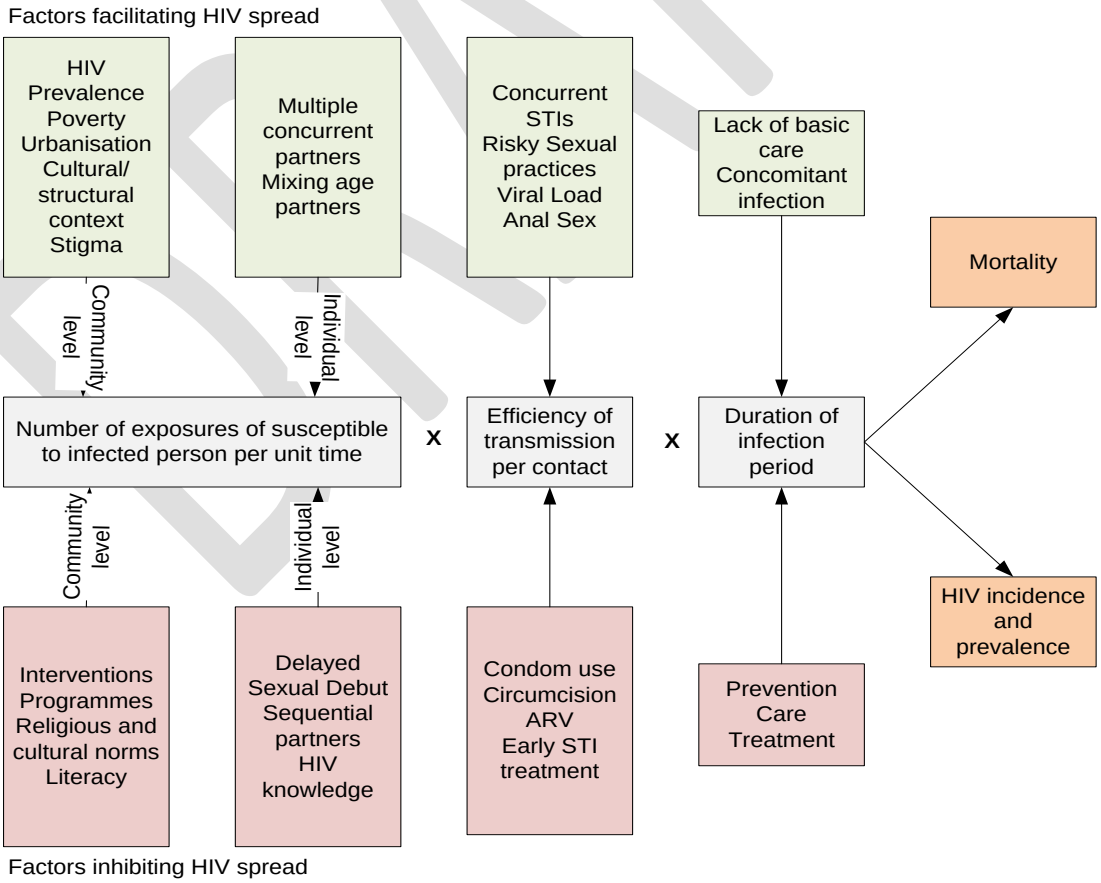

Figure 33: Factors influencing HIV associated risk and outcomes

Appendix B: Terms, Definitions and calculations

ANC client HIV 1st test positive rate (routine health indicator DHIS 2015)	Short Name - ANC HIV 1st test pos rate Numerator - Antenatal client HIV 1st test positive Denominator - Antenatal client HIV 1st test Indicator Type - % Definition - Antenatal clients tested HIV positive as proportion of antenatal clients HIV tested for the first time during current pregnancy
Antenatal client HIV re-test positive rate (routine health indicator DHIS 2015)	Short Name - ANC HIV re-test pos rate Numerator - Antenatal client HIV re-test positive Denominator - Antenatal client HIV re-test Indicator Type - % Definition - Antenatal clients re-tested positive for HIV as proportion of antenatal clients re-tested for HIV
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)	Short Name - Delivery 18 rate Numerator - Delivery under 18 years in facility Denominator - Delivery in facility - total Indicator Type - % Definition - Deliveries to women under the age of 18 years as proportion of total deliveries in health facilities
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 (routine health	Short Name - Fem condom dist cov Numerator - Female condoms distributed

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 health indicator DHIS	Short name - HIV test 18m pos rate Numerator - HIV test positive around 18 months Denominator - HIV test around 18 months

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	Heteroses (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 ÷ 40) x100= 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

	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.
Qualitative data	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
Quantitative data	Numeric information (e.g., numbers, rates, and percentages).
Rate	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. $\frac{\text{number of HIV diagnoses}}{\text{Population}} X\ 100000 = \text{population rate of HIV diagnosis}$ 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. 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 ÷ 400,000 × 100,000 = 50 per 100,000
Routine health service based information	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. 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

<table>
<tr><td></td><td>defined as specific indicators and used in Focus for Impact to ensure standardization of indicators across the different geographical areas.

Source: Department of Health. 2015. NDOH Data Directory. Available online from http://dd.dhmis.org/index.html</td></tr>
<tr><td>Service area</td><td>The jurisdictions of service areas or planning regions of respective planning groups. Example Health districts, sub- districts, wards or health facility catchment areas</td></tr>
<tr><td>Socio-demographic factors</td><td>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</td></tr>
<tr><td>Socio-economic status (SES)</td><td>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)</td></tr>
<tr><td>South Africa Multidimensional Poverty Index (SAMPI[16]) (StatSSA, 2014)</td><td>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 to 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).

