South Africa Country Operational Plan 2016 (COP16)

Strategic Direction Summary (SDS)

Implementation - October 2016 - September 2017

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Goal Statement

In support of the South Africa National Strategic Plan (NSP) for HIV and AIDS, TB and STIs (NSP), the United States through PEPFAR will implement a broad portfolio of programs toward the goal of epidemic control in the 27 highest HIV burden focus districts in South Africa, representing 82 percent of PLHIV. The strategy for the PEPFAR Country Operational Plan for the period from October 1, 2016 through September 30, 2017 (COP16) will continue program strategic priorities identified and implemented in COP15.   The overall goals align PEPFAR with South African government, Global Fund and other 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.

PEPFAR's support to the national HIV program is coordinated under the South African and U.S. governments' Partnership Framework Implementation Plan (PFIP), which establishes joint work streams to support alignment of PEPFAR's contributions to the NSP. In COP16 PEPFAR is using the South Africa National Development Plan, the NSP, epidemiologic and expenditure data, and South Africa's Investment Case, to plan and strategically focus on achieving 90-90-90 in five of the 27 focus districts by September 2017. PEPFAR's support for health systems strengthening initiatives will support sustainability and contribute to South Africa's goals to improve health care in the public health system in anticipation of National Health Insurance. On May 10, 2016 South African Minister of Health Motsoaledi announced that South Africa will implement an evidence-based policy of offering ART to all people living with HIV beginning in September 2016. National adoption of WHO guidelines recommending Test and Treat (ending CD4 eligibility criteria initiating ART) will begin in September 2016. PEPFAR will support the national rollout by initiating test and treat in four of the 27 focus districts in COP15, then in all 27 focus districts in COP16, along with innovations to transition/decant stable ART clients to alternative modes of service and ARV delivery, in order to decongest public health facilities. In COP16 PEPFAR will focus key prevention interventions, including alignment with five DREAMS[1] priority districts and the expanded coverage of voluntary male medical circumcision (VMMC) services in all 27 focus districts. COP16 programs include increased effectiveness of HIV testing, enhancing men's access to services, improved health information management systems, electronic medical records and use of data for strategic planning. PEPFAR will continue with the South Africa government to make the best use of evidence in monitoring and evaluating the program, and align the PEPFAR POART[2] process of quarterly reviews with the South African-led District HIV/TB Implementation Plans (DIP) process.

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[1] DREAMS: Determined, Resilient, Empowered, AIDS-free, Mentored and Safe adolescent girls and young women (AGYW)
[2] PEPFAR Oversight and Accountability Results Team (POART) process reviews performance quarterly.

In COP16 PEPFAR specific inputs will focus on:

- Technical Assistance (TA) and in some circumstances direct service delivery (DSD) for care and treatment services to identify and support 3.8 million South Africans on ART in the 27 focus districts by September 2017
- Increasing yield and effectiveness of HIV testing in communities and facilities, and strengthening linkage to care
- Improving clinical facility and community linkages, and enhancing the decanting of 650,000 stable ART patients
- Improving treatment adherence, retention and viral load suppression
- Combination prevention, including prevention of mother-to-child transmission (PMTCT), condoms, VMMC, ART, 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)), and other comprehensive prevention programs
- Holistic OVC programs linked to ART and prevention interventions
- National and provincial level systems strengthening and strategic program areas for information systems, human resources, laboratory, and improved service delivery and supply chain.

1.0 Epidemic, Response, and Program Context

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

South Africa's HIV epidemic is largely driven by heterosexual transmission, with underlying behavioral, socio-cultural, economic, and structural factors that influence HIV transmission risk. These factors include population 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, black women aged 25-34 years having the highest prevalence, at 31.6 percent, and highest incidence, at 4.54 percent.[3]

1. **Total population**: 54.96 million, approximately 51 percent (28.07 million) are females. Life expectancy at birth for 2015 was estimated at 60.6 years for males and 64.3 years for females, while infant mortality rate was 34.4 per 1,000 live births[4].

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[3] Human Sciences Resource Council (HSRC) Household survey, 2012
[4] Statistics South Africa (StatsSA) Mid-year population estimates 2015. Statistical Release P0302, Statistics South Africa: Pretoria.

2. **HIV disease burden**: UNAIDS estimates (2014), 6,800,000 [6,500,000 - 7,500,000] people were living with HIV with 18.9 [17.9 - 19.9] percent of adults (15-49 years) HIV-positive.

3. **Current progress towards epidemic control**: The number of people on ART has steadily increased. As of 2016, the NDoH[5] reports over 3.2 million people on ART.

4. **Major gaps in achieving epidemic control**: Meeting the NSP goal to reduce new HIV infections by 50 percent by 2016 is a challenge. UNAIDS estimates 370,106 new HIV infections per year in South Africa in 2015. Incidence among adolescent girls and young women remains a significant gap. The nexus with the tuberculosis epidemic continues to drive high morbidity and mortality. The legacy of apartheid and significant income inequity pose additional challenges to the response.

5. **Gross National Income (GNI) per capita**: Estimated GNI per capita is $6,800[6]. According to National Treasury officials, the South African government expects to continuously increase the allocated HIV budget amount by an estimated R1.5 billion ($100 million) per year to accommodate the anticipated increasing numbers of South Africans on ART.[7]

6. **Percent of GNI spent on HIV response and/or the health sector**: The total expenditure on health was 8.93 percent of the gross domestic product in 2013[8]. The 2015 South Africa national budget projected that total health spending will reach R178 billion by 2017/18. The government plans to spend R502 billion on health, with R46.6 billion earmarked for the HIV/AIDS epidemic by 2018.[9] 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 increase vulnerability to HIV. Tables 1.1.1 and 1.1.2 below summarize the key HIV epidemiological data and a national view of the 90-90-90 cascade.

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[5] National Department of Health (NDoH)

[6] World Bank 2015

[7] Ministry of Finance (2015). Budget Speech 2015. Online: http://www.treasury.gov.za/documents/national%20budget/2015/speech Accessed 11 Feb, 2016

[8] World Bank: World Development Indicators. Online: http://data.worldbank.org/indicator/ Accessed 11 Feb, 2016.

[9] Ministry of Finance (2015). Budget Speech 2015. Online: http://www.treasury.gov.za/documents/national%20budget/2015/speech Accessed 11 Feb, 2016

Table 1.1.1 Key National Demographic and Epidemiological Data											Source, Year
	Total		<15				15+				
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
Total Population (2014)	54,956,920	100	8,252,643	15.0	8,359,400	15.2	19,825,988	36.1	18,518,889	33.7	StatsSA[2], 2015
HIV Prevalence (percent)		12.2		2.4		2.3		19.1		13.2	Shisana *et al*[1], 2012
AIDS Deaths (per year)	100 731		2,988		2,889		53,613		41,241		UNAIDS[5], 2015
PLHIV	6,670,356		183,894		169,748		3,688,961		2,627,753		UNAIDS[5], 2015
Incidence Rate (year)		1.1		0.5		NA		2.28		1.21	Shisana *et al*[1], 2012 No data available for males 2-14yrs
New Infections (year)	370,106										UNAIDS[5], 2015
Annual births	1,250,782	100									Stats SA[2], 2015
% of Pregnant Women with at least one ANC visit	1,171,479	97.0	NA	NA			NA	NA			UNICEF[8]
Pregnant women needing ARVs	205,950	NA									UNAIDS[5], 2015
Orphans (maternal, paternal, double)	3,963,804 (Total) 604,000 (Maternal) 1,999,000 (Paternal) 765,000 (Double)	3.3 (Maternal) 10.8 (Paternal) 4.1 (Double)									UCT Children's Institute[9], 2013
Notified Tuberculosis (TB) cases (year)	318,193		13,834		17,985		124,510		161,864		WHO[10], 2015
TB/HIV co-infection	179,756	61.0	NA	NA	NA	NA	NA	NA	NA	NA	WHO[10], 2015

					NA	NA					Shisana *et al[1]*, 2012
Males circumcised	12,525,283	46.4							NA	NA	Numbers calculated using Shisana *et al[1]* male circumcision rate and StatsSA 2015[2] mid-year estimates
Key Populations											
Estimated Population Size of MSM*	654,979 (621,205-688,753)	NA									SANAC[11], 2015
MSM HIV Prevalence	NA	9.9 8.6 10.4 – 34.5									UNAIDS[12], 2013 UCSFI[13], 2015
Estimated Population Size of FSW	195,299 (185,357-205,240)	NA									SANAC[11], 2015
FSW HIV Prevalence	85,560	56.0									SANAC[14], 2013 UCSF, Anova, WRHI[15], 2014
Estimated Population Size of PWID	75,701	100									SANAC[11], 2015
PWID HIV Prevalence	10,598	14.0									Scheibe *et al.[16]*, 2014 Number calculated using prevalence rate of Scheibe *et al[16]* applied to SANAC estimated size
Estimated Population Size of Priority Population: Military	73,104	0.2	NA	NA	NA	NA	20,481	25.6	52,623	74.4	South African National Defense Force[17], 2015
Estimated Population Size of Priority Population: Black African women 20-34 years	6,248,161	11.4									StatsSA[2], 2015 (Percent of total population)
Estimated Population Size of Priority Population: Black African men 25-49 years	7,628,881	13.9									StatsSA[2], 2015 (Percent of total population)
If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.											

References

1. Shisana O et al. (2014) South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press.

2. Statistics South Africa (StatsSA) Mid-year population estimates 2015. Statistical Release P0302, Statistics South Africa: Pretoria.

3. UNAIDS South Africa Country Profile. HIV and AIDS Estimates 2014. Online: http://www.unaids.org/en/regionscountries/countries/southafrica Accessed 11 Feb, 2016

4. NDoH Programme Data DHIS

5. UNAIDS Spectrum Estimates for South Africa 2014. Version 5.4 EPP/Spectrum. Online: http://unaids.org/en/dataanalysis/datatools/spectrumepp Accessed 11 Feb, 2016.

6. World Bank: World Development Indicators. Online: http://data.worldbank.org/indicator/ Accessed 11 Feb, 2016.

7. Ministry of Finance (2015). Budget Speech 2015. Online: http://www.treasury.gov.za/documents/national%20budget/2015/speech Accessed 11 Feb, 2016

8. UNICEF Antenatal Care Coverage Data

9. University of Cape Town Children's Institute. Statistics on Children in South Africa, 2013. Online: http://www.childrencount.org.za/indicator.php?id=1&indicator=4 Accessed 11 Feb, 2016

10. World Health Organization (2015) Global TB Report 2015. 20th Edition. WHO; Geneva

11. SANAC Programmatic Mapping and Size Estimation Study of Key Populations in South Africa, 2015 Final Report, October 2015.

12. UNAIDS GLOBAL REPORT; UNAIDS report on the global AIDS epidemic 2013

13. UCSF, Anova Health Institute & WRHI (2014). South Africa Health Monitoring Study (SAHMS), Final Report: The Integrated Biological and Behavioral Survey among Female Sex Workers, South Africa 2013-2014. San Francisco: UCSF.

14. SANAC. Sex Worker Estimation Size Study, 2013

15. 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.

16. 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

17. South African National Defense Force 2015

Table 1.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (12 months)								
				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	On ART (#)	Retained on ART 12 Months (#)	Viral Suppression 12 Months (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	54,956,920[10]	12.2[11]	6,669,360[12]	3,217,097[3]	74%[13]	79%	10,498,232[3,14]	924,735[7]	852,401[3]
Population less than 15 years	16,612,043	2.4	353,645[3]	163,155[3]	N/A	N/A	N/A	N/A	29,461[3]
Pregnant Women	1,171,479[15]	‡29.7	347,929	N/A	N/A	N/A	1,028,311[3]	202,458[16]	197,932[7]
MSM	654,979 (621,205-688,753)[17]	9.9 8.6 (10.4 – 34.5)[18]	N/A	N/A	N/A	N/A	N/A	N/A	N/A
FSW	195,299 (185,357-	56.0	85,560	N/A	N/A	N/A	N/A	N/A	N/A

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[10] Stats SA
[11] Shisana O et al. (2014) South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press
[12] SA National data (DHIS)
[13] under-reported in DATIM
[14] figure is for clients aged 15-49 and excludes ANC
[15] UNICEF Antenatal Care Coverage Data

[16] DATIM numbers

[17] SANAC[14], 2015
[18] UNAIDS[12], 2013

	205,240)								
PWID	10,598	14.0	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Priority Pop (Military)	73,104		N/A	N/A	N/A	N/A	N/A	N/A	N/A

1.2 Investment Profile

The HIV response in South Africa is funded through public revenue, external development partners (donors) and the private sector.

In 2015, as in previous years, the HIV response in South Africa was funded primarily through R13.96 billion in public revenue raised through individual and business taxes ($1.1 billion). PEPFAR was the second largest source of funds, and contributed R6.89 billion towards the HIV response ($459 million – COP14) (PEPFAR-South African Government Joint AIDS Expenditure & Budget Report, Results for Development, December 2015). The Global Fund to Fight AIDS, TB and Malaria (The Global Fund) was the next largest funding source, and will contribute $311.8 million over three years in its next funding cycle, 2016-19. There are other external sources (bilaterals, multilaterals, and foundations) that, according to the 2013 National AIDS Spending Assessment, accounted for around seven percent of funds. Private companies and insurances contributed around eight percent.

In Fiscal Year (FY) 2016/2017, the South Africa Government budget allocation for HIV is R 14.48 billion ($1.03 billion), with planned increases to approximately R 15.20 billion ($1.09 billion) by 2017/18. The South African government has spent R43.4 billion ($3.4 billion) on HIV and AIDS programs from 2012-2014 and has allocated a budget of R43.5 billion ($3.11 billion) for 2016-2018. (Note – the Rand-USD has changed significantly in this time period from R9=$1USD to R15 = $1USD.)

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. The South Africa Investment Case concludes that the 90-90-90 scenario should have the most significant impact on HIV infections and life years saved. This strategy requires a steadily increasing investment in HIV programs starting in 2016/17. Given South Africa's constrained economy, the government has leveled funding for many services, and future increases resulting from HIV and TB treatment costs will consume an increasing share of the health budget.

Table 1.2.1 Investment Profile by Program Area					
Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
Clinical care, treatment and support	$984,196,603	12%	4%	84%	Not available
Community-based care, treatment, and support	$109,314,370	18%	3%	78%	Not available
PMTCT	$44,045,133	54%	0%	46%	Not available
HTC	$105,983,346	33%	0%	67%	Not available
VMMC	$79,856,432	76%	0%	24%	Not available
General & Priority population prevention	$69,805,827	42%	27%	30%	Not available
Key population prevention	$22,480,214	26%	46%	29%	Not available
OVC	$118,758,957	28%	12%	60%	Not available
Laboratory	$551,538,282	1%	1%	99%	Not available
SI, Surveys and Surveillance*	$37,591,981	80%	20%	N/A	Not available
HSS*	$14,968,658	81%	19%	N/A	Not available
Total	$2,138,539,803	18%	5%	78%	Not available
There is no information on the GoSA's Communications, M&E, Other Prevention, Policy and Systems Development spending and budget allocations because data were unavailable and/or not disaggregated in the BAS; this does not mean that the RSA is not spending anything on these activities as RSA funds nearly 80% of the national HIV and TB response.					
Data for GoSA and PEPFAR are based on FY'2014/15 and FY'15 expenditures respectively, and the GF data is based on a proposed budget.					
*SI and HSS in the PEPFAR expenditure is included across all program areas. This amount is SI and HSS expenditures not directly allocated to program areas.					
The investment profile table is a broad profile of expenditures and budgets for HV spending in South Africa, and is not meant to be comprehensive of all HIV expenditures in South Africa					

Table 1.2.2 Procurement Profile for Key Commodities					
Program Area	Total Expenditure (USD)	Percent PEPFAR	Percent GF	Percent RSA	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 USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	--				
USAID TB	**$12,000,000**				**To provide Technical Assistance to SA Government on TB**
USAID Malaria	--				
Family Planning	--				
NIH	--				
CDC NCD	--				
Peace Corps	--				
DOD Ebola	--				
MCC	--				
Total	**$12,000,000**				

Table 1.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP (1 Oct 2016-30 Sept 2017) USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total PEPFAR NON-COP Resources	Total PEPFAR Resources	Total Non-COP Co-funding PEPFAR IMS	#Co-funded IMS	PEPFAR COP Co-Funding Contribution	Objectives
ACT	N/A					
DREAMS	$66,646,763 (FY16 and FY17)					Partnership to reduce new HIV infections among adolescent girls and young women
DREAMS Innovation	N/A					
DREAMS Test and Treat	N/A					
VMMC	$24,789,393					VMMC plus up funds anticipated complement the existing VMMC PEPFAR South Africa program
Viral Load	N/A					
*Other PEPFAR Central Initiatives	$4,701,467.00					Implementation Science Capacity Building; SI Country Model; PopART
Other Public Private Partnerships	$7,000,000.00					PEPFAR will leverage private sector funding as a matching for CO16 Public Private Partnerships
Test and Treat						Announced May 10 to start nationally in September 2016
TOTAL	**$103,137,623.44**					

1.3 National Sustainability Profile

The South Africa government (RSA), UNAIDS and the PEPFAR team have worked together to develop a draft 2016 Sustainability Index and Dashboard (SID). The draft SID is under review with the RSA leadership and will be shared and discussed in a stakeholders' meeting to include the National Department of Health (NDoH) and other RSA departments' technical and leadership staff, representatives of the South Africa National AIDS Council (SANAC) and local civil society, UNAIDS, Global Fund and South Africa's Country Coordinating Mechanism (CCM).

The draft SID shows that South Africa has sustainable and approaching sustainability elements in each of the four domains of the SID.[19] COP16 supports programs that address issues identified in the draft SID, including service delivery; human resources for health; commodity security and supply chain; quality management; laboratory; epidemiological and health data; policies and governance; and civil society and private sector engagement.

The stakeholders' meeting will help to strengthen alignment with other funders, including SAG, and complement the ongoing and routine sharing of information regarding the various funded initiatives that support South Africa's health and HIV/AIDS programs.[20]

1.4 Alignment of PEPFAR investments geographically to disease burden

Figures 1.4.1 and 1.4.2 compare PEPFAR expenditure to burden of disease by district (as measured by the number of PLHIV). In 2015, the PEPFAR program spent an average expenditure of $57 per PLHIV. Among the 27 focus districts contained in this submission – the expenditure per PLHIV ranges from $18-$63. In general, relatively more funds were expended in the urban areas (e.g., Johannesburg and eThekwini) compared with non-urban areas, which may be reflective of the underlying population size associated with urban-based programs. The South Africa government is responsible for the majority of expenditures for HIV programs. The PEPFAR program has reviewed the available epidemiological and expenditure data in an effort to focus on programs and locations for increased impact and epidemic control.

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[19] The four domains of the SID include: Governance, Leadership and Accountability; National Health Systems and Service Delivery; Strategic Investments, Efficiency and Sustainable Financing; and Strategic Information.
[20] PEPFAR SA leadership is routinely engaged in coordination and information sharing discussions through the regular bilateral PFIP structures, the CCM, and the AIDS and Health Development Partner Forum (AHDPF) which assist in the coordination of various key intervention areas identified in the SID.

Figure 1.4.1 Percent of PLHIV by District and PEPFAR 2015 Expenditure Per PLHIV

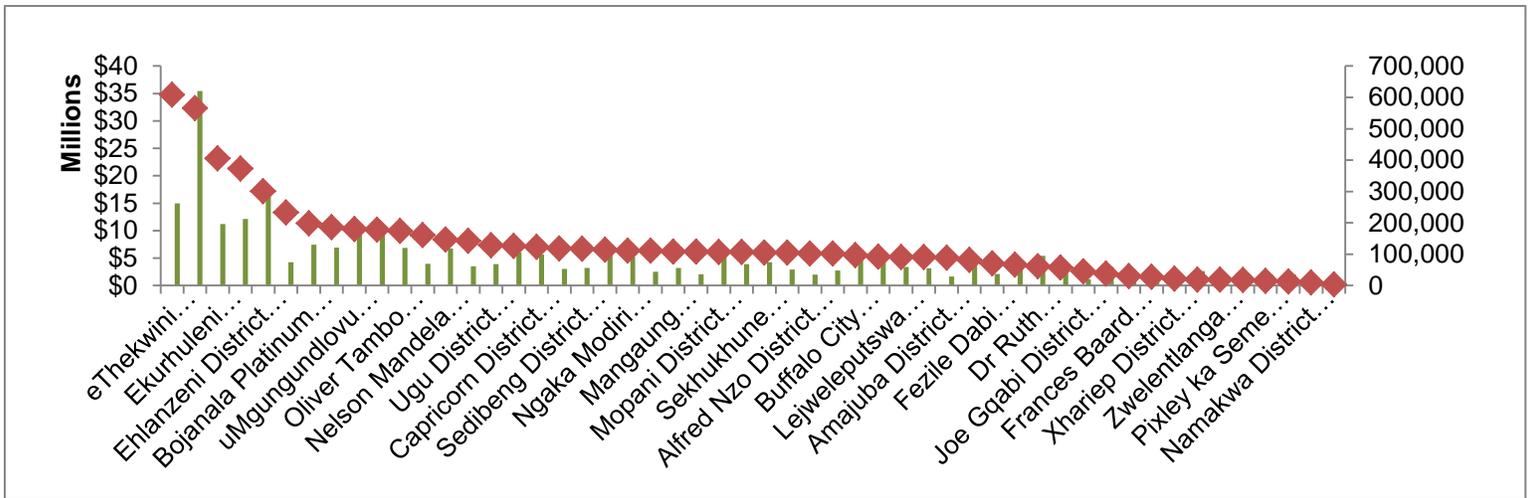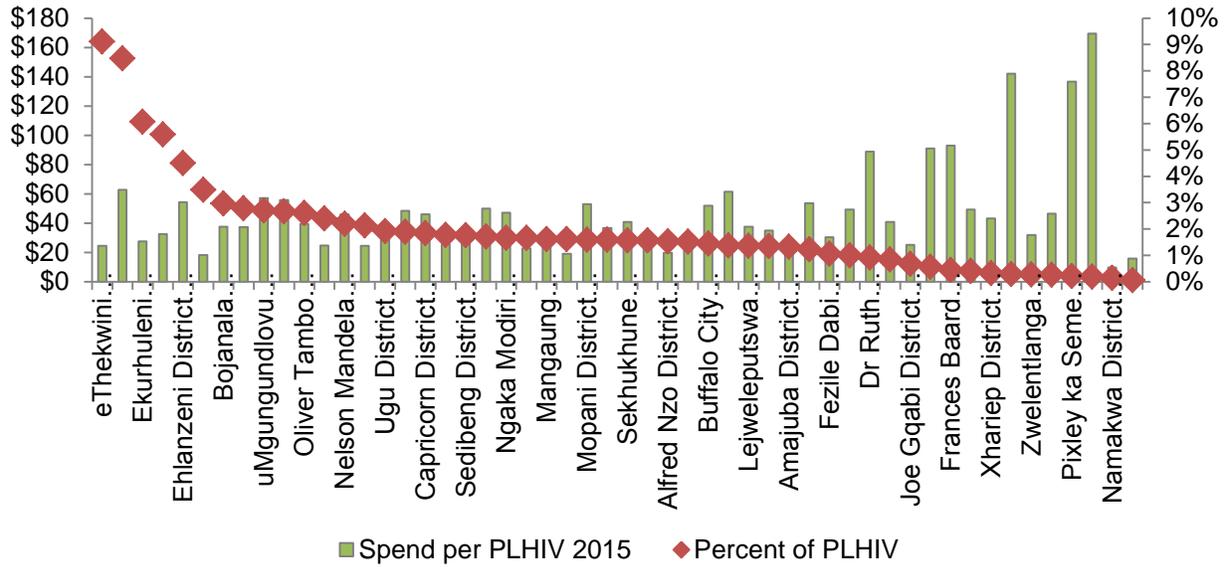Legend: ■ Spend per PLHIV 2015   ◆ Percent of PLHIV

Figure 1.4.2 Total Expenditure and PLHIV by District

1.5 Stakeholder Engagement

PEPFAR regularly engages with a broad range of stakeholders involved in HIV and health initiatives. PEPFAR works closely with the South Africa government through the structures established by the PFIP, including technical work streams (technical working groups), the Management Committee, and the Steering Committee, which is co-chaired by the Minister of Health and the U.S. Ambassador. COP16 has been reviewed and approved through these structures. PEPFAR also works closely with multiple South Africa government departments in the design and implementation of PEPFAR programs, including the National Department of Health, the Department of Social Development, the Department of Higher Education and Training, the Department of Basic Education, the Department of Justice, the Department of Correctional Services, the Department of Defense, and the National Treasury. PEPFAR supports South Africa governmental institutions including the South Africa Medical Research Council, the National Health Laboratory Service (including the National Institute of Communicable Diseases), the Human Sciences Research Council and the Council of Scientific and Industrial Research. PEPFAR also engages directly with provincial and district South Africa government officials and organizations, and has posted PEPFAR staff in provincial Department of Health offices.

