United States Department of State

Washington, D.C. 20520

FY 2015 South Africa Country Operational Plan (COP)

The following elements included in this document, in addition to "Budget and Target Reports" posted separately on www.PEPFAR.gov, reflect the approved FY 2015 COP for South Africa.

1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

   Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the "COP 15 Targets by Subnational Unit" sheets that follow for final approved targets.

2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on www.PEPFAR.gov in the "FY 2015 Country Operational Plan Budget and Target Report."

Country Operational Plan

(COP) 2015

Strategic Direction Summary

September 30, 2015

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Goal Statement

The United States government will work in collaboration with the South African government to 'Focus for Impact' (i.e. scale up) to achieve the ambitious goal of reaching epidemic control in South Africa. The strategy will focus on both programmatic and geographic areas, in order to improve the efficiency and effectiveness of Technical Assistance (TA) and Direct Service Delivery (DSD) in an environment of limited resources. The objectives are to refocus the President's Emergency Plan for AIDS Relief (PEPFAR) and South African government resources to support the Joint United Nations Program on HIV/AIDS (UNAIDS) "90-90-90" targets (90 percent of all people living with HIV know their status, 90 percent of all people diagnosed with HIV infection receive Antiretroviral Therapy (ART), 90 percent of all people receiving ART have viral suppression), and improve linkages and program planning between prevention, treatment and Orphans and Vulnerable Children (OVC) programs at the community and facility levels.

In 2012, the South African government and the U.S. government signed a Partnership Framework Implementation Plan (PFIP), which outlines the progressive transfer of U.S. government support from direct service delivery to TA. This fiscal year, the U.S. government is using epidemiologic, expenditure, and yield data to realign its PEPFAR program, while reducing the budget by 10 percent ($46 million). The goal is to maximize the impact of investments, in order to reach epidemic control within two years, in a select number of areas with the highest concentration of HIV infected people and where incidence rates among specific populations are high.

PEPFAR is currently supporting HIV treatment services in all 52 districts. Working with the National Department of Health (NDoH), PEPFAR used district HIV prevalence and census data to estimate the total number of People Living with HIV (PLHIV) at the district level, and then ranked priority districts based on the greatest burden of PLHIV. The team calculated targets based on the goal of reaching 90-90-90 at current treatment guidelines (CD4 ≤ 500) in a select number of districts, and then applied prior year expenditure analysis data to assess the affordability of shifting to Scale-up districts and increasing and layering support to reach 90-90-90. After significant bilateral discussion, PEPFAR will shift programs to focus on achieving 90-90-90 in 27 districts, by primarily increasing the number of people tested to approximately 13.6 million people, supporting 4.2 million people with access to ART, and reaching 1.2 million people through prevention activities by 2017. To complement these activities, South Africa prepared a proposal for the Determined, Resilient, Empowered, AIDS-free, Mentored and Safe Women ((DREAMS) initiative by focusing additional resources in five of the 27 highest burden districts with high impact prevention activities targeting young girls and women. Within these five districts, the South Africa DREAMS initiative will focus in 18 sub-districts with the greatest number of PLHIV.

A new element contained in the 2015 COP is the proposal to pilot universal test and treat (UTT) programs in select sub-districts where the DREAMS initiative will be implemented, upon concurrence of the South African government. PEPFAR plans to work with government counterparts and other stakeholders to develop proposals and the necessary consensus for successful UTT pilots.

As PEPFAR continues to progressively transition many programs from direct service provision to TA, specific inputs will focus on:

- TA for care and treatment services to support the South African government's effort to increase the number of people on treatment from 2.7 million to 4.8 million.
- Combination prevention (e.g., Prevention of Mother-to-Child Transmission (PMTCT), condoms, voluntary medical male circumcision (VMMC), ART, and services tailored to reach key and other vulnerable populations (e.g., young women and girls, Men who have Sex with Men (MSM), and Female Sex Workers (FSW)).
- Holistic OVC programs that are linked to ART and prevention interventions.
- National-level systems strengthening programs (above district level) for human resources.

The table below depicts the number of sites by program area that will be scaled-up, transitioned in the longer term (on/about September 2016), and transitioned in the short term (on/about December 2015).

Technical Area	Number of Sites	Scale-Up Sites	Sustained Sites (Long term transition)	Transition Sites (Short term transition)
OVC	878	822	45	11
PMTCT	3,430	1,950	197	1,283
Prevention (KP)	13	6	2	5
Prevention (General Population)	24	16	4	4
VMMC	475	442	36	0
Care and Treatment	4,183	1,969	198	2,015
Supply Chain	1,909	1,909	NA	NA
Laboratory	2,365	1,970	0	395

1.0Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden, and country or regional profile[i]

The HIV epidemic is largely driven by heterosexual transmission, with a number of underlying behavioral, socio-cultural, economic, and structural factors that influence risk for HIV transmission. These include mobility and migration; race, economic, and educational status; alcohol and drug use; early sexual debut; sexual violence; low prevalence of male circumcision; lack of knowledge of HIV status; intergenerational sex; multiple and concurrent sexual partners; discrimination and stigmatization; and inconsistent condom use, especially in longer-term relationships and during pregnancy/post-partum. In particular, gender dynamics and unequal power relations between men and women play a significant role in heterosexual HIV transmission. Approximately 54 percent of HIV-infected adults are women, with the demographic of black women aged 25-34 having the highest prevalence, at 31.6 percent and highest incidence at 4.54 percent (Human Sciences Resource Council (HSRC) Household survey, 2012).

1. **Total population**: 54 million, of which approximately 51 percent (27.64 million) are females. Life expectancy at birth for 2014 was estimated at 59.1 years for males and 63.1 years for females, while infant mortality rate was 34.4 per 1,000 live births.

2. **HIV disease burden**: 6.4 million South Africans are living with HIV. UNAIDS estimates that 19.1 percent of adults (15-49 years) are HIV-positive.
3. **Current progress towards epidemic control**: The number of people on ART has steadily increased with a stated goal of reaching 4.8 million people on ART by 2016. As of 2014, the NDoH reports over 2.7 million people on ART (NDoH, 2014).
4. **Major gaps in achieving epidemic control**: South Africa is not meeting its National Strategic Plan (NSP) goal to reduce new HIV infections by 50 percent by 2016. UNAIDS estimates there were 340,000 new HIV infections per year in South Africa in 2013, (UNAIDS, 2013) while the HSRC estimated 469,000 new infections per year in 2012.
5. **Gross National Income (GNI) per capita**: According to the World Bank, South Africa has a per capita annual income of $12,240. The South African government currently funds approximately three-quarters of the national HIV/AIDS response. The South African government consolidated national and provincial budget for HIV/AIDS expenditure for 2014/2015 is R13 billion ($1.2 billion). According to National Treasury officials, the South African government expects to continuously increase the allocated budget amount by an estimated R1.5 billion ($150 million) per year to accommodate the anticipated increasing numbers of South Africans on ART.
6. **Percent of GNI spent on HIV response and/or the health sector**: The total expenditure on health was 8.8 percent of the gross domestic product in 2012. The 2015 budget projects that total health spending will reach R178 billion by 2017/18. In the next three years, the government plans to spend R502 billion on health with R46.6 billion earmarked for the HIV/AIDS epidemic. Out-of-pocket expenditures are estimated at 13.8 percent of total health expenditures.

Prevalence and incidence vary significantly across geographic areas (54 percent of PLHIV are concentrated in the Gauteng and KwaZulu-Natal provinces), and migration and mobility are important risk factors that dramatically increase vulnerability to HIV. Table 1.1.1 below summarizes the key HIV epidemiological data.

Table 1.1.1 Key Epidemiological Data											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	Percent	N	Percent	N	Percent	N	Percent	N	Percent	
Total population (2014)	54,002,000	100		14.8	8,164,881	15.1	19,621,061	36.3	18,201,126	33.7	StatsSA[1], 2014
HIV Prevalence (percent)		12.2		2.4		2.3		19.1		13.2	HSRC.[2], *2012*
AIDS related deaths (per year)	251,912		NA		NA		127,484[1]		124,429[1]		Murray *et al.*[3], 2014 [1]For all ages, disaggregation by gender only
PLHIV[2]	6,500,000		192,357		187,792		3,740,321		2,395,217		StatsSA[a], 2014 HSRC.[b], *2012* [2]StatsSA 2014 population estimates used with HSRC age-specific prevalence

[1] Statistics South Africa Mid-year population estimates 2014. Statistical Release P0302, Statistics South Africa: Pretoria.
[2] Shisana O et al. (2014) South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press.
[3] Murray, C.J. L., Ortblad, K.F., Guinovart, C., *et al.*(2014) Global, regional, and national incidence and mortality for HIV, tuberculosis , and malaria during 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. The Lancet 10.1016/S0140-6736(14)60844-8.

Incidence rate (year)		1.1		0.5[3]		NA[3]		2.28		1.21	StatsSA[a], 2014 HSRC.[b], 2012 Ages 2-14, no data available for males in this age range
New Infections (year)	469,000										HSRC.[b], 2012
Annual births	1,207,711	22.4									Stats SA[a], 2014
Percent >= 1 ANC visit	1,171,479	97.0	NA	NA			NA	NA			UNICEF[4]
Pregnant women needing ARVs	280,000	23.1									UNAIDS[5], 2013
Orphans (e.g., maternal, paternal, double)	3,963,804	7%	1,156,695	29%	1,183,997	30%	208,534	5%	204,559	5%	Stats SA, 2011
Tuberculosis (TB) cases	313,887		16,831		20,412		125,575		151,069		WHO[6], 2014
TB/HIV co-infection	191,471	61.0[5]	NA	NA	NA	NA	NA	NA	NA	NA	WHO[f], 2014 [5] HIV prevalence among people with TB
Males circumcised	8,437,786	46.4			NA	NA			8,437,786	46.4	HSRC.[b], 2012
Key Populations											

[4] UNICEF Antenatal Care Coverage Data
[5] UNAIDS GLOBAL REPORT; UNAIDS report on the global AIDS epidemic 2013
[6] WHO (2014) Global tuberculosis report 2014

Total MSM*	1,200,000	NA									McIntyre *et al.*[7], *2013*
MSM HIV Prevalence	NA	9.9 8.6 10.4 – 34.5 28.0									UNAIDS[8], 2013 HSRC.[b], *2012* McIntyre *et al.*[g], *2013* UCSF[9], 2015
Total FSW	138,000	NA									SANAC[10], 2013
FSW HIV Prevalence	85,560	56.0									SANAC[j], 2013 UCSF, Anova, WRHI[11], 2014
Total PWID	67,000	NA									Scheibe *et al.*[12], *2014*
PWID HIV Prevalence	NA	14.0									Scheibe *et al.*[1], *2014*
Priority Population: Military	73,104	0.2	NA	NA	NA	NA	20,481	25.6	52,623	74.4	South African National Defense Force[13], 2015

[7] McIntyre, J., Jobson, G., Struthers, H. Rebe, K. Rapid Assessment of HIV Prevention, Care and Treatment Programming for MSM in South Africa. Summary Report 2013, Anova Health Institute, Johannesburg.
[8] UNAIDS. UNAIDS Spectrum Estimates for South Africa 2013
[9] University of California, San Francisco (2015). Report of the South Africa Men-who-have-sex-with- men Data Triangulation Project. San Francisco: UCSF. Global Health Sciences.
[10] SANAC. Sex Worker Estimation Size Study, 2013
[11] UCSF, Anova Health Institute & WRHI (2014). South Africa Health Monitoring Study (SAHMS), Final Report: The Integrated Biological and Behavioural Survey among Female Sex Workers, South Africa 2013-2014. San Francisco: UCSF.
[12] Scheibe, A., Brown, B., dos Santos, M. Rapid assessment of HIV prevalence and HIV-related risks among people who inject drugs in five South African cities, draft study report v2, 2014.
13 South African National Defense Force 2015

Priority Population: Black African women 20-34 years	5,890,209	31.6	NA	NA	NA	NA	NA	NA	NA	NA	StatsSA[a], 2014
Priority Population: Black African men 25-49 years	1,861,306	11.0	NA	NA	NA	NA	NA	NA	NA	NA	StatsSA[a], 2014
**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*											

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months)										
				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Total PLHIV (#)**	**In Care (#)**	**On ART (#)**	**Retained on ART 12 Months (#)***	**Viral Suppression 12 Months***	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	54,002,000	12.2	6,500,000	3,427,778	2,742,222	74%**	78%**	7,137,284***	841,208***	637,412
Population less than 15 years	16,179,765	2.3	380,149	196,896	157,517	78%	71%	NA	NA	24,921
Pregnant Women	1,207,711****	30.0	362,331	N/A	N/A	NA	NA	707,062	247,404	180,387
MSM	1,200,000	9.9 8.6 10.4 – 34.5 28.0	NA	NA	NA	NA	NA	NA	NA	NA
FSW	138,000	60.0	NA	NA	NA	NA	NA	NA	NA	NA
PWID	67,000	NA	NA	NA	NA	NA	NA	NA	NA	NA
Priority Pop: Military	73,104	NA	NA	NA	NA	NA	NA	NA	NA	73,104

*Only data available are figures for "end of month," no data for 12 months

**Figures for ages 15 and above only

***Figures for ages 15-49 only

****Number of pregnant women is not available, live births used as a proxy; Statistics South Africa Mid-year population estimates 2014

1.2 Investment Profile

The HIV response in South Africa is funded primarily through public revenue (77 percent in 2013/14), raised through individual and business taxes. PEPFAR is the second largest source of funds, and accounts for approximately 15-20 percent of HIV resources (excluding TB spending). The Global Fund to Fight AIDS, TB and Malaria (The Global Fund) is the next largest funding source, accounting for three percent in 2013/14, according to the UNAIDS Investment Case findings (2015). There are other external sources (bi-laterals, multilaterals, and foundations) that were not tracked in the Investment Case, but according to the 2013 National AIDS Spending Assessment, they accounted for around seven percent of funds. Private companies and insurances contributed around eight percent.

In Fiscal Year (FY) 2014/2015, the South African government budget allocation for HIV through conditional grants was R13 billion ($1.2 billion), with planned increases to approximately R15.7 billion ($1.5 billion) by 2016/17. The South African government spent R41 billion ($4.1 billion) on HIV and AIDS programs over the past five years and has allocated a budget of R43.5 billion ($4.35 billion) for the next three years.

Due to the high HIV burden in South Africa, and the already large number of patients on treatment, HIV costs are expected to increase over the next decade, primarily driven by ART costs. Through the Investment Case we learned that the 90-90-90 scenario would have the most significant impact on HIV infections and life years saved, but a steadily increasing investment would be needed starting in 2016/17. Given South Africa's constrained economy, the government has leveled funding for many services. Public spending on HIV increased by 15 percent from 2011 to 2012, and increased again by 34 percent in 2013. Such public increases for HIV, largely focused on treatment will consume an increasing share of the health budget.

Table 1.2.1 Investment Profile by Program Area[14]

Program Area	Total Expenditure (USD)	Percent PEPFAR	Percent GF	Percent SAG	Percent Other
Clinical care, treatment, and support	953,593,483	16	4	80	Not available
Community-based care	249,377,442	10	1	89	Not available
PMTCT	47,814,578	60	2	38	Not available
HIV Testing and Counseling (HTC)	106,996,88	26	8	66	Not available
VMMC	74,737,992	73	5	22	Not available
Priority population prevention	56,126,991	58	2	40	Not available
Key population prevention	19,255,705	36	4	60	Not available
OVC	108,789,107	23	3	74	Not available
Laboratory	9,030,773	100	0	N/A	Not available
Strategic Information (SI), Surveys, and Surveillance	11,248,098	99	1	N/A	Not available
Health System Strengthening (HSS)	69,677,373	100	Not tracked	Not tracked	Not available
All Other SA HIV Spending	214,546,191	0	3	97	Not available
Total	1,819,694,819	20	3	77	Not available

Sources: SA Investment Case (2015) and PEPFAR EA (2014)

[14] (GRP, National AIDS Spending Assessment , 2012), all amounts in 2012 USD

NB. Clinical care, treatment, and support do not only refer to ART.
These figures exclude SAG TB spending.
For SAG expenditures, lab spending is captured under specific program areas.
For SAG expenditures, HSS spending is captured under general health spending and not specifically marked for HIV. For PEPFAR, HSS expenditure is captured in support of other program areas. The $69million indicted here represents above site level HSS program expenditure.
'Other sources' were not captured in the SA Investment Case.

Table 1.2.2 Procurement Profile for Key Commodities					
Program Area	**Total Expenditure (USD)**	**Percent PEPFAR**	**Percent GF**	**Percent SAG**	**Percent Other**
ARVs	383,144,012	1	8	91	Not available
Rapid test kits	7,910,380	8	1	91	Not available
Other drugs	35,036,771	0	0	100	Not available
Lab reagents	5,840,439	8	32	60	Not available
Condoms	30,645,877	1	0	99	Not available
VMMC kits	18,213,356	29	0	71	Not available
Other commodities	176,766,792	3	0	97	Not available
Total	622,557,629	2	5	93	Not available

Sources: PEPFAR EA (2014), Global Fund Primary Recipient ad-hoc request (2014), SAG Basic Accounting System (BAS) (FY 2013/14)

Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives					
	Total Non-Country Operational Plan (COP) Resources	**Non-COP Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
USAID Maternal and Child Health (MCH)	NA	NA	NA	NA	NA
USAID TB	NA	NA	NA	NA	NA
USAID Malaria	NA	NA	NA	NA	NA
Family Planning (FP)	NA	NA	NA	NA	NA
National Institutes of Health (NIH)	NA	$3,000,000	1	$1,500,000	Leveraging TB cohorts across Brazil, India and South Africa to address common questions
Centers for Disease Control and Prevention (CDC) Non-Communicable Diseases (NCD)	NA	NA	NA	NA	NA
Peace Corps	NA	NA	NA	NA	NA
Department of Defense (DoD)	NA	NA	NA	NA	NA

Ebola					
Millennium Challenge Corporation (MCC)	NA	NA	NA	NA	NA
Private Sector	$8,757,110	$8,757,110	11	$8,264,262	Leveraging private sector resources for innovative prevention activities
PEPFAR Central Initiatives	$5,836,019	$5,836,019	11	$15,200,000	• Medical Male Circumcision (MMC) Plus-up • SI Initiative for mHealth/ MOMConnect • PopART • PrePex • Public Private Partnership (PPP) Incentive Fund

1.3 National Sustainability Profile

The PEPFAR team developed the first Sustainability Index and Dashboard (SID) which will be used as an ongoing planning and monitoring resource in future years. South Africa has good scores in various elements of the five domains: institutionalizing data availability, domestic program and service delivery, health financing and strategic investments, government accountability and transparency, and enabling environment. Analysis of the SID revealed accountability and transparency and the enabling environment as the two areas with the most positive measures of sustainability. However, concerted efforts are required to improve the quality of institutional data availability, domestic program and service delivery, and health financing and strategic investments. Based on the SID diagnostic, quality management/ improvement was the lowest-scoring domain, needing improvement for sustainability of the HIV response in the next two to three years both at a service delivery level, and cutting across the health system. Human Resources for Health (HRH) continue to be a major bottleneck to doubling the number of people on ART. Additionally, spending of the HIV Conditional Grant, especially below the provincial level, represents a key issue and an opportunity to improve the allocative efficiency of the South African government's response.

While the supply chain scored well on strengths at the national level, stock outs continue to be frequent at the lower levels of the system as there is a lack of visibility of stock levels below the provincial level. For the epidemiologic and health data domain, although the score is light green, most activities are being funded by donors and partners, and require increased funding from the South African government in order to be sustainable. Use of epidemiologic and EA data for decision-making and strategic targeting needs to be improved, in order to improve technical efficiency. Finally, the link between government and civil society needs to be strengthened. Although civil society is active in South Africa, particularly through The Global Fund's Country Coordinating Mechanism (CCM) and South African National AIDS Council (SANAC) there could be a more formal and routine process to seek inputs from advocacy and community groups on national planning processes and decision-making.

With resource constraints at government-supported care and treatment sites, districts with the highest HIV burden may not have the capacity to scale-up testing and treatment services to meet

the government's 90-90-90 targets. See Appendix A for a summary of program/system support and technical area-specific sustainability activities.

1.4 Alignment of PEPFAR investments geographically to disease burden

Figures 1.4.1 and 1.4.2 compare PEPFAR expenditures to burden of disease (as measured by HIV prevalence) by province. In 2014, the PEPFAR program spent an average of $63 per PLHIV. This varied by province from $33 (KwaZulu-Natal) to $80 (Western Cape) per PLHIV. Figure 1.4.3 presents province-level burden of disease as reported by HIV prevalence and estimated number of PLHIV. An analysis of the 2014 PEPFAR expenditure by HIV burden at the provincial and district level demonstrates a higher degree of correlation at the provincial level and a moderate degree of correlation of spending and disease burden at the district level with some outliers. An estimated $8.9 million was spent by PEPFAR in Cape Town Metro (estimated HIV prevalence: 4.6 percent) in Western Cape Province, with a heavy concentration of programs focusing on key populations, which can be more expensive to implement. Conversely, $1.6 million was spent in Sedibeng District (estimated HIV prevalence: 22.4 percent) in Gauteng province. In general, more funds were expended in the urban areas (e.g., Tshwane (Pretoria), Johannesburg, Cape Town, eThekwini (Durban)) than in non-urban areas.

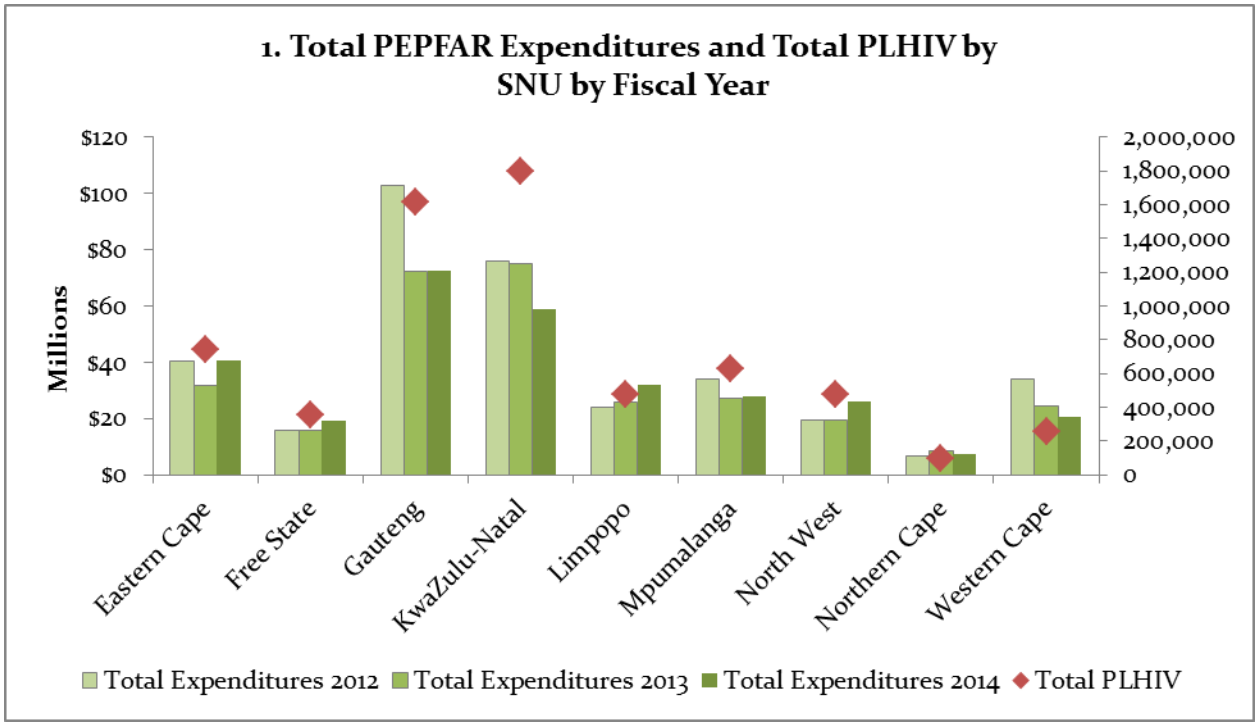

Figure 1.4.1: PEPFAR Expenditure per PLHIV and Prevalence by Province 2012-2014

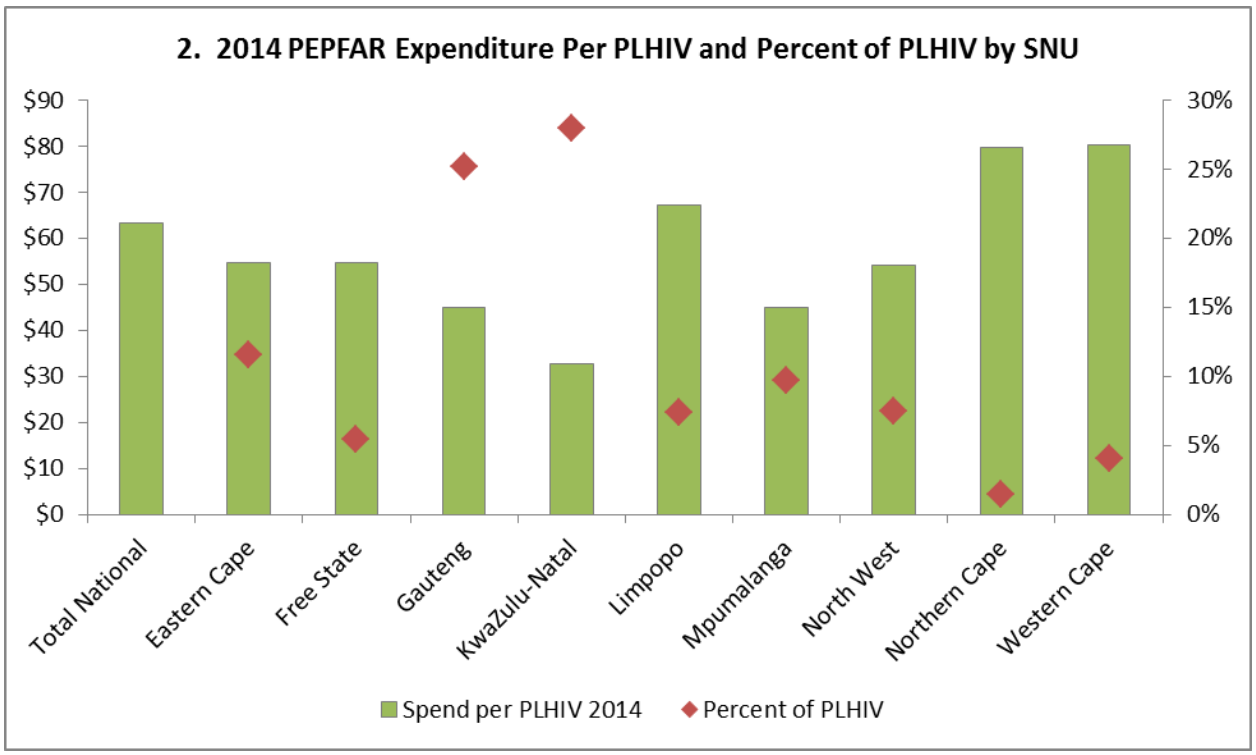

Figure 1.4.2: 2014 PEPFAR Expenditure per PLHIV and Prevalence by Province

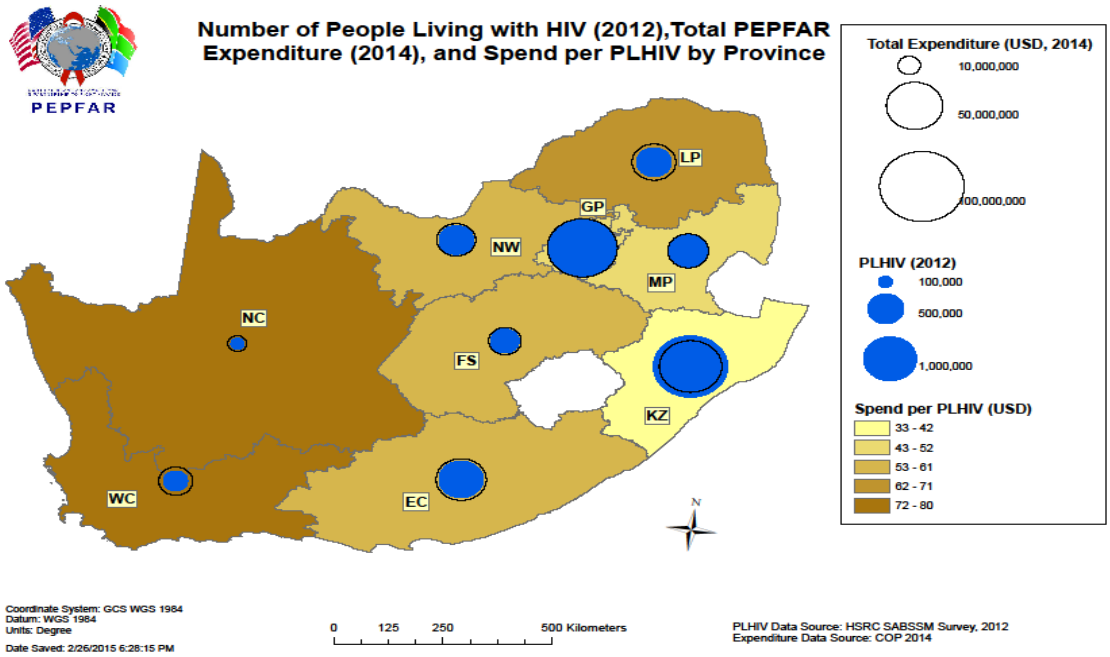

Figure 1.4.3: Total expenditure, PLHIV, and Expenditure per PLHIV by Province

1.5 Stakeholder Engagement

In order to achieve the goals and objectives of COP15, it was important to engage with multiple stakeholders during the process to determine the 'focus for impact'. Discussions occurred first

with the South African government to jointly determine the highest burden areas, scale-up districts, and sustained sites for longer term transition. The November 2014 PEPFAR Strategic Review consisted of a review together with South African government to determine the 'coreness' of current PEPFAR activities, classifying them into high, medium and low impact. The ultimate goal of this process was to assign COP15 funding only to high and medium impact activities. Discussions were held with the CCM, as well as the South Africa Global Fund management team from Geneva, to ensure that the principles and outcomes of 'focusing for impact' will be considered in the design of the July 2015 Concept Note. A draft PEPFAR stakeholder engagement and communications strategy was developed in January 2015 to serve as the basis for planning and communicating the key messages around 'focusing for impact' and other key changes. Meetings led by the Deputy President's office were held with Provincial representatives of Member of the Executive Council (MEC) offices, as well as the PFIP Management Committee and the Minister of Health, to present the strategy and solicit feedback. The PEPFAR team met with UNAIDS, civil society representatives and the country's AIDS and Health Development Partners Forum to share the strategy and seek inputs.