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.

The SAMPI includes an additional dimension –the economic activity indicated by adult unemployment
<table>
<tr><th>Dimension</th><th>Indicator</th><th>Deprivation cut-off</th></tr>
<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>Education</td><td>Years of schooling

School attendance</td><td>If no household member aged 15 or older has completed 5 years of schooling
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>
</table>
</td></tr>
</table>

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

	ideal: positive)
TB suspect sputum test rate (routine health indicator DHIS 2015)	Short name - TB susp sputum test rate Numerator - TB suspect 5 years and older sputum sent Denominator - TB suspect 5 years and older identified Indicator Type - % Description - Proportion of TB suspects with sputum sent to the laboratory for testing Growth-Sentiment: positive (low values are negative, high values are ideal: positive)
TB suspect treatment initiation rate (routine health indicator DHIS 2015)	Short name - TB suspect treatment rate Numerator - TB suspect 5 years and older initiated on treatment Denominator - TB suspect 5 years and older test positive Indicator Type - % Description - Proportion of smear positive TB suspects initiated on treatment Growth-Sentiment - positive (low values are negative, high values are ideal: positive)
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 be stakeholders and partners to ensure a standardised approach in the development and updating of the risk profile.

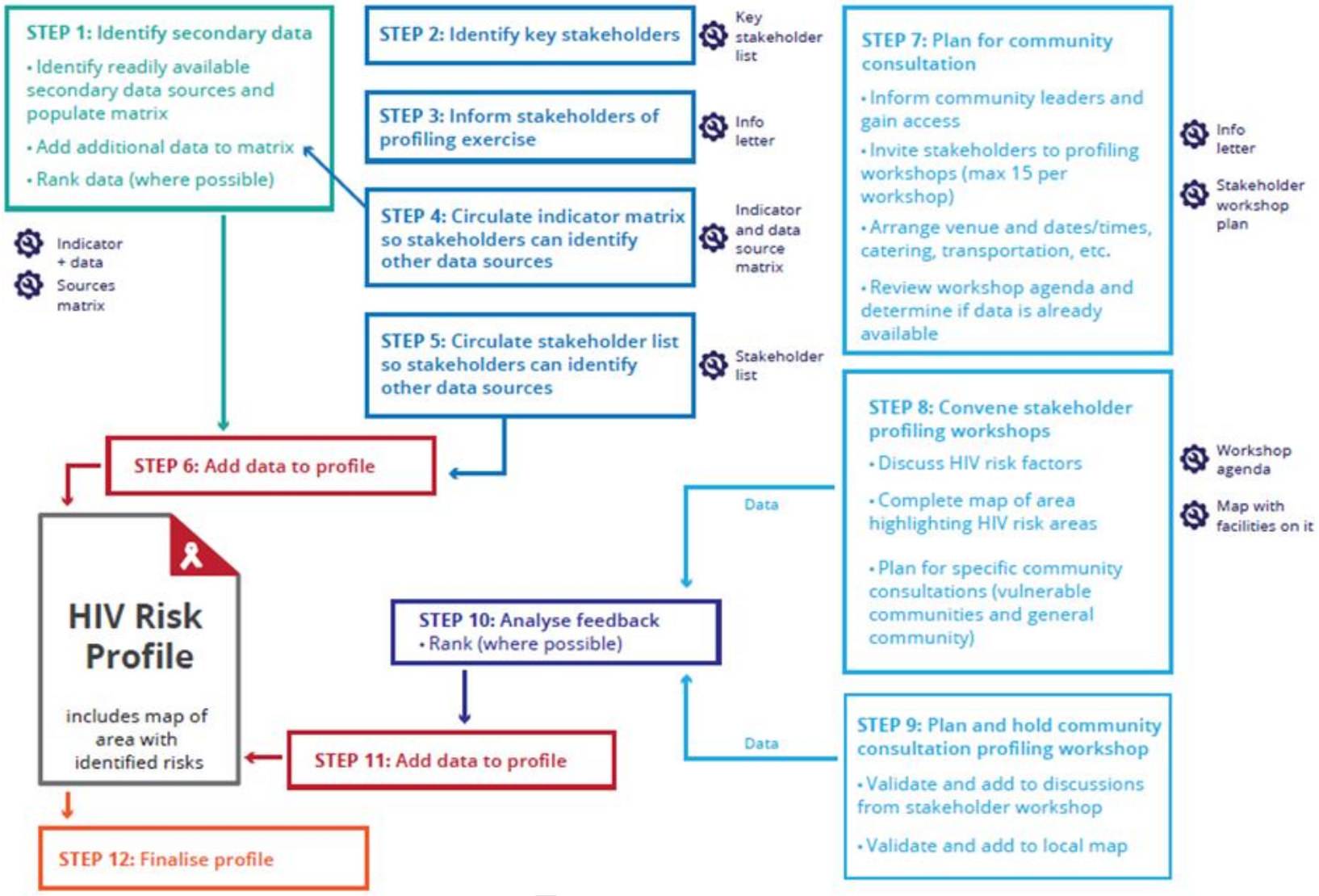

Figure 34: Steps for development of HIV associated risk profile