PEPFAR supports and works closely with the South Africa National AIDS Council (SANAC) and collaborates with SANAC on priority initiatives. PEPFAR also supports and works with provincial and district AIDS councils in areas where PEPFAR programs are implemented. PEPFAR engages regularly with the SANAC civil society forum (CSF), which comprises 18 civil society sectors representing constituencies affected, infected, and engaged in the national HIV response. In preparation for COP16, several meetings were held with the CSF steering committee, leadership, and sectors. PEPFAR held a special multi-site digital video conference through Embassy and Consulate's American Corners in libraries bringing together CSF representatives from five cities around the country to share the COP16 process, overview the general COP16 plan and to solicit inputs and recommendations through the CSF sectors. PEPFAR will continue to proactively engage with the CSF, and is scheduled to present regular updates at the CSF quarterly meetings. The alignment with civil society and strengthening of South African coordination structures is an important component of PEPFAR South Africa's external partner engagement.

PEPFAR supports over 100 implementing partners, which, together with sub-awardees, represent a broad cross-section of NGOs, academic institutions, implementers, community organizations and faith-based organizations. Engagement with both national and international private sector partners continues through active consultation and joint programming – for example, around DREAMS implementation and innovations in ART service delivery. PEPFAR regularly meets with various private sector individuals and coordination structures (e.g., the American Chamber of Commerce) to help align and leverage corporate social responsibility and HIV programs.

PEPFAR also actively collaborates with multilateral organizations and other funding organizations in the design of programs and strategies to ensure alignment and effective use of resources. PEPFAR regularly engages with the UN family of organizations, including WHO, UNAIDS and UNICEF. The USG actively participates in the South Africa AIDS and Health Development Partners Forum and shares information regarding PEPFAR goals and programs.

In consideration of the opportunities for alignment of strategic and operational objectives between PEPFAR and The Global Fund to Fight AIDS, TB and Malaria, PEPFAR regularly engages with Global Fund leadership and implementers. USG representatives participate in the Country Coordinating Mechanism, Oversight Committee, and other Global Fund engagements. The USG provided recommendations during the design of the most recent concept note submission for Global Fund support.

PEPFAR participates actively in multiple South Africa initiatives to share information and design high impact strategies and implementation plans. USG staff are active in national initiatives such the national HIV Think Tank, TB Think Tank, and the HIV/TB Implementation Research Advisory Committee. PEPFAR also actively participates in important national planning exercises such as the mid-term review of the NSP, the Investment Case, and the development of new policies such as the policy in development regarding Pre-Exposure Prophylaxis (PrEP). PEPFAR also supports, organizes and participates in multiple national workshops and conferences to engage with experts and stakeholders at many levels.

In the development and initial implementation of the DREAMS proposal, PEPFAR, the South Africa government, SANAC, civil society, and implementers have engaged in a robust process at national, provincial and district levels to ensure a broad spectrum of stakeholders are fully involved and can contribute to the objectives of that initiative.

Through all of these engagements, PEPFAR South Africa solicits strategic input and shares information and strategic direction in order to enhance collective efforts to address HIV goals.

2.0 Core, Near-Core and Non-Core Activities

In preparation of COP15 and COP16 the PEPFAR team and the South Africa government reviewed PEPFAR programs through each technical working group (TWG) and PFIP work stream. In COP16 the majority of these priority activities and objectives will continue. COP16 core focused high impact activities in support of the NSP include: Decanting of stable ART patients to decongest public health facilities; Viral Load suppression; methodologies to improve Testing yield and focus on men; Key Populations and clinical cascade; Heath Systems Strengthening to support HR development, supply chain, and data use for 90-90-90; and support to OVC.

3.0 Geographic and Population Prioritization

The geographic prioritization for COP16 builds on the COP15 focus for impact on South Africa's 27 highest burden districts. In COP15 the 27 highest burden districts were identified using results from the South African National HIV Prevalence, Incidence and Behavior Survey, 2012 (HSRC) to determine the estimated proportion of people living with HIV at the provincial level. Provincial estimates were then applied to the district level to determine estimated PLHIV and HIV testing targets in-line with 90-90-90. PEPFAR focus districts were selected based on this information; the 27 districts with the highest HIV burden represent 82% of the estimated national PLHIV.

For COP16, updated Spectrum model data and Small Area Estimations validate the identification of 27 high burden districts. In COP15, four of the 27 focus districts are planned for initial roll out of Test and Treat in conjunction with a sustained plan to decant stable patients from public health facilities. This initiative will provide implementation experience and lessons learned for the national roll out of Test and Treat beginning in September 2016. A strategy to actively decant stable patients and scale-up the number of people on ART will be applied in COP16 in all of the high burden priority districts as of national policy revision in September 2016.

By the end of COP14 (September 2015) PEPFAR supported the South Africa government to provide ART to 2,958,723 PLHIV. By the end of COP15 the estimated target for PEPFAR support of PLHIV on ART is 3,384,784. COP16 targets PEPFAR support for 3,908,411PLHIV on ART in the 27 focused districts by September 2017.

In COP16 prevention services are strategically planned to support and align with the NSP, and with COP16's treatment targets and geographic focus. Scaling up focused HTC programming in the 27 focus districts will support reaching the first 90. Additionally, VMMC activities will be prioritized to reach 80% of the 15-34 age group within the 27 focus districts. Other prevention interventions will be directly linked to supporting the first and second 90s. Prevention interventions will be conducted in all 27 focus districts, while key populations (KPs) programs will be provided 14 high-burden districts and 3 non-focus districts. Select key population interventions will be implemented outside the 27 focus districts based on epidemiologic data.

Within the geographic focus, PEPFAR SA will continue to work with the South Africa government to support programs that address specific population groups as follows:

Adolescent girls, young women (AGYW), their partners and parents: South Africa has the highest number of estimated new HIV infections globally per week (2,363) among AGYW aged 15-24 years (UNAIDS, 2013). PEPFAR aims to support South Africa government goals to aggressively address HIV incidence among this population to achieve an AIDS-free generation, particularly with concentrated evidence based-efforts, complementing the DREAMS initiative. By the end of COP16, PEPFAR will support HIV testing for 322,083 AGYW nationally and will provide approximately 3,000 female sex workers with PrEP in two DREAMS districts. In June 2016, the South Africa government plans to launch a national strategy for young women and girls, highlighting five goals: (1) reducing HIV incidence; (2) decreasing teenage pregnancy; (3) decreasing gender-based violence; (4) keeping girls in school; and (5) increasing economic opportunities for young people.

Males: Modeling suggests that uncircumcised men, aged 15-34, are a priority target population for prevention, and PEPFAR will focus on achieving the greatest magnitude and immediate reduction in HIV incidence by prioritizing circumcision of men within this age group. Additionally, PEPFAR has collaborated closely with the Department of Correctional Services (DCS), as there is growing evidence of the association between incarceration and increased risk for acquisition of HIV and treatment interruption. The inmate population is estimated at 320,000 per year. Miners are an additional high risk group and continue to have the highest TB incidence among a working population group globally. Given the high rates of co-infection with HIV, PEPFAR will support South Africa programs that target HIV prevention and TB programs in these communities and the peri-mining communities at risk.

Key Populations: Modelled estimates indicated that 9.2% of new HIV infections nationally are attributable to male-to-male sex, and 19.8% are attributable to sex work.[21] Additionally, recent studies indicate a HIV prevalence of between 40% - 89% among FSW and between 28% and 52% among MSM.[22] There are an estimated 138,000 FSWs and 1.2 million MSM.[23] In March, 2016 the South Africa government launched a South Africa National Sex Worker HIV Plan based on the findings from a PEPFAR-supported Integrated Biological and Behavioral Survey.

Migrant Farmworkers: According to the NSP 2012-2016, HIV risk is higher among individuals with personal migration experience or who have sexual partners who are migrants. According to the 2011 Census, 759,127 households with an aggregate population of 2,732,605 (5.28% of South Africa's population) lived in South African farm areas with large migrant populations.

Military Personnel: Estimates for HIV prevalence among members of the South African National Defense Force range from 8.5% to 17.5% (HIV Directorate, SAMHS).

OVC: OVC programs play a critical role in identifying vulnerable children and families and referring them to services. In COP15, an analysis of the OVC burden was conducted and districts with the highest

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[21] SACEMA 2010 cited in National Strategic Plan for HIV, TB and STIs, 2012-2016. SANAC, 2012.
SACEMA = South African Centre for Epidemiological Modelling and Analysis. The SACEMA study took place in 2010.
[22] UCSF. South African Health Monitoring Survey, Survey on female sex workers in South Africa, 2013-2014. 2014.
UCSF. MSM in South Africa. Data Triangulation Project. Pretoria, 2015.
[23] SWEAT. Estimating the size of the sex worker population in South Africa, 2013. Cape Town, 2014.
The MSM population size is based on the Elton John/ANOVA assessment.

OVC burden were determined. These areas were largely aligned with the 27 highest burden districts. In COP16, PEPFAR will support OVC services in collaboration with the Department of Social Development in the 27 focus districts as well as the DREAMS District of Umkhanyakhude and sites with Peace Corps Volunteers.

Laboratory: The laboratory program prioritizes activities and resources aligned with the 27 highest burden districts. The program focuses on strengthening the delivery of comprehensive quality diagnostic services with the National Health Laboratory Services (NHLS) to support the accuracy and reliability of HIV point of care testing, improving laboratory quality management systems, minimizing wastage, increasing a skilled laboratory workforce and strengthening all pre- and post-laboratory analytical phases at facilities level. During COP16, PEPFAR programs will address viral load coverage improvements including clinic-laboratory linkages.

4.0 Program Activities for Epidemic Control in Scale-up Locations and Populations

4.1 Targets for priority locations and populations

In line with decisions made in the COP15 planning and implementation cycle, PEPFAR will focus the majority of its programming support in the 27 highest burden districts, which account for an estimated 82% of the South Africa's PLHIV burden (see Figure 4.1.1 below). PLHIV estimates at the district level are based on the 2014 Spectrum estimates that generated provincial level data and then were extrapolated to the district level based on population size. These district estimates were also triangulated with other estimates (e.g., 2012 HSRC Household Survey, Small Area Estimations).

Unmet HIV treatment need and targeted coverage in the highest burden districts, as a proportion of estimated PLHIV, were used as a basis for determining other program area targets with the overall goal to achieve at least 81% all PLHIV on ART (see Figure 4.1.2 below) at the district level. By the end of COP16 implementation (September 2017/FY17) PEPFAR plans to support the South Africa government to provide ART for 81% of the estimated PLHIV in five districts, and in all 27 focus districts by the end of COP17 implementation (September 2018/FY18). COP16 HIV treatment targets take into consideration the plan to decant 650,000 stable ART clients to alternative models of care and drug resupply. DREAMS targets are aligned with the COP16 targets. Test and Treat proposed additional funding and activities in COP15 and 16 were considered in the setting of COP16 targets.

Associated program area (e.g., HTC, VMMC, and OVC) coverage and achievement targets have been aligned with need and these HIV treatment coverage goals (see Figure 4.1.3 below).
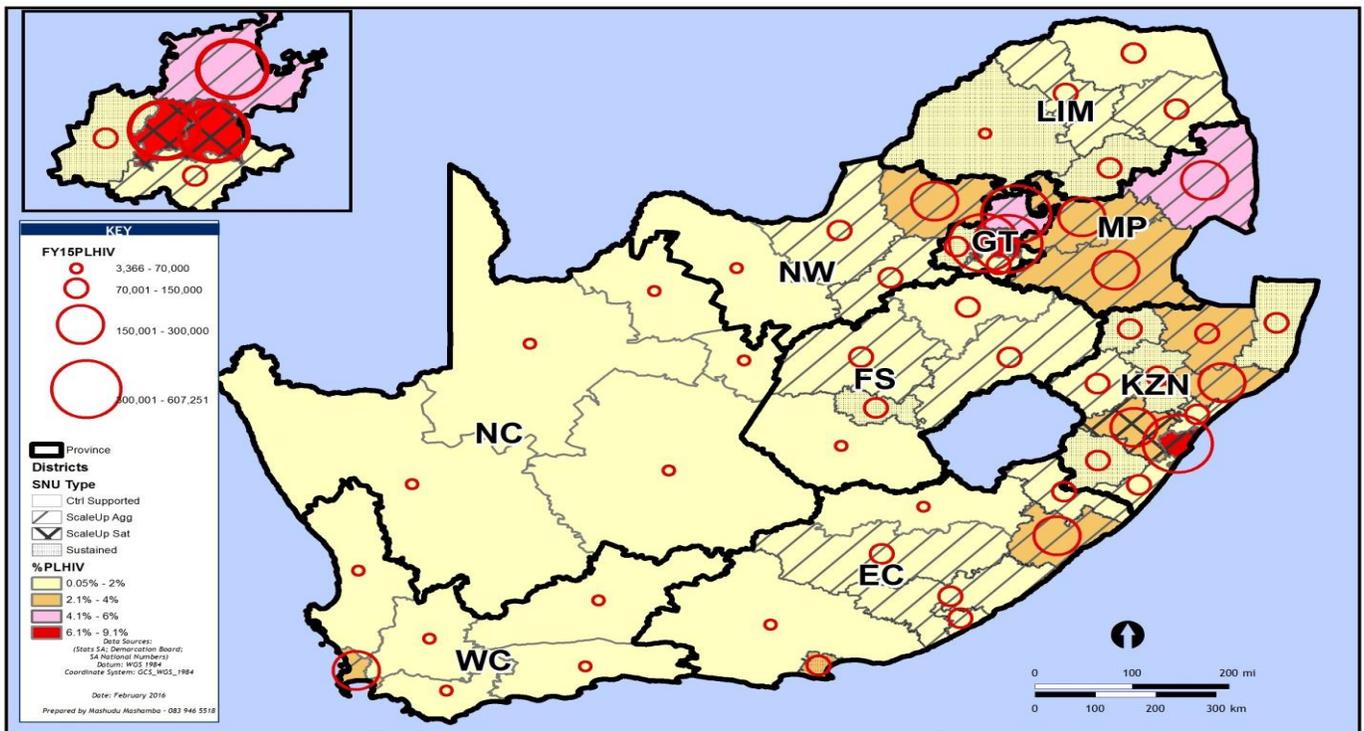
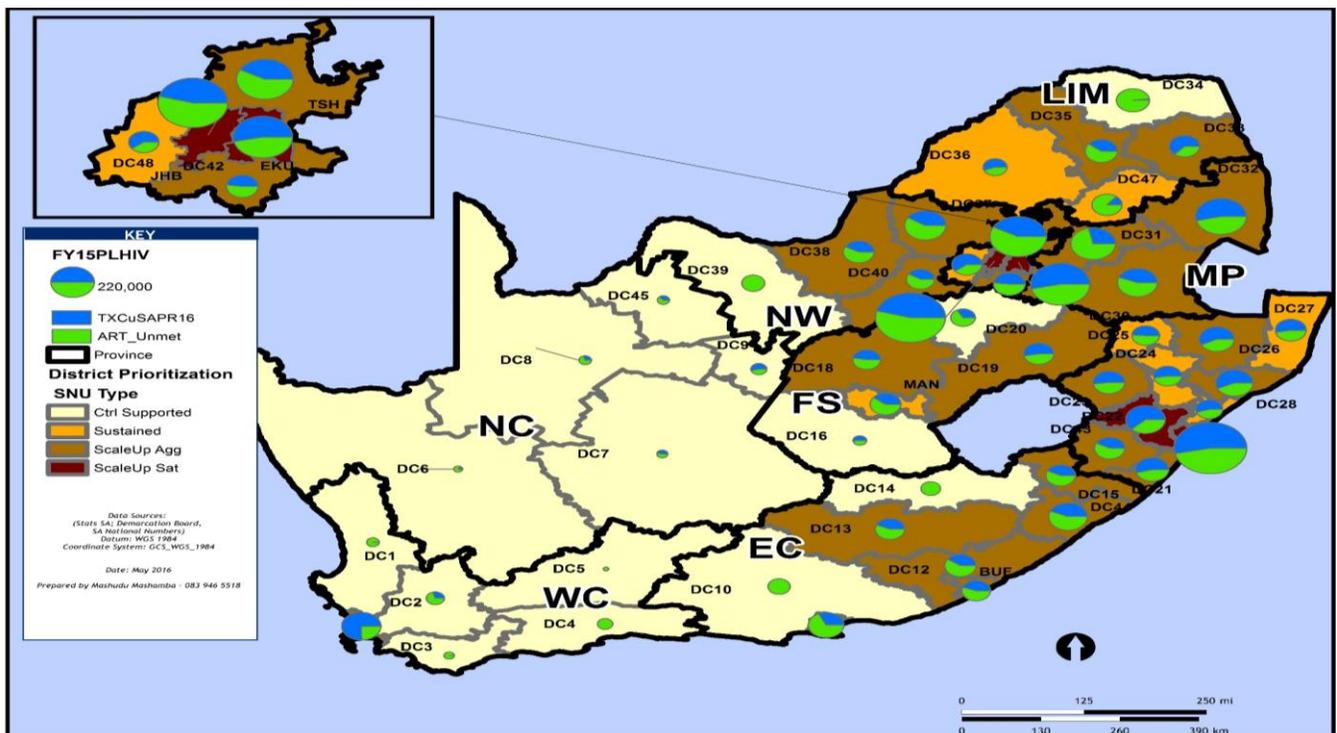**Figure4.1.1:** Percentage and Total Number of PLHIV by District, South Africa FY15

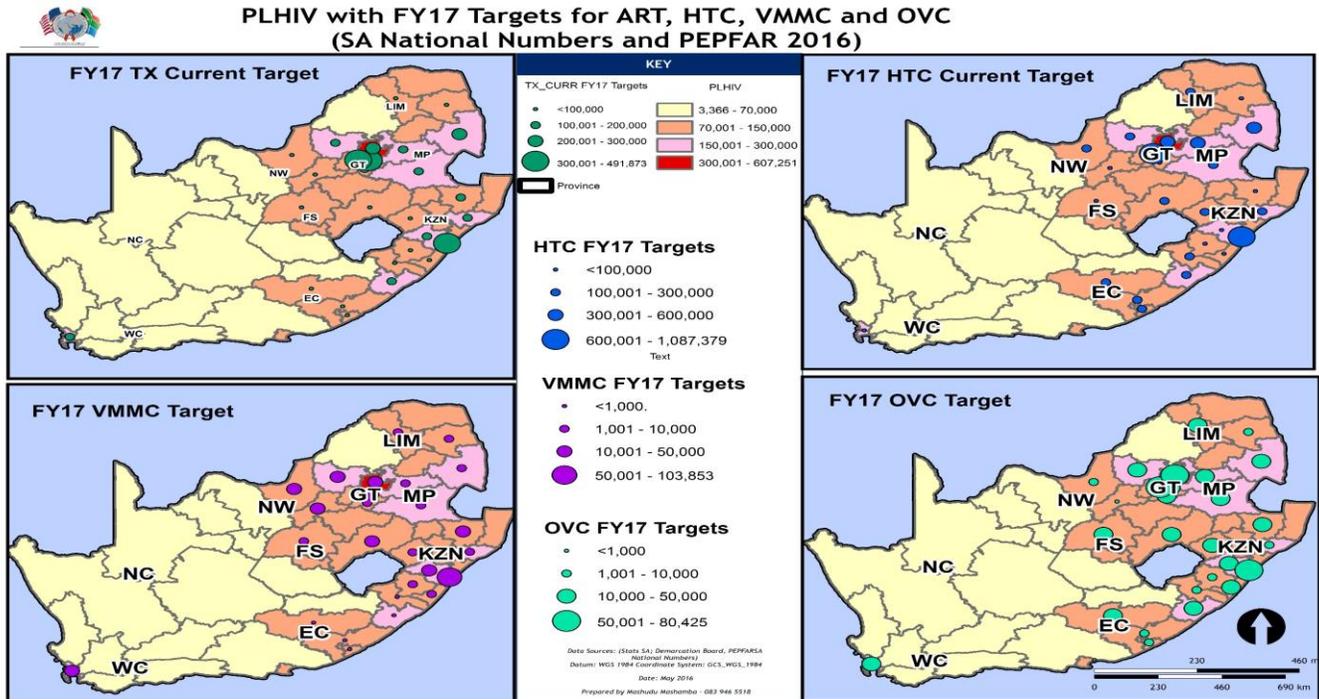**Figure 4.1.2:** HIV Treatment Coverage and Unmet Need, South Africa (SAPR16)

Figure 4.1.3: HIV Burden (PLHIV) with Treatment, HTC, VMMC, and OVC COP16 PEPFAR Targets, South Africa

Laboratory: COP16 program laboratory program objectives were identified in discussions during portfolio reviews and subsequent meetings with NDoH, NHLS, NICD, and the PEPFAR Laboratory TWG. Laboratory program activities will support both prevention and care and treatment in toward achievement of 90-90-90 goals. Laboratory program targets are aligned with the 1,969 supported facilities in the 27 highest burden districts. Highest volume HTC sites will be prioritized for laboratory activities during COP16 with the highest volume facilities receiving support first.

The program will continue to support NHLS in the implementation of Quality Assurance (QA) for HIV point of care testing to ensure the accuracy and reliability of testing. PEPFAR implementing partners will provide support to all testing sites (facility, community, home-based, mobile testing) within the 27 priority districts and will align to recently released WHO Consolidated Guidelines on HTS and the national HTS revised guidelines. The laboratory program will also facilitate implementation of QA for community and home-based HIV rapid tests (RT) and CD4 POCT. At the facility level, the laboratory program will facilitate implementation of QA for HIV rapid test and strengthening of pre/post analytical phases (i.e., Clinical-Lab Interface).

Targets for the implementation of the WHO-African Society for Laboratory Medicine (ASLM) step-wise accreditation process[24] to improve quality management systems in diagnostic laboratories have been set for 12 laboratories which provide HIV diagnostic services to facilities within the 27 priority districts.

The PEPFAR-supported laboratory training center, African Centre for Integrated Laboratory Training (ACILT), has been integrated into the NHLS's national laboratory workforce training platform, within the NHLS Learning Academy. The laboratory program will provide technical assistance on curricula development, and subject matter expert facilitation at key strategic courses, including courses for novel diagnostic assays and technologies.

In COP16 the laboratory program will assist in the achievement of the first and third 90 goals. Focus will be on addressing the low documented VL completion. Several key system barriers have been identified and the role of the laboratory program will be to provide key support to activities that will assess the current viral load and early infant diagnosis (EID) testing capacity as well as accessibility, expand the existing national viral load testing capacity, pilot decentralized service delivery models aimed at improving testing efficiencies, and intensify clinic-lab interface support to ensure documentation and capture of laboratory results in the relevant health information systems to ensure improved data quality for program evaluation and monitoring. Laboratory support will also include evaluating the impact of the introduction of EID POCT testing to inform policy makers on a possible plan to take it to scale.

Prevention: The prevention portfolio comprises several distinct programs in support of NSP goals including (a) VMMC; (b) HTS[25]; and (c) priority and key population prevention.

VMMC targets are based on low MMC prevalence and high HIV incidence with a goal to achieve 80% coverage of males 15-34 years by the end of September 2017. Nine of 27 focus districts are expected to reach 80% coverage of males 15-34 by September 2016, with an additional 17 districts and one DREAMS district reaching 80% coverage by September 2017. To increase the immediacy of impact, VMMC programs will target the high priority age band with a goal that 70% of VMMCs reach 15-34 year old men. Some COP16 programs will continue in districts that will reach 80% coverage by the end of COP15 to support the NDoH to maintain the achieved VMMC coverage in high HIV burden districts.

VMMC supports 90-90-90 goals by incorporating referrals to HTS as an integral part of service delivery, and through the development of successful linkages to treatment for positive men. Although HIV positivity varies across districts, on average the HIV positivity seen is 3% among uncircumcised men, and ensuring their successful linkage will contribute to initiating PLHIV on treatment.

With additional central funds (approximately USD 24 million) in COP16, PEPFAR will support an additional 174,132 VMMCs, for a total of 428,486 VMMCs to support the VMMC goal of 80% of 15-34 year old men by September 2017. PEPFAR has requested that VMMC partners focus on the target age range, and will support operational research regarding innovative methods to recruit men.

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[24] Strengthening Laboratory Management Towards Accreditation (SLMTA) and Stepwise Laboratory Improvement Process Towards Accreditation (SLIPTA).
[25] HIV testing services (HTS)

HIV Testing Services (HTS) will aggressively scale-up community and facility testing in support of the first 90. In COP16 PEPFAR plans to support HIV testing for 5,753,546 people in facility and community settings, with a goal to identify 695,787 PLHIV who will be linked to treatment. The variable number of PLHIV who know their HIV status in focus districts demonstrates the need for a targeted and integrated community-based HTC[26] to identify new PLHIV. District data on HIV prevalence, estimated number of undiagnosed PLHIV, HTC yield, as well as estimated unmet ART need, were used to calculate the number of new HIV diagnoses required to reach 90% of people with unknown status.

South Africa has increased the availability of HTS services in public health facilities, with 66% utilization by the population. PEPFAR's community based HTS program will focus on identifying the remaining 34% PLHIV who are not accessing public health facilities. This will be achieved through scale-up and integrated implementation of high-yield HIV testing modalities in targeted high burden communities in the 27 focus districts.

Key populations partners will use strategies like social networking to increase uptake and yield of hard-to-reach populations. High-risk negative individuals are urged to test regularly through risk reduction counselling and through peer networks.

