Focus for Impact

Community profile
Catchment area for Mkuze Clinic (Ward 20)

Jozini Local Municipality
uMkhanyakude District
KwaZulu-Natal

August 2017

Table of Contents

ABBREVIATIONS VI

FOCUS FOR IMPACT – UNDERSTANDING THE BACKGROUND VII

ACKNOWLEDGEMENT IX

INTRODUCTION TO PROFILE 1

1. SOCIO-DEMOGRAPHIC PROFILE 3

1.1 DEMARCATED BOUNDARIES 3

1.2 POPULATION BY SEX AND AGE 5

1.3 POPULATION BY RACE 8

2. EPIDEMIOLOGICAL PROFILE 10

2.1 CAUSES OF DEATH 10

2.2 HIV 10

2.3 TB 17

2.4 STIS 21

3. ASSOCIATED RISK PROFILE 23

3.1 BIOMEDICAL PROFILE 23

3.1.1 HIV TESTING 23

3.1.2 CIRCUMCISION 23

3.1.3 ARV TREATMENT 24

3.1.4 PEP AND PREP 24

3.1.5 LUBRICANT 24

3.2 BEHAVIOUR THAT CAN INFLUENCE RISK FOR HIV INFECTION 24

3.2.1 HIV KNOWLEDGE 25

3.2.2 SEXUAL RISKY BEHAVIOURS 25

3.2.3 SUBSTANCE ABUSE 25

3.2.4 CONDOMS 26

3.2.5 KEY AND VULNERABLE POPULATIONS 28

3.3 SOCIAL AND STRUCTURAL FACTORS THAT INFLUENCE HIV RISK 30

3.3.1 ORPHAN HOOD 30

3.3.2 CULTURAL AND RELIGIOUS NORMS 31

3.3.3 GENDER NORMS AND GENDER-BASED VIOLENCE 32

3.3.4 STIGMA 32

3.3.5 POVERTY 32

3.3.6 EMPLOYMENT 41

3.3.7 TYPES OF SETTLEMENTS 43

3.3.8 MIGRATION PATTERNS IN THE AREA 43

3.3.9 EDUCATION AND LITERACY 43

3.3.10 HATE CRIMES – XENOPHOBIC, HOMOPHOBIC, OTHER 43

3.3.11 DISABILITY 43

4. SERVICES IN THE LOCAL MUNICIPALITY 44

4.1 HEALTH FACILITIES 44

5. RECOMMENDATIONS FOR MULTI-SECTORAL INTERVENTIONS AND FOCUS ON KEY AND VULNERABLE POPULATIONS 45

APPENDIX A: SELECTING DATA FOR THE PROFILE 57
APPENDIX B: TERMS, DEFINITIONS AND CALCULATIONS 61
APPENDIX C: METHODOLOGY FOR STAKEHOLDER ENGAGEMENT TO EXPLORE LOCAL LEVEL DATA 68

Table of Figures

Figure 1: Local Municipalities' uMkhanyakude district 3
Figure 2: Distribution of Wards in the Jozini Local Municipality 4
Figure 3: Population Pyramid Jozini Local Municipality 6
Figure 4: Dependency ratio Jozini Local Municipality (Source Census 2011) 7
Figure 5: Population Pyramid Mkuze clinic catchment area (Source Census 2011) 7
Figure 6: Dependency ratio Mkuze clinic catchment area (Source Census 2011) 8
Figure 7: Population group distribution in Jozini Local Municipality (Source Census 2011) 8
Figure 8: ANC client HIV 1st test positive rate uMkhanyakude district (Source: KZN DHIS 2015) 11
Figure 9: Infant 1st PCR test positive around 6 weeks rate uMkhanyakude district (Source: KZN DHIS 2015) 12
Figure 10: Infant rapid HIV test around 18 months positive rate uMkhanyakude district (Source: KZN DHIS 2015) 13
Figure 11: HIV test positive child 12-59 months rate uMkhanyakude district (Source: KZN DHIS 2015) 14
Figure 12: HIV test positive child 5-14 years rate uMkhanyakude district (Source: KZN DHIS 2015) 15
Figure 13: HIV prevalence amongst client tested 15-49 years rate uMkhanyakude district (Source: KZN DHIS 2015) 16
Figure 14: TB (pulmonary) case finding index uMkhanyakude district (Source: KZN DHIS 2015) 17
Figure 15: TB suspect sputum test rate uMkhanyakude district (Source: KZN DHIS 2015) 18
Figure 16: TB suspect smear positive rate uMkhanyakude district (Source: KZN DHIS 2015) 19
Figure 17: TB suspect treatment initiation rate uMkhanyakude district (Source: KZN DHIS 2015) 20
Figure 18: Male urethritis syndrome rate uMkhanyakude district (Source: KZN DHIS 2015) 22
Figure 19: Female condom distribution rate uMkhanyakude district (Source: KZN DHIS 2015) 26
Figure 20: Male condom distribution rate uMkhanyakude district (Source: KZN DHIS 2015) 27
Figure 21: Teenage Pregnancy rate uMkhanyakude district (Source: KZN DHIS 2015) 28
Figure 22: Total number of Orphans with percentage that are double orphans per ward (Source Census 2011) 31
Figure 23: SAMPI (poverty Index) 2001 - ward level, Jozini Local Municipality 33

Figure 24: SAMPI (poverty Index) 2011 - ward level, Jozini Local Municipality 35
Figure 25: SAMPI 2001 poverty headcount - ward level, Jozini Local Municipality 37
Figure 26: SAMPI 2011 poverty headcount - ward level, Jozini Local Municipality 39
Figure 27: Female and Male employment Jozini Local Municipality (Source Census 2011) 41
Figure 28: Youth unemployment Jozini Local Municipality (source Census 2011) 41
Figure 29: Female and Male employment Mkuze clinic catchment area (Source Census 2011) 42
Figure 30: Youth unemployment Mkuze clinic catchment area (source Census 2011) 42
Figure 31: Distribution of health facilities in Jozini Local Municipality 44
Figure 32: Data pyramid used for risk profiles 58
Figure 33: Factors influencing HIV associated risk and outcomes 59
Figure 34: Steps for development of HIV associated risk profile 69

List of Tables

Table 1: Population per age groups per ward, Jozini Local Municipality 5
Table 2: Youth population per sex and five-year age groups per ward, Jozini Local Municipality 5
Table 3: Ward level population distribution by Race in Jozini Local Municipality 9
Table 4: Main cause of deaths in the uMkhanyakude District (Source STATSSA) 10
Table 5: HIV Positivity Rate (Antenatal 1st Test) uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017) 11
Table 6: HIV Positivity Rate (6 weeks) uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017) 12
Table 7: HIV Positivity Rate (18 months) uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017) 13
Table 8: HIV Positivity Rate (12-59 months) uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017) 14
Table 9: HIV Positivity Rate (5 - 14 years) uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017) 15
Table 10: HIV Positivity Rate (15 - 49 years) uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017) 16
Table 11: TB (pulmonary) case finding index uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017) 17
Table 12: TB (Sputum Test Rate) uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017) 18
Table 13: TB suspect smear positive rate uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017) 19
Table 14: TB suspect treatment initiation rate uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017) 20
Table 15: Male urethritis syndrome rate uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017) 22
Table 16: Female condom distribution rate uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017) 26
Table 17: Male condom distribution rate uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017) 27

Table 18: Teenage Pregnancy rate uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017) 28
Table 19: Key and vulnerable population groups 29
Table 20: Orphan hood for Census 2011 at Ward level in Jozini Local Municipality 30
Table 21: Poverty measures for Census 2011 at Ward level in Jozini Local Municipality 32
Table 22: SAMPI (poverty Index) 2001 - ward level, Jozini Local Municipality 33
Table 23: SAMPI (poverty Index) 2011 - ward level, Jozini Local Municipality 35
Table 24: SAMPI 2001 poverty headcount - ward level, Jozini Local Municipality 37
Table 25: SAMPI 2011 poverty headcount - ward level, Jozini Local Municipality 39
Table 26: Key and vulnerable populations as well as priority interventions identified in high burden areas 46
Table 27: Recommended multi-sectoral intervention packages 47

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
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis

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 which have become 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. This will lead to 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 as well as key and vulnerable populations, not forgetting adolescent boys and young men.

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

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

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

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

(c) ***Who*** is the most vulnerable population?

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

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

The ultimate success of the NSP 2017 – 2022, relies 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 completed 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

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.

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 Jozini Local Municipality in the uMkhanyakude 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

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

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

For this profile, the catchment area for Mkuze Clinic, Jozini Local Municipality is defined as Jozini Ward 20. For this specific profile, two stakeholder and community workshops held on 3 and 4 August 2017 in Mkuze Hall and uMkhanyakude District Municipality Council Chamber, Mkuze. The workshops were attended by 66 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 Jozini 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 Mkuze clinic catchment area:

- Key and vulnerable populations:
  - Sex workers
  - Drug users
  - Young women and girls
- Interventions that address:
  - Poverty, especially livelihoods support, to mitigate transactional sex as a source of income
  - Comprehensive, targeted, location-specific HIV prevention programmes designed for sex workers and truck drivers
  - Substance abuse, particularly among youth and by-law enforcement at liquor outlets (licensing conditions)
  - Employment programmes targeted at vulnerable populations
  - Overcrowding in RDP settlements that contribute to sexual risk behaviour

1. Socio-demographic profile

1.1 Demarcated boundaries

uMkhanyakude District is one of the 11 district municipalities of KwaZulu-Natal province. The Jozini Local Municipality is one of the five Local Municipalities in uMkhanyakude district. The rest are Mhlabuyalingana, Hlabisa, Mtubatuba and The Big 5 False Bay Local Municipalities.

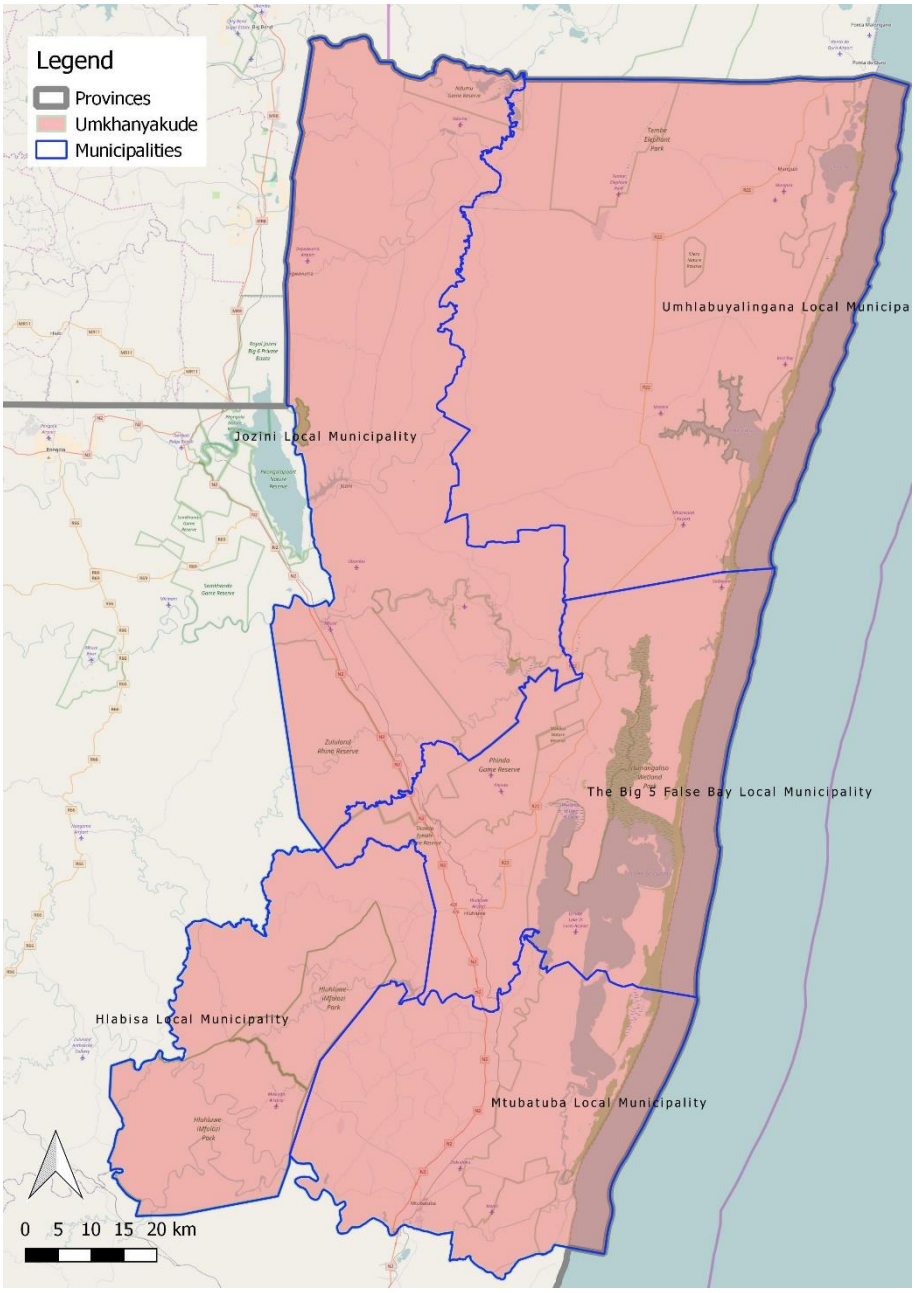

Figure 1: Local Municipalities' uMkhanyakude district

The Jozini Local Municipality constitute of 20 administrative wards (see Figure 2).

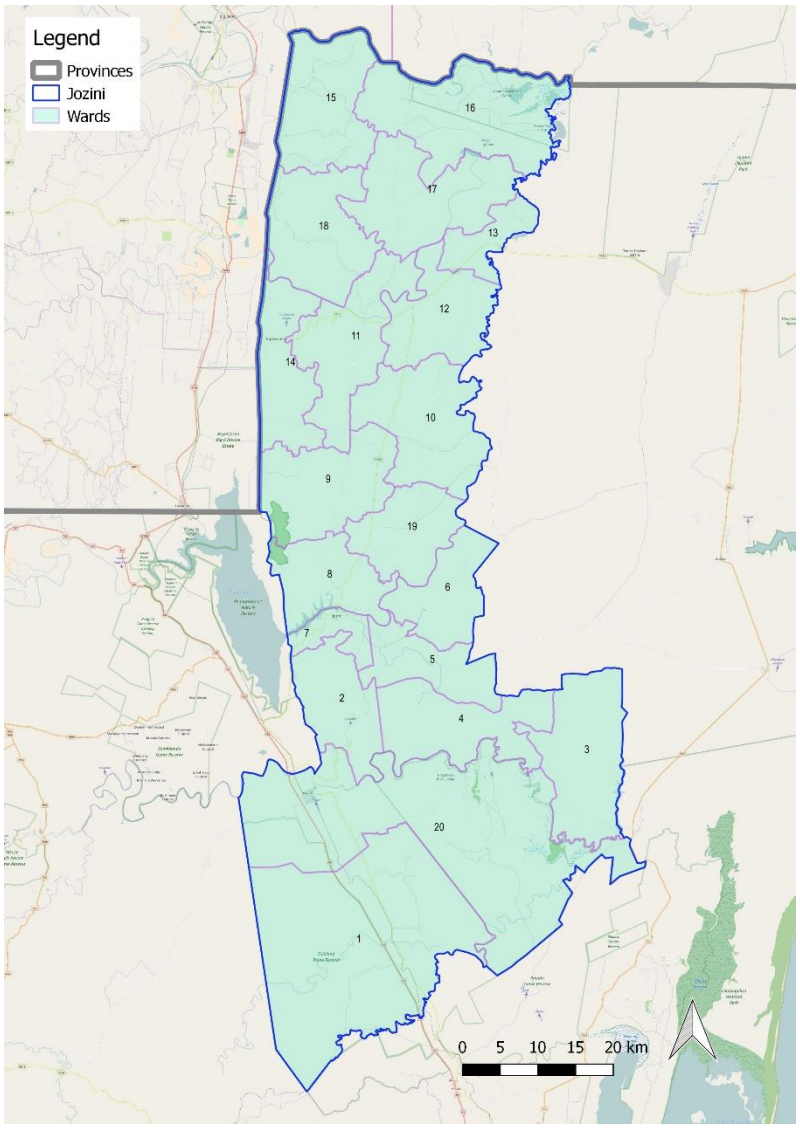

Figure 2: Distribution of Wards in the Jozini Local Municipality

1.2 Population by sex and age

During the 2011 Census 186 468 people were counted in the 20 wards. Table 1 summarises the age and sex per population in these wards. Females constitute 54% of population, compared to males at 46%. Young people ≤ 25 years (65%) make up the majority of population in the Local Municipality. The detail for Ward 20 that forms the catchment area for Mkuze Clinic is highlighted in the table below.

