ISIFUNDAZWE SAKWAZULU-NATALI
PROVINCE OF KWAZULU-NATAL

Multi-Sectoral Provincial Strategic Plan for HIV and AIDS, STIs and TB 2012-2016 for Kwazulu-Natal

TOWARDS **ZERO** NEW HIV AND TB INFECTIONS

ISIFUNDAZWE SAKWAZULU-NATALI
PROVINCE OF KWAZULU-NATAL
PROVINSIE VAN KWAZULU-NATAL

Multi-Sectoral Provincial Strategic Plan for HIV and AIDS, STIs and TB 2012-2016 for KwaZulu-Natal

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Premier: KwaZulu-Natal
DR Zweli Mkhize

Foreword

At the beginning of this term of office, I invited elected leaders from all political parties, in provincial and local governments, traditional, religious leaders and those in civil society to work with government to intensify the Fight Against HIV, AIDS and TB. We extended this invitation because we realized as government that this fight cannot be won by government alone on behalf of society.

This resulted in the launch of the PARTNERSHIP AGAINST AIDS on 8 October 2009.
Government received support from Members of Parliament, leaders of political parties; mayors, councillors, religious leaders of all faiths and denominations, Amakhosi, Izinduna, Amagosa and all traditional healers and other structures such as non-governmental organizations, labour and business. We all agreed to a plan focusing on all wards to create bases to mobilize all local forces to unite their action. Critically, since the beginning of this term of office, the KwaZulu-Natal AIDS Council has been meeting regularly and attended by provincial executive council, mayors, municipality managers and other key stakeholders.

The Council endorsed an integrated campaign focusing on nutrition, treatment of HIV and AIDS and TB with a view to reduce the spread, the emergence of resistant strains, reducing the defaulter rate and improving the cure rate. The focus is also on the management of secondary infections in an attempt to reduce maternal mortality. We have scaled up the availability of Anti-retroviral Treatment, especially to protect the pregnant mothers and newborn babies, reducing the maternal and peri-natal mortality rates.

Roving teams are now moving into primary healthcare clinics to ensure quick response, shorter waiting lists for ARV initiation and strong social support for all affected. The expansion of the voluntary counseling and testing and partner tracing has been strengthened using the HCT campaign. Results are there for everybody to see. It is significant that whilst new TB infections have not declined, there are encouraging signs in the rate of spread of HIV infections, e.g. reduction in mother to child transmission reduced from 22% in 2005 to 2, 8% in 2010.

It is worth noting that more than 500 000 patients receive ARV treatment and waiting lists have been eliminated through roving initiation teams. It is also important to observe that all District AIDS Councils and Local AIDS Councils are now in place and there are NGO's deployed in all districts to do work in the wards. The participation of councilors in these programs
is encouraging. The importance of this development has already attracted the attention of various bodies such as the UNAIDS Executive Director Dr Michelle Sedibe who visited our province to pay tribute for the progress that has been registered. He further paid tribute to His Majesty King Goodwill Zwelithini for his leadership in the area of Male Medical Circumcision which has exceeded 75 000 operations without any complications so far.

A significant development was the formation of South African Business Coalition Against HIV and AIDS representing business effort and have been invited to be part of the AIDS Council. The Provincial Council on AIDS has also adopted the Provincial Strategy on Prevention of AIDS for year 2011 to 2016.

The major focus is to reduce the rate of new HIV infections from 2,3% to 1%; reduce mother to child transmission to 1,4%, reduce maternal deaths to 200 per 100 000 and increase the TB cure rate from 67,2%; etc.

The challenge of HIV and AIDS is the fact that the pandemic is embedded deeply in the conditions of poverty under which most of our people live. Similarly, its transmission is fuelled by psycho-social and economic dynamics that define our daily lives. It is in the ignorance, the

negative attitudes and prejudices of our people that the pandemic thrives.

One person's sickness must be the concern of all. It is the disease but not the person that must be the enemy. If we ensure that one person is cured of the ailment that will save many more. Every ward must focus on curing the sick, ensuring food security and take responsibility for behavioral change. This is a real war and it will be won in your house, your village and in your ward.

Dr Zweli Mkhize

Premier of KwaZulu-Natal and Chairperson of the Provincial AIDS Council


KZN PREMIER : CHAIRPERSON OF THE
PROVINCIAL COUNCIL ON AIDS
DR ZL MKHIZE

Director-General
Office of the Premier
Mr N. V. E. Ngidi

ACKNOWLEDGEMENTS

The multi-sectoral HIV and AIDS, STIs and TB Provincial Strategic Plan 2012- 2016 for KwaZulu-Natal is a culmination of the hard work, cooperation and collaboration put in by numerous individuals and stakeholder organizations over a considerable period of time. Development and finalization of this document involved consultative processes at all levels. Individuals and organizations at provincial, district and local levels contributed to the success of this process.

It was necessary that this process be employed to ensure that all relevant elements were incorporated and that the plan reflects the provincial agenda to responding to HIV and AIDS, STIs and TB for the next five years. The high degree of ownership of the process is reflected in the document and this will certainly filter through to implementation.

The province wishes to acknowledge all those individuals and stakeholder organizations at all levels that participated in the review process and in consultative workshops at various stages of the development of this plan. They certainly had to make hard choices for the benefit of the province. The process was enriched by contributions of development partner organizations either through providing resource persons or participants. Gratitude is therefore extended to the different National, Provincial and Local Government, Civil Society Organisations, Development partners - UNAIDS, UNDP, UNFPA, the International Organisation on Migration, the World Bank and USAID.

The province also wishes to thank the Chief Directorate: HIV and AIDS in the Office of the Premier for leading the process of development of this plan. In addition, the province is gratefulto the consulting team that provided technical support to the process. Obviously there are many specific contributions that were made by a host of other stakeholders and individuals. As much as it is not possible to mention all of them here, I extend gratitude to all of them.

Mr N V E Ngidi

Director General: Office of the Premier

ABBREVIATIONS/ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal clinic
ART	Antiretroviral therapy
ARV	Antiretroviral (drugs)
ASSA	Actuarial Society of South Africa
BCC	Behaviour Change Communication
CBO	Community Based Organisation
CHH	Child-headed Households
CD HIV and AIDS	Chief Directorate HIV and AIDS in the Office of the Premier
COGTA	Department of Cooperative Governance and Traditional Affairs
DAC	District AIDS Council
DAC	Department of Arts and Culture and Tourism
DAEARD	Department of Agriculture, Environmental Affairs and Rural Development
DED	Department of Economic Development
DCSL	Department of Community Safety and Liaison
DOE	Department of Education
DOH	Department of Health
DHS	Department of Human Settlements
DSD	Department of Social Development
DPSA	Department of Public Service and Administration
ECD	Early Childhood Development
FBO	Faith-Based Organisation
HAST	HIV, AIDS, STIs and TB
HBC	Home-Based Care
HCT	HIV Counselling and Testing

HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
IEC	Information, Education and Communication
IDP	Integrated Development Plan
IPT	Isoniazid Prophylactic Therapy
JWG	Joint Working Group
KZNPSP	HIV and AIDS Strategy for the Province of KwaZulu-Natal
LGBTI	Lesbian, Gay, Bisexual, Transsexual, Transgender, Transvestite, and Intersex People
LAC	Local AIDS Council
Mand E	Monitoring and Evaluation
MDGs	Millenium Development Goals
MDR	Multi-drug Resistant Tuberculosis
MEXCO	Management Executive Committee within the Office of the Premier
MCWHand N	Maternal, Child and Women's Health and Nutrition
MTCT	Mother-to-Child Transmission
NGO	Non-governmental Organisation
OVC	Orphans and Other Vulnerable Children
PAAU	Provincial AIDS Action Unit
PAC	Provincial AIDS Council
PCA	Provincial Council on HIV and AIDS
PEP	Post-exposure Prophylaxis
PHC	Primary Health Care
PGDS	Provincial Growth and Development Strategy
PLHIV	People/Person living with HIV or AIDS
PMTCT	Prevention of Mother-to-Child Transmission

PrPEP	Pre-exposure Prophylaxis (for HIV infection)
SABCOHA	South African Business Coalition on HIV and AIDS
SANAC	South Africa National AIDS Council
SBST	School Based Support Team
SMT	Senior Management Teams
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary Counselling and Testing
XDR	Extremely Drug-resistant Tuberculosis

GLOSSARY OF TERMS

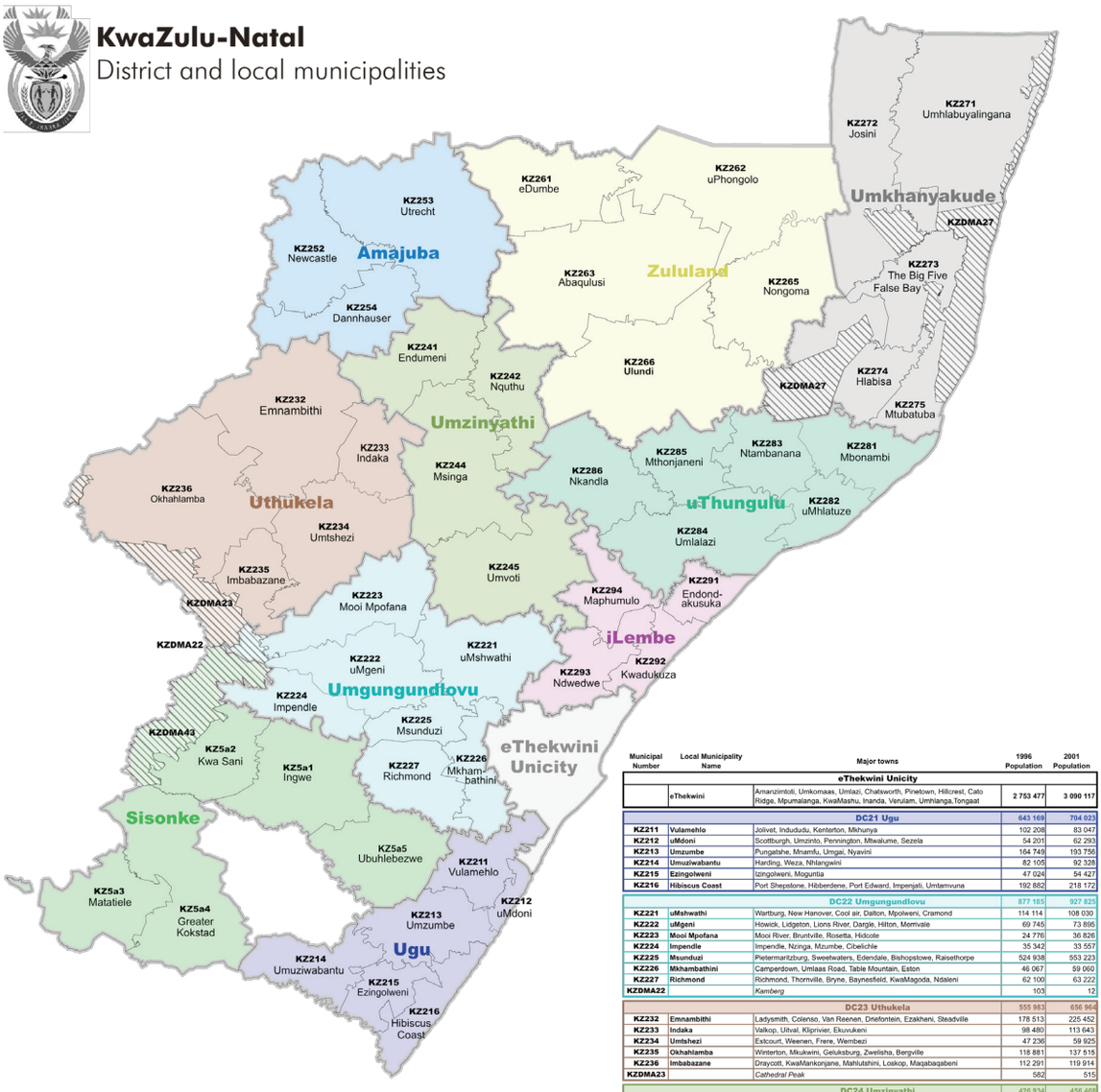
A person Living with HIV or AIDS	Refers to a person who is infected with HIV.
Acquired Immune Deficiency Syndrome (AIDS)	A disease of the human immune system that is caused by infection with HIV and characterized by a reduction in the numbers of CD4-bearing helper T-cells to 20% or less of normal, thereby rendering the subject highly vulnerable to life-threatening opportunistic infections.
Activity	Actions taken or work performed through which inputs such as funds, technical assistance, and other types of resources are mobilized to produce specific outputs.
Adult Mortality Rate	The probability of dying between ages 15 and 60 or % of 15 year olds that will die before their 60th birthday.
Advocacy	Efforts made to get due support and recognition for a cause, policy or recommendation.
Affected Person	A person whose life is changed in any way by HIV and AIDS due to the broader impact of this epidemic.
Antiretroviral Therapy	A treatment consisting of drugs that work against HIV infection in the body.
Civil Society Organisations	A generic term used to refer collectively to NGOs, FBOs and CBOs.
Effectiveness	The extent to which an intervention has attained or is expected to attain its major relevant objectives efficiently in a sustainable fashion and with positive institutional development impact.
Epidemic	An outbreak of disease that is in excess of usual background levels.
Gender	All attributes associated with women and men, boys and girls, which are socially and culturally ascribed and which vary from one society to another and over time.

Gender Mainstreaming	A strategy to ensure that gender analysis is used to incorporate women's and men's needs, constraints and potential into all development policies and strategies and into all stages of planning, implementing and evaluation of development interventions.
Human Immuno-deficiency Virus (HIV)	A virus that weakens the body's immune system, ultimately causing AIDS.
Infant Mortality Rate	The number of children less than 12 months old who die annually per 1000 live births.
Infected Person	A person who is infected with HIV, the virus that causes AIDS.
Intervention	A specific activity or set of activities intended to bring about change in some aspect(s) of the status of the target population.
Life Skills	Practical skills and values to prepare a child, youth or adult for real living and to be more self-assured and self-reliant. Subject content often includes teaching people how to protect themselves from harm, including HIV infection.
Mainstreaming	Mainstreaming implies that HIV and AIDS responses are aligned with the core mandate of the sector, and not considered an 'add-on' issue. Mainstreaming HIV and AIDS means all sectors determine how the spread of HIV is caused or contributed by their sector; how the epidemic is likely to affect their sectors goals, objectives and programmes and where their sector has a comparative advantage to respond to limit the spread of HIV; and to mitigate the impact of the epidemic.
Marginalised or Disadvantaged	These two terms are used almost interchangeably, and refer to those people in society who are deprived of opportunities for living a reasonable life and for self-respect which is regarded as normal by the community to which they belong. Thus, these concepts are defined in the context of a particular community.
Maternal Mortality Rate	The proportion of women who die whilst pregnant or within the first 42 days post-partum, per 100,000 births, in a given year.

Mitigation	Efforts made to reduce the severity or appease the expected impact or outcome.
Mobilization	The act of marshaling and organizing and making ready for use or action.
Opportunistic Infections	Infections caused when the immune system is weakened by HIV such as TB, pneumonia.
Orphan	A child whose parent or parents have died. The child may be classified as a maternal orphan (one who has lost a mother) or paternal orphan (one who has lost a father) or a double orphan (one who has lost both parents).
Outreach	Extension of assistance or services to groups not previously reached.
Peer Education	Refers to activities aimed at providing information by people of a similar merit, age, social group, status or position as those that information is being passed on to.
Peer Educator	A person (child or adult) trained or equipped to train and support another person equal in merit, age, social group, status or position.
Post-Exposure Prophylaxis (PEP)	Treatment available to reduce the risk of infection in an individual immediately after exposure to HIV through sexual contact, blood transmission or needle sticks injury.
Psychosocial Support	Physical, economic, moral or spiritual support provided to an individual under any form of stress.
Stigmatisation	Refers to the process of labelling people with the intent of treating them differently.
Sustainability	The continuation of benefits from a development intervention after major development assistance has been completed.
Under-5 Mortality Rate	The proportion of children who die before reaching the age of 5 years, per 1000 live births, in a given year.

Universal infection control precautions	A simple standard of infection control practice to be used to minimize the risk of exposure to and transmission of blood-borne pathogens.
Voluntary Counselling and Testing (VCT)	A confidential dialogue between a client and a care provider aimed at enabling the client to cope with stress and take personal decisions related to HIV and AIDS, including testing for HIV.
Vulnerable Child	A child who has been, is in, or is likely to be in, a situation, where she/he may suffer physical, emotional or mental harm and includes children with special needs such as physical or mental disability.
Workplace	Refers to occupational settings, stations and places where workers spend time for employment.

Map of KwaZulu-Natal



Municipal Number	Local Municipality Name	Major towns	1996 Population	2001 Population
		eThekwini Unicity		
	eThekwini	Amanzimtoti, Umkomaas, Umlazi, Chatsworth, Pinetown, Hillcrest, Cato Ridge, Mpumalanga, KwaMashu, Inanda, Verulam, Umhlanga,Tongaat	2 753 477	3 090 117
		DC21 Ugu	643 169	704 023
KZ211	Vulamehlo	Jolivet, Indududu, Kenterton, Mkhunya	102 208	83 047
KZ212	uMdoni	Scottburgh, Umzinto, Pennington, Mtwalume, Sezela	54 201	62 293
KZ213	Umzumbe	Pungatshe, Mnamfu, Umgai, Nyavini	164 749	193 756
KZ214	Umuziwabantu	Harding, Weza, Nhlangwini	82 105	92 328
KZ215	Ezingolweni	Izingolweni, Moguntia	47 024	54 427
KZ216	Hibiscus Coast	Port Shepstone, Hibberdene, Port Edward, Impenjati, Umtamvuna	192 882	218 172
		DC22 Umgungundlovu	877 185	927 825
KZ221	uMshwathi	Wartburg, New Hanover, Cool air, Dalton, Mpolweni, Cramond	114 114	108 030
KZ222	uMgeni	Howick, Lidgeton, Lions River, Dargle, Hilton, Merrivale	69 745	73 895
KZ223	Mooi Mpofana	Mooi River, Bruntville, Rosetta, Hidcote	24 776	36 826
KZ224	Impendle	Impendle, Nzinga, Mzumbe, Cibeliche	35 342	33 557
KZ225	Msunduzi	Pietermaritzburg, Sweetwaters, Edendale, Bishopstowe, Raisethorpe	524 938	553 223
KZ226	Mkhambathini	Camperdown, Umlaas Road, Table Mountain, Eston	46 067	59 060
KZ227	Richmond	Richmond, Thornville, Bryne, Baynesfield, KwaMagoda, Ndaleni	62 100	63 222
KZDMA22		*Kamberg*	103	12
		DC23 Uthukela	555 983	656 964
KZ232	Emnambithi	Ladysmith, Colenso, Van Reenen, Driefontein, Ezakheni, Steadville	178 513	225 452
KZ233	Indaka	Valkop, Ulival, Kliprivier, Ekuvukeni	98 480	113 643
KZ234	Umtshezi	Estcourt, Weenen, Frere, Wembezi	47 236	59 925
KZ235	Okhahlamba	Winterton, Mkukwini, Geluksburg, Zwelisha, Bergville	118 881	137 515
KZ236	Imbabazane	Draycott, KwaMankonjane, Mahlutshini, Loskop, Maqabaqabeni	112 291	119 914
KZDMA23		*Cathedral Peak*	582	515
		DC24 Umzinyathi	426 934	456 468
KZ241	Endumeni	Dundee, Witbank, Sibongile, Wasbank, Glencoe, Thembalihle	44 404	51 105
KZ242	Nquthu	Nqutu, Nondweni, Ndlovana, Mpukunyoni	128 793	145 036
KZ244	Msinga	Tugela Ferry, Pomeroy, Mhlumeni, Rorke's Drift	161 342	168 037
KZ245	Umvoti	Kranskop, Greytown, Herrmansberg, Muden, Nhlalahle, Nturijambili	92 395	92 290
		DC25 Amajuba	410 789	468 037
KZ252	Newcastle	Newcastle, Charlestown, Oslzweni, Madadeni, Chelmsford	287 662	332 980
KZ253	Utrecht	Utrecht, Swaartkop, Klipspruit, Bloodriver	23 909	32 286
KZ254	Dannhauser	Dannhauser, Hattingspruit, Normandien	99 218	102 771
		DC26 Zululand	648 388	722 264
KZ261	eDumbe	Paulpietersburg, Frischgewaagd, Waterloo, Dumbe, Simlangetsha	65 372	82 230
KZ262	uPhongolo	Pongola, Golela, Magudu, Vusumuzi, Mvutshini	98 273	119 782
KZ263	Abaqulusi	Vryheid, Louwsburg, Clifton, Ekuthuthukeni	167 903	191 016
KZ265	Nongoma	Nongoma, Ezilonyeni, Mvulazi, Mahashini, Sidinsi, Bhekumthetho	188 959	198 435
KZ266	Ulundi	Ulundi, Kwambambo, Mahlabathini, Dingaanstat, Nkonjeni, Dlebe	193 253	212 971
		DC27 Umkhanyakude	503 758	573 316
KZ271	Umhlabuyalingana	Phelandaba, KwaNgwanase, Nhlazana, Tshongwe	122 306	140 940
KZ272	Josini	KwaNdongeni, Ingwavuma, Jozini, Ubombo, Mkhuze, Tendeka	151 647	184 083
KZ273	The Big Five False Bay	Hluhluwe, Dukumbane	26 292	31 098
KZ274	Hlabisa	Mpembeni, Hlabisa	168 482	176 694
KZ275	Mtubatuba	KwaMsane, Mtubatuba	25 650	35 215
KZDMA27		*Masundwini, Kosi Bay, St Lucia*	9 381	5 086
		DC28 uThungulu	762 586	885 939
KZ281	Mbonambi	KwaMbonambi, Cwaka	96 233	106 945
KZ282	uMhlatuze	Richards Bay, Empangeni, Ongoye, Esikhawini, Kwadlangezwa	196 128	289 192
KZ283	Ntambanana	Qude, Nomponjwana	72 700	84 764
KZ284	Umlalazi	Eshowe, Gingindlovu, Mtunzini	231 207	221 067
KZ285	Mthonjaneni	Melmoth, Ekuthuleni, KwaMagwaza	36 828	50 381
KZ286	Nkandla	Babanango, Nkandla, Vumanhlamvu	129 490	133 586
		DC29 iLembe	534 977	560 377
KZ291	Endondakusuka	Mandeni, Dunn's Reserve, Sundumbili, Tugela Mouth	111 883	128 672
KZ292	Kwadukuza	Zinkwazi, Stanger, Shakas Kraal, Salt Rock, Ballito	131 044	158 586
KZ293	Ndwedwe	Ndwedwe, Glendale Heights	167 373	152 482
KZ294	Maphumulo	Mapumulo	124 677	120 637
		CBDC43 Sisonke	234 468	298 361
KZ5a1	Ingwe	Creighton, Donnybrooke, Ncwadi, Nqumeni	95 138	107 554
KZ5a2	Kwa Sani	Underberg, Himeville, Bushmans Nek, Okhalweni	14 565	15 308
KZ5a3	Matatiele	Matatiele, Cedarberg, Itsokolele	10 145	16 216
KZ5a4	Greater Kokstad	Kokstad, Franklin, Swartberg, Bhongweni	34 726	56 528
KZ5a5	Ubuhlebezwe	Ixopo, Highflats, Umgodi	78 540	101 946
KZDMA43		*Sani Pass, Cobham*	1 351	809

The Structure of the KZNPSP

This document is structurally organised in the following manner:

Vision, Mission and Values: The vision, mission and values are presented at the beginning of the document. The vision is based on the twenty-year national vision and sets the foundation for the provincial mission and values to attain the vision.

Executive Summary: The executive summary provides a synopsis for the entire document. It is aimed at pinpointing key information contained in the document and includes a summary of the results framework.

Introduction: The introductory section makes up Chapter 1 of this document. The section primarily articulates contextual information that is critical to understanding of subsequent chapters. It is composed of a preamble, the purpose of the KZNPSP and background information. The background information describes the geographical, demographic and the socio-economic profile of the province, all of which have a bearing on the HAST situation and response. The provincial HAST situation and the response are also described under the background information sub-section.

KZNPSP 2007-2011: Achievement and Gaps: The second chapter highlights the achievement and gaps as per findings of the review of the KZNPSP 2007-2011, which is predecessor to this document. Paying attention to the achievement and gaps is critical for the response to HAST in the future since information on what worked well and what did not is highlighted. In this manner opportunities and emerging issues can be built upon. Further, practical solutions to the gaps and challenges can be addressed.

The Context and Environment of the HAST Reponses in KZN: Chapter 3 contends that this plan will not be implemented in isolation. For this reason understanding the context and environment within which the plan has been drafted and will be implemented is necessary. The alignment context in relation to global, national and provincial commitments as described in various documents that range from the constitution of the Republic of South Africa, to international resolutions and to national policy documents is discussed. It also discusses the contexts of administration and governance; cultural and traditional; and economic and developmental. Further it discusses the services delivery approach from a poverty alleviation and health care perspective, crucial to the HAST response.

The Strategic Results Framework: Chapter 4 is the strategic results framework divided into five sub-sections that are based on the five strategic objectives that the HAST response will focus on. These strategic objectives are Addressing social and structural drivers of HIV, STI and TB Prevention, Care and Impact; Preventing new HIV, STI and TB Infections; Sustaining Health and Wellness; Ensuring Protection of Human Rights and Improving Access to Justice;; and Coordination, Monitoring and Evaluation. For each of these strategic objectives, the aim is to illustrate the logical linkage to goals, objectives and interventions. In addition, the corresponding indicators at impact, outcome and output level are provided for guidance on the expected measurement and to emphasise the need for results. The results framework sets the stage for implementation.

Governance and Management: Chapter 5 discusses the importance of governance and management within the authority of the coordinating structures under the principle of the "Three Ones". It highlights the linking of Operation Sukuma Sakhe programme to these structures and also points out some of the major challenges and suggests specific actions that will resolve them.

Monitoring, Evaluation and Research: Monitoring, Evaluation and Research forms chapter 6 of this plan. The section mainly focuses on strengthening of the Monitoring and Evaluation System and development of the research agenda.

Thereafter two annexures follow, namely, Annexure A: Combination Intervention Approach to Prevention of HAST and Annexure B: Key Results Framework.

Executive Summary

Introduction

The KwaZulu-Natal Provincial HAST Plan 2012-2016 sets out the broad strategic directions that will guide the HAST response over the next five years. Development of the plan is borne out of a series of consultations with stakeholders and results of a review of the previous plan, the KZNPSP 2007-2011.

Vision, Mission, Values and Purpose

The province has set a twenty year vision of zero new HAST infections, zero new infections due to vertical transmission; zero preventable deaths associated with HIV and TB and zero discrimination associated with HIV, STI, and TB. Through this vision the people of KZN, commit to putting in place a well-coordinated, managed and demonstrably effective response to HAST that is informed by evidence and geared towards eliminating new infections and ensuring the infected and affected enjoy a high quality of life. In achieving the vision, the province is cognizant of the values that will propel it to achieve this vision. These values are: (1) transparency and accountability; (2) partnerships, collaboration and collective accountability; (3) public participation and involvement; (4) upholding human rights and equity and (5) Ubuntu and integrity.

In addition to acting as the framework within which various initiatives will be implemented by the diverse stakeholders in the province, the plan also forms the basis for measuring progress in the provincial response. Secondly, the plan will serve as an advocacy and resources mobilisation tool for the HAST response.

Background Information

KZN province is situated on the east coast of the Republic of South Africa and covers an area of 92,100 square kilometres; accounting for 7, 6% of the total land surface of South Africa. With an estimated population of 10,819,130 persons, KZN is the second most populous province in the country and accounts for 21.4% of the country's population. The population growth rate has decreased from 0,47% in 2000 to 0,28% in 2009 signifying a decline in fertility rates. The male: female population ratio stands at 1:1,07 (StatsSA, 2011) indicating that females have a slight edge over males in terms of numbers. It is estimated that 54% of the population, most of whom are women and children live in rural areas. About 10% of the population in the urban areas live in informal settlements. It is further estimated that the province had a net migration of 1,800 (out-migration of 196,100 and in-migration of 197,900) people between 2008 and 2011. The PGDS states that the urban environment will receive another 3.6 million people from migration by 2030. About 72% of the population is below the age of 35 and the average life expectancy is estimated at 42,7 years for males and 47,8 years for females. Administratively, the Province is divided into 1 Metropolitan municipality, 10 districts, 50 local municipalities and 823 wards.

KZN is the second largest economy in South Africa. Manufacturing is the main economic activity and is supported by other activities such as tourism, finance, insurance, transport, storage and other business services. Tourism is a particularly key sector in the province's economy. In agricultural terms, information indicates that agricultural activity is decreasing and this poses a threat to both food security and employment.

The Provincial Growth and Development Strategy 2011 states that the quality of life of the population 85% of whom are Africans has not improved as evidenced by the still high poverty levels and equally high disease levels including HIV and AIDS, STIs and TB. Unemployment remains significant and a main contributor to poverty. Statistics indicate that in 2005, 5.3 million people, most of whom resided in the rural areas were classified as poor.

The provincial Human Development Index - a composite index of life expectancy, literacy and standards of living- is 0.6. Evidence suggests that the gap between the rich and the poor is widening (CEGAA, 2011). The Gini coefficient for the province which is an indicator of income inequality estimated at 0.7 is indicative of the widening gap between the rich and the poor.

The HAST Situation

KZN has the highest burden of disease associated with underdevelopment and poverty in the country, which includes HIV and AIDS, STIs and Tuberculosis (TB). A Human Science Research Council study on HIV prevalence in South Africa states that HIV prevalence is 15.8%, 11.9% higher than the prevalence in the Western Cape (the province with lowest prevalence). Prevalence among pregnant women has been consistently higher than the national average over the years.

The estimated number of PLHIV in the province is 1,622,870 (15.8%) of the total population. If 30% are presumed to have CD4 counts of 200 and below, the estimate for patients in need of ART is 486,861. The province has the highest incidence of HIV, estimated at 2.3% in 2009 as compared to the national average of 1.8%.

The repercussions of HIV and AIDS at both macro and micro level are well documented. It is estimated that slightly over one million children lost one or both parents to HIV related illnesses.

In regards to sexually transmitted infections (STIs) data indicates that new episodes have not gone down for a considerable period of time. The total number of new episodes in 2010/2011 stood at over 440,000 cases. In addition, despite a 100% partner notification rates only 22% of these were treated.

The province has the unenviable position of having the highest number of TB infections in the country. Tuberculosis (TB) remains the leading cause of mortality in the province, a DOH report estimated that diagnosed TB cases increased from 98,498 in 2005, 109,556 in 2007 to 118,162 in 2009. This represents a caseload of 1,156 cases per 100 000 population.

The HAST Response

The provincial response has been in existence since 1996; from that period changes in the response have been dictated by developments that have taken place in the HAST situation. The response initiatives have included the setting up of HIV and AIDS sub-directorate in DOH, the launch of the Cabinet Initiative; the launch of the AIDS 2000 challenge and the establishment of PAAU. More recently, the putting in place of the Chief Directorate of HIV and AIDS within the Office of the Premier underscored need for enhanced coordination and technical support for the growing number of stakeholders.

At coordination level, the PCA is the only coordinating authority for the response at the provincial level in line with the principle of the "Three Ones." This has been cascaded down to the district and local municipal level with the establishment district and local municipalities AIDS councils. The on-going establishment of Ward AIDS councils or Committees (WAC) will contribute to ensuring that coordination of the response at ward level is enhanced. The PCA is chaired by the Premier, while the DAC and LAC are chaired by respective mayors. The WACs on the other hand are chaired by the respective ward councillors. In this respect, the province has achieved the principle of having one coordinating authority at the three levels and is moving towards fully achieving this at the fourth level, viz; ward level.

For the last five years, the response has been guided by one plan namely, the KZNPSP 2007-2011. The plan envisioned a province that is free of new HIV infections where all infected and affected enjoy a high quality of life. It focussed on responding to the HIV and AIDS with reference to the following priority areas: 1) Prevention; 2) Treatment, Care and Support; 3) Management, Monitoring, Research, and Surveillance and 4) Human Rights, Access to Justice and Enabling Environment. The existence of one strategic plan confirms the province having achieved the second of the "Three Ones" principle.

As for the "Third One", the province developed one M and E framework, complete with the indicators at impact, outcome, output and input level. Attempts were made to align these indicators with international, national and provincial indicators. Further, the provincial vision was to have a system where implementers regularly collected data, reported on them in the relevant forums and used the data for planning and programme improvement.

In line with the multi-sectoral approach, all the KZN stakeholders are expected to participate and collaborate in the implementation of the KZNPSP. Implementing organisations vary in scope, and according to the KZN 911 HIV and AIDS Service Organisations Directory there are 2,532 organisations dedicated to the response in the province. On the overall response services are fairly comprehensive and include prevention (both medical and social), treatment, care and support and; research and surveillance.