Priority and key population prevention: In COP16 PEPFAR will continue to support evidence-based prevention programs for priority and key populations at risk of HIV aligned with the NSP and South Africa's programs. To identify key populations, PEPFAR has used the best available data, including national census data (STATSSA, 2015) to determine denominators at sub-district and ward levels, and HIV prevalence data sourced from the National Household Survey and other studies. Geographically, prevention program priority sites have been identified according to the highest burden districts, with an emphasis on high incidence areas such as informal settlements, densely populated urban areas, mining areas and trucking routes. Within these areas, PEPFAR will support focused prevention activities to reach approximately 20% of priority populations, while an overall 80% coverage is likely through coordinated efforts with South Africa government programs and other development partners.

Key populations (KP) activities will focus on high burden populations, including the high prevalence female sex worker group in hotspots around the country. The second largest KP group is MSM. PEPFAR will support programs to reach fifty-five percent of FSW and 15% of the estimated MSM population, and PEPFAR supported partners will aim to test 55% of FSWs who have unknown status, and 15% of MSM of unknown status in the priority districts.

PEPFAR partners will support interventions to increase uptake of HTS through mobilization, risk reduction counselling, and through active referrals for provision of HTS through mobile services. These programs will support the second 90 through systematic linkages to treatment for HIV-positive individuals through peer navigation systems, while regular adherence support groups and peer education will support the third 90. COP16 will support PEPFAR partners to implement innovative recruitment strategies to expand programs into new social networks. Sensitization activities will include clinical

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[26] HIV testing and counseling services (HTC)

competency training. A new curriculum will be rolled out to Regional Training Centers and other academic institutions.

Demand creation will improve uptake into clinical services, which in turn will lead to increased identification of PLHIV, providing the opportunity to link them to treatment. Condom programming will improve condom availability, accessibility and increased usage through expanded service points.

Key population programs will utilize a monthly standardized data collection tool currently under development. In addition, PEPFAR will support the development of a KP cascade and confidential reporting system that will provide information to the national public health system.
SIMS and site visits will be utilized to monitor targets. The PEPFAR targets for key populations include some results supported through comprehensive DREAMS programs.

Table 4.1.1 ART Targets in Scale-up Sub-national Units for Epidemic Control

District/Sub-national Unit	Total PLHIV	Expected current on ART (APR FY 16)	Additional patients required for 80% ART coverage	Target current on ART (APR FY17) TX_CURR	Newly initiated (APR FY 17) TX_NEW	ART Coverage (APR 17)
ec Alfred Nzo District Municipality	101,877	54,672	26,830	71,473	19,340	70.1%
ec Amathole District Municipality	113,483	51,344	39,442	75,729	26,422	66.7%
ec Buffalo City Metropolitan Municipality	96,011	55,168	21,641	68,730	16,329	71.6%
ec Chris Hani District Municipality	101,128	57,219	23,683	72,039	17,661	71.2%
ec Oliver Tambo District Municipality	173,529	84,736	54,087	111,321	34,904	68.1%
fs Lejweleputswa District Municipality	90,448	63,055	9,303	69,180	9,664	76.5%
fs Thabo Mofutsanyane District Municipality	106,100	62,096	22,784	76,403	17,456	72.0%
gp City of Johannesburg Metropolitan Municipality	564,735	356,903	94,885	479,047	124,823	81.0%
gp City of Tshwane Metropolitan Municipality	372,026	197,998	99,623	248,363	117,254	69.9%
gp Ekurhuleni Metropolitan Municipality	404,750	292,248	31,552	339,979	55,196	81.0%
gp Sedibeng District Municipality	116,706	102,950	0	103,077	6,185	88.2%
kz eThekwini Metropolitan Municipality	607,251	372,938	112,863	510,538	146,783	81.0%
kz Harry Gwala District Municipality	81,397	49,840	15,278		13,225	73.1%

			64,180		
kz Ugu District Municipality	127,450	79,430	22,530	93,884	15,308	73.5%
kz uMgungundlovu District Municipality	179,539	157,394	0	157,396	9,440	81%
kz Uthukela District Municipality	117,989	67,192	27,199	84,222	20,381	71.4%
kz Uthungulu District Municipality	160,091	96,284	31,789	116,904	25,138	72.7%
kz Zululand District Municipality	141,756	99,185	14,220	108,666	15,126	76.6%
lp Capricorn District Municipality	122,526	62,967	35,054	84,737	24,679	69.2%
lp Mopani District Municipality	106,116	53,855	31,038	73,122	14,804	68.9%
mp Ehlanzeni District Municipality	299,726	158,990	80,791	209,918	57,443	69.8%
mp Gert Sibande District Municipality	185,164	110,549	37,582	135,017	29,767	72.5%
mp Nkangala District Municipality	232,191	69,982	115,771	136,172	63,404	60.7%
nw Bojanala Platinum District Municipality	197,846	111,705	46,572	154,517	38,448	71.2%
nw Dr Kenneth Kaunda District Municipality	91,335	55,805	17,263	67,172	14,251	73.0%
nw Ngaka Modiri Molema District Municipality	110,596	59,718	28,759	79,311	21,302	70.2%
wc City of Cape Town Metropolitan Municipality	177,285	115,545	26,283	117,314	135,993	78.9%
Total	**5,179,051**	**3,099,768**	**1,066,821**	**3,908,411**	**1,090,726**	**74.9%**

Table 4.1.2 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts

Entry Streams for ART Enrollment	Tested for HIV	Identified Positive	Newly initiated (APR FY 17)

	(APR FY17)	(APR FY17)		TX_NEW
Adults				
Clinical care patients not on ART*	3,321,765	NA	199	
HIV+ TB Patients not on ART**	202,087	121,252		109,127
HIV-positive Pregnant Women	623,389	92,622		105,062
Other priority and key populations***	47,338	6627		NA
Pediatrics				
Clinical care pediatrics not on ART	NA		NA	
HIV Exposed Infants	151,141	1,071		1,060
Orphans and Vulnerable Children	536,017	33,233		29,910
Provider Initiated Testing	NA	NA	NA	
Total				

Data sources:

*'PITC' section of 'HTC Data Entry' Datapack

**TB/HIV section of 'Summary & Targets' Datapack

***'Other Service Delivery' of 'HTC Data Entry' Datapack

Target Populations	Population Size Estimate* (SNUs)	Current Coverage* (date)	VMMC_CIRC** (in FY17)	Expected Coverage* (in FY17)
ec Alfred Nzo District Municipality	159,399	132,482	731	95%
ec Amathole District Municipality	193,145	134,986	705	80%
ec Buffalo City Metropolitan Municipality	137,227	97,508	602	82%
ec Chris Hani District Municipality	153,295	104,859	1,000	80%
ec Oliver Tambo District Municipality	285,479	209,292	516	80%
fs Lejweleputswa District Municipality	121,973	71,943	6,115	80%
fs Thabo Mofutsanyane District Municipality	150,965	82,657	13,900	80%
gp City of Johannesburg Metropolitan Municipality	805,253	579,801	30,000	91%
gp City of Tshwane Metropolitan Municipality	563,039	375,162	18,567	80%
gp Ekurhuleni Metropolitan Municipality	597,113	390,321	15,969	80%
gp Sedibeng District Municipality	166,838	105,077	4,051	80%
kz eThekwini Metropolitan Municipality	611,354	274,736	103,853	80%
kz Harry Gwala District Municipality	93,699	48,117	8,990	80%
kz Ugu District Municipality	150,732	93,260	2,843	80%
kz uMgungundlovu District Municipality	199,436	95,453	23,405	80%
kz Uthukela District Municipality	128,916	78,172	5,443	80%
kz Uthungulu District Municipality	163,715	96,128	9,033	80%
kz Zululand District Municipality	163,747	90,067	10,314	80%
lp Capricorn District Municipality	249,548	216,457	3,740	96%
lp Mopani District Municipality	218,943	180,818	2,278	93%
mp Ehlanzeni District Municipality	313,729	221,395	8,088	84%
mp Gert Sibande District Municipality	223,261	151,182	5,373	84%
mp Nkangala District Municipality	296,386	230,613	6,018	86%
nw Bojanala Platinum District Municipality	297,268	165,352	29,106	80%
nw Dr Kenneth Kaunda District Municipality	126,581	66,386	14,917	80%
nw Ngaka Modiri Molema District Municipality	180,464	73,028	38,193	80%

Table 4.1.3 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

wc City of Cape Town Metropolitan Municipality	661,928	267,081	31,870	50%
kZ Umkhanyakude District Municipality***	125,279	40,555	32,866	80%
Total	**7,413,433**	**4,672,888**	**428,486 [1]**	

*Males (15-34 years)   **All ages

***DREAM district, not one of the 27 focus districts

4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY17)	FY17 Target
AGYW + partners	1,639,770	18.5 %	303,867
Miners	85,000	28.2 %	24,000
Migrant Farm Workers	115,010	29%	33,800
Inmates	81,894	55 %	45,942
FSW	72,692	53.8%	35,084
MSM	185,272	14.5%	27,544
PWID	21,175	6.2%	1,315
Total	**2,200,813**	--	**471,552**

Table 4.1.5 Targets for OVC and Linkages to HIV Services

	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY17 Target)	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY17 Target)
		OVC_SERV	**OVC_KNOWNSTAT**
ec Alfred Nzo District Municipality	53226	1,169	1052
ec Amathole District Municipality	83519	3,936	3542
ec Buffalo City Metropolitan Municipality	37922		8619

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[1] COP16 funds only. VMMC additional funds of $24 million would bring the total target to 428,486

		9,577	
ec Chris Hani District Municipality	77033	24,719	22247
ec Oliver Tambo District Municipality	252601	24,948	22455
fs Lejweleputswa District Municipality	49893	17,864	16078
fs Thabo Mofutsanyane District Municipality	69372	15,334	13801
gp City of Johannesburg Metropolitan Municipality	154382	103,869	72383
gp City of Tshwane Metropolitan Municipality	90469	50,470	45351
gp Ekurhuleni Metropolitan Municipality	133873	43,167	30378
gp Sedibeng District Municipality	47649	16,000	14400
kz eThekwini Metropolitan Municipality	221572	75,685	49515
kz Harry Gwala District Municipality	55785	7,179	6461
kz Ugu District Municipality	78122	12,558	11302
kz uMgungundlovu District Municipality	88618	44,317	31744
kz Umkhanyakude District Municipality	72192	15,326	9702
kz Uthukela District Municipality	75420	7,087	13685
kz Uthungulu District Municipality	99107	16,729	6288
kz Zululand District Municipality	104278	18,091	15002
lp Capricorn District Municipality	95223	6,654	16210
lp Mopani District Municipality	81600	32,580	5917

mp Ehlanzeni District Municipality	135560	27,200	29286
mp Gert Sibande District Municipality	88571	25,141	24480
mp Nkangala District Municipality	71577	29,362	22609
nw Bojanala Platinum District Municipality	77076	720	26426
nw Dr Kenneth Kaunda District Municipality	42661	5,475	648
nw Ngaka Modiri Molema District Municipality	68940	9,168	4928
wc City of Cape Town Metropolitan Municipality	96687	1,169	11508
Total in 27 districts & Umkhanyekude	**2,602,928**	**644,325**	**536,017**

Program Area Summaries 4.2-4.10

4.2 Priority and KP Prevention

South Africa's policies and guidelines provide critical direction for priority and key populations prevention interventions, including:

- UNAIDS 90-90-90 strategy
- HTS revised policy and guidelines based on WHO's recommendations (NDoH,)
- National PrEP Guidelines in development, including a focus on FSWs as the first phase of roll out (NDoH)
- National Condom Distribution Plan (NDoH,)
- Draft Combination Prevention Strategy (NDoH)
- National Sex Worker Strategy (SANAC)

In COP15, the PEPFAR and South African government team undertook an extensive portfolio review with 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. COP16 will continue to focus on the core areas, which include improving condom (male and female) distribution and demonstration in emphasizing unconventional community access points (e.g., taverns, gas stations) and increased use; implementing evidence-based structured prevention interventions for HIV and sexual and gender-based violence risk reduction/prevention and service demand creation with linkages for uptake of medical and legal services; behavioral interventions focused on vulnerable populations (i.e., adolescent girls, young women and their male sexual partners, especially those in informal settlements; truckers and clients of FSW), migrant farmers, and male inmates; and a comprehensive package of services for key populations, all underscored by a strong peer educator network and complementary activities to reduce stigma and discrimination through sensitization and clinical training for health workers.

PEPFAR's Site Improvement through Monitoring System (SIMS) will be used to monitor PEPFAR-supported partners' performance on a regular basis. PEPFAR continues to identify opportunities to strengthen alignment of SIMS monitoring activities with South Africa program review initiatives, including the district implementation plans.

In COP16 PEPFAR will strengthen the integration of gender issues to ensure access to health services and other HIV prevention interventions. In COP15 PEPFAR supported a gender analysis to fine-tune programming for priority and key population interventions. Access to and utilization of health services will be a key prevention intervention in COP16. In COP16 partner monitoring tools and standardized systems to improve access to health systems will be strengthened and aligned with NDoH. Key populations sensitization programs will be rolled out to support the growth of KP-friendly and competent services. Peer navigation – where peers are embedded within facilities – will be used to accompany KP

clients through large health facilities.   Direct service delivery through mobile services staffed by professional and Nurse Initiated Management of ART (NIMART) trained (task shifted) nurses, lay counselors and peers will continue to reach out to FSWs and MSM.

NDoH has procured scented and colored condoms that appeal to most populations, however, lubricants and female condoms are often unavailable in community-based sites. In COP16 PEPFAR will conduct a survey and social marketing strategy to determine condom needs, distribution strategies, and improved use. In COP16 the KP program will continue to purchase and provide branded lubricant and condoms to KPs.

4.3 VMMC

VMMC targets are based on low MMC prevalence and high HIV incidence with a goal to achieve 80% coverage of males 15-34 years by the end of September 2017. Nine of 27 focus districts are expected to reach 80% coverage of males 15-34 by September 2016, with an additional 17 districts and one DREAMS district reaching 80% coverage by September 2017. To increase the immediacy of impact, VMMC programs will target the high priority age band with a goal that 70% of VMMCs reach 15-34 year old men. Some COP16 programs will continue in districts that will reach 80% coverage by the end of COP15 to support the NDoH to maintain VMMC coverage in high HIV burden districts.

While the NDoH has noted that 15-49 is the target age group for the national program, 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 (15-34 years). Mathematical modeling through the DMPPT 2.0[27] has also shown that targeting this age group is the most cost-effective in terms of infections averted.

In COP15 and 16 PEPFAR will continue to assist the South African government to scale up VMMC through planning, coordination, and implementation including advocacy, communication, and social mobilization to meet its national scale-up goal of circumcising 4.3 million adult males (ages 15-49) by December 2016. PEPFAR's supported program includes a network of approximately 800 sites.

By the end of COP14 (September 2015), PEPFAR provided support for 1.3 million VMMCs approximately 58% of the national VMMC total of 2.25 million.

In COP16 PEPFAR will continue to support a comprehensive minimum package of services in public, private and non-governmental facilities in urban and rural communities with low rates of VMMC and high HIV prevalence. Implementing partners will continue to develop improved understanding and consideration of the personal and cultural values of target audiences, identifying gender-related barriers (e.g., potentially harmful male norms), and work with local community and traditional leaders to ensure VMMC can serve their constituents while preserving dignity and tradition.

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[27] The Decision Makers' Program Planning Tool (DMPPT) 2.0, prepared by the USAID- and PEPFAR-funded Health Policy Project (HPP), seeks to answer key strategic and programmatic questions about VMMC. The overarching goal of the model is to help VMMC program planners focus and prioritize their VMMC programs by client age group and subnational region. DMPPT 2.0 can determine the impact (HIV infections averted), cost per HIV infection averted, numbers of circumcisions needed (by age group), and cost savings of various targeting strategies, allowing for comparison of potential VMMC scale-up scenarios.

PEPFAR will continue to ensure that external quality assurance and continuous quality improvement activities are routinely conducted. Emphasis will be on those who test positive will to see they receive post-test counseling and are linked to care and treatment. VMMC services will also address harmful male norms and behaviors that may promote high-risk sex behaviors, limit access and/or adherence to HIV prevention services, including VMMC, or directly or indirectly contribute to gender-based violence (GBV). Integration or referral/linkage of other men's health services and programs that promote gender equitable norms with VMMC services will be encouraged by implementing partners.

The VMMC team will prioritize roll-out of innovations to increase follow-up rates and explore ways to recruit older men for VMMC services. Currently PEPFAR is funding and providing technical assistance through UNICEF to support the formative work needed to thoughtfully plan and resource a long-term sustainable approach to high male circumcision coverage, though delivery of Early Infant Male Circumcision (EIMC). The EIMC program is expected to be sustained through South African government initiatives.

4.4 Preventing Mother to Child Transmission (PMTCT)

South Africa has achieved great strides in prevention of mother to child transmission (PMTCT), high coverage of HIV testing and antiretroviral treatment above 95% for HIV+ pregnant women, and early infant diagnosis (EID) testing. South Africa has adopted and implemented Option B+ with additional critical interventions such as viral load (VL) testing for HIV diagnosed pregnant women already on antiretroviral treatment at first antenatal care consultations (ANC); birth PCR testing; repeat PCR testing at 10 weeks, 18 weeks and less than 18 months for high-risk infants. South Africa has reached a point where the elimination of pediatric HIV infection is within reach.   Due to South Africa's strong leadership and commitment the country is planning to apply for the WHO pre-validation process for dual elimination of MTCT of HIV and congenital syphilis.

Despite the successful implementation of the PMTCT program with MTCT rates less than 2% at 6 weeks and less than 5% for the final transmission rate (UNAIDS 2015), major obstacles still exist. South Africa is still faced with late HIV diagnosis for pregnant women due to late ANC attendance of less than 60% at 20 weeks gestation (DHIS 2015); low coverage for re-testing of HIV-negative pregnant women before delivery (66% DHIS 2015); EID above 6 weeks for the high-risk infants and linkage to treatment services, high absolute numbers of HIV infections in infants despite the low MTCT rates (absolute numbers above 50/100 000 per annual live births required for countries to be validated for eradication of MTCT of HIV); challenge with tracking mother-infant pairs for improved linkage to care, adherence and retention in care and treatment reducing HIV related maternal and neonatal deaths, and weak comprehensive programs for primary prevention of HIV and unintended pregnancies.

Ambitious but feasible programmatic targets for re-testing of HIV negative women, early ANC booking and real-time monitoring of PCR + have been included in district and facility 90-90-90 plans. The PMTCT technical working group (TWG) reviewed and provided input to the DIPs during the "annual stock-taking exercise" in all districts. PEPFAR partners supported the technical development, completion and submission of the plans. PEPFAR partners will address some of the health system barriers (e.g., human resources, Tier.net implementation) by deploying temporary lay counsellors and community workers to link them with pregnant women at high burden/high transmission facilities to improve retesting of HIV negative pregnant/breastfeeding women, male partner testing, quality assurance of HIV rapid testing, TB

screening, EID testing after 6 weeks, adherence, retention, and linkages to family planning services. Ward-based outreach teams (WBOTs) and other community workers will be capacitated to improve adolescent services and ANC booking before 20 weeks gestation through demand creation.

PEPFAR partners will support South Africa MTCT objectives in the DIPs through facility-based QI initiatives; strengthen the use of programmatic data together with laboratory data for real-time monitoring of the IED; linkages to treatment and to the VMMC program; tracking mother-infant pairs using the expanded community mother peer support program/community care-givers (CCGs) and build capacity for CBOs to strengthen the bidirectional referral systems. The district support program is aligned to the OVC program in the focus districts to strengthen family planning, HIV testing and clinical cascade outcome of the OVC child.

4.5 HIV Testing Services (HTS)

The revised national HTS Policy Guidelines based on WHO's recommendations will be implemented during COP15. These guidelines will provide impetus to expand targeted HTS services beyond facility levels. A strategic mix of HTS models will be based on coordination with NDoH and analysis of epidemiological, social, and programmatic contexts. A revised HTS register will be uniformly implemented in facility and community settings to collect expanded data on targeted populations (including KPs and couples), age disaggregation, first versus repeat tester information and by modality. This register will also enable analysis of HIV positivity yield by modality and by finer age disaggregation.

COP16 HTS Service Delivery Package will target the following:

Target Population	Modality	Location
Men	➢ Mobile testing ➢ Index-client model ➢ Pilot Self-Testing ➢ VMMC platforms	➢ Mines, Farms, Employment-seeking spots, inmates
Men and discordant couples	➢ Home-based testing ➢ Mobile testing	➢ High-yield communities and hot spots ➢ ANC settings
Young Women and Girls	➢ Stand alone ➢ Mobile testing ➢ Home-based testing ➢ Social Franchising model	➢ Social networks ➢ In- and out-of-school youth ➢ Higher education Institutions
Key Populations	➢ Mobile testing and peer navigation model	➢ Trucking spots
Symptomatic clients including pediatrics	➢ PITC (PMTCT, TB, STI, OPD, Immunizations (EPI), IMCI, FP, in-patient medical wards ➢ Index client model ➢ Partner notification	➢ High volume/ burden facilities ➢ PLHIV, TB patients, ART patients

The HTS package comprises targeted demand creation, HIV rapid testing (including Quality Assurance) following the serial testing algorithm, and active connection to HIV care and treatment. Enhanced active linkage to HIV care and treatment through on-foot tracking of PLHIV until linked to care in addition to regular telephone follow-ups will be implemented. This package will continue to be implemented through an informed consent process in a confidential manner.

PEPFAR partners will tailor program interventions through targeted and integrated outreach at workplaces and higher education institutions in focus districts, different models of home-based HTS, activities that increase effective linkages such as foot-tracking of PLHIV in community-based settings until linked to care and treatment, as well as fast-tracking referral for HIV treatment for discordant couples. PEPFAR partners will also support NDoH efforts to increase quality HTC services including training in QA and proficiency testing in all settings and support for targeted HTC campaigns in focus districts to reach priority populations.

The following strategies will be employed to deliver the HTS package to reach high risk populations:

- Pilot incentivized peer referral interventions through VMCC, KP, and index-client model
- Pilot HIV self-testing projects with home-based linkage to treatment

HTS is 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 young women through HTC interventions in five DREAMS districts.

VMMC is pivotal in accessing men for HIV testing. PEPFAR's VMMC and prevention partners will integrate male-friendly HTS stand-alone services for men, their social networks and sexual partners and link those testing positive to care and treatment. In COP16 couples/partner testing services will also be promoted in VMMC settings.

Expenditures Analysis data were used to identify efficiencies, along with partner reports, budget review and analysis by type of HIV testing and counseling and priority areas. In COP16, PEPFAR will support the South Africa HTS program in 27 focus districts, in 1,969 facilities with a projected average HIV positivity rate of 12.1%. During COP16 PEPFAR in coordination with the Department of Correctional Services will also provide technical support to correctional facilities to extend the reach of HTC.

HTS SIMS Scores

SIMS findings indicate several issues related to HTC Quality (15% red and 30 % yellow on Quality Assurance); as well as red scores (6%) and yellows (9%) for compliance with the HIV testing algorithm. In COP16 the Quality Assurance program will be rolled out nationally in both community and facility settings, including Proficiency Testing (NDoH/NHLS/PEPFAR Lab initiative). The HTS register has been standardized for community and facility settings to ensure compliance with HIV testing algorithms.

4.6 Facility and Community-Based Care and Support

The National Adherence Guidelines for HIV, TB and Non-Communicable Diseases (NAGL) were released in February 2016. These policy and service guidelines focus on timely linkage to care, adherence to treatment, and improved retention in ART. The adherence guidelines center on the provision of a minimum package of interventions to increase adherence, improve health outcomes and reduce overall health costs. These guidelines include standardized, updated education and counseling approaches, repeat prescription collection (RPC) strategies for decanted stable patients, tracing of all early missed appointments/lost to follow up, and patient tracking and integration of health services to ensure one-stop-shop. Under COP16, PEPFAR SA and partners will support the nationwide implementation of the strategy. Under the NAGL, the decanting of stable patients to community structures such as adherence clubs is an important priority. Through RPC strategies, which allow a patient to collect two months of prescription at a community pick-up point, facility services will be decongested and the cost of service will decrease as patients transition to a community ART model.

In COP16 PEPFAR will focus on aligning community approaches to the clinical cascade, national adherence guidelines and the UNAIDS 90-90-90 targets. PEPFAR will support the NDoH strategy to initiate a differentiated service delivery model which categorizes distinct packages for new, stable and unstable ART patients as outlined in the NAGL. Through this model, an estimated 650,000 current ART patients will be decanted to community drug pick-up points to decongest health facilities and reduce the burden on health workers and allow new patients to be enrolled in ART. Partners will scale-up community approaches to dispense ART, including increasing the number of adherence clubs serving as pick-up points. Implementing partners will also increase the number and strengthen coordination with

Central Chronic Medicines Dispensing and Distribution (CCMDD) pick-up points. Health facilities will use fast lane/spaced appointments to ensure expedited ART pick up at facility level as well. The Adherence Club model will be scaled up, in which stable patients are grouped voluntarily together for routine check-ups and drug refills managed by a lay health care worker. This model provides adherence support, and encourages only sick patients to contact the facility, thereby reducing the frequencies of clinic visits. Adherence club membership will be conditional on remaining stable, which is an incentive to remain in care. The development of bi-directional referral systems between community and facility services will be supported in order to reduce loss to follow-up (LTFU).