Table 1: Population per age groups per ward, Jozini Local Municipality

Ward	Age							Sex		
	0-9	10-14	15-19	20-24	25-49	50+	Total	Female	Male	Total
Ward 001	1953	1065	954	624	1653	915	7164	3864	3300	7164
Ward 002	2007	1005	984	840	2265	1041	8142	4308	3834	8142
Ward 003	2721	1344	1275	981	2094	1002	9417	5133	4284	9417
Ward 004	2406	1167	1095	834	1827	954	8283	4470	3813	8283
Ward 005	3666	1956	1941	1377	3300	1440	13680	7230	6450	13680
Ward 006	1890	1035	918	720	1620	753	6936	3669	3267	6936
Ward 007	2226	954	1089	1128	3330	846	9573	5097	4476	9573
Ward 008	2241	1104	1134	936	2127	957	8499	4554	3945	8499
Ward 009	2706	1281	1347	948	2019	1212	9513	5055	4458	9513
Ward 010	3429	1548	1473	1002	2472	1164	11088	6054	5034	11088
Ward 011	2166	1113	1167	837	1899	906	8088	4269	3819	8088
Ward 012	3180	1398	1440	1047	2430	915	10410	5661	4749	10410
Ward 013	3147	1491	1509	1107	2556	960	10770	5844	4926	10770
Ward 014	3057	1488	1536	1179	3039	1329	11628	6342	5286	11628
Ward 015	2568	1206	1080	852	1878	879	8463	4599	3864	8463
Ward 016	2658	1326	1323	948	2277	951	9483	5124	4359	9483
Ward 017	3210	1581	1488	954	2094	1098	10425	5682	4743	10425
Ward 018	2454	1053	1032	798	1725	876	7938	4314	3624	7938
Ward 019	2604	1215	1242	900	1959	900	8820	4830	3990	8820
Ward 020	1611	705	843	1014	3315	660	8148	4272	3876	8148
	51900	25035	24870	19026	45879	19758	186468	100371	86097	186468
%	28%	13%	13%	10%	25%	11%		**54%**	**46%**	

Table 2: Youth population per sex and five-year age groups per ward, Jozini 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	555	519	321	285	222	510	435	303	210	177	**3537**
Ward 002	489	486	393	390	309	516	498	447	345	213	**4086**
Ward 003	684	648	546	393	261	660	627	435	285	180	**4719**
Ward 004	558	555	414	372	255	609	540	420	207	150	**4080**
Ward 005	927	951	732	573	438	1029	990	645	429	309	**7023**
Ward 006	483	429	393	291	213	552	489	327	210	147	**3534**
Ward 007	459	576	630	618	447	495	513	498	441	387	**5064**
Ward 008	531	582	510	432	264	573	552	426	285	174	**4329**

Ward	Female					Male					
	10-14	15-19	20-24	25-29	30-34	10-14	15-19	20-24	25-29	30-34	
Ward 009	627	627	522	357	285	654	720	426	258	189	**4665**
Ward 010	756	750	585	453	330	792	723	417	285	192	**5283**
Ward 011	549	543	450	339	243	564	624	387	252	168	**4119**
Ward 012	672	663	612	453	306	726	777	435	291	171	**5106**
Ward 013	744	747	582	510	297	747	762	525	300	180	**5394**
Ward 014	747	846	639	498	348	741	690	540	396	300	**5745**
Ward 015	600	564	438	333	246	606	516	414	216	162	**4095**
Ward 016	627	654	534	426	315	699	669	414	258	186	**4782**
Ward 017	819	723	540	387	294	762	765	414	192	141	**5037**
Ward 018	519	543	420	369	219	534	489	378	168	129	**3768**
Ward 019	594	621	510	384	243	621	621	390	255	129	**4368**
Ward 020	363	444	546	579	456	342	399	468	486	393	**4476**
	12303	**12471**	**10317**	**8442**	**5991**	**12732**	**12399**	**8709**	**5769**	**4077**	**93210**

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

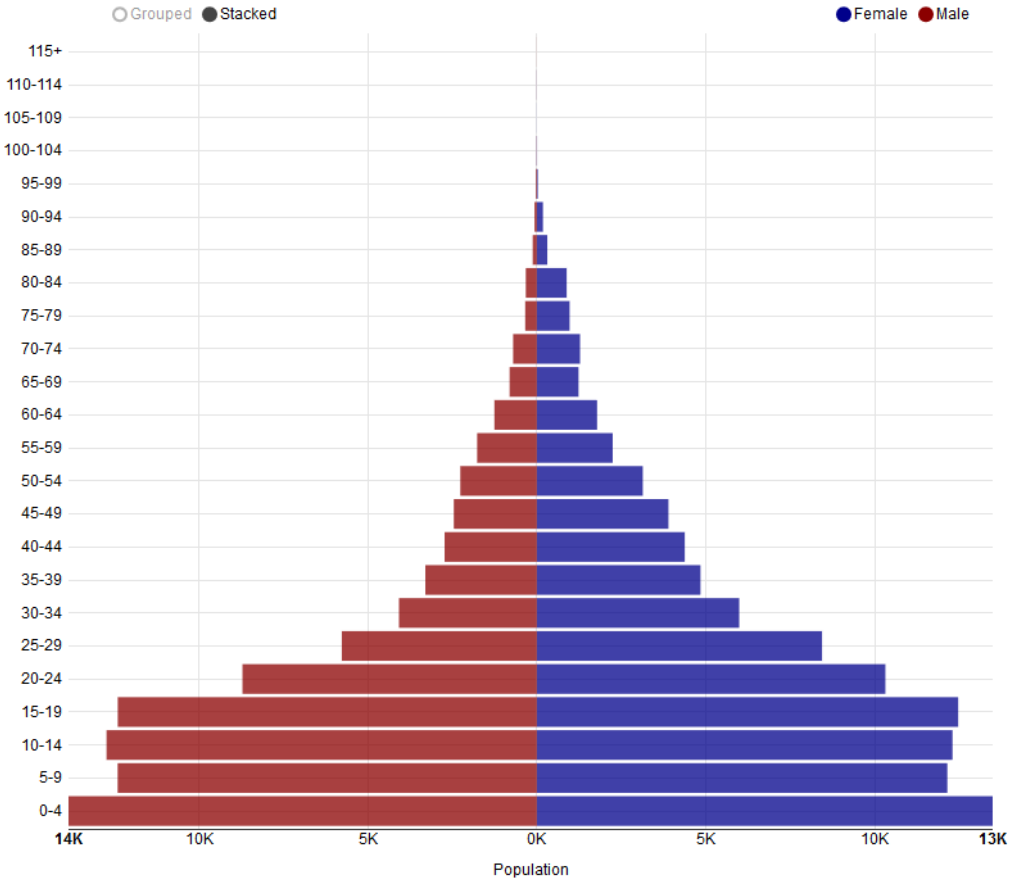

Figure 3: Population Pyramid Jozini Local Municipality

From this population, 41.3% children and 3.9% elderly are dependent on the 54.8% economically productive ages in the population of the Jozini Local Municipality (Figure 4).

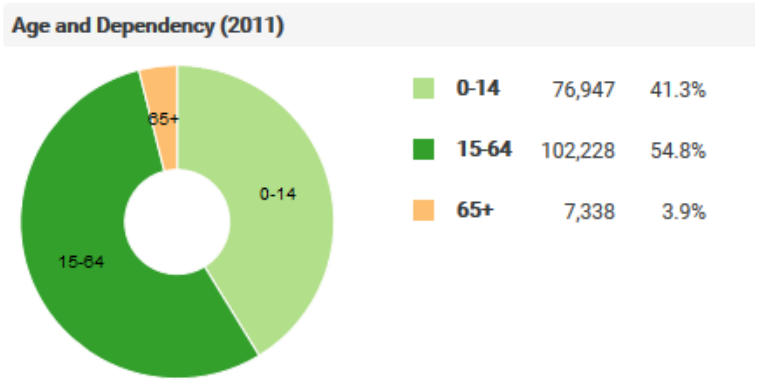

Figure 4: Dependency ratio Jozini Local Municipality (Source Census 2011)

In the catchment area for the Mkuze Clinic (Jozini Ward 20) there is a change in the population profile (Figure 5) with a youth bulge and different male to female distribution to that seen in the Jozini Local Municipality population pyramid in Figure 3.

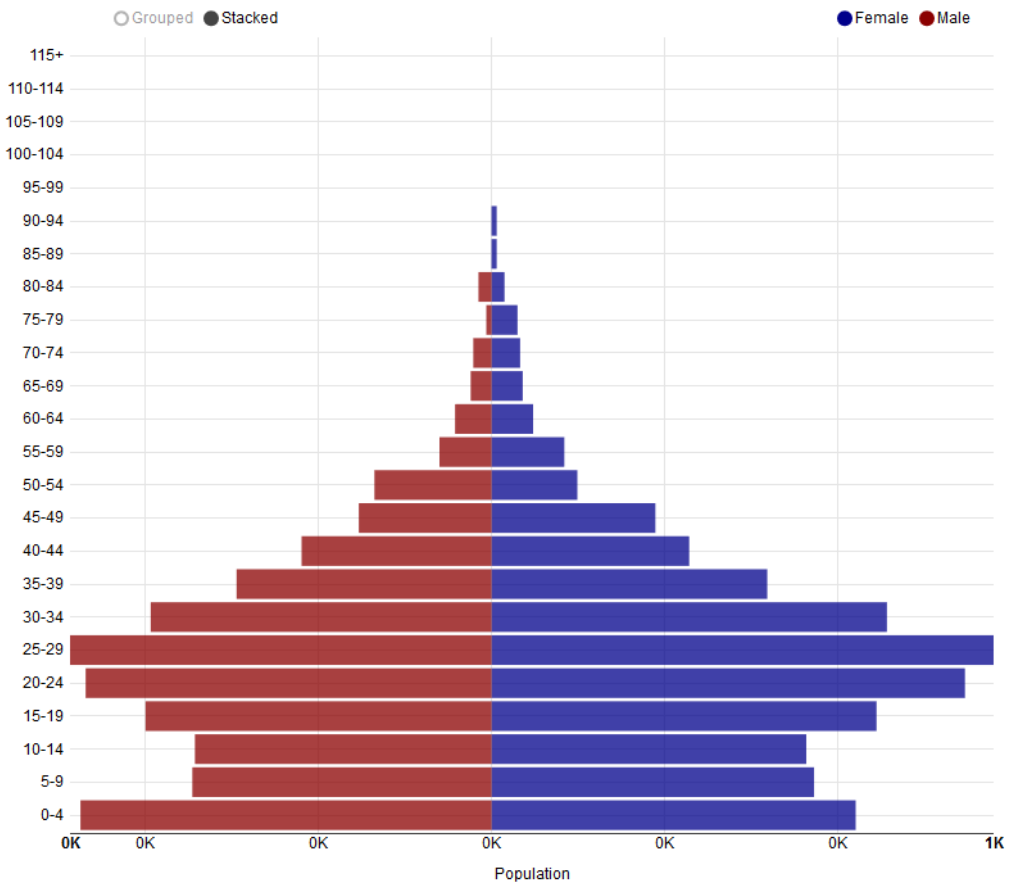

Figure 5: Population Pyramid Mkuze clinic catchment area (Source Census 2011)

In the same catchment population, 28.4% children and 2.2% elderly are dependent on the 69.3% economically productive age group (Figure 6).

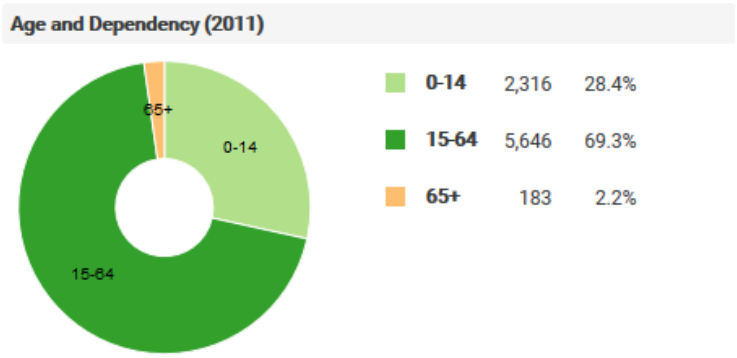

Figure 6: Dependency ratio Mkuze clinic catchment area (Source Census 2011)

1.3 Population by race

The dominant population group in Jozini Local Municipality is Black African at 99.2% followed by white at 0.3% (detail in Figure 7 and Table 3).

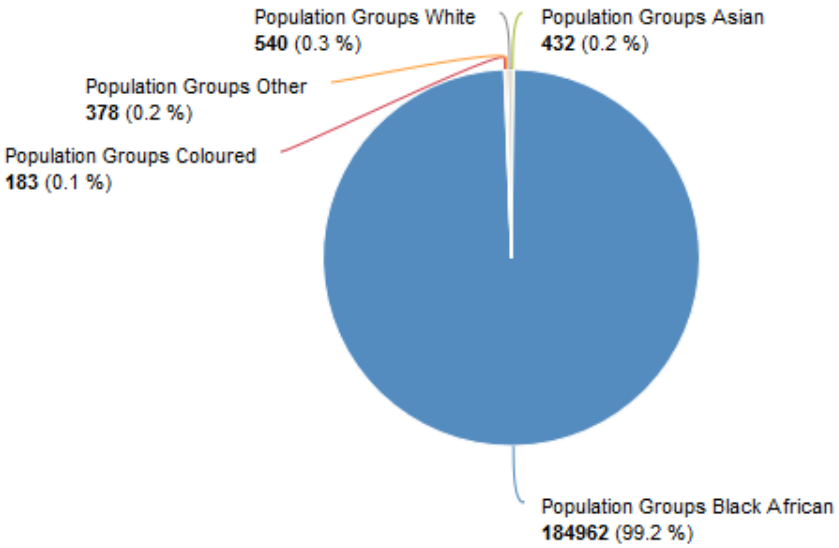

Figure 7: Population group distribution in Jozini Local Municipality (Source Census 2011)

The detail for Ward 20 that forms the catchment area for Mkuze Clinic, are highlighted in the table below.

Table 3: Ward level population distribution by Race in Jozini Local Municipality

Ward	Asian	Black African	Coloured	Other	White	Total
Ward 001	3	7140	3		27	**7173**
Ward 002	33	8037	45	6	24	**8145**
Ward 003	9	9381	6	18	9	**9423**
Ward 004	6	8274	3		9	**8292**
Ward 005	15	13587	18	12	42	**13674**
Ward 006	9	6909	9	12	3	**6942**
Ward 007	129	9300	15	48	78	**9570**
Ward 008	6	8484	6	3	6	**8505**
Ward 009	3	9417		78	6	**9504**
Ward 010	12	11064	3	3	3	**11085**
Ward 011	21	8025	9	21	18	**8094**
Ward 012	24	10302	6	69	6	**10407**
Ward 013	21	10704	3	3	45	**10776**
Ward 014	33	11529	18	30	24	**11634**
Ward 015	6	8454	6			**8466**
Ward 016	27	9435	3	18	15	**9498**
Ward 017		10407	3	9		**10419**
Ward 018	6	7926			3	**7935**
Ward 019	15	8781	3		9	**8808**
Ward 020	54	7806	24	48	213	**8145**
	432	**184962**	**183**	**378**	**540**	**186495**

2. Epidemiological profile

2.1 Causes of death

With the roll out of ART in South Africa, AIDS is now considered a chronic disease since many people living with HIV are living longer. The main causes of death, the uMkhanyakude 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 uMkhanyakude District (Source STATSSA)

Cause	Number of deaths	Percent deaths
Tuberculosis		
HIV Disease		
Diabetes Mellitus		
Cerebrovascular Disease		
Hypertensive Disease		
Intestinal Infectious Disease		
Other forms of Heart Disease		
Ischaemic Heart Disease		
Influenza and Pneumonia		
Malignant/neoplasm		
Other Natural Causes		
Non-Natural Causes		

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 in the uMkhanyakude district. The definitions for these indicators can be found in Appendix B.

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

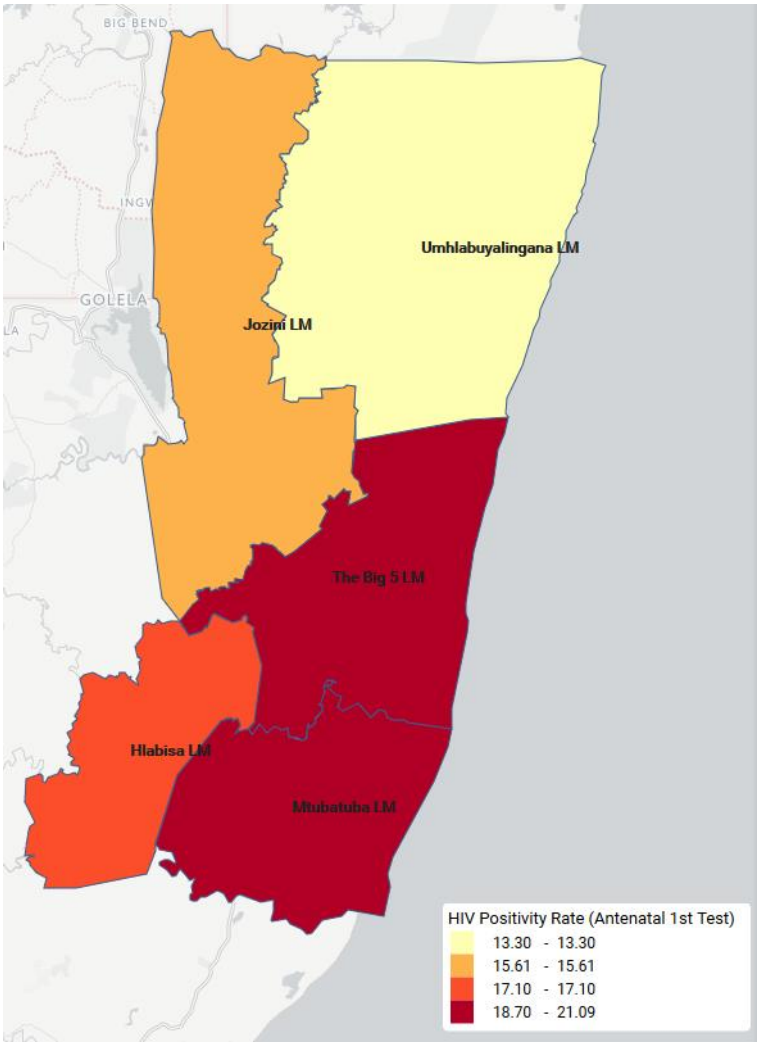

Figure 8: ANC client HIV 1st test positive rate uMkhanyakude district (Source: KZN DHIS 2015)

Table 5: HIV Positivity Rate (Antenatal 1st Test) uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017)

