Office of the Premier

Isifundazwe SaKwaZulu-Natali

Province of KwaZulu-Natal

PROVINSIE VAN KWAZULU-NATAL

Review Report

KwaZulu-Natal

HIV and AIDS, STI Provincial Strategic Plan

2007-2011

Draft 1: 17 August 2011

Acknowledgements

Abbreviations/Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal clinic
ART	Antiretroviral therapy
ARV	Antiretroviral (drugs)
ASSA	Actuarial Society of Southern Africa
CBO	Community Based Organisation
CD HIV & AIDS	Chief Directorate HIV & AIDS in the Office of the Premier
DAC	District AIDS Council
DOE	Department of Education KwaZulu-Natal
DOH	Department of Health, KwaZulu-Natal
DOHo	Department of Housing KwaZulu-Natal
DOW	Department of Welfare KwaZulu-Natal
DPSA	Department of Public Service and Administration
ECD	Early Childhood Development
FBO	Faith-Based Organisation
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
IEC	Information, Education and Communication
IDP	Integrated Development Plan
JWG	Joint Working Group
KZNPSP	HIV & AIDS Strategy for the Province of KwaZulu-Natal
LAC	Local AIDS Council
M&E	Monitoring and Evaluation
MEXCO	Management Executive Committee within the Office of the Premier
MTCT	Mother-to-Child Transmission
NGO	Non-governmental Organisation
NMF	Nelson Mandela Foundation
OVC	Orphans and Other Vulnerable Children
PAAU	Provincial AIDS Action Unit (KwaZulu-Natal)
PAC	Provincial AIDS Council (KwaZulu-Natal)
PEP	Post-exposure Prophylaxis
PLHIV	People/Person living with HIV or AIDS
PMTCT	Prevention of Mother-to-Child Transmission
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary Counselling and Testing

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Executive Summary

1. Introduction

The Office of the Premier commissioned the review of the current strategic plan document (KZNPSP 2007-2011) in order to: (1) determine progress made in the implementation of programmes and interventions; (2) identify main achievements, challenges and opportunities and (3) identify emerging issues. The findings of the review are aimed at assisting in the determination of key priorities for and in the development of a new KZNPSP that will guide the response to HIV & AIDS over the next five years.

2. Background

KZN is one of the 9 provinces of the Republic of South Africa with a projected population of 10 645 400, making it the second most populous province in the country. Like other provinces KZN has a young population structures with sexually active age group of 15-49 forming 44.4% of the total population. It is a predominantly rural province with high levels of poverty, unemployment and deprivation. Administratively KZN is divided into 1 Metro, 10 districts and 50 municipalities.

The HIV and AIDS response in the province is characterized as multi-sectoral in nature and guided by the "3 –ones" approach. PCA provides the overall provincial coordination while DACS provide coordination at district level. The KZNPSP 2007-11 is the key guiding document of the provincial response. It envisions a province that is free of new HIV infections where all infected and affected enjoy a high quality of life and aimed to, within five years: reduce new HIV infections by 50%; and provide a package of treatment, care and support to at least 80% HIV infected people in order to reduce AIDS-related deaths by 50%. Furthermore it identified the following priority areas: (1) Prevention; (2) Treatment, care & support; (3) Management, Monitoring, Research, and Surveillance of the response and (4) Human rights, Access to justice and Enabling Environment.

This review forms part of the process of development of the KZNPSP 2012-2016. It was undertaken in order to determine the progress made in implementation of KZNPSP 2007-11 and identify emerging issues. The objectives of the review are to:

- Assess the extent to which output, outcome and impact targets of KZN PSP and district plans for the period 2007-2011 were achieved
- Identify and document main achievements, challenges and gaps in implementation of KZN PSP programmes and interventions
- Identify and document emerging issues and themes in the KZN HIV, STI and TB responses
- Identify and agree on main priorities for the PSP 2012–2016

3. Methodology of the Review

The review principally used qualitative methods to gather and analyse information. This included documents and literature review; key informants interview and stakeholders workshop.

4. Achievements

(a) Prevention

- The incidence of HIV is estimated to have declined from 3.8% in 2005 to 2.3% in 2008:
- All primary schools provide life skills-based education (mention “My Life My Future Campaign”, which has been launched in all districts.
- Forty eight (48) High Transmission Areas (HTAs) have been established in KZN
- HIV transmission rate from mother to child declined from 22% in 2005 to 2.8% in 2010
- All government and private health facilities provide continuous supply of PEP medicines
- All blood and blood products are screened in a quality assured manner
- Strategies have been put in place to address poverty
- Access to water and sanitation at community level has improved
- Male circumcision has been introduced and accepted in the province

(b) Treatment, Care and Support

- HCT coverage has increased
- ART programme has achieved universal coverage
- HBC is provided in an integrated manner by CCG
- Over 40,000 OVC were provided with services
- TB and HIV integration interventions are being implemented in KZN

(c) Management, Monitoring, Research and Surveillance

- PCA, 82% of DAC and 53% of LAC are fully functional in KZN
- Sectors collecting data and reporting to the PCA

(d) Human and Legal Rights and Enabling Environment

- Strong political commitment

5. Challenges and gaps

(a) Prevention

KZN remains the province with the highest HIV incidence and prevalence

Sexual behaviour change interventions have not yet achieved the desired effect. The following are key determinants for risk

- *Gender*
- *Race*
- *Marital Status*

- *Education*
- *Informal settlements (location)*
- *Correct knowledge on HIV and AIDS*
- *Sexual behaviour: No. of sexual partners & Transactional sex*

STI services have not yet reach optimum effect
Condom distribution is inadequate
The coverage of MMC remains significantly low.
Inadequate integration of services

(b) Treatment, care and support

Poor follow-up of ART patients
OVC services: There appears inadequate coverage
HBC: Coverage of the HBC programme cannot be ascertained

6. Conclusion and recommendations

It is clear from the review that KZN has made some progress in the implementation of its strategy; however there are a number of areas that need to be improved in order to attain the vision of a KZN "free of new HIV infections where all infected and affected enjoy a high quality of life". We thus recommend the following:

- Re-focusing on and improving investment in prevention, while continuing to provide equitable treatment, care and support. Proven emerging prevention intervention should be embraced and scaled up with pace.
- Prevention is central to the success of any HIV and AIDS response. It is more cost-effective than treatment, care and support. All prevention efforts thus need to be brought to scale and at a faster pace.
- Consider rapidly scaling up emerging new prevention technologies such as MMC
- The ART programme has matured over the years. Consideration should be made to integrate it with the other Primary Health care programmes.
- Encourage continued political commitment in order to ensure individuals and departments engage with the various processes.
- Strengthen the DACs and LACs to improve their effectiveness
- Ensure that the multi-sectoral plans, monitoring framework and tools are well aligned with the sectoral activities
- Streamlining coordination and making district level structures more effective
- Synchronise Planning and M&E, so that strategic and operational plans are supported seamlessly by a practical M&E system

- Build capacity and capability for M&E systems within the Province
- Strengthening the M&E system, ensuring that the sectoral M&E systems are well aligned to the multi-sectoral one. This may require alignment of indicators and capacity building.
- Strengthen the capacity of the HIV and AIDS directorate to better monitor the sectoral responses.
- Strengthen the ward-based apporoach to implementation of the HIV and AIDS response.
- Ensure that usable reports are produced and disseminated and shared amongst stakeholders at all levels. Furthermore, information should be disseminated to the public at regular intervals.
- Build upon existing research coordinating mechanisms and develop a provincial research agenda that cuts across scientific, social and economic aspects of HIV & AIDS response
- The agenda and intervention on the human and legal rights must be made clearer and monitored regularly. Clearly defining interventions around human and legal rights and monitor them consistently.

1 Introduction

As part of the process of developing the "KZNPSP 2012-16, the Office of the Premier commissioned the review of the KwaZulu-Natal Provincial HIV and AIDS and STIs Strategic Plan (KZNPSP) in order to determine progress made in the implementation of programmes and interventions; identify main achievements, challenges and opportunities; and identifying emerging issues. The findings of the review will assist in determining the key priorities for the development of KZNPSP 2012 – 16. This report presents the findings and recommendations from the review.

The report is structured into the following sections: 1) Introduction, 2) Background information, 3) Methodology, 4) Findings, 5) Achievements, challenges and gaps; 6) Conclusion and; 7) Recommendations.

The background section provides context to the review, including its purpose and objectives. The section on Methodology describes the approach and methods used in conducting the review. It also discusses the strength and limitation of the review. The section on findings provides detailed results and analysis of the review in terms of progress, strength, weakness and opportunities. It is divided into sub-sections based the key elements of the provincial response strategy. This will include the sub-sections on:

- Progress in achieving the KZNPSP 2007-11 targets based on impact indicators
- Progress towards achieving the outcome targets in the four priority areas of: prevention; treatment, care and support; Monitoring, Research and Surveillance; and Human Rights and Access to Justice.
- Programmatic achievements and Gaps

Section 5 of the report presents the conclusive statement of the review while section six provides recommendation for the way forward.

2 Background

2.1 Geography and demography

KZN is one of nine provinces of the Republic of South Africa (RSA) situated in the east coast of the country. It covers an area of 92,100 square kilometres accounting for 7.6% of the total land surface of South Africa and shares national borders with Lesotho, Mozambique and Swaziland. It has an ocean coastline of about 1000 kilometres (km.) and shares its internal borders with the Free State, Mpumalanga and Eastern Cape provinces (StatsSA, 2010). The topography in KZN is characterized by hills and valleys.

KZN has a total of population of 10,819,130 and accounts for 21.4% of the country's population. It is the second most populous province after Gauteng province. The male: female population ratio stands at 1:1.07 (StatsSA, 2011). It is estimated that 54% of the population live in rural areas, with about 10% of those who live in urban areas living in informal settlements. It is estimated that the province had a net migration of 1 800 (out-migration of 196 100 and in-migration of 197 900) people between 2008 and 2011. About 72% of the population are below the age of 35 and the average life expectancy is 42.7 years for males and 47.8 years for females in 2009.

Table 1 below shows the population breakdown by age group and sex. The sexually active group of 15-49 age group forms about 53% of the total population.

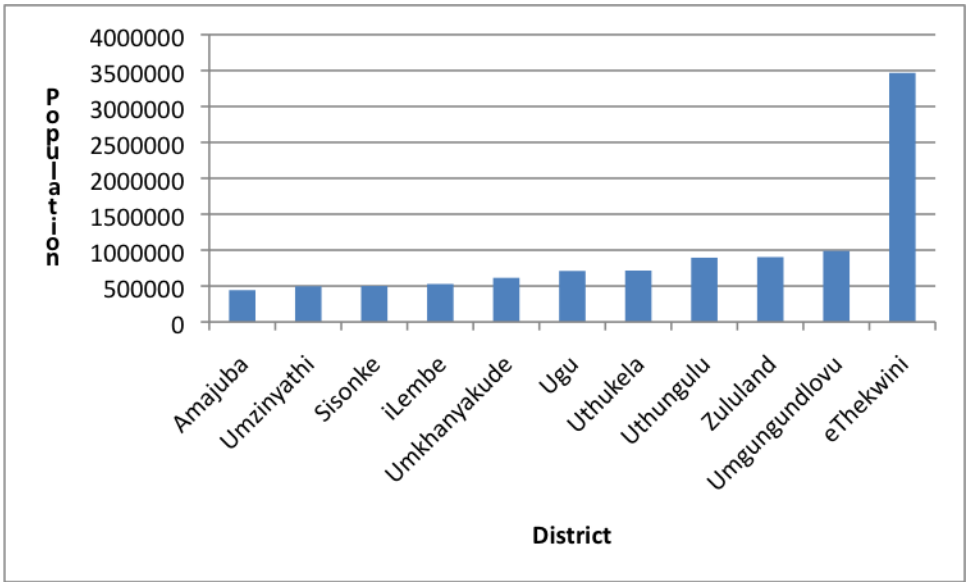
Table 1: KZN Population by Age Group (Mid-year 2010 estimates)

Age	Number	%
0-4	1220882	11.3%
5-9	1228646	11.4%
10-14	1212070	11.2%
15-19	1195857	11.1%
20-24	1096194	10.1%
25-29	998783	9.2%
30-34	823321	7.6%
35-39	710320	6.6%
40-44	487821	4.5%
45-49	420211	3.9%
50-54	374063	3.5%
55-59	307829	2.8%
60-64	264645	2.4%
65-69	188851	1.7%
70-74	136241	1.3%
75-79	84739	0.8%
80+	68657	0.6%
Total	10819130	100.0%

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

Distribution of the population by district is shown in the figure 2 below (StatsSA, 2007).

Figure 2: Chart showing KZN population by districts



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

The provincial population density is estimated at 107.52 people per km^2 with eThekwini having the highest at approximately 1,394 people per km^2 and Sisonke having the lowest population density of approximately 42 people per km^2.

Geographical and demographic profile of the province such its topography; population composition; density; and related social development have a significant bearing on HIV and AIDS services delivery in terms of availability, access and utilization. It therefore has to be considered in priority setting and resource allocation in order to address inequalities.

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

2.2 Socio-economic

KwaZulu-Natal remains a predominantly rural province, with high dependency ratios and poverty levels particularly in the rural areas. Unemployment remains significant and a main contributor to poverty. Unemployed poor people in KwaZulu-Natal are concentrated among:

Africans; in rural areas; among women; and the youth. Employment prospects are worsened by the high illiteracy rate, at 26% for the 15+ age group (CEEGA, 2011).

According to the District Health Barometer the ten most deprived districts in South Africa fell within three provinces namely KwaZulu-Natal, Eastern Cape and Limpopo with households living on less than R800 per month ranging between 63% and 82% in 2006 (HST, 2010). The province has The Human Development Index (HDI) is 0.6[1]. The Gini coefficient is estimated at 0.7 (CEGAA, 2011). This is an indicator of income inequality and is indicative of the widening gap between the rich and the poor The Gini coefficient varies between zero and one, although in reality values usually range between 0.20 and 0.30 for countries with a low degree of inequality and between 0.50 and 0.70 for countries with highly unequal income distributions.

According to the Income and Expenditure Survey (2003) KwaZulu-Natal contributed approximately 16.5% to the National GDP. There are approximately 496,230 households in KwaZulu-Natal that are involved in non-commercial subsistence farming (Provide Project, 2005). Although the province has a large rural population involved in agricultural activities, agriculture does not represent a significant income source.

These contextual factors are significant drivers of the epidemic, for example it is stated in the KYE report that “in a youth survey in Metro Durban and rural Mtunzini, relative economic disadvantage was found to signify increased likelihood of unsafe sexual behaviours. It also lowered the female chances of secondary abstinence.”i

2.3 HIV, AIDS and TB Situation

According to the Office of the Premier in KZN the province has the highest burden of diseases associated with underdevelopment and poverty. More than half (54%) of the adult PLHIV live in KwaZulu Natal (SANAC, 2011).

A study conducted by the Human Science Research Council on HIV prevalence in South Africa (Shisana, Rehle, Simbayi, Parker et al., 2008) put KwaZulu-Natal Province at the top of the other provinces with a 15,8% HIV prevalence, which is 11,9% higher than the prevalence in the Western Cape (the province with lowest prevalence). The current number of PLHIV in the province is 1,622,870 (15.8%) of the total population. If 30% are presumed to have CD4 counts of 200 and below, the estimate for patients in need of ART is 486,861.

[1] HDI is a composite index of life expectancy, literacy and standards of living.