In COP16 PEPFAR partners will provide training and mentoring at site and above that impact site results. Assistance will reinforce government-led planning and provide supportive supervision to clinicians and community lay-persons on the core components of care and adherence. Additional community lay workers (CHWs) will be trained to provide facilitated referrals between the facility and the community and vice-versa. In order to achieve the 90-90-90 targets, PEPFAR will support the implementation of differentiated models of care at facility level, with clustered activities linked to defined patient cohorts (e.g., early, stable, and unstable) as defined by 2015 WHO guidelines. Training and mentoring will be provided through NDoH, Regional Training Centers and District Support Partners and will ensure skills and competencies within government structures for continued technical guidance, training and mentoring.

Facilitated linkage from testing to treatment (in the community and between units in health facilities) is an integral component of seamless transition from testing to ART initiation. Test and Treat will be initiated in four of 27 focus districts leading into COP16. In COP16, the RSA will adopt a national policy of Test and Treat. Linkage to care and support interventions, including adherence clubs and individual adherence counseling, will ensure new patients are enrolled in ART and maintain their treatment regimen. Community health workers will also promote uptake of viral load testing per national guidelines so that stable patients can be identified in a timely way and decanted to community CCMDD pick up points, adherence clubs, or facility-based fast lane appointments.

The human resources for health planning and investment at community level are instrumental to sustainable scale up of community ART and related care and support activities. Interventions for increased adherence to treatment and retention in care and treatment requires an adequate number of Community Health Care Workers (CHWs) who are appropriately trained to provide effective services in the facility/community continuum of care. For example, CHWs will be responsible for facilitating adherence clubs, and initiating and following up on referrals. In addition, CHWs will be important in tracing defaulters in order to bring them back into care, thereby reducing LTFU. PEPFAR SA is supporting the development of a national training curriculum for CHWs as well as investing resources towards training additional cadres for improved linkage of vulnerable families. Through systematic linkages between the PEPFAR OVC portfolio and care and treatment partners, the OVC cadre of community care givers (CCGs) will be trained in counseling and referral to ART. CCGs will also be available during HTS outreach days and linked with clinical focal persons for facilitated referral to ART enrollment at the community level.

Facility – community linkages to community care and support services consistently scored poorly in PEPFAR SA SIMS assessments due to lack of a standardized system to track referrals, services received, and any return to facilities. PEPFAR plans to work with the South Africa government to address these issues through increased investment in community programming for COP16.

The community ART model and repeat prescription collection methods will lead to improved efficiency and cost effectiveness within the South Africa ART program. Cost per patient is substantively reduced by maintaining a differentiated treatment regimen at the community level. Spaced clinical appointments reduce the burden of routine drug pick up at health facilities and streamline clinical services to focus on routine patient assessment (new patients), monitoring viral load, and clinical care for unstable patients.

Family Planning/HIV Integration

PEPFAR supports integration of services to strengthen the broader family planning (FP) and HIV access by allowing women and couples living with HIV to utilize these services both to prevent unintended pregnancies and to plan for healthy pregnancies when desired. FP/HIV integration is appropriate to achieve 90-90-90 within multiple PEPFAR-supported programs including PMTCT, TB/HIV care, support and treatment, key populations services, maternal health and adolescent services and young women under DREAMS, ensuring access and health systems strengthening. The below interventions are expected to improve FP/HIV integration services:

- PEPFAR will focus on supporting RSA and implementing partners in strengthening FP integration into HIV care and treatment platforms for easy access to voluntary counseling, expanded FP method mix and good quality care services; helping women living with HIV and women in sero-discordant relationships achieve safe conception and pregnancy; and provide an opportunity to engage men in terms of shared responsibility.
- Continued support for FP services as an alternative platform to keep women living with HIV adherent to treatment and compliant with viral load testing and other health interventions.
- Strengthen collaboration efforts with community health workers (CHWs) and WBOTs to increase access to FP information, voluntary counseling and referrals to existing FP service delivery points.
- Utilize FP services as an entry point to integrate gender into care to narrow gender gaps and empower women.
- Referral systems strengthened between all levels of care.

PEPFAR implementing partners will support FP/HIV integration services through: training and capacity building using the updated National Contraception and Fertility Planning training curriculum, to ensure health care providers are mentored and have the skills to provide holistic and good quality FP services; and improved supportive supervision for CHWs and WBOTs. Additionally, utilization of mHealth mobisites, i.e., Mom Connect and B-Wise, to promote healthy lifestyles including sexual and reproductive health and rights/ TB/HIV for young people will play a critical role in ensuring the uptake of FP services.

4.7 TB/HIV

Despite the steady decline in the number of TB cases reported in South Africa since 2012, TB continues to be the driver of morbidity and mortality among PLHIV in South Africa. In 2014, a total of 318,193 TB cases were notified in South Africa, 93% of whom had a known HIV status (Global TB Report, 2015). The TB/HIV co-infection rate remains high at 61%. South Africa has made significant strides in ensuring that HIV positive TB patients are initiated on ART, from 66% in 2013 to 79% in 2014 (Global TB Report, 2015).

The South Africa government funds the majority of its TB and TB/HIV programs and in its FY16/17 domestic TB funding will come through the Provincial HIV/TB Conditional Grants. The remaining funding comes from bilateral (PEPFAR, USAID), and multilateral (Global Fund) donors and private foundations such as the Bill and Melinda Gates Foundation.

In FY16/17 the NDoH will be in its second year of implementing the TB 90-90-90 strategy. There is political commitment to ensure achievement of these targets. In March 2015 the NDoH in collaboration with partners embarked on an unprecedented robust exercise to support districts in the development of district implementation plans (DIPs) in order to effectively monitor the implementation of the TB 90-90-90 strategy. These plans were finalized for implementation at the beginning of South Africa's fiscal year 16/17. The use of cascades and the bottleneck analyses during the development of the DIPs has assisted the NDoH in the identification of leakages in the cascades and how these can be minimized. The point of entry to the TB/HIV cascade is through the identification and treatment of TB cases. In FY 16/17 the NDoH will be monitoring primary health care (PHC) clients screened for TB as one of the DIP quality tracer indicators in an effort to increase TB case detection. Undetected TB disease among PLHIV continues to undermine efforts to control both the HIV and TB epidemics. TB clinics are known to be high HIV yield settings and there is also mounting evidence to suggest that HIV prevalence rates among presumed TB cases (suspects) are equally high.

 In FY 17, PEPFAR will work closely with the NDoH and other partners to ensure HIV testing of all TB suspects as one of the approaches to identify PLHIV who might not be aware of their HIV positive status. To increase the ART coverage to 90% among co-infected TB patients, PEPFAR will support partners roving teams to support facilities with ART initiation for all patients, including TB patients co-infected with HIV. These teams will also mentor nurse TB focal persons who are trained on Nurse Initiated Management of ART (NIMART) to ensure ART initiation in the TB clinic.

One of the challenges related to immediate access to ART for co-infected TB patients is that not all TB focal persons are professional nurses and therefore cannot initiate and manage ART. To address this gap, PEPFAR will continue to support training nurses on NIMART. In addition, in an effort to reduce patient attrition in the event that the TB focal nurse is not NIMART trained, PEPFAR will also scale up the use of counselors/clinic navigators to support facilitated referrals between TB clinics and ART initiation sites, which has been identified as one of the leakages in the TB/HIV cascade. To narrow the gender gap and improve women's access to TB/HIV services, PEPFAR will continue to support expanded entry points by strengthening the integration of TB/HIV services in ANC and PMTCT/MCH clinics.

Technical assistance will be provided to strengthen TB/HIV collaborative activities through support for evidence-based contextualized TB/HIV integration policies, capacity building, training, mentoring and coaching. The following technical priorities and service delivery package will be supported through technical assistance and direct service delivery in PEPFAR focus districts:

- Update policies in the TB/HIV integration manual using evidence generated from PEPFAR supported sites
- Scale-up TB symptom screening for PLHIV at every visit including children, pregnant women, diabetic patients, prisoners, miners and peri-mining communities, including stand-alone HCT centers and community (for decanted patients)
- Scale-up Isoniazid Preventive Therapy (IPT) provision for PLHIV through implementation of demand creation strategies
- Strengthen implementation and monitoring of TB infection prevention and control (IPC) interventions in health care settings, communities as well as congregate settings
- HIV testing services (HTS) for TB patients and presumptive TB cases with immediate access to ART for all co-infected TB patients. PEPFAR will support lay counselors to provide PITC services for all patients including TB patients in high-volume sites
- Targeted support for the implementation of the national integrated HIV and TB information system. PEPFAR will deploy data capturers in high volume sites to fast-track roll-out of the TB module in Tier.Net
- Improve initiation of TB second-line treatment for PLHIV who are diagnosed with MDR-TB

The technical assistance provided by PEPFAR to NDoH focuses on strengthening systems and capacity building of the work force at all levels. PEPFAR also participates in the TB and HIV Think Tanks and Technical Working Groups (TWGs). Through capacitating and supporting local organizations including universities, the private for-profit health sector, Ward Based Outreach Teams (WBOTs), Community Based Organizations (CBOs), Faith Based Organizations (FBOs), Traditional Health Practitioners (THPs) and community representatives such as clinic committees, PEPFAR ensures skills transfer to local entities to ensure sustainability of the TB/HIV response.

4.8 Adult Treatment

In 2015, South Africa revised national guidelines to expand ART eligibility to include all asymptomatic persons with HIV infection and CD4 count <500 cells/mm³. During COP16 South Africa will implement Test and Treat beginning September 2016, as well as provision of PrEP to key populations such as HIV-

negative female sex workers (FSWs), to begin in June 2016. Prior to national roll out, PEPFAR will assist RSA to implement Test and Treat in four districts (including the sub-districts that have also been designated for DREAMS activities in those districts) where DREAMS activities are occurring, with the goal of having 90% of PLHIV diagnosed and 80% of PLHIV on ART by the end of September 2017. This Test and Treat bridge-to-scale-up will include leveraging DREAMS activities focused on identifying, linking to care, initiating and retaining on ART, men ages 20-49 within these four districts with a goal of having 80% of males with HIV infection in care and on ART by September 2017.

In COP16, PEPFAR will support RSA efforts to implement the national Test and Treat policy and support program implementation readiness, primarily through demonstration in DREAMS districts and national program expansion to the remaining 23 focus districts. In addition, PEPFAR will support scale-up of facility-based PITC at all entry points in all supported public health facilities in the 27 focus districts in order to identify cohorts of clients eligible for ART and support implementation of differentiated models of care (and best practices), with clustered activities linked to defined patient cohorts (e.g., early, stable, delayed, lost) as defined by new WHO guidelines. It is anticipated that in COP16, about 650,000 of the 1.6 million HIV ART stable patients will be decanted to the CCMDD, GP and community adherence programs.

While PEPFAR has supported ART expansion in South Africa over the past decade, with an estimated 3.2 million HIV infected patients currently on ARVs, reaching the second 90 or 81 percent of PLHIV based on COP16 treatment targets (an additional 2 – 3 million HIV infected people in South Africa will need to be initiated on ART), will require new strategies and innovations in how services are provided. In view of this, PEPFAR will support South Africa in reconfiguring service delivery approaches to achieve greater efficiency and reduce costs through accelerated implementation of the Test and Treat policy to simplify treatment eligibility, and differentiated care service delivery models for stable patients on ART. PEPFAR will also support RSA through technical assistance and, where needed, staffing such as General Practitioner contracting to improve service delivery for HIV-infected patients and implement standard, high-quality, patient-centered HIV service delivery to optimize the care continuum; reduce intensity and frequency of clinical visits per guidelines for stable patients on ART; and support patient-centered models. PEPFAR will also support advanced planning of supply chain needs for successful decentralization and community drug-delivery models and for adequate buffer stock to ensure less frequent drug pickup; support evidence-based adherence interventions, including community-based cadres, peer counselors, and mobile phone text messages and other reminder devices; promote a choice of ART delivery options such as facility-based fast track and community-led models of ART provision; including community adherence groups (CAGs), community-led adherence clubs, and community drug delivery through the CCMDD where feasible. During COP16 PEPFAR will support clinic the laboratory interface (CLI) activities at facility level. Activities will include: (1) training of health care workers (HCW) on specimen and test result tracking; test request form completion; and specimen handling (collection, packaging, storage and transportation); (2) Quality Assurance training; and (3) entering laboratory data into Tier.net.

In addition, PEPFAR will continue to support the NDoH District Implementation Planning (DIP) process as this will serve as the node for planning, management and coordination of HIV programs at the district level, including programs supported by PEPFAR implementing partners. The intent is to use the DIP to

support a rationalized mentoring program for service delivery sites in order to support a uniform NDoH mentoring approach and increase intensity of mentoring efforts to respond to DIP priorities. PEPFAR will also continue to support expansion of service delivery platforms through scale-up of HIV service delivery activities in public sector facilities; implementation of innovative/best practice service delivery activities at community level to improve early initiation, active referral and retention in care; support the role of private sector involvement (private health facilities, general practitioners) in supporting continuum of care activities and intensify targeted/focused trainings essential for 90-90-90. PEPFAR will also step-up synergies and coordination with community-based programs to increase utilization of NDoH CHWs and Ward-based Outreach Teams; engage CBO support for HCT, linkage and retention, treatment adherence and work with DSPs to adopt a district approach of coordination with HIV prevention and OVC programs.

Expanding access to viral load (VL) testing is in progress in South Africa. To date, the program achieved 50% viral load coverage and 80% viral load suppression among patients who had viral load. However, there are significant variations in VL completion and suppression across districts. Although there is high VL suppression among the VL done, documented VL coverage is low.

There has also been evidence of under reporting, highlighting issues related to data quality. A study in South Africa, conducted by NHLS, indicates more viral loads were completed than reported in Tier.net. There are red SIMS CEEs for poor documentation across multiple districts and partners.

PEPFAR will continue support and provide enhanced support to South Africa's efforts to scale up VL scale-up with a goal of the routine use of VL for all patients on ART. Experience to date in South Africa suggests that existing VL platform/equipment is underutilized with 40 percent or more volume that could be added to existing platforms with improved planning and adequate staffing. PEPFAR will work with the NHLS to increase testing capacity and efficiency of existing platforms; and improve efficiency of laboratory networks (to link ART support to VL testing capacity, improve specimen transport networks, and results return; educate patients, clinicians, and laboratorians on the importance of routine VL testing and improve monitoring). In addition, PEPFAR will focus communication efforts related to improving patient level understanding of viral load and the importance of achieving viral suppression in order to improve outcomes as well as to prevent transmission and expand the use and application of viral load testing to improve patient outcomes. VL reports serve as a proxy of success at the district level for achievement of large-scale viral suppression.

4.9 Pediatric Treatment
South Africa has the highest burden of people living with HIV of which an estimated 5.4%, or 340, 000 are children under 15 years of age (UNAIDS 2014). The antiretroviral coverage among these children is 49.4% (UNAIDS). Despite the reduction in HIV incidence to less than 2% among exposed infants through the PMTCT program, there are infected older children who remain untested and present when symptomatic.

Late diagnosis of HIV has a significant impact on the associated morbidity and resultant mortality among these children besides the debilitating neurological effects resulting in motor abnormalities and cognitive dysfunction. In COP16 PEPFAR partners will expand innovative methods to identify these children before

the infection has had a significant effect on their quality of life. PEPFAR plans to support increased case finding initiatives with a target of 90% ART coverage of the children tested positive by September 2017.

In COP16 PEPFAR will work with the NDoH and other partners to enhance contact tracing using the index patient by testing all family members including children of any known HIV positive case. PEPFAR will also expand targeted testing/PITC amongst orphans; in clinics among children on TB treatment; with malnutrition and growth delayed children; with recurrent lower respiratory tract infections or gastroenteritis; as well as using the IMCI testing algorithm. Primary caregiver (parent, grandparent, other relative) and child discussions related to HIV and HCT will be addressed through the KIDZ Alive program disclosure guidelines. The KIDZ Alive guidelines and program are expected to be rolled out by NDoH during COP15. The guidelines address health care workers and caregivers to help them address all the potential issues around testing, disclosure of HIV, ART and adherence to treatment. The program also helps in providing safe and child-friendly spaces and will help to increase uptake of HCT among children and adolescents as well as increased case finding, improved retention in care and adherence to treatment.

One of the gaps identified via SIMS is that primary care clinics often lose contact with new mothers post-delivery, especially if the delivery was at a district hospital; and even when they retain contact, lower level primary health care facilities often are unaware of the child's birth PCR/HIV test results. During COP16 PEPFAR will support NDoH to expand the use of community health care workers to ensure that all HIV-positive as well as HIV-negative mothers are linked back and retained into care post-delivery. HIV-positive mothers will be retained on treatment and their infants tested regularly especially if the mother is breastfeeding. The HIV-negative mothers will be re-tested post-delivery and at regular intervals when the mother is still breastfeeding.

TB screening and diagnosis continues to be a challenge among children due to inconsistencies in obtaining clinical history and specimens from children; continued supervision and mentoring of clinic staff by the district support partners will help improve the TB case finding in children. Pediatric growth monitoring and absence of resultant referrals remain a challenge identified during SIMS visits. To address this gap, PEPFAR DSPs will support the NDoH efforts to provide consistent use of pediatric clinical registries.

Strengthening community linkages is critical for all three 90-90-90 goals as well as preventing new HIV infections in infants. Using community health workers strategically can help timely access to treatment as well as adherence and retention in care. South Africa has not yet adopted the CCMDD[28] for younger children who need to be followed regularly for weight monitoring and resultant dose changes; however, PEPFAR is working with NDoH for how older children already on adult doses may be able to obtain medications through the CCMDD program, fast lanes, and adherence clubs.

Regular viral load monitoring is key to ensuring that children on ART are suppressed and retained on treatment. Viral loads among children are often delayed or not done due to inexperience in pediatric phlebotomy. PEPFAR will introduce demand driven roving teams to provide direct service delivery and

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[28] CCMDD- Centralized Chronic Medicines Dispensing and Distribution

mentorship to clinic staff to address pediatric ART initiation bottlenecks as well as to address virological failure in children. Second line regimens are not available at the primary care facilities and children are often required to be referred back to their nearest district hospital, which has both time and cost constraints for the primary caregivers. Empowering the nursing staff on when to change and when to refer children for assessments to the hospital will make a significant impact on the quality of care received by the children.

During COP16 PEPFAR will support a Pediatric HIV Drug Resistance survey among children on ART with virological failure; the study will help to ensure that the appropriate second and third line regimens are used. In COP16 PEPFAR will also focus on enhancing adolescent and youth friendly clinic services including late hour or weekend clinic services to accommodate school/university students; sensitive HCT; nondiscriminatory sexual and reproductive health services; support groups; availability of chronic medication dispensation systems for older children stable on ART; as well as transition into adult health services.

4.10 Orphans and Vulnerable Children (OVC)

According to UNAIDS, about 2.3 million South African children aged 0-17 were orphaned due to AIDS. The 2011 Census estimates there are 3,344,832 orphans aged 0-17, about 78 percent are located in the 27 focus districts. These data reflect all orphans and not only children orphaned by HIV/AIDS, and do not include children made vulnerable by HIV/AIDS (e.g., those living with HIV or with HIV-positive caregivers). In COP16, PEPFAR partners, in support of DSD, will provide services to 644,325 OVC program beneficiaries. This target is based on OVC burden, HIV prevalence, APR 2015 data, partner capacity and EA data.

OVC are at increased risk of HIV infection and efforts to increase access to HTS[29] and other health and social services that address the enabling factors essential to successful prevention, care, and treatment can contribute directly to 90-90-90 and epidemic control. Through structured home visits, HIV education, referrals and linkages, the OVC program will aim to provide access to HTC to 90 percent (579,892) of OVC program beneficiaries. Based on HSRC 2012 data, about 6.2 percent of beneficiaries (35,000) may test positive. The OVC program aims to enroll 90 percent of children and caregivers who test positive into care and treatment services and provide adherence monitoring and support.

PEPFAR partners will support additional OVC who know their HIV status. PEPFAR will monitor this program element to determine whether OVC partners are proactively promoting HIV status knowledge and to ascertain if children in OVC programs have received appropriate HIV services. The OVC TWG has taken specific actions to facilitate community/clinic linkages, improve counselling (including family-centered disclosure) and referrals, as well as promote quality case management. Examples include a Supportive Referrals for HTS activity, a Community Grants solicitation, and CDC's technical approach in which DSPs provide support to OVC activities.

Through effective case management, household visits, and improved use of data and targeting methods, OVC partners will identify the most vulnerable children (including AGYW) and provide one-on-one

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[29] HTS-HIV Testing Services

support that empowers them to stay in and progress in school; access health services and grants; be adherent and retained in care; and reduce abuse and prevent new infections. Through DREAMS, OVC partners will support the South Africa government plans to provide school-based interventions, parenting/caregiver programs, socio-economic empowerment, social asset building, and youth-friendly sexual and reproductive healthcare (including linkages to health services and provision of HTS) that will empower AGYW, strengthen families and mobilize communities.

During the identification of interventions for DREAMS, it was noted that there was a lack of an evidence-based parenting program that focused on caregiver/adolescent communication around sexual risk behaviors and HIV in the African context. "Let's Talk" was developed to address key issues facing adolescents affected by HIV/AIDS, including elevated risk for poor psychological health, sexual risk behavior and HIV infection. These efforts are accentuated by parallel support for caregivers, addressing their personal challenges and working to build skills for effective emotional coping and parenting. Roll out has begun in South Africa and across the continent.

Strategic investments in critical social systems strengthening will continue through three partners that provide support to the Department of Social Development to address the social and structural barriers that increase the vulnerability of OVC to HIV. This includes: strengthening the social welfare workforce serving children (including improved child protection interventions to prevent and respond to neglect, violence and exploitation of children and adolescents); supporting the national rollout of RSA social behavior change activities; and supporting the Community-Based Information Management System (CBIMS) electronic data management training.

5.0 Program Activities in Sustained Support Locations and Populations

5.1 Package of services in sustained support locations and populations

By the end of COP15, PEPFAR will have completed the transition of PEPFAR supported services from non-focus districts (see Section 5.2). However, there are some exceptions and the following services are proposed to remain in non-focus districts in COP16:

- High-risk mobile populations: interventions will continue to reach highly mobile populations such as a limited number of sites located on high transmission trucking routes that support FSWs, and in VMMC sites with a demonstrated high yield performance, particularly in mining areas.
- Incarcerated populations: In general, correctional services are not linked to district health systems and their epidemiology is not linked to local geography. PEPFAR will continue to support correctional services as a part of a national program.
- Department of Defense prevention, HCT and VMMC programs will continue to work on national level, and in military centers.

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts			
Sustained Support Volume by Group	**Expected result APR 16**	**Expected result APR 17**	**Percent increase (decrease)**
HIV testing in PMTCT sites	*80,138*	0	-
HTS (only maintenance ART sites in FY 17)	*613,143*	0	-
Current on ART	*338,510*	0	-
OVC	*20,487*	*11,900*	*-41.9%*

5.2 Transition plans for redirecting PEPFAR support to scale-up locations and populations
District support partners (DSPs) transitioned out of the 16 short-term transition districts as of December 31, 2015. A bilateral Transition Task Team developed a systematic process of recording PEPFAR investments in human resources, training and equipment and developed a plan to transition programs in each district. District Management teams signed PEPFAR Partner Transition Plans and identified elements to be continued with funding from the RSA through DIPs and HIV/TB Conditional Grants and other funding.

DSPs continue to provide support to high volume clinics in nine long-term transition districts through September 2016. Transition plans for these nine districts were jointly developed by DSPs and District Management Teams and have been submitted to PEPFAR and the NDoH. Plans received sign-off from district managers. All DSPs will have transitioned from long-term transition districts by September 30, 2016 and will submit close-out reports to the long-term transition districts by October 31, 2016. PEPFAR will submit these reports to the NDoH. No challenges are anticipated as DSPs have already substantially scaled back in these districts and transition planning began early in the process. For the OVC program in the transition districts, teams developed a phased transition plan based on evidence and careful planning and using graduation models to ensure continuity of services for children who will shift to non-PEPFAR funded service providers.

Strategic Information and Health Systems Strengthening

PEPFAR is focusing its strategic information (SI) activities to support the Prevention, HIV Testing and Counseling (HTC), and Care and Treatment programs towards meeting the 90-90-90 targets. The COP16 SI activities have been identified by the bilateral PFIP Workstream to focus on important programmatic areas identified as barriers to meeting the 90-90-90 targets and from the gaps in available epidemiological information required to inform effective programs for sustained epidemic control.

The portfolio review and subsequently the Systems and Budget Optimization Review and Template (SBOR) processes identified the need to further support HMIS specifically to improve monitoring of clinical cascades, viral load reporting and linkage to care. PEPFAR will support South Africa goals to enhance HMIS through Tier.net expansion, with the target to improve data quality and use for effective monitoring of the HIV treatment cohorts and clinical cascades towards meeting the 90-90-90 targets. The PEPFAR SI portfolio will include a comprehensive approach to support HMIS including assisting the NDoH to form governance structures for M & E and to develop and implement data quality and data use improvement strategies. PEPFAR will provide support NDoH in HMIS development and improved operational capacity, including the capacity to enhance linkages and retention in HIV care. These activities will encompasses operationalization of the HTC and Pre-ART modules in Tier.net and supporting the linkage of HIV and TB health information systems. Improved data quality processes will allow for the early detection of data errors and missing information and improve the viral load reporting along other reported HIV clinical elements.