KZ UMKHANYAKUDE DISTRICT MUNICIPALITY: **16.7 %**								
	Local Municipality	**2015 : HIV Positivity Rate (Antenatal 1st Test)**					**NUM %**	**DEN %**
1	kz Mhlabuyalingana Local Municipality	13.30	%	(463	/	3481)	21.83 %	27.40 %
2	kz Jozini Local Municipality	15.61	%	(615	/	3941)	29 %	31.02 %
3	kz Hlabisa Local Municipality	17.10	%	(210	/	1228)	9.90 %	9.67 %
4	kz The Big 5 False Bay Local Municipality	18.70	%	(172	/	920)	8.11 %	7.24 %
5	kz Mtubatuba Local Municipality	21.09	%	(661	/	3134)	31.16 %	24.67 %

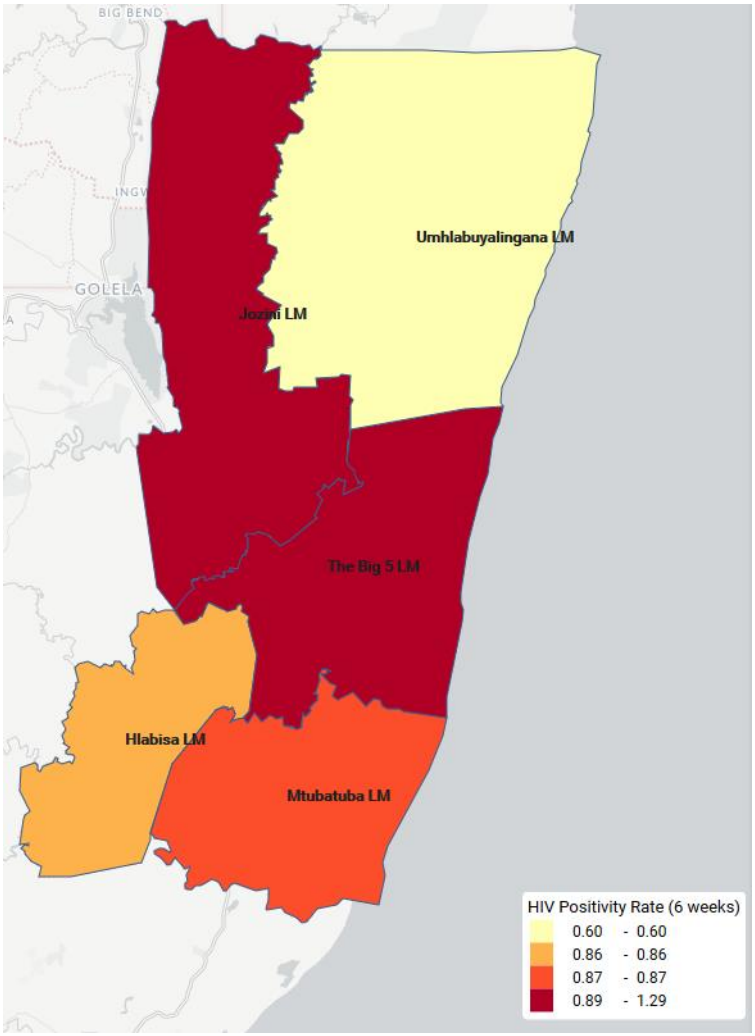

Figure 9: Infant 1st PCR test positive around 6 weeks rate uMkhanyakude district (Source: KZN DHIS 2015)

Table 6: HIV Positivity Rate (6 weeks) uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017)

KZ UMKHANYAKUDE DISTRICT MUNICIPALITY: **0.9 %**								
	Local Municipality	**2015 : HIV Positivity Rate (6 weeks)**					**NUM %**	**DEN %**
1	kz Mhlabuyalingana Local Municipality	0.60	%	(6	/	1008)	16.67 %	25.97 %
2	kz Hlabisa Local Municipality	0.86	%	(3	/	348)	8.33 %	8.96 %
3	kz Mtubatuba Local Municipality	0.87	%	(10	/	1143)	27.78 %	29.44 %
4	kz The Big 5 False Bay Local Municipality	0.89	%	(2	/	224)	5.56 %	5.77 %
5	kz Jozini Local Municipality	1.29	%	(15	/	1159)	41.67 %	29.86 %

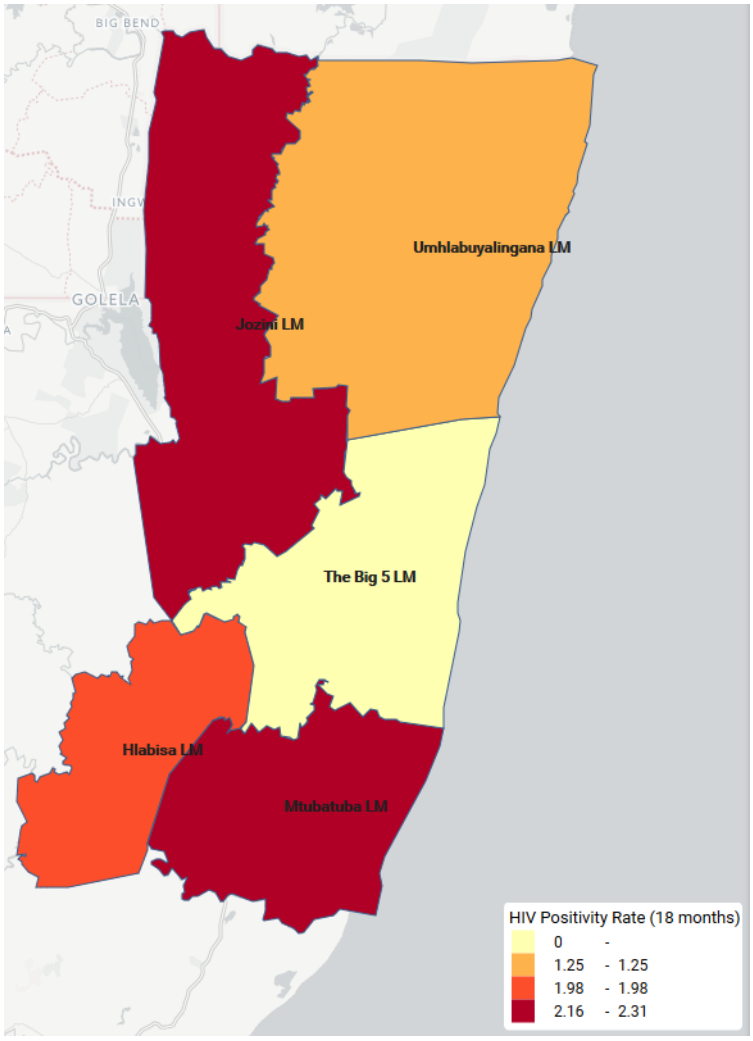

Figure 10: Infant rapid HIV test around 18 months positive rate uMkhanyakude district (Source: KZN DHIS 2015)

Table 7: HIV Positivity Rate (18 months) uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017)

KZ UMKHANYAKUDE DISTRICT MUNICIPALITY: **1.8 %**								
	Local Municipality	**2015 : HIV Positivity Rate (18 months)**					**NUM %**	**DEN %**
1	kz The Big 5 False Bay Local Municipality	0	%	(-	/	177)	0 %	5.11 %
2	kz Mhlabuyalingana Local Municipality	1.25	%	(13	/	1044)	20.63 %	30.11 %
3	kz Hlabisa Local Municipality	1.98	%	(5	/	253)	7.94 %	7.30 %
4	kz Jozini Local Municipality	2.16	%	(15	/	696)	23.81 %	20.07 %
5	kz Mtubatuba Local Municipality	2.31	%	(30	/	1297)	47.62 %	37.41 %

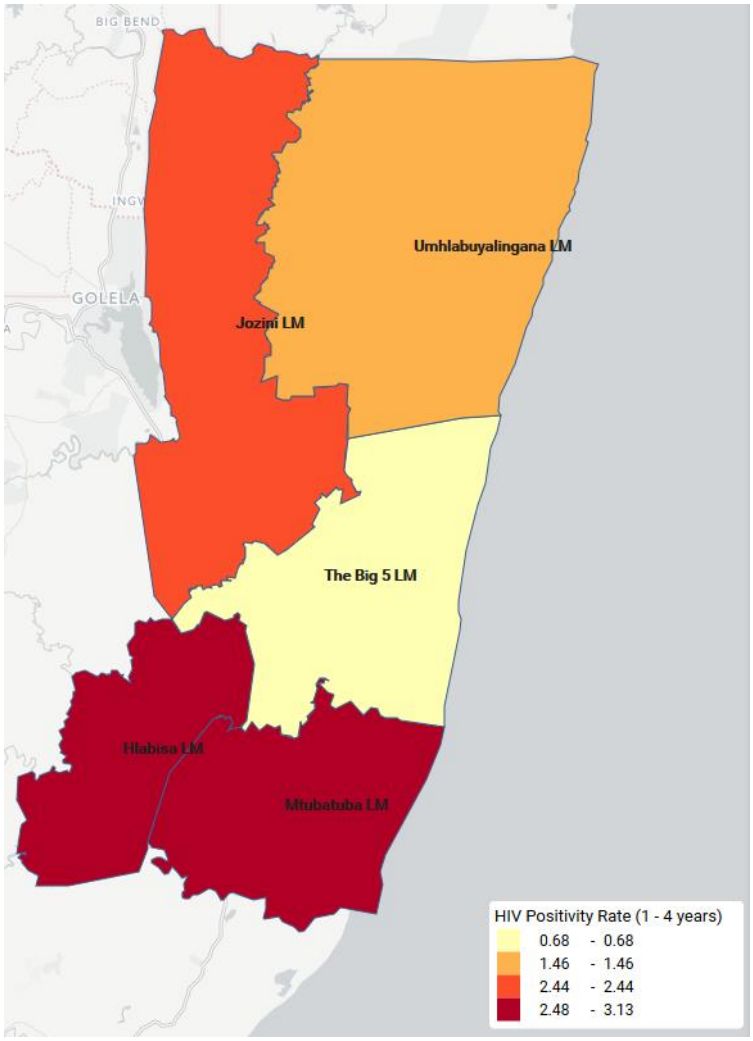

Figure 11: HIV test positive child 12-59 months rate uMkhanyakude district (Source: KZN DHIS 2015)

Table 8: HIV Positivity Rate (12-59 months) uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017)

KZ UMKHANYAKUDE DISTRICT MUNICIPALITY: **2.2 %**									
	Local Municipality	**2015 : HIV Positivity Rate (1 - 4 years)**					**NUM %**	**DEN %**
1	kz The Big 5 False Bay Local Municipality	0.68	%	(3	/	444)	1.92 %	6.37 %
2	kz Mhlabuyalingana Local Municipality	1.46	%	(32	/	2195)	20.51 %	31.48 %
3	kz Jozini Local Municipality	2.44	%	(37	/	1516)	23.72 %	21.74 %
4	kz Hlabisa Local Municipality	2.48	%	(16	/	646)	10.26 %	9.26 %
5	kz Mtubatuba Local Municipality	3.13	%	(68	/	2172)	43.59 %	31.15 %

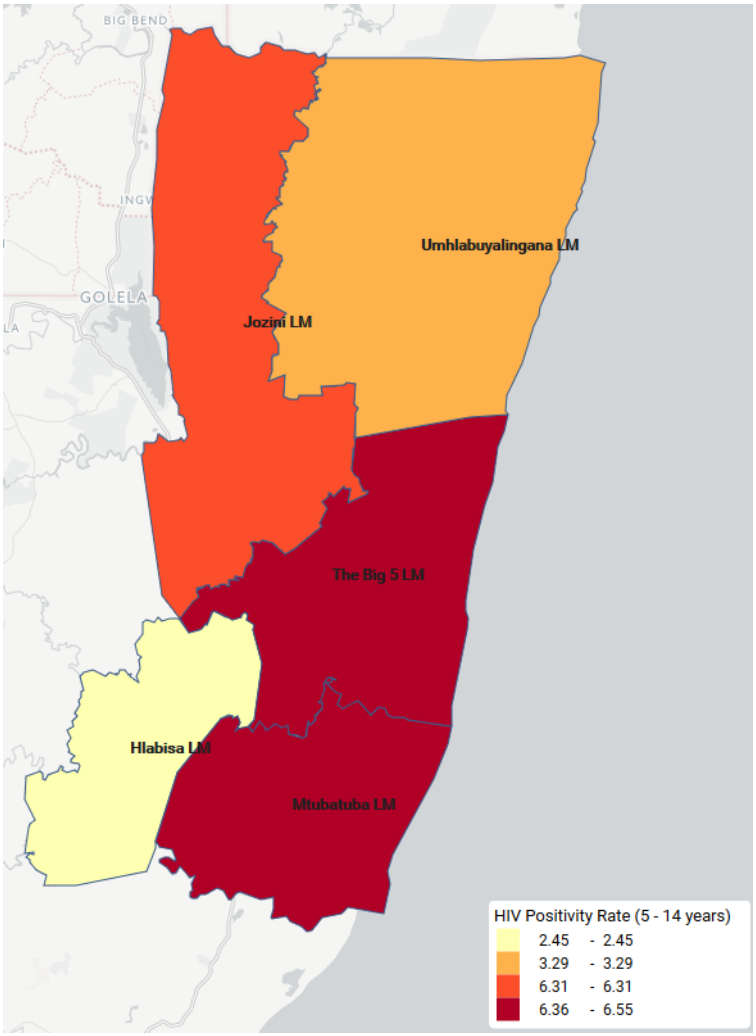

Figure 12: HIV test positive child 5-14 years rate uMkhanyakude district (Source: KZN DHIS 2015)

Table 9: HIV Positivity Rate (5 - 14 years) uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017)

KZ UMKHANYAKUDE DISTRICT MUNICIPALITY: **4.8 %**									
	Local Municipality	**2015 : HIV Positivity Rate (5 - 14 years)**						**NUM %**	**DEN %**
1	kz Hlabisa Local Municipality	2.45	%	(18	/	736)		9.38 %	18.58 %
2	kz Mhlabuyalingana Local Municipality	3.29	%	(34	/	1035)		17.71 %	26.13 %
3	kz Jozini Local Municipality	6.31	%	(78	/	1236)		40.63 %	31.20 %
4	kz The Big 5 False Bay Local Municipality	6.36	%	(15	/	236)		7.81 %	5.96 %
5	kz Mtubatuba Local Municipality	6.55	%	(47	/	718)		24.48 %	18.13 %

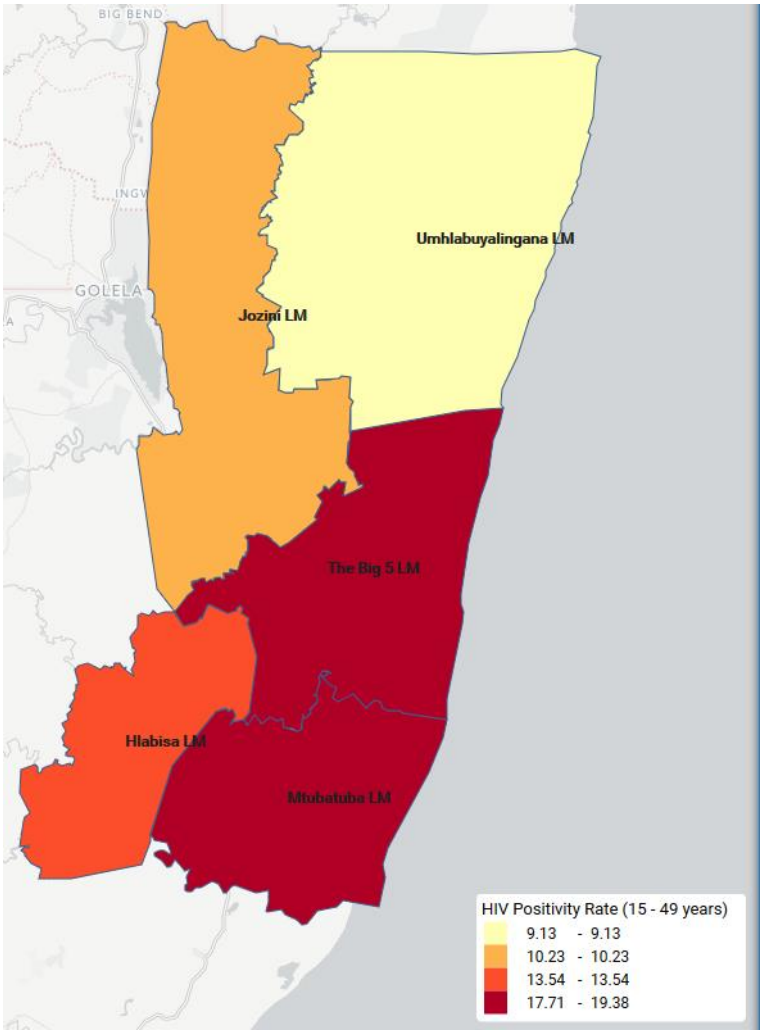

Figure 13: HIV prevalence amongst client tested 15-49 years rate uMkhanyakude district (Source: KZN DHIS 2015)

Table 10: HIV Positivity Rate (15 - 49 years) uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017)

KZ UMKHANYAKUDE DISTRICT MUNICIPALITY: **12.1 %**								
	Local Municipality	**2015 : HIV Positivity Rate (15 - 49 years)**					**NUM %**	**DEN %**
1	kz Mhlabuyalingana Local Municipality	9.13	%	(2490	/	27266)	26.55 %	35.22 %
2	kz Jozini Local Municipality	10.23	%	(2603	/	25448)	27.76 %	32.87 %
3	kz Hlabisa Local Municipality	13.54	%	(918	/	6782)	9.79 %	8.76 %
4	kz The Big 5 False Bay Local Municipality	17.71	%	(1143	/	6453)	12.19 %	8.33 %
5	kz Mtubatuba Local Municipality	19.38	%	(2223	/	11472)	23.71 %	14.82 %