The PEPFAR team is committed to the following communication objectives:

- Support communication to relevant groups or individuals, in order to answer questions and solicit feedback on proposed strategic shifts.
- Engage in communications and joint planning with implementing partners and health authorities to outline process expectations.
- Prepare a communications strategy and revise regularly according to feedback.

South Africa is a Country Health Partnership (CHP) country, and works closely with the South African government to monitor progress against objectives set forth in the NSP for HIV/AIDS, TB and Sexually Transmitted Infections (STI), the Medium Term Expenditure Framework (MTEF), and the National Development Plan as applicable. Periodic national reviews are conducted (the last one in spring 2014) to make adjustments to programs and joint financing plans of the HIV epidemic. The recently approved South African Civil Society Priorities Charter was also considered during COP15 planning, and Technical Working Groups (TWG) were asked to consider the following cross-cutting priorities stated in the charter:

- Monitoring and evaluation (M&E).
- Research and innovation.
- Necessity of enabling environments.
- Capacity Building of community health systems.
- Consultative and collaborative work processes.
- Diversity in demographic and geographic considerations.

Recommendations from three consultation meetings with civil society in preparation of COP 15 highlighted the need for further research and building a stronger evidence base for socio-behavioral interventions, particularly at the community level, and to demonstrate the effectiveness of efforts to fight stigma and discrimination.

The table below represents the consultations and meetings that occurred with all stakeholders during the COP process. Additionally, the Stakeholder Engagement Plan for PEPFAR South Africa is attached as part of the COP supplemental documents.

Table 1.5.1. Stakeholder Consultations and meetings		
Meeting / Correspondence	**Objective**	**Participants/Recipients**
One page briefer on PEPFAR strategic shift	▪ Provide a concise, clear briefer on why PEPFAR is shifting its HIV/AIDS strategy and how it will affect SA.	▪ PEPFAR Team ▪ Public Affairs Section (PAS) ▪ Shared with Implementing Partners (IPs), South African government, and civil society
Donor coordination meeting	▪ Present to the donor and development partner forum the PEPFAR Focusing for Impact strategy	▪ All key donors
Global Fund CCM South Africa meeting to present Focusing for Impact strategy	▪ Share data and planned strategic shifts with the members of the CCM, to inform the Concept Note preparation	▪ SANAC, civil society, private sector and other CCM members
Pre-consult with civil society leaders	▪ Guidance meeting on how to approach civil society and communicate the PEPFAR Focus for Impact	▪ Select civil society leaders ▪ PEPFAR Oversight committee members
DREAMS launch and visit of Ambassador Birx	▪ Launch of the DREAMS Initiative and strategic planning for 10 selected countries	▪ PEPFAR country teams, Ambassador Birx, UNAIDS
Consultation meeting with provincial South African government representatives on the Focusing for Impact Strategy	▪ Discuss the PEPFAR strategy and the impact/role of provinces in ensuring services.	▪ South African government, SANAC, PEPFAR Coordinator, PEPFAR agency representatives
COP15 Partnership Framework Implementation Plan (PFIP) Management Committee presentation	▪ Present Focusing for Impact strategy to the PFIP Management Committee and discuss concerns with multi-sector South African government representatives	▪ PEPFAR agency heads ▪ South African government representatives from health, social, financial and education sectors
COP15 Steering Committee meeting (planned)	▪ Meet with the Ambassador and Minister of Health to approve COP15	▪ U.S. Ambassador ▪ Minister of Health ▪ PEPFAR Oversight Committee members
DREAMS Civil Society meeting	▪ Meet with members of civil society involved in supporting HIV prevention among young girls/women, OVC and in high burden communities to present and discuss the DREAMS proposal and Focusing for Impact	▪ PEPFAR DREAM team leads ▪ PEPFAR Coordinator ▪ UNAIDS ▪ Civil society representatives
Civil society meeting	▪ Share Focusing for Impact strategy and discuss with civil society representatives PEPFAR's strategic shifts and the implications for their activities ▪ Gather feedback to inform COP15 and focusing for impact ▪ Determine a schedule of follow-up meetings with civil society	▪ Representative group of civil society partners, participants based on guidance during pre-consult with civil society. ▪ Representatives from PEPFAR, including agency leadership and technical teams
Partners information sharing meeting	▪ Present and discuss the strategic shifts with PEPFAR Implementing Partners (IPs) and implications for their activities.	▪ PEPFAR interagency team ▪ All prime IPs ▪ South African government
Provincial communication and consultation roadshow (planned)	▪ Jointly coordinated meetings by PEPFAR provincial liaisons and government counterparts to share the	▪ PEPFAR Provincial Liaisons (PPL) ▪ PEPFAR agency representatives ▪ South African government

Table 1.5.1. Stakeholder Consultations and meetings		
Meeting / Correspondence	**Objective**	**Participants/Recipients**
	new strategic shift and vision for PEPFAR and implications for each province.	representatives

2.0 Core, Near-Core and Non-Core Activities

As noted earlier, the PEPFAR team undertook an extensive portfolio review in November 2014 with South African government counterparts to identify high impact activities that were deemed 'core' for contributing to and achieving epidemic control. In defining core, near-core and non-core activities, the team considered the comparative advantage of PEPFAR involvement, return on investment, alignment to the South Africa NSP, stakeholder perspectives, transition status, scientific evidence, and duplication. The following areas were identified as core activities for each program area:

Table 2.0.1. Key decisions Overview by Technical Area	
Technical Area	**Key Decisions Overview**
HSS	The following areas were identified as core activities moving forward: 1) development of health care workers (HCWs) that are critical to the HIV response, 2) policy and curriculum development for cadres of HCWs essential for HIV service provision, 3) Competencies and job profiling for HCWs, 4) support the Office of Health Standards Compliance to accredit facilities to deliver health care services, 5) supply chain systems strengthening, and 5) HIV financing. Activities that will be phased out include the development of formal qualifications of health information systems, stipends for health economics graduate students, leadership and management training for Clinical Associates.
SI	1) Health Management Information Systems (HMIS) support, 2) eHealth/mHealth implementation, the mobile platform, and its integration into the national health architecture, 3) Drug HMIS ("Rx Solutions"), 4) HIV incidence surveillance (HIPSS), 5) Mapping, population size estimation for key populations (e.g. MSM, FSW), Bio-Behavioral Survey (BBS) in the target geographic area, 6) Cost and budget modelling for HIV and TB programs, 7) Developing and maintaining a local DATIM Instance, and 8) Capacity in use of geographic information systems (GIS) data and tools, and phase 6 TIER.net enhancement and expansion.
HLAB	1) Providing support for the improvement of quality of laboratory diagnostic services including point of care testing, 2) Supporting the implementation of laboratory testing cost saving measures, 3) Providing support to laboratory-based surveys and surveillance and operational research activities, and 4) Support to clinic lab interface at the facility level.
HTC	District Implementation Plans for 90 90 90 will include district targets and activities supported by DOH and PEPFAR. 1) Scaling up and intensifying high yield HTC modalities in high transmission areas and hotspots in communities 2) Ensuring linkages to HIV treatment, care and prevention services through scale-up strategies for linking, tracking and tracing clients who are diagnosed HIV positive 3) Targeted demand creation for HTC among priority and key populations including YWGs 4) Using innovative high yield interventions to track and follow up PLHIV and families 5) Strengthen and scale-up technical assistance for PICT to increase uptake of HTC amongst priority populations, including children and implementation of facility-based PITC, and 6) Systems strengthening for linkages to treatment for key and priority populations
OVC	1) Assessing child and family socio-economic status (across all areas: healthy, safe, stable, and schooled), 2) Developing care/case management plans for vulnerable households (children & caregivers) with monitoring of referral completion and case closure goals, 3) Implementing special studies to measure programming impact and identify gaps, and 4) Identifying children and adolescent subpopulations made vulnerable by HIV and AIDS and linking them to appropriate testing, prevention, care and treatment

Table 2.0.1. Key decisions Overview by Technical Area	
Technical Area	**Key Decisions Overview**
	services.
Care & Treatment	District Implementation Plans for 90 90 90 will include district targets and activities supported by DOH and PEPFAR. 1)TA addressing a broad range of support for diagnosis, linkages to care, treatment initiation, maintenance and viral suppression, treatment adherence and retention in care, and supportive systems at facility and program (district, province, national) levels. 2) Most core activities (approximately 75%) are supporting clinical programs directly in facilities delivering services, with additional focus supporting patients in the continuum from community level to facilities, and support for higher level program outcomes at district, province and national program levels.
Prevention	1) Comprehensive VMMC package of service, training, quality improvement and demand creation, 2) HTC with focus on targeted community-based outreach for increased positive case findings, 3) Improving condom (male and female) distribution and demonstration in emphasizing unconventional community access points (taverns, gas stations) and increased consistent use, 4) Implementing evidence-based structured HIV prevention interventions to reduce sexual and gender-based violence and increase uptake of HIV services and linkages treatment and care 5) Evidence-based behavioral interventions focused on priority populations especially young women and girls, and 6) Comprehensive package of services for key populations, with a strong peer educator network and structural interventions to reduce stigma and discrimination.

3.0 Geographic and Population Prioritization

PEPFAR is currently implementing HIV/AIDS care and treatment activities in all 52 districts. However, over the past two years PEPFAR has undergone a progressive shift of a majority of the care and treatment portfolio from DSD to TA support. The PFIP outlines PEPFAR resources declining from an annual budget of approximately $500 million in 2012 to $250 million USD by 2017. Simultaneously, the South African government's allocation for the national HIV response has steadily increased (see Figure 3.0.1). In line with the funding trajectories outlined in the PFIP and principles of 'focusing for impact', the PEPFAR team is proposing to focus on achieving the UNAIDS 90-90-90 goals at current treatment guidelines within 27 high burden scale-up districts by 2017. These districts include 74 percent of the overall South African population and, as per the 2014 EA, accounted for 73 percent of the district level PEPFAR expenditures.

PEPFAR and the South African government are currently engaged in development of HIV and TB District Implementation Plans that will guide further focus of high impact activities within the 27 scale-up districts.

These goals will require, by 2017, reaching 4.2 million individuals on ART in these districts where, as of September 2014, there were a reported 2.2 million people on ART (2.7 million receiving ART nationally). Given the planned budget reductions, accelerated targets for COP15 were calculated to achieve at least 70 percent of this goal in FY 2016. It is estimated that this will require testing 13.6 million people over a period of two years. As per the COP15 planning level letter, 55 percent of the budget is allocated to care and treatment programs that will focus primarily in these scale-up districts. The PEPFAR program is expecting to expend an estimated $55 per patient in focus districts, higher than historical per patient expenditure. Scaling up focused HTC programming in these select districts will also support the identification of the HIV status of 90 percent of the

estimated 2.2-2.6 million HIV-infected individuals who do not know their status in those districts. From an analysis of epidemiology and EA data, an estimated $18.5 million[15] will be allocated to support HTC programs in the 27 scale-up districts to achieve the above-stated targets, through cost savings and increased yield of PLHIV identified and linked to services. Estimated HIV prevalence and proposed sites for COP15 PEPFAR support in scale-up districts are presented in the following figure:

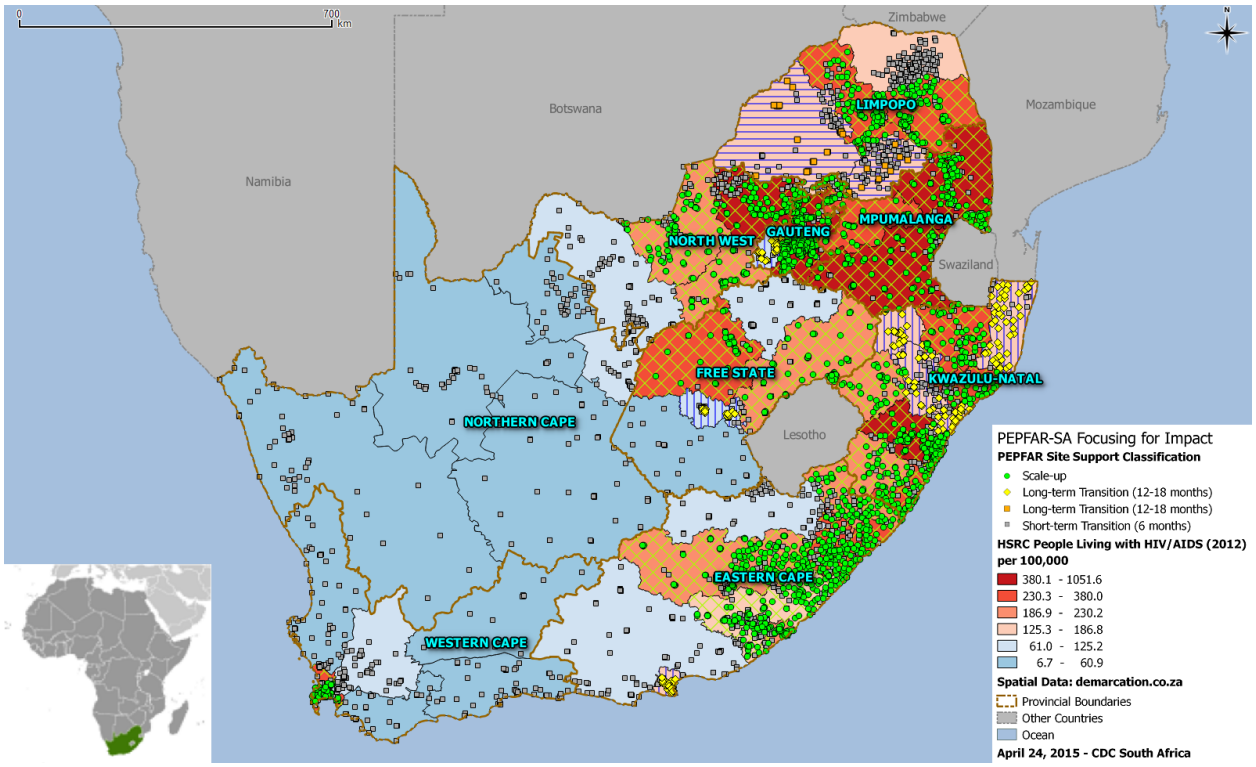

Figure 3.0.1: PLHIV + Districts + Sites

Populations PEPFAR will prioritize are:

- **PMTCT**: PMTCT targets developed for these districts will result in 743,386 pregnant women being tested for HIV and 98% of those infected with HIV being initiated on ART (i.e., Option B+). PEPFAR partners will provide TA and capacity building to districts, facilities and communities using the four-pronged approach for PMTCT. Transition plans will be conducted in 170 high volume sites outside of the 27 scale-up districts, while low impact activities will be transitioned to the South African government. Transition plans will be developed and implemented for all low burden districts/sites.
- **Uncircumcised males:** Modeling studies suggest that men, aged 15-34, who are uncircumcised, are a priority population. Investments in VMMC will maximize epidemic impact through saturation of interventions in 27 high burden districts, as well as sub-districts with low MC prevalence.

[15] Note that an estimated 20-25 percent of the total care, treatment, and HTC budget will be allocated to supporting 'above-national' and 'national' level expenditures and would not be attributable to individual level patient achievement reporting.

- **Key Populations**: Modelled estimates indicate that 9.2 to 19.8 percent of new infections are attributable to MSM and FSW behavior, respectively. This is corroborated by recent integrated biological and behavioral surveillance (IBBS) data which reported extremely high HIV prevalence among FSW. Though limited, size estimation efforts indicate that the majority of key populations are located within sub-districts in a sub-set of the 27 scale-up districts. More comprehensive mapping activities are being planned by PEPFAR and The Global Fund. Other priority populations that are at higher risk for HIV include migrant populations, truckers and other clients of sex workers, and those living in informal settlements.
- **OVC**: The OVC TWG conducted an analysis of the OVC burden and determined the districts with the highest OVC burden. These areas were largely aligned with the PEPFAR focus areas. Most OVC partners are already working in high prevalence districts based on the recent selection of new OVC partners.
- **Male Inmates**: The total Department of Correctional Services (DCS) inmate population is estimated at an average of 160,000 inmates at any given time; however, due to inmate turn-over and high numbers of awaiting-trial offenders the total population is estimated at 320,000 per year. While the epidemiology in DCS is not yet well understood, there is evidence of association between incarceration and increased risk for sexual assault, risky sexual behavior, acquisition of HIV and treatment interruption issues.
- **Miners and Peri-mining communities**: In South Africa there are about 41,000 cases of active TB reported in the mines every year (8 percent of national total, 1 percent of population). This is the highest incidence of TB among a working population group in the world. There are about 500,000 miners in South Africa and about 5 million people live in peri-mining communities. TB in the mining population is due to a combination of occupational exposure as well as community acquisition, and high HIV rates. Continuous exposure to silica dust in gold mines heightens one's risk for developing TB disease. This is further compounded by the HIV epidemic, and prevention activities in these areas include intensified HTC, MMC, and services to the FSWs.
- **Military Personnel**: Although the true HIV prevalence in the South African National Defense Force (SANDF) is unknown, estimates range from 8.5 to 17.5 percent. The military is composed of members from all geographic (risk) areas. Military risk includes repeated deployments to high risk areas despite residence in (possibly) low-risk areas. A mobile population, often away from their home environment, governed more by peer pressure than social convention, is surrounded by opportunities for casual sex and is inclined to take risks. High risk behaviors include alcohol abuse/binges and liaisons with SWs due to expendable income. As the military health system is not linked to district health systems and military epidemiology is not linked to local geography, this program supports a national system, and is not bound to the 27 identified sub-national units (SNUs).
- **Adolescent Girls and Young Women**: Despite considerable progress in the overall global HIV/AIDS response, females aged 15-24 years continue to be at high risk for HIV infection. Globally, 15 percent of women living with HIV/AIDS are aged 15-24, with 80 percent living in sub-Saharan Africa. AIDS is the leading cause of death for adolescent girls in Eastern and Southern Africa (Nabukkalu, 2013). Among these countries, South Africa has the highest number of estimated new HIV infections per week (2,363) among adolescent girls and young women aged 15-24 years (UNAIDS, 2013). According to HSRC (2012), adolescent girls aged 15-19 years are up to 8 times more likely to be infected by HIV, while young women aged 20-24 years are more than 3 times more likely to be

infected with HIV than males in the respective age groups. Prevention efforts to date have failed to reach this population effectively. An urgent response that supports a shift in programming is needed to keep adolescent girls and young women healthy, educated, safe, and resilient. As such, PEPFAR South Africa aims to aggressively address HIV incidence among this population to achieve an AIDS-free generation.

4.0 Program Activities for Epidemic Control in Priority Locations and Populations

4.1 Targets for priority locations and populations

The team assessed programmatic and financial feasibility based on program data, 'coreness' and the FY 2015 budget of $413 million. To determine resource needs two key components were required – target calculations and unit expenditures. Given the priority to achieve epidemic control, PEPFAR calculated targets and unit expenditures for HTC as well as ART. Historically, HTC, ART and related support services represent approximately 60 percent of the total PEPFAR program budget. HTC targets to yield 90 percent of HIV-infected persons knowing their status for each district were estimated using the following formula: Care-New+Estimated LTFU/district positivity rate.

From EA data in 2014, PEPFAR noted that Gauteng unit expenditure for adult ART was at $41 per patient, Kwa-Zulu Natal at $19, compared with Northern Cape which topped at $94. Combined with prevalence and burden, EA data was taken into consideration when finalizing geographic prioritization to afford cost savings and scale up.

ART needs and targets for epidemic control were based on the above-described PLHIV diagnosed estimates and within the context of national guidelines. A new element contained in the 2015 COP is the proposal to pilot universal test and treat (UTT) programs in select sub-districts where the DREAMS initiative will be implemented, upon concurrence of the South African government. PEPFAR plans to work with government counterparts and other stakeholders to develop proposals and the necessary consensus for successful UTT pilots. The 2014 (October 2013 to September 2014) PEPFAR APR, EA, as well as costing data were available for specific interventions and used to determine unit expenditures to project future resource needs.

PEPFAR will transition out of providing direct funding to no/low yield sites and sites in low prevalence/burden geographic areas by the end of FY 2015. Services will be phased out in non-scale-up SNUs and at sites with marked or consistent underutilization relative to other sites, as indicated by higher unit expenditures and lower service volumes. By improving ground-level demand creation, PEPFAR expects to utilize key sites more effectively. No common issues were noted during the Site Improvement Monitoring System (SIMS) visits, and none had >50 percent red or yellow scores.

Table 4.1.1 ART Targets in Scale-Up Districts for Epidemic Control					
SNU	**Total PLHIV**	**Expected current on ART (APR 15)**	**Additional patients required for 80 percent ART coverage**	**Target current on ART (APR 2016)**	**Newly initiated in FY 2016**
Eastern Cape					
Alfred Nzo District Municipality	102,719	48,066	27,316	58,572	19,292
Amathole District Municipality	98,884	52,401	28,061	55,856	11,834
Buffalo City Metropolitan Municipality	103,943	49,084	30,104	58,532	18,228
Chris Hani District Municipality	110,030	46,068	35,346	60,916	23,985
Oliver Tambo District Municipality	163,793	88,127	35,700	95,,755	21,991
Free State					
Lejweleputswa District Municipality	122,038	45,020	48,493	64777	29,473
Thabo Mofutsanyane District Municipality	114,282	57,570	29,431	37,830	5,674
Gauteng					
City of Johannesburg Metropolitan Municipality	533,960	254,034	142,839	304,222	95,822
City of Tshwane Metropolitan Municipality	352,182	161,762	98,556	19,9351	67,492
Ekurhuleni Metropolitan Municipality	468,521	215,909	131,622	265,052	88,901
Sedibeng District Municipality	205,035	59,575	86,503	107,322	63,845
KwaZulu Natal					
eThekwini Metropolitan Municipality	516,167	334,587	55,905	318,737	47,811
Harry Gwala District Municipality	97,684	46,199	26,074	55,673	17,825
Ugu District Municipality	147,379	74,434	33,153	85,850	24,294
uMgungundlovu District Municipality	225,284	112,592	48,736	13,1814	38,994
Uthukela District Municipality	116,758	59,836	28,569	67,322	17,585
Uthungulu District Municipality	166,927	99,780	18,323	103,006	18,677
Zululand District Municipality	176,355	79,615	49,034	99,921	35,294
Limpopo					

Capricorn District Municipality	121,410	57,178	40,005	66,915	19,774
Mopani District Municipality	132,069	65,692	34,185	75,589	21,235
Mpumalanga					
Ehlanzeni District Municipality	286,246	160,457	62,224	167,393	32,045
Gert Sibande District Municipality	211,236	95,110	72,988	115,407	37,608
Nkangala District Municipality	128,986	83,434	29,055	75,124	11,269
North West					
Bojanala Platinum District Municipality	211,339	98,234	54,295	121,082	41,010
Dr Kenneth Kaunda District Municipality	101,877	51,843	28,203	57,759	14,580
Ngaka Modiri Molema District Municipality	115,103	47,977	32,774	64,985	26,755
Western Cape					
City of Cape Town Metropolitan Municipality	177,587	134,789	258	115,354	17,303
Total	5,307,794	2,570,045	1,501,480	3,040,635	961,082

Table 4.1.2 Target Populations for Newly Initiating ART Patients in Scale-Up Districts

Target Populations	Tested for HIV (in FY 2016)	Identified Positive (in FY 2016)	Enrolled on ART (in FY 2016)
Clinical care patients not on ART	5,411,550	649,386	591,997
TB-HIV Patients not on ART	224,823	134,894	125,911
HIV-positive Pregnant Women	743,386	176,596	176,341
Other priority and key populations*	952,029	114,244	66,833
Total	7,331,788	1,075,120	961,082

**Community HTC*

Table 4.1.3 VMMC Coverage and Targets by Age Bracket

Target Populations	Population Size Estimate (priority SNUs)	Current Coverage Sept. 30, 2015 (projected)	*VMMC_CIRC* (in FY 2016)	Expected Coverage (in FY 2016)
Males 15-24	1,926,762	42 percent	166,132	55.2 percent
Males, other than 15-24	2,352,931	42 percent	142,466	55.2 percent
Total/Average	4,281,693	42 percent	308,598	55.2 percent

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control services.