Gaps and challenges identified through the COP16 planning portfolio review and SBOR process included a lack of information to support the development of Key Populations clinical cascades. In COP16 PEPFAR will work with NDoH and other partners to support surveys on Key Populations to quantify access to HIV services and activities to enhance the use of routine data, when it is available, and triangulation of data on Key Populations.

In COP16 PEPFAR will support SI activities to close the gaps in epidemiological data and information, and focus on enhancing data availability and use to inform programs towards epidemic control, and leverage the DIP process. COP16 activities include Small Area Estimations and mapping existing data sources to identify sub-national HIV burden, HIV Case Reporting, Drug Resistance Surveillance, Cause-Specific Mortality validation, National HIV Prevalence, Incidence and Behavior Surveys.

In COP16 the laboratory program will be in the 27 focused districts having transitioned out of all non-priority districts. Currently, Limpopo Province has taken over the implementation of Quality Assurance for HIV rapid testing in all facilities that are not in the focus districts and the province has an itemized budget for the procurement of independent Quality Control (IQC) materials and facility enrollment into the NHLS Serology Proficiency Testing program.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

PEPFAR identified key programmatic gaps in a collaborative and transparent manner through an iterative process with South African government and the PFIP workstreams and bilateral partners. PEPFAR initiated the Systems and Budget Optimization Review (SBOR) process with TWG analysis of PEPFAR district profiles, which contain data such as HIV prevalence and other health indicators, and identification of sites with PEPFAR support, and PEPFAR partner expenditure and achievements. Each profile identifies South Africa and PEPFAR-supported activities and strategies to achieve 90-90-90, identifying programmatic gaps. The end product is a list of identified systems challenges for clinical and community services that has been reviewed in the PFIP workstream meetings.

From this analysis, priority program gaps were identified based on the strength of their impact on the epidemic and achieving 90-90-90. The priority program gaps affected both Community and Clinical Services (e.g., Key Populations). They are:

1. Documented Viral Load Completion
2. Facility/Community Continuum of Care
3. Lack of targeted and data-driven service provision to Key Populations

Evidence of barriers for the gaps was reviewed, and a root cause analysis was conducted. The barriers and outcomes were reviewed for alignment with the DIP process, including the bottleneck analysis.

PEPFAR and NDoH representatives held meetings to review and discuss the findings and to assure that all SBOR programmatic gaps and related activities are aligned with South Africa's vision and plans. National, provincial and district data were used in the analyses.

<u>Documented Viral Load (VL) Completion</u>

Documentation of VL data is critical for monitoring of clinical outcomes, and progress towards achieving the third 90 as well as detecting drug resistance. WHO also recommends VL monitoring as the preferred approach to monitoring patient response to ART. Furthermore, as the South African government introduces new service delivery methods, documenting VL suppression is crucial in identifying the type of care to be provided to patients, especially in distinguishing between stable and unstable patients.

However, based on PEPFAR's Annual Performance Report (APR) and SIMS reports, it is clear that there are significant variations in VL completion and suppression across partners/districts. Although there is high VL suppression among the VL done, documented VL coverage is low.

There has also been evidence of under reporting, highlighting issues related to data quality. A study in South Africa, conducted by NHLS, indicates more viral loads were completed than reported in Tier.net. There are red SIMS CEEs for poor documentation across multiple districts and partners.

System barriers that have been identified as contributing to low VL documentation include the following:

a. *Health information systems capacity* - Tier.net is the patient-level ART and TB monitoring system in South Africa. Tier.net phase 6 is not available in all the facilities (only 70%), there is no information exchange linking NHLS directly to Tier.net and there is no unique identifier to link patients' results from NHLS to Tier.net.

b. *Capacity of HRH* - Early review of Work Load indicators of Staffing Needs (WISN) data, SIMS and the District Implementation Plans (DIPs) indicate an insufficient supply of and inadequately trained health workers.

c. *Systems to track patients* - Factors such as sub-optimal use of Tier.net to identify defaulters and prevent loss to follow up, limited implementation of mhealth tools to trace patients, and the lack of a standardized system to track referrals and counter-referrals.

d. *Centralized VL systems and efficiency of existing VL testing platforms* - There is evidence of a high rate of specimen rejection, low viral coverage and more VL done than documented in Tier.net.

Facility/Community Continuum of Care

Until recently, RSA health care has mainly been provided in fixed health care facilities, with limited community involvement. New service delivery models have recently been introduced emphasizing community participation. Although community programs are critical for achieving the first and the second 90s, linkages between the two levels, i.e., community and facility, can be strengthened. Poor linkages result in low patient initiation and retention. In order to achieve 90-90-90, HIV-infected patients are identified, initiated on treatment, and provided support at a variety of venues and levels. Both community and facility services are essential to achieve this goal. Meta-analysis of HTC Modalities & Outcomes in Sub-Sahara Africa shows highest linkage to ART (above 80%) with facilitated home testing (using CHWs). This demonstrates the importance of services at both facility and community settings.

Annual Program Reporting (APR) data identifies significant loss-to-follow-up between HIV+ test and enrollment in care/treatment as well as low treatment retention. Across multiple districts and partners there are consistent red SIMS in elements that relate to linkages of HIV+ to treatment and retention in care

System barriers that have been identified as contributing to weak facility-community continuum of care include the following:

a. Lack of a bi-directional (Facility/Community) referral system - Bi-directional referral systems are needed to support patients at all levels. SIMS revealed a lack of a standardized system to track referrals and counter-referrals from facility to community and vice versa. Poor bi-directional referrals have been identified as a gap within the NDoH's National Adherence Guidelines and its PHC Re-engineering Strategy. There is also no standardized referral policy across South African government departments.

b. Limited health information system capacity (e.g., Tier.Net, Health Patient Registration System, Patient Tracking System) - The Health Patient Registration System (electronic medical records) has only been rolled-out to a limited number of sites. There are not yet nationwide systems using unique patient-identifiers and there are limited community-based information systems to facilitate tracking of patients. There is sub-optimal use of Tier.net to track linkages, as well as a lack of information sharing by different South African government departments' information systems.

c. *Capacity of Ward-Based Outreach Teams (WBOT) and community cadres* – WBOT's database and WISN reveal that there is an inadequate supply of CHWs and Enrolled Nurse supervisors. There is also a lack of other community cadres (e.g., Child and Youth Care Workers, Social Auxiliary Workers) that may serve to identify PLHIV and link them to care. There are 60,000 Home-based Carers (skilled in palliative care) who will need to be re-skilled for adherence support and other community functions. There is no community-based information system to track performance and productivity, contributing to poor linkages between community and facility levels.

d. *Linkages between services provided by the public sector and community- based/faith-based organizations (CBOs/FBOs)* - The scope and quality of services provided by CBOs/FBOs is largely undocumented and sharing of information between the public sector and CBOs/FBOs is limited. The information systems of these organizations are not aligned with the public sector information systems and DIPs do not capture the contributions of these organizations, resulting in poor linkages of services provided by the public sector and CBO's and FBO's.

Targeted and data-driven service provision to Key Populations

As epidemic control is pursued, there is a need to understand the microepidemics' contribution to the general population epidemic. In response to SA's recently approved Truvada for PrEP, systems need to be in place for individuals most at risk to access and use PrEP, and to monitor the impact of PrEP over time.

There are five significant systems barriers that will be addressed to improve service provision to Key Populations.

a. *Surveillance for KPs* – In addition to a lack of accurate information on KP's (size, prevalence estimates, and mapping), there is a dearth of information on how HIV is impacting KP's, and how HIV infected KP's are influencing the epidemic. Specifically, there is limited information on the KP cascade and limited HIV surveillance data for KPs or priority populations that is of sufficient quality or granularity to allow micro-targeting of HIV. South African government and partners are unable to demonstrate impact and monitor progress among KP's due to limited data.

b. *Limited exchange of routinely collected information between the public sector and the organizations serving KPs* - According to the PEPFAR FY15 APR, only a few partners and facilities report KP-disaggregated program data, resulting in a lack of data regarding care and treatment service provision and need among KPs. Due to human rights concerns, KPs are not disaggregated in public sector information systems. In order to fully address KP priorities, there is a need for improved data collection, communication and collaboration between all stakeholders.

c. *KPs experience stigma and discrimination when accessing services at public health facilities* - The Stigma Index[30] revealed stigma and discrimination targeted at KPs in public health facilities. Many health workers lack the skills to provide appropriate services to KPs; facilities do not have KP-specific interventions.

d. *Limited systems in place for PEP provision* - This reflects health care worker's limited clinical knowledge about PEP and awareness of PEP amongst KPs, resulting in a low uptake, negatively affecting supply chain demand planning.

e. *Limited systems for PrEP provision for KPs* - Contributing factors include pending National PrEP guidelines, unknown demand and low uptake due to inadequate awareness amongst KP and limited clinical knowledge among HCWs. The low uptake also affects supply chain.

f. Although the same cross-cutting activities address more than one key systems barrier, it has been documented in the tables below under the barrier where the activity will have the most impact.

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[30] The People Living With HIV Stigma Index: South Africa 2014, Summary Report, May 2015

Table 6.1.1 Key Programmatic Gap 1: Low Documented Viral Load (VL) Completion						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP16 Activities	Budget Code(s)	Activity Budget Amount	Associated IM	*[REDACTED]*
Limited health information system capacity (e.g., clinic/lab interface, electronic medical record, Unique Identifier)	- 100% coverage of Tier.net (HIV electronic medical record) in PEPFAR-supported sites - Improved efficiency and completeness of reporting from National Health Laboratory Service (NHLS) to patient records, including Tier.net. - Increase coverage of the Health Patient Registration System (including unique identifier) in PEPFAR-supported sites. - 90% of all viral load results available in patient records 90% of all viral loads done captured into tier.net < 1% viral load specimen rejection rates - 100% of PEPFAR supported sites covered by the health patient registration system.	1.1.1 To ensure improved efficiency and completeness of reporting from National Health Laboratory Service (NHLS) to patient records, facilitate deduplication of data at patient level as well as eliminate data duplication between the NHLS Corporate Data Warehouse (CDW) and Tier.net databases, support will be provided to NHLS to advocate for and facilitate consistent or routine use of the unique identifier as well as facilitate linkage of the NHLS CDW to Tier.net of NDoH. Furthermore, linkages and communication between the facility and laboratory to ensure the timely return of laboratory results will also be strengthened. In addition, through the implementation of Electronic Gate Keeping systems and clinic-lab interface activities, support for training of Health Care	HLAB	$ 579,000.00	17493	*[REDACTED]*

		Workers (HCW) on specimen handling, results management and test ordering will also be provided.				
		1.1.2 Together with the National Department of Health (NDoH), develop and pilot models for Clinic/Lab interface through operational research	OHSS	$ 100,000.00	13750	*[REDACTED]*
		1.1.3 Support NDoH on Health Management	HVSI	$ 400,000.00	14846	*[REDACTED]*

				$ 150,000.00	TBD	
		Information System (HMIS) policies (i.e., District Health Management Information System [DHMIS] Policy, National Indicator Data Set [NIDS], DHIS2, Tier.net, unique patient identifier, National Health Information System of South Africa [NHISSA], VL testing, etc.) and strategies that reflect the evolving HMIS e.g. roll-out of web-based tier.net. Support ongoing development of HMIS governance structures to improve alignment with NDoH governance structures and Health Management information needs at all levels, and improve strategic development and utilization of Health Information.				
		1.1.4 Provide support for HMIS development/programming/ maintenance i.e. support development, and expansion of enterprise	HVSI	$ 798,354.00	TBD	*[REDACTED]*

	architecture and interoperability standards, including linking NHLS VL results to facility (Tier.net) and setting up reminders to perform VL at clinic, health information exchange, Health Patient Registration System (HPRS), etc. and supporting adherence to standards. Support maintenance of HMIS.		$ 900,000.00	14846	
	1.1.5 HMIS support at Department of Corrections (DCS)	HTXS	$ 300,000.00	16775	*[REDACTED]*
	1.1.6 Support the district health team to review HIV VL data quarterly and implement corrective action plans in the twenty-seven priority districts	HTXS	$ 1,298,800.00 + Resources from "facility" lump sums	TBD, 17020, 17023, 17036, 17046, 17038, 17021, 17037	*[REDACTED]*
	1.1.7 Support Health Information Systems/Monitoring and Evaluation (M&E) systems	HVSI	$ 719,254.00	14846	*[REDACTED]*

		for improved data quality and use: 1. Supporting the development of a data quality improvement strategy (e.g. Incorporate a bottleneck analysis to determine system barriers) and systems including Data Quality Improvement Standard Operation Procedures (SOP), data quality auto-reports, and supporting information officers and program managers to achieve timeliness and completeness of NDoH reports, and 2. Support the generation of reports and dashboards for program review including incorporating results in district implementation plans and other documents to inform evidence-based decisions and 3. Support the development and implementation of a data quality improvement strategy.		$ 800,000.00	TBD, 16773	
Limited capacity of Human Resources for Health (HRH) (e.g., Health Workers, Data Capturers)	- Adequate supply of trained HRH (e.g. Health Workers and Data Capturers) to address the viral load gap in PEPFAR supported sites. - 100% of PEPFAR-supported facilities have health information workers (data	1.2.1 Support HR capacity development: building competence-based health informatics and HMIS capacity in RSA staff. Develop/update training materials and SOPs on evolving HMIS.	OHSS	$ 200,000.00	14846	*[REDACTED]*
			HVSI	$ 250,000.00	TBD	*[REDACTED]*

clerks, information officers) trained on the Department of Health Standardized Data Capturer Curriculum. 100% of PEPFAR-supported facilities have implemented quality improvement processes to improve VL documentation to 90%.	1.2.2 Training of NIMART nurses and clinicians on switching to 2nd line ART for adult patients with confirmed virologic failure (through DSPs, Regional Training Centers [RTC]/Training of Trainers [TOT], Accelerating Comprehensive Care [ACC] partners) in NDoH and DCS facilities	HTXS	Resourced under Facility-Based Unit Expenditure	17020, 17023, 17036, 17046, 17038, 17021, 17037 , 16675, TBD	[REDACTED]
		HTXS	$ 200,000.00	17506	
		HTXS	$ 200,000.00	16808	
		HTXS	$ 200,000.00	17507	
		HTXS	$ 300,000.00	17768	
	1.2.3 Strengthen the in-service learning platforms which include Skillsmart, RTCs and Knowledge hub for the training of HCWs on VL algorithms, epidemiologic data and new guidelines related to capturing data & VL	OHSS	$ 400,000.00	TBD	[REDACTED]
	1.2.4 Support DCS facilities in the management of 1st or 2nd line virologic failure	HTXS	$ 1,700,000.00	17507	[REDACTED]
		HTXS	$ 2,000,000.00	16808	[REDACTED]
		HTXS	$ 1,100,000.00	17506	[REDACTED]

			HTXS	Resourced under Correctional Facility-Based Unit Expenditure	16675	[REDACTED]
		1.2.5 Support South African government (SAG) with roving teams for data entry	HTXS	Resourced under Facility-Based Unit Expenditure	17020, 17023, 17036, 17046, 17038, 17021, 17037, 16775, TBD	[REDACTED]
		1.2.6 Secondment of key staff to temporarily fill SAG vacancies	HTXS	Resourced under Facility-Based UE	17020, 17023, 17036, 17046, 17038, 17021, 17037, 13761, TBD	[REDACTED]
		1.2.7 Social behavior change communication/mass media to increase treatment literacy, adherence, and importance of viral load testing	HTXS	$ 4,000,000.00	17537	[REDACTED]
		1.2.8 Viral Load training material developed using the change management approach and piloted in three PEPFAR supported	OHSS	$ 200,000.00	TBD	[REDACTED]

		sites.				
		1.2.9 Increase the supply of data capturers	OHSS	$ 200,000.00	TBD	*[REDACTED]*
		1.2.10 Review the HRH retention strategy for data capturers as part of the HRH strategy review process and propose amendments accordingly	OHSS	$ 250,000.00	TBD	*[REDACTED]*
		1.2.11 Review and include relevant information such as VL clinic/lab interface, algorithms, and relevant policy and guidelines into pre-service curricula	OHSS	$ 150,000.00	13923	*[REDACTED]*
			OHSS	$ 100,000.00	13750	*[REDACTED]*
		1.2.12 The NHLS is expanding their national training platform which will see the integration of the PEPFAR supported regional training program. Support will be provided to NHLS to further strengthen their in-service training platform specifically designed for the development of a skilled laboratory workforce.	HLAB	$ 150,000.00	17493	*[REDACTED]*
		1.2.13 Training of district health teams and health facility staff to analyze HIV VL cascade	HTXS	Resourced under Facility-Based Unit Expenditure	17020, 17023, 17036, 17046, 17038, 17021,	*[REDACTED]*

					17037, TBD	
			HTXS	$ 200,000.00	17506	*[REDACTED]*
			HTXS	$ 200,000.00	16808	*[REDACTED]*
			HTXS	$ 200,000.00	17507	*[REDACTED]*
			HTXS	Resourced under Correctional Facility-Based Unit Expenditure	16675	*[REDACTED]*
		1.2.14 Support training of Health Care Workers on specimen handling (e.g. collection, storage, package); results management (test result tracking and filing); and test ordering.	HTXS	Resourced under Facility-Based UE and correctional facilities-based UE	17020, 17023, 17036, 17046, 17038, 17021, 17037, 16775, TBD, 16775	*[REDACTED]*
		1.2.15 Monitor DIPs at District level	HTXS, HVTB, MTCT, PDTX	Resourced under Facility-Based UE	17020, 17023, 17036, 17046, 17038, 17021, 17037, 16775,	

					TBD, 16775	
		1.2.16 Support NDoH to monitor DIPs progress related to HIV VL monitoring implementation	HTXS, HVTB, MTCT, PDTX	$ 50,000.00	16807	
		1.2.17 Support DCS providing quality HIV VL monitoring within correctional facilities	HLAB	$ 39,333.00	16775	
Extremely centralized VL system and lack of efficiency of existing VL testing platforms	- Improve efficiency of laboratory network (to link ART support to Viral load testing capacity, improved specimen transport networks, results return and captured on Tier.net) - Improve efficiency of existing VL testing platforms to more than 90% - Decentralized testing capacity using hub system implementation of near-point-of-care VL testing devices e.g. . Pilot use of GeneXpert platform. - Reduced specimen rejection rates to <5% - 100% of viral load tests done	1.3.1 Support assessment of current viral load and EID testing capacity and accessibility	HLAB	$ 100,000.00	17493	*[REDACTED]*
		1.3.2 Support expansion of existing viral load testing capacity	HLAB	$ 300,000.00	17493	*[REDACTED]*
		1.3.3 Support the piloting of a decentralized service delivery model to improve testing efficiencies and accessibility to VL testing	HLAB	$ 300,000.00	17493	*[REDACTED]*
		1.3.4 Support expansion of HIV VL resistance testing capacity	HLAB	$ 150,000.00	17493	*[REDACTED]*
		1.3.5 Support delivery of quality laboratory diagnostic services through implementation of WHO-	HLAB	$ 150,000.00	17493	*[REDACTED]*

	within stipulated turn-around-times as per the national laboratory user handbook	ASLM quality management systems			
			Total	$ 17,035,941	

Table 6.1.2 Key Programmatic Gap 2: Clinical-Community Continuum of Care						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP16 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Associated IM**	*[REDACTED]*
Lack of a bi-directional (Facility/Community) referral system	- There will be a government-wide referral and linkage policy (NDoH, Department of Social Development) - Existing NDoH guidelines reviewed and amended for referral and linkage - 90% of facilities using standardized national referral system (PHC Re-engineering) - All PEPFAR-supported primary health care facilities qualify as Ideal Clinics	2.1.1 Support an inter-ministerial Technical Working Group (TWG) to strengthen implementation for referral and linkage	HBHC	$ 40,000.00	14291	*[REDACTED]*
			OHSS	$ 80,000.00	17769	*[REDACTED]*
		2.1.2 Support SAG to develop community-facility referral tools modification, consolidation, and dissemination nationally	HBHC	$ 100,000.00	14291	*[REDACTED]*
			HBHC	$ 100,001.00	17533	*[REDACTED]*
			OHSS	$ 100,000.00	TBD	*[REDACTED]*
		2.1.3 Support the NDoH to develop role profiles, competencies and assessment of managers to ensure 90% of facilities are using standardized referral systems	OHSS	$ 250,000.00	TBD	*[REDACTED]*
			OHSS	$ 450,000.00	TBD	
		2.1.4 Support training for Facility Boards, Ward AIDS Councils, district management teams. Support NDoH to includes information on the community and facility continuum of care within Ideal Clinic	OHSS	$ 250,000.00	TBD	*[REDACTED]*
		1.2.15 Monitor DIPs at District level	HTXS, HVTB, MTCT, PDTX	Resourced under Facility-Based UE	17020, 17023, 17036, 17046, 17038, 17021, 17037, 16775, TBD,	

					16775	
		1.2.16 Support NDoH to monitor DIPs	HTXS, HVTB, MTCT, PDTX	$ 50,000.00	16807	
		2.1.5 Operational research to evaluate the impact of various interventions to strengthen linkage to care in selected districts	HBHC, HXTX,	$400,000	17033	
Limited health information system capacity (e.g. Tier.Net, Health Patient Registration System, Patient Tracking System)	- 100% coverage of Tier.net (HIV electronic medical record) in PEPFAR-supported sites - Increase coverage of the Health Patient Registration System (including unique identifier) in PEPFAR-supported sites. - Patients will be enrolled in standardized patient tracking	2.2.1 National HMIS support (Tier.net, DHIS, ETR.net [TB Electronic Medical Record]) - -provide support for HMIS development and capacity -improve information systems, data quality, and data use	HVSI	$200,000	TBD	*[REDACTED]*

systems. - Support technology-focused innovation which can link community health workers to Facility/National data systems - 100 % of PEPFAR supported sites covered by the health patient registration system - 90 % of community health workers in PEPFAR-supported districts reporting data on a mobile device	2.2.2 Support NDoH to implement innovative mHealth initiatives that facilitate community-facility linkages. Examples include: 1) Leverage MomConnect infrastructure to support coordination of Community Health Worker (CHW) Ward-Based Outreach Team (WBOT) programs; 2) Leverage MomConnect to support transition of patients from HIV diagnosis to care and viral load suppression; 3) expanding momConnect messaging for HIV + pregnant women (pilot, evaluate and scale)	HVSI	$ 400,000.00	14846	*[REDACTED]*
	2.2.3 Support the NDoH and Provincial DoH in developing and implementing a GIS strategy. Support the NDoH in implementing the DHMIS policy regarding GIS. Support the NDoH in collecting and updating outstanding GPS coordinates for facilities. Support Provincial DoH (Mpumalanga, North West and Free State) in developing Geodatabases	HVSI	$ 219,254.00	14846	*[REDACTED]*

		2.2.4 Provide support for the NHISSA and HIS task team structures. Assist NDoH in formulating a governance structure for M&E (e.g. national M&E TWG, support seminars and stakeholder workshops)	HVSI	Costs covered under Programmatic Gap 1	14846	*[REDACTED]*
		2.2.5 Support the NDoH to operationalize and evaluate the implementation of the HTC and pre-ART modules in tier.net. -demonstrate the capacity of tier.nt to enhance linkages and retention to HIV care through full implementation of the HTC and pre-ART modules in a select number of facilities. - assess the impact of 'full implementation' on clinic operations, data quality and utility, and patient management.	HVSI	$ 350,000.00	TBD	*[REDACTED]*
Limited capacity of Ward-Based Outreach Teams (WBOT) and community cadres	- Adequate number of WBOTs, CHWs and other community cadres to strengthen the facility/community continuum of care.	2.3.1 Support the Investment case for the WBOTS – including identification of cadres required	OHSS	$ 300,000.00	TBD	*[REDACTED]*
	- CHWs appropriately skilled to provide effective services in the facility/community continuum of care.	2.3.2 Review, modify or develop role profiles, competencies for the WBOTS	OHSS	$ 200,000.00	TBD	*[REDACTED]*
	- 70% of WBOTS in the PEFPAR priority districts have 70% of	2.3.3 Determine the workload, demand, supply & performance for WBOTS	OHSS	$ 100,000.00	TBD	*[REDACTED]*

		2.3.4 Develop new training or modify existing material and train relevant cadres through RTCs	OHSS	$ 300,000.00	TBD	[REDACTED]
			HVOP	$150,000	13608	
		2.3.5 District learning pre-service education platforms to support the WBOTS	OHSS	$ 100,000.00	16807	[REDACTED]
		2.3.6 Develop 3-year transition plan for absorption of community cadre into national health workforce.	HTXS	$ 100,000.00	14291	[REDACTED]
			HTXS	$ 100,000.00	TBD	
			OHSS	$ 100,000.00	TBD	[REDACTED]
		2.3.7 TA and skills development for existing WBOTs and CHWs	HTXS	Resourced under Facility-Based Unit Expenditure	17020, 17023, 17036, 17046, 17038, 17021, 17037 , TBD	
			HTXS	$ 500,000.00	14291	[REDACTED]
		2.3.8 Training and Mentoring of Child and Youth Care Workers based on an accredited curriculum; theory coupled with practical work at household level and safe parks	HKID	$ 1,000,000.00	17017	[REDACTED]
Lack of linkages between services provided by the public sector and community-based/ Faith Based organizations	- Improved documentation of linkages and referrals between the public sector, the CBO/FBOs, and the private sector providers. - Improved reporting by CBOs/FBOS and sharing of	2.4.1 Assess services provided by Faith-Based/CBOs organizations, including mapping of service delivery, referral process and support to	OHSS	$ 250,000.00	TBD	[REDACTED]
			HBHC	Resourced under Community UE	14291	[REDACTED]

their staff trained and mentored on national curriculum, strengthening the facility/community continuum of care.

