Focus for Impact

Community profile
Catchment area for Khanyiselani Health Post (Ward 6)

Greater Kokstad local municipality
Harry Gwala District
KwaZulu-Natal

July 2017

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Abbreviations

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

Acknowledgement

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

Focus for Impact – understanding the background

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

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

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

(a) ***Where*** in a particular district ***are the areas with the highest HIV and/or TB burden***?

(b) ***Why*** does a ***specific area*** have a higher HIV and/or TB burden (i.e. what are the contributing/associated factors)?

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

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

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

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

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

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

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

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

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

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

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

Introduction to Profile

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

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

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

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

For this profile, the catchment area for Khanyiselani Health Post, Greater Kokstad local municipality is defined as Greater Kokstad Ward 6. For this specific profile, two stakeholder and community workshops were held on 11 and 12 July 2017 in Nkululeko Thuntulwane Community Hall, Kokstad. The workshops were attended by 160 stakeholders and community members during these two days. As more local level profiles are completed within the local municipality, a richer picture of the context within Greater Kokstad local municipality will evolve. The same applies to more granular data that becomes available for this specific catchment area. This profile will be updated accordingly and should therefore be considered a living document.

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

- Key and vulnerable populations:
    - Young women and girls;
    - Sex workers;
    - Orphans and vulnerable children;
- Interventions that address:
    - Sexual abuse and gender based violence – especially non-reporting of cases;
    - Stigma and discrimination – self and perceptions of facility;
    - HIV prevention after circumcision;
    - Sufficient coverage of outreach and mobile services
    - HIV knowledge among children;
    - High rate of substance abuse and drugs that triggers high risk behaviour; and
    - Shortage in female condom supply and education on correct use of female condoms.

1. Socio-demographic profile

1.1 Demarcated boundaries

Harry Gwala District is one of the 11 district municipalities of KwaZulu-Natal province. The Greater Kokstad local municipality is one of the five local municipalities in Harry Gwala district. The rest are Ingwe, Kwa Sani, Ubuhlebezwe, and uMzimkhulu local municipalities.

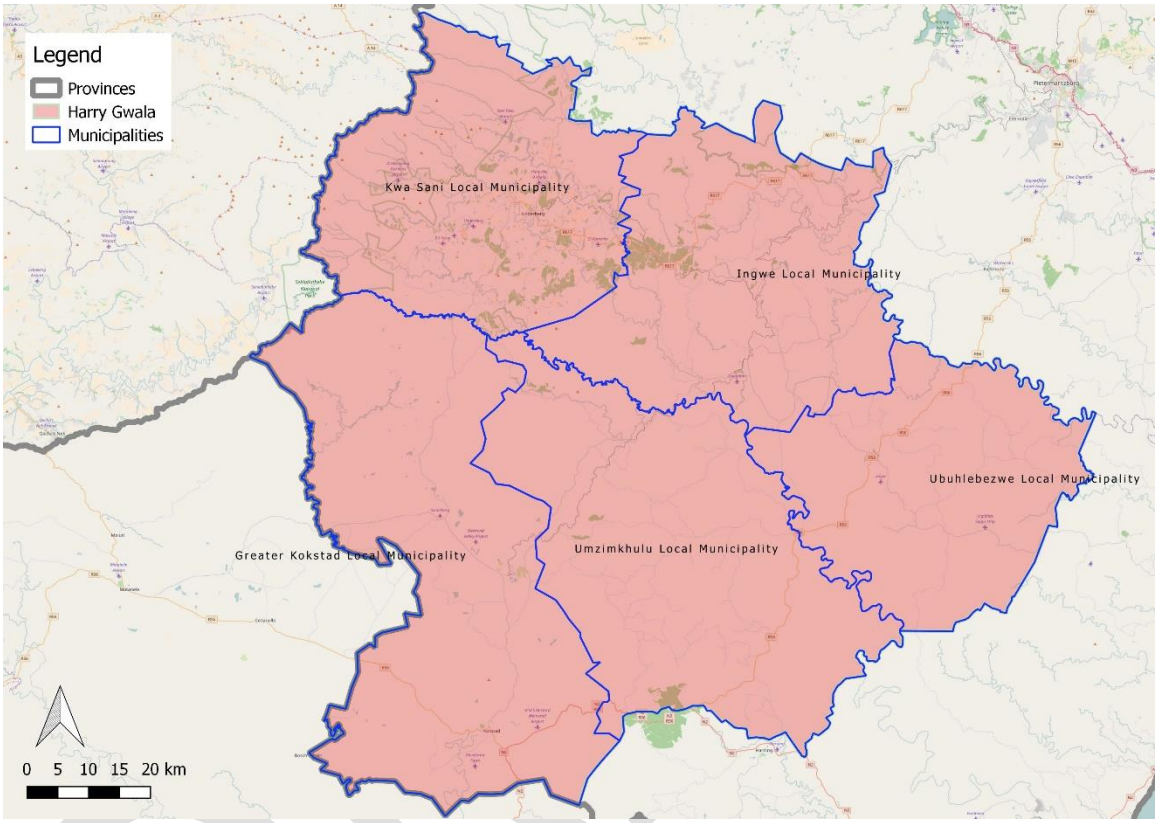

Figure 1: Local municipalities' Harry Gwala district

The Greater Kokstad local municipality constitute of 8 administrative wards (see Figure 2).

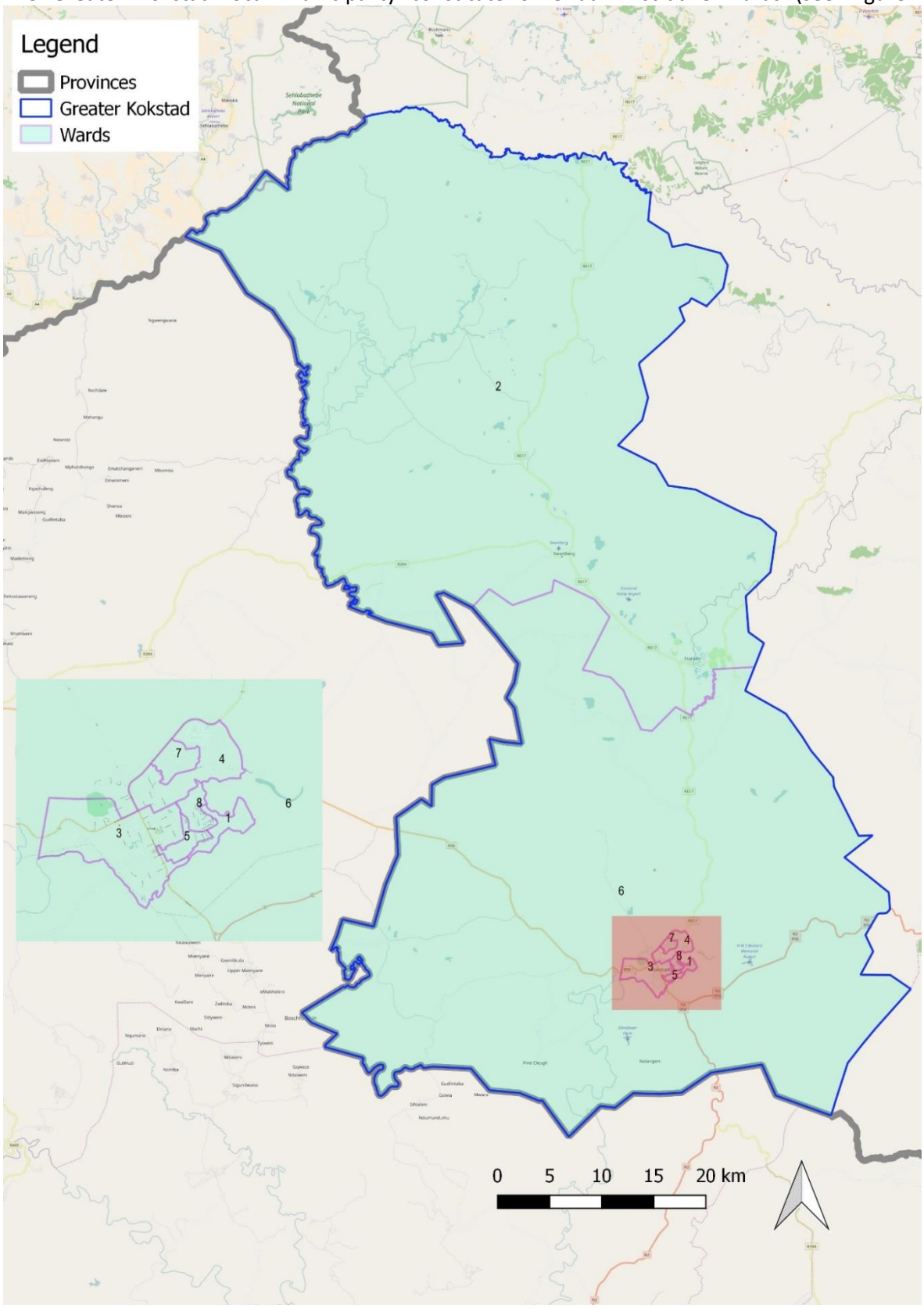

Figure 2: Distribution of Wards in the Greater Kokstad local municipality

1.2 Population by sex and age

During the 2011 Census 65 955 people were counted in 8 wards. Table 1 summarises the age and sex per population in these wards. Females constitute 51% of population, compared to 49% males. The young people ≤ 25 years (52%) make up the majority of population in the local municipality. The detail for Ward 6 that forms the catchment area for Khanyiselani Health Post, is highlighted in the table below.

Table 1: Population per age groups per ward, Greater Kokstad local municipality

Ward	Age							Sex		
	0-9	10-14	15-19	20-24	25-49	50+	Total	Female	Male	Total
Ward 001	2658	1062	1176	1425	4266	858	**11445**	5904	5541	**11445**
Ward 002	1614	855	804	774	2346	924	**7317**	3642	3675	**7317**
Ward 003	1077	555	564	642	3060	870	**6768**	3225	3543	**6768**
Ward 004	2601	1104	1314	1290	4359	948	**11616**	6078	5538	**11616**
Ward 005	576	270	318	441	1398	420	**3423**	1782	1641	**3423**
Ward 006	2049	945	825	1014	3483	1308	**9624**	4842	4782	**9624**
Ward 007	1533	762	774	828	2442	594	**6933**	3687	3246	**6933**
Ward 008	1698	810	918	1059	3339	1005	**8829**	4779	4050	**8829**
Total	**13806**	**6363**	**6693**	**7473**	**24693**	**6927**	**65955**	**33939**	**32016**	**65955**
%	**21%**	**10%**	**10%**	**11%**	**37%**	**11%**		**51%**	**49%**	

Table 2 reflects the sex and age breakdown of the youth between 10 and 35 years for the same geographic area in five year bands:

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

Ward	Female					Male					
	10-14	15-19	20-24	25-29	30-34	10-14	15-19	20-24	25-29	30-34	
Ward 001	534	627	756	726	510	528	549	669	729	555	6183
Ward 002	417	396	363	306	216	438	408	411	372	267	3594
Ward 003	288	291	327	303	315	267	273	315	411	468	3258
Ward 004	558	681	684	651	510	546	633	606	609	510	5988
Ward 005	132	174	246	207	156	138	144	195	237	150	1779
Ward 006	471	405	465	453	366	474	420	549	438	291	4332
Ward 007	375	408	432	339	306	387	366	396	381	294	3684
Ward 008	450	501	561	576	423	360	417	498	528	420	4734
	3225	3483	3834	3561	2802	3138	3210	3639	3705	2955	33552

Figure 3 below reflects the population pyramid for Greater Kokstad local municipality. This figure visualises sex (male and female) and age in five-year age bands for this population. It is noted that the biggest group is in the age group 25-29, followed closely by the age group 20-24 year old.

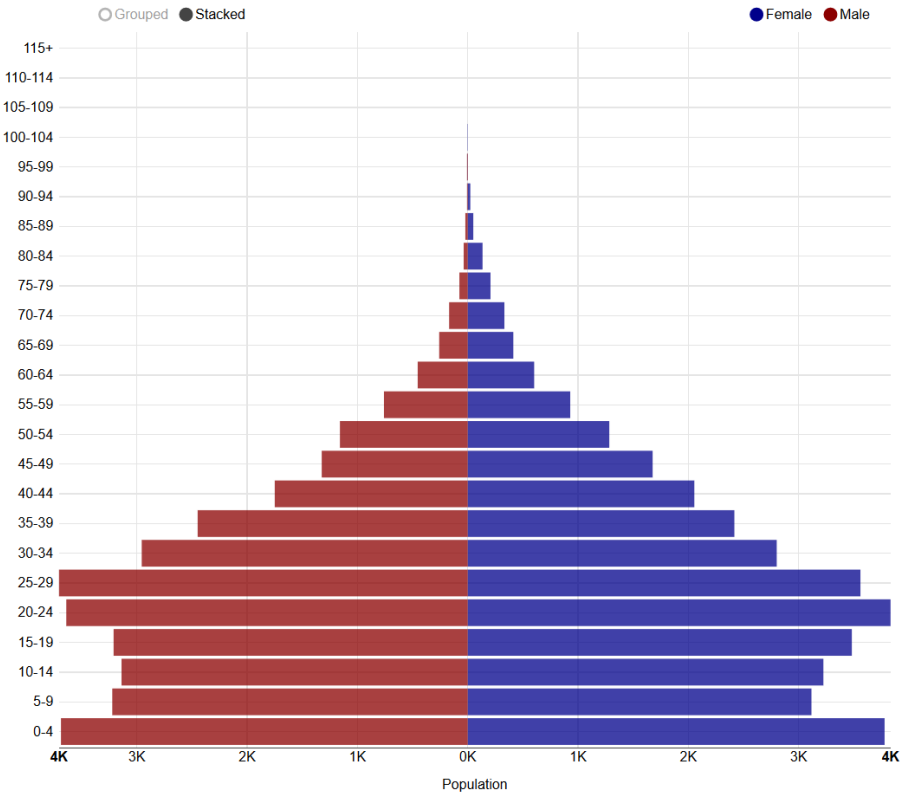

Figure 3: Population Pyramid Greater Kokstad local municipality

From this population, 30.6% children and 2.7% elderly are dependent on the 66.7% economically active population of the Greater Kokstad local municipality (Figure 4).

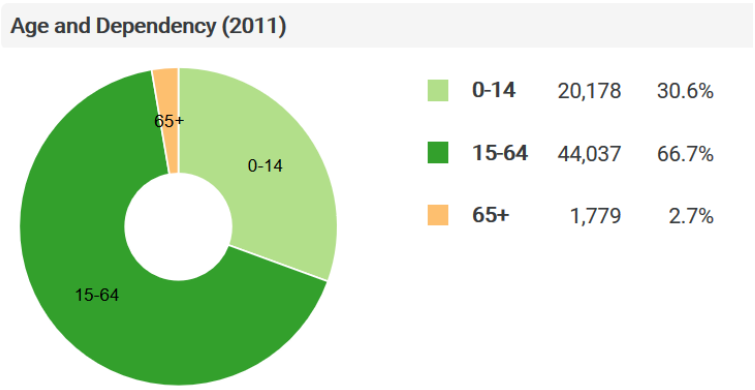

Figure 4: Dependency ratio Greater Kokstad local municipality (Source Census 2011)

In the catchment area for the Khanyiselani Health Post (Greater Kokstad Ward 6) there is a significant change in the population profile (Figure 5) with a larger 20-24 age group and different male to female distribution to that seen in the Greater Kokstad local municipality population pyramid in Figure 3.

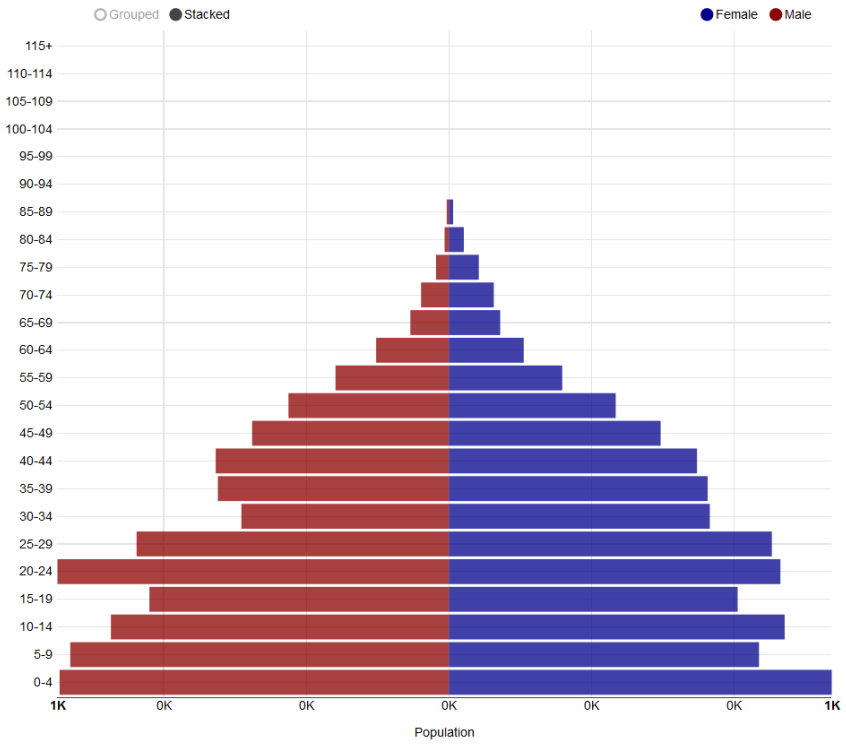

Figure 5: Population Pyramid Khanyiselani Health Post catchment area (Source Census 2011)

In the same catchment population, 31.1% children and 3.5% elderly are dependent on the 65.4% economically active population (Figure 6).

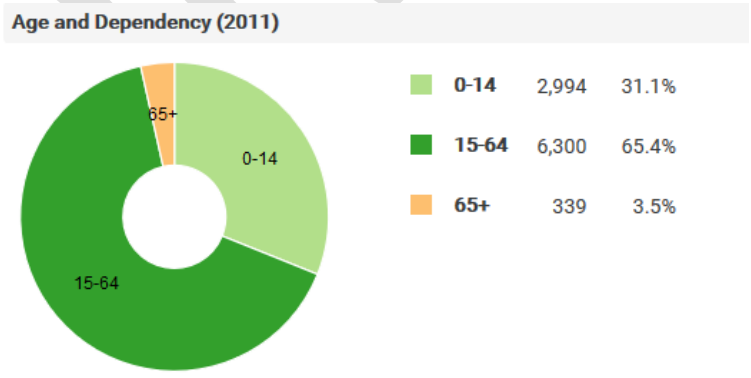

Figure 6: Dependency ratio Khanyiselani Health Post catchment area (Source Census 2011)

1.3 Population by race

The dominant population group in Greater Kokstad local municipality is Black African at 87.2% followed by coloured population at 8.2% (detail in Figure 7 and Table 2).