The Achievement and Gaps of the KZNPSP 2007-2011 Review

Prior to the development of the KZNPSP 2012-2016, a review of the previous plan was carried out with intent to determine progress, identify challenges and gaps and document emerging issues. The information would be applied to strengthen the response. The following is a list of achievements grouped according to priority areas.

Priority Area 1: Prevention

(1) Reduction in incidence (2) Reduction in MTCT (3) Provision of life skills in 100% of the schools and introduction of "My Life My Future" Programme (4) Increase in number of HTA sites (5) 100% of facilities offering PEP (6) 100% of blood units and products screened in a quality assured manner; (7) Poverty eradication Programme Operation Sukuma Sakhe (OSS) established. The programme is critical to integration and mainstreaming of HIV and AIDS activities; (8) Increased access to clean water and sanitation and (9) Adoption of MMC

Priority Area 2: Treatment, Care and Support

(1) Reduced HIV related deaths; (2) Increased HCT coverage (3) ART Universal coverage (4) HBC integration; (5) OVC support and (6) TB and HIV integration

Priority Area 3: Management, Monitoring, Research and Surveillance

(1) The province has achieved the "Three Ones" principle of one coordinating authority; (2) Most of the AIDS councils are functional: (3) The province has been able to put in place one M and E framework, thereby consolidating the "Three Ones" principle and (4) there is recognition of value Mand E by stakeholders in the response.

Priority Area 4: Human Rights, Access to Justice and Enabling Environment

(1) Strong political commitment

The gaps identified in the review are summarised below per priority area:

Priority Area 1: Prevention

(1) STI services sub-optimal; (2) Inadequate condom distribution (3) High teenage pregnancy

(4) Low MMC coverage and (5) Inadequate integration

Priority Area 2: Treatment, Care and Support

(1) Poor ART follow up (2) Inadequate OVC services coverage and (3) Inadequate HBC coverage

Priority Area 3: Management, Monitoring, Research and Surveillance

(1) Low M and E practice; (2) Non-alignment of stakeholder the multi-sectoral M and E framework and

(3) Uncoordinated research

Priority Area 4: Human Rights, Enabling Environment and Access to Justice

(1) Lack of data to determine extent of progress in this area

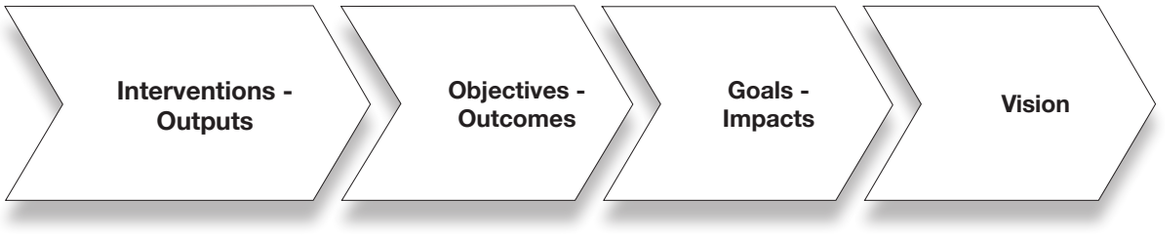
The Context and Environment of the KZN HAST Response

The response to HIV and AIDS, STIs and TB is linked to the wider development efforts at international, national and provincial level. It therefore cannot be implemented in isolation. For this reason, the KZNPSP 2012-2016 has been developed in the context of a number of global, national and provincial developmental commitments. It is aligned to and consistent with the NSP 2012– 2016, the KZN Provincial Growth and Development Strategy (PGDS) and the South African Mid-term Strategic Framework 2009-2014. This will ensure that the response contributes to meeting the country's and provincial developmental aspirations. Further the plan has been influenced by the governance and administrative context; the cultural and traditional context, the economic and development context and the services delivery approach to ensure that it is sensitive and relevant to the aspirations of the province.

The Strategic Plan Framework

The strategic plan framework guiding principles are as follows (1) Results and Evidence Based; (2) Rights Based and Gender Sensitive Approach; (3) Innovation (4) Alignment; (5) Sustainability; (6) Realistic Targets; (7) Community Empowerment; (8) Committed Leadership; (9) Multi-sectoral Approach and (10) Partnership.

The result framework forms the foundation upon which the entire KZN HAST response will be implemented for the next five years. It provides a coherent chain of results that lead towards the attainment of the provincial HAST long term vision as shown by the figure below.



The results framework is structured around the five strategic objectives for which results are expected and represents a comprehensive and coherent array of interventions designed to achieve specified objectives and goals. The goals of the each strategic objective are listed below:

Strategic Objective 1: Addressing Social and Structural Drivers of HAST Prevention, Care and Impact.

1. **To reduce vulnerability to HIV, STI and TB due to poverty, socio-cultural norms and gender imbalance by 2016**

The objectives for this goal address (1) reducing poverty, unemployment and gender inequality (2) promoting positive socio-cultural norms and values.

The expected result is a reduced poverty level, reduced unemployment and gender inequality levels; favourable socio-economic and cultural environment.

Strategic Objective 2: Prevention of new HAST Infections

1. **To reduce new HIV infections to less than 1.2% by 2016**
2. **To reduce new smear positive TB infection to less than 200 per 100,000 population by 2016**
3. **To reduce STI incidence to less than 0.5% by 2016**

To achieve these goals, the plan proposes addressing the following areas: (1) Behaviour Change Communication; (2) Prevention of Mother to Child Transmission, (3) Male Medical Circumcision, (4) Sexually Transmitted Infections Treatment, (5) HIV and TB Screening, (6) Condoms distribution and use, (7) Treatment of TB, (8) HIV transmission through blood and blood products, (9) HIV transmission from occupational exposure, sexual violence and discordance.

The expected result is (1) Reduced HIV Incidence in the general population to less than 1.2% by 2016; (2) Zero HIV Transmission to infants by 2016; (3) Reduced HIV prevalence for age group 15-24 years to less than 10% by 2016; (4) Reduced TB infection to less than 200 new smear positive TB per 100,000 population by 2016; (5) Reduced STI incidence to less than 0.5% by 2016

Strategic Objective 3: Sustaining Health and Wellness

1. **To reduce mortality, sustain wellness and improve quality of life of at least 80% of those infected and affected and 70% of those on treatment to be still on treatment by 2016.**

To achieve this goal the plan has developed objective to address the following areas: (1) Increased access to treatment and support, adherence (to treatment) and optimum health for PLHIV, (2) Increased access treatment (TB) and services that are responsive (3) Increased access to support for the affected (4) Increased quality care for OVC.

The expected result is (1) A reduction in TB associated mortality by 80% by 2016 and (2) An improved quality of life of HIV and TB infected individuals and their families by 2016.

Strategic Objective 4: Ensuring Protection of Human Rights and Improving Access to Justice

1. **To reduce vulnerability to HIV, STIs and TB by creating a supportive policy, human rights and regulatory environment and; promoting desirable social norms in the province by 2016.**

To achieve this goal, objective have been developed to address the following-(1) Strengthening leadership to speak out against, stigma, discrimination (2) Adherence to existing legislation and policy on human rights and promotion of access to justice (3) Capacity building on policies and legislation relating to HIV and AIDS and TB (4) Greater involvement of PLHIV and LGBT. The expected result is that the rights of those infected and affected upheld by a supportive policy, human rights and regulatory environment.

Strategic Objective 5: Coordination, Monitoring and Evaluation

1. **To have a well-coordinated provincial response to HIV and AIDS, STI and TB that is informed by an effective M and E system by 2016.**

The objectives aimed at achieving this goal address (1) Strengthening coordination and management (2) Strengthening Monitoring and Evaluation system at all levels (3) Strengthening the research component of the response. The expected result is an effective coordination and M and leading to achievement of targets.

The summary results framework is appended in annexure 2.

Governance and Management

The first of the "Three Ones", i.e. one coordination authority, is crucial to successful implementation of the KZNPSP 2012-16. The Office of the Premier has demonstrated political will and leadership to ensure that coordinating structures at all levels function effectively. Coordinating authorities will have to ensure that they perform their roles effectively.

The introduction of Operation Sukuma Sakhe (OSS) and linking it to HIV and AIDS and TB coordinating structures implies that coordination; monitoring is now linked directly to an implementation mechanism and that there is greater level of accountability. This has enabled the province to decentralise planning to the local, including the integration of HIV and AIDS and TB into the IDP. Challenges however still remain regarding coordination and management.

Monitoring, Evaluation and Research

The province has one monitoring and evaluation system that needs to become fully functional. The HIV and AIDS Chief Directorate in the OTP will coordinate and ensure that the provincial reporting system is functional as well as establish reporting and feedback links with SANAC. A functional monitoring and evaluation system will allow the province to assess progress in implementation and determine effectiveness of interventions and programmes proposed in this plan. Monitoring reports will provide the basis for discussion within coordinating structures such as the Provincial Council on AIDS, District AIDS Councils, Local AIDS Councils and Ward AIDS Councils.

For KZNPSP 2012-16 an M and E framework and plan will be developed as a separate document and will provide details of how the M and E function will operate in the province. The framework will establish a clear and logical pathway to track progress from the processes to the achievement of the overall result from input level to impact level.

The province will have to place research high on the provincial response agenda. In this manner, the province will be able to have the required evidence to make effective decisions on planning and implementation and come up with innovative ideas that can be fed into response.

Vision, Mission and Values

The province has set a twenty year vision of zero new HAST infections, zero new infections due to vertical transmission; zero preventable deaths associated with HIV and TB and zero discrimination associated with HIV, STI, and TB. Through this vision the people of KZN, commit to putting in place a well-coordinated, managed and demonstrably effective response to HAST that is informed by evidence and geared towards eliminating new infections and ensuring the infected and affected enjoy a high quality of life. In achieving the vision, the province is cognizant of the values that will propel it to achieve this vision.

Vision

A KwaZulu-Natal Province that has zero new HAST infections, zero new infections due to vertical transmission, zero preventable deaths associated with HIV and TB and zero discrimination associated with HIV and TB.

Mission

The people of the Province of KwaZulu-Natal commit themselves to putting in place a well-coordinated, managed and demonstrably effective response to HIV and AIDS, STI and TB informed by evidence and geared towards eliminating new infections and ensuring a high quality of life for the infected and affected.

Values

In striving to achieve the HAST vision and mission, the province will be guided by the following values:

Transparency and Accountability
Partnerships, Collaboration and Collective Accountability
Public Participation and Involvement
Upholding Human Rights and Equity
Integrity and Ubuntu

CHAPTER 1

1 Introduction

1.1 Preamble

It is now fifteen years since the province of KwaZulu-Natal embarked on a structured response to HIV and AIDS with the setting up of the HIV and AIDS sub-directorate in 1996. Through this time the province has put in place a series of initiatives and plans as part of its effort in curbing the spread of HIV and AIDS. Similarly, over these years, there have been various changes in policy, prevention technologies, funding, the scale of implementation, coordination and monitoring and evaluation, among others all of which have contributed to shaping these initiatives and plans and the response as a whole.

The development of the KZN HIV and AIDS, STIs and TB Provincial Strategic Plan (KZNPSP) 2012-2016 therefore continues in the path the province set in 1996. This plan is a product of a participatory and inclusive process that involved a wide range of stakeholders from the provincial, district and local levels. It has been designed to build on the achievements and address the gaps identified in KZNPSP 2007-11 as well as on the emerging issues.

The Office of the Premier, Chief Directorate on HIV and AIDS, with assistance from technical working groups, led and provided guidance through the entire plan development process. Seven Technical Working Groups (TWG) were established to lead the process in the following specific technical areas.

- TWG 1: Biomedical Prevention and Social Prevention
- TWG 2: Treatment and Care
- TWG 3: Support / Impact Mitigation
- TWG 4: Management and Coordination
- TWG 5: Human Rights, Legal and Policy Environment
- TWG 6: Monitoring and Evaluation
- TWG 7: Research and Surveillance

The process commenced with the review of the KZNPSP 2007-11 to determine the achievements and gaps and identify main priority issues. To underscore participation and inclusiveness, three stakeholders' workshops were held as part of the process. The initial workshop was primarily aimed at introducing the plan development process; the second workshop presented the findings of the review and deliberated on the drafting of the strategic plan. It involved the setting of goals, objectives, interventions as well as corresponding indicators and targets. The third workshop involved validating information on the draft plan culminating in coming up with a final plan.

The KZNPSP is focused on the long-term vision of the province with regard to HIV and AIDS STIs and TB (HAST). The goals are therefore linked to the vision of the NSP 2012-2016. The initiatives and interventions are based on evidence, guided by the national priorities and linked to the Provincial Growth and Development Strategy (PGDS). The design of the plan is result based with emphasis on accountability in which impacts, outcomes, outputs and responsibilities are clearly spelt out. The KZNPSP 2012-16 will be operationalized through sectoral operational plans, district operational plans, local municipal operational plans and ward level plans.

1.2 Purpose of the KZNPSP

The purpose of KZNPSP 2012-2016 is to provide strategic guidance to the provincial HAST response and act as framework within which various initiatives will be implemented by diverse stakeholders in the province. It forms the basis for measuring progress in the provincial response. Secondly, the plan will serve as an advocacy and resources mobilisation tool for the HAST response.

1.3 Background Information

1.3.1 Geography and Demography

KwaZulu-Natal (KZN) is one of nine provinces of the Republic of South Africa (RSA). It is situated on the east coast of the country and covers an area of 92,100 square kilometres; accounting for 7,6% of the total land surface of South Africa. The province shares inter-national borders with Lesotho, Mozambique and Swaziland. Internally, it shares its borders with the Free State, Mpumalanga and Eastern Cape provinces. The province has an ocean coastline of about 1000 kilometres (km) and has a topography that is characterised by undulating hills and valleys.

With an estimated population of 10,819,130 persons, KZN is the second most populous province in the country and accounts for 21.4% of the country's population. The population growth rate has decreased from 0,47% in 2000 to 0,28% in 2009 signifying a decline in fertility rates. The male: female population ratio stands at 1:1,07 (StatsSA, 2011) indicating that females have a slight edge over males in terms of numbers. It is estimated that 54% of the population live in rural areas, making it one of the most rural provinces in the country. The majority of rural dwellers are women and children, suggesting that menfolk may have migrated to the urban areas in search of employment. 10% of the population in the urban areas live in informal settlements, perhaps underlining the problem of poverty. It is further estimated that the province had a net migration of 1,800 (out-migration of 196,100 and in-migration of 197,900) people between 2008 and 2011. The PGDS states that the urban environment will receive another 3.6 million people from migration by 2030. About 72% of the population is below the age of 35 and the average life expectancy is estimated at 42,7 years for males and 47,8 years for females. Table 1 below shows the population breakdown by age group, and percentage composition. The sexually active group i.e. 15-49 age group forms about 53% of the total population.

Table 1: KZN Population by Age Group (Mid-year 2011 estimates)

Age	Number	%	Age	Number	%
0-4	1220882	11.3%	50-54	374063	3.5%
5-9	1228646	11.4%	45-49	420211	3.9%
10-14	1212070	11.2%	50-54	487821	4.5%
15-19	1195857	11.1%	55-59	307829	2.8%
20-24	1096194	10.1%	60-64	264645	2.4%
25-29	998783	9.2%	65-69	188851	1.7%
30-34	823321	7.6%	70-74	136241	1.3%
35-39	710320	6.6%	75-79	84739	0.8%
			80+	68657	0.6%
Total Population: 10,819,130					

(Source: StatsSA Statistical Release Mid-year Estimates 2011)

As indicated in the table below, eThekwini, the commercial centre of KZN is the most populous followed by uMgungundlovu , where the provincial administrative seat is located. Amajuba is the least populated of the districts.

Table 2: KZN Population by Districts

District	Population
Amajuba	442,266
Sisonke	500,082
Umkhanyakude	614,046
Umzinyathi	495,737
uThukela	714,908
Uthungulu	894,260
Zululand	902,890
eThekwini	3,468,086
iLembe	528,198
uMgungundlovu	988,837
Ugu	709,918

(Source of Data: Statistic South Africa; Community Survey, 2007 Basic Results: Municipalities)

The provincial population density is estimated at 107.52 people per kilometre square. eThekwini metropolitan council has the highest density at approximately 1,394 people per kilometre square, while Sisonke district has the lowest population density at approximately 42 people per kilometre square.

Administratively, the Province is divided into 1 Metropolitan municipality, 10 districts, 50 local municipalities and 823 wards. The HIV and AIDS coordination boundaries are aligned with the municipal and district boundaries as determined by the Municipal Demarcation Board.

1.3.2 Socio-Economic Profile

According to the Income and Expenditure Survey (2003) KwaZulu-Natal contributed approximately 16.5% to the National GDP. It is the second largest economy in South Africa. Manufacturing is the main economic activity and is supported by other activities such as tourism, finance, insurance, transport, storage and other business services. Tourism is a particularly key sector in the province's economy. In agricultural terms, information indicates that agricultural activity is decreasing and this poses a threat to both food security and employment. Approximately 496,230 households most of which are based in the rural areas, are involved in non-commercial subsistence farming (Provide Project, 2005). Agriculture does not represent a significant income source among the rural dwellers. eThekwini is the largest contributor to economic activity followed a distant second by uMgungundlovu.

The Provincial Growth and Development Strategy 2011 classifies quality of life, social necessities and social relations as those that define the provincial social landscape. The document goes further to state that the quality of life of the population 85% of whom are Africans has not improved as evidenced by the still high poverty levels and equally high disease levels including HIV and AIDS, STIs and TB. Given that the province is principally rural, the low quality of life is mostly predominant and glaring in these areas.

Unemployment remains significant and a main contributor to poverty. Statistics indicate that in 2005, 5.3 million people, most of whom resided in the rural areas were classified as poor. In addition 2.1 million of these were living on less than two dollars a day or two hundred rands a month. According to the District Health Barometer report, KwaZulu-Natal is one of three provinces with the ten most deprived districts in South Africa where 63% to 82% of households live on less than R800 per month (HST, 2010).

The provincial Human Development Index - a composite index of life expectancy, literacy and standards of living- is 0.6. Evidence suggests that the gap between the rich and the poor is widening (CEGAA, 2011).

The Gini coefficient for the province which is an indicator of income inequality estimated at 0.7 is indicative of the widening gap between the rich and the poor.

1.3.3 HIV, AIDS, STI and Tuberculosis Situation

The province has the highest burden of disease associated with underdevelopment and poverty in the country which include HIV and AIDS, STIs and Tuberculosis (TB). A Human Science Research Council study on HIV prevalence in South Africa (Shisana, et al., 2008) put KwaZulu-Natal Province at the top of the other provinces with a 15,8% HIV prevalence, 11,9% higher than the prevalence in the Western Cape (the province with lowest prevalence). Prevalence among pregnant women has been consistently higher than the national average over the years, although the trend now suggests some stabilisation.

When one translates prevalence to numbers, the estimated number of PLHIV in the province is 1,622,870 (15.8%) of the total population. The Actuarial Society of South Africa (ASSA) projections of 2011 estimate the number of PLHIV at 1,576,025. If 30% are presumed to have CD4 counts of 200 and below, the estimate for patients in need of ART is 486,861. More than half (54%) of the adult PLHIV live in KwaZulu Natal (SANAC, 2011). KZN also has the highest incidence of HIV, estimated at 2.3% in 2009 as compared to the national average of 1.8%. In 2009 the estimated number of AIDS related deaths was 115, 716.

The repercussions of HIV and AIDS at both macro and micro level are well documented. It is estimated that slightly over one million children lost one or both parents to HIV related illnesses. This not only contributes to breakdown of family structure but is also detrimental to the economic fabric of the province.

In regards to sexually transmitted infections (STIs) data indicates that new episodes have not gone down for a considerable period of time. The total number of new episodes in 2010/2011 stood at over 440,000 cases. In addition despite a 100% partner notification rates only 22% of these were treated.

The province has the unenviable position of having the highest number of TB infections in the country. Tuberculosis (TB) is the leading cause of mortality in the province with diagnosed TB cases increasing from 98,498 in 2005, 109,556 in 2007 to 118,162 in 2009 (DOH Annual Report, 2010). This represents a caseload of 1,156 cases per 100 000 population, which is more than four times the epidemic threshold according to the World Health Organisation.

1.4 The KZN Provincial HIV and AIDS Response

KZN began experiencing a rapidly growing problem of HIV and AIDS in the late 80's and early 90's. In response to the enormous challenge, the province developed and implemented several initiatives. These included the setting up of HIV and AIDS sub-directorate in DOH in 1996 followed by the launch of the Cabinet Initiative and the AIDS 2000 challenge in 1998 and 1999 respectively. In 2000 the Provincial AIDS Action Unit (PAAU) was established by Cabinet to drive a province-wide response to HIV and AIDS with a vision of "AIDS-free KZN". PAAU implemented a number of interventions that included: partnership development; capacity building; community mobilisation and support; and coordination of programmes such as home-based care, PMCT and life skills education.

Because of the need to scale up and broaden the scope of the response, in 2004, the Cabinet resolved to dissolve PAAU and placed the coordination of all sectors and transversal issues of HIV and AIDS response with the Chief Directorate of HIV and AIDS within the Office of the Premier. The KZN Provincial AIDS Council was subsequently established in November 2008 and named the Provincial Council on AIDS (PCA). The PCA is the only coordinating authority for the response at provincial level in line with the principle of the "Three Ones." This has been cascaded down to the district and local municipal level with the establishment district and local municipalities AIDS councils (DACs and LACs). The on-going establishment of Ward AIDS Committees (WAC) will contribute to ensuring that coordination of the response at ward level is enhanced. The PCA is chaired by the Premier, while the DAC and LAC are chaired by respective mayors. The WACs on the other hand are chaired by the respective ward councillors.

In this respect, the province has achieved the principle of having one coordinating authority at the three levels and is moving towards fully achieving this at the fourth level, viz; ward level.

For the last five years, the response has been guided by one plan namely, the KZNPSP 2007-2011. The plan envisioned a province that is free of new HIV infections where all infected and affected enjoy a high quality of life; The response has been based on the multi-sectoral approach, focussed on responding to the HIV and AIDS with reference to the following priority areas: 1) Prevention; 2) Treatment, Care and Support; 3) Management, Monitoring, Research, and Surveillance and 4) Human Rights, Access to Justice and Enabling Environment. The existence of one strategic plan confirms the province having achieved the second of the "Three Ones" principle. The KZNPSP was aligned to the National Strategic Plan for HIV and AIDS and STIs (NSP 2007-2011) and implementing stakeholders were expected to develop their operational plans based on the KZNPSP.

In regard to the "Third One", the province developed one M and E framework, complete with the indicators at impact, outcome, output and input level. Attempts were made to align these indicators with international, national and provincial indicators. Further, the provincial vision was to have a system where implementers regularly collected data, reported on them in the relevant forums and used the data for planning and programme improvement.

In line with the multi-sectoral approach, all the KZN stakeholders are expected to participate and collaborate in the implementation of the KZNPSP. Further, provincial government departments are expected to have internal programmes aimed at workplace responses to ensure employee wellness and that of their immediate families are catered for. In addition, a number of departments are involved in the external response programmes. For example the DOH is a key department in health sector oriented responses such as counselling and testing, antiretroviral therapy (ART) and prevention of mother to child transmission (PMTCT) among others.

Other departments playing a major part in the external response include the department of education (DOE), department of social development (DSD), department of agriculture, environmental affairs and rural development (DEARD), department of cooperative governance and traditional affairs (COGTA), department of human settlements (DHS) and the department of economic development and tourism (DEDT).

Several non-governmental organisations (NGOs), faith based organisations (FBOs) and community based organisations (CBOs) are also actively involved in the response in the province. They provide a variety of services and a wide range of interventions. The business community and traditional health practitioners are also recognised as important partners in the response. A broad range of direct services is being provided by some business programmes and traditional practitioners. There are also a number of international partners who provide resources and collaborate in research within the province.

Implementing organisations vary in scope, and according to the KZN 911 HIV and AIDS Service Organisations Directory there are 2,532 organisations dedicated to the response in the province. On the overall response services are fairly comprehensive and include prevention (both medical and social), treatment, care and support and; research and surveillance.

CHAPTER 2

2 KZNPSP 2007-11: Achievements and Gaps

The review of the KZNPSP 2007-2011 revealed a number of achievements, gaps and challenges. Summary information on achievements and gaps is provided below.

2.1 Main Achievements

Prevention

Reduction in Incidence: The incidence of HIV is estimated to have declined from 3.8% in 2005 to 2.3% in 2008.

Reduction in MTCT: HIV transmission rate from mother to child declined from 22% in 2005 to 2.8% in 2010.

Provision of Life Skills: 100% of primary schools in KZN provide life skills-based education. Further the "My Life My Future" Behaviour Change Programme has been introduced to supplement the Life Skills Programme.

Increase in HTAs: Forty eight (48) High Transmission Areas (HTAs) have been established.

PEP: 100% of government and private health facilities provide continuous supply of PEP medicines.

Blood Screening: 100% of all blood and blood products are screened in a quality assured manner.

Poverty Eradication: The Operation Sukuma Sakhe (OSS)-the flagship poverty eradication programme in KZN is addressing poverty through intensified and renewed strategies that directly focus on individuals and households at community level. The programme is critical to integration and mainstreaming of HIV and AIDS, TB and STI activities.

Increased Access to Clean Water: 86.2% of the population in KZN has access to clean water as compared to 70.3% in 2005. Similarly the population with access to sanitation increased to 80.5% from 74.1% in 2005.

Adoption of MMC: Voluntary male medical circumcision has been introduced and accepted in the province. The province reported 54 670 MMC operations in the period April 2010 to June 2011 surpassing its yearly target of 53000. It is the province with the highest MMC operations in the country. It is critical that strong political and cultural leadership that provides advocacy for this programme.

Increased Access to Clean Water: 86.2% of the population in KZN has access to clean water as compared to 70.3% in 2005. Similarly the population with access to sanitation increased to 80.5% from 74.1% in 2005.

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Treatment, Care and Support

Reduced HIV Deaths: The estimated number of reported deaths due to HIV and AIDS has reduced from 67, 429 in 2008/09 to 54,337 in 2010/11.

Increased HCT Coverage: HCT coverage has increased and achieved 95% of its target. The increase has been attributed to the 2010/11 HCT mobilisation campaign.

ART Universal Coverage: ART programme has achieved universal coverage with cumulative total of 459,670, of which 45, 598 are children, having been registered for ART in 2011.

HBC Integration: HBC is provided in an integrated manner by the Community Care Givers

OVC Support: Over 40,000 OVC were provided with services

TB and HIV Integration: TB and HIV integration interventions have witnessed successful implementation. For example, there was increased uptake of IPT leading to a 71,5%(124,963 patients) achievement against the target of 170,000 patients by June 2011.

Management, Monitoring, Research and Surveillance

Coordination: The province has one coordinating authority at provincial, district and local level, thereby achieving the "Three Ones" principle of one coordinating authority.

Functionality of AIDS Councils: The Provincial Council on AIDS is fully functional while 82% of the District AIDS Councils and 53% of Local AIDS Councils are fully functional.

Mand E Framework: The province has been able to put in place one Mand E framework, thereby consolidating the "Three Ones" principle.

Recognition of Mand E: Stakeholders in the response have recognised the value of Mand E.

Human Rights, Access to Justice and Enabling Environment

Political Commitment: There is strong political commitment for Human rights, access to justice and in governance of the response.

2.2 Main Gaps and Challenges

Prevention

STI Services Sub-optimal: STI services have not yet reached optimum effect as there is still a high volume of new cases. For example, the total number of new episodes treated in 2010/2011 was 440,714. Further, despite 100% partner notification, only 22% of the partners were treated.

Inadequate Condoms Distribution: Condom distribution remains inadequate. About 18% of male and 27% of female condoms were distributed.

High Teenage Pregnancy: Teenage pregnancy remains high. The Department of Education data indicated that 14000 pregnancies occurred in schools in 2010.

Low MMC Coverage: The coverage of MMC remains significantly low.

Inadequate Integration: Integration of services remains inadequate.

Treatment, Care and Support

Poor ART Follow Up: Poor follow-up of ART patients. Anecdotal evidence suggests that following up patients is weak.

Inadequate OVC Services Coverage: OVC services coverage is inadequate. Only 40% of OVC requiring services were reached.

HBC Coverage: Coverage of the HBC programme cannot be ascertained suggesting gaps in data collection.

Management, Monitoring, Research and Surveillance

Low Mand E Practice: The practice of Mand E has not been fully entrenched as evidenced by absence of data sets for this review.

Non-Alignment of Mand E Framework: The Mand E framework has not been fully aligned to stakeholder operational plans.

Uncoordinated Research: Research in uncoordinated and the absence of a provincial research agenda means a lost opportunity to ensure that the provincial research needs are fully addressed.

Human Rights, Enabling Environment and Access to Justice

Lack of Data: Very little information is available to determine extent of implementation and effectiveness of human rights, access to justice and enabling environment interventions.

CHAPTER 3

3 The Context and Environment of the HAST Response in KZN

3.1 Alignment Context

The response to HIV and AIDS, STIs and TB is linked to the wider development efforts at international, national and provincial level. It therefore cannot be implemented in isolation. For this reason, the KZNPSP 2012-2016 has been developed in the context of a number of global, national and provincial developmental commitments. It is aligned to and consistent with the NSP 2012– 2016 and the KZN Provincial Growth and Development Strategy (PGDS). This will ensure that the response contributes to meeting the country's and provincial developmental aspirations. Some of the main commitments that the KZNPSP 2012-2016 is aligned to are described below:

The South Africa Constitution: The South African constitution is the supreme legislative framework for all laws in the country. Section 2 of the constitution states that the Constitution is the supreme law of the Republic; law or conduct inconsistent with it is invalid, and the obligations imposed by it must be fulfilled. In this regard therefore development of any developmental framework must take place within the structure of the constitution.

The National HIV and AIDS, STIs and TB Strategic Plan 2012-2016: The National HAST plan 2012-2016 is the main guiding strategy for the implementation of the response in South Africa. Provinces are therefore expected to ensure that their plans are aligned to the NSP. Building on the successes of the last plan period, while at the same time having to ensure that the new interventions are implemented, the NSP aims at achieving 5 broad goals. The goals center around the following:

- Reduction of new HIV infections by using combination prevention approaches

- Initiating eligible patients on antiretroviral treatment (ART) leading to a reduction of mortality from this population
- Reduction on the number of new TB infections as well as TB related deaths.
- Enabling and accessing a legal framework that protects and promotes human rights and
- Reduction of self-reported stigma related to HIV and TB.

The Millennium Development Goals (MDGs): MDGs are a set of eight international developmental goals that all United Nations member states, South Africa included; and some international organisations have agreed to achieve by 2015. Targets to achieving the MDGs have been set by and are reported on in the UN general assembly annually. MDGs targets that are particularly relevant to this plan are: MDG 4 - to reduce child mortality; MDG 5 - to improve maternal health and; MDG - 6 combating HIV, malaria and other major diseases by 2015. The achievement of the objectives in this plan will contribute to the achievement of MDGs.

Universal Access: The concept of universal access was endorsed by United Nations in 2005 following a relative success of the "3 by 5" targets which aimed at putting 3 million people on treatment by 2005. The aim was to have universal access to HIV treatment, prevention and care in all countries by 2010. However, the World Health Organisation (WHO) 2008 Universal Access report showed that most countries would not meet the 2010 targets of 80 percent of those in need receiving treatment. Therefore in 2011, there was a recommitment to the goal of universal access where countries committed to achieving universal access by 2015. This plan takes cognizance of the universal access target.

UNGASS Political Declaration, June 2011: The United Nations General Assembly Special Session on HIV/AIDS (UNGASS) Political Declaration of June 2011 calls on all UN Member States to redouble their efforts to achieve universal access to HIV prevention, treatment, care and support by 2015 as a critical step towards ending the global AIDS epidemic.

It also noted the need to expand efforts to combat TB by improving TB screening, prevention, access to diagnosis and to treatment of both drug susceptible and drug resistant TB; and access to antiretroviral therapy. It further calls on member states to implement integrated TB and HIV services in line with the Global Plan to Stop TB 2011-2015. The following are the UNGASS targets:

- Reduce by 50% the sexual transmission of HIV—including among key populations, such as young people, men who have sex with men, in the context of sex work; and prevent all new HIV infections as a result of injecting drug use;
- Eliminate HIV transmission from mother to child;
- Reduce by 50% tuberculosis deaths in people living with HIV;
- Ensure HIV treatment for 13 million people;
- Reduce by 50% the number of countries with HIV-related restrictions on entry, stay and residence; and
- Ensure equal access to education for children orphaned and made vulnerable by AIDS.

The Stop TB Strategy: The WHO launched the Global TB Strategy in 2006 to ensure equitable access to quality care for all TB patients through public or private health care providers. The six components of the strategy include:

- Pursuing high-quality directly observed treatment strategy (DOTS) expansion and enhancement;
- Addressing TB/HIV and MDR-TB and other special challenges;
- Contributing to health systems strengthening;
- Engaging all care providers;
- Empowering people with TB, and communities; and
- Enabling and promoting research.