After HIV and AIDS related illnesses, Tuberculosis (TB) is the second leading cause of mortality in the province with diagnosed TB cases increasing from 98,498 in 109,556 in 2007 to 118,000 in 2009 (DOH Annual Report, 2010). This represents a caseload of 1,156 cases per 100 000 population, which is more than four times the epidemic threshold according to the World Health Organisation. KZN also has the highest incidence of HIV, estimated at 2.3% in 2009.

Besides poverty and underdevelopment which are cited as contributors to the high prevalence of HIV a very low prevalence of male medical circumcision; concurrent sexual partnerships, transactional sex and late marriage further contribute (SANAC, 2011).

These contextual factors thus have to be considered in the design of a response strategy.

2.4 Background to KZN Provincial HIV/AIDS response

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

Because of the need to scale up and broaden the scope of the response, in 2004, the Cabinet resolved to dissolve PAAU and place the coordination of non-health sector, transversal issues of HIV and AIDS response with the Chief Directorate of HIV and AIDS within the Office of the Premier. The KZN Provincial AIDS Council was subsequently established in November 2008.

The provincial HIV and AIDS response is based on the principles of the multi-sectoral approach. As such, other structures that have been created to facilitate the multi-sectoral coordination in line with the Three Ones principle include the district municipalities and local municipalities AIDS councils (DACs & LACs). They are chaired by respective mayors as well as AIDS Units with various departments. These structures have been formed in accordance with the national HIV and AIDS response structure.

Provincial government departments are expected to have internal programmes aimed at workplace responses to ensure employee wellness and that of their immediate families are catered for. In addition a number of departments are involved in the external response

Programme	2008/09	2009/10	2010/11	% Change

programmes. For example The DOH is a key department in health sector oriented responses such as voluntary counselling & testing, ART and prevention of mother to child transmission (PMTCT) to name a few. Other departments playing a major part in the external response include the DLGTA's, DOE, DSD and the department of housing. Several non-governmental organisations and community based organisations (NGOs, FBOs and CBOs) are also actively involved in the response in the province. They provide a variety of services and are involved in a wide range of interventions.

The Business Community and traditional health practitioners are also recognised as important partners in the response. A broad range of direct services is being provided by some business programmes and traditional practitioners. There are also many international partners who provide resources and collaborate in research within the province.

In terms of HIV and AIDS funding the province has yet to have central coordination of funds, which leaves it diminishes its capacity to dictate the direction of the response. The largest proportion of funding for the multi-sectoral response comes from the DOH in the form of the conditional grant and voted funds from the various departments. The balance comes from external funders and the private sector. External funders generally do not account to and send their reports to the PCA except in instances where their funds go through a government department. Further, they appear to work autonomously of each other although they do have a donor forum group. They also run programmes parallel to state programmes and are not keen to share their information. The province has no information on their current and long-term commitments. This does not foster a harmonised and integrated response, which is guided by the provinces' priorities. Nor does it enhance the government's ability to measure future funding requirements, and to address funding gaps in a sustained and aligned manner, so as to reduce overlap and gaps in key areas (NASA, 2011).

Approximately 93% of HIV and AIDS public funds are spent by DOH. DSD and DOE spend the balance primarily on OVC and life skills programmes. Less than 1% is spent in central management and coordination of the provincial response by the OTP.

	Audited Outcome	Audited Outcome	Pre-audited Outcome	between 2008 and 2010
	R	R	R	
PMTCT	1,073,658,989	121,259,347	77,616,329	-27.71%
Life Skills	41,054,758	41,482,398	40,010,287	-2.54%
STI	732,876	732,876	3,168,287	332.33%
PEP	20,399,886	20,623,291	15,851,816	-22.29%
MMC			9,903,085	
Blood	102,710,945	225,492,263	244,323,208	33.28%
VCT	151,413,706	169,636,230	201,803,704	33.28%
TB & HIV	910,159	183,556		-100%
ART	679,216,545	857,890,617	821,109,833	20.89%
OVC	24,480,000	26,023,000	56,757,000	131.85%
HBC	70,564,220	87,168,735	71,902,879	1.90%

Table 2: HIV and AIDS Expenditure by Department

(Source: PETS Survey Presentation, 2011)

The budget for PMTCT programmes, decreased by 28% from 2008/9 to 2009/10. Life skills also had a marginal decrease in the same year while the budget for STI remained unchanged. The budget for PEP decreased by 22% while the ART budget increased by 22%.

Table 3: Expenditure by HV and AIDS programme

Department	2008/09 Audited Outcome R	2009/10 Audited Outcome R	2010/11 Pre-audited Outcome R
Health	1,239,364,337	1,534,545,731	1,500,249,377
Social Development	24,480,000	26,023,000	56,757,000
Education	41,054,758	41,482,389	40,010,287

Housing			82,000
Transport	10,536,763	11,542,219	11,783,291
Sports	7604,21	2,903,603	4,314,086
Office of the Premier	8,488,365	8,941,828	9,695,188

(Source: PETS Survey Presentation, 2011)

ART has the biggest slice of the budget, at around 55% in any given year. The budget for OVC is about 6% of the HIV and AIDS budget. Given the number of OVC, the allocation is insignificant. The Minister of Health announced in August 2011 that ART would now be offered to individuals at CD 4 counts 350 and below. This will increase the demand for the service. With the majority of funds already diverted to the most costly programme, the province will battle to allocate funds to non-treatment related activities henceforth. There is then a need to find innovative ways of closing the tap through effective BCC, with a view to preventing new infections.

The KZNPSP 2007-11 envisions a province that is free of new HIV infections where all infected and affected enjoy a high quality of life. It aimed to, within five years: reduce new HIV infections by 50%; and provide a package of treatment, care and support to at least 80% HIV infected people in order to reduce AIDS-related deaths by 50%. The priority areas stated in the plan in line with NSP are: (1) Prevention; (2) Treatment, care & support; (3) Management, Monitoring, Research, and Surveillance of the response and (4) Human rights, Access to justice and Enabling Environment.

In line with the multi-sectoral response, all the KZN stakeholders were expected to participate and collaborate in the implementation of the KZNPSP. The review is designed to determine the extent to which progress has been made in the achievement of the stated goals and objectives; and implementation of the plan. The main gaps, challenges and opportunities will also be determined in order to chart the way forward for the next strategic plan.

2.5 Purpose and objectives of the review

2.5.1 Purpose

The overall purpose of this review is to assess the progress in implementation of the current PSP focusing on output, outcome and impact indicators and examine the policy environment and governance of the response.

2.5.2 Objectives

The following are the objectives of the review:

(a) Assess the extent to which output, outcome and impact targets of KZN PSP and district plans for the period 2007-2011 were achieved

(b) Identify and document main achievements, challenges and gaps in implementation of KZN PSP programmes and interventions

(c) Identify and document emerging issues and themes in the KZN HIV, STI and TB responses

(d) Identify and agree on main priorities for the PSP

3 Methodology

3.1 Methodology of the review

Qualitative methods that included extensive literatures and documents review; stakeholders' consultative workshops and key informants interviews were used to gather information for the review.

Document review: Documents pertinent to the KZN response were identified with the assistance of the Chief Directorate for HIV and AIDS in the OTP. Each of the documents was critically appraised and valid information relevant to determining the progress in the KZN response were extracted and analysed. All the documents reviewed are listed in the Reference section of the report.

Stakeholders' consultative workshop: A stakeholders' workshop at provincial level to obtain their perspectives and input into the review process was convened from 27th-28th July 2011. Up to 124 stakeholders were participated.

Key informants interview: Key informants were identified at the provincial and district levels. A few key informants were selected on the basis the organization they represent in order to ensure a broad representation and perspectives. All the identified key informants were interviewed using a standard interview guide. This approach brought about varied perspectives from stakeholders and a collective way of identification of gaps, strengths, needs and suggestions on priority for KZNPSP 2012-2016.

3.1 Strengths and limitations of the review

3.1.1 Strengths

The main strength of the review is that a participatory process involving a wide range of stakeholders and partners was used. This brought about different perspectives and created a collaborative and networking environment among stakeholders. The approach potentially will be a key lever for collaboration in the development and implementation of KZNPSP 2012-2016.

Secondly most of literature used in the review were peer reviewed and thus of acceptable quality and validity and likely to represent the true picture in the province.

3.1.2 Limitations

The main limitation of this review was the unavailability of data representing the 2011 situation in KZN. Most of the data available was from 2009 reports. Time constrains also played a negative role in the review in that it was difficult to get all the key informants within the timeframe of the review.

4 Findings

This section of the report presents key findings of the review based on literature review; key informants interviews; and stakeholders' workshops. It is organized under the headings of: progress in achieving the KZNPSP 2007-11 goals; objectives and programmatic interventions and achievements and challenges. Each section begins with a brief introduction, followed by specific key findings and brief discussion of findings.

4.1 Progress in achieving goals and objectives of KZN PSP 2007-11

In line with the NSP, the KZN PSP 2007-2011 stated a number of goals and objectives under the four priority areas. The priority areas represent a comprehensive response that accommodates diverse interventions designed to address the needs of the province. The findings on achievement of goals, objectives and programmatic interventions are presented under each priority area.

4.1.1 Strategic Priority Area 1: Prevention

HIV and AIDS has been the major impediment to achieving healthy and equitable societies where children are able to grow into healthy, secure and productive adults. To prevent a vicious cycle of HIV transmission it is essential that effective HIV prevention interventions are developed and implemented. The KZN PSP 2007-2011 identified the goal of reducing the annual rate of new infection by 50% by 2011 as the desired impact to be achieved.

The overall level of achievement of this goal and programmatic effectiveness is reflected in indicators such reduction in incidence of HIV in the general population and reduction of HIV prevalence in the young age group.

Below are the figures and facts showing progress that has been made in achieving the prevention goal, objectives and programmatic intervention targets. A discussion on the achievement, gaps and challenges is also provided.

4.1.1.1 Progress in achieving the goal target

The impact indicators, targets and achievements figures are summarized in the table below:

Table 4: Progress in achieving Impact targets

Primary Goal 1: To reduce the annual rate of new infection by 50% by 2011						
Expected Impact: 50% reduction in annual rate of new HIV infections by 2011						
Indicator	**Baseline (2005/06)**	**Mid-term (2008/09)**		**End-term (2010/11)**		**Comments**
		Target	**Achievement**	**Target**	**Achievement**	
1.Percentage reduction in annual HIV Incidence rate amongst the population of KZN 2 years an older	*3.8%) (Source: South African National HIV Survey, 2005)*	*25% reduction (2.85%)*	*2.3% (source: 2009 EPP estimates, E Gouws) 100,787 (Source: KYE report)*	*50% reduction (1.9%)*	No data for 2011.	Estimates used for 2008
2.Percentage of women and men aged 15-24 who are HIV infected	*16.1% (Source: South African National HIV Survey, 2008)*	*25% reduction (12%)*	*15.3%*	*8.05% (target: 50%) reduction)*	No data	

Incidence of HIV

Currently there is no consensus on a "gold standard" approach to measuring HIV incidence. Despite this methodological challenge, South Africa uses several methods to estimate incidence. The Human Sciences research Council in particular uses immunoassay sero-technology to detect recent infections and mathematical modelling to estimate HIV incidence in young people. (Shisana, et.al., 2009).

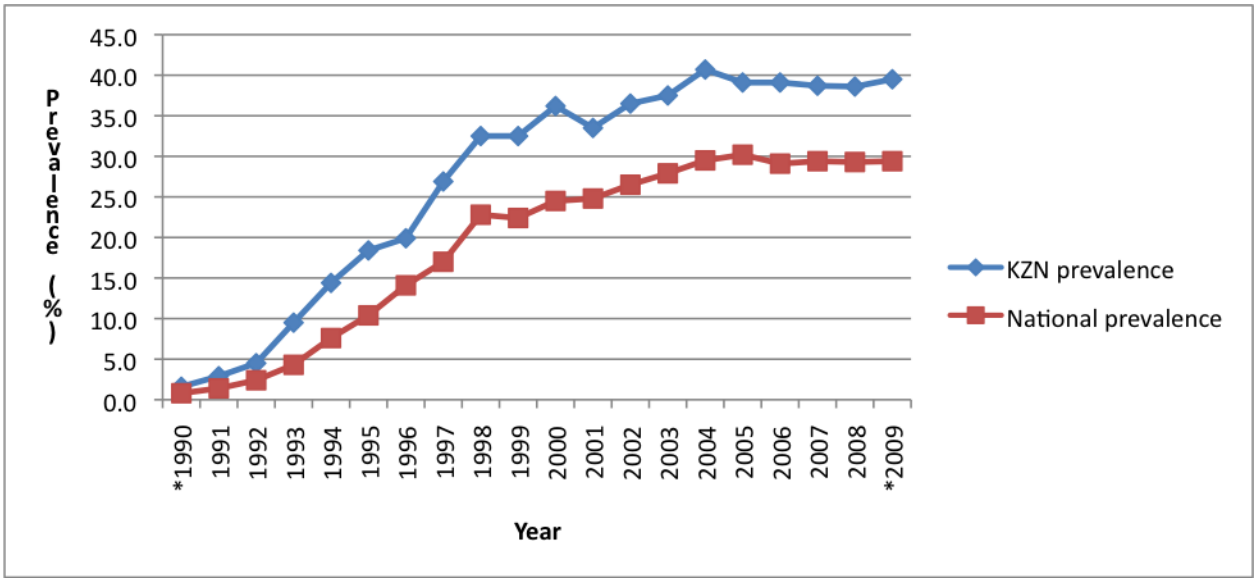
Estimates show that HIV incidence in KZN has reduced from 3.8% in 2005 to 2.3% in 2008 (E Gouws, 2009 EPP). At present there is no annual estimate for 2010/11. Based on this source of data, there is indication that the incidence of HIV is reducing in KZN. The mid-term estimates represent a 39.5% (3.8% to 2.3%) reduction from baseline. However compared to national incidence, KZN's rate remains unacceptably high. In 2008 the national incidence was estimated at 1.49% compared to 2.3% in KZN. This implies that although there is evidence that progress has been made, KZN still needs to double its effort to at least reach the national rate.

HIV prevalence

HIV prevalence in the age group 15-24 was used as the second impact indicator for the goal of reducing new infection. Trends in HIV prevalence among younger age group provide indication of trends in recent infection rates given that young people would have been recently infected. The estimated HIV prevalence in the age group 15-24 was 15.3% in 2008 (Shisana, et.al.,

2009), an insignificant reduction from 16.1% in 2005. In addition, the highest provincial HIV prevalence among pregnant women in 2008 was recorded in KwaZulu-Natal at 39.5% (95%CI: 38.1 – 41.0) (DoH, 2009). As shown in figure 3 below, HIV antenatal prevalence in KZN has been consistently higher than the national prevalence although it levelled off in the early 2000's. The large Anti-Retroviral Therapy (ART) programme may have contributed towards stabilizing HIV prevalence albeit at very high levels.