2.3 TB

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

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

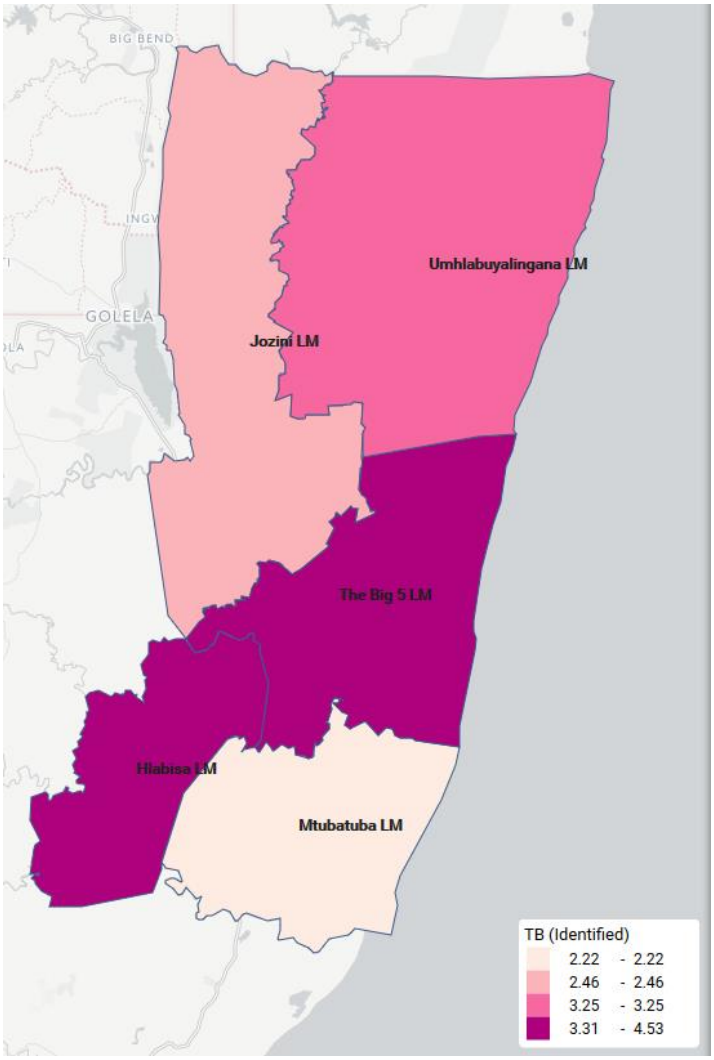

Figure 14: TB (pulmonary) case finding index uMkhanyakude district (Source: KZN DHIS 2015)

Table 11: TB (pulmonary) case finding index uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017)

KZ UMKHANYAKUDE DISTRICT MUNICIPALITY: **2.9 %**								
	Local Municipality	**2015 : TB (Identified)**					**NUM %**	**DEN %**
1	kz Mtubatuba Local Municipality	2.22	%	(10220	/	459340)	19.39 %	25 %
2	kz Jozini Local Municipality	2.46	%	(14101	/	574313)	26.75 %	31.26 %
3	kz Mhlabuyalingana Local Municipality	3.25	%	(15946	/	490172)	30.25 %	26.68 %
4	kz The Big 5 False Bay Local Municipality	3.31	%	(4712	/	142552)	8.94 %	7.76 %
5	kz Hlabisa Local Municipality	4.53	%	(7728	/	170678)	14.66 %	9.29 %

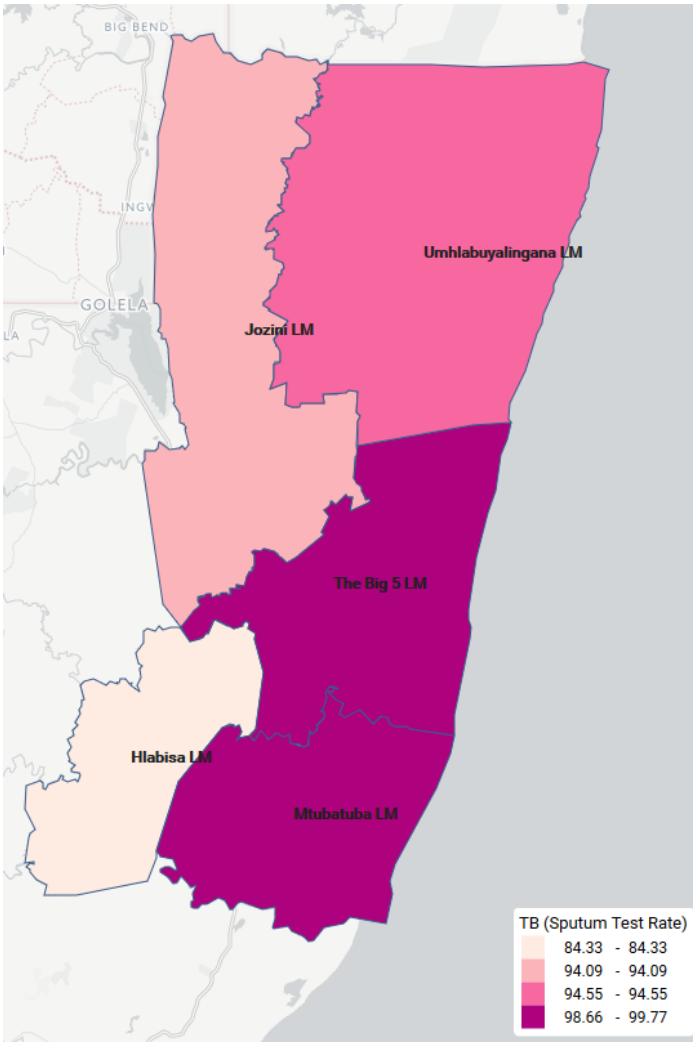

Figure 15: TB suspect sputum test rate uMkhanyakude district (Source: KZN DHIS 2015)

Table 12: TB (Sputum Test Rate) uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017)

KZ UMKHANYAKUDE DISTRICT MUNICIPALITY: **94 %**								
	Local Municipality	**2015 : TB (Sputum Test Rate)**					**NUM %**	**DEN %**
1	kz Hlabisa Local Municipality	84.33	%	(7728	/	9164)	14.66 %	16.34 %
2	kz Jozini Local Municipality	94.09	%	(14101	/	14986)	26.75 %	26.71 %
3	kz Mhlabuyalingana Local Municipality	94.55	%	(15946	/	16865)	30.25 %	30.06 %
4	kz Mtubatuba Local Municipality	98.66	%	(10220	/	10359)	19.39 %	18.47 %
5	kz The Big 5 False Bay Local Municipality	99.77	%	(4712	/	4723)	8.94 %	8.42 %

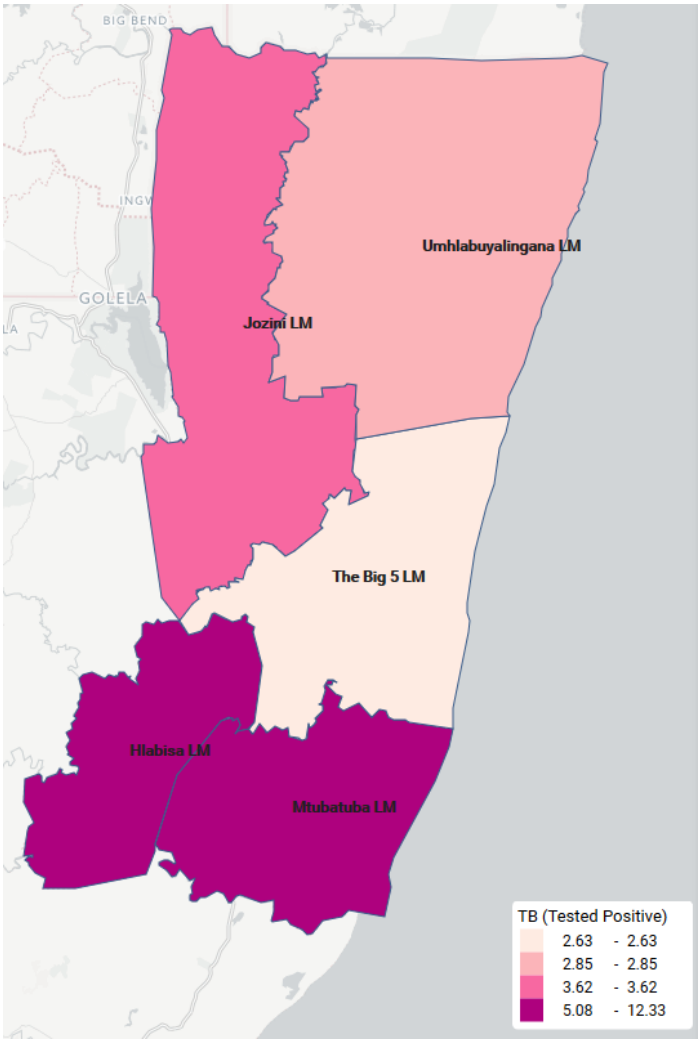

Figure 16: TB suspect smear positive rate uMkhanyakude district (Source: KZN DHIS 2015)

Table 13: TB suspect smear positive rate uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017)

KZ UMKHANYAKUDE DISTRICT MUNICIPALITY: **4.9 %**								
	Local Municipality	**2015 : TB (Tested Positive)**					**NUM %**	**DEN %**
1	kz The Big 5 False Bay Local Municipality	2.63	%	(124	/	4712)	4.84 %	8.94 %
2	kz Mhlabuyalingana Local Municipality	2.85	%	(454	/	15946)	17.73 %	30.25 %
3	kz Jozini Local Municipality	3.62	%	(511	/	14101)	19.95 %	26.75 %
4	kz Mtubatuba Local Municipality	5.08	%	(519	/	10220)	20.27 %	19.39 %
5	kz Hlabisa Local Municipality	12.33	%	(953	/	7728)	37.21 %	14.66 %

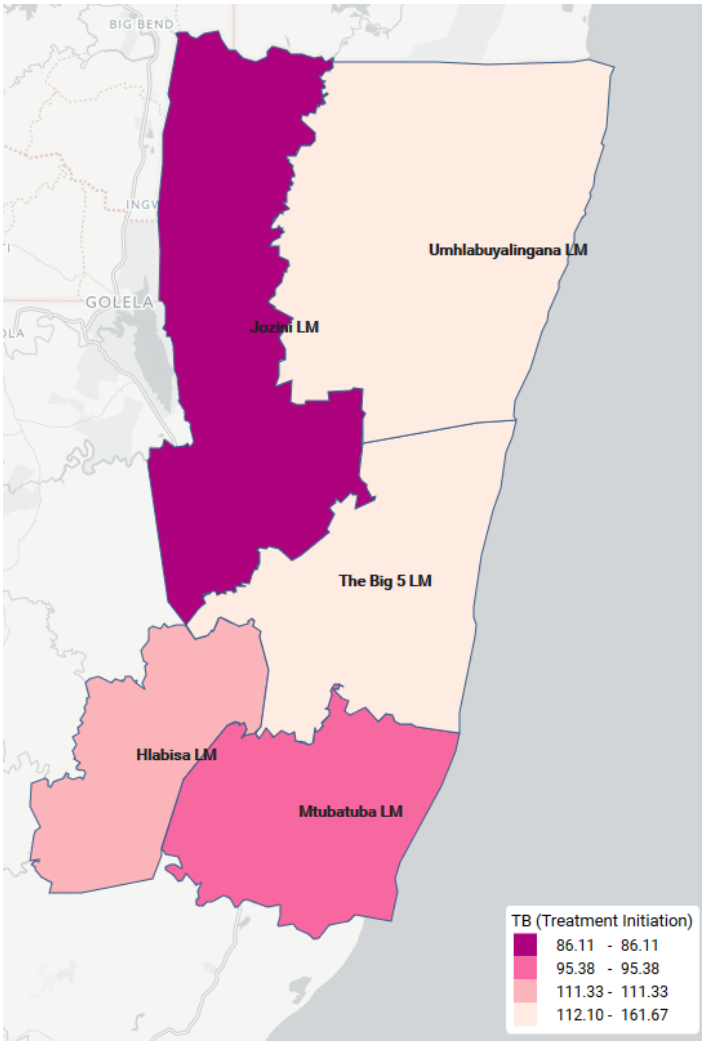

Figure 17: TB suspect treatment initiation rate uMkhanyakude district (Source: KZN DHIS 2015)

Table 14: TB suspect treatment initiation rate uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017)

KZ UMKHANYAKUDE DISTRICT MUNICIPALITY: 112 %									
	Local Municipality	**2015 : TB (Treatment Initiation)**					**NUM %**	**DEN %**
1	kz Jozini Local Municipality	86.11	%	(440	/	511)	15.34 %	19.95 %
2	kz Mtubatuba Local Municipality	95.38	%	(495	/	519)	17.25 %	20.27 %
3	kz Hlabisa Local Municipality	111.33	%	(1061	/	953)	36.98 %	37.21 %
4	kz The Big 5 False Bay Local Municipality	112.10	%	(139	/	124)	4.84 %	4.84 %
5	kz Mhlabuyalingana Local Municipality	161.67	%	(734	/	454)	25.58 %	17.73 %

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 in the uMkhanyakude district. At this point the most robust data is for Male urethritis syndrome rate. As the data quality for other STI routine health indicators improve, it will be included in updated profiles. The definitions for this indicator can be found in Appendix B. Due to the small numbers at a local level, it is not included at ward level in this report. See note on small number 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

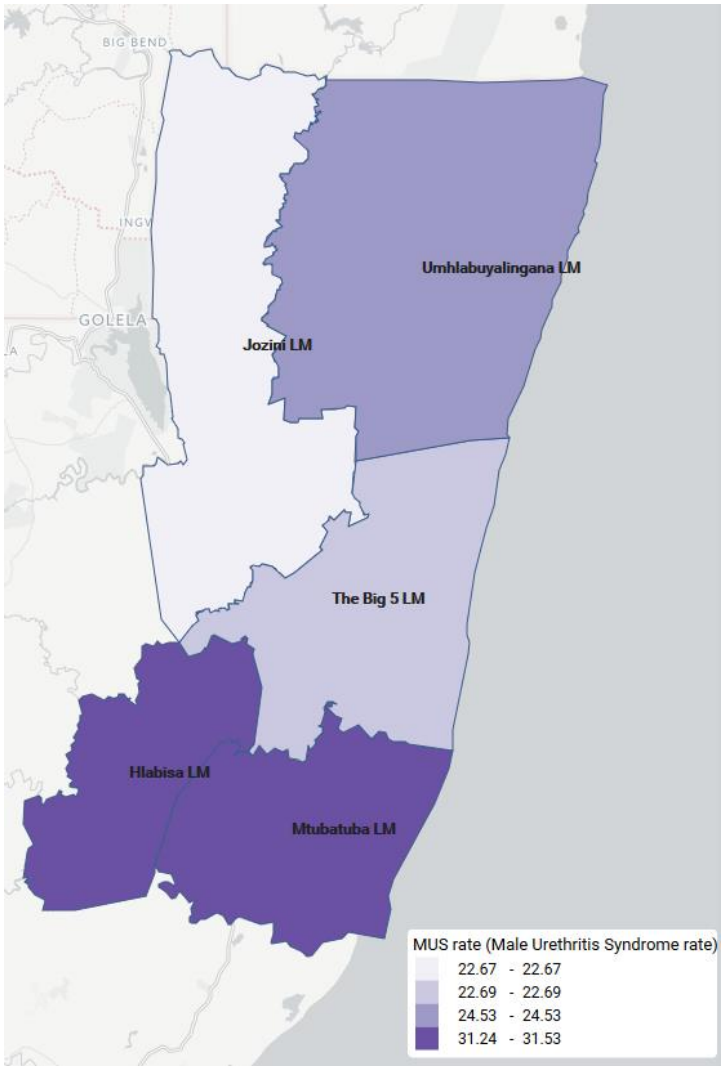

Figure 18: Male urethritis syndrome rate uMkhanyakude district (Source: KZN DHIS 2015)

Table 15: Male urethritis syndrome rate uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017)

KZ UMKHANYAKUDE DISTRICT MUNICIPALITY: **25.9 %**									
	Local Municipality	**2015 : MUS rate (Male Urethritis Syndrome rate)**						**NUM %**	**DEN %**
1	kz Jozini Local Municipality	22.67	%	(2282	/	10068)		27.39 %	31.25 %
2	kz The Big 5 False Bay Local Municipality	22.69	%	(802	/	3535)		9.62 %	10.97 %
3	kz Mhlabuyalingana Local Municipality	24.53	%	(2155	/	8786)		25.86 %	27.27 %
4	kz Hlabisa Local Municipality	31.24	%	(657	/	2103)		7.88 %	6.53 %
5	kz Mtubatuba Local Municipality	31.53	%	(2437	/	7728)		29.25 %	23.99 %

3. Associated risk profile

3.1 Biomedical Profile

3.1.1 HIV Testing

Awareness of one's HIV status through HIV Testing Services (HTS) is pivotal to accessing prevention, care services, and ARV treatment which mitigate the impact of HIV [7]. It is therefore important to determine the success of routine HIV testing and counselling by the department of health. From the National 2013 HIV testing campaign, nearly two-thirds of respondents (65.5%) indicated that they had tested for HIV with females reporting higher rates of testing (71.5%) than of males (59%)[8]. 78% of adults aged 25–49 years reported testing compared to youth aged 15–24 years (50.6%) and the elderly (aged 50 years and older) (54.8%)[9].

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

- Testing is available at clinics for free;
- The people who test are mainly women. Pregnant women must test for HIV on their first visit in order to not infect their baby with HIV; and
- Most men do not want to test. They prefer to be in denial about HIV, or they are afraid to know their status.