This plan integrates all these components of the stop TB agenda, which are consistent with national and provincial stop TB goals and objectives.

Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV 2010-14: This agenda was launched at the 54th UN meeting on the Commission on the Status of Women, held in New York in March 2010. It aims to address gender inequalities and human rights violations that continue to put women and girls at risk of HIV infection. Its focus is on understanding and responding to particular effects of HIV on women and girls; translating political commitments into scaled-up action to address the needs of women and girls in the context of HIV; and creating an enabling environment for the fulfillment of the human rights of women and girls; and their empowerment in the context of HIV. Specific recommended actions include the following:

- Improving data collection and analysis to better understand how the epidemic affects women and girls.
- Reinforcing the End Violence against Women campaign through the AIDS response.
- Ensuring that Violence against Women response is integrated into HIV prevention, treatment, care and support programmes.
- Analysing the impact of socio-cultural and economic factors that prevent women and girls from protecting themselves against HIV.
- Supporting women‘s groups and networks of women living with HIV to map commitments made by governments on women and HIV.
- Scaling up engagement of men‘s and boys’ organizations to support the rights of women and girls.

The Abuja Declaration: The Abuja Declaration of 2001 on HIV/AIDS, Tuberculosis and other infectious diseases signed by African Countries reaffirmed its concern for the continuing rapid spread of HIV infection and deaths caused by AIDS, TB and other infectious diseases;

and that this was a threat to the continent's development agenda, social cohesion and political stability among others. Reversing the spread of HIV/AIDS, TB and other infectious diseases should be the top priority in the twenty first century.

The Maseru Declaration: One of the objectives of the Southern Africa Development Cooperation (SADC) of which South Africa is a member is to combat HIV and AIDS and other communicable diseases. The declaration calls for action in the following priority areas:

- Prevention and Social Mobilisation
- Improving care, Access to counseling and testing services, Treatment and Support
- Accelerating development and mitigating the impact of HIV and AIDS
- Intensifying resource mobilisation
- Strengthening Institutional and Monitoring and Evaluation mechanism

The Youth and Adolescent Health Policy 2001: The policy on youth and adolescent health is encapsulated in the Youth and Adolescent Health Guidelines published by the DOH in 2001 and under draft currently. The guidelines recognise the following guiding principles for adolescent and youth health:

- Adolescent development underlies the prevention of health problems
- Problems are interrelated
- Adolescence and youth are times of opportunity and risk
- The social environment influences behavior
- Not all young people are equally vulnerable
- Gender considerations are fundamental

It therefore outlines five general intervention strategies for adolescent and youth health: (a) promoting a safe and supportive environment, which includes relationships with families, social norms and cultural practices, mass media, accessibility of key opportunities and commodities, and legislation and policies; (a) providing information; (b) building skills; (c) counselling; and (e) access to health services.

Departmental and Sector Strategic Plans: This plan takes into cognizance departmental and sector strategic plans. In many instances it has attempted to incorporate departmental and sector strategies relating to HAST and other relevant developmental aspects. Several critical factors are brought forward here, one of which is mainstreaming. In this manner, HAST activities will seamlessly fit into the departments and sectors implementation activities. Towards this end, numerous strategic plans were referred to as a way of achieving mainstreaming and ensuring that the plan remained within the broader developmental goals of the province and the country as a whole.

3.2 Administrative and Governance Context

Administratively KZN province consists of 3 tiers of authority, namely provincial, district and local municipal authorities. The province has 1 metro municipality and 10 district municipalities, which are further divided into 51 local municipalities that consist of a total of 823 wards. The constitution vests the Executive Authority of the province in the Premier and exercises this Authority with the Members of the Executive Council (MEC). Likewise the Executive Authority of each district and local municipality is vested in the respective Mayors.

Coordination and management of the HAST response falls under the responsibility of the Provincial Council on AIDS (PCA), which is chaired by the Premier. The PCA is supported by the HIV and AIDS Directorate located within the Office of the Premier which serves as its secretariat. At the district and local municipal levels District/Local AIDS Councils (DAC/LAC) coordinate all HIV response activities. DACs and LACs are also expected to have secretariats. The province is in the process of setting up ward AIDS councils (WACs) in all the 823 wards. WACs will assume the role of being the main co-ordinating authorities at ward level.

The province has 16 provincial government departments which facilitate implementation of plans in their areas of responsibility. They work collaboratively with other spheres of government and relevant agencies. All these departments are expected to integrate and mainstream HAST activities into their mandates.

Coordination of these departments is done through four cabinet clusters namely; economic sector and infrastructure development; social protection, human and community development; governance and administration and justice, crime prevention and security.

Additionally, the province has a House of Traditional Leaders and eleven local houses of traditional leaders based at district level and two hundred and sixty five traditional councils at local level. These structures are critical to the response to HAST.

3.3 Cultural and Traditional Context

KZN is a culturally diverse province supported by an equally diverse population composed of an African majority, Indians, Whites and Coloured. KwaZulu-Natal is home to the Zulu traditional monarchy and is headed by King Goodwill Zwelithini kaBhekuzulu. Culture and tradition are particularly important in the province and affect all spheres of life for the majority of population of the province. Although not holding direct political power, the Zulu king has considerable influence among the Zulu people and is a central figure in the response to HAST issues.

Current data indicates that the majority population (about 83%) is the most affected by HIV and AIDS, STI and TB. Towards this end, the King has been instrumental in curbing its spread through for example, use of the “Reed Dance” ceremony in line with traditional culture to promote virginity of girls until marriage. More recently, the traditional practice of male circumcision has been revived and the King is on record for having made pronouncements that strongly support the practice. He urges his male subjects to undergo medical male circumcision in an effort to further contain the spread of HIV.

3.4 Economic and Development Context

The KZN PGDS is the framework for accelerated economic growth and development in KZN designed to bring all stakeholders together in pursuit of the vision of "a prosperous province with a healthy, secure and a skilled population, acting as a gateway to Africa and the World". The KZN PGDS aims to grow the provincial economy and improve the quality of life of all people living in the province. Its main thrusts are the following:

- Job creation;
- Human resources development;
- Human and community development;
- Strategic infrastructure development;
- Response to climate change;
- Governance and policy; and
- Spatial equity.

The PGDS recognises that the HAST epidemic is a major impediment to the attainment of its aspirations. In its goals and objectives it addresses most of the structural underlying determinants of HIV, STI and TB transmission; namely poverty, unemployment, inequality and informal settlements. On the other hand, achievement of the KZNPSP goals will facilitate the attainment of the PGDS goals and objectives and hence the KZNPSP will operate within the broader PGDP priorities.

3.5 Services Delivery Approach

The services delivery approach for KZNPSP 2012-2016 will be underpinned by three national and provincial agendas. These are: (a) Operation Sukuma Sakhe; (b) the Primary Health Care (PHC) Re-engineering and; (c) the National Health Insurance (NHI) policy.

Operation Sukuma Sakhe (OSS): OSS was launched in July 2009, under the campaign "One Home, One Garden, One Product, One Village", with the following objectives:

- Making meaningful household intervention on poverty; and fighting diseases which are HIV and AIDS and TB
- Behavioural change to address HIV and AIDS, teenage pregnancy, crime, substance abuse, road accidents, gender-based abuse and violence;
- Empowerment of Women and Youth and Addressing the needs of the most vulnerable and deprived communities and households; by Creating opportunities for skills development and employment;
- Ensure food security and making rural development a realizable vision;
- Ensuring integration and cooperative governance for better and faster service delivery.

The Operation Sukuma Sakhe delivery model is designed to address the critical areas of community participation, integrated services delivery, behaviour change, economic empowerment and environmental care. In the OSS model, coordination of services delivery at the ward level is centred on the "war room". Each war room has a dedicated team that include community care givers, who provide services at household level, youth ambassadors who promote behaviour change and healthy lifestyle; extension officers who provide services for implementation of one home one garden; sports volunteers to support sports and recreation;social crime prevention volunteers for crime prevention and community development workers (CDWs) who provide advice, secretariat functions and monitor interventions initiated through the war rooms, all government departments officials who deliver the services and the civil society organisations who play a supportive, advocacy and accountability role. The primary thrust of the OSS is the household. All government departments have been mandated to align their operational plans with OSS and have indeed translated the mandate into action and aligned their operations to OSS.

The province's leadership provides the OSS oversight and support. Hence the district and local levels mayors are OSS champions at district and local municipality levels while the councillors are ward level champions. Additionally, The Premier, MEC and heads of departments (HODs) are also champions and oversee OSS implementation in specified districts.

All the outputs and outcomes of OSS initiatives are reported to WAC, LAC, and DAC and ultimately to the PCA.

Considering that the interventions in the KZNPSP 2012-2016 are an inherent part of the OSS programme and will be implemented through OSS, the approach augurs very well for the sustainability of the KZNPSP.

Re-engineering PHC in South Africa: Despite having a strong healthcare infrastructure and the PHC principles underpinning the National Health System, over the years insufficient attention has been paid to effective implementation of the PHC approach of comprehensive community-based services, disease prevention, health promotion, community participation and inter-sectoral collaboration. This has led to poor overall health outcome. It is against this backdrop, that the DOH produced a strategy for "Re-engineering PHC in South Africa". This approach is based on the following tenets:

- Strengthening the district health system (DHS), through the implementation of chapter 5 of the National Health Act, and by doing the basics better;
- Placing much greater emphasis on population based health and outcomes, which includes a new strategy for community-based services through a PHC outreach team based on the community health workers (CHW) and mobilising communities; and
- Paying greater attention to those factors outside of the health sector that impact on health, the social determinants of health.

The approach is centred on a team of professional and lay health workers who will provide services at community level through an outreach and community based models.

Implementation of the interventions proposed in the KZNPSP is consistent with the PHC re-engineering approach and strategy.

The National Health Insurance: South Africa is in the process of introducing a system of health financing that will ensure that all the people of South Africa have access to appropriate, efficient and quality health services. This system is expected to be phased-in over 14-year period and will have far reaching changes to service delivery structure, administrative and management system. It is intended to bring about improved services delivery, promote equity and efficiency and ensure that all have access to affordable and quality health services regardless of socio-economic status. The KZNPSP will ensure that services delivery under the plan is consistent with the NHI policy.

3.6 Key Populations

This plan is designed to target the following key populations that the province has identified as critical to reversing the epidemic; young boys and girls (15-25 years); children under the age of 15; women; men; people with multiple and/or concurrent partners; people with disabilities; people in correctional facilities; sex workers; mobile casual and atypical farm workers; men who have sex with men; refugees and migrants; people living with HIV; people who inject drugs and the poor.

Table 3: Estimated size of key populations

Key populations	Population size
People 15 – 49 who are sexually active = 5,734,139	
People with multiple and or concurrent sexual partners (15-49)	303,823[1]
People living with HIV	1,576,025[2]
People with disabilities	649,148[3]
Young girls and boys (15-25)	2,292,051
Children under 15 (addressing sexual debut)	3,661,598[4]
Mobile/migrant populations: prisoners, people living in informal settlements, long-distance drivers, students and adults living in hostels	Unknown
LGBTI	Unknown
Substance Abusers and IDU	Unknown
Commercial Sex Workers	Unknown
MSM and WSW	Unknown

CHAPTER 4

4 The Strategic Plan Framework

The Strategic Plan Framework

This chapter provides long term (5 year) and broad direction for the HAST response in KZN. It reflects the commitment of the province to achieve the vision of "a KwaZulu-Natal that is free of new HAST infections, free of deaths associated with HIV and TB and free of discrimination where all infected and affected enjoy a high quality of life". The KZN HAST response is to be guided by the following strategic objectives which will also act as the key results areas.

1. Addressing Social and Structural Drivers of HAST Prevention, Care and Impact
2. Prevention of HIV, STI and TB Infections
3. Sustaining Health and Wellness
4. Ensuring Protection of Human Rights and Improving Access to Justice
5. Coordination, Monitoring and Evaluation

4.1 Guiding Principles

The principles that underpin the development and implementation of the KZN PSP 2012 –2016 are outlined below. These principles should and will be upheld throughout the implementation of the plan.

Results and Evidence Based: Where possible interventions proposed in this plan have been proved to work, have high impact and can be scaled up. The interventions are also based on their cost effectiveness.

Rights Based and Gender Sensitive Approach: The development and implementation of this plan is to be based on rights and gender sensitive considerations. Monitoring, protecting and promoting human rights will form the cornerstone of implementation of this plan.

Innovation: Innovation and new approaches will be encouraged throughout the implementation of KZN PSP 2012-16. This will contribute to finding new ways that can equally have positive impact on the response.

Alignment: HAST responses cannot be implemented in isolation and therefore must be linked to the broader developmental goals at national, provincial and international levels. The goals, objectives of this plan are therefore aligned to national, provincial and international plans and obligations.

Sustainability: The interventions in this plan have been designed to make sustainable impacts that are expected to outlast the lifespan of the PSP.

Realistic Targets: This plan has avoided setting targets that will not be achievable. Targets that have been set for the goals, objectives and interventions are result based, achievable, feasible and have an in built flexibility. Accountabilities for the interventions have been included in the plan to ensure effective implementation and monitoring.

Community Empowerment: The initiatives proposed in this plan have been based on engagement and consultations with various stakeholders. The participation of affected people has been central in the formulation of these initiatives. Participation and ownership is critical to the success of any plan.

Committed Leadership: Leadership at all levels of society in the province will continue to be committed the HAST response.

Multi-sectoral Approach: It is only through combining the resources, skills and experiences of all sectors of society that the PSP goals and objectives can be achieved.

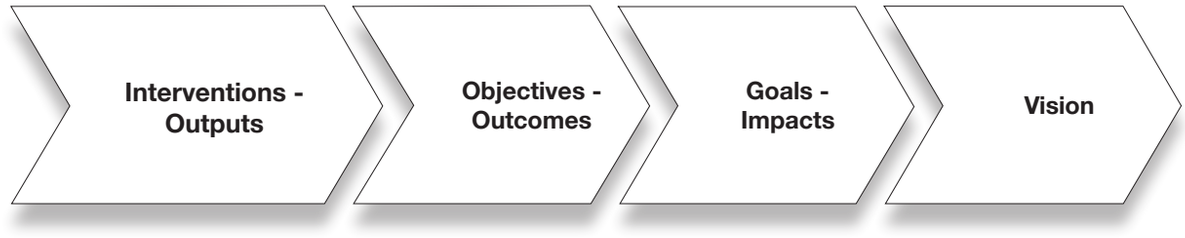
The multi-sectoral approach based on commitment from all stakeholders in the province and the support of leadership at all levels and guided by the “Three Ones” principles will underline the KZN provincial response.

Partnership: The KZNPSP 2012-16 will promote true partnerships and ownership among all stakeholders in the provincial response.

4.2 Results Framework

This result framework forms the foundation upon which the entire KZN HAST response will be implemented for the next five years. It provides a coherent chain of results that lead towards the attainment of the provincial HAST long term vision, as shown by the figure below. The results framework is structured around the five priority areas for which results are expected and represents a comprehensive and coherent array of interventions designed to achieve specified objectives and goals. The description that follows provides information under each strategic objective on the goals, objectives and main interventions.

Figure 2: Results Framework



4.2.1 Strategic Objective 1: Addressing Social and Structural Drivers of HAST Prevention, Care and Impact.

The structural determinants of the HIV and TB epidemics include socio-cultural, gender, infrastructure and economic contexts. These factors influence both transmission of infection and access and utilization of HIV, STI and TB services. There is a need to address this structural vulnerability if the province is to achieve the vision of HAST response.

Improvement of socio-economic status, eradication of poverty and changing negative societal norms require prolonged interventions. The approach to addressing these factors requires implementation of the broader Provincial Growth and Development Strategy (PGDS).

Moreover, the impact of the epidemics undermines some of the objectives that are articulated in the PGDS. Conversely the PGDS presents opportunities to address the structural drivers as well as making it possible for the province to achieve its millennium development goals.

In seeking to address structural determinants of HAST, a multi-sectoral approach must be used. Traditional leaders and the education sector have a critical role to play in shaping societal norms and values for instance, take leadership in instilling positive values on the learners. Other actors in the multi-sectoral approach include faith-based organizations, cultural institutions and social groupings (e.g. sport).

Men and boys as partners need to be mobilised to understand the importance of gender equality (including the need to change norms related to male masculinity), communities must understand the importance of keeping girls in school and the increase in risky behaviour that is related to alcohol and substance abuse.

This priority area deals with vulnerabilities due to poverty, socio-cultural norms and gender norms around masculinity and violence.

Goal: The goal under this priority area is the following:

1. **To reduce vulnerability to HIV, STIs and TB due to poverty, socio-cultural norms and gender imbalance by 2016.**

Rationale

Deeply rooted socio-cultural norms are known to fuel HIV, STI and TB epidemics. Changing these undesirable contextual factors is expected to greatly reduce vulnerability to the HIV, STI and TB. These require appropriate socio-economic policies and strategies as well as promotion of positive community and family values.

A multi-faceted approach that involves strengthening leadership on these aspects, social mobilisation of communities, and economic empowerment critical to achieving this goal.

Shifting norms around masculinity, gender violence, multiple concurrent partnerships, inter-generational sex, substance abuse and other social drivers of risk behaviours will be the cornerstone of achieving this goal.

Expected Impact

It is expected that implementing strategies and interventions for this goal should reduce vulnerability to HIV, STIs and TB due to socio-cultural related factors by 50% by 2016.

The following table illustrates indicators that will be used to measure the above impact.

Table 4: Addressing Social and Structural Drivers Impact Indicators

Goal 1: To reduce vulnerability to HIV, STIs and TB due to poverty, socio-cultural norms and gender imbalance by 2016.			
Impact Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Gini coefficient	tbd	tbd	tbd
Percentage of people reporting favourable socio-cultural environment	tbd	tbd	tbd

Objectives

The objectives for this priority area are as follows:

1. To reduce vulnerability to HAST transmission due to poverty, unemployment and gender inequality by 2016.
2. To promote positive socio-cultural norms and values

Objective 1: To reduce vulnerability to HAST transmission due to poverty, unemployment and gender inequality by 2016.

Rationale

Poverty, unemployment and relative deprivation are well-documented contextual determinants of HAST transmission. In a youth survey in Metro Durban and rural Mtunzini, relative economic disadvantage was found to signify increased likelihood of unsafe sexual behaviours. It also lowered the female chances of secondary abstinence (KYE). Poverty levels are high in KZN, and the province has been classified as one the three poorest provinces in South Africa. The province is a predominantly rural, with high unemployment, high illiteracy rates and the gap between the rich and the poor that is widening (CEGAA, 2011).

KZN has specific practices which deny women and children the right to exercise their rights in sexual relationships and put them at risk for HIV infection, e.g. young girls are forced into marriage at a young age, denying them the right to education and the right to choose their sexual partners. They are also cut off from their parental homes at an age when they cannot fend for themselves and have no income generation skills. In addition they generally get married to older people, where they have no power to negotiate their sexual relationship. Since such practices are deeply entrenched and indeed endorsed in some communities, it requires strong commitment, bold leadership and community mobilisation to eradicate such practices.

Poverty, unemployment and gender inequality are significant determinant of HIV transmission that have to be addressed if the province is to make any headways in stemming the tide of the HAST epidemics. This objective therefore deals with these contextual determinants of HIV transmission.

Expected Outcome

The expected outcome, indicators and target for objective 1 are shown in the table below.

Table 5: Addressing Social and Structural Drivers Outcome Indicators and Targets for Objective 1

Objective 3: To reduce vulnerability to HAST transmission due to poverty, unemployment and gender inequality by 2016			
Outcome Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Poverty levels reduced by 2016*	tbd	tbd	tbd
Reduce gender inequality by 2016	tbd	tbd	tbd
Reduce unemployment by 2016*	tbd	tbd	tbd
Reduce the proportion of women and children who have ever experienced sexual violence from an intimate partner by 2016	tbd	tbd	tbd
Reduce the proportion of women and children who have ever experienced sexual violence from an intimate partner by 2016	tbd	tbd	tbd
Reduce the proportion of women aged 18-24 who were married before the age of 18 by 2016	tbd	tbd	tbd
Increase the proportion of men and boys that agree that women should have the same rights as men by 2016	tbd	tbd	tbd

Strategies for Achieving Objective 1

The main strategy will, in the long run, lead to transformation and empowerment of vulnerable households economically. In the immediate term those in need of support will be provided with support through existing mechanisms such as OSS approach.

Key Interventions to Achieve Objective 1

The main intervention designed to achieve objective 1 is described below.

Key Intervention 1 - Monitoring the Impact of OSS: OSS coordination is intricately linked with HAST response and coordination. The OSS objective is to reduce poverty and ensure food security, through the DAC, LACS and WAC its success and impact will be monitored to determine its effectiveness.

This will be done by ensuring that OSS implementation is reported through the HIV and AIDS M and E system.

The aim is to determine the effectiveness of OSS output targets, target groups, indicators and sectors responsible for this intervention are shown in the table below.

Table 6: Addressing Social and Structural Drivers Output Indicator and Targets for Objective 1 Intervention 1

Intervention: Monitoring implementation of OSS						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of war rooms functional	tbd	tbd	tbd	tbd	tbd	tbd
Proportion of wards with youth ambassadors						
Number of wards reporting on OSS outputs	tbd	tbd	tbd	tbd	tbd	tbd
Target Group	OSS programme					
Lead Agency	OTP					
Main Stakeholders	DAC, DSR and all government departments, CSO and private sector					

Objective 2: To promote positive socio-cultural norms and values.

Rationale

For effective change in societal norms participation of all people at all levels of society. Peer education skills need to be applied at a community level to drive social change. This builds on existing initiatives such as the youth ambassador programme, which are the change agents at ward level.

Expected Outcome: The expected outcome, indicators and target for objective 2 are shown in the table below:

Table 7: Addressing Social and Structural Drivers Outcome Indicators and Targets for Objective 2

Objective 2: To promote positive socio-cultural norms and values.			
Outcome Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of schools that train their staff on sexual and gender-based violence issue	tbd	tbd	tbd
Proportion of men and women who have ever been exposed to gender-based violence prevention messages	tbd	tbd	tbd
Proportion of people who believe that child marriages should be stopped	tbd	tbd	tbd

Strategies for Achieving Objective 2

The main strategy is to mobilise communities and use the education system to change undesirable norms and promote positive norms and values.

Key Intervention to Achieve Objective 2: The main interventions designed to achieve objective 2 are described below.

Key Intervention 1 - Community Mobilisation: This entails mobilising the community leaders and members on rights entrenched in the constitution of South Africa; specifically with regard to gender roles, gender-based violence, alcohol and drug abuse. This will be based on a provincial campaign that would have been developed. All levels of leadership will be expected to promote positive norms.

The output targets, target group, indicators and sectors responsible for this intervention are shown in the table below:

Table 8: Addressing Social and Structural Drivers Output Indicator Targets for Objective 2 Intervention 1

Intervention: Community mobilization						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of programmes implemented for boys and men that include examining gender and culture norms related to gender-based violence	tbd	tbd	tbd	tbd	tbd	tbd
Number of peer educators deployed per key population area	tbd	tbd	tbd	tbd	tbd	tbd
Number of community mobilisation activities carried by leaders	tbd	tbd	tbd	tbd	tbd	tbd
Target Group	The public					
Lead Agency	OTP					
Main Stakeholders	All government departments, CSO and private sector					

Key Intervention 2 - Promote Positive Socio-cultural Norms and Values: Promotion of positive norms and values throughout the community of KZN will include building capacity of teachers, peer educators, youth ambassadors and peer educators in other settings to inculcate positive norms and values.

The output targets, target populations, indicators and sectors responsible for this intervention are shown in the table below.

Table 9: Addressing Social and Structural Drivers Output Indicators and Targets for Objective 2 Intervention 2

Intervention: Promote Positive Socio-cultural Norms and Values						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of peer educators deployed in HTAs	tbd	tbd	tbd	tbd	tbd	tbd
Number of peer educators trained on sexual and reproductive health and HIV related life skills	38,290	45,950	56,270	66,590	76,910	76,910
No of youth Ambassadors in the wards	2300	4400	4400	4400	4400	4400
Target Group	All settings with key populations					
Lead Agency	DOE, DOH					
Main Stakeholders	OTP, COGTA, CSO, Private sector					

4.2.2 Strategic Objective 2: Prevention of HIV, AIDS, STIs and TB

Evidence from the National AIDS Spending Assessment (NASA) data shows that over the last five years, KZN has witnessed limited investment in primary prevention interventions compared to treatment, care and support; particularly those aimed at sexual behavioural change. For example, in 2007/08 and 2008/09 the province spent only about 2% of voted expenditure on communication prevention; no funds were voted for communication prevention in 2009/10. ART on the other hand (ARV and ART nutrition) received up to 36% of the voted funds in 2008/09. No conditional grant was allocated to behaviour change interventions, providing further testimony to inadequate investment in prevention. While the imperative of treatment and care programmes cannot be ignored, additional focus on prevention needs is necessary as is drastic scaling up on investment in order to halt the epidemic and achieve the provincial vision. Focus on prevention and scaling up means that a multi-pronged approach will be adopted where biomedical, behavioural, social and structural approaches are simultaneously applied.

Goals: The prevention priority area aims at achieving the following three goals.

1. **To reduce new HIV infection to less than 1.2% by 2016.**
2. **To reduce new smear positive TB infection to less than 200 per 100,000 population by 2016.**
3. **To reduce STI incidence to less than 0.5% by 2016**

Rationale

KZN has set itself a provincial vision of eliminating new HAST infections. If this vision is to be attained, the prevention efforts must succeed. While the KZNPSP 2007-11 end-term review showed that HIV prevention efforts have made positive gains, it also indicated that there were some areas that fell short of expectations. Such include high STI and TB incidence and high teenage pregnancy. Though a reduction in HIV incidence was noted from 3.8 to 2.3%, it is still high when compared to the national incidence.

Prevention therefore remains a priority and KZN has set an ambitious but achievable prevention goal in this regard over the next five years. This will however require adequate investment in prevention and scaling up access to high quality and effective interventions targeted at all the key populations. It should be noted that reducing the rate of new HIV infections has in the long run an additional benefit, of greatly reducing the need for treatment, care and support in the province.

Expected Impact: By working towards achieving the above goal, KZN expects to attain the following impacts.

1. Reduced HIV incidence in the general population to less than 1.2% by 2016
2. Zero HIV infection among infants born to mothers who are HIV infected by 2016
3. Reduced HIV prevalence among young men and women aged 15-24 years to less than 10% by 2016
4. Reduced new TB infections to less than 200 new smear positive TB per 100,000 population by 2016
5. Reduced STI incidence to less than 0.5% by 2016

The table below provides a summary of the goal and corresponding impact indicators. The baseline, mid-term and end-term targets are also indicated; these will be used to assess the attainment of these impacts.

Table 10: Prevention Goals, Impact Indicators, Baseline and Targets

Goal 1: To reduce the incidence HIV infection to less than 1% by 2016			
Impact Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
HIV incidence in the general population	2.3 (2009)	1.7	<1.2
HIV prevalence among men and women aged 15 -25 years	15.3 (2008)	11.5	<10
Percentage of HIV infected infants born to HIV positive mother	2.8 (2010)	2	Zero
Goal 2: To reduce new smear positive TB infection to less than 200 per 100,000 population by 2016.			
Annual incidence of TB infections	262/100,000 (2009)	< 196/100,000	< 131/100,000
Goal 3: To reduce incidence of STIs by at least 80% by 2016			
Annual incidence of STI infection	2.7% (DHIS)	<1.5	<0.5

Objectives: The advantages of the prevention combination approach are that it is more effective in preventing the spread of HAST than isolated and fragmented approaches.

This plan recognises that prevention strategies and interventions should and will focus on both sexual and vertical transmission of HAST geared towards key populations. This is conceptually depicted in the illustration in Annexure 1.

The prevention goal has the following nine objectives.

1. To decrease behaviours that put men and women aged 15-49 years at risk of HAST by 80% through implementation of focussed programmes by 2016
2. To reduce risk of MTCT of HIV to less than 1% by 2016
3. To scale up medical male circumcision services to 80% of males aged 0-49 by 2016
4. To ensure that 80% of STI infected men and women receive early and appropriate treatment by 2016
5. To ensure that 80% of men and women age 15-49 know their HIV status and receive TB screening by 2016
6. To ensure that 100% of men and women age 15-49 have access to condoms by 2016

7. To increase access to early detection, diagnosis and early treatment of TB to 80% of exposed people by 2016
8. To maintain zero transmission of HIV through blood and blood products.
9. To reduce the risk of HIV transmission from occupational exposure, sexual violence and discordance to less than 1% by 2016

Objective 1: To decrease behaviours that put men and women aged 15-49 years at risk of HAST by 80 % through implementation of focussed programmes by 2016.

Rationale

The KZNPSP 2007-11 review report states that the HIV epidemic is associated with a number of behaviours that put men and women at risk of acquiring HIV. These include: inconsistent condom use; unprotected sex; sexual violence; transactional sex; migration; remaining unmarried while sexually active; multiple sexual partnerships and; a high level of alcohol consumption.

The population of KZN is predominantly young; 72% of the provincial population is composed of those less than 35 years of age. The sexually active 15-49 age group forms about 53% of the total population. Data indicates that the highest HIV prevalence is concentrated among the 19–30 year age group.

This objective seeks to have up to 80% of sexually active men and women change a range of risky behaviours that contribute to increase in HAST. The province's main focus for the behaviour change intervention will however be on young people who form the bulk of the population and are generally recognised to be amenable to behaviour change; particularly when programmes create a supportive and inclusive environment. Very often disease prevention programmes are not tailored to the needs of young people and, if they are, tend to be implemented in a generic and standardized way.

This calls for inclusion of young people in making decisions on interventions that involve them. As a result, interventions will most likely be focussed, and the province will ensure that prevention programmes geared towards young people are not generic. Effectively addressing the drivers of HIV, STI and TB infections among young people, as well as perceptions of personal risk and promoting risk avoidance, would go a long way in reducing HAST incidence in the province. As much this objective seeks to deliberately target the younger population age group other key populations will not be neglected.

Expected Outcomes: The expected outcomes for this objective are as follows.

1. Less than 5% of men and women aged 15 to 49 have multiple concurrent partners
2. 100% of men and women aged 15 to 49 with more than one sexual partners consistently use condoms by 2016
3. 100% of men and women aged 15 to 49 have the correct knowledge of ways of preventing HIV, STI and TB
4. Less than 2.5% of sexually active men and women aged 15-25 have their sexual debut before age 15

These outcomes address adoption of safer sexual practices. The table below provides a summary of the objective, and corresponding outcome indicators. The baseline, mid-term and end-term targets are also indicated; these will be used to assess the attainment of these outcomes.

Table 11: Prevention Outcomes, Indicators and Targets for Objective 1

Objective 1: To decrease behaviours that put men and women aged 15-49 years at risk of HAST by 80 % through implementation of focussed programmes by 2016.			
Outcome Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of women and men age 15 to 49 who have had more than one sexual partner in past 12 months	10.2% (2009)	7.7%	<5%
Percentage of women and men age 15 to 49 who have had more than one sexual partner in past 12 months reporting use of condom during their last sexual intercourse	66.2% (2009)	83%	100%
Percentage of women and men aged 15 to 24 who reject misconceptions about HAST transmission	tbd*	tbd	100%
Percentage of women and men aged 15 to 24 who correctly identify ways of preventing sexual transmission of HIV	30% (2008)	60%	90%
Number of learners who fall pregnant	13,725 (2010)	5,490	2,745
Percentage of young men and women aged 15-24 who have had sexual intercourse before 15	4.9% (2009)	3.7%	<2.5%

Strategies to Achieve Objective 1: The KZNPSP 2007-11 review revealed several behaviour change initiatives had been implemented over the past years, but these remained scattered, fragmented and largely ineffective. This situation calls for a change of strategy and approach that would contribute to making these initiatives effective. Globally, a number of critical success factors for effective behavioural change programmes have been identified. These include:

- Specific interventions targeting different age groups and different risk groups (Albarracin, et al, 2005)
- Sustained multi-faceted approaches aimed at achieving different behavioral outcomes (Coates, et al, 2008)
- Applying interventions that promote supportive social norms and values at different levels in society (families, social and sexual networks, institutions, and entire communities (Coates, et al, 2008)

- Ensuring that interventions are at a sufficient scale and intensity to have effects (Stover, et al, 2002)
- Response to the structural dimensions of HIV infection that shape people's response to circumstance and increase tolerance of risk (Gupta, et al, 2008)

The province will therefore design and implement innovative youth behaviour change interventions that take into consideration the above factors through strategies and approaches that are multi-pronged and multi-faceted in order to achieve the desired behaviour change among people aged 15-49 years. As alluded to earlier, the youth will be at the centre of the design and implementation of the interventions to ensure that interventions meet their needs. This will involve segmenting young people into specific age and sex groups and have appropriate messages targeting these specific segments.