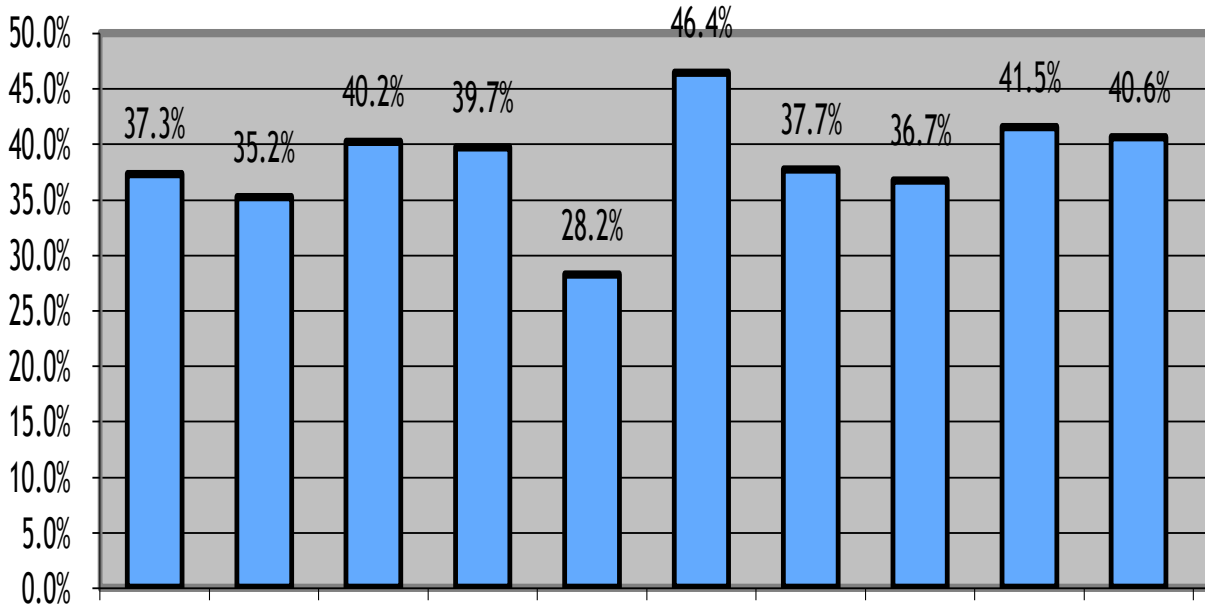
Figure 3: KwaZulu Natal Antenatal HIV Prevalence against National Prevalence 1990-2009



(Source: Graph compiled with Information from National Department of Health Antenatal Surveys 1990-2009)

HIV antenatal prevalence by districts in 2009 is shown in figure 4 below. As shown in the graph, Uthukela had the highest recorded ante-natal HIV prevalence in 2009 at 46.4% (see figure 4 below). This is a clear indication that each district in the province has unique challenges that need to be addressed individually.

Figure 4: Antenatal HIV Prevalence by District 2009



(Source: Graph compiled with Information from National DOH Antenatal Survey 2009)

4.1.1.2 Progress in Achieving the Objective targets

In order to achieve the goal of reducing new infection, the KZNPSP2007-11 identified the following objectives to be achieved within the plan period:

i. To ensure that at least 50% of sexually active population in KZN adopt safer sexual practices by 2011
ii. To reduce risk of MTCT of HIV to less than 5% by 2011
iii. To reduce the risk of HIV transmission from occupational exposure and through injecting drug use & use of contaminated instruments to less than 1% by 2011
iv. To eliminate the risk of HIV transmission through blood and blood products by 2011
v. To reduce vulnerability to HIV transmission due to poverty, culture and gender inequality by 2011

Table 3 below summarizes data showing progress towards achieving the prevention objectives.

Table 5: Outcome indicators, targets and achievements

Objective 1: To ensure that at least 50% of sexually active population in KZN adopt safer sexual practices by 2011						
Expected outcome: Adoption of safer sexual behaviours and practices by at least 50% of sexually active population in KZN *(safer sexual behaviour in terms of delayed sexual debut; abstinence; no multiple partners; and consistent condom use)*						
Indicator	**Baseline (2005)**	**Mid-term (2008/2009)**		**End-term (2010/2011)**		**Comments**
		Target	**Achievement**	**Target**	**Achievement**	
Percentage of women and men age 15 to 49 who have had more than one sexual partner in past 12 months	10.6% *(Shisana, et.al., 2009)*	25% reduction (7.95%)	*10.2% (Shisana, et.al., 2009)*	50% reduction (5.3%)	No data	
Percentage of young men and women aged 15-24 who have had sexual intercourse before 15	4.5% *(Shisana, et.al., 2009)*	25% reduction (3.4%)	*4.9% Shisana, et.al., 2009) (*	50% reduction (2.3%)	No data	
Median age of partners among pregnant women aged 15-19	5 years older	25% reduction	*No data*	50% reduction	No data	
Percentage of women and men age 15 to 49 who reporting use of a condom at last sex	36.2% *(Shisana, et.al., 2009)*	100%	*66.2% (Shisana, et.al., 2009)*	100%	No data	
Objective 2: To reduce risk of MTCT of HIV to less than 5% by 2011						
Expected outcome: Reduced risk of mother-to-child transmission of HIV to less than 5% by 2011						
Indicator	**Baseline (2005/06)**	**Mid-term (2008/09)**		**End-term (2010/11)**		**Comments**
		Target	**Achievement**	**Target**	**Achievement**	
Percentage of infants born to HIV-infected mothers who are infected	No data	<10%	8.2% (NHLS data from MRC study)	<5%	2.8% (Source: PMTCT survey from MRC study)	*(NB: DHIS gives 5% and NHLS gives 2.3%)*
Objective 3: To reduce the risk of HIV transmission from occupational exposure and through injecting drug use & use of contaminated instruments to less than 1% by 2011						
Expected outcome: Risk of transmission of HIV from occupational exposure and through injecting drug use & use of contaminated instruments reduced to less than 1% by 2011						
Indicator	**Baseline (2005)**	**Mid-term (2008/2009)**		**End-term (2010/2011)**		**Comments**
		Target	**Achievement**	**Target**	**Achievement**	
Percentage transmission of HIV through occupational exposure	No data	<1%	No data	<1%	No data	
Incidence of HIV amongst injection drug users*	No data	<5%	No data	<1%	No data	
Objective 4: To eliminate the risk of HIV transmission through blood and blood products by 2011						
Expected outcome: Zero transmission of HIV through blood and blood products by 2011						
Indicator	**Baseline (2005)**	**Mid-term (2008/2009)**		**End-term (2010/2011)**		**Comments**
		Target	**Achievement**	**Target**	**Achievement**	
Percentage transmission of HIV through transfusion of blood and	No data	0%	100%	0%	100%	No provincial source of data

blood products						
Objective 5: To reduce vulnerability to HIV transmission due to poverty, culture and gender inequality by 2011						
Expected outcome: Reduced vulnerability to transmission of HIV due to poverty, culture and gender inequality by 50% by 2011						
Indicator	**Baseline (2005)**	**Mid-term (2008/2009)**		**End-term (2010/2011)**		**Comments**
		Target	**Achievement**	**Target**	**Achievement**	
Percentage reduction in poverty	0.57	*25% increase*	0.60	*50% increase*	0.62	PGDS 2011
Percentage of population with sustainable access to an improved water sources	70.3%	*No target*	82.9%	*No target*	86.2% *(COGTA: 2011)*	
Percentage of population with access to basic sanitation	74.1%	*No target*	78%	*No target*	80.5% *(COGTA: 2011)*	
Percentage of population with access to electricity	72%	*No target*	75.2%	*No target*	*77% (COGTA: 2011)*	
Gini coefficient	0.71 (PROVIDE , 2005)	*No target*	No data	*No target*	0.7 *(CEGAA, 2011).*	

Objective 1: Sexual Behaviour Change

The following are the fifteen interventions designed to achieve the behaviour change objective:

i. Strengthening Behavioural Change programmes and interventions, targeting higher risk and vulnerable populations such as: young women and pregnant women; older men and women; and populations in informal settlements, farms and rural areas

ii. Introduction and implementation of life skills education, SRH and other HIV prevention programmes in all primary and secondary schools.

iii. Implementation of Life skill curricula customised to different target groups. Example: Primary school children; Secondary school children; Higher Education Institution students; and Youths out of formal schooling etc.

iv. Implementation of interventions that address sexual & reproductive health; and HIV and alcohol & substance abuse through a gender sensitive package targeting schools with high rates of teenage pregnancies.

v. Implementation of legislation and policies that are aimed at keeping young people in schools (especially Orphans and Vulnerable children)

vi. Condom promotion and distribution targeting high risk settings such as: beer halls; clubs; pubs; brothels; shebeens; and location for ceremonies

vii. Rollout of a comprehensive prevention package (includes access to IEC; VCT; male and female condoms; STI management and TB screening) in all workplaces in KZN

viii. Implementation of parenting programmes that promote positive engagements and communication between parents and children

ix. Provision of youth friendly health services in public health facilities
x. Development of and implement a comprehensive package that promote male sexual health including:
xi. Promotion of Human and Legal rights
xii. Life skills education for males including drug abuse
xiii. Adapting recommendation on of male circumcision (Will await for national policy on circumcision)
xiv. Roll-out of customized comprehensive HIV prevention packages to special groups. These groups include: Uniformed services; mine workers; Long distance transport services workers; Agricultural workers; Hospitality industry workers; Domestic workers and gardeners; prisoners; MSM, Lesbians and transsexuals; and sex workers and their customers.
xv. Provision of a comprehensive package of sexual assault care in accordance with National Policy on Sexual Assault Care, including PEP, in al l health facilities.
xvi. Provision of accessible social and mental health services to support children and adult victims of gender based violence
xvii. Implementation of programmes that reduce stigma and promote voluntary disclosures by PLHIV
xviii. Implementation of prevention programmes and interventions that specifically target PLHIV.

Below is a table showing progress on some of the key programmatic output targets.

Table 6: Progress on key behaviour change programmatic output indicators

Indicator	Baseline (2005/06)	Mid-term (2008/09)		End-term (2010/11)		Comments
		Target	Achievement	Target	Achievement	
Number of male condoms distributed annually by public and private sector	*90%*	*100%*	No data	*100%*	26,459,032 (18%)	DOH DORA Indicators
Number of female condoms distributed annually by public and private sector	*90%*	*100%*	No data	*100%*	383,404 (27%)	DOH DORA Indicators
Number and percent of males undergoing circumcision		No target		186,703	54,689 (29%)	DOH Programme report
Percent of schools that provide life skills-based HIV education in the last academic year	No data	30%	100%	70%	100%	DOE Report
Percentage of most-at-risk-populations reached with HIV prevention programmes	No data	*No data*	50%	*100%*	No data	
Proportion of those health	No data	*80%*	No data	*95%*	88%	DOH Annual

facilities offering a comprehensive package of sexual assault care in accordance with National Policy Guidelines, including PEP						report

Behaviour change communication

BCC positively promotes self-efficacy and personal behaviours that reduce the risk of HIV transmission, such as reducing the number of sexual partners and condom use. Communication campaigns seek to tackle beliefs, attitudes and social norms that underlie risky behaviour, such as values that contribute to the notion of women-as-property and coercive sex. BCC is also essential in ensuring the uptake of and adherence to treatment, care and support interventions and the reduction of stigma, which can be a barrier to individuals seeking healthcare and other help.

Coverage is uneven across the province and within districts and covers about 10% of schools. The BCC programmes in place in KZN are; School cultural competition, Beautification of Public places, Family Tree, Siyadlala, Sport for Life, Recreation, Club Development, My Life My Future, Game W! and Operation Hlasela.

Several departments have BCC specific to HIV and AIDS response but KZN has identified that BCC is not coordinated. There is no system in place to coordinate and monitor BCC interventions. Consequently, a initiative is underway to house all BCC under the Youth Ambassador programme in the Office of the Premier. Currently, there are 2056 Youth Ambassadors covering all districts. Not only will Youth Ambassadors be engaged as change agents but they will also provide essential life skills to youth out of school within their communities. An added advantage of utilising community-based youth for BCC is that they will provide targeted BCC interventions at community and household levels, rather than the generic approach that characterises the current approach.

Condom promotion, distribution and use

According to the DoH DORA report 26,649,032 male condoms and 383,404 female condoms were distributed during the financial year 2010/11 (DOH Report). However this fell short of the target by 82% and 73% for the male and female condoms respectively. Use of condom during the last sexual encounter was reported to have increased from 36.2% in 2005 to 66.2% in 2008

(KYE, 2011). Other evidence of low condom use include the increasing rate of STI among patients on ART and well as increasing rate of teenage pregnancy.

The mid-term review noted that a twin problem of perceived condom quality and disruptions in supply exacerbated the existing problems of getting more people to use condoms. There is a much lower demand for female condoms due to high costs and little knowledge about them.

Since male and female condoms are the only technology available that can prevent sexual transmission of HIV and other STIs, availability and access to condoms should be monitored and have resources directed accordingly. Persons at risk for sexual transmission of HIV should have consistent access to high quality condoms. The provincial HIV and AIDS programme should implement activities to increase both availability of and access to condoms. The indicators above highlight the distribution of condoms. However, even if condoms are widely distributed, this does not mean that individuals can or do access them. The distribution data should be interpreted with caution, given that access to condoms could not be ascertained during the review.

STI services

KZN has made little progress towards addressing STI problem. According to antenatal surveillance report of 2009, KwaZulu Natal had the third lowest prevalence of syphilis in the country. Syphilis prevalence in KZN was 0.8 % in 2009 compared to 0.8% in 2007 and 0.6 % in 2008 (DoH, 2009). This shows that syphilis incidence has remained stable over the three years.

The STI programme is implemented through hospitals, PHCs, mobile clinics and HTA sites. Besides providing treatment and care of STIs, the programme is tasked with distribution of male and female condoms. The total number of treated new episodes of STIs in 2010/11 was 440,714 but the STI partner treatment rate was only 22%, in spite of the high rate of partner notification (100%). The high volume of new cases is indicative of the low rate of condom use. This low rate of treatment of partners is of serious concern, since high prevalence of STIs not only indicates low rate of condom use but also contributes to high risk of HIV transmission.

Medical male circumcision (MMC)

The PSP set a target of 100% against implementation of a comprehensive package that promotes male sexual health. Male medical circumcision falls under this intervention.

Male circumcision (MC) has been shown in the South African MC efficacy trial at Orange Farm near Johannesburg to reduce men's risk of getting HIV infected by 61%. In the 2005 HSRC survey, men who reported having been circumcised before first sex were significantly less likely to be HIV-positive.

In KZN there are 37 sites offering free MMC in public health facilities, which includes all hospitals and some CHCs. The target for 2010/11 was 186,703 circumcisions. From April 2010 to June 2011 up to 54,689 MMC were performed, of which 18,000 were in the last three months of the period. This indicates that only about 20% of the annual target was achieved. Considering that the cumulative target for 2014/15 is 2 333 788, very serious efforts need to be made if the province is to come any close to achieving this target.

Multiple partnerships

There was hardly any reduction in the self reported multiple partnerships from 2005 to 2008. In the context of poor availability of condoms, the risk of transmission of STIs and HIV cannot be contained.

Life skills education

Good achievement was made in providing life skills-based HIV education in schools in that all the schools in the province provide life skills-based education services to learners. Despite this achievement the MTR reports indicated that students continue to have unsafe sex, with many of them being reluctant to undergo testing due to the perception that a positive result would destruct them from their studies.

The life skills-based HIV education intervention is led by DOE with the overall aim of mainstreaming Life Skills into the curriculum. Although this is primarily within the prevention priority area it also provides interventions under Care and Support for OVC.

The DOE implements the curriculum-based life skills programme as part of the National Integrated Plan for Children Infected and Affected with HIV/AIDS. The programme capacitates learners on HIV and AIDS education and peer education. It also offers training for care and support, lay counselling and first aid for master trainers; and management of the response for School Governing Bodies (SGBs) and SMTs. The outputs of DOE for 2010/11 are shown in table 5 below.