	Target Populations	Population Size Estimate (Priority sub-districts)	Coverage Goal[16] (in FY16)	FY16 Target
1	Females 10-14	324,803	13 percent	42,637
2	Females 15-19	362,433	22 percent	79,248
3	Females 20-24	315,550	11 percent	35,204
4	Females 25-49	1,407,169	6 percent	79,098
5	Males 10-14	302,330	13 percent	40,297
6	Males 15-19	329,649	23 percent	74,422
7	Males 20-49	1,945,016	6 percent	113,904
8	Truck drivers - specialized sites	1,700	80 percent	1,360
9	Migrant Farm workers	NA by district	NA by district	48,300
10	Inmates	4,800	72 percent	3,490
11	Military	7,600	26 percent	2,000
12	FSW	37,568	30 percent	20, 890
13	MSM	104,309	22 percent	29,639
14	PWID	4,234	31 percent	1,344
	Total	5,001,051	N/A	575, 913

Table 4.1.5 Targets for OVC HIV Testing, Care and Treatment					
Estimated # of Children PLHIV (<15)	**Estimated # of OVC**	**Target # of active OVC (FY 2016 Target)**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services (FY 2016 Target)**	**Target # of OVC tested (FY 2016 Target)**	**Target # of OVC on ART**
385,016	3,963,804	664,119	549,607	494,646	10,684

COP15 will prioritize specific populations at high risk of HIV infection and with high ART need, including Adolescent Girls and Young Women (AGYW). Through the DREAMS Initiative, PEPFAR will fast track prevention interventions for AGYW in five high burden in alignment with the PEPFAR South Africa geographic focus for impact plan to leverage PEPFAR clinical/PMTCT platforms as well as community platforms, while simultaneously aligning to the PEPFAR Care and Treatment portfolio in the selected districts. The table below reflects a summary of locations where holistic services or coverage of the DREAMS package' (including piloting test and treat) using ANC positivity and district PLHIV data) will be implemented.

[16] The prevention aim was to reach 80% of these populations, but the limited budget prohibited this, and targets were adjusted accordingly.

DREAMS Focus Sub-Districts[17]	ANC Positivity data (DHIS July 2014)[18]	Number of Sites	District PLHIV (est.)[19]
Gauteng			
City of Johannesburg Metropolitan Municipality	13.4 percent	71	510,005
Johannesburg A Health sub-District	11.1 percent	13	
Johannesburg D Health sub-District	13.8 percent	28	
Johannesburg E Health sub-District	11.9 percent	10	
Johannesburg G Health sub-District	15.7 percent	20	
Ekurhuleni Metropolitan Municipality	13.2 percent	51	460,878
Ekurhuleni East 2 Health sub-District	10.2 percent	16	
Ekurhuleni North 2 Health sub-District	14.9 percent	17	
Ekurhuleni South 2 Health sub-District	13.1 percent	18	
KwaZulu Natal			
eThekwini Metropolitan Municipality	15.5 percent	109	512,912
eThekwini Metropolitan Municipality Sub	15.5 percent	109	
uMgungundlovu District Municipality	14.9 percent	45	217,801
Impendle Local Municipality	14.4 percent	2	
Mkhambathini Local Municipality	13.6 percent	2	
Mooi Mpofana Local Municipality	13.9 percent	1	
Richmond Local Municipality	11.9 percent	3	
The Msunduzi Local Municipality	14.8 percent	25	
uMngeni Local Municipality	18.7 percent	5	
uMshwathi Local Municipality	14.3 percent	7	
Umkhanyakude District Municipality	18.0 percent	12	87,618
Hlabisa Local Municipality	21.9 percent	4	
Mtubatuba Local Municipality	16.0 percent	8	
Grand Total	14.7 percent	288	1,789,215

4.2 Priority Population Prevention

The PEPFAR prevention program aligns with the South African government's NSP. PEPFAR partners will provide prevention services to target populations in the 27 scale-up districts. This focus will ensure that various entry points for prevention services are properly utilized such as HTC, PMTCT, GBV, VMMC, and treatment platforms. Referring and linking patients to the appropriate HIV services is important for PEPFAR-supported programs to succeed and enhance the impact of government- led initiatives to achieve epidemic control. Prevention activities will address the specific needs among priority populations by age, sex, and risk profile, through demand creation and risk-reduction interventions. PEPFAR will continue to employ high impact

[17] Dreams focused Sub-Districts
[18] Antenatal clinic program data, July 1, 2013 – June 30, 2014
[19] Estimated numbers of PLHIV in the district (*South Africa National Prevalence, Incidence, and Behaviour Survey, 2012*).

combination prevention approaches targeted at diagnosed and undiagnosed priority and key populations in scale-up districts.

PEPFAR investments are based on national epidemiological data on HIV incidence and prevalence rates. The priority prevention program will focus on: adolescent girls (incidence for this group is eight times higher than for males by age), young women partners of young women and potential perpetrators of sexual violence, mobile and migrant populations, clients of sex workers, truckers, and male inmates. Adolescents located in priority high burden districts (specifically in informal settlements and "hot spots") will be targeted with age-adapted sexual and reproductive health (SRH) services. School and community-based sexuality and HIV prevention interventions will be focused at reducing risky behaviors. Parents and caregivers will also be empowered to support children through evidence based parenting interventions. Leveraging with the DREAMS Initiative, adolescent girls and youth will be identified at the community level to receive HTC, ART, HIV and pregnancy prevention services and increase awareness of GBV services, in addition to behavioral risk reduction inventions.

Key populations remain important high-risk groups in need of services. PEPFAR is strengthening efforts to target MSM, SW and their clients and partners to address, the challenges of marginalization and poor access to HIV services. PEPFAR will also support a demonstration project targeted at People who Inject Drugs (PWID) in three South African cities. This is the country's first intervention to build evidence to inform policy and practice.

In the next two years, evidence-based prevention interventions suitable to the South African context will reach close to 80 percent of target populations in scale-up districts. The shift from largely single-encounter small group interventions to more multi-session, structured and evidence-based interventions will improve health outcomes. PEPFAR will conduct quarterly site visits and Site Improvement Monitoring System (SIMS) visits, to monitor program implementation and quality of care.

4.3 Voluntary medical male circumcision (VMMC)

Approximately 1.8 million of the 4.3 million VMMCs targeted for December 2016 by the South African National Department of Health were performed. The Minister of Health revised the target to 1.6 million VMMCs to be completed between April 2015 and March 2016. Given that PEPFAR represents approximately 54 percent of the VMMCs performed in South Africa, and currently delivers VMMC operations in 49 of 52 districts, there is an expectation that the PEPFAR team will expand its service delivery and demand creation activities. Based on the technical considerations and the South Africa modeling work (DMPPT 2.0), PEPFAR will focus on achieving the greatest magnitude and most immediate reduction in HIV incidence by prioritizing circumcision of older adolescent and young adult males. It will further focus on supporting MMC sites in districts that have the greatest unmet ART need, based on the PEPFAR SA ART-need analysis.

PEPFAR will prioritize VMMC investments to maximize epidemic impact through:

- Mapping services to SNUs with the highest HIV prevalence and low male circumcision prevalence, in coordination with ART scale up.
- Focusing demand creation and service design on reaching clients 15-34 years, those most at risk of acquiring HIV heterosexually.
- Reaching highest risk sub-populations of the VMMC eligible population.

To meet ambitious targets, the program will actively engage with targeted communities and the private sector, particularly with stakeholders in male-dominated industries (e.g., mining) where there is low uptake. PEPFAR will also work with private medical health schemes to provide insurance for VMMC services. Through a Public-Private Partnership (PPP), PEPFAR is training private general practitioners (GPs) to provide high quality MMC services as part of a HIV prevention package. VMMC will continue to be offered as a package of services, i.e., as part of combination prevention and treatment referrals. In most facilities PEPFAR-funded project staff works closely with NDoH staff, building their capacity to implement high volume facility-based VMMC services. PEPFAR also provides TA for the development of a national MMC M&E/Quality Assurance (QA) system. Procurement of MMC kits will be closely monitored to ensure cost effective mechanisms and strong distribution systems.

Targeted demand creation, led by community-based teams will help address cultural sensitivities around VMMC and the seasonality of male circumcision, which results in peak circumcision demand during winter (June-August) and relatively low facility utilization in the summer (December–February). Hard-to-reach populations are served by outreach facilities, mobile services or through organized bussing men to MMC sites.

4.4 Prevention of mother-to-child transmission (PMTCT)

As of January 2015, South Africa started implementing revised and consolidated PMTCT guidelines across all program areas. The revisions include the adoption of Option B+, virological monitoring at baseline for pregnant women already on ART, and targeted birth PCR and 12 weeks extended NVP/dual prophylaxis for babies born from high risk mothers. Option B+ will strengthen the broader maternal and child health (MCH) services including infant feeding practices for HIV-free survival and HIV-infected babies. Furthermore the guidelines advocate for a family-centered approach for mother and infant pairs, which offers an opportunity for male partners to accompany them for HIV testing and linkages to VMMC services and treatment. The NDOH has also developed a process to create 90 90 90 plans for each district which includes all components of the new guidelines as well as district cascades, targets, action plans and dashboards for both district and facility level.

In 2016, PEPFAR will focus on supporting high burden scale-up sites/districts (identified using epidemiological and program data such as: ANC HIV prevalence, high OVC burden, high unmet ART need, routine performance data, and the MRC-Led SA PMTCT effectiveness of 2012) with high impact and evidence-based activities. These TA and capacity building activities aim to improve service delivery and program monitoring. Given the progress made by the SA PMTCT program, activities classified as core below were agreed upon with the South African government and PMTCT counterparts:

- Continued support for the roll-out of Option B+ and for the HMIS to reflect the shift.
- Focus on joint tracking, adherence and retention of mother and infant pairs.
- Improving the M&E system using dashboard indicators at facility and community levels.
- Strengthening integration and linkages in maternal, newborn, child and women and nutritional services.
- Quality improvement (QI) and rapid HIV Quality Assurance (QA) interventions.
- Strengthening community linkages and supply chain management.

PEPFAR will be refocusing support to high burden scale-up sites/districts, while long term, and shorter term transition plans will be developed as appropriate for low burden transition districts and sites. Rapid testing, QA and QI will be integrated into the program. Additionally, using the Investment Case framework, PEPFAR will work with other donors such as UNICEF, UNFPA, WHO, and The Global Fund to leverage resources appropriately, develop joint plans and build capacity at Regional Training Centers (RTCs), district, facility and community level using a robust mentorship program. PEPFAR will assess the feasibility of using routine PMTCT data for surveillance to replace the SA PMTCT effectiveness for sustainability. TA activities will be implemented in collaboration with the DREAMS Initiative to improve identifying and linking adolescents and youth to PMTCT interventions that impact long term targets. Additionally, Mom Connect and the Partnership for HIV Free Survival (PHFS) involving UNICEF and other partners will focus on tracking mother infant pairs during ANC and post-natal care. All these interventions are expected to improve early ANC attendance, adherence, and retention of HIV infected pregnant women and lactating mothers on treatment.

The roll-out of Option B+ will increase the threshold of pregnant women eligible for ART and hence potentially increase the number of stock-outs of ARVs. To mitigate these concerns, PEPFAR has contracted a partner to provide TA and capacity building activities at the national level to support the South African government's supply chain management (SCM).

Community-based interventions to strengthen the four-pronged strategy and the continuum of care will be included in the increased support for scale-up sites/districts. District/facility and prevention partners will support facility managers to improve collaborative efforts between facility providers and community based partners (OVC, community care givers (CCGs), community-based organizations (CBOs), peer educators, mother support, clinic committee, and communities). All HIV infected babies should be referred for assessment by OVC services (social services). Communities will be empowered to form support groups for mothers to address gender-based violence (GBV) and adherence and retention in care.

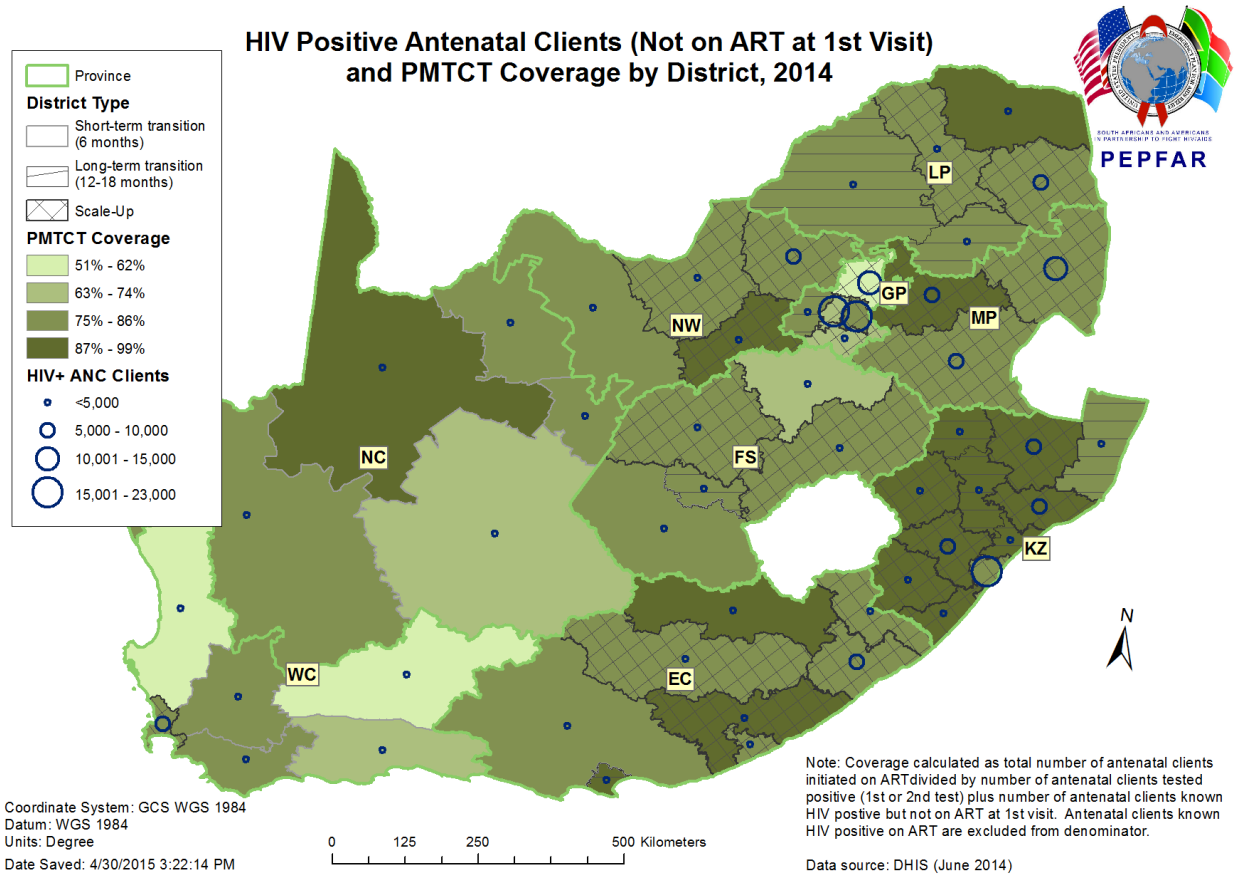

Figure 4.4.1: HIV-Positive Antenatal Clients and PMTCT Coverage by District, 2014

4.5 HIV Testing and Counseling (HTC)

The revised National HTC Policy guidelines, to be issued during FY 2016, will focus on the expansion of HTC models of service delivery beyond facility-based HTC. This approach will aim to increase access to and coverage of services and to maximize efficiency, impact and equity. Implementation of a combination of HTC models will be based on an analysis of South Africa's epidemiological, social, and programmatic context. A revised HTC register will be used concurrently to collect data on key populations, couples tested, as well as the HTC yield by the different modalities. In addition, NDOH has embarked on a process to develop district based testing cascades, targets, action plans and dash boards with support from PEPFAR partners.

South Africa has increased the availability of HTC services in public health facilities, with 66.2 percent utilization by the population. In priority districts, the variable number of PLHIV that know their status demonstrates the need for a more targeted and integrated community-based HTC to identify new PLHIV. District data on HIV prevalence, number of new people to be enrolled on care; estimated number of those lost to follow-up; average number of PLHIV not aware of their status, HTC yield, as well as estimated number of unmet ART need, were taken into consideration to calculate the required number of new HIV diagnoses in order to reach the 90 percent HIV treatment coverage in high burden scale-up areas. PEPFAR SA will test 13.6 million

people over a period of two years through intensifying high yield HIV testing modalities in the 27 scale-up districts. The focus will be to identify PLHIV for treatment initiation.

The implementation of a variety of core HTC activities will include a comprehensive package of HTC services targeting priority populations, including AGYW and their male sex partners, key populations, and OVC in high transmission areas and hotspots in community settings. PEPFAR partners will tailor program interventions through to scale-up high-yield modalities such as different models of home-based HTC, index-client model, activities that increase effective linkages such as Point of Care (POC) CD4 testing in community-based settings, as well tracking and tracing identified PLHIV and linking them to treatment and care services and fast-tracking referral for HIV treatment for discordant couples. PEPFAR will also support activities to increase HTC impact, including training in QA and HTC data triangulation, technical support to NDOH for national guidelines for linkages, and limited support for targeted HTC campaigns in PEPFAR focus districts. In facility-based settings, increased TA will be provided for scaling up and strengthening Provider-Initiated Testing and Counseling (PITC) service delivery and reporting in high volume sites within the 27 scale-up districts and in high volume sites identified for longer term transition (in nine districts). PEPFAR will support activities for improved HIV diagnostics services and quality of HTC services through training in QA/QI in collaboration with the Laboratory and Blood-safety program.

HTC forms a critical part of the DREAMS package of services. PEPFAR partners will implement interventions that will support the objectives of this initiative to reach adolescent girls and youth through HTC interventions in priority districts. In facility-based settings, increased TA will be provided for scaling up and strengthening Provider-Initiated Testing and Counseling (PITC) service delivery and reporting in high volume sites within the scale-up and the sites for longer-term transition (in nine additional districts).

In order to determine resources required to support HTC activities and targets, the following assumptions were made: i) sites with similar HTC yield have roughly the same capacity and positivity rates; ii) facilities with similar yield and positivity rates fall within the same range of unit expenditures (UEs) for HTC and also that different HTC modalities in community settings have on average varying unit expenditures; iii) increased access, acceptance and uptake of HIV testing due to recent changes in national treatment guidelines; iv) scale-up of TA to increase HTC and treatment coverage of pediatric and adolescent services will occur through PITC; v) community-based HTC targets will be obtained through collaborating with other programs including OVC and VMMC; and vi) combination prevention for demand creation and linkages between community and facilities will support the cascade.

Efficiencies were identified through assessment of EA data and partner reports, budget review and analysis by HTC modality and priority areas, consolidated demand creation efforts, and streamlining the systems for linkages in order to leverage resources. For example, in COP14, PEPFAR SA supported HTC services at facilities and sites in all 52 districts with varying positivity rates and yields. For COP15, the program will be implemented in 27 scale-up districts that have an estimated 1,970 facilities with an average HIV positivity rate of 12.1 percent. Additionally, above-site support through TA is provided to correctional facilities to extend the reach of HTC.

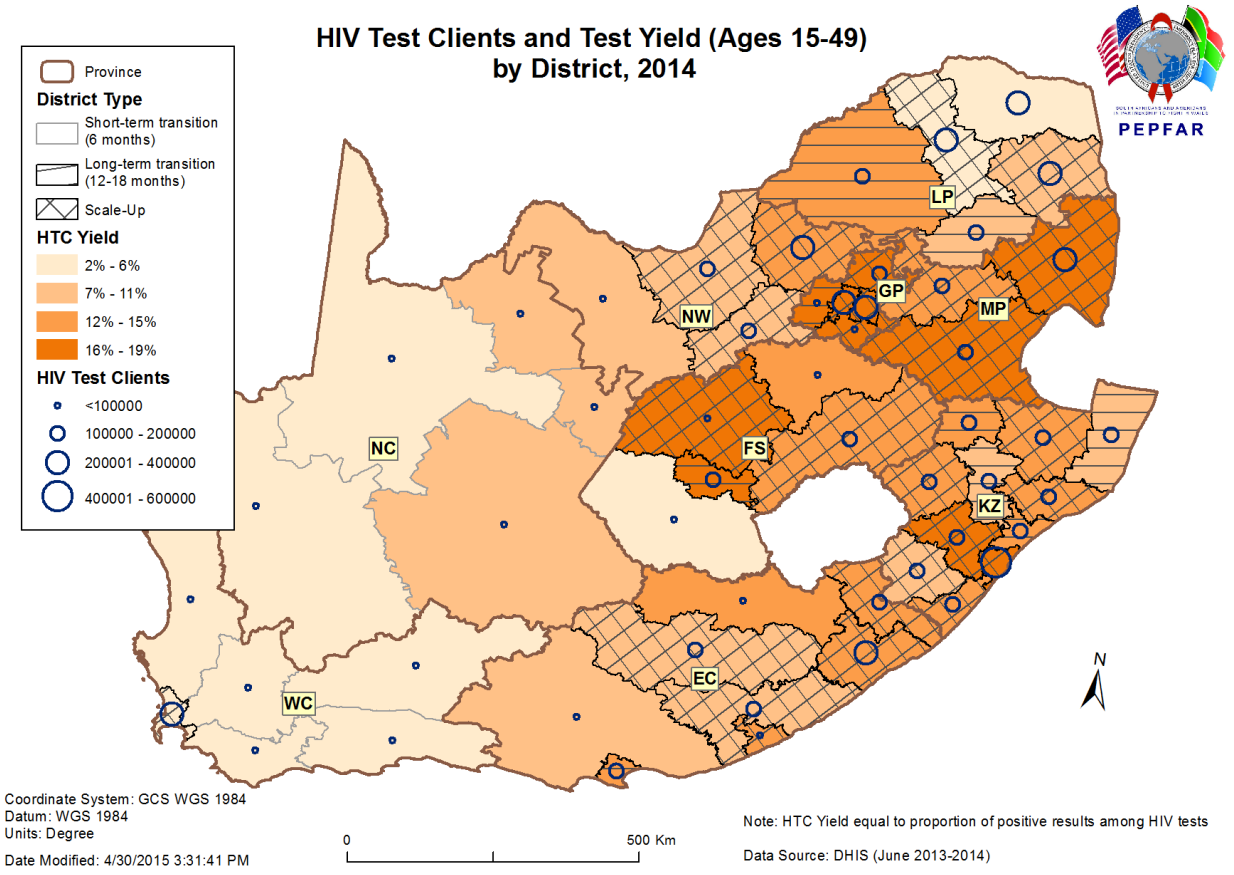

Figure 4.5.1: HIV Counseling and Testing Yield and Coverage by District, 2014

4.6 Facility and community-based care and support

South Africa has endorsed the 90 90 90 process and has required that each of the 52 districts develop District Implementation Plans (DIP) to focus plans using data. The NDOH led process is supported by UNAIDS and PEPFAR and includes district based cascades for each program area, targets and a dash board. In addition, high volume clinics have a "three-foot approach plan" which is an assessment of poor performing indicators, action plans for facilities and communities and dash boards.

The 2015 Consolidated ART Guidelines for PMTCT and the Management of HIV in Children, Adolescents and Adults in South Africa, cites two key leakages in the treatment cascade: adult patients lost between a positive HIV test and the CD4 test, and those lost between the CD4 test and the return visit for the result. Access to care and treatment services for pediatric HIV cases and poor clinical outcomes also pose significant challenges for the program.

In COP15, PEPFAR will strengthen district and service delivery systems by providing targeted TA through specialized provincial and national partners. TA will be provided to support the provision of the minimum package outlined below to ensure high impact care and support activities linked to epidemic control in the facility and community settings (where appropriate):

- Regular clinical and laboratory monitoring, including WHO staging, and CD4 count and/or viral load, per country guidelines.

- Screening of TB clinic clients with HIV testing and clinical care, including fast-tracking for initiation of ART for PLHIV with TB.
- CTX prophylaxis for those who are eligible, per country guidelines.
- Implementation of the adherence and retention strategy to optimize positive health outcomes for those on ART.
- Intensified nutrition assessment, counseling, and support (NACS) case findings for acute malnutrition.

These evidence-based interventions are also outlined as key strategies in the South African National Adherence Guidelines for HIV, TB and Non-Communicable Diseases, which will be finalized in 2015. Specifically, facility-based priorities include: an increased focus on loss to follow-up (LTFU) through early tracing of missed appointments and defaulters, the expanded roll-out of the Integrated Access to Care and Treatment (I-ACT), improved education and counseling for newly diagnosed PLHIV, routine decanting of stable patients to CBOs for adherence support, non-clinic based dispensation of medication including courier services, effective running of a spaced, fast-lane appointment system, enhanced adherence counseling and inclusion of the private sector GPs. PEFPAR and its IPs will be instrumental in supporting the implementation of these guidelines, with a prioritization of high burden sites and community health systems strengthening.

PEPFAR will also place an increased focus on community-based interventions to strengthen retention and adherence to ART services. I-ACT partners will facilitate the formation of support groups for adults at the community and facility levels. Stable patients will be referred to community-based partners for continuous monitoring on ART. For effective tracking of adults on ART, the facility manager will link with, e.g. the Ward-Based Outreach Teams (WBOT), CCGs, etc. Key populations will be reached through mobile clinics, CBOs, OVC programs and referral networks, WBOTs and through outreach activities by prevention partners. PEPFAR initiated its first SIMS visits in August 2014. A total of 45 CDC and 32 USAID facility and community visits were conducted by the end of 2014. Due to the limited number of visits so far, a meaningful analysis of Core Essential Elements (CEEs) and scores is challenging. However, plans to follow-up with partners scoring >50 percent red or yellow are already under development. A strategy will be fully implemented in the next year.

The multiple intervention platforms, human resources and investments will be leveraged to strengthen linkages across the continuum of care from services provided and data generated from central initiatives underway in South Africa, such as DREAMS. Resources will be targeted to offer the most critical curative and preventative services (behavioral and biomedical) at facility and community level, with a particular focus on girls and younger women as well as key populations. Groups at the highest risk of HIV/AIDS transmission often face limited access to services (see Section 4.2. Priority Population Prevention); PEPFAR will continue to customize interventions to ensure that these clients have access to needed health services.

4.7 TB/HIV

The TB/HIV program is primarily funded by the South African government, PEPFAR, and The Global Fund. The NDoH 90-90-90 TB strategy advocates for the following: i) symptomatic TB screening of at least 90 percent of all vulnerable groups; ii) diagnostic evaluation of those suspected of having TB with initiation on treatment of at least 90 percent of confirmed TB cases; and iii) 90 percent treatment success rate of those on treatment. The vulnerable populations

include PLHIV, children, prisoners, miners, and peri-mining communities. NDOH is leading the DIP process which includes TB/HIV cascades, targets and action plans for each district.

With increased domestic funding for TB/HIV, the South African government is funding most of the TB/HIV activities including prevention, care and treatment, and laboratory services. PEPFAR supports TA to the South African government, including infection control, program electronic data systems, quality improvement and M&E in the National TB Program, the scale up of decentralized approaches to managing drug resistant TB, and focused case detection and treatment for peri-mining communities and prisons. PEPFAR also supports the procurement of diagnostic equipment. The Global Fund is primarily funding the decentralization of MDR–TB services and TB control in correctional facilities.