Key Interventions to Achieve Objective 1: The main interventions to achieving objective 1 are as follows:

1. Development and implementation of a comprehensive provincial multi-media HAST strategy
2. Advocacy on Youth HAST prevention by Leaders
3. Community Outreach and Mobilisation
4. Life Skills-Based education for Youth in School
5. Strengthening of workplace/occupational health prevention programmes

A description of these interventions follows below.

Key Intervention 1 - Development and Implementation of a Comprehensive Provincial Multimedia HAST Communication Strategy: Multimedia programmes should filter through the environment with information and messages and set the stage for more intensive and comprehensive community mobilization. The multimedia strategy will engage the public and key populations;

and will be supported by interpersonal communication efforts to promote discussions about HIV and AIDS, STI, TB, sex and sexuality as well as addressing structural antecedents of high risk behaviour and promoting positive values. The strategy will focus primarily on youth programmes and will be based on available literature supported by rapid assessments. It will also include M and E indicators for measuring success of use of the strategy.

The implementation of the multimedia strategy will entail; (1) identifying and partnering with relevant private sector agencies, Youth NGOs, FBOs and other stakeholders; (2) development and production of messages targeted at specific segments of populations through social networks, electronic and print media and; (3) establishing a call centre. Specific materials and messages will target a population estimated estimated at 5,8 million people.

Expected Output: The expected output for this intervention will be 100% of targeted men and women reached with multi-media communication (disaggregated by key population).

The table below provides a summary output indicators, baseline and corresponding targets, the target group and lead agency responsible for ensuring that the intervention is implemented.

Table 12: Prevention Output Indicators and Targets for Objective 1 Intervention 1

Intervention: Development and implementation of a comprehensive provincial multi-media strategy						
	Target					
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Multimedia strategy developed and adopted		Multimedia strategy developed and adopted	Impleme ntation	Multimedia strategy reviewed and updated	Impleme ntation	Multimedia strategy reviewed
Number of men and women reached with multimedia campaigns (disaggregated by key population)	Unknown	5,734,139	5,734,139	5,734,139	5,734,139	5,734,139[1]
Target Group	Men and women (disaggregated by key population)					
Lead Agency	Office of the Premier (OTP), DAC					
Main stakeholder	Civil Society Organisations (CSOs) Private sector, All government departments, DAC, LAC and WAC. War Rooms/Youth Ambassador					

Key Intervention 2 - Advocacy on Youth HAST Prevention by Leaders: Advocacy for HAST prevention, particularly for young people, will further solidify the environment necessary to implement the specified multi-media strategy. It will aim to engage political, cultural, community, religious leaders and; policy makers and government institutions to champion and support youth behaviour change efforts financially, institutionally, through policy development and through making public statements. It will work to bring leaders, the media and civil society organizations more firmly on board, which will have substantial benefit for prevention overall. It entails development of a comprehensive package for advocacy for political leaders, policy makers, community leaders, cultural leaders, religious leaders, youth ambassadors and media followed by orientating and training the leaders on the package and approach. To ensure measurability of this intervention, there will be need to get commitments from the leaders on how they will advocate for youth HAST prevention efforts at financial, institutional and policy development level.

The output indicators, targets, target group and the lead agency responsible for this intervention are shown in the table below:

Table 13: Prevention Output Indicators and Targets for Objective 1 Intervention 2

Intervention	**Advocacy for youth HAST prevention by leaders**					
Output	All leaders in the province in the various government departments, cultural, political, NGO and private sector advocating for youth HAST prevention					
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of leaders advocating for HAST prevention among the youth	tbd	tbd	tbd	tbd	tbd	tbd
Number of youth reached as a result of advocacy by leaders	Unknown	5,734,139	5,734,139	5,734,139	5,734,139	5,734,139[1]
Target Group	All key leaders in the various government departments, cultural, political, NGO and private sector and Youth					
Lead Agency	Office of the Premier					
Main Stakeholders	CSOs, All government departments, cultural institutions, political leaders, traditional leaders, private sector					

Key Intervention 3 - Community Outreach and Mobilisation: This intervention will be implemented through the war room task team, youth ambassadors, NGO, CBOs, FBOs and sectoral groups such as the men's sector. The focus of the intervention will be to reduce the risk and vulnerabilities to HAST. The behaviours targeted will be: multiple concurrent partnerships and intergenerational sex; stigma and discrimination; sexual violence; alcoholism and; behaviours that predispose people to TB spread. Communications will address underlying reasons for risky behaviours such as low levels of knowledge about the risks; high levels of consumerism and material aspirations among young people and; the perceived compulsion to agree to relationships with older men due to traditions of the young obeying the old or women obeying men. It will require developing an appropriate comprehensive package for community behavior change mobilization and training the implementers who will mobilise communities.

Groups in the community will be segmented according messaging needs. Good practice interventions that have been implemented by groups such as "Brothers for Life", "Men to Men Project" , women's sector and the provincial men's sector will be rolled out across the province.

The table below presents information on the output indicator, targets, target group and the lead agency responsible for intervention 3.

Table 14: Prevention Output Indicator and Targets for Objective 1 Intervention 3

Intervention	**Community Outreach and Mobilization**					
Output	All members of the community aged 15-49 mobilised and reached with community outreach interventions					
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of members of the community aged 15-49 reached with community mobilisation sessions	60,000*	2,867,070	5,734,139	5,734,139	5,734,139	5,734,139[1]
Target Group	All members of the community aged 15 - 49					
Lead Agency	DAC					
Main Stakeholders	OTP, DOE, All CSOs, All government departments, cultural institutions, political leaders, war rooms, youth ambassadors, DAC, LAC, WAC, men's and women's sectors and forums					

Key Intervention 4 - Life Skills-Based Education for Youth in School: The review indicated that all schools are now offering life skills based education, there was however inadequate data to determine whether this was making any positive changes. Further, the province introduced the "My Future, My Life" programme to supplement the life skills based education. This component seeks to have continuity in the life skills education activity and proposes a delivery approach based on peers. Training of guidance and counselling teachers as supervisors of peer educators in schools and training of the peer educators in schools will be necessary.

The output indicator, targets, target group and responsible lead agency for the intervention are shown in the table below.

Table 15: Prevention Output Indicators and Targets for Objective 1 Intervention 4

Intervention	**Life skills-based education for youth in school**					
Output	100% of the learners reached with life skills education					
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of educators trained to effectively integrate SRH into the curriculum	5,000	9,000	10,960	13,360	15,760	15,760
Number of learners reached through life skills education	2,841,135	2,841,135	2,841,135	2,841,135	2,841,135	2,841,135
Target Group	All learners in primary, secondary and tertiary1					
Lead Agency	DOE					
Main Stakeholders	DAC, DOH, OTP, DSD, relevant CSO, DAC, LAC, WAC, War Rooms/Youth Ambassadors					

Key Intervention 5 – Scale-up workplace/occupational health prevention programmes: The sexually reproductive age group 15-49 spend a significant amount of their day time at work, about 75%. In some instances, their work activities predispose them to high risk of infection or limit access to health facilities, e.g. migration for drivers, sales people, construction workers, travel industry employees and migrant miners, farm workers and

health workers among others. By virtue of being located in the workplace, employees generally have limited access to prevention services. In most private sector entities, employers do provide occupational health services, which are mostly well-resourced with regard to personnel and equipment. In the public sector, government has implemented employee health and wellness programmes that ensure provision of prevention, care and support for employees infected and affected by HAST. The focus of this intervention is to scale-up workplace health and wellness programmes and to strengthen participation and visibility of workplace programmes within the multi-sectoral response.

The output indicator, targets, target group and responsible lead agency for the intervention are shown in the table below.

Table 16: Prevention Output Indicators and Targets for Objective 1 Intervention 5

Intervention	**Scale-up workplace/occupational health prevention programmes**					
Output	All employees reached with HAST prevention activities					
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of Employees Pre-test counselled	6000					
Number of employees testing Positive for HIV during Wellness Testing Sessions	100					
Number of employees referred for TB screening	0					
Number of male condoms distributed in the workplace						
Number of employers / sectors with workplace HIV and AIDS policies	15 provincial departments					
Number of female condoms distributed in the workplace						
Number of employees and dependants receiving ART from the private sector						
Number of employees and dependants receiving MTCTP from the private sector						
Number of employees living with HIV						
Number of awareness sessions conducted on HAST	200					
Target Group	Private sector, public sector, employees					
Lead Agency	OTP – Employee Health and Wellness					

Objective 2: To reduce risk of Mother to Child Transmission of HIV to less than 1% by 2016

Rationale

Significant progress has been made in improving the PMTCT programme coverage and performance. Through government and non-governmental health facilities more that 90% of pregnant women now have access to PMTCT services. The KZNPSP 2007-11 review report indicates that the risk of mother to child transmission has been reduced from 22% in 2005 to 2.8% in 2011. This important gain needs to be sustained and improved upon. It is therefore necessary to set new targets while focussing on the challenges that need to be addressed.

Towards this end, the programme noted a number challenges that were major obstacles for optimum effectiveness of PMTCT interventions. These include late attendance of the first ANC service by pregnant women and low attendance of post-natal services. In addition there is still a need to ensure that all hard to reach populations such as the farm workers and immigrants receive the full range of PMTCT services. Further new guidelines require that all HIV positive pregnant women receive lifelong ART and this will require tackling all the noted challenges.

According to the World Health Organization (WHO) the risk of mother to child transmission of HIV can be reduced to less than 2% if appropriate interventions are applied (WHO, UNICEF, IATT, 2007). With all health facilities in KZN now able to provide PMTCT services, invigorated mobilisation of women to take up ANC services early enough and providing access to PMTCT services to all hard to reach populations is likely to reduce the rate of mother to child transmission to the desired target of less than 1% by 2016.

Expected Outcome: The expected outcome for this objective is:

1. Reduced transmission of HIV to Infants born to HIV infected mothers to less than 1% by 2016.

The table below provides information on outcome indicator and targets for objective 2.

Table 17: Prevention Outcome Indicator and Targets for Objective 2

Objective 2: To reduce risk of MTCT of HIV to less than 1% by 2016			
Outcome Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of infants born to HIV-infected mothers who are infected	2.8% (2010)	<2%	<1%

Strategies for Achieving Objective 2: The key strategies to achieve this objective will be through supporting the public sector to continue providing PMTCT services as part of (Maternal Child Women's Health and Nutrition (MCWHandN) programme and building strong partnerships with community based organizations to improve the quality of PMTCT services and expand it to all pregnant women. Additionally, PMTCT services will be integrated with the primary health care services and strategically linked to other HIV prevention, treatment, care and support interventions. This will include adequate linkage to the ART programme; community caregivers' programme and PLHIV support groups. The integrated approach will ensure the delivery of a comprehensive care services to pregnant women, mothers, new-borns and children.

Key Interventions to Achieve Objective 2: The main interventions designed to achieve objective 2 are:

1. Providing access to comprehensive sexual and reproductive health (SRH) services
2. Community outreach and mobilisation for PMTCT
3. Scaling up access to early diagnosis of HIV in babies born to HIV infected mothers
4. Ensuring access to the full package of PMTCT

These are described below.

Key Intervention 1 - Providing Access to Comprehensive Sexual and Reproductive Health Services: Access to comprehensive contraceptive services provides opportunity for women to make and effect decisions on their reproductive choices. HIV positive women who decide not have children will have the means to prevent unintended pregnancies and thereby have the opportunity to avert the need for PMTCT.

Although fertility management interventions are available in all health facilities, there is need to ensure that women generally, and HIV infected women in particular have access to them. Emphasis will be placed on prevention of infections and unintended pregnancies. Dual contraceptives including condoms will be promoted as a choice for HIV-infected women as this has the added benefit of preventing STIs. In addition, SRH clients will be encouraged to undergo HCT. This intervention would therefore ensure that women in the reproductive age group have access to a wide selection of contraceptive methods, including dual methods combining condoms and other contraceptives. 100% of all women aged 12-49 will have access to family planning services. Male partners will also be mobilised to support women's decisions to avoid unintended pregnancies using effective contraceptives and will be encouraged to adopt safer sex practices.

The output indicators, targets, target group and lead agency responsible for this intervention are indicated in the table below.

Table 18: Prevention Output Indicators and Targets for Objective 2 Intervention 1

Intervention	**Providing access to comprehensive contraceptive services**					
		Target				
Indicators	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of females aged 15-49 who received contraceptive services	tbd	tbd	tbd	tbd	tbd	tbd
Number of females less than 18 years who are accepters of contraception						
Couple year protection rate1	21.6%	35%	45%	55%	65%	70%
Target Group	Women aged 12-49					
Lead Agency	DOH					
Main Stakeholders	Relevant CSO, Private sector					

Key Intervention 2 - Community Outreach and Mobilization for PMTCT: This intervention is intended to create awareness on PMTCT and mobilise pregnant women to attend ANC and PNC in a timely manner. It will address the challenge of late attendance of ANC and low PNC attendance. This intervention will be implemented through the war room task team and youth ambassadors as with other behavior change interventions.

It is expected that all women aged 15-49 will be reached with PMTCT community mobilization package. The output indicator, targets, target group and lead agency responsible for this intervention are shown in the table below.

Table 19: Prevention Output Indicator and Targets for Objective 2 Intervention 2

Intervention	**Community outreach and mobilization on PMTCT**					
		Target				
Indicators	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of females and males aged 12 and above reached with comprehensive package PMTCT community mobilization package (defined in communication plan)	Unknown	7,157,532	7,157,532	7,157,532	7,157,532	7,157,532
Target Group	Males and females age 15 and above					
Lead Agency	DOH					
Main Stakeholders	COGTA, OTP, all government departments, CSO, DAC, LAC, WAC, War Rooms/Youth Ambassador					

Key Intervention 3 - Scaling up Access to Early Diagnosis of HIV in Babies Born to HIV Infected Mothers: A baby who is HIV infected has a good chance of surviving childhood and living a long, healthy life if given prophylactic antibiotics, such as cotrimoxazole, soon after birth and antiretroviral therapy (ART) as soon as is medically indicated. Offering DNA-PCR tests provides opportunity for early diagnosis of HIV in babies born to HIV infected mothers. Although the KZNPSP 2001-11 Review Report suggests that up to 94% received PCR, there is need to up this figure to 100%; and that PCR is done in a timely manner. For this reason this intervention will ensure that all health facilities are able to collect the blood samples and obtain results in a timely manner.

It is expected that 100% of infants born to HIV infected women receive DNA PCR according to guidelines and that 100% of health facilities provide collect samples and obtain results for DNA PCR. The output indicators, targets, target groups, and lead agency responsible for this intervention are shown in the table below.

Table 20: Prevention Output Indicators and Targets for Objective 2 Intervention 3

Intervention	**Scaling up access to early diagnosis of HIV in babies born to HIV infected mothers**					
		Target				
Indicators	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of infants born to HIV positive mothers annually	tbd					
Number of infants born to HIV positive mothers who receive PCR tests according to guidelines	51,000					
Percentage of infants born to HIV infected women who receive PCR according to guidelines (define the numerator and denominator)	65%	80 %	90 %	95 %	100%	100%
Percentage of postnatal care facilities providing DNA PCR services *	100%	100%	100%	100%	100%	100%
Target Groups	Infants born to HIV infected women Health Facilities					
Lead Agency	DOH					
Main Stakeholders	Relevant Private Sector Organisations					

Key intervention 4 - Ensuring Access to the Full Package of PMTCT: This intervention is to ensure that all pregnant women receive the full PMTCT package in accordance with the guidelines of the time. This will include providing a lifelong ART to all HIV-infected pregnant women in their first pregnancy, irrespective of CD4 status.

This intervention expects reaching 100% of HIV positive pregnant women with a full package of PMTCT services based on guidelines and according to their needs. The output indicator, targets, target group and lead agency responsible for this intervention are shown in the table below.

Table 21: Prevention Output Indicator and Targets for Objective 2 Intervention 4

Intervention	**Ensuring access to the full package of PMTCT**					
		Target				
Indicators	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Percentage of HIV positive pregnant women that have been counselled and tested and know their HIV status	98%	98%	98%	100%	100%	100%
Target Group	HIV positive pregnant women					
Lead Agency	DOH					
Main Stakeholders	Relevant Private Sector Organisations					

Objective 3: To scale up of medical male circumcision services to 80% of males aged 0-49 by 2016

Rationale

Evidence suggests that medical male circumcision reduces the risk of HIV transmission from women to men. Three randomized controlled trials have shown that circumcision reduces the odds of male HIV infection more than 40%. No protective effect has however been demonstrated on women but it is plausible to assume that the fewer the infected men the less risk there is to women.

Mathematical modelling has shown possible large and sustained declines in HIV prevalence over time among both men and women in high HIV prevalence settings where male circumcision is routinely practiced. With 80% male circumcision uptake, reduction in HIV prevalence ranges from 45%-67% over a decade.

Scaling up MMC in KZN can contribute positively to reducing the incidence and prevalence of HIV which has persistently remained high in the face of several preventive measures that have been put in place over the years.

Already, MMC has been revived and is widely accepted and strongly supported by cultural and political leaders in the province. So far about 55,000 males have undergone MMC since commencement of MMC programme in April 2010. If the province will have to achieve the 80% coverage it has to vigorously accelerate it its efforts to provide MMC services. Currently only 37 sites across the province provide MMC services. Capacity to provide services in terms of human resources, equipment and systems are still inadequate. In addition demand creation efforts need to be sustained.

Expected Outcome: The expected outcome is 80% of males aged 0-49 circumcised by 2016. The corresponding outcome indicator and targets for objective 3 are shown in the table below.

Table 22: Prevention Outcome Indicator and Targets for Objective 3

Objective 3: To scale up of medical male circumcision services to 80% of males aged 0-49 by 2016			
Outcome Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of males aged 0-49 that are circumcised	1.3%	%	%

Strategies for Achieving Objective 3: The estimated number of males 0-49 in the province in 2011 is 4,748, 612. Achieving the objective of circumcising 80% of males within the 0-49 age group calls for innovative approaches that create capacity for rapid provincial scale-up of safe male circumcision services coupled with increased demand for MMC services. This means creating demand for MMC services and improving capacity to provide MMC services to meet the demand created. Approaches such as mobile outreach services including during holiday seasons to target school going youth; additional outreach services; involvement of private practitioners; expansion of the number of fixed health facilities that provide MMC and; intensified community mobilization will be used to improve services coverage. It is critical that women also be educated on MMC in order to create an enabling environment for this intervention.

Key Interventions to Achieve Objective 3: The main interventions designed to achieve objective 3 are as follows:

1. Community outreach and mobilisation for MMC
2. Multimedia campaign for MMC
3. Advocacy for MMC by Leaders
4. Provide comprehensive MMC Services

A description of these key interventions follows:

Key Intervention 1-Community Outreach and Mobilisation for MMC: This intervention is intended to mobilise men and parents to come forward or bring their children for MMC. This will be one of the interventions implemented through the war room task team and youth ambassadors programme as part of behavior change interventions.

The output will be 100% of males aged 15-49 reached with a community mobilization package of MMC. The output indicator, targets, target group and lead agency responsible for this intervention are shown in the table below.

Table 23: Prevention Output Indicators and Targets for Objective 3 Intervention 1

Intervention	**Community outreach and mobilization for MMC**					
		Target				
Indicators	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of males aged 15-49 reached with MMC multimedia campaign	Unknown					2,753,793
Target Group	Males aged 15-49					
Lead Agency	DOH and DAC					
Main Stakeholders	OTP, COGTA, DOH, Relevant Private Sector, CSO, DAC, LAC, WAC , Youth Ambassador/War Room					

Key Intervention 2 - Multimedia Campaign for MMC: This intervention is intended to develop and produce messages for radio, television and print media on MMC. It will be part of the provincial behaviour change multimedia strategy.

The expected output is 100% of male aged between 15-49 reached with multi-media campaign package on MMC. The table below shows the output indicators, targets, target group and lead agency responsible for this intervention.

Table 24: Prevention Output Indicators and Targets for Objective 3 Intervention 2

Intervention	**Community outreach and mobilization for MMC and HCT**					
		Target				
Indicators	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of learners mobilised to support and participate in the behaviour change communication campaign including HCT and MMC	0	72,000	tbd	tbd	tbd	tbd
Number of males aged 15 -49 reached with through multimedia campaign	unknown	tbd				
Target Group	Males aged 15-49					
Lead Agency	DOH, DAC and OTP					
Main Stakeholders	DOE, COGTA, Relevant Private Sector, CSO, DAC, LAC, WAC, Youth Ambassadors					

Key Intervention 3 - Advocacy for MMC by Leaders: Advocacy for MMC by cultural, community and political leaderships is very crucial for its success. It will help to dispel several misconceptions about MMC and further create the environment that encourages men to come forward for MMC and parents to bring their children for MMC. It will aim to particularly engage cultural leaders, who are already on board, to continue encouraging men to undergo MMC, reviving what was a well-established cultural practice. The intervention will entail development of a comprehensive standardized package for advocacy; orientation and training of the leaders on the package and approach; and thereafter advocacy by leaders. It will form part of the multi-media communication strategy.

It is expected that all leaders at all levels will advocate for MMC. The output indicator, target, target group and lead agency responsible for this intervention are shown in the table below.

Table 25: Prevention Output Indicator and Targets for Objective 3 Intervention 2

Intervention	**Advocacy for MMC by Leaders**					
		Target				
Indicators	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of leaders who advocate for MMC in public meeting	unknown	tbd	tbd	tbd	tbd	tbd
Number of leaders trained on the advocacy package	-	-	-	-	-	-
Target Group	All leaders					
Lead Agency	OTP, COGTA and DOH					
Main Stakeholders	CSO, All government departments, cultural institutions, political leaders, private sector					

Key Intervention 4 - Provide Comprehensive MMC Services: This intervention entails providing the comprehensive MMC services according to national guidelines. The services may be provided through fixed, outreach and mobile facilities. The target groups for MMC include males aged 0– 49.

For optimum effectiveness MMC services provision will follow the following principles:

- Integration into a comprehensive package for HIV prevention
- Targeting young male population for greatest public health impact
- Foster strong collaboration between traditional and formal health care systems
- Ensuring safe and standardized services
- Ensuring standardized male circumcision surgical services
- Involve different cadres of service providers ("task shifting")

Effective implementation of this main intervention will include several activities such as training of providers, building infrastructure capacity and procuring additional equipment. The expected output is 100% of males aged 15-49 circumcised and 100% of all male neonates aged between 0-3 months circumcised by 2016. The table below shows output indicators, targets, target groups and lead agency responsible for this intervention.

Table 26: Prevention Output Indicators and Targets for Objective 3 Intervention 4

Intervention	**Provide comprehensive MMC services**					
		Target				
Indicators	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of males aged 15-49 circumcised	105 888	174 826	174 826	219 000	446 000	600 000
Number of neonates and infants male aged 0-3 months circumcised	90	180	360	440	520	620
Target Groups	Males aged 15-49 and Neonates and infants aged 0-3 months males					
Lead Agency	DOH					
Main Stakeholders	Private sector					

Objective 4: To ensure that 80% of sexually transmitted infections infected men and women receive early and appropriate treatment by 2016.

Rationale

Little progress in reducing the incidence of STI and tracing and treating contacts of people diagnosed with STIs has been made. The volume of new episodes remains high, for example, in 2010/11 up to 440,714 new episodes of STIs were treated and yet only 22% of notified partners received treatment. This situation is contributed to by various factors, which include poor condom distribution, low rate of use and a host of other behavioural factors. STIs, particularly genital ulcer disease and genital herpes, substantially increase the risk of HIV transmission. The efficacy of an intervention to address STI infection is estimated to be about 42%. This situation underscores the need to prevent and promptly treat STIs as an HIV prevention strategy as well as a reproductive and sexual health intervention. South Africa uses the syndromic approach in STI management in order to improve efficacy of STI services. Both prevention and early treatment of STIs need to be scaled up substantially in KZN if objective 4 is to be achieved.

Expected Outcome: The expected outcome for this objective is:

(1) Reduced incidence of STI to 3.4% by 2016.

The table below provides information on the outcome indicator and targets for objective 4.

Table 27: Prevention Outcome Indicator and Targets for Objective 4

Objective 4: To ensure that 80% of STI infected men and women receive early and appropriate treatment by 2016.			
Outcome Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of population 15 years and above and treated with STI	6.8% (2009)1	4.1%	1.4%

Strategies for Achieving Objective 4: The main strategies that will be used to achieve objective 4 will include creating community awareness on the need to seek early treatment for STI, expanding access of STI services to key populations and improving the capacity of the health system to effectively carry out contact tracing and provide friendly services. Strategies to reduce stigma as a barrier to treatment seeking behaviour will also be pursued.

Key Interventions to Achieve Objective 4: The main interventions designed to achieve objective 4 are described below.

1. Community outreach and mobilisation for STIs
2. Providing access to the full package of STIs services

A description of the key interventions is provided below.

Key Intervention 1 - Community Outreach and Mobilisation for STIs: This intervention is intended to create awareness on the need to prevent STI and seek early treatment if infected. Awareness will also be created on the need for contacts to come forward for treatment. As in other behavior change interventions STI community outreach and mobilisation will be implemented through the war room task team and youth ambassadors in conjunction with other behavior change interventions. The multi-media campaign strategy will be the main reference point. Traditional health practitioners (THPs) will be oriented to refer their clients for appropriate treatment whenever they have symptoms suggestive of STIs.

The output for this intervention will be 100% of men and women aged 15-49 reached with the STIs community mobilization package. The output indicator, target, target group and lead agency responsible for this intervention are shown in the table below.

Table 28: Prevention Output Indicator and Targets for Objective 4 Intervention 1

Intervention	**Community outreach and mobilization on STIs**					
		Target				
Indicators	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of men and women reached with STIs community mobilisation package	Unknown	5,732,139	5,732,139	5,732,139	5,732,139	5,732,139
Target Group	Men and women aged 15-49					
Lead Agency	DOH					
Main Stakeholders	DAC, DSR, private sector, traditional health practitioners, OTP, all government departments					

Key Intervention 2 - Providing Access to the Full Package of STI Services: This intervention requires that all STI infected individual receive the full package of STI services in a timely manner in accordance with guidelines. This may include providing routine STI screening; quality syndromic management; early antimicrobial prescribing and; effective partner notification.

The expected output is 100% of STI infected men and women receiving a package of appropriate STI services. The output indicators, targets, target groups and lead agency responsible for this intervention are shown in the table below.

Table 29: Prevention Output Indicators and Targets for Objective 4 Intervention 2

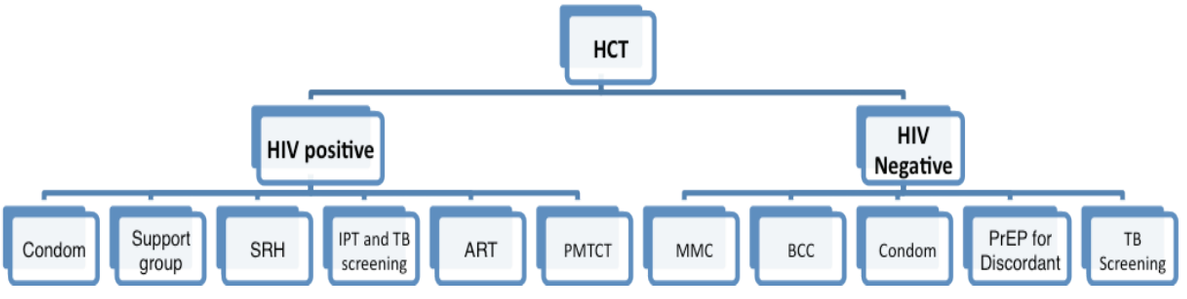
Intervention	**Providing access to the full package of STI services based guidelines**					
		Target				
Indicators	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of new STI episodes treated	440,714	396,642	352,572	308,500	264,429	220,357
Number of contacts of STI treated	96,957 (22% of those treated)	25%	30%	35%	40%	45%
Target Groups	STI Infected men and women and Contacts of STI infected men and women					
Lead Agency	DOH					
Main Stakeholders	Privates sector, traditional health practitioners, OTP, all government departments					

Objective 5: To ensure that 80% of men and women age 15-49 know their HIV status and receive STI and TB screening by 2016.

Rationale

HIV counseling and testing (HCT) is an important entry point to both HIV prevention and treatment services. Figure 3 illustrates the linkage of HCT as an entry point to various services.

Figure 2: Linkage of HCT with other Interventions



The WHO recommends that HIV testing must be voluntary, confidential and be accompanied by appropriate counseling, whether client or provider initiated.

KZN has made a relatively good progress in providing HCT services in 2011. All the province's fixed PHC facilities now offer HCT. In the financial year 2010/11 2,920,433 out of a target of 3,059,234 HIV tests were done, translating to 95% achievement against the target. During the same campaign 1,959,706 clients were screened for TB, 300,603 of whom were referred for clinical diagnosis. This objective seeks to build on these achievement and increase as well as sustain the coverage of HCT and TB screening.

Expected Outcome: The expected outcomes for this objective are as follows.

1. 80% of men and women aged 15–49 tested for HIV and know their HIV status by 2016

2. 80% of men and women aged 15–49 are screened for TB by 2016

The expected outcome indicator and targets for this objective are shown in the table below.

Table 30: Prevention Outcome Indicators and Targets for Objective 5

Objective 5: To ensure that 80% of men and women age 15-49 know their HIV status and receive TB screening by 2016.			
Outcome Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of men and women aged 15-49 who received an HIV test in the last 12 months and who know their results	24.1% (2008)	60%	80%
Percentage of men and women aged 15-49 who have been screened for TB in the last 12 months	tbd	60%	80%

Strategies for Achieving Objective 5: All sexually active individuals will be encouraged to have regular HCT and TB screening. This will be part of the full PHC package services. The key strategies to achieve objective 5 will therefore be through supporting the public sector to continue providing HCT services and building strong partnerships with community based organizations to create and meet demand for HCT for both those who have not tested and those coming for repeat testing. In addition HCT will be positioned as an entry point for prevention, treatment and care interventions. Implementation of the PHC package services through strengthening referrals and linkages between services (male circumcision, HIV/TB, PMTCT, Youth, mental health) will be promoted. The youth ambassador programmes and the war rooms will play crucial roles in mobilising and referring young people for testing at the ward level.

Key Interventions to Achieve Objective 5: The main interventions geared to achieving objective 5 are as follows:

1. Community outreach and mobilisation for HCT and TB screening
2. Annual provincial HCT and TB screening campaigns

Below is a description of these interventions.

Key Intervention 1 - Community Outreach and Mobilisation for HCT and TB Screening: This intervention is intended to mobilise men and women to make positive decisions and commit to HCT. Coupled with intensive multimedia campaigns this intervention is expected to increase demand for HCT. As in other behavior change interventions, it will be implemented through the war room task team and youth ambassadors' programmes. Agencies such as NGOs, FBOs, government departments, trade unions and traditional leaders will all be involved in outreach and mobilization campaigns.

It is planned that all women and men will be reached with an HCT community mobilisation package. The output indicators, target, target group and lead agency responsible for this intervention are shown in Table 31.

Table 31: Prevention Output Indicators and Targets for Objective 5 Intervention 1

Intervention	**Community outreach and mobilization for HCT, STI and TB screening**					
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of educators mobilised to support and participate in BCC and HCT	5,000	19,400	tbd	tbd	tbd	tbd
Number of men and women aged 15 years and older reached with HCT community mobilisation package	unknown	5,732,139	5,732,139	5,732,139	5,732,139	5,732,139
Target Group	Men and women aged 15 years and older					
Lead Agency	DOH and OTP					
Main Stakeholders	DAC, DSR, DOE, CSO, all government departments, war room teams, private sector organisations, OTP, private health practitioners, and all government departments					

Key Intervention 2 - Annual Provincial HCT and TB Screening Campaigns: This intervention aims at having HCT and TB screening services provided at various locations based on an annual inter-stakeholder campaign plan. These locations include health facilities, workplaces, schools, HTA sites, community sites, correctional services and social grants distribution points.

The expected output is to have HIV testing carried out among all men and women aged 15–49 annually and to have all men and women aged 15–49 screened for TB annually. Target groups, indicators and lead agency responsible for this intervention are shown in the table below.

Table 32: Prevention Output Indicators and Targets and Objective 5 Intervention 2

Intervention	**Providing HCT, STI and TB screening services through annual campaigns**					
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid -term)**	**2015**	**2016 (end term)**
Number of HIV tests carried out annually	2,920,433	3,500,000	4,100,000	5,000,000	5,732,139	5,732,139
Number of men and women screened for TB annually	1,959,706					
Percentage of HCT clients 15-49 screened for TB	67%	80%	100%	100%	100%	100%
Target Group	Men and Women aged 15-49 HCT clients aged 15-49					
Lead Agency	DOH					
Main Stakeholders	CSO, all government departments, war room teams, private sector, traditional health practitioners, OTP and all government departments.					

Objective 6: To ensure that 100% of men and women age 15-49 have access to condoms by 2016.

Rationale

Condom is an efficacious method for HIV and STI prevention. Condoms accessibility in terms of distribution in the last plan period was inadequate. Only 19% and 26% of the targeted number of male and female condoms respectively were distributed during the financial year 2010/11. The current system of distribution and education has not been effective in province. It is therefore imperative that access to condoms is improved and its use vigorously promoted. This objective deals with ensuring that there is adequate access to and promotion of both male and female condoms.