(CBOs/FBOs)	information by the public sector	marginalized populations.				
	- 70% of CHWs and Home-Based Caregivers in the PEFPAR priority districts are trained and mentored on a revised national curriculum, strengthening the facility/community continuum of care. - 100% of PEPFAR supported sites covered by the health patient registration system. 70% of CBO/FBOs from SANAC's NGO Sector will document referrals into the health patient registration system. - There will be bi-directional sharing of information on HIV services between the NDOH and 70% of CBO's/FBO's from SANAC's NGO Sector.	2.4.2 Strengthened referral system linking OVC and their families to the facility for testing, CD4 count, ART initiation. Strengthened referral documentation that allows tracking of referrals. Mapping of facility and clinical PEPFAR partners and establishing referral agreements between OVC partners and health facilities as well as Clinical PEPFAR partners	HKID	$ 500,000.00	14631, 14295	*[REDACTED]*

Table 6.1.3 Key Programmatic Gap 3: Understanding the Key Populations (KP) Cascade						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP16 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Associ ated IM**	*[REDACTED]*
Surveillance for KPs is limited (e.g. size/prevalence estimates, mapping, data triangulation)	- KP size estimates and prevalence estimates for all KP groups - Skills transfer to HCWs to ensure regular KP mapping - Data triangulation and/or method identification to district level size estimation of key populations - Estimate of KP HIV burden in sub-national unit will be available to monitor progress towards 90-90-90 - 100% KP implementing partners and 60% of selected health facilities in High Transmission Areas are able to conduct regular mapping of KPs - KP population size estimates	3.1.1 Incidence testing support provided to partners conducting surveillance studies for KPs (e.g. lab testing support for the Integrated Bio-Behavioral Surveillance [IBBS] study for KPs). The implementation of quality assurance for POCT during these studies will also be supported. In addition, support to expand the capacity of the program for detection and monitoring of resistance in both HIV and TB for KPs will be also provided.	HLAB	$ 228,552.00	17493	*[REDACTED]*

	available by key population in all PEPFAR-supported districts with KP programming	3.1.2 KP size estimation, mapping and IBBS – - Support for key pops size estimations (via special surveys routine data). - Data triangulation and/or method identification to district level size estimation of Key Populations - Determining key population characteristics and locations to guide targeted interventions to bring KPs in for treatment (IBBS, HSS) - Generation of evidence for directing decisions and improving service for KPs.	HVSI	$ 400,000.00	16932	[REDACTED]
		3.1.3 Survey of key pops to quantify access to services (90 90 90) with a focus on using routine data sources if/when possible. Potential solutions: expand currently planned IBBSs (e.g. MSM IBBS (Anova, UCSG, HSRC); additional rounds of data triangulation exercises.	HVSI	$ 500,000.00	17459	[REDACTED]

Limited exchange of routinely collected information between the public sector and the organizations serving KPs	- Appropriate information is shared between to the public sector and organizations serving KPs - KP access to services (90-90-90) is quantified using routine data sources. - 100% of PEPFAR-supported KP organizations reporting to and receiving data from RSA health information systems - 100% of PEPFAR-supported KP organizations able to quantify KP access to services (90-90-90)	3.2.1 Develop systems and unique identifier to be used among KP health providers without compromising confidentiality. Work with Global Fund, PEPFAR and other NGOs and government to develop and support this system.	HVSI; HVOP	$ 250,000.00	TBD	*[REDACTED]*
KPs experience stigma and discrimination when accessing services at public health facilities.	- Scaling up sensitization and clinical training on KP prevention and treatment package for HCWs - Stigma and discrimination training included in all training curricula	3.3.1 Develop coordinated curriculum with facilitator and trainee manual. Roll out training to academic and training centers and KP NGOs.	HVOP	$ 150,000.00	13608	*[REDACTED]*
	- Develop standardized country owned KP training materials for different health cadres of workers - Regional Training Centers to reach 100% of health facilities and 60% of community-based organizations working with KPs	3.3.2 Develop stigma and discrimination reduction training for HCWs within all PEPFAR supported programs to strengthen HIV continuum of care.	HTXS	Resourced under Facility-Based and Correctional Facility-Based Unit Expenditure	17020, 17023, 17036, 17046, 17038, 17021, 17037, TBD, 16775	*[REDACTED]*

		3.3.3 Develop district level stigma and discrimination reduction benchmarks within DIPs for all 27 focus districts	HTXS	$ 100,000.00	17020, 17023, 17036, 17046, 17038, 17021, 17037, TBD	*[REDACTED]*
Limited systems in place for PrEP/PEP provision for KPs	- Finalization of PrEP national guidelines - Targeted education campaigns aimed at HCWs and KP creating awareness of PEP/PreP - Increased uptake of PEP and PrEP by key populations	3.4.1 Preparation plan for PrEP	HVOP	$ 50,000.00	13793	*[REDACTED]*
		3.4.2 Review and include relevant information on PEP/PrEP into pre-service curricula	OHSS	$ 150,000.00	17452	*[REDACTED]*
				$ 100,000.00	13923	*[REDACTED]*
				$ 35,000.00	16807	*[REDACTED]*
		3.4.3 Strengthen PrEP implementation and competency training to HCWs	HTXS	Resourced under Facility-Based UE	17020, 17023, 17036, 17046, 17038, 17021, 17037, TBD	*[REDACTED]*
				$ 1,963,552.00		

6.2 Critical Systems Investments for Achieving Priority Policies

Successful implementation of Test and Treat will require a number of systems barriers to be addressed. The current national treatment guidelines for ART initiation are at <500 CD4 count for the general population. Second, the rapid testing quality assurance processes remain limited and need to be strengthened as the adoption of Test and Treat increasingly relies on the quality of rapid testing. The public health supply system can be improved to strengthen availability of medicines and commodities. The Workforce Indicators of Staffing Needs (WISN) assessment identifies a lack of human resources in public health facilities, and there is a need to strengthen the capacity of HRH and systems to attract, retain, and contract additional talent.

In COP16 PEPFAR aligned with NDoH and the National Adherence Strategy will support a differentiated care model which leverages new and efficient models of service delivery. To support this approach a number of systems barriers exist which hamper these models of alternative service delivery. Current policies are not yet adapted for multi-month dispensing of medicines, and most patients must pick-up medicines monthly. Updated national treatment policy offering Test and Treat will be launched in September 2016, prior to the start of COP16. The Centralized Chronic Medicines Dispensing and Distribution (CCMDD) program lacks sufficient pick-up points, limiting the number of patients that can be decanted from public health facilities. The private sector has not been sufficiently engaged in order to further decant patients from public health facilities. The expansion of Adherence Clubs has been limited, thereby causing yet another barrier to decanting patients from public health facilities. The advent of Test and Treat will allow for the consideration of innovative models like community initiation of ARVs, which to-date has been limited. And finally, innovative models to increase the yield of HIV testing (e.g., self-testing, partner notification, index-client tracing) have also been limited.

Table 6.2.1 Priority Policy 1: Test and Treat						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP16 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Associated IM**	*[REDACTED]*
Current treatment guidelines do not recommend Test and Treat with the exception of under 5, pregnant women, and co-infected TB/Hepatitis B NB: Government of South Africa has announced adoption of Test and Treat in September, 2016	- Guidelines and policy developed and implemented, including mandatory HIV rapid test quality assurance requirements and a testing/retesting strategy. - Clinical and community staff trained in policy and guidelines. - District Implementation plans developed and operationalized to reach 90-90-90 targets for TB and HIV - Test and Treat policy and guidelines includes the HIV rapid testing quality assurance. - 90% of clinical and community staff will be oriented to implement the Test and Treat policy and guidelines.	4.1.1 The NHLS is integral to the development of lab related national policies and guidelines. Support will subsequently be provided to the NHLS to facilitate the development of guidelines and policies, including POCT policy and Quality Assurance, in alignment to WHO testing recommendations. To improve communications between the NHLS and NDoH as well as facilitate NDoH oversight of the national laboratory program, support for the recruitment of a National Laboratory Coordinator to be based at NDoH will be provided. the coordinator will also provide guidance to laboratory related policies and implementation strategies	HLAB	$ 150,000.00	17493	*[REDACTED]*

		4.1.2 Support policy and guidelines on Test and Treat at the Dept of Correctional Services (DCS) facilities	HTXS	$ 50,000.00	16775	*[REDACTED]*
		4.1.3 Support the NDoH to develop policy and guidelines on Test and Treat	HTXS	$ 300,000.00 $ 150,000.00	16722, 17020, 17023, 17036, 17046, 17038, 17021, 17037, TBD	*[REDACTED]*
		4.1.4 Training of site-based providers on new Test and Treat guidelines	HTXS	Resourced under Facility-Based UE	17020, 17023, 17036, 17046, 17038, 17021, 17037, TBD	*[REDACTED]*
		4.1.5 Printing and distribution of Test and Treat Guidelines, flowcharts/Pocket book, ART Guidelines, Support the NDoH with HIV Clinical Management Training	HTXS	$ 100,000.00	16772	*[REDACTED]*
		4.1.6 Study on HTC-ART linkages to inform Test and Treat guidelines	HTXS	$ 400,000.00	17033	*[REDACTED]*
		4.1.7 Activities related to research questions derived from Implementation	OHSS, HTXS, HVTB,H VCT	$744,750	13750	*[REDACTED]*

		Science Research Committee				
		4.1.8 Policy and guidelines training included in Pre- service education	OHSS	$ 150,000.00	17452	*[REDACTED]*
			OHSS	$ 150,000.00	13923	
			OHSS	$ 35,000.00	16807	
		4.1.9 Support NDoH to monitor DIP implementation at : a) National and provincial b) district levels	HTXS, HVTB, PDCS, PDTX, MTCT	$ 200,000.00	16807	
		4.1.10 Support NDoH establish youth- and adolescent-friendly HIV C&T programs	HBHC, HTXS, HVTB, PDCS, PDTX, MTCT	$ 450,000.00	17968	
Limited HIV rapid testing quality assurance implementation	- HCWs adequately trained on HIV rapid testing quality assurance - Implementation of HIV rapid testing quality assurance in all PEPFAR priority districts. - 100% facilities providing HIV testing services enrolled in an independent quality control program - 90% of facilities providing HIV testing services and enrolled in a HIV serology proficiency testing program receive satisfactory results - All health care workers	4.2.1 Support training of HCWs through provision of TOTs for Quality Assurance of HIV Re-testing	HLAB	$ 300,000.00	17493	*[REDACTED]*
		4.2.2 Support enrollment of all priority district HTC sites into proficiency testing schemes for POCT	HLAB	$ 100,000.00	17493	*[REDACTED]*
		4.2.3 Support provision of IQC and proficiency testing panels as well as provide support and technical assistance to the NHLS Serology and CD4 PT schemes	HLAB	$ 400,000.00	17493	*[REDACTED]*

	providing HIV testing services certified as testers	4.2.4 Strengthen pre- and post-market surveillance of HIV RT tests	HLAB	$ 300,000.00	17493	*[REDACTED]*
		4.2.5 Support the assessment and certification of facilities and testers using the WHO approved SPI-RT checklist	HLAB	$ 300,000.00	17493	*[REDACTED]*
		4.2.6 QA of HIV rapid testing within DCS facilities	HTXS	$ 78,667.00	16775	*[REDACTED]*
Demand planning of medicines required for Test and Treat is hampered by a supply chain with limited visibility and inefficient delivery models.	- All PEPFAR-supported facilities have an Electronic Stock Management System (ESMS) for the detection of stock outs of medicines - All PEPFAR-supported facilities reporting stock availability at national surveillance center to monitor medicine availability - All provinces will have a Provincial Medicine Procurement Unit (PMPU) for the management of direct delivery of medicines established	4.3.1 Support the NDoH to improve the visibility, analytics, and continuous process improvement of the public health supply chain	HSS/CT/SI	$ 8,000,000.00	New - Global Health Supply Chain Program	*[REDACTED]*
		4.3.2 Support the NDoH to optimize distribution models for public health supply chain				
Domestic resources required to immediately implement Test	- Greater allocative efficiency through more accurate and results-based budgeting of	4.4.1 Costing Studies to improve the allocative efficiency of HIV/AIDS investments	OHSS/HVSI	$ 950,000.00	17025	*[REDACTED]*

and Treat are insufficient	the DIPs - 100% of PEPFAR-supported districts using a standardized and evidence-based budget allocation tool for the DIPs - 100% of PEPFAR-supported districts conducting annual assessments of budget execution.	4.4.2 Building the capacity of districts and provinces to improve budget execution	OHSS	$ 50,000.00	17025	*[REDACTED]*
		4.4.3 Supporting staff at Departments of Treasury and Health to unlock additional resources to sustain the HIV/AIDS investment	OHSS	$ 316,020.00	14295	*[REDACTED]*
		4.4.4 Supporting to the NHI work streams to ensure sustained HIV investment in the context of NHI	OHSS	$ 1,000,000.00	New - Health Finance and Govern ance	*[REDACTED]*
Limited capacity of HRH and systems to attract, retain, contract additional talent (e.g., GP Contracting, Foreign Qualified Doctors)	- Adequate supply of trained HCWs to support Test and Treat - Strengthen the utilization of mid-level health care workers to provide clinical services related to Test and Treat, including enhancements of related policies. - All PEPFAR-supported health facilities benchmarked against staffing normative guides - New basic Nursing qualification programs and draft curricula developed - All managers at PEPFAR-	4.5.1 Support the NDoH to recruit and place Foreign Qualified Doctors	HTXS	$ 400,000.00	16981	*[REDACTED]*
		4.5.2 Secondment of key staff to temporarily fill SAG vacancies	HTXS	Resourced under Facility-Based Unit Expenditure	17020, 17023, 17036, 17046, 17038, 17021, 17037, 16775, TBD	*[REDACTED]*
		4.5.3 Support the Albertina Executive Leadership Program in Health program to give managers the tools to advance 90-90-90	OHSS	$ 800,000.00	16984	*[REDACTED]*

supported facilities accessing coaching and mentoring accredited by the Academy for Leadership in Health programme - All managers at PEPFAR-supported sites using the knowledge hub information system	4.5.4 Support and strengthen the activities of the Academy for Leadership in Health to ensure quality capacity building of managers to lead & direct the response to achieve 90-90-90	OHSS	$ 200,000.00	TBD	*[REDACTED]*
- 80% of funded posts in PEPFAR supported facilities are filled with HCWs authorized to implement Test and Treat. - 60% of facilities are using mid-level workers to support the provision of Test and Treat - 80% of HCWs performing statutory community service cohorts will have a systemized orientation to Integrated Clinical Services Model (ICSM).	4.5.5 Interdisciplinary pre-service delivery platforms to be developed to increase supply and improve quality of HIV related services provided in PEPFAR priority districts /rural areas	OHSS	$ 100,000.00	16807	*[REDACTED]*
	4.5.6 Determine supply and demand of HRH for Test and Treat	OHSS	$ 50,000.00	17767	*[REDACTED]*
	4.5.7 Design, develop/ interoperability and maintain a system to plan and monitor supply, demand, tracking & performance of HRH	OHSS	$ 600,000.00	TBD	*[REDACTED]*
	4.5.8 Systems monitoring HRM of health practitioner contracting developed /interoperability with existing systems approved by NDoH on HRIS	OHSS			

		4.5.9 Development of relevant HRH and education policies. This includes support of South African Government's analysis and refinement of policies	OHSS	$ 50,000.00	17767	*[REDACTED]*
			OHSS	$ 250,000.00	TBD	
		4.5.10 Systems developed to support HRH to meet Statutory and regulatory requirements to practice includes Community cadres and nurses	OHSS	$ 434,056.00	TBD	*[REDACTED]*
		4.5.11 Train, mentoring, coaching and strengthen the National Department of Health to provide the relevant HRH for service delivery	OHSS	$ 600,000.00	9865	*[REDACTED]*
			OHSS	$ 250,000.00	TBD	
		4.5.12 Continued support for PC101 training initiatives to enable nurses to deliver Test and Treat services	OHSS	$ 150,000.00	TBD	*[REDACTED]*
		4.5.13 Strengthen the utilization of mid-level health care workers to provide clinical services related to Test and Treat, including evaluation of related mid-level-workers	OHSS	$ 450,000.00	17452	*[REDACTED]*

		4.5.14 Continued support and strengthening of Pharmacovigilance and Adverse events reporting.	OHSS	$ 345,000.00	TBD	[REDACTED]
		4.5.15 Training of relevant HCWs on Anti microbial resistance	OHSS	$170,000	17769	[REDACTED]
		4.5.16 Job profiles, competencies developed and assessed for relevant HCWs	OHSS	$ 50,000.00	17767	[REDACTED]
		4.5.17 Strengthen in-service learning systems of the Knowledge Hub , RTCs, distance & eLearning platform for HIV prevention , care and treatment service delivery including Test and Treat in collaboration with District management teams and DSPs & NDoH	OHSS	$ 800,000.00	TBD	[REDACTED]
		4.5.18 Strengthen and support the Office of Health Standards compliance processes including maintain and update the OHSC dashboard, to develop core service standards for community services	OHSS	$ 200,000.00	TBD	[REDACTED]
		4.5.19 Continued support for the	OHSS	$ 250,000.00	TBD	[REDACTED]

		coordination, development and implementation of Ideal Clinic initiatives to achieve 90-90-90		$ 50,000.00	TBD	
				$ 50,000.00	17767	
				$255,121	TBD	
		4.5.20 Conduct a Health Labor Market Analysis to better inform health care worker contracting in partnership with South African government	OHSS	$ 350,000.00	New: Chemonics	*[REDACTED]*
				$ 21,078,614		

Table 6.2.2 Priority Policy 2: New Models of Service Delivery						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP16 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Associated IM**	*[REDACTED]*
Differentiated care model defined in the NDoH Adherence Guidelines yet to be fully operationalized	- 90% of eligible patients decanted to alternative service delivery models in PEPFAR focus districts	5.1.1 Policy and guidelines training included in Pre service education	OHSS	$ 30,000.00	16807	*[REDACTED]*
		5.1.2 Dissemination and training of health care workers on the National Adherence Guidelines	HTXS	$ 100,000.00	17533	
			HTXS	$ 100,000.00	14291	*[REDACTED]*
		5.1.3 Support NDoH to develop a protocol on decanting patients and SOPs for CCMDD, Adherence Clubs, multi-month dispensing, and Fast Lane developed and disseminated to 27 focus districts	HTXS	$ 200,000.00	17020, 17023, 17036, 17046, 17038, 17021, 17037, TBD	*[REDACTED]*
		5.1.4 In partnership with NDoH, conduct implementation science research to evaluate adherence guidelines and alternate models of service delivery	HTXS	$ 2,000,000.00	17025	*[REDACTED]*
		5.1.5 Printing and distribution of National Adherence Guidelines and tools such as SOPs, Education flip files.	HBHC	$ 40,000.00	16772	*[REDACTED]*
		5.1.6 Support the NDoH to roll-out the National Adherence Guidelines to improve HIV/TB/NCDs outcomes	HBHC	$ 460,000.00	16772	*[REDACTED]*

		5.1.7 Support the NDoH and its partners to strengthen and cascade the HIV/AIDS care and support services down to facility level and contribute effectively to epidemic control	HBHC, PDCS, HTSX, PDTX, HVTB	$ 3,500,000.00	17533	*[REDACTED]*
		5.1.8 To support the NDoH, Provincial Departments of Health, Regional Training Centers (RTCs) and District Support Partners in the roll-out of the National adherence guidelines in order to improve health outcomes and contribute effectively towards UNAIDS targets 90-90-90 through strengthening linkage to care, retention in care and treatment adherence in the HIV cascade including paeds and adolescents				*[REDACTED]*
		5.1.9 Support the NDoH to establish national decanting targets and incorporate in DIPs	HTXS	$ 135,000.00	17020, 17023, 17036, 17046, 17038, 17021, 17037, TBD	*[REDACTED]*
		5.1.10 Support NDoH at national and provincial levels in setting-up New Models of HIV Service Delivery including the training of CHW and clinicians on the new National Adherence Guidelines	HBHC, HTXS, HVTB	$ 4,300,000.00	TBD	

		5.1.11 Support NDoH monitor DIP implementation as it relates to the roll-out of the National Adherence Guidelines	HTXS, HVTB, PDCS, PDTX, MTCT	$ 150,000.00	16807	
		5.1.12 Support NDoH at national and provincial level establishment of youth- and adolescent-friendly C&T programs	HBHC, HTXS, HVTB, PDCS, PDTX, MTCT	$ 450,000.00	17968	
There are a limited number of Centralized Chronic Medicines Dispensing and Distribution (CCMDD) pick-up points (PuP)	- Increase number and improve distribution of CCMDD PuPs. - One million patients receiving medicines through the centralized chronic medicine dispensing & distribution system - 1,480,000 HIV patients receiving medicines through community-based PuPs	5.2.1 Work with NDoH to leverage private sector models (i.e.., Coca-Cola) to increase the number and coverage of CCMDD PuPs	HTXS	$ 500,000.00	New: Global Health Supply Chain Program	*[REDACTED]*
		5.2.2 Support CCMDD administrative, management, implementation and monitoring processes supported at national, provincial.	OHSS/HTXS	$ 600,000.00	TBD	*[REDACTED]*
Private sector engagement to enhance the clinical cascade has been limited.	- The NDoH will have visibility of the contribution of the private sector to the 90-90-90 cascade. - Eligible patients will be increasingly decanted from public health facilities to receive services from the private sector, including contracted	5.3.1 Strengthen how workforce indicators of staffing needs (WISN) data is used to determine optimal sites for GP/HCW contracting	HTXS	Resourced under Community UE	17020, 17023, 17036, 17046, 17038, 17021, 17037, TBD	*[REDACTED]*
		5.3.2 Advocate for a change in the categorization of HIV services in the private medical schemes	HTXS	$ 300,000.00	17021	*[REDACTED]*

	GPs. - Private sector reports HIV testing, treatment and viral suppression in 100% of PEPFAR-supported districts - 1,480,000 HIV patients receiving semi-annual clinical visits in the private sector	5.3.3 Capacity building of private sector health providers	HTXS	Resourced under Community UE	17020, 17023, 17036, 17046, 17038, 17021, 17037, TBD	*[REDACTED]*
		5.3.4 Data Sharing with private sector to quantify contribution of private sector patients	HTXS	Resourced under Community UE	17020, 17023, 17036, 17046, 17038, 17021, 17037, TBD	*[REDACTED]*
		5.3.5 Contracting with private sector health providers	HTXS	Resourced under Community UE	17020, 17023, 17036, 17046, 17038, 17021, 17037, TBD	*[REDACTED]*
Limited extent of Adherence Clubs (ACs) for expanded service delivery	Fully operational community-based Adherence Clubs in all communities and aligned with all public health facilities	5.4.1 Determine the workload, supply, demand role profiles & competencies of relevant HCWs for Adherence Clubs	OHSS	$ 50,000.00	17767	*[REDACTED]*
			HTXS	$ 270,000.00	17020, 17023, 17036, 17046, 17038, 17021, 17037, TBD	*[REDACTED]*
		5.4.2 Review of relevant training material	OHSS	$ 50,000.00	TBD	*[REDACTED]*
		5.4.3 Coordinate / implement training including the through the RTCs to deliver the new service model	OHSS	$ 50,000.00	TBD	*[REDACTED]*
		5.4.4 Develop the system to measure and monitor performance of the HCWs towards delivery of services	OHSS	$ 95,508.00	TBD	*[REDACTED]*

		5.5.5 Pre-service education platforms including district learning platforms to support the new service delivery models	OHSS	$ 100,000.00	16807	*[REDACTED]*
Limited innovative models for linkage to ART initiation	- Ensure DIPs integrate evidence-based strategies to improve linkage to ART initiation - 90% of PLHIV on treatment in PEPFAR-supported districts	5.5.6 Coordinate with NDOH on national best practices conference and integration into district action planning (DIPs) to promote dissemination of evidenced models for improved linkage to ART initiation.	HTXS	Resourced under Facility-Based UE	17020, 17023, 17036, 17046, 17038, 17021, 17037, TBD	*[REDACTED]*
		5.5.7 Operationalize Adherence Guidelines SOPs for fast track ART initiation across all districts.	HTXS	Resourced under Facility-Based UE	17020, 17023, 17036, 17046, 17038, 17021, 17037, TBD	*[REDACTED]*
		Activities related to research questions derived from Implementation Science Research Committee	OHSS, HTXS, HVTB,HVCT	$744,750	13750	
				$ 13,480,508.00		

