South Africa

Country Operational Plan 2017 (COP17)

Strategic Direction Summary (SDS)

Final Approved COP17 draft 18 May 2017

Contents

1. Goal Statement

In support of the new 2017-2022 South Africa National Strategic Plan for HIV, Tuberculosis (TB), and Sexually Transmitted Infections (STIs)[1] (NSP), the United States (U.S.) through the President's Emergency Plan for AIDS Relief (PEPFAR) Country Operational Plan 2017 (COP17) will implement a strategic portfolio of programs aimed at epidemic control. During COP17, PEPFAR[2] will prioritize South Africa's (SA's) 27 highest HIV burden districts—accounting for 82% of SA's estimated people living with HIV (PLHIV). PEPFAR support to the national HIV program is coordinated under the SA and U.S. governments' Partnership Framework Implementation Plan (PFIP). In partnership with the government of South Africa (GoSA) and development partners, PEPFAR will disrupt HIV transmission by prioritizing HIV prevention, orphans and vulnerable children (OVC), services for adolescent girls and young women (AGYW), scaling-up saturation of voluntary medical male circumcision (VMMC) for men (15-39 years), and reaching the Joint United Nations Program on HIV/AIDS (UNAIDS) 90-90-90 targets and beyond, especially in priority sex/age bands (women 15-25; men 20-30). In COP17, PEPFAR will work to achieve full attainment[3] in six of the 27 focus districts and saturation[4] of 90-90-90 in the remaining 21 districts by September 2018[5]. Through its TB/HIV interventions, PEPFAR will also support SA's national TB program.

PEPFAR supports the national rollout of Universal Test and Treat (UTT) and same-day initiation,[6] and new and efficient service delivery models aligned with the National Department of Health (NDoH) HIV Testing Services (HTS) and Adherence Policy and Guidelines. In order to achieve COP17's ambitious targets, PEPFAR will scale-up direct service delivery support to sites and accelerate health systems strengthening initiatives, including those focused-on health financing, Human Resources for Health (HRH), information systems, laboratory services, quality of service delivery, and supply chain. The GoSA and PEPFAR will continue to innovatively use and share data to adaptively manage the HIV response, in collaboration with civil society, faith-based organizations (FBO) and implementing partners.

In COP17 PEPFAR SA inputs will focus on:

[1] The NSP was developed through a robust consultative and data-driven approach.
[2] PEPFAR is implemented in South Africa by several U.S. government agencies: Department of State, Agency for International Development (USAID); HHS/Centers for Disease Control (CDC); HHS/Health and Human Services Administration (HRSA); Peace Corps; and Department of Defence.
[3] Attainment is defined as sub national units (districts) that have achieved >/= 81% Antiretroviral Treatment (ART) coverage among both males, and females in the following age bands: (1) <15 years, (2) 15-24 years, and (3) ≥25 years.
[4] Saturation is defined as sub-national units (districts) that have achieved the >/= 81% ART coverage for the PLHIV population overall.
[5] COP17 implementation will begin October 2017 and end in September 2018.
[6] UTT and same-day initiation policy launched in September 2016.

- Dramatically improving linkage to treatment and retention in care to above 90%;
- Reaching more than 2 million people with new and efficient service delivery models (e.g., Adherence Clubs, Centralized Chronic Medicine Dispensing and Distribution);
- Layering and integrating combination prevention interventions to protect AGYW and marginalized populations in the highest-burden districts, including greater integration of interventions implemented under DREAMS;[7] and
- Accelerating testing, VMMC, and HIV treatment for men.

2. Epidemic, Response, and Program Context

2.1 Summary Statistics, Disease Burden, and Country Profile

SA is an upper-middle income country with significant influence in the sub-Saharan African region. SA's economy is one of the largest in sub-Saharan Africa, and its pluralistic makeup which encompasses a wide variety of cultures, languages, races, and religions, largely shaping its health profile. The population is estimated at 55.91 million, with approximately 51% (28.53 million) being female. Life expectancy at birth is estimated to be 62.4 years (65.1 years for females; 59.7 years for males) while the infant mortality rate is 33.7 per 1,000 live births. [8]

In 2016, the HIV disease burden is estimated to have increased, with an estimated 7,104,706 PLHIV.[9] The majority (55-60%) of HIV-infected adults are women. Black women aged 25-34 years have the highest prevalence at 31.6%, and highest incidence, at 4.54 percent.[10]

South Africa's HIV epidemic is largely driven by heterosexual transmission, with underlying behavioral, socio-cultural, economic, and structural factors influencing HIV transmission risk. These factors include population mobility and migration; economic and educational status; alcohol and drug use; early sexual debut; sexual and gender-based violence (GBV); low prevalence of male circumcision; lack of knowledge of HIV status; intergenerational sex; multiple and concurrent sexual partners; discrimination and stigmatization; inconsistent condom use, especially in longer-term relationships and during pregnancy/post-partum; and gender dynamics, including unequal power relations between men and women.

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[7] DREAMS is the Determined, Resilient, Empowered, AIDS-free, Mentored and Safe Initiative for HIV Prevention among AGYW launched by GoSA and PEPFAR in 2015, with full implementation begun in April 2016.

[8] Statistics South Africa [StatsSA], Mid-year population estimates, 2016. Statistical Release P0302, Statistics, South Africa: Pretoria.

[9] Comprising: 351,025 children less than 15 years; 5,758,182 adults between 15-49 years; and, 995,589 adults 50 years and older. Source: Johnson LF, et al. (2016) Prospects for HIV control in South Africa: a model-based analysis. Global Health, Action. 9: 30314.

[10] Shisana, O, Rehle, T, Simbayi LC, Zuma, K, Jooste, S, Zungu N, Labadarios, D, Onoya, D et al. (2014) South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press.

The GoSA-led current progress towards epidemic control includes a targeted HTS program, which has resulted in 3.8 million people on antiretroviral treatment (ART), including 171,536 children (<15 years) and 3,636,076 adults (1,206,080 males and 2,429,996 females, ≥15 years).[11] South Africa accounts for the largest national treatment program in the world, although with the recently adopted universal ART eligibility, overall treatment coverage is only 53.6% (48.9% for children; 47.5% for adult males; and 57.7% for adult females).[12] With respect to VMMC, it is estimated that 47.5% of males aged ≥15 years will be circumcised in 2016.[13] In 2016, progress was made with the adoption of UTT, same-day initiation, differentiated service delivery, including the establishment of centralized chronic medicines dispensing and distribution (CCMDD) models as vehicles towards universal access to ART and multi-month Antiretroviral (ARV) supply, and pre-exposure prophylaxis (PrEP) targeted at key population groups. Additionally, in June 2016, the GoSA launched She Conquers, a national campaign and strategy for AGYW focusing on five crucial objectives: (1) reducing HIV incidence; (2) decreasing teenage pregnancy; (3) decreasing GBV; (4) keeping girls in school; and (5) increasing economic empowerment opportunities for girls and young women.

Major programmatic and system gaps or barriers to achieving epidemic control remain. The number of new HIV infections remains high, with an estimated 266,618 new HIV infections in 2016, with these new infections disproportionately higher among AGYW.[14] The nexus with the TB epidemic continues to drive high morbidity and mortality, with the legacy of apartheid and significant income inequality posing additional challenges to the TB and HIV response.

Gross National Income (GNI) per capita is estimated at USD $6,800[15]. Total health expenditure is estimated to be about 8.93% of the gross domestic product (GDP) with health spending expected to reach R178 billion (approximately USD$ 13.7 billion) in 2017/18[16]. There is clear commitment by the GoSA to continuously increase budgetary support towards the HIV response. In the 2017 budget, an additional R885 million (approximately USD $68 million) was added to support the implementation of UTT.[17]

HIV prevalence and incidence vary significantly across geographic areas (54% of PLHIV are concentrated in the Gauteng and KwaZulu-Natal provinces). Tables 2.1.1 and 2.1.2 below summarize the key HIV epidemiological data and provide a national view of the 90-90-90 cascade.

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[11] Johnson LF, et al. (2016) Prospects for HIV control in South Africa: a model-based analysis. Global Health Action. 9: 30314. The estimation of 3.8 million on ART includes estimations of private health providers ART clients.
[12] In the work cited (Op. cit.) 10
[13] Op. cit. 7
[14] Op. cit. 10
[15] World Bank: World Development Indicators. Online: http://data.worldbank.org/indicator/
[16] Op. cit. 12
[17] National Treasury, 2017 Budget Speech. Online: http://www.treasury.gov.za

Table 2.1.1 Host Country Government Results															
	Total		**<15 years**				**15-24 years**				**≥25 years**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	55,908,900	100%	8,315,788	14.9%	8,491,453	15.2%	5,076,221	9.1%	5,112,942	9.1%	15,137,128	27.1%	13,775,333	24.6%	*Statistics South Africa, Mid-year population estimates, 2016*
HIV Prevalence (%)		12.8%		2.2%		2.2%		11.1%		3.3%		23.3%		16.8%	*Johnson LF, et al. (2016). Prospects for HIV control in South Africa: a model-based analysis. Global Health Action. 9: 30314.*
AIDS Deaths (per year)	146,307		N/A	AIDS deaths in male & female children <15= 14,082	N/A		N/A	AIDS deaths in female adults ≥15= 60,557	N/A	AIDS deaths in male adults	N/A		N/A		*Johnson LF, et al. (2016). Prospects for HIV control in South Africa: a model-*

										≥15= 71,668					*based analysis. Global Health Action. 9: 30314.*
# PLHIV	7,104,796		N/A	#PLHIV Children (<15) = 351,025	N/A	#PLHIV Adults (15-49) = 5,758,182	N/A	#PLHIV Adults (≥50) = 995,589	N/A		N/A		N/A		*Johnson LF, et al. (2016). Prospects for HIV control in South Africa: a model-based analysis. Global Health Action. 9: 30314.*
Incidence Rate (Yr.)		1.07 %		0.49%		N/A		2.54%		0.55 %		1.62 %		1.29 %	*Shisana et al. (2014), South African National HIV Prevalence, Incidence and Behaviour Survey, 2012*

New Infections (Yr.)	266,618														*Johnson LF, et al. (2016). Prospects for HIV control in South Africa: a model-based analysis. Global Health Action. 9: 30314.*
Annual Births	1,198,861	100 %													*Statistics South Africa, Mid-year population estimates, 2016*
% of Pregnant Women with at least one ANC visit	N/A	97%	N/A	N/A			N/A	N/A			N/A	N/A			*United Nations International Children's Emergency Fund (UNICEF), 2008*
Pregnant Women needing ARVs	N/A	N/A													

Orphans (maternal, paternal, double)	1,560,000 Maternal; 2,530,000 Paternal; 820,000 Double		N/A		N/A		N/A		N/A		N/A		N/A		*UNAIDS South Africa Spectrum, 2016*
Notified TB Cases (Yr.)	294,603		N/A		N/A		N/A		N/A		N/A		N/A		*World Health Organization (WHO) (2016). Global Tuberculosis Report, 2015*
% of TB cases that are HIV infected	157,505	57%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	*WHO (2016). Global Tuberculosis Report, 2015*
% of Males Circumcised		46.4 %			N/A	N/A			N/A	N/A			N/A	N/A	*Shisana, et al. (2014), South African National HIV Prevalence, Incidence and Behaviour Survey, 2012*

Estimated Population Size of Men who have sex with men (MSM)*	654,979 (621,205 - 688,753)	N/A													*South African National AIDS Council (SANAC), 2015*
MSM HIV Prevalence	N/A	28% (range of 22% - 48%)													*University of California, San Francisco (UCSF), 2015*
Estimated Population Size of Female Sex workers (FSW)	195,299 (185, 357 - 205,240)	N/A													*SANAC, 2015*
FSW HIV Prevalence	85,560	56%					N/A	N/A			N/A	N/A			*SANAC, 2015*
Estimated Population Size of People who inject drugs (PWID)	75,701	100 %													*SANAC, 2015*

PWID HIV Prevalence	10,598*	14.0 %														*Scheibe, et al, 2014 *Number calculated using prevalence rate of Scheibe et al applied to SANAC estimated population size of PWID*
Estimated Size of Priority Populations: Military	73,104	100 %														*South African National Defense Force (SANDF), 2015*
Estimated Size of Priority Populations: Black African Females 15-34 years	7,530,319	100 %														*Statistics South Africa, Mid-year population estimates, 2016*
Estimated Size of Priority Populations: Black African	8,038,652	100 %														*Statistics South Africa, Mid-year population estimates, 2016*

Males 25-49 years															

References-

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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

Shisana, O, Rehle, T, Simbayi, LC, Zuma, K, Jooste, S, Zungu, N, Labadarios, D, Onoya, D et al. (2014). South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press

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UNICEF Antenatal Care Coverage Data

World Bank: World Development Indicators. Online: http://data.worldbank.org/indicator/

World Health Organisation [WHO] (2016). Global Tuberculosis Report, 2015

Table 2.1.2 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[18] (#)	Retained on ART 12 Months (%)	Viral Suppression 12 Months (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	55,908,900[19]	12.2%[20]	7,104,796	3,437,467	74%[21]	79%	10,498,232[22]	924,735[7]	852,401
Population less than 15 years	16,807,241	2.2%	351,025	169,878	N/A	N/A	N/A	N/A	29,461
Pregnant Women	1,171,479[23]	29.7%	347,929	N/A	N/A	N/A	1,028,311	202,458[24]	197,932[7]
MSM	1.2 million – 1.4 million[25]	28% (range of 22%-48%)	336,000	33%	33%	N/A	26,175	N/A	N/A
FSW	153,000[26]	56.0% (range of 40%-89%)	85,560	23.6% (range of 19%-27.8%)[27]	23.6% range (19%-27.8%)	N/A	17,881	N/A	N/A
PWID	67,000[28]	14.0%		N/A	N/A	N/A	N/A	N/A	N/A
Inmates	159,331[29]	No data	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Priority Population (Military)	73,104	No data	N/A	N/A	N/A	N/A	N/A	N/A	N/A

[18] DHIS. Nov 2016 (public sector data)

[19] Stats SA, 2016.

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

[21] As reported in DATIM

[22] Figure is for clients aged 15-49 and excludes ANC

[23] UNICEF Antenatal Care Coverage Data

[24] As reported in DATIM

[25] USCF. MSM in South Africa: Data Triangulation Project. 2014

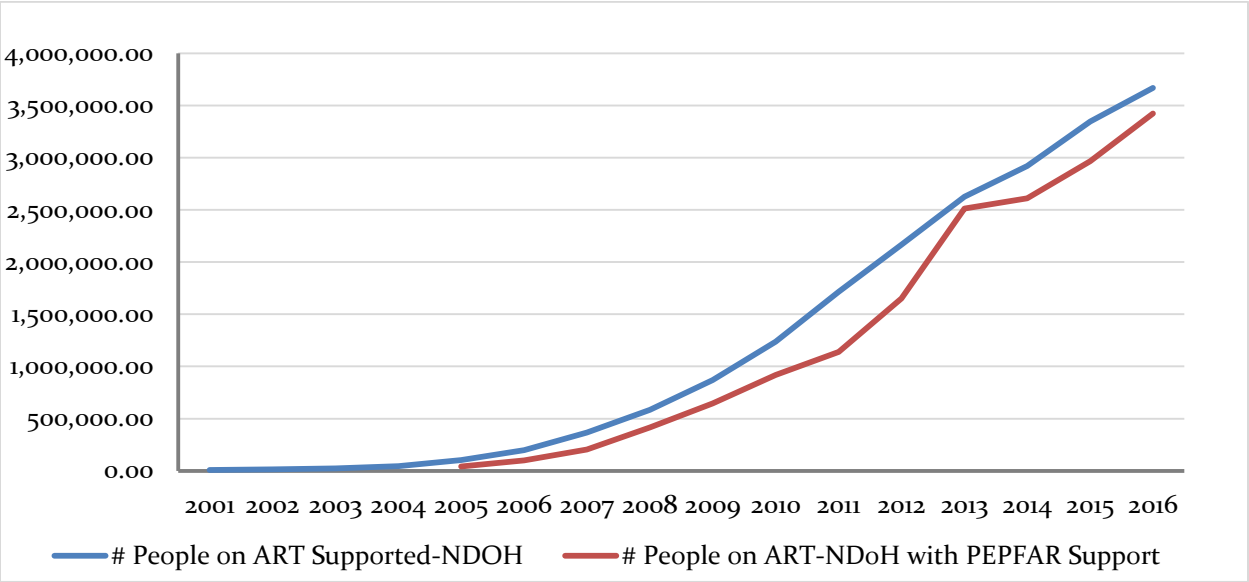
[26] The South African National Sex Workers HIV Plan 2016-2019. SANAC, 2016

[27] IBBS & Konstant 2013 and Stakeholder consensus (Feb 2017) for data for 12 districts (City of Johannesburg Metropolitan Municipality, eThekwini Metropolitan Municipality, City of Cape Town Metropolitan Municipality, City of Tshwane Metropolitan Municipality, Nelson Mandela Bay Municipality, Ehlanzeni District Municipality, Mangaung Metropolitan Municipality, Gert Sibande District Municipality, uMgungundlovu District Municipality, Capricorn District Municipality, Ngaka Modiri Molema District Municipality, Pixley ka Seme District Municipality)

[28] Petersen, Z et al. Availability of HIV prevention and treatment services for people who inject drugs: findings from 21 countries. Harm Reduction Journal 10(1), 2013.

[29] Department of Correctional Services (DCS). Annual Report, 2014. Note: The DCS can house 159,331 inmates at any given time, but due to overcrowding and rapid turnover of inmates, the annual inmate population is estimated at 322,000.

Figure 2.1.3. National and PEPFAR SA Trend for Individuals Currently on Treatment



2.2 Investment Profile

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

In 2016/17, the SA HIV response was funded primarily through the GoSA at R17.32 billion (USD $1.31 billion[30]). PEPFAR was the second largest source of funds, and contributed R5.88 billion (USD $399.75 million XRT[31] 14.71[32]). The Global Fund to Fight AIDS, TB and Malaria (The Global Fund) was the next-largest funding source, and will contribute USD $311.8 million over three years in its current funding cycle, 2016-19. The 2013 National AIDS Spending Assessment reported other external sources (bilaterals, multilaterals, and foundations) accounting for about 3% of HIV response funding. Private companies and insurance contributed around 8 percent.

Within the GoSA response, the NDoH is the largest spender on HIV services, primarily via the conditional grant (R20.5 billion in 2018/19), followed by Department of Social Development (DSD) (R1.8 billion for 2018/19). An additional R1.9 billion is being allocated in 2017/18 and 2018/19 to support implementation of the HIV and TB Investment Cases and the new NSP including the continued expansion of providing ART to PLHIV. PEPFAR's anticipated FY2018 HIV funding in SA is R6.28 billion[33].

Due to the high HIV burden in SA, and the already large number of patients on treatment, HIV costs are expected to increase over the next decade, primarily driven by ART costs. Modeling

[30] Based on department budgets; 13.2 Exchange Rate
[31] XRT = exchange rate
[32] PEPFAR FY 2016 Expenditure Analysis; 14.71 Exchange Rate
[33] COP 2017; 13 Exchange Rate (USD $483million); USD $51.5 million for VMMC is additive this amount.

undertaken as part of the SA HIV and TB Investment Case found that maximizing prevention efforts (specifically condom provision, VMMC and social and behavior change communication) were more cost-effective than treatment, and that an approach that combines treatment and prevention is necessary to achieve the 90-90-90 targets. This strategy requires a steadily increasing investment in HIV programs to reach 90-90-90. Given SA's constrained economy, the GoSA has leveled funding for many services, and future rising HIV and TB treatment costs are projected to consume an increasing share of the health budget.

Table 2.2.1 Investment Profile by Program Area					
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
Clinical care, treatment and support	$900,111,344	14.41%	4.10%	81.49%	N/A
Community-based care, treatment, and support	$122,378,625	18.96%	2.98%	78.06%	N/A
PMTCT	$44,320,990	43.27%	0.00%	56.73%	N/A
HTC	$128,789,795	51.00%	0.00%	49.00%	N/A
VMMC	$77,678,185	66.37%	0.00%	33.63%	N/A
General & Priority population prevention (including condoms)	$175,626,414	11.24%	19.07%	69.70%	N/A
Key population prevention	$27,690,185	24.57%	37.54%	37.89%	N/A
OVC*	$71,381,054	60.45%	0.00%	39.55%	N/A
Laboratory	$147,847,277	4.88%	0.34%	94.78%	N/A
SI, Surveys and Surveillance**	$33,139,947	69.72%	23.52%	6.76%	N/A
HSS**	$12,898,073	81.16%	18.84%	0.00%	N/A
Other: Program Management***	$64,161,143	0.00%	17.64%	82.36%	N/A
Other: Training/Capacity Building***	$12,504,135	0.00%	0.00%	100.00%	N/A
Total	**$1,818,527,167**	**21.98%**	**5.86%**	**72.16%**	**N/A**
There is no information on the Government of South Africa's Communications, M&E, Other Prevention, Policy and Systems Development spending					

and budget allocations because data were unavailable and/or not disaggregated in the Basic Accounting System (BAS); this does not mean that the GoSA is not spending anything on these activities.
*The GoSA does not track OVC investments in their basic accounting system. OVC investments in this table include DSD HIV/AIDS investments and DBE life skills education grant. This does not mean the GoSA is not investing in OVC programming in their other departments.
**SI and HSS in the PEPFAR expenditure are included across all program areas. The SI and HSS expenditures are not directly allocated to program areas. GoSA HSS funding amount and portion is not available from the (GoSA) Budget Accounting System.
***PEPFAR's program management costs and training costs are built into the program areas, whereas associated costs for the GoSA are separated out. Training and capacity building for the GoSA are from the HIV CG for Regional Training Centers.
The GoSA figures are based on their departmental budget allocations for FY2016/17 (XRT: 13.2). PEPFAR data are based on FY2016 expenditures. The Global Fund figures come from the final approved PR budgets.
The investment profile table is a broad profile of expenditures and budgets for HIV spending in SA, and is not meant to be comprehensive of all HIV expenditures in SA.

Table 2.2.2 Annual Procurement Profile for Key Commodities[34]					
Commodity Category	**Total Expenditure (USD$)**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
ARVs	$339,524,206	0%	3%	97%	N/A
Rapid test kits	$9,669,786	3%	0%	97%	N/A
Other drugs	$35,036,771	0%	0%	100%	N/A
Lab reagents	$7,008,116	11%	8%	81%	N/A
Condoms	$39,595,579	1%	0%	99%	N/A
Viral Load commodities	$280,655	0%	100%	0%	N/A
VMMC kits	$12,360,457	50%	0%	50%	N/A
Other commodities	$184,112,247	7%	0%	93%	N/A
Total	**$627,587,817**	**3%**	**2%**	**95%**	**0%**

[34] Table 2.2.2 notes: Rapid test kits XRT 13; budget estimate FY2017/18, VMMC kits, Condoms XRT 13.2; FY 2016/17, Other drugs & commodities are from FY2014/15.

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration					
Funding Source	**Total US Government(USG) Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
USAID MCH	N/A	N/A	N/A	N/A	N/A
USAID TB	$15,000,000	N/A	N/A	N/A	To provide Technical Assistance to the GoSA on TB. USAID received an additional (one-time) USD $3 million in FY16 to respond to the White House National Action Plan for Combating Multidrug Resistant TB
USAID Malaria	N/A	N/A	N/A	N/A	N/A
Family Planning	N/A	N/A	N/A	N/A	N/A
NIH	N/A	N/A	N/A	N/A	N/A
CDC (Global Health Security)	N/A	N/A	N/A	N/A	N/A
Peace Corps	$2,300,000	N/A	N/A	N/A	N/A
DoD Ebola	N/A	N/A	N/A	N/A	N/A
MCC	N/A	N/A	N/A	N/A	N/A
Total	**$17,300,000**	**N/A**	**N/A**	**N/A**	**N/A**

Table 2.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, Headquarter Operation Plan (HOP)						
Funding Source	**Total PEPFAR Non-COP Resources**	**Total Non-PEPFAR Resources**	**Total Non-COP Co-funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
DREAMS Innovation	$6,791,971	N/A	N/A	N/A	N/A	N/A
VMMC – Central Funds	$51,503,884	N/A	N/A	N/A	N/A	N/A
LCI	N/A	N/A	N/A	N/A	N/A	N/A
Other PEPFAR Central Initiatives	$1,753,327	N/A	N/A	N/A	N/A	Implementation Science; SI Country Model; PopART
Other Public Private Partnership (PPP)	$2,500,000	N/A	N/A	N/A	N/A	VMMC and UTT Demand Creation via Airtime Voucher Messaging; HCT in Private Sector Pharmacies; Improving Management and Leadership for the HIV response
Total	**$62,549,182**	**N/A**	**N/A**	**N/A**	**N/A**	

2.3 National Sustainability Profile Update

The GoSA, UNAIDS and the PEPFAR team worked together during COP16 planning to develop a draft 2016 Sustainability Index and Dashboard (SID). The SID was approved by the SA leadership, and has been shared and presented in various stakeholders' meetings through the PFIP and other fora including the Health (Development) Partners Forum and SA National AIDS Council (SANAC)'s Civil Society Forum.

The SA SID shows sustainable and approaching sustainability elements in each of its four domains.[35] In COP17, programs will continue that address issues identified in the SID, including service delivery; HRH; commodity security and supply chain; quality management; laboratory; epidemiological and health data; policies and governance; and civil society and private sector engagement.

[35] 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.

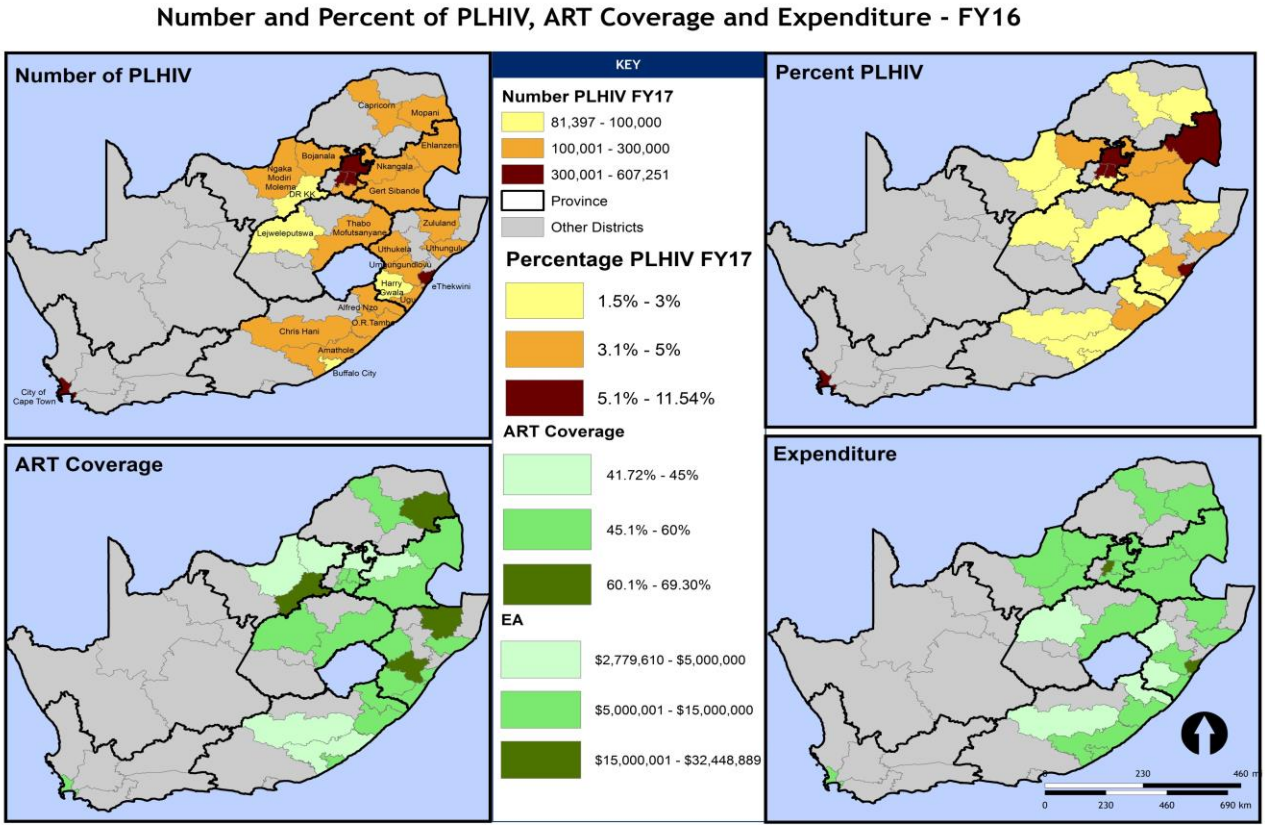
Through increased regular outreach and meetings with stakeholders PEPFAR SA is working with the GoSA departments and other funders to complement the ongoing, routine sharing of information regarding the various initiatives that support SA's health and HIV/AIDS programs.[36]

2.4 Alignment of PEPFAR Investments Geographically to Disease Burden

Figure 2.4.1 compares PEPFAR expenditure to burden of disease by district (as measured by the number of PLHIV). In 2016, the PEPFAR program spent an average expenditure of USD $42.54 per PLHIV. 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 and DREAMS. The GoSA is responsible for the majority of HIV programs expenditures. Among the 27 focus districts the FY16 expenditure per PLHIV ranged from US$17-US$83. The PEPFAR program has reviewed its available epidemiological and expenditure data in an effort to focus on programs and locations for increased impact and epidemic control in COP17. During COP16 implementation PEPFAR will support the NDoH to generate and make use of age/sex cohorts from Tier.net. This will provide additional program monitoring information and tracking efforts to improve program management and age/sex cohort monitoring of attainment.