Expected Outcome: The expected outcome is increased access of male and female to condoms and an increased proportion of men and women aged 15-49 reporting condom use at last sex. The outcome indicator and targets for objective 6 are shown in the table below.

Table 33: Prevention Outcome Indicator and Targets for Objective 6

Objective 6: To ensure that 100% of men and women age 15-49 have access to condoms by 2016.			
Outcome Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of men and women aged 15-49 who report easy access to condom at last sex	66.2%	83%	95%

Strategies for Achieving Objective 6: Two key approaches will be used to improve condom distribution and use. First, main reasons and capability to efficiently distribute condoms will be determined. Secondly, innovative approaches to improve access to condoms will be developed. These approaches will build on existing efforts and complement broader national efforts.

Key Interventions to Achieve Objective 6: The main interventions designed to achieve objective 6 are as follows.

1. Rapid assessment of condom distribution processes and development of efficient distribution mechanism
2. Implementing an efficient system for condom education and distribution in the province

Description of these interventions follows below.

Key Intervention 1 - Rapid Assessment of Condom Distribution Processes and Development of Efficient Distribution Mechanism: The assessment will cover condom availability in the province, distribution mechanism and accessibility to the public. Given the fact that condoms are procured at national level there could be unidentified bottlenecks in the supply chain that are beyond and within KZN. This intervention is intended to determine and document why low numbers of condoms are being distributed in the province and how this can be corrected. The view will be to improve access to condoms. It is advisable that a short-term intervention leading to the design of an efficient distribution mechanism should involve identifying access challenges at community level by obtaining views of the beneficiaries at ward level.

The expected output is an efficient condom distribution system developed. The table below shows the output indicator, target, target group and leading agency responsible for this intervention.

Table 34: Prevention Output Indicator and Targets for Objective 6 Intervention 1

Intervention	**Providing HCT and TB screening services through annual campaigns**					
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Availability of assessment report and recommendations for efficient condom distribution mechanism	None	Assessment completed and new mechanism put in place	Implementation	Mechanism reviewed/updated	Implementation	Mechanism reviewed/updated
Target Group	Condom supply chain					
Lead Agency	DOH					
Main Stakeholders	OTP,CSO, all government departments, private sector.					

Key Intervention 2 - Implementing an Efficient System for Condom Education and Distribution in the Province: This intervention aims to have an efficient distribution mechanism implemented. It will also include educating the public on how they can access condoms and use them effectively. Additionally, it will involve distribution of male and female condoms to both health facilities, and non-traditional outlets such as airports, malls, tertiary education institutions, municipalities, community centre, traditional health practitioners' practices and traditional leaders' offices.

The expected output is that all targeted number of condoms is distributed. The output indicators, targets, target group and lead agency responsible for this intervention are shown in the table below.

Table 35: Prevention Output Indicators and Targets for Objective 6 Intervention 2

Intervention	**Implementing an efficient system for condom education and distribution in the province**					
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of female condoms distributed	383,404	700,000	980,000	1,120,000	1,260,000	1,400,000 (100%)
Percentage of female condoms distributed	27%	50%	70%	80%	88%	
Number of male condoms distributed	26,459,032	74,000,000	88,000,000	118,000,000	132,295,160	146,994,622 (100%)
Percentage of male condoms distributed	18%	50%	60%	80%	90%	146,994,622 (100%)
Target population	Men and women aged 15-49					
Lead Agency	DOH					
Main Stakeholders	OTP, CSO, all government departments, private sector.					

Objective 7: To increase access to early detection, diagnosis and early treatment of TB to 80% of exposed people by 2016

Rationale

KZN has one of the worst dual epidemics of HIV and TB in the country. TB remains the most common opportunistic infection in people living with HIV and the leading cause of mortality. The incidence of smear positive TB in KZN was 1,160 per 100,000 populations in 2009. HIV, by weakening the immune system, increases a person's risk of progressing from latent TB infection to active TB disease to 10% per year. It is estimated that 1.8% of new TB cases and 6.7% of retreatment TB cases are multi-drug resistant (MDR). The thrust of this objective is thus to improve prevention efforts to reduce new infections through reducing exposure, early case finding, treatment and case holding.

Expected Outcome: The expected outcome is having an 85% of TB cure rate. The table below shows the outcome indicator and targets for objective 7.

Table 36: Prevention Outcome Indicator and Targets for Objective 7

Objective 7: To increase access to early detection, diagnosis and early treatment of TB to 80% of exposed people by 2016			
Outcome Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Cure rate of TB	67.2%	75%	85%

Strategies for Achieving Objective 7: The main strategies that will be used to achieve objective 7 will include strengthening TB advocacy, communication and social mobilisation. This will increase community awareness on the symptoms and signs of TB and need to seek early treatment. Additionally the capacity of the health systems to detect cases, provide appropriate treatment and ensure compliance will be strengthened.

Key interventions to Achieve Objective 7: The main interventions are:

1. Community Outreach and Mobilisation on TB

2. Providing TB Prevention Services according to Guidelines

The main interventions designed to achieve objective 7 are described below.

Key Intervention 1 - Community Outreach and Mobilisation on TB: This intervention is intended to create awareness on TB and HIV co-infection. As in other behavior change interventions, the war room task team and youth ambassadors will support its implementation. Traditional Health Practitioners will have to be brought on board and orientated to refer their clients who present with symptoms of TB. HCT campaigns will continue to be combined with TB screening.

The expected output is reaching all adults with TB communication and community mobilisation strategy. The output indicator, target, target group and the lead agency responsible for this intervention are shown in the table below.

Table 37: Prevention Output Indicator and Targets for Objective 7 Intervention 1

Intervention	**Community outreach and mobilization on TB**					
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of male and females aged 15 and above reached with TB community mobilization package	Unknown	7,157,532	7,157,532	7,157,532	7,157,532	7,157,532
Target Group	Males and females aged 15 and above					
Lead Agency	DOH,					
Main Stakeholders	OTP, DAC, DSR, CSO, all government departments, war room teams, DAC, LAC, WAC					

Key Intervention 2 - Providing TB Prevention Services according to Guidelines: TB prevention services will include:

- Screening children for TB at postnatal, routine child health visits, and as part of immunisation services.
- Ensuring that all facilities providing HIV and TB care implement infection control measures.
- Providing IPT for all HIV infected individuals without active TB according to guidelines.
- Implementing active TB and HIV case finding, including active TB contact tracing

The services will also target early detection of MDR and XDR and appropriate management. It is expected that all HIV infected persons will receive IPT according to the guidelines. The output indicators, targets, target groups and lead agency responsible for this intervention are shown in the table below.

Table 38: Prevention Output Indicators and Targets for Objective 7 Intervention 2

Intervention	**Community outreach and mobilization on TB**					
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Percentage of newly diagnosed HIV positive patients started on INH prevention therapy (IPT)	77% (2011)	80%	90%	100%	100%	100%
Percentage of TBHIV +ve patients receiving IPT	76%	80 %	90 %	100 %	100%	100%
Percentage of TBHIV +ve patients receiving ART	70%	85%	90%	100%	100%	100%
Percentage of TB patients tested for HIV	*85%*	*100%*	*100%*	*100%*	*100%*	*100%*
Target Group	PLHIV TB patients					
Lead Agency	DOH					
Main Stakeholders	DAC, DSR, OTP, CSO, all government departments, war room teams, DAC, LAC, WAC					

Objective 8: To maintain zero transmission of HIV through blood and blood products.

Rationale

Data from national DOH indicates that all donated blood is screened in a quality assured way. Further, there has been no documented transmission of HIV through blood or blood products in KZN over the KZNPSP 2001-11 plan period. This objective is therefore to ensure that the province continues to screen blood and blood product in a quality assured way and maintains zero transmission through blood and blood products.

Expected Outcome: The expected outcome is therefore to maintain zero transmission of HIV through blood and blood products by transfusion. The table below shows the outcome indicator and target for objective 8.

Table 39: Prevention Outcome Indicator and Targets for Objective 8

Objective 8: To maintain zero transmission of HIV through blood and blood products.			
Outcome Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage transmission of HIV through transfusion of blood and blood products	0%	0%	0%

Strategies for Achieving Objective 8: Safety and quality of transfused blood is assured by the national blood transfusion services. Laboratory standards and trainings are under the national blood transfusion services. The province's role will be to monitor and ensure that these standards are adhered to.

Key Interventions to Achieve Objective 8: The main intervention for achieving objective 8 is:

1. Monitoring blood and blood transfusion products

This intervention is described below.

Key Intervention 1 - Monitoring Blood and Blood Transfusion Standards: This will be to ensure that all blood and blood products for transfusion are screened using the best technology available, according to national guidelines.

It is expected that 100% of blood units transfused is screened in a quality assured way. Table 40 provides a summary of the output indicator, targets and the lead agency responsible for this intervention.

Table 40: Prevention Output Indicator and Targets for Objective 8 Intervention 1

Intervention	**Monitoring blood and blood transfusion standards**					
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Percentage of units screened for HIV in a quality assured manner	100%	100%	100%	100%	100%	100%
Target Group	Blood and Blood Products					
Lead Agency	DOH					
Main Stakeholders	Private Sector					

Objective 9: To reduce the risk of HIV transmission from occupational exposure, sexual violence and discordance to less than by using ARV to less than 1% by 2016

Rationale

The prevalence of exposure to HIV through occupational exposure, sexual violence and discordance has not been quantified in the province. However, these associated risks can effectively be addressed using ARV post exposure prophylaxis.

Expected Outcome: The expected outcomes are twofold: risk of HIV transmission from occupational exposure (PEP reduced to zero) by 2016 and reduction of risk of HIV transmission from non-occupational exposure to less than by using ARV to 1% by 2016 . Table 41 shows the outcome indicator and targets for objective 9.

Table 41: Prevention Outcome Indicators and Targets for Objective 9

Objective 9: To reduce the risk of HIV transmission from occupational exposure, sexual violence and discordance to less than by using ARV to less than 1% by 2016			
Outcome Indicators	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Number of individuals with new HIV infections due to occupational exposure	51	Zero	Zero
Number of individuals with HIV due to non-occupational risk exposure.	tbd	tbd	<1%

Strategies for Achieving Objective 9: The main strategy will be to strengthen systems to ensure that survivors of sexual violence and those exposed occupationally are started on post-exposure prophylaxis (PEP) within 72 hours of presentation to police or a healthcare facility. For discordant couples ART needs to be provided with urgency in order to prevent HIV infection in the HIV-negative partner. In addition pre-exposure ARV prophylaxis will be provided to high-risk priority groups based on national guidelines (to be determined).

Key Interventions to Achieve Objective 9: The main intervention designed to achieve objective 9 is

1. Providing Services that prevent transmission due to occupation, sexual violence and discordance

Key Intervention 1 - Providing Services that Prevent Transmission due to Occupation, Sexual Violence and Discordance: This will entail:

- Implementation of infection control guidelines in all Health Facilities
- Provision of PEP to all those occupationally exposed to HIV according to PEP guidelines
- Provide PEP to sexual violence survivors in all health facilities
- Provide PrEP to all discordant partners who want to conceive according to national guidelines.

It is expected that with implementation of this intervention, all individuals accidentally exposed to HIV due to their occupation and those exposed to HIV due to sexual violence will receive PEP. Further all discordant couples who want to conceive will receive PrEP. The output indicators, targets, target groups and lead agency are shown in table 42.

Table 42: Prevention Output Indicators and Targets for Objective 9 Intervention 1

Intervention	**Providing services that prevent transmission due to occupation, sexual violence and discordance**					
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of accidentally exposed HW who receive PEP	51	42	37	25	12	0
Number of non-occupational exposure survivors who receive PEP (NOPEP)	5071	tbd	tbd	tbd	tbd	tbd
Target Groups	Health workers; Discordant couples, sexual violence survivors and where status undisclosed					
Lead Agency	DOH					
Main Stakeholders	Private Sector					

4.2.3 Strategic Objective 3: Sustaining Health and Wellness

KZN has made enormous progress in establishing and expanding access to ART to HIV positive people over the past decade. By the end of the financial year 2010/11 459,670 (estimated need was 486,861) HIV positive people were registered for ART in KZN. This success is in part attributable to government's commitment to funding ART and ensuring universal access. ART is the single most programme with the highest allocation of funding. The newly announced changes in the treatment guidelines are likely to create additional needs for the ART as more PLHIV will be eligible for treatment. In addition there is need to ensure that the quality of care and support services provided lead to sustained wellness and high quality of life of those infected and affected.

Tuberculosis (TB) remains a leading cause of mortality in KZN with diagnosed TB cases increasing from 98,498 in 109,556 in 2007 to 118,000 in 2009 (DOH Annual Report, 2010). The 2009 figure represents a caseload of 1,156 cases per 100,000 population, which is more than four times the epidemic threshold according to the World Health Organisation. The dual epidemic of TB and HIV are the leading cause of infectious diseases burden in the province, calling for an effective integrated approach in addressing the two conditions. Syphilis prevalence in KZN has remained relatively stable over the years at 0.8 % in 2009 compared to 0.8% in 2007 and 0.6 % in 2008 (DOH, 2009). The main challenge with STI is that new episodes of other STIs have remained high and very few contacts received treatment.

The Health and Wellness priority area will therefore primarily focus on providing treatment, palliative care and social support to people infected and affected by HIV and TB.
Goal: The goal under the priority area is the following:

1. **To reduce mortality, sustain wellness and improve quality of life of at least 80% of those infected and affected by 2016.**

Rationale

A number of studies have shown that providing early treatment for HIV and TB decreases mortality reduces morbidity and leads to increased life expectancy. The government of South Africa has already announced a shift in eligibility to ART to a CD4 count of 350 or below. Key to the success of this intervention will be early diagnosis. This implies that linkages between HCT expansion and CD4 eligibility assessment need to be strengthened. HIV infected people on ART are known to be less likely to transmit HIV; treatment therefore also plays a key role as a prevention intervention.

In recent years there has been a rise in cases of drug resistant TB in South Africa, where KZN is considered the epicenter of the problem. To eliminate this problem requires deliberate and aggressive interventions in terms of finding cases, providing early and effective treatment and ensuring adherence to treatment.

The dual epidemic of HIV and TB, poses enormous socio-economic difficulties on individuals, families and the communities as a whole and this province is no exception. It is common knowledge that they are a major cause of chronic illnesses and orphan hood within the community. This goal deals with effectively managing these conditions and mitigating their negative impacts.

Expected Impact: The expected impacts of this goal are a reduction of TB associated mortality by 80% by 2016 and improved quality of life of HIV and TB infected individuals and families by 2016. The expected impact indicators and targets for the goal under priority area 2 are shown in the table below.

Table 43: Sustaining Health and Wellness Impact Indicators and Targets

Goal 1: To reduce mortality, sustain wellness and improve quality of life of at least 80% of those infected and affected by 2016.			
Impact Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Cause specific mortality rate (TB related)	tbd	tbd	80% reduction
Quality of life for HIV and TB infected people and their families	tbd	tbd	80%

Objectives: The following are objectives of the priority area 2:

1. To ensure that at least 90% of HIV infected people have access to treatment and support, remain adherent to treatment and maintain optimum health.
2. To ensure that 90% of people infected with TB have access to services that are responsive to their needs and are of high quality.
3. To ensure that 80% of infected and affected people and households have access to support in order to reduce disability and improve quality of life.
4. To increase access to quality care and support to at least 90% of orphans and vulnerable children (OVC) by 2016.

Objective 1: To ensure that at least 90% of HIV infected people have access to treatment and support, remain adherent to treatment and maintain optimum health.

Rationale

Noting the major successes in the treatment programme over the last five years, there are still challenges and emerging issues that need to be addressed in order to improve the quality of care of those on treatment. For example, there are already a large number of patients on treatment. The revised eligibility criteria will most certainly increase the number of people who need treatment. The review report indicated that there was a chance that effective follow-up would be a challenge.

This together with management of treatment failure and drug toxicities all need to be strengthened to ensure better quality of care for those in need. This objective thus focuses on both improving the quality of care and expanding access to those who need and are eligible for treatment.

Expected Outcomes: The expected outcome is that 100% of all eligible HIV-positive people have access to appropriate ART by 2016 and 90% all HIV-positive people on ART remain adherent by 2016. Table 44 below provides information on the outcome indicators and targets for objective 1.

Table 44: Sustaining Health and Wellness Outcome Indicators and Targets for Objective 1

Objective 1: To ensure that at least 90% of HIV infected people have access to treatment and support, remain adherent to treatment and maintain optimum health.			
Outcome Indicators	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of eligible HIV positive adults receiving antiretroviral therapy	tbd	tbd	100%
Percentage of eligible HIV positive children receiving antiretroviral therapy	tbd	tbd	100%
Percentage of adults with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	tbd	tbd	90%
Percentage of children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	tbd	tbd	90%

Strategies for Achieving Objective 1: The main strategy to achieve this objective involves putting in place mechanisms to ensure that systems and services remain responsive to the needs of people infected with HIV. This involves expanding the services of the "roving teams" and mentor teams to provide services at hard to reach settings; expanding treatment to other primary health care settings that provide HCT; task shifting (Nurse Initiated and Management of Anti-Retroviral Therapy - NIMART) and; intensifying community mobilization and patient follow up through the war room task team approach. Central to this strategy is access to appropriate treatments early enough and retention of HIV infected people on treatment and care programmes.

HIV infected people are to be processed promptly after HCT through quick CD4 testing and provided with treatment or referred where applicable. They will have to receive correct treatment and consistent care and follow-up.

Key Interventions to Achieve Objective 1: Below is a listing of the the main interventions designed to achieve objective 1 of a description follows thereafter.

1. Providing access to comprehensive ART Services
2. Community mobilization and adherence monitoring

Key Intervention 1 - Providing Access to Comprehensive ART Services: Providing access to comprehensive ART services for all eligible patients (CD4 <350 or WHO stage 3 or 4) entails:

1. Ensuring ARV medicines are available at all PHC facilities.
2. Ensuring that professional health workers have correct ART diagnosis and management skills and provide appropriate treatment.
3. Providing Cotrimoxazole prophylaxis for all patients living with HIV.
4. Promoting facility-based and community adherence strategies to ensure patients remain on TB and ART treatment.
5. Monitoring and maintaining quality standards for HIV care and treatment services, including quality standards for community-based care and support.

Although ART is available in most government health facilities, there is a need to ensure that all health facilities provide ART services through the nurse-initiated and managed ART (NIMART). While this intends to ensure integration into the primary health care system, down-referrals to PHC facilities and NIMART compete for the same human resources to the extent that nurses spend more time managing down-referred clients than initiating new clients. Further, counselors spend more time conducting adherence support modules than on HCT and tracking adherence.

Allocation of resources to support both NIMART and down-referrals needs to be increased at PHC level in order to increase enrolment of new ART clients, increase monitoring of clients lost to follow-up and to increase HCT and MMC uptake rate. Emphasis will also be placed on expanding the roving and mentoring support to all hard to reach settings so that the waiting list remains zero.

With implementation of this intervention, it is expected that all eligible HIV people will receive comprehensive ART services by 2016. The output indicators, targets, target groups and lead agency responsible for this intervention are shown in the table below.

Table 45 : Sustaining Health and Wellness Output Indicators and Targets for Objective 1 Intervention 1

Intervention: Providing access to comprehensive ART services						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of eligible children receiving ART	45,598	56,720	78,544	85,539	94,678	94,687
Number of eligible adults receiving ART	414,324	620,674	706,893	864,892	1,013,750	1,013,750
Proportion of newly HIV/TB diagnosed patients started on cotrimoxazole prophylaxis	77%	85%	95%	100%	100%	100%
Target Groups	All eligible HIV infected children and adults Discordant couples, sexual violence survivors and where status undisclosed					
Lead Agency	DOH					
Main Stakeholders	Private Sector, CSO					

Key Intervention 2 - Community Mobilization and Adherence Monitoring: This intervention is intended to keep HIV infected people adherent to ART. This plan proposes that it be implemented through the war room task team, community caregiver (CCG), youth ambassadors and other CBOs in line with other behaviour change interventions.

With effective community mobilisation for adherence, it is expected that no patient on ART is lost to follow-up. The output indicator, targets, target group and lead agency responsible for this intervention are shown in the table 46.

Table 46: Sustaining Health and Wellness Output Indicator and Targets for Objective 1 Intervention 2

Intervention: Community mobilization and ART adherence monitoring						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of ART patients de-registered due to loss of follow-up	2,900	2,175	1,450	725	363	<100
Target Group	People started on ART					
Lead Agency	DOH					
Main Stakeholders	CSO, war room teams, private sector, all government departments					

Objective 2: To ensure that 90% of people infected with TB have access to services that are responsive to their needs and are of high quality.

Rationale

KZN has a severe TB epidemic that is closely associated with and fuelled by the HIV epidemic and TB is considered the leading cause of mortality in the province. The TB programme is currently performing sub-optimally as evidenced by cure rate below the national target and the increase in the number of cases of MDR and XDR TB. Information from DOH Annual performance Plan 2011/12 – 2013/14 indicates that the TB cure rate in the province is 67.2%, TB defaulting is 7.1% and 69.4% of TB patients are HIV positive.

Furthermore, the 2009 review of the TB programme indicated the need to strengthen TB programme in the areas of human resources; TB and HIV services integrations and; implementation of the DOTS strategy. The Starting ART at 3 Points in TB (SAPIT) trial in KwaZulu-Natal showed that early initiation of ART in TB patients' results in a 56% decrease in mortality and cotrimoxazole preventive therapy has decreased hospitalisations and mortality in HIV-infected TB patients by 50%.

Addressing the dual epidemic of TB and HIV in an integrated manner will therefore greatly reduce morbidity and mortality in the province.

Expected Outcome: With this objective, it is expected that there will be:

1. Increased TB cure rate to 85% by 2016

2. Reduced TB defaulter rate
3. Reduced new MDR TB infections by 50% by 2016
4. Reduced new MDR TB infections by 50% by 2016

The baseline, outcome indicators and targets for Objective 2 are indicated in table 47 below.

Table 47: Sustaining Health and Wellness Outcome Indicators and Targets for Objective 2

Objective 2: To ensure that 90% of people infected with TB have access to services that are responsive to their needs and are of high quality.			
Outcome Indicators	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Annual cure rate for TB	*67.2%*	*75%*	*85%*
Annual smear positive defaulter rate	*7.1%*	*4.6%*	*3%*
Percentage of TB patients with MDR	*2.8%*	*2.1%*	*1.4%*
Percentage of TB patients with XDR	*10%*	*7.5%*	*5%*

Strategies to Achieve Objective 2: Central to the strategy for achieving objective 2 is ensuring that TB and HIV services are integrated. This requires carrying out activities geared towards better collaboration between the two services. Implementing community mobilization models that will be effective and reduce cost; for example the use of the war room task team described earlier to conduct community mobilization, carrying out contact tracing and implementing patient follow up strategy can be effective yet low cost.

Key Interventions to Achieve Objective 2: The main interventions designed to achieve objective 2 are:

1. Advocate for greater integration of HIV and TB Services
2. Ensuring adherence to DOTs strategy guidelines and expansion of access to TB/HIV Services
3. Strengthen social mobilization on TB/HIV Co-infection
4. Strengthening Follow Up of Patients and Expanding Community Management of MDR TB

These are described below.

Key Intervention 1 - Advocate for Greater Integration of HIV and TB Services: This intervention involves advocating to policy makers, programme managers and implementers within government, civil society organizations and community leaders to commit to TB/HIV services integration. The DOH will take the lead in advocating to the various stakeholders within health institutions and communities.

The end result should be that all key stakeholders are reached with advocacy on HIV and TB services integration. The output indicator, targets, target groups and lead agency responsible for this intervention are indicated in the table below.

Table 48: Sustaining Health and Wellness Output Indicator and Targets for Objective 2 Intervention 1

Intervention: Advocate for greater integration of HIV and TB services						
		Target				
Indicator	**2011 (Baseline)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of stakeholders reached with advocacy on integration of TB/HIV services	tbd	tbd	tbd	tbd	tbd	tbd
Target Groups	Policy makers, managers and implementers					
Lead Agency	DOH					
Main Stakeholders	OTP, Private sector					

Key Intervention 2 - Ensuring Adherence to DOTs Strategy Guidelines and Expansion of Access to TB/HIV Services: This entails expanding TB diagnosis; care and treatment services to a variety of settings in order to increase the coverage of TB and HIV integrated services. These settings may include tertiary education institutions, prisons, and NGO-funded facilities, workplaces and community settings. In addition TB molecular testing will be expanded to public sector facilities for intensified case findings for TB. These interventions are expected to lead to early detection and improved management of people who are TB/HIV co-infected.

This will contribute to having all TB/HIV co-infected patients put on appropriate TB treatment and ART. Table 49 indicates the output indicators, targets, target groups and lead agency responsible for this intervention.

Table 49: Sustaining Health and Wellness Output Indicators and Targets for Objective 2 Intervention 2

Intervention: Ensure Adherence to DOTs Strategy guidelines and expand access to TB/HIV Services						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of TB patients receiving DOTs	80%	85%	90%	100%	100%	100%
Proportion of TB/HIV co-infected referred for ART	41%	50%	60%	70%	80%	90%
Proportion of TB/HIV co-infected initiated on ART						
Target Groups	TB patients TB/HIV co-infected patients					
Lead Agency	DOH					
Main Stakeholders	OTP, Private sector					

Key Intervention 3 - Strengthen social mobilization on TB/HIV Co-infection: Targeted communication and social mobilization will be used to increase knowledge on TB, and the links with HIV. This will ensure that all TB patients have DOTs supporters.

The output indicator, target, target group and lead agency responsible for this intervention are shown in table 50.

Table 50: Sustaining Health and Wellness Output Indicator and Target for Objective 2 Intervention 3

Intervention: Strengthen social mobilisation on TB/HIV co-infection						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of TB patients with DOT supporters	80%	85%	90%	100%	100%	100%
Target Group	Public					
Lead Agency	DOH					
Main Stakeholders	OTP, CSOs, private sector, war room teams					

Key Intervention 4 - Strengthening Follow Up of Patients and Expanding Community Management of MDR TB: This intervention is intended to keep HIV infected people adherent to TB treatment in order to reduce the risk of MDR and provide access to treatment for those with MDR. This will entail:

- Promoting facility-based and community adherence strategies to ensure patients remain on TB treatment.
- Monitor and maintain quality standards for TB care and treatment services, including quality standards for community-based care and support.
- Enhancing referral from community setting to health facilities and on to higher-level facilities if needed in order to ensure that patients with complex presentations, experiencing complex toxicity or multi-drug resistance have access to appropriate treatment.
- Establishing community-based management teams for MDR TB and expanding MDR TB treatment centres.

This intervention will lead to having all TB patients remain adherent to treatment and all patients with MDR and XDR receiving appropriate treatment. The output indicators, targets, target groups and lead agency responsible for this intervention are indicated in the table below

Table 51: Sustaining Health and Wellness Output Indicators and Targets for Objective 2 Intervention 4

Intervention: Strengthening follow up of patients and expanding community management of MDR TB						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of TB patients lost to follow up	7.1%	6%	5%	4%	3.5%	3%
Number of MDR patients who received appropriate treatment	tbd	tbd	tbd	tbd	tbd	tbd
Number of XDR patients who received appropriate treatment	tbd	tbd	tbd	tbd	tbd	tbd
Target Groups	Patient on TB treatment TB patients with MDR/XDR					
Lead Agency	DOH					
Main Stakeholders	CSOs, private sector, war room teams					

Objective 3: To ensure that 80% of infected and affected people and households have access to support in order to reduce disability and improve quality of life.

Rationale

The provision of care and support to people with life limiting conditions is in line with the policy of providing high quality care to all patients. The ASSA model projection of 2008 estimated that up to 149,621 PLHIV in KZN would be AIDS sick by 2011. Because of wide access to ART needs, nature of care for HIV and TB infected people has changed over the years. This objective deals with access to appropriate nutrition, palliative care and psychosocial support. The links between good nutrition and maintaining health and wellness are well established. Food insecurity may lead to increased risk-taking and contributes to poor adherence to treatment and more rapid heath deterioration. Good nutrition maintains the immune system, helps to prevent opportunistic infections and supports optimal quality of life.

Expected Outcomes: The expected outcome is to have 80% of HIV and TB infected people with life limiting conditions receiving appropriate supportive and palliative care to reduce disability and improve their quality of life by 2016. The expected outcome indicator and targets for objective 3 are shown in the table below.

Table 52: Sustaining Health and Wellness Outcome Indicator and Targets for Objective 3

Objective 3: To ensure that 80% of infected and affected people and households have access to support in order to reduce disability and improve quality of life.			
Outcome Indicators	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of patients in need of supportive and palliative care reporting having received a comprehensive package of care in the past 12 months	tbd	tbd	80%

Strategies to Achieve Objective 3: KZN over the years has provided support and care to AIDS patients through hospices, step down facilities and in the community through community care givers (CCGs).

There is still a need to strengthen palliative care to ensure that every individual living with HIV has access to holistic, quality care from the time of diagnosis to death, if necessary. This also includes support for the affected families. The main strategy to achieve this objective will therefore be to strengthen and expand these approaches. The CCG programme will take the path of an integrated approach.

Key Interventions to Achieve Objective 3: The main interventions designed to achieve objective 3 are:

1. Provision of community based support for people infected and affected.
2. Provision of a comprehensive package of palliative care to eligible children and adults
3. Provision of psycho-social support
4. Development and implementation of appropriate care and support programmes for people with disability

The description of these interventions follows below:

Key Intervention 1 - Provision of Community Based Support for People Infected and Affected by HIV: All CCGs in the province have now been combined into one group that provides integrated services at community level. The total number of caregivers on stipends currently is 10,810, with 1,905 from DSD and 8,915 from DOH. An additional 4000 are not on stipend and work as volunteers. Through the integrated care programme the care and support needs of households will be provided through the CCG and other CBOs. This will include provision of food security to eligible households and encouraging home and community food production. Eligible persons will include PLHIV, the elderly, people with disabilities, adolescents on ART, mothers on PMTCT and those on TB treatment.

The intervention should ensure that all those infected and affected and need support, receive the support and that all eligible households received food security. The output indicators, targets, target groups and lead agency responsible for this intervention are shown in the table below.

Table 53: Sustaining Health and Wellness Output Indicators and Targets for Objective 3 Intervention 1

Intervention: Provision of community based support for people infected and affected by HIV						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of beneficiaries receiving community care services	tbd	tbd	tbd	tbd	tbd	tbd
No of beneficiaries receiving home based care	tbd	tbd	tbd			
Number of households provided with food security	tbd	tbd	tbd	tbd	tbd	tbd
Target Groups	PLHIV , Older persons, CCG, CHH,OVC, Senior Citizen, adolescents on ART, Mothers on PMTCT, TB patients Eligible households					
Lead Agency	DSD					
Main Stakeholders	DOH, DOE, CSO					

Key Intervention 2 - Provision of a comprehensive package of palliative care to eligible children and adults: This intervention focuses on adults and children with life limiting conditions that require palliative care. It is geared towards improving the quality of life of people with life limiting conditions. Through this intervention, it is expected that all eligible adults and children will receive a package of palliative care. Table 54 provides information on the output indicators, targets, target groups and lead agency responsible for this intervention.

Table 54: Sustaining Health and Wellness Output Indicators and Targets for Objective 3 Intervention 2

Intervention: Provision of a comprehensive package of palliative care to eligible children and adult						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of eligible adults receiving palliative care services	tbd	tbd	tbd	tbd	tbd	tbd
Number of eligible children receiving palliative care services	tbd	tbd	tbd	tbd	tbd	tbd
Target Groups	Eligible adults with life limiting conditions Eligible children with life limiting conditions					
Lead Agency	DSD, DOH					
Main Stakeholders	CSO					

Key Intervention 3 - Provision of psycho-social support: This will involve provision of psycho-social support including, disclosure, bereavement and adherence counselling to those infected and affected. Household support needs will be assessed through the community care programme and appropriate actions taken.

It is hoped that all those needing this kind of support will receive it. The output indicator, targets, target groups and lead agency responsible for this intervention are shown in the table below.

Table 55: Sustaining Health and Wellness Output Indicator and Targets for Objective 3 Intervention 3

Intervention: Provision of psycho-social support including, disclosure, bereavement and adherence counselling to those infected and affected						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of people in need of psychosocial support who received support and counselling	tbd	tbd	tbd	tbd	tbd	tbd
Target Groups	Infected and affected people in need of psychosocial support					
Lead	DSD					
Main Stakeholders	CSO					

Key Intervention 4 - Development and Implementation of Appropriate Care and Support Programmes for People with Disability: People with disabilities have not been incorporated appropriately into the response. They have special needs and their care and support should be provided in a manner that meets their specific needs.

As a result, those requiring these specific services should be able to receive them. The outputs, indicators, targets and lead agency responsible for this intervention are indicated in the table below.