Table 7: Life Skills Programme Outputs for 2010

Activity	Target	Actual	% Achieved	Comment
Advocacy				
World AIDS Day, HCT campaign, teenage pregnancy awareness campaign and social mobilisation	13000	11220	86.3%	Includes 3463 learners and 250 educators reached through pregnancy awareness campaigns
Training				
Master training: trained on support for school programmes		6087		Includes 96 members of SMT
Peer education: trained to provide education on sexuality education, peer pressure, teenage pregnancy, etc.	3600 learners & 360 educators	3450 learners & 300 educators	96% of learners and 83% of educators	Exceeds 70% KZN PSP target
Soul Buddyz: peer education	1000	450	45%	Reasons not provided
Care and support				
Lay Counselling: train educators as lay counsellors	420	400	95%	
Lay counselling mentoring for educators		600		
OVC support	1620	2029	125%	

Where targets could not be reached, the main reason was the limited time that the district coordinators had, especially after the 2010 World Cup. The prolonged strike in 2010 also impacted on service delivery in general and disrupted training schedules. Although coordinators reviewed their plans and implemented recovery plans, they did not manage to reach all targets. Some districts battled with human resource constraints, which impeded implementation. Learner pregnancy rate is high and the DOE is focussing on bringing it down.

The Department of Basic Education is not responsible for institutions of higher learning. No data was available to appraise progress made by higher education institutions against the targets set in the KZNPSP. Teenage pregnancy rates are cited as high but the rate in the province and in specific districts have not been established. This needs further research to enable the province to establish the baseline and track the indicators going forward.

DOE is looking at a more vigorous approach to move towards the behaviour change amongst the learners. Three socials ills are to be addressed which are reducing the rate of new HIV &

AIDS infections, combating the drug and alcohol abuse and eradicating the learner pregnancy. The campaign is called “My Life, My Future”. The DOE is also an active participant in Operation Sukuma Sakhe and will use this platform to further its objectives with regard to prevention, treatment and care activities.

In view of the fact that institutions of higher learning are designated as HTAs, the lack of availability of data may indicate a lack of focus on life skills education in this sub-population. This needs to be escalated to the national Ministry of Higher Education and investigated further.

High Transmission Areas (HTAs)

HTAs are socio-demographically defined areas where government provides targeted intervention for populations designated as high-risk for HIV transmission. There are 48 HTA sites in KZN, which include prisons, truck stops and institutions of higher learning. Although the total number exceeds the target of 45, functionality of the sites varies. The four specific interventions at HTAs are: (1) HCT; (2) treatment of STIs; (3) BCC and; (4) distribution of male and female condoms. They are also provided through peer educators.

With regard to female condom distribution at HTAs, 94% of the annual target of 133,000 was achieved. Distribution of male condoms exceeded the target. The challenge was that the targets do not appear to be based on established needs. Although recommendations were made by the national department of health to appoint a service provider to avert the problems with the distribution of condoms, this service appears to exclude HTAs, leaving them vulnerable to stock-outs. The province designated 35 Correctional Services sites as target HTA sites, but by the end of 2010, only 16 had received targeted HTA intervention services.

Although training of peer educators at HTA sites is provided for in the business plan, there was little activity during 2010. Training was provided for 103 peer educators. It is however not possible to establish where these peer educators have been deployed.

Workplace prevention programmes

There was no information received to enable the review team to assess progress made with respect to employee wellness programmes in governments. Government departments do not have information on workplace programmes in the private sector. However, based on reports

submitted by SABCOHA at the Partnership Conference, the big industries do have functioning workplace prevention programmes, as part of their occupational health programmes.

Objective 2: Prevention of Mother to Child Transmission of HIV

The following interventions were designed to reduce mother to child transmission of HIV:

i. Scale up of provision of PMTCT services within public and private sector Primary Health Care Services
ii. Implementation of provider initiated VCT to all pregnant women attending public and private health facilities
iii. Promotion of infant feeding counselling that adheres to set quality standards
iv. Development/scaling up/strengthening of community based strategies/programmes that support HIV women during and after pregnancy
v. Provision of access to CD4 testing to all HIV positive pregnant women
vi. Provision of ARV treatment for all eligible pregnant women and children as per guidelines
vii. Provision of nutritional support to HIV infected women who choose to exclusively breast feed.
viii. Provision of formula milk to children of HIV infected women who choose and are eligible for replacement feeding and those unable to breast feed

Progress in achieving the key output indicators of PMTCT interventions are summarized in the table below.

Table 8: Progress on key PMTCT programmatic output indicators

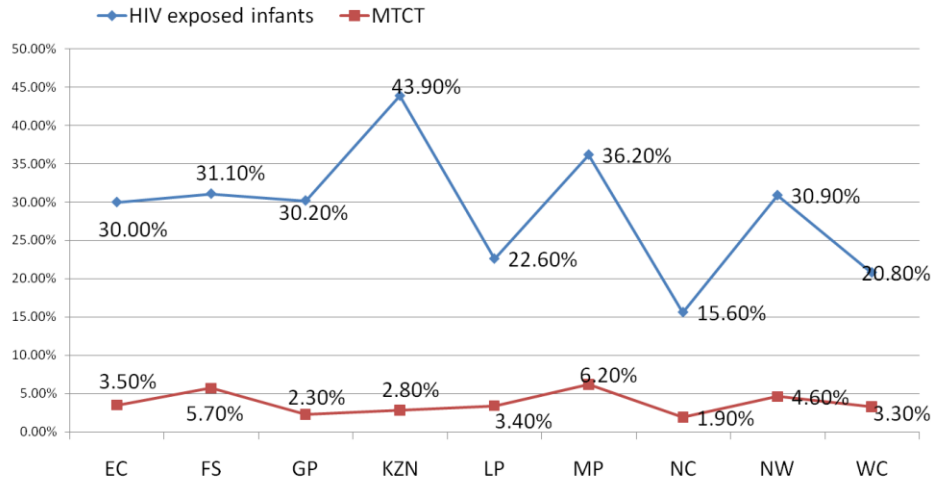
Indicator	Baseline (2005/06)	Mid-term (2008/09)		End-term (2010/11)		Comments
		Target	Achievement	Target	Achievement	
Number and percentage of HIV-positive pregnant women receiving a complete course of ART to reduce MTCT					19737 *(DOH report)*	
Proportion of the infants in national PMTCT programme receiving PCR				*90%*	94.8% *(DOH report)*	

As can be seen from the table progress has been made in the implementation of the PMTCT programme. The national PMTCT survey conducted by the MRC indicates that only 2.8% of children born to HIV positive mothers were HIV infected in 2010 (Goga & Dihn, 2011). This is a good reduction from estimated transmission rate of 22% in 2005 and 12% in 2008. Compared

to other provinces KZN has performed well in reducing MTCT as shown in figure 5 below. Despite the overall provincial success, the 11 districts have had a varying degree of success in reducing the rate of Mother to Child Transmission as shown in figure 6 below.

Some of the contributing factors for this variation and inability to achieve a transmission rate below 2.8% include late booking for ante-natal care by pregnant women, high rate of teenage pregnancy and missed opportunities for early post-natal care for both baby and mother. In Newcastle (Amajuba district) for example, only 28% of pregnant women booked for ante-natal care before 20 weeks of pregnancy and 58.3% and 58.7% of babies and mothers attended post-natal care within 6 weeks of delivery respectively in 2010.

Figure 5: Rate of Mother to Child Transmission of HIV exposed children by province

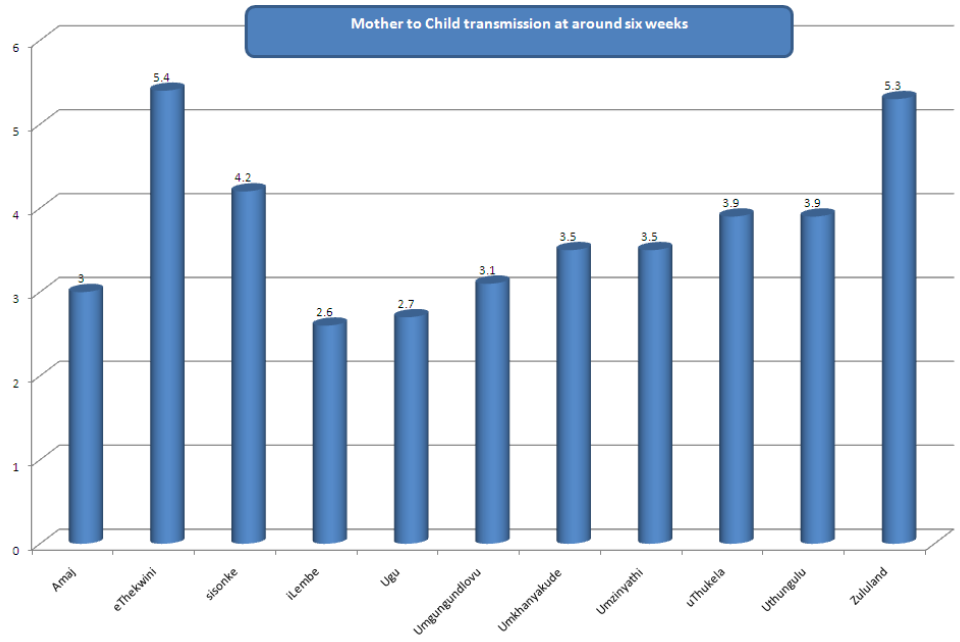


All fixed primary facilities in the province now offer PMTCT to all pregnant women with the intention of providing early diagnosis and intervention in which pregnant women undergo HIV testing in their first trimester of pregnancy. The coverage for HIV testing of antenatal clients has been good. About 218,021 pregnant women had HIV tests in 2010, which was 96% of the target as compared to 96% in 2006/07 and 98% in 2007/08 (KZN MTR).

Of the eligible babies, 82% received Nevirapine against a target of 100%. The number of babies that underwent PCR tests within 6 weeks exceeded the target. A large number of babies in the rural areas who are born at home and whose first contact with health facilities is after

Source: MRC survey 2011

Figure 6: Mother to Child transmission rate at 6 weeks by district



(Source: KZN Department of Health)

Objective 3: Occupational exposure and injecting drug use prevention

The following were the interventions design to reduce transmission through occupational exposure and through injecting drug use & use of contaminated instruments to less than 1%.

i. Implementation of infection control guidelines in all health facilities
ii. Implementation of infection control guidelines in home based care and palliative care settings.
iii. Provision of PEP to all those occupationally exposed to HIV according to PEP guidelines
iv. Training of traditional health practitioners on infection control
v. Raising public awareness on HIV risk through unsafe traditional practices
vi. Provision of supplies to traditional practitioners to ensure safe practices
vii. Establishment of public sector drug rehabilitation centres

Progress in achieving the key output indicator for occupational exposure is presented in table 6 below.

Table 9: Progress on key Occupational exposure programmatic output indicators

Indicator	Baseline (2005/06)	Mid-term (2008/09)		End-term (2010/11)		Comments
		Target	Achievement	Target	Achievement	
Proportion of public and private facilities with a continuous supply of PEP drugs		*100%*	100%	*100%*	100% hospitals (DoH report)	
Proportion of those occupationally exposed who receive PEP drugs		*100%*	100%	*100%*	100% hospitals (DoH report)	

Post-exposure prophylaxis

Although outcome data on reduction of occupational and drug use related transmission of HIV is currently unavailable, some progress has however been noted in implementing interventions that address this aspect of HIV prevention. It was reported that all Government and private health facilities provide PEP and have a continuous supply of PEP drugs. According to DORA indicators report for financial year 2010/11up to 1,125 people were started on PEP.

Training of traditional health practitioners

Training of traditional health practitioners in infection control, including virology and germ theory was implemented in all districts, out of which 1199 THPs graduated. They also were capacitated to identify and refer cases to local clinics for HCT and other interventions (Gqaleni, et.al., 2011).

Objective 4: Blood supply and blood products

The following two interventions were designed to eliminate HIV transmission through blood and blood products.

i. Screening of all blood and blood products for transfusion using the best technology available
ii. Creating awareness of the potential risk of HIV transmission through blood transfusion

Progress made in achieving the target for the main output indicators is shown in table 7 below.

Table 10: Progress on the key safe blood supply programmatic output indicators

Indicator	Baseline (2005/06)	Mid-term (2008/09)		End-term (2010/11)		Comments
		Target	Achievement	Target	Achievement	
Percentage of donated	No data	*100%*	No data	*100%*	No data	

blood units screening for HIV in a quality secured manner						

No data was available on the blood supply screening at the provincial level. It however appears that the National Blood Transfusion Services is contracted to and remains accountable to the national DoH. Data from nation DoH indicates that all donated blood is screened in a quality assured way. Since the national achievement on this indicator has been 100% for the past four years, we could infer that all donated blood in KZN is also screened in a quality assured manner.

Objective 5: Poverty, culture and gender inequality

The interventions designed to achieve the objective of reducing vulnerability to HIV transmission due to poverty, culture and gender inequality include:

i. Scaling up implementation of poverty reduction strategies
ii. Scaling up programmes to empower women and educating of men on human rights.
iii. Development and implementation of strategies to address gender violence

Progress on output indicators and targets are shown in the table below:

Table 11: Progress on the key safe blood supply programmatic output indicators

Indicator	Baseline (2005/06)	Mid-term (2008/09)		End-term (2010/11)		Comments
		Target	Achievement	Target	Achievement	
Percentage of eligible population that have access to poverty reduction programmes						
Poverty gap reduction						
Percentage of districts implementing the comprehensive package of sexual assault care		*60%*		*90%*	88% CHCs and 100% hospitals	

Poverty reduction strategies

The War on Poverty Programme (WOP) is the South African national government's strategy to eradicate poverty in South Africa. In response to the War on Poverty call, the KZN Province developed its Flagship Programme, now re-branded as "Operation Sukuma Sakhe", to address the socio-economic issues with a specific focus on poverty eradication. Operation Sukuma Sakhe rests on three pillars: (a) food security and emerging farmer programme; (b) healthy and sustainable communities' programme; and (c) empowerment of youth and women programme. The three sub-programmes aim to grow the economy, develop communities, create jobs and ultimately eradicate poverty. The Operation Sukuma Sakhe (OSS) theory is that by implementing the three sub-programmes in all the wards in the province, poverty and social ills at household and individual level would be halved and quality of life will improve. The three OSS sub-programmes that are being rolled-out in all 823 wards will augment existing service delivery sectoral interventions. The focus for Operation Sukuma Sakhe is community involvement, behavioural change, integrated government services at the ward level, economic empowerment and environmental care.

PIMD scores were initially used to identify the first layer for intensive interventions, which were the 57 "most deprived wards" in KZN. The next layer of the 350 "deprived wards" would also be targeted with specific, albeit less intensive interventions. These deprived wards are still considered to be at risk for falling into the "most deprived" category and need to be stabilized. Considering the large poverty-gap ratio even within wards categorised as "deprived" the province resolved to implement interventions simultaneously in all households in the 823 wards in the province, regardless of the PIMD ward scores (StatsSA), although there is more of a focus on the 57 "most deprived wards". Of these 151 were fully functional by March 2011. The first intervention is profiling of households in order to assess their specific needs.

Operation Sukuma Sakhe has 5 interdependent phases, with the first three being state-supported and the final two self-sustaining: (a) identification phase (needs assessment); (b) Stabilisation phase (first intervention phase); (c) development phase (second intervention phase); (d) consolidation phase (first self-sustaining phase); and (e) the graduation phase (last phase, with self-sustaining households).