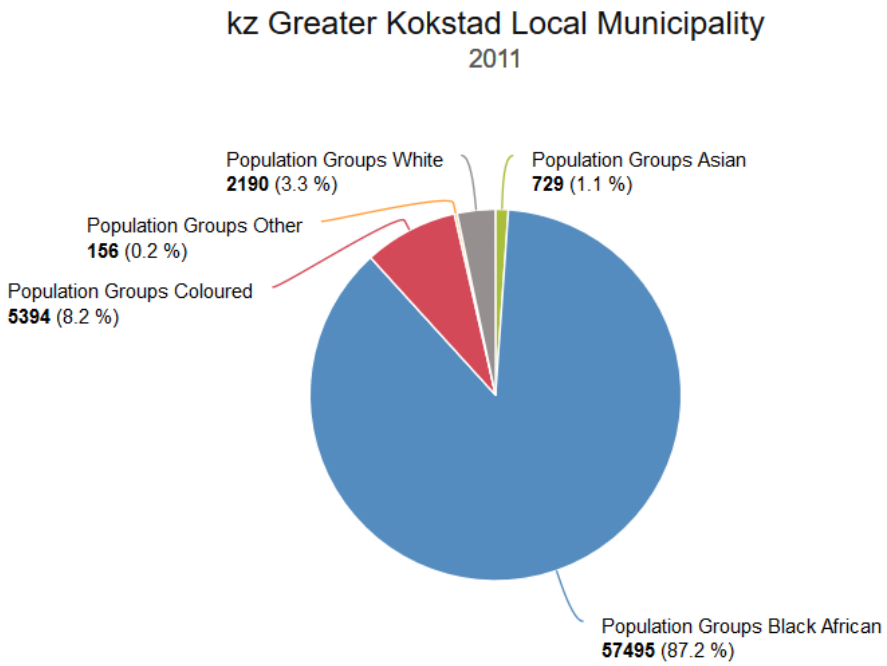

Figure 7: Population group distribution in Greater Kokstad local municipality (Source Census 2011)

The detail for Ward 6 that forms the catchment area for Khanyiselani Health Post, are highlighted in the table below.

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

Ward	Asian	Black African	Coloured	Other	White	Total
Ward 001	6	11355	57	15	3	**11436**
Ward 002	9	6354	642	3	318	**7326**
Ward 003	432	3816	1872	75	579	**6774**
Ward 004	132	9984	1323	18	153	**11610**
Ward 005	21	2718	648	18	33	**3438**
Ward 006	120	7974	420	15	1098	**9627**
Ward 007	6	6507	414	9		**6936**
Ward 008	3	8787	18	3	6	**8817**
Total	**729**	**57495**	**5394**	**156**	**2190**	**65964**

2. Epidemiological profile

2.1 Causes of death

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

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

Cause	Number of deaths	Percent deaths

2.2 HIV

The figures that follow below reflects the HIV positivity rate based on the routine health data collected, collated and reported in health facilities under the Harry Gwala district. The definitions for these indicators can be found in Appendix B: Terms, Definitions and calculations.

Due to the small numbers at a local level, it is not included at ward level in this report. See note on small number in Appendix A: Selecting Data for the Profile.

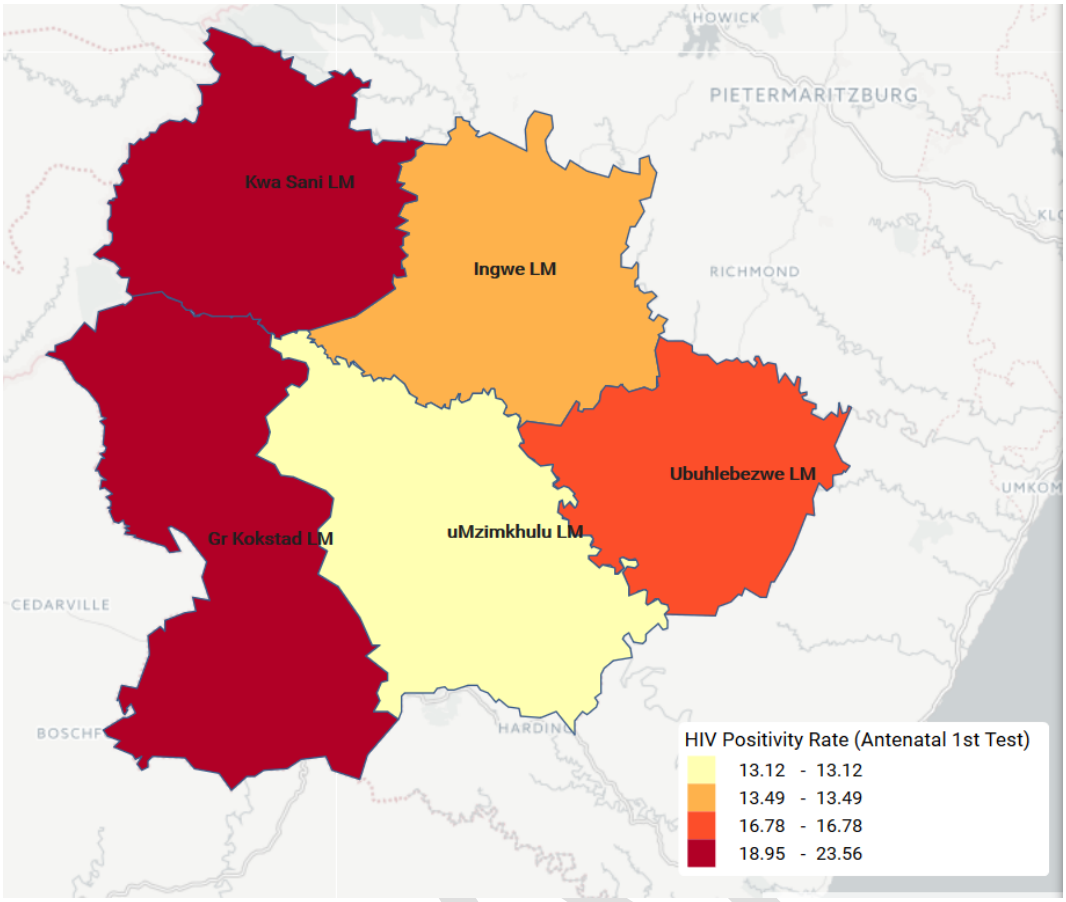

Figure 8: ANC client HIV 1st test positive rate Harry Gwala district (Source: KZN DHIS 2015)

Table 5: HIV Positivity Rate Harry Gwala district (Antenatal 1st Test) (Source: KZN DHIS 2015 report 5 July 2017)

KZ HARRY GWALA DISTRICT MUNICIPALITY: **15.5 %**								
	local municipality	**2015 : HIV Positivity Rate (Antenatal 1st Test)**					**NUM %**	**DEN %**
1	kz uMzimkhulu local municipality	13.12	%	(464	/	3537)	35.23 %	41.62 %
2	kz Ingwe local municipality	13.49	%	(152	/	1127)	11.54 %	13.26 %
3	KS Ubuhlebezwe local municipality	16.78	%	(317	/	1889)	24.07 %	22.23 %
4	kz Greater Kokstad local municipality	18.95	%	(306	/	1615)	23.23 %	19 %
5	kz Kwa Sani local municipality	23.56	%	(78	/	331)	5.92 %	3.89 %

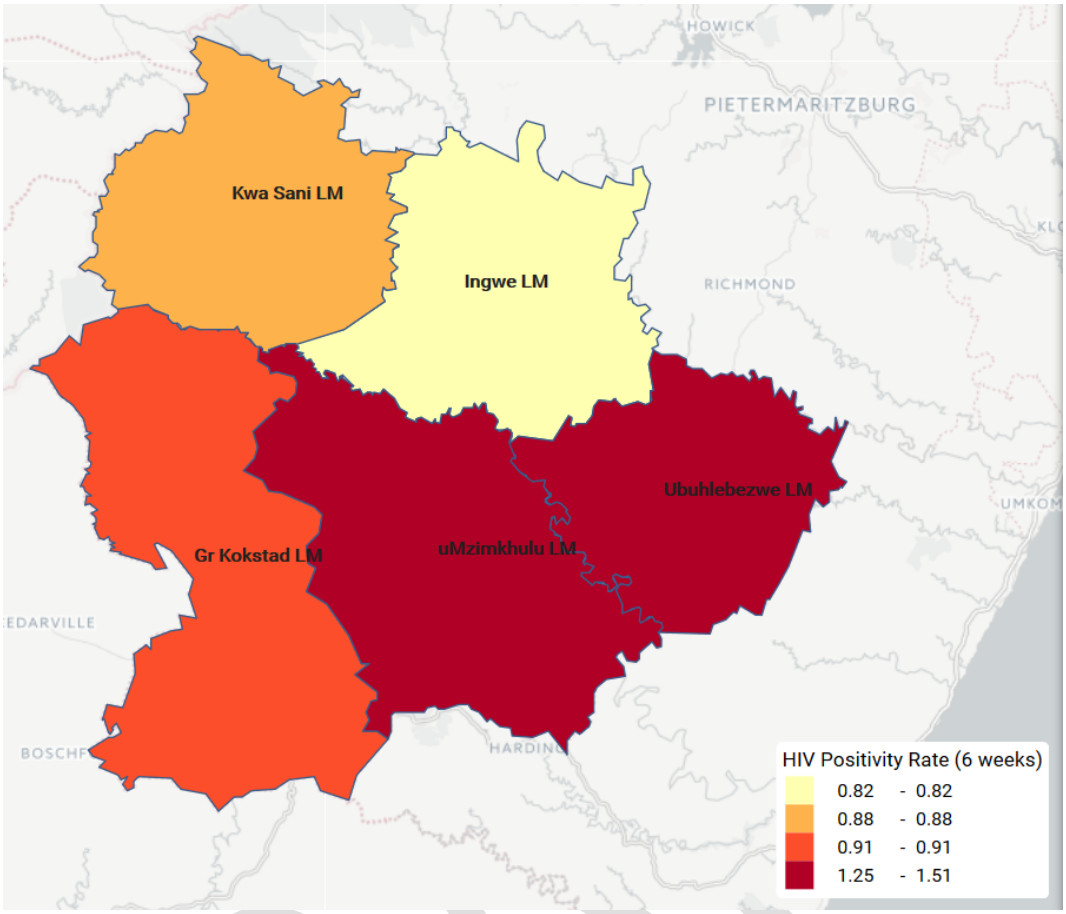

Figure 9: Infant 1st PCR test positive around 6 weeks rate Harry Gwala district (Source: KZN DHIS 2015)

Table 6: HIV Positivity Rate Harry Gwala district (6 weeks) (Source: KZN DHIS 2015 report 5 July 2017)

KZ HARRY GWALA DISTRICT MUNICIPALITY: **1.2 %**								
	local municipality	**2015 : HIV Positivity Rate (6 weeks)**					**NUM %**	**DEN %**
1	kz Ingwe local municipality	0.82	%	(4	/	486)	10.81 %	15.80 %
2	kz Kwa Sani local municipality	0.88	%	(1	/	113)	2.70 %	3.67 %
3	kz Greater Kokstad local municipality	0.91	%	(5	/	551)	13.51 %	17.92 %
4	kz Ubuhlebezwe local municipality	1.25	%	(10	/	798)	27.03 %	25.95 %
5	kz uMzimkhulu local municipality	1.51	%	(17	/	1127)	45.95 %	36.65 %

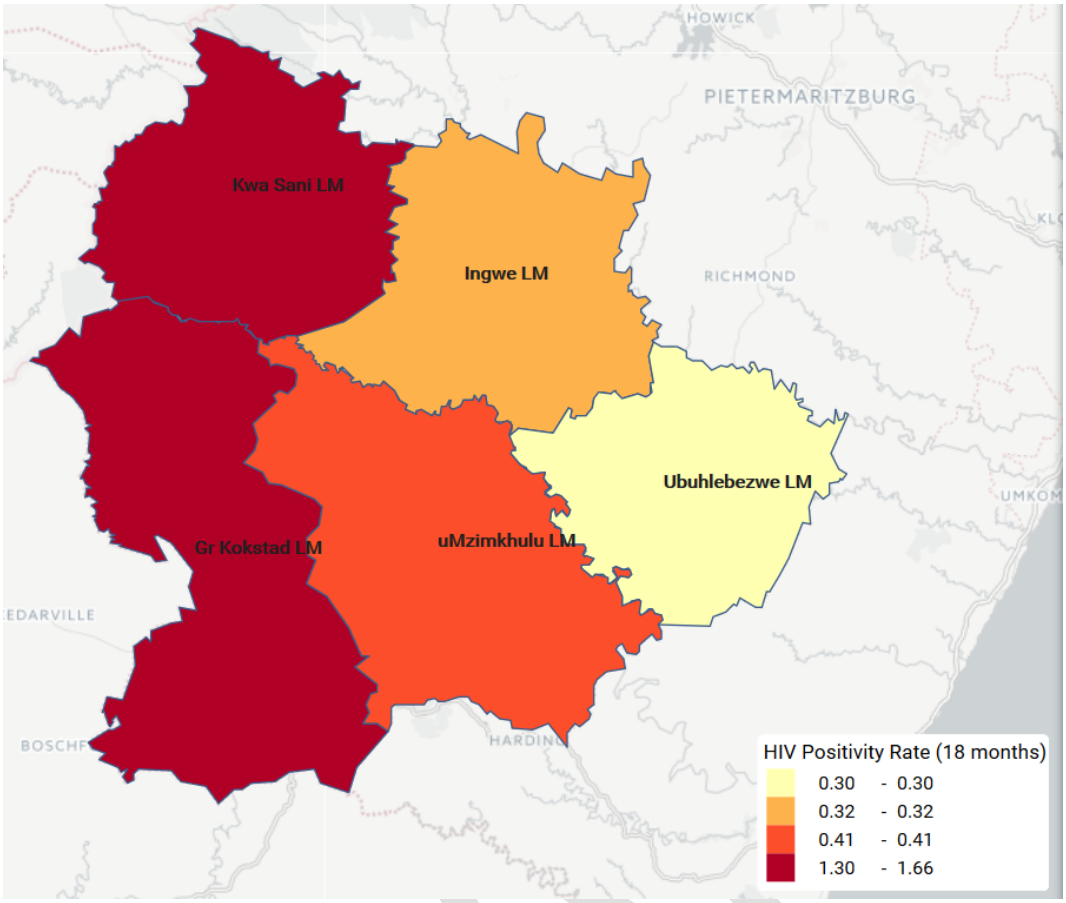

Figure 10: Infant rapid HIV test around 18 months positive rate Harry Gwala district (Source: KZN DHIS 2015)

Table 7: HIV Positivity Rate (18 months) Harry Gwala district (Source: KZN DHIS 2015 report 5 July 2017)

KZ HARRY GWALA DISTRICT MUNICIPALITY: **0.5 %**								
	local municipality	**2015 : HIV Positivity Rate (18 months)**					**NUM %**	**DEN %**
1	kz Ubuhlebezwe local municipality	0.30	%	(5	/	1671)	13.89 %	24.60 %
2	kz Ingwe local municipality	0.32	%	(4	/	1246)	11.11 %	18.34 %
3	kz uMzimkhulu local municipality	0.41	%	(12	/	2920)	33.33 %	42.99 %
4	kz Kwa Sani local municipality	1.30	%	(3	/	231)	8.33 %	3.40 %
5	kz Greater Kokstad local municipality	1.66	%	(12	/	725)	33.33 %	10.67 %

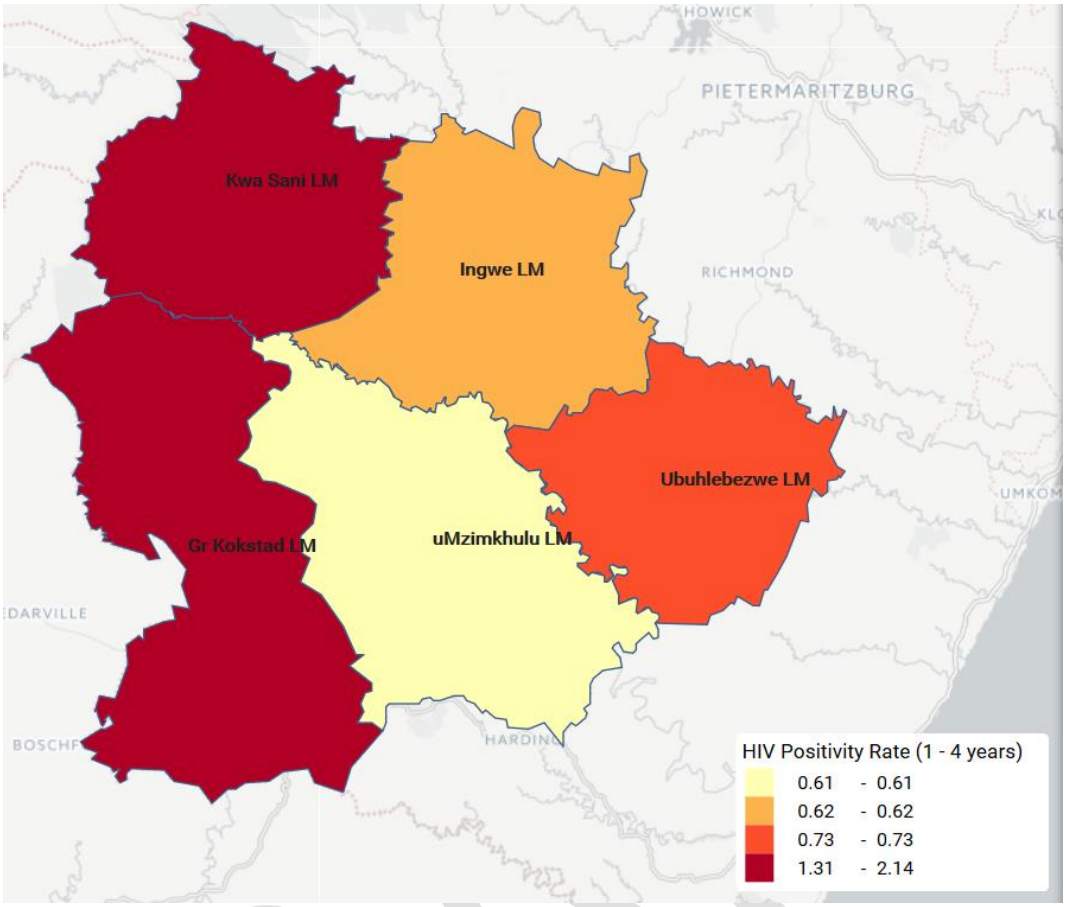

Figure 11: HIV test positive child 12-59 months rate Harry Gwala district (Source: KZN DHIS 2015)

Table 8: HIV Positivity Rate (12-59 months) Harry Gwala district (Source: KZN DHIS 2015 report 5 July 2017)

KZ HARRY GWALA DISTRICT MUNICIPALITY: **0.8 %**								
	local municipality	**2015 : HIV Positivity Rate (1 - 4 years)**					**NUM %**	**DEN %**
1	kz uMzimkhulu local municipality	0.61	%	(32	/	5281)	33.68 %	44.23 %
2	kz Ingwe local municipality	0.62	%	(14	/	2249)	14.74 %	18.84 %
3	kz Ubuhlebezwe local municipality	0.73	%	(22	/	3030)	23.16 %	25.38 %
4	kz Kwa Sani local municipality	1.31	%	(4	/	305)	4.21 %	2.55 %
5	kz Greater Kokstad local municipality	2.14	%	(23	/	1075)	24.21 %	9 %