[36] PEPFAR SA leadership is routinely engaged in coordination and information sharing discussions through the regular bilateral PFIP structures, SA's Global Fund Country Coordinating Mechanism (CCM), the Health (Development) Partner Forum, the HIV and TB Think Tanks, information sharing with key foundations such as Clinton Health Access Initiative (CHAI), Bill and Melinda Gates Foundation (BMGF) and others which assist in the coordination and leveraging of PEFPAR investments in the various key intervention areas identified in the SID.

Figure 2.4.1 Percent PLHIV by Sub-National Unit (SNU), total PLHIV by SNU, and coverage of total PLHIV with ART and expenditure by SNU.



2.5 Stakeholder Engagement

The GoSA is a key stakeholder and leader in PEFPAR's program. Under the bilateral U.S and SA governments' PFIP, joint technical workstreams oversee the implementation of the PEPFAR SA program. These workstreams are guided by the PFIP Management Committee, co-chaired by the Deputy President's Advisor for Health and Social Sector and the interagency PEPFAR Coordinator, along with representation of senior officials from all the key GoSA departments. The bilateral partnership is led by the PFIP Steering Committee, co-chaired by the Minister of Health and the U.S. Ambassador to South Africa, along with the deputy ministers from key GoSA departments. The COP17 plan has been reviewed and discussed with the workstreams and Management Committee. The Steering Committee endorsed COP17 on April 21, 2017.

The COP17 plan also has been reviewed and discussed with Civil Society through meetings with PLHIV organizations, U.S. Embassy Community Grants outreach meetings to the 27 focus districts, and the overall SANAC Civil Society Forum. Information has been shared electronically and is also posted on the U.S. Embassy's website. Representatives from these organizations participated in the COP17 review and approval in Johannesburg, April 24-26, 2017.

PEPFAR shared the COP17 plan and planning process with bilateral and multilateral stakeholders through both the Health Partners Forum and the United Nations (UN) Regional Coordinator's Office. Additionally, the interagency PEPFAR team reviewed and discussed the COP17 planning process and final draft SDS with key foundations and other partners including BMGF, CHAI and others. Additionally, in COP16 and into COP17, PEPFAR will increase its engagement with the private sector, developing collaborative opportunities through large employers.

3. Geographic and Population Prioritization

In COP17 prevention services are strategically planned to support and align with the new NSP, She Conquers, DREAMS, and with the overall geographic focus. Emphasis will be on integration of prevention services with care and treatment, and VMMC programs. Updated district-specific analysis of the HIV burden and projected treatment coverage progression over time by age group and sex have led PEPFAR to update and accelerate the treatment coverage targets of the current 27 focus districts. To reach epidemic control in these districts, six districts, representing 30% of the overall HIV burden, are planned to achieve "attained" treatment coverage by the end of COP17. The remaining 21 focus districts, representing 49% of the overall HIV burden, will achieve "saturation" treatment coverage (see Table 3.1 below). In COP17 PEPFAR will work with the GoSA, other funding partners, implementing partners, Civil Society, private sector and CBOs/FBOs to accelerate increased PLHIV identification and linkage to treatment. To support accelerated achievement PEPFAR will work with the GoSA and implementing partners to provide a strategic mix of facility support interventions. These facility-focused interventions will include "roving mentoring teams", additional short-term clinic staff support, and secondments of PEPFAR-funded staff as appropriate to respond specific site needs.

She Conquers is initially focused on 22 sub-districts, and is receiving support from DREAMS in four of these sub-districts. She Conquers also receives support for AGYW programming in 13 PEPFAR-supported scale-up districts and in 10 Global Fund-supported districts. Scaling up

targeted HTS in the 27 focus districts will support reaching the first 90. In COP17 PEPFAR will support the GoSA in the implementation of the National Department of Basic Education's (DBE) HIV, TB and STIs policy. The policy covers prevention, care and support within the school context. PEPFAR will work with DBE and other departments and partners to operationalize the policy initially in the DREAMS districts. Other prevention interventions will support the first and second 90s (e.g., mobilization and linkages) and primary prevention. Priority population prevention interventions for AGYW and under 30 year-olds in general will be implemented in 14 of the 27 focus districts, in sub-districts and their wards with the most vulnerable young people (those who fall below the poverty line). Key population (KP) programs will be provided in 15 high-burden districts and three non-focus districts, based on high KP presence and HIV burden (e.g., metropolitan areas, truck stops, mining areas).

In COP17 PEPFAR SA will continue to work with the GoSA to support programs that address specific population groups as follows:

AGYW, their partners, and parents: SA has the highest number of estimated new HIV infections globally per week (2,363) among AGYW aged 15-24 years (UNAIDS, 2013). The CAPRISA 2016 phylogenetic study shows that sexual partnering between young women and older men significantly increases young women's HIV risk, and is a key feature of the sexual networks driving HIV transmission. Targeted combination prevention strategies need to include interventions to address age-disparate sexual partnering.[37] PEPFAR SA will continue to aggressively support the GoSA's goals to address HIV incidence among AGYW to achieve an AIDS-free generation, particularly with concentrated DREAMS evidence-based efforts. In June 2016, the GoSA launched She Conquers, a national campaign and strategy for AGYW focusing on: (1) reducing HIV incidence; (2) decreasing teenage pregnancy; (3) decreasing GBV; (4) keeping girls in school; and (5) increasing economic empowerment opportunities for AGYW. PEPFAR prevention interventions will complement She Conquers, including HIV testing for 322,083 AGYW in focused sub-districts.

Males: In COP17 PEPFAR will continue to work with NDoH and Provincial Departments of Health (PDoH) to focus more services and improved access to men in general. Linked with the VMMC program, as well as HTS, emphasis is on increasing the linkages of HIV-positive males to treatment and as well-focused prevention messaging for HIV-negative men, as well as VMMC. Modeling suggests that uncircumcised men, aged 15-34, are a priority target population for prevention. With the GoSA, PEPFAR will focus on achieving the greatest magnitude and immediate reduction in HIV incidence by increasing services to men, and prioritizing circumcision of men within the 15- to 34-year-old age group. Miners, predominantly men, are a high-risk group due to their mobility, 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 HIV prevention and TB programs among approximately 32,000 miners.[38]

[37] Transmission networks and risk of HIV infection in KwaZulu-Natal, South Africa: a community-wide phylogenetic study, CAPRISA, 2016.
[38] Target was set last year and was not changed this year. Originally, was under CareWorks and is now under Foundation for Professional Development.

KP: Modelled estimates indicate that 9.2% of new HIV infections nationally are attributable to MSM, and 19.8%[39] are attributable to sex work.[40] Studies show an HIV prevalence of 40% - 72% among FSW[41] and 28% - 52% among MSM.[42] There are an estimated 138,000 FSWs[43] and 1.2 million MSM.[44] Although prisons are equipped to house 159,331 inmates, SA's inmate population is estimated at 320,000. High-risk sexual behaviours, gender dynamics, and injecting practices may contribute to new infections in these facilities. A peer-based prevention intervention, "Strengthening Prevention Services" (STEPS) is a six-week module that teaches peers about HIV, risky sexual behavior, and the harms of injecting drug use. In collaboration with NDoH and Department of Correctional Services (DCS), a situational analysis focusing on risk behaviors and seroconversion in prisons will be carried out in COP17 to strengthen interventions to reach prisoners. In COP17 PEPFAR will work with PDoHs to support services to injecting drug users leveraging resources with other partners. While the program remains a small component, the HIV prevalence of PWID is 14%. In COP17 PEPFAR will work with provinces and implementing partners to rollout the "STEP-UP[45]" program. The PEPFAR support is complemented with funds and resources from Global Fund and other donors and focuses on HIV prevention, testing and linkages to ART.

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 SA's population) lived in farm areas, with large migrant populations. As a result, migrant farmworkers will constitute a special focus within the larger migrant population.

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 OVC burden were determined. These areas were largely aligned with the 27 highest-burden districts. In COP17, PEPFAR SA will support OVC services in collaboration with the Department of Social Development in the 27 focus districts, as well as the DREAMS district of uMkhanyakude, KwaZulu-Natal.

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 (POCT), improving laboratory quality management systems, minimizing waste, increasing

[39] There are more recent estimation models of HIV transmission attributable to sex work, but these models use a "frequency-dependent" assumption which lead to underestimation in transmission data.
[40] South African Centre for Epidemiological Modelling and Analysis (SACEMA) 2010 cited in National Strategic Plan for HIV, TB and STIs, 2012-2016. SANAC, 2012. The SACEMA study took place in 2010.
[41] UCSF. South African Health Monitoring Survey, Survey on female sex workers in South Africa, 2013-2014. 2014.
[42] UCSF. MSM in South Africa. Data Triangulation Project. Pretoria, 2015.
[43] Sex Worker Education and Advocacy Task force (SWEAT). Estimating the size of the sex worker population in South Africa, 2013. Cape Town, 2014.
[44] ANOVA Health Institute, Elton John AIDS Foundation. Rapid Assessment of HIV Prevention, Care and Treatment Programming for MSM in South Africa. November, 2013.
[45] STEP-UP is a harm and HIV reduction set of interventions focused on PWID.

a skilled laboratory workforce, and strengthening all pre- and post-laboratory analytical phases at facility level. During COP17, PEPFAR SA programs will continue to address viral load (VL) cascade improvements, including clinic-laboratory linkages.

Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP17**	**# Current on ART (FY16)**	**# of SNU COP16 (FY17)**	**# of SNU COP17 (FY18)**
Attained	2,004,148/30%	1,097,809	0	6
Scale-up Saturation	3,253,656/49%	1,575,615	4	21
Scale-up Aggressive	N/A	N/A	23	0
Central Support(KP and correctional facilities)	1,431,535/21%	893,214	25	25

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

4.1 Targets for Priority Locations and Populations

In line with focus for impact decisions made in the COP15/FY16 planning and implementation, in COP17/FY18 PEPFAR programming will support NDoH and PDOH services in the 27 highest-burden districts, which account for an estimated 82% of SA's PLHIV burden (see Figure 4.1.1 below). PLHIV estimates at the district level are based on the 2015 Spectrum AIDS Impact Model (AIM) 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 HIV burden estimates (e.g., 2012 HSRC Household Survey, Small Area Estimations) with appropriate adjustments made to select districts.[46]

In COP17 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% of all PLHIV on ART (see Figure 4.1.2 below) at the district level. By the end of COP17 implementation (September 2018, the end of the USG FY2018) PEPFAR plans to support the GoSA's provision of ART to 81% of the estimated PLHIV in all 27 focus districts, with attainment focus in six districts (City of Johannesburg, eThekwini, Ekurhuleni, uMgungundlovu, Zululand, and Mopani). Resource allocations will be adjusted as required to focus on results achievement in the highest burden districts and largest volume sites.

In COP17 PEPFAR will work with the GoSA, implementing partners, other funding partners, civil society, private sector and CBOs/FBOs to improve linkages to treatment and expedite attainment (81% ART coverage for estimated PLHIV in 0-15; 15-24 and 25≥ male and female age cohorts in six focus districts) while achieving saturation (81% ART coverage) in the remaining 21 focus districts. In COP17 PEPFAR will work with the GoSA to accelerate attainment and saturation through intensified models of facility-focused support including roving mentoring teams and facility support, short-term human resources staff support for three to six months, and secondments of PEPFAR-funded staff for up to 12 months. In the six attained districts, PEPFAR will use more detailed age and sex disaggregated data from implementing partners and

[46] PEPFAR SA consulted with a variety of stakeholders to review the current PLHIV estimates using various Thembisa- and program-data based extrapolations. Given the majority of estimates for district burdens were aligned at a relative level with the Spectrum and updated estimates will be informed by the HSRC Household Survey available in 2017, PEPFAR SA and NDoH decided to maintain the Spectrum-based estimates for COP17 planning. Two districts were adjusted to align directly with the Thembisa-based estimate (Cape Town increased and Nkangala decreased). This was based on triangulation of the various estimates and reported program data (e.g., current on treatment). In COP18 planning PEPFAR SA and NDoH will update district-level PLHIV estimates based on the HRSC Household Survey and modeling data expected to be released in 2017.

NDoH systems to assist with monitoring attainment progress. These data are currently compiled manually, using site-level systems. In COP16 PEPFAR is working with NDoH and TIER.net developers to make monitoring in all districts more compete, efficient and systematic. Future TIER.net reports will enable routine flow of data as outlined by the NDoH SOPs and provide the necessary data elements for improved monitoring. PEPFAR anticipates that the new reporting capacity will be in use by August 2017.

In COP17, associated program area (e.g., HTC, VMMC, and OVC) coverage and achievement targets have been aligned with both need and these HIV treatment coverage goals (see Figure 4.1.3 below).

Figure 4.1.1: Percentage of Treatment Targets by Age and Sex by District, South Africa COP17/FY18

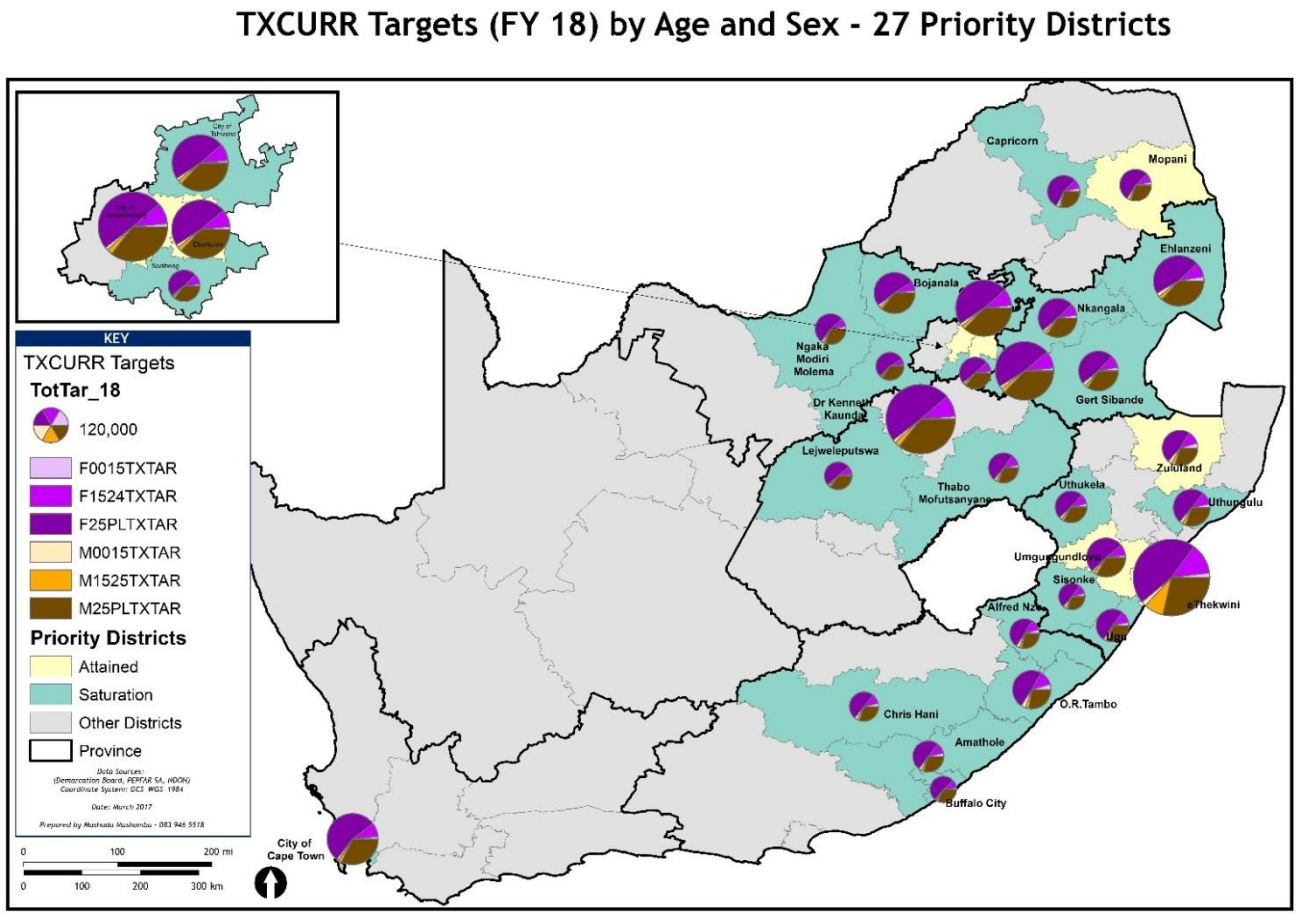


Figure 4.1.2: HIV Treatment Coverage and Unmet Need, South Africa end COP15/FY16

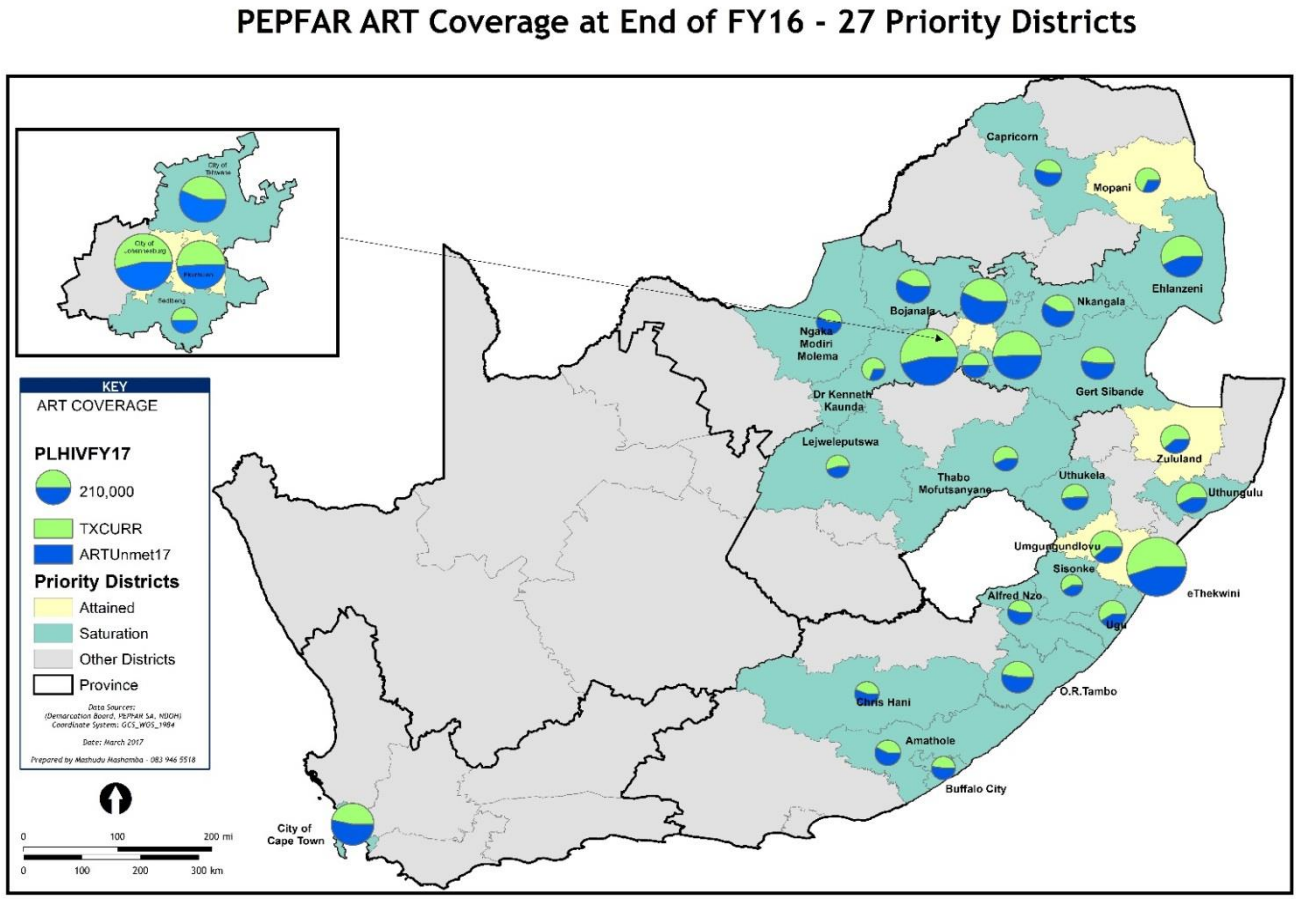
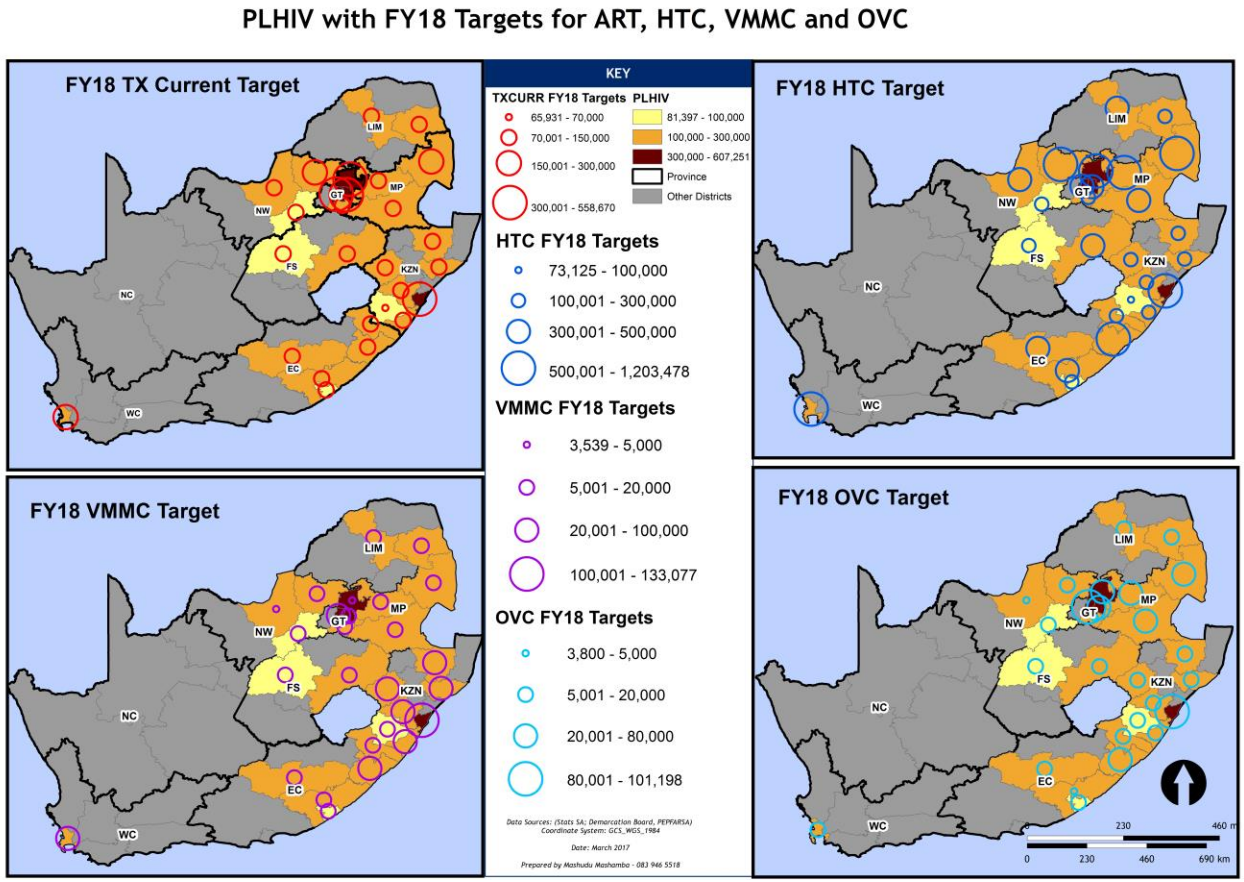


Figure 4.1.3: HIV Burden (PLHIV) with Treatment, HTC, VMMC, and OVC COP17/FY18 PEPFAR Targets, South Africa



Laboratory:

COP17 laboratory program objectives were identified in discussions during portfolio reviews and subsequent meetings with the NDoH, NHLS, National Institute for Communicable Diseases (NICD), and the PEPFAR Laboratory Technical Working Group (TWG). Laboratory program activities will support both prevention and care and treatment interventions toward achievement of 90-90-90 goals. Laboratory program targets are aligned with the 1,969 supported facilities in the 27 highest-burden districts. The highest-volume HTS sites have been enrolled in the continuous quality improvement (CQI) program. PEPFAR will continue to expand the program to enroll all 1,969 facilities in COP17. Through capacity and strategy activities with NDoH and PDoHs, PEPFAR lab programs are leveraged to expand through these organizations to the other 25 districts and their facilities.

The program will continue to support NHLS in the implementation of Quality Assurance (QA) for HIV POCT to ensure the accuracy and reliability of testing for HIV-rapid test, early infant diagnosis and VL. For HIV-rapid test, PEPFAR implementing partners will provide QA to all PEPFAR-supported 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. PEFPAR will support the GoSA laboratory program for implementation of QA for community-and home-based HIV-rapid tests (RT) and CD4 POCT for early infant diagnosis (EID). At the facility level, the laboratory program will facilitate implementation of QA for HIV rapid testing (RT) 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[47] to improve quality management systems in diagnostic laboratories have been set for 18 laboratories which provide HIV diagnostic services to facilities within the 27 priority districts.

In COP17 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 strengthen the current VL and EID testing cascade, as well as increase testing efficiencies of existing platforms within the VL laboratories, and intensify clinic-lab interface support to ensure proper handling and tracking of specimens, documentation, and capture of laboratory results in the relevant health information systems(HIS) to ensure improved uptake of the results for patients' management and reporting of VL completed.

Prevention: The prevention portfolio comprises several distinct programs in support of NSP goals including (a) VMMC; (b) HTS;[48] (c) priority population prevention; and (d) KP prevention.

VMMC targets are based on low medical male circumcision prevalence and high HIV incidence, with a goal to achieve 80% VMMC coverage of males 15-34 years in the 27 focus districts by the end of FY18. Eleven of the 27 districts are expected to reach at least 80% coverage of males 15-34 by the end of FY17, with an additional 13 districts reaching 80% coverage by September 2018. To increase the immediacy of impact, VMMC programs will target the high priority age band with a goal that 80% of VMMCs reach 15-34 year old men. Active partner monitoring and strategic management with NDoH and PDoHs will be continued and expanded to ensure that PEPFAR-funded programs help realize SA's ambitious VMMC targets supporting achievement of an AIDS-free generation.

[47] Strengthening Laboratory Management Towards Accreditation (SLMTA) and Stepwise Laboratory Improvement Process Towards Accreditation (SLIPTA).

As part of the VMMC program, referrals to HTS are an integral part of service delivery, and provide linkages to treatment for HIV-positive men. On average the HIV positivity rate is 4% among uncircumcised men presenting for VMMC services.

With COP17 funds, PEPFAR will support the GoSA to achieve 240, 118 VMMCs. Supplementary COP17 central funds (approximately USD $51 million[49]), may support an additional 341,538 VMMCs, for a potential total contribution of 581,656 VMMCs to the VMMC goal of at least 80% of 15-34 year old men by September 2018. PEPFAR will work with implementing partners to ensure focus on the target age range, and apply findings from operations research to expand innovative methods to recruit older men and increase achievement of targets. Effective demand creation focused on the target group is a COP17 VMMC program priority.

HTS: PEPFAR will work with the GoSA to aggressively scale-up community and facility testing in support of the first 90 with a strong emphasis on measures to improve linkage to treatment in alignment with UTT. Community testing will focus on the highest-yield modalities, specifically index case testing, as well as community outreach testing targeting hard-to-reach high-risk populations who do not utilize facility-based services, and an emphasis on men, as described in detail in Section 4.5 below. In COP17 PEPFAR will work with the GoSA to support HIV testing for 10,885,120 people in facility and community settings (inclusive of testing in other settings such as VMMC), with a goal to identify 1,027,472 PLHIV who will be linked to treatment.