In FY 2016, PEPFAR will support the South African government in achieving the 90-90-90 TB and HIV targets. PEPFAR supports TB/HIV service delivery through training, capacity building, coaching, and mentoring, including:

- TB screening for PLHIV, children under five, pregnant women, prisoners, miners, and per-mining communities.
- INH prophylaxis for all HIV+ populations.
- Laboratory investments for TB/HIV, including limited GeneXpert equipment, test kits, other consumables and other TB diagnostics (biosafety cabinets, AFB smear and culture) for the purpose of training and mentoring activities (not roll-out).
- Screening of TB patients with HIV testing and clinical care, including fast-tracking for initiation of ART for PLHIV with TB.
- Services that target TB/HIV activities in special populations such as pediatrics, prisoners, miners, and per-mining communities.
- Human resources to accelerate planning and implementation of collaborative TB/HIV activities, including site-level integration of TB and HIV activities.

Activities will focus on priority districts for epidemic control, screening, and prevention of TB, as well as TB/HIV management for co-infected patients, and will focus on the following technical priorities:

- HIV testing for all TB suspects and immediate ART for all co-infected patients.
- TB symptom screening for all PLHIV, and all children, pregnant women, prisoners, miners, and peri-mining community members.
- Active follow-up of co-infected patients to ensure treatment completion, and provision of IPT for PLHIV who do not have TB.
- Strengthened integration of TB/HIV clinical services to ensure linkage and retention.TB infection prevention and control in communities, healthcare and congregate settings.
- Strengthened M&E through TB and HIV systems integration (TIER.net, ETR.net, and EDR.web).

To ensure sustainability of the TB/HIV response, PEPFAR collaborates closely with the South African government, academics, researchers, and private organizations, through the TB and HIV Think Tanks, the Transition Task Team, and PFIP Committees. Communities play a critical role in reducing community transmission of TB and HIV as well as linkage to care and treatment. Through CCGs, CBOs, and Faith-based Organizations (FBOs), communities participate in creating awareness of TB/HIV, infection prevention and control, and adherence to treatment

support. PEPFAR and Global Fund support NDoH to improve diagnosis and treatment of MDR-TB, through decentralization of MDR-TB management and the recruitment of linkage officers who are based in communities. The linkage officers are used to follow-up and trace patients to prevent initial defaulters. Hard-to-reach populations remain a strong focus for the TB/HIV program. These populations will be reached through Mobile Service Units, community outreach teams and the WBOTs. These interventions will contribute to the ultimate goal of increasing ART coverage among TB/HIV co-infected patients to 80 percent and TB treatment success rate of 90 percent by 2016.

4.8 Adult treatment

South Africa has endorsed the 90 90 90 process and has required that each of the 52 districts develop District Implementation Plans (DIP) to focus plans using data. The NDOH led process is supported by UNAIDS and PEPFAR and includes district based cascades for each program area, targets and a dash board. In addition, high volume clinics have a "three-foot approach plan" which is an assessment of poor performing indicators, action plans for facilities and communities and dash boards.

In 2013, South Africa introduced a fixed-dose combination (FDC) regimen to improve adherence and retention, and in 2014, it expanded access by raising the threshold for initiation of ART to CD4 ≤500. The NDoH 2020 targets of 90-90-90 reflect these changes and others to increase access and impact:

- Initiation of ART at CD4 count ≤500 cells/µl. Harmonized ART regimen across populations, mainly for pregnant and breastfeeding women, adolescents and adults.
- ART for all HIV/TB co-infected patients.
- ART for all HIV/hepatitis B (HBV) co-infected patients. Use of simplified FDC regimens for ART.
- Use of viral load for monitoring treatment and early identification of failure.
- Inclusion of guidance on HIV for key populations.
- Cryptococcal screening for all HIV-infected patients with CD4 <100 cells/µl.

With strong progress in HIV treatment coverage nationally since the start of the PFIP (2012), and South Africa reaching a tipping point ratio of about of 0.6 by 2014, PEPFAR will refocus support to high burden scale-up districts for maximum impact in epidemic control going forward. Approximately 78% of the funding and activities in care and treatment are going to be provided at the district level in COP 15. Over the past three to four years, many of the larger treatment partners worked at the above site level or with special populations. These innovation partners' costs were high outliers with UEs five times the district support partner average. As such they will transition and end over the next year. Within scale-up districts, PEPFAR will provide intensive TA and capacity building to districts, facilities, and communities on all core aspects of the care and treatment program (see Appendix Table A.1 and A.2), in order to achieve success in the clinical cascade and reach 90-90-90 targets. Sustained sites (longer-term transition) in nine districts will receive focused facility (only) clinical program support for an 18 month period. Shorter-term transition plans will be developed as appropriate for low burden transition sites and all sites that fall outside PEPFAR scale-up districts. Care and treatment partners will coordinate with the DREAMS initiative by identifying and linking adolescent girls and youth to HIV and SRH clinical services. Where VMMC is co-located in facilities, HIV-positive VMMC candidates identified both in facility and outreach service delivery will be linked to care and treatment.

PEPFAR will provide TA to districts, facilities, and communities on developing DIPs using program specific cascades for targets, action plans and related dashboards. DIPs will include core program strategies, including implementation of the new consolidated treatment guidelines, viral load monitoring, clinical laboratory interface, TB screening, early diagnosis and treatment, implementation of the new national adherence and retention strategy, NACS, DQA/DQI, SCM strengthening, HIV drug resistance, strengthening TIER.net and cohort monitoring, and new strategies to decant stable patients to community follow up. The expansion of treatment access will increase the risk of stock-outs of ARVs and test kits. To mitigate this risk, PEPFAR will continue to provide TA and capacity building at national and local levels to support the South African government's SCM.

There will be increased focus on community-based interventions to strengthen retention and adherence to ART services. I-ACT partners will capacitate strong support group programs at community and facility levels. Stable patients will be referred to community-based partners for continuous monitoring on ART. For effective tracking of adults on ART, the facility staff will link with WBOTs and CCGs (See Section 4.6).

A new element contained in the 2015 COP is the proposal to pilot universal test and treat (UTT) programs in select sub-districts where the DREAMS initiative will be implemented, upon concurrence of the South African government. PEPFAR plans to work with government counterparts and other stakeholders to develop proposals and the necessary consensus for successful UTT pilots.

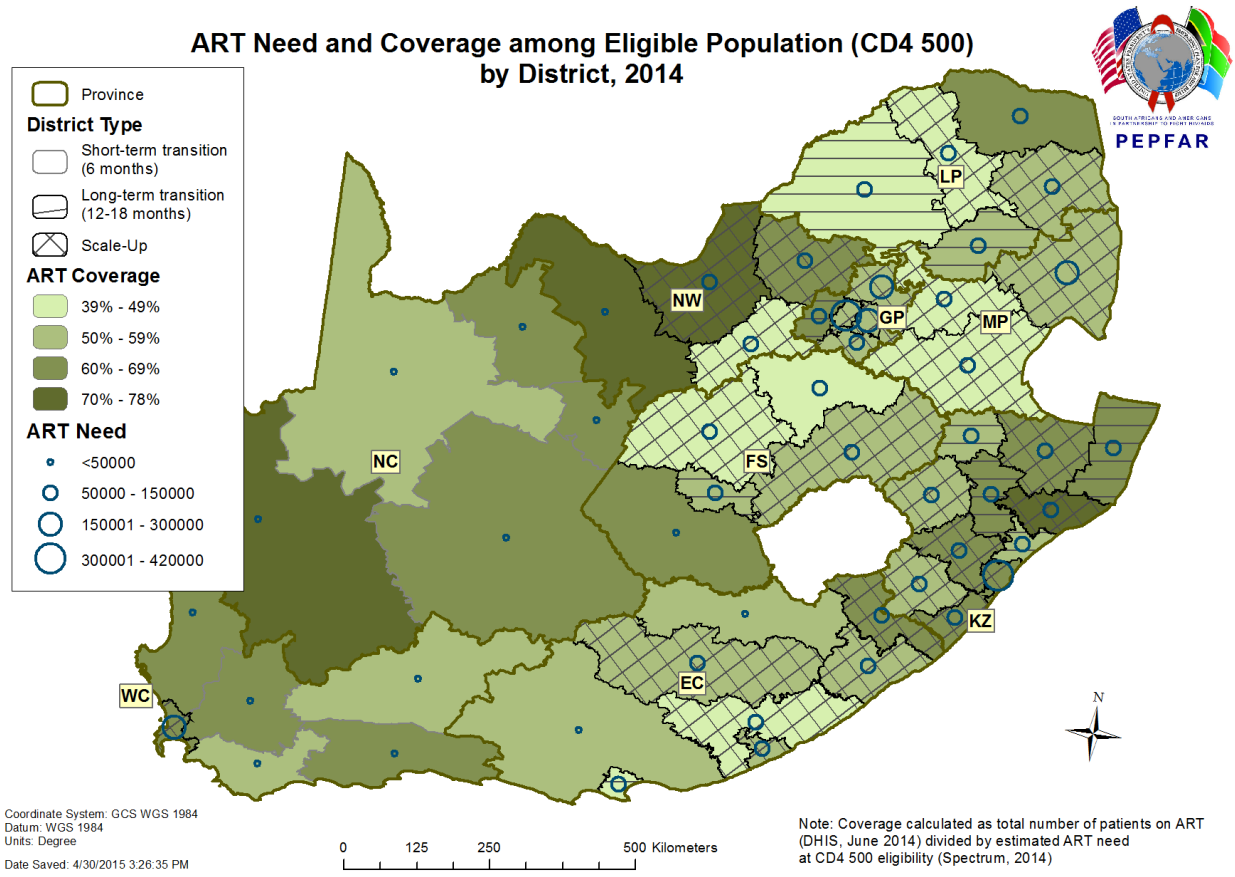

Figure 4.8.1: ART Need and Coverage by District, 2014

4.9 Pediatric Treatment

South Africa revised and consolidated guidelines across all program areas and implementation related to the change in eligibility criteria from CD4≤350 to CD4≤500, in January 2015. All children under five years of age with HIV qualify for treatment. Revisions include:

- Universal testing of children < 18 months.
- Eligibility of children above 5 years with CD4 <500.
- Retention and adherence strategy.
- National roll out of Pediatric I-ACT.
- Benefit from Option B+ as few infants are expected to enroll into care and treatment services.

PEPFAR partners support the implementation of all of these key strategies at both national and district levels. The impact of these changes is that all children will be initiated early to facilitate improved linkages in accordance with PMTCT guidelines and protocols. Although South Africa is not part of the Accelerating Children's HIV/AIDS Treatment (ACT) initiative countries, accelerated treatment for children will be adopted under UNAIDS 90-90-90 strategy, strengthening implementation of the Blueprint for Pediatric Active Enhanced Disease Surveillance (PAEDS), and findings from the NDoH's TB/HIV and PMTCT program evaluation of

2013. PEPFAR partners will provide TA and capacity building to districts, facilities, and communities using the four-pronged approach of PMTCT. In addition, PEPFAR partners will support the development of DIPs which includes district pediatric treatment cascades, targets, action plans and dash boards. Furthermore, through DREAMS interventions, pregnant adolescents and their partners who test positive will be linked to care and treatment to further build resilience and be empowered to adhere to treatment and prevent perinatal and neonatal HIV transmission. The MomConnect initiative will improve tracking and follow-up of mother infant pairs from birth until 18 months and will contribute to improving infant morbidity and mortality rates.

In 2016, PEPFAR partners will provide TA to facilities and districts on core activities including retention and tracking of infants, children and adolescents; improving M&E; SCM and commodities; integration and linkages; and QA and QI. Additionally, the partners will improve integration of SRH with HIV services and community linkages to ensure that early child development centers are reached with activities classified as core.

Key priorities for the next two years include:

- Intensifying HIV/TB/NACS case finding in EPI, TB, malnutrition, IMCI, OVC, inpatients and outpatients programs for all children.
- Improving linkages to HIV care and treatment.
- Increasing support groups for care givers and children to help track defaulters.
- Supporting clinical and lab monitoring of infants, children and adolescents, and improved implementation of adherence and retention strategy.
- Supporting M&E using the PAEDS cascade indicators, QI and QA initiatives, PAEDS HIV drug resistance monitoring, HMIS for PAEDS cohort monitoring, and pharmacovigilance.

South Africa benefits from multiple donors (UNICEF, UNFPA, The Global Fund, etc.) which also support local capacity for the provision of pediatric care and treatments services. PEPFAR supports robust mentorship programs at RTCs and at district, facility, and community levels to improve the quality and sustainability of programs. PEPFAR will also collaborate with other partners to support longer-term transition in sustained sites.

The community has an important role to play in pediatric care. Peer educators, CCGs, WBOTs and CHWs are pivotal to increase HIV testing at the community level, create support groups for care givers and children, and track defaulters. Hard to reach areas in the priority districts will be accessed through mobile units, OVC programs and WBOTs.

4.10 OVC

About 2.4 million children nationwide aged 0-17 were orphaned due to AIDS. The best OVC data available are from the 2011 Census, which estimates 3,963,804 orphans in South Africa, 3,111,285 of whom are located in the 27 focus districts. However, these data reflect all orphans and not only children orphaned by AIDS, and do not include children made vulnerable by HIV/AIDS (e.g., those with AIDS-sick caregivers or living with HIV), and cover ages 0-19. In COP15, 664,119 OVC will be reached. This target is based on OVC burden, HIV prevalence, APR 2014 data, partner capacity and EA data.

OVC programs contribute to the UNAIDS 90-90-90 target by addressing enabling factors essential to successful prevention, care, and treatment. Through structured home visits, HIV

education, referrals and linkages, the OVC program will aim to provide access to HIV services to 90 percent of OVC receiving DSD and 80 percent receiving TA (549,607). Ninety percent of these children will be tested (494,646). Based on HSRC 2012 data, about 2.4 percent of these children (11,872) will test positive. Ninety percent of these children (10684) will be initiated on treatment.

Through socio-economic interventions that strengthen family stability and promote children's resilience, OVC programs reduce HIV risk and support client retention in HIV services. OVC home visiting programs implemented by a trained social welfare workforce provide a critical component to the HIV response, as they work at the household level to identify neglected and hard to reach groups such as HIV affected children, children of young mothers, and out of school adolescent girls. Social workforce cadres can intervene at critical developmental periods and address social and environmental determinants critical in improving outcomes and reducing disparities in health and wellbeing. They also increase access to social protection interventions such as social grants that reduce risky sexual behavior and school fee exemptions that assist in keeping girls in school reducing their vulnerability to HIV.

Adolescent males and females will be reached through intensive small group interventions that aim to increase risk perception, skills development and self-efficacy to use condoms as well as improve their SRH. In addition to the current OVC portfolio, DREAMS will target OVC adolescent girls as well as those young women that age out of the OVC programs in five districts in two provinces with an evidence-based package aimed to reduce HIV.

A new Early Childhood Household Stimulation program will be implemented in seven districts in four provinces. Trained home visitors will work at the household and community levels to reach vulnerable children ages 0-5 and their caregivers with early child development activities. Parenting activities will address developmental delays, encourage retention for PMTCT, reduce LTFU, promote EID, and increase access to health and social services. Evidence-based parenting programs specifically developed for adolescents and their caregivers will be rolled out to build skills to change HIV-related sexual behaviors and decrease exposure to negative outcomes (e.g. abuse).

The OVC TWG will undertake the data collection for MER 1.5 indicators to measure the success of the refocused program. These indicators will allow comparisons across geographic areas as well as amongst countries.

In developing the COP15 budget, the OVC TWG used historical burn rates; IP pipeline; available FY15 resources; FY14 EA data and funding was added for scale up activities in scale-up SNUs. The OVC CORE guidance; the 2012 OVC Guidance and the DREAMS guidance together with the 90-90-90 goals reinforced strategic directions that shaped activities, requisite resources and resulting effects on targets.

4.11 Strategic Information

Although SI activities are at the above-site level and SI does not have MER indicators requiring targets, enhanced TA for data collection and systems at the national, provincial, and district levels will be provided to ensure data quality is improved and to support a sustainable system. Efforts will be made to work more closely with provincial leaders, PEPFAR's Provincial Liaisons, and IPs to improve the capacity for data reporting, management, and use in facilities and communities.

Section 6.2, Appendix A, and the SI log framework sections of the SDS provide significant details on the PEPFAR SI program.

In March 2014, the NDoH released the *National Health Normative Standards Framework for Interoperability in eHealth in South Africa*, which provides guidance for PEPFAR HMIS partners and will be used by the SI TWG to guide HMIS activities. Greater engagement in the National Health Information System of South Africa (NHISSA) activities is also important to facilitate strategic work with provincial level health information officers and others in SI roles. The SI TWG is also collaborating with the NDoH on a surveys and surveillance strategic plan to ensure collection of high quality data for epidemic and program monitoring while ensuring the most efficient use of resources to avoid duplication.

The SI TWG collaborates with the South African government to strengthen systems and improve data quality from key systems (e.g., TIER.net, District Health Information System (DHIS), ETR.net, and EDR.web) via training, evaluation, and to support the roll-out of select systems. Efforts are underway to increase TA to the NDoH on data use and M&E topics. Activities impacting epidemic control at the facility or community levels will continue to be prioritized. While SI partners receive Central Initiative funds, the funds are used to support health messaging for pregnant women, with the goal of increasing the percentage of women with early ANC bookings and ensuring follow-up at 18 months. To support the latter objective, funds are being used to support interoperability work that will allow follow-up of mother-infant pairs across facilities.

5.0 Program Activities to Maintain Support for Other Locations and Populations

5.1 Sustained/Long term transition package of services in other locations and populations
PEPFAR is committed to working with the South African government at the national, provincial, and district levels, as well as civil society and other stakeholders, to implement changes in a method that places the wellbeing of patients and vulnerable and affected populations at the center of all interventions.

How PEPFAR will exit from lower burden sustained sites and transition districts:

- To facilitate communication around the 'focusing for impact' proposal, a meeting may be scheduled in each province to discuss the process of shifting PEPFAR support with partners and district authorities.
- The South African government and PEPFAR will develop a standardized checklist that all partners will complete in non-focus districts. Each Implementing Partner (IP) will be required to complete the checklist, and write a close-out report that is reviewed with the district manager and key district level authorities. Each report may include key challenges and issues of concern, for which the IP assesses that the phasing out of PEPFAR support could lead directly to an important gap in HIV-related services.

Special exceptions in sustained sites and transition districts:
PEPFAR reviewed program and epidemiologic data to develop criteria for the selection of programs and sites that will need longer term support. These include:

1) High-risk mobile populations: some specialized programs that reach key or high-risk populations, especially linked to high-transmission hot-spots, may be considered for continued support on a one-on-one basis. These include:
    - highly mobile populations, i.e. at sites located on trucking routes programs that support FSWs particularly those in high transmission areas like truck-stops and other hot spots.
    - programs for high risk populations in mining areas.
    - VMMC sites with a demonstrated high yield performance
2) Incarcerated populations: In general, correctional services are not linked to district health systems and their epidemiology is not linked to local geography, so correctional services will be supported as a part of a national program.
3) Department of Defense prevention, HCT and VMMC programs will continue to work on national level, and in military centers.
4) A number of high volume care and treatment sites (500+ patients) identified in nine districts will be specifically supported for a longer period of time to ensure that they are 'graduated' and systems are in place to maintain patients on treatment (at sustained/longer-term transition sites).
5) Combination prevention impact evaluation conducted in Dr Ruth S. Mompati district, North West Province. This evaluation will conclude September 2016.

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Non-Priority Districts

Long-term Transition: Volume by Group	Indicator	Expected result APR 2015	Expected result APR 2016	percent increase (decrease)
HIV testing in PMTCT sites	PMTCT_STAT	NA	81,000	NA
HTC (only at transition ART sites in FY 2016)	HTC_TST	NA	457,500	NA
Current on care (not yet initiated on ART)	CARE_CURR-TX_CURR	NA	481,000	NA
Current on ART	TX_CURR	NA	333,000	NA
OVC	OVC_SERV	NA	18,673	NA

5.2 Short-Term Transition plans for redirecting PEPFAR support to priority locations and populations

In transition districts and sustained sites PEPFAR will support two types of transition plans, namely short term transition support to end on or about December 2015 for transition districts and longer-term transition support to end on or about September 2016 for sustained sites. Epidemiological and programmatic data (e.g., number of PLHIV, HIV prevalence, ANC prevalence, HTC yield, PMTCT yield, and performance data) were used to determine transition districts and sustained sites.

Sites for the longer-term transition for care and treatment were selected high volume sites outside of the scale-up districts. First, all facilities in the country were ranked by "total on ART." Any that fell within 80 percent of total on ART were defined as high volume. PEPFAR assessed high volume

sites that fell outside of the 27 scale-up districts and included districts that had at least 25,000 on ART in high volume facilities. This accounted for the selection of 198 longer-term care and treatment sustained sites in nine transition districts including sites located in two districts in Limpopo Province (Greater Sekhukhune and Waterberg) based on a request from the Minister of Health. Both have considerable mining and SW populations. PEPFAR will support these 198 high volume facilities in these nine districts with a package of TA for core activities until on or about September 2016 to ensure that all components of the clinical cascade and some components of supportive systems are functional and sustainable, to allow the site to 'graduate'. TA for the development and use of the clinical cascade will be provided to counterparts by means of QA/QI methodologies, including supportive supervision. TA for supportive systems will address recoding and reporting systems, viral load monitoring, clinic-laboratory interface for appropriate patient monitoring, DQA/DQI, and SCM for drugs and commodities. For recording and reporting, support will ensure these sites achieve full implementation of TIER.net (phase 6) and ETR.net with acceptable data quality and effective use of data. TA for clinic-laboratory interface will strengthen the feedback loop for use of timely laboratory results. TA will be tailored to the individual facilities based on level of performance and will be aimed at having sites achieve graduation with sustainable patient outcome improvements.

Sites for Transition: Transition sites for short-term transition)include sites that are: 1) outside of scale-up districts and which are not included in the selection of sustained (long-term transition) sites; 2) low volume sites within scale-up districts (e.g., low HIV prevalence, low HIV HCT yield, < 500 patients on ART). Transition out of these sites will include: 1) rapid review of seconded HR in facilities and finalization of absorption or retrenchment of staff; and 2) complete assessment of site performance through SIMS conducted by the supporting implementing partner and sent to the District Management Team (DMT). During the transition period (6-12 months) PEPFAR will work with the DMTs to formulate recommendations and implementation plans to address common key issues and gaps identified during SIMS assessments.

Care and treatment will transition all non-core activities to national or provincial departments of health by 1 October 2015. Examples of care and treatment activities that will be transitioned are listed in the table below:

Non-Core activities	**Time frame for transition**	**Stakeholders**	**Anticipated challenges**
Home based palliative and end-of-life care	1 October 2015	National and Provincial Departments of Health	None
Ideal Clinic (non-HIV related aspects)	1 October 2015	National and Provincial Departments of Health	May impact the SAG National Health Insurance - limited resources to implement within government
Procurement of first line ARVs	1 October 2015	National and Provincial Departments of Health	None
TB drug procurement	1 October 2015	National and Provincial Departments of Health	None
Health facility maintenance and operations support	1 October 2015	National and Provincial Departments of Health	SAG constraints may impact program achievements
Implementation science for non-core program	1 October 2015	Health information, Monitoring and Evaluation	Limited capacity to implement implementation

Non-Core activities	Time frame for transition	Stakeholders	Anticipated challenges
areas		units at NDoH	science within NDoH

OVC Transition: The South Africa OVC TWG plans to shift its programs to maximize synergies and linkages with other PEPFAR-supported HIV and AIDS services and interventions within scale-up SNUs. The OVC program will work closely with the district support partners and community-based prevention partners to ensure those children and their caregivers are linked to services and that the referral loop is closed. This also includes TB/HIV services as 22 percent of children with TB in South Africa are living with HIV,[20] highlighting the need to leverage TB service systems to promote HIV testing for children (and vice versa). Working closely with the existing prevention, care, and treatment platforms will allow PEPFAR to maximize linkages and optimize efficiencies to access more OVC and their caregivers. OVC currently served with core interventions in transition areas (primarily promotion of HTC and confirmatory HIV testing, clinic-based child abuse and GBV response, and continued support for primary and secondary education) will continue to be supported through the end of FY 2016 and will then be transitioned along with other OVC services in these areas. This extended period responds to a specific request from the Minister of Health.

Prevention transition:

The following is a table of Transition Districts (short term) for Prevention:

Province	District	# of Sites	# of Patients on ART	Target population/intervention	PEPFAR Partner
Eastern Cape	Nelson Mandela Bay	1	43, 646	FSW	THCA
		1		MSM	ICAP
Free State	Mangaung	1	37, 154	HTC	PSI
		1		MSM	ICAP
		1		Families Matter	PSI
Limpopo	Capricorn	1	40,677	MSM	ICAP
	Vhembe	1		Contract mine workers: saturation reached	Careworks
	Vhembe (Musina)	1		Migrants and Mobile populations on	International Organization for

[20] Hesseling AC et al., High incidence of tuberculosis among HIV-infected infants: Evidence from a South African population-based study highlights the need for improved tuberculosis control strategies, Clin Infect Dis, 2009, 48:108-114.

				commercial farms and surrounding informal settlements	Migration
Northern Cape	Frances Baard	1	15,425	Families Matter!	SCI
		1		MSM	ICAP
Kwazulu Natal	uMzinyati	1	37,320	Families Matter	SCI
	Umgungundlovu: Mpendle	1		General population/Standalone HTC	AFSA
Western Cape	West Coast	1	16,111	General population/Standalone HTC	THCA
Mpumalanga	Ehlanzeni	1		General population/Standalone HTC. Another PEPFAR partner serving	PSI

**KP services are mobile and move across sub-districts as hotspots move. No long-term transition for CDC*
**Existing HTC sites will be transitioned once saturation is reached*

The estimated timeframe for exiting a short-term transition district is six to nine months from April 2015. Partners should plan in general to continue program engagement and support at least through end September 2015 and to achieve final close-out no later than December 2015.