Table 56: Sustaining Health and Wellness Output Indicators and Targets for Objective 3 Intervention 4

Intervention: Development and implementation of appropriate care and support programmes for people with disability						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number persons with disabilities accessing services in funded protective workshops	4,500	5,000	5,500	5,500	6,000	6,000
Number of people with disability who received support	10,000	# tbd (90%)	# tbd (90%)	# tbd (90%)	# tbd (90%)	# tbd (90%)
Target Groups	People with disability					
Lead Agency	DSD					
Main Stakeholders	DOH/CSO					

Objective 4: To increase access to quality care and support to at least 90% of orphans and vulnerable children (OVC) by 2016.

Rationale

Support for OVCs is a major part of mitigation of HIV and AIDS epidemic impact as most orphan hood and vulnerability arises from AIDS related deaths. In such cases, OVCs will be exposed to conditions that limit the fulfillment of their right to development. Policies and strategies should therefore reflect OVCs issues and interventions as defined by the province.

This objective ensures that all OVCs receive quality care and support so that they grow up in an environment that provides them opportunities to develop normally into productive adults.

Expected Outcomes: It is estimated that 90% of estimated number of OVC will have access to quality care and support by 2016. Table 57 provides outcome indicator targets for objective 4.

Table 57: Sustaining Health and Wellness Outcome Indicators and Targets for Objective 4

Objective 4: To increase access to quality care and support to at least 90% of orphans and vulnerable children (OVC) by 2016.			
Outcome Indicators	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of orphans and vulnerable children aged 0-17 whose households have received at least one support in caring for the child	tbd	tbd	90%
Number of child care forums in existence at ward level	tbd	tbd	tbd
Percentage of child headed households placed in the supervision of an adult and receiving care and support services	tbd	tbd	90%
Current school attendance among orphans and non-orphans aged 10-14	tbd	tbd	100%

Strategies to Achieve Objective 4: The main strategy to achieve objective 4 will be to strengthen community level identification of OVCs, management of the OVC database and monitoring of community programmes for OVC. This will ensure that all OVCs have access to appropriate care and support.

Key Interventions to Achieve Objective 4: The main interventions to achieving objective 4 are as follows.

1. Tracking and linking OVCs and child headed households
2. Identifying and building capacity of civil society organisation

3. Provision of support for children in need in schools and early childhood development centres.

These are described below

Key Intervention 1 - Tracking and Linking OVCs and Child Headed Households (CHH):

This will enable identifying, tracking and linking OVCs and CHH to social grants benefits and social services at local level. It will ensure that they receive support through the social grants, CCG services and other services at the community level.

The intervention aims at having all OVCs and CHH receive the social services they require at local level. The output indicators and targets and lead agency responsible for this intervention are shown in the table below.

Table 58: Sustaining Health and Wellness Output Indicators and Targets for Objective 4 Intervention 1

Intervention: Identifying, tracking and linking OVCs and CHH to social grants benefits and social services at local level						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
System for identifying and tracking OVC and CHH in place		Annual register in place	Annual register update	Annual register update	Annual register update	Annual register update
Number of OVCs provided with subsidies per district	tbd	tbd	tbd	tbd	tbd	tbd
Number of CHHs provided with subsidies per district	tbd	tbd	tbd	tbd	tbd	tbd
Number of OVC receiving social services at local level	40 000	50 000	60 000	70 000	80 000	90 000
Number of CHH receiving social services at local level	tbd	tbd	tbd	tbd	tbd	tbd
Number of OVC placed in alternative placement						
Number of orphans and other children made vulnerable by HIV and AIDS receiving services		98140	102854	109751		
Target Group	OVCs					
Lead Agency	DSD					
Main Stakeholders	DHS, SASSA, DHA, DOE, DOH, CSO, COGTA, Traditional Leaders					

Key Intervention 2 - Identifying and Building Capacity of Civil Society Organisations: This intervention entails facilitating the registration and capacity building for registered and unregistered civil society organisations in order to standardize and improve quality of services. This will include organisational programme support and mentoring.

Eventually all CSOs involved with OVC will be identified, registered and capacitated. The output indicators, targets and lead agency responsible for this intervention are shown in the table below.

Table 59: Sustaining Health and Wellness Output Indicators and Targets for Objective 4 Intervention 2

Intervention: Identifying and building capacity of civil society organisation						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Availability of OVC CSOs register		All OVC CSO registered	Annual register update	Annual register update	Annual register update	Annual register update
Number of CSOs capacitated	tbd	tbd 20%	tbd 40%	tbd 60%	tbd 80%	tbd 100%
Target Groups	OVCs					
Lead	DSD					
Main Stakeholders	DOH, CSO, COGTA, Traditional Leaders					

Key Intervention 3 - Provision of Support for Children in Need in Schools and Early Childhood Development Centres: This intervention entails capacitating educational institutions to provide psychosocial, educational and adherence support to children in need. The target group are OVCs and other children who need support and care and are attending these institutions.

The expected output is to have all OVC in educational institutions in need of support receiving required support. Table 60 provides information on the output indicators, targets, target group and lead agencies responsible for this intervention.

Table 60: Sustaining Health and Wellness Output Indicators and Targets for Objective 4 Intervention 3

Intervention: Provision of support for children in need in schools and early childhood development centres.						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of senior management team (SMT) members trained to develop school implementation plans focusing on keeping young people in school.	6,300	8,460	tbd	tbd	tbd	tbd
Number of educators trained to minimise barriers to retention and achievement in school for learners who are HIV affected or infected through establishment of School-Based Support Teams (SBST)	2,830	3,250	tbd	tbd	tbd	tbd
Number of learners in previously disadvantaged schools identified and provided with relevant support to minimise barriers to retention and achievement in schools	40,200	90,200	tbd	tbd	tbd	tbd
Number of children in Early Childhood Development (ECD) facilities	tbd	tbd	tbd	tbd	tbd	tbd
Target Group	Children in need who are in educational institutions					
Lead Agencies	DOE, DSD					
Main Stakeholders	DOH, CSO, COGTA, Traditional Leaders					

4.2.4 Strategic Objective 4: Ensuring Protection of Human Rights and Improving Access to Justice

Access to health care services is a fundamental right enshrined in the South African constitution. Ensuring access to health care services requires that interventions be planned and implemented in a manner that addresses the specific needs and barriers to access to health services by key populations. Further, inadequate human rights protection and access to justice contribute to vulnerability to HIV, STI and TB infections. These include stigma and discrimination, gender inequality, gender violence, and other forms of discrimination. These factors are amenable to changes in social norms; enforcement of laws and policies through proactive leadership. This priority area deals with vulnerabilities due to factors that are influenced by human rights, policies, legal environment and social norms. It will involve:

- Strengthening political and public leadership commitment in addressing the undesirable social norms
- Building the capacity of service providers to deal effectively deal with issues of human rights and undesirable social norms
- Equipping service providers, law enforcement officers, social workers, and teachers with the relevant skills, and creating the necessary environment within the service delivery area and the community to enforce these laws and policies

Goal: The goal under this priority area is to:

1. To reduce vulnerability to HIV, STIs and TB by creating a supportive policy, human rights and regulatory environment and; promoting desirable social norms in the province by 2016.

Rationale

According to the Know Your Epidemic (KYE) Report some deeply rooted social, cultural, gender practices and human rights infringements influence HIV, STI and TB transmission. These have created the conditions for the twin epidemics to grow and flourish.

Changing these undesirable factors is expected to greatly reduce vulnerability to the HIV, STI and TB. This requires that appropriate policies and laws are developed, implemented and monitored; and supportive environment created. It calls for a multi-faceted approach that involves strengthening leadership on these aspects, social mobilization of communities, monitoring implementation of appropriate policies and laws and empowering stakeholders to deal with specific cases.

Expected Impact: The expected impact is a supportive political and regulatory environment that ensures the rights of all the infected and affected by 2016.

The following indicators will be used to measure the above impact indicators.

Table 61: Protection of Human Rights Impact Indicators and Targets

Goal 1: To reduce vulnerability to HIV, STIs and TB by creating a supportive policy, human rights and regulatory environment and; promoting desirable social norms in the province by 2016.			
Impact Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of people who report adequate human rights protection and access to justice (survey)	tbd	tbd	80%

Objectives

The objectives of this priority area are as follows:

1. To strengthen at all levels of society to publicly promote the human rights and speak out against stigma, discrimination and related behaviours to create a more equal society.
2. To identify and address legal barriers to implementation of interventions in order to ensure that all existing legislation and policy relating to human and access to justice are adhered to by 2016.
3. To strengthen capacity building on all relevant policy framework and legislation relating to HIV and AIDS
4. To promote and support the greater involvement of people living with HIV in the provincial HAST responses by 2016.

Objective 1: To strengthen all levels of society to publicly promote the human rights and speak out against stigma, discrimination and related behaviours to create a more equal society.

Rationale

Leaders at all levels of society play a vital role in entrenching and sustaining positive socio-cultural norms. These include political, cultural, religious leaders at provincial, district, local and community levels. It is also known that risk tolerance can be driven by lack of social cohesion and perceptions of lack of choice, and a vision for the future. Because these issues are complex, they may require much longer timeframes for meaningful impact to be realised. Providing effective leadership is one way societal cohesion may be attained and sustained. This will further promote adherence to human rights practices and improved access to justice.

Expected Outcome: This objective aims to realise a visible, decisive and effective leadership in promoting human rights at all levels of society by 2016. The expected outcome, indicator and targets for this objective are shown in the table below:

Table 62: Protection of Human Rights Outcome Indicator and Targets for Objective 1

Objective 1: To strengthen all levels of society to publicly promote the core values of the South African Constitution and speak out against stigma, discrimination and related behaviours to create a more equal society.			
Outcome Indicators	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of people who report that leadership is visible, decisive and effective in promoting human rights within the province.	tbd	tbd	90%

Strategies to Achieve Objective 1

For changes in socio-cultural norms to be effective there is need for the input and active participation from leaders at all levels of society, including young people. The main strategy for achieving this objective will therefore be strengthening capacity of political, cultural, youth and public leadership at every level of society to advocate for positive norms, human rights and values that reduce vulnerability to HIV, STI and TB.

Key Interventions to Achieve Objective 1: The main interventions for objective 1 are as follows

1. Develop a package for advocacy by leaders on promoting human rights, positive societal values and norms
2. Building capacity of leaders on promoting human rights, positive values and socio-cultural norms
3. Leaders at all levels of society to publicly promote human rights and speak out against discrimination

Below is the description for these key interventions.

Key Intervention 1 - Develop a package for advocacy by leaders on promoting human rights, positive societal values and norms: This intervention involves development of standard package that leaders at all levels will use in their advocacy work. The package should be on promoting human rights, positive values and socio-cultural norms. With the development of the package, a mapping exercise to identify the leaders that would be trained to use them will be conducted. This activity is intended for completion in the first year of KZNPSP implementation.

The expected output is having leaders who us the advocacy package to promote human rights, positive values and socio-cultural norms. The output indicator, targets, target group and lead agency responsible for this intervention are shown in the table below.

Table 63: Protection of Human Rights Output Indicator and Targets for Objective 1 Intervention

Intervention: Develop a package for advocacy by leaders on promoting human rights, positive societal values and norms						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Advocacy package	Package developed	Implementation	Package reviewed/updated	Implementation	Implementation	Package reviewed/ updated
Lead Agency	OTP					
Main Stakeholders	COGTA, CSO, Community Liaison and Safety					

Key Intervention 2 - Building capacity of leaders on promoting human rights, positive values and socio-cultural norms: This intervention involves developing the capacity of all leaders and individuals to advocate for and promote human rights and positive societal norms and values. This activity will be initiated within the first year of implementation of the KZNPSP 2012-2016.

It is expected that all the people of KZN will have the capacity to promote human rights, positive values and socio-cultural norms arising from implementation of this intervention. Table 64 provides summary information on the output indicator, target, target group and lead agency responsible for this intervention.

Table 64: Protection of Human Rights Output Indicator Targets for Objective 1 Intervention 2

Intervention: Building capacity of leaders on promoting human rights, positive values and socio-cultural norms						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of leaders capacitated on promotion of human rights, positive values and socio-cultural norms	Zero	50%	60%	70%	80%	90%
Target Group	Leaders at all levels					
Lead Agency	OTP					
Main Stakeholders	DAC, COGTA, CSO, Community Liaison and Safety					

Key Intervention 3 - Leaders at all levels of society to publicly promote human rights and speak out against discrimination: This intervention involves leaders at speaking out the core values of the South African Constitution and promoting human rights; positive values and norms and; promoting a more equal society. They will also be expected to speak against stigma, discrimination and related behaviours. This activity will be implemented and reviewed throughout the lifetime of the KZNPSP 2012-2016.

The people in KZN are expected to benefit through being reached with messages on the core values of the South African Constitution from various leaders. The output indicator, target, target group and lead agency responsible for this intervention are shown in the table below.

Table 65: Protection of Human Rights Output Indicator and Targets for Objective 1 Intervention 3

Intervention: Leaders at all levels of society to publicly promote the core values of the South African Constitution						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Percentage of population reached with messages on the core values of the South African Constitution from various leaders	Zero	20%	50%	60%	80%	100%
Target Group	The Public of KZN					
Lead Agency	OTP					
Main Stakeholders	COGTA, CSO, Community Liaison and Safety					

Objective 2: To identify and address legal barriers to implementation of interventions in order to ensure that all existing legislation and policy relating to human rights and access to justice are adhered to by 2016.

Rationale

The South African Constitution enshrines human rights and gender equality. A number of legislations and policies have been developed to effect the provisions enshrined in the constitution. The adherence to and enforcement of these policies and legislation should go a long way in changing the undesirable practices that may render some sections of the population vulnerable to HIV, STIs and TB.

Expected Outcomes: This objective aims at having all existing legislation and policies relating to human and legal rights are adhered to by all by 2016. The expected outcome, indicator and targets for objective 2 are shown in the table below.

Table 66: Protection of Human Rights Outcome Indicator and Targets for Objective 2

Objective 2: To ensure that all existing legislation and policy relating to human and access to justice are adhered to by 2016.			
Outcome Indicators	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage adherence to legislation and policies relating to human and legal rights	tbd	50%	100%

Strategies to Achieve Objective 2

The thrust of the strategy to achieve objective 2 is to identify all policies and laws relating to human rights and legal rights and monitor their implementation.

Key Intervention to Achieve Objective 2: The key intervention for objective 2 is as follows

1. Monitor the implementation of policy guidelines and legislation relating to human rights

Key Intervention 1 - Monitor the implementation of policy guidelines and legislation relating to Human Rights: This intervention involves identifying all laws and policies relating to human and access to justice; developing mechanism and tools for monitoring their implementation and; active monitoring of their implementation.

The output indicator, targets, target group and lead agency responsible for this intervention are shown in the table below:

Table 67: Protection of Human Rights Output Indicators and Targets for Objective 2 Intervention 1

Intervention: Monitor the implementation of policy guidelines and legislation relating to human rights						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of sectors monitored for compliance with policy guidelines and legislation relating to human rights	Zero	Preparation: Development of a monitoring tool.	20% of sectors	50% of sectors	60% of sectors	80% of sectors
Target Groups	Sectors					
Lead Agency	OTP					
Main Stakeholders	COGTA, CSO, Community Liaison and Safety; Chapter 9 Institutions					

Objective 3: To strengthen capacity building on all relevant policy frameworks and legislation relating to HIV and AIDS

Rationale

The subject of human and legal rights is broad and includes the right to services, protection, non-discrimination, equal opportunity, education and to live free from violence and abuse among others. Providers and the public alike need to understand these rights and be galvanized around the attainment of those rights. These require that, coordination structures (PCA, DAC, LAC, and WAC), service providers and the public are knowledgeable on issues of human and legal rights.

Expected Outcomes: The expected outcome, indicator and targets for objective 3 are shown in the table below:

Table 68: Protection of Human Rights Outcome Indicators and Targets for Objective 3

Objective 3: Capacity building on all relevant policy framework and legislation relating to HIV and AIDS			
Outcome Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of people aware of policy framework and legislation relating to HAST and human rights	tbd	tbd	100%

Strategies to Achieve Objective 3

This objective will be achieved through orientation of targeted stakeholders and public campaigns.

Key Interventions to Achieve Objective 3: The key interventions to achieving this objective are as follows

1. Orientation of all relevant stakeholders on HAST related policy framework and legislation and gender and human rights dimensions
2. Public awareness campaigns on human and legal rights issues related to HAST and gender and human rights dimensions

Key Intervention 1 - Orientation of all Relevant Stakeholders on HAST Related Policy Framework and Legislation and Gender and Human Rights Dimensions: The stakeholders that will be orientated will include PCA members, DAC members, LAC members, WAC members and sectoral members.

The output target, target group, indicators and sectors responsible for this intervention are shown in the table below:

Table 69: Protection of Human Rights Output Indicator and Targets for Objective 3 Intervention 1

Intervention: Orientation of all relevant stakeholders on policy framework and legislation relating to HIV, AIDS, TB, STI and gender and human rights dimensions						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of stakeholders orientated	tbd	(# tbd) 30%	(# tbd) 50%	(# tbd) 60%	(# tbd) 70%	(# tbd) 90%
Target Groups	Stakeholders					
Lead Agency	OTP					
Main Stakeholders	COGTA, CSO					

Key Intervention 2 - Public Awareness Campaigns on Human and Legal Rights Issues related to HAST and Gender and Human Rights Dimensions: This entails planning and conducting public awareness campaigns throughout the province by the leadership and stakeholder that would have been orientated.

The output indicator, corresponding targets and lead agency responsible for this intervention are shown in the table below.

Table 70: Protection of Human Rights Output Indicators and Targets for Objective 3 Intervention 2

Intervention: Public awareness campaigns on Human and Legal Rights issues related to HIV, AIDS, TB, STI and gender and human rights dimensions						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of awareness campaigns conducted per district	Zero	1	3	3	4	5
Number of public reached with awareness campaign.	Zero	20%	40%	60%	70%	80%
Target Group	The public					
Lead Agency	DAC					
Main Stakeholders	COGTA, OTP, CSO					

Objective 4: To promote and support the greater involvement of people living with HIV, LGBTI and people with disabilities in the provincial HAST responses by 2016.

Rationale

Involvement of PLHIV, LGBTI (lesbian, gay, bisexual, transsexual, transgender, transvestite, and intersex people) and people with disabilities in planning and implementation of intervention of HAST responses ensures that their needs and perception are central to those interventions. This is particularly important in having their need addressed more effectively and in eliminating stigma and discrimination.

Expected Outcome

Table 71 summarises the expected outcome, indicator and targets for objective 4.

Table 71: Protection of Human Rights Outcome Indicators and Targets for Objective 4

Objective 4: To promote and support the greater involvement of people living with HIV, LGBTI and people with disabilities in the provincial HAST responses by 2016.			
Outcome Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of organisations of PLHIV, LGBTI and people with disabilities reporting involvement in the HAST response	tbd	80%	100%

Strategies to Achieve Objective 4

The main strategy will be to include PLHIV, LGBTI and people with disabilities in all coordinating, planning, implementation and M and E processes.

Key Interventions to Achieve Objective 4: The key interventions are as follows

1. Involvement of PLHIV, LGBTI and people with disabilities in all Coordination Structures
2. Empowerment of PLHIV, LGBTI and people with disabilities to recognize and deal with Human Rights violations
3. Promoting Access to Justice

These key interventions are described below

Key Intervention 1 - Involvement of PLHIV and LGBTI in all Coordination Structures: This entails including PLHIV, LGBTI and people with disabilities in all coordination structures of the HAST response.

The result should be having all the coordination structure with PLHIV, LGBTI and people with disabilities at all levels. The output indicator, targets and lead agency responsible for this intervention are shown in the table below.

Table 72: Protection of Human Rights Output Indicator and Targets for Objective 4 Intervention 1

Intervention: Involvement of PLHIV, LGBTI and people with disabilities in all coordination structures						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of coordination structures with PLHIV, LGBTI and people with disabilities	tbd	tbd	tbd	tbd	tbd	tbd
Target Groups	PLHIV , LGBTI, People with disabilities					
Lead	OTP					
Main Stakeholders	Relevant CSO					

Key Intervention 2 - Empowerment of PLHIV, LGBTI and people with disabilities to recognize and deal with Human Rights violations: This intervention involves developing the capacity and empowering of PLHIV, LGBTI and people with disabilities to recognise and stand up for their human rights. This includes non-discrimination, respect for their rights in employment and services in all sectors and greater openness and public acceptance of PLHIV, LGBTI and people with disabilities.

It is expected that all PLHIV, LGBTI and people with disabilities will benefit from this intervention. The output indicator, target and agency responsible for this intervention are shown in the table below.

Table 73: Protection of Human Rights Output Indicators and Targets for Objective 4 Intervention 2

Intervention: Empowerment of PLHIV, LGBTI and people with disabilities to recognize to deal with Human Rights violations						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of PLHIV, LGBTI and people with disabilities	tbd	tbd	tbd	tbd	tbd	tbd
Number of PLHIV, LGBTI and people with disabilities empowered	tbd	tbd	tbd	tbd	tbd	tbd
Target Group	PLHIV , LGBTI, People with disabilities					
Lead Agency	OTP					
Main Stakeholders	Relevant CSO					

Key Intervention 3 - Promoting Access to Justice: This entails monitoring and addressing all reported cases of rights violations in relation to HAST and gender.

Table 74 outlines the output targets for this intervention.

Table 74: Protection of Human Rights Output Indicators and Targets for Objective 4 Intervention 3

Intervention: Promoting Access to Justice						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Proportion of cases of gender-based violence that resulted in conviction						
Number of reported cases of rights violations reported to the police	tbd	tbd	tbd	tbd	tbd	tbd
Target Group	PLHIV LGBTI The public					
Lead Agency	SAPS,					
Main Stakeholders	OTP, DCSL, Relevant CSO					

4.2.5 Strategic Objective 5: Coordination and Monitoring and Evaluation

Coordination, monitoring, evaluation and research are critical support components to a successful implementation of the response. The support provided by the the Office of the Premier in the form of a demonstrated political will and leadership has for example, contributed to jump starting functionality of the coordinating structures at all levels. The introduction of Operation Sukuma Sakhe (OSS) and linking it to HIV and AIDS coordinating structures implies that coordination and M and E are now directly linked to an implementation mechanism that reaches the household. This has been made possible because of commitment of the Premier; improved political will at local level and; improved stakeholder accountability. The province is currently in the process of cascading the establishment of coordination structures to the ward level by creating Wards AIDS Committees. This has enabled the province to decentralize planning to the local, including the integration of HIV and AIDS and TB into the IDP. One of the guiding principles of this plan is to have a response that is based on evidence. The role of research is to provide the evidence required for decision making, planning and implementation in the HAST response. Proper application of research should thus result in an effective and coordinated response that is evidence based.

The end term review of the PSP 2007-2011 documented several achievements. These included:

1. Some sectors having functional M and E structures at provincial and district level that are linked to standardised planning and reporting. This includes formation of M and E task teams, use of standardised forms and reporting on output and outcome indicators.
2. Information and reports shared during meetings
3. Satisfactory functionality of the DAC and LAC.
4. Strong leadership and political will at the provincial level
5. The provincial level has compelled a number of sectors to report their activities.

On the other hand the review identified several gaps. These were:

1. Inadequate investment in M and E and capacity at all levels of coordination
2. No dedicated M and E units at municipalities
3. Limited use of information arising out of M and E data for decision-making.
4. Limited use of the M and E framework and tools developed for KZNPSP 2007-11 partly due to lack of capacity building among implementers and coordination structures.
5. Most civil society organisations not reporting to coordination structures using data collection tools.
6. Lack of baseline data for most interventions in the KZNPSP 2007-11.
7. Concentration of research capacity in institutions of higher learning and those specialising in research.
8. Lack of a research agenda and uncoordinated research actions
9. Weak coordination of development partners

This plan recognises the progress that has been made in establishing coordination structures and strengthening M and E mechanism in the province, but contends that this still needs strengthening.

Goal: The goal under this priority area is the following:

To have a well-coordinated provincial response to HIV and AIDS, STI and TB that is informed by an effective M and E system by 2016.

Rationale

Several challenges in the coordination mechanism have been noted. These include the following:

Inadequate coordination and adherence to the reporting framework: While some DACs, LACs, NGOs and Government sectors report regularly others do not. Moreover most reports reflect inconsistent use of data collection tools and; inadequate recording, analysis and use of information.

Inadequate coordination of donor/development partners at the provincial level: Most development partners are not aware of the coordination efforts of the province and are thus not networked among each other and with other stakeholders. Further, many development partners do have seem to be aware of the Premier's OSS vision.

Inadequate NGO/CSO coordination: CSO are not well linked with other sectors. Some of them feel left out as they are not properly coordinated at district/ward levels

Inadequate capacity of DACS and LACS: Some DAC and LAC still functioning sub-optimally and have inadequate capacity. This is evidenced by lack of a dedicated focal person; lack of expertise; lack of dedicated M and E units; lack of action plans and; inadequate participation from some sectors.

Expected Impact: The expected impact of the KZN HIV and AIDS, STI and TB response is to achieve its intended impact and outcome targets by 2016. The expected impacts and indicator targets for the goal under priority area 5 are shown in the table below.

Table 75: Coordination, Monitoring and Evaluation Impact Indicators

Goal 1: To have a well-coordinated provincial response to HIV and AIDS, STI and TB that is informed by an effective M and E system by 2016.			
Impact Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Number of KZNPSP 2012 – 2016 impact targets fully achieved	tbd	tbd	100%
Number of KZNPSP 2012 – 2016 outcome targets fully achieved	tbd	tbd	100%

Objectives

The following are objectives of the priority area:

1. To strengthen coordination and management for an effective provincial response by 2016
2. To strengthen monitoring and evaluation systems at all levels and ensure that at least 90%. of the sectors consistently report to the coordination structures by 2016
3. To strengthen the research component of the response by 2016

Objective 1: To ensure that the provincial response is effectively coordinated and managed by 2016. (To strengthen coordination and management for an effective provincial response by 2016)

Rationale

Although there have been major successes in strengthening coordination and management of the provincial HAST response over the last five years, there are still challenges and emerging issues that need to be addressed. For example, there is still a weak link with development partners and CSO at the provincial level. Furthermore the planning and reporting systems are still inadequately aligned with existing systems. Although designated members do attend PCA meetings regularly, their engagement with the issues affecting the response in the province needs to be improved. Weak engagement with HAST issues in the lower level coordination structures is also prevalent. Additionally, reporting is generally not to the required standard.

There is need to improve this to ensure better coordination of the provincial response. This objective thus focuses on both strengthening coordination mechanism and capacities of the PCA and other coordinating structures.

Expected Outcomes: The expected outcome is that the provincial HAST response is well coordinated by 2016. The table below provides information on the outcome indicators targets for these objective.

Table 76: Coordination, Monitoring and Evaluation Outcome Indicators and Targets for Objective 1

Objective 1: To ensure that the provincial response is effectively coordinated and managed by 2016.			
Outcome Indicators	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of sectors reporting satisfaction with HAST coordination and management in KZN	tbd	tbd	100%
PCA fully functional *(monitors the implementation of KZNPSP 2012-2016 operational plan through quarterly reporting and PCA meetings in which at least 70% of designated members attend; mobilises and monitor usage of resources according to the plan)*	tbd	tbd	100%

Strategies for Achieving Objective 1

The main strategy to achieve this objective involves building the capacity of the PCA secretariat to better provide technical support to sectors and monitor implementation of the KZNPSP 2012-2016.

Key Interventions to Achieve Objective 1

The main interventions designed to achieve objective 1 are described below.

Key Intervention 1 - Strengthening the human and financial capacity of CD HIV and AIDS in OTP: The Chief Directorate HIV and AIDS is critical to the response. Some of its functions include providing the day-to-day support to coordination, planning, implementation; mobilising partnerships and resources; monitoring and evaluation and reporting among other functions.

In order to carry out its function effectively, there is need to have additional skilled human resources placed in the secretariat.

The output targets, target population, indicators and sectors responsible for this intervention are shown in the table below.

Table 77: Coordination, Monitoring and Evaluation Output Indicator and Target for Objective 1 Intervention 1

Intervention: Strengthening the capacity of CD HIV and AIDS in OTP						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of skilled staff placed at the CD HIV and AIDS in OTP	*3*	*6*	*6*	*6*	*6*	*6*
Target	CD HIV and AIDS in OTP					
Lead Agency	OTP HR					
Main Stakeholders	Development Partners					

Key Intervention 2 - Establishing effective partnerships, communication and mechanisms at all levels: This intervention is intended to keep all sectors and stakeholders working collaboratively and informed of the progress and issues with HAST responses in the province.

The output targets, target group, indicators and sectors responsible for this intervention are shown in the table below.

Table 78: Coordination, Monitoring and Evaluation Output Indicators and Targets for Objective 1 Intervention 2

Intervention: Establishing an effective communication framework with feedback mechanisms at all levels						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of feedback reports provided to sectors	tbd	quarterly (4)	quarterly (4)	quarterly (4)	quarterly (4)	quarterly (4)
Target Group	People started on ART					
Lead Agency	CD HIV and AIDS in the OTP					
Main Stakeholders	All sectors					

Key Intervention 3 - Strengthening the Capacity of DACs, LACs and WACs: This intervention is intended to ensure that all the local level coordination structures are fully functional. This entails establishing WACs in all the wards and linking it OSS; training and orientating local leaders and managers; development and implementation of joint HAST planning mechanism; setting up of district secretariats; facilitating resource mobilisation and allocation as per needs and; strengthening partnership at the local level.

The output targets, target group, indicators and sectors responsible for this intervention are shown in the table below.

Table 79: Coordination, Monitoring and Evaluation Output Indicators and Targets for Objective 1 Intervention 3

Intervention: Strengthening the capacity of DACs, LACs and WACs						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of fully functional DACs		11	11	11	11	11
Number of fully functional LACs		52	52	52	52	52
Number of fully functional WACs	80	400	640	740	822	822
Target Groups	DACs, LACs, DACs					
Lead Agency	CD HIV and AIDS in the OTP/COGTA					
Main Stakeholders	All sectors					

Objective 2: To strengthen monitoring and evaluation system of the multi-sectoral response and ensure that at least 90% of sectors consistently reporting to the coordination structures by 2016.

Rationale

Despite the existence of a multi-sectoral M and E system for HAST, very little progress has been made in fully implementing the system. This has been partly due to limited capacity for data collection analysis and reporting; lack of clear alignment to existing the sectoral systems and; unclear lines of accountability. Most notable is the fact that there was an absence of readily available data to monitor and evaluate the response under KZNPSP2007-2011. Strengthening the M and E system is expected to lead to effective monitoring and evaluation of the KZNPSP 2012-2016.

Expected Outcome

The outcomes of achieving this objective are the following:

1. All sectors report to PCA, DACs and LACs quarterly
2. Annual reviews conducted
3. KZNPSP mid-term review conducted
4. KZNPSP end-term evaluation conducted

Table 80: Coordination, Monitoring and Evaluation Outcome Indicators and Targets for Objective 2

Objective 2: To strengthen monitoring and evaluation system of the multi-sectoral response and ensure that at least 90% of sectors consistently reporting to the coordination structures by 2016.			
Outcome Indicators	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of sectors providing quarterly reports	tbd	45%	90%
Percentage of annual output targets of the KZNPSP2012-2016 measured	tbd	tbd	100%
Percentage of outcome indicators with data readily available	tbd	100%	100%
Percentage of impact indicators with data readily available	tbd	-	100%

Strategies to Achieve Objective 2

The main strategy for achieving objective 2 is through building capacity of the CD HIV and AIDS in the OTP to provide technical support to sectors as well as implementing an effective reporting system.

Key Interventions to Achieve Objective 2

The main interventions designed to achieve objective 2 are described below.

Key Intervention 1 - Establish all the baseline data for KZNPSPS 2012-2016 outcome and output indicators: This intervention involves collecting baseline data for all indicators for which data is not currently available. This expected to be completed in 2012.

The output targets, target groups, indicators and sectors responsible for this intervention are shown in the table below.

Table 81: Coordination, Monitoring and Evaluation Output Indicator and Target for Objective 2 Intervention 1

Intervention: Establish all the baseline data for KZNPSPS 2012-2016 outcome and output indicators						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
% of indicators with baseline data	tbd	100%	100%	100%	100%	100%
Target Groups	Policy makers, managers and implementers					
Lead Agency	CD HIV and AIDS in OTP					
Main Stakeholders	All sectors					

Key Intervention 2 - Building capacity of multi-sectoral coordination structures in planning, M and E and coordination: This entails building of capacity of the PCA, DACs, LACs and WACs to support sectors collect, analyse and report data as well as provide feedback to sectors.

The output targets, target group, indicators and sectors responsible for this intervention are shown in the table below.