KP implementing partners will employ social network strategies, peer mobilization, and mapping to increase uptake and yield of hard-to-reach populations. High-risk HIV-negative individuals are urged to test regularly through risk reduction counselling and through peer networks.

Priority population prevention: In COP17 PEPFAR (including DREAMS activities) will work with the GoSA to focus on priority prevention sites in the highest-burden districts, with an emphasis on high-incidence areas, such as informal settlements, densely populated urban areas, mining areas, and trucking routes. DREAMS interventions will remain focused in the four scale-up saturation districts, plus uMkhanyakude. For AGYW and their partner populations, the denominator for COP17 is consistent between COP and DREAMS targets and is based on the proportion of local municipality populations living below the poverty line and within the target age groups (StatsSA, 2016). To determine GBV denominators, PEPFAR has used program data and Victims of Crime Survey, Medical Research Council (SAMRC) and South African Police (SAPS) report data. The recent SAPS 2015/2016 statistics released indicate that 110 rape reports are made every day in SA. PEPFAR will directly support 8,303 (15% of annual estimates) of all rape survivors who report, with comprehensive medical, legal and psychosocial services offered by trained and sensitive personnel. Support for rape survivors will also cover HTS, post-exposure prophylaxis (PEP) provision, pregnancy testing, and referrals. Condom dispensing and distribution support will take place in all priority population sites. Demand creation will be

[49] Per COP17 Approval (April 26, 2017), a first tranche of central VMMC funding, $28 million, may be available after VMMC program results review through July 31, 2017; if approved, there may be the possibility of an additional tranche of central VMMC funding.

integrated into all interventions at all sites to improve uptake into clinical services, which in turn will lead to increased identification of PLHIV, providing the opportunity to link them to treatment.

KP prevention: KP activities will focus on high-burden populations, including FSWs, MSM, transgender women (including those who engage in sex work), people who inject drugs (PWID), and inmates. PEPFAR has used the best available data from PEPFAR and Global Fund programs and other sources (e.g., IBBS, Household Survey, UNAIDS) to determine KP denominators. PEPFAR will support the GoSA to reach 46% of FSW and 14% of the estimated MSM population in supported districts, and PEPFAR implementing partners in coordination with NDoH and PDoHs will test 55% of FSWs and 15% of MSM of unknown status in the districts in which they work. In collaboration with the GoSA, prevention interventions will reach 55% of inmates in all male correctional facilities in SA, and 7% of PWID in three PEPFAR-supported districts.

These programs will support the second 90 through systematic linkages to treatment for HIV-positive individuals through peer navigation, while regular adherence support groups and peer education will support the third 90. In COP17 PEPFAR will work with NDoH and PDoHs to implement innovative recruitment strategies to expand programs into new social networks. KP sensitization will include clinical competency training. A sensitization toolkit—inclusive of all KP—will be developed, piloted, and rolled out through the NDoH's Regional Training Centers and PEPFAR implementing partners. This toolkit will be used to train health providers and other government officials like Department of Correctional Services officials on gender orientation and identities, attempt to minimize stigmatization, and encourage respectful behavior. An additional focus will be on clinical competencies, such managing hormone-ART interactions for women.

The ongoing development of a KP cascade and unique identifiers will enable effective monitoring of the KP prevention and treatment cascades. PEPFAR's Site Improvement Monitoring System (SIMS) and other site visits will be utilized to monitor performance.

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

District/Sub-national Unit[50]	Total PLHIV	Expected current on ART (APR[51] FY 17)	Additional patients required for 81% ART coverage	Target current on ART (APR FY18) TX_CURR	Newly initiated (APR FY 18) TX_NEW	ART Coverage (APR 18) %
ec Alfred Nzo District	103,600	72,259	11,752	84011	19,589	81%

[50] Provinces noted as: ec = Eastern Cape, fs = Free State, gp = Gauteng, kz = KwaZulu-Natal, lp = Limpopo, mp = Mpumalanga, nw = North West, wc = Western Cape

[51] APR = Annual Program Results

Municipality						
ec Amathole District Municipality	113,484	67,399	24,756	92155	21,329	81%
1ec Buffalo City Metropolitan Municipality	96,011	59,795	18,652	78447	17,564	82%
ec Chris Hani District Municipality	101,129	59,792	22,255	82047	19,082	81%
ec Oliver Tambo District Municipality	173,529	100,189	40,799	140988	32,541	81%
fs Lejweleputswa District Municipality	90,448	68,903	4,206	73109	17,339	81%
fs Thabo Mofutsanyane District Municipality	106,100	73,347	12,475	85822	20,278	81%
gp City of Johannesburg Metropolitan Municipality	564,736	455,095	10,050	465145	99,591	82%
gp City of Tshwane Metropolitan Municipality	372,026	235,945	67,480	303425	68,601	82%
gp Ekurhuleni Metropolitan Municipality	404,750	295,782	34,356	330138	74,612	82%
gp Sedibeng District Municipality	116,706	73,185	21,742	94927	21,779	81%
kz eThekwini Metropolitan Municipality	607,251	510,538	46,931	557469	49,782	92%
kz Harry Gwala District Municipality	81,397	63,538	1,730	65268	16,129	80%
kz Ugu District Municipality	127,450	93,884	10,789	104673	22,777	82%
kz uMgungundlovu District Municipality	179,539	127,491	19,146	146637	32,902	82%
kz Uthukela District Municipality	117,988	82,538	13,125	95663	22,325	81%
kz Uthungulu District Municipality	160,091	115,735	15,181	130916	29,175	82%
kz Zululand District Municipality	141,756	114,099	7,257	121356	20,400	86%
lp Capricorn District	122,526	82,195	17,394	99589	22,937	81%

Municipality						
lp Mopani District Municipality	106,116	93,450	2,295	95745	10,371	90%
mp Ehlanzeni District Municipality	299,725	214,956	28,323	243279	56,446	81%
mp Gert Sibande District Municipality	185,165	110,714	40,256	150970	34,195	82%
mp Nkangala District Municipality	178,097	108,938	35,802	144740	33,357	81%
nw Bojanala Platinum District Municipality	197,845	120,523	40,882	161405	36,440	82%
nw Dr Kenneth Kaunda District Municipality	91,335	67,172	7,581	74753	16,582	82%
nw Ngaka Modiri Molema District Municipality	110,597	65,828	23,916	89744	20,853	81%
wc City of Cape Town Metropolitan Municipality	308,407	183,210	66,798	250008	58,399	81%
Total	5,257,804	3,716,500	645,929	4,362,429	895,375	82%

[1] Provinces noted as: ec = Eastern Cape, fs = Free State, gp = Gauteng, kz = KwaZulu-Natal, lp = Limpopo, mp = Mpumalanga, nw = North West, wc = Western Cape

[1] APR = Annual Program Results

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 (APR FY18)**	**Identified Positive (APR FY18)**	**Newly initiated () TX_NEW (APR FY18)**
Adults			
Clinical care patients not on ART*	NA	NA	51,374
HIV+ TB Patients not on ART**	104,553	62,731	59,663
HIV-positive Pregnant Women	636,131	100,489	113,019
Other priority and key populations***	903,872	85,962	75,647
Provider Initiated Testing	7,389,844	704,555	634,099
Home-based Testing	378,871	30,358	27,322
Index Testing	651,722	51,294	46,164
Pediatrics			
Clinical care pediatrics not on ART	NA	NA	NA
HIV Exposed Infants	176,577	397	389
Orphans and Vulnerable Children	271,016	12,045	10,840
Provider Initiated Testing	264,836	10,834	9,751
Home based Testing	95,660	957	861
Index testing	12,038	241	217
Total	**10,885,120**	**1,059,862**	**1,027,472**

Data sources:

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

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

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

Table 4.1.3 VMMC Coverage and Targets by Age Bracket in Scale-up Districts				
District[52]	**FY18 Total male population, age 15-34**	**Expected Cumulative Number of Circumcised Men, age 15-29 (end of FY17)**	**Target ge 15-34**	**FY18 Target Coverage, age 15-34 %**
ec Alfred Nzo District Municipality	166,303	133,011	11,851	80%
ec Amathole District Municipality	197,974	131,657	5,318	>90%
ec Buffalo City Metropolitan Municipality	140,902	117,201	13,049	80%
ec Chris Hani District Municipality	159,211	107,160	15,218	80%
ec Oliver Tambo District Municipality	298,575	218,514	27,849	80%
fs Lejweleputswa District Municipality	124,612	87,150	17,002	>90%
fs Thabo Mofutsanyane District Municipality	152,306	107,431	8,323	80%
gp City of Johannesburg Metropolitan Municipality	840,341	758,438	25,000	>90%
gp City of Tshwane Metropolitan Municipality	580,719	476,209	4,130	>90%
gp Ekurhuleni Metropolitan Municipality	609,042	495,799	10,261	>90%
gp Sedibeng District Municipality	167,464	149,186	6,000	>90%
kz eThekwini Metropolitan Municipality	620,740	444,657	133,077	60%
kz Harry Gwala District Municipality	96,218	65,251	11,410	80%
kz Ugu District Municipality	154,608	98,432	29,709	68%
kz uMgungundlovu District Municipality	206,676	138,076	38,764	80%
kz Uthukela District Municipality	131,582	77,408	23,937	80%
kz Uthungulu District Municipality	166,970	111,843	45,927	80%
kz Zululand District Municipality	168,609	96,080	35,935	80%
lp Capricorn District Municipality	256,388	272,814	5,697	>90%
lp Mopani District Municipality	223,865	223,973	11,887	90%
mp Ehlanzeni District Municipality	318,548	274,484	10,039	>90%
mp Gert Sibande District Municipality	231,250	162,666	15,895	>90%
mp Nkangala District Municipality	307,555	263,719	11,178	85%

[52] Provinces noted as the following: ec = Eastern Cape, fs = Free State, gp = Gauteng, kz = KwaZulu-Natal, lp = Limpopo, mp = Mpumalanga, nw = North West, wc = Western Cape

nw Bojanala Platinum District Municipality	309,526	214,632	10,814	80%
nw Dr Kenneth Kaunda District Municipality	129,635	98,819	10,935	>90%
nw Ngaka Modiri Molema District Municipality	182,717	146,934	3,539	>90%
wc City of Cape Town Metropolitan Municipality	682,880	378,572	28,142	60%
kz Umkhanyakude District Municipality	128,455	116,124	10,769	>90%
Total	**7,753,670**	**5,966,241**	**581,655**	

4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY18)	FY18 Target
AGYW + partners	2,144,940	24%	516,975
Miners	85,000	38%	32,000
Inmates	159,331	45%	71,089
FSW	87,472	46%	40,051
MSM	322,052	14%	44,902
Total	**2,798,795**	--	**705,017**

Table 4.1.5 Targets for OVC and Linkages to HIV Services			
SNU	**Estimated # of OVC**	**Target # of a OVC (FY18Ta OVC_SER**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY18 Target) OVC***
gp City of Johannesburg Metropolitan Municipality	154,382	101,198	101,198
gp City of Tshwane Metropolitan Municipality	90,469	48,381	48,381
kz eThekwini Metropolitan Municipality	221,572	86,989	86,989
ec Buffalo City Metropolitan Municipality	37,922	14,000	14,000
mp Nkangala District Municipality	71,577	24,740	24,740
mp Gert Sibande District Municipality	88,571	25,700	25,700
gp Ekurhuleni Metropolitan Municipality	133,873	33,360	33,360
kz Ugu District Municipality	78,122	19,400	19,400
ec Chris Hani District Municipality	77,033	19,000	19,000
mp Ehlanzeni District Municipality	135,560	31,540	31,540
nw Bojanala Platinum District Municipality	77,076	17,508	17,508
fs Thabo Mofutsanyane District Municipality	69,372	15,361	15,361
lp Mopani District Municipality	81,600	17,915	17,915

kz Harry Gwala District Municipality	55,785	12,200	12,200
kz uMgungundlovu District Municipality	88,618	18,459	18,459
lp Capricorn District Municipality	95,223	19,200	19,200
kz Uthungulu District Municipality	99,107	19,853	19,853
wc City of Cape Town Metropolitan Municipality	96,687	17,900	17,900
ec Alfred Nzo District Municipality	53,226	9,580	9,580
fs Lejweleputswa District Municipality	49,893	8,600	8,600
nw Dr Kenneth Kaunda District Municipality	42,661	7,200	7,200
kz Uthukela District Municipality	75,420	11,355	11,355
kz Umkhanyakude District Municipality	72,192	10,119	10,119
kz Zululand District Municipality	104,278	9,908	9,908
ec Oliver Tambo District Municipality	252,601	22,548	22,548
gp Sedibeng District Municipality	47,649	4,000	4,000
nw Ngaka Modiri Molema District Municipality	68,940	4,975	4,975
ec Amathole District Municipality	83,519	3,800	3,800
Total (27 districts & Umkhanyakude)	**2,602,928**	**634,789**	**634,789**

4.2 Priority Population Prevention and KP Prevention

South Africa's policies and guidelines provide critical direction for priority and KP prevention interventions. These include:

- NSP (2017-2022)
- UNAIDS strategy Fast-Track: ending the AIDS epidemic by 2030, which includes the 90-90-90 targets
- HTS revised policy and guidelines based on WHO's recommendations 2016 (NDoH)
- National PrEP Guidelines with a focus on FSW and MSM June 2016 (NDoH)
- National Condom Distribution Plan (NDoH)
- Health Sector HIV Prevention Strategy 2016
- Draft National Department of Basic Education HIV, STI and TB Policy
- The South African National Sex Worker HIV Plan 2016-2019 (SANAC)
- Draft Lesbian, Gay, Bisexual, Transgender and/or Intersex (LGBTI) Strategy (SANAC)

COP17 will continue to focus on improved condom (male and female) distribution at unconventional community access points including taverns, gas stations, informal shops and retailers, to dispense, promote and empower AGYW and youth to increase condom use. Through DREAMS, PEPFAR SA will expand the supply of female condoms, and emphasize the importance of dual protection with condoms and comprehensive sexual reproductive health and rights education and services to decrease HIV risk, as well as abstinence and behavioral change messages. DREAMS will continue to emphasize intervention layering/services integration and linkages to ensure that AGYW have access to and receive comprehensive services. Layering occurs at multiple levels (e.g., within programs of an implementing partner, between implementing partners and from implementing partners to/from GoSA), and is often based on a case management approach to respond to an individual's needs. In COP17 priority prevention will scale up the evidence-based, structured behavioral interventions for HIV prevention and demand creation for the uptake of testing services focused on vulnerable populations (i.e., adolescent girls in school; young women and their male sexual partners, especially those in informal settlements; truckers and clients of FSW), migrant farmers, and male inmates. HTS will be integrated into priority population prevention sites to maximize targeted use of testing, counseling services and linkages to treatment for HIV-positives. In collaboration with the GoSA institutions, including the Department of Basic Education and Department of Social Development, multi-session evidence-based structured curricula to address risk avoidance of GBV and promotion of equitable gender norms to prevent HIV infection will also reach young boys through school-based interventions.

In COP17 PEPFAR will work with the GoSA to expand PrEP services to include AGYW and MSM. In COP16 PrEP focus is on FSW as a component of DREAMS-funded interventions. In COP17, DREAMS/AGYW-focused funding will maintain 3,000 FSWs on PrEP who were initiated in COP15/FY16 and COP16/FY17 in the five target districts. In COP17/FY18 DREAMS/AGYW-focused funding will expand PrEP to 3,735 AGYW in the four DREAMS districts[53]. In COP17 funds will also be used to support PrEP for 8,599 MSM and FSWs and 2,231 AGYW. PEPFAR COP17 support for PrEP for AGYW in select districts will be in collaboration with NDoH as part of learning sites to inform future program expansion. PrEP is implemented as a risk reduction strategy within the broader prevention

[53] PrEP is not planned to expand, but to be maintained in uMkandekude.

package that includes condom promotion, HIV counseling and testing, family planning, and reproductive health services.

KP: In COP17 KP access to and utilization of health services will be a priority. A unique identifier collaboratively developed with NDoH and Global Fund-funded principal recipients will support linkages, tracking, follow-up and de-duplication efforts for FSWs. KP peer navigators who are embedded in sensitized clinics will be deployed to sites that do not have drop-in centers with Nurse Initiated Management of ART (NIMART) trained nurses. In COP17 increasing outreach to hard-to-find populations and strengthening KP linkages to prevention, care and treatment services will be a priority. Social media and regular hotspot mapping will be used to reach new FSWs to increase outreach, focused testing, and improved linkages to care and treatment. PEPFAR implementing partners will use enrolled nurses[54] as part of mobile outreach units to provide basic health care, testing, counseling and initiating ART and offering of PrEP (for HIV-positive and HIV-negative persons). Mobile units also leverage trained peer educators to conduct HTS. Professional and NIMART-trained nurses will operate from drop-in centers to initiate PrEP and ART for clients. In COP17, implementing partners will also focus on improved and expanded screening and treatment for STIs among FSWs and MSM, including those who are on PrEP.

In coordination with NDoH, SANAC and other multi-sectoral partners, in COP17 PEPFAR will support standardized and piloted programs nationally focused on MSM and inmates. Project Boithato, an evidence-based program grounded upon Mpowerment[55] focuses on young MSM with the provision of prevention, HTS, and linkages to treatment. Social Network Strategy (SNS), PrEP, STI prevention and STI presumptive treatment will be piloted with the Boithato program in Mpumalanga in COP16/17 and rolled out to all MSM sites in COP17. In collaboration with NDoH, DCS and SANAC, more than half (55%) of inmates will be reached with structured, peer-based prevention interventions (STEPS). These interventions will be informed and strengthened by a situational analysis conducted with NDoH and DCS in correctional facilities to determine rates of HIV seroconversion in prisons, STIs, hepatitis, and high risk sexual and injecting behaviors. In COP17, in collaboration with NDoH and PDoHs, an HIV prevention program accompanied by HTC, linkages/provision of ART will be provided to PWID. These activities will be complemented through NDoH and Global Fund funding. During COP17 an integrated biological and behavioral survey (IBBS) in two sites in collaboration with NDoH will support further development of the PWID program.

In COP16 and into COP17 PEPFAR with continue to work with the GoSA and implementing partners to have joint management sessions focused on performance monitoring. These sessions will use a partner monitoring tool, through regular check-ins (by emails, calls, and meetings), monthly site visits and reporting. Emphasis will be on improving linkages between prevention and treatment services.

4.3 VMMC

In COP17 PEPFAR will work with the GoSA to support a total of 581,655VMMCs.[56] VMMC targets are focused in districts with HIV-burden with a goal to achieve 80% coverage of males 15-34 years by the end of FY18. While the GoSA's national VMMC program targets 15-49 year old men, and PEPFAR

[54] Trained Enrolled Nurses are used rather than more expensive professional nurses for mobile outreach.
[55] Mpowerment is a model HIV prevention program that has been specifically designed to address the needs of young gay and bisexual men.
[56] Op. cit. 50

supports its goals, PEPFAR SA focuses its targets to achieve the most immediate reduction in HIV incidence by prioritizing circumcision of older adolescent and young adult males (15-34 years).

Modeling has also shown that targeting this age group is the most cost-effective in terms of infections averted. Eleven of the 27 focus districts are expected to reach at least 80% coverage of males 15-34 years by the end of FY17, with an additional 13 districts reaching 80% coverage by September 2018. Once 80% coverage is reached, with the GoSA concurrence PEPFAR SA will extend the VMMC program to adolescent boys 10-14 years of age.

By the end of FY16, PEPFAR has contributed 1.6 million VMMCs, in support of GoSA's national VMMC total of 2.8 million (approximately 57%). In COP17 PEPFAR will continue to assist the GoSA to scale up the national VMMC program through planning, coordination, and implementation including advocacy, communication, and social mobilization. PEPFAR will continue to support the WHO-recommended minimum package of services in public, private and non-governmental facilities in urban and rural communities with low rates of VMMC coverage and high HIV prevalence. PEPFAR will continue to ensure that external quality assurance (QA) and continuous quality improvement (CQI) activities are routinely conducted. VMMC services will also address harmful male norms and behaviors that may promote high-risk sexual behaviors, limit access and/or adherence to HIV prevention services, or directly or indirectly contribute to GBV. Integration of or referral/linkage to other men's health services and programs that promote gender equitable norms with VMMC services will be reinforced. PEPFAR VMMC support in eThekwini Metropolitan Municipality will be substantially increased in COP17 with a comprehensive strategy for demand creation and service delivery to guide achievement of 133,077 VMMCs in the municipality. Prior implementation challenges are being addressed with the introduction of a new partner and expanded responsibilities for two partners with strong performance records. The implementing partners will use both mobile clinics and roving teams to improve access to VMMC in rural settings. Demand creation will be tailored, using local celebrities and leaders to promote VMMC. Additionally, PEPFAR has established strong partnerships with male-dominated industries in the area such as fisheries, transportation companies and the port authority to increase access to older men. The intensified efforts in eThekwini will be monitored weekly, with monthly partner meetings, more frequent reporting of performance and intensified provincial and municipal engagement, and introduction of the Site Capacity/Utilization Tool.

In COP17 PEPFAR will prioritize roll out of innovations to increase follow-up rates and to recruit older men for VMMC services. One specific innovation for increasing follow-up rates includes follow-up calls to encourage recently circumcised males to return to the clinics. The impact of the follow-up calls has been impressive, increasing 14-day follow-up visits from 39% to 60-90%, this will be standardized throughout the VMMC program. To recruit older men, PEPFAR implementing partners will offer tailored services (e.g., extended clinic hours in the evenings and during the weekends, and separate waiting rooms for older men), use province-specific celebrities and messages, and distribute airtime vouchers). PEPFAR will support the NDoH in implementation of a comprehensive and cohesive national demand creation strategy for VMMC. PEPFAR implementing partners will develop messaging and demand creation to better reach different age groups within the 15- to 34-year-old target audiences, and will work with local community and traditional leaders to ensure VMMC can serve their constituents while preserving dignity and tradition. In COP17 PEPFAR will also provide technical assistance through UNICEF to support policy discussions with the GoSA to explore the need for a policy and strategy for Early Infant Male Circumcision (EIMC). These PEPFAR-funded policy

discussions will assist with establishing priorities and next steps for GoSA's EIMC efforts, particularly in provinces where the VMMC program is reaching saturation.

In COP17, PEPFAR will continue to support the national VMMC program with new strategic information tools, including an online geographic information system (GIS) and site capacity utilization monitoring for more accurate geographic and age targeting and efficient resource allocation. PEPFAR will also roll out innovative training methods to expand the number of VMMC private providers in SA, including a hybrid of online and practical training in the VMMC procedure.

4.4 PMTCT

SA has made great strides in prevention of mother-to-child transmission (PMTCT) of HIV. There was high coverage of HIV testing and ART above 95% for HIV-positive pregnant women in COP15/FY16. SA implements Option B+ with additional critical interventions such as VL monitoring of pregnant women already on ART at first antenatal clinic (ANC) visit; every three-month VL monitoring of newly diagnosed pregnant/breastfeeding women; birth polymerase chain reaction (PCR) testing; and repeat PCR testing at 10 weeks, 18 weeks, and ≤ 18 months. SA has reached a point where elimination of pediatric HIV infection is within reach. Instead of applying for WHO pre-validation for dual elimination of mother-to-child-transmission of HIV and congenital syphilis, the GoSA, PEPFAR, and other development partners have developed the "Last Mile Plan (2016-2021)," which focuses on reducing the leakages in the PMTCT cascade.

Despite the successful implementation of the PMTCT program with MTCT rates < 2% at 6 weeks and < 5% for the final transmission rate (UNAIDS 2015), major obstacles still exist. SA is still faced with late HIV diagnosis for pregnant women due to late ANC attendance (<60% at 20 weeks gestation [DHIS 2015]); low coverage for retesting of HIV-negative pregnant women before delivery (66% DHIS 2015); high number of pregnant women with unsuppressed VL; low utilization of DNA PCR testing at birth and at 18 months; low ART coverage for HIV-infected infants < 1 year; high absolute numbers of HIV infections in infants despite low MTCT rates (absolute numbers >50/100 000 per annual live births); challenges with tracking mother-infant pairs for improved linkage to care, adherence and retention in care and treatment; and weak comprehensive programs for primary prevention of HIV and unintended pregnancies.

Ambitious but feasible programmatic targets for retesting of HIV negative women, early ANC booking, VL completion, and real-time monitoring of PCR-positive infants have been included in district and facility 90-90-90 plans. The PMTCT technical working group reviewed and provided input to the District Implementation Plans (DIPs) during the 2016/17 "annual stock-taking exercise" in 14 of 27 PEPFAR-supported priority districts. Working with NDoH and PDoHs, PEPFAR implementing partners supported the technical development, completion and submission of the Last Mile plans in these districts. In COP17 PEPFAR partners will address some of the health system barriers (e.g.,HRH) by deploying temporary lay counsellors, clinicians, and community workers to improve retesting of HIV-negative pregnant/breastfeeding women, male partner testing, QA of HIV rapid testing, TB screening, increased access to EID testing at birth, adherence, VL monitoring, retention, and linkages to family planning services. In COP17 PEPFAR will continue to support ward-based outreach teams (WBOTs) and other community workers (e.g., through the Mentor Mother program) to improve adolescent services and ANC booking before 20 weeks gestation through awareness raising and demand creation. Additionally, PEPFAR will continue to support efforts to improve birth testing in districts that fall below the national average for completed birth testing in all the 27 districts (>80%),.

The challenges, which are related to a combination of data quality and service delivery issues, will be addressed in COP17 through ongoing training and mentoring focused on the new national indicator data sets (NIDS) and the testing guidelines at all delivery sites (e.g., hospital and maternity obstetric units).In COP17 PEPFAR implementing partners will support SA's Last Mile Plan linked to the District Implementation Plan (DIP) 90-90-90 objectives through facility-based QI initiatives; strengthened use of programmatic and laboratory data for real-time monitoring of misdiagnosis and tracking PCR-positive infants; tracking mother-infant pairs using community mother peer support care givers; and building capacity of community-based organizations (CBOs) to strengthen bi-directional referral services. In COP17 PEPFAR care and treatment implementing partners (District Support Partners or DSPs) will continue to expand alignment with the OVC and prevention program in the focus districts to strengthen family planning, HIV testing and clinical cascade outcomes of OVC.

4.5 HTS

SA rolled out UTT in September 2016. In COP15/FY16, PEPFAR exceeded its HTC_POS target but achieved only 63% of its TX_NEW target. PEPFAR identified an expected number of HIV-positive test results; however only 63% of these HIV-positive test results/proxy of individuals were initiated on treatment. While COP16/FY17 Q1 results show improvements in several districts, linkage to treatment is a challenge, with 30% of the annual target for HTC_POS having been reached in Q1 while only achieving 19% of the TX_NEW target. In the remainder of COP16 and in COP17 high yield testing strategies will be paired with strengthened linkage to treatment activities to maximum impact on epidemic control. Roughly 80% of HTS_POS have been identified through facility-based testing (PITC and co-located Voluntary Counseling and Testing). While testing yield in facilities has been high, there have been missed opportunities within facilities resulting from less than universal testing among family planning clients, STI patients, partners of pre-natal women, and non-surgical, non-orthopedic patients in adult and pediatric inpatient units. In COP16/FY16, 56.8% of TB patients were HIV co-infected, identifying the critical need that 100% of TB patients be tested for HIV. A major emphasis in COP16, which will be continued and expanded in COP17, is the deployment of linkage and retention officers at PEPFAR supported facilities. PLHIV are given preferential consideration in filling these positions, who then accompany newly diagnosed PLHIV from the testing site to the care and treatment site (when sites are not co-located) to accompany individual's treatment initiation. Linkage and retention officers then maintain contact with the patient until they are well established on treatment. In PEPFAR-supported facilities, operating hours will also be expanded to improve access for men, and children and adolescents in schools.