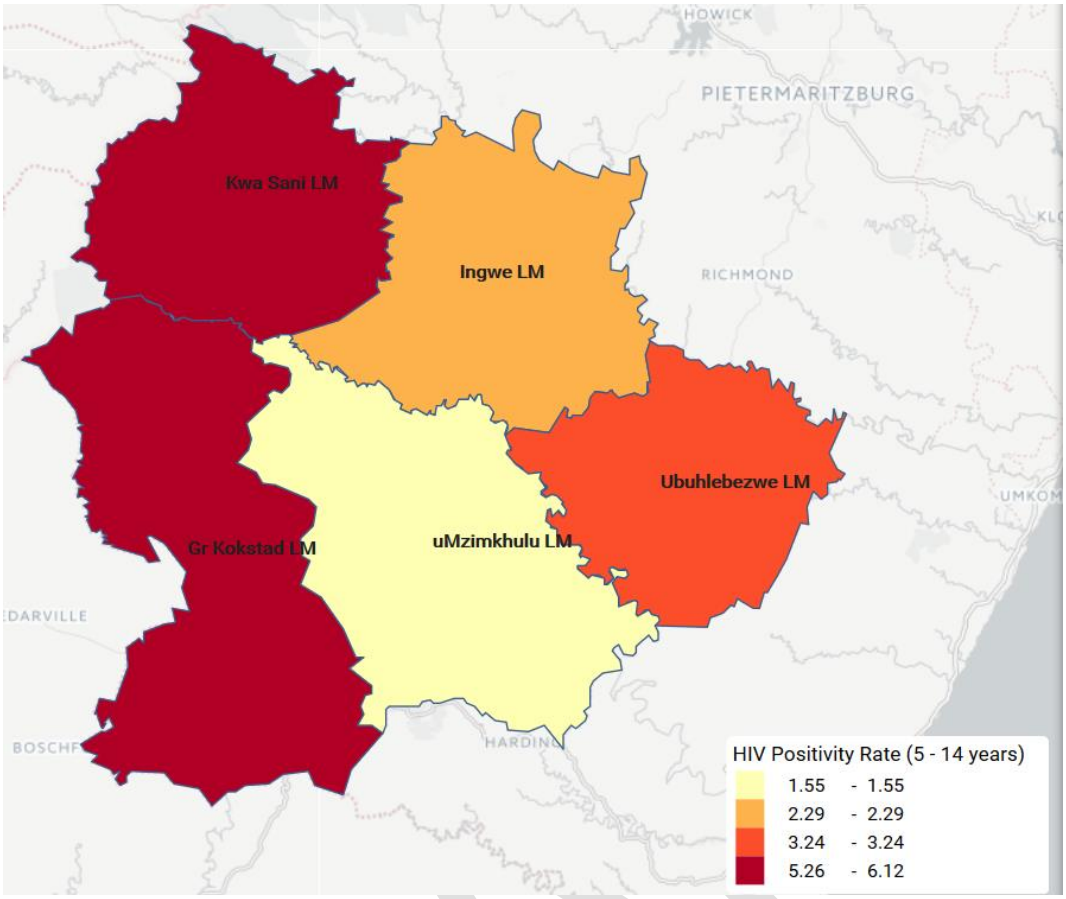

Figure 12: HIV test positive child 5-14 years rate Harry Gwala district (Source: KZN DHIS 2015)

Table 9: HIV Positivity Rate (5 - 14 years) Harry Gwala district (Source: KZN DHIS 2015 report 5 July 2017)

KZ HARRY GWALA DISTRICT MUNICIPALITY: **2.4 %**								
	local municipality	**2015 : HIV Positivity Rate (5 - 14 years)**					**NUM %**	**DEN %**
1	kz uMzimkhulu local municipality	1.55	%	(53	/	3418)	31.55 %	48.36 %
2	kz Ingwe local municipality	2.29	%	(38	/	1663)	22.62 %	23.53 %
3	kz Ubuhlebezwe local municipality	3.24	%	(49	/	1511)	29.17 %	21.38 %
4	kz Kwa Sani local municipality	5.26	%	(7	/	133)	4.17 %	1.88 %
5	kz Greater Kokstad local municipality	6.12	%	(21	/	343)	12.50 %	4.85 %

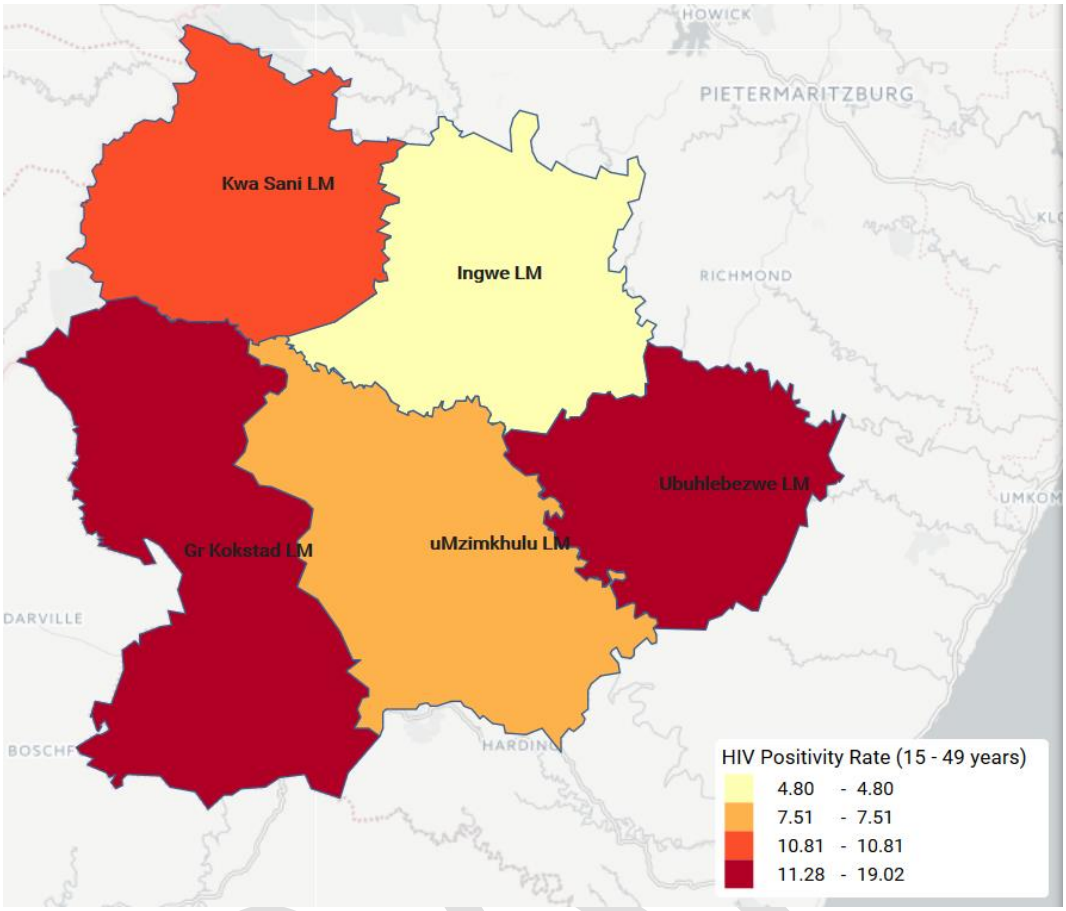

Figure 13: HIV prevalence amongst client tested 15-49 years rate Harry Gwala district (Source: KZN DHIS 2015)

Table 10: HIV Positivity Rate (15 - 49 years) Harry Gwala district (Source: KZN DHIS 2015 report 5 July 2017)

KZ HARRY GWALA DISTRICT MUNICIPALITY: **8.7 %**								
	local municipality	**2015 : HIV Positivity Rate (15 - 49 years)**					**NUM %**	**DEN %**
1	kz Ingwe local municipality	4.80	%	(1350	/	28132)	16.34 %	29.73 %
2	kz uMzimkhulu local municipality	7.51	%	(2546	/	33913)	30.82 %	35.84 %
3	kz Kwa Sani local municipality	10.81	%	(410	/	3793)	4.96 %	4.01 %
4	kz Ubuhlebezwe local municipality	11.28	%	(2214	/	19630)	26.80 %	20.75 %
5	kz Greater Kokstad local municipality	19.02	%	(1742	/	9157)	21.08 %	9.68 %

2.3 TB

The figures that follow reflects the TB burden based on the routine health data collected, collated and reported in health facilities under the Harry Gwala district. The definitions for these indicators can be found in Appendix B: Terms, Definitions and calculations.

Due to the small numbers at a local level, it is not included at ward level in this report. See note on small number in Appendix A: Selecting Data for the Profile.

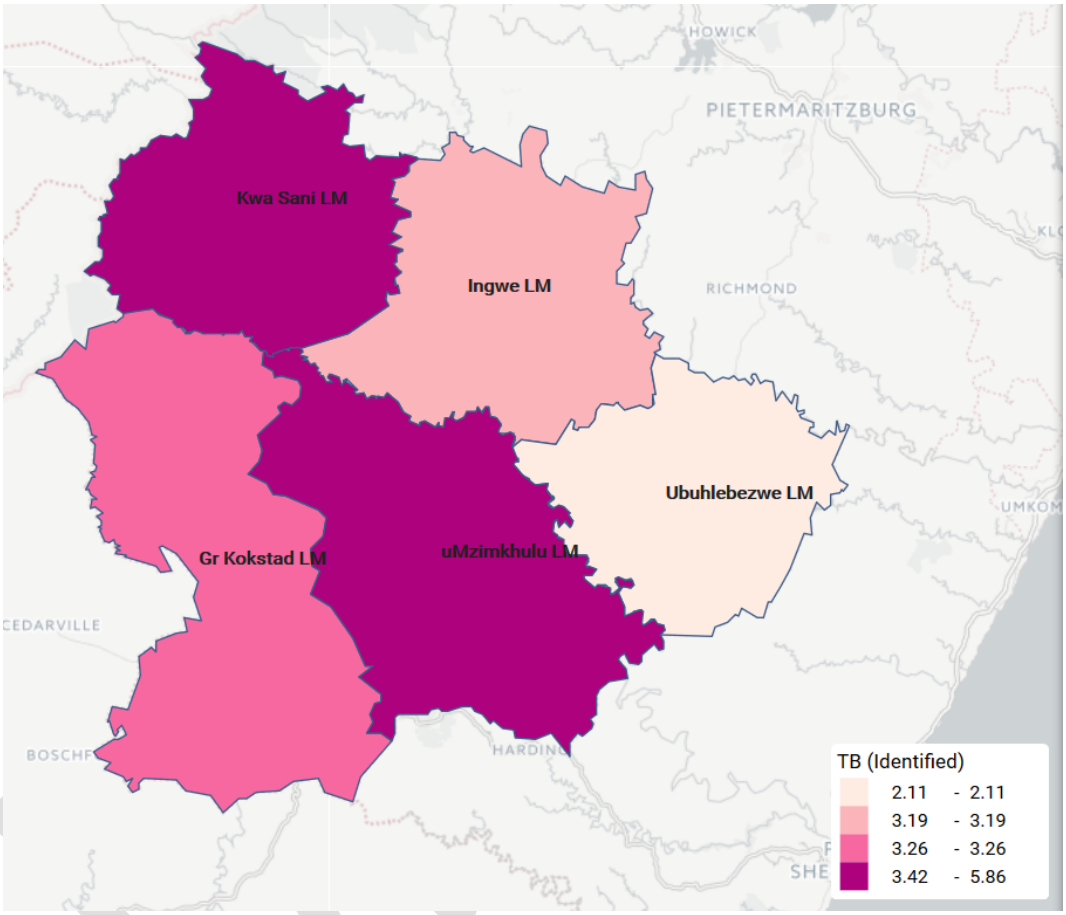

Figure 14: TB (pulmonary) case finding index Harry Gwala district (Source: KZN DHIS 2015)

Table 11: TB (pulmonary) case finding index Harry Gwala district (Source: KZN DHIS 2015 report 5 July 2017)

KZ HARRY GWALA DISTRICT MUNICIPALITY: **3.2 %**									
	local municipality	**2015 : TB (Identified)**						**NUM %**	**DEN %**
1	kz Ubuhlebezwe local municipality	2.11	%	(5910	/	280582)		15.94 %	24.16 %
2	kz Ingwe local municipality	3.19	%	(8448	/	265083)		22.79 %	22.82 %
3	kz Greater Kokstad local municipality	3.26	%	(5348	/	164204)		14.42 %	14.14 %
4	kz uMzimkhulu local municipality	3.42	%	(12761	/	373079)		34.42 %	32.12 %
5	kz Kwa Sani local municipality	5.86	%	(4608	/	78641)		12.43 %	6.77 %

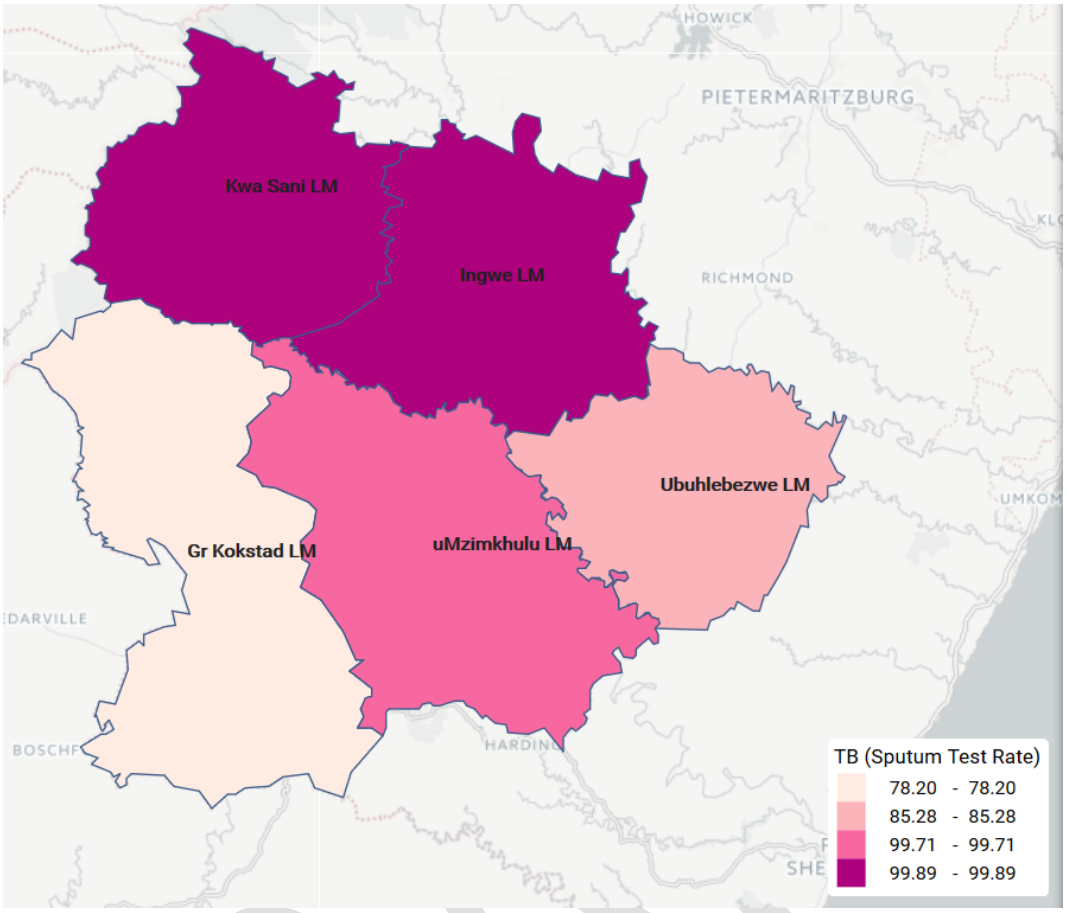

Figure 15: TB suspect sputum test rate Harry Gwala district (Source: KZN DHIS 2015)

Table 12: TB (Sputum Test Rate) Harry Gwala district (Source: KZN DHIS 2015 report 5 July 2017)

KZ HARRY GWALA DISTRICT MUNICIPALITY: **93.5 %**									
	local municipality	**2015 : TB (Sputum Test Rate)**					**NUM %**	**DEN %**
1	kz Greater Kokstad local municipality	78.20	%	(5348	/	6839)	14.42 %	17.25 %
2	kz Ubuhlebezwe local municipality	85.28	%	(5910	/	6930)	15.94 %	17.48 %
3	kz uMzimkhulu local municipality	99.71	%	(12761	/	12798)	34.42 %	32.29 %
4	kz Kwa Sani local municipality	99.89	%	(4608	/	4613)	12.43 %	11.64 %
5	kz Ingwe local municipality	99.89	%	(8448	/	8457)	22.79 %	21.34 %

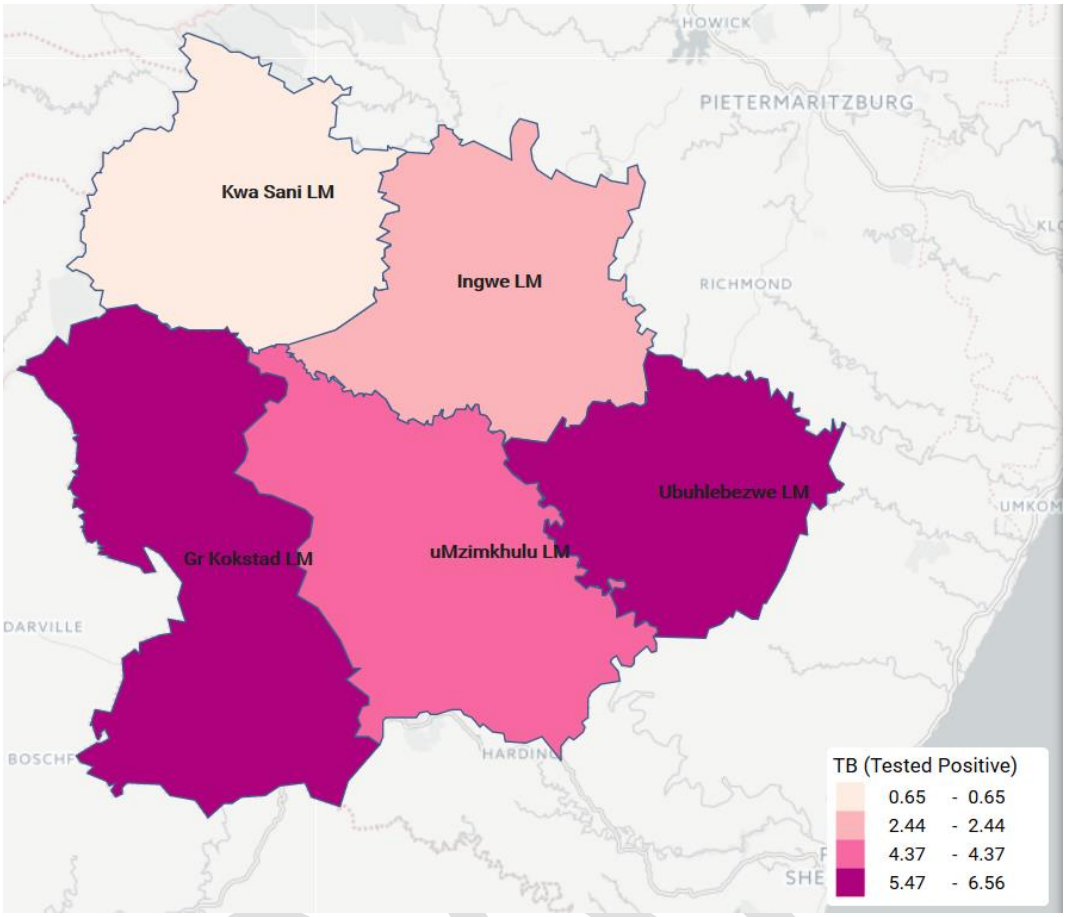

Figure 16: TB suspect smear positive rate Harry Gwala district (Source: KZN DHIS 2015)