Longer term transition districts for PEPFAR VMMC sites

	Agency	Site	Sub-district	District	Province	HIV Prevalence	ANC Prevalence	MMC Prevalence
Non-prioritized districts	USAID	Mukondeni	Unknown	Vhembe	Limpopo	5.10%	14.60%	72.60%
	USAID	Mutale Health	Unknown	Vhembe	Limpopo	5.10%	14.60%	72.60%
	USAID	PARYS HOSPITAL	Ngwathe LM	Fezile Dabi	Free State	20.00%	35.60%	36.00%
	USAID	SASOLBURG HOSPITAL	Metsimaholo LM	Fezile Dabi	Free State	20.00%	35.60%	36.00%
	CDC	Mapela Clinic	Mogalakwena	Waterberg	Limpopo	5.10%	14.60%	72.60%
	CDC	Ellisras Hospital	Mogalakwena	Waterberg	Limpopo	5.10%	14.60%	72.60%
	CDC	RSM DoH PHC	Greater Taung, Kagisano Molopo, Mamusa, Lekwa	Ruth Segomotsi Mompati	North West	13.90%	20.00%	36.70%
	CDC	Galeshewe VMMC	Sol Plaatje LM	Frances baard	Northern Cape	12%	12.00%	20.30%
	CDC	Old Wit Lokasie	Knysna	Eden	Western Cape	5%	8.00%	41.00%
	CDC	Wellington CHC	Drakenstein LM	Winelands	Western Cape	4.60%	8.00%	41.00%
	CDC	Groberlasdal	Makhudatamakga	Sekhukhune	Limpopo	5.10%	14.60%	72.60%
	CDC	Nelson Mandela	Kopanong LM	Xhariep	Free State	20.00%	35.60%	36.00%
	CDC	Malmesbury Site	Swartland	West Coast	Western Cape	4.60%	8.00%	41.00%
Supplementary Districts	USAID	Bethesda Hospital	Jozini*	Umkhanyakude	KZN	28.00%	35.00%	23.20%
	USAID	Mseleni Hospital	Umhlabuyalingana SD*	Umkhanyakude	KZN	28.00%	35.00%	23.20%
	USAID	Dr Dimo Surgery	Merafong City	West Rand	Guateng	18.00%	35.60%	14.20%
	USAID	Leratong Hospital	Mogale City	West Rand	Guateng	18.00%	35.60%	14.20%
	USAID	Munsenville	Mogale City	West Rand	Guateng	18.00%	35.60%	14.20%
	USAID	Carryou Minnistries	Randfontein	West Rand	Guateng	18.00%	35.60%	14.20%
	USAID	Bekkerdal west	Westonaria (Sub A)	West Rand	Guateng	18.00%	35.60%	14.20%
	USAID	Yusuf Dadoo	Mogale City	West Rand	Guateng	18.00%	35.60%	14.20%
	USAID	Rhenosterspruit	Mogale City	West Rand	Guateng	18.00%	35.60%	14.20%
	USAID	Carletonville	Merafong City	West Rand	Guateng	18.00%	35.60%	14.20%
	CDC	Krugersdorp DCS	Mogale City	West Rand	Guateng	18.00%	35.60%	14.20%
	CDC	Madadeni Hospital	Newcastle	Amajuba	KZN	28.00%	35.00%	23.20%
	CDC	Maphumulo Clinic	Maphumulo LM	Ilembe	KZN	28.00%	35.00%	23.20%
	CDC	Stanger Hospital	KwaDukuza LM	IlLembe	KZN	28.00%	35.00%	23.20%
	CDC	Manguzi Hospital	Umhlbuyalingana LM	Umkanyakude	KZN	28.00%	35.00%	23.20%
	CDC	Church of Scotland Hospital	Msinga LM	Umziynathi	KZN	28.00%	35.00%	23.20%
	CDC	Greytown Hospital	Umvoti LM	Umziynathi	KZN	28.00%	35.00%	23.20%
	CDC	Charles James TB Hospital	Nquthu LM	Umziynathi	KZN	28.00%	35.00%	23.20%
	CDC	Bayview clinic*	Nelson Mandela	Nelson Mandela bay	Eastern cape	20.00%	12.00%	74.00%
	CDC	Pelonomi**	Motheo	Mangaung (Motheo)	Free State	20.00%	35.60%	36.00%
	Total	**33**	**26**	**17**	**8**	**17.55%**	**19.34%**	**27.59%**

The NDOH has set an ambitious target to achieve 4.3 million MMCs by 31 December 2016. The PEPFAR VMMC program plans to have its partners assist through the provision of dedicated staff for the VMMC program in the selected sites through a national training program, quality assurance, demand creation and kit procurement.

Furthermore this time period will allow PEPFAR sufficient time to allow for a smooth transition of a limited number of sites to the NDOH, and to engage with provincial authorities to support the development of successful, district-owned VMMC programs. The PEPFAR program has been a significant contributor to national VMMC target achievement.

In order to ensure a transition of the program, while maintaining performance and quality the PEPFAR team will work closely with the National and respective Provincial DOH. Engagement has begun through the National MMC Technical Working Group.

The HSS core activities requiring a longer-term transition include TA to RTCs and for development and implementation of the HR Development audit system. Examples of non-core HSS transition activities are listed below.

Non-Core activities	Transition Time Frame	Stakeholders	Anticipated Challenges
Increase reach and support of clinical associate program.	1 October 2015	National and provincial Departments of Health, AIHA	The role of the clinical associate as part of the health team may not be well understood by their supervisors, district managers, and the community.
Support the correctional services to identify gaps in Epidemiology and operations research to inform epidemiology training.	1 October 2015	National and provincial Departments of Correctional Services, University of Washington (ITECH)	Correctional services do not have the technical capacity and resources to address this issue.
Leadership and management training for clinical associates	1 October 2015	National and provincial Departments of Health, American International Health Alliance (AIHA)	None
Provincial Depot Support	1 October 2015	National and provincial Departments of Health	
Patient Pharmacy Week Campaigns	1 October 2015	National and provincial Departments of Health	
Drug Procurement	1 October 2015	National and provincial Departments of Health	
Health information system qualifications development	1 October 2015	Health Information Systems Program (HISP), National and provincial Departments of Health, University of South Africa.	There may be limited resources to implement this within government.

For SI, the activities supported by the SI TWG are implemented at the national and sub-national levels. Activities impacting epidemic control at the facility or community level may be further re-prioritized to align with the geographic areas highlighted as part of the geographic refocus work (e.g., selected districts, facilities, or sub-districts) including data management, data quality, and health information systems.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Laboratory strengthening

Laboratory services are essential in patient diagnosis and treatment response monitoring, population screening, surveillance and surveys, and detection of outbreak of diseases. The role of quality laboratory services is very important in achieving the 90-90-90 targets. The National Health Laboratory Service (NHLS) provides diagnostic pathology and related services to the South African public sector through a robust national network of laboratories. PEPFAR is working with NHLS and National Institute for Communicable Diseases (NICD) to ensure improved quality of patient care through achievement of laboratory strengthening objectives set during the consultation between PEPFAR and stakeholders (NDoH, NHLS, NICD, and Provincial Departments of Health (PDoH)). Since activities and processes occurring outside laboratories affect the quality of laboratory services, PEPFAR is working with district support partners to strengthen laboratory related activities at clinics and communities. PEPFAR's efforts in strengthening laboratory services have focused on supporting key areas: development of laboratory capacities and systems to conduct laboratory-based surveillance and incidence studies; development of an adequate laboratory workforce; development of quality assured laboratory services; development of systems and structures to ensure adequate coordination and implementation of laboratory programs and services; and improvement of access to laboratory services in hard-to-reach areas. However, with the recent PEPFAR and NDoH geographic prioritization and refocus for impact strategy, PEPFAR laboratory programs will be refocused and re-aligned to support four major objectives: i) implementation and roll out of the national QA program for HIV POC testing; ii) development and implementation of systems and processes for laboratory testing efficiencies, effectiveness and cost saving measures, known as electronic gate keeping (EGK); iii) support to laboratory-based surveys and surveillance, and operations research; iv) support laboratory system strengthening and improvement in healthcare facilities (clinic laboratory interface).

1. Brief Activity Description	**Deliverables**		**Budget codes and allocation (USD)**		**6.Associated Implementing Mechanism (s) ID**	**7. Relevant Sustainability Index Score**	**Impact on epidemic control**				
	2. 2015	**3. 2016**	**4. 2015**	**5. 2016**			8. HTC	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Support improvement of quality of laboratory diagnostic services											

1. Provide support to NDoH, NHLS, and NICD to implement QA for HIV POC testing (HIV rapid testing, CD4, VL, and EID) nationally	TA to 57 clinical labs, 59 POC (community) and 1,000 clinics. The partner would develop training materials, conduct trainings, produce, and distribute proficiency testing (PT) and internal quality control panels and conduct analysis of proficiency testing.	TA to 87 clinical labs, 59 POC (community), and 1806 clinics. The partner would develop training materials, conduct trainings, produce and distribute PT and internal quality control panels, conducts analysis of proficiency testing.	HLAB 2,200,000	HLAB 1,870,000	NHLS 9522	NA	X	X	X	X	X
	DSD for laboratory testing and QA (e.g., PT, IQC) programs for 1 clinical lab. The partner will support specimen collection and laboratory testing for survey and surveillance purposes. Test that would be conducted include: HIV testing, CD4 , Viral Load, resistance testing, LAg assay etc.	DSD for laboratory testing and QA (e.g., PT, IQC) programs for 1 clinical lab. The partner will support specimen collection and laboratory testing for survey and surveillance purposes. Test that would be conducted include: HIV testing, CD4 , Viral Load, resistance testing, LAg assay etc.	$200,000	$170,000	Epicenter/CAPRISA 13695	NA					

	DSD for laboratory testing in key populations. The partner will provide HIV rapid testing, CD_4 testing, and support QA services for the tests provided, including PT and IQC.	DSD for laboratory testing in key populations. The partner will provide HIV rapid testing, CD_4 testing, and support QA services for the tests provided, including PT and IQC.	$100,000	$85,000	Human Sciences Research Council (HSRC) 13558	NA					
	DSD delivery for laboratory testing and QA for HIV and TB services (e.g. PT, IQC) programs for 4 community sites. The partner will support Laboratory testing needs for the determination of incidence in MMC program evaluation, as well as other tests that are not routinely offered by the program.	DSD for laboratory testing and QA for HIV and TB services (e.g. PT, IQC) programs for 4 community sites. The partner will support laboratory testing needs for determination of incidence in MMC program evaluation, as well as other tests that are not routinely offered by the program.	$55,000	$46,750	Population Services International (PSI) 13888	NA					
	DSD for laboratory testing in key populations. The partner would support laboratory testing and QA for HIV and TB services (e.g. PT, IQC) for surveillance/survey	DSD for laboratory testing in key populations. The partner would support laboratory testing and QA for HIV and TB services (e.g. PT, IQC) for surveillance/survey and incidence testing	$100,000	$85,000	University of California at San Francisco (UCSF) 13567	NA					

	and incidence testing needs.	needs.									
Support NHLS and Provinces in implementation of efficient, effective and cost saving measures for TB and HIV laboratory testing services.											
Support NHLS and Provinces to implement Electronic Gate Keeping & laboratory intelligence unit to facilitate appropriate utilization of HIV and TB tests and prevent unnecessary repeats and wastages	Partner would support implementation in 27 hospitals. Support would include setting up of systems, protocol development and implementation, strengthening of IT and monitoring systems, coordination of activities and engagement with stakeholders (e.g. NDoH, hospitals, and NHLS).	Partner would support implementation in 27 hospitals. Support would include setting up of systems, protocol development and implementation, strengthening of IT and monitoring systems, coordination of activities and engagement with stakeholders (e.g. NDoH, hospitals, and NHLS).	$650,000	$552,500	NHLS 9522	NA	X	X	X	X	X
Laboratory based survey and surveillance, and operations research											
Provide TA for implementation of sustainable HIV and TB drug resistance testing	Activities would focus on supporting national priorities as needed e.g. 1. Generation of information on trend and status of epidemics e.g.	Activities would focus on supporting national priorities as needed e.g., 1. Generation of information on trend and status of epidemics e.g. incidence and prevalence	$350,000	$297,500	NHLS 9522	NA	X	X	X	X	X

programs in line with the National priority Programs and to support the roll out of cryptococcal screening program.	incidence and prevalence 2. Measurement of the performance of interventions or programs etc.	2. Measurement of the performance of interventions or programs etc.									
Laboratory system strengthening (clinic laboratory interface)											
Provide TA to NDoH and Clinics in Provinces to ensure adequate and optimal quality of Laboratory services are provided	The partner would support 170 facilities in 2 Districts (72 Bojanala & 98 Ekurhuleni). Activities would include: Support for implementation of quality assurance of point of care tests (e.g. HIV rapid test, CD_4 measurement), specimen handling, test result management etc.	The partner would support 170 facilities in 2 Districts (72 Bojanala & 98 Ekurhuleni). Activities would include: Support for implementation of quality assurance of point of care tests (e.g. HIV rapid test, CD_4 measurement), specimen handling, test result management etc.	$100,000	$85,000	Aurum Health Research 16583	NA	X	X	X	X	X
	The partner would support 310 facilities (115 OR Tambo; 42 Lejweleputswa; 66 Zululand, 42 Uthukela, 45	The partner would support 310 facilities (115 OR Tambo; 42 Lejweleputswa; 66 Zululand, 42 Uthukela,	$100,000	$85,000	Health System Trust (HST) 13797	NA					

	Umgungundlovu). Activities would include: Support for implementation of quality assurance of point of care tests (e.g. HIV rapid test, CD4 measurement), specimen handling etc.	45 Umgungundlovu). Activities would include: Support for implementation of quality assurance of point of care tests (e.g. HIV rapid test, CD4 measurement), specimen handling etc.									
	The partner would support 232 facilities in 3 districts (45 Nelson Mandela; 127 Amathole; 60 Buffalo City). Activities would include: Support for implementation of quality assurance of point of care tests (e.g. HIV rapid test, CD4 measurement), specimen handling, test result management etc.	The partner would support 232 facilities in 3 districts (45 Nelson Mandela; 127 Amathole; 60 Buffalo City). Activities would include: Support for implementation of quality assurance of point of care tests (e.g. HIV rapid test, CD4 measurement), specimen handling, test result management etc.	$100,000	$85,000	Beyond Zero 16584	NA					
	The partner would support 242 facilities nationally (Not confined to 27 districts). Activities would include: Support for implementation of	The partner would support 242 facilities national (Not confined to 27 districts). Activities would include: Support for implementation of quality assurance of point of care tests (e.g.	$100,000	$85,000	Aurum-Department of Correctional (DCS)	NA					

	quality assurance of point of care tests (e.g. HIV rapid test, CD_4 measurement), specimen handling, test result management etc.	HIV rapid test, CD_4 measurement), specimen handling, test result management etc.			16775						

6.2 Strategic information (SI)

SI is critical to implementing, monitoring, and evaluating a successful and efficient HIV response in South Africa. The PEPFAR SI program will continue to build on its achievements by focusing on five key objectives: 1) strengthening capacity to build strong M&E programs; 2) strengthening information systems, including surveillance and health management systems, that provide high-quality data to program planners, policy makers and other stakeholders; 3) identifying a process for routine data use and data sharing (e.g., DHIS, TIER.net, ETR.net); 4) strengthening data quality to ensure that the correct data are driving decisions; and 5) enhancing programmatic ability to implement innovative, appropriate, and cost-effective approaches through operations research and evaluation. To achieve these objectives, PEPFAR will focus its SI activities on:

1. **Health Information System (HIS)**: 1) National HMIS support (TIER.net, DHIS, ETR.net); 2) eHealth/mHealth implementation; 3) Drug HMIS ("Rx Solutions"); 4) SCM information systems; 5) DATIM, E-Learning platform development; 6) Maternal and Child Morbidity and Mortality Surveillance System (MIMMS); 7) *[REDACTED];* and 8) District Health Management Information System (DHMIS) policy implementation, NHISSA governance.

2. **Surveillance and surveys**: 1) South African National HIV Prevalence, Incidence and Behavior Survey; 2) KZN HIV Incidence Provincial Surveillance System (HIPSS);

3) Gender-based Violence (GBV) project; 4) Strengthening existing data collection of HIV cause-specific mortality (vital registration system); 5) ANC/PMTCT comparison; 6) Pharmacovigilance strengthening support; 7) KP size estimation, mapping and IBBS; and 8) Department of Correctional Services (DCS) routine surveillance feasibility assessment.

3. **M&E activities**: 1) DATIM for reporting and analysis; 2) Strategic information capacity building for data quality and use; 3) Capacity building: GIS application data and tools, 4) M&E staffing at Provincial AIDS Councils (PAC), 5) TIER.net enhancement and expansion (e.g. Phase 6) and evaluation; (6) District Implementation Planning Process; and 7) Cost & budget modelling for HIV and TB Programs.

4.

1. Brief Activity Description	Deliverables		Budget codes and allocation (USD)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression

Provide support to the NDoH for HMIS development, deployment, data management, and human resource capacity building to improve information systems, data quality, and data use	Strengthened HIS (DHIS, TIER.net, ETR.net) to deliver higher quality data; Improved information management processes; and Increase number of skilled HMIS workers in the public sector	Continued strengthening of HIS and increasing number of skilled HMIS workers	HVSI $2,000,000	HVSI *[REDACTED]*	13682	1.1 Epidemiological and Health Data (11.8) 1.3 Performance Data (20) 2.2 Human Resources for Health (0) 2.4 Quality Management (0)	X	X	X	X	X
Provide development and management support to and maintain a local interface for DATIM for PEPFAR SA reporting	Facilitate timely and accurate reporting of program performance data	Support the analysis of program monitoring data for program improvement				1.1 Epidemiological and Health Data (11.8)	X	X	X	X	X
Support NDoH to enhance the mobile platform and its integration into the national health architecture (MomConnect part of activity)	Strengthen the National HIS and support the development of an interoperable system	Increased interoperability of national data systems (DHIS, Tie.Net, ETR.NET) for program improvement				1.1 Epidemiological and Health Data (11.8) 1.3 Performance Data (20)	X	X	X	X	X
Conduct SI capacity building activities to strengthen health information systems and support eHealth/mHealth implementation	Improved management and use of health information systems and increased assistance with foundational building blocks of interoperability across systems	Improved implementation of national eHealth / mHealth strategy	HVSI $2,000,000	HVSI	14846	1.1 Epidemiological and Health Data (11.8) 2.4 Quality Management (0)	X	X	X	X	X

Support the E-learning platform development	Develop e-learning platform to host DHMIS trainings and make widely available to health officials	Sustainable e-learning program				1.3 Performance Data (20) 2.2 Human Resources for Health (0)	X	X	X		
Provide support for the NHISSA and HIS task team structures	Implemented DHMIS policy and updates, M&E framework for health, eHealth strategy, mHealth strategy, HIS strategy	Development of a broad-based multisectoral NHISSA approach				4.2 Oversight and Stewardship (0) 5.1 Policies, Laws and Regulations (0) 5.2 Leadership	X	X	X		
Develop capacity of national, provincial and district officials in application and use of GIS data and tools	A national strategy on the use of GIS; Developed training; Provided master facility list; Updated Evidence-based district planning tool developed.	Increased GIS capacity as required by DHMIS policy				1.1 Epidemiological and Health Data (11.8)	X	X	X		
Support SI capacity building for data quality and use	Data quality improvement plan; Revised SASQAF-based DQA Tool; Dissemination and analysis of audit performance findings	Improved data quality, demand, and use				2.4 Quality Management	X	X	X	X	X

Roll out of Electronic Logistics Management Information Systems for facilities and Provincial Control Towers	Ensure Rx Solution operating in 615 new clinics, Rx PMPU established in 3 new Provincial Control Towers	Continue work on Rx Solution operating in 615 new clinics, Rx PMPU established in 3 new Provincial Control Towers	HVSI $536,759	HVSI	14617	2.3 Commodity Security and Supply Chain (0) 2.4 Quality Management (0)		X	X	X	X
Support the South Africa National HIV Prevalence, Incidence and Behavior survey/ HIV Impact Assessment	Develop and submit protocol for clearance; Initiate pilot survey	Conduct national survey National HIV and analyze data for dissemination	HVSI $2,140,415	HVSI $2,300,000	17459	1.1 Epidemiological and Health Data (11.8)	X	X	X	X	X
Support the HIV Rapid Assessment and Response (RAR) project for understanding the vulnerability of South African women (20-34 years) and men (25 - 49 years)	Implementation of the assessment	Develop HIV risk reduction intervention for women and men based on the results from the RAR.				1.1 Epidemiological and Health Data (11.8)	X	X	X	X	X
Support Maternal Mortality (MIMMS) Survey	Finalize data collection and analysis	This project will close December 2015.				1.1 Epidemiological and Health Data (11.8) 1.3 Performance Data (20)		X			
Support KZN HIV incidence surveillance (HIPSS)	Generate prevalence and direct incidence estimates; Asses risk factors (HIV, TB, STI, pregnancy, exposure to services (e.g. ART, HTC, VMMC,	Data analyzed and disseminated	HVSI $400,000	HVSI $300,000	13695	1.1 Epidemiological and Health Data (11.8)	X	X	X	X	X

	etc.)) data collected										
Support integration of National Communications Survey components into HSRC household survey	Provide technical assistance on behavioral modules for HSRC survey	Continue TA to HSRC	HVSI $286,759	HVSI	17538	1.1 Epidemiological and Health Data (11.8) 2.1 Access and Demand	X	X	X		
Support ANC/PMTCT comparison study	Develop protocol and initiate data collection review	Finalize data collection and prepare report	HVSI $100,000	HVSI $200,000	17033	1.1 Epidemiological and Health Data (11.8) 3.4 Technical Efficiency	X	X	X		
Supporting GBV project	Different types of GBV data collected and analyzed	Prevalence and incidence of different types of GBV				1.1 Epidemiological and Health Data (11.8)	X	X	X		
Strengthen existing data collection of HIV cause-specific mortality (vital registration system)	Training provided; HIV-related mortality data abstracted and analyzed	HIV-related mortality data analysis result disseminated				1.1 Epidemiological and Health Data (11.8) 1.3 Performance Data (20)	X	X	X	X	X
Strengthen facility drug adverse events provider support and pharmacovigilance	Finalize data collection, analysis, and dissemination	Project will close at the end of FY16	HVSI $150,000	HVSI This activity will close at the end of FY16.	13644	1.1 Epidemiological and Health Data (11.8) 1.3 Performance Data (20) 1.1 Patient			X		

						Tracking (ART Patients)					
Conduct mapping, population size estimation for key populations (e.g. MSM, FSW, etc.), and bio-behavioral survey (BBS) in the target geographic area	Develop protocol and collect data	Finalize data collection and disseminate results	HVSI $300,000	HVSI $300,000	13567	1.1 Epidemiological and Health Data (11.8)	X	X	X		
Support for cost and budget modelling for HIV and TB Programs	Conduct applied research and evaluation projects via economics and epidemiology	Cost effectiveness data available to maximize outcomes with limited resources	HVSI $536,759	HVSI	17537	1.2 Financial and Expenditure Data 20.5 Cost Analysis, Efficiency Analysis, Economic Analysis, and Financing	X	X	X		
Support provincial M&E staffing for provincial AIDS Councils (PAC)	Hire and place provincial M&E staff at PACs; Train & orient staff	Improved strategic planning /M&E at provincial level	HVSI $100,000	HVSI $100,000	16773	1.1 Epidemiological and Health Data (11.8) 1.3 Performance Data (20)	X	X	X		
Support TIER.net enhancement and expansion(e.g. Phase 6) and evaluation	TA to support TIER.net 6 transition and roll-out evaluation	Improved quality ART program monitoring data (# on ART, CD4, VL, ART outcome, retention, LTFU, transfer)	HVSI $100,000	HVSI $200,000	16772	1.1 Epidemiological and Health Data (11.8) 1.3 Performance Data (20)		X	X		

Support the development and implementation of District Implementation Plans to monitor progress toward 90-90-90	Provide support for district-level consultants as well as tool development and program implementation	Implementation of district-level activity to monitor progress toward 90-90-90 and providing guidance to ensure performance				1.1 Epidemiological and Health Data (11.8) 1.3 Performance Data (20)	X	X	X	X	X
Technical Assistance (TA) Indicators to monitor transition from service delivery to TA program	Develop and implement TA to monitor how U.S. government funding supports and strengthens the national health system	Develop indicators; Use of results to strengthen the NDOH through capacity building and to monitor the transition of services	HVSI $100,000	HVSI $100,000	17510	1.1 Epidemiological and Health Data (11.8) 1.3 Performance Data (20)	X	X	X	X	X
HIV Innovations for Improved Patient Outcomes for Priority Populations (INROADS: Innovations Research on HIV/AIDS)	Conduct innovations Research on HIV/AIDS	Continue conducting innovations research and utilize for program planning	HVSI $536,759	HVSI	17025	1.1 Epidemiological and Health Data (11.8) 1.3 Performance Data (20)	X	X	X	X	X
[REDACTED]	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*

6.3 Health System Strengthening (HSS)

In alignment with the overall PEPFAR focus for impact, the HSS program will support national, provincial, and priority district level programs that have a clear, direct impact on PLHIV. The HSS TWG developed and refined their core activities through discussions with the NDoH, reviewing SIMS results, and identifying activities that fill the sustainability gap. Going forward, HSS activities will focus on supply chain, health finance, and Human Resources for Health (HRH).

Commodity availability at the facility and community level is still a concern. While South Africa is generally able to pay for and obtain commodities at a national level, stock visibility is often less robust at the lower levels of the system where stock-outs may occur. This finding has been confirmed by various assessments and above-site SIMS assessments. The HSS portfolio will support the national, provincial, and facility systems to improve drug availability for those on ART. Additionally, supply chain strengthening efforts will work to improve condom supply to support key prevention interventions.

While domestic financing for HIV has increased significantly since 2011, there continue to be opportunities to improve processes for planning and expenditures of the HIV budget at the national, provincial, and district levels. PEPFAR will increase its support to improve the processes and communications regarding the HIV conditional grant and equitable share funds. The NDOH and the SID identify HRH as priority for PEPFAR support. PEPFAR South Africa's HRH comparative competencies and activities align with the objectives of the PEPFAR HRH Strategy, including:

1) Conduct baseline assessment of HR capacity to deliver HIV services in high-risk populations.
2) Focus on increasing production of new CHWs in priority districts.
3) Continue to support the strengthening of an HR information system to improve HR planning, management and retention.
4) Continue to develop and maintain the PEPFAR transition database.
5) Continue to strengthen training systems, such as the RTCs and HIV/AIDS in-service training, to improve the quality of service delivery.
6) Continue to support the strengthening of leadership and management within districts and facilities to improve HRH performance.