3.1.2 Circumcision

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

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

- Medical male circumcision is done in this area; and
- Although men are educated about the necessity of condom use after circumcision, they tend to behave differently, as they misinterpret reduction in the risk of infection, as being equivalent to immunity.

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

3.1.3 ARV treatment

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

- ARV Treatment is available for free at all nearby clinics;
- There are also places such as the community hall where people can collect their medication from the Community Care Givers (CCG);
- People do have sufficient knowledge as there are CCGs who work in the area who go door-to-door, educating the community about different illnesses. They tend to be avoidant of the correct behaviour;
- There are no barriers to access in terms of collecting treatment as there are various collection methods available;
- Alcohol is a major hindrance when it comes to people adhering to their treatment;
- There is loss to follow up to some extent when people use aliases rather than the names in their ID books; and
- The single pill treatment is good, but it is seen as causing people to become hypersexual.

3.1.4 PEP and PrEP

PrEP and PEP is not known to the community.

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.

3.2 Behaviour that can influence 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 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.

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

3.2.1 HIV Knowledge

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

- Some people are knowledgeable about HIV, while others are not;
- There is still not enough education about HIV, how to prevent it or where to access treatment;
- However, CCGs do run awareness campaigns, and distribute condoms;
- Some men believe that if they are circumcised, they cannot be infected;
- Some men believe that sleeping with a virgin; a young child; or an old woman; can cure HIV; and
- Traditional healers sometimes use one razor blade on multiple people during ritual cutting without understanding the possible risks of infection.

3.2.2 Sexual risky behaviours

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

- There are those men and women who have more than one partner, and they are dishonest about it;
- Some women engage in sex work. Men do as well, however they tend to hide that they are in a relationship purely for financial gain;
- People do not disclose that they are on ART;
- Lack of money, and work, as well as a love of material goods can make people engage in risky sexual behaviours; and
- There are blessers, sugar mamas, ben10s. Older women sleep with younger men by enticing them with money. Older men tend to chase after women much younger than them.

3.2.3 Substance abuse

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

- People who abuse drugs are at risk of infection;
- In this area there is drug abuse, but people do not use needles; and
- Alcohol abuse results in taking poor decisions, and it is rife in this area. The Lindela area nearby, has many taverns which makes it easy for people to engage in risky behaviours while they are under the influence.

3.2.4 Condoms

In Figure 19 and Figure 20 the condom distribution for females and males (annualised) are reflected at Local Municipality level in uMkhanyakude 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.

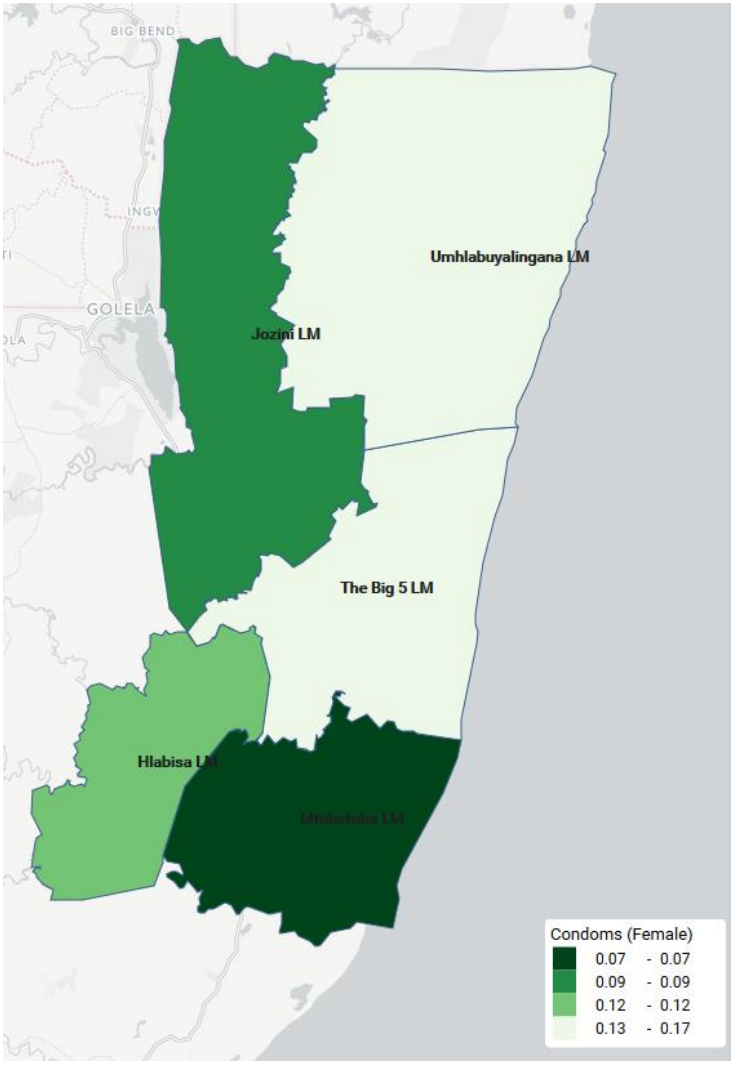

Figure 19: Female condom distribution rate uMkhanyakude district (Source: KZN DHIS 2015)

Table 16: Female condom distribution rate uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017)

KZ UMKHANYAKUDE DISTRICT MUNICIPALITY: **11 No**								
	Local Municipality	**2015 : Condoms (Female)**					**NUM %**	**DEN %**
1	kz Mtubatuba Local Municipality	0.07	No	(53908	/	761688)	18.24 %	28.25 %
2	kz Jozini Local Municipality	0.09	No	(67343	/	788772)	22.79 %	29.25 %
3	kz Hlabisa Local Municipality	0.12	No	(37196	/	304992)	12.59 %	11.31 %
4	kz The Big 5 False Bay Local Municipality	0.13	No	(20573	/	155688)	6.96 %	5.77 %
5	kz Umhlabuyalingana Local Municipality	0.17	No	(116451	/	685092)	39.41 %	25.41 %

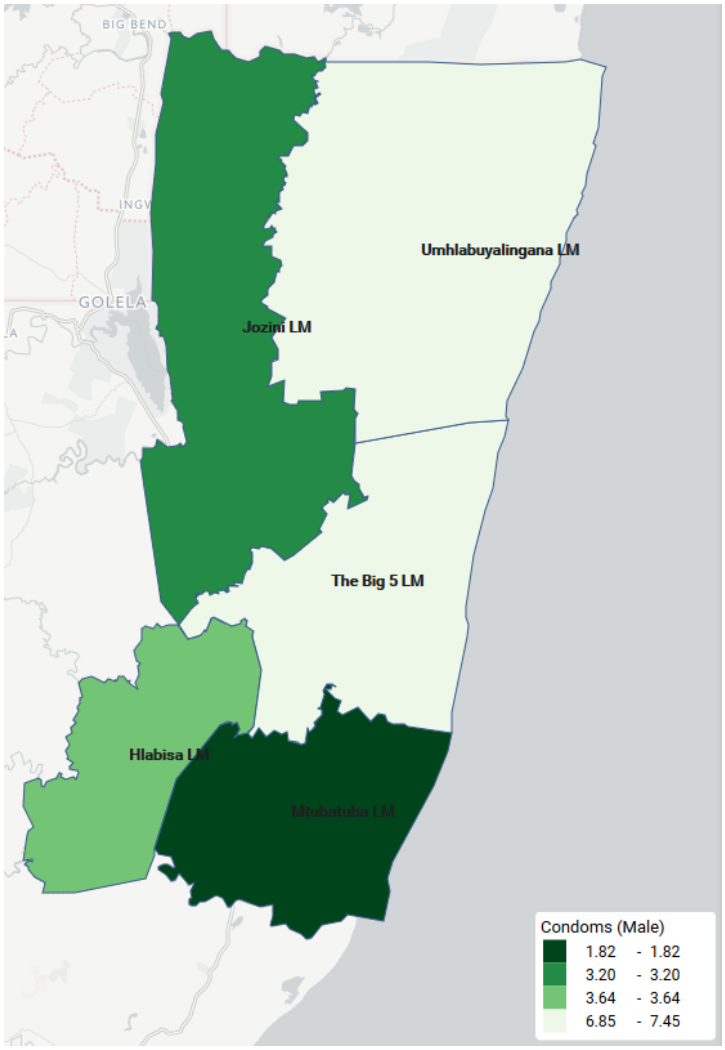

Figure 20: Male condom distribution rate uMkhanyakude district (Source: KZN DHIS 2015)

Table 17: Male condom distribution rate uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017)

KZ UMKHANYAKUDE DISTRICT MUNICIPALITY: **400.4 No**									
	Local Municipality	**2015 : Condoms (Male)**						**NUM %**	**DEN %**
1	kz Mtubatuba Local Municipality	1.82	No	(1146378	/	629748)		13.18 %	28.99 %
2	kz Jozini Local Municipality	3.20	No	(2034379	/	635940)		23.39 %	29.28 %
3	kz Hlabisa Local Municipality	3.64	No	(875300	/	240588)		10.06 %	11.08 %
4	kz Umhlabuyalingana Local Municipality	6.85	No	(3644493	/	532056)		41.90 %	24.49 %
5	kz The Big 5 False Bay Local Municipality	7.45	No	(997931	/	133884)		11.47 %	6.16 %

Condoms are readily available in health facilities and NGOs.

3.2.5 Key and vulnerable populations

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

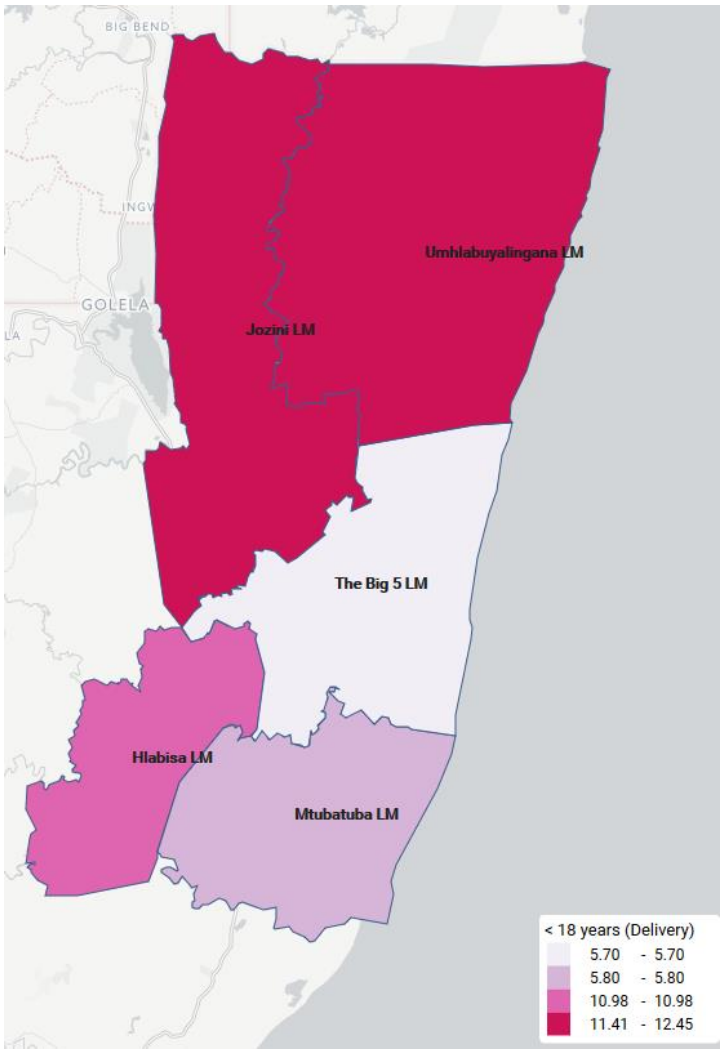

Figure 21: Teenage Pregnancy rate uMkhanyakude district (Source: KZN DHIS 2015)

Table 18: Teenage Pregnancy rate uMkhanyakude district (Source: KZN DHIS 2015 report 4 August 2017)

KZ UMKHANYAKUDE DISTRICT MUNICIPALITY: **11.1 %**								
	Local Municipality	**2015 : < 18 years (Delivery)**					**NUM %**	**DEN %**
1	kz The Big 5 False Bay Local Municipality	5.70	%	(9	/	158)	0.55 %	1.07 %
2	kz Mtubatuba Local Municipality	5.80	%	(65	/	1121)	3.97 %	7.62 %
3	kz Hlabisa Local Municipality	10.98	%	(452	/	4116)	27.63 %	27.97 %
4	kz Umhlabuyalingana Local Municipality	11.41	%	(552	/	4837)	33.74 %	32.87 %
5	kz Jozini Local Municipality	12.45	%	(558	/	4483)	34.11 %	30.47 %

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	There are many young women in the community and they are seen to be in danger of becoming infected, due to poverty and lack of education
Youth	There is a significant number of youth in the area, and they are in danger because they are unemployed, and also uneducated. This leaves them susceptible to relationships where they exchange sex for financial or material gain. They are at risk of indulging in drugs and alcohol, which can also lead to risky sexual behaviour
Sex workers	Sex workers are known to operate in the area (which lies along a major highway). They are mostly known to service the truck drivers who work along that highway
Orphans and vulnerable children	Some children are abandoned by their parents, while others are kicked out of home due to rebellious behaviour. In both cases, such children can fall victim to sexual abuse or exploitation.
Drug users	The use of drugs seems to be one of the propellers of HIV transmission, due to the poor decision making induced by them.
Disabled	Disable people are sexually abused because of their disability and they are afraid to report
Migrant workers	Fear of getting to the local clinics by the people from other countries for HIV testing spreads HIV because they end up having sex with local people. Sexual relationships easily take place amongst the population in these settlements. People of other countries are suspected to have illnesses and selling drugs. They are seen to be taking away jobs from the local community.

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 has been associated with high proportion of orphans[14] , albeit at provincial level. The detail for Ward 20 that forms the catchment area for Mkuze Clinic is highlighted in the table below.

Table 20: Orphan hood for Census 2011 at Ward level in Jozini Local Municipality

Ward	Maternal orphans			Paternal orphans			Double orphans		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Ward 1	49	48	96	156	175	330	67	74	140
Ward 2	62	76	138	264	264	527	105	109	214
Ward 3	75	79	154	374	403	777	158	147	305
Ward 4	72	94	166	370	347	717	114	122	236
Ward 5	146	149	295	485	437	922	162	138	300
Ward 6	50	64	113	300	278	578	127	93	220
Ward 7	64	44	107	304	247	550	96	119	216
Ward 8	78	75	152	381	328	709	207	175	382
Ward 9	69	74	144	328	312	640	122	102	224
Ward 10	102	88	191	347	362	708	152	154	306
Ward 11	110	89	198	290	281	572	120	124	244
Ward 12	82	89	170	370	299	669	126	109	234
Ward 13	99	101	200	364	364	728	91	75	166
Ward 14	91	104	195	344	380	724	179	144	324
Ward 15	83	94	177	317	295	613	113	142	255
Ward 16	85	64	149	360	360	720	110	113	224
Ward 17	102	75	177	396	404	800	146	163	309
Ward 18	65	61	127	313	227	541	201	205	405
Ward 19	87	81	167	273	302	575	96	110	206
Ward 20	43	47	90	179	198	377	59	73	131

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

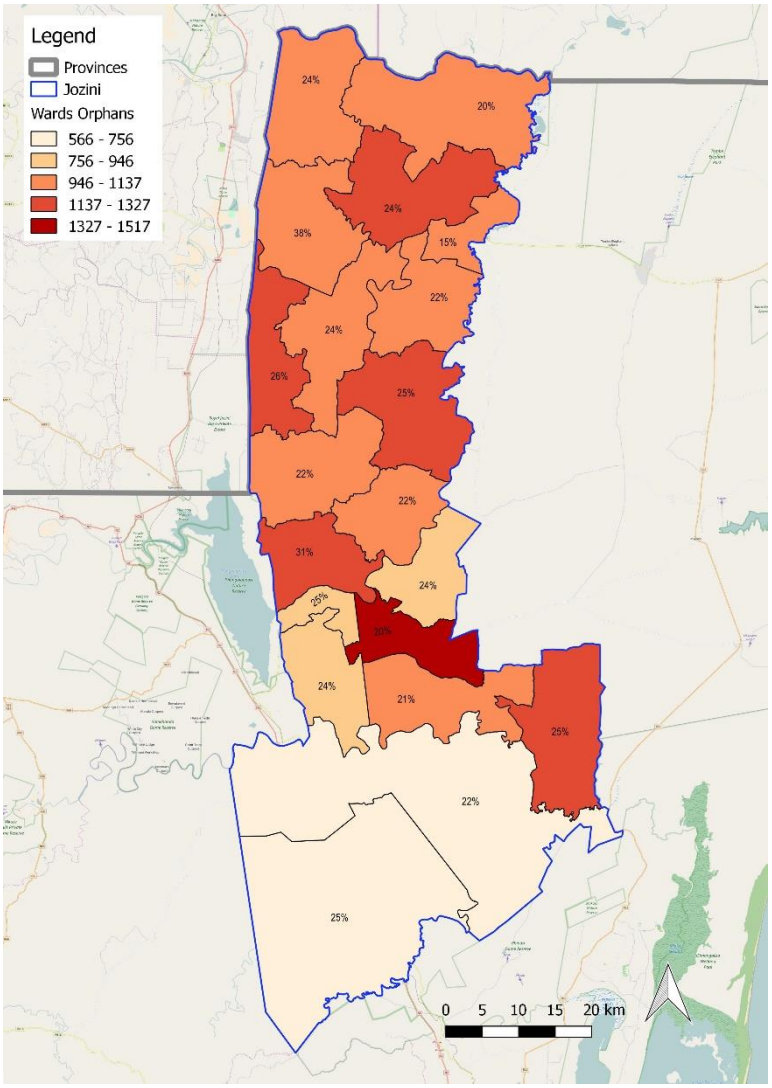

Figure 22: Total number of Orphans with percentage that are double orphans per ward (Source Census 2011)

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

- Some children are abandoned by their parents, while others are kicked out of home due to rebellious behaviour; and
- In both cases, such children can fall victim to sexual abuse or exploitation.