COP17 HTS Service Delivery Package will target the following:

Table 4.5.1 Hard-to-Reach Target Populations and Modalities to Reach Them

Target Population	Modality	Location
Men (40% of HTS target)	➢ Mobile testing: 40% ➢ Index-client model: 30% ➢ VMMC platforms: 20% ➢ Private GP model: 5% ➢ Pilot Self-testing: 5%	➢ Mines, farms, employment-seeking spots, inmates
Men (<30) and discordant couples	➢ Mobile testing: 80% ➢ Index-clinet model: 18% ➢ Self-testing: 2%	➢ High-yield communities and hot spots Initiated at health care facility ANC settings
AGYW	➢ Stand alone: 30% ➢ Mobile testing: 20% ➢ Home-based testing: 15% ➢ Social franchising mode: 5% ➢ School clinics: 5% ➢ Facilities with adolescent-friendly services: 5%	➢ Social networks ➢ In- and out-of-school youth ➢ Higher education institutions ➢ High school clinics
KP	➢ Mobile testing and peer navigation model: 80% ➢ Specialized KP-friendly health services: 20%	➢ Trucking spots
Symptomatic clients including pediatrics	➢ PITC (PMTCT, TB, STI, Outpatient Department, Immunizations (EPI)), Integrated Management of	➢ High volume/ burden facilities

	Childhood Illness, FP, in-patient medical wards): 80% ➢ Index client model: 10% ➢ Partner notification: 10%	➢ PLHIV, TB patients, ART patients

In COP17 PEPFAR will support CBO's, Ward Based Outreach Teams(WBOTS), community health workers (CHW), and (for KPs) peer navigators to serve as community linkage officers to assure PLHIV newly diagnosed in the community are successfully referred to the nearest facility, where the facility linkage and retention officers will ensure enrollment in care and treatment. Agreements and effective linkages between community-testing partners and DSPs will help to ensure reinforcement of the community-facility linkages. Men age 25-40 and AGYW are specifically being targeted to address a key mode of HIV transmission. In COP17 other strategies to strengthen linkage will include provision of adolescent-friendly services, fast tracking those newly diagnosed to minimize waiting time, extending clinic hours to improve access for men and youth, increasing PLHIV access to GPs in the private sector for ART initiation and management, and a mass media campaign promoting UTT and encouraging anyone with an exposure risk to be tested. PEPFAR will continue to support NDoH in the process of operationalizing a unique patient identifier, which will enhance monitoring of patients through the clinical and community cascades. In COP17 PEPFAR implementing partners will assist with its rollout to supported facilities.

In COP17 strategies for optimizing yield from community-based testing will be customized across age/sex bands to maximize effectiveness in identifying and linking to treatment for PLHIV among key and priority populations. In COP16 and continued into COP17 PEPFAR is interrogating its own yield data from multiple testing modalities to determine the most effective testing modalities for specific age/sex bands, as detailed in the Table 4.5.1 above. Testing modalities supported in prior years that resulted in low yield, such as house-to-house testing, are no longer supported.

In COP17 in all districts, 79% of the overall HTS target will be identified through PITC in health facilities. The hard-to-reach populations as well as the asymptomatic PLHIV not accessing health care services will be targeted through community testing, using index testing as well as mobile services.

In COP17 HTS will focus primarily on identifying <30 year old male and female clients through scaled-up index and partner and mobile testing and linkage to treatment. Based on COP15/FY16 and COP16/FY17 Q1 results, both index and mobile testing had higher yield (8%) than other modalities. These modalities will be effective in identifying PLHIV in the critical age group of 15-24 years. Similarly, MSM programs are focused on young men <30 years. Intensive case finding of men between the ages of 25-40 will be conducted in DREAMS districts to identify the sexual partners of AGYW in those districts. PEPFAR HTS programs will also focus on identifying men through mobile testing, by systematically utilizing prevention and GBV platforms such as community dialogues in saturation districts and link HIV-positive men into treatment. Workplace mobile testing will be scaled-up as well as partner notification at facility level. In COP17 targeted inmate testing, as well as focused programming in mining areas will be intensified.

In COP16 and COP17 PEPFAR will continue monthly meetings with all facility- and community-based partners to review monthly performance data, with a focus on HTC_POS and TX_NEW to identify

and address performance gaps with corrective actions. “All partners meetings” will be held to share best practices in reaching the hard-to-reach PLHIV and initiating and retaining them on treatment.

SIMS findings indicate several issues related to HTC Quality (15% red and 30% yellow on QA), as well as red scores (6%) and yellows (9%) for compliance with the HIV testing algorithm. In COP17 PEPFAR will support the NDoH QA program 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

In COP17 PEPFAR will continue to focus on aligning community approaches to the clinical cascade, national adherence guidelines, the UNAIDS 90-90-90 targets, attainment, as well as interventions aimed at improving the quality of life of PLHIV. PEPFAR will support the NDoH strategy to expand its differentiated service delivery model which categorizes distinct packages for new, stable and unstable ART patients as outlined in the National Adherence Guidelines. Through this model, by the end of COP17/FY18, an estimated 1.7 million stable ART patients will have been “decanted” to community drug pick-up points to decongest health facilities and reduce the burden on health workers, allowing more new patients to be enrolled in care. With formal implementation of UTT nationwide and the setting of ambitious TX_NEW targets going forward decongestion of health facilities is critical to achieving epidemic control.

The National Adherence Guidelines were adopted in June 2016 and detail the criteria for decanting. As of end of September 2017 (COP16/FY17 Q1), PEPFAR implementing partners had already achieved 34% of their annual decanting target with 497,008 stable PLHIV decanted to receive multi-month drug supplies at external pick-up points. [Nationwide, more than one million patients on chronic medications (including hypertensives, diabetics, etc.) had been decanted by end of FY17 Q1)]. In collaboration with NDoH and PDoHs implementing partners have scaled-up differentiated models of care that focus on community approaches to dispensing ART, including increasing the number of pick-up points in community settings such as CBOs, NGOs, private pharmacies, and adherence clubs. Implementing partners are also strengthening coordination with the CCMDD system that is responsible for pre-packing and distribution of medicines to the pick-up points. Health facilities are utilizing spaced, fast-lane appointments to ensure expedited ART pick up at facility level as well. Stable patients still require twice yearly assessments by the prescribing clinician at the facility, but by enabling those patients to pick up multi-month drug supplies in the community, facility-based health care providers have more time to focus care on sick PLHIV, those with unsuppressed VL, and those on treatment less than one year, as well as absorb the anticipated number of PLHIV requiring treatment initiation.

In COP17 PEPFAR implementing partners will provide training and mentoring of key linkage and retention personnel at both the facility and community level, consistent with government-led planning. At the facility level, PEPFAR implementing partners are training and deploying linkage and retention officers, as detailed in Section 4.5 above. At the community level, the CHWs cadre and the OVC cadre of Community Care Givers (CCGs) are uniquely positioned to identify and link vulnerable populations to testing and known PLHIV to facility-based services as well as support adherence, initiate and follow-up on referrals, and assist in tracing defaulters. In COP16 PEPFAR is

supporting the development of a national training curriculum for CHWs as well as investing resources towards training the OVC cadre of CCGs 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. Training and mentoring will be provided through NDoH, Regional Training Centers and PEPFAR implementing partners, and will ensure sustainable skills and competencies within government structures for continued technical guidance, training and mentoring. These efforts will be further augmented by development of a national referral policy that will standardize bi-directional referrals within health care facilities as well as between community and facility, strengthening linkage and retention, as well as improving access to community-based support services. The unique patient identifier, discussed in Section 4.5 above, will be an essential element of this referral process and its monitoring.

Facility linkages to community care and support services consistently scored poorly in PEPFAR SIMS assessments due to lack of a standardized system to track referrals, services received, and any return to facilities. In COP17 the activities detailed above in conjunction with the finalization of the GoSA's national referral policy and unique patient identifier rollout are expected to address these issues.

4.7 Family Planning/HIV Integration

In COP17, PEPFAR implementing partners will support NDoH and PDoHs integration of services to strengthen broader family planning (FP) and HIV access by encouraging women and couples living with HIV to utilize these services to prevent unintended pregnancies, reduce new pediatric HIV infections, and prevent maternal deaths related to HIV. FP/HIV integration is integral to achieving 90-90-90 across multiple PEPFAR-supported programs including PMTCT, TB/HIV care, care and support, KP services, maternal health, AGYW, and DREAMS. The below interventions are expected to improve FP/HIV integration services:

- Strengthen FP integration within HIV programming for 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 identify men and children for HTS and linkage to care and treatment.
- Leverage FP services as an entry point to increase access and acceptability of HTS and TB screening among women and their partners. Given an HIV prevalence among pregnant women of 25%, strengthening HIV testing among women seeking FP services is expected to contribute significantly to HTS_POS and TX_NEW.
- Continued support for FP services as a means of helping to keep women living with HIV adherent to treatment and compliant with VL testing and other health interventions.
- Strengthen collaboration efforts with CHWs and WBOTs to increase access to FP information, voluntary counseling and referrals.
- Utilize FP services as an entry point to integrate gender into care to narrow gender gaps and empower women.
- Continue to support implementation of patient tracking and follow-up tools in order to strengthen referral system for FP.

PEPFAR implementing partners will support FP/HIV integration services through: 1) training and capacity building using the updated National Contraception and Fertility Planning curriculum; 2) improved supportive supervision for CHWs and WBOTs; and 3) provision of FP Information, Education and Communication materials. Additionally, utilization of mHealth mobisites, i.e.,

MomConnect and B-Wise, has been introduced to promote healthy lifestyles, increase HIV awareness, and create demand for integrated FP/HIV services among young people.

4.8 TB/HIV

Despite continuing declines in the number of TB cases reported in SA since 2012, TB still accounts for 7.2% of all deaths in the country and is the leading cause of death for PLHIV. Increasing numbers of multi-drug-resistant (MDR) TB and extensively drug-resistant (XDR) TB cases further complicates control efforts. The TB/HIV co-infection rate declined from 61% to 57% in 2016. COP15/FY16 results show 95% of TB patients in the 27 PEPFAR-supported districts had a documented HIV status and 83% of TB/HIV co-infected patients had received ART.

The GoSA funds the majority of its TB and TB/HIV programs. In FY16/17 domestic TB funding is via the Provincial HIV/TB Conditional Grants. The remaining funding is from bilateral (PEPFAR, USAID), and multilateral (including GF) donors and private foundations such as the BMGF.

In FY17/18 the NDoH will be in its third 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 identifying leakages in the cascades and how these may 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 among PLHIV continues to undermine efforts to control both the HIV and TB epidemics.

In COP17, PEPFAR will continue to work closely with the NDoH, PDoHs and other partners to improve knowledge of HIV status among TB patients from 95% to 99% in all 27 districts supported by PEPFAR. SA currently does not track HIV testing of presumptive TB cases. In COP16 and COP17 PEPFAR will work with NDoH and other partners to develop and test a standard approach to systematically monitor services for presumptive TB cases across the HIV and TB care cascade. This strategy will be piloted in COP17 and is expected to inform future policy.

One of the challenges related to 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. In COP17 PEPFAR will work with NDoH to improve ART uptake among TB/HIV co-infected patients from 83% to 95% in the 27 focus districts and continue support for training of nurses on NIMART. In COP17 additional human resources (HR) support will be provided to facilities experiencing low uptake of ART among TB patients. To address the issue of patient attrition in the event that the TB focal nurse is not NIMART trained, in COP17 PEPFAR will also increase the use of counselors/clinic navigators to support facilitated referrals between TB clinics and ART initiation sites. In COP17, 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.

In COP17 to reduce progression from Latent TB Infection (LTBI) to active TB, PEPFAR will place more emphasis on PT initiation and completion among ART patients. There are currently no data on Isoniazid Preventive Therapy (IPT) outcomes in SA since this indicator is not part of the national indicator data set (NIDS). In COP17 PEPFAR will work with NDoH and partners to support documentation of IPT outcomes on Tier.net.

Additional TB/HIV activities in COP17 will include:

- Technical assistance provided to strengthen TB/HIV collaborative activities through support for evidence-based, contextualized TB/HIV integration policies, capacity building, and training, mentoring and coaching. The following technical priorities and service delivery package will be supported through technical assistance and direct service delivery in SA supported focus districts:
- 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).
- Update TB/HIV policy (TB/HIV integration manual) using evidence generated from PEPFAR-supported sites.
- Scale-up IPT provision for PLHIV through implementation of demand creation strategies.
- Strengthen implementation and monitoring of TB infection prevention and control (IPC) interventions in communities, congregate settings and health care settings, particularly PHC facilities and hospitals.
- Support development of policies for management of LTBI amongst HCWs.
- HTS for TB patients and presumptive TB cases with immediate access to ART for all co-infected TB patients. PEPFAR SA 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 SA 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.
- Maximize TB case finding through household testing and assure HIV testing of those identified TB cases in the household.
- Provide technical assistance to district management and facility staff to implement the NDoH QA/QI approach as an effective strategy for improving the quality of TB/HIV care across the cascade.
- Support institutionalization of TB/HIV cascade analysis at facility and district level to improve tracking of PLHIV screened for TB through diagnosis until treatment initiation.
- Provide technical assistance to improve compliance with the TB diagnostic algorithm and ensure consistent use of GeneXpert as the initial diagnostic test for PLHIV.

In COP17 to further increase the proportion of TB patients with a known HIV status to attain 99% testing rate and increase ART uptake amongst co-infected TB patients and PLHIV completing TB preventive therapy (TPT), PEPFAR will closely monitor partner performance through: review of the

entire TB/HIV cascade during SIMS visits, technical review meetings with partners to discuss performance, mitigation strategies monthly reviews, and quarterly joint program progress meetings.

4.9 Adult Treatment

In September 2016, SA adopted policy changes that include UTT for all PLHIV, as well as provision of PrEP to KP such as HIV-negative FSW. COP17 targets and strategies assume full implementation of UTT and same-day initiation nationwide in all of SA's nine provinces. Twenty-one of the 27 priority districts supported by PEFPAR are targeted for saturation in COP17, with the remaining six expected to achieve attainment57 status. Monitoring achievement will be facilitated by enhanced reporting capacity within TIER.net. Using the modified system, provinces' capacities will be supported to conduct analyses and generate reports with site-level data disaggregated by age and sex. PEPFAR partners will be authorized to utilize these reports for program management and monitoring/evaluation, and reporting.

In COP17, PEPFAR will continue NDoH and PDoHs' support for the implementation of UTT and finalization of a same-day initiation policy through ongoing scale-up in the 27 focus districts. To promote GoSA's UTT policy and increase awareness of treatment access for all HIV-positive persons, PEPFAR is supporting a national media campaign. The campaign is currently in the preparatory phase, but DSPs have already started conducting district-specific media campaigns to create demand for services and improve TX_NEW achievement in the highest burden districts and highest volume sites. In COP17 PEPFAR will assure that appropriate testing at all facility-based PITC entry points (with particular focus on inpatient units where testing has been inconsistent and not adequately monitored) is maximized. PEPFAR will also continue support of differentiated models of care, targeting 1.7 million stable PLHIV on ART through the CCMDD, GP and community adherence programs.

In COP17 PEPFAR will work with NDoH to identify efficiencies, new strategies and innovations in ART service delivery. In COP17 PEPFAR will support GoSA towards achieving an increase of approximately one million PLHIV on ART in the 27 focus districts. PEPFAR will work with NDoH and PDoHs in reconfiguring service delivery approaches to achieve greater efficiency and reduce costs through accelerated implementation of the UTT policy and differentiated care service delivery models for stable ART patients. Ongoing discussions and decisions about the use of various service delivery options occur through PEPFAR's participation in PFIP Care and Treatment Workstream meetings which include health strengthening team members, and other relevant planning sessions and discussions with provinces, districts and facility managers. PEPFAR will also support NDoH and PDoHs through technical assistance and placing human resources through roving mentoring teams that provide part-time support to multiple facilities, short-term human resources staff support or "surge" teams that assist for 3-6 months to strengthen a key cascade component(s) while implementing system improvements to allow facilities to continue to sustain improved performance, and secondments of PEPFAR-funded staff to a specific facility for up to 12 months. Facility-based staff support may include, lay counsellors, linkage officers, peer navigators, nurses and doctors in high-volume clinics with low performance to improve service delivery for HIV-infected patients. As of December, 2016, PEPFAR was supporting 964 clinicians and clinical support staff and 476 data capturers in facilities, communities and field offices. Specifically with regard to the clinicians and

[57] Op. cit. 2 (above)

clinical support staff, there are 75 medical doctors, 517 professional nurses, 19 clinical associates and 100 pharmaceutical staff. The remainder is comprised of a variety of occupational classifications (i.e., medical specialists, medical researchers and related professionals, etc.). It is expected that these numbers will change as PEPFAR supports NDoH's implementation of differentiated models of care.

Facility-based technical assistance is guided by several factors, including: the volume of PLHIV served at the site (with the highest volume facilities most likely to warrant the most support); the gap between the number of patients currently enrolled on treatment at the facility and the estimated number of PLHIV in the catchment area; the gap between newly enrolled patients on treatment and the target; and the HTS positivity rate. The decision to provide technical assistance is predicated on an enabling environment at the facility, including adequate infrastructure to support work of additional staff and strong facility management. The determination of the level of technical assistance (i.e., the "model") to utilize is based on the extent of the gap between performance level and established targets. PEPFAR will support NDoH and PDoHs to implement standard, high-quality, patient-centered HIV services to optimize the care continuum; reduce intensity and frequency of clinical visits per guidelines for stable ART patients; and support patient-centered models. It is expected that the volume of HIV patients in facilities will decrease as attainment and saturation is achieved and as stable patients are decanted to alterative services delivery including multi-month ARV resupply and community pick-up points. Accordingly PEPFAR funding for seconded facility-based staff will decrease. These efforts will also be aligned with general strategies to mainstream HIV care as a chronic condition.

In COP17 PEPFAR will 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 phone application reminder systems; 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 COP17 PEPFAR will support clinic-laboratory interface (CLI) activities at the facility level. Activities will include: (1) training of HCWs on specimen and test result tracking; test request form completion (specifically addressing the use of the unique identifier); (2) recruitment of partner-based laboratory coordinators to provide technical assistance to facilities on laboratory-related activities; (specimen collection, packaging, storage, transportation, and tracking); (3) QA training; and (4) entering laboratory data onto patient chart and into Tier.net.

In addition, PEPFAR will continue to support the NDoH 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. 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, GPs) in supporting continuum of care activities and intensify targeted/focused trainings essential for 90-90-90. PEPFAR will also intensify synergies and coordination with community-based programs to increase utilization of NDoH, CHWs and WBOTS; engage CBO support for HCT, linkage and retention, and treatment adherence; and work with

implementing partners to adopt a district approach of coordination with HIV prevention and OVC programs.

Improving utilization of VL testing is in progress in SA. To date, the program achieved 64% VL coverage and 87% VL suppression among patients who had VL done. However, there are significant variations in completion and suppression across districts. Although there is high VL suppression among the VL done, documented VL coverage is low.

There is evidence of VL underreporting, highlighting issues related to data flow and quality. A study in SA, conducted by NHLS, indicates more VL were completed than reported in Tier.net. There are red SIMS Core Essential Elements (CEEs) for poor VL documentation across multiple districts and partners. In COP17 data capturers will be placed in facilities to support capturing VL and other patient data in Tier.net.

In COP17 PEPFAR will continue support to SA's efforts to scale up VL completed and reported with a goal of the routine use of VL completed and reported for all ART patients. Experience to date suggests that existing VL platform/equipment is underutilized with 40% or more testing volume that could be done by existing platforms with strengthening the pre-analytic phase within the lab, appropriate planning, and adequate staffing. In COP17 PEPFAR will work with the NHLS to increase testing capacity and efficiency of existing platforms by strengthening the pre-analytical phase within the lab; and improving efficiency of laboratory networks (by improving specimen handling, tracking, transport networks, and results return to clinic, entry into patient chart, and into Tier.net and educating patients, clinicians, and laboratorians on the importance of routine VL testing and improved monitoring). In addition, in COP16 and in COP17 PEPFAR will continue focused communication efforts to improve patient-level understanding of VL and the importance of achieving viral suppression to improve health as well as to prevent transmission. VL reports serve as a proxy of success at the district level for achievement of large-scale community viral suppression.

4.10 Pediatric Treatment

In SA an estimated 340,000 children under the age of 15 are living with HIV (UNAIDS 2014). Under 15- year-old ART coverage is 51.7% (UNAIDS, 2016). Despite reduction in HIV incidence to <2% at birth among exposed infants through the PMTCT program, there are infected older children who remain untested and present only when symptomatic. Most of the estimated children living with HIV (243,744; 71.7% of total) reside in the 27 PEPFAR-supported districts; and 135,650 or 55.7% of them are on ART as of COP15/FY16, (slightly higher coverage in the 27 districts).

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 COP17 PEPFAR with NDoH, PDoHs and implementing partners will expand innovative methods to identify these children before the infection has had a significant effect on their quality of life. In COP17 PEPFAR plans to support case finding initiatives with high yield including testing family members of index cases either at the facility or at patients' homes; improving OVC screening; and ensuring all children and adolescents presenting at school health services and health facilities are screened using age-appropriate algorithms. In COP17 PEPFAR targets linking more than 90% of identified <15 year old PLHIV children to initiation of ART.

In COP17 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 OVC using the screening algorithm developed by the OVC TWG, as well as amongst children and adolescents attending clinics for recurrent lower respiratory tract infections or gastroenteritis, TB, malnutrition, or developmental delay. The IMCI testing algorithm will be used for screening children <5 attending well-baby clinics. Primary caregiver (parent, grandparent, other relative) and child discussions related to HIV and HCT will be addressed through the KIDZ Alive program disclosure guidelines. These tools are being rolled out by NDoH in COP16. The guidelines help HCWs and caregivers address issues around testing, disclosure, ART, and adherence to treatment. Both interventions will help assure safe and child-friendly spaces, increased uptake of HCT and case finding, and 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 PHC facilities often are unaware of the child's birth PCR/HIV test results. During COP17 PEPFAR will support NDoH and PDoHs to expand the use of CHWs 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. HIV-negative mothers will be retested post-delivery and at regular intervals while 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 facility-based partners will help improve 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 is working with the NDoH and PDoHs and implementing partners to ensure that all facilities have access to appropriate tools such as mid upper arm circumference (MUAC) tapes for screening patients. PEPFAR is also supporting NDoH and PDoHs efforts to provide consistent use of pediatric clinical registries.

Strengthening community linkages is critical for the three 90-90-90 goals as well as preventing new HIV infections in infants. Using CHWs strategically can help timely access to treatment as well as adherence and retention in care. SA has not yet adopted differentiated care models and CCMDD[58] for younger children who need to be followed regularly for weight monitoring and resultant dose changes; however, PEPFAR is recommending NDoH to adopt a differentiated model of care for children and adolescents who are stable on treatment.

Regular VL monitoring is key to ensuring that children on ART are suppressed and retained on treatment. VLs among children are often delayed or not done due to inexperience in pediatric phlebotomy. In COP17 PEPFAR will use roving teams to provide direct service delivery and mentorship to clinic staff to address pediatric ART initiation bottlenecks as well as to address virologic failure in children. Empowering facility nursing staff on when regimens need to be changed and when to refer children for assessments to the hospital will make a significant impact on the

quality of care. In COP17 PEPFAR will also be working with NHLS to ensure that dry blood spots for VL are approved and available for children and adolescents.

In COP16 and continuing in COP17, PEPFAR is working with NDoH to support a Pediatric HIV Drug Resistance survey among children with virologic failure on ART. The survey will help ensure that appropriate second-and third-line regimens are used. In COP16 and 17 PEPFAR SA is also focusing on enhancing sensitized adolescent and youth-friendly clinic services including late-hour and 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. In COP17 PEPFAR also intends to support NDoH efforts to empower HIV-positive adolescents through IEC materials and improve demand creation for treatment and VLs through social media platforms.

4.11 OVC

According to UNAIDS estimates (2015), about 2.1 million SA children aged 0-17 years were orphaned due to AIDS. The 2011 Census estimates there are 3,344,832 orphans aged 0-17 years, with about 78% located in the 27 focus districts. These data reflect all orphans and not only orphaned children attributed to HIV/AIDS; these data also do not include children made vulnerable by HIV/AIDS (e.g., those living with HIV or with HIV-positive caregivers). In COP17, PEPFAR in collaboration with the National Department of Social Development (NDSD) and implementing partners will provide services to 634,789 OVC. This target is based on OVC burden, HIV prevalence, APR 2016 data, partner capacity and Expenditure Analysis data.

OVC are at increased risk of HIV infection and efforts to increase access to HTS 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 targets and epidemic control. In COP17 all PEPFAR OVC program beneficiaries (<18 years old) will have their HIV status reported to the implementing partners (including status not reported), disaggregated by status type. In COP17 in coordination with NDSD, PDSDs and implementing partners, community/clinic linkages will be facilitated and improved, including counselling (including family-centered disclosure) and referrals, as well as expanded quality case management.

Through effective case management, household visits, and improved use of data and targeting, OVC implementing partners will identify the most vulnerable children (including AGYW) and provide one-on-one 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/AGYW focused funding, OVC partners will support the GoSA's 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. In COP17, PEPFAR implementing partners will increase the delivery of an evidence-based package of services to beneficiaries 15-17 years of age especially girls. This includes a new program which seeks to expand youth health and development programs for OVC ages 15-17 in three saturation districts. Implementing partners will also prioritize risk avoidance strategies for girls 10-14 years to ensure that they stay HIV-negative.

In COP16 PEPFAR was awarded Plus Up funding for COP16 GBV activities. These child protection and GBV activities aligned with NDSD will be integrated into COP17. In addition, the portfolio will have greater focus on prevention of GBV and improved linkages to post-violence care and PEP as well as using post-violence care facilities as an entry point to maximize the potential to increase uptake of HIV interventions.

Strategic investments in critical social systems strengthening will continue through coordination with NDSD and implementing partners that provide support to NDSD and PDSDs to address the social and structural barriers that increase the vulnerability of OVC to HIV. These activities include: 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 social behavior change activities; and supporting the NDSD's Community-Based Information Management System (CBIMS) electronic data management training.

4.12 Addressing COP17 Technical Considerations

Increased focus on prevention and care services for under 30 year-olds:

- Specific DREAMS prevention activities to be expanded to 22 sub-districts in non-DREAMS priority districts, supporting the GoSA's She Conquers prevention campaign.
- PEPFAR implementing partners have scaled up focus and support for AGYW in all 27 priority districts.
- School health clinics to introduce sexual reproductive health (SRH) services including HIV testing.
- OVC programming to focus on the 10- to 24-year-old age band, stressing reproductive health education and postponement of sexual debut for 10-13 year olds and assuring HIV testing for 14- to-24-year olds following sexual debut; Community Care Givers to accompany those testing positive to enroll in treatment.
- PrEP currently available only for FSWs; PEPFAR to fund commodities and expansion to MSM and vulnerable AGYW that will support GoSA with additional demonstration projects.
- PEPFAR to fund training and implementation of post-violence care.
- VMMC to improve demand creation and targeting of 15-to-29-year old age band.
- PEPFAR supports the NDoH's *Phila* public health messaging campaign, a major aspect of which is promoting condom use and responsible male sexual practices. PEPFAR continues to support partners providing testing and treatment services to prison inmates, migrant farm workers and miners.

Mix of HIV testing modalities to improve testing coverage, yield & efficiency:
PEPFAR has interrogated its own yield data from multiple testing modalities to determine what appear to be the most effective testing modalities for specific age/sex bands. In COP16 and continued into COP17 strategies for optimizing yield from community-based testing will be customized across age/sex bands to maximize effectiveness in identifying and linking PLHIV to treatment among key and priority populations. Both index and mobile testing modalities had higher yield (8%) than other modalities. In COP17, HTS will focus primarily on identifying <30 year old males and females through scaled-up index and partner testing and mobile testing and link them to treatment.

- Identification of men (40% of HTS COP17 target) through:
    - Index case identification as noted above;

- Mobile testing through systematic utilization of PP-PREV and GBV platforms such as community dialogues in saturation districts and link them to HIV treatment;
- Workplace mobile testing will be scaled-up and target male-dominated industries for the 25- to 40-year old age group;
- Facility-based services including Pilot partner notification for partners of PMTCT clients; STI and TB/HIV clients;
- Targeted inmate testing nationally, as well as intensified mining programs; and
- Saliva-based self-testing currently undergoing certification for use in SA. During COP16, PEPFAR is providing NDoH technical assistance to development self-testing national guidelines. In COP17, use of self-testing will be piloted especially to improve partner testing of ANC clients.

- Identification of AGYW in and out of school through a mix of targeted HTS modalities including:
  - Stand-alone centers;
  - Mobile testing;
  - Home-based testing; and
  - Social Franchising model and facilities with adolescent-friendly clinics.

Currently, women seeking FP services are not routinely tested for HIV. The resulting positivity rate is expected to approach that for pregnant women (13.3% newly positive in COP16/FY17 Q1). In COP17 PEPFAR will support NDoH and PDoHs to scale up HIV testing of FP clients.

As highlighted earlier in the SDS, throughout COP15/FY16 and continuing into COP16/FY17 Q1, TX_NEW has significantly under-performed in comparison to HTC_POS. To address the ongoing challenge in linking newly diagnosed PLHIV to treatment, the following mix of linkage strategies will be implemented to achieve 90% linkage in COP17:

- Expand deployment of linkage and retention officers at high-volume facilities to accompany newly diagnosed PLHIV from the testing site to the care and treatment site within a facility for same-day initiation;
- Provide adolescent-friendly services and fast tracking those newly diagnosed to minimize waiting time;
- Increase PLHIV access to GPs in the private sector for ART initiation and management; and
- CBOs, CHWs, and peer navigators for KPs to serve as community linkage and retention officers to ensure newly diagnosed PLHIV are successfully linked to the nearest facility for same-day enrollment in care and treatment.