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015 - COP 2015	3. 2016- COP 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Support provided to the Department of Correctional services to improve HIV care and treatment in correctional facilities through HRH capacity building to provide quality health care services to HIV/AIDS clients	Strategic plan for HRH capacity building developed.	No intervention	OHSS: 300 000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2%	13709	5. Human Resources for Health: 11.2	X	X	X	X	X
Pre service training of Clinical Associates, Pharmacy Technicians, Pharmacy Assistants and CHWs to ensure the adequate supply of HCWs to deliver quality health care services to HIV/AIDS at PEPFAR supported sites.	162 Clinical Associates graduated, 65 Pharmacy Technicians, 85 Pharmacy Assistants graduated and absorbed into DOH vacant funded posts.	173 Clinical Associates graduated, 105 Pharmacy Technicians, 120 Pharmacy Assistants graduated and absorbed into DOH vacant funded posts.	OHSS: 600,000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2%	17452	5. Human Resources for Health: 11.2	X	X	X	X	X
	186 Medical Students, 99 Pharmacy students, 27 Bachelor of nursing students graduate from UKZN MEPI and absorbed into	187 Medical Students, 98 Pharmacy students, 59 Bachelor of nursing students will from UKZN and absorbed	Central Funding	Overall PEPFAR SA COP 16 budget will be reduced by 15.2%	18863	5. Human Resources for Health: 11.2	X	X	X		X

	DOH vacant funded posts.	into DOH vacant funded posts.									
	211 Medical Students graduate from Stellenbosch University MEPI and absorbed into DOH vacant funded posts.	231 Medical Students graduate from Stellenbosch University MEPI and absorbed into DOH vacant funded posts.	Central Funding	Overall PEPFAR SA COP 16 budget will be reduced by 15.2%	21652	5. Human Resources for Health: 11.2	X	X	X		X
Support the development of new Pre-service education models to ensure the adequate supply of HCWs to deliver quality health care services to HIV/AIDS at PEPFAR supported sites.	Models to increase the supply of Clinical HCWs in high yield sites developed.	Model piloted in 2 high yield PEPFAR priority sites.	OHSS: 750 000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2%	16807	5. Human Resources for Health: 11.2	X	X	X		X
Recruitment of foreign trained doctors for HIV burden HIV facilities	50 doctors recruited of foreign HCWs to fill critical gaps in rural settings in high burden HIV areas.	50 doctors recruited of foreign HCWs to fill critical gaps in rural settings in high burden HIV areas.	OHSS: 400,000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2%	16981	5. Human Resources for Health: 11.2	X	X	X	X	X
Increase supply of Social Auxiliary Workers for OVC and their households	2,741 new Social Auxiliary Workers trained in HIV education, referrals and linkages to target orphans and vulnerable	2,500 new Social Auxiliary Workers trained in HIV education, referrals and linkages to target	HKID: 2,000,000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2%	17017	5. Human Resources for Health: 11.2	X	X	X	X	X

	children and their families.	orphans and vulnerable children and their families.									
Support provided to the National and provincial DOH to improve the delivery of HIV services in high HIV/AIDS disease burden PEPFAR scale-up sites through improving the quality of the education platform and HRH capacity building.	900 CHWs trained with the pre-service qualification at 6 accredited sites in 6 PEPFAR priority provinces and absorbed by DOH.	1200 CHWs trained with the pres-service qualification at 8 accredited sites in 8 PEPFAR priority provinces and absorbed by DOH.	OHSS: 650 000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2%	13709	5. Human Resources for Health: 11.2	X	X	X		X
	3 Nursing colleges strengthened to provide quality HIV/AIDS related training.	3 Nursing colleges strengthened to provide quality HIV/AIDS related training, 140 midwifery graduated and placed in high yield sites.	OHSS: 550 000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2%	13923	5. Human Resources for Health: 11.2	X	X	X		X
	Strategic plan and implementation report to strengthen 6 Regional Training Centers (RTCs) submitted to NDOH. Distance	Distance learning platform for 6 RTCs transitioned to provincial DOH. Pharmacovigilance and PC101 in service	OHSS: 3.645 000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2%	13709	5. Human Resources for Health: 11.2	X	X	X		X

	learning platform for 6 RTCs developed and in use to deliver HIV/AIDS related training. CPD Model for nurses piloted in 1 province. PC101 mentorship guidelines developed. Job profiles & competencies for 2 nursing cadres developed. Strategic direction provided to high yield scale-up sites for the implementation of the new service delivery model (Ideal Clinic) Social franchising model to deliver quality HIV/AIDS services in clinics piloted in 1 clinic	training provided in the 6 RTCs. Pilot for CPD Model for nurses evaluated and expanded to 2 more provinces. Components of the Model implemented in 2015 transitioned to DOH .job profiles competencies for 2 new nursing cadres, CHW and Clin Ass developed. Social franchising model evaluated and transitioned to DOH.									
	Master and facility trainers trained in PC 101 in 4 Provinces. 9 Provincial Primary Health	Master and facility trainers trained in PC 101 in an additional 4	OHSS: 0	Overall PEPFAR SA COP 16 budget will be reduced by	16772	5. Human Resources for Health: 11.2	X	X	X		X

	Care Coordinators monitor the ward-based outreach teams.	provinces.		15.2 %							
TA provided to the NDOH to provide mandatory guidance to all levels of the health care system, and other stakeholders such as HEIs, Statutory Councils towards development, integration and implementation of HIV/ AIDS interventions. (PEPFAR HRH OBJ 2)	Mid-level worker policy developed and transitioned to NDOH. Nursing qualification policies being developed	Nursing qualification policy developed and transitioned to NDOH.	OHSS: 125 000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2 %	17767	5. Human Resources for Health: 11.2	X	X	X		X
	Development of a National Nursing Education Policy Framework	Policy Framework finalized & piloted in 3 NEI's supported by NEPI	OHSS: 75 000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2%	13923	5. Human Resources for Health: 11.2	X	X	X		X
Support the National and Provincial DOH in the development and implementation of HRIS for HR Planning, HR Development and redeployment of HIV /AIDS trained staff to high yield sites.	HRIS used to deploy community service HCWs and foreign doctors to high yield scale-up sites.	HRIS used to quantify HRH providing services in high yield scale-up sites (WISN)	OHSS: 881 000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2%	13682	5. Human Resources for Health: 11.2	X	X	X		X
	PEPFAR transition database provides information on the transition process to NDOH	PEPFAR transition database provides information on the transition process to NDOH	OHSS: 100 000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2%	13709	5. Human Resources for Health: 11.2	X	X	X		X

	HRIS used to support HRH capacity building for HCW to provide quality HIV/AIDS services in high burden scale-up areas in 3 provinces.	HRIS used to support HRH capacity building for HCW to provide quality HIV/AIDS services in high burden scale-up areas in in 3 additional provinces.	OHSS: 405 000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2 %	13709	5. Human Resources for Health: 11.2	X	X	X		X
HIV and TB cost modelling	Updated National AIDS Cost Model and the National TB cost model to reflect updates in new HIV and TB policy for determining future budgets for HIV and TB	Updated National AIDS Cost Model and the National TB cost model to reflect updates in new HIV and TB policy for determining future budgets for HIV and TB	OHSS: 50,000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2 %	17025	2. Financial/ Expenditure Data: 15.5 10. Allocative Efficiency: 10.0	X	X	X	X	X
Cost effectiveness research for HIV interventions	Investment case updated to determine most cost effective HIV/AIDS interventions at the Provincial level. Cost effectiveness analysis of key HIV service delivery interventions conducted and	Investment case updated to determine most cost effective HIV/AIDS interventions at the Provincial level. Cost effectiveness analysis of key HIV service	HBHC: 196,795; HTXS: 590,384; HVTB: 223,034; MTCT: 91,838; PDCS: 52,479; PDTX: 157,436; HVSI: 536,759	Overall PEPFAR SA COP 16 budget will be reduced by 15.2 %	17025	2. Financial/ Expenditure Data: 15.5 11. Technical Efficiency: 12.0	X	X	X	X	X

	results disseminated to inform program policy. Key interventions include HCT, third line regimens, MDR-TB treatment, integrated HIV care and treatment, supply chain strengthening, treatment and retention of adolescents, and alternate booking systems.	delivery interventions conducted and results disseminated to inform program policy. Key interventions include HCT, third line regimens, MDR-TB treatment, integrated HIV care and treatment, supply chain strengthening , treatment and retention of adolescents, and alternate booking systems.									
HIV budgeting and execution support	Cost projections for the HIV/TB Provincial Strategic Implementation Plans and training of provincial managers to budget and track HIV expenditure. Evidenced based budget bids for HIV services developed and	Cost projections for the HIV/TB Provincial Strategic Implementation Plans and training of provincial managers to budget and track HIV expenditure. Evidenced based budget	OHSS: 201,276	Overall PEPFAR SA COP 16 budget will be reduced by 15.2 %	17025	10. Allocative Efficiency: 10.0	X	X	X	X	X

	submitted to National Treasury to secure future year funding.	bids for HIV services developed and submitted to National Treasury to secure future year funding.									
Support the DOH to provide strategic and operational leadership and management towards providing effective and efficient delivery of high quality HIV/AIDS services in high yield PEPFAR priority sites.	In service training model developed to train facility managers to use epidemiology for making decisions towards providing HIV/AIDS services in high HIV disease burden scale-up areas.	15 facility managers & data collection team members trained to use epidemiology for making decisions towards providing HIV/AIDS services in high HIV disease burden scale-up areas	OHSS: 150,000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2 %	17769	5. Human Resources for Health: 11.2	X	X	X		X

	5 Provincial policy & planning units are able to develop Strategic and annual performance plans which include the HIV/AIDS district and provincial plans. Strategic plans to build the HRH leadership capacity at District, sub district levels developed. Job profiles & competencies for Drs, Pharmacists developed. Provincial and district managers from 8 provinces are able to quantify HRH providing services at high yield scale-up sites.	Mentorship of the 5 policy and planning units transitioned to DOH. 3 additional provincial planning units are able to develop Strategic and annual performance plans which include the HIV/AIDS district and provincial plans. Job profiles & competencies for Pharmacy Assistants developed.	OHSS: 175 000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2 %	17767	5. Human Resources for Health: 11.2	X	X	X		X

	Training model to provide HIV/AIDS services using a change management approach developed and tested. Competencies for district managers developed & assessments completed in 4 districts. Office of Health Standards Compliance accreditation of facilities supported. Alternate access to chronic medication including ART systems development and implementation.	Training model to provide HIV/AIDS services using a change management approach roll out in 2 high yield districts. Competencies for district managers developed & assessments completed in 6 additional districts. Office of Health Standards Compliance accreditation of facilities supported.	OHSS: 1,800 000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2 %	13797	5. Human Resources for Health: 11.2	X	X	X		X
Support the NDOH in the development and implementation of new service delivery models to provide high quality standardized services with high HIV/AIDS burden scale-up sites.	Development of a manual for clinics to provide quality standardized services within high HIV/AIDS burden scale-up sites.	No intervention	OHSS: 100,000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2 %	16583	5. Human Resources for Health: 11.2	X	X	X		X

	200 ICSM clinics rolled-out	500 ICSM clinics rolled-out	MTCT: 100,000; HTXS: 100,000; PDTX: 100,000; HVTB:100,000; HBHC:100,000; PDCS100,000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2 %	9464; 17020; 16583; 13761; 17039; 17023; 17024; 17036; 13797; 16584; 17046; 17038; 17021; 17037	4. Access and Demand: 12.4	X	X	X	X	X
	Model for a dashboard that assess compliance and measures the quality of systems to provide the HIV care within a clinic developed	Pilot of the dashboard at all PEPFAR supported clinics and districts.	OHSS: 200 000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2 %	13797	7. Quality Management: 7	X	X	X		X
Support HIV/AIDS integration in the Integrated Chronic Services Management (ICSM).	200 ICSM clinics rolled-out	500 ICSM clinics rolled-out	MTCT: 100,000; HTXS: 100,000; PDTX: 100,000; HVTB:100,000; HBHC:100,000; PDCS100,000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2 %	9464; 17020; 16583; 13761; 17039; 17023; 17024; 17036; 13797; 16584; 17046; 17038; 17021; 17037	4. Access and Demand: 12.4	X	X	X	X	X

Provide TA Central Procurement Unit at NDoH to improve forecasting and supplier management for ARVS	Key personnel trained on nationwide drug forecasting, including ARVs. Permanent staff positions created and advertised for HIV drug forecasting and drug supplier contract management.	Permanent staff positions for HIV drug forecasting and contract management hired.	OHSS: 300,000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2%	14617	6. Commodity Security and Supply Chain: 14.0	X	X	X	X	X
Development and roll out of Supply Chain Control Tower Model to improve drug visibility and logistics, including ARVs	Model established in 3 new Provinces	Model established in 2 new Provinces	OHSS: 1,000,000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2%	14617; 9526	6. Commodity Security and Supply Chain: 14.0	X		X		X
Roll out of Electronic Logistics Management Information Systems for facilities and Provincial Control Towers.	Rx Solution operating in 615 new clinics, Rx PMPU established in 3 new Provincial Control Towers.	Rx Solution operating in 615 new clinics, Rx PMPU established in 3 new Provincial Control Towers.	OHSS; HVSI: $3,863,241	Overall PEPFAR SA COP 16 budget will be reduced by 15.2%	14617; 9526	6. Commodity Security and Supply Chain: 14.0	X		X		X
Support to roll out Centralized Chronic Medicines Dispensing and Distribution support to improve access to ARVs at the lowest levels of the system	Community pick up points and direct delivery models reaching 20% of eligible patients.	Community pick up points and direct delivery models reaching 40% of eligible patients.	OHSS: 500,000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2 %	14617; 9526	6. Commodity Security and Supply Chain: 14.0	X		X		X

Pharmaceutical Budget Development Program for pharmacists to improve budgeting, planning and forecasting for pharmaceuticals, including ARVs	320 facility level pharmacists trained in budgeting, planning and forecasting for pharmaceuticals including ARVs.	320 facility level pharmacists trained in budgeting, planning and forecasting for pharmaceuticals including ARVs.	OHSS: 200,000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2%	14617	6. Commodity Security and Supply Chain: 14.0	X		X		X
TA to develop National Pharmaceutical Procurement Policy	National drug procurement policy developed to include ARVs and other HIV kits		OHSS: 500,000	Overall PEPFAR SA COP 16 budget will be reduced by 15.2%	14617; 9526	6. Commodity Security and Supply Chain: 14.0	X		X		X

7.0 Staffing Plan

The PEPFAR COP15 staffing plan aligns with the strategic decision to focus on achieving epidemic control in the highest burden areas of the country. Staff are positioned to provide TA and oversight in program areas determined to be core and near-core. To promote sustainability of the program, PEPFAR aims to recruit highly qualified locally employed staff (LES) and is proactively working to improve staff retention. Locally employed staff are playing a critical role in the provision of TA, and enhancing the USG relationships with South African government and other key stakeholders.

The DREAMS Initiative will lead to an increased focus on programs addressing the needs of young women and girls. Thus far, agencies have tasked existing staff to work on the initiative. The increased use of strategic information, data, and analysis of that data to inform programmatic decision making, not only for DREAMS but for all programs, will require additional SI-focused staff; either permanent or as mid- to long-term consultants. Existing staff positions are being repurposed to fill programmatic needs and new positions may be required.

Substantial increases in staff time and effort will also be needed to effectively implement SIMS. Limitations set by the Department of State on the U.S. government staffing footprint in South Africa and the limited capacity of the U.S. Mission to support additional staff means that it is unlikely that PEPFAR implementing agencies will be authorized to hire new staff. USAID will revisit plans to engage a contractor to assist with specific elements of the SIMS process pending results of efforts to implement SIMS without external support. CDC will utilize a percentage of the approved COP14 SMS positions for SIMS.

The cost of doing business for all PEPFAR agencies will increase due to inflation in South Africa. However, CDC will experience a steeper increase directly related to increased ICASS and OBO costs CDC is moving from its current leased space into a newly constructed government office building in August 2015. CDC will incur salary and support costs for three previously approved LE staff. All PEPFAR agencies will incur added travel costs related to SIMS.

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP15			
Program Area	**Core Activities**	**Near-core Activities**	**Non-core Activities**
HTC			
	Facility and community-based HTC including door-door; client index model, demand creation, test and treat (i.e., fast track referral), linkages to C&T, targeted HTC in work places, education institutions, and POC CD4 testing. HTC social mobilization for AGWY in informal settlements, other high risk sites. HCT campaigns in priority districts. Provide TA for monitoring special campaigns. Enhance counseling and support for vulnerable AGYW 10-19 testing positive. QA training/mentoring for rapid tests. POC CD4, counseling QA tools.	National linkages guidelines, national register revision; training for couples testing and home-based HTC; training on HTC data reporting.	
Care and Treatment			
Estimation of HIV/TB burden	For adults, pediatrics, adolescents, pregnant women, CSW, MSM, prisoners, miners/communities, and informal settings: • Review existing HIV and TB data • District level mapping and planning/Know your Epidemic, Know your Response • Key micro epidemics mapping	For IDU: • Review existing HIV and TB data • District level mapping and planning, know epidemic, and know response • Key micro epidemic mapping	

Diagnostics	For adults: Training for all key components of HIV/TB diagnostics •Mentoring on all key components of HIV/TB diagnostics •Implement quality improvement methodology to improve performance in all aspects of HIV/TB diagnosis •Facility-based PITC •Routine TB screening/diagnostic for TB suspects For pediatrics: •Same as for adults •EID •Scale-up of 'Blueprint for Action' For adolescents: •Same as for adults •Adolescent-friendly testing services For pregnant women: •Same as for adults •Implementation of PMTCT guidelines For FSW/MSM: •Same as for adults •Testing services for FSW/MSM For prisoners, miners, communities/informal settings/farm workers •Same as for adults •Testing services for those communities	For PWID: • Same as adults • Testing services for PWID	
Linkage to Care	For adults, adolescents, FSW, MSM, miners/communities, informal settings, and farm workers: • Training for all key components of HIV/TB linkage to care • Mentoring on all key components of HIV/TB linkage to care • Implement quality improvement methodology to improve performance in all aspects of HIV/TB linkage to care • Destigmatization of services • Pre-test and post-testing	For PWID: •Training for all key components of HIV/TB linkage to care •Mentoring on all key components of HIV/TB linkage to care •Implement quality improvement methodology to improve performance in all aspects of HIV/TB linkage to care •De-stigmatization of services •Pre- and post-testing counseling •IACT •Referral/follow-up of linkage and enrollment in care	

	counseling • IACT • Referral/follow-up of linkage and enrollment in care • Appointment/patient-reminder systems • Identification of early LTFU/tracing of LTFU patients • IPT • PHDP (e.g., risk reduction counseling, condom provision, partner testing, treatment adherence counseling, STI screening and management, family planning) For pediatrics: • Same as for adults • Mother-infant pair follow-up For pregnant women: • Same as for Adults • MomConnect For male inmates: • Same as for adults • Linkage to care post-release from prison	• Appointment/patient-reminder systems • Identification of early LTFU/ Tracing of LTFU patients • IPT • PHDP (e.g., risk reduction counseling, condom provision, partner testing, treatment adherence counseling, STI screening and management, family planning)	
Treatment Initiation / Treatment Maintenance/Viral Load Suppression	For adults, male inmates, miners/communities: •Training and Mentoring for all key components Nof HIV/TB treatment and clinical care •Implement quality improvement methodology to improve performance in all aspects of HIV/TB treatment and clinical care •Implementation of 'Consolidated ART Guidelines' and 'TB Treatment Guidelines' •DR-TB management in co-infected patients •Scale-up of NIMDR-TB program •Screening and management of drug side effects, drug resistance, and clinical depression •Routine nutritional assessment and management of malnutrition •Implement cryptococcal screen-and-treat	For PWID: • Same as for adults • Treatment services for PWID	• Home-based palliative care • End-of-life care

	•SRH services •Nutrition services • PHDP • Support effective integration of services • Improve quality of clinical patient records • Strengthen advanced clinical management of HIV For pediatrics: • Same as for Adults • Scale-up of 'Blueprint for Action' • Infant nutrition and breastfeeding • Integration of HIV, EPI, IMCI services For adolescents: • Same as for Adults • Integrated adolescent-friendly treatment services • Integration with SRH services For pregnant women: • Same as for Adults • Implementation of 'PMTCT Guidelines' (B+) • Mother-infant pair follow-up • Integration with FP and nutrition services For FSW, MSM, Informal settlements and farm workers: • Same as for adults • Treatment services for those communities		
Retention in Care/ Treatment Adherence	For adults, adolescents, pregnant women, rape, survivors, FSW, MSM, prisoners, miners/communities, informal settlement, farm workers: • Training and mentoring for all key components of HIV/TB treatment retention in care • Implement quality improvement methodology to improve	For IDU: • Training and Mentoring for all key components of HIV/TB treatment retention in care • Implement quality improvement methodology to improve performance in all aspects of HIV/TB retention in care • Destigmatization of services	

	performance in all aspects of HIV/TB retention in care • Destigmatization of services • Adherence counseling • Development of educational materials on adherence • IACT • Adherence clubs • Appointment/patient-reminder systems • Identification of missed appointments / Tracing of LTFU patients • SRH services • Viral load testing every 12 months For pediatrics • Same as for adults • Mother-infant pair follow-up	• Adherence counseling • Development of educational materials on adherence • IACT • Adherence clubs • Appointment/patient-reminder systems • Identification of missed appointments/tracing of LTFU patients • SRH services • Viral load testing every 12 months	
Supportive Systems	Ideal clinic: • Implementation of HIV related aspects Pharmacy: • Facility forecasting, ordering and supply management • District forecasting, ordering and supply management • Training pharmacy assistants • Rx solutions Clinic-lab interface • Quality of specimens • Feedback loop strengthened and timely Infection Control • Support implementation of IC at facility level • Capacitate for IC planning, management and assessments Pharmacovigilance • Establish pharmacovigilance in districts/hospitals Drug resistance:	SI: • DHIS Leadership/management: • LMT for HIV program managers at district level • LMT for other managers at district or higher level • District health planning • Develop district capacity for conducting clinical services training, mentoring and supportive supervision HR support: • Strategic HIV program leadership staff (e.g., district, provincial, national) • Essential clinical staff in non-focused districts Drug procurement: • Second and third line ARVs Evaluations: • Other program evaluations that may be evaluated for refined	Ideal clinic: • Implementation of non-HIV related aspects Drug procurement: • First line ARVs • TB drugs Infrastructure: • Health facility equipment and infrastructure • Health facility maintenance and ops support Evaluations: • Implementation science

	• Support national HV DR surveillance SI: • TIER.net scale up • ETR/EDR scale up • Support data quality improvement and data use Leadership/management: • LMT for facility managers HR Support • Essential clinical staff in focused districts Evaluations: • Outcome evaluations • Evaluation of benefit, outcome, and/or impact of PEPFAR-supported programs and interventions	prioritization	
Prevention			
VMMC	VMMC services delivery (e.g., CQI, EQA, DQA), training for service providers, demand creation through mass media and social mobilization.	MMC unit cost study Adolescent MMC study	VMMC policy development
Condoms	Condoms (male and female): improved distribution, increase access at secondary community level sites; social marketing for demand creation and increased use, especially among young women and partners, and key populations.		
Behavior Change	Risk reduction and behavior change for pre/early adolescent girls and boys through school-based programs; link with MMC. Improved quality of school-based interventions.	National campaigns National population based survey to assess communications programs Improve interventions with pre-adolescents to reduce SGBV Impact evaluation for sexuality education intervention. Targeted communication interventions (mass communication, local 'out of home' communication, social mobilization) for AGYW	Operations research to explore economic skills building leveraging South African government child care grant, beyond OVC (defer to future year). Studies that can shift to NDOH and local research organizations: Combination prevention impact study, Youth Risk Behavior Survey, Educator HIV-Survey

		and young males to increase service uptake, condom use and reduce risky behaviors, shift gender norms. TA to make FP, HTC, STI services acceptable to adolescents. Skills building for parents, teachers, caregivers to communicate, monitor youth behavior.	
AGYW	Risk reduction and behavior change, gender norms change among adolescent girls, young women and young men – small group interventions for linkages to FP, condoms HTC, MMC, and increase condom use. Focus in-school, after-school, in communities, in higher-education institutions.	Use Integrated School Health Program to strengthen linkages with SRH services Risk reduction and behavior change, gender norms change among adolescent girls, young women and young men - small group interventions for linkages to FP, condoms HTC, MMC, increase condom use and reduce GBV. Focus in-school, after-school, in communities, in higher-education institutions.	
PHDP	Prevention with positives (see C&T)		
GBV	Post-rape/assault care, including PEP provision and adherence, HCT, comprehensive care. Community mobilization to increase awareness of available post-rape/assault services.	Capacity building for providers to manage SGBV cases. Pilot intervention to build evidence for scale-up option to address alcohol abuse as driver of GBV and HIV GBV and HIV incidence study	Strengthen local leaders' capacity to lead community support for local responses to reduce HIV and GBV
Migrant Populations	Migrant/mobile populations – HTC, risk reduction, linkages to C&T, condoms, MMC, and address GBV.	Sensitize NDOH health workers to increase services to migrants	Address human rights for migrants
Key Populations	Key Populations (e.g., FSW, MSM, PWID): Direct service delivery providing condoms and lubricants, condom negation skills, risk reduction counseling, HTC, successful linkages to care and treatment, PEP, STI screening and treatment. Peer-led prevention interventions. Targeted sensitization training and mentoring of health care workers to the needs of key populations. Introducing PreP with sex workers	Family planning for FSWs (mostly by public health facilities). Alcohol and substance abuse education. Gender norms and GBV for FSWs, but beginning to transfer to NGOs and NDoH.	Development of policies and guidelines, PEPFAR staff support and provide TA.

	and MSM. Harm reduction programs for PWID through a demonstration project.		
Male inmates	Inmates: HTC, condoms and lube distribution and demonstrations	Inmates: peer education and mobilization for services uptake, risk reduction	
OVC			
Case Management	• Assessing child & family socio-economic status (across all areas: healthy, safe, stable, schooled). • Developing care / case management plans for vulnerable HH (children & caregivers) with monitoring of referral completion and case closure goals. • Implementing special studies to measure programming impact & identify gaps. • Identifying children and adolescent subpopulations made vulnerable by or to HIV and AIDS and linking them to appropriate HIV prevention, care and treatment services.	• Mapping services within targeted communities, review existing networking & referral mechanisms and developing service directories. • Supporting the development of National Management Information systems. • Training in case management for CCG, CYCW, SAW & SW within PEPFAR catchment areas.	
Healthy (Access to Health/HIV Services)	• Promotion of HIV testing of OVC program participants, including EID, and confirmatory HIV testing • Implement interventions focused on keeping adolescents HIV-free for those who test HIV-negative, especially adolescent girls, • Coordination with health facilities and counseling providers to ensure that dual protection is accessible to adolescent OVC • Facilitating uptake of and monitoring successful referrals • Integrating care and treatment adherence assessment, counseling, support and retention into routine household support using family centered approach • Addressing psychosocial health	• Strengthening referral mechanisms and other systems for linking clinical and social services (cross-referrals) • Strengthen psychosocial wellbeing polices & guidelines • Improve and institutionalize HIV prevention community interventions as part of DSD basket of services	• Providing HH supplies such as blankets and mattresses. • Providing food packages / nutritional support.

	among children and their caregivers through individual, group-based and relationship-based activities. • Coordination with NACS (e.g., referral of suspected malnutrition, nutrition education)		
Safe (Protection)	• Supporting Community and national level child protection/GBV prevention and response activities. • Supporting clinic-based child abuse and GBV response services (access) especially given the rates of sexual violence against children (especially girls). The DREAMS initiative may be used as a vehicle for improving access to comprehensive GBV response services including PEP for sexual assault. • Positive Parenting skills (including discipline, communication on adolescent risk, HIV disclosure) • Support to "safe spaces" approach for adolescents at high risk especially girls • Skill building for improved parent child communication & prevention of child abuse interventions.. • Facilitating birth registration and succession planning.	• Strengthening government-managed and case management systems to prevent and respond to child abuse especially sexual abuse. • Strengthening structures for community-based mediation of child abuse cases. • Support to develop child protection policy for Children's Act. • Professional Development for child and youth care, social and para-social workers. • M&E systems for National child protection / social welfare efforts.	• Carrying out large-scale child rights awareness campaigns. Supporting advocacy and policy efforts to improve safety of children from violence.
Stable (including economic strengthening)	• Facilitating group-based Household Economic Strengthening (HES) activities, such as savings groups. • Supporting access to and uptake of social protection efforts (such as social grants, bursaries, etc.)	• Supporting vocational training and other individual HES activities. • Supporting market linked vocational training and other individual HES activities • Carrying out market assessments for Income generating Activities (IGAs)	• Directly supporting IGAs with funds and other inputs. • Support for food gardens.