3.3.2 Cultural and Religious Norms

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

- Some religious leaders encourage their congregants to stop taking treatment and receive healing in the church;
- Sometimes traditional healers use the same razor on multiple people during ritual cutting; and
- If a man is in a polygamous marriage, he most likely won't use a condom with any of his wives and that can contribute to the spread of HIV.

3.3.3 Gender norms and gender-based violence

Stakeholder and community engagement workshops revealed that a man can beat a woman just because he does not want to engage in safe sex.

3.3.4 Stigma

Stakeholder and community engagement workshops revealed that people fear reporting on their status to others due to feeling ashamed, and fearing being looked down upon by the people around them.

3.3.5 Poverty

Poverty is measured through the South Africa Multidimensional Poverty Index (SAMPI)[15]. The detail for Ward 20 that forms the catchment area for Mkuze Clinic is highlighted in the table below.

Table 21: Poverty measures for Census 2011 at Ward level in Jozini Local Municipality

	Poverty Headcount (H)	Intensity of Poverty (A)	SAMPI (HxA)
Ward 1	25.7	42.8	0.110
Ward 2	18.3	42.9	0.079
Ward 3	25.5	41.3	0.105
Ward 4	30	41.8	0.125
Ward 5	20.1	43.3	0.087
Ward 6	23.8	42.7	0.102
Ward 7	7.1	41.6	0.030
Ward 8	21.5	41.6	0.089
Ward 9	26.9	42.5	0.114
Ward 10	32.2	43.2	0.139
Ward 11	21.6	41.3	0.089
Ward 12	29.9	44.3	0.132
Ward 13	29.4	45.7	0.134
Ward 14	20.5	41.6	0.085
Ward 15	30.3	42.7	0.129
Ward 16	19.4	40.4	0.078
Ward 17	28.5	42.2	0.120
Ward 18	27.5	42.9	0.118
Ward 19	26.1	42.1	0.110
Ward 20	7.6	41.8	0.032

Ward 10 was the poorest Ward in Jozini Local Municipality with 32.2% being poor households (Table, Appendix B). Ward 7 had the lowest head count at 7.1%. The greatest contributors to high poverty measures in KZN are health (measured by child mortality) and education (measured by years of schooling and school attendance). The Multidimensional Poverty Index for Jozini Local Municipality

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

changed between 2001 (Figure 23) and 2011 (Figure 24). In 2001 the highest Poverty Index was 28.13. This reduced to 13.91 in 2011.

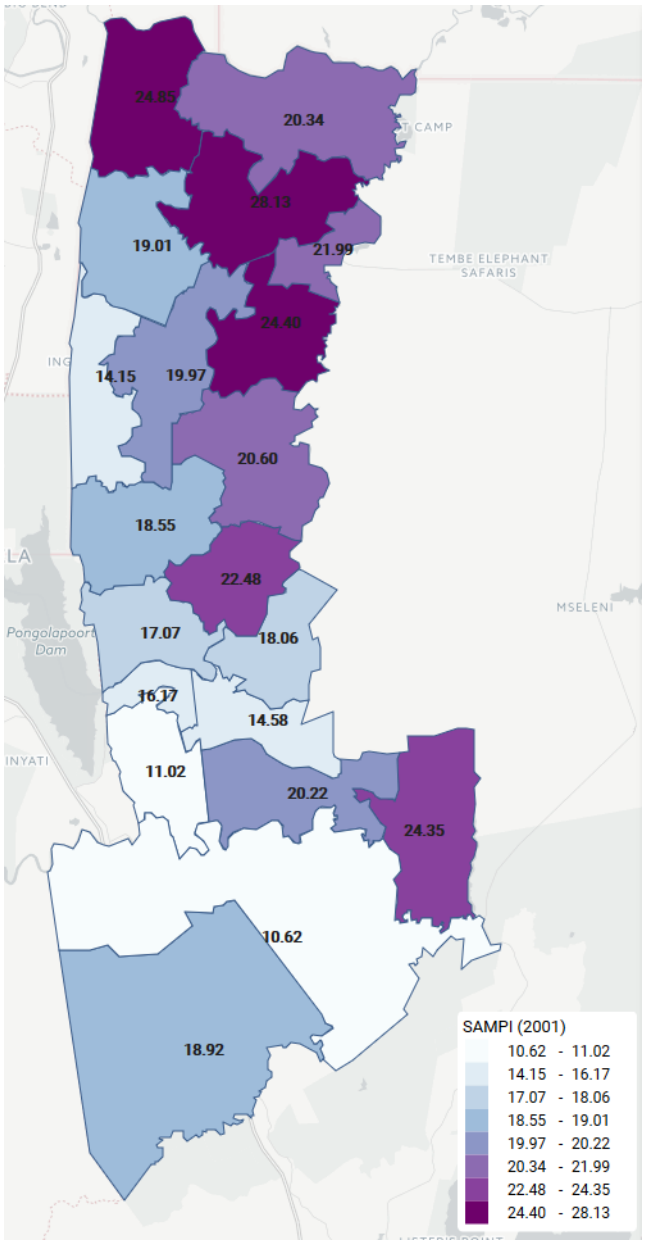

Figure 23: SAMPI (poverty Index) 2001 - ward level, Jozini Local Municipality

Table 22: SAMPI (poverty Index) 2001 - ward level, Jozini Local Municipality

KZ JOZINI LOCAL MUNICIPALITY: 19.5 %						
	Ward (2011)	**SAMPI (2001)**				
1	kz Jozini Ward 020	10.62	%	(10.6	/	100)
2	kz Jozini Ward 002	11.02	%	(11	/	100)
3	kz Jozini Ward 014	14.15	%	(14.1	/	100)
4	kz Jozini Ward 005	14.58	%	(14.6	/	100)
5	kz Jozini Ward 007	16.17	%	(16.2	/	100)
6	kz Jozini Ward 008	17.07	%	(17.1	/	100)
7	kz Jozini Ward 006	18.06	%	(18.1	/	100)

KZ JOZINI LOCAL MUNICIPALITY: 19.5 %						
	Ward (2011)	**SAMPI (2001)**				
8	kz Jozini Ward 009	18.55	%	(18.5	/	100)
9	kz Jozini Ward 001	18.92	%	(18.9	/	100)
10	kz Jozini Ward 018	19.01	%	(19	/	100)
11	kz Jozini Ward 011	19.97	%	(20	/	100)
12	kz Jozini Ward 004	20.22	%	(20.2	/	100)
13	kz Jozini Ward 016	20.34	%	(20.3	/	100)
14	kz Jozini Ward 010	20.60	%	(20.6	/	100)
15	kz Jozini Ward 013	21.99	%	(22	/	100)
16	kz Jozini Ward 019	22.48	%	(22.5	/	100)
17	kz Jozini Ward 003	24.35	%	(24.4	/	100)
18	kz Jozini Ward 012	24.40	%	(24.4	/	100)
19	kz Jozini Ward 015	24.85	%	(24.9	/	100)
20	kz Jozini Ward 017	28.13	%	(28.1	/	100)

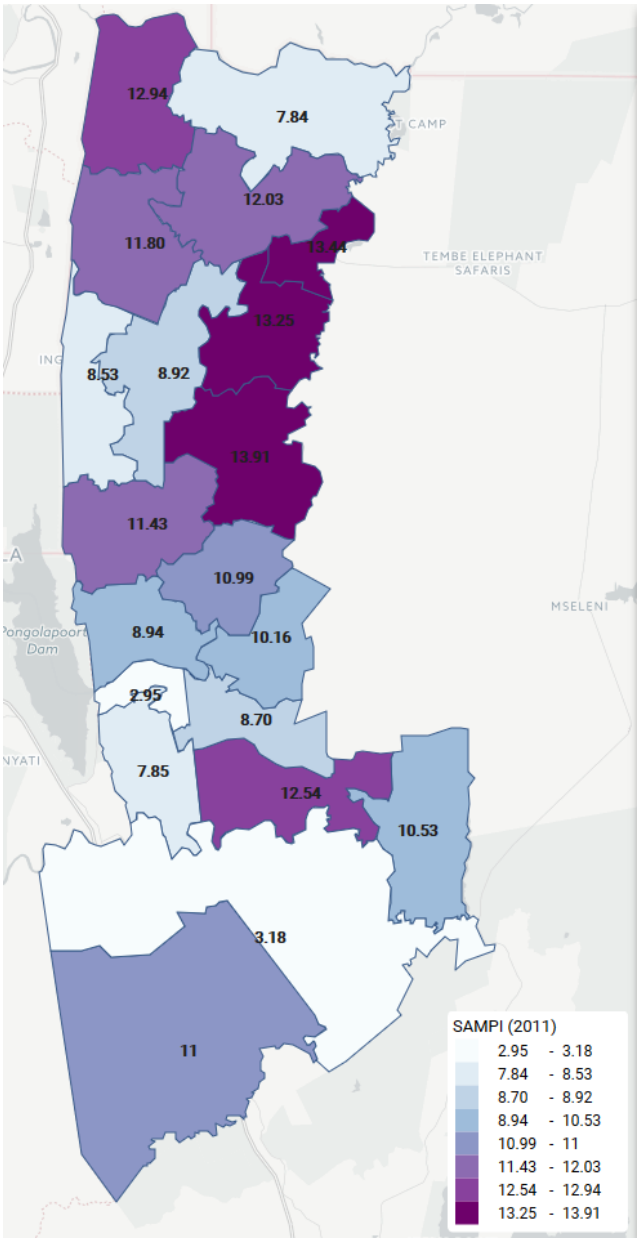

Figure 24: SAMPI (poverty Index) 2011 - ward level, Jozini Local Municipality

Table 23: SAMPI (poverty Index) 2011 - ward level, Jozini Local Municipality

KZ JOZINI LOCAL MUNICIPALITY: 10.8 %						
	Ward (2011)	**SAMPI (2011)**				
1	kz Jozini Ward 007	2.95	%	(3	/	100)
2	kz Jozini Ward 020	3.18	%	(3.2	/	100)
3	kz Jozini Ward 016	7.84	%	(7.8	/	100)
4	kz Jozini Ward 002	7.85	%	(7.9	/	100)
5	kz Jozini Ward 014	8.53	%	(8.5	/	100)
6	kz Jozini Ward 005	8.70	%	(8.7	/	100)
7	kz Jozini Ward 011	8.92	%	(8.9	/	100)
8	kz Jozini Ward 008	8.94	%	(8.9	/	100)
9	kz Jozini Ward 006	10.16	%	(10.2	/	100)
10	kz Jozini Ward 003	10.53	%	(10.5	/	100)

KZ JOZINI LOCAL MUNICIPALITY: 10.8 %						
	Ward (2011)	**SAMPI (2011)**				
11	kz Jozini Ward 019	10.99	%	(11	/	100)
12	kz Jozini Ward 001	11	%	(11	/	100)
13	kz Jozini Ward 009	11.43	%	(11.4	/	100)
14	kz Jozini Ward 018	11.80	%	(11.8	/	100)
15	kz Jozini Ward 017	12.03	%	(12	/	100)
16	kz Jozini Ward 004	12.54	%	(12.5	/	100)
17	kz Jozini Ward 015	12.94	%	(12.9	/	100)
18	kz Jozini Ward 012	13.25	%	(13.2	/	100)
19	kz Jozini Ward 013	13.44	%	(13.4	/	100)
20	kz Jozini Ward 010	13.91	%	(13.9	/	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 Jozini was 63.50. This reduced to 32.20 in 2011.

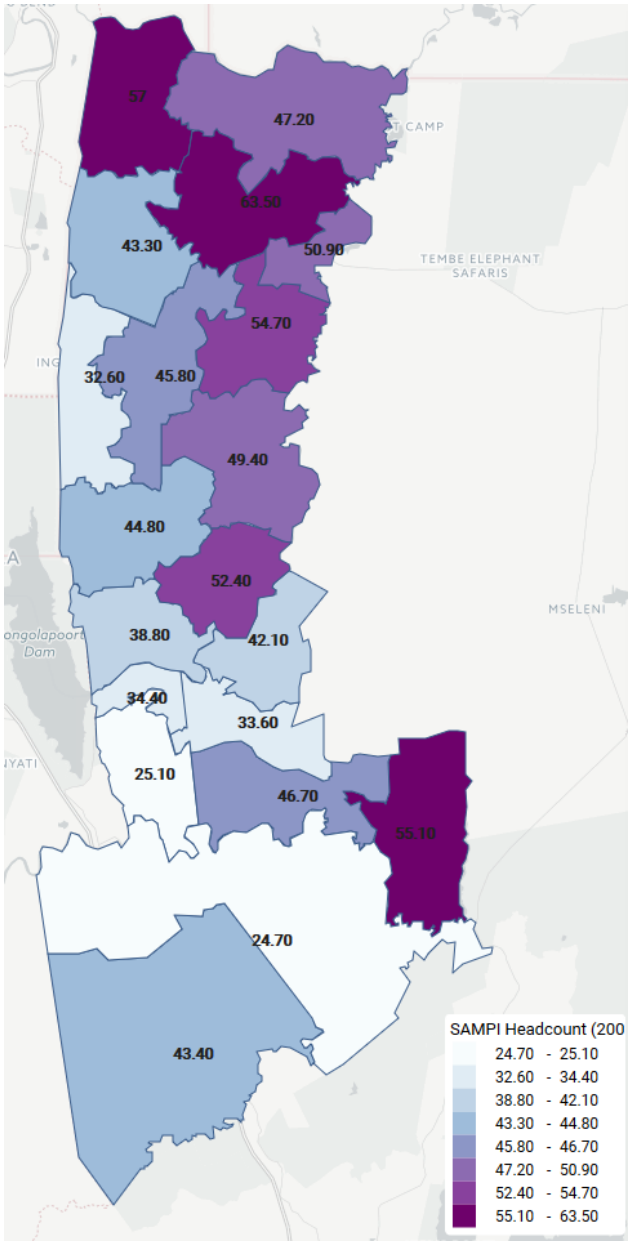

Figure 25: SAMPI 2001 poverty headcount - ward level, Jozini Local Municipality

Table 24: SAMPI 2001 poverty headcount - ward level, Jozini Local Municipality

KZ JOZINI LOCAL MUNICIPALITY: 45.3 %						
	Ward (2011)	SAMPI Headcount (2001)				
1	kz Jozini Ward 020	24.70	%	(24.7	/	100)
2	kz Jozini Ward 002	25.10	%	(25.1	/	100)
3	kz Jozini Ward 014	32.60	%	(32.6	/	100)
4	kz Jozini Ward 005	33.60	%	(33.6	/	100)
5	kz Jozini Ward 007	34.40	%	(34.4	/	100)
6	kz Jozini Ward 008	38.80	%	(38.8	/	100)

KZ JOZINI LOCAL MUNICIPALITY: 45.3 %						
	Ward (2011)	**SAMPI Headcount (2001)**				
7	kz Jozini Ward 006	42.10	%	(42.1	/	100)
8	kz Jozini Ward 018	43.30	%	(43.3	/	100)
9	kz Jozini Ward 001	43.40	%	(43.4	/	100)
10	kz Jozini Ward 009	44.80	%	(44.8	/	100)
11	kz Jozini Ward 011	45.80	%	(45.8	/	100)
12	kz Jozini Ward 004	46.70	%	(46.7	/	100)
13	kz Jozini Ward 016	47.20	%	(47.2	/	100)
14	kz Jozini Ward 010	49.40	%	(49.4	/	100)
15	kz Jozini Ward 013	50.90	%	(50.9	/	100)
16	kz Jozini Ward 019	52.40	%	(52.4	/	100)
17	kz Jozini Ward 012	54.70	%	(54.7	/	100)
18	kz Jozini Ward 003	55.10	%	(55.1	/	100)
19	kz Jozini Ward 015	57	%	(57	/	100)
20	kz Jozini Ward 017	63.50	%	(63.5	/	100)