6.3 Proposed system investments outside of programmatic gaps and priority policies.

Proposed COP16 Activities	Budget Code(s)	Activity Budget Amount	Associated IM
6.1 Building evidence on impact of OVC interventions	HKID	$ 193,686.00	14667
6.2 ASPIRES Economic Strengthening Project	HKID	$ 500,000.00	17536
6.3 Strengthen the capacity of the NDoH to provide quality and sustainable clinical care for HIV-infected patients with complicated HIV and HIV/TB treatment management, including 2nd and 3rd line and other antiretroviral therapy, through the establishment of reliable referral networks staffed by adequately trained clinical staff, with locally appropriate comprehensive monitoring and evaluation systems allowing for ongoing program efficacy monitoring.	HTXS, PDTX, HVTB	$ 2,100,000.00	17507
		$ 2,100,000.00	16808
		$ 1,300,000.00	17506
6.4 Support the NDoH to strengthen and improve IC and WM practices in public health facilities and the communities in order to reduce transmission of TB, HIV, and other communicable diseases, reduce TB morbidity and deaths, and promote health among healthcare workers, and among the SA population at large.	HVTB	$ 500,000.00	TBD

6.5 Support RTCs and NDoH to improve indicator performance in order to meet the 90-90-90 targets for TB/HIV and promote positive health outcomes through continuous alignment of curricula and targeted short course training materials, Support development and dissemination of podcasts and self-directed eLearning modules to address critical gaps in TB and HIV care, Update and disseminate Clinical Case Compendium	HVTB	$ 425,000.00	17769
6.6 Support the validation activities for eMTCT plan through impact evaluation of option B+	MTCT	$ 1,200,000.00	13608
6.7 Increase access to TB/HIV care among women and infants in ante-natal care settings	HVTB	$ 400,000.00	17033
6.8 Support the NDoH to improve the quality of TB and TB/HIV data 6.9 Support decentralization of MDR-TB services including initiation and/or management of HIV co-infections (>74%) and management of drug-drug interactions through nurse-initiated MDR-TB care and strengthen the MDR-TB CoEs Support the roll-out of audiometry (drug-drug interaction with TDF) Improve treatment success rate by supporting the roll out bedaquiline	HVTB	$ 1,300,000.00	16772
6.10 Support TB/HIV data use workshops and the roll-out of the TB module onto Tier.net	HVTB	$ 200,000.00	16772
6.11 Funds will be used to support the national NDoH strategic direction for achieving their last mile of the elimination plan. Funds will be uses for the development and dissemination of the SOPs for the management of complex HIV infected neonates	MTCT	$ 250,000.00	16772

6.12 Provide technical support to the SAG at national, and provincial level for the prevalidation and accomplishment of the "last mile". UNICEF will disseminate the tools for the prevalidation at all levels. The main focus will be at priority districts which are poorly performing with high actual numbers of PCR positive babies.	MTCT	$ 400,000.00	17505
6.13 Support the national department of health with early warning indicators EWI to improve TB and HIV patient outcomes	HTXS ,PDTX, HVTB	$ 350,000.00	17512
6.14 Effectively and sustainably build national and provincial capacity to implement standardized evidence informed HIV prevention care and treatment programs for adolescent girls and young women (AGYW). This will be achieved through Community mobilization and promoting norms change, Providing TA for strengthening national and provincial policy makers, program managers and regional training structures.	HTXS,HBHC,PDTX,PDCS,HVTB, MTCT	$ 900,000.00	17968
6.15 Support a study of cost drivers for Technical Assistance to facilities and identification of efficiencies	HTXS,HBHC,PDTX,PDCS,HVTB, MTCT	$ 400,000.00	TBD
6.16 South African National HIV Prevalence, Incidence and Behavior Survey- a) to inform the HIV response in South Africa including key policy, planning and programming efforts b) for reporting on the progress of the epidemic e.g. UNGASS reports c) is a key element in modelling of the epidemic in South Africa including the UNAIDS Spectrum.	HVSI, HLAB	$1,350,000.00	17459

6.17 KZN HIV Incidence Provincial Surveillance System (HIPSS) -Generate prevalence and direct incidence estimates; Asses risk factors (HIV, TB, STI, pregnancy, exposure to services (e.g. ART, HTC, VMMC, etc.)) data collected.	HVSI	$ 200,000.00	13695
6.18 KZN HIV Incidence Provincial Surveillance System (HIPSS) -Generate prevalence and direct incidence estimates; Asses risk factors (HIV, TB, STI, pregnancy, exposure to services (e.g. ART, HTC, VMMC, etc.)) data collected.	HVSI	$ 100,000.00	17033
6.19 ANC/PMTCT comparison –assessing the feasibility of using routine PMTCT data for antenatal HIV surveillance in the South African context as a recommendation from the WHO	HVSI	$ 100,000.00	17033
6.20 HIV Case Reporting (HCRS): Support the establishment and mechanisms for tracking individuals in the diagnosis, care and treatment continuum, including mortality resulting from HIV/AIDS in priority districts with emphasis on data quality. Utilize existing systems to monitor sentinel event.	HVSI	$ 200,000.00	16772, 9562
6.21 Drug Resistance surveillance + Early Warning Indicators (EWI) (Care & Tx)	HVSI	$ 100,000.00	17493
6.22 Technical assistance in the area of TB/HIV strategic information including improved monitoring of integrated TB/HIV programs and HIV surveillance among TB patients.	HVSI	$ 50,000.00	17512
6.23 Small area estimations and mapping that utilize existing data sources (e.g. program data, ANC sentinel surveillance) to identify sub-national burden.	HVSI	$300,000	New: UNAIDS

6.24 Support the roll out the National Pediatric Disclosure Guidelines	PDCS, PDTX	$ 250,000.00	16772
6.25 Support the training of NIMART nurses	HBHC, PDCS, HTSX, PDTX, HVTB	$ 300,000.00	17768
6.26 Improve HIV/TB patient outcomes by strengthening health and patient management systems at district level; build capacity of district management teams and systems for HSS; identify and implement policies; support transition to a sustainable model	Facility/District Lump sum HTXS, HVTB, MTCT, PDCS, PDTX	$19,996,711	17020, 17023, 17036, 17046, 17038, 17021, 17037, TBD; 17024, 17039
6.27 Innovations Models for policy formation and scale up , for Farmworkers	HBHC, HTSX, PDTX, HVTB	$1,486,063	17018
6.28 Innovations Models for policy formation and scale up for MSM	HBHC, HTSX, HVTB	$1,736,974	17019
6.29 Innovations Models for policy formation and scale up for PMTCT	MTCT	$2,306,514	17026
6.30 Innovations Models for policy formation and scale up for QI PMTCT	MTCT	$3,328,779	17022
6.31 Innovations Models for policy formation and scale up for adolescents WRHI	HBHC, HTSX, PDTX, HVTB	$1,441,034	17028
6.32 Innovations Models for policy formation and scale up for informal settlements	HBHC, HTSX, PDTX, HVTB	$1,812,550	17029
6.33 Innovations Models for policy formation and scale up forSEX WORKERS	HBHC, HTSX, HVTB	$1,665,508	17027
6.34 Support the rapid testing, monitoring, evaluation, and scale up of new approaches to identify HIV + patients, link them, retain them on treatment, and assure high ART adherence at reach the 90-90-90-saturation targets by 2017 and 2018 in priority districts.	HBHC, PDCS, HTSX, PDTX, HVTB	$ 1,340,000.00	TBD
6.35 Provide ACC at Provincial and DCS	HTXS, PDTX, HVTB, HBHC, PDCS	$ 600,000.00 $ 1,000,000.00 $ 900,000.00	17506 16808 17507

6.36 DSPs provide TA for ACC at District Level	HTXS, PDTX, HVTB, HBHC, PDCS	Facility UE	17020, 17023, 17036, 17046, 17038, 17021, 17037, 16775, TBD
6.37 Support NDoH monitor DIP implementation and address issues using a CQI approach	HTXS, HVTB, PDCS, PDTX, MTCT	$ 100,000.00	16807/Stellenbosch
6.38 Support staffing at NDoH for TB/HIV services as well as planning, implementing, and monitoring HIV services	HBHC, HTXS, HVTB, PDCS, PDTX, MTCT	$ 1,150,000.00	16772
6.39 Support the training of HCW and district health management teams in the diagnosis and management of mental health disorders	HBHC	$ 500,000.00	17769

7.0 Staffing Plan

COP16 staffing plan aligns with PEPFAR's focus on achieving epidemic control in the highest burden areas of the country. The interagency team organizational structure provides high quality TA and oversight in core and near-core program areas. The interagency structure reflects the priority interventions aligned with South Africa, PEPFAR and the agencies. Adjustments to the COP16 staffing footprint reflect the increased complexity of the program including increased use of data for decision making aligned with POART and PFIP structures, implementing funding from several central initiatives (i.e., DREAMS and Test and Treat), integration across program areas, enhanced alignment with South African government agencies' HIV program monitoring and management processes and initiatives, and strengthening linkages with key issues such gender-based violence. To address programming changes, USAID proposes to add five new positions, while CDC and State will strategically repurpose existing positions to fill programmatic needs. With this, the agencies will be well positioned to promote efficiencies and maximize skills. PEPFAR staff are fully utilized to meet SIMS requirements.

•High Burden Districts: CDC's COP14 plan for two positions at the U.S. Consulate in Durban to provide technical oversight and monitoring of programs as quality improvement specialists has been approved by the Consulate and the Embassy, and are now being classified prior to recruitment. USAID in COP16 is requesting two new positions as project development specialists for integration to also be approved and placed in Durban. Together, these positions demonstrate the team's prioritization of staffing in South Africa's highest HIV burden province and districts.

•DREAMS: In addition to current staff working on DREAMS, CDC has identified and is repurposing a position to support emerging programmatic requirements around the DREAMS Initiative and PEPFAR transition to priority districts to meet 90-90-90. USAID's two new project development specialists, noted above, will also focus on DREAMS in KwaZulu Natal.

•CDC Prevention Branch reorganization will be finalized in COP16. This reorganization will better address the programmatic requirements of the first 90 for HCT scale up, key populations, bio-medical prevention programs, and the DREAMS initiative.

•During COP15 PCO's Provincial Liaisons are being aligned to reflect the 27 focus districts and provincial distributions; additional coordination support is being provided in KwaZulu Natal Province, which includes seven focus districts and two DREAMS districts. Additionally, PCO is in the process of recruiting a SI Liaison, pending classification of the position. An additional two vacancies in the PCO are also being reevaluated pending an organizational review, to include the Community Grants program positions.

To promote program sustainability, PEPFAR continues to recruit highly qualified locally engaged staff (LES) who play a critical role in the provision of TA and program management and enhance the USG relationships with South African government and other key stakeholders. PEPFAR agencies are also proactively working to improve staff retention. In COP16 CDC will have a locally engaged Co-Prevention Branch Chief; a senior level advisor to the NDoH, and an Extramural Branch Team Lead (re-purposed from within the Extramural Branch).

PEPFAR Technical staff provide TA, as well as participate in SIMS and provide oversight of assistance mechanisms. *[REDACTED]* PEPFAR is in the process of filling the vacancies that resulted from significant staff turnover in 2014 and 2015. At approximately 25% overall, CDC vacancy rates are high and still consistent with previous years. At approximately 5% (Health Office), USAID vacancy rates are modest. The trend toward filling the vacancies for both agencies, however, is looking positive. *[REDACTED]* PEPFAR is seeing increased numbers of interested and qualified applicants to our positions and expects a more stable workforce over the COP16 implementation period. *[REDACTED]* CDC's LES vacancies that remain vacant for over six months are being systematically reviewed and in some cases the PDs re-written and re-classified for more successful recruitment. In other cases, the positions are re-advertised.

[REDACTED]

State continues to provide overall support through the PCO and strong ties to the Department of State's Economic and Public Affairs Sections. In COP15 the U.S. Ambassador's Community Grants program will be more closely aligned with CDC, USAID and PC programming and strengthened in COP16.

[REDACTED]

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP16			
Level of Implementation	**Core Activities**	**Near-core Activities**	**Non-core Activities**
Care and Treatment			

Site level	TA for CT services implementation and quality improvement
	
	New Service delivery models
	Stable patients (ART patients with confirmed HIV VL undetectable after 12 months on ART then annually)
	▪ 6month ART prescriptions and 2 months dispensing
	▪ Patient friendlier meds dispensing
	   o Fast-track medication pick-up lane at facilities
	   o Community dispensing (CCMDD and Adherence Clubs)
	▪ Every 6 month clinician visits
	▪ HIV VL 6 and 12 months after ART initiation; annually thereafter
	▪ Community adherence support
	▪ Progressive switch for CD4 to HIV VL monitoring
	▪ Training of clinicians and CHW on the new models of service delivery
	▪ Monitor closely quality of services and support improvements as needed
	▪ Collaborations with private sector to address bottlenecks for treatment scale-up and decanting of stable patients
	Diagnostics
	For adults:
	▪ Monitor and map high yield areas to		

	find undiagnosed PLHIV and optimize the testing strategies ▪ Optimizing HTS delivery models to successfully link pregnant /breastfeeding women , neonates, children, adolescents and adults living with HIV using community navigators ▪ 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 ▪ Support the national roll out of disclosure guidelines in children. For adolescents: ▪ Same as for adults ▪ Adolescent-friendly testing services ▪ Support the national campaign for adolescent and young girls outside the DREAMS districts For pregnant women: ▪ Same as for adults ▪ Implementation of PMTCT guidelines ▪ QA for HIV rapid testing For FSW/MSM, PWID: ▪ Same as for adults ▪ Testing services for FSW/MSM, PWID For prisoners, miners, communities/informal settings/farm workers: ▪ Same as for adults ▪ Testing services for those communities		

Linkage to Care
For adults, adolescents, FSW, MSM, PWID, miners/communities, informal settings, and farm workers:
- Improve bidirectional community facility interface referral tools
- Support the development of care teams linking facility and community based ART
- 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-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
- 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: - Test and Treat irrespective of CD4 count - Initiated in the DREAMS districts - Lessons learned from initial launch applied to further roll-out - Support roll-out of Test and Treat to all 27 priority districts - Improve bidirectional community-facility interface referral tools - Support the development of care teams linking facility and community based ART - Standardize trainings for all community workers in the priority districts - Support community social mobilization for VL testing - Training and Mentoring for all key components of HIV treatment and clinical care - Implement quality improvement methodology to improve performance in all aspects of HIV treatment and clinical care - Implementation of 'Consolidated ART Guidelines' - 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
For FSW, MSM, PWID, Informal settlements and farm workers:
  ▪ Same as for adults
  ▪ Treatment services for those communities
 	
Retention in Care / Treatment Adherence
For adults, adolescents, pregnant women, FSW, MSM, PWID, prisoners, miners/communities, informal settlement, farm workers:
  ▪ Improve bidirectional community-facility interface referral tools
  ▪ Support the development of care teams linking facility and community based ART
  ▪ Standardize trainings for all community workers in the priority districts
  ▪ Support community social mobilization for VL testing
  ▪ 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 - De-stigmatization 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 TB/HIV - Update and fast track implementation of the revised TB/HIV integration manual - TB symptom screening for PLHIV - Isoniazid Preventive Therapy (IPT) for PLHIV - TB Infection prevention and control - HIV testing services (HTS) for TB patients and presumptive TB cases - ART for all co-infected TB patients. - TB second line treatment for PLHIV diagnosed with MDR-TB - Focused TB/HIV training and mentoring Supportive Systems Ideal clinic: - Implementation of HIV related aspects Pharmacy: - RxSolution/Stock Visibility Solution - Centralized Chronic Dispensing and		

	Distribution Pick-Up Points ▪ Facility stock management Clinic-lab interface: ▪ Quality of specimens ▪ Feedback loop strengthened and timely return of results 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 HR Support: ▪ Roving clinician teams to support facility-based patient management ▪ Roving counselor teams to support facility-based PITC ▪ Roving data-capturer teams to support facility-based data management ▪ Essential staff at facility level ▪ Essential staff for community-based program Leadership/management: ▪ LMT for facility managers		
Sub-national level	TA for CT program planning and implementation Estimation of HIV/TB Burden For adults, pediatrics, adolescents, pregnant women, CSW, MSM, PWID, prisoners, miners/communities, and informal settings: ▪ Review existing HIV and TB data ▪ District level mapping and planning/Know your Epidemic, Know your Response New service delivery models Stable patients (ART patients with confirmed HIV VL undetectable after 12 months on ART then annually) ▪ 6month ART prescriptions and 2	Institutional capacity development: - Assess and build capacity of FBOs/CBOs that provide HIV services Health Financing: - Financial capacity building through support of the DIPs and HIV/AIDS Conditional Grant proposals and budget execution -	▪

	months dispensing
	  ■ Patient friendlier meds dispensing
	    ○ Fast-track medication pick-up lane at facilities
	    ○ Community dispensing (CCMDD and Adherence Clubs)
	  ■ Every 6 month clinician visits
	  ■ HIV VL 6 and 12 month after ART initiation; annually thereafter
	  ■ Community adherence support
	  ■ Progressive switch for CD4 to HIV VL monitoring
	  ■ Training of clinicians and CHW on the new models of service delivery
	  ■ Monitor closely quality of services and support improvements as needed
	  ■ Collaborations with private sector to address bottlenecks for treatment scale-up and decanting of stable patients
	
	Diagnostics
	For adults:
	  ■ Monitor and map high yield areas to find undiagnosed PLHIV and optimize the testing strategies
	  ■ Optimizing HTS delivery models to successfully link pregnant /breastfeeding women, neonates children, adolescent and adults living with HIV using community navigators
	  ■ 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 • Support the national roll out of disclosure guidelines in children For adolescents: • Same as for adults • Adolescent-friendly testing services • Support the national campaign for adolescent and young girls outside the DREAMS districts For pregnant women: • Same as for adults • QA for HIV rapid testing For FSW/MSM, PWID: • Same as for adults • Testing services for FSW/MSM, PWID For prisoners, miners, communities/informal settings/farm workers • Same as for adults • Testing services for those communities Linkage to Care For adults, adolescents, FSW, MSM, PWID, miners/communities, informal settings, and farm workers: • Improve bidirectional community facility interface referral tools • Support the development of care teams linking facility and community based ART • 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-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: - Test and Treat irrespective of CD4 count - Initiated in the DREAMS districts - Lessons learned from initial launch applied to further roll-out - Support roll-out of Test and Treat to all 27 priority districts - Improve bidirectional community facility interface referral tools - Support the development of care teams linking facility and community based ART - Standardize trainings for all community workers in the priority districts - Support community social	

mobilization for VL testing
- Training and Mentoring for all key components of HIV treatment and clinical care
- Implement quality improvement methodology to improve performance in all aspects of HIV treatment and clinical care
- Implementation of 'Consolidated ART Guidelines' 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

	For FSW, MSM, PWID, Informal settlements and farm workers: ■ Same as for adults ■ Treatment services for those communities Retention in Care / Treatment Adherence For adults, adolescents, pregnant women, FSW, MSM, PWID, prisoners, miners/communities, informal settlement, farm workers: ■ Improve bidirectional community facility interface referral tools ■ Support the development of care teams linking facility and community based ART ■ Standardize trainings for all community workers in the priority districts ■ Support community social mobilization for VL testing ■ 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 ■ De-stigmatization 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		

	TB/HIV
	    ▪ Fast track implementation of the revised TB/HIV integration manual
	    ▪ TB symptom screening for PLHIV at every visit
	    ▪ Isoniazid Preventive Therapy (IPT) for PLHIV
	    ▪ TB Infection prevention and control
	    ▪ HIV testing services (HTS) for TB patients and presumptive TB cases
	    ▪ ART for all co-infected TB patients.
	    ▪ TB second line treatment for PLHIV diagnosed with MDR-TB
	    ▪ Focused TB/HIV training and mentoring
	
	Supportive Systems
	Ideal clinic:
	    ▪ Implementation of HIV related aspects
	Supply Chain:
	    ▪ Provincial Medicine Procurement Unit
	    ▪ District supply management
	    ▪ Visibility and Analytics Network, formerly Control Tower
	    ▪ CCMDD Oversight
	Clinic-lab interface:
	    ▪ Quality of specimens
	    ▪ Feedback loop strengthened and timely return of results
	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
	    ▪ Integration of ETR.net into Tier.net/
	    ▪ DHIS (e.g. transition to DHIS 2.0		

	(web-based)) ▪ Support data quality improvement and data use ▪ Operationalize and evaluate the implementation of the HTC and pre-ART modules in tier.net ▪ HIV Case Reporting: Support the establishment and mechanisms for tracking individuals in the diagnosis, care and treatment continuum, including mortality resulting from HIV/AIDS in priority districts with emphasis on data quality ▪ Survey of key pops to quantify access to services (90 90 90) with a focus on using routine data sources ▪ M&E Technical support to provinces: Multi-sectoral monitoring and reporting of provincial HIV/AIDS planning and response Leadership/management: ▪ District Implementation Plans HR Support ▪ Essential staff in districts and provinces		
National level	TA for CT strategy, policy and guidelines Estimation of HIV/TB Burden Small area estimations and mapping that utilize existing data sources (e.g. program data, ANC sentinel surveillance) to identify sub-national burden For adults, pediatrics, adolescents, pregnant women, CSW, MSM, PWID, 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 New Service delivery models Stable patients (ART patients with confirmed HIV VL undetectable after 12 months on ART	HR support: - Strategic HIV program leadership staff (e.g., district, provincial, national) - Pre-service education for essential HIV/AIDS care providers in priority districts - Workforce planning e.g., WISN, labor market analysis, retention analysis, transition of PEFPAR support staff, - Strengthen the utilization of mid-level health care workers - Human Resource Information System, including in-service delivery platform - Support to the Regional Training Centers (RTCs) Policy: - Support the South African Government's analysis and refinement of relevant HRH and education policies	▪

	then annually)
	   ▪ 6month ART prescriptions and 2 months dispensing
	   ▪ Patient friendlier meds dispensing
	       o Fast-track medication pick-up lane at facilities
	       o Community dispensing (CCMDD and Adherence Clubs)
	   ▪ Every 6 month clinician visits
	   ▪ HIV VL 6 and 12 month after ART initiation; annually thereafter
	   ▪ Community adherence support
	   ▪ Progressive switch for CD4 to HIV VL monitoring
	   ▪ Training of clinicians and CHW on the new models of service delivery
	   ▪ Monitor closely quality of services and support improvements as needed
	   ▪ Collaborations with private sector to address bottlenecks for treatment scale-up and decanting of stable patients
	
	Diagnostics
	For adults:
	   ▪ Monitor and map high yield areas to find undiagnosed PLHIV and optimize the testing strategies
	   ▪ Optimizing HTS delivery models to successfully link pregnant /breastfeeding women , neonates children , adolescent and adults living with HIV using community navigators
	   ▪ 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
		- Systems developed to meet Statutory and regulatory requirements to practice
		Supply Chain:
		- Training pharmacy assistants
		- Procurement of female condoms
		Health Financing:
		- Costing Studies
		Ensuring HIV/AIDS services are sustained under NHI
		Evaluations:
		- Other program evaluations that may be evaluated for refined prioritization	

	- Routine TB screening/diagnostic for TB suspects For pediatrics: - Same as for adults - EID - Support the national roll out of disclosure guidelines in children For adolescents: - Same as for adults - Adolescent-friendly testing services - Support the national campaign for adolescent and young girls outside the DREAMS districts For pregnant women: - Same as for adults - QA for HIV rapid testing For FSW/MSM, PWID: - Same as for adults - Testing services for FSW/MSM, PWID For prisoners, miners, communities/informal settings/farm workers - Same as for adults - Testing services for those communities Linkage to Care For adults, adolescents, FSW, MSM, PWID, miners/communities, informal settings, and farm workers: - Improve bidirectional community-facility interface referral tools - Support the development of care teams linking facility and community based ART - 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-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:
- Test and Treat/Start irrespective of CD4 count
  - Initiated in the DREAMS districts
  - Lessons learned from initial launch applied to further roll-out
  - Support roll-out of Test and Treat to all 27 priority districts
- Improve bidirectional community-facility interface referral tools
- Support the development of care teams linking facility and community-based ART
- Standardize trainings for all community workers in the priority

	districts		

districts
- Support community social mobilization for VL testing
- Training and Mentoring for all key components of HIV treatment and clinical care
- Implement quality improvement methodology to improve performance in all aspects of HIV treatment and clinical care
- Implementation of 'Consolidated ART Guidelines' 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 For FSW, MSM, PWID, Informal settlements and farm workers: - Same as for adults - Treatment services for those communities Retention in Care / Treatment Adherence For adults, adolescents, pregnant women, FSW, MSM, PWID, prisoners, miners/communities, informal settlement, farm workers: - Improve bidirectional community-facility interface referral tools - Support the development of care teams linking facility and community-based ART - Standardize trainings for all community workers in the priority districts - Support community social mobilization for VL testing - 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 - De-stigmatization 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

TB/HIV
    ▪ Update and fast track implementation of the revised TB/HIV integration manual
    ▪ TB symptom screening for PLHIV
    ▪ Isoniazid Preventive Therapy (IPT) for PLHIV
    ▪ TB Infection prevention and control
    ▪ HIV testing services (HTS) for TB patients and presumptive TB cases
    ▪ ART for all co-infected TB patients.
    ▪ TB second line treatment for PLHIV diagnosed with MDR-TB
    ▪ Focused TB/HIV training and mentoring

Supportive Systems
Ideal clinic:
    ▪ Implementation of HIV related aspects
Supply Chain:
    ▪ VMMC kit procurement and demand planning
    ▪ Emergency procurement of ARV's and other HIV commodities
Health Financing
    ▪ Domestic Resource Mobilization for Scale Up of Test and Treat
Clinic-lab interface
    ▪ Quality of specimens
    ▪ Feedback loop strengthened and timely return of results
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 - Integration of ETR.net in Tier.net - DHIS (e.g. transition to DHIS 2.0 (web-based)) - HIV Case Reporting: Support the establishment and mechanisms for tracking individuals in the diagnosis, care and treatment continuum, including mortality resulting from HIV/AIDS in priority districts with emphasis on data quality - Support strategic Information Capacity Building for Data Quality and Use - Developing capacity of national, provincial and district officials in application and use of GIS data and tools **Leadership/management:** - LMT for facility managers **HR Support** - Essential staff at national level **Evaluations:** - Outcome evaluations - Operations Research of new models of Service Delivery - 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. Improved quality of school-based interventions.	- 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	Strengthen local leaders' capacity to lead community support for local responses to reduce HIV and GBV

	• 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. • Prevention with positives (see C&T) • Community mobilization for and provision of Post-rape/assault care, including PEP, comprehensive care, linkages • Migrant/mobile populations – HTC, risk reduction, linkages to C&T, condoms, MMC, GBV. • Inmates – risk reduction counseling, HCT, peer education, condom, VMMC • Key Populations (e.g., FSW, MSM, PWID): Direct service delivery providing condoms and lubricants, risk reduction counseling, HTC, linkages to CTx, PEP, STI. Peer-led interventions. Sensitization training and mentoring of health care workers. Basic harm reduction package for PWID through a demonstration project.	services uptake, risk reduction • Use Integrated School Health Program to strengthen linkages with SRH services	
Sub-national level	• Development of KP cascade to quantify access to services (90 90 90) with a focus on using routine data sources	• Adolescent MMC study • TA to make FP, HTC, STI services acceptable to adolescents • Capacity building for providers to manage SGBV cases, including PrEP • Evaluate male partner testing in PMTCT platform • Combination Prevention Evaluation	
National level	• HSRC Household survey- South African National HIV Prevalence, Incidence and Behavior Survey • Development of KP cascade to quantify access to services (90 90 90) with a focus on using routine data sources	• National population based survey to assess communications programs • Improve interventions with pre-adolescents to reduce SGBV • Sensitize NDOH health workers to increase services to migrants	• 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

	• SRH services 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	•	research organizations: Combination prevention impact study, Youth Risk Behavior Survey, Educator HIV-Survey • Policy/ guidelines for FSWs • Development of policies and guidelines, PEPFAR staff support and provide TA.