With regard to the planning cycle, profiling of households offers an excellent opportunity for bottom-up planning, which will be driven by community needs. The outputs enable sectors to

identify and quantify household-specific needs, making their service delivery more relevant than previously. The strength of this approach is that is has fostered a culture of collaborative approach between provincial government, local government and communities and is driven by community needs rather than the top-down approach.

Each ward has a war room, Youth Ambassadors (Change Agent) allocated according to voting districts in the ward and are primarily responsible for behaviour change for youth. The integrated community caregivers are allocated households, responsible for identification of needs through profiling of households, health education and psychosocial support, while community development workers (CDWs) are the secretariat and monitor interventions and extension field officer ensures that food security programme through One Home one garden extended to one school one garden one clinic one garden is implemented in the wards. The Youth Ambassador programme targets unemployed youth within communities. It is a two-year programme, which is envisaged as an entry-level for nursing, basic ambulance assistants and auxiliary social workers within DSD and DOH. This is not only providing career paths for youth and caregivers with limited opportunities but also injects human resources into OSS at community level. Currently OSS has enrolled 2056 Youth Ambassadors (peer educators) who have been undergone induction training. The next level of training involves 4 months training on discipline at the South African National Defence Force, followed by specific curricular training in community development.

Considering that the outputs of the Provincial HIV and AIDS Strategic Plan are an inherent part of the programme, this augurs well for the sustainability of the PSP interventions. All departments have been mandated to align their operational plans with OSS and the KZN PSP. All government department have translated the mandate into action aligned their operations to OSS to some extent. Evidence of this is the active involvement of officials in the communities and output reports provided to the Provincial Council on HIV and AIDS (PCA). The number of households profiled and those that have received comprehensive packages of services under the programme is growing and shows good progress. However, the proclivity in sectors to work in silos is still prevalent, to the extent that outputs of the programme are not an inherent part of routine sectoral reports.

Some of the data used by to measure outputs was compared with data extracted from the concept document for the OSS. While the programme as whole focuses on service delivery with

a view to eradicating poverty, it also has specific interventions that are aligned with PSP Interventions. The table below illustrates this alignment:

Table 12: Operation Sukuma Sakhe Interventions by KZN PSP Priority Area, Objectives and Interventions

PRIORITY AREA 1: PREVENTION		
Objective	**Intervention**	**Sukuma Sakhe Intervention**
To ensure that at least 50% of sexually active population in KZN adopt safer sexual behaviour by 2011	Develop and implement a comprehensive package that promotes male sexual health	MMC
To ensure that at least 50% of sexually active population in KZN adopt safer sexual behaviour by 2011	Condom promotion and distribution targeting high risk settings such as beer halls, pubs, clubs, brothels, convenient settings, shebeens and locations for ceremonies	Condoms distribution
To reduce the risk of HIV transmission from occupational exposure and through injecting drug use & use of contaminated instruments to less than 1% by 2011	Establishment of public sector drug rehabilitation centres	Clients referred to rehabilitation centre
To reduce the risk of HIV transmission from occupational exposure and through injecting drug use & use of contaminated instruments to less than 1% by 2011	Establishment of public sector drug rehabilitation centres	Awareness on substance abuse
To ensure that at least 50% sexually active population in KZN adopt safer sexual behaviour by 2011	Provision of accessible social and mental health services to support children and adult victims of abuse & violence	Alleged sexual abuse
PRIORITY AREA 2: TREATMENT, CARE AND SUPPORT		
Objective	**Intervention**	**Sukuma Sakhe Intervention**
Increase coverage and uptake of HIV counselling and testing services	Scaling up VCT services in order to increase the number of adults who have ever had an HIV test, with a special focus on men	HCT
To increase access to comprehensive treatment and care packages	Provision of support to eligible households	Identity Documents
To increase access to support by population infected and affected in order to mitigate the impact of `HIV and AIDS	Development and implementation of income generating project owned by communities and support groups	Farming equipment
To increase access to comprehensive treatment and care packages	Provision of support to eligible households	Food parcels
To increase access to comprehensive treatment and care packages	Provision of food support to eligible households	Household gardens
To increase access to comprehensive treatment and care packages	Scaling access to appropriate services to eligible children	OVC
To increase access to comprehensive treatment and care packages	Scaling access to appropriate services to eligible children	Social relief
To increase access to quality care and support to OVC	Implementation of mechanisms for identifying, tracking and linking OVC and child-headed households to grants, benefits ans social services at local level	Birth certificates
To increase access to quality care and support to OVC	Implementation of service delivery guidelines defining core services at local level for OVC (exemption of school and health services fees, child support grants and birth registration	Social grants
To increase access to quality care and support to OVC	Implementation of service delivery guidelines defining core services at local level for OVC (exemption of school and health services fees, child support	School uniforms

	grants and birth registration	
To increase access to support by population infected and affected in order to mitigate the impact of HIV and AIDS	Development and implementation of income generating project owned by communities and support groups	Community gardens
To increase access to support by population infected and affected in order to mitigate the impact of HIV and AIDS	Development and implementation of income generating project owned by communities and support groups	Fencing for communal gardens
PRIORITY AREA 3: MANAGEMENT, MONITORING, RESEARCH AND SURVEILLANCE OF THE RESPONSE		
Objective	**Intervention**	**Sukuma Sakhe Intervention**
To strengthen monitoring and evaluation practice and have at least 80% of sectors consistently reporting and using M&E report by 2011	Monitoring implementation of the provincial HIV and AIDS Strategy	Submission of district reports to PAC

Implementation teams involved in OSS utilise departmental M&E tools. In doing so, they collect data aligned with departmental M&E indicators. However, not all departments have been able to achieve this. DSD, for example, reports on two various data sets for departmental and OSS outputs. This makes it difficult to assess progress since there is no indication of alignment of data sets.

The lack of one coordinating M&E framework for the programme leads to fragmentation of the reporting process and opened rooms for parallel data collection processes. Further if departments have to institutionalize OSS more attention needs to be paid to alignment between indicators used by government departments and OSS.

Among assumptions and risks of the programme identified for OSS are three risks and assumptions that relate specifically to M&E, i.e. assumptions: (a) Effective monitoring and evaluation systems at both the household and programme level; (b) There is sufficient capacity within the departments to manage, train and monitor the volunteers/cadres on an ongoing basis; and (c) There will be a suitable system in place to evaluate household data on a regular basis.

Gender-based violence

The target of 95% of health facilities providing a comprehensive package of sexual assault care in accordance with National Policy on Sexual Assault Care has been met for hospitals. The availability in community health care centres is around 81%, which is 14% short of the target for 2011. Data from DSD reflects that the province has 2 registered care centres and 4 temporary safe care facilities for support of children and adult victims of gender based violence (DSD APP 2009/10). Although the location of these centres could not be ascertained, it is safe to assume

that the target of 90% of districts municipalities having such facilities by 2011 has not been met. About 2,728 sexual assault cases were reported in 2010, of which 57% received PEP. No data is routinely collected on the outcome of this intervention.

The Department of Community Safety and Liaison implements programmes intended to prevent crime and ensure the safety of communities. They work within the same facilities as South African Police, but focus on providing victim-friendly facilities. About 83% of all police stations in the province have Victim Friendly Facilities (VFF) resulting in victims having to be interviewed at the Community Service Centres (CSC), which is undesirable and traumatic to victims. VFFs also serve as temporary shelter and provide counseling and support to abused women and children, while SAPS takes up the investigation.

4.1.2 Strategic Priority Area 2: Treatment, Care and Support

This section of the report discusses the achievements of the priority area treatment, care and support whose goal was to provide appropriate package of treatment, care and support services to HIV positive people and their families in order to reduce morbidity, mortality and other impacts of HIV and AIDS by 50% by 2010. Several objectives identified and interventions were designed to achieve goal treatment, care and support. Indeed over the years HIV and AIDS have had a significant negative impact on the quality of life of the people of KZN, and have left many families and children vulnerable and stigmatized. It has been a major cause of deaths among young adults as well as creation of orphans and vulnerable children. It is therefore imperative that the measures put forward by the province to respond to the epidemic be assessed for impact and effectiveness.

DOH is the lead agency in the majority of interventions in this priority area but it most cases it has to work in collaboration with other sectors, private sector, traditional leaders and the business sector. There are interventions that remain a gap in the PSP because they were not implemented or incorporated into sectoral plans. DSD is also a critical stakeholder in the provision of care. It provides social welfare services to persons affected by substance abuse; victims of crime and violence; the elderly and people with disabilities; those infected and affected by HIV and AIDS and; social relief to distressed individuals and families. Since the department has not mainstreamed HIV and AIDS, the only sub-programme reporting regularly to the PCA is the HIV and AIDS sub-programme.

4.1.2.1 Progress in achieving the goal target

The table below summarizes the achievements under priority area treatment, care and support.

Table 13: Treatment, care and support impact indicators achievements

Primary Goal 1: To reduce the annual rate of new infection by 50% by 2011						
Expected Impact: 50% reduction in annual rate of new HIV infections by 2011						
Indicator	**Baseline (2005/06)**	**Mid-term (2008/09)**		**End-term (2010/11)**		**Comments**
		Target	**Achievement**	**Target**	**Achievement**	
Cause specific mortality rate (AIDS related)	*81885 (ASSA estimates)*	*25% reduction*	*67429 (ASSA estimates)*	*50% reduction*	54337 (ASSA estimates)	

Percentage of persons attending wellness clinics who died prior to initiation of ART	*No data*	*25% reduction*	*No data*	*50% reduction*	No data	

There is currently no data on the chosen impact indicators for priority area 2. The ASSA model projection of 2008 estimates AIDS death in KZN in 2005 to be 81,885 and percentage of death due to AIDS of 57%. The crude mortality rate was projected to decline from 17/1,000 in 2005 to 15/1,000 in 2008 and 14/1,000 in 2010. The under-5 mortality rate was also projected to decline from 92/1,000 in 2005 to 74/1,000 and 64/1000 in 2008 and 2010 respectively. The actual under-5 mortality rate was 87.7/1,000 in health facility in 2010, 36% higher that the projected figure (OTP MTR, 2011). Some of the underlying behavioural determinants that relate to health-seeking behaviours include late reporting of sick children to facilities, late reporting of pregnant women to antenatal health facilities and inadequate education of the parents, especially in instances where the parent in HIV positive. Given that the target for under-5 mortality rate for 2014 is 20/1,000 the province has to invest in effective programmes to reach the intended target.

4.1.2.2 Progress in Achieving the Objectives

The following objectives were identified under the treatment, care and support priority area in the KZNPSP2007-11.

i. To increase coverage and uptake of HIV testing and counselling services
ii. To increase access to comprehensive treatment and care packages
iii. To increase access to quality care and support by Orphans and Vulnerable children (OVC)
iv. To increase access to support by population infected and affected in order to mitigate the impact of HIV and AIDS.

A summary of achievement against the objectives under priority area 2 are provided in table 13 below.

Table 14: Progress in achieving outcome indicator targets under priority area treatment, care and support

Objective 2: To increase access to comprehensive treatment and care packages
Expected Outcome 2: 80% of the eligible population have access to comprehensive treatment, care and support package s by 2011

Indicator	Baseline (2005/06)	Mid-term (2008/09)		End-term (2010/11)		Comments
		Target	Achievement	Target	Achievement	
1.Percentage of men and women aged 15-49 who received an HIV test in the last 12 months and who know their results*	10.4% *(Shisana, et. al., 2009)*	*60%*	*29% (Shisana, et. al., 2009)*	*80%*	No data	
2.Percentage of the most at risk population that have received an HIV test in the last 12 months*	No data	60%	*No data*	*80%*	No data	*MARPS for KZN not defined*
Objective 2: To increase access to comprehensive treatment and care packages						
Expected Outcome 2: 80% of the eligible population have access to comprehensive treatment and care package s by 2011						
Indicator	**Baseline (2005/06)**	**Mid-term (2008/09)**		**End-term (2010/11)**		**Comments**
		Target	**Achievement**	**Target**	**Achievement**	
1.Percentage (Number) of adults and children with advanced HIV infection receiving antiretroviral therapy*	No data	60%	No data	80%	459,670, of which ***45 598 are children*** (DOH DORA indicators)	
2.Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy*	No data	60%	No data	80%	No data	
3.Percentage of HIV positive adults and children on antiretroviral therapy receiving supplement meals and micronutrient supplements*	No data	70%	No data	80%	10% of total HIV clients	
Proportion of people in need who are receiving ART			45% *(Adam & Johnson, 2009)*	80%	74% (KZN DOH report)	Estimate
Objective 3: To increase access to quality care and support by Orphans and Vulnerable children (OVC)						
Expected Outcome 3: 80% of OVC have access to quality care and support by 2011						
Indicator	**Baseline (2005/06)**	**Mid-term (2008/09)**		**End-term (2010/11)**		**Comments**
		Target	**Achievement**	**Target**	**Achievement**	
1.Percentage of orphans and vulnerable children aged 0-17 whose households have received a basic external support in caring for the child*	No data	60%	No data	80%	40% *(DSD Report)*	

2.Percentage of child headed households receiving care and support services	No data		*60%*	*80%*	58% (7014/12,000 child headed households receiving care)	OTP Nerve Centre & DSD Annual Report 2010/11.
3.Current school attendance among orphans aged 10-14	No data	*60%*	98% *(Shisana, et. al., 2009)*	*80%*	No data	
4.Current school attendance among non-orphans aged 10-14	No data	*60%*	No data	80%	No data	
Objective 4: To increase access to support by population infected and affected in order to mitigate the impact of HIV and AIDS.						
Expected Outcome 4*:* 80% of the infected and affected have appropriate support to mitigate the impact of HIV and AIDS by 2011						
Indicator	**Baseline (2005/06)**	**Mid-term (2008/09)**		**End-term (2010/11)**		**Comments**
		Target	**Achievement**	**Target**	**Achievement**	
1.Percentage of patients in need of home based Care receiving home based care	No data	60%	No data	80%	185,048 (DOH report)	*DSD data missing*
2.Percentage of PLHIV and households with access to appropriate package of services	No data	60%	No data	80%	No data	

Objective 1: HCT

HIV counselling and testing serves a critical entry point to HIV prevention, treatment and care services. For example testing and counselling provides opportunities for sharing information and discussion on ways of reducing risk for HIV transmission. In also provides opportunities for early diagnosis and hence treatment and care. The KZN PSP2007-11 designed a number of interventions to scale up access to HTC services in the province. These interventions include:

i. Implementation of provider-initiated HIV counselling and testing to all clients attending health facilities, with the special focus on STI, TB, antenatal, IMCI, family planning and general curative service
ii. Conducting regular VCT campaigns in workplace and through organised trade unions
iii. Scaling up VCT services in order to increase the number of adults who have ever had an HIV test, with a special focus on men

Progress towards achievement of outputs of these interventions is summarized in table 4 below

Table 15: Progress on key HIV Testing and Counseling (HTC) programmatic output indicators

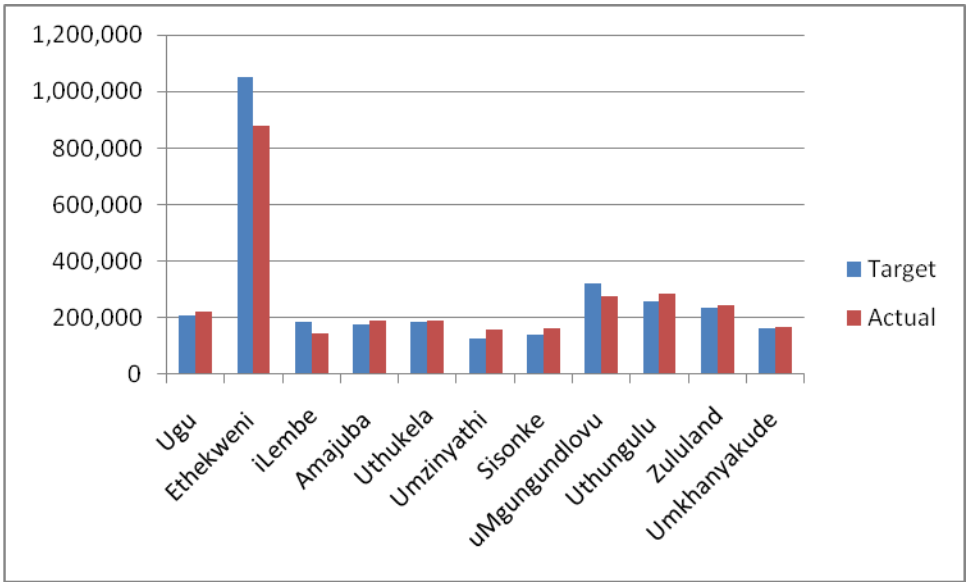
Indicator	Baseline (2005/06)	Mid-term (2008/09)		End-term (2010/11)		Comments
		Target	Achievement	Target	Achievement	
Number and percentage of people counselled and tested for HIV including provision of results	No data			3,059,234 (100%)	2,920,433 (95%)	
Percentage of most at risk population that have received an HIV test in the last 12 months and who know their results	No data	No data	No data	No data	No data	

All fixed PHC facilities in KZN offer HCT. The DoH report indicates that 2,920,433 out of a target of 3,059,234 HIV tests, excluding ANC clients, were done in 2010. This translates to 76% achievement against the target. No new lay counselors were trained but 1,851 are receiving stipends. As mentioned earlier there were no counselors deployed to HCT sites or non-medical sites.