Improved Linkage, Retention, and Viral Suppression:
Though UTT is official policy, there is not clear guidance regarding same-day ART initiation. At the national level, PEPFAR supporting NDoH with technical assistance to develop eligibility criteria for same-day initiation, enhancing both linkage and retention. In COP17 PEPFAR will:

- Emphasize the implementation and scale up of the use of a Unique Patient Identifier (called National Health Identifier in the Technical Considerations), which will reduce loss to follow-up (LTFU) by at least 30% by being able to account for silent transfers and enable better tracking of patients across the treatment cascade and across care facilities.

- Provide technical assistance to NDoH in revising post-test counseling messaging for HIV-positive persons, emphasizing the importance of early treatment to improve linkage.
- Increase funding for facility-based linkage and retention officers.
- Fund national media campaigns to highlight UTT, intended to increase demand among known HIV-positives individuals who have not sought care and encourage testing of those with potential risk.
- Expand adolescent, youth friendly services and clinic office hours to increase enrollment of PLHIV < 30 years old in care and treatment and help retain them in care. Peer support groups providing psychosocial support will be embedded in the routine service package.
- Launch and implement an e-Health App to improve adherence and retention.
- KP-friendly service delivery sites—that have been developed and managed by Non-governmental organizations (NGOs)—are now providing ART. Currently five FSW sites are providing PrEP and ART in COP16. While FSW are highly mobile and at increased risk of being LTFU, strengthened peer navigation and education will help assure ongoing follow-up across facilities. The patient ID for KP discussed above will also assist. In COP17, 11 sites will support FSWs and three will serve MSM.
- Among PMTCT clients, there is inadequate monitoring through end of breast feeding and poor recording of infant status post-cessation of breast feeding. Mentor mother peer support groups will be enhanced in COP17 and utilized to retrieve defaulters.
- VL performance varied significantly across districts in COP15/FY16, with VLD/TX_CURR ranging from 90% to 40%, median 63%. Among those tested suppression rates ranged across districts from 94% to 73%, median 85%. Only two districts had a suppression rate <80%. Bottlenecks in clinical-laboratory interface have been identified as root causes of poor VLD performance. One important bottleneck is inadequate results management and documentation in clinics. PEPFAR SA is addressing this by funding facility-level data capturers through its partners and mentoring by facility-based partners. The NHLS with PEPFAR funding will utilize the ECHO platform, developed in the U.S. for assisting rural health care providers in management of chronic disease, to train HCW in proper documentation of VL results. Additionally, PEPFAR implementing partners provide on-site mentoring on treatment failure. A target of 90% for TX_VIRAL has been set for COP17.

Ensuring Access to Quality, Sustainable HIV Delivery Systems:

- In COP15/FY16 the GoSA implemented differentiated service delivery models that allowed stable patients to be decanted to community-based drug pick-up sites for dispensing of multi-month prescriptions, with visits to facility-based health care provider decreased to twice yearly. In COP15/FY16 and through COP16/Q1FY17, approximately 497,008 PLHIV have been decanted to these alternative service delivery sites.
- In COP17, PEPFAR will strengthen sustainability by funding development of curriculum for CHWs that will enhance their capacity to assess status of stable patients decanted to community and link those needing medical attention back to facility.
- PEPFAR's facility-support partners will subcontract with PLHIV organizations to identify and train PLHIV as linkage and retention officers to be placed in supported facilities.
- PEPFAR staff will provide TA in developing a tool for monitoring retention of PLHIV decanted to alternative community-based sites.

4.13 Commodities

Currently there are no commodities stock-outs or projected funding gaps; however, with COP17's more aggressive attainment and saturation targets PEPFAR is working closely with the NDoH to ensure that the necessary commodities are available. PEPFAR is regularly speaking with the GF about these issues, as it may be able to assist if there are short-term bridging needs for commodities. PEPFAR and NDoH are monitoring this closely and follow-up with SGAC as needed.

4.14 Collaboration, Integration and Monitoring

In COP17, PEPFAR will support the GoSA to more holistically monitor the HIV/AIDS clinical cascade from diagnosis, linkage to care and treatment, retention on treatment, and viral suppression. Data from this monitoring will be used to identify areas of deficiency (e.g., leakage along the cascade) by location and population for immediate action.

Specific activities that will be continued/initiated in COP17 include:

- Support to the DIP process to focus on information use and better integration of data from the facility to sub-district and district level. In COP17 PEPFAR will also work more closely with PDoHs to assist in the quarterly DIP and sharing of PEPFAR quarterly reporting. DIPs are rigorous plans built around the Tier.net and DHIS systems designed to achieve 90-90-90 at the district level. Additionally, NDoH's monitoring of provincial HIV conditional grants are tied to DIPs.
- Support to key SA information systems (e.g., Tier.Net, DHIS) that are used to capture patient- and program-level data along the continuum of HIV services. Support will include: data quality and analysis support at the national- and sub-national levels; enhancement of Tier.Net to include the HTC, pre-ART, TB, adherence club, and maternal/child health modules; and movement to a web-based DHIS reporting system to facilitate more timely data entry and analysis, as well as the finer age/sex disagregations needed to monitor attainment.
- Utilizing the existing reporting systems, establish HIV case-based surveillance (pending findings from the COP16-supported pilot) for more 'real-time' monitoring of the clinical cascade. Support the implementation of the unique patient identifier system (Health Patient Registration System, HPRS) to better monitor patients across services and service-delivery points.
- In addition to host country systems, PEPFAR will continue to collect critical program data and custom indicators (e.g., DREAMS, decanting, direct service delivery/technical assistance) monthly to monitor partner performance in real-time.
- PEPFAR will routinize analytics of routine and custom indicators to share with the GoSA, implementing partners, and other stakeholders.
- PEPFAR will continue to support Best Practices meetings, partner meetings and bilateral USG/GoSA meetings to foster on-going collaboration, learning, and adapting.

5. Program Activities in Sustained Support Locations and Populations

In COP17 PEPFAR is supporting SA to achieve attainment in six districts and saturation in 21 districts. In COP18 it is envisioned that PEPFAR will have sustained and attained districts and specific support interventions to assist the NDoH and provincial departments of health to maintain saturation and attainment.

6. Program Support Necessary to Achieve Sustained Epidemic Control

During COP17 PEPFAR will continue to address the three programmatic gaps and two priority policies identified in COP16.

Programmatic Gaps:
1) Documented VL Completion
2) Facility/Community Continuum of Care
3) Targeted and Data-Driven Service Delivery to KPs

Priority Policies:
1) UTT[59]
2) New and Efficient Service Delivery Models[60]

In SA, all direction, guidance and decisions are set at a national level and implemented at the provincial, district and facility levels. The provinces are administratively responsible for the planning, management, implementation and monitoring of all government services. For example, decisions for filling vacant positions related to test and treat and new service delivery models as well as the operationalization and implementation of policies such as UTT are based on provincial mandates. In certain instances, national and provincial departments of health lack adequate numbers of staff for the successful implementation of NSP (2017-2022) and PEPFAR priorities. PEPFAR must align with the national and provincial structures and systems to ensure that joint goals may be met. COP17 continues support in building capacity and strengthening HR and systems at national and provincial levels to ensure success of NSP and PEPFAR program priorities at the district and facility levels. To strengthen monitoring of systems investments, annual benchmarks have been included in COP17 to measure progress of activities towards the three-year outcomes described in the COP16 Systems Budget Optimization Review (SBOR). Through extensive consultation with stakeholders and robust interagency discussion, PEPFAR confirmed which activities continue to be relevant and will be continued, with a limited number of activities modified or discontinued.

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

PEPFAR reviewed the COP16 SBOR and confirmed the key programmatic gaps to achieving 90-90-90:

Documented VL Completion

Facility/Community Continuum of Care

[59] See Appendix 3 for Tables 6.1., 6.2., and 6.3
[60] i.e. Implementation of the NDoH Adherence Guidelines

Lack of targeted and data-driven service provision to KPs

Documented VL Completion

PEPFAR supported NHLS, NDoH, PDoHs to increase the number of VL done (TX_VIRAL) by almost 50% from 1,074,447 to 1,502,691, but documentation of VLs completed still remains a critical gap for clinical management of patients and enrolling patients on new and efficient service delivery models (e.g., CCMDD, Community Adherence Clubs). Two of the three systems barriers to be addressed in COP16 remain unchanged for COP17: (1) Limited HIS capacity; and (2) Limited capacity of HRH. The third systems barrier has been modified to (3) Weak VL cascade specifically before and after the Laboratory (Clinic/Lab interface). The change reflects a more strategic direction in resolving the clinic/lab interface.

Activity changes include: the HIS activities have been refined to be more strategic, increase accountability, and yield immediacy of impact. HRH investments have been modified to reflect the changing direction put forth in the NDoH HRH Strategy currently under development, and PEPFAR has discontinued funding for an activity to pilot decentralized testing, as the activity is completed with GF resources.

Facility/Community Continuum of Care

PEPFAR is working with NDoH and PDoHs to bridge the gap between HIV-positive test results and HIV services—an early outcome of this shift is increasing the treatment linkage proxy indicator (HTC_POS/TX_NEW) from 65% in COP15/FY16 to 74% in COP16/FY17, even before test and start was fully implemented. The four systems barriers from COP16 remain unchanged: (1) Lack of a bi-directional referral system; (2) Limited HIS capacity; (3) Limited capacity of WBOTs and community cadres; and (4) Linkages between services provided by the public sector and CBOs/faith-based organizations (FBOs). In addition, in consultation with external stakeholders, PEPFAR SA has included high LTFU as a fifth systems barrier.

Activity changes include: the HIS activities have been refined to be more strategic, increase accountability, and yield immediacy of impact; support to WBOTs has been modified to support the new structure and scope of WBOTs, which includes a more focused role in UTT and new and efficient models of service delivery; and increasing support to the NDoH-led National LTFU Plan.

Targeted and data-driven service provision to KPs

As epidemic control is pursued, there is a need to understand the micro-epidemics' contribution to the general population epidemic. PrEP guidelines have been established to initiate FSWs on PrEP. PEPFAR SA continues to address the four systems barriers identified in COP16: (1) Limited surveillance of KPs; (2) Limited exchange of routinely collected information between the public sector and organizations serving KPs; (3) KPs experience stigma and discrimination when accessing services at public health facilities; and (4) Limited systems in place for PEP and PrEP provision.

Activity changes include: collecting and utilizing more routine data for size estimates, mapping, and cascade analysis; expanding PrEP eligibility to MSM and AGYW; purchasing of PrEP drugs and labs; and implementing demand creation activities for PrEP, particularly for FSWs and MSM. Demand creation will be done through peer education and support.

6.2 Critical Systems Investments for Achieving Priority Policies

PEPFAR reviewed systems barriers inhibiting UTT and new and efficient service delivery models from the COP16 SBOR. Two major successes in the past year include the GoSA's announcement of UTT in September 2016 and over 1 million patients enrolled in CCMDD.

The systems barrier related to the UTT policy has shifted to operationalizing same-day initiation. Furthermore, the systems barrier related to HRH personnel shortages has been modified to a shortage of HRH capacity, including training needs. Major activity-level changes include: the completion of the Health Labor Market Analysis and graduation from hiring foreign-qualified doctors as a stand-alone activity, which will be integrated into provincial and district level support; a substantial increase to the CCMDD program, in terms of activities and resources; and, increased investment in HRIS including the Knowledge Hub, Workforce Indicators of Staffing Needs (WISN) assessments and PERSAL (salary management) systems.

6.3 Proposed system investments outside of programmatic gaps and priority policies

PEPFAR also reviewed the systems investments outside the programmatic gaps and priority policies. All activities have been refined to align with 90-90-90 and epidemic control. Major changes include the graduation of TB training interventions which have been handed over to universities for continuation; alignment of surveillance activities to the National Strategic Plan for Surveys and Surveillance; and elimination of site-level activities included in the COP16 SBOR.

7. Staffing Plan

[REDACTED]

APPENDIX A

A.1 and A.2 Sub National Unit (SNU) Prioritization

District	COP 15 Prioritization	APR16 Achievement	COP16 Prioritization	Expected Achievement By APR17	COP17 Prioritization
gp City of Johannesburg Metropolitan Municipality	ScaleUp Sat	47%	ScaleUp Sat	81%	1_Attained
gp Ekurhuleni Metropolitan Municipality	ScaleUp Sat	51%	ScaleUp Sat	73%	1_Attained
kz eThekwini Metropolitan Municipality	ScaleUp Sat	56%	ScaleUp Sat	84%	1_Attained
kz uMgungundlovu District Municipality	ScaleUp Sat	69%	ScaleUp Sat	71%	1_Attained
kz Zululand District Municipality	ScaleUp Agg	62%	ScaleUp Agg	80%	1_Attained
lp Mopani District Municipality	ScaleUp Agg	68%	ScaleUp Agg	88%	1_Attained
ec Alfred Nzo District Municipality	ScaleUp Agg	49%	ScaleUp Agg	70%	2_Saturation
ec Amathole District Municipality	ScaleUp Agg	43%	ScaleUp Agg	59%	2_Saturation
ec Buffalo City Metropolitan Municipality	ScaleUp Agg	47%	ScaleUp Agg	62%	2_Saturation
ec Chris Hani District Municipality	ScaleUp Agg	44%	ScaleUp Agg	59%	2_Saturation
ec Oliver Tambo District Municipality	ScaleUp Agg	49%	ScaleUp Agg	58%	2_Saturation
fs Lejweleputswa District Municipality	ScaleUp Agg	55%	ScaleUp Agg	76%	2_Saturation
fs Thabo Mofutsanyane District Municipality	ScaleUp Agg	57%	ScaleUp Agg	69%	2_Saturation
gp City of Tshwane Metropolitan Municipality	ScaleUp Agg	44%	ScaleUp Agg	63%	2_Saturation
gp Sedibeng District Municipality	ScaleUp Agg	53%	ScaleUp Agg	63%	2_Saturation
kz Harry Gwala District Municipality	ScaleUp Agg	59%	ScaleUp Agg	78%	2_Saturation
kz Ugu District Municipality	ScaleUp Agg	61%	ScaleUp Agg	74%	2_Saturation
kz Uthukela District Municipality	ScaleUp Agg	55%	ScaleUp Agg	70%	2_Saturation
kz Uthungulu District Municipality	ScaleUp Agg	64%	ScaleUp Agg	72%	2_Saturation
lp Capricorn District Municipality	ScaleUp Agg	45%	ScaleUp Agg	67%	2_Saturation
mp Ehlanzeni District Municipality	ScaleUp Agg	56%	ScaleUp Agg	72%	2_Saturation
mp Gert Sibande District Municipality	ScaleUp Agg	48%	ScaleUp Agg	60%	2_Saturation
mp Nkangala District Municipality	ScaleUp Agg	32%	ScaleUp Agg	61%	2_Saturation
nw Bojanala Platinum District Municipality	ScaleUp Agg	43%	ScaleUp Agg	61%	2_Saturation

nw Dr Kenneth Kaunda District Municipality	ScaleUp Agg	51%	ScaleUp Agg	74%	2_Saturation
nw Ngaka Modiri Molema District Municipality	ScaleUp Agg	43%	ScaleUp Agg	60%	2_Saturation
wc City of Cape Town Metropolitan Municipality	ScaleUp Agg	84%	ScaleUp Agg	59%	2_Saturation
ec Cacadu District Municipality	Ctrl Supported	39%	Ctrl Supported	0%	3_Ctrl Supported
ec Joe Gqabi District Municipality	Ctrl Supported	48%	Ctrl Supported	0%	3_Ctrl Supported
fs Fezile Dabi District Municipality	Ctrl Supported	48%	Ctrl Supported	2%	3_Ctrl Supported
fs Xhariep District Municipality	Ctrl Supported	53%	Ctrl Supported	2%	3_Ctrl Supported
lp Vhembe District Municipality	Ctrl Supported	83%	Ctrl Supported	0%	3_Ctrl Supported
nc Frances Baard District Municipality	Ctrl Supported	67%	Ctrl Supported	0%	3_Ctrl Supported
nc John Taolo Gaetsewe District Municipality	Ctrl Supported	81%	Ctrl Supported	0%	3_Ctrl Supported
nc Namakwa District Municipality	Ctrl Supported	25%	Ctrl Supported	1%	3_Ctrl Supported
nc Pixley ka Seme District Municipality	Ctrl Supported	48%	Ctrl Supported	1%	3_Ctrl Supported
nc Zwelentlanga Fatman Mgcawu District Municipality	Ctrl Supported	40%	Ctrl Supported	2%	3_Ctrl Supported
nw Dr Ruth Segomotsi Mompati District Municipality	Ctrl Supported	53%	Ctrl Supported	0%	3_Ctrl Supported
wc Cape Winelands District Municipality	Ctrl Supported	399%	Ctrl Supported	0%	3_Ctrl Supported
wc Central Karoo District Municipality	Ctrl Supported	45%	Ctrl Supported	15%	3_Ctrl Supported
wc Eden District Municipality	Ctrl Supported	67%	Ctrl Supported	1%	3_Ctrl Supported
wc Overberg District Municipality	Ctrl Supported	74%	Ctrl Supported	3%	3_Ctrl Supported
wc West Coast District Municipality	Ctrl Supported	43%	Ctrl Supported	0%	3_Ctrl Supported
ec Nelson Mandela Bay Municipality	Sustained	34%	Sustained	0%	3_Ctrl Supported
fs Mangaung Metropolitan Municipality	Sustained	44%	Sustained	1%	3_Ctrl Supported
gp West Rand District Municipality	Sustained	58%	Sustained	0%	3_Ctrl Supported
kz Amajuba District Municipality	Sustained	55%	Sustained	1%	3_Ctrl Supported
kz iLembe District Municipality	Sustained	58%	Sustained	0%	3_Ctrl Supported
kz Umkhanyakude District Municipality	Sustained	67%	Sustained	0%	3_Ctrl Supported
kz Umzinyathi District Municipality	Sustained	56%	Sustained	0%	3_Ctrl Supported

lp Sekhukhune District Municipality	Sustained	47%	Sustained	1%	3_Ctrl Supported
lp Waterberg District Municipality	Sustained	61%	Sustained	3%	3_Ctrl Supported

Table A.2 ART Targets by Prioritization for Epidemic Control

Prioritization Area	Total PLHIV	Expected current on ART (APR FY 17)	Additional patients required for 80% ART coverage	Target current on ART (APR FY18) *TX_CURR*	Newly initiated (APR FY 18) *TX_NEW*	ART Coverage (APR 18)
Attained	2,004,148	1,596,454	120,035	1,716,490	287,658	0.85
Scale-Up Saturation	3,253,656	2,120,045	525,894	2,645,939	607,717	0.81
Central Support (KP and correctional facilities)	1,431,535	10,642	NA	10,642	957	NA
Commodities (if not included in previous categories)						
Total	**6,689,339**	**3,727,141**	**645,929**	**4,373,071**	**896,332**	

APPENDIX B

B.1 COP17 Planned Spending in 2017

Table B.1.1 Total Funding Level		
Applied Pipeline	**New Funding**	**Total COP17 Planned Spend**
$29,741,331	**$ 453,582,050**	**$$483,323,381**

*Data included in Table B.1.1 should match FACTS Info records, and can be checked by running the "Summary of Planned Funding by Agency" report.

*Table B.1.1 Resource Allocation by PEPFAR Budget Code *Note: subject to final budget code allocations*		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	$17,003,823
HVAB	Abstinence/Be Faithful Prevention	$5,414,914
HVOP	Other Sexual Prevention	$29,835,205
IDUP	Injecting and Non-Injecting Drug Use	$70,000
HMBL	Blood Safety	$0
HMIN	Injection Safety	$0
CIRC	Male Circumcision	$35,824,932
HVCT	Counseling and Testing	$35,691,717
HBHC	Adult Care and Support	$47,903,572
PDCS	Pediatric Care and Support	$8,090,431
HKID	Orphans and Vulnerable Children	$37,304,551
HTXS	Adult Treatment	$149,301,358
HTXD	ARV Drugs	$906,213
PDTX	Pediatric Treatment	$8,472,757
HVTB	TB/HIV Care	$34,493,642
HLAB	Lab	$4,330,889
HVSI	Strategic Information	$10,178,556
OHSS	Health Systems Strengthening	$25,906,624
HVMS	Management and Operations	$32,594,196
TOTAL		**$483,323,381**

***Table B.1.2 Resource Allocation by PEPFAR Budget Code (new funds only)**

Note: subject to final budget code allocations

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	$15,651,084
HVAB	Abstinence/Be Faithful Prevention	$4,969,970
HVOP	Other Sexual Prevention	$28,039,162
IDUP	Injecting and Non-Injecting Drug Use	$70,000
HMBL	Blood Safety	0
HMIN	Injection Safety	0
CIRC	Male Circumcision	$25,615,740
HVCT	Counseling and Testing	$31,795,894
HBHC	Adult Care and Support	$46,718,062
PDCS	Pediatric Care and Support	$7,914,061
HKID	Orphans and Vulnerable Children	$37,213,069
HTXS	Adult Treatment	$146,421,984
HTXD	ARV Drugs	$906,213
PDTX	Pediatric Treatment	$8,346,387
HVTB	TB/HIV Care	$33,500,150
HLAB	Lab	$4,330,889
HVSI	Strategic Information	$8,833,076
OHSS	Health Systems Strengthening	$24,341,773
HVMS	Management and Operations	$28,914,535
TOTAL		**$ 453,582,050**

*Notes-Tables B1.1 and B1.2: The difference between Table B 1.1 and B 1.2 is the amount of pipeline applied by agencies in COP17; a total of $29,741,331 of previous years' funds is applied in COP17. The ~$453m includes $40m of treatment performance funding. In addition to the ~$453m, there is central VMMC funding of $51,503,884, of which $5m is performance funding. Decisions on performance funding allocation to the South Africa COP17 implementation will be determined after COP16/FY17 Q2 results review.

B.2 Resource Projections

Data was pulled from the Datapack for targets, PBAC and FSW reflect interagency planning and use of estimated unit expenditures, estimated service package costs, and budgets for above site activities.

APPENDIX C

Section 6.0 Tables: Program Support Necessary to Achieve Sustained Epidemic Control

Key program gap	Key Systems Barrier	Outcomes expected after 3 years of investment	Year One (COP/ ROP16) Annual Benchmark	Year Two (COP/ ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)
Table 6.1.1	**Low viral load documentation**									
Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion	1. Limited health information system capacity (e.g., clinic/lab interface, electronic medical record, Unique Identifier)	- 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.	- 60% of all lab request forms and results have a unique ID and results are entered into the patients through the clinic lab interface. - 80% of lab results returned to clinics/facilities within the set turn around time as stipulated in the NHLS handbook and monitored through the clinic/ lab interface systems. - 60% of facility HCW within the priority districts receive clinic /lab interface systems training.	- 80% of all lab request forms and results have a unique ID and results are entered into the patients through the clinic lab interface. - 90% of lab results returned to clinics/facilities within the set turn around time as stipulated in the NHLS handbook and monitored through the clinic/ lab interface systems. - 80% of facility HCW within the priority districts receive clinic /lab interface systems training.	TX_PVLS	1.1.1. Strengthen Health inofrmation systems to ensure 90-90-90 including: a) Clinic lab interface for result reporting for patient management. b) The electronic gate keeper system to ensure unnecessary test ordering. c) Training of HCWs on specimen handling , result management and test ordering.	HLAB	$579,000	17493	10. Laboratory (6.67)
Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion	1. 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.	Performance Monitoring Dashboards updated Quarterly with one external data source (DHIS) to monitor PEPFAR and DIP results	Performance Monitoring Dashboards updated Quarterly with one external data source (e.g., Tier.net, NHLS, National Supply Chain Surveillance Center) to monitor PEPFAR and DIP results	Performance Monitoring Dashboards	1.1.2 Technical Support for Business Intellegence Tools / Data Analytics across Systems	HVSI	$810,000	14846	15. Performance Data (8.73)
Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion	1. 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.	Provincial DQI pilots completed in three provincesand reports disseminated	National Data Quality Improvement Plan developed; Data Quality Dashboards Developed; PEPFAR/SA quarter lag reduced	Department of Health Annual Performance Plan	1.1.3 Technical Support for Systems Information Quality to ensure focus transitioned from diagnostics to DQI approach	HVSI	$810,000	14846	13. Epidemiological and Health Data (6.77)

Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion	Limited Interoperability between health information systems including Tier.net, ETR. Net, Mom Connect systems and NHLS data ware house and web DHIS to address low documented viral load completion.	Increased coverage by 50% of the Health Patient Registration System (including unique identifier) in PEPFAR-supported sites 90% tracking of patients in all HPRS facilities. 30% integrated data between Tier.net and HPRS to improve HIV treatment in retention 80% technical expertise competency on all HPRS facilities 90% monthly patient headcounts on webDHIS through HPRS at facility, sub-district, district, province, and national levels	Increased number of provincial or district departments of health with operational HIS governance structures for HIE (8 provinces and District implemeting webDHIS). Integration and availability of registration pregnant women, NHLS, TIER, ETR,EDRweb,WBOTS data into webDHIS (9 province and District implemeting webDHIS). Improved linkage to care, retention and preventation (90% WBOTS data captured into webDHIS) increase availability of PreArt, ART, Viral load testing data).Improved availability and access to DQ and program performance feedback (9 Pronvinces with dashboards on quarterly basis)	Improved availability and easy- access of mutiple source data PMTCT,NHLS,TB,HIV through a single one interface i.e. webDHIS in 8 provinces. Increase the effecient monitoring and reporting by programs to improve patient care (dashboard developed in 8 provinces).Increase the linkage and service integration to improve HIV Testing, ART provision and aherence to treatment and vital load supression (100% facilities that utilize digital TB Module).100 % Capturing of HIV testing data into TIER.Net and linkage of data across all modules and high levels in all facilities with digitize TB Module .Linkage of HIV community services e.g.	No of provinces and districts with Health Information Exxhnage structures.Use and availability of integrated.IV/TB/lab,PMTCT data (No of provinves with key indicators programme Dashboards).Evaluation of 90-90-90 targets achievement (No of provinves with APP daschboards developed e.g. HTC, ART, Viral Supression achievements).No of facilities which employ HTC Modules and TB Module. % of data quality achieved in the programs	1.1.4 Development of ehealth/mHealth Architecture to support the platform of Interoperability between Health Information Systems including TIER.Net, ETR.Net, EDRweb,MomConnect, NHLS datawarehouse, webDHIS and WBOTS/ community based care data with the aim of centralizing HIV/TB/PMTCT,lab results data to strengthen the linkage to care, HIV testing, ART retention and viral load completion e.g deployment of Pre-Art module into TIER.Net, Mobile SMS platform ; sending SMS to get people for viral load tests, and appointement reminders. house hold Tracker database	HVSI	$800,000	18021	13. Epidemiological and Health Data (6.77)
Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion	Limited data consistency between DATIM and DOH systems (Web DHIS)	- Increase coverage of the Health Patient Registration S	DHMIS DATIM data comparison automated process and report completed to review the data for the improvement of data quality SOP to be completed	Routine comparison and review of data from DATIM and DHIS2 to improve data alignment and reliability, accesibility, accuracy and completeness System maintainance	Routine comparison and review of data from DATIM and DHIS2 to improve data alignment and reliability, accesibility, accuracy and completeness System maintainance	1.1.5. Development of a Data Quality Improvement System between DATIM and DHIS2 to strenthen alignment between DATIM and DHIS2, support NDoH HIV programs and PEPFAR's performance monitoring, transparency and accountability	HVSI	$100,000	18021	13. Epidemiological and Health Data (6.77)
Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion	Inadequate integration of patient level data to link with HIS.	- Increased by 50 % of patients in HPRS with unique 90% tracking of patients in all HPRS facilities. 30% integrated data between TIER.Net and HPRS to improve HIV treattment in retention. 90% technical expertise competency in all HPRS to improve data quality	Increased by 50% number of patients in HPRS with Unique Identify. 20% integration between TIER.Net and HPRS . 50% patient tracked for better monitoring and management of patient. 30% technical expertise competency in all HPRS to improve data quality	Increased by 50% number of patients in HPRS with Unique Identify. 40% integration between TIER.Net and HPRS . 70% patient tracked for better monitoring and management of patient. 60% technical expertise competency in all HPRS to improve data quality	No of HPRS facailities to capture patient level data with Uinique Identifier. % of integrated data from TIER.Net and HPRS. % of integrated aggregated data on webDHIS. % of patients with Unique Idientifier in al HPRS facilities. No of Competent personel with system and data management knowledge.	1.1.6 Support RSA fully integrated '700 facilities/ePHC project', interoperability of mHealth /eHealth initiatives) Rolling out of Health Patient Record System (HPRS) and National Unique Identify . It aims to place computers in clinics, connect them to the internet and register patient visits, provide appointment times and improve the efficiency of patient file retrieval Data exchange between HPRS and DHIS2, DDC and eRegister rollout to optimise tracking of patients at fcailities to improve DQ and use of information as well as capturing by clinicians as first step towards Health Patient records.	HVSI	$200,000	18021	13. Epidemiological and Health Data (6.77)
Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion	limited Interoperability between health information systems including Tier.net, ETR. Net, Mom Connect systems and NHLS data ware house and web DHIS to address low documented viral load completion.	100% VLD captured on Tier.net 95% of TX_CURR will have VL done (Denominator TX_PVLS) 90% performance on TX_PVLS	95% VLD captured on Tier.net 80% of TX_CURR will have VL done (Denominator TX_PVLS) 80% performance on TX_PVLS	100% VLD captured on Tier.net 90% of TX_CURR will have VL done (Denominator TX_PVLS) 90% performance on TX_PVLS	TX_PVLS	1.1.7 HMIS support at Department of Corrections (DCS)	HTXS	Correctional Facility UE	16775	13. Epidemiological and Health Data (6.77)
Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion	limited Interoperability between health information systems including Tier.net, ETR. Net, Mom Connect systems and NHLS data ware house and web DHIS to address low documented viral load completion.	100% VLD captured on Tier.net 95% of TX_CURR will have VL done (Denominator TX_PVLS) 90% performance on TX_PVLS	95% VLD captured on Tier.net 80% of TX_CURR will have VL done (Denominator TX_PVLS) 80% performance on TX_PVLS	100% VLD captured on Tier.net 90% of TX_CURR will have VL done (Denominator TX_PVLS) 90% performance on TX_PVLS	TX_PVLS	1.1.8 Support the district health team to review HIV VL data quarterly and implement corrective action plans in the twenty-seven priority districts	HTXS/PDTX	Facility UE	17020, 17023, 17036, 17046, 17038, 17021, 17037, 16675, 18482, 18481, 18484, 17506, 16808, 17507, 17768	13. Epidemiological and Health Data (6.77)

Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion		95% of TX_CURR will have VL done (Denominator TX_PVLS)								
Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion	2. Limited capacity of Human Resources for Health (HRH) (e.g., Health Workers, Data Capturers)	100% VLD captured on Tier.net 95% of TX_CURR will have VL done (Denominator TX_PVLS) 90% performance on TX_PVLS	At least 2 certified NIMART-trained nurses per facility (DOH) At least 1 clinician (MD) supporting a facility - trained on advanced clinical care (ACC)	At least 3 certified NIMART-trained nurses per facility At least 1 clinician (MD) supporting a facility - trained on advanced clinical care (ACC)	Skillsmart	1.1.9 Training of NIMART nurses and clinicians on switching to 2nd line ART for adult patients with confirmed virologic failure (through District Support Partners [DSP], Regional Training Centers [RTC]/Training of Trainers [TOT], Accelerating Comprehensive Care [ACC] partners) in DOH and DCS facilities.	HTXS	Facility UE	17020, 17023, 17036, 17046, 17038, 17021, 17037, 16675, 18482, 18481, 18484, 17506, 16808, 17507, 17768	7. Human Resources for Health (6.97)
Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion	2. Limited capacity of Human Resources for Health (HRH) (e.g., Health Workers, Data Capturers)	60% increase in the number of HCWs trained on the use of epidemiologic data for decision-making, including and viral load documentation in 15 districts	20% increase in the number of HCWs trained on the use of epidemiologic data for decision-making, including and viral load documentation	40% increase in the number of HCWs trained on the use of epidemiologic data for decision-making, including and viral load documentation in 7 districts	Documented viral load completion	1.1.10 Disseminate HIV/AIDS related guidelines and policies about viral load documentation, coordinate and conduct training for HIV prevention, care and treatment service delivery including test & offer, NIMART, antimicrobial resistance, Viral loads, pharmacovigilance etc via in-service training.	OHSS	$187,500	17769	
Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion										
Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion										
Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion	2. Limited implementation of Test and Start policy in 27 focus districts	20% increase in uptake of treatment Reduction of LTFU from 25% to <9%	Reach 7,523,840 18-34 year-olds within Living Standards Measure 1-7, with tailored messages for PLHIV not currently on treatment (Treatment Defaulters and yet to be initiated on treatment), sexual partners, family, friends, health workers, and community leaders about treatment initiation, adherence, and viral load suppression	Reach 9,404,800 18-34 year-olds within Living Standards Measure 1-7, with tailored messages for PLHIV not currently on treatment (Treatment Defaulters and yet to be initiated on treatment), sexual partners, family, friends, health workers, and community leaders about treatment initiation, adherence, and viral load suppression	TX_NEW; TX_CURR; TX_RET; TX_VIRAL	1.1.11 Behavioral communication interventions to increase UTT, adherence, retention and importance of viral load testing	HTXS, HBHC	$800,000	17537	6. Service Delivery (7.69)

Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion	2. Limited implementation of Test and Start policy in 27 focus districts	20% increase in uptake of treatment Reduction of LTFU from 25% to <9%	10% increase in uptake of treatment Reduction of LTFU from 25% to <9%	10% increase in uptake of treatment Reduction of LTFU from 25% to <9%	TX_NEW; TX_CURR; TX_RET; TX_VIRAL	1.1.12 Support SAG efforts to design and implement combination HIV/TB interventions in the community-facility interface to achieve epidemic control .The FPD approach draws on the power of local media platforms in combination with interpersonal communication to promote behavioural, structural and biomedical prevention solutions to facilitate and support client's retention, adherence and VL suppression.	HTXS, HBHC	$1,833,272	18480	6. Service Delivery (7.69)
Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion	2. 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.	Curricula updated and implemented in pre-service nursing educational programs;	Completed						
Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion	2. 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.				(Integration discussions are still on-going, resolution yet to be reached. All training for Lab key programs will be catered for under the viral load and continuous quality improvement activities.)				
Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion	2. 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.								
Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion	2. 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.				Combined with similar activity under PP1				
Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion	2. 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.				Combined with similar activity under PP1				

Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion	2. 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.	95% VLD captured on Tier.net 80% of TX_CURR will have VL done (Denominator TX_PVLS) 80% performance on TX_PVLS	100% VLD captured on Tier.net 90% of TX_CURR will have VL done (Denominator TX_PVLS) 90% performance on TX_PVLS	TX_PVLS	1.1.13 Support DCS providing quality HIV VL monitoring within correctional facilities	HLAB	Correctional Facility UE	16775	10. Laboratory (6.67)
Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion	3. Weak viral load cascade specifically before and after the Lab (Clinic/Lab inteface)	- 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%	50% of VL and EID labs have increased testing capacity, which includes: - reduced turn-around times - increased in the number of VL and EID test results received by the clinics -increased number of VL and EID test results documented in the patient charts and Tier.net	100% of EID/VL labs have increased testing capacity - reduced turn-around times - increased in the number of VL and EID test results received by the clinics -increased number of VL and EID test results documented in the patient charts and Tier.net	Number of EIV/VL labs with increased testing capacity	1.1.14 Strengthen existing viral load testing capacity.	HLAB	$271,168	17493	10. Laboratory (3.75)
Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion	3. Weak viral load cascade specifically before and after the Lab (Clinic/Lab inteface)	- 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%				(Activity currently being supported by a grant from Global Fund through the National Priority Programs at the NHLS).	HLAB		17493	10. Laboratory (3.75)
Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion	3. Weak viral load cascade specifically before and after the Lab (Clinic/Lab inteface)	- 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% - Reduced specimen rejection rates to <5%	60% of the EID/VL labs enrolled in WHO-ASLM CQI process	100% of EID/VL labs enrolled in WHO-ASLM CQI process	1. Number of EID/VL labs enrolled in CQI process 2. Number of labs with passing proficiency score	1.1.15 Support the delivery of quality laboratory diagnostic services through the implementation of WHO-ASLM quality management systems. Provide additional support to the NHLS' QA Department for EID/VL POCT EQA program including training of HCW in POCT related QA activities.	HLAB	$399,750	17493	10. Laboratory (3.75)
Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion	2. Limited capacity of Human Resources for Health (HRH) (e.g., Health Workers, Data Capturers)	90% PVLS 65% TSR for MDR-TB	80% PVLS 50% TSR for MDR-TB	90% PVLS 60% TSR for MDR-TB	TX_PVLS; Treatment success for MDR TB	1.1.16 Strengthen the capacity of the South African Government's Department of Health (SAG DOH) to provide quality and sustainable clinical care for HIV-infected patients with complicated HIV and HIV/TB. This includes clinical management of patients on 2nd and 3rd line ART, establishment of reliable referral networks, adequately trained clinical staff and appropriate comprehensive monitoring and evaluation systems. This activity will be carried out in Kwa-Zulu Natal and Northwest provinces.	HTXS, PDTX, HVTB	$3,000,000	16808	9. Quality Management (8.38)

Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion	2. Limited capacity of Human Resources for Health (HRH) (e.g., Health Workers, Data Capturers)	90% PVLS 65% TSR for MDR-TB	80% PVLS 50% TSR for MDR-TB	90% PVLS 60% TSR for MDR-TB	TX_PVLS; Treatment success for MDR TB	1.1.17 Strengthen the capacity of the South African Government's Department of Health (SAG DOH) to provide quality and sustainable clinical care for HIV-infected patients with complicated HIV and HIV/TB. This includes clinical management of patients on 2nd and 3rd line ART, establishment of reliable referral networks, adequately trained clinical staff and appropriate comprehensive monitoring and evaluation systems. This activity will be carried out in the Free State, Gauteng, and Mpumalanga provinces.	HTXS, PDTX, HVTB	$2,325,000	17507	
Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion	2. Limited capacity of Human Resources for Health (HRH) (e.g., Health Workers, Data Capturers)	90% PVLS 65% TSR for MDR-TB	80% PVLS 50% TSR for MDR-TB	90% PVLS 60% TSR for MDR-TB	TX_PVLS; Treatment success for MDR TB	1.1.18 Strengthen the capacity of the South African Government's Department of Health (SAG DOH) to provide quality and sustainable clinical care for HIV-infected patients with complicated HIV and HIV/TB. This includes clinical management of patients on 2nd and 3rd line ART, establishment of reliable referral networks, adequately trained clinical staff and appropriate comprehensive monitoring and evaluation systems. This activity will be carried out in Eastern Cape and Limpopo provinces.	HTXS, PDTX, HVTB	$1,800,000	17506	
Table 6.1.1 Key Programmatic Gap #1: Low Documented Viral Load (VL) Completion	2. Limited capacity of Human Resources for Health (HRH) (e.g., Health Workers, Data Capturers)	90% PVLS 65% TSR for MDR-TB	80% PVLS 50% TSR for MDR-TB	90% PVLS 60% TSR for MDR-TB	TX_PVLS; Treatment success for MDR TB	1.1.19 Strengthen the capacity of the South African Government's Department of Health (SAG DOH) to provide quality and sustainable clinical care for HIV-infected patients with complicated HIV and HIV/TB. This includes clinical management of patients on 2nd and 3rd line ART, establishment of reliable referral networks, adequately trained clinical staff and appropriate comprehensive monitoring and evaluation systems.	HTXS, PDTX, HVTB	Facility UE	17023; 17036; 17046; 17038; 17021; 17037; 18482; 18481; 18484	9. Quality Management (8.38)
Table 6.1.2 Key Programmatic Gap #2: Clinical-Community Continuum of Care										
Table 6.1.2 Key Programmatic Gap #2: Clinical-Community Continuum of Care	2.1 Lack of a bi-directional (Facility/Community) referral system	- There will be a government-wide referral and linkage policy (DOH, Department of Social Development) - Existing DOH 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	10% increase in linkage to treatment (TX_NEW/HTC_POS Linkage Proxy) and adhrence (TX_RET)	10% increase in linkage to treatment (TX_NEW/HTC_POS Linkage Proxy) and adhrence (TX_RET)	TX_NEW Proxy HTC_POS:TX_NEW	2.1.1 Activate an inter-ministerial Technical Working Group (TWG) to strengthen implementation for referral and linkage to develop common referral protocols across departments for facility and community services in order to facilitate comprehensive services for PLHIV and AGYW	HBHC	$151,399	14291	2. Polices and Governance (8.45)
Table 6.1.2 Key Programmatic Gap #2: Clinical-Community Continuum of Care	2.1 Lack of a bi-directional (Facility/Community) referral system	20% increase in uptake of treatment	10% increase in uptake of treatment	10% increase in uptake of treatment	TX_NEW Proxy HTC_POS:TX_NEW	2.1.2 Support a multi-sectoral Technical Working Group (TWG) to strengthen implementation for referral and linkage	HBHC	$29,193	17533	2. Polices and Governance (8.45)
Table 6.1.2 Key Programmatic Gap #2: Clinical-Community Continuum of Care	2.1 Lack of a bi-directional (Facility/Community) referral system	- There will be a government-wide referral and linkage policy (DOH, Department of Social Development) - Existing DOH 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	10% increase in linkage to treatment (TX_NEW/HTC_POS Linkage Proxy) and adhrence (TX_RET)	10% increase in linkage to treatment (TX_NEW/HTC_POS Linkage Proxy) and adhrence (TX_RET)	TX_NEW Proxy HTC_POS:TX_NEW	2.1.3 Develop and roll-out community-facility referral tools	HBHC	$150,000	14291	2. Polices and Governance (8.45)
Table 6.1.2 Key Programmatic Gap #2: Clinical-Community Continuum of Care	2.1 Lack of a bi-directional (Facility/Community) referral system	Facilites referral plans approved by management in 24 districts. 30% increased linkage (Txnew\HTC Pos) in pre scale up districts	Facilities referral plans approved by management in 3 districts. 10% increased linkage in pre scale up districts.	Facilites referral plans approved by management in 10 districts. 20% increased linkage in pre scale up districts.	Quarterly DIPs reports Tx new and HTC Pos	2.1.4 Support the DOH and civil society organisations to strengthen planning and implementation for bi directional referral and linkage.	OHSS	$1,370,000	18481	7. Human Resources for Health (6.97)
Table 6.1.2 Key Programmatic Gap #2: Clinical-Community Continuum of Care						Merged with activity above				

Table 6.1.2 Key Programmatic Gap #2: Clinical-Community Continuum of Care	2.1 Lack of a bi-directional (Facility/Community) referral system	- There will be a government-wide referral and linkage policy (DOH, Department of Social Development) - Existing DOH 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	10% increase in uptake of treatment	10% increase in uptake of treatment	TX_NEW Proxy HTC_POS:TX_NEW	2.1.5 Cascade Integrated Chronic Services Management training to all PEPFAR-supported districts	OHSS	$100,000	14295	9. Quality Management (8.38)
Table 6.1.2 Key Programmatic Gap #2: Clinical-Community Continuum of Care						Combined with similar activity under PP1				
Table 6.1.2 Key Programmatic Gap #2: Clinical-Community Continuum of Care						Combined with similar activity under PP1				
Table 6.1.2 Key Programmatic Gap #2: Clinical-Community Continuum of Care	2.1 Lack of a bi-directional (Facility/Community) referral system	20% increase in uptake of treatment in all 27 focus districts	10% increase in uptake of treatment in study districts	10% increase in uptake of treatment in study districts	TX_NEW Proxy HTC_POS:TX_NEW	2.1.6 A study to establish current baseline on patient linkage between HIV diagnosis and ART initiation, looking at different settings and testing modalities. Linkage barriers will be identified and a set of subsequent linkage strengthening interventions based on the data will be developed and then implemented and evaluated. Study findings will allow for programmatic adjustments to strengthen linkage to care.	HBHC, HTXS	$350,000	17033	12. Technical and Allocative Efficiencies (8.61)
Table 6.1.2 Key Programmatic Gap #2: Clinical-Community Continuum of Care	2.2 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 systems. - Support technology-focused innovation which can link community health workers to Facility/National data systems				Modified below and in PG1				
Table 6.1.2 Key Programmatic Gap #2: Clinical-Community Continuum of Care	2.2 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 systems. - Support technology-focused innovation which can link community health workers to Facility/National data systems	1,450 PHC facilities implementing improved patient administration and web-based information systems (unique identifier)	2450 PHC facilities implementing improved patient administration and web-based information systems (unique identifier)	NDOH Annual Performance Plan	2.1.7 Technical Support to align e-Healtth and m-Health Strategy, SOPs and Governance Structures (e.g., eHealth Strategy revised and costed, Creation of an mHealth repository, landscape analysis of all mHealth and eHealth interventions)	HVSI	$810,000	14846	13. Epidemiological and Health Data (6.77)
Table 6.1.2 Key Programmatic Gap #2: Clinical-Community Continuum of Care						Eliminated due to lack of progress				
Table 6.1.2 Key Programmatic Gap #2: Clinical-Community Continuum of Care						Modified and combined with Activity 2.2.2				

Table 6.1.2 Key Programmatic Gap #2: Clinical-Community Continuum of Care	2.2 Limited health information system capacity (e.g. Tier.Net, Health Patient Registration System, Patient Tracking System)	To reach 40% national coverage where all 9 provinces, 52 districts, 247 sub-districts, at least 500 PHC facilities as well as 100 regional and districts hospitals will be reporting directly into webDHIS (instead of stand alone system). 60% reduction of Timeliness:data available at National level from facilities connected. Improve 70% data accuracy, 100% completeness at the webDHIS facilities to Improved HIV care and continuum cascade. 80% collection of Community data. Dashboard developed for 100% provinvce coverage for intergrated community and facility level data to strenthen then patient continuum	9 provinces, will capture and report data into webDHIS , Increase 50% completeness and accuracy of data on all the connected pronvinces, districts and facility levels 70% data access and use from all the connected levels.WebDHIS foundation training coverage, district- 88.5%, Sub-district - 87.0%. Total no of Master trainers 187 50% increase of d Data management and system knowledge. 100% webDHIS support within the less response time	52 districts and 247 Sub-district, will capture data into webDHIS to improve data quality, and this will depend on connectivity by NDoh.Timeliness: data flow to NDoH will be reduced from 6 weeks to 20 days 90% data access and use to strengthen transparency and accountability for epidemic control and monitoring at all levels from national to facilities on all connected ones 100% integration of WBOT, HBC and other non-facility and facility health care services.Total no of Master trainers 187 50% increase of d Data management and system knowledge. 100% webDHIS support within the less response tim	% System effeciency. % of improved Data quality on connecetd level % of Knowledge and skill competency at the relavant DoH level Evaluation of 909090 targets achievement at the Province % of integration of of community data with facility data	2.1.8 Strengthen the capacity of routine HIV/TB systems. WebDHIS Transition roll out. Transitioning from DHIS1 to DHIS2(webDHIS). Aim at capturing data directly into the web based system. This aims to achieve facility daily data capturing which would have a major impact on (timeliness) and through its built-in verification and quality controls functionalities would improve data quality. Support NDoH to develop and implement a webDHIS Community Health Care Database which integrates WBOT, HBC and other non-facility health care services. Data exchange and set up dashboards for integrated analysis with health facility data to monitor impact and need for Community services.	HVSI	$800,000	18021	13. Epidemiological and Health Data (6.77)
Table 6.1.2 Key Programmatic Gap #2: Clinical-Community Continuum of Care	2.2 Limited health information system capacity (e.g. Tier.Net, Health Patient Registration System, Patient Tracking System)	100% of implementing partners provide disaggregated HTS data.	100 % of implementing partners trained on HTS module of Tier.net	100% of implementing partners provide disaggregated HTS data.	100% HTS reporting	2.1.9 Increase use of HTS module of Tier.Net to ensure capturing finer HTS data into the national system	HVOP	$400,000	18481	13. Epidemiological and Health Data (6.77)
Table 6.1.2 Key Programmatic Gap #2: Clinical-Community Continuum of Care	2.2 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 systems. - Support technology-focused innovation which can link community health workers to Facility/National data systems				Activities modified below and in PG1				
Table 6.1.2 Key Programmatic Gap #2: Clinical-Community Continuum of Care	2.3 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. - CHWs appropriately skilled to provide effective services in the facility/community continuum of care.				-Modified and merged with 2.3.1				
Table 6.1.2 Key Programmatic Gap #2: Clinical-Community Continuum of Care	2.3 Limited capacity of Ward-Based Outreach Teams (WBOT) and community cadres	90% increase in number of HIV (LTFU and new) identified patients contacted by WBOTs in 27 districts.	33% increase in number of HIV (LTFU and new) identified patients contacted by WBOTs in 5 high burden districts.	67% increase in number of HIV (LTFU and new) identified patients contacted by WBOTs in 10 high burden districts.	TX_CURR AND TX_NEW CHW logbook	2.1.10 Support HRH for new service models including implementing a bridge to scale up program for WBOTs (including CHWs) to strengthen linkages.	OHSS	$500,000	13709	7. Human Resources for Health (6.97)
Table 6.1.2 Key Programmatic Gap #2: Clinical-Community Continuum of Care	2.3 Limited capacity of Ward-Based Outreach Teams (WBOT) and community cadres	20% increase in uptake of treatment Reduction of LTFU from 25% to <9% 90% PVLS	10% increase in uptake of treatment Reduction of LTFU from 25% to <9% 80% PVLS	10% increase in uptake of treatment Reduction of LTFU from 25% to <9% 90% PVLS	TX_NEW; TX_CURR; TX_RET; TX_VIRAL	2.1.11 TA and skills development for existing WBOTs and CHWs	HBHC, HVTB, MTCT, PDCS	Facility UE	17023; 17036; 17046; 17038; 17021; 17037; 18482; 18481; 18484	7. Human Resources for Health (6.97)

Table 6.1.2 Key Programmatic Gap #2: Clinical-Community Continuum of Care	2.3 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. - CHWs appropriately skilled to provide effective services in the facility/community continuum of care.	10% increase in uptake of treatment	10% increase in uptake of treatment	TX_NEW Proxy HTC_POS:TX_NEW	2.1.12 TA and skills development for existing WBOTs and CHWs	HBHC	$500,000	14291	7. Human Resources for Health (6.97)
Table 6.1.2 Key Programmatic Gap #2: Clinical-Community Continuum of Care	2.4 Lack of linkages between services provided by the public sector and community-based/ Faith Based organizations (CBOs/FBOs)	- Adequate number of WBOTs, CHWs and other community cadres to strengthen the facility/community continuum of care. - CHWs appropriately skilled to provide effective services in the facility/community continuum of care.	10% increase in uptake of treatment	10% increase in uptake of treatment	TX_NEW Proxy HTC_POS:TX_NEW	2.1.13 Support HRH for new service models including WBOTS and piloting linkages between FBO/CBOs.	HBHC	$500,000	14291	
Table 6.1.2 Key Programmatic Gap #2: Clinical-Community Continuum of Care	HIV Case-based Surveillance: Operationalizing and evaluating the implementation of the HTS and pre-ART modules in Tier.net	Reduction in loss to follow-up of Patients on ART from 25% to <9%	91% Retention in care and treatment in the first 12 months	92% Retention in care and treatment; National Plan implemented by all DSPs	Implementation of the activities and preliminary data analysis and feedback to stakeholders	2.1.14 support to establish a logitudinal database with unique identifier aimed at tracking patients from HIV testing to viral suppression to monitor 90/90/90 and WHO indicators/sentinel events along the continuum of care	HVSI	$560,000	17493	13. Epidemiological and Health Data (6.77)
Table 6.1.2 Key Programmatic Gap #2: Clinical-Community Continuum of Care	5. High Loss-to-Follow-Up	Reduction of LTFU from 25% to <9%	Reduction of LTFU from 25% to <9%	Reduction of LTFU from 25% to <8%	TX_RET	2.1.15 Finilzation of National loss-to-follow-up plan	HBHC, PDCS	$400,000	17533	2. Polices and Governance (8.45)
		Reduction of LTFU from 25% to <9%	Reduction of LTFU from 25% to <9%	Reduction of LTFU from 25% to <8%	TX_RET	2.1.15 Implementation of National loss-to-follow-up plan	HBHC, PDCS	$500,000	14291	2. Polices and Governance (8.45)
Table 6.1.2 Key Programmatic Gap #2: Clinical-Community Continuum of Care	5. High Loss-to-Follow-Up		94% Retention in care and treatment; National Plan finalized	95% Retention in care and treatment; National Plan implemented by all DSPs	TX_RET	2.1.16 Finilzation and implementation of National loss-to-follow-up plan	HBHC, PDCS	Facility UE	17023; 17036; 17046; 17038; 17021; 17037; 18482; 18481; 18484, 17020,	2. Polices and Governance (8.45)

Table 6.1.3 Key Programmatic Gap #3:										
Table 6.1.3 Key Programmatic Gap #3: Understanding the Key Populations (KP) Cascade	3.1 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% of all planned specialized testing conducted and data analyses completed (tests will include LAg assay, VL, STI, HIV and TB drug resistance)	100% of all planned specialized testing conducted and data analyses completed (tests will include LAg assay, VL, STI, HIV and TB drug resistance)	Number of specialized tests completed	3.1.1. Through the National Health Laboratory Service (NHLS): - incidence testing support will be provided to PEPFAR partners conducting surveillance studies for KPs (e.g., lab testing support for integrated bio-behavioral surveillance study for KPs) - support for the implementation of quality assurance for POCT during these studies will be provided - support will be provided to expand the capacity for the detection and monitoring of resistance of both HIV and TB for KPs.	HLAB	$328,552	17493	13. Epidemiological and Health Data (6.77)
Table 6.1.3 Key Programmatic Gap #3: Understanding the Key Populations (KP) Cascade	3.1 Surveillance for KPs is limited (e.g. size/prevalence estimates, mapping, data triangulation)	- KP size estimates and prevalence estimates for all KP groups in the three major cities that account for the large majority of sex workers in South Africa (1. Johannesburg Metro , 2. Cape Town Metro, 3. Durban-eThewkini Metro). - 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	1. Estimates in the 90-90-90 clinical cascade. Incidence and prevalence will be completed. 2. 90% HCWs trained on regular mapping.	1. Finalized FSW Triangulation Report and dissemination	1. Triangulation report on FSWs produced. 2. 90-90-90 cascade report for all KP produced (excluding inmates).	3.1.2 KP size estimation, mapping and IBBS - Support for key pops size estimations (via special surveys routine data). - Data triangulation of secondary data (surveys and routine program data) to generate prevention, care, and treatment cascades at national and sub national level. - 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. - Triangulation of FSW data to produce collective data on FSWs.	HVSI, HVOP	$830,000	18484	13. Epidemiological and Health Data (6.77)
Table 6.1.3 Key Programmatic Gap #3: Understanding the Key Populations (KP) Cascade	3.1 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	Conduct Stocktaking of Key Populations Activities; Programmatic maps and size estimates completed for Johannesburg/Cape Town (MSM/TG)	Programmatic maps and size estimates completed for all interventions sites and expansion sites	Updated population denominators and maps	3.1.3 Leverage program data to map (including social network mapping) and quantify key populations in catchment areas	HTXS	$50,000	17019	13. Epidemiological and Health Data (6.77)
Table 6.1.3 Key Programmatic Gap #3: Understanding the Key Populations (KP) Cascade	3.1 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	Conduct Stocktaking of Key Populations Activities; Programmatic maps and size estimates completed for Gauteng Province (Sex Workers);	Programmatic maps and size estimates completed for all interventions sites and expansion sites	Updated population denominators and maps	3.1.4 Leverage program data to map (including social network mapping) and quantify key populations in catchment areas	HTXS	$100,000	17027	13. Epidemiological and Health Data (6.77)
Table 6.1.3 Key Programmatic Gap #3: Understanding the Key	3.1 Surveillance for KPs is limited (e.g. size/prevalence estimates, mapping, data triangulation)	Evidence informed prevention intervention targeted at inmates.	Protocol approved, data collected	Data analysis, report completed and disseminated to all relevant stakeholders.	Conduct analysis, develop report, disseminate results	3.1.5 Conduct a situational analysis of inmates in selected correctional services, including HIV seroconversion, STIs and Hepititis infections, risk behaviors among male inmates.	HVOP	$200,000	16775	13. Epidemiological and Health Data (6.77)
Table 6.1.3 Key Programmatic Gap #3: Understanding the Key Populations (KP) Cascade	3.1 Surveillance for KPs is limited (e.g. size/prevalence estimates, mapping, data triangulation)	Evidence informed prevention intervention targeted at MSM through project Boithato	Data on HIV, STI, and Hep infections among MSM, and results of demonstration project pertaining to PrEP and STI treatment uptake and adherence.	70% increase in MSMs with STIs linked and treated 100 MSM initiated on PrEP	Implement, collect data and monitor resulst.	3.1.6 Incorporate social network strategy (SNS), PrEP, STI screening and treatment into an evidence-based MSM program (Boithato/MPowerment). Activities include rapid situational analysis, implementation, and monitoring and uptake. ~100 - 200 MSM will be enrolled on PrEP.	HVOP	$200,000	18484	13. Epidemiological and Health Data (6.77)