	• Positive Parenting skills building (including topics on adolescent risk, HIV disclosure, child health & development knowledge). • Succession planning & family functioning.	• Linking businesses/agricultural projects to markets/value chain development	
Schooled (Education)	• Focus on progression and retention of children in schools • Advocate for children in no fee schools • Structured, measured small group HIV prevention Education combined with skill building & gender norms shifts • Facilitating access to primary and secondary education through PEPFAR supported CBOS and FBOs referral networks to DSD and DBE • School-based psychosocial support (including psychosocial support for children [cash+care]; after school programs for behavior risk reduction. • Supporting early childhood development (ECD) at the HH level - (in coordination with PMTCT & Pediatric HIV). • School based Sexuality Education: HIV education, SRH & risk reduction behaviors • Effectively using PEPFAR-supported partners to integrate ECD into HIV care & treatment for children under five & their care givers.	• Facilitating access to primary (and secondary education for girls). • Improving education quality, especially making classroom environments gender and HIV sensitive. • Based on analysis of gender • disparities in completion rates (primary and secondary levels) • identify key at risk groups for education support • Facilitating access to primary and secondary education through temporary and targeted support,	• Supporting community education councils and PTAs. • Support to purchase school uniforms • Providing temporary school • block grants to promote • enrollment and progression
SI			
Formative Work, Demonstrations, Projects	Conduct mapping, population size estimation for key populations (e.g. MSM, FSW, etc.) and a bio-behavioral survey in the target geographic	▪ Maternal mortality survey (MIMMS) ▪ Conduct activities to inform establishing an HIV surveillance system in correctional facilities and if routine program monitoring	Formative Work, Demonstrations, Projects

	area	data be used for surveillance	
Surveys and Surveillance	• HSRC Household Survey • KZN HIV Incidence project (HIPSS project)	• GBV Survey • National Communication Survey (NCS)	• Technical Assistance for DHS • Procurement and TA for DHS
Health Management Information Systems	• Provide support to the NDoH for HMIS development, deployment and management for web-based DHIS and other systems • Support eHealth/mHealth initiative and implementation: Strategic Information capacity building to strengthen health information systems • Drug HMIS- training and support of RxSolutions to improve access to medicines in South Africa	• Building a sustainable e-Learning program • National Health Information Systems of South Africa (NHISSA) and Health Information Systems Task Team structures	• Scale-up of mHealth activities related to the NDOH • MomConnect maternal messaging project • Data Capturer (3535)Training
Program Planning & Monitoring	• Develop, manage and maintain DATIM for PEPFAR reporting • Developing capacity of national, provincial and district officials in application and use of GIS data and tools • Strategic Information Capacity Building for Data Quality and Use	• Strengthen facility drug adverse events and pharmacovigilance • Provincial M&E Staff hired and placed at provincial AIDS councils • Development and implementation of Technical Assistance indicators for monitoring how U.S. government funding is supporting and strengthening the national health system	• Develop, manage and maintain system for PEPFAR reporting
Program Evaluations & Operations Research	• TIER.net enhancement, expansion (e.g. Phase 6) and evaluation • Support NDOH with cost and budget modelling for HIV and TB programs	• Pre-ART surveillance (defining the program cascade - testing->Rx initiation) • Strengthening data collection of cause-specific mortality (vital registration system) • ANC/PMTCT comparison/assessment	
Laboratory			
Site Level	**1. Support improvement of quality of Lab diagnostic services:**	**1. Support improvement of quality of Lab diagnostic services:** • WHO-ASLM Accreditation initiative and site	

	• QA for POCT • Training of HCW on QA	supervision Training of skilled laboratory workforce: Dx, monitoring, and IC	
	2. Lab-based surveys and surveillance and OP research: • Lab testing for Key population studies supporting Prevention Programs • Lab testing for National priority surveys and surveillance activities (TB and HIV)		
	3. Support implementation of Lab testing cost saving measures (EGK): • Electronic Gate Keeping (EGK) and Laboratory Intelligence Unit		
	4. Laboratory System Strengthening: • Quality assurance for general lab activities (Clinic-Lab interface)		

Table A.2 Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Care and Treatment			
Site level	TA for CT services implementation and quality improvement Diagnostics For adults: • Training for all key components of HIV/TB diagnostics • Mentoring on all key components of HIV/TB diagnostics • Implement quality improvement methodology to improve performance in all aspects of HIV/TB diagnosis • Facility-based PITC	Diagnostics For IDU: • Training for all key components of HIV/TB diagnostics • Mentoring on all key components of HIV/TB diagnostics • Implement quality improvement methodology to improve performance in all aspects of HIV/TB diagnosis • Facility-based PITC • Routine TB screening/diagnostic for TB suspects	Within Treatment Initiation / Treatment Maintenance / Viral Load Technical Area: • Home-based palliative care • End-of-life care Within Supportive Systems Technical Area: Ideal clinic: • Implementation of non-HIV related aspects

	• Routine TB screening/diagnostic for TB suspects For pediatrics: • Same as for adults • EID • Scale-up of 'Blueprint for Action' For adolescents: • Same as for adults • Adolescent-friendly testing services For pregnant women: • Same as for adults • Implementation of PMTCT guidelines For CSW/MSM: • Same as for adults • Testing services for CSW/MSM For prisoners, miners, communities/informal settings/farm workers • Same as for adults Testing services for those communities Linkage to Care For adults, adolescents, CSW, MSM, miners/communities, informal settings, and farm workers: • Training for all key components of HIV/TB linkage to care • Mentoring on all key components of HIV/TB linkage to care • Implement quality improvement methodology to improve performance in all aspects of HIV/TB linkage to care • Destigmatization of services	Testing services for IDU Linkage to Care For IDU: • Training for all key components of HIV/TB linkage to care • Mentoring on all key components of HIV/TB linkage to care • Implement quality improvement methodology to improve performance in all aspects of HIV/TB linkage to care • Destigmatization of services • Pre- and post-testing counseling • IACT • Referral/follow-up of linkage and enrollment in care • Appointment/patient-reminder systems • Identification of early LTFU/ Tracing of LTFU patients • IPT • PHDP (e.g., risk reduction counseling, condom provision, partner testing, treatment adherence counseling, STI screening and management, family planning) Treatment Initiation / Treatment Maintenance / Viral Load Suppression For IDU: • Training and Mentoring for all key components of HIV/TB treatment and clinical care • Implement quality	

	• Pre-test and post-testing counseling • IACT • Referral/follow-up of linkage and enrollment in care • Appointment/patient-reminder systems • Identification of early LTFU/tracing of LTFU patients • IPT • PHDP (e.g., risk reduction counseling, condom provision, partner testing, treatment adherence counseling, STI screening and management, family planning) For pediatrics: • Same as for adults • Mother-infant pair follow-up For pregnant women: • Same as for Adults • MomConnect For prisoners: • Same as for adults Linkage to care post-release from prison Treatment Initiation / Treatment Maintenance / Viral Load Suppression For adults, prisoners, miners/communities: • Training and Mentoring for all key components of HIV/TB treatment and clinical care • Implement quality improvement methodology to improve performance in all aspects of HIV/TB treatment and clinical care • Implementation of 'Consolidated ART Guidelines' and 'TB Treatment Guidelines' • DR-TB management in co-	improvement methodology to improve performance in all aspects of HIV/TB treatment and clinical care • Implementation of 'Consolidated ART Guidelines' and 'TB Treatment Guidelines' • DR-TB management in co-infected patients • Scale-up of NIMDR-TB program • Screening and management of drug side effects, drug resistance, and clinical depression • Routine nutritional assessment and management of malnutrition • Implement cryptococcal screen-and-treat • SRH services • Nutrition services • PHDP • Support effective integration of services • Improve quality of clinical patient records • Strengthen advanced clinical management of HIV • Treatment services for IDU Retention in Care / Treatment Adherence For IDU: • Training and Mentoring for all key components of HIV/TB treatment retention in care • Implement quality improvement methodology to improve performance in all aspects of HIV/TB retention in care	

	infected patients • Scale-up of NIMDR-TB program • Screening and management of drug side effects, drug resistance, and clinical depression • Routine nutritional assessment and management of malnutrition • Implement cryptococcal screen-and-treat • SRH services • Nutrition services • PHDP • Support effective integration of services • Improve quality of clinical patient records • Strengthen advanced clinical management of HIV For pediatrics: • Same as for Adults • Scale-up of 'Blueprint for Action' • Infant nutrition and breastfeeding • Integration of HIV, EPI, IMCI services For adolescents: • Same as for Adults • Integrated adolescent-friendly treatment services • Integration with SRH services For pregnant women: • Same as for Adults • Implementation of 'PMTCT Guidelines' (B+) • Mother-infant pair follow-up • Integration with FP and nutrition services	• Destigmatization of services • Adherence counseling • Development of educational materials on adherence • IACT • Adherence clubs • Appointment/patient-reminder systems • Identification of missed appointments/tracing of LTFU patients • SRH services • Viral load testing every 12 months	

	For CSW, MSM, Informal settlements and farm workers: • Same as for adults Treatment services for those communities Retention in Care / Treatment Adherence For adults, adolescents, pregnant women, CSW, MSM, prisoners, miners/communities, informal settlement, farm workers: • Training and mentoring for all key components of HIV/TB treatment retention in care • Implement quality improvement methodology to improve performance in all aspects of HIV/TB retention in care • Destigmatization of services • Adherence counseling • Development of educational materials on adherence • IACT • Adherence clubs • Appointment/patient-reminder systems • Identification of missed appointments / Tracing of LTFU patients • SRH services • Viral load testing every 12 months For pediatrics • Same as for adults Mother-infant pair follow-up Supportive Systems Ideal clinic: • Implementation of HIV related aspects Pharmacy: • Facility forecasting, ordering		

	and supply management • Rx solutions Clinic-lab interface • Quality of specimens • Feedback loop strengthened and timely Infection Control • Support implementation of IC at facility level SI: • TIER.net scale up • ETR/EDR scale up • Support data quality improvement and data use		
Sub-national level	TA for CT program planning and implementation Estimation of HIV/TB Burden For adults, pediatrics, adolescents, pregnant women, CSW, MSM, prisoners, miners/communities, and informal settings: • Review existing HIV and TB data • District level mapping and planning/Know your Epidemic, Know your Response Diagnostics For adults: • Training for all key components of HIV/TB diagnostics • Mentoring on all key components of HIV/TB diagnostics • Implement quality improvement methodology to improve performance in all aspects of HIV/TB diagnosis	Estimation of HIV/TB Burden For IDU: • Review Existing HIV and TB data • District level mapping and planning, know epidemic, and know response Diagnostics For IDU: • Training for all key components of HIV/TB diagnostics • Mentoring on all key components of HIV/TB diagnostics • Implement quality improvement methodology to improve performance in all aspects of HIV/TB diagnosis • Facility-based PITC • Routine TB screening/diagnostic for TB suspects Testing services for IDU	Within Treatment Initiation / Treatment Maintenance / Viral Load Technical Area: • Home-based palliative care • End-of-life care Within Supportive Systems Technical Area: Ideal clinic: • Implementation of non-HIV related aspects Infrastructure: • Health facility equipment and infrastructure • Health facility maintenance and ops support

	• Facility-based PITC • Routine TB screening/diagnostic for TB suspects For pediatrics: • Same as for adults • EID • Scale-up of 'Blueprint for Action' For adolescents: • Same as for adults • Adolescent-friendly testing services For pregnant women: • Same as for adults • Implementation of PMTCT guidelines For CSW/MSM: • Same as for adults • Testing services for CSW/MSM For prisoners, miners, communities/informal settings/farm workers • Same as for adults Testing services for those communities Linkage to Care For adults, adolescents, CSW, MSM, miners/communities, informal settings, and farm workers: • Training for all key components of HIV/TB linkage to care • Mentoring on all key components of HIV/TB linkage to care • Implement quality improvement methodology to improve performance in all aspects of HIV/TB linkage to care	Linkage to Care For IDU: • Training for all key components of HIV/TB linkage to care • Mentoring on all key components of HIV/TB linkage to care • Implement quality improvement methodology to improve performance in all aspects of HIV/TB linkage to care • Destigmatization of services • Pre- and post-testing counseling • IACT • Referral/follow-up of linkage and enrollment in care • Appointment/patient-reminder systems • Identification of early LTFU/ Tracing of LTFU patients • IPT • PHDP (e.g., risk reduction counseling, condom provision, partner testing, treatment adherence counseling, STI screening and management, family planning) Treatment Initiation / Treatment Maintenance / Viral Load Suppression For IDU: • Training and Mentoring for all key components of HIV/TB treatment and clinical care • Implement quality improvement methodology to improve performance in all	

	• Destigmatization of services • Pre-test and post-testing counseling • IACT • Referral/follow-up of linkage and enrollment in care • Appointment/patient-reminder systems • Identification of early LTFU/tracing of LTFU patients • IPT • PHDP (e.g., risk reduction counseling, condom provision, partner testing, treatment adherence counseling, STI screening and management, family planning) For pediatrics: • Same as for adults • Mother-infant pair follow-up For pregnant women: • Same as for Adults • MomConnect For prisoners: • Same as for adults Linkage to care post-release from prison Treatment Initiation / Treatment Maintenance / Viral Load Suppression For adults, prisoners, miners/communities: • Training and Mentoring for all key components of HIV/TB treatment and clinical care • Implement quality improvement methodology to improve performance in all aspects of HIV/TB treatment and clinical care • Implementation of 'Consolidated ART Guidelines' and 'TB Treatment Guidelines'	aspects of HIV/TB treatment and clinical care • Implementation of 'Consolidated ART Guidelines' and 'TB Treatment Guidelines' • DR-TB management in co-infected patients • Scale-up of NIMDR-TB program • Screening and management of drug side effects, drug resistance, and clinical depression • Routine nutritional assessment and management of malnutrition • Implement cryptococcal screen-and-treat • SRH services • Nutrition services • PHDP • Support effective integration of services • Improve quality of clinical patient records • Strengthen advanced clinical management of HIV • Treatment services for IDU Retention in Care / Treatment Adherence For IDU: • Training and Mentoring for all key components of HIV/TB treatment retention in care • Implement quality improvement methodology to improve performance in all aspects of HIV/TB retention in care • Destigmatization of services • Adherence counseling	

	• DR-TB management in co-infected patients • Scale-up of NIMDR-TB program • Screening and management of drug side effects, drug resistance, and clinical depression • Routine nutritional assessment and management of malnutrition • Implement cryptococcal screen-and-treat • SRH services • Nutrition services • PHDP • Support effective integration of services • Improve quality of clinical patient records • Strengthen advanced clinical management of HIV For pediatrics: • Same as for Adults • Scale-up of 'Blueprint for Action' • Infant nutrition and breastfeeding • Integration of HIV, EPI, IMCI services For adolescents: • Same as for Adults • Integrated adolescent-friendly treatment services • Integration with SRH services For pregnant women: • Same as for Adults • Implementation of 'PMTCT Guidelines' (B+) • Mother-infant pair follow-up • Integration with FP and	• Development of educational materials on adherence • IACT • Adherence clubs • Appointment/patient-reminder systems • Identification of missed appointments/tracing of LTFU patients • SRH services • Viral load testing every 12 months Supportive Systems SI: • DHIS Leadership/management: • LMT for HIV program managers at district level • LMT for other managers at district or higher level • District health planning • Develop district capacity for conducting clinical services training, mentoring and supportive supervision HR support: • Strategic HIV program leadership staff (e.g., district, provincial, national) • Essential clinical staff in non-focused districts	

	nutrition services For CSW, MSM, Informal settlements and farm workers: • Same as for adults Treatment services for those communities Retention in Care / Treatment Adherence For adults, adolescents, pregnant women, CSW, MSM, prisoners, miners/communities, informal settlement, farm workers: • Training and mentoring for all key components of HIV/TB treatment retention in care • Implement quality improvement methodology to improve performance in all aspects of HIV/TB retention in care • Destigmatization of services • Adherence counseling • Development of educational materials on adherence • IACT • Adherence clubs • Appointment/patient-reminder systems • Identification of missed appointments / Tracing of LTFU patients • SRH services • Viral load testing every 12 months For pediatrics • Same as for adults Mother-infant pair follow-up Supportive Systems Ideal clinic: • Implementation of HIV related aspects Pharmacy:		

	• Facility forecasting, ordering and supply management • District forecasting, ordering and supply management • Rx solutions Clinic-lab interface • Quality of specimens • Feedback loop strengthened and timely Infection Control • Support implementation of IC at facility level • Capacitate for IC planning, management and assessments Pharmacovigilance • Establish pharmacovigilance in districts/hospitals SI: • TIER.net scale up • ETR/EDR scale up • Support data quality improvement and data use Leadership/management: • LMT for facility managers HR Support • Essential clinical staff in focused districts		
National level	TA for CT strategy, policy and guidelines Estimation of HIV/TB Burden For adults, pediatrics, adolescents, pregnant women, CSW, MSM, prisoners, miners/communities, and informal settings: • Review existing HIV and TB data • District level mapping and planning/Know your Epidemic, Know your Response • Key micro epidemics mapping	Estimation of HIV/TB Burden For IDU: • Review Existing HIV and TB data • District level mapping and planning, know epidemic, and know response • Key micro epidemic mapping Diagnostics For IDU: • Training for all key components of HIV/TB diagnostics	Within Treatment Initiation / Treatment Maintenance / Viral Load Technical Area: • Home-based palliative care • End-of-life care Within Supportive Systems Technical Area: Ideal clinic: • Implementation of non-HIV related aspects Drug procurement: • First line ARVs

	Diagnostics For adults: • Training for all key components of HIV/TB diagnostics • Mentoring on all key components of HIV/TB diagnostics • Implement quality improvement methodology to improve performance in all aspects of HIV/TB diagnosis • Facility-based PITC • Routine TB screening/diagnostic for TB suspects For pediatrics: • Same as for adults • EID • Scale-up of 'Blueprint for Action' For adolescents: • Same as for adults • Adolescent-friendly testing services For pregnant women: • Same as for adults • Implementation of PMTCT guidelines For CSW/MSM: • Same as for adults • Testing services for CSW/MSM For prisoners, miners, communities/informal settings/farm workers • Same as for adults Testing services for those communities Linkage to Care For adults, adolescents, CSW, MSM, miners/communities, informal settings, and	• Mentoring on all key components of HIV/TB diagnostics • Implement quality improvement methodology to improve performance in all aspects of HIV/TB diagnosis • Facility-based PITC • Routine TB screening/diagnostic for TB suspects Testing services for IDU Linkage to Care For IDU: • Training for all key components of HIV/TB linkage to care • Mentoring on all key components of HIV/TB linkage to care • Implement quality improvement methodology to improve performance in all aspects of HIV/TB linkage to care • Destigmatization of services • Pre- and post-testing counseling • IACT • Referral/follow-up of linkage and enrollment in care • Appointment/patient-reminder systems • Identification of early LTFU/ Tracing of LTFU patients • IPT • PHDP (e.g., risk reduction counseling, condom provision, partner testing, treatment adherence	• TB drugs Infrastructure: • Health facility equipment and infrastructure • Health facility maintenance and ops support Evaluations: • Implementation science

	farm workers: • Training for all key components of HIV/TB linkage to care • Mentoring on all key components of HIV/TB linkage to care • Implement quality improvement methodology to improve performance in all aspects of HIV/TB linkage to care • Destigmatization of services • Pre-test and post-testing counseling • IACT • Referral/follow-up of linkage and enrollment in care • Appointment/patient-reminder systems • Identification of early LTFU/tracing of LTFU patients • IPT • PHDP (e.g., risk reduction counseling, condom provision, partner testing, treatment adherence counseling, STI screening and management, family planning) For pediatrics: • Same as for adults • Mother-infant pair follow-up For pregnant women: • Same as for Adults • MomConnect For prisoners: • Same as for adults Linkage to care post-release from prison Treatment Initiation / Treatment Maintenance / Viral Load Suppression	counseling, STI screening and management, family planning) Treatment Initiation / Treatment Maintenance / Viral Load Suppression For IDU: • Training and Mentoring for all key components of HIV/TB treatment and clinical care • Implement quality improvement methodology to improve performance in all aspects of HIV/TB treatment and clinical care • Implementation of 'Consolidated ART Guidelines' and 'TB Treatment Guidelines' • DR-TB management in co-infected patients • Scale-up of NIMDR-TB program • Screening and management of drug side effects, drug resistance, and clinical depression • Routine nutritional assessment and management of malnutrition • Implement cryptococcal screen-and-treat • SRH services • Nutrition services • PHDP • Support effective integration of services • Improve quality of clinical patient records • Strengthen advanced clinical management of HIV • Treatment services for IDU	

	For adults, prisoners, miners/communities: • Training and Mentoring for all key components Nof HIV/TB treatment and clinical care • Implement quality improvement methodology to improve performance in all aspects of HIV/TB treatment and clinical care • Implementation of 'Consolidated ART Guidelines' and 'TB Treatment Guidelines' • DR-TB management in co-infected patients • Scale-up of NIMDR-TB program • Screening and management of drug side effects, drug resistance, and clinical depression • Routine nutritional assessment and management of malnutrition • Implement cryptococcal screen-and-treat • SRH services • Nutrition services • PHDP • Support effective integration of services • Improve quality of clinical patient records • Strengthen advanced clinical management of HIV For pediatrics: • Same as for Adults • Scale-up of 'Blueprint for Action' • Infant nutrition and breastfeeding • Integration of HIV, EPI, IMCI	Retention in Care / Treatment Adherence For IDU: • Training and Mentoring for all key components of HIV/TB treatment retention in care • Implement quality improvement methodology to improve performance in all aspects of HIV/TB retention in care • Destigmatization of services • Adherence counseling • Development of educational materials on adherence • IACT • Adherence clubs • Appointment/patient-reminder systems • Identification of missed appointments/tracing of LTFU patients • SRH services • Viral load testing every 12 months Supportive Systems SI: • DHIS Leadership/management: • LMT for HIV program managers at district level • LMT for other managers at district or higher level • District health planning • Develop district capacity for conducting clinical services training, mentoring and supportive supervision HR support: • Strategic HIV program	

	services For adolescents: • Same as for Adults • Integrated adolescent-friendly treatment services • Integration with SRH services For pregnant women: • Same as for Adults • Implementation of 'PMTCT Guidelines' (B+) • Mother-infant pair follow-up • Integration with FP and nutrition services For CSW, MSM, Informal settlements and farm workers: • Same as for adults Treatment services for those communities Retention in Care / Treatment Adherence For adults, adolescents, pregnant women, CSW, MSM, prisoners, miners/communities, informal settlement, farm workers: • Training and mentoring for all key components of HIV/TB treatment retention in care • Implement quality improvement methodology to improve performance in all aspects of HIV/TB retention in care • Destigmatization of services • Adherence counseling • Development of educational materials on adherence • IACT • Adherence clubs • Appointment/patient-reminder systems • Identification of missed appointments / Tracing of LTFU patients	leadership staff (e.g., district, provincial, national) • Essential clinical staff in non-focused districts Drug procurement: • Second and third line ARVs Evaluations: Other program evaluations that may be evaluated for refined prioritization	

	• SRH services • Viral load testing every 12 months For pediatrics • Same as for adults Mother-infant pair follow-up Supportive Systems Ideal clinic: • Implementation of HIV related aspects Pharmacy: • Facility forecasting, ordering and supply management • District forecasting, ordering and supply management • Training pharmacy assistants • Rx solutions Clinic-lab interface • Quality of specimens • Feedback loop strengthened and timely Infection Control • Support implementation of IC at facility level • Capacitate for IC planning, management and assessments Pharmacovigilance • Establish pharmacovigilance in districts/hospitals Drug resistance: • Support national HV DR surveillance SI: • TIER.net scale up • ETR/EDR scale up • Support data quality improvement and data use Leadership/management: • LMT for facility managers HR Support		

	• Essential clinical staff in focused districts Evaluations: • Outcome evaluations Evaluation of benefit, outcome, and/or impact of PEPFAR-supported programs and interventions		
Prevention			
Site level	• Condoms (male and female): improved distribution, increase access at secondary community level sites; social marketing for demand creation and increased use, especially among young women and partners, and key populations. • Risk reduction and behavior change for pre/early adolescent girls and boys through school-based programs; link with MMC. Improved quality of school-based interventions. • Skills building for parents, teachers, caregivers to communicate, monitor youth behavior • Risk reduction and behavior change, gender norms change among adolescent girls, young women and young men – small group interventions for linkages to FP, condoms HTC, MMC, and increase condom use. Focus in-school, after-school, in communities, in higher-education institutions. • Use Integrated School Health Program to strengthen linkages with SRH services • Strengthen local leaders' capacity to lead community support for local responses to reduce HIV and GBV • Prevention with positives (see C&T) • Post-rape/assault care, including PEP, comprehensive care, linkages to advanced care where needed. • Community mobilization to increase awareness of available post-rape/assault	• Targeted communication interventions (mass communication, local 'out of home' communication, social mobilization) for AGYW and young males to increase service uptake, condom use and reduce risky behaviors, shift gender norms. • Pilot intervention to build evidence for scale-up option to address alcohol abuse as driver of GBV and HIV • Inmates: peer education and mobilization for services uptake, risk reduction	

	services. • Migrant/mobile populations – HTC, risk reduction, linkages to C&T, condoms, MMC, and address GBV. • Inmates – risk reduction counseling, HCT, peer education, condom and lubricants dissemination • Key Populations (e.g., FSW, MSM, PWID): Direct service delivery providing condoms and lubricants, condom negation skills, risk reduction counseling, HTC, successful linkages to care and treatment, PEP, STI screening and treatment. Peer-led prevention interventions. Targeted sensitization training and mentoring of health care workers to the needs of key populations. Introducing PreP with sex workers and MSM. NSP and MAT for PWID through a demonstration project. • Inmates: HTC, condoms and lube distribution and demonstrations		
Sub-national level		• MMC unit cost study • Adolescent MMC study • TA to make FP, HTC, STI services acceptable to adolescents • Capacity building for providers to manage SGBV cases, including PrEP • OPRA study (violence against women study)	
National level	• GBV and HIV incidence study	• National population based survey to assess communications programs • Improve interventions with pre-adolescents to reduce SGBV • Impact evaluation for sexuality education intervention. • Sensitize NDOH health workers to increase services to migrants • Family planning for FSWs (mostly by public health facilities). Alcohol and substance abuse education. Gender norms and GBV for FSWs, but beginning to	• VMMC policy development • Operations research to explore economic skills building leveraging South African government child care grant, beyond OVC (defer to future year). • Studies that can shift to NDOH and local research organizations: Combination prevention impact study, Youth Risk Behavior Survey, Educator HIV-Survey • Policy/ guidelines for FSWs

		transfer to NGOs and NDoH	• Development of policies and guidelines, PEPFAR staff support and provide TA.
HSS			
Site level			
Sub-national level	Support Provincial and District level HIV/AIDS financial planning, expenditure analysis, and capacity building.	• Support the strengthening of Regional Training Centers that provide accredited HIV in- service training through innovative delivery platforms	
National level	• Support the production of doctors, nurses, pharmacists, pharmacist assistance, technicians and clinic associates • Improve the quality of the HCW education platform • Support the HIV focused curriculum development for doctors, nurses, pharmacists, Clinical Associates and CHWs • Provide accredited HIV /AIDS related short courses and workshops to HCWs for effective and efficient service delivery in high burden scale-up sites • Control Tower Model • eLMIS • Centralized Chronic Medicines Dispensing and Distribution support • NDoH GF grant management support for ARV procurement • Support the recruitment and placement of foreign and local clinicians as a temporary stop-gap measure to address critical HRH needs. • Development of job profiles and competencies for clinic, district and sub district managers, nurses, doctors, pharmacists and CHWs to ensure there	• Procurement policy development • Support the development of a national Mid-level workers policy which will create new categories of health care workers who will to provide HIV services. Nursing education policy to integrate HIV in nursing education, review and amendment of section 38 (A) of the Nursing Act to allow nurses to prescribe ARVs • Support the development of an HR database that would provide information for decision making which would provide information on HR planning (How many Dr and Nurses are required in the health system to deliver HIV/AIDS and other services.), HR management (staff turnover in facilities) and development (e.g., who require NIMART training, updates of Clinical guidelines. This will link to HEIs , NDOH, RTCs and Statutory Councils • Support the implementation of Skillsmart in all PEPFAR supported provinces to identify HRD competencies and training needs for the provision of HIV/AIDS services. • Development of a PEPFAR transition database	• Increase reach and support of clinical associate program • Support services to identify gaps in Epi and operations research to inform epi and OR training • Leadership and management training for Clinical Associates • Quantification training • Provincial depot support • Patient Pharmacy Week Campaigns • Drug Procurement • HIS qualification development

	will be an increased ability to effectively lead the implementation of the local HIV program. • Support the accreditation process of health care facilities by the Office of Health Standards Compliance to deliver HIV/AIDS services. • Support HIV/AIDS integration in the Integrated Chronic Services Management (ICSM) • Support National HIV/AIDS financial planning, expenditure analysis, and capacity building	• Executive Leadership and Management Training • Supply Chain for non-pharma • Develop a model for the delivery of HIV/AIDS service in a standardized manner using components of social franchising • Develop and implement a dashboard that measures the quality of systems to provide the HIV care within a clinic	
OVC			
Site level	• Assessing child & family socio-economic status (across all areas: healthy, safe, stable, schooled). • Developing care / case management plans for vulnerable HH (children & caregivers) with monitoring of referral completion and case closure goals. • Identifying children and adolescent subpopulations made vulnerable by or to HIV and AIDS and linking them to appropriate HIV prevention, care and treatment services. • Facilitating uptake of and monitoring successful referrals • Promotion and referral for EID and confirmatory HIV testing • Referral to interventions focused on keeping adolescents HIV Free • Integrating care and treatment adherence assessment, counseling, support and retention into routine household support using family centered approach • Addressing psychosocial health among children and their caregivers through individual, group-based and relationship-based activities. • Supporting clinic-based child abuse and	• Training in case management for CCG, CYCW, SAW & SW within PEPFAR catchment areas. • Improve and institutionalize HIV prevention community interventions as part of DSD basket of services • Supporting HH to access services and pursue prosecution of child abuse and GBV cases especially sexual violence & abuse. • Strengthening structures for community-based mediation of child abuse cases. • Supporting vocational training and other individual HES activities. • Facilitating access to primary (and secondary education for girls). • Improving education quality, especially making classroom environments gender and HIV sensitive.	• Providing HH supplies such as blankets and mattresses. • Providing food packages / nutritional support. • Directly supporting IGAs with funds and other inputs. • Support for food gardens. • Supporting community education councils and PTAs. • Support to purchase school uniforms

	GBV response services (access) especially given the rates of sexual violence against children (especially girls). The DREAMS initiative may be used as a vehicle for improving access to comprehensive GBV response services including PEP for sexual assault but other linkages with NDOH services should also be encouraged in other scale-up districts. • Positive Parenting for HIV risk reduction & prevention of sexual abuse. • Facilitating birth registration and succession planning. • Supporting Community level child protection/GBV prevention and response activities. • Facilitating group-based Household Economic Strengthening (HES) activities, such as savings groups. • Supporting access to and uptake of social protection efforts (such as social grants, bursaries, etc.) • Positive Parenting skills building (including topics on adolescent risk, HIV disclosure, child health & development knowledge). • Succession planning & family functioning. • School-based psychosocial support (including psychosocial support for children [cash + care]; after school programs for behavior risk reduction. • Supporting early childhood development (ECD) at the HH level - (in coordination with PMTCT & Pediatric HIV). • School based Sexuality Education: HIV education, SRH & risk reduction behaviors • Using current facility-based partnerships to increase OVC access to adolescent – friendly services and dual protection		
Sub-national level	• Facilitating access to primary and secondary education through PEPFAR	• Mapping services within targeted communities, review existing networking	• Carrying out large-scale child rights awareness campaigns.

	supported CBOS and FBOs referral networks to DSD and DBE • Effectively using PEPFAR-supported partners to integrate ECD into HIV care & treatment for children under five & their care givers e.g. I-ACT. • Implementing special studies to measure programming impact & identify gaps.	& referral mechanisms and developing service directories. • Strengthening government-managed and case management systems to prevent and respond to child abuse especially sexual abuse. • Strengthening referral mechanisms and other systems for linking clinical and social services (cross-referrals) • Professional Development for child and youth care, social and para-social workers.	• Carrying out market assessments for Income generating Activities (IGAs).
National level	• Supporting national level child protection/GBV prevention and response activities. • Coordination with NACS (e.g., referral of suspected malnutrition, nutrition education)	• Supporting the development of National Management Information systems. • Strengthen psychosocial wellbeing polices & guidelines • Support to develop child protection policy for Children's Act. • M&E systems for National child protection / social welfare efforts.	