HCT coverage has declined from 88% in 2007/08 compared to the current coverage of 76%. Reasons for this decline could not be ascertained. In order to boost HTC coverage in 2010/11 KZN participated in the national campaign to expand testing. About 19% of those who tested were HIV positive. During the same campaign 1,959,706 clients were screened for TB, 300, 603 of whom were referred for clinical diagnosis.

The breakdown of the campaign achievements by district against their target is shown in figure 7 below.

Figure 7: 2010/11 HCT Campaign achievement by district



Objective 2: ART

The KZN ART programme was established the aim of providing treatment to all eligible HIV infected individuals. All adolescents and adults, including pregnant women, with HIV infection and a CD4 count at or below 200 cells/mm3 were deemed eligible to be started on antiretroviral therapy, according to DoH criteria. The thrust of the provincial strategy was to rapidly scaling-up access to ART through alternate delivery sites that would be identified, established and accredited. A number of interventions were designed to rapidly scale up access to ART. These include:

i. Provision of access to wellness services to newly HIV diagnosed adults
ii. Initiating ART to all eligible clients within 3 weeks of assessment
iii. Provision of Psycho-social support including counselling for bereavement, disclosure and adherence to ARV to those infected and affected
iv. Provision and implementation of community based ART support and literacy programme
v. Improvement and implementation of ARV adherence support programmes and intervention for both children and adults

vi. Improvement and implementation of monitoring and surveillance systems for actively tracing patients on ART

vii. Establishment of drug resistance testing facility within the province

Achievement toward programmatic output targets are summarized in table below

Table 16: Progress on key ART programmatic output indicators

Indicator	Baseline (2005/06)	Mid-term (2008/09)		End-term (2010/11)		Comments
		Target	Achievement	Target	Achievement	
Number of new patients (adults and children) starting ART				*220,650*	122,038 *(DOH report)*	
Number of patients lost to follow up						
Number of deaths						
Number of facilities providing ART				*100%*	100% (DOH report)	
Number of people with HIV receiving Cotrimoxazole prophylaxis						

All hospitals and fixed PHC facilities in the province provide ART. At end of the financial year 2010/11 cumulative total of 459,670 patients were registered. Of these over 122,000 patients were started on ART during the financial year 2010/11. There are no reported waiting lists or stock outs at ARV service points currently. The waiting list fell from 17,984 in 2007/08 and 7,278 in 2008/09 to zero in 2010/11. One of the reasons why the programme has performed well in terms of providing access and eliminating the waiting lists is the introduction of the roving teams and intensified monitoring through the district-based war rooms designed to eliminate backlog. All accredited ART sites also offer nutritional services to patients on ART who need nutritional support. These findings indicate that KZN has made substantial progress in making anti-retroviral treatment available to its population.

Despite this impressive progress there are areas could be improved in regard to ART services. Even with the roving teams in place and task shifting to nurses being employed follow up of patients on ART is still problematic. The DORA report 2010/11 had no data on number of patients who are loss to follow up, indicating that the nature and size of default from treatment is unknown. Defaults are often associated with poor adherence and a high risk of treatment failure. Another emerging problem is related to unprotected sex as the number of ART patients treated for STIs remains high, at 15,776. (DORA report 2010/11)

The newly announced changes in the treatment guidelines are like to create new gaps in the ART programme coverage as more PLWHIV will be eligible for and need treatment. An appropriate measure will have to be put in place to address the increasing need that will arise from changes in treatment guidelines.

Objective 3: OVC

The main strategy under the KZN PSP was to capture and utilize information on OVC in order to establish and maintain effective social protection for all of them in the province. Several interventions were thus designed to achieve the objective of providing quality care and support to OVCs. These include:

i. Implementation of mechanisms for identifying, tracking and linking OVC and child-headed households to grants, benefits and social services at local level
ii. Implementation of service delivery guidelines defining core services at local level for OVC (exemption from school and health services fees, child support grants and birth registration)
iii. Provision of registered civil society organizations with organizational programme support and mentoring
iv. Provision of child headed household with services of a community caregiver
v. Capacity development of schools, educators and early childhood development centres to provide psychosocial, educational and adherence support to children in need.

Achievements towards achievement of programmatic outputs are provided the table below:

Table 17: Progress on key OVC programmatic output indicators

Indicator	Baseline (2005/06)	Mid-term (2008/09)		End-term (2010/11)		Comments
		Target	Actual	Target	Achievement	
Number of OVC reached			33,546	95,140	37,448 (39%) (DSD	Poor record keeping

					Annual report)	
Number of child-headed households reached			4,448		7,014 *(DSD Annual Report)*	
Number of children placed in foster care			39,072	51,499 (DSD APP 2009/10)	9128 *(DSD Annual Report 2010/11)*	Data inconsistent
				33,156	9128 *(DSD Annual Report 2010/11)*	

The school attendance by orphans was reported to be 97.9% in 2009. Community care centres encourage and support retention of OVC in school, through provision of cooked meals, uniforms and psychosocial support under one roof. At household level, services are provided by community caregivers. Supervised through HCBC entities.

According to the Mid-term Review Report There are about 12,000 child-headed households (OTP Mid-term Review, 2011). DSD has about 37,448 OVC in their records, which receive provision for school uniforms, material support, cooked meals, food parcels and psychosocial support (DSD Annual Report, 2011). This translates to 39% achievement against the target for 2010. However, departmental targets do not reflect the needs of the target population. The departmental target for OVC of 95,140 is still about 25% of the estimated need. According to ASSA estimates for maternal orphans the number of maternal orphans for 2010 is 383,803.

Two reports from DSD gave different targets for the number of children placed in foster care, i.e. DSD Annual Report 2010/1 and DSD Annual Performance Plan 2009/10. This makes it difficult to rely on either one as the actual target. However if using the lower and higher targets, the actual achievement is 27.5% and 18% respectively.

Objective 4: Home-based care

The main strategy to ensure that infected and affected have appropriate support to mitigate the impact of HIV and AIDS was to expand access to home-based care and other innovative community services in an integrated manner. Several interventions were designed to the objective of mitigating the impact of HIV and AIDS. These include

i. Development and implementation of targeted care and support programmes and material support for people with disabilities
ii. Integration and equitable representation of LGBT people in care, treatment and support programmes
iii. Design and implementation of ward-based community competency programmes targeting the most vulnerable communities
iv. Development and implementation of income generating project owned by communities and support groups
v. Scaling up access to support by older persons through CHBC
vi. Recruit, train and support new community care givers (including CHWs) with emphases on men/ father

The ASSA model projection of 2008 estimated that up to 149,621 PLHIV would be AIDS sick in 2011. Although the actual need for HBC is hard to estimate due to the dynamic nature of AIDS disease. Patients who need Home base care at one point in time may recover after ART and become productive members of society.

Reports indicate that 185,048 patients served by CCGs in their households and 3,785,346 home visits conducted were conducted in 2010/11 and 19,573 HBC kits distributed throughout the province. The MTR report indicated that there were up to 11,826 Community Care Givers (CCG) receiving a stipend from the Department of Health for their work in 2008/09. CCGs workers have added the much needed value to the care and support of the vulnerable groups such as people with disabilities, the elderly and sick people.

The province has now made a decision to combine all CCGs under various departments into one group that provide integrated services at community level. Total number of caregivers on stipends is 10810, with 1905 from DSD and 8915 from DOH. An additional 4000 are not on stipend and work as volunteers.

Household information collected by CBC/CHW is not often analysed at provincial level except by individual care workers and their supervisors.

HIV and TB

Like the rest of the country KZN has a serious dual epidemic of TB and HIV. Estimates show that KZN has a grave and still-to-be controlled tuberculosis (TB) epidemic. The numbers of TB cases diagnosed each year have risen. Mortality due to TB also remains remained high. KZN places TB as one of the top five cause of mortality in the province. It is known that more than 70% of TB patients are co-infected with HIV but hardly half of them know their HIV status. (WHO). TB screening among HIV infected persons remains low and access to isoniazid preventive therapy (IPT) dismal.

Although programmes to address this dual disease burden have historically been run vertically, KZN has made stride in integrating the two interventions. Such attempts include

- Referring for HIV testing and treatment
- Testing for HIV and referring for treatment
- Referring for TB screening and treatment
- Screening for TB and referring for treatment.

Specific achievements in KZN include:

- All health facilities implementing both HIV and TB services
- Linking TB screening to HCT programme
- Improving screening of TB amongst HIV positive patients
- Increased uptake of IPT leading to a 71.5% (124,963 patients) achievement against target of 170 000 patients by June 2011

The mains challenges are that IPT uptake at hospitals is still low and TB its incidence has continued to grow since the early 1990's to 1131/100,000 in 2010. (DoH, 2011). This incidence is considered as one of the highest in the world.

4.1.3 Strategic Priority Area 3: Management, Monitoring, Research and Surveillance

This section of the report deals with Management, monitoring, evaluation and research in the provincial response.

Management of the response: The Office of the Premier (OTP) provides multi-sectoral HIV and AIDS coordination in the province. HIV and AIDS Directorate located within the OTP and serves as the secretariat for the Provincial Council on AIDS (PCA). PCA is composed of both government and non-state actors and meets every four months to discuss HIV and AIDS issues.

At the district and local municipal levels District/Local Aids Councils (DAC/LAC) coordinate all HIV response activities.

Regarding the Government departments, the interdisciplinary task team on HIV and AIDS is the structure that receives direction from the Office of the Premier. Programme managers from all government departments meet regularly to discuss collaboration on programmes. For example National Integrated Pilot (NIP) sites are the result of active collaboration between three government departments (Department of Social Development, Department of Health and the Department of Education) to meet the needs of OVC.

The key strategy use for strengthening the sectoral participation in the KZN HIV and AIDS response is through expansion of partnerships to ensure effective mainstreaming of responses and improved communication and cooperation. Civil society organisations and the private sector which are also represented in the PCA are an essential component to the fight against the HIV epidemic in KwaZulu Natal.

Monitoring and Evaluation is a collaborative effort to collect, process, report and use information and knowledge to influence decision making and actions. The role of multi-sectoral M&E system in the provincial response was therefore to deliver timely, reliable and valid information to allow the province to gage progress towards achieving the KZNPSP2007-11 strategic goals and objectives. To this end the task of the KZNPSP2007-11 set a goal of an effective and coordinated provincial response to HIV & AIDS that is informed by monitoring, evaluation & research.

The overarching strategic consideration included the following:

- Establishing and maintaining monitoring and evaluation systems based on agreed

provincial and district indicators.

- Managing, monitoring and evaluating implementation of the provincial HIV and AIDS strategy and disseminating reports to the public at specified intervals.
- Managing all HIV and AIDS-related information, and facilitate the dissemination and use of this to inform to strengthen services, programmes and projects.
- Strengthening and utilise information, systems and processes to improve HIV and AIDS-related prevention, treatment, care and support; and impact mitigation services and programmes.

The following interventions were designed to achieve the M&E objectives:

i. Setting up a provincial multi-sectoral M&E system
ii. Setting up sectoral and district M&E units
iii. Development of capacity in M&E, research & surveillance
iv. Development of provincial multi-sectoral research agenda and coordination mechanism
v. Monitoring implementation of the Provincial HIV and AIDS Strategy
vi. Evaluation of PSP the Provincial HIV and AIDS Strategy
vii. Involvement in Surveillance systems
viii. Building Capacity of coordination structures
ix. Development and implementation of Joint HIV & AIDS planning mechanism
x. Equitable Resource allocation

The progress in achieving the goals and objectives of priority area 3 is presented below.

4.1.3.1 Progress in achieving the goal target

The discussion below summarizes the achievements under priority area Management, Monitoring, Research and Surveillance

4.1.2.2 Progress in Achieving the Objective targets

The following objectives were identified under Management, Monitoring, Research and Surveillance priority area in the KZNPSP 2007-11.

i. To ensure that 80% of coordination structures at various level are effective by 2011.
ii. To strengthen monitoring & evaluation practice and have at least 80% of sectors consistently reporting and using M&E report by 2011

A summary of achievement against the objectives under priority area 3 are provided in the table below.

Table 18: Output indicators for priority area 3

Objective 1:	To ensure that 80% of coordination structures at various level are effective by 2011.				
Expected Output 1:	Effective coordination in 80% of sectors, district and local municipalities				
Indicator	**Baseline (2005)**	**Mid-term achievement (2008)**	**End-term Target (2010/2011)**	**Actual Achievement 2011**	**Comments**
1. Proportion of coordination structures capacitated in areas of planning, M&E & coordination	0%	No data	70%	100% capacitated on planning and reporting	
2. Proportion of organisations using harmonised planning to plan for their activities	0%	No data	No data	0%	
3. Proportion of districts with functional M&E systems	0%	No data	100%	80% of DAC and 55% LAC functional	
4. Proportion of districts and sectors with M&E units	No data	No data	100%	No data	
5. Percentage of key stakeholders trained on M&E	0%	No data	100%	50% of sector departments and 100% of DACs	
6. Percentage research agenda items implemented	No data	No data	(target: 30%)	0%	Research forum established
7. Proportion of DACs and LACs reporting quarterly	0%	No data	(target: 100%)	100% districts and 25% sectors	DOH, DOE, DSD and DAEARD reporting
8. Mid-term evaluation	No data	No data	Mid-term and end evaluation done	Mid-term and end evaluation done	MTR done and end term evaluation underway
9. Implementation of surveillance	No data	No data	(target: 100%)	No data	
10. Regular public addresses on HIV and AIDS by all leaders on *standardised communication framework*	No data	No data		DACT - about 70 events in 2010 (DACT report) All leaders Members of Executive Council, Mayors using the framework	

11. Annual review meeting with all stakeholders	No data	No data	Annual review meeting held	Achieved	
12. Annual HIV and AIDS Indaba with all stakeholders	No data	No data	Annual HIV and AIDS Indaba held	Achieved	Partnership conferences

Objective 1: Management of the response

The Office of the Premier in Kwazulu Natal is leading and coordinating the provincial response. The province uses one strategy, one coordination structure and one M&E system. The Provincial Council on HIV and AIDS, with the HIV and AIDS Directorate have achieved the goal of ensuring a multi-sectoral response. However, not all sectors and local council are reporting and the functionality of the structures varies. The expanded role of the PCA, which includes leading Operation Sukuma Sakhe, is driving mainstreaming of HIV and AIDS across the sectors. However, mainstreaming remains a big challenge across the board.