HSS

Site level			
Sub-national level		• 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 • Develop and distribute accredited HIV/AIDS related short courses and workshops to HCWs for effective and efficient service delivery in high burden sites • Control Tower Model • eLMIS • Centralized Chronic Medicines Dispensing and Distribution support • NDoH Global Fund 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 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. • ICSM • Update and maintain PEPFAR transition database to track PEFPAR supported staff.	• 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 doctors 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. • Maintenance and utilization of a PEPFAR transition database • 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	• 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

	• Clinical Associate evaluation		
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 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 priority districts. • Positive Parenting for HIV risk reduction & prevention of sexual abuse. • Facilitating birth registration and succession planning. • Supporting Community level child	• 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. •

	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 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.	• Mapping services within targeted communities, review existing networking & 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 large-scale child rights awareness campaigns. • 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 Social Welfare Workforce	• 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 /	

	Strengthening at National Level, through roll out of training and mentoring of Child and Youth Care Workers.	social welfare efforts.	
LAB			
Site-Level	**Improvement of quality of laboratory diagnostic services** • Support the implementation of quality assurance for POCT (HIV rapid testing, CD4, VL) • Facilitate the enrollment of all PEPFAR-supported HTC sites into the NHLS Serology proficiency testing scheme • Support training of HCWs through provision of TOTs for Quality Assurance of HIV RT • Facilitate site support visits, site assessments and site and tester certification for QA implementation using the WHO approved Stepwise Process for Improving the Quality of HIV Rapid Testing (SPI-RT) checklist • Increase NHLS capacity to provide IQC and PT panels to all sites enrolled in the QA program • Strengthen pre- and post-market surveillance of HIV RT devices • Support delivery of quality laboratory diagnostic services through implementation of WHO-ASLM quality management systems **Laboratory System Strengthening** • Support assessment of current viral load and early infant diagnosis (EID) testing capacity and accessibility • Expand existing national viral load testing, to include pilot of decentralized service delivery models aimed at improving testing efficiencies • Intensify clinic-lab interface support to ensure documentation and capture of laboratory results in the relevant health information systems and improved data quality for program evaluation and monitoring		

	• Evaluate the impact of the introduction of EID POCT to inform policy • Advocate for and facilitate consistent or routine use of unique identifier • Facilitate linkage of the NHLS Corporate Data Warehouse (CDW) to Tier.net of NDoH		

Sub-National Level	**Implementation of laboratory testing cost saving measures**
	• Support the implementation of an Electronic Gate Keeping system (EGK)
	  - Electronic infrastructure
	  - Gatekeepers support at clinical facility
	Lab-based surveys and surveillance and OP research:
	• Support provision of HIV incidence testing capacity
	• Support capacity expansion for detection and monitoring of resistance in both HIV and TB
	• Lab testing for Key population studies supporting Prevention Programs		

National Level	**Improvement of quality of laboratory diagnostic services** • Strengthen pre- and post-market surveillance of HIV RT devices particularly for tender selection at NDoH **Implementation of laboratory testing cost saving measures** • Support the development of a Laboratory Information Management Unit - Enables collection, integration, analysis, and presentation of pertinent and relevant NHLS operational and laboratory business, and public-health related information, to inform business decision making and facilitate risk assessment, at	**Improvement of quality of laboratory diagnostic services** • Support the development of guidelines and policies, including POCT policy in alignment to WHO testing recommendations • Support the recruitment of a National Laboratory Coordinator to be based at NDoH to provide guidance to laboratory related policies and implementation strategies **Laboratory System Strengthening:** • Support strengthening of the national in-service training platform (Learning Academy) for laboratory workforce development.	

	the same time providing relevant programmatic health information, with a focus on efficiencies and planning for improved, cost effective lab operations for HIV and TB/HIV co-infected clients. **Laboratory-based surveys and surveillance and Operational Research** • Lab testing for National priority surveys and surveillance activities (TB and HIV)	

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP16			
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), self-testing, linkages to C&T, and targeted male HTC. HTC social mobilization for AGWY in informal settlements, other high risk sites. Support national campaigns in priority districts. 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, home-based HTC; training on HTC data reporting Provide TA for monitoring special campaigns.	
Care and Treatment			

New models of service delivery	Stable patients (ART patients with confirmed HIV VL undetectable after 12 months on ART then annually)
	• 6month ART prescriptions and 2 months dispensing
	• Patient friendlier meds dispensing
	   o Fast-track medication pick-up lane at facilities
	   o Community dispensing (CCMDD and Adherence Clubs)
	• Every 6 month clinician visits
	• HIV VL 6 and 12 month after ART initiation; annually thereafter
	• Community adherence support
	• Progressive switch for CD4 to HIV VL monitoring
	• Training of clinicians and CHW on the new models of service delivery
	• Monitor closely quality of services and support improvements as needed
	• Collaborations with private sector to address bottlenecks for treatment scale-up and decanting of stable patients		

Estimation of HIV/TB burden	For adults, pediatrics, adolescents, pregnant women, FSW, MSM, PWID, 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	▪	
Diagnostics	For adults: ▪ Monitor and map high yield areas to find undiagnosed PLHIV and optimize the testing strategies ▪ Optimizing HTS delivery models to successfully link pregnant /breastfeeding women , neonates children , adolescent and adults living with HIV using community navigators ▪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 ▪Support the national roll out of disclosure guidelines in children Action' For adolescents: ▪Same as for adults ▪Adolescent-friendly testing services ▪ Support the national campaign for adolescent and young girls outside the DREAMS districts For pregnant women: ▪Same as for adults ▪Implementation of PMTCT guidelines ▪ QA for HIV rapid testing		

	For FSW/MSM, PWID:
	▪Same as for adults
	▪Testing services for FSW/MSM, PWID
	For prisoners, miners,
	  communities/informal settings/farm
	  workers
	▪Same as for adults
	▪Testing services for those communities		

Linkage to Care	For adults, adolescents, FSW, MSM, PWID, miners/communities, informal settings, and farm workers:
	  ▪ Improve bidirectional community facility interface referral tools
	  ▪ Support the development of care teams linking facility and community based ART
	  ▪ 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-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 male inmates: ▪ Same as for adults ▪ Linkage to care post-release from prison		

Treatment Initiation / Treatment Maintenance/Viral Load Suppression	For adults, male inmates, miners/communities:
	▪ Test and Treat irrespective of CD4 count
	  o Initiated in the DREAMS districts
	  o Lessons learned from initial launch applied to further roll-out
	  o Support roll-out of Test and Treat to all 27 priority districts
	▪ Improve bidirectional community facility interface referral tools
	▪ Support the development of care teams linking facility and community based ART
	▪ Standardize trainings for all community workers in the priority districts
	▪ Support community social mobilization for VL testing
	▪Training and Mentoring for all key components of HIV treatment and clinical care
	▪Implement quality improvement methodology to improve performance
		▪	▪

	in all aspects of HIV treatment and clinical care ▪Implementation of 'Consolidated ART Guidelines' ▪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 For FSW, MSM, PWID, Informal settlements and farm workers: ▪ Same as for adults ▪ Treatment services for those communities		
Retention in Care/	For adults, adolescents, pregnant women,	▪	

| Treatment Adherence (see also above New Models of Service Delivery) | rape, survivors, FSW, MSM, PWID, prisoners, miners/communities, informal settlement, farm workers:
▪ Improve bidirectional community facility interface referral tools
▪ Support the development of care teams linking facility and community based ART
▪ Standardize trainings for all community workers in the priority districts
▪ Support community social mobilization for VL testing
▪ 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
▪ De-stigmatization 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 | | |
| TB/HIV | ▪ Update and fast track implementation of the revised TB/HIV integration manual
▪ TB symptom screening for PLHIV
▪ Isoniazid Preventive Therapy (IPT) for PLHIV
▪ TB Infection prevention and control | | |

	▪ HIV testing services (HTS) for TB patients and presumptive TB cases ▪ ART for all co-infected TB patients. ▪ TB second line treatment for PLHIV diagnosed with MDR-TB ▪ Focused TB/HIV training and mentoring		
Supportive Systems	Ideal clinic/OHSC: ▪ Implementation of HIV related aspects Supply Chain: ▪ Facility stock management ▪ District supply management ▪ RxSolution/Stock Visibility Solution ▪ Visibility and Analytics Network (formerly Control Tower) ▪ Provincial Medical Procurement Units ▪ Centralized Chronic Dispensing and Distribution ▪ VMMC Kit Procurement and Demand Planning ▪ Emergency Procurement of ARV's and HIV Commodities Clinic-lab interface ▪ Quality of specimens ▪ Feedback loop strengthened and timely return of results 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	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) ▪ Pre-service education for essential HIV/AIDS care providers in priority districts ▪ Workforce planning e.g., WISN, labor market analysis, retention analysis, transition of PEFPAR support staff, ▪ Strengthen the utilization of mid-level health care workers ▪ Human Resource Information System, including in-service delivery platform ▪ Support to the Regional Training Centers (RTCs) Policy: ▪ Support the South African Government's analysis and refinement of relevant HRH and education policies ▪ Systems developed to meet Statutory and regulatory requirements to practice Supply Chain: ▪ Training pharmacy assistants ▪ Procurement of female condoms	▪

	- ETR/EDR scale up - Support data quality improvement and data use - DHIS (e.g. transition to DHIS 2.0-web-based) Leadership/management: - LMT for facility managers - District Implementation Plans (DIPs) HR Support - Roving clinician teams to support facility based patient management - Roving counselor teams to support facility-based PITC - Roving data-capturer teams to support facility-based data management - Essential staff at facility level - Clinical staff - Data capturers - Essential staff for community-based program - Capacity building of ward-based outreach teams and community cadres - In-Service Training on HIV related service delivery Health Financing - Domestic Resource Mobilization for Scale Up of Test and Treat Evaluations: - Evaluation of benefit, outcome, and/or impact of PEPFAR-supported programs and interventions - Operations Research of new models of Service Delivery - Clinical Associate evaluation	Health Financing: - Costing Studies - Financial capacity building through support of the DIPs and HIV/AIDS Conditional Grant proposals and budget execution - Ensuring HIV/AIDS services are sustained under NHI Evaluations: - Other program evaluations that may be evaluated for refined prioritization Institutional capacity development: - Assess and build capacity of Faith-Based/CBOs organizations that provide HIV services	
Prevention			
VMMC	VMMC services delivery (e.g., CQI, EQA, DQA), training for service providers, demand creation through mass media and social mobilization.	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 school-aged adolescent girls and boys; link with MMC, HTC. Improved quality of school-based interventions.	National campaigns National population based survey to assess communications programs Improve interventions with pre-adolescents to reduce SGBV Targeted communication interventions (mass communication, social mobilization) for AGYW 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. Combination Prevention Evaluation	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 Evaluation of ISHP
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 (ISHP) to strengthen linkages with SRH services	Evaluation of ISHP
PHDP	Prevention with positives (see C&T)		
GBV	Post-rape/assault care, including PEP provision and adherence, HCT, comprehensive care. Community mobilization to increase	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	Strengthen local leaders' capacity to lead community support for local responses to reduce HIV and GBV

	awareness of available post-rape/assault services.	and HIV GBV and HIV incidence study	
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 basic package of prevention: condoms and lubricants, risk reduction counseling, HTC, linkages to care and treatment, PEP, STI screening and treatment. Peer-led interventions. Targeted sensitization training (including clinical competency) and mentoring of health care workers. Development of a standardized KP cascade to measure impact of program. Harm reduction programs for PWID through a demonstration project. Alcohol and substance abuse education. Gender norms and GBV for FSWs (other organizations provide GBV)		Development of policies and guidelines, PEPFAR staff support and provide TA.
Male inmates	Inmates: HTS, VMMC, risk reduction interventions, condoms and lube distribution and demonstrations. Peer education and mobilization for services uptake, risk reduction.		
OVC			
Case Management	▪ Early identification of children and adolescents made vulnerable by or to HIV and AIDS through structured home visits. ▪ Assessing child & family socio-economic status (across all areas: healthy, safe, stable, schooled). ▪ Developing care / case management plans for vulnerable households (children & caregivers) with monitoring of	▪ 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-supported catchment areas.	

	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.		
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 among children and their caregivers through individual, group-based and relationship-based activities. ▪ Coordination with NACS (e.g., referral of suspected malnutrition, nutrition education)	▪ 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 Department of Social Development basket of services	▪ Providing household supplies such as blankets and mattresses. ▪ Providing food packages / nutritional support.
Safe (Protection)	▪ Supporting Community and national level child protection/GBV prevention and response activities. ▪ Supporting clinic-based child abuse and GBV response services (access) given the rates of sexual	▪ 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.	▪ Carrying out large-scale child rights awareness campaigns. Supporting advocacy and policy efforts to improve safety of children from violence.

	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.	▪ 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. ▪ Create safe space for young woman and girls to meet on a regular basis (Peer Support Group) ▪	
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.) ▪ Positive Parenting skills building (including topics on adolescent risk, HIV disclosure, child health & development knowledge). ▪ Succession planning & family functioning.	▪ 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) • Linking businesses/agricultural projects to markets/value chain development	▪ Directly supporting IGAs with funds and other inputs. ▪ Support for food gardens.

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
		▪ 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
		  o disparities in completion rates (primary and secondary levels)
		  o identify key at risk groups for education support
		▪ Facilitating access to primary and
			▪ Supporting community education councils and PTAs.
			▪ Providing temporary school
			▪ block grants to promote
			▪ enrollment and progression

	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.	secondary education through temporary and targeted support to purchase school uniform, school shoes, stationery, books ▪ Payment of school fees to enable consistent school attendance , SGB fees, ▪ Facilitate home work group to enhance school performance which will enable progression ▪ School support – enrollment, attendance & progression. ▪ Link youth for bursary opportunities as well as application for Tertiary education ▪ Create and facilitate Safe Spaces for girls to meet on a regular basis (Peer Support Group)	
SI			
Formative Work, Demonstrations, Projects	▪ Conduct mapping, population size estimation, and IBBS for KP (e.g. MSM, FSW, etc.) in select geographic areas		
Surveys and Surveillance	▪ HSRC Household Survey (HIV Impact Assessment); completion of survey and on-going analysis and interpretation of findings ▪ HIV Case Reporting: Support the establishment and mechanisms for tracking individuals in the diagnosis, care and treatment continuum, including mortality resulting from HIV/AIDS in priority districts with emphasis on data quality. ▪ Technical assistance in the area of TB/HIV strategic information including improved monitoring of integrated TB/HIV programs and HIV surveillance among TB patients.	▪ ANC/PMTCT comparison assessing the feasibility of using routine PMTCT data for antenatal HIV surveillance in the South African context as a recommendation from the WHO ▪ Cause-specific validation study: Strengthening existing data collection of HIV cause-specific mortality (vital registration system), provides estimates for HIV / TB cause-specific mortality (primary and underlying cause) and data source for monitoring NSP targets on HIV//TB related mortality	

	▪ KZN HIV Incidence project (HIPSS project) ▪ Survey of key populations to quantify access to services (90 90 90) with a focus on using routine data sources ▪ Drug Resistance surveillance		
Health Management Information Systems	▪ Provide support to the NDoH for HMIS development, deployment and management for web-based DHIS, tier.net ▪ Support district HMIS policies and implementation. ▪ 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 ▪ Support NDoH to enhance the mobile platform and its integration into the national health architecture (MomConnect part of activity)	▪ Scale-up of mHealth activities related to the NDOH ▪ MomConnect maternal messaging project ●
Program Planning & Monitoring	▪ Small area estimations and mapping that utilize existing data sources (e.g. program data, ANC sentinel surveillance) to identify sub-national burden ▪ 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	▪ Provincial M&E Staff hired and placed at provincial AIDS councils to provide M&E technical support to provinces: Multi-sectoral monitoring and reporting of provincial HIV/AIDS planning and response.	
Program Evaluations & Operations Research	▪ TIER.net enhancement, expansion (e.g. Phase 6) and evaluation ▪ Operationalize and evaluate the implementation of the HTC and pre-ART modules in tier.net ▪ Support NDOH with cost and budget modelling for HIV and TB programs	▪ Strengthening data collection of cause-specific mortality (vital registration system) ▪ ANC/PMTCT comparison/assessment	▪
Laboratory			

Support improvement of quality of Lab diagnostic services	• Support training of HCWs through provision of TOTs for Quality Assurance of HIV RT • Support enrollment of all priority district HTC sites into proficiency testing schemes for POCT • Strengthen pre- and post-market surveillance of HIV RT tests • Support the assessment and certification of facilities and testers using the WHO approved Stepwise Process for Improving the Quality of HIV Rapid Testing (SPI-RT) checklist	• Support the development of guidelines and policies, including POCT policy in alignment to WHO testing recommendations • Support the recruitment of a National Laboratory Coordinator to be based at NDoH to provide guidance to laboratory related policies and implementation strategies • Support delivery of quality laboratory diagnostic services through implementation of WHO-African Society for Laboratory Medicine (ASLM) quality management systems	
Laboratory-based surveys and surveillance and Operational Research	• Support provision of HIV incidence testing capacity • Support capacity expansion for detection and monitoring resistance in HIV and TB • Lab testing for Key population studies supporting Prevention Programs • Lab testing for National priority surveys and surveillance activities (TB and HIV)		

Support implementation of Lab testing cost saving measures (EGK)	• Support the implementation of an (EGK) system
	  - Electronic infrastructure
	  - Gatekeepers support at clinical facility
	• Support the development of a Laboratory Information Management Unit
	▪ Enables collection, integration, analysis, and presentation of pertinent and relevant NHLS operational and laboratory business, and public-health related information, to inform business decision making and facilitate risk assessment, at the same time providing relevant programmatic health information, with a focus on efficiencies and planning for improved, cost effective lab operations for HIV and TB/HIV co-infected clients		

Viral Load (VL) Testing	▪ Support assessment of current VL and EID testing capacity and accessibility	▪ Facilitate linkage of the NHLS Corporate Data Warehouse (CDW) to Tier.net of NDoH	

	- Support expansion of existing VL testing capacity - Support the piloting of a decentralized service delivery model to improve testing efficiencies and accessibility to VL testing - Support expansion of HIV VL resistance testing capacity - Support training of Health Care Workers on specimen handling (e.g. collection, storage, package); results management (test result tracking and filing); and test ordering. - Advocate for and facilitate consistent or routine use of unique identifier	- Strengthen linkages and communication between facility and laboratory to ensure timely return of laboratory results - Support strengthening of the in- service training platform for laboratory workforce development.	

Table A.3 Transition Plans for Non-core Activities						
Transitioning Activities	Type of Transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
Scale-up of mHealth activities related to the NDOH MomConnect maternal	Transition to Government	$0	$0		2016	• The NDoH will absorb the MomConnect activity in its FY17 budget. PEPFAR Central Initiative funds were awarded in FY14 and are supporting the activity.
Support for TA and procurement for Demographic Health Survey (DHS)	Transition to Government	$0	$0		2015	• The South African Government will fund future DHS activities. PEPFAR is providing TA support for this activity.
Develop, manage and maintain system for PEPFAR Info Management System (PIMS)	Phasing Out	$0	$0		2014	• PIMS is being replaced by a Global DATIM system implemented by OGAC. A Local Instance of DATIM will be developed and implemented to PEPFAR SA reporting.
Strengthen facility drug adverse events and pharmacovigilance	Phasing out	350,000.00	$0		Sept 2016	End of CoAg with the University of Cape Town and sustainability discussions are ongoing with the Global Fund, NDoH and Medicines Control Council.
Maternal and Infant Mortality Surveillance (MIMS)	Phasing Out	150,000.00	$0		March 2016	Considered as Non-Core by the WorkStream Meeting with NDoH. NDoH to explore the expansion of the national confidential enquiries on maternal deaths.
Support provincial M&E staffing at provincial AIDS council (PAC)	Phasing Out		$0			
TOTAL		**$500,000**	**$0**			

APPENDIX B

[REDACTED]

[REDACTED]		
[REDACTED]	*[REDACTED]*	*[REDACTED]*
[REDACTED]	*[REDACTED]*	*[REDACTED]*

Table B.1.1 Resource Allocation by PEPFAR Budget Code		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	$17,366,364
HVAB	Abstinence/Be Faithful Prevention	$4,871,617
HVOP	Other Sexual Prevention	$16,820,275
IDUP	Injecting and Non-Injecting Drug Use	$70,000
HMBL	Blood Safety	$0
HMIN	Injection Safety	$0
CIRC	Male Circumcision	$36,209,874
HVCT	Counseling and Testing	$26,185,990
HBHC	Adult Care and Support	$44,378,952
PDCS	Pediatric Care and Support	$9,469,171
HKID	Orphans and Vulnerable Children	$31,812,930
HTXS	Adult Treatment	$119,072,247
HTXD	ARV Drugs	$0
PDTX	Pediatric Treatment	$10,342,617
HVTB	TB/HIV Care	$30,378,639
HLAB	Lab	$4,025,552
HVSI	Strategic Information	$8,799,546
OHSS	Health Systems Strengthening	$17,840,070
HVMS	Management and Operations	$32,356,156
TOTAL		**410,000,000**

B.2 Resource Projections

The PEPFAR SA team engaged in a rigorous analysis of evidence and published documents to calculate the resources required to implement the proposed program activities in the coming year. All inter-agency TWGs convened multiple times to a) review the FY2015 expenditure analysis (EA) data and b) calculate unit expenditures with technical support from the in-country EA leads and our SGAC EA Advisor (who provided support both in-country and remotely). *[REDACTED]*

APPENDIX C

Systems Investments for Section 6.0

Included Activities	Excluded Activities
Human Resources for Health (HRH): Systems/Institutional Investments	
Pre-service training; in-service training systems support and institutionalization; HRH performance support/quality; HRH policy planning and management; HR assessments and information systems; other HRH activities not classified as above	N/A
Human Resources for Health (HRH): Personnel Costs for Service Delivery	
In-service training; all HRH support at sites and community across all program areas	Other site-level investments such as purchase of vehicles, equipment and furniture, construction and renovation, and site-level recurrent categories such as ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, building rental and utilities
Governance	
Technical area-specific guidelines, tools, and policy; general policy and other governance; other governance activities not classified as above	N/A
Finance	
Expenditure tracking; efficiency analysis and measurement; health financing; costing/cost modeling; other health financing activities not classified as above	N/A
Systems Development	
Supply chain systems; health information systems (HIS); laboratory strengthening; other systems development activities not classified above	ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, freight for transport of commodities to sites and other supply chain costs incurred at the site-level
Institutional and Organizational Development	
Civil society and non-governmental organizations (NGOs); government institutions; social welfare systems strengthening; other institutional and organizational activities not classified above	N/A
Strategic Information	
Monitoring and evaluation; surveys; operations research; geographic mapping, spatial data, and geospatial tools; surveillance; other strategic information activities not classified above	N/A
Laboratory	
Quality management and biosafety systems; implementation and evaluation of diagnostics (POC and VL monitoring); laboratory information and data management systems; laboratory workforce; quality management system; sample referral systems; accreditations; technical assistance to assure or improve quality of laboratory services	Vehicles, equipment and furniture, construction and renovation for site labs, and recurrent categories from site labs such as lab reagents an supplies, travel and transport, building rental and utilities will not be included

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