Table 6.1.3 Key Programmatic Gap #3: Understanding the Key Populations (KP) Cascade	3.1 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	(i) Complete survey using routinely collected data	(i) Build initial KP HIV prevention, care, and treatment cascades at the national and sub-national level	Survey will provide information on the (i) HIV prevention, care, and treatment cascades using surveillance data from previously conducted IBBS surveys and routinely collected data	3.1.7 Survey of key pops to quantify access to services (90 90 90) with a focus on using routine data sources	HVSI	$200,000	18307	13. Epidemiological and Health Data (6.77)
Table 6.1.3 Key Programmatic Gap #3: Understanding the Key Populations (KP) Cascade	3.2 Limited exchange of routinely collected information between the public sector and the organizations serving KPs	Development of a unique identifier and regular mapping will lead to successful linkages, tracking and follow up of KP along the prevention and treatement cascade. 70% of FSWs accessing Global Fund and PEPFAR sites will be assigned confidential unique identifiers	Unique identifier developed and implemented by 100% of KP partners funded by Global Fund and PEPFAR	100 HCWs trained on regular mapping of hot spots 50% of FSWs accessing Global Fund and PEPFAR sites will be assigned confidential unique identifiers	Train 100 KP workers on mapping Develop unique identifier system	3.1.8 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. Develop and train KP workers to conduct regular mapping of hotspots.	HVOP	$100,000	16773	
Table 6.1.3 Key Programmatic Gap #3: Understanding the Key Populations (KP) Cascade	3.2 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.	Conduct Stocktaking of Key Populations Activities; Develop framework for microplanning and data collection tools	Cascade estimates for key populations supported in catchment areas	Quarterly Reports	3.1.9 Aggregate primary microplanning/reporting data to quantify the key populations cascade for program management in catchment areas	HTXS	$50,000	17019	13. Epidemiological and Health Data (6.77)
Table 6.1.3 Key Programmatic Gap #3: Understanding the Key Populations (KP) Cascade	3.2 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.	Conduct Stocktaking of Key Populations Activities; Develop framework for microplanning and data collection tools	Cascade estimates for key populations supported in catchment areas	Quarterly Reports	3.1.10 Aggregate microplanning/reporting data to quantify the key populations cascade	HTXS	$100,000	17027	13. Epidemiological and Health Data (6.77)
Table 6.1.3 Key Programmatic Gap #3: Understanding the Key Populations (KP) Cascade	3.3 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 - Develop standardized country owned KP training materials for different health cadres of workers	Curriculum developed, piloted in two districts (curriculum includes sensitization to gender identities and orientation with a focus on developing respectful treatment, and clinical competency including rectal examinations and gender-affirming surgery and all hormonal treatment)	250 RTC and community KP workers trained on the new curriculum, which involves sensitization to gender identities and orientation with a focus on developing respectful treatment, and clinical competency including rectal examinations and gender-affirming surgery and all hormonal treatment	RTC quarterly reports	3.1.11 Develop coordinated curriculum with facilitator and trainee manual, and roll out training through regional training centers and KP NGOs.	HVOP	$250,000	17769	7. Human Resources for Health (6.97)
Table 6.1.3 Key Programmatic Gap #3: Understanding the Key Populations (KP) Cascade										
Table 6.1.3 Key Programmatic Gap #3: Understanding the Key Populations (KP) Cascade										

Table 6.1.3 Key Programmatic Gap #3: Understanding the Key Populations (KP) Cascade	3.4 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	Guidelines finalized. Targeted and standadised messeging,	Roll out of PrEP and PEP demand creation strategy amoung KP	Number of KP on PrEP or PEP	3.1.12 Develop demand creation plan for KP PrEP and PEP rollout	HVOP	IP UE	18482	2. Polices and Governance (8.45)
Table 6.1.3 Key Programmatic Gap #3: Understanding the Key Populations (KP) Cascade	3.4 Limited systems in place for PrEP/PEP provision for KPs	7,000 patients on PrEP	N/A	3,500 patients on PrEP	PrEP_NEW	3.1.13 Purchasing of PrEP drugs	HTXD	$300,000	16772	2. Polices and Governance (8.45)
Table 6.1.3 Key Programmatic Gap #3: Understanding the Key Populations (KP) Cascade	3.4 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	10 sites trained and providing PrEP	20 sites providing PrEP	Number of individuals who have been newly enrolled on (oral) antriretriviral pre-exposure prophylaxis to prevent HIV infection	3.1.14 Strengthen PrEP implementation and competency training to HCWs	HTXS	$100,000	17027	7. Human Resources for Health (6.97)
Table 6.2.1: Test and START										
Table 6.2.1: Test and START	Lack of dedicated laboratory personnel within the National Department of Health to provide oversight to the national laboratory program including the NHLS.	- 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.	Laboratory program and policy discussions between NHLS and NDOH initiated	Laboratory program and policy discussions between NHLS and NDOH established Mandatory HIV rapid test quality assurance requirements developed 80% of clinical and community staff trained in associated laboratory policies and guidelines	Coordinator hired Training registers	4.1.1 Support the recruitment of a laboratory coordinator to be seconded within the National Department of Health: 1) To improve communications between the NHLS and NDoH 2) Facilitate NDoH oversight of the national laboratory program 3) Provide guidance to laboratory related policies and implementation strategies	HLAB	$150,000	17493	10. Laboratory (3.75)
Table 6.2.1: Test and START										
Table 6.2.1: Test and START										
Table 6.2.1: Test and START	Limited capacity of NIMART nurses and doctors to implement Test and Start	20% increase in uptake of treatment Reduction of LTFU from 25% to <9% 90% PVLS	10% increase in uptake of treatment Reduction of LTFU from 25% to <9% 80% PVLS	10% increase in uptake of treatment Reduction of LTFU from 25% to <9% 90% PVLS	TX_NEW; TX_CURR; TX_RET; TX_VIRAL	4.1.2 Training of site-based providers on new Test and Offer guidelines	HTXS	Facility UE	17020, 17023, 17036, 17046, 17038, 17021, 17037, 18484, 18482, 18418, 16577	2. Polices and Governance (8.45)
Table 6.2.1: Test and START	Not all facilities in 27 focus districtshave access to updated Test and Start guidelines	20% increase in uptake of treatment Reduction of LTFU from 25% to <9% 90% PVLS	10% increase in uptake of treatment Reduction of LTFU from 25% to <9% 80% PVLS	10% increase in uptake of treatment Reduction of LTFU from 25% to <9% 90% PVLS	TX_NEW; TX_CURR; TX_RET; TX_VIRAL	4.1.3 Support dissemination of Test and Start Guidelines, flowcharts/Pocket book, ART Guidelines, Support the DOH with HIV Clinical Management Training	HTXS	$100,000	16772	2. Polices and Governance (8.45)
Table 6.2.1: Test and START						Modified and moved to PG2				

Table 6.2.1: Test and START	Limited test and start implementation in 27 PEPFAR priority sites	Application of results, lessons learned, and other research-related finding to achieve 90/90/90. Lessons learned are likely to include test and offer, clinic lab interface, and new service delivery models.	Approved operational research topics related to clinic lab interface, test and offer and new service delivery models in the PEPFAR priority districts.	100% completion of all research related activities	% of research topics approved % of research reports completed % of research studies completed	4.1.4 Operational research to achieve 90/90/90 as prioritized by the South African government and PEPFAR. Priority topics may include test and offer, clinic lab interface. Capacity building of HCWs from PEPFAR priority districts that will participate in the model through operational research.	OHSS	$250,000	16807	2. Polices and Governance (8.45)
Table 6.2.1: Test and START	Limited test and start implementation in 27 PEPFAR priority sites	40% increase in the rate of treatment initiation after in-service capacity building.	Capacity building: 100 pre-service students implement test and offer as part of their clinical rotation	20% increase in the rate of treatment initiation after in-service capacity building..	TX_NEW	4.1.5 Strengthen the capacity and utilization of mid-level health care workers to provide clinical services related to Test and Start (Pre service education completed in COP16. In service continues)	OHSS	$204,685	17452	7. Human Resources for Health (6.97)
Table 6.2.1: Test and START	Monitoring of Test and Start implementation and remedial interventions at national level to be strengthened	20% increase in uptake of treatment Reduction of LTFU from 25% to <9% 90% PVLS	10% increase in uptake of treatment Reduction of LTFU from 25% to <9% 80% PVLS	10% increase in uptake of treatment Reduction of LTFU from 25% to <9% 90% PVLS	TX_NEW; TX_CURR; TX_RET; TX_VIRAL	4.1.6 Support NDOH to monitor DIP implementation at National and provincial; Collaborate with District Supporting Partners to support poor performing districts	HTXS, HVTB, MTCT, PDTX	$250,000	16807	15. Performance Data (8.73)
Table 6.2.1: Test and START	Monitoring of Test and Start implementation and remedial interventions at district level to be strengthened	20% increase in uptake of treatment Reduction of LTFU from 25% to <9% 90% PVLS	10% increase in uptake of treatment Reduction of LTFU from 25% to <9% 80% PVLS	10% increase in uptake of treatment Reduction of LTFU from 25% to <9% 90% PVLS	TX_NEW; TX_CURR; TX_RET; TX_VIRAL	4.1.7 Monitor DIPs at District level (Modified and Consolidated from PG1)	HTXS, HVTB, MTCT, PDTX	District UE	17020, 17023, 17036, 17046, 17038, 17021, 17037, 18482, 18481, 18484	15. Performance Data (8.73)
Table 6.2.1: Test and START	Low treatment coverage among AGYW	81% treatment coverage in AGYW in 22 NDoH priority districts	60% treatment coverage in AGYW in 22 NDoH priority districts	70% treatment coverage in AGYW in 22 NDoH priority districts	TX_NEW TX_CURR	4.1.8 Support NDOH to implement evidence informed HIV prevention care and treatment programs for adolescent girls and young women (AGYW) [Moved from Table 6.3]	HTXS, HBHC, PDTX, PDCS, HVTB, MTCT	$600,000	17968	9. Quality Management (8.38)
Table 6.2.1: Test and START	Ongoing test and treat implementation challenges (Justification: guidelines completed, implementation ongoing)	- 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 Start policy and guidelines includes the HIV rapid testing quality assurance.	Roll out of "She Conquers" program in 50% of 22 NDOH priority districts	Roll out of "She Conquers" program in 100% of 22 NDOH priority districts	All 90-90-90 MER indicators specifically for adolescents	4.1.9 Support NDOH to implement evidence informed HIV prevention care and treatment programs for adolescent girls and young women (AGYW) [Moved from Table 6.3]		$1,500,000	17028	
Table 6.2.1: Test and START	Low treatment coverage among adolescents	81% treatment coverage in adolescents Reduction of LTFU from 25% to <9% 90% PVLS	60% treatment coverage in adolescents Reduction of LTFU from 25% to <9% 80% PVLS	70% treatment coverage in adolescents Reduction of LTFU from 25% to <9% 90% PVLS	TX_NEW; TX_CURR; TX_RET; TX_VIRAL	4.1.10 Support NDOH to expand youth- and adolescent-friendly services through the revision of the curriculum and training of trainers. [Moved from Table 6.3]	PDTX, PDCS,	$30,000	17533	9. Quality Management (8.38)

Table 6.2.1: Test and START	Implementation of HIV rapid testing quality assurance is limited	All PEPFAR supported facilities (1,969 facilities) will be implementing quality assurance activities 100% of facilties enrolled and participating in a proficiency testing program for HIV rapid testing 100% of facilities implementing IQC All HCWs trained in quality assurance for point of care testing (POCT)	80% of all PEPFAR supported facilities enrolled in a HIV serology proficiency testing scheme - 80% of facilities participating in PT receiving satisfactory results - 80% of all PEPFAR supported facilities conducting IQC activities - 60% of HCW in all PEPFAR supported facilities trained in quality assurance for POC testing	100% of all PEPFAR supported facilities enrolled in a HIV serology proficiency testing scheme - 95% of facilities participating in PT receiving satisfactory results -100% of all PEPFAR supported facilities conducting IQC activities - 80% of HCW in all PEPFAR supported facilities trained in quality assurance for POC testing	1. Number of HCW trained in quality assurance systems for POCT 2. Number of facilities enrolled in the CQI process 3. Number of facilities performing IQC 4.Number of facilities obtaining a passing PT score	4.1.11 Support the implementation of a comprehensive quality assurance program for point of care test including: - Training of HCWs in Quality Assurance of HIV testing by utilizing innovative training platforms such as the "ECHO Project" platform - Support enrollment of all priority district HTC sites into proficiency testing schemes for POCT - Provide support to the NHLS' Quality Assurance Department to facilitate the provision of IQC and proficiency testing panels as well as create capacity to manage and analyze all QA testing data - Strengthen pre- and post-market surveillance of HIV RTDs - Support the assessment and certification of facilities and testers using the WHO approved SPI-RT checklist	HLAB	$878,155	17493	10. Laboratory (3.75)
Table 6.2.1: Test and START	Implementation of HIV rapid testing quality assurance is limited	All PEPFAR supported Department of Correctional Services (DCS) facilities will be implementing quality assurance activities 100% of DCS facilties enrolled and participating in a proficiency testing program for HIV rapid testing 100% of DCS facilities implementing IQC All HCWs in DCS facilities trained in quality assurance for point of care testing (POCT)	80% of all PEPFAR supported DCS facilities enrolled in a HIV serology proficiency testing scheme - 80% of DCS facilities participating in PT receiving satisfactory results - 80% of all PEPFAR supported DCS facilities conducting IQC activities	100% of all PEPFAR supported DCS facilities enrolled in a HIV serology proficiency testing scheme - 95% of DCS facilities participating in PT receiving satisfactory results -100% of all PEPFAR supported DCS facilities conducting IQC activities	1. Number of DCS facilities enrolled in the CQI process 2. Number of DCS facilities performing IQC 3.Number of DCS facilities obtaining a passing PT score	4.1.12 Support the implementation of QA for HIV rapid testing within PEPFAR supported DCS facilities.	HLAB	Correctional Facility UE	16775	10. Laboratory (3.75)
Table 6.2.1: Test and START	Implementation of HIV rapid testing quality assurance is limited	100% of PEPFAR supported facilities participating in PT receiving satisfactory results	80% of all PEPFAR supported facilities enrolled in a HIV serology proficiency testing scheme - 80% of facilities participating in PT receiving satisfactory results - 80% of all PEPFAR supported facilities conducting IQC activities	100% of all PEPFAR supported DCS facilities enrolled in a HIV serology proficiency testing scheme - 95% of DCS facilities participating in PT receiving satisfactory results -100% of all PEPFAR	1. Number of DCS facilities enrolled in the CQI process 2. Number of DCS facilities performing IQC 3.Number of DCS facilities obtaining a passing PT score	4.1.13 Support the implementation of QA for HIV rapid testing within PEPFAR supported DCS facilities.	HTXS	Facility UE	17023, 17036, 17046, 17038, 17021, 17037, 18482, 18481, 18484, 16775	10. Laboratory (3.75)
Table 6.2.1: Test and START	Demand planning of health products (medicines and medical supplies) required for test and start 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 functional Provincial Medicine Procurement Unit (PMPU) for the management of direct delivery of medicines established - Two provinces have implemented supply chain processes according to the South African VAN blueprint - A central selection and contracting framework for medical supplies developed and incorporated into the VAN blue print	All PEPFAR supported PHCs have implemented the Stock Visibility Solution	All PEPFAR supported PHCs are routinely reporting stock availability (TB and HIV medicine) on the Stock Visibility Solution; Dolutegravir-based Fixed Dose Combination introduced as first-line regimen	Affordable Medicines Unit Monthly Dashboard	4.1.14 Support the DOH to improve the visibility, analytics, and continuous process improvement of the public health supply chain	OHSS, SI	$2,789,970	18321	Commodity Security and Supply Chain (4.67)
Table 6.2.1: Test and START	Demand planning of health products (medicines and medical supplies) required for test and start 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 functional Provincial Medicine Procurement Unit (PMPU) for the management of direct delivery of medicines established - Two provinces have implemented supply chain processes according to the South African VAN blueprint - A central selection and contracting framework for medical supplies developed and incorporated into the VAN blue print	85% of ARV orders delivered on-time and in-full (OTIF) in six provinces (Limpopo, Eastern Cape, North West, Gauteng, KZN, Free State)	90% of ARV orders delivered on-time and in-full (OTIF) in eight provinces (Limpopo, Gauteng, Free State, Eastern cape, North West, Kwazulu Natal; New: Mpumalanga and Nothern Cape)	Annual Performance Plan	4.1.15 Support the DO to optimize distribution models for public health supply chain	OHSS, HTXS	$3,900,000	18321	Commodity Security and Supply Chain (4.67)

Table 6.2.1: Test and START	Domestic resources required to immediately implement test and start are insufficient	- Greater allocative efficiency through more accurate and results-based budgeting of the DIPs	5 costing studies completed and integrated into HIV and TB investment case	6 costing studies completed and integrated into HIV and TB investment case	Conditional Grant Reviews	4.4.16 Costing Studies to improve the allocative efficiency of HIV/AIDS investments	OHSS/HVSI	$1,458,000	17025	12. Technical and Allocative Efficiencies (8.61)
Table 6.2.1: Test and START	Domestic resources required to immediately implement test and start are insufficient	- All PEPFAR-supported facilities have an Electronic Stock Management System (ESMS) for the detection of stock outs of medicines - All PEPFAR-supported facilities reporting stock availability at national surveillance center to monitor medicine availability - All provinces will have a functional Provincial Medicine Procurement Unit (PMPU) for the management of direct delivery of medicines established - Two provinces have implemented supply chain processes according to the South African VAN blueprint - A central selection and contracting framework for medical supplies developed and incorporated into the VAN blue print	10% increase in value for money of HIV Conditional Grants (results/$)	10% increase in value for money of HIV Conditional Grants (results/$)	Conditional Grant Reviews	4.1.17 Building the capacity of districts and provinces to improve budget execution		$395,000	14631	12. Technical and Allocative Efficiencies (8.61)
Table 6.2.1: Test and START	Domestic resources required to immediately implement test and start are insufficient	- All PEPFAR-supported facilities have an Electronic Stock Management System (ESMS) for the detection of stock outs of medicines - All PEPFAR-supported facilities reporting stock availability at national surveillance center to monitor medicine availability - All provinces will have a functional Provincial Medicine Procurement Unit (PMPU) for the management of direct delivery of medicines established - Two provinces have implemented supply chain processes according to the South African VAN blueprint - A central selection and contracting framework for medical supplies developed and incorporated into the VAN blue print	10% increase in value for money of HIV Conditional Grants (results/$)	10% increase in value for money of HIV Conditional Grants (results/$)	Conditional Grant Reviews	4.1.18 Building the capacity of districts and provinces to improve budget execution	OHSS	$405,000	17025	12. Technical and Allocative Efficiencies (8.61)
Table 6.2.1: Test and START	Domestic resources required to immediately implement test and start are insufficient	- Greater allocative efficiency through more accurate and results-based budgeting of the DIPs	5% increase in TX_CURR relative to Conditional Grant Spend (i.e., If Condintional Grant Spend is flatlined then the TX_CURR will increase 5%; If Conditional Grant Spend is increased by 20% then the TX_CURR will increase 6%)	5% increase in TX_CURR relative to Conditional Grant Spend (i.e., If Condintional Grant Spend is flatlined then the TX_CURR will increase 5%; If Conditional Grant Spend is increased by 20% then the TX_CURR will increase 6%)	Conditional Grant Reviews	4.1.19 Supporting staff at Departments of Treasury and Health to unlock additional resources to sustain the HIV/AIDS investment	OHSS	$214,473	14295	12. Technical and Allocative Efficiencies (8.61)
Table 6.2.1: Test and START	Domestic resources required to immediately implement test and start are insufficient	- Greater allocative efficiency through more accurate and results-based budgeting of the DIPs	90% Budget Execution of HIV Conditional Grant	95% Budget Execution of HIV Conditional Grant	Conditional Grant Reviews	4.1.20 Building the capacity of districts and provinces to improve budget execution	OHSS	$790,000	18298	12. Technical and Allocative Efficiencies (8.61)
Table 6.2.1: Test and START						Placement of HRH will be driven by DSPs in response to burden, volume, and need				
Table 6.2.1: Test and START						Site Level				

Table 6.2.1: Test and START	Limited: 1) Capacity of HRH and systems to attract, retain, contract additional talent (e.g., GP Contracting, Foreign Qualified Doctors) 2) Skills and competencies to implement test and start	- Increase supply of trained HCWs to support Test and Start - Strengthen the utilization of mid-level health care workers to provide clinical services related to Test and Start, 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-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	5% increase in TX_CURR relative to Conditional Grant Spend (i.e., If Condintional Grant Spend is flatlined then the TX_CURR will increase 5%; If Conditional Grant Spend is increased by 20% then the TX_CURR will increase 6%)	5% increase in TX_CURR relative to Conditional Grant Spend (i.e., If Condintional Grant Spend is flatlined then the TX_CURR will increase 5%; If Conditional Grant Spend is increased by 20% then the TX_CURR will increase 6%)	TX_NEW Proxy HTC_POS:TX_NEW	4.1.21 Support the Albertina Executive Leadership Program in Health program to improve the capacity of district health managers and hospital CEOs to implement the National Strategic Plan for HIV/AIDS, TB, and STIs by improving District Implementation Plans and Facility Implementation Plans especially emphasizing streamlinined systems, effective resource allocation, and developing the workforce.	OHSS	$656,000	16984	7. Human Resources for Health (6.97)
Table 6.2.1: Test and START	Limited: 1) Capacity of HRH and systems to attract, retain, contract additional talent (e.g., GP Contracting, Foreign Qualified Doctors) 2) Skills and competencies to implement test and start	80% Increase in approval rate of DIPs & APPs at national and provincial levels 80% increase in the implementation of test and offer. (This is due to capacity building through the knowledge which is the HR development auditing system. It identifies the competencies and skills gaps to provide HIV/TB related services and directs the HCW to service providers and mentors for the in service training. e.g NIMART training.). 8 provinces setting HIV/TB targets	40% Increase in approval rate of DIPs & APPs at national and provincial levels 40% increase in the implementation of test and offer. (This is due to capacity building through the knowledge which is the HR development auditing system. It identifies the competencies and skills gaps to provide HIV/TB related services and directs the HCW to service providers and mentors for the in service training. e.g NIMART training.) 4 provinces setting HIV/TB targets	60% Increase in approval rate of DIPs & APPs at national and provincial levels 60% increase in the implementation of test and offer. (This is due to capacity building through the knowledge which is the HR development auditing system. It identifies the competencies and skills gaps to provide HIV/TB	% of DIP approval rates % of approved APPs % increase in implementation of test and offer	4.1.22 Support the DOH to increase the supply of skilled HRH to deliver HIV /TB related services for 90/90/90 including Test and start.	OHSS	$1,761,677	18484	7. Human Resources for Health (6.97)
Table 6.2.1: Test and START	Limited: 1) Capacity of HRH and systems to attract, retain, contract additional talent (e.g., GP Contracting, Foreign Qualified Doctors) 2) Skills and competencies to implement test and start	Human resource staff trained to manage PERSAL to identify staffing gaps in 8 provinces 30% increase in HCWs (nurses, data capturers, lay counsellors) implementing test and offer in 8 provinces	Collection of 100% of baseline information of staffing gaps at DOH health facilities Capacity building of human resource staff to manage PERSAL to identify staffing gaps at DOH, which will improve implementation of test and offer	Human resource staff trained to manage PERSAL to identify staffing gaps in 5 provinces 20% increase in HCWs (nurses, data capturers, lay counsellors) implementing test and offer in 5 provinces	WISN (Workload Indicators for Staffing Needs) PERSAL (a personnel management system) HRID (Human Resource Information Development)	4.1.23 Support the DOH to coordinate, plan, develop and manage HRH for test and start	OHSS	$250,000	17767	7. Human Resources for Health (6.97)
Table 6.2.1: Test and START	Limited: 1) Capacity of HRH and systems to attract, retain, contract additional talent (e.g., GP Contracting, Foreign Qualified Doctors) 2) Skills and competencies to implement test and start	80% of HRH (data capturers, nurses, doctors, pharmacists) allocated in PEPFAR priority facilities in 27 districts.	40% of HRH (data capturers, nurses, doctors, pharmacists) allocated in PEPFAR priority facilities in 27 districts. Mapping of contracted practitioners placed on District Health Systems (DHS) in PEPFAR priority facilites in 27 districts.	60% of HRH (data capturers, nurses, doctors, pharmacists) allocated in PEPFAR priority facilities in 27 districts. Final HRH indicators adopted by NDOH. Development of the HRM monitoring framework.	HRIS databases including WISN, PERSAL, ICSP, HRID	4.1.24 Support the DOH to increase the supply of data capturers & improve Human Resource planning, development, management, monitoring as well as continuous process improvement of the Human Resource Information Systems to ensure the adequate supply of health care workers providing quality HIV/TB related services including test and offer.	OHSS	$1,526,882	18021	7. Human Resources for Health (6.97)
Table 6.2.1: Test and START										

Table 6.2.1: Test and START	Limited: 1) Capacity of HRH and systems to attract, retain, contract additional talent (e.g., GP Contracting, Foreign Qualified Doctors) 2) Skills and competencies to implement test and start	40 DOH staff trained to implement and manage the policy implementation feedback tool in 2 provinces Scale-up and rollout of a CPD policy framework providing HIV-related clinical services in 2 provinces, which will increase quality of HIV services provided by nurses	Policy-formation training to build capacity for 25 NDOH staff Assessment of capacity and related needs of NDOH to implement test and start policy at a national and provinicial level Development of an organizational capacity assessment at the SA Nursing Council to determine most appropriate system for tracking nurses' continuous professional development (CPD) policy framework, including HIV-related clinical skills	Development of a policy implementation feedback tool using HIV-related policies to identify, analyze, and overcome barriers to test and start implementation Two provinces utilize the policy implementation feedback tool to identify, analyze, and overcome barriers to test and start implementation Development of a CPD policy framework for nurses providing HIV-related clinical services	Number of staff trained Assessment reports	4.1.25 Support the SA government's policy and regulatory systems to implement of HIV-related policies such as Test and start.	OHSS	$625,000	13709	7. Human Resources for Health (6.97)
Table 6.2.1: Test and START	Limited: 1) Capacity of HRH and systems to attract, retain, contract additional talent (e.g., GP Contracting, Foreign Qualified Doctors) 2) Skills and competencies to implement test and start	90% increase in staff trained to implement test and start	33% increase in staff trained to implement test and start Development of a pharmacovigilance implementation strategy, and an RTC Strategy, and a model for training nurses on PC 101, which included HIV/TB services	67% increase in staff trained to implement test and start	Number of staff trained Reports of strategies developed	4.1.26 Disseminate HIV/AIDs related guidelines and policies, coordinate and conduct training for HIV prevention, care and treatment service delivery including test & offer, NIMART, Viral loads, pharmacovigilance etc via inservice training.	OHSS	$668,036	13709	7. Human Resources for Health (6.97)
Table 6.2.1: Test and START										
Table 6.2.1: Test and START	Limited: 1) Capacity of HRH and systems to attract, retain, contract additional talent (e.g., GP Contracting, Foreign Qualified Doctors) 2) Skills and competencies to implement test and start	90% of PEPFAR supported clinics are classified as 'ideal'	50% of PEPFAR supported clinics are classified as 'ideal'	70% of PEPFAR supported clinics are classified as 'ideal'	Ideal clinic dashboard Office of health standards complaince dashboard. Patient satisfaction surveys	4.1.27 Support the DOH to strengthen implementation and monitoring of ideal clinic/ facility initiatives to improve limited capacity of HRH and systems towards achieving 90/90/90 including test and start	OHSS HTXS; HVTB; PDTX; MTCT	$1,370,000	18481	
Table 6.2.1: Test and START	Limited: 1) Capacity of HRH and systems to attract, retain, contract additional talent (e.g., GP Contracting, Foreign Qualified Doctors) 2) Skills and competencies to implement test and start	90% of PEPFAR supported clinics are classified as 'ideal'	50% of PEPFAR supported clinics are classified as 'ideal'	70% of PEPFAR supported clinics are classified as 'ideal'	Ideal' clinic dashboard Office of health standards complaince dashboard. Patient satisfaction surveys	4.1.28 Support the DOH and PEPFAR/SA to plan, coordinate, develop, implement, manage and monitor ' ideal clinic/facility' initiatives to improve limited capacity of HRH and systems towards achieving 90/90/90 including test and start	OHSS	$600,000	16772	9. Quality Managemer
Table 6.2.1: Test and START	Limited: 1) Capacity of HRH and systems to attract, retain, contract additional talent (e.g., GP Contracting, Foreign Qualified Doctors) 2) Skills and competencies to implement test and start	90% of PEPFAR supported clinics are classified as 'ideal'	50% of PEPFAR supported clinics are classified as 'ideal'	70% of PEPFAR supported clinics are classified as 'ideal'	Ideal' clinic dashboard Office of health standards complaince dashboard. Patient satisfaction surveys	4.1.29 Support the DOH and PEPFAR/SA to plan, coordinate, develop, implement, manage and monitor ' ideal facility' initiatives to improve limited capacity of HRH and systems towards achieving 90/90/90 including test and start	OHSS	$200,000	16807	9. Quality Managemer
Table 6.2.1: Test and START	Limited: 1) Capacity of HRH and systems to attract, retain, contract additional talent (e.g., GP Contracting, Foreign Qualified Doctors) 2) Skills and competencies to implement test and start	90% of PEPFAR supported facilites implement patient centered care test and offer services 90% of PEPFAR supported clinics are classified as 'ideal'	50% of PEPFAR supported facilites implement patient centered care test and offer services 50% of PEPFAR supported clinics are classified as 'ideal'	70% of PEPFAR supported facilites implement patient centered care test and offer services 70% of PEPFAR supported clinics are classified as 'ideal'	# Quarterly monitoring reports of DIPs and DOH annual performance plans. # of partners, provincial stakeholders trained on the change management model for Ideal Health Care	4.1.30 Support the DOH and PEPFAR/SA to plan, coordinate, develop, implement, manage and monitor ' ideal facility' initiatives to improve limited capacity of HRH and systems towards achieving 90/90/90 including test and start	OHSS	$900,000	13709	9. Quality Managemer
Table 6.2.1: Test and START										