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP15	Estimated Funding in COP16	# of IMs	Transition End date	Notes
Care and Treatment						
Home based palliative care and end of life	Close-out of activity	0	0	0	1 October 2015	Since the introduction of ART the need for HIV related home based palliative and end of life care is much reduced. Palliative care related to other conditions and illnesses will be continued by CBOs supported by DOH or other funding sources
Ideal clinic (implementation of non HIV related aspects)	Reduction of support, to be limited to HIV related aspects only	0	0	0	1 October 2015	This may impact the South African government National Health Insurance (NHI) program and there may also be limited resources to implement this within government.

						However, PEPFAR partners will continue to support the HIV related aspects of this program and thus, indirectly, support the program as a whole.
Drug procurement of first line ARVs	Close-out of activity	0	0	0	1 October 2015	The SAG has systems in place that are functional and can successfully procure first line ARVs without additional support.
Health facility equipment and infrastructure	Close-out of activity	0	0	0	1 October 2015	There may be limited resources and systems to efficiently implement this within government
Health facility maintenance and ops support	Close-out of activity	0	0	0	1 October 2015	There may be limited resources and systems to efficiently implement this within government
Implementation science	Ongoing IS projects will be completed. No new projects will be initiated unless very strong justification	2 150 000	3 500 000	2	TBD in negotiation with SAG	There may be limited resources and capacity within the Department of Health to implement IS. PEPFAR investment will be lost if IS activities already underway are ended abruptly before completion. Furthermore, IS activities in selected programmatic areas that are considered 'core' may be justified to continue.
OVC						
Supporting advocacy and policy efforts to improve safety of children from violence		0	0	1	June 2016	PEPFAR has been supporting advocacy and policy efforts through the Thogomelo Project Child Protection Interventions; utilizing the child protection booklet throughout South Africa. Thogomelo project is being implemented with co-funding from the Department

						of Social Development. Over the years, with PEPFAR support, the Department gradually absorbed the project and all its interventions including child protection policy efforts and advocacy. In June 2016 the Department will fully fund the Thogomelo project, and sustain the project.
Support once-off household supplies such as blankets and mattresses as part of winter clothing.	1st June 2015	0	0	1	30th September 2015	PEPFAR has been supporting provision of household supplies such as blankets and mattresses for OVC. This activity will be transitioned out, but PEPFAR will continue working with Department of Social Development to ensure that these children receive support from the department through social grants or other relevant support.

APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level		
Applied Pipeline	**New Funding**	**Total Spend**
$112,904,275	$300,095,725	$413,000,000

PEPFAR Budget Code	Budget Code Description	New Funding (USD)
MTCT	Mother to Child Transmission	11,973,998
HVAB	Abstinence/Be Faithful Prevention	2,753,675
HVOP	Other Sexual Prevention	10,796,758
IDUP	Injecting and Non-Injecting Drug Use	17,978
HMBL	Blood Safety	-
HMIN	Injection Safety	-
CIRC	Male Circumcision	34,863,647
HVCT	Counseling and Testing	17,952,822
HBHC	Adult Care and Support	18,190,642
PDCS	Pediatric Care and Support	7,292,924
HKID	Orphans and Vulnerable Children	26,410,483
HTXS	Adult Treatment	89,713,814
HTXD	ARV Drugs	108,035
PDTX	Pediatric Treatment	19,597,702
HVTB	TB/HIV Care	26,844,410
HLAB	Lab	4,336,024
HVSI	Strategic Information	9,319,608
OHSS	Health Systems Strengthening	10,892,949
HVMS	Management and Operations	9,030,256
TOTAL		300,095,725

B.2 Resource Projections

	Inputs and Methods used to Calculate Required Resources using Expenditure Analysis data and Costing Studies
Overall Care and Treatment	Through FY14, PEPFAR has taken an approach of supporting care and treatment services in the national HIV program through a comprehensive TA and capacity building support partnership model, focused on supporting facilities and districts (health teams) for the comprehensive program. This model combines support for adult and pediatric HIV and TB care, treatment and support, including HTC, PMTCT, SRH, some limited prevention objectives, laboratory, data and health system strengthening all in one combined program support model. The required resources for Care and Treatment in COP15 were calculated based on historical EA data which was adjusted based on the combined and comprehensive program approach. A revised UE was calculated for the program area based on the EA results for applicable district support partners (DSPs). Total expenditures for each program were collated including program management, strategic information and health system strengthening for DSPs. Spending for program areas not considered "core" were removed or adjusted. Costs attributable to HR support and NGO clinics were removed as these are transitioning to SAG funding. The basic "unit" was calculated to be persons on ART for funding the program at the facility and district level at $50 per person current on ART. Given this unique approach, expenditures were validated by back-calculating unit expenditures by program area and beneficiary type and comparing with historical UEs from EA.
VMMC	Direct service unit costs for each IM were used to determine the targets they could reach within their budget constraints. QA, training and demand creation budgets were either based on historical cost structures from EA and validated using literature figures or calculated based on a market-driven agreed upon amount per MC.
HTC	Resources required were determined for each IM based on the cost structure of the modality. For example, testing hard to reach populations is more expensive than testing through mobile clinics, so UEs were determined separately. Demand creation for HTC was costed for a community mobilization model. Unit costs for each modality were calculated based on the EA and literature.
OVC	EA data was used to develop the resources required for OVC. The "core" activities in FY16 have changed significantly from FY14 activities in order to focus on the geographic and programmatic pivot. Therefore, EA cost categories were adjusted to reflect these changes based on expected FY16 activities.
PP-PREV	Prevention activity requirements were calculated using UEs by modality. The structured, multi-session intervention UE was based on programmatic data of intervention costs. Social behavior change communication costs were calculated using UEs from literature sources. Small group/individual intervention benchmarked against one IM with representative UE from EA. Costing study used for Parenting Programmes
Key Populations Prevention	The required resources for MSM were calculated using the EA unit expenditure and validated through a review of costing literature. The process was similar for FSW in that the UE from EA was used. Historical costs were not available for PWID and so activities were costed using programmatic data and a standard KP HTC cost.
Health Systems Strengthening	Activities and targets for COP15 were agreed upon following various interagency and South African government consultations in alignment to the PEPFAR geographic focus areas and priorities. The HSS TWG used activity based costing for each mechanism using historical knowledge of partners' past performance and cost of activities. Additionally, priority core activities were given higher consideration for funding needs within the limited overall resources available for HSS activities. The TWG looked at the expenditure data for the above site activities to validate assumptions about activity costs; however, the TWG did not look at UEs since HSS does not track targets in the same way as other program areas. The HSS TWG also considered the non-core activities as these will not be budgeted for in COP 15.

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South Africa COP15 Targets by District: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
ec Alfred Nzo District Municipality	177,361	19,751	73,607	18,011	54,672
ec Amathole District Municipality	220,871	14,885	72,614	10,974	51,344
ec Buffalo City Metropolitan Municipality	160,820	20,964	72,699	17,188	55,168
ec Cacadu District Municipality	4,750	213	433	112	296
ec Chris Hani District Municipality	331,533	15,407	46,601	22,675	57,219
ec Joe Gqabi District Municipality	493	25	51	13	19
ec Nelson Mandela Bay Municipality	17,752	2,936	60,217	5,891	38,332
ec Oliver Tambo District Municipality	224,438	21,582	108,081	19,491	84,736
fs Fezile Dabi District Municipality	11,179	563	1,145	296	781
fs Lejweleputswa District Municipality	220,226	32,870	85,063	28,657	63,055
fs Mangaung Metropolitan Municipality	20,611	1,972	73,400	4,741	30,410
fs Thabo Mofutsanyane District Municipality	175,592	19,646	85,294	16,816	62,096
fs Xhariep District Municipality	4,352	192	391	102	317
gp City of Johannesburg Metropolitan Municipality	821,517	109,314	620,347	133,664	332,215
gp City of Tshwane Metropolitan Municipality	406,234	80,975	380,394	67,134	197,998
gp Ekurhuleni Metropolitan Municipality	674,871	93,066	352,030	118,039	289,876
gp Sedibeng District Municipality	408,451	65,236	151,378	61,220	102,950
gp West Rand District Municipality	17,579	2,400	73,876	7,489	49,474
kz Amajuba District Municipality	120,904	13,355	75,880	10,643	46,147
kz eThekwini Metropolitan Municipality	520,573	40,604	442,462	70,432	341,451
kz Harry Gwala District Municipality	223,939	18,250	64,039	15,498	49,840
kz iLembe District Municipality	14,352	1,786	58,915	6,182	41,136
kz Ugu District Municipality	231,007	24,530	107,347	22,491	79,430
kz uMgungundlovu District Municipality	359,661	40,422	171,313	64,072	150,557
kz Umkhanyakude District Municipality	31,895	2,209	73,482	7,525	50,149
kz Umzinyathi District Municipality	201,871	13,921	51,152	13,047	38,346
kz Uthukela District Municipality	164,720	19,786	90,046	17,569	67,192
kz Uthungulu District Municipality	169,261	18,005	130,469	17,558	96,284
kz Zululand District Municipality	348,112	38,106	133,046	35,058	99,185
lp Capricorn District Municipality	365,553	23,280	87,815	18,625	62,967
lp Mopani District Municipality	239,426	23,184	98,234	15,165	53,855
lp Sekhukhune District Municipality	51,663	3,892	23,810	3,110	17,057
lp Vhembe District Municipality	11,807	548	1,138	315	761
lp Waterberg District Municipality	50,375	1,152	4,467	3,297	21,875
lp_Vhembe_AGRIAIDSFARMS	-	-	-	-	-
mp Ehlanzeni District Municipality	214,964	38,388	222,013	30,571	158,990
mp Gert Sibande District Municipality	248,583	44,328	153,380	36,255	110,549
mp Nkangala District Municipality	105,982	9,633	103,513	10,555	69,982
nc Frances Baard District Municipality	7,884	351	712	398	1,173
nc John Taolo Gaetsewe District Municipality	1,764	44	90	23	62
nc Namakwa District Municipality	99	8	15	4	10
nc Pixley ka Seme District Municipality	2,120	85	170	44	116
nc Zwelentlanga Fatman Mgcawu District Municipality	2,593	108	219	57	150
nw Bojanala Platinum District Municipality	308,517	44,630	167,159	37,842	111,705
nw Dr Kenneth Kaunda District Municipality	176,303	17,608	92,048	14,176	55,805
nw Dr Ruth Segomotsi Mompati District Municipality	3,696	10	20	5	14
nw Ngaka Modiri Molema District Municipality	395,074	24,986	76,097	24,586	59,718
nw_BOJANALA_AGRIAIDSFARMS	-	-	-	-	-
nw_KENNETH KAUNDA_AGRIAIDSFARMS	-	-	-	-	-
wc Cape Winelands District Municipality	30,759	616	1,252	324	854
wc Central Karoo District Municipality	396	27	33	10	28
wc City of Cape Town Metropolitan Municipality	268,229	6,880	181,303	18,030	115,545
wc Eden District Municipality	5,849	206	419	108	287
wc Overberg District Municipality	4,358	219	446	116	305
wc West Coast District Municipality	13,054	411	834	216	569
Other_ South Africa	1,000	-	-	-	-
Total	**8,794,973**	**973,565**	**4,870,959**	**1,026,420**	**3,373,052**

South Africa COP 15 Targets by District: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
ec Alfred Nzo District Municipality	518	-	2,474
ec Amathole District Municipality	524	-	2,893
ec Buffalo City Metropolitan Municipality	620	-	19,306
ec Cacadu District Municipality	1,275	-	-
ec Chris Hani District Municipality	5,511	-	24,531
ec Joe Gqabi District Municipality	28	-	-
ec Nelson Mandela Bay Municipality	2,927	-	-
ec Oliver Tambo District Municipality	2,200	791	5,427
fs Fezile Dabi District Municipality	1,710	-	3,064
fs Lejweleputswa District Municipality	915	-	14,275
fs Mangaung Metropolitan Municipality	2,119	17	4,589
fs Thabo Mofutsanyane District Municipality	33,456	-	14,982
fs Xhariep District Municipality	213	-	-
gp City of Johannesburg Metropolitan Municipality	421,327	4,893	61,412
gp City of Tshwane Metropolitan Municipality	30,735	5,103	56,859
gp Ekurhuleni Metropolitan Municipality	201,718	599	52,776
gp Sedibeng District Municipality	2,665	-	33,715
gp West Rand District Municipality	216	-	-
kz Amajuba District Municipality	127	-	553
kz eThekwini Metropolitan Municipality	426,937	13,420	54,722
kz Harry Gwala District Municipality	499	-	5,918
kz iLembe District Municipality	21	-	744
kz Ugu District Municipality	4,304	-	27,172
kz uMgungundlovu District Municipality	166,075	4,513	56,768
kz Umkhanyakude District Municipality	25,601	-	4,300
kz Umzinyathi District Municipality	276	-	3,717
kz Uthukela District Municipality	904	-	6,114
kz Uthungulu District Municipality	16,384	-	40,428
kz Zululand District Municipality	373	893	31,186
lp Capricorn District Municipality	1,193	-	27,495
lp Mopani District Municipality	29,467	-	5,304
lp Sekhukhune District Municipality	398	-	2,800
lp Vhembe District Municipality	16,621	1,627	420
lp Waterberg District Municipality	8,452	-	300
lp_Vhembe_AGRIAIDSFARMS	-	-	-
mp Ehlanzeni District Municipality	35,879	2,032	38,122
mp Gert Sibande District Municipality	18,118	1,478	15,911
mp Nkangala District Municipality	22,557	971	41,776
nc Frances Baard District Municipality	386	-	-
nc John Taolo Gaetsewe District Municipality	49	-	-
nc Namakwa District Municipality	8	-	-
nc Pixley ka Seme District Municipality	93	-	-
nc Zwelentlanga Fatman Mgcawu District Municipality	358	1,138	-
nw Bojanala Platinum District Municipality	19,186	80	26,622
nw Dr Kenneth Kaunda District Municipality	7,050	1,197	648
nw Dr Ruth Segomotsi Mompati District Municipality	3,511	-	-
nw Ngaka Modiri Molema District Municipality	700	-	3,236
nw_BOJANALA_AGRIAIDSFARMS	-	-	-
nw_KENNETH KAUNDA_AGRIAIDSFARMS	-	-	-
wc Cape Winelands District Municipality	679	-	-
wc Central Karoo District Municipality	22	-	-
wc City of Cape Town Metropolitan Municipality	78,769	3,000	4,365
wc Eden District Municipality	226	-	-
wc Overberg District Municipality	243	-	-
wc West Coast District Municipality	762	-	-
Other_ South Africa	2,000	-	-
Total	**1,596,905**	**41,752**	**694,924**

South Africa COP15 Targets by District: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
ec Alfred Nzo District Municipality	17,096	3,422
ec Amathole District Municipality	15,101	3,146
ec Buffalo City Metropolitan Municipality	15,336	3,859
ec Cacadu District Municipality	-	-
ec Chris Hani District Municipality	13,138	2,662
ec Joe Gqabi District Municipality	-	-
ec Nelson Mandela Bay Municipality	10,163	2,045
ec Oliver Tambo District Municipality	33,180	7,794
fs Fezile Dabi District Municipality	-	-
fs Lejweleputswa District Municipality	11,735	2,850
fs Mangaung Metropolitan Municipality	9,869	2,405
fs Thabo Mofutsanyane District Municipality	13,542	3,090
fs Xhariep District Municipality	-	-
gp City of Johannesburg Metropolitan Municipality	84,468	18,880
gp City of Tshwane Metropolitan Municipality	59,798	12,135
gp Ekurhuleni Metropolitan Municipality	66,072	16,539
gp Sedibeng District Municipality	15,549	3,593
gp West Rand District Municipality	13,027	3,198
kz Amajuba District Municipality	8,403	2,266
kz eThekwini Metropolitan Municipality	74,351	23,795
kz Harry Gwala District Municipality	10,762	2,490
kz iLembe District Municipality	10,543	3,074
kz Ugu District Municipality	15,426	4,630
kz uMgungundlovu District Municipality	18,675	5,825
kz Umkhanyakude District Municipality	12,520	3,599
kz Umzinyathi District Municipality	7,044	1,368
kz Uthukela District Municipality	13,345	3,567
kz Uthungulu District Municipality	20,114	5,558
kz Zululand District Municipality	18,236	4,847
lp Capricorn District Municipality	24,654	4,097
lp Mopani District Municipality	19,594	3,618
lp Sekhukhune District Municipality	2,482	359
lp Vhembe District Municipality	-	-
lp Waterberg District Municipality	6,351	1,124
lp_Vhembe_AGRIAIDSFARMS	-	-
mp Ehlanzeni District Municipality	36,587	10,954
mp Gert Sibande District Municipality	21,067	6,394
mp Nkangala District Municipality	22,581	4,965
nc Frances Baard District Municipality	125	-
nc John Taolo Gaetsewe District Municipality	-	-
nc Namakwa District Municipality	-	-
nc Pixley ka Seme District Municipality	-	-
nc Zwelentlanga Fatman Mgcawu District Municipality	-	-
nw Bojanala Platinum District Municipality	28,452	7,355
nw Dr Kenneth Kaunda District Municipality	13,275	3,018
nw Dr Ruth Segomotsi Mompati District Municipality	-	-
nw Ngaka Modiri Molema District Municipality	9,504	1,721
nw_BOJANALA_AGRIAIDSFARMS	-	-
nw_KENNETH KAUNDA_AGRIAIDSFARMS	-	-
wc Cape Winelands District Municipality	1	-
wc Central Karoo District Municipality	-	-
wc City of Cape Town Metropolitan Municipality	57,482	5,268
wc Eden District Municipality	-	-
wc Overberg District Municipality	-	-
wc West Coast District Municipality	-	-
Other_ South Africa	-	-
Total	**829,648**	**195,510**

South Africa COP15 Targets by District: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
ec Alfred Nzo District Municipality	4,278	2,054
ec Amathole District Municipality	5,180	2,490
ec Buffalo City Metropolitan Municipality	5,391	2,581
ec Cacadu District Municipality	91	42
ec Chris Hani District Municipality	5,857	2,794
ec Joe Gqabi District Municipality	11	5
ec Nelson Mandela Bay Municipality	8,277	3,976
ec Oliver Tambo District Municipality	10,779	5,382
fs Fezile Dabi District Municipality	239	115
fs Lejweleputswa District Municipality	5,294	2,542
fs Mangaung Metropolitan Municipality	4,683	2,248
fs Thabo Mofutsanyane District Municipality	3,873	1,862
fs Xhariep District Municipality	80	40
gp City of Johannesburg Metropolitan Municipality	24,150	19,278
gp City of Tshwane Metropolitan Municipality	11,685	5,606
gp Ekurhuleni Metropolitan Municipality	11,232	9,780
gp Sedibeng District Municipality	4,490	2,156
gp West Rand District Municipality	3,291	1,580
kz Amajuba District Municipality	2,390	1,150
kz eThekwini Metropolitan Municipality	32,207	15,451
kz Harry Gwala District Municipality	3,799	1,823
kz iLembe District Municipality	4,285	2,054
kz Ugu District Municipality	6,839	3,282
kz uMgungundlovu District Municipality	8,495	9,759
kz Umkhanyakude District Municipality	4,715	2,262
kz Umzinyathi District Municipality	2,131	1,130
kz Uthukela District Municipality	4,587	2,201
kz Uthungulu District Municipality	9,042	4,339
kz Zululand District Municipality	7,562	3,629
lp Capricorn District Municipality	3,143	1,513
lp Mopani District Municipality	2,717	1,296
lp Sekhukhune District Municipality	1,036	499
lp Vhembe District Municipality	257	125
lp Waterberg District Municipality	1,760	847
lp_Vhembe_AGRIAIDSFARMS	-	-
mp Ehlanzeni District Municipality	8,311	3,993
mp Gert Sibande District Municipality	4,454	2,155
mp Nkangala District Municipality	3,778	1,815
nc Frances Baard District Municipality	149	69
nc John Taolo Gaetsewe District Municipality	19	9
nc Namakwa District Municipality	3	2
nc Pixley ka Seme District Municipality	36	18
nc Zwelentlanga Fatman Mgcawu District Municipality	46	22
nw Bojanala Platinum District Municipality	7,862	3,845
nw Dr Kenneth Kaunda District Municipality	11,297	5,427
nw Dr Ruth Segomotsi Mompati District Municipality	4	2
nw Ngaka Modiri Molema District Municipality	4,313	2,116
nw_BOJANALA_AGRIAIDSFARMS	-	-
nw_KENNETH KAUNDA_AGRIAIDSFARMS	-	-
wc Cape Winelands District Municipality	262	127
wc Central Karoo District Municipality	8	5
wc City of Cape Town Metropolitan Municipality	24,817	12,152
wc Eden District Municipality	88	42
wc Overberg District Municipality	93	44
wc West Coast District Municipality	175	83
Other_ South Africa	-	-
Total	**269,561**	**147,817**

South Africa COP15 Targets by District: Voluntary Male Medical Circumcision (VMMC)

	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program
ec Alfred Nzo District Municipality	-
ec Amathole District Municipality	2,860
ec Buffalo City Metropolitan Municipality	2,880
ec Cacadu District Municipality	594
ec Chris Hani District Municipality	-
ec Joe Gqabi District Municipality	-
ec Nelson Mandela Bay Municipality	-
ec Oliver Tambo District Municipality	2,000
fs Fezile Dabi District Municipality	1,287
fs Lejweleputswa District Municipality	4,500
fs Mangaung Metropolitan Municipality	1,022
fs Thabo Mofutsanyane District Municipality	9,000
fs Xhariep District Municipality	540
gp City of Johannesburg Metropolitan Municipality	55,005
gp City of Tshwane Metropolitan Municipality	33,000
gp Ekurhuleni Metropolitan Municipality	34,000
gp Sedibeng District Municipality	5,001
gp West Rand District Municipality	7,746
kz Amajuba District Municipality	3,135
kz eThekwini Metropolitan Municipality	52,800
kz Harry Gwala District Municipality	-
kz iLembe District Municipality	1,699
kz Ugu District Municipality	7,000
kz uMgungundlovu District Municipality	15,078
kz Umkhanyakude District Municipality	3,538
kz Umzinyathi District Municipality	2,124
kz Uthukela District Municipality	-
kz Uthungulu District Municipality	14,553
kz Zululand District Municipality	13,000
lp Capricorn District Municipality	8,700
lp Mopani District Municipality	5,300
lp Sekhukhune District Municipality	135
lp Vhembe District Municipality	467
lp Waterberg District Municipality	3,496
lp_Vhembe_AGRIAIDSFARMS	-
mp Ehlanzeni District Municipality	11,995
mp Gert Sibande District Municipality	8,500
mp Nkangala District Municipality	14,001
nc Frances Baard District Municipality	936
nc John Taolo Gaetsewe District Municipality	-
nc Namakwa District Municipality	-
nc Pixley ka Seme District Municipality	-
nc Zwelentlanga Fatman Mgcawu District Municipality	-
nw Bojanala Platinum District Municipality	22,569
nw Dr Kenneth Kaunda District Municipality	12,000
nw Dr Ruth Segomotsi Mompati District Municipality	-
nw Ngaka Modiri Molema District Municipality	-
nw_BOJANALA_AGRIAIDSFARMS	-
nw_KENNETH KAUNDA_AGRIAIDSFARMS	-
wc Cape Winelands District Municipality	535
wc Central Karoo District Municipality	-
wc City of Cape Town Metropolitan Municipality	5,637
wc Eden District Municipality	936
wc Overberg District Municipality	-
wc West Coast District Municipality	538
Other_ South Africa	1,000
Total	**369,107**