Table 13: TB suspect smear positive rate Harry Gwala district (Source: KZN DHIS 2015 report 5 July 2017)

KZ HARRY GWALA DISTRICT MUNICIPALITY: **4 %**									
	local municipality	**2015 : TB (Tested Positive)**					**NUM %**	**DEN %**
1	kz Kwa Sani local municipality	0.65	%	(30	/	4608)	2.04 %	12.43 %
2	kz Ingwe local municipality	2.44	%	(206	/	8448)	14.03 %	22.79 %
3	kz uMzimkhulu local municipality	4.37	%	(558	/	12761)	38.01 %	34.42 %
4	kz Ubuhlebezwe local municipality	5.47	%	(323	/	5910)	22 %	15.94 %
5	kz Greater Kokstad local municipality	6.56	%	(351	/	5348)	23.91 %	14.42 %

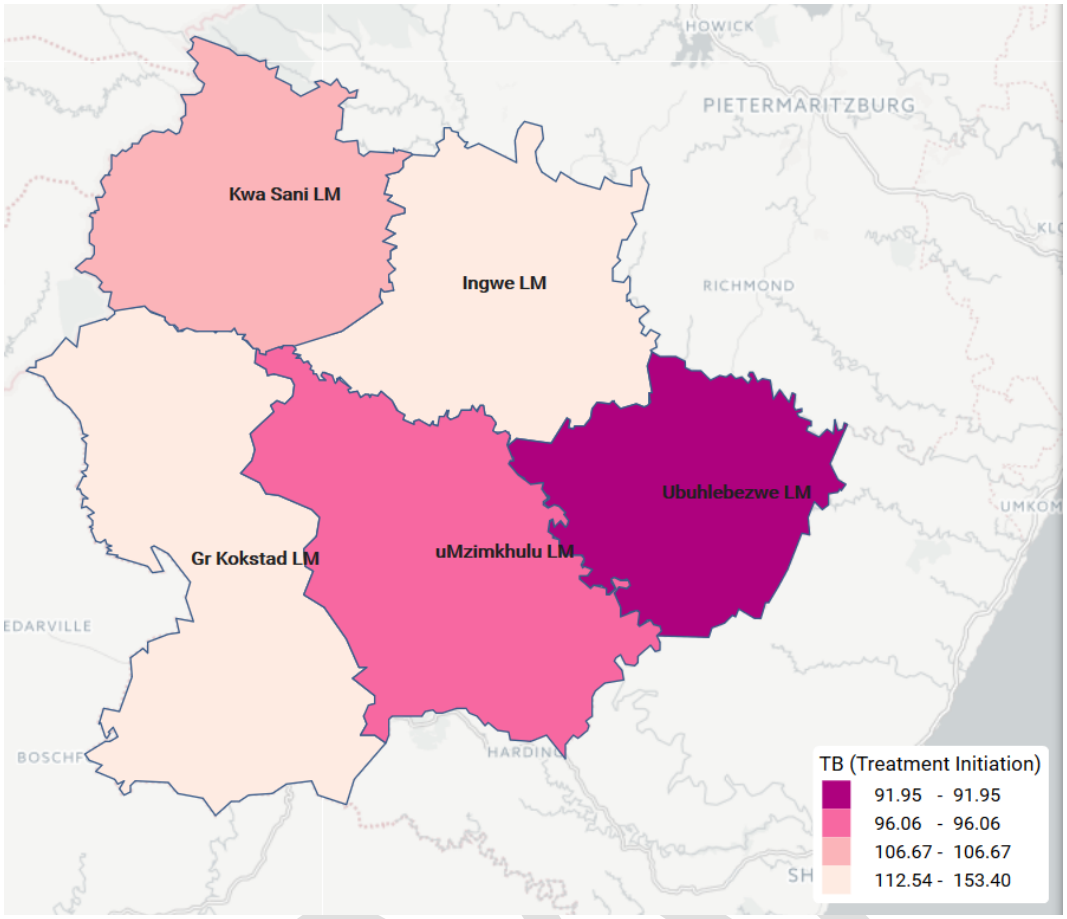

Figure 17: TB suspect treatment initiation rate Harry Gwala district (Source: KZN DHIS 2015)

Table 14: TB suspect treatment initiation rate Harry Gwala district (Source: KZN DHIS 2015 report 5 July 2017)

KZ HARRY GWALA DISTRICT MUNICIPALITY: **107.4 %**								
	local municipality	**2015 : TB (Treatment Initiation)**					**NUM %**	**DEN %**
1	kz Ubuhlebezwe local municipality	91.95	%	(297	/	323)	18.85 %	22 %
2	kz uMzimkhulu local municipality	96.06	%	(536	/	558)	34.01 %	38.01 %
3	kz Kwa Sani local municipality	106.67	%	(32	/	30)	2.03 %	2.04 %
4	kz Greater Kokstad local municipality	112.54	%	(395	/	351)	25.06 %	23.91 %
5	kz Ingwe local municipality	153.40	%	(316	/	206)	20.05 %	14.03 %

2.4 STIs

Sexually transmitted infections (STIs) are a major risk factor to the human immunodeficiency virus (HIV) epidemic[1]. The presence of a sexually transmitted infection, such as syphilis, gonorrhoea, or herpes simplex virus infection, greatly increases the risk of acquiring or transmitting HIV infection (by two to three times, in some populations). The HIV-1 infected persons with STIs are at increased risk of transmitting HIV-1 because genital tract shedding of HIV-1 is elevated in the presence of genital tract inflammation[23]. v. In 2014, HIV co-infection amongst STI patients remained relatively high with a HIV co-infection of 30.1% [45] among those with male urethritis syndrome, 40.3% among those with vaginal discharge syndrome and 46.3% among those with genital ulcer syndrome[6] Location is also a factor. Ramjee et.al confirms the high prevalence and incidence of STIs among women living in rural and urban communities of KwaZulu-Natal. Therefore, STI control programmes need to be embedded in HIV care and treatment programmes and vice-versa in order to achieve optimal benefit in ameliorating the impact of HIV, AIDS and STIs.

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

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

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

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

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

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

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

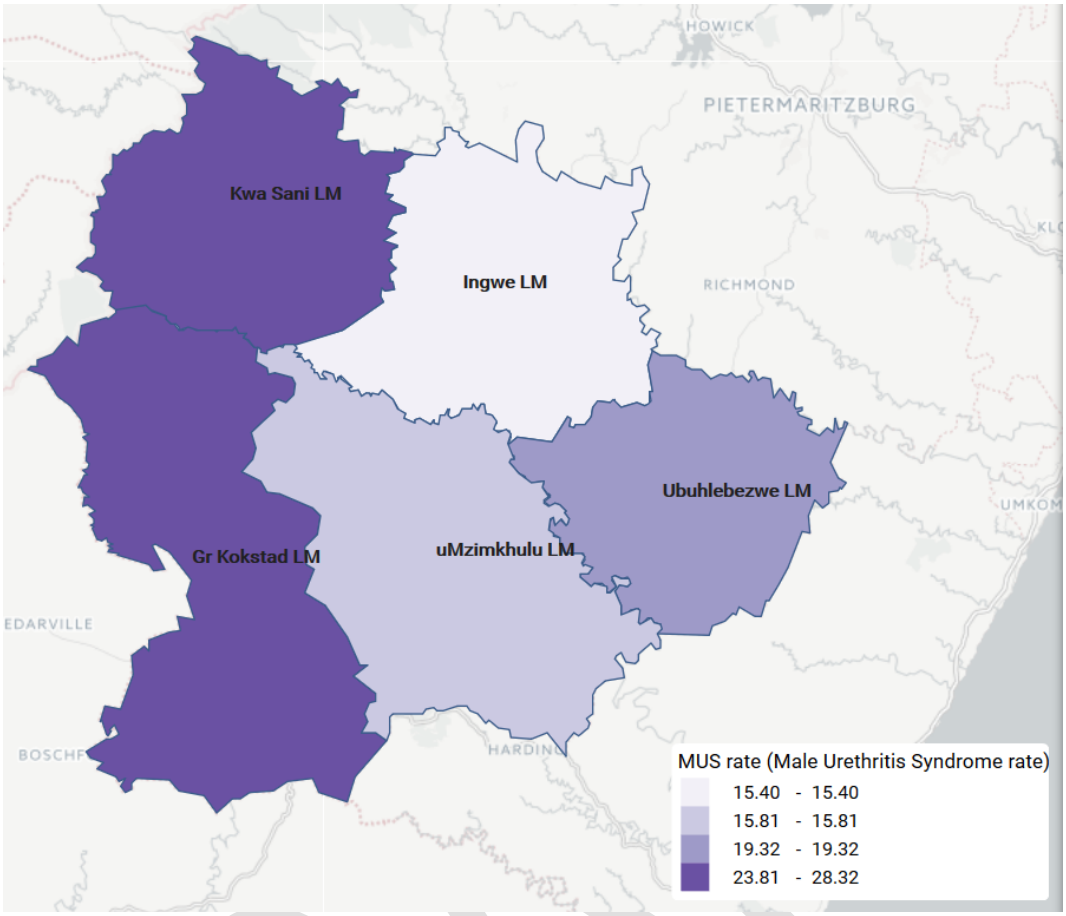

Figure 18: Male urethritis syndrome rate Harry Gwala district (Source: KZN DHIS 2015)

Table 15: Male urethritis syndrome rate Harry Gwala district (Source: KZN DHIS 2015 report 5 July 2017)

KZ HARRY GWALA DISTRICT MUNICIPALITY: **20.4 %**								
	local municipality	**2015 : MUS rate (Male Urethritis Syndrome rate)**					**NUM %**	**DEN %**
1	kz Ingwe local municipality	15.40	%	(582	/	3780)	13.10 %	17.33 %
2	kz uMzimkhulu local municipality	15.81	%	(1004	/	6352)	22.60 %	29.12 %
3	kz Ubuhlebezwe local municipality	19.32	%	(870	/	4503)	19.58 %	20.64 %
4	kz Kwa Sani local municipality	23.81	%	(245	/	1029)	5.51 %	4.72 %
5	kz Greater Kokstad local municipality	28.32	%	(1742	/	6152)	39.21 %	28.20 %

3. Associated risk profile

3.1 Biomedical Profile

3.1.1 HIV Testing and TB screening

Awareness of one's HIV status through HIV Testing Services (HTS) is pivotal to accessing prevention, care services, and ARV treatment which mitigate the impact of HIV [7]. It is therefore important to

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

determine the success of routine HIV testing and counselling by the Department of Health. From the National 2013 HIV testing campaign, nearly two-thirds of respondents (65.5%) indicated that they had tested for HIV with females reporting higher rates of testing (71.5%) than of males (59%)[8]. 78% of adults aged 25–49 years reported testing compared to youth aged 15–24 years (50.6%) and the elderly (aged 50 years and older) (54.8%)[9].

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

- Few people are willing to test for HIV;
- Some women only have HIV tests when they are pregnant;
- Some community member are getting an HIV test in order to get an SRD Voucher;
- More community members are keen to test for TB than HIV because it is less stigmatising; and
- People don't test because of self-stigma.

3.1.2 Circumcision

Voluntary medical male circumcision (VMMC) is being scaled up in the country because it has been shown to be partially effective in reducing HIV infection among males[10]. Nationally, there are reported about 46.4% circumcisions, with a significant lower percentage of men aged 15–19 years compared to all age groups. High percentage of black Africans (52.4%) reported that they were circumcised compared to the other three race groups[11].

[8] ibid
[9] ibid
[10] SANAC. 2011. NSP 2012–2016
[11] Shisana, O., T. Rehle, et al. (2014). South African National HIV Prevalence, Incidence and Behaviour Survey,2012. Cape Town, HSRC Press.

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

- After traditional circumcision young men felt that they had now reached manhood and that the way to cleanse oneself after the ritual of circumcision is to have sex with a new woman rather than one's current partner;
- People who come from the Eastern Cape practice unprotected sex after traditional circumcision;
- The boys who have been medically circumcised assume that they will no longer be infected with HIV and they are involved in unsafe sexual intercourse and don't use condoms.

3.1.3 ARV treatment

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

- ARV Treatment is erratically available at Khanyiselani Health Post where there is a problem of "stock-outs" of ART from time to time;
- Clients take medication at different times which interferes with scheduled treatment and affects adherence. One of the main reasons mentioned in this area is the lack of food as a result of poverty.
- The requirement for medication to be taken with meals is a major factor in reduced levels of adherence.
- People go out drinking, do not take their medication with them, and then they end up going home with whomever they meet at the bar/club, thus defaulting on their medication for that time period;
- Clinic files are picked up at different entrances and there are different points for collecting ARVs, this contributes to stigma;
- Staff attitude from some nurses in the clinic makes people not want to return to the clinic;
- There are not enough Community Care Givers (CCGs), and those who are available are spread too thin in terms of the tasks they are required to fulfil. Due to the CCGs no longer being there specifically for the monitoring of PLHIV, they are finding it difficult to keep consistent monitoring of these patients;
- Health practitioners who were also present at the discussion said some of the patient who are taking ARV treatment gives them wrong addresses and they are unable remind them to call in to the clinic.
- Some community members move from one place to another living with different partners. There was also the issue of wrong addresses being given by patients, and people moving houses constantly.
- In addition to this, the issue of people going from a facility where they are known, to an area far away from them is a contributor to poor adherence and the loss to follow up; and
- There are long distances that people need to travel to collect their ARV medication and that this is a contributing factor when it comes to loss to follow up and poor adherence.

3.1.4 PEP and PrEP

There was limited knowledge among the participants about what exactly ***post-exposure antiretroviral prophylaxis (PEP) and pre-exposure antiretroviral prophylaxis (PrEP)*** are and what their functions are. To rectify this, there was a discussion held where the uses and processes involved were clarified for those attending. According to those who did know about them:

- PrEP is not available in Greater Kokstad; and
- While PEP is available, it is only available in the big hospital in town, and not in any of the local clinics.

3.1.5 Lubricant

During the stakeholder and community engagement workshops it was noted that in general the community do not have access and do not know about ***lubricants***. The lack of knowledge in this area was widespread, but full clarification was given by members of AFSA, and the facilitators.

3.2 Behaviour that influences risk for HIV infection

The reported high incidence among young women aged women aged 15–24 years (2.54; 2.04–3.04) approximately 116 000 new infections compared to young men (0.55; 0.45–0.65) approximately 26 000 new infections[12] calls for need to address the associated social factors such as age-disparate relationships, particularly at a much local level. However, data on factors influencing risk of HIV infection e.g. condom use, multiple sexual partnerships, intergenerational sex, transactional sex, risky sexual practices (anal sex) are not routinely collected. Such data are mostly obtained from independent behavioural surveys[13], and are reported at provincial level which is much higher that district, local municipalities, and high burden areas. There is need for the department of health to devise approaches to routinely collect quantitative data on sexual risk behaviours in identified local levels and/or high burden areas.

3.2.1 HIV Knowledge

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

- There is a lack of knowledge about HIV among community members;
- Sharing of instruments, like razor blades, between clients, by traditional healers contributes to a high rate of new HIV infections amongst their clients;
- Although condoms are distributed, there is still unprotected sex happening in the communities (sex without a condom);
- There is a perception of lack of co-operation between CCGs, health workers and health promoters;
- Alcohol and drug abuse is viewed as a major contributor to the spread of HIV as they lead to decreased rational thought and behaviour;
- Lack of knowledge about HIV prevention among the elderly who were seen as the ones most responsible for taking care of the ill;
- The prevalence of multiple sexual partners and mixed age relationships increase HIV risk in the community; and
- Prevention -of-mother to child transmission (PMTCT) requirements are not being properly adhered to increasing transmission to infants of Mothers living with HIV

3.2.2 Sexual risky behaviours

The following was discussed around ***risky sexual behaviour*** that increases risk of infection during the stakeholder and community engagement workshops in the area:

- Denial of HIV positive status by young people who continue practising unsafe sex in spite of testing positive for HIV is likened to revenge;
- Multiple sexual partners fuel infection;

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

- Young people are running away from home and living in the streets;
- "Ukuwinwa"- when a woman goes home with a man she just met after he supplies her with alcohol, is prevalent; and,
- There are women and girls who are undisclosed sex workers.

3.2.3 Substance abuse

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

- Due to unemployment people feel hopeless and use alcohol – intoxication results in sex without condoms and with different partners;
- There is a high rate of substance abuse and drugs that trigger high risk behaviour; and
- Young men are engaging in intravenous drug use and sharing of needles;
- Alcohol abuse results in poor decisions.

3.2.4 Condoms

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

- Male condoms are most available and most well-known;
- The youth of Kokstad are reluctant to use the government condoms and preferred to use the branded ones;
- Female condoms are not usually available and this transfers the responsibility of condom use to men who then decide whether they will use condoms or not;
- Education on the correct use of female condoms is absent i.e. when they should be inserted, how long they may remain inserted etc.;
- If men also don't know about female condoms they will potentially be resistant to a women unilaterally deciding to use female condoms;
- Female condoms are impractical as you cannot plan ahead for intercourse; and
- In a long term relationship partners no longer use condoms as they know each other but they do not go to the clinic to test for HIV before stopping condoms.

In Figure 19 and Figure 20 the condom distribution for females and males (annualised) are reflected at local municipality level in Harry Gwala district. The definitions for these indicators can be found in Appendix B: Terms, Definitions and calculations.

Due to the small numbers at a local level, it is not included at ward level in this report. See note on small number in Appendix A: Selecting Data for the Profile.