Of the sectors DOH, DOE, DSD and DAEARD (Department of Agriculture, Environmental Affairs and Rural Development) report regularly to the PCA. It was established during the review that Community Safety Liaison, Employee Wellness and the Human Rights office at OTP were implementing HIV and AIDS activities but their outputs were not submitted for review.

The HIV communication framework is in place and is revised annually. The framework has 14 messages. It is used by all levels of leadership when communicating on HIV and AIDS, especially in public platforms. All MECs have been allocated to lead district OSS campaigns in partnership with the district mayors. They lead the BCC interventions in their districts and they use the standardised framework regularly as and when they address their constituencies, including OSS campaigns.

Significant effort has been put into training stakeholders on the M&E framework. All the DACs and LACs as well as 50% of sectors have been trained. Implementation thereof is a challenge for some LACs but DACs are al reporting against the indicators in the framework.

Partnership with development partners, CSOs and the private sector are evident, in that they participate actively in the Partnership Conference and the PCA. Except in instances where these sectors submit data to sectors, there was little evidence of them using the provincial M&E framework.

The main challenge with the effectiveness of the PAC is ensuring consistent representation from different PAC members. Although the HIV and directorate is active in coordinating the different stakeholders, its capacity in terms of human resources is inadequate.

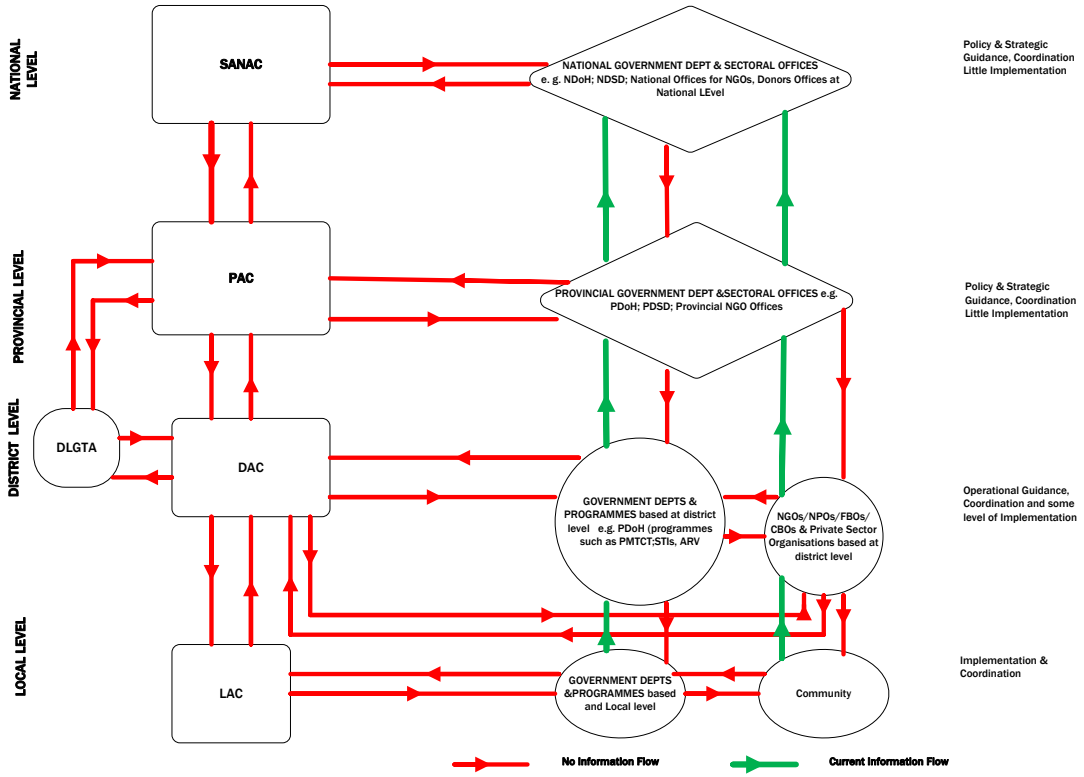
The relationship between NGOs and CBO appears to be healthy with the former making use of the latter's strategic position to mobilise the community when needed.

There was no data received from the private sector on any of the indicators under review. There were also no programmatic outputs provided to the Office of the Premier on related activities. Information from the Mid-term review of the National Strategic Plan (2008) reflected similar findings.

Objective 2: Monitoring and Evaluation

The KZNPSP 2007-11 envisaged an M&E system there would be data vertically to and fro between the grassroots and provincial level as well as horizontally among stakeholders. The figure below depicts this vision.

Figure 8: Envisaged HIV and AIDS Data and Information Flow Pathway.



Source: KZN M&E Framework

Overall, the findings of the review suggest there is growing acknowledgement of value and potential contribution of an effective M&E system in improving service delivery. There has been progress regular reporting by sectors and setting up coordination and management structures. Likewise the review found a number of challenges; most importantly the lack of integration of M&E into planning, inadequate M&E skills and lack of ownership of the provincial M&E tools. The lack of recent data on outcome indicators is a clear indication there has been inadequate alignment between the planning process and M&E; and that information flow does not seem to follow the envisioned pathway. The M&E framework and tools does not appear to be effectively used by stakeholders as each institution has their own systems that do not feed into the multi-

sectoral one. It must be noted however that bulk of the reporting responsibilities on the KZNPSP falls with the department of health and yet the systems are not well aligned. There seems to be very little reporting to the coordinating structures from NGOs and private sector as most do not receive funding directly from government.

Lack of capacity in terms of skilled human resources and financial allocations for M&E and research has also affected adequate information collection, management and use.

Data sharing among different stakeholders is sub-optimal although efforts are being made by the HIV and Directorate in the OTP to encourage stakeholders to share data and information.

In terms of research, the M&E directorate in the OTP is mandated to coordinate all researches in the province including HIV and AIDS research agenda.

The research agenda is yet to be set by the province. However, In terms of research the province has been informed by existing research, e.g. MPTCT, MMC and ART. *The Provincial Department of Health has created a Health Research and Knowledge Management Secretariat which intends to formulate and maintain research policy, strategy and protocol for the province. The office works will work closely with academic and research institutions such as the Nelson Mandela School of Medicine and the Health Economics and HIV/AIDS Research Division (HEARD) located at the University of KwaZulu-Natal.*

4.1.4 Strategic Priority Area 4: Human and Legal Rights and Enabling Environment

This section of the report deals with human and legal rights and enabling environment to the response to the epidemic.

4.1.4.1 Progress in achieving the goal target

Objective data was not collected to ascertain progress against indicators for the interventions in this priority area. However anecdotal information indicates that there is a very strong political will and commitment to the HIV and AIDS response in the province.

4.1.4.2 Progress in Achieving the Objective targets

In order to achieve the goal priority area 4 the following objectives were identified:

i. To strengthen political and public leadership commitment in order to create a visible, decisive and effective leadership within all sectors by 2011
ii. To mainstream HIV and AIDS into all sectors mandates and plans at all level by 2011
iii. To ensure that all existing legislation and policies relating to HIV and AIDS are adhered to by 2011.
iv. To promote and protect a human and legal rights of all vulnerable groups by 2011.

The Office on the Status of Women in the OTP exists to coordinate, facilitate and monitor gender equality and empowerment of women in the province. It implements programmes to raise awareness on gender violence related policies; generate and disseminate gender equality information through newsletters and booklets; embarks on women's rights campaigns, raise awareness on domestic violence; coordinates programs for economic empowerment of women and poverty eradication (MDGs) and; advocates for protection of vulnerable women.

For example, programmes are in place to raise awareness on the rights of widows as one of the vulnerable group. Widows are provided with specific empowerment programmes through the OTP, in the form of widow's forums, which have been launched in 5 districts, namely Ethekwini, Umgungundlovu, Uthungulu, Ilembe, and Uthukela.

No data was available to ascertain the extent to which the objectives of this priority area were

achieved.

4.2 Achievements, challenges/gaps and opportunities

Achievements

The achievements are discussed under each of the four priority areas:

Prevention

The incidence of HIV is estimated to have declined from 3.8% in 2005 to 2.3% in 2008: Although available data is based on estimates and may not be same with that actual figure, it shows that the trend in HIV incidence is declining in the province.

All primary schools provide life skills-based education: The Life skills-based education programme capacitates learners on HIV and AIDS and offers lay counselling as well as first aids.

Forty eight (48) High Transmission Areas (HTAs) have been established in KZN: These are socio-demographically defined areas where targeted intervention that include HCT; treatment of STIs; BCC and; male and female condoms are provided to populations designated as high-risk for HIV transmission

HIV transmission rate from mother to child declined from 22% in 2005 to 2.8% in 2010: Data from the PMTCT (Goga & Dihn, 2011) survey indicate significant achievement in PMTCT outcomes. In terms of output currently all PHC facilities provide PMTCT services and up to 96% of pregnant women were tested for HIV in 2010. Eighty two percent of eligible babies received Nevirapine prophylaxis.

All government and private health facilities provide continuous supply of PEP medicines: All the facilities provide PEP for occupational exposure and all hospitals and 88% of CHC provide PEP for sexual assault.

All blood and blood products are screened in a quality assured manner

Strategies have been put in place to address poverty: Operation Sukuma Sakhe (OSS) which is coordinated by the Provincial Council on AIDS has been designed to address socio-economic issues, improve and integrate services delivery at the community level. OSS rests on the three pillars of food security, health and sustainable community programmes and youth & women's empowerment.

Improved access to water and sanitation at community level has improved:

Male Circumcision has been introduced and accepted in the province: Through the intervention of His Royal Highness, King Zwelithini who advocated for male medical circumcision as a revival of a cultural practice and endorsement of performance of this procedure at health facilities, MMC has been accepted as a traditional practice.

Treatment, Care and Support

HCT coverage has increased : All the fixed PHC facilities offer HCT. A HCT campaign was conducted in 2010/11 that achieved 79% of its target.

ART programme has achieved universal coverage: The province achieved a coverage of 459,670 in 2011, which close to the needs projected through the ASSA model.. All hospitals and fixed PHC facilities now provide ART. In addition a roving team provides services to hard to reach locations. The waiting list for ART has declined from 17,984 in 2007 to zero in 2011.

HBC is provided in an integrated manner by CCG: CCG have now been combined into one group that provide integrated services at community level. Up to 3, 785,346 home visits were conducted in 2011 serving over 185, 000 clients.

Over 40,000 OVC were provided with services: OVC are provided with services through NIP sites, stop centres and community care workers. About 98% school attendance rate was achieved by orphans in 2009.

TB and HIV integration interventions are being implemented in KZN: All health facilities implementing both HIV and TB services, linking TB screening to HCT programme . HIV positive patients are screened for TB and IPT has increased to 71.5% (124,963 patients) against target of 170 000 clients by June 2011

Management, Monitoring, Research and Surveillance

PCA, 82% of DAC and 53% of LAC are fully functional in KZN: Using the eleven functionality criteria it has been determined that the KZN PCA is fully functional. 82% of DACs and 53% of LACs have also been found to be fully functional.

Sectors collecting data and reporting to the PCA: Provincial sectors, DACs and LACs report to PCA using a standardized tool.

Human and Legal Rights and Enabling Environment

Strong political commitment: Political leaders at all levels are reported to be supportive of the HIV and AIDS response.

Challenges and gaps

Prevention

KZN remains the province with the highest HIV incidence and prevalence: Despites significant decline in estimated incidence KZN remains the province with highest incidence and prevalence of HIV in the country and yet it is the second most populous province.

- In 2008, HIV prevalence was exceptionally high in urban informal areas at 33.8%.
- In 2008, HIV prevalence was significantly higher in those never married but had sex (31.8%), compared to those married (10.2%), those divorced/ widowed (7.6%) and those never married and never had sex (5.8%).
- Those sexually active in the current year had significantly higher HIV prevalence in 2008 (23.8%) than People reporting secondary abstinence (15.9%)

Sexual behaviour change interventions have not yet achieved the desired effect: Much as a number of interventions have been developed around sexual behaviour change the actual impact remains below expectations. The actual coverage of the interventions is also not known. For example, it was reported that learners at tertiary institution continue to have risky sexual behaviour.

- *Gender:* Gender remains a key determinant for risky behaviour. Among males, unprotected sex was associated with lower education, lower HIV-related knowledge, negative condom attitudes, alcohol before sex, recent clinical STI treatment, and having a partner who was trying to conceive. Among females, unprotected sex was associated with unemployment, negative condom attitudes, weaker condom use norms & intentions, lower behavioural skills, lower HIV stigma, lower perceived power, being threatened with physical violence, and experiencing physical violence.
- *Sexual violence:* In a survey in the IMAGE study in three districts in KZN and the Eastern Cape in 2008, more than 1 in 4 men reported having committed rape, 14% reported sexual intimate partner violence, and 9% reported gang rape (3% of the rape incidents involved another man or a boy) (Jewkes *et al.*, 2009)
- *Transactional sex:* The NCS 2009 reported the following percentages of people saying that they provided sex in exchange for money or gifts in the past year in KZN (national average): Youth 16-24: 6.0% (nat. 2.7%); Adults 25-55: 4.5 (nat. 3.4%); Females: 6.4%

(nat. 2.1%); Males: 4.0% (nat. 4.1%). The data suggest that KZN females practice transactional sex more frequently than females in any other provinces of South Africa.

- *Migration:* Barnighausen *et al.* (2007) found that migration was significantly associated with HIV incidence (adjusted Hazard Ratio migrant vs. non-migrant: 0.48). Also from KZN, Camlin (2008) reported that women's involvement in migration exacerbates their disproportionate infection risk relative to men.

- *Workplace:* 2007 KwaZulu-Natal Impact Study showed that the overall HIV prevalence among employees was 21.1% (Colvin et al., 2007). Sector specific HIV prevalence was 23.4% (agriculture), 19.7% (manufacturing), 16.1% (transport) and 24.3% (tourism/services).

- *Correct knowledge on HIV and AIDS:* The last two HSRC surveys (2005 & 2008) compared the prevalence of 'correct knowledge on prevention and the rejection of misconceptions'. . The prevalence of correct knowledge on HIV and AIDS was 49% in 2005 and 30% in 2008. In KZN, just like in Eastern Cape, Limpopo and Mpumalanga, there was a significant decrease noted levels of correct knowledge on HIV and AIDS

STI services have not yet reach optimum effect: While STI services and partner contact tracing are provided by most health facilities it was reported during the MTR that the percentage of partners coming for treatment remains low. In addition the incidence of syphilis remains unchanged since 2007. The number of patients on ART presenting with STI remains high.

Condom distribution is inadequate: Condom distribution and reported utilisation rates are lower than expected. Perceived poor quality of condom and disruption in supply are believed to be contributing factors. The demand for female condoms is low due to high costs and little knowledge about them.

The coverage of MMC remains significantly low: The low uptake of MMC need targeted BCC and ongoing advocacy at political and traditional leadership levels. Coverage may improve when capacity of the department improves, for example, with provision of roving teams.