Table 82: Coordination, Monitoring and Evaluation Output Indicators and Target for Objective 2 Intervention 2

Intervention: Building capacity of Multi-sectoral coordination structures in planning, M and E and coordination						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
% of DACs with a functional M and E units	tbd	tbd	tbd	90%	90%	90%
% of LACs with a functional M and E units	tbd	tbd	tbd	70%	75%	80%
% of WACs collecting data and reporting to M and E units	tbd	tbd	tbd	tbd	tbd	tbd
Target Groups	DACs, LACS and WACs					
Lead	OTP/COGTA					
Main Stakeholders	DACS, LACS and WACS					

Key Intervention 3 - Monitoring and Evaluating the KZNPSP 201-2016 implementation:

This involves quarterly reporting from sectors, annual reviews, mid-term review and end-term evaluation, using agreed templates.

The output targets, target group, indicators and sectors responsible for this intervention are shown in the table below.

Table 83: Coordination, Monitoring and Evaluation Output Indicators and Targets for Objective 2 Intervention 3

Intervention: Monitoring and evaluating the KZNPSP 201-2016 implementation						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of sectors providing quarterly report	tbd	tbd	tbd	tbd	tbd	tbd
Number of annual reviews conducted	Zero	1	2	3	4	4
Mid-term review conducted	-	-	1		-	1
End-term review conducted	-	-	-	-	-	1
Target Groups	Public					
Lead Agency	CD HIV and AIDS in OTP					
Main Stakeholders	All sectors					

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

Rationale

The research component of the response is generally weak. There is an absence of a research agenda, existence of uncoordinated research and the presence of research work that is mostly carried out by academic institutions, results of which may not necessarily be helpful to the provincial response. Capacity for research is limited. Strengthening the research component will allow the province to better identify information gaps that require research, have the requisite skills to conduct research to inform decisions, policy and programming, and have requisite capacity to evaluate performance of the KZNPSP in the province. Further, there is a need for the province to develop a research agenda.

Strategies to Achieve Objective 3

The main strategies for achieving objective 3 is through building capacity for research to provide technical support as well as putting in place an effective research coordination mechanism. This research coordination mechanism should be based in the Office of the Premier.

Key Interventions to Achieve Objective 3

Key Intervention 1 - Establish an Effective Research Coordination Structure: This will involve putting in place a multi-sectoral research coordination structure that will be charged with coordinating, directing, and providing advising on all matters of research in the response. As part of the coordination mechanism a database of all research carried out in the province will be created and mechanism for widely disseminating findings developed. This may include creation of HIV and AIDS information resource centres at provincial and district levels. Further, this mechanism will be responsible for developing the provincial research agenda.

The output targets, target group, indicators and sectors responsible for this intervention are shown in the table below.

Table 84: Coordination, Monitoring and Evaluation Output Indicators and Targets for Objective 3 Intervention 1

Intervention: Establish an effective research coordination structure						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Research coordination structure established		Existence of coordination structure	-	Review of structure	Existence of reviewed structure	End term review of existing structure
Research agenda developed		1	2	3	4	5
Research data base developed	-	-	1		-	1
Target Groups	Research coordination structure					
Lead Agency	CD HIV and AIDS in OTP					
Main Stakeholders	All sectors					

Key Intervention 2 - Develop Capacity of Researchers in the Province: This will entail developing capacity of new and existing researchers in the province to ensure that the human pool of research is adequate and well skilled. There will be need to develop a data base of all researchers and research institutions in the province.

Table 85: Coordination, Monitoring and Evaluation Output Indicators and Targets for Objective 3 Intervention 2

Intervention: Develop Capacity of Researchers						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of research entities on database	tbd	tbd	tbd	tbd	tbd	tbd
Number of staff trained on research	tbd	tbd	tbd	tbd	tbd	tbd
Target Groups						
Lead Agency	CD HIV and AIDS in OTP					
Main Stakeholders	All sectors, development partners					

CHAPTER 5

5 Governance and Management

The first of the "Three Ones", i.e. one coordination authority, is crucial to successful implementation of the KZNPSP 2012-16. The Office of the Premier has demonstrated political will and leadership to ensure that coordinating structures at all levels function effectively. The Chief Directorate HIV and AIDS provides day to day support to coordination, planning, implementation, mobilising partnerships and resources and monitoring and evaluation and reporting among other functions.

The introduction of Operation Sukuma Sakhe (OSS) and linking it to HIV and AIDS coordinating structures implies that coordination, monitoring is now linked directly to an implementation mechanism. This has been made possible because of commitment from the Premier, improved political will at local level and improved stakeholder accountability. The province is currently in the process of cascading the establishment of coordination structures to the ward level by creating Wards AIDS Committees. This has enabled the province to decentralize planning to the local, including the integration of HIV and AIDS into the IDP.

The challenges that still remain regarding coordination and management of the response include:

1. Poor adherence to the reporting framework/guidelines:
   Some DACs, LACs, NGOs and Government sectors report regularly while others do not. Moreover most reports do not reflect adequate analysis.
2. Inadequate coordination of donor/development partners at the provincial level.
3. Inadequate resources for the coordination structures at all levels.
4. Some DAC and LAC still functioning sub-optimally and have inadequate capacity: This is evidenced by lack of a dedicated focal person, lack of expertise, lack of action plans and inadequate participation from some sectors.

This chapter describes the mechanism for strengthening coordination, governance and management of the response under KZNPSP 2012-16.

5.1 Institutional Arrangements and Coordination

Provincial Council on AIDS

Provincial Council on AIDS (PCA) remains the highest HAST Coordinating body in the province. It is comprised of members from Government departments, civil society organizations, private sector and mayors of district municipalities. Chaired by the Premier, the main role of PCA is to provide strategic directions, leadership and stewardship; coordination of all stakeholders; monitoring and evaluating the provincial multi-sectoral response and creating environment for effective partnership in the response. The following actions will be taken to allow the PCA better execute it role during the KZNPSP 2012-16:

1. Improving the capacity of the Chief directorate of HIV and AIDS in OTP to better monitor and provide day-to-day coordination.
2. Strengthening partnership with CSO and Development partners for better coordination
3. Putting in place mechanism for resources mobilization
4. Establishing an effective communication framework with feedback mechanisms and tools at all levels
5. Quarterly monitor and annual review implementation of multi-sectoral strategy.

Civil Society Organisations

This sector includes NGO, FBOs and CBOs. Its role in coordination of the response include the following:

1. To be part of the response.
2. Participate meaningfully and effectively.
3. Collaborate with relevant stakeholders for maximum effectiveness of participation.

4. Advocate to government in implementing relevant policies and strategies.
5. Advise on the issues on the ground.
6. Share information (e.g. research), skills, and resources regarding all interventions done.

The action for the CSO will be to coordinate participation and involvement of all its stakeholders in the province in AIDS coordination structures at all levels.

Development Partners

Development partners play an important in the KZN HIV and AIDS,STI and TB response. The roles of development partners include the following:

1. Participate in the response meaningfully and effectively.
2. Collaborate with relevant stakeholders for maximum effectiveness of the response.
3. Share information (e.g. research), skills, and resources regarding all interventions done.

   There is poor coordination of development partners' activities. The OTP will need to institute a mechanism to better coordinate these agencies.

District AIDS Council

At the District level, District AIDS councils coordinate the district HIV and AIDS and TB response and OSS activities. The main actions to strengthen DACs will include the following:

1. Facilitating inclusion of all key stakeholders, including PLHIV and People with TB in DACs
2. Strengthening the capacity of DACs on coordination, planning and M and E
3. Resource mobilisation and allocation as per needs
4. Strengthening partnership by report back by leadership
5. DAC secretariat cascading information to LACs

Local AIDS Council

LACs are the coordinating bodies at the Local Municipal level. The review report indicated that only 53% of LACs are currently functional, this call for efforts to ensure that all LACs are functional by 2016. The actions under KZNPSP 2012 -16 will include the following:

1. Facilitating and supporting capacity building of the LM's political leadership and management
2. Building capacity of LACs on coordination, management and M and E
3. Development and implementation of joint HIV and AIDS, TB, STI, and MCWH planning mechanism
4. Resource mobilisation and allocation as per needs
5. Strengthening partnership by report back by leadership
6. LAC secretariat cascading information to WACs

Ward AIDS Council

WACs are the community based committees that will coordinate HAST response activities at the ward level and closely linking it with OSS implementation. As of now the majority of wards do not have WACs. It therefore expected that WACs would be established and capacitated in all wards in the province by 2016. Specific actions for WACs include the following:

1. Buy in by management and leadership at WAC level
2. Establish and capacitate WACs in each ward in KZN
3. Integration of OSS and other forums within the Ward

5.2 Costing

Costing of the KZNPSP will be reflected in the operational plan. This will involve determining financial estimates of the various interventions / programmes to come up with an estimated budget for the response. Implementing stakeholder budget allocations will be used as source documents for this information.

This will be done before the end of January 2012 in order to allow departments to adjust their budgets in time for 2012/13 financial year.

CHAPTER 6

6 Monitoring, Evaluation and Research

6.1 Monitoring and Evaluation

A functional Monitoring and Evaluation system will allow the province to assess progress in implementation and determine effectiveness of intervention programmes proposed in this plan.

Monitoring reports will provide the basis for discussion within coordinating structures such as the PCA, DACs and LACs. The HIV and AIDS Chief Directorate in the OTP will coordinate and ensure that the provincial reporting system is functional as well as establish reporting and feedback links with SANAC.

One monitoring and evaluation (M and E) system fulfils the global principles of “three ones” where M and E is the third of the three ones. The foundational principles of monitoring and evaluation include the following:

1. Alignment of multiple actors around a set of core indicators and core elements of an M and E system that emphasises performance and accountability.
2. Adoption of one monitoring and evaluation system that provides high-quality data for tracking the performance of provincial response.
3. Investment at implementation and coordination levels in building essential human-capacity and infrastructure to meet monitoring and evaluation needs.

For KZNPSP2012-16 an M and E framework and plan will be developed as a separate document and provides details of how M and E will function the province. The development of the M and E Framework employs the same participatory approach and methodology as the review and development of KZNPSP2012-16, commitment to the successful implementation was emphasized during the process.

The main purpose of the M and E framework includes:

Guiding decisions, coordination and implementation of the HIV interventions; assessing the effectiveness of the HIV response; and to identify areas of intervention that require improvement. The framework therefore establishes a clear and logical pathway to track progress from the processes to the achievement of the overall result. This pathway includes the following major components:

1. **Outputs:** The products and services, which result from the completion of interventions within the plan.
2. **Outcomes:** Results arising from achieving the strategic objectives. Preferably determined through population-based data.
3. **Impacts:** The overall results that arise from the achievement of the goals within the KZNPSP.
4. **Indicators:** Quantitative or qualitative variables that allow the verification of changes produced by intervention relative to what was planned.
5. **Targets:** Reference point or standard against which progress or achievements can be assessed.

6.2 Research

It will be necessary that research be high on the priority of the provincial response agenda. In this manner, the province will be able to have the required evidence to make effective decisions on planning and implementation and come up with innovative ideas that can be fed into response.

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Annexures

Annexure A: Combination Prevention Interventions for HAST Transmission

	Combination interventions to prevent HAST transmission among specific target groups									
Target Group and Agencies	**Condoms**	**PEP**	**HCT**	**TB screening**	**MMC**	**BCC**	**STI Treatment**	**PrEP**	**PMTCT**	**Addressing contextual issues**
Adult females	Easy access to both female and male condoms	PEP provided within 72hrs of exposure. (e.g. sexual violence, occupational exposure, discordant couples)	Regular HCT (e.g. yearly)	Regular TB screening;	N/A	Mass media with messages targeting healthy lifestyles and promotion of effective programmes	Prompt treatment of those infected	HIV negative who wants to conceive with HIV infected partner	Appropriate PMTCT services including primary prevention of HIV and pregnancies	Economic and social empowerment
Agency/ Agencies	DOH	DOH, DCSL, SAPS	DOH	DOH		OTP, DAC	DOH	DOH	DOH	DED, DAERD, DSD
	Consistent condom promotion			Investigations if contact or symptomatic		Participation in social network activities	Tracing and treatment of contacts			Violence reduction
Agency/ Agencies	*DOH, COGTA*			DOH		OTP, DAC	DOH			DCSL, SAPS
						Community conversations and mobilization	Counselling			Appropriate human settlement
Agency/ Agencies						OTP, DAC				COGTA, DHS
						Toll free help line				Access to clean water and sanitation
Agency/ Agencies						DOH				COGTA DAERD

	Combination interventions to prevent HAST transmission among specific target groups									
Target Group and Agencies	**Condoms**	**PEP**	**HCT**	**TB screening**	**MMC**	**BCC**	**STI Treatment**	**PrEP**	**PMTCT**	**Addressing contextual issues**
Adult men	Easy access to both female and male condoms	PEP provided within 72hrs of exposure. (e.g. sexual violence, occupational exposure, discordant couples)	Regular HCT (e.g. yearly)	Regular TB screening;	Providing MMC services	Mass media with messages targeting healthy lifestyles and promotion of effective programmes	Prompt treatment of those infected	HIV negative who wants to conceive with HIV infected partner	N/A	Economic and social empowerment
Agency/ Agencies	DOH	DOH, DCSL, SAPS	DOH	DOH	DOH	OTP, DAC	DOH	DOH		DED, DAERD, DSD
	Consistent condom promotion			Investigations if contact or symptomatic		Participation in social network activities	Tracing and treatment of contacts			Violence reduction
Agency/ Agencies	*DOH, COGTA*			*DOH*		*OTP, DAC*	*DOH*			DCSL, DSD
				Early TB treatment if infected		Community conversations and mobilization	Counselling			Appropriate human settlement
Agency/ Agencies				*DOH*		OTP, DAC, DCS	DOH			COGTA, DHS
						Toll free help line				Access to clean water and sanitation
Agency/ Agencies						DOH				COGTA DAERD

	Combination interventions to prevent HAST transmission among specific target groups									
Target Group and Agencies	**Condoms**	**PEP**	**HCT**	**TB screening**	**MMC**	**BCC**	**STI Treatment**	**PrEP**	**PMTCT**	**Addressing contextual issues**
Young girls under 15	Easy access to both female and male condoms for those over 12 years	PEP provided within 72hrs of exposure. (e.g. sexual violence)	Yearly HCT for those over 12 years	Yearly TB screening for those over 12 years	NA	Life skills-based education to enable the make safe choices e.g. delaying sexual debut	Prompt treatment of those infected	N/A	Appropriate PMTCT services including primary prevention of HIV and pregnancies	Violence reduction
Agency/ Agencies	DOH	DOH, DCSL, SAPS	DOH	DOH		DOE, DAC, OTP	DOH		DOH	DCSL, DSD
	Consistent condom promotion for those over 12 years			Investigations if contact or symptomatic			Tracing and treatment of contacts			Appropriate human settlement
Agency/ Agencies	*DOH, DOE, COGTA*			*DOH*			*DOH*			COGTA, DHS
				Early TB treatment if infected			Counselling			Access to clean water and sanitation
Agency/ Agencies				*DOH*			DOH			COGTA DAERD

	Combination interventions to prevent HAST transmission among specific target groups									
Target Group and Agencies	**Condoms**	**PEP**	**HCT**	**TB screening**	**MMC**	**BCC**	**STI Treatment**	**PrEP**	**PMTCT**	**Addressing contextual issues**
Infants and male children under 15	Easy access to both female and male condoms for those over 12 years	PEP provided within 72hrs of exposure.	Yearly HCT for those over 12 years	Yearly TB screening for those over 12 years	Infant and adolescent MMC	Life skills-based education to enable the make safe choices e.g. delaying sexual debut	Prompt treatment of those infected	N/A	Appropriate PMTCT services including primary prevention of HIV and pregnancies	Violence reduction
Agency/ Agencies	DOH	DOH, DCSL, SAPS	DOH	DOH	DOH	DOE, DAC, OTP	DOH			DCSL, DSD
	Consistent condom promotion for those over 12 years			Investigations if contact or symptomatic			Tracing and treatment of contacts			Appropriate human settlement
Agency/ Agencies	*DOH, DOE, COGTA*			*DOH*			*DOH*			COGTA, DHS
				Early TB treatment if infected			Counselling			Access to clean water and sanitation
Agency/ Agencies				*DOH*			DOH			COGTA DAERD

	Combination interventions to prevent HAST transmission among specific target groups									
Target Group and Agencies	**Condoms**	**PEP**	**HCT**	**TB screening**	**MMC**	**BCC**	**STI Treatment**	**PrEP**	**PMTCT**	**Addressing contextual issues**
Inmates at correctional services facilities	Easy access to Condom distribution	PEP provided within 72hrs of exposure. (e.g. sexual violence)	Regular HCT (e.g. yearly)	Regular TB screening;	Providing MMC services	Behaviour change communication with massages targeting healthy lifestyle	Prompt treatment of those infected	N/A	Appropriate PMTCT services including primary prevention of HIV and pregnancies	Economic and social empowerment
Agency/ Agencies	DOH	DOH, DCS	DOH	DOH	DOH	DOE, DAC, OTP	DOH		DOH	DCSL, DSD
				Investigations if contact or symptomatic			Tracing and treatment of contacts			Violence reduction
Agency/ Agencies	*DOH, DOE, COGTA*			*DOH*			*DOH*			DSD, DCS
				Early TB treatment if infected			Counselling			Appropriate human settlement
Agency/ Agencies				*DOH*			DOH			DCS
										Access to clean water and sanitation
Agency/ Agencies										COGTA DAERD

	Combination interventions to prevent HAST transmission among specific target groups									
Target Group and Agencies	**Condoms**	**PEP**	**HCT**	**TB screening**	**MMC**	**BCC**	**STI Treatment**	**PrEP**	**PMTCT**	**Addressing contextual issues**
Sex workers, their clients and substance abusers	Easy access to both female and male condoms	PEP provided within 72hrs of exposure. (e.g. sexual violence, occupational exposure, discordant couples)	Regular HCT (e.g. yearly)	Regular TB screening;	Providing MMC services	Mass media with messages targeting healthy lifestyles and promotion of effective programmes	Prompt treatment of those infected		N/A	Economic and social empowerment rehabilitation for substance abuse
Agency/ Agencies	*DOH, COGTA*	*DOH, DCSL, SAPS*	*DOH*	*DOH*	*DOH*	*OTP, DAC,DSR*	*DOH*			*DEDT, DAERD, DSD*
	Consistent condom promotion			Investigations if contact or symptomatic			Tracing and treatment of contacts			Violence reduction
Agency/ Agencies	*DOH, COGTA*			*DOH*			*DOH*			DCSL, DSD
				Early TB treatment if infected		Community conversations and mobilization	Counselling			Appropriate human settlement
Agency/ Agencies				*DOH*		OTP, DAC,	DOH			COGTA, DHS
						Toll free help line				Access to clean water and sanitation
Agency/ Agencies						DOH				COGTA DAERD

Combination interventions to prevent HAST transmission among specific target groups										
Target Group and Agencies	**Condoms**	**PEP**	**HCT**	**TB screening**	**MMC**	**BCC**	**STI Treatment**	**PrEP**	**PMTCT**	**Addressing contextual issues**
Immigrants and mobile populations (including students in tertiary institutions, tourists, long distance drivers, informal settlement dwellers	Easy access to both female and male condoms	PEP provided within 72hrs of exposure.	Regular HCT (e.g. yearly)	Regular TB screening;	Providing MMC services	Mass media with messages targeting healthy lifestyles and promotion of effective programmes	Prompt treatment of those infected	HIV negative who wants to conceive with HIV infected partner	Appropriate PMTCT services including primary prevention of HIV and pregnancies	Economic and social empowerment
Agency/ Agencies	*DOH, COGTA, DOT, DCS, DOE, DHA*	*DOH, DCSL, SAPS*	*DOH, DCS, DOT,*	*DOH*	*DOH*	*DOT, DCS, DOE, DAC, OTP*	*DOH*	*DOH*	*DOH*	*DOT, DED, DAERD, DSD, DHA, DCS*
	Consistent condom promotion			Investigations if contact or symptomatic			Tracing and treatment of contacts			Violence reduction
Agency/ Agencies	*DOH, COGTA*			*DOH*			*DOH*			DCSL, DSD
				Early TB treatment if infected		Community conversations and mobilization	Counselling			Appropriate human settlement especially for informal settlements
Agency/ Agencies				*DOH*		OTP, DAC,	DOH			COGTA, DHS
						Toll free help line				Access to clean water and sanitation
Agency/ Agencies						DOH				COGTA DAERD

	Combination interventions to prevent HAST transmission among specific target groups									
Target Group and Agencies	**Condoms**	**PEP**	**HCT**	**TB screening**	**MMC**	**BCC**	**STI Treatment**	**PrEP**	**PMTCT**	**Addressing contextual issues**
Employees	Easy access to both female and male condoms	PEP provided within 72hrs of exposure.	Yearly HCT for those over 12 years	Yearly TB screening for those over 12 years	Infant and adolescent MMC	Life skills-based education to enable the make safe choices e.g. delaying sexual debut	Prompt treatment of those infected	N/A	Appropriate PMTCT services including primary prevention of HIV and pregnancies	Economic and social empowerment
Agency/ Agencies	DOH,OTP COGTA, All departments and Private secxtor	DOH, DCSL, SAPS	DOH OTP COGTA, All departments and Private sector	DOH OTP COGTA, All departments and Private sector	DOH OTP COGTA, All departments and Private sector	DDOH OTP COGTA, All departments and Private sector	DOH OTP COGTA, All departments and Private sector	DOH OTP COGTA, All departments and Private sector	DOH OTP COGTA, All departments and Private sector	DED, DAERD, DSD OTP COGTA, All departments and Private sector
	Consistent condom promotion			Investigations if contact or symptomatic			Tracing and treatment of contacts			Violence reduction
Agency/ Agencies	*DOH, COGTA OTP COGTA, All departments and Private secxtor*			*DOH*			*DOH*			DCSL, DSD OTP COGTA, All departments and Private sector
				Early TB treatment if infected		Community conversations and mobilization	Counselling			Access to clean water and sanitation
Agency/ Agencies				*DOH*		OTP, DAC	DOH			EMPLOYERS
						Toll free help line				Access to clean water and sanitation
Agency/ Agencies						DOH				COGTA DAERD

	Combination interventions to prevent HAST transmission among specific target groups									
Target Group and Agencies	**Condoms**	**PEP**	**HCT**	**TB screening**	**MMC**	**BCC**	**STI Treatment**	**PrEP**	**PMTCT**	**Addressing contextual issues**
LGBTI	Easy access to both female and male condoms	PEP provided within 72hrs of exposure.	Regular HCT (e.g. yearly)	Regular TB screening;	Providing MMC services	Mass media with messages targeting healthy lifestyles and promotion of effective programmes	Prompt treatment of those infected	Need to be considered	N/A	Economic and social empowerment
Agency/ Agencies	DOH	DOH, DCSL, SAPS	DOH	DOH	DOH	OTP, DAC	DOH	DOH		DED, DAERD, DSD
	Consistent condom promotion			Investigations if contact or symptomatic			Tracing and treatment of contacts			Violence reduction
Agency/ Agencies	*DOH, DAERD Municipalties*			*DOH*			*DOH*			DCSL, DSD
				Early TB treatment if infected		Community conversations and mobilization	Counselling			Appropriate human settlement
Agency/ Agencies				*DOH*		DAERD, OTP, DAC and Municipalities	DOH			COGTA, DHS
						Toll free help line				Access to clean water and sanitation
Agency/ Agencies						DOH				COGTA DAERD

	Combination interventions to prevent HAST transmission among specific target groups									
Target Group and Agencies	**Condoms**	**PEP**	**HCT**	**TB screening**	**MMC**	**BCC**	**STI Treatment**	**PrEP**	**PMTCT**	**Addressing contextual issues**
Farm dwellers	Easy access to both female and male condoms	PEP provided within 72hrs of exposure.	Regular HCT (e.g. yearly)	Regular TB screening;	Providing MMC services	Mass media with messages targeting healthy lifestyles and promotion of effective programmes	Prompt treatment of those infected	HIV negative who wants to conceive with HIV infected partner	Appropriate PMTCT services including primary prevention of HIV and pregnancies	Economic and social empowerment
Agency/ Agencies	DOH, DAERD, Municipalities		DOH	DOH	DOH	OTP, DAERD, Municipalities	DOH	DOH	DOH	DED, DAERD, DSD, Municipalities
	Consistent condom promotion			Investigations if contact or symptomatic			Tracing and treatment of contacts			Violence reduction
Agency/ Agencies	*DOH, DAERD Municipalties*			*DOH*			*DOH*			DCSL, DSD
				Early TB treatment if infected		Community conversations and mobilization	Counselling			Appropriate human settlement
Agency/ Agencies				*DOH*		DAERD, OTP, DAC and Municipalities	DOH			COGTA, DHS
						Toll free help line				Access to clean water and sanitation
Agency/ Agencies						DOH				COGTA DAERD

Annexure B: Summary Key Results Framework

Strategic Objective 1: Addressing Social and Structural Drivers of HAST Prevention, Care and Support

Addressing Social and Structural Drivers Impact Indicators

Goal 1: To reduce vulnerability to HIV, STIs and TB due to poverty, socio-cultural norms and gender imbalance by 2016.			
Impact Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Gini coefficient	tbd	tbd	tbd
Percentage of people reporting favourable socio-cultural environment	tbd	tbd	tbd

Addressing Social and Structural Drivers Outcome Indicators and Targets for Objective 1

Objective 3: To reduce vulnerability to HAST transmission due to poverty, unemployment and gender inequality by 2016			
Outcome Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Poverty levels reduced by 2016*	tbd	tbd	tbd
Reduce gender inequality by 2016	tbd	tbd	tbd
Reduce unemployment by 2016*	tbd	tbd	tbd
Reduce the proportion of women and children who have ever experienced sexual violence from an intimate partner by 2016	tbd	tbd	tbd
Reduce the proportion of women and children who have ever experienced sexual violence from an intimate partner by 2016	tbd	tbd	tbd
Reduce the proportion of women aged 18-24 who were married before the age of 18 by 2016	tbd	tbd	tbd
Increase the proportion of men and boys that agree that women should have the same rights as men by 2016	tbd	tbd	tbd

Addressing Social and Structural Drivers Output Indicator and Targets for Objective 1 Intervention 1

Intervention: Monitoring implementation of OSS						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of war rooms functional	tbd	tbd	tbd	tbd	tbd	tbd
Proportion of wards with youth ambassadors						
Number of wards reporting on OSS outputs	tbd	tbd	tbd	tbd	tbd	tbd
Target Group	OSS programme					
Lead Agency	OTP					
Main Stakeholders	All government departments, CSO and private sector					

Addressing Social and Structural Drivers Outcome Indicators and Targets for Objective 2

Objective 2: To promote positive socio-cultural norms and values.			
Outcome Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of schools that train their staff on sexual and gender-based violence issue	tbd	tbd	tbd
Proportion of men and women who have ever been exposed to gender-based violence prevention messages	tbd	tbd	tbd
Proportion of people who believe that child marriages should be stopped	tbd	tbd	tbd

Addressing Social and Structural Drivers Output Indicator Targets for Objective 2 Intervention 1

Intervention: Community mobilization						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of programmes implemented for boys and men that include examining gender and culture norms related to gender-based violence	tbd	tbd	tbd	tbd	tbd	tbd
Number of peer educators deployed per key population area	tbd	tbd	tbd	tbd	tbd	tbd
Number of community mobilisation activities carried by leaders	tbd	tbd	tbd	tbd	tbd	tbd
Target Group	The public					
Lead Agency	OTP					
Main Stakeholders	All government departments, CSO and private sector					

Addressing Social and Structural Drivers Output Indicators and Targets for Objective 2 Intervention 2

Intervention: Promote Positive Socio-cultural Norms and Values						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of peer educators deployed in HTAs	tbd	tbd	tbd	tbd	tbd	tbd
Number of peer educators trained on sexual and reproductive health and HIV related life skills	38,290	45,950	56,270	66,590	76,910	76,910
Target Group	All settings with key populations					
Lead Agency	DOE, DOH					
Main Stakeholders	OTP, COGTA, CSO, Private sector					

Strategic Objective 2: Prevention of HIV, AIDS, STIs and TB Infections

Prevention Goals, Impacts Indicators, Baseline and Targets

Goal 1: To reduce the incidence HIV infection to less than 1% by 2016			
Impact Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
HIV incidence in the general population	2.3 (2009)	1.7	<1.2
HIV prevalence among men and women aged 15 -25 years	15.3 (2008)	11.5	<10
Percentage of HIV infected infants born to HIV positive mother	2.8 (2010)	2	<1
Goal 2: To reduce new smear positive TB infection to less than 200 per 100,000 population by 2016.			
Annual incidence of TB infections	262/100,000 (2009)	< 196/100,000	< 131/100,000
Goal 3: To reduce incidence of STIs by at least 80% by 2016			
Annual incidence of STI infection	2.7% (DHIS)	<1.5	<0.5

Prevention Outcomes, Indicators and Targets for Objective 1

Objective 1: To decrease behaviours that put men and women aged 15-49 years at risk of HAST by 80 % through implementation of focussed programmes by 2016.			
Outcome Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of women and men age 15 to 49 who have had more than one sexual partner in past 12 months	10.2% (2009)	7.7%	<5%
Percentage of women and men age 15 to 49 who have had more than one sexual partner in past 12 months reporting use of condom during their last sexual intercourse	66.2% (2009)	83%	100%
Percentage of women and men aged 15 to 24 who reject misconceptions about HAST transmission	tbd	tbd	100%
Percentage of women and men aged 15 to 24 who correctly identify ways of preventing sexual transmission of HIV	30% (2008)	60%	90%
Number of learners who fall pregnant	13,725 (2010)	5,490	2,745
Percentage of young men and women aged 15-24 who have had sexual intercourse before 15	4.9% (2009)	3.7%	<2.5%

Prevention Output Indicators and Targets for Objective 1 Intervention 1

Intervention: Development and implementation of a comprehensive provincial multi-media strategy						
	Target					
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Multimedia strategy developed and adopted		Multimedia strategy developed and adopted	Implementation	Multimedia strategy reviewed and updated	Implementation	Multimedia strategy reviewed
Number of men and women aged reached with multimedia campaigns (disaggregated by key population)	Unknown	5,734,139	5,734,139	5,734,139	5,734,139	5,734,139
Target Group	Men and women aged 15-49 (disaggregated by key population)					
Lead Agency	Office of the Premier (OTP), DAC					
Main stakeholder	Civil Society Organisations (CSOs) Private sector, All government departments, DAC, LAC and WAC. War Rooms/Youth Ambassador					

Prevention Output Indicator and Targets for Objective 1 Intervention 2

Intervention	**Advocacy for youth HAST prevention by leaders**					
Output	All leaders in the province in the various government departments, cultural, political, NGO and private sector advocating for youth HAST prevention					
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of leaders advocating for HAST prevention among the youth	tbd	tbd	tbd	tbd	tbd	tbd
Number of youth reached as a result of advocacy by leaders	Unknown	5,734,139	5,734,139	5,734,139	5,734,139	5,734,139
Target Group	All key leaders in the various government departments, cultural, political, NGO and private sector and Youth					
Lead Agency	Office of the Premier					
Main Stakeholders	CSOs, All government departments, cultural institutions, political leaders, traditional leaders, private sector					

Prevention Output Indicators and Targets for Objective 1 Intervention 3

Intervention	**Community Outreach and Mobilization**					
Output	All members of the community aged 15-49 mobilised and reached with community outreach interventions					
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of members of the community aged 15-49 reached with community mobilisation sessions	60,000*	2,867,070	5,734,139	5,734,139	5,734,139	5,734,139[1]
Target Group	All members of the community aged 15 - 49					
Lead Agency	DAC					
Main Stakeholders	OTP, DOE, All CSOs, All government departments, cultural institutions, political leaders,					

Prevention Output Indicator and Targets for Objective 1 Intervention 4

Intervention	**Life skills-based education for youth in school**					
Output	100% of the learners reached with life skills education					
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of educators trained to effectively integrate SRH into the curriculum	5,000	9,000	10,960	13,360	15,760	15,760
Number of learners reached through life skills education	2,841,135	2,841,135	2,841,135	2,841,135	2,841,135	2,841,135
Target Group	All learners in primary, secondary and tertiary[1]					
Lead Agency	DOE					
Main Stakeholders	DAC, DOH, OTP, DSD, relevant CSO, DAC, LAC, WAC, War Rooms/Youth Ambassadors					

Prevention Output Indicators and Targets for Objective 1 Intervention 5

Intervention	**Scale-up workplace/occupational health prevention programmes**					
Output	All employees reached with HAST prevention activities					
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of Employees Pre-test counselled	6000					
Number of employees testing Positive for HIV during Wellness Testing Sessions	100					
Number of employees referred for TB screening	0					
Number of male condoms distributed in the workplace						
Number of employers / sectors with workplace HIV and AIDS policies	15 provincial departments					
Number of female condoms distributed in the workplace						
Number of employees and dependants receiving ART from the private sector						
Number of employees and dependants receiving MTCTP from the private sector						
Number of employees living with HIV						
Number of awareness sessions conducted on HAST	200					
Target Group	Private sector, public sector, employees					
Lead Agency	OTP – Employee Health and Wellness					