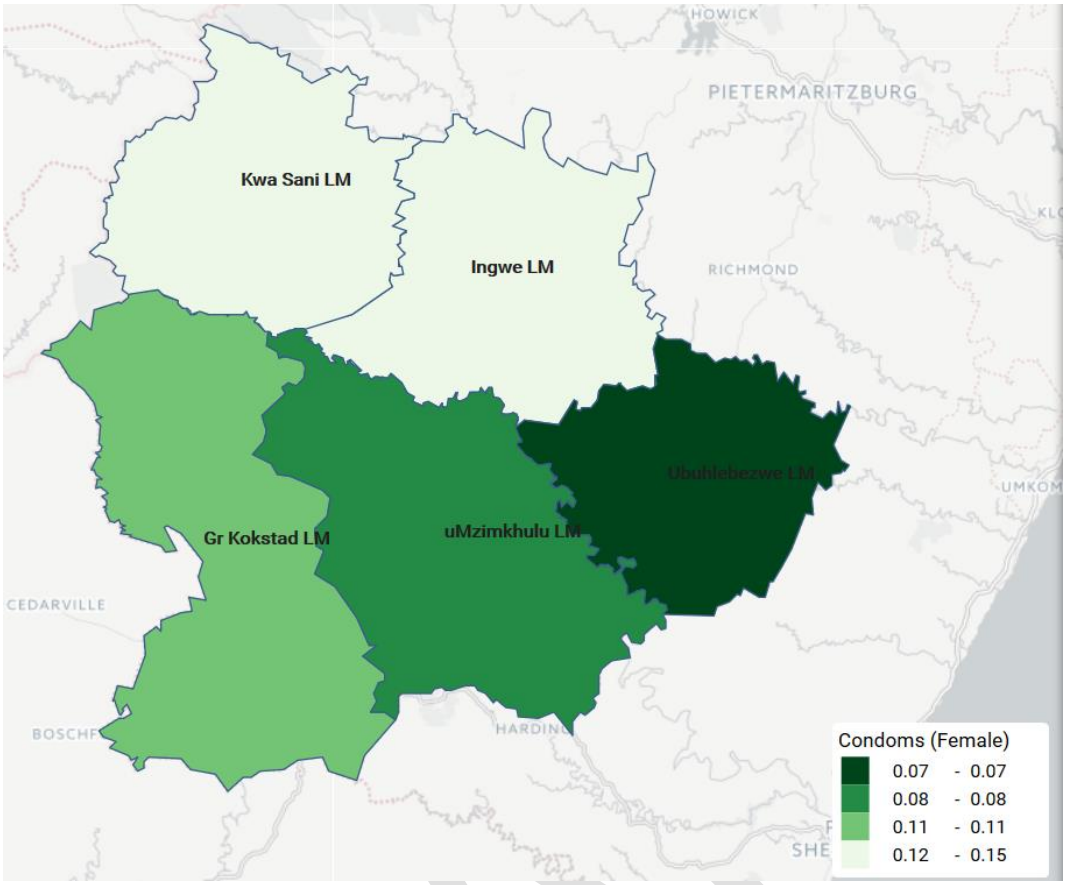

Figure 19: Female condom distribution rate Harry Gwala district (Source: KZN DHIS 2015)

Table 16: Female condom distribution rate Harry Gwala district (Source: KZN DHIS 2015 report 5 July 2017)

KZ HARRY GWALA DISTRICT MUNICIPALITY: **9.5 No**								
	local municipality	**2015 : Condoms (Female)**					**NUM %**	**DEN %**
1	kz Ubuhlebezwe local municipality	0.07	No	(32829	/	449076)	16.95 %	22.02 %
2	kz uMzimkhulu local municipality	0.08	No	(65537	/	787572)	33.85 %	38.62 %
3	kz Greater Kokstad local municipality	0.11	No	(33344	/	309276)	17.22 %	15.16 %
4	kz Ingwe local municipality	0.12	No	(53015	/	432864)	27.38 %	21.22 %
5	kz Kwa Sani local municipality	0.15	No	(8901	/	60660)	4.60 %	2.97 %

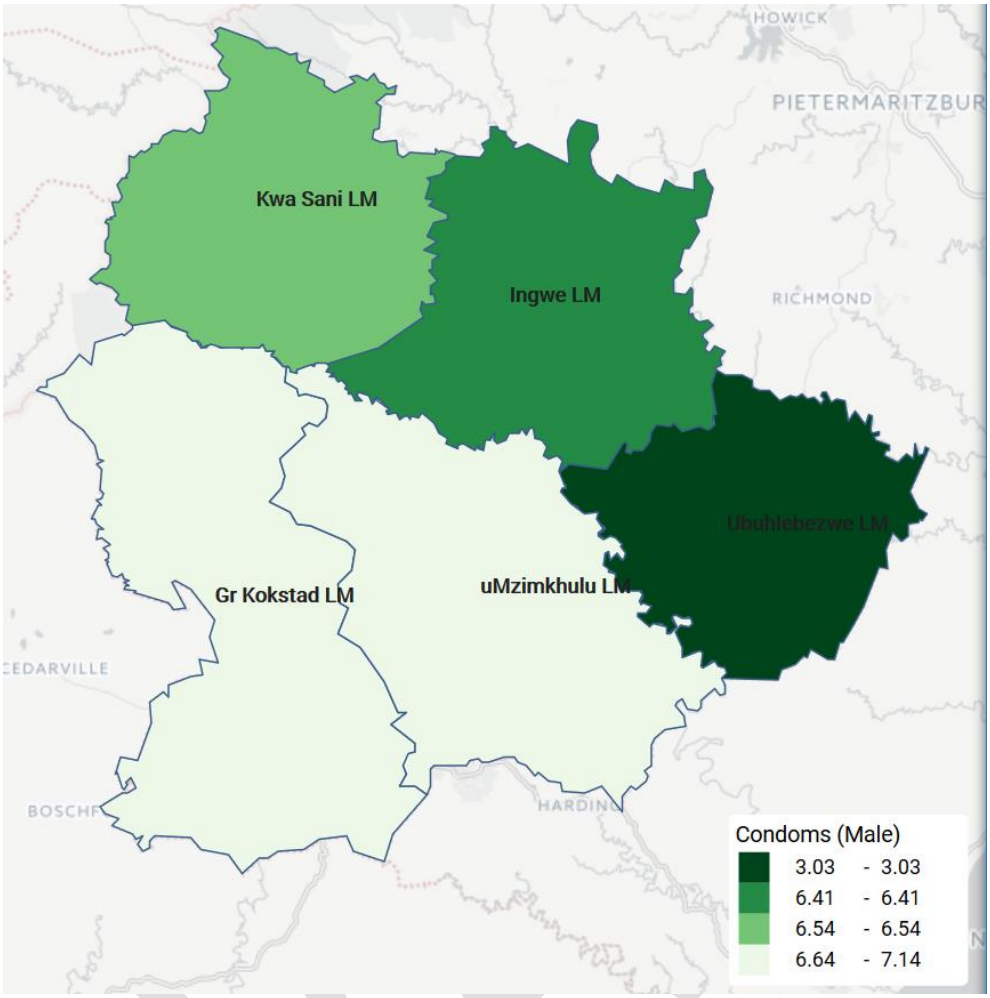

Figure 20: Male condom distribution rate Harry Gwala district (Source: KZN DHIS 2015)

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

KZ HARRY GWALA DISTRICT MUNICIPALITY: **588.3 No**								
	local municipality	**2015 : Condoms (Male)**					**NUM %**	**DEN %**
1	kz Ubuhlebezwe local municipality	3.03	No	(1096369	/	362400)	11.35 %	22.07 %
2	kz Ingwe local municipality	6.41	No	(2178617	/	340116)	22.55 %	20.71 %
3	kz Kwa Sani local municipality	6.54	No	(447744	/	68460)	4.63 %	4.17 %
4	kz uMzimkhulu local municipality	6.64	No	(3787136	/	569940)	39.20 %	34.70 %
5	kz Greater Kokstad local municipality	7.14	No	(2152078	/	301380)	22.27 %	18.35 %

3.2.5 Key and vulnerable populations

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

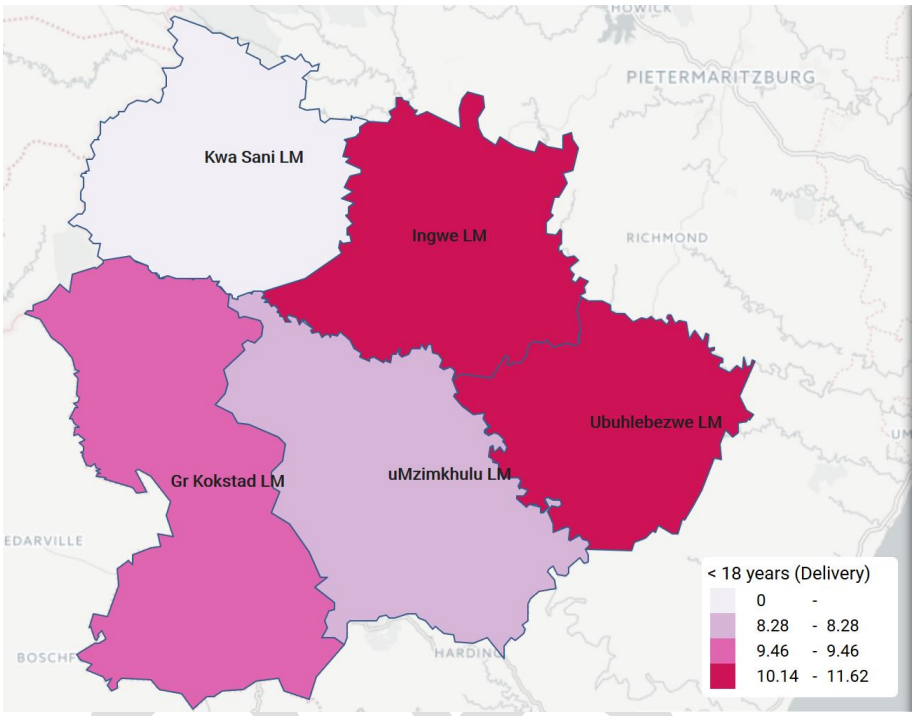

Figure 21: Teenage Pregnancy rate Harry Gwala district (Source: KZN DHIS 2015)

Table 18: Teenage Pregnancy rate Harry Gwala district (Source: KZN DHIS 2015 report 5 July 2017)

KZ HARRY GWALA DISTRICT MUNICIPALITY: **9.8 %**								
	local municipality	**2015 : < 18 years (Delivery)**					**NUM %**	**DEN %**
1	kz Kwa Sani local municipality	0	%	(-	/	32)	0 %	0.38 %
2	kz uMzimkhulu local municipality	8.28	%	(194	/	2344)	23.46 %	27.72 %
3	kz Greater Kokstad local municipality	9.46	%	(203	/	2147)	24.55 %	25.39 %
4	kz Ingwe local municipality	10.14	%	(185	/	1824)	22.37 %	21.57 %
5	kz Ubuhlebezwe local municipality	11.62	%	(245	/	2109)	29.63 %	24.94 %

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

Table 19: Key and vulnerable population groups

Key and vulnerable population group	Stakeholder and community feedback
Young women	Young people "drop out" of school at an early age which exposes them to sex at an early age. The youth of Kokstad are not interested in education. Lack of recreational facilities drives youth to start having sex early. Infections spread in various ways, some schools teachers have sex with school girls and these girls also have sex with their boyfriends. Young girl and women are lured by men with "GP" number plates in German cars who can offer some money and leave. The risk of not using condoms is high.
Youth	Pornography is easily accessible through cell phones. This contributes to risky sexual behaviour amongst the youth. Some school premises are used to sell drugs.
Sex workers	Foreigners engage in paid sex in order to get a place to sleep and forget about hunger. HIV rapidly spread through sexual networks which encompass sex workers.
Orphans and vulnerable children	Child headed households suffer because a child who is heading a household is sometimes forced to have sex with an older person in order to get food.
Drug users	Bluetoothing is prevalent.
Disabled	Disable people are sexually abused because of their disability and more so they cannot be able to express themselves; and People with disabilities, especially women, are vulnerable to rape. Men take advantage of disabled women especially those that are mentally disabled. More education is needed for gaurdians. There are minimal facilities for aiding the disabled community, and they are also neglected by their families. Some disabled people are seen to exploit their situations, by exchanging their food parcels.
Truck drivers	Truck Drivers have casual sexual encounters without condoms on their routes.
Migrant workers	Migrants are perceived to be negligent or apathetic about testing because they feel safe about being non-permanent members of those communities. They are seen to lure local women with money, and the women are also be lax about condom use.

3.3 Social and structural factors that influence HIV risk

3.3.1 Orphan hood

In 2011, the proportion of orphans was especially high in the rural Wards. High level of HIV prevalence in KwaZulu-Natal had been associated with high proportion of orphans[14] , albeit at provincial level. The detail for Ward 6 that forms the catchment area for Khanyiselani Health Post, are highlighted in the table below.

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

Ward	Maternal orphans			Paternal orphans			Double orphans		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Ward 1	55	57	112	370	368	739	123	122	245
Ward 2	32	41	73	192	205	396	60	56	116
Ward 3	19	18	37	82	81	163	30	28	58
Ward 4	65	50	115	316	357	673	100	97	197
Ward 5	19	13	32	61	64	125	8	18	26
Ward 6	62	39	101	227	186	414	67	61	128
Ward 7	43	38	81	217	186	402	68	92	159
Ward 8	58	53	112	249	301	550	66	88	154

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

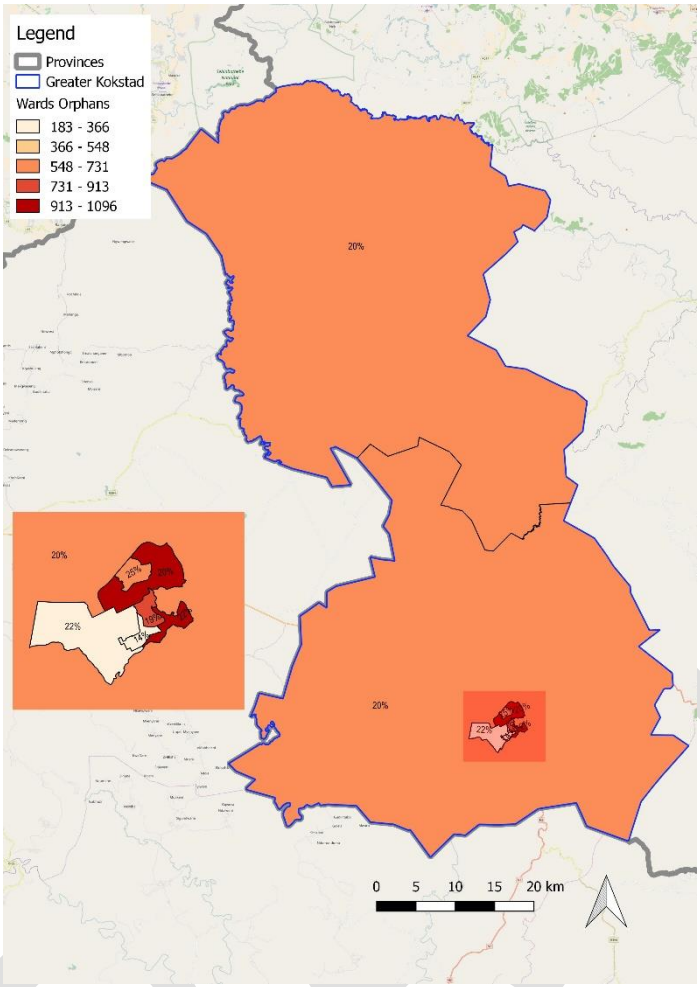

Figure 22: Total number of Orphans with percentage that are double orphans per ward (Source Census 2011)

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

- Sexual abuse of vulnerable groups such as orphans is common in this area
- Child headed household suffers because a child who is heading a household is sometimes forced to have sex with an older person in order to get food.

3.3.2 Cultural and Religious Norms

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

- Young men believe that when they have circumcised they won't be get infected by HIV;
- Young women are victims of pastors - pastors prey on young girls giving them tasks within their churches in exchange for bursaries, and then take advantage of them;
- Other young men they turn to bad behaviour after coming from circumcision;
- Circumcision is being undertaken by young boys (those who have not come of age), as a result they feel they are older than what they are;
- Both elderly and young people practise kukupa (meaning cohabiting without marriage);
- Ukuthwala - the practice of kidnapping girls and forcing them in to marriage- is practiced in this area;

- Child marriages occur in the community.

3.3.3 Gender norms and gender-based violence

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

- There are arguments between couples over money;
- There was a suggestion that men sometimes coerce their partners in to buying alcohol or making loans against the children's grant money or SASSA cards; and
- When parents are engaged in these patterns they do not take care of their children's needs.

3.3.4 Stigma

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

- People who are working in the local clinics are people who also reside within the community and as a result local people are reluctant to go to the clinic to collect medication or even get medical attention because they fear to be labelled as the HIV infected group and therefore be mistreated;
- The prevailing stigma results in stubbornness of male partners to go for HIV testing and share their status;
- Men are reluctant to get tested, and would tend to use their partners status as a proxy;
- The attitude of the staff in the clinic also contributes to stigma;
- People leave the area because of stigma;
- People are fearful to disclose to their intimate partner and continue the relationship with disclosing their status; and
- Sometimes people "self-discriminate", meaning that an individual will isolate him/herself due to the shame or embarrassment he/she feels following diagnosis.

3.3.5 Poverty

Poverty is measured through the South Africa Multidimensional Poverty Index (SAMPI)[15]. The detail for Ward 6 that forms the catchment area for Khanyiselani Health Post, are highlighted in the table below.

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

	Poverty Headcount (H)	Intensity of Poverty (A)	SAMPI (HxA)
kz Greater Kokstad Ward 001	19.5	43.4	0.085
kz Greater Kokstad Ward 002	13.3	37.5	0.050
kz Greater Kokstad Ward 003	0.29	43.4	0.001
kz Greater Kokstad Ward 004	2.4	39.7	0.010
kz Greater Kokstad Ward 005	5.6	46.1	0.026
kz Greater Kokstad Ward 006	10.2	39.2	0.040
kz Greater Kokstad Ward 007	3.1	41.4	0.013
kz Greater Kokstad Ward 008	13.5	49.6	0.067
kz Greater Kokstad	**8.5**	**42.5**	**0.036**

Ward 1 was the poorest Ward in Greater Kokstad local municipality with nearly a fifth of the households (19.5%) being poor (Table 21, Appendix B). Ward 3 had the lowest poverty head count at 0.29%. The greatest contributors to high poverty measures in KZN are health (measured by child mortality) and education (measured by years of schooling and school attendance). The Multidimensional Poverty Index for Greater Kokstad local municipality changed between 2001 (Figure 23) and 2011 (Figure 24). In 2001 the highest Poverty Index was 28.72. This reduced to 8.46 in 2011.

In the catchment area for Khanyiselani Health Post, the poverty headcount is 10.2 with an intensity of 39.2%, making it the fourth highest in Greater Kokstad local municipality. This is visible with the darker shading in Figure 26 for the SAMPI poverty headcount for the ward level.