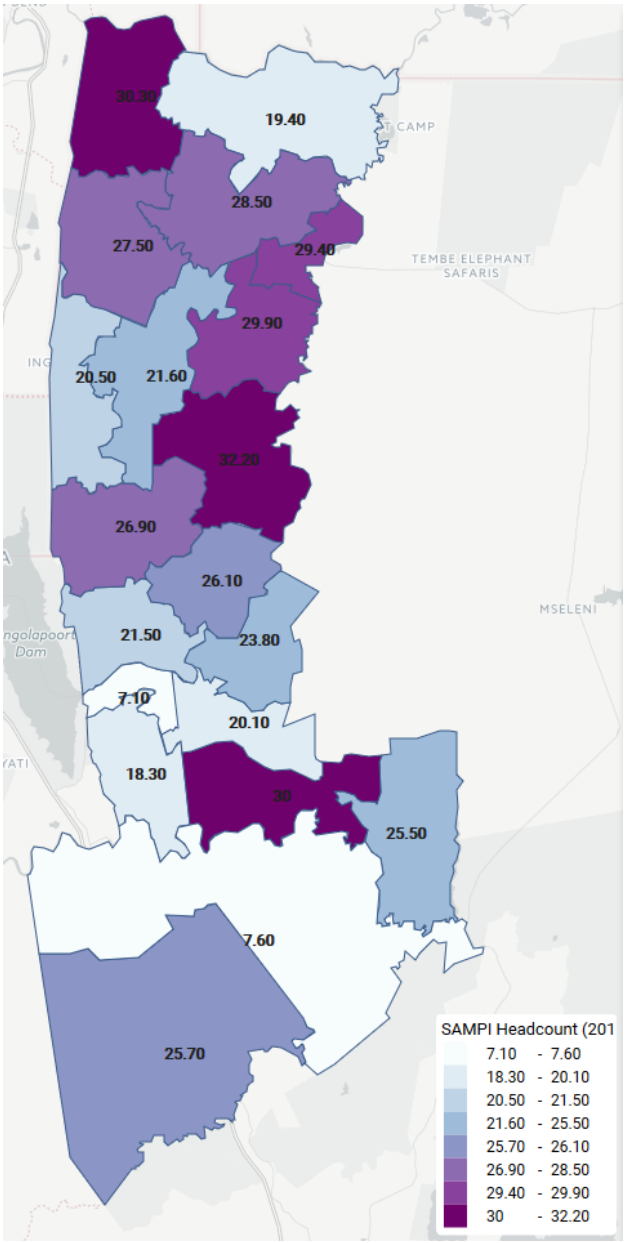

Figure 26: SAMPI 2011 poverty headcount - ward level, Jozini Local Municipality

Table 25: SAMPI 2011 poverty headcount - ward level, Jozini Local Municipality

KZ JOZINI LOCAL MUNICIPALITY: 25.6 %						
	Ward (2011)	2015 : SAMPI Headcount (2011)				
1	kz Jozini Ward 007	7.10	%	(7.1	/	100)
2	kz Jozini Ward 020	7.60	%	(7.6	/	100)
3	kz Jozini Ward 002	18.30	%	(18.3	/	100)
4	kz Jozini Ward 016	19.40	%	(19.4	/	100)
5	kz Jozini Ward 005	20.10	%	(20.1	/	100)
6	kz Jozini Ward 014	20.50	%	(20.5	/	100)
7	kz Jozini Ward 008	21.50	%	(21.5	/	100)
8	kz Jozini Ward 011	21.60	%	(21.6	/	100)
9	kz Jozini Ward 006	23.80	%	(23.8	/	100)

KZ JOZINI LOCAL MUNICIPALITY: 25.6 %						
	Ward (2011)	**2015 : SAMPI Headcount (2011)**				
10	kz Jozini Ward 003	25.50	%	(25.5	/	100)
11	kz Jozini Ward 001	25.70	%	(25.7	/	100)
12	kz Jozini Ward 019	26.10	%	(26.1	/	100)
13	kz Jozini Ward 009	26.90	%	(26.9	/	100)
14	kz Jozini Ward 018	27.50	%	(27.5	/	100)
15	kz Jozini Ward 017	28.50	%	(28.5	/	100)
16	kz Jozini Ward 013	29.40	%	(29.4	/	100)
17	kz Jozini Ward 012	29.90	%	(29.9	/	100)
18	kz Jozini Ward 004	30	%	(30	/	100)
19	kz Jozini Ward 015	30.30	%	(30.3	/	100)
20	kz Jozini Ward 010	32.20	%	(32.2	/	100)

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

- Sex work is something that occurs in the area due to lack of employment opportunities;
- Too many people living in close proximity allow diseases to flourish; and
- Sometimes the breadwinner in the family dies, and the children left behind are forced to exchange sex for necessities.

3.3.6 Employment

In Jozini Local Municipality, 14% of the female population at economically active age are employed while 16% of the economically active males are employed. See Figure 27 below.

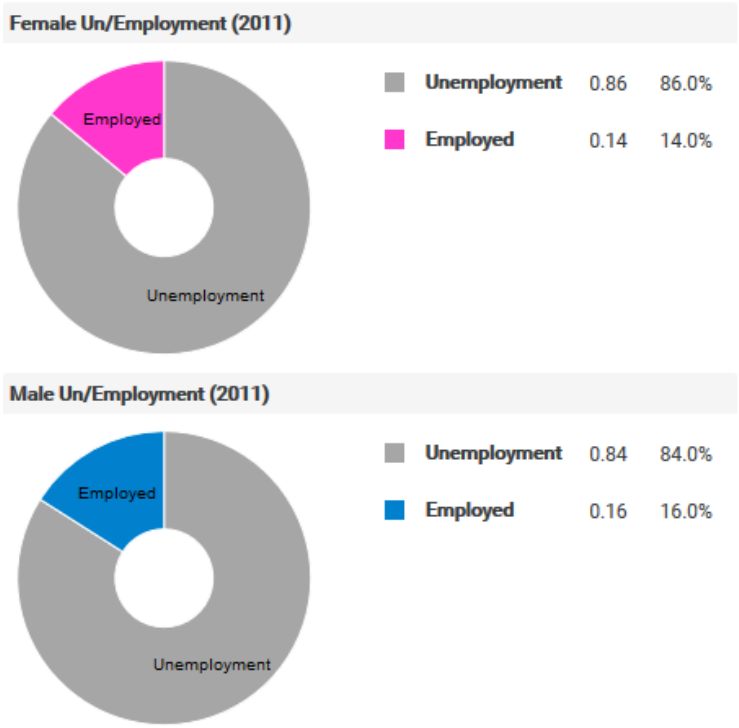

Figure 27: Female and Male employment Jozini Local Municipality (Source Census 2011)

Unemployment of youth in Jozini Local Municipality is at 88.4%.

Figure 28: Youth unemployment Jozini Local Municipality (source Census 2011)

In comparison with the Jozini Local Municipality a bigger percentage of females and males are employed from the total population in the Mkuze clinic catchment area. In this area 33% of the female population and 44% of the male population is employed (see Figure 29).

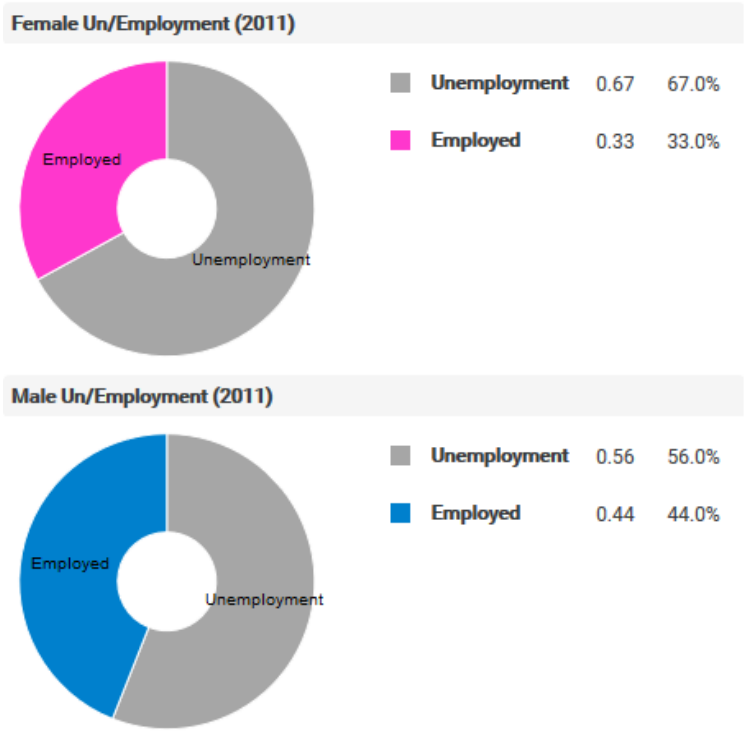

Figure 29: Female and Male employment Mkuze clinic catchment area (Source Census 2011)

Fewer youth (66.1%) are unemployed in the Mkuze clinic catchment area than the Jozini Local Municipality (88.4%).

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

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

- There are limited job opportunities in the area. The sentiment is that foreign nationals are the ones who are hired, while local people are left without jobs; and
- There are instances of nepotism reported, or one has to exchange money or sex to find employment.

3.3.7 Types of settlements

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

- The types of dwellings in the area are of a poor standard;
- The area is underdeveloped and there is overcrowding;
- In RDP houses, there is overcrowding, with between 20 and 30 people living in the same house;
- In squatter camps and rented back rooms, there is also overcrowding;
- Children share spaces with adults and end up learning adult habits such as, sex and alcohol use. This can end up in children being raped and engaging in continuous sexual activity; and
- There are too many taverns where people over indulge in alcohol and end up having unsafe sex.

3.3.8 Migration patterns in the area

People from outside countries bring diseases with them, such as HIV with different strains from other regions in Africa.

3.3.9 Education and literacy

School children sometimes sleep with their teachers, due to lack of food and necessities at home, as a result of parents being unemployed.

3.3.10Hate crimes – xenophobic, homophobic, other

Foreign nationals are seen to be the ones who bring drugs to sell. They then engage in sexual activity with local people and spread the virus in that way.

3.3.11 Disability

Participants in stakeholder and community engagement workshops felt that the ***people with disabilities*** are sexually abused, and end up being infected with different STIs, as well as HIV. They also have a fear of reporting, which keeps their health status hidden.

4. Services in the Local Municipality

4.1 Health facilities

There are 16 health facilities in Jozini Local Municipality. See Figure 31 below for distribution of these facilities.

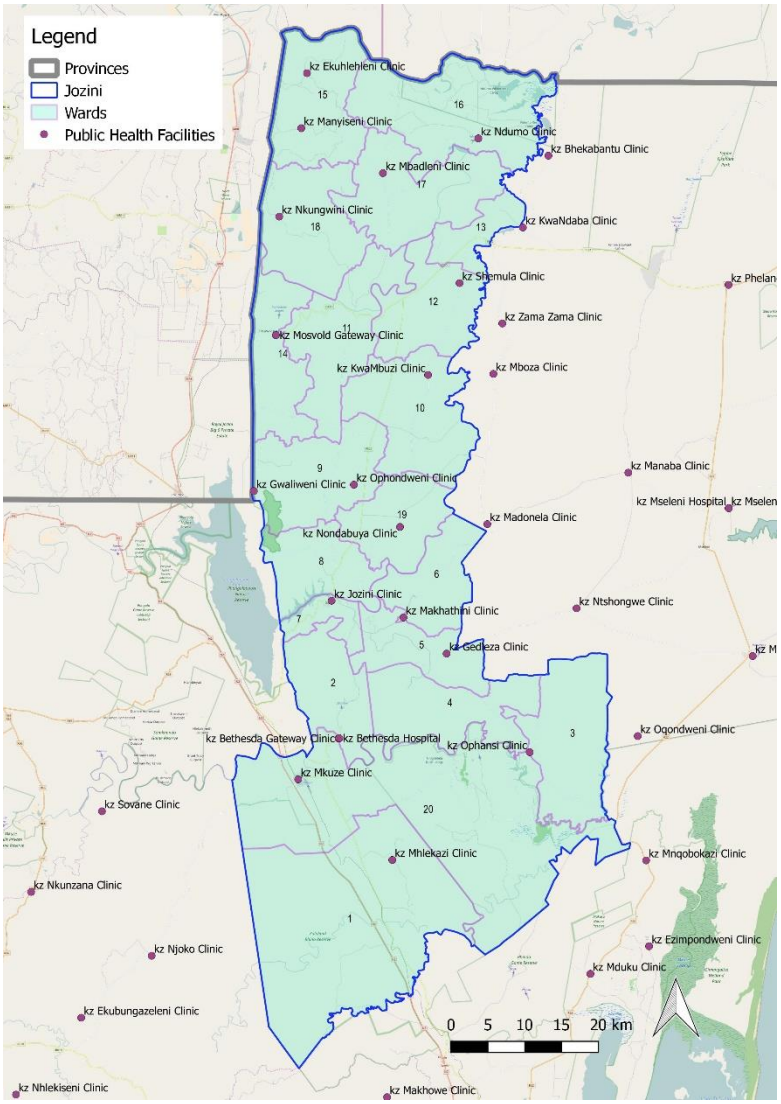

Figure 31: Distribution of health facilities in Jozini Local Municipality

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

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

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

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

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

Table 26 summarises the key and vulnerable populations as well as priority interventions identified during the development of the community profiles in each of the seven local municipalities in the District. 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 in high burden areas

Key and vulnerable populations TB	**Priority interventions**
• People living with HIV • Household contacts of TB index patients • Health care workers • Pregnant women • Children < 5 years old • People living in informal settlements	• TB contact tracing, testing and post-exposure management • Enhanced health education about HIV/TB co-infection, reinfection • Service delivery and treatment delivery points in community, non-traditional settings
Key and vulnerable populations HIV	**Priority interventions**
• Sex workers • Drug users • Young women and girls	• Poverty, especially livelihoods support, to mitigate transactional sex as a source of income • Comprehensive, targeted, location-specific HIV prevention programmes designed for sex workers and truck drivers • Substance abuse, particularly among youth and by-law enforcement at liquor outlets (licensing conditions) • Employment programmes targeted at vulnerable populations • Overcrowding in RDP settlements that contribute to sexual risk behaviour

Considering the priorities identified during the stakeholder and community workshops as well as the general profile, the following service delivery packages are recommended in line with the National Strategic Plan for HIV, TB and STIs (2017 to 2022) and other relevant strategic documents. These service delivery packages need to be unpacked and included in the implementation plan referred to above based on the existing resource envelop in the area. Priority is given to the key and vulnerable populations identified, followed by other interventions identified in the NSP.

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 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)	• 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
	• Screening for and protection from the sexual exploitation of children • Community empowerment	
People who use drugs, including people who inject drugs	• Peer-led outreach • Harm reduction counselling • Linkage to rehabilitation centres • Case management to ensure a continuum of care • Needle and syringe programmes • Opioid Substitution Therapy • Accelerated nutritional and social grant support, if indicated • Hepatitis B screening and immunisation • Hepatitis C screening and treatment when policy is developed	• DoH • NGOs • DSD
HIV and STI vulnerable populations		

Children and orphans and vulnerable children	• Health education, with a particular focus on sexual exploitation in the absence of primary caregivers
	• Accelerated nutritional and social grant support
	• Youth-friendly sexual and reproductive health services in schools and community settings which include:
	  ○ HPV vaccination
	  ○ Contraceptives including condoms
	  ○ Choice of termination of pregnancy
	• Comprehensive sexuality education in residential, school and non-school and youth-friendly settings
	• Intensive psychosocial support
	• Gender norms education, including risk reduction in relation to age-disparate relationships
	• School retention
		• DSD
		• DBE
		• DoH

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

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

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

Comprehensive package of services for the general population, that will then be supplemented and customised to the age and population served			Multi-sectoral 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**
Children	• Child abuse screening • Age-appropriate HIV testing, treatment, adherence support • Support for disclosure of HIV status • HIV testing of household adult or adolescent index client • Contact tracing from adult, adolescent TB cases • Sputum induction for TB testing • Update hospital admission requirements for DR-TB treatment	• Health facility-based • School-based • Community-based • Mobile services	• DoH • DBE • DSD • CBOs • NGOs • Private employers • Private healthcare providers

Population	Services/Interventions/Approaches	Setting	Multisectoral partner
	• Comprehensive sexuality education: Sexuality, puberty education, gender and empowerment, GBV, reproductive health, contraception, alcohol and drug use prevention, decision-making, self-esteem		
PLHIV (adults, adolescents)	• Hearing and vision screening, referral, treatment • Partner HIV testing, disclosure support, treatment, adherence support • Hepatitis B and HPV vaccine where eligible • PMTCT and enhanced adherence support through pre- and post-natal period, including breastfeeding • Gender norms • Health and health rights literacy • Economic empowerment and health promotion • School retention • Accelerated nutritional and social grant support, if indicated • Targeted demand creation for services • Targeted, PLHIV-friendly IEC materials and SBCC, including social media and materials for those with vision and hearing impairment • Service delivery points in community, non-traditional settings	• Health facility-based • School-based • Community-based • Mobile services	• DoH • DBE • DCS • DSD • CBOs • NGOs • Private employers • Private healthcare providers
Persons with TB (adults, adolescents)	• TB contact tracing, testing and post-exposure management • Partner HIV testing, disclosure support, treatment, adherence support • Enhanced health education about HIV/TB co-infection, reinfection • Hearing and vision screening, referral, treatment • 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	• Clinic-based • School-based • Community-based • Mobile services	• DoH • DBE • DCS • DSD • CBOs • NGOs • Private employers • Private healthcare providers

Population	Services/Interventions/Approaches	Setting	Multisectoral partner
Discordant couples	• Partner HIV testing, disclosure support, treatment, adherence support • Hepatitis B and HPV vaccine where eligible • PMTCT and enhanced adherence support through pre- and post-natal period, including breastfeeding if pregnant and HIV-positive • Gender norms • Health and health rights literacy • Economic empowerment and health promotion • Accelerated nutritional and social grant support, if indicated • Targeted demand creation for services	• Clinic-based • Community-based • Mobile services	• DoH • DCS • DSD • CBOs • NGOs • Private employers • Private healthcare providers

Generic HIV, TB and STI prevention, management and care		
Focus	**Activities**	**Multi-sectoral partner**
Promote retention in care for all PLHIV on ART	This will be supported and strengthened by: • Increased efforts to implement the test and treat policy at facility level through the DIP process • Increased quality assurance to promote adherence to guidelines • Expansion of implementation strategies to include community based ART initiation demonstration projects for well patients, including the use of GPs • Prioritise rapid and same day ART initiation • Implement extended hours services for working people and adolescents • Use PLHIV in health facilities and communities to encourage linkage to care • Explore innovative ways to improve patients' linkage to services • Differentiated ART delivery for stable patients, including a minimum of 3 months drug supply and optimised prescription periods to meet the needs of key and vulnerable populations and improve adherence • Ensure a functional fast lane for collection of repeat drug prescriptions at all pharmacies • Use of approved patient representatives to collect ART refills • 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	• 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**
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
Improve laboratory diagnostics to deliver optimal DS and DR-TB services	• Universal implementation of Xpert MTB/RIF as initial diagnostic tests • Monitoring and optimising implementation of all existing algorithms • Implementing robust reflex testing for samples found to be Xpert RIF resistant • Developing a platform for introduction of new diagnostics • Prepare and train on guidelines and algorithms in advance of Xpert Ultra introduction • Upgrade the laboratories to ensure sufficient second line LPA coverage to ensure optimal implementation of MDR-TB short regimen • Implement lessons learnt from Xpert rollout • All labs doing second line LPA should be either able to conduct phenotypic second line drug sensitivity testing or have easy referral to a lab that has this capability.	• DoH
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
Reduce initial loss to follow-up rates for DS and DR TB cases	• Retrain staff and implement on-going clinical governance using QI approach • Establish initial loss to follow-up rate as a management priority as part of the DIP process	• DoH • Districts • Facilities