Inadequate integration of services: There is inadequate integration of sexual and reproductive health services with HIV, AIDS, STI and MC&WH services.

Treatment, care and support

Poor follow-up of ART patients: The massive roll out ART has left little opportunity to consider the quality and comprehensiveness of the services offered to beneficiaries. For example no routinely collected data is available on lost to follow-up patients, therefore outcomes on these patients are unknown.

OVC services: There also appears to be a substantial gap in care and support to the deprived and vulnerable urban communities, such as informal settlements and people living in hostels.

HBC: Coverage of the HBC programme cannot be ascertained since programmatic data focuses on process indicators rather than the beneficiary coverage.

5 Conclusions

This review identifies a number of areas of progress as well as weaknesses in the provincial response. Some of these could be built upon or addressed as priorities in the next strategic plan. Based on the need for a coordinated multi-sectoral response in the province, it is inherent that all structures and spheres of government, their agencies, the private sector, non-governmental structures, civil society including PLHIV associations, communities and all other stakeholders commit and apply themselves to the response. There are many and diverse types of response efforts that need to be coordinated and scaled up. Coordination thus plays a central role in enabling the response. Clearly identifying target and priority groups whose vulnerabilities put them at more risk of either acquiring HIV or suffering from its impact would provide equity in resources allocation. These priority groups would include children, women, young adults and adolescents, people with disabilities and most-at-risk groups.

Although there was limited recent information on the KZNPSP 2007-11 progress the information obtained for the review suggests that progress has been made in the implementation of KZNPSP 2007-11.

In line with the international 3 ones principles, KZN established one coordinating body, one strategic framework and one national M&E system. Further there is high level of political commitment to the HIV and AIDS response with the Premier chairing the Provincial Council on AIDS.

The PAC has done commendable work and provided leadership in driving the poverty alleviation programme from the top. The success of the operation is testament to strong leadership from the Office of the Premier. While a lot of ground has been covered, there are opportunities for improvement that need to be exploited in order to strengthen the response. Mainstreaming the “poverty” agenda into departmental and municipal strategic plans is no mean feat and will require ongoing advocacy at all levels of government and the community.

There is an urgent need for a fully functioning, well-staffed M&E office for OSS and the KZN PSP. It should have the authority monitor and report on an agreed upon M&E Framework.

Participation of existing District and Local AIDS Councils (DACs) needs to be strengthened, not least because this may demonstrates ownership of OSS by local political leaders. The expanded role of the Provincial Council on HIV and AIDS as implemented through OSS has contributed significantly to increased participation in and ownership of the KZN PSP. The province now has to identify related challenges and resolve them with a view to having one implementation strategy and one M& E framework incorporating both the KZN PSP and OSS.

However challenges that need to addressed remains. Notably the effectiveness of DACs need to be improved. The effectively of intervention that influence behaviours, most especially those around sex and sexuality remains a big challenge facing the provincial response, as KZN remains the province with highest prevalence. Achievements in terms of treating and caring for those already infected have been made. While such programmes are very vital, they should not dominate in the response. Focus must be balanced with to prevention efforts which the province needs to work in order to break the back of this epidemic.

6 Recommendations

From the analysis in this review the main priority strategies to be considered for KZNPSP2012-16 could the following:

Prevention

- Re-focusing on and improving investment in prevention, while continuing to provide equitable treatment, care and support. Proven emerging prevention intervention should be embraced and scaled up with pace.
- Prevention is central to the success of any HIV and AIDS response. It is more cost-effective than treatment, care and support. All prevention efforts thus need to be brought to scale and at a faster pace.
- Consider rapidly scaling up emerging new prevention technologies such the MMC

Treatment

- The ART programme has matured over the years. Consideration should be made to integrate it with the other Primary Health care programmes.

Management and Coordination

- Encourage continued political commitment in order to ensure individuals and departments engage with the various processes.
- Strengthen the DACs and LACs to improve their effectiveness
- Ensure that the multisectoral plans, monitoring framework and tools are well aligned with the sectoral activities
- Streamlining coordination and making district level structures more effective

M&E, Research and Surveillance

- Synchronise Planning and M&E, so that strategic and operational plans are supported seamlessly by a practical M&E system
- Build capacity and capability for M&E systems within the Province

- Strengthening the M&E system, ensuring that the sectoral M&E systems are well aligned to the multi-sectoral one. This may requires alignment of indicators and capacity building.
- Strengthen the capacity of the HIV and AIDS directorate to better monitor the all the sectoral responses.
- Ensure that usable reports are produced and disseminated and shared amongst stakeholders at all levels. Furthermore, information should be disseminated to the public at regular intervals.
- Build upon existing research coordinating mechanisms and develop a provincial research agenda that cuts across scientific, social and economic aspects of HIV & AIDS response;

Access to Justice and Rights

- The agenda and intervention on the human and legal rights must be made clearer and monitored regularly. Clearly defining interventions around human and legal rights and monitor them consistently.

7 Annexes

Table of NSP Aligned Provincial Indicators

Type of Indicator	Indicator	Baseline 2005	Actual 2008	Target 2011	Actual 2010/11	Data source	Comments
Budget and expenditure							
Input	Budget and expenditure in private and public sectors (by priority areas)	No data	R2,163,082,440		R3,533,818,166*	KZN NASA Report 2011	**Data for 2010. 2011unavailable*
Prevention							
Incidence and prevalence (HIV and TB)							
Impact	Number of new HIV infections	No data	100,787	No data	No data	*KYE draft report 2011*	*The most recent data is 2009 incidence estimates in adults aged 15-49*
Impact	Percentage of new HIV infections	*3.8%*	*2.3%*	*1.9%*	No data	*2009 EPP estimates, E Gouws*	*No data for 2011*
Impact	Percentage of young women and men aged 15-24 who are HIV infected	*16.1%*	*15.3%*	*8.7%*	No data	*Shisana, et. al, 2009*	*No data for 2011*
Impact	Number of new TB infections	No date	No data	No data	118,000	*DoH Annual Report 2009/10*	
Impact	Percentage of new TB infection				1,156/100,000	*DOH Annual Report 2009/10*	
PMTCT							

Output	Number of HIV-positive pregnant women receiving a complete course of ART to reduce MTCT	No data	No data	No data	19737	*DoH update report*	
Output	Percentage of HIV-positive pregnant women receiving a complete course of ART to reduce MTCT	No data	No data	100%	88%	*DoH update report*	
Outcome	Percentage of infants born to HIV infected mothers who are HIV-infected	No data	8.20%	< 5%	DHIS - 5%, NHLS - 2.3%, PMTCT Survey - 2.8%	*DHIS, NHLS, MRC (2010) PMTCT Survey*	
Output	Proportion of the infants in national PMTCT programme receiving PCR within 6 weeks	No data	No data	90%	94.80%	*DoH update report*	
Sexual behavior							
Output	Number of male and female condoms distributed annually by public and private sector	No data	No data	100% of quantity forecasted	*26,459,032 (18%) for male condoms and 383,404 (27%) for female condoms*	*DoH update report*	
Outcome	Percentage of women and men 15-49 who have had sexual intercourse with more than one partner in the last 12 months	*10.6%*	*10.2%*	*5.3%*	*No data*	*KYE draft report 2011*	No data for 2011
Outcome	Percent of young men and women 15-24 and 25-49 reporting the use of a condom with their last sexual partner at last sex	*36.2%*	*66.2%*	*100.0%*	*No data*	*KYE draft report 2011*	Data for age 15+, 2008
Outcome	Percentage of young men and women who have had sexual intercourse before age 15 (Age at first sexual debut)	4.5%	4.9%	2.3%	*No data*	*KYE draft report 2011*	Age group 15-24, 2008 data

Output	Percent of schools that provide life skills-based HIV education in the last academic year	50.0%	80.0%	100.0%	*98.0%*	DOE Programme data	
Outcome	Percentage of most-at-risk-populations reached with HIV prevention programmes	*No data*	*No data*	80.0%	*No data*	*HSRC KYR report*	Denominator is not known, implementers report 2006-2008
Outcome	Percentage of most-at-risk-populations who correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission	*No data*	*No data*	*No data*	*No data*	_	No data
Gender-based violence							
Output	Proportion of facilities offering the comprehensive package of sexual assault care in accordance with the National Policy on Sexual Assault Care of NDOH	40.00%	No data	95.00%	88.0%	DOH Annual Report 2009/10	DOH Annual Report 2009/10
Post-exposure prophylaxis							
Output	Proportion of public and private facilities with a continuous supply of PEP drugs	No data	No data	95.0%	100.0%	*DoH update report*	
Blood supply							
Output	Percentage of donated blood units screening for HIV in a quality secured manner	No data	No data	100.0%	No data	_	No data
HIV counseling and testing (general population)							
Output	Number of people counselled and tested for HIV including provision of results	No data	757,262	3,059,234	2,324,546	*KYR draft report, DOH Report*	
Output	Percentage of people counselled and tested for HIV including provision of results	10.40%	29.0%	No data	*75.0%*	*Shisana, et. al, 2009*	

Output	Percentage of most at risk population that have received an HIV test in the last 12 months and who know their results	No data	No data	80.00%	*No data*	_	
Care, treatment and support							
ART							
Output	Total number of people in need (adults and children) receiving ART	No data		No data	*459,670*	*DoH DORA indicators*	
Output	Proportion of people in need (adults and children) receiving ART	No data	45.0%	80.0%	*55%*	*DoH, report*	Reported by National DOH
Outcome	Percentage of adults and children (by age groups) with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	No data	No data	80.0%	*No data*	_	No data
Output	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	No data	18.0%	80.0%	56.0%	*DoH Annual Performance Plan 2011-2014*	
Output	Number of new patients (adults and children) starting ART	No data	No data	220650	*122,038*	*DoH, report*	Reported by National DOH
Output	Number of people with HIV receiving Cotrimoxazole prophylaxis	No data	No data	No data	*No data*	_	
Palliative care							
Output	Number of people with AIDS being supported with a package of care	No data	No data	No data	*No data*	_	
Health systems strengthening							
Output	% of facilities in the province initiating clients on ART			100.0%	100.0%	_	
OVC							

Output	Percentage of Orphaned and Vulnerable Children (boy/girl) aged 0-17 whose households have received a basic external support in caring for the child	No data	No data	80.00%	*40.0%*	*DSD Report*	
Outcome	Current school attendance among orphans and among non-orphans aged 10-14	No data	*97.9%*	80.00%	*No data*	*Shisana, et. al, 2009*	
Research, monitoring and surveillance							
Outcome	Number of core indicators in plan available and collected	No data	No data	No data	*No data*	_	
Input	Percent of AIDS spending on HIV monitoring and evaluation	No data	No data	No data	*No data*	_	
Output	Number of national and community campaigns to reduce HIV stigma and discrimination	No data	No data	No data	*No data*	_	
Output	Number of legal support services for people living with HIV	No data	No data	No data	*No data*	_	
Output	Number of legal and social support services for women care-givers and victims of sexual violence	No data	No data	No data	*No data*	_	

8 References

Centre for Economic Governance and AIDS in South Africa (CEGAA), 2011. KZN National AIDS Spending Assessment - Final Report. July 2011.

Department of Governance and Traditional Affairs (COGTA) – KZN, 2011. Progress report on development of municipal infrastructure and associated service delivery (12 August 2011).

DOH, 2010. KwaZulu Natal Department of Health Annual Report 2009/10.

Department of Social Development, 2010. DSD Kwazulu Natal Annual Performance Plan.

Dorrington, R.E., Johnson, L.F., Bradshaw, D. and Daniel, T. (2006). The demographic impact of HIV/AIDS in South Africa. National and provincial indicators for 2006. Cape Town: Centre for Actuarial Research, South African Medical Research Council, Actuarial Society of South Africa; 2006.

Department of Health (DOH), 2009. Antenatal Clinic HIV Survey of Pregnant Women attending Public Clinics. Government of the Republic of South Africa.

Department of Health (DOH), 2010. KwaZulu Natal Department of Health Annual Report 2009/10.

Department of Health Annual Performance Plan (DOH APP) 2011. KwaZulu Natal Department of Annual Performance Plan 2011/12 – 2013/14.

Dorrington, R. Bradshaw, D. and Budlender, D. 2010. HIV/AIDS profile in the provinces of South Africa. Centre for Actuarial Research, University of Cape Town.

Guthrie, T. A Cross-Country Comparison of Spending on HIV/AIDS in the Southern African Region. www.cegaa.org

Goga, A., Dinh, T. (2010). Results of an Evaluation of Effectiveness of the National PMTCT Programme at Six Weeks Postpartum, SA [Powerpoint Presentation]

Health Systems Trust, 2009. District Health Barometer 2008/9. Available at http://www.hst.org.za [Accessed 1 August 2011]

Human Sciences Research Council, 2009. South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008: A Turning Tide among Teenagers? Cape Town: HSRC Press.

Human Sciences Research Council (2009), 'South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008: A Turning Tide Among Teenagers?'

Jewkes, R., 2009. Mens's use of physical and sexual violence against women: initial findings from the International Men and Gender Equality Survey (IMAGES) and the South African Study of men, masculinities, rape and HIV. Sexual Violence Research Initiative Forum 2009. 6-9 July 2009.

Kautzky, K. and Tollman, S.M. 2008. South African Health Review. Health Systems Trust.

Meyer-Rath, G. et al. 2009. Calculating the National Cost of ART Provision in South Africa, 2009-2016, Health Economics and Epidemiology Research Office, Wits Health Consortium, Johannesburg, South Africa/Center for International Health and Development, Boston University, Boston, USA

National Treasury. 2010. Estimates of Provincial Expenditure. KwaZulu-Natal Provincial Government.

Ndlovu, N., Sithole, S., Vilakazi, M., Mbatha, K. Guthrie, T. 2010. Budget 2010: A story of hope on national HIV and AIDS policy and funding in South Africa. CEGAA & TAC Policy Brief. [Online]. Available at: www.cegaa.org/products

Office of the Premier – Kwazulu Natal (OTP), Planning Commission, 2011. Provincial Growth and Development Strategy.

Office of the Premier – Kwazulu Natal (OTP), Monitoring and Evaluation, 2011. Kwazulu Natal Provincial Government Mid-term Review 2009-2011.

Office of the Premier – Kwazulu Natal (OTP), 2007. HIV and AIDS Strategy for the Province of Kwazulu Natal 2007-2011. Available at http://www.kwazulunatal.gov.za/premier/ [Accessed 21 April, 2011]

PROVIDE, 2005. A profile of KwaZulu-Natal: Demographics, poverty, inequality and unemployment – Background paper 2005:1(5). (website and check updated copy) – CHECK http://www.elsenburg.com/provide

SANAC, 2009. Mid-term Review of the National HIV, AIDS and STI Strategic Plan, 2008.

SANAC, 2011. Epidemic Response Synthesis, KwaZulu Natal Province, South Africa.

SANAC, 2011. The HIV epidemic in South Africa: What do we know and how has it changed?

Shisana, O., Rehle, T., Simbayi, L.C., Parker, W., Zuma, K., Bhana, A., Connolly, C., Jooste, S., Pillay, V. et al. (2005) South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005. Cape Town: HSRC Press

Shisana, O., Rehle, T., Simbayi, L.C, Parker, W., Zuma, K. and Bhana, A. (2008). South African national HIV prevalence, HIV incidence, behaviour and communication survey. Cape Town: HSRC Press.

Statistics South Africa (StatsSA), 2010. Mid-year Population Estimates

Statistics South Africa; Community Survey, 2007 Basic Results: Municipalities