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

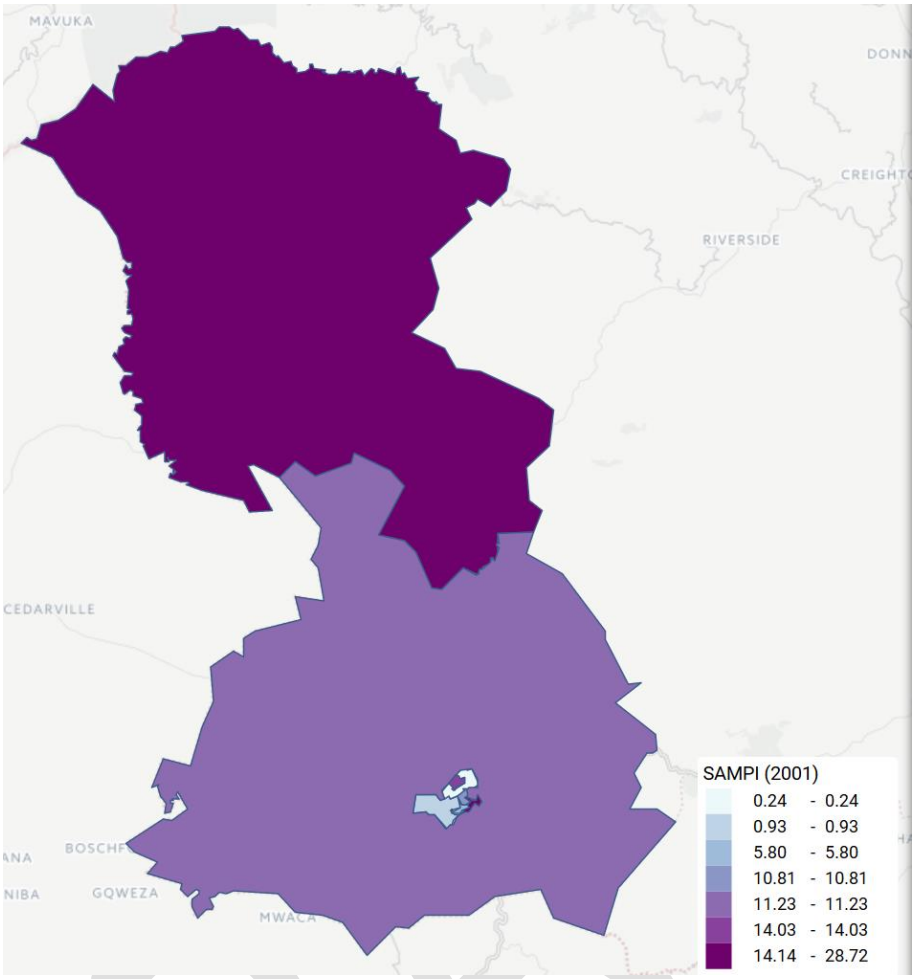

Figure 23: SAMPI (poverty Index) 2001 - ward level, Greater Kokstad local municipality

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

KZ GREATER KOKSTAD LOCAL MUNICIPALITY: **11 %**						
	Ward (2011)	**SAMPI (2001)**				
1	kz Greater Kokstad Ward 004	0.24	%	(0.2	/	100)
2	kz Greater Kokstad Ward 003	0.93	%	(0.9	/	100)
3	kz Greater Kokstad Ward 005	5.80	%	(5.8	/	100)
4	kz Greater Kokstad Ward 008	10.81	%	(10.8	/	100)
5	kz Greater Kokstad Ward 006	11.23	%	(11.2	/	100)
6	kz Greater Kokstad Ward 007	14.03	%	(14	/	100)
7	kz Greater Kokstad Ward 002	14.14	%	(14.1	/	100)
8	kz Greater Kokstad Ward 001	28.72	%	(28.7	/	100)

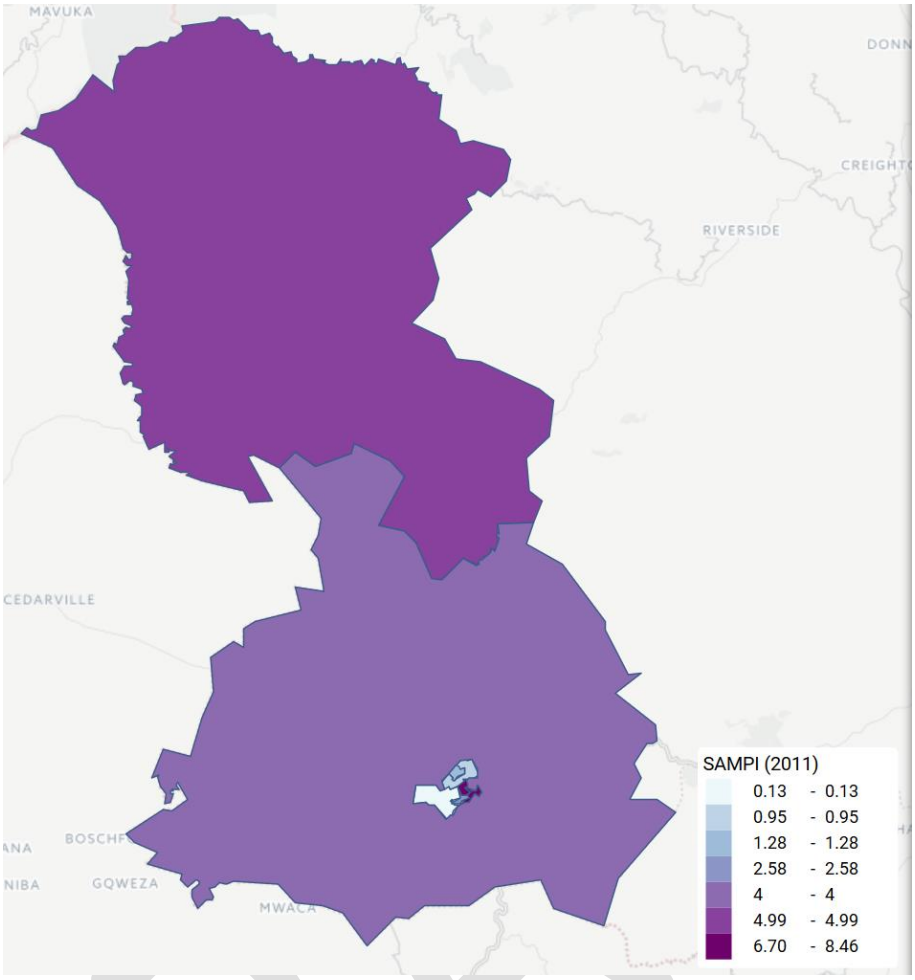

Figure 24: SAMPI (poverty Index) 2011 - ward level, Greater Kokstad local municipality

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

KZ GREATER KOKSTAD LOCAL MUNICIPALITY: **3.3 %**						
	Ward (2011)	**SAMPI (2011)**				
1	kz Greater Kokstad Ward 003	0.13	%	(0.1	/	100)
2	kz Greater Kokstad Ward 004	0.95	%	(1	/	100)
3	kz Greater Kokstad Ward 007	1.28	%	(1.3	/	100)
4	kz Greater Kokstad Ward 005	2.58	%	(2.6	/	100)
5	kz Greater Kokstad Ward 006	4	%	(4	/	100)
6	kz Greater Kokstad Ward 002	4.99	%	(5	/	100)
7	kz Greater Kokstad Ward 008	6.70	%	(6.7	/	100)
8	kz Greater Kokstad Ward 001	8.46	%	(8.5	/	100)

It is important to note that changes between the 2001 (Figure 25) and 2011 (Figure 26) for SAMPI at ward level. In 2001 the highest headcount amongst the wards in Greater Kokstad was 57.1%. This reduced to 19.5 in 2011.

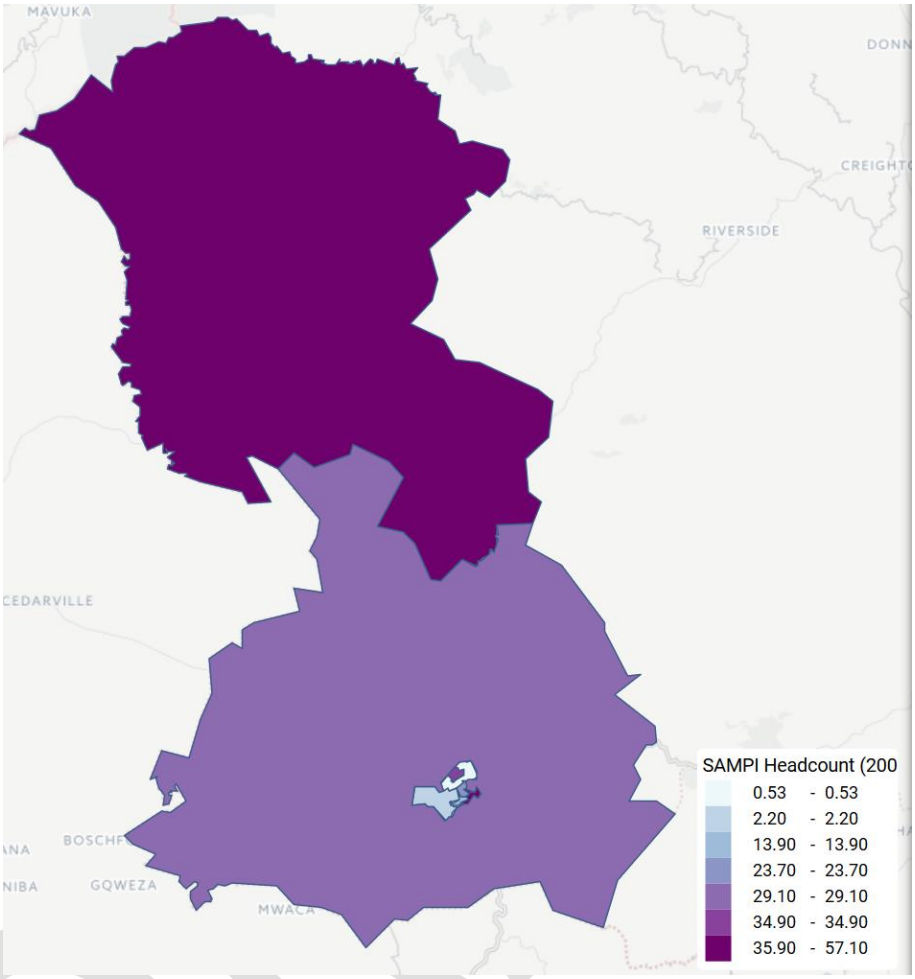

Figure 25: SAMPI 2001 poverty headcount - ward level, Greater Kokstad local municipality

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

KZ GREATER KOKSTAD LOCAL MUNICIPALITY: **26.4 %**						
	Ward (2011)	**SAMPI Headcount (2001)**				
1	kz Greater Kokstad Ward 004	0.53	%	(0.5	/	100)
2	kz Greater Kokstad Ward 003	2.20	%	(2.2	/	100)
3	kz Greater Kokstad Ward 005	13.90	%	(13.9	/	100)
4	kz Greater Kokstad Ward 008	23.70	%	(23.7	/	100)
5	kz Greater Kokstad Ward 006	29.10	%	(29.1	/	100)
6	kz Greater Kokstad Ward 007	34.90	%	(34.9	/	100)
7	kz Greater Kokstad Ward 002	35.90	%	(35.9	/	100)
8	kz Greater Kokstad Ward 001	57.10	%	(57.1	/	100)

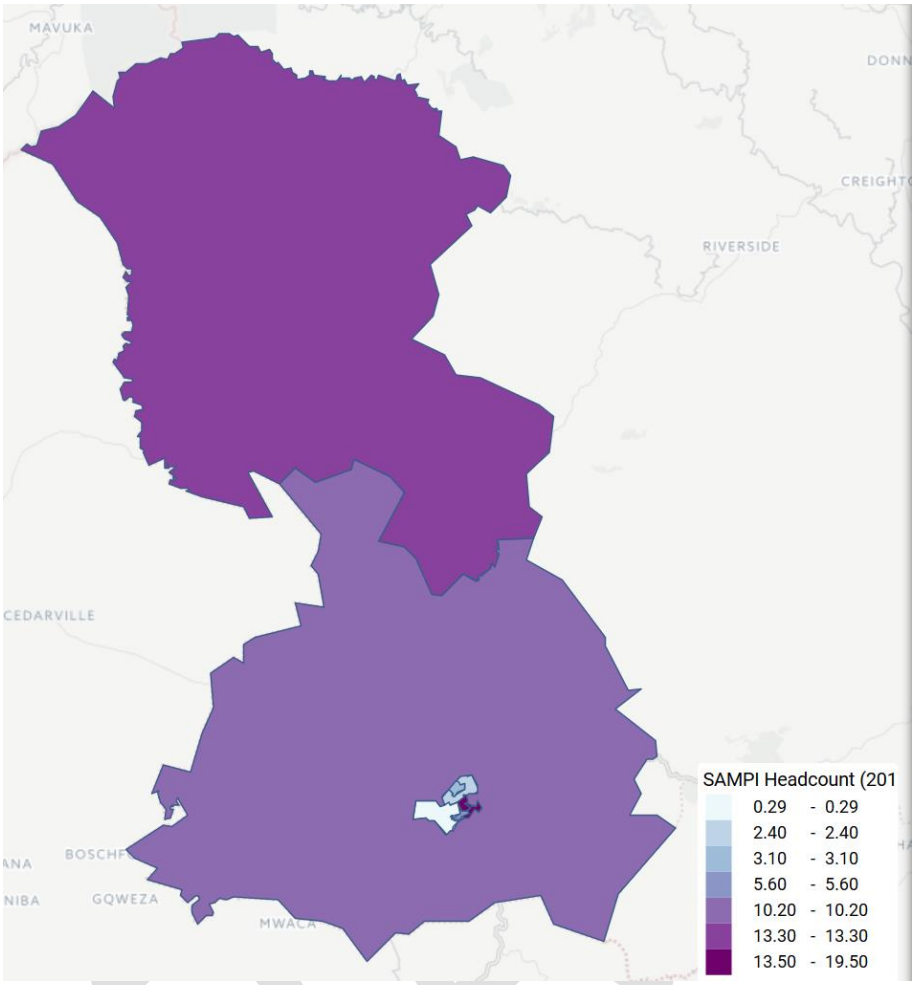

Figure 26: SAMPI 2011 poverty headcount - ward level, Greater Kokstad local municipality

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

KZ GREATER KOKSTAD LOCAL MUNICIPALITY: **7.9 %**						
	Ward (2011)	**SAMPI Headcount (2011)**				
1	kz Greater Kokstad Ward 003	0.29	%	(0.3	/	100)
2	kz Greater Kokstad Ward 004	2.40	%	(2.4	/	100)
3	kz Greater Kokstad Ward 007	3.10	%	(3.1	/	100)
4	kz Greater Kokstad Ward 005	5.60	%	(5.6	/	100)
5	kz Greater Kokstad Ward 006	10.20	%	(10.2	/	100)
6	kz Greater Kokstad Ward 002	13.30	%	(13.3	/	100)
7	kz Greater Kokstad Ward 008	13.50	%	(13.5	/	100)
8	kz Greater Kokstad Ward 001	19.50	%	(19.5	/	100)

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

- People, especially women, tended to be less assertive as a result of being in a dependent or disadvantaged position;
- Women are unlikely to refuse the demands of a man, especially if he is providing for them;
- Due to lack of money and high level of unemployment young women and girls get involved in transactional relationships;
- The older men called blessers provide money and money is misused by young people knowing that the blesser after another sex encounter will provide money;
- Young people are also vulnerable to blessers and sugar mamas because they are lured by material things that their parents cannot afford;
- People are unable to provide for themselves, they can't even afford the basic needs this also results in young woman and girls being involved in transactional sex and relationships such as blessers, sugar daddies and sugar mamas; and
- Health care facility is too far and people can't afford to travel to the facilities and end up not getting proper health care.

3.3.6 Employment

In Greater Kokstad local municipality, 40% of the female population at economically active age is employed while 48% of the economically active males are employed. See Figure 27 below.

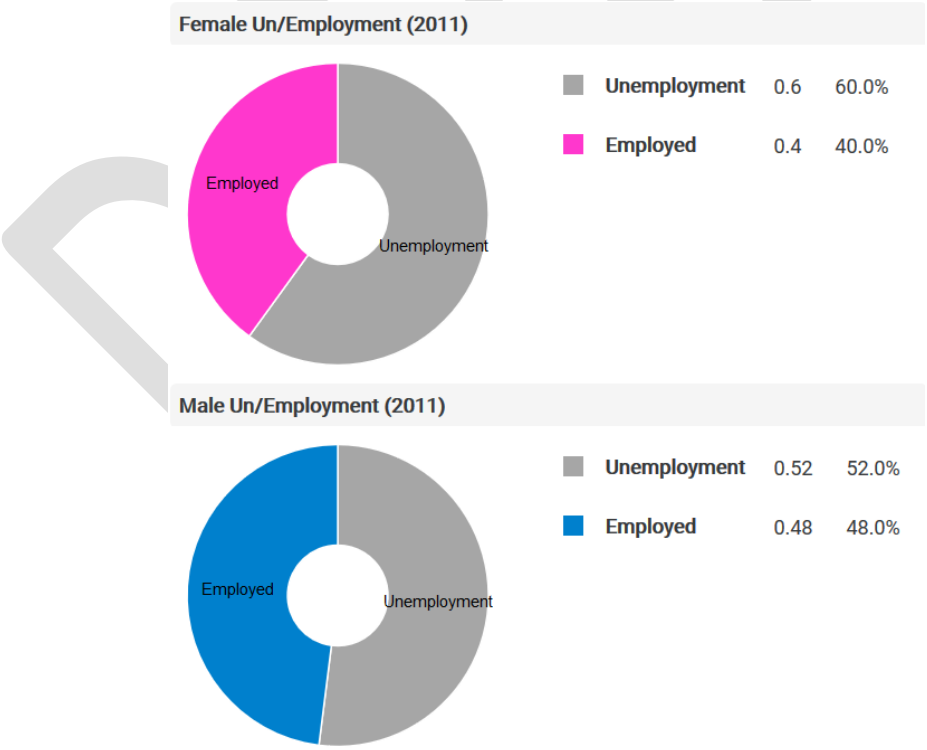

Figure 27: Female and Male employment Greater Kokstad local municipality (Source Census 2011)

Unemployment of youth in Greater Kokstad local municipality is at 65%.

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

In comparison with the Greater Kokstad local municipality a larger percentage of females and males are employed from the total population in the Khanyiselani Health Post catchment area. In this area 57% of the female population and 67% of the male population is employed (see Figure 29)

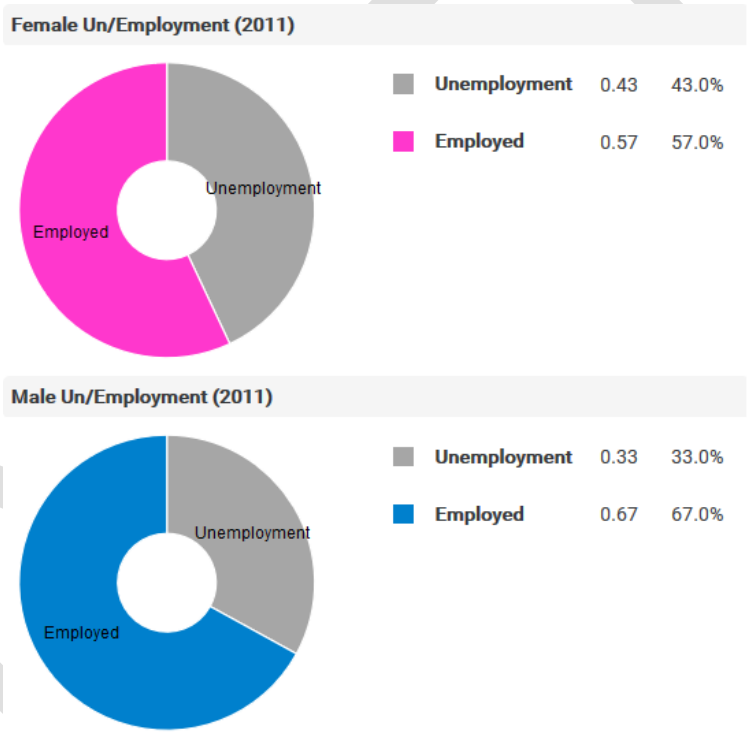

Figure 29: Female and Male employment Khanyiselani Health Post catchment area (Source Census 2011)

Nearly half of the youth (50.1%) are unemployment in the Khanyiselani Health Post catchment area

Figure 30: Youth unemployment Khanyiselani Health Post catchment area (source Census 2011)

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

- The majority of young people end up being involved in relationship with older man who referred to as (blessers) for example 14 year olds being exposed to sex to get money for food;
- In Greater Kokstad this was seen to occur on either side of the gender line. I.e. young men in relationships with older women and vice versa;
- The scholars have to travel a long distance to access high school and some of them cannot afford to pay for local transportation system so they drop out of schools; and
- Young people are engaged in sex work (undisclosed) due to unemployment.