Prevention Outcome Indicator and Targets for Objective 2

Objective 2: To reduce risk of MTCT of HIV to less than 1% by 2016			
Outcome Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of infants born to HIV-infected mothers who are infected	2.8% (2010)	<2%	<1%

Prevention Output Indicators and Targets for Objective 2 Intervention 1

Intervention	**Providing access to comprehensive contraceptive services**					
		Target				
Indicators	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of females aged 15-49 who received contraceptive services	tbd	tbd	tbd	tbd	tbd	tbd
Number of females less than 18 years who are accepters of contraception						
Couple year protection rate1	21.6%	50%	60%	70%	80%	90%
Target Group	Women aged 12-49					
Lead Agency	DOH					
Main Stakeholders	Relevant CSO, Private sector					

Prevention Output Indicator and Targets for Objective 2 Intervention 2

Intervention	**Community outreach and mobilization on PMTCT**					
		Target				
Indicators	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of females and males aged 12 and above reached with comprehensive package PMTCT community mobilization package (defined in communication plan)	Unknown	7,157,532	7,157,532	7,157,532	7,157,532	7,157,532
Target Group	Males and females age 15 and above					
Lead Agency	DOH					
Main Stakeholders	COGTA, OTP, all government departments, CSO, DAC, LAC, WAC, War Rooms/Youth Ambassador					

Prevention Output Indicators and Targets for Objective 2 Intervention 3

Intervention	**Scaling up access to early diagnosis of HIV in babies born to HIV infected mothers**					
		Target				
Indicators	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of infants born to HIV positive mothers annually	tbd					
Number of infants born to HIV positive mothers who receive PCR tests according to guidelines	51,000					
Percentage of infants born to HIV infected women who receive PCR according to guidelines (define the numerator and denominator)	65%	80 %	90 %	95 %	100%	100%
Percentage of postnatal care facilities providing DNA PCR services	100%	100%	100%	100%	100%	100%
Target Groups	Infants born to HIV infected women Health Facilities					
Lead Agency	DOH					

Prevention Output Indicator and Targets for Objective 2 Intervention 4

Intervention	**Ensuring access to the full package of PMTCT**					
		Target				
Indicators	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Percentage of HIV positive pregnant women that have been counselled and tested and know their HIV status	98%	98%	98%	100%	100%	100%
Target Group	HIV positive pregnant women					
Lead Agency	DOH					
Main Stakeholders	Relevant Private Sector Organisations					

Prevention Outcome Indicator and Targets for Objective 3

Objective 3: To scale up of medical male circumcision services to 80% of males aged 0-49 by 2016			
Outcome Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of males aged 0-49 that are circumcised	1.3%	40%	80%

Prevention Output Indicators and Targets for Objective 3 Intervention 1

Intervention	**Community outreach and mobilization for MMC**					
		Target				
Indicators	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of males aged 15-49 reached with MMC multimedia campaign	Unknown					2,753,793
Target Group	Males aged 15-49					
Lead Agency	DOH					
Main Stakeholders	COGTA, DOH, Relevant Private Sector, CSO, DAC, LAC, WAC , Youth Ambassador/War Room					

Prevention Output Indicators and Targets for Objective 3 Intervention 2

Intervention	**Community outreach and mobilization for MMC and HCT**					
		Target				
Indicators	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of learners mobilised to support and participate in the behaviour change communication campaign including HCT and MMC	0	72,000	tbd	tbd	tbd	tbd
Number of males aged 15-49 reached with through multimedia campaign	unknown					
Target Group	Males aged 15-49					
Lead Agency	DOH, COGTA, DAC					
Main Stakeholders	DSR, DOE, OTP, Relevant Private Sector, CSO, DAC, LAC, WAC, Youth Ambassadors					

Prevention Output Indicator and Targets for Objective 3 Intervention 3

Intervention	**Advocacy for MMC by Leaders**					
		Target				
Indicators	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of leaders who advocate for MMC in public meeting	unknown	tbd	tbd	tbd	tbd	tbd
Number of leaders trained on the advocacy package	-	-	-	-	-	-
Target Group	All leaders					
Lead Agency	DOH, COGTA and DAC					
Main Stakeholders	OTP, CSO, All government departments, cultural institutions, political leaders, private sector					

Prevention Output Indicators and Targets for Objective 3 Intervention 4

Intervention	**Provide comprehensive MMC services**					
		Target				
Indicators	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of males aged 15-49 circumcised	65,000	110,152	440,607	881,214	1,321,820	2,203034
Number of neonates and infants male aged 0-3 months circumcised	90	180	360	440	520	620
Target Groups	Males aged 15-49 and Neonates and infants aged 0-3 months males					
Lead Agency	DOH					
Main Stakeholders	Private sector					

Prevention Outcome Indicator and Targets for Objective 4

Objective 4: To ensure that 80% of STI infected men and women receive early and appropriate treatment by 2016.			
Outcome Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of population 15 years and above and treated with STI	6.8% (2009)1	4.1%	1.4%

Prevention Output Indicator and Targets for Objective 4 Intervention 1

Intervention	**Community outreach and mobilization on STIs**					
		Target				
Indicators	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of men and women aged 15-49 reached with STIs community mobilisation package	Unknown	5,732,139	5,732,139	5,732,139	5,732,139	5,732,139
Target Group	Men and women aged 15-49					
Lead Agency	DOH					
Main Stakeholders	Privates sector, traditional health practitioners, OTP, all government departments or					

Prevention Output Indicators and Targets for Objective 4 Intervention 2

Intervention	**Providing access to the full package of STI services based guidelines**					
		Target				
Indicators	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of new STI episodes treated	440,714	396,642	352,572	308,500	264,429	220,357
Number of contacts of STI treated	96,957 (22% of those treated)	25%	30%	35%	40%	45%
Target Groups	STI Infected men and women and Contacts of STI infected men and women					
Lead Agency	DOH					
Main Stakeholders	Privates sector, traditional health practitioners, OTP, all government departments					

Prevention Outcome Indicators and Targets for Objective 5

Objective 5: To ensure that 80% of men and women age 15-49 know their HIV status and receive TB screening by 2016.			
Outcome Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of men and women aged 15-49 who received an HIV test in the last 12 months and who know their results	24.1% (2008)	60%	80%
Percentage of men and women aged 15-49 who have been screened for TB in the last 12 months	tbd	60%	80%

Prevention Output Indicators and Targets for Objective 5 Intervention 1

Intervention	**Community outreach and mobilization for HCT, STI and TB screening**					
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of educators mobilised to support and participate in BCC and HCT	5,000	19,400	Tbd	tbd	tbd	tbd
Number of men and women aged 15 years and older reached with HCT community mobilisation package	unknown	5,732,139	5,732,139	5,732,139	5,732,139	5,732,139
Target Group	Men and women aged 15 years and older					
Lead Agency	DOH, OTP					
Main Stakeholders	DAC, DSR, DOE, CSO, all government departments, war room teams, private sector organisations, OTP, private health practitioners, and all government departments					

Prevention Output Indicators and Targets and Objective 5 Intervention 2

Intervention	**Providing HCT, STI and TB screening services through annual campaigns**					
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid -term)**	**2015**	**2016 (end term)**
Number of HIV tests carried out annually	2,920,433	3,500,000	4,100,000	5,000,000	5,732,139	5,732,139
Number of men and women screened for TB annually	1,959,706					
Percentage of HCT clients 15-49 screened for TB	67%	80%	100%	100%	100%	100%
Target Group	Men and Women aged 15-49 HCT clients aged 15-49					
Lead Agency	DOH					
Main Stakeholders	CSO, all government departments, war room teams, private sector, traditional health practitioners, OTP and all government departments.					

Prevention Outcome Indicator and Targets for Objective 6

Objective 6: To ensure that 100% of men and women age 15-49 have access to condoms by 2016.			
Outcome Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of men and women aged 15-49 who report easy access to condom at last sex	66.2%	83%	95%

Prevention Output Indicator and Targets for Objective 6 Intervention 1

Intervention	**Providing HCT and TB screening services through annual campaigns**					
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Availability of assessment report and recommendations for efficient condom distribution mechanism	None	Assessment completed and new mechanism put in place	Implementation	Mechanism reviewed/updated	Implementation	Mechanism reviewed/updated
Target Group	Condom supply chain					
Lead Agency	DOH					
Main Stakeholders	OTP, CSO, all government departments, private sector.					

Prevention Output Indicators and Targets for Objective 6 Intervention 2

Intervention	**Implementing an efficient system for condom education and distribution in the province**					
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of female condoms distributed	383,404	700,000	980,000	1,120,000	1,260,000	1,400,000 (100%)
Percentage of female condoms distributed	27%	50%	70%	80%	88%	
Number of male condoms distributed	26,459,032	74,000,000	88,000,000	118,000,000	132,295,160	146,994,622 (100%)
Percentage of male condoms distributed	18%	50%	60%	80%	90%	146,994,622 (100%)
Target population	Men and women aged 15-49					
Lead Agency	DOH					
Main Stakeholders	OTP, CSO, all government departments, private sector.					

Prevention Outcome Indicator and Targets for Objective 7

Objective 7: To increase access to early detection, diagnosis and early treatment of TB to 80% of exposed people by 2016			
Outcome Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Cure rate of TB	67.2%	75%	85%

Prevention Output Indicator and Targets for Objective 7 Intervention 1

Intervention	**Community outreach and mobilization on TB**					
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of male and females aged 15 and above reached with TB community mobilization package	Unknown	7,157,532	7,157,532	7,157,532	7,157,532	7,157,532
Target Group	Males and females aged 15 and above					
Lead Agency	DOH					
Main Stakeholders	OTP, CSO, all government departments, war room teams, DAC, LAC, WAC					

Prevention Output Indicators and Targets for Objective 7 Intervention 2

Intervention	**Community outreach and mobilization on TB**					
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Percentage of newly diagnosed HIV positive patients started on INH prevention therapy (IPT)	77% (2011)	80%	90%	100%	100%	100%
Percentage of TBHIV +ve patients receiving IPT	76%	80 %	90 %	100 %	100%	100%
Percentage of TBHIV +ve patients receiving ART	70%	85%	90%	100%	100%	100%
Percentage of TB patients tested for HIV	*85%*	*100%*	*100%*	*100%*	*100%*	*100%*
Target Group	PLHIV TB patients					
Lead Agency	DOH					
Main Stakeholders	OTP, CSO, all government departments, war room teams, DAC, LAC, WAC					

Prevention Outcome Indicator and Targets for Objective 8

Objective 8: To maintain zero transmission of HIV through blood and blood products.			
Outcome Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage transmission of HIV through transfusion of blood and blood products	0%	0%	0%

Prevention Output Indicator and Targets for Objective 8 Intervention 1

Intervention	**Monitoring blood and blood transfusion standards**					
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Percentage of units screened for HIV in a quality assured manner	100%	100%	100%	100%	100%	100%
Target Group	Blood and Blood Products					
Lead Agency	DOH					
Main Stakeholders	Private Sector					

Prevention Outcome Indicators and Targets for Objective 9

Objective 9: To reduce the risk of HIV transmission from occupational exposure, sexual violence and discordance to less than by using ARV to less than 1% by 2016			
Outcome Indicators	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Number of individuals with new HIV infections due to occupational exposure	51	Zero	Zero
Number of individuals with HIV due to non-occupational risk exposure.	tbd	tbd	<1%

Prevention Output Indicators and Targets for Objective 9 Intervention 1

Intervention	**Providing services that prevent transmission due to occupation, sexual violence and discordance**					
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of accidentally exposed HW who receive PEP	51	42	37	25	12	0
Number of non-occupational exposure survivors who receive PEP (NOPEP)	5071	tbd	tbd	tbd	tbd	tbd
Target Groups	Health workers; Discordant couples, sexual violence survivors and where status undisclosed					
Lead Agency	DOH					
Main Stakeholders	Private Sector					

Strategic Objective 2: Prevention of HIV, AIDS, STIs and TB Infections

Sustaining Health and Wellness Impact Indicators and Targets

Goal 1: To reduce mortality, sustain wellness and improve quality of life of at least 80% of those infected and affected by 2016.			
Impact Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Cause specific mortality rate (TB related)	tbd	tbd	80% reduction
Quality of life for HIV and TB infected people and their families	tbd	tbd	80%

Sustaining Health and Wellness Outcome Indicators and Targets for Objective 1

Objective 1: To ensure that at least 90% of HIV infected people have access to treatment and support, remain adherent to treatment and maintain optimum health.			
Outcome Indicators	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of eligible HIV positive adults receiving antiretroviral therapy	tbd	tbd	100%
Percentage of eligible HIV positive children receiving antiretroviral therapy	tbd	tbd	100%
Percentage of adults with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	tbd	tbd	90%
Percentage of children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	tbd	tbd	90%

Sustaining Health and Wellness Output Indicators and Targets for Objective 1 Intervention 1

Intervention: Providing access to comprehensive ART services						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of eligible children receiving ART	45,598	56,720	78,544	85,539	94,678	94,687
Number of eligible adults receiving ART	414,324	620,674	706,893	864,892	1,013,750	1,013,750
Proportion of newly HIV/TB diagnosed patients started on cotrimoxazole prophylaxis	77%	85%	95%	100%	100%	100%
Target Groups	All eligible HIV infected children and adults Discordant couples, sexual violence survivors and where status undisclosed					
Lead Agency	DOH					
Main Stakeholders	Private Sector, CSO					

Sustaining Health and Wellness Output Indicators and Targets for Objective 3 Intervention 1

Intervention: Providing access to comprehensive ART services						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of eligible children receiving ART	45,598	56,720	78,544	85,539	94,678	94,687
Number of eligible adults receiving ART	414,324	620,674	706,893	864,892	1,013,750	1,013,750
Proportion of newly HIV/TB diagnosed patients started on cotrimoxazole prophylaxis	77%	85%	95%	100%	100%	100%
Target Groups	All eligible HIV infected children and adults Discordant couples, sexual violence survivors and where status undisclosed					
Lead Agency	DOH					
Main Stakeholders	Private Sector, CSO					

Sustaining Health and Wellness Output Indicator and Targets for Objective 1 Intervention 2

Intervention: Community mobilization and ART adherence monitoring						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of ART patients de-registered due to loss of follow-up	2,900	2,175	1,450	725	363	0
Target Group	People started on ART					
Lead Agency	DOH					
Main Stakeholders	CSO, war room teams, private sector, all government departments					

Sustaining Health and Wellness Outcome Indicators and Targets for Objective 2

Objective 2: To ensure that 90% of people infected with TB have access to services that are responsive to their needs and are of high quality.			
Outcome Indicators	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Annual cure rate for TB	*67.2%*	*75%*	*85%*
Annual smear positive defaulter rate	*7.1%*	*4.6%*	*3%*
Percentage of TB patients with MDR	*2.8%*	*2.1%*	*1.4%*
Percentage of TB patients with XDR	*10%*	*7.5%*	*5%*

Sustaining Health and Wellness Output Indicator and Targets for Objective 2 Intervention 1

Intervention: Advocate for greater integration of HIV and TB services						
		Target				
Indicator	**2011 (Baseline)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of stakeholders reached with advocacy on integration of TB/HIV services	tbd	tbd	tbd	tbd	tbd	tbd
Target Groups	Policy makers, managers and implementers					
Lead Agency	DOH					
Main Stakeholders	OTP, Private sector					

Sustaining Health and Wellness Output Indicators and Targets for Objective 2 Intervention 2

Intervention: Ensure Adherence to DOTs Strategy guidelines and expand access to TB/HIV Services						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of TB patients receiving DOTs	80%	85%	90%	100%	100%	100%
Proportion of TB/HIV co-infected referred for ART	41%	50%	60%	70%	80%	90%
Proportion of TB/HIV co-infected initiated on ART						
Target Groups	TB patients TB/HIV co-infected patients					
Lead Agency	DOH					
Main Stakeholders	OTP, Private sector					

Sustaining Health and Wellness Output Indicator and Target for Objective 2 Intervention 3

Intervention: Strengthen social mobilisation on TB/HIV co-infection						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of TB patients with DOT supporters	*80%*	*85%*	*90%*	*100%*	*100%*	*100%*
Target Group	Public					
Lead Agency	DOH					
Main Stakeholders	OTP, CSOs, private sector, war room teams					

Sustaining Health and Wellness Output Indicators and Targets for Objective 2 Intervention 4

Intervention: Strengthening follow up of patients and expanding community management of MDR TB						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of TB patients lost to follow up	7.1%	6%	5%	4%	3.5%	3%
Number of MDR patients who received appropriate treatment	tbd	tbd	tbd	tbd	tbd	tbd
Number of XDR patients who received appropriate treatment	tbd	tbd	tbd	tbd	tbd	tbd
Target Groups	Patient on TB treatment TB patients with MDR/XDR					
Lead Agency	DOH					
Main Stakeholders	CSOs, private sector, war room teams					

Sustaining Health and Wellness Outcome Indicator and Targets for Objective 3

Objective 3: To ensure that 80% of infected and affected people and households have access to support in order to reduce disability and improve quality of life.			
Outcome Indicators	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of patients in need of supportive and palliative care reporting having received a comprehensive package of care in the past 12 months	tbd	tbd	80%

Sustaining Health and Wellness Output Indicators and Targets for Objective 3 Intervention 1

Intervention: Provision of community based support for people infected and affected by HIV						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of beneficiaries receiving HCBC services	tbd	tbd	tbd	tbd	tbd	tbd
Number of households provided with food security	tbd	tbd	tbd	tbd	tbd	tbd
Target Groups	PLWHIV , Older persons, CCG, CHH,OVC, Senior Citizen, adolescents on ART, Mothers on PMTCT, TB patients Eligible households					
Lead Agency	DSD					
Main Stakeholders	DOH, DOE, CSO					

Sustaining Health and Wellness Output Indicators and Targets for Objective 3 Intervention 2

Intervention: Provision of a comprehensive package of palliative care to eligible children and adult						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of eligible adults receiving palliative care services	tbd	tbd	tbd	tbd	tbd	tbd
Number of eligible children receiving palliative care services	tbd	tbd	tbd	tbd	tbd	tbd
Target Groups	Eligible adults with life limiting conditions Eligible children with life limiting conditions					
Lead Agency	DSD, DOH					
Main Stakeholders	CSO					

Sustaining Health and Wellness Output Indicator and Targets for Objective 3 Intervention 3

Intervention: Provision of psycho-social support including, disclosure, bereavement and adherence counselling to those infected and affected						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of people in need of psychosocial support who received support and counselling	tbd	tbd	tbd	tbd	tbd	tbd
Target Groups	Infected and affected people in need of psychosocial support					
Lead	DSD					
Main Stakeholders	CSO					

Sustaining Health and Wellness Output Indicators and Targets for Objective 3 Intervention 4

Intervention: Development and implementation of appropriate care and support programmes for people with disability						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number persons with disabilities accessing services in funded protective workshops	4,500	5,000	5,500	5,500	6,000	6,000
Number people with disability who received support	10,000	# TBD (90%)	# tbd (90%)	# tbd (90%)	# tbd (90%)	# tbd (90%)
Target Groups	People with disability					
Lead Agency	DSD					
Main Stakeholders	DOH/CSO					

Sustaining Health and Wellness Outcome Indicators and Targets for Objective 4

Objective 4: To increase access to quality care and support to at least 90% of orphans and vulnerable children (OVC) by 2016.			
Outcome Indicators	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of orphans and vulnerable children aged 0-17 whose households have received at least one support in caring for the child	tbd	tbd	90%
Number of child care forums in existence at ward level	tbd	tbd	tbd
Percentage of child headed households placed in the supervision of an adult and receiving care and support services	tbd	tbd	90%
Current school attendance among orphans and non-orphans aged 10-14	tbd	tbd	100%

Sustaining Health and Wellness Output Indicators and Targets for Objective 4 Intervention

Intervention: Identifying, tracking and linking OVCs and CHH to social grants benefits and social services at local level						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
System for identifying and tracking OVC and CHH in place		Annual register in place	Annual register update	Annual register update	Annual register update	Annual register update
Number of OVCs provided with subsidies per district	tbd	tbd	tbd	tbd	tbd	tbd
Number of CHHs provided with subsidies per district	tbd	tbd	tbd	tbd	tbd	tbd
Number of OVC receiving social services at local level	40 000	50 000	60 000	70 000	80 000	90 000
Number of CHH receiving social services at local level	tbd	tbd	tbd	tbd	tbd	tbd
Number of OVC placed in alternative placement						
Number of orphans and other children made vulnerable by HIV and AIDS receiving services		98140	102854	109751		
Target Group	OVCs					
Lead Agency	DSD					
Main Stakeholders	DHS, SASSA, DHA, DOE, DOH, CSO, COGTA, Traditional Leaders					

Sustaining Health and Wellness Output Indicators and Targets for Objective 4 Intervention 2

Intervention: Identifying and building capacity of civil society organisation						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Availability of OVC CSOs register		All OVC CSO registered	Annual register update	Annual register update	Annual register update	Annual register update
Number of CSOs capacitated	tbd	tbd 20%	tbd 40%	tbd 60%	tbd 80%	tbd 100%
Target Groups	OVCs					
Lead	DSD					
Main Stakeholders	DOH, CSO, COGTA, Municipalities, Traditional Leaders					

Sustaining Health and Wellness Output Indicators and Targets for Objective 4 Intervention 3

Intervention: Provision of support for children in need in schools and early childhood development centres.						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of senior management team (SMT) members trained to develop school implementation plans focusing on keeping young people in school.	6,300	8,460	tbd	tbd	tbd	tbd
Number of educators trained to minimise barriers to retention and achievement in school for learners who are HIV affected or infected through establishment of School-Based Support Teams (SBST)	2,830	3,250	tbd	tbd	tbd	tbd
Number of learners in previously disadvantaged schools identified and provided with relevant support to minimise barriers to retention and achievement in schools	40,200	90,200	tbd	tbd	tbd	tbd
Number of children in Early Childhood Development (ECD) facilities	tbd	tbd	tbd	tbd	tbd	tbd
Target Group	Children in need who are in educational institutions					
Lead Agencies	DOE, DSD					
Main Stakeholders	DOH, CSO, COGTA, Traditional Leaders					

Strategic Objective 4: Protection of Human Rights and Improving Access to Justice

Protection of Human Rights Impact Indicators and Targets

Goal 1: To reduce vulnerability to HIV, STIs and TB by creating a supportive policy, human rights and regulatory environment and; promoting desirable social norms in the province by 2016.			
Impact Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of people who report adequate human rights protection and access to justice (survey)	tbd	tbd	80%

Protection of Human Rights Outcome Indicator and Targets for Objective 1

Objective 1: To strengthen all levels of society to publicly promote the core values of the South African Constitution and speak out against stigma, discrimination and related behaviours to create a more equal society.			
Outcome Indicators	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of people who report that leadership is visible, decisive and effective in promoting human rights within the province.	tbd	tbd	90%

Protection of Human Rights Output Indicator and Targets for Objective 1 Intervention 1

Intervention: Develop a package for advocacy by leaders on promoting human rights, positive societal values and norms						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Advocacy package	Package developed	Implementation	Package reviewed/ updated	Implementation	Implementation	Package reviewed/ updated
Lead Agency	OTP					
Main Stakeholders	COGTA, CSO, Community Liaison and Safety					

Protection of Human Rights Output Indicator Targets for Objective 1 Intervention 2

Intervention: Building capacity of leaders on promoting human rights, positive values and socio-cultural norms						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of leaders capacitated on promotion of human rights, positive values and socio-cultural norms	Zero	50%	60%	70%	80%	90%
Target Group	Leaders at all levels					
Lead Agency	OTP					
Main Stakeholders	DAC, COGTA, CSO, Community Liaison and Safety					

Protection of Human Rights Output Indicator and Targets for Objective 1 Intervention 3

Intervention: Leaders at all levels of society to publicly promote the core values of the South African Constitution						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Percentage of population reached with messages on the core values of the South African Constitution from various leaders	Zero	20%	50%	60%	80%	80%
Target Group	The Public of KZN					
Lead Agency	OTP					
Main Stakeholders	COGTA, CSO, Community Liaison and Safety					

Protection of Human Rights Outcome Indicator and Targets for Objective 2

Objective 2: To ensure that all existing legislation and policy relating to human and access to justice are adhered to by 2016.			
Outcome Indicators	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage adherence to legislation and policies relating to human and legal rights	tbd	50%	100%

Protection of Human Rights Output Indicators and Targets for Objective 2 Intervention 1

Intervention: Monitor the implementation of policy guidelines and legislation relating to human rights						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of sectors monitored for compliance with policy guidelines and legislation relating to human rights	Zero	Preparation : Development of a monitoring tool.	20% of sectors	50% of sectors	60% of sectors	80% of sectors
Target Groups	Sectors					
Lead Agency	OTP					
Main Stakeholders	COGTA, CSO, Community Liaison and Safety; Chapter 9 Institutions					

Protection of Human Rights Outcome Indicators and Targets for Objective 3

Objective 3: Capacity building on all relevant policy framework and legislation relating to HIV and AIDS			
Outcome Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of people aware of policy framework and legislation relating to HAST and human rights	tbd	tbd	100%

Protection of Human Rights Output Indicator and Targets for Objective 3 Intervention 1

Intervention: Orientation of all relevant stakeholders on policy framework and legislation relating to HIV, AIDS, TB, STI and gender and human rights dimensions						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of stakeholders orientated	tbd	(# tbd) 30%	(# tbd) 50%	(# tbd) 60%	(# tbd) 70%	(# tbd) 90%
Target Groups	Stakeholders					
Lead Agency	OTP					
Main Stakeholders	COGTA, CSO					

Protection of Human Rights Output Indicators and Targets for Objective 3 Intervention 2

Intervention: Public awareness campaigns on Human and Legal Rights issues related to HIV, AIDS, TB, STI and gender and human rights dimensions						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of awareness campaigns conducted per district	Zero	1	3	3	4	5
Number of public reached with awareness campaign.	Zero	tbd	tbd	tbd	tbd	tbd
Target Group	The public					
Lead Agency	DAC					
Main Stakeholders	COGTA, OTP, CSO					

Protection of Human Rights Outcome Indicators and Targets for Objective 4

Objective 4: To promote and support the greater involvement of people living with HIV, LGBTI and people with disabilities in the provincial HAST responses by 2016.			
Outcome Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of organisations of PLHIV, LGBTI and people with disabilities reporting involvement in the HAST response	tbd	80%	100%

Protection of Human Rights Output Indicator and Targets for Objective 4 Intervention 1

Intervention: Involvement of PLHIV, LGBTI and people with disabilities in all coordination structures						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of coordination structures with PLHIV, LGBTI and people with disabilities	tbd	tbd	tbd	tbd	tbd	tbd
Target Groups	PLHIV , LGBTI, People with disabilities					
Lead	OTP					
Main Stakeholders	Relevant CSO					

Protection of Human Rights Output Indicators and Targets for Objective 4 Intervention 2

Intervention: Empowerment of PLHIV, LGBTI and people with disabilities to recognize to deal with Human Rights violations						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of PLHIV, LGBTI and people with disabilities	tbd	tbd	tbd	tbd	tbd	tbd
Number of PLHIV, LGBTI and people with disabilities empowered	tbd	tbd	tbd	tbd	tbd	tbd
Target Group	PLHIV , LGBTI, People with disabilities					
Lead Agency	OTP					
Main Stakeholders	Relevant CSO					

Intervention: Promoting Access to Justice						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Proportion of cases of gender-based violence that resulted in conviction						
Number of reported cases of rights violations reported to the police	tbd	tbd	tbd	tbd	tbd	tbd
Target Group	PLHIV LGBTI The public					
Lead Agency	SAPS,					
Main Stakeholders	OTP, DCSL, Relevant CSO					

Strategic Objective 5: Coordination and Monitoring and Evaluation

Coordination, Monitoring and Evaluation Impact Indicators

Goal 1: To have a well-coordinated provincial response to HIV and AIDS, STI and TB that is informed by an effective M and E system by 2016.			
Impact Indicator	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Number of KZNPSP 2012 – 2016 impact targets fully achieved	tbd	tbd	90%
Number of KZNPSP 2012 – 2016 outcome targets fully achieved	tbd	tbd	90%

Coordination, Monitoring and Evaluation Outcome Indicators and Targets for Objective 1

Objective 1: To ensure that the provincial response is effectively coordinated and managed by 2016.			
Outcome Indicators	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of sectors reporting satisfaction with HAST coordination and management in KZN	tbd	tbd	90%
PCA fully functional *(monitors the implementation of KZNPSP 2012-2016 operational plan through quarterly reporting and PCA meetings in which at least 70% of designated members attend; mobilises and monitor usage of resources according to the plan)*	tbd	tbd	100%

Coordination, Monitoring and Evaluation Output Indicator and Target for Objective 1 Intervention 1

Intervention: Strengthening the capacity of CD HIV and AIDS in OTP						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of skilled staff placed at the CD HIV and AIDS in OTP	*3*	*6*	*6*	*6*	*6*	*6*
Target	CD HIV and AIDS in OTP					
Lead Agency	OTP HR					
Main Stakeholders	Development Partners					

Coordination, Monitoring and Evaluation Output Indicators and Targets for Objective 1 Intervention 2

Intervention: Establishing an effective communication framework with feedback mechanisms at all levels						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of feedback reports provided to sectors	tbd	quarterly (4)	quarterly (4)	quarterly (4)	quarterly (4)	quarterly (4)
Target Group	People started on ART					
Lead Agency	CD HIV and AIDS in the OTP					
Main Stakeholders	All sectors					

Coordination, Monitoring and Evaluation Output Indicators and Targets for Objective 1 Intervention 3

Intervention: Strengthening the capacity of DACs, LACs and WACs						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of fully functional DACs		11	11	11	11	11
Number of fully functional LACs		42	45	48	48	48
Number of fully functional WACs	80	350	500	700	750	800
Target Groups	DACs, LACs, DACs					
Lead Agency	CD HIV and AIDS in the OTP/COGTA					
Main Stakeholders	All sectors					

Coordination, Monitoring and Evaluation Outcome Indicators and Targets for Objective 2

Objective 2: To strengthen monitoring and evaluation system of the multi-sectoral response and ensure that at least 90% of sectors consistently reporting to the coordination structures by 2016.			
Outcome Indicators	**Baseline (2011)**	**Mid-term Target (2013)**	**End-term Target (2016)**
Percentage of sectors providing quarterly reports	tbd	45%	90%
Percentage of annual output targets of the KZNPSP2012-2016 measured	tbd	tbd	90%
Percentage of outcome indicators with data readily available	tbd	80%	80%
Percentage of impact indicators with data readily available	tbd	-	80%

Coordination, Monitoring and Evaluation Output Indicator and Target for Objective 2 Intervention 1

Intervention: Establish all the baseline data for KZNPSPS 2012-2016 outcome and output indicators						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
% of indicators with baseline data	tbd	70%	80%	90%	95%	95%
Target Groups	Policy makers, managers and implementers					
Lead Agency	CD HIV and AIDS in OTP					
Main Stakeholders	All sectors					

Coordination, Monitoring and Evaluation Output Indicators and Target for Objective 2 Intervention 2

Intervention: Building capacity of Multi-sectoral coordination structures in planning, M and E and coordination						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
% of DACs with a functional M and E units	tbd	tbd	tbd	90%	90%	90%
% of LACs with a functional M and E units	tbd	tbd	tbd	70%	75%	80%
% of WACs collecting data and reporting to M and E units	tbd	tbd	tbd	tbd	tbd	tbd
Target Groups	DACs, LACS and WACs					
Lead	OTP/COGTA					
Main Stakeholders	DACS, LACS and WACS					

Coordination, Monitoring and Evaluation Output Indicators and Targets for Objective 2 Intervention 3

Intervention: Monitoring and evaluating the KZNPSP 201-2016 implementation						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of sectors providing quarterly report	tbd	tbd	tbd	tbd	tbd	tbd
Number of annual reviews conducted	Zero	1		1	1	
Mid-term review conducted	-	-	1	-	-	-
End-term review conducted	-	-	-	-	-	1
Target Groups	Public					
Lead Agency	CD HIV and AIDS in OTP					
Main Stakeholders	All sectors					

Coordination, Monitoring and Evaluation Output Indicators and Targets for Objective 3 Intervention 1

Intervention: Establish an effective research coordination structure						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Research coordination structure established		Existence of coordination structure	-	Review of structure	Existence of reviewed structure	End term review of existing structure
Research agenda developed		1	-	-	-	-
Research data base developed	-	-	1	-	-	1
Target Groups	Research coordination structure					
Lead Agency	CD HIV and AIDS in OTP					
Main Stakeholders	All sectors					

Intervention: Develop Capacity of Researchers						
		Target				
Indicator	**Baseline (2011)**	**2012**	**2013**	**2014 (mid-term)**	**2015**	**2016 (end term)**
Number of research entities on database	tbd	tbd	tbd	tbd	tbd	tbd
Number of staff trained on research	tbd	tbd	tbd	tbd	tbd	tbd
Target Groups						
Lead Agency	CD HIV and AIDS in OTP					
Main Stakeholders	All sectors, development partners					

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