Generic HIV, TB and STI prevention, management and care		
Focus	**Activities**	**Multi-sectoral partner**
	• Reduce duration and number of visits from symptom onset to treatment initiation.	• Development partners
Provide standard care for DS-TB cases	• Provision of adherence support and retention of patients in care for treatment duration including referral for psychosocial support as needed • Bacteriological monitoring of treatment outcomes and implementation of recommendations from reviews • National research priority studies to determine what health facility and programme management interventions impact on treatment outcomes, whether alternative drug dispensing strategies affect adherence and patient outcomes and what clinical management and adherence support strategies improve treatment outcomes? • The multi-sectoral TB Think Tank using the findings to timeously review and update policies.	• DoH • Civil society (PLHIV, PTB sectors) • NGOs
Scale up short-course MDR-TB treatment and provide decentralised MDR-TB care	• Training and mentoring of staff on these at PHC level and referral centres • Adaptation of the EDR to accommodate new regimens • Monitoring the initiation rate of patients on the new regimen as part of the DIP process to optimise uptake • Provision of psychosocial support to patients who need it.	• DoH
Implement a quality improvement (QI) initiative to close gaps in the TB care cascade and improve programme outcomes.	• Development of DoH capacity to undertake QI (district and sub-district teams established; leadership and QI skills developed; tools and guidelines developed; learning networks established) with demonstration sites for QI established • All implementing partners to implement TB QI projects • Then undertake district baseline assessments and set targets for national scale-up based on successful models including nurse initiated care.	• DoH • Support partners
Implement the National STI National Framework guidance on the detection and treatment of asymptomatic STIs	• Developing, testing and validation of the sexual history tool for different populations and different ages as the basis for screening tests and / or presumptive treatment • Building capacity of health workers on the use of the tool and integrating it into all customised delivery sites. • Improved ACSM in high burden districts through targeted STIs messages. • Using the sexual history tool to screen and treat priority populations (pregnant women, AGYW and SW) for asymptomatic STIs	• DoH, NICD, NHLS • Dept. of Transport • Civil society (key population sectors) • District Management Teams • Private health sector

Generic HIV, TB and STI prevention, management and care		
Focus	**Activities**	**Multi-sectoral partner**
Appropriate syndromic management of STIs	• Ensuring appropriate management of cases non-responsive to the syndromic approach • The use of mobile outreach services for men with extended hours • Implementation of strategies to strengthen partner notification and contact tracing especially for key populations • Training and re-training of HCWs on syndromic management • Quality assurance programmes and advanced level STI management in secondary hospitals and CHCs with the necessary tools and training.	• DoH • DHET/HEAIDS • Private health sector
Screening of all pregnant women for syphilis at first ANC visit	• Screening for syphilis at birth for all infants born to Syphilis positive women or to women who were unbooked or untested • Linking all children diagnosed with congenital syphilis to care and ensuring they 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

Addressing social and structural drivers	**Service**	**Multi-sectoral partner**
Strengthened and scaled-up community based one-stop Khuseleka Centres	• Integrate community support programmes in one-stop centres	• DSD • SAPS • DoH • DOJ
Strengthened and scaled-up community-based 'white-door' shelters	• Provide short-term (72-hour) places of safety and shelter within communities and referral/integration with HIV/TB/STI services	• DSD • SAPS • DoH

Addressing social and structural drivers	Service	Multi-sectoral partner
		• DOJ
Identify and speedily allocate social grants to all who are eligible	• Link PLHIV, TB clients to social security programmes for access to social relief distress grants	• DSD • Civil society including NGOs
Scaled-up provision of food parcels, and nutritional supplementation to all eligible PLHIV and PTB	• Strengthen capacity of HIV/TB providers to screen for food insecurity • Ensure access to sufficient food in particular for PLHIV and PWTB • Expand drop-in centres especially in high-burden districts • Expand access through Isibindi model	• DSD • NGOs • SANAC sectors
Expand inpatient and outpatient rehabilitation facilities	• Develop adolescent-friendly practices • Sensitise and capacitate HCWs to screen for and refer and provide interim support for people with harmful use of alcohol and drugs • Expand availability of inpatient rehabilitation facilities	• DSD • DoH • DBE • NGOs
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
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

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.

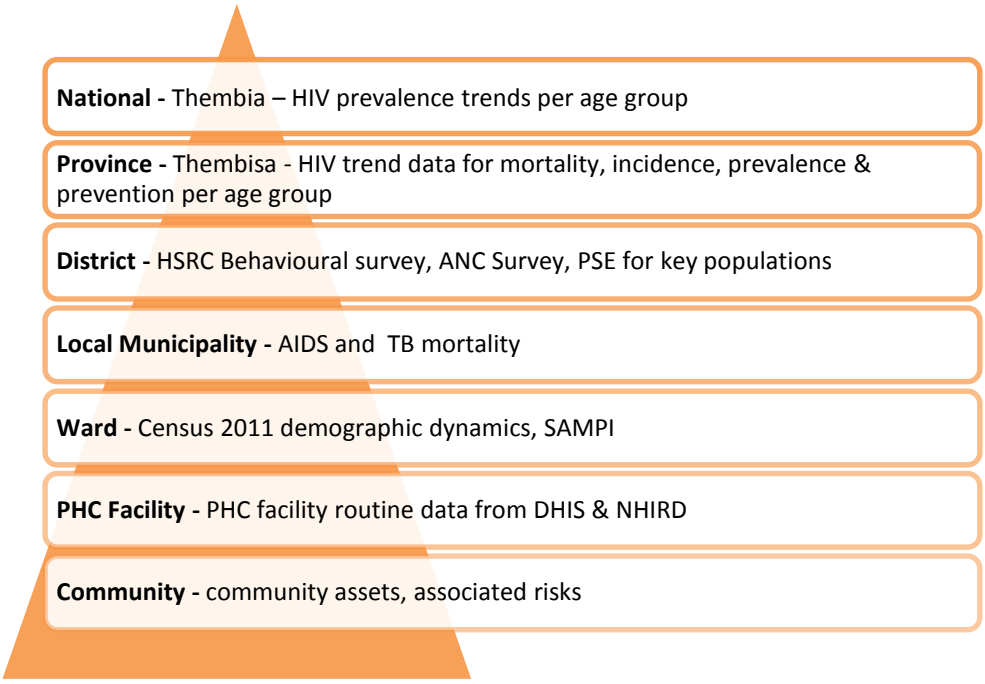

Figure 32: Data pyramid used for risk profiles

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).

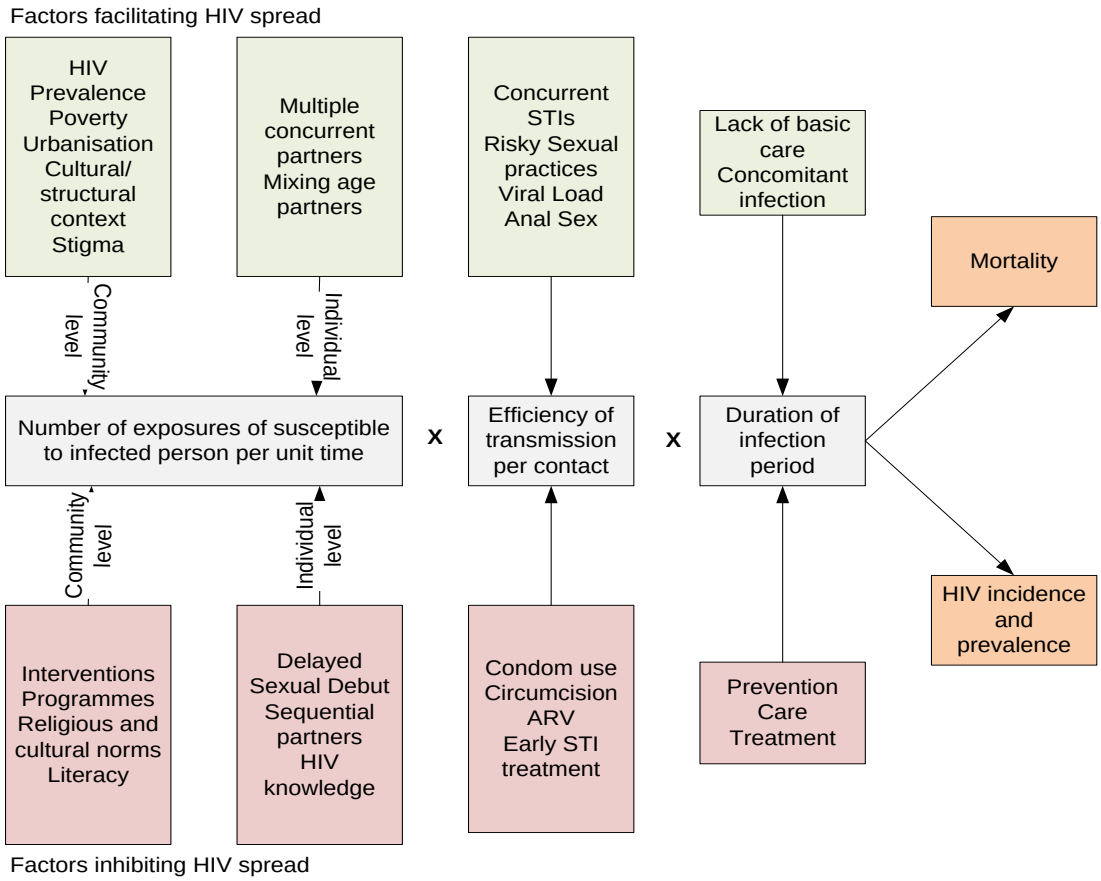

Figure 33: Factors influencing HIV associated risk and outcomes

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
Behavioral data	Data collected from studies of human behavior that is relevant to disease risk. Relevant behaviors for HIV risk may include sexual activity, substance use, needle sharing, condom use, or responses to primary and secondary prevention messages, knowledge of HIV transmission and prevention
Data	Raw, unprocessed numbers
Delivery in facility under 18 years rate (routine health indicator DHIS 2015)	Short Name - Delivery 18 rate Numerator - Delivery under 18 years in facility Denominator - Delivery in facility - total Indicator Type - % Definition - Deliveries to women under the age of 18 years as proportion of total deliveries in health facilities
Dependency ratio	The dependency ratio is an indicator of potential dependency burden of children and the elderly on those who are of economically productive ages in a population. Source Census 2011
Epidemiologic profile	A document that describes the distribution of HIV in various populations and identifies characteristics both of HIV-infected and HIV-negative persons in defined geographic areas. It is composed of information gathered to describe the effect of HIV on an area in terms of socio-demographic, geographic, behavioral, and clinical characteristics. Identifies characteristics of the general population and of populations who are living with, or at high risk for HIV infection in the pre-defined geographic areas in need of primary and secondary prevention or care services; and also identifies social, behavioral, cultural, factors driving local HIV infection. This providing information required to conduct needs assessments and gap analyses to complete the local HIV profile
Female condom distribution coverage (routine health 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 analyzed data that adds context through relationships between data to allow for interpretation and use
Intensity of poverty	The average proportion of indicators in which poor households are deprived. Example, an intensity of 44% in 2011 means the average intensity of poverty was 44% amongst the 20% poor households
Male condom distribution coverage (routine health indicator DHIS 2015)	Short Name - Male cond dist cov Numerator - Male condoms distributed Denominator - Male population 15 years and older Indicator Type - % Definition - Male condoms distributed from a primary distribution site to health facilities or points in the community (e.g. campaigns, non-traditional outlets, etc.)
Male urethritis syndrome rate (routine health indicator DHIS 2015)	Short Name - MUS rate Numerator - Male Urethritis Syndrome treated - new episode Denominator - STI male - new episode Indicator Type - % Definition - Male Urethritis Syndrome new episodes treated as a proportion of total males with STI new episodes treated
Modes of HIV transmission or mode of HIV exposure	Heterosex (or heterosexual contact with a partner who is HIV positive or at increased risk for HIV. Often this level of knowledge about sexual partners (anonymous, casual, or exclusive) may be unknown; Men who have sex with men (MSM); People who Inject Drugs (PWID); Joint risk of MSM/PWID; and Other mode of exposure including (transplant, hemophilia, transfusion or mother with HIV or HIV risk (PMTCT)
Morbidity	The presence of illness in the population.
Mortality	The total number of persons who have died of the disease of interest. Usually expressed as a rate, mortality (total number of deaths over the total population) measures the effect of the disease on the population as a whole
Percentage	A proportion of the whole, in which the whole is 100. Example: Assume that 10 of the 40 cases of AIDS in a given year in a Ward occurred in men. (10 ÷ 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

<table>
<tr><td></td><td>standardization of indicators across the different geographical areas.

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

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

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

School attendance</td><td>If no household member aged 15 or older has completed 5 years of schooling
If any school-aged child (aged 7 to 15) is out of school</td></tr>
<tr><td>Standard of living</td><td>Fuel for lighting</td><td>If household is using paraffin/candles/nothing/other</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 heating	If household is using paraffin/wood/coal/dung/other/ none
		Fuel for cooking	If household is using paraffin/wood/coal/dung/other/ none
		Water access	If no piped water in dwelling or on stand
		Sanitation type	If not a flush toilet
		Dwelling type	If an informal shack/traditional dwelling/caravan/tent/other
		Asset ownership	If household does not own more than one of radio, television, telephone or refrigerator and does not own a car
	Economic activity	Unemployment (all adults)	If all adults (aged 15 to 64) in the household are unemployed

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

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

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

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

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

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

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

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

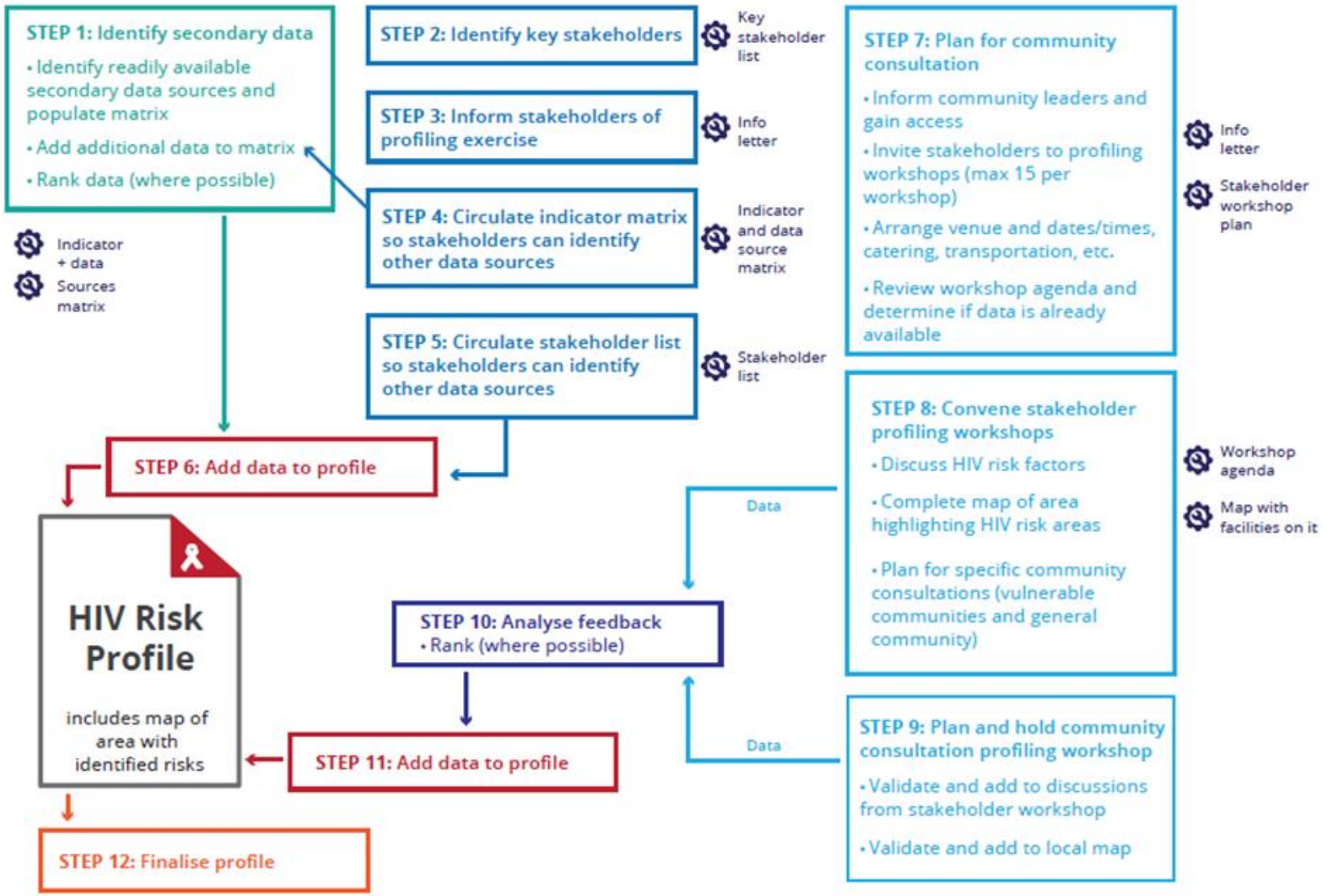

Figure 34: Steps for development of HIV associated risk profile