3.3.7 Types of settlements

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

- Children witness their parents having sexual intercourse and they usually practice this with other children who are at their ages. This contributes to early sexual debut and possible infection;
- Lack of resources make it difficult to educate people about HIV in informal settlements.

3.3.8 Migration patterns in the area

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

- Migration pattern in the area is very high;
- The community accommodates people from different countries who come through Lesotho;
- This also contribute to high level of unemployment because it is said that these people accept low rate of income compared to the local people as a result the employers prefer them compared to the local people.

3.3.9 Education and literacy

Because higher education is very expensive the majority of the community members only study up to matric senior certificate level. This also contributes on the high level of unemployment and increased HIV infection for reasons mentioned above. The youth of Greater Kokstad were seen to be uninterested in education. Unemployment within the community is also due to the result of school drop outs. Some of the wards only have primary schools and there are no high schools.

3.3.10Hate crimes – xenophobic, homophobic, other

Xenophobia is the subject that appeared the most in this area. There was a feeling of hostility towards migrant workers. They were seen to be luring people's girlfriends with money. Spaza shop owners were seen to destroy local business, and are suspected of buying stolen goods.

3.3.11Disability

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

- Disable people are sexually abused because of their disability and more so they cannot be able to express themselves;
- Females with disabilities are continuously raped; especially to those that are mentally disabled;
- More education is needed for guardians of disabled people.

4. Services in the local municipality

4.1 Health facilities

There are seven health facilities in Greater Kokstad local municipality. See Figure 31 below for distribution of these facilities.

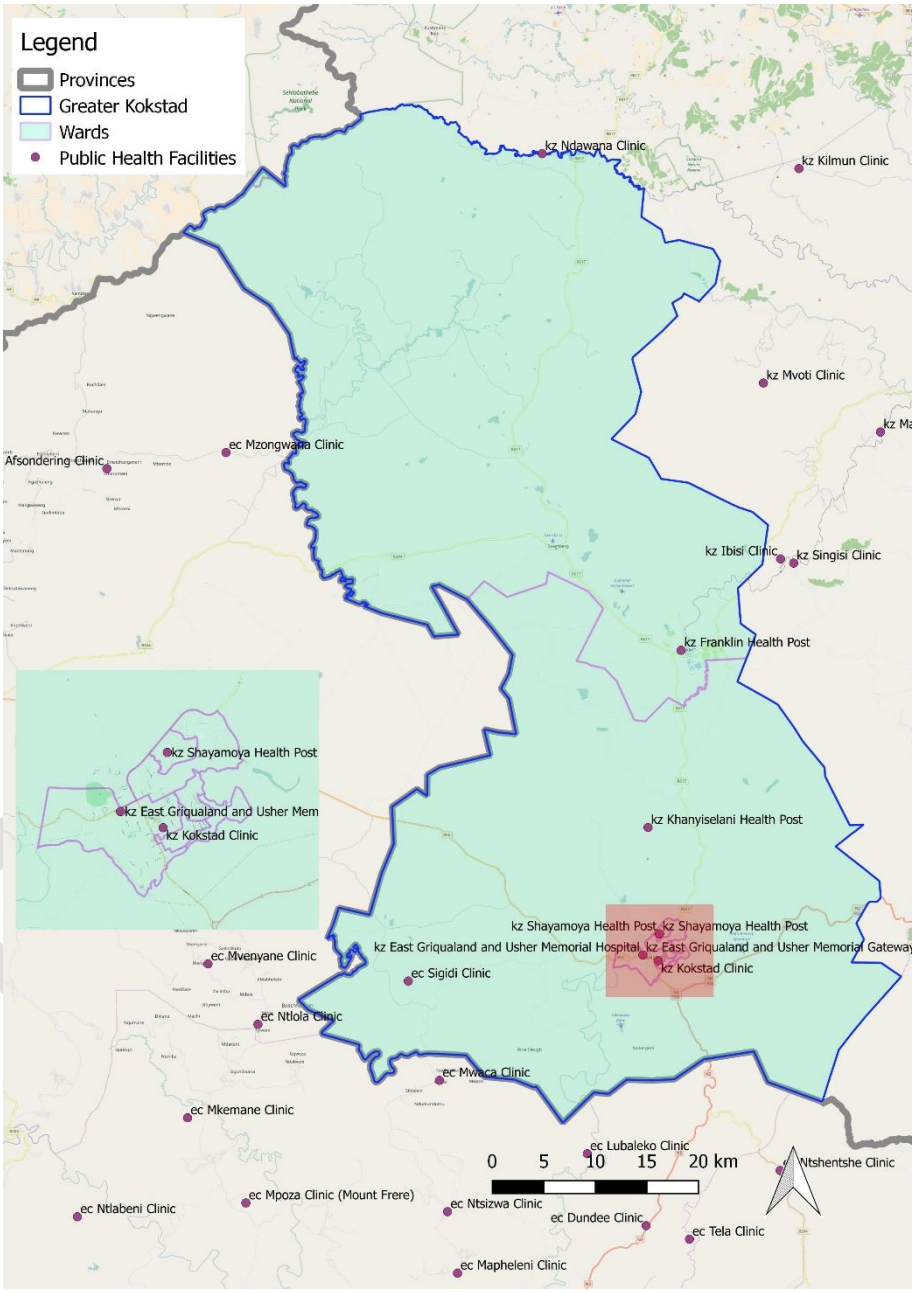

Figure 31: Distribution of health facilities in Greater Kokstad local municipality

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

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

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

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

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

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

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

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

Key and vulnerable populations for TB	**Priority interventions**
• People living with HIV • Household contacts of TB index patients • Health care workers • Pregnant women • Children < 5 years old • Diabetics • People living in informal settlements	• TB contact tracing, testing and post-exposure management • Enhanced health education about HIV/TB co-infection, reinfection • Service delivery and treatment delivery points in community, non-traditional settings
Key and vulnerable populations for HIV	**Priority interventions**
• Young women and girls; • Sex workers; • Orphans and vulnerable children.	• Sexual abuse and gender based violence – especially non-reporting of cases; • Stigma and discrimination – self and perceptions of facility; • HIV prevention after circumcision; • Sufficient coverage of outreach and mobile services • HIV knowledge among children; • High rate of substance abuse and drugs that triggers high risk behaviour; and • Shortage in female condom supply and education on correct use.

Table 27: Recommended multi-sectoral intervention packages

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

• Service delivery in non-traditional settings, including after-hours and weekend hours
• Health information, customised to client needs
• Sexual and reproductive health services
• HIV screening, testing and treatment
• STI screening, treatment
• TB screening, treatment (including preventive therapy) and contact tracing for DS- and DR-TB
• Mental health screening and psychosocial support
• Access to PEP and post-sexual assault support
• Alcohol and drug use screening and referral to harm reduction services
• Violence screening and referral to psychosocial and other support services
• Condom and lubricant promotion and provision
• Targeted social and behaviour change communication
• Core rights-based programme components:
  ○ Human rights and constitutional protection
  ○ Health empowerment
  ○ Economic empowerment
  ○ Gender norms and equality
  ○ Justice
  ○ Principles of universal design and accommodation that enables reasonable access for persons with disabilities
		• NGOs
		• DoH
		• DSD
		• DBE
		• NPA
		• PCA, DAC, LAC
		• SAPS
		• DOT

HIV and STI vulnerable populations		

Adolescent girls and young women	• Peer-led outreach
	• Youth-friendly sexual and reproductive health services in schools and community settings which include:
	  ○ PrEP (for over 18 years olds)
	  ○ Complete two dose HPV vaccine (Grade 4 learners)
	  ○ PMTCT
	  ○ Choice of termination of pregnancy
	  ○ Family planning services
	  ○ Male and female condom provision in school
	  ○ Sanitary towels
	• Programmes to keep girls in schools, including support for pregnant learners
	• Access to peer groups and clubs
		• DBE
		• DHET
		• DoH
		• DSD
		• NGOs
		• DoL
		• Private sector

Inclusive package of services for all key and vulnerable populations that will be customised to age and population served		Multi-sectoral partner
	• Access to parenting programmes • Economic empowerment programmes • Increased access to further education opportunities • Increased access to mentorship and internships • Comprehensive sexuality and gender education • Provide reasonable accessibility for girls and young women with disabilities • Age-specific support to HIV-positive adolescents (support for disclosure, adherence)	
HIV key populations	**Service**	**Multi-sectoral partner**
Sex workers	• Peer-led outreach • PrEP • Female and male condoms and lubricant • Intensified psychosocial support • Periodic presumptive treatment for STIs • Social mobilisation, use of formal/informal peer networks to create demand • PMTCT • Hepatitis B screening and immunisation • Annual Pap smears • CTOP (Choice of Termination of Pregnancy) • Screening for and protection from the sexual exploitation of children • Community empowerment	• DoH • DSD • NGOs
Men who have sex with men	• Peer-led outreach • PrEP • Lubricant, condom options • Hepatitis B screening and immunisation • Rectal care and treatment	• DoH • DSD • NGOs
Transgender persons	• Peer-led outreach • Specialised counselling support • PrEP • Female condoms and lubricant • Rectal care and treatment	• DoH • DSD • NGOs

Inclusive package of services for all key and vulnerable populations that will be customised to age and population served		Multi-sectoral partner
TB key populations		
Children <5 yrs	• Household TB and HIV screening, immediate linkage to treatment • Improved diagnostic and treatment capacity for paediatric TB • Promote activism for child-friendly TB formulations and introduce as soon as they are available • Improve sputum induction at PHC and hospital level • Screening for and protection from the sexual exploitation of children	• DoH • NGOs • Civil Society • DSD
Healthcare workers	• Implement guidelines for TB in HCWs • Institute regular TB screening and offer HIV testing for all HCWs • Offer TB preventive therapy to all HCWs who are living with HIV • Develop a recording and reporting system for TB and DR-TB in HCWs • Appoint a DoH-led task force to monitor implementation and further elucidate the effort–effect ratio of screening all HCWs annually with symptom screening and CXR, and to investigate the role of preventive therapy for HCWs • Implement the FAST model in facilities (finding cases actively by cough surveillance and rapid molecular sputum testing, separating safely, and treating effectively, based on rapid drug susceptibility testing)	• DoH • DoH
Household contacts of TB index patients	• Implement simplified screening algorithms for TB-exposed children • Implement community education and mobilisation programmes to improve acceptance of contact investigations and to create awareness of the benefits of preventive therapy • Strengthen routine M&E for TB contact investigations, HIV testing, TB preventive therapy including outcomes, and pharmacovigilance	• DoH • NGOs
People living in informal settlements (also a vulnerable population for HIV and STIs)	• Facilitate access and demand creation to increase community HIV, TB and STI service provision • Intensify GBV programmes and screening • Accelerate social support • Community education • Provide mobile services to improve accessibility • Infection control strategy for TB	• DoH • DSD • NGOs
People living with HIV	• Prompt ART initiation as a component of TB prevention • Adherence and psychosocial support • Peer education and support for TB prevention and treatment	• DoH

Inclusive package of services for all key and vulnerable populations that will be customised to age and population served		Multi-sectoral partner
	• Optimal uptake of preventive therapy for TB • Infection control in facilities, communities and households • TB symptom screening at each visit, linkages to treatment and care • HIV screening for household members, including partners and children • Cohort monitoring of HIV/TB co-infected patients • Support groups specifically addressing internalised stigma	
Pregnant women and neonates	• Full access to PMTCT services • Household TB and HIV screening, immediate linkage to treatment • Improve mother–child pair tracing and service delivery • Improve TB screening and testing among pregnant women to reduce congenital and perinatal TB transmission • Improve diagnostic and treatment capacity for neonatal TB	• DoH • NGOs • DSD

Addressing social and structural drivers	Service	Multi-sectoral partner
Community awareness and advocacy programmes	• Implement programmes to increase awareness of services	• DSD • Civil society including NGOs
Training for adolescent girls and young women	• Empower young women, such as through SABCOHA's BizAIDS programme, to start and improve their own businesses • Encourage companies to support the programme through co-funding and job opportunities	• SABCOHA and other private sector • Organised labour • DOT
Combination socio-economic programmes	• Strengthen economic capacities through support to access further education, training, job placements and entrepreneurial activities, including for PWDs	• DSD • Private sector • DHET • Civil society including NGOs
Implementation of harm reduction services to identify and support people who use substances and alcohol	• The Drug Master Plan harm reduction interventions including the provision of Opioid Substitution Therapy • Needle and syringe exchange programmes by NGOs • Identify for referral to in- and out-patient rehabilitation services	• DSD • DoH • NGOs • DBE • DHET

Addressing social and structural drivers	Service	Multi-sectoral partner
Strengthened and scaled-up community-based 'white-door' shelters	• Provide short-term (72-hour) places of safety and shelter within communities and referral/integration with HIV/TB/STI services	• DSD • SAPS • DoH • DOJ
Identify and speedily allocate social grants to all who are eligible	• Link PLHIV, TB clients to social security programmes for access to social relief distress grants	• DSD • Civil society including NGOs
Scaled-up provision of food parcels, and nutritional supplementation to all eligible PLHIV and PTB	• Strengthen capacity of HIV/TB providers to screen for food insecurity • Ensure access to sufficient food in particular for PLHIV and PWTB • Expand drop-in centres especially in high-burden districts • Expand access through Isibindi model	• DSD • NGOs • SANAC sectors
Implementation of harm reduction services to identify and support people who use substances and alcohol	• The Drug Master Plan harm reduction interventions including the provision of Opioid Substitution Therapy • Needle and syringe exchange programmes by NGOs • Identify for referral to in- and out-patient rehabilitation services	• DSD • DoH • NGOs • DBE • DHET
Community awareness and advocacy programmes	• Implement programmes to increase awareness of services	• DSD • Civil society including NGOs
Combination socio-economic programmes	• Strengthen economic capacities through support to access further education, training, job placements and entrepreneurial activities, including for PWDs	• DSD • Private sector • DHET • Civil society including NGOs

Comprehensive package of services for the general population, that will then be supplemented and customised to the age and population served			Multisectoral partner
• Accessible, friendly, comprehensive service delivery and health education, customised to client needs • HIV screening, testing, treatment • STI screening, testing, treatment • TB screening, testing, treatment and contact tracing for DS- and DR-TB • Medical male circumcision, referral • Comprehensive SRH services (including: cervical cancer screening, Pap smears, access to emergency contraception, choice of termination of pregnancy) • Prevention of mother-to-child transmission (PMTCT) of HIV • Mental health screening and psychosocial support • Access to PEP and post-sexual assault support • Alcohol and drug-use screening, referral • Violence screening, referral • Condom promotion and provision • Targeted social and behaviour change communication			• All implementing agencies • DoH • DSD • NPA • DBE • NGOS • PCA and DAC
Population	**Services/Interventions/Approaches**	**Setting**	**Multisectoral partner**
PLHIV (adults, adolescents)	• Hearing and vision screening, referral, treatment • Partner HIV testing, disclosure support, treatment, adherence support • Hepatitis B and HPV vaccine where eligible • PMTCT and enhanced adherence support through pre- and post-natal period, including breastfeeding • Gender norms • Health and health rights literacy • Economic empowerment and health promotion • School retention • Accelerated nutritional and social grant support, if indicated • Targeted demand creation for services • Targeted, PLHIV-friendly IEC materials and SBCC, including social media and materials for those with vision and hearing impairment • Service delivery points in community, non-traditional settings	• Health facility-based • School-based • Community-based • Mobile services	• DoH • DBE • DCS • DSD • CBOs • NGOs • Private employers • Private healthcare providers
Persons with TB (adults, adolescents)	• TB contact tracing, testing and post-exposure management • Partner HIV testing, disclosure support, treatment, adherence support	• Clinic-based • School-based • Community-based	• DoH • DBE • DCS

Population	Services/Interventions/Approaches	Setting	Multisectoral partner
	• Enhanced health education about HIV/TB co-infection, reinfection • Hearing and vision screening, referral, treatment • Hepatitis B and HPV vaccine where eligible • PMTCT and enhanced adherence support through pre- and post-natal period, including breastfeeding, if indicated • Mental health screening • Gender norms education • Health and health rights literacy • Economic empowerment and health promotion • School retention • Accelerated nutritional and social grant support, if indicated • Targeted, TB-friendly IEC materials and SBCC, including social media and materials for those with vision and hearing impairment • Service delivery and treatment delivery points in community, non-traditional settings	• Mobile services	• DSD • CBOs • NGOs • Private employers • Private healthcare providers

Generic HIV, TB and STI prevention, management and care		
Focus	**Activities**	**Multi-sectoral partner**
Promote retention in care for all PLHIV on ART	This will be supported and strengthened by: • Increased efforts to implement the test and treat policy at facility level through the DIP process • Increased quality assurance to promote adherence to guidelines • Expansion of implementation strategies to include community based ART initiation demonstration projects for well patients, including the use of GPs • Prioritise rapid and same day ART initiation • Implement extended hours services for working people and adolescents • Use PLHIV in health facilities and communities to encourage linkage to care • Explore innovative ways to improve patients' linkage to services • Differentiated ART delivery for stable patients, including a minimum of 3 months drug supply and optimised prescription periods to meet the needs of key and vulnerable populations and improve adherence	• DoH • DoT • Dept. of Agriculture • Private Sector • Civil society (PLHIV sector)

Generic HIV, TB and STI prevention, management and care		
Focus	**Activities**	**Multi-sectoral partner**
	• Ensure a functional fast lane for collection of repeat drug prescriptions at all pharmacies • Use of approved patient representatives to collect ART refills • Expand of the Central Chronic Medicine Dispensing and Distribution programme • Implementation of a return friendly system in all facilities • Track and improve the management of chronic diseases and their complications, as the population on ART ages	
Improve adherence support	• Implementation of a comprehensive and age appropriate psychosocial package to enhance adherence • Promoting the establishment of peer-led differentiated support groups for new and stable patients • Ensuring their linkages to psychosocial support.	• DSD • DoH • Private Sector
Intensified facility-level TB case-finding	• Passive case-finding (test individuals presenting with symptoms of TB • Routine symptom screening for all adult clinic attendees • Undertaking Xpert MTB/RIF test for symptomatic individuals not tested for TB in the last 3 months and undertaking culture test for HIV+, Xpert-negative cases	• DoH • Private healthcare providers
Active case-finding for key and vulnerable populations	• Screening of household contacts under 5 years of age • Intensified TB screening and access to appropriate treatment in correctional facilities, mines, informal settlements and antenatal clinics and for diabetics, PLHIV, health care workers and all household contacts • Contact tracing for all household members of TB index cases • Routine screening for health care workers • TB screening and testing among pregnant women to reduce congenital and perinatal TB transmission • Improved paediatric sputum induction at PHC and hospital level.	• DoH • NGOs and CBOs working in this area • DBE • DSD • Private healthcare providers
Appropriate syndromic management of STIs	• Ensuring appropriate management of cases non-responsive to the syndromic approach • The use of mobile outreach services for men with extended hours • Implementation of strategies to strengthen partner notification and contact tracing especially for key populations • Training and re-training of HCWs on syndromic management • Quality assurance programmes and advanced level STI management in secondary hospitals and CHCs with the necessary tools and training.	• DoH • DHET/HEAIDS • Private health sector

Generic HIV, TB and STI prevention, management and care		
Focus	**Activities**	**Multi-sectoral partner**
Screening of all pregnant women for syphilis at first ANC visit	• Screening for syphilis at birth for all infants born to Syphilis positive women or to women who were unbooked or untested • Linking all children diagnosed with congenital syphilis to care and ensuring they receive treatment; • Intensified notification process • Routine congenital syphilis monitoring and tracing and management of confirmed syphilis clients.	• DoH • Private health sector
Promote integration of STI prevention care and treatment into HIV, TB, ANC, sexual and reproductive health services	• Strengthened ART initiation at STIs services or linkage to ARV services	• DoH • Private health sector

Appendix A: Selecting Data for the Profile

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

- **Completeness of the data:** How well do the prevalence of HIV and the associated factors represent the true number of persons living with HIV in the selected service and/or administrative area?

- **Representativeness of the data:** How well do the characteristics from a data source correspond to the characteristics of the overall population? For example, data from a hospital-based sample may not represent all HIV-infected persons or all HIV-infected persons in care in the area covered by the survey.

- **Age of the data:** For example, a behavioural survey conducted in 2000 might not provide data that are sufficiently up-to-date for current prevention activities.

- **Timeliness of the data:** if dealing with administrative data, how long is the reporting delay between the diagnosis of HIV and associated socio demographic characteristics recorded and reported to relevant departments?

- **Surrogate, or proxy, markers:** A proxy variable can be used as a marker for other variables when what we really want to measure is too difficult to measure directly. For example, some areas may use STI data as a proxy when data on sexual behaviours are not available.

- **Reliability of the data:** How accurate and complete are the data? For example, how well was information e.g. age, recorded whether in a survey or in administrative records and transcribed to the case report from the medical record.

- **Small numbers:** Small numbers of cases need to be interpreted with caution because small absolute changes in the number of cases can produce large relative or proportionate changes in rates that may be misinterpreted by end users. Rates calculated from numerators smaller than 10 should be denoted in a footnote as unreliable.

Data assumptions and limitations

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

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

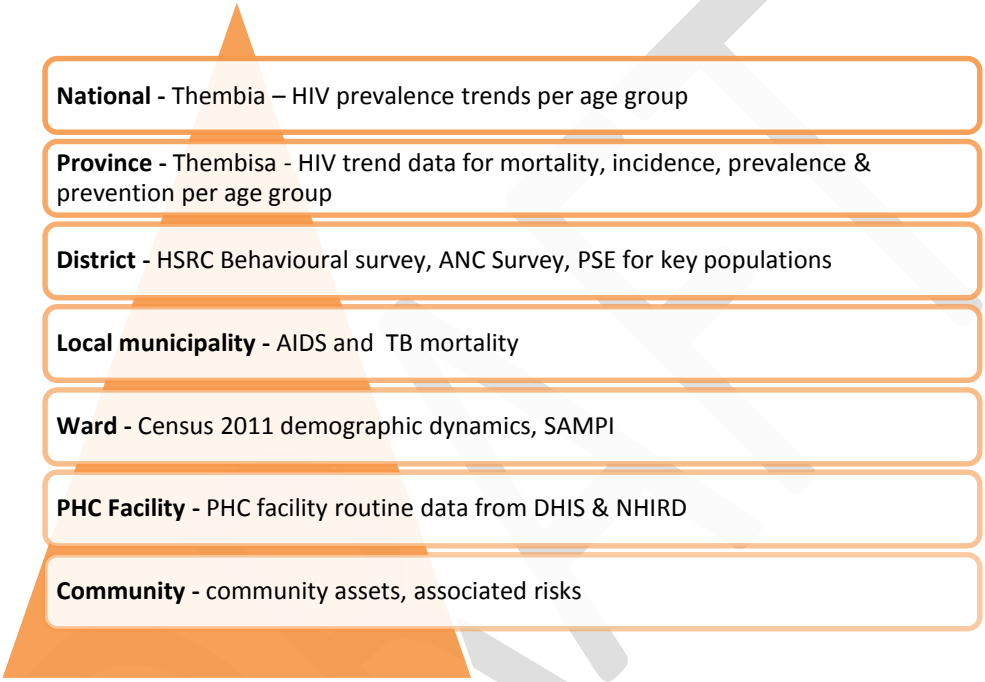

Figure 32: Data pyramid used for risk profiles

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

Catchment area and catchment populations

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

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

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

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

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

HIV associated risks

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

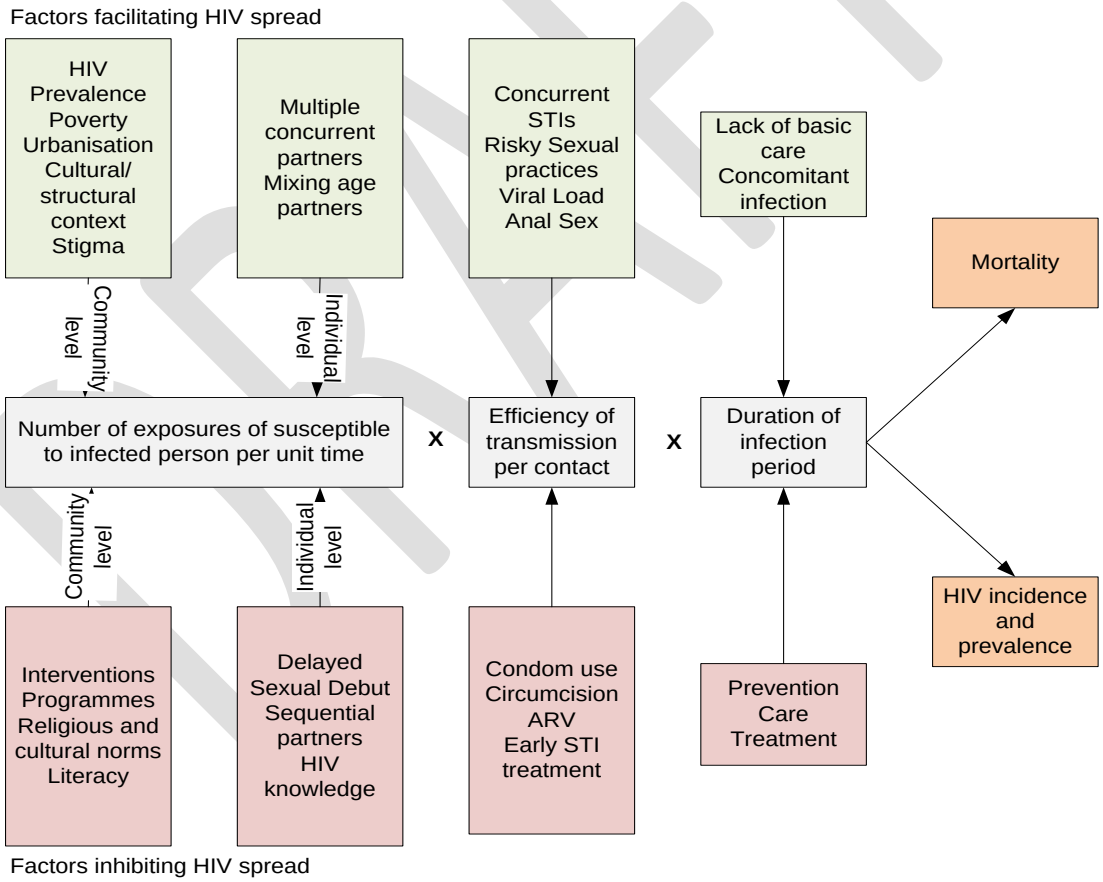

Figure 33: Factors influencing HIV associated risk and outcomes

Appendix B: Terms, Definitions and calculations

ANC client HIV 1st test positive rate (routine health indicator DHIS 2015)	Short Name - ANC HIV 1st test pos rate Numerator - Antenatal client HIV 1st test positive Denominator - Antenatal client HIV 1st test Indicator Type - % Definition - Antenatal clients tested HIV positive as proportion of antenatal clients HIV tested for the first time during current pregnancy
Antenatal client HIV re-test positive rate (routine health indicator DHIS 2015)	Short Name - ANC HIV re-test pos rate Numerator - Antenatal client HIV re-test positive Denominator - Antenatal client HIV re-test Indicator Type - % Definition - Antenatal clients re-tested positive for HIV as proportion of antenatal clients re-tested for HIV
Behavioural data	Data collected from studies of human behavior that is relevant to disease risk. Relevant behaviors for HIV risk may include sexual activity, substance use, needle sharing, condom use, or responses to primary and secondary prevention messages, knowledge of HIV transmission and prevention
Data	Raw, unprocessed numbers
Delivery in facility under 18 years rate (routine health indicator DHIS 2015)	Short Name - Delivery 18 rate Numerator - Delivery under 18 years in facility Denominator - Delivery in facility - total Indicator Type - % Definition - Deliveries to women under the age of 18 years as proportion of total deliveries in health facilities
Dependency ratio	The dependency ratio is an indicator of potential dependency burden of children and the elderly on those who are of economically productive ages in a population. Source Census 2011
Epidemiologic profile	A document that describes the distribution of HIV in various populations and identifies characteristics both of HIV-infected and HIV-negative persons in defined geographic areas. It is composed of information gathered to describe the effect of HIV on an area in terms of socio-demographic, geographic, behavioural, and clinical characteristics. Identifies characteristics of the general population and of populations who are living with, or at high risk for HIV infection in the pre-defined geographic areas in need of primary and secondary prevention or care services; and also identifies social, behavioural, cultural, factors driving local HIV infection. This providing information required to conduct needs assessments and gap analyses to complete the local HIV profile
Female condom distribution coverage (routine health indicator DHIS 2015)	Short Name - Fem condom dist cov Numerator - Female condoms distributed Denominator - Female population 15 years and older Indicator Type - %

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

	Description - Infants tested positive for HIV antibodies around 18 months after birth as the proportion of Infants tested for HIV antibodies around 18 months
Information	Processed or analysed data that adds context through relationships between data to allow for interpretation and use
Intensity of poverty	The average proportion of indicators in which poor households are deprived. Example, an intensity of 44% in 2011 means the average intensity of poverty was 44% amongst the 20% poor households
Male condom distribution coverage (routine health indicator DHIS 2015)	Short Name - Male cond dist cov Numerator - Male condoms distributed Denominator - Male population 15 years and older Indicator Type - % Definition - Male condoms distributed from a primary distribution site to health facilities or points in the community (e.g. campaigns, non-traditional outlets, etc.)
Male urethritis syndrome rate (routine health indicator DHIS 2015)	Short Name - MUS rate Numerator - Male Urethritis Syndrome treated - new episode Denominator - STI male - new episode Indicator Type - % Definition - Male urethritis Syndrome new episodes treated as a proportion of total males with STI new episodes treated
Modes of HIV transmission or mode of HIV exposure	Heterosex (or heterosexual contact with a partner who is HIV positive or at increased risk for HIV. Often this level of knowledge about sexual partners (anonymous, casual, or exclusive) may be unknown; Men who have sex with men (MSM); People who Inject Drugs (PWID); Joint risk of MSM/PWID; and Other mode of exposure including (transplant, hemophilia, transfusion or mother with HIV or HIV risk (PMTCT)
Morbidity	The presence of illness in the population.
Mortality	The total number of persons who have died of the disease of interest. Usually expressed as a rate, mortality (total number of deaths over the total population) measures the effect of the disease on the population as a whole
Percentage	A proportion of the whole, in which the whole is 100. Example: Assume that 10 of the 40 cases of AIDS in a given year in a Ward occurred in men. (10 ÷ 40) x100= 25%
Poverty Headcount	The proportion of households defined as multi-dimensionally poor using the poverty cut-off. Example a headcount of 20% in 2011, based on 2011 census, means that 20% of households in South Africa were poor.
Prevalence	The proportion of cases of a disease in a population at risk, measured at a given point in time (often referred to as point prevalence). Prevalence can also be measured over a period of time (e.g., a year; known as period prevalence). Prevalence does not indicate how long a person has had a disease. It can provide an estimate of risk for a disease at a specific time.

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

<table>
<tr><td></td><td>Source: Department of Health. 2015. NDOH Data Directory. Available online from http://dd.dhmis.org/index.html</td></tr>
<tr><td>Service area</td><td>The jurisdictions of service areas or planning regions of respective planning groups. Example Health districts, sub- districts, wards or health facility catchment areas</td></tr>
<tr><td>Socio-demographic factors</td><td>Background information about the population of interest (e.g., age, sex, race, educational status, income, geographic location). These factors are often thought of as explanatory because they help us to make sense of the results of our analyses</td></tr>
<tr><td>Socio-economic status (SES)</td><td>A measure of social and economic factors that helps to describe a person's standing in society (e.g., income level, relationship to the national poverty line, educational achievement)</td></tr>
<tr><td>South Africa Multidimensional Poverty Index (SAMPI[16]) (StatSSA, 2014)</td><td>The SAMPI is based on the global Multidimensional Poverty Index (MPI) which is an international measure of acute poverty. The MPI "complements traditional income/ expenditure-based poverty measures by capturing the severe deprivations that each person or household faces with respect the following dimensions: - education (measured by years of schooling and school attendance indicators), health (measured by nutrition and child mortality indicators), and living standards (measured by indicators such as cooking fuel, Sanitation, water, electricity, floor, and assets).

The MPI creates a comprehensive picture of who and where people are that are living in poverty… [and it also] permits comparisons within countries by population group, settlement type, as well as other key household and community characteristics.

The SAMPI includes an additional dimension –the economic activity indicated by adult unemployment
<table>
<tr><th>Dimension</th><th>Indicator</th><th>Deprivation cut-off</th></tr>
<tr><td>Health</td><td>Child mortality</td><td>If any child under the age of 5 has died in the past 12 months</td></tr>
<tr><td>Education</td><td>Years of schooling

School attendance</td><td>If no household member aged 15 or older has completed 5 years of schooling
If any school-aged child (aged 7 to 15) is out of school</td></tr>
<tr><td rowspan="2">Standard of living</td><td>Fuel for lighting</td><td>If household is using paraffin/candles/nothing/other</td></tr>
<tr><td>Fuel for heating</td><td>If household is using paraffin/wood/coal/dung/other/ none</td></tr>
</table>
</td></tr>
</table>

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

		Fuel for cooking	If household is using paraffin/wood/coal/dung/other/ none
		Water access	If no piped water in dwelling or on stand
		Sanitation type	If not a flush toilet
		Dwelling type	If an informal shack/traditional dwelling/caravan/tent/other
		Asset ownership	If household does not own more than one of radio, television, telephone or refrigerator and does not own a car
	Economic activity	Unemployment (all adults)	If all adults (aged 15 to 64) in the household are unemployed

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

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

In an extremely poor society where all households are poor and are deprived in all dimension indicators, the SAMPI score would be 1, 0. However, in an impoverished society where 50% of households are poor and experienced deprivation on 50% of all dimensions, the SAMPI score would be 0. 25.

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

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

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

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

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

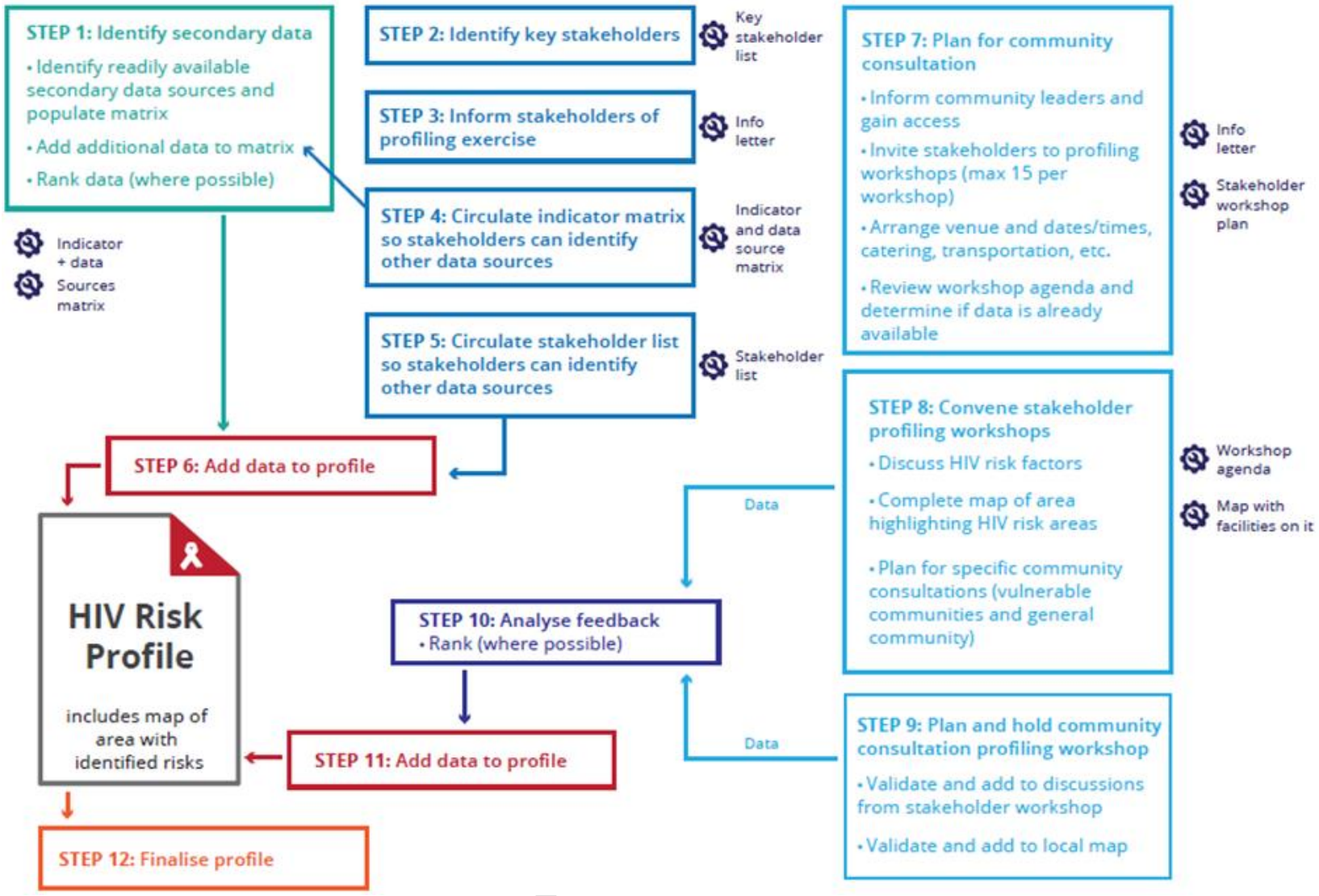

Figure 34: Steps for development of HIV associated risk profile