Table 6.2.1: Test and START	Limited: 1) Capacity of HRH and systems to attract, retain, contract additional talent (e.g., GP Contracting, Foreign Qualified Doctors) 2) Skills and competencies to implement test	- Adequate supply of trained HCWs to support Test and Start - Strengthen the utilization of mid-leve		Adaptation of training curric	Revised curriculum implemen	4.1.31 Adapt ART curriculum to include ART manage	HTXS	$66,422	18231	9. Quality Managemer
Table 6.2.1: Test and START	Limited: 1) Capacity of HRH and systems to attract, retain, contract additional talent (e.g., GP Contracting, Foreign Qualified Doctors) 2) Skills and competencies to implement test	- Adequate supply of trained HCWs to support Test and Start - Strengthen the utilization of mid-leve		60% (108/180)of doctors, nu	108 doctors, nurses, social wo	4.1.32 conduct training in ART delivery for doctors,	HTXS	$48,578	18231	9. Quality Managemer
Table 6.2.1: Test and START	Limited: 1) 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 Start - Strengthen the utilization of mid-leve		Adaptation of mentoring mo	108 (100%) of trained military	4.1.33 Military supervisors to conduct mentoring of t	HTXS	$6,667	18231	9. Quality Managemer
Table 6.2.1: Test and START	Limited: 1) 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 Start - Strengthen the utilization of mid-leve		Existing stigma and discrimin	Stigma and discrimination cur	4.1.34 In consultation with the military, adapt an exis	HTXS	$53,389	18231	9. Quality Managemer
Table 6.2.1: Test and START	Limited: 1) Capacity of HRH and systems to attract, retain, contract additional talent (e.g., GP	- Adequate supply of trained HCWs to support Test and Start - Strengthen the utilization of mid-leve		50% (total 125) of unit comn	Number of unit commanders	4.1.35 Train Unit Commanders in stigma and discrim	HTXS	$10,000	18231	9. Quality Managemer
Table 6.2.1: Test and START	Limited: 1) Capacity of HRH and systems to attract, retain, contract additional talent (e.g., GP	- Adequate supply of trained HCWs to support Test and Start - Strengthen the utilization of mid-leve		60% (38/62) of health facility	Number of health facilities tra	4.1.36 Training of facility staff in stigma and discrimi	HTXS	$2,667	18231	9. Quality Managemer
Table 6.2.2: New and efficient service										
Table 6.2.2: New and efficient service delivery models										
Table 6.2.2: New and efficient service delivery models	1. Differentiated care model defined in the NDOH Adherence Guidelines yet to be fully operationalized	90% HCW trained on National Adherence Guidelines 90% of eligible patients decanted to alternative service delivery models in PEPFAR focus districts	50% of HCW trained on National Adherence guidelines	80% of trained HCW on National Adherence guidelines 60% stable patients on ART decanted	TX_RET All 90-90-90 MER Indicators	5.1.1 Support the National Department of Health (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. Support the NDoH, Provincial Departments of Health, Regional Training Centers (RTCs) and District Support Partners in the roll-out of the National adherence guidelines, and the Pediatrics and Adolescent Disclosure Guidelines targetting CBOs	HBHC PDCS HTSX PDTX HVTB	$2,650,000	17533	7. Human Resources for Health (6.97)
Table 6.2.2: New and efficient service delivery models	1. Differentiated care model defined in the NDOH Adherence Guidelines yet to be fully operationalized	Reduction of LTFU from 25% to <9% 70% stable patients on ART decanted	Reduction of LTFU from 25% to <9% 25% stable patients on ART decanted	Reduction of LTFU from 25% to <9% 60% stable patients on ART decanted	TX_RET Number of stable patients decanted	5.1.2 Operationalize Adherence Guidelines SOPs for fast track ART initiation across all districts. Determine the workload, supply, demand role profiles & competencies of relevant HCWs for Adherence Clubs. Training of health care workers on the National Adherence Guidelines.	HTXS	$50,000	17533	7. Human Resources for Health (6.97)
Table 6.2.2: New and efficient service delivery models							HTXS	Facility UE	18482, 18481, 18484, 17020, 17023, 17036,17045, 17038, 17021, 17037, 14291	7. Human Resources for Health (6.97)
Table 6.2.2: New and efficient service delivery models	1. 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	15 Implementation Science Papers and Presentations completed	15 Implementation Science Papers and Presentations completed	HEERO Website	5.1.3 In partnership with DOH, conduct implementation science research to evaluate adherence guidelines and alternate models of service delivery	HTXS	$1,215,000	17025	12. Technical and Allocative Efficiency (8.61)

Table 6.2.2: New and efficient service delivery models	1. Differentiated care model defined in the NDOH Adherence Guidelines yet to be fully operationalized	20% increase in uptake of treatment Reduction of LTFU from 25% to <9% 90% PVLS	10% increase in uptake of treatment Reduction of LTFU from 25% to <9% 80% PVLS	10% increase in uptake of treatment Reduction of LTFU from 25% to <9% 90% PVLS	TX_NEW; TX_CURR; TX_RET; TX_VIRAL	5.1.4 In partnership with DOH, conduct formative research and evaluation of community-based C&T programme activities in three districts/provinces. To describe and document the process, to describe how HCWs and communities participated in and responded to the community program, to explore barriers and facilitators that impact on the community program and the outcomes, and to assess the effectiveness (outcomes) in linking and retaining patients in care and promoting ART adherence.	HTXS, HVTB, PDCS, PDTX, MTCT, HBHC	$1,499,815	18483	12. Technical and Allocative Efficiency (8.61)
Table 6.2.2: New and efficient service delivery models			Completed							
Table 6.2.2: New and efficient service delivery models							HTXS	Community UE	18482	2. Policies and Governance (8.45)
Table 6.2.2: New and efficient service delivery models						Moved to Programmatic Gap 2				
Table 6.2.2: New and efficient service delivery models			1.4 million patients registered on CCMDD; 1700 external PUPs contracted by NDOH			Modified and Moved to PP1				
Table 6.2.2: New and efficient service delivery models	2. Limited implementation of alternative medicine distribution models	- Increase number and improve distribution of CCMDD PuPs. - Three million patients receiving medicines through the centralized chronic medicine dispensing & distribution system	1.4 million patients registered on CCMDD; 1700 external PUPs contracted by NDOH	2 million patients registered on CCMDD; 2400 external PUPs contracted by NDOH	NDOH Monthly Reports	5.1.5 Work with DOH to leverage private sector models (i.e.., Coca-Cola) to increase the number and coverage of CCMDD PuPs	HTXS	$702,000	18321	9. Quality Management (8.38)
Table 6.2.2: New and efficient service delivery models	2. Limited implementation of alternative medicine distribution models	- Increase number and improve distribution of CCMDD PuPs. - Three million patients receiving medicines through the centralized chronic medicine dispensing & distribution system	800,000 patients receiving treatment through CCMDD	2000 000 patients receiving treatment through CCMDD	# of eligible patients receiving medication through CCMDD PuPs	5.1.6 Support CCMDD administrative, management, implementation, and distribution at national and provincial levels, including the development and maintanance of a robust and harmonized monitoring, and reporting system across the three decanting streams: CCMDD, Adherence Clubs and Spaced Fast Lane Appointments (SFLA)	HTXS PDCS HVSI OHSS	$1,660,624	18481	8. Commodity Security and Supply Chain (4.67)
Table 6.2.2: New and efficient service delivery models	2. Limited implementation of alternative medicine distribution models	- Increase number and improve distribution of CCMDD PuPs. - Three million patients receiving medicines through the centralized chronic medicine dispensing & distribution system	800,000 patients receiving treatment through CCMDD	2000000 patients receiving treatment through CCMDD	# of eligible patients receiving medication through CCMDD PuPs	5.1.7 Support CCMDD through management (including salary support for pharmacy staff), implementation, and distribution initiatives	OHSS	$5,000,000	16772	8. Commodity Security and Supply Chain (4.67)
Table 6.2.2: New and efficient service delivery models	2. Inadequate monitoring of implementation of alternative medicine distribution models	Reduction of LTFU from 25% to <9% 70% stable patients on ART decanted	Reduction of LTFU from 25% to <9% 25% stable patients on ART decanted	Reduction of LTFU from 25% to <9% 60% stable patients on ART decanted	TX_RET Number of stable patients decanted	5.1.8 Development and implementation of a robust monitoring and reporting system for decanted patients	HBHC, PDCS	$320,000	17533	8. Commodity Security and Supply Chain (4.67)
Table 6.2.2: New and efficient service delivery models									18482	8. Commodity Security and Supply Chain (4.67)

Table 6.2.2: New and efficient service delivery models	3. Private sector engagement to enhance the clinical cascade has been limited.	- The Department of Health 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 GPs.		All sites assessed semi-annually	HRIS	5.1.9 Strengthen how workforce indicators of staffing needs (WISN) data is used to determine optimal sites for GP/HCW contracting	HTXS	Facility UE	18482, 18484, 17020, 17023, 17036, 17046, 17038, 17021, 17037	8. Commodity Security and Supply Chain (4.67)
Table 6.2.2: New and efficient service delivery models	3. Private sector engagement to enhance the clinical cascade has been limited.	- The Department of Health 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 GPs.	Number of schemes with current cost coverage for HIV/AIDS	All sites assessed semi-annually	HRIS	5.1.10 Strengthen how workforce indicators of staffing needs (WISN) data is used to determine optimal sites for GP/HCW contracting	HTXS	Facility UE	18481, 18484, 17020, 17023, 17036, 17046, 17038,17021, 17037	7. Human Resources for Health (6.97)
Table 6.2.2: New and efficient service delivery models	3. Private sector engagement to enhance the clinical cascade has been limited.	- The Department of Health 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 GPs.	Number of GPs providing TX-New and TX-Curr	Number of medical schemes with reduced cost for coverage due to increased life expectancy	Not a MER indicator	5.1.11 Advocate for a change in the categorization of HIV services in the private medical schemes	HTXS	Provincial UE	17021	4. Private Sector Engagement (6.50)
Table 6.2.2: New and efficient service delivery models	3. Private sector engagement to enhance the clinical cascade has been limited.	20% increase in uptake of treatment Reduction of LTFU from 25% to <9% 90% PVLS	10% increase in uptake of treatment Reduction of LTFU from 25% to <9% 80% PVLS	10% increase in uptake of treatment Reduction of LTFU from 25% to <9% 90% PVLS	TX_NEW; TX_CURR; TX_RET; TX_VIRAL	5.1.12 Capacity building of private sector health providers	HTXS	District UE	18482	4. Private Sector Engagement (6.50)
Table 6.2.2: New and efficient service delivery models	3. Private sector engagement to enhance the clinical cascade has been limited.	20% increase in uptake of treatment Reduction of LTFU from 25% to <9% 90% PVLS	10% increase in uptake of treatment Reduction of LTFU from 25% to <9% 80% PVLS	10% increase in uptake of treatment Reduction of LTFU from 25% to <9% 90% PVLS	TX_NEW; TX_CURR; TX_RET; TX_VIRAL	5.1.13 Data Sharing with private sector to quantify contribution of private sector patients	HTXS	District UE	18481, 18484, 17020, 17023, 17036, 17046, 17038, 17021, 17037, 18482	4. Private Sector Engagement (6.50)
Table 6.2.2: New and efficient service delivery models	3. Private sector engagement to enhance the clinical cascade has been limited.	20% increase in uptake of treatment Reduction of LTFU from 25% to <9% 90% PVLS	10% increase in uptake of treatment Reduction of LTFU from 25% to <9% 80% PVLS	10% increase in uptake of treatment Reduction of LTFU from 25% to <9% 90% PVLS	TX_NEW; TX_CURR; TX_RET; TX_VIRAL	5.1.14 Contracting with private sector health providers	HTXS	District UE	18481, 18484, 17020, 17023, 17036, 17046, 17038, 17021, 17037, 18482	4. Private Sector Engagement (6.50)
Table 6.2.2: New and efficient service delivery models							HTXS	District UE	18481, 18484, 17020, 17023, 17036, 17046, 17038, 17021, 17037, 18482	4. Private Sector Engagement (6.50)
Table 6.2.2: New and efficient service delivery models	3. Private sector engagement to enhance the clinical cascade has been limited.	20% increase in Tx new at facilities that received a 25% increase through HRH student support	Pre service curricula updates completed in COP16	Undergraduates clinical students from 3 universities provide additional HIV /TB service delivery support in high volume sites in 5 districts. (n=500)	student elogbooks	5.1.15 Increase the supply of relevant HCWs and improve the quality of HIV related services provided in PEPFAR priority districts areas through the development of Interdisciplinary pre-service delivery platforms and pre service curricula.	OHSS	$800,000	16807	7. Human Resources for Health (6.97)
Table 6.2.2: New and efficient service delivery models										
Table 6.2.2: New and efficient service delivery models										
Table 6.2.2: New and efficient service delivery models	Inadequate recognition and management of mental health conditions as a determinant of linkage and retention	Reduction of LTFU from 25% to <9% 90% PVLS	Reduction of LTFU from 25% to <9% 80% PVLS	Reduction of LTFU from 25% to <9% 90% PVLS	TX_RET PVLS	5.1.16 Support the training of HCW and district health management teams in the diagnosis and management of mental health disorders	HBHC	$562,500	17769	7. Human Resources for Health (6.97)

	Limited capacity of NIMART nurses and doctors to implement Test and Start	20% increase in uptake of treatment Reduction of LTFU from 25% to <9% 90% PVLS	10% increase in uptake of treatment Reduction of LTFU from 25% to <9% 80% PVLS	10% increase in uptake of treatment Reduction of LTFU from 25% to <9% 90% PVLS	TX_NEW; TX_CURR; TX_RET; TX_VIRAL	5.1.17 Support the NDoH with the development and implementation of revised NIMART training and mentoring guidelines and materials in order to strengthen the NIMART program	HTXS	$450,000	17768	7. Human Resources for Health (6.97)
	Weak community-based care and treatment program implementation in support of differentiated care model	20% increase in uptake of treatment Reduction of LTFU from 25% to <9% 90% PVLS	10% increase in uptake of treatment Reduction of LTFU from 25% to <9% 80% PVLS	10% increase in uptake of treatment Reduction of LTFU from 25% to <9% 90% PVLS	TX_NEW; TX_CURR; TX_RET; TX_VIRAL	5.1.18 Support the training of CHWs to strengthen all the community-based aspects of the CT program	HTXS, HBHC, PDCS, PDTX, MTCT, HVTB	$3,175,000	17769	7. Human Resources for Health (6.97)
	Weak community-based care and treatment program implementation in support of differentiated care model	20% increase in uptake of treatment Reduction of LTFU from 25% to <9% 90% PVLS		Review existing service delivery platforms Establishment of a new framework to include service delivery platforms for new HIV/TB related clinical services.	Approved Framework for service delivery platforms	5.1.19 Support the DOH to improve access to service delivery platforms that provide services for HIV/TB.	OHSS	$450,000	18480	9. Quality Managemer

Table 6.3 Other Proposed Systems Investments									
Activity	**For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control. (Teams may select more than one.)**	**Outcomes expected after 3 years of investment**	**Year One (COP/ROP16) Annual Benchmark**	**Year Two (COP/ROP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Relevant SID Element and Score (if applicable)**
Finance									
6.15 Support a study of cost drivers for Technical Assistance to facilities and identification of efficiencies			Study protocol developed	Study implementation ongoing	Study findings disseminated and applied	HTXS,HBHC,PDTX, PDCS,HVTB, MTCT			12. Technical and Allocative Efficiencies (8.61)
[Add rows as needed]									
Governance									
[Add rows as needed]									
HRH - Systems/Institutional Investments									
~~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.~~			To be Completed in FY16						
~~Support the strengthening of the NIMART program~~	~~1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.~~	~~90% PLHIV identified; 90% PLHIV on ART ;90% PLHIV on ART virally suppressed~~	~~70% PLHIV identified; 70% PLHIV on ART ;70% PLHIV on ART virally suppressed~~	~~90% PLHIV identified; 80% PLHIV on ART ;80% PLHIV on ART virally suppressed~~	~~All 90-90-90 MER indicators~~	~~**HBHC, PDCS, HTSX, PDTX, HVTB**~~	~~**$364,500**~~	~~**17768**~~	~~7. Human Resources for Health (6.97)~~
6.38 Support staffing at NDOH for planning, implementing, and monitoring of TB and HIV District Implementation Plans (DIP)	Sustained Epi Control.	80% of key indicators for TB and HIV in the DIP monitored and remedial actions taken	50% of key indicators for TB and HIV in the DIP monitored and remedial actions taken	70% of key indicators for TB and HIV in the DIP monitored and remedial actions taken	All 90-90-90 DIP Indicators	**HBHC, HTXS, HVTB, PDCS, PDTX, MTCT**	**$256,540**	**16772**	7. Human Resources for Health (6.97)
~~6.39 Support the training of HCW and district health management teams in the diagnosis and management of mental health disorders.~~ Moved to Priority Policy 2.									

Inst & Org Development									
~~Strengthen the capacity of the South African Government's Department of Health (SAG DOH) 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.~~ Moved to Programmatic Gap 1 (1.3.6)									
6.4 Support the SA DoH 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.	Sustained Epi Control.	30% Reduction in TB incidence	10% Reduction in TB incidence	20% Reduction in TB incidence	Routine TB data	**HVTB**	**$604,500**	**18083**	9. Quality Management (8.38)
Increase access to TB/HIV care among women and infants in ante-natal care settings	Sustained Epi Control	60% Reduction in maternal/infant mortality associated with TB/HIV	20% Reduction in maternal/infant mortality associated with TB/HIV	40% Reduction in maternal/infant mortality associated with TB/HIV	All TB/HIV MER indicators	**HVTB**	**$1,650,000**	**17033**	9. Quality Management (8.38)
Assess the impact of option B+ on MTCT using programmatic routine data nationally	Sustained Epi Control.	< 0.8% MTCT rate at birth	< 1.4 % MTCT rate at birth	< 1% MTCT rate at birth	All PMTCT MER indicators			17033	
Support decentralization of MDR-TB/HIV services including initiation and/or management of HIV co-infections (>74% co-infection rate), rollout of 9 - 12 month MDR-TB regimen,	Sustained Epi Control.	90% DR TB/HIV patients accessing treatment for Drug Resistant TB and HIV	60% DR TB/HIV patients accessing treatment for Drug Resistant TB and HIV	80% DR TB/HIV patients accessing treatment for Drug Resistant TB and HIV	All MER TB/HIV indicators	**HVTB** **PDCS** **PDTX** **HBHC**	**$1,000,000**	**16772**	9. Quality Management (8.38)
6.24 Support the roll out the National Pediatric Disclosure Guidelines	1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.	90% ART coverage for pediatric patients	70% ART coverage for pediatric patients	80% ART coverage for pediatric patients	TX_Ret TX_New HTC_TST	PDCS, PDTX		17033	~~9. Quality Management (8.38)~~
Support the national DoH strategic direction for achieving their last mile of the elimination plan. Funds will be used for the development and dissemination of the SOPs for the management of complex HIV infected neonates	1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.	90% HIV positive infants initiated on Tx	70% HIV positive infants initiated on Tx	80% HIV positive infants initiated on Tx	TX_New less than 1 year	MTCT		16772	~~1. Planning and Direction (9.67)~~
6.12 Provide technical support to the SAG at national, provincial and district level to implement and monitor the accelerated " Last Mile Plan (2016-2021) in the 14 selected high burden districts	Sustained Epi Control.	< 0.8% MTCT rate at birth in the 14 high burden districts	< 1.4 % MTCT rate at birth in the 14 high burden districts	< 1% MTCT rate at birth in the 14 high burden districts	All PMTCT MER indicators	**MTCT**	**$470,000**	**17505**	1. Planning and Direction (9.67)
~~6.14 WRHI aims to 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).~~	~~1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.~~	~~Reduced HIV incidence in AGYW~~	~~Roll out of "She Conquers" program in 50% of 22 NDOH priority districts~~	~~Roll out of "She Conquers" program in 100% of 22 NDOH priority districts~~	~~All 90-90-90 MER indicators for AGYW~~	~~HTXS,HBHC,PDTX, PDCS,HVTB, MTCT~~		~~17968~~	~~9. Quality Management (8.38)~~

6.26 Support implementation of NDOH TB and HIV QI /QA in the District Implementation plans to improve HIV and TB patient outcomes; through 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.	Sustained Epi Control.	80% of key indicators for TB and HIV in the DIP monitored and remedial actions taken	50% of key indicators for TB and HIV in the DIP monitored and remedial actions taken	70% of key indicators for TB and HIV in the DIP monitored and remedial actions taken	All 90-90-90 DIP Indicators	HTXS, HVTB, MTCT, PDCS, PDTX	Facility UE	18481, 18484, 17020, 17023, 17036, 17046, 17038, 17021, 17037, 17039, 18482	9. Quality Management (8.38)
~~6.29 Innovations Models for policy formation and scale up for PMTCT M2M~~			Program Mainstreamed			**HVTB**	**Facility UE**	**18481, 18484, 17020, 17023, 17036, 17046, 17038, 17021, 17037, 17039**	9. Quality Management (8.38)
~~6.30 Innovations Models for policy formation and scale up for QI PMTCTSTELLENBOSCH~~			Program Mainstreamed						
Development and implementation of Transition guidelines for adolescents	1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.	90% of Adolescents successfully transitioned and integrated into the Adult ART program	70% of Adolescents successfully transitioned and integrated into the Adult ART program	80% of Adolescents successfully transitioned and integrated into the Adult ART program	All 90-90-90 MER indicators	PDCS PDTX		17533	13. Epidemiological and Health Data
Assess the implementation of the KIDZ Alive Program	First 90	90% of Children living with HIV tested and linked into care	70% of Children living with HIV tested and linked into care	80% of Children living with HIV tested and linked into care	All 90-90-90 MER indicator	PDCS PDTX		17033	13. Epidemiological and Health Data
[Add rows as needed]									
Laboratory									
6.16 South African National HIV Prevalence, Incidence, Behavior and Communications Surveys (SABSSM)	1st, 2nd, 3rd and Sustained Epi control	i) 5th HIV Household Survey conducted, reported and data available for planning. ii) 6th Survey development along lines of population-based HIV Impact Assessment	All laboratory testing completed and preliminary data analysis underway	Final report on 5th survey available	Survey would serve as HIV Impact Assessment providing information on: (i) HIV prevalence and burden (PLHIV); (ii)HIV incidence; (iii) PLHIV exposured to ART; (iv) ARV drug resistance; (v) Exposure to HIV Information, Education and Communication messages;	**HLAB**	**$100,000**	**17459**	13. Epidemiological and Health Data
[Add rows as needed]									

Strategic Information									
~~Support the validation activities for eMTCT plan through impact evaluation of option B+~~ [Rolled up withother MRC operational research activities above]	~~First 90; Second 90; Third 90; Sustained Epi Control~~	~~Policy Change~~	~~Protocol development ongoing~~	~~Protocol completed, study implementation ongoing~~	~~Study findings disseminated and applied~~	~~MTCT~~		~~17033~~	~~13. Epidemiological and Health Data (6.77)~~
~~6.8 Support the NDoH to improve the quality of TB and TB/HIV data . Moved to 6.38~~									
~~6.10 Support TB/HIV data use workshops and the roll-out of the TB module onto Tier.net~~ *[Merged with other NDoH CoAg activities above]*	~~1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.~~	~~Improved accuracy of TB/HIV data and completeness of reporting as well as increased data usage to inform programmatic decision making~~	~~At least one workshop conducted per province~~	~~At least two workshop conducted per province~~	~~All MER TB/HIV indicators~~	~~HVTB~~		~~16772~~	~~13. Epidemiological and Health Data (6.77)~~
6.13 Support the national department of health with early warning indicators EWI to improve TB and HIV patient outcome	Sustained Epi Control.	90% Viral suppression and TB treatm	70% Viral suppression and TB treatment sud	80% Viral suppression an	All 90-90-90 MER indicators	HTXS, PDTX, HVTB		17512	13. Epidemiological and Health Data (6.77)
~~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.~~			Program Mainstreamed						13. Epidemiological and Health Data (6.77)
~~6.40 Support NDOH to monitor DIP implementation at : a) National and provincial b) district levels.~~ Moved to PP1									13. Epidemiological and Health Data (6.77)
Strengthen screening and linkage of mine workers to HIV and TB services in Bojanala and Lejweleputswa districts	1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.	90% of mine workers screened and linked to TB and HIV services in the study areas	60% of mine workers screened and linked to TB and HIV services in the study areas	80% of mine workers screened and linked to TB and HIV services in the study areas	90-90-90 MER indicators	**HVTB, HTXS**	**$300,000**	**18484**	13. Epidemiological and Health Data (6.77)
South African National HIV Prevalence, Incidence, Behavior and Communication Surveys (SABSSM) & Know Your Epidemic and Know Your Response (KYE-KYR)	1st, 2nd, 3rd and Sustained Epi control	(i) 5th HIV Household Survey conducted, reported and data available for planning. (ii) 6th Survey development along lines of Population-based HIV Impact Assessment	(i) Complete field work/data collection for the 5th HIV Household Survey (ii) Preliminary analysis of survey data	(i) Final Report on 5th survey available (ii) Data from 5th Survey available for planning (iii) Protocol for 6th survey completed and submitted to Review Committees	Survey would serve as HIV Impact Assessment providing information on: (i) HIV prevalence and burden (PLHIV); (ii)HIV incidence; (iii) PLHIV exposured to ART; (iv) ARV drug resistance; (v) Exposure to HIV Information, Education and Communication messages; (vi) HIV risk behaviors - condom use, multiple partners, male medical circumsion,	**HVSI**	**$252,600**	**17459**	13. Epidemiological and Health Data (6.77)
~~Assessment of the utility of PMTCT program data for HIV sentinel surveillance among pregnant women~~			Complete fieldwork and feedback workshops to stakeholders						
~~South African National 5-year Strategic Plan for HIV, TB and STI Surveys and Surveillance~~			Complete the National 5-year strategic plan for surveys and surveillance aligned to the NSP for HIV/AIDS for SA						
Laboratory-based Surveillance of Acquired HIV Drug Resistance among Adults on Antiretroviral therapy in South Africa	3rd	Report writing, data available for planning and publish manuscripts	Data collection and preliminary data analysis	Report wrtiting, dissemination of results and preparation of manuscripts	Prevalence of acquired HIV drug resistance among adult	**HVSI**	**$250,000**	**17493**	13. Epidemiological and Health Data (6.77)
National HIV Cause of Death Validation Study	3rd	Report writing and data available as per dissemination plan, peer reviewed publications	Protocol completed and cleared for implementation.	Implementation of the survey and preliminary data analysis and feedback to stakeholders	Improved estimates for HIV mortality available routinely through vital statistics	**HVSI**	**$100,000**	**17033**	13. Epidemiological and Health Data (6.77)
Strategic Information for sub-national programming - Modelling, estimations and mapping of sub-national HIV burden	1st, 2nd, 3rd and Sustained Epi control	Consensus on district-level HIV estimates including on prevalence and burden (PLHIV) for South Africa	Protocol completed and cleared for implementation.	Accurate and precise HIV prevalence estimates available at district level	Improved estimates of HIV prevalence and burden available for all districts in South Africa	**HVSI**	**$297,500**	**18313**	13. Epidemiological and Health Data (6.77)
~~PMTCT Process evaluation~~			Protocol completed and cleared for implementation						
~~PMTCT Cohort monitoring~~			Protocol completed and cleared for implementation						

~~Case-based surveillance in PMTCT~~			Protocol completed and cleared for implementation						
~~TB/HIV Integration (Increasing access to TB/HIV care among women and infants in antenatal care settings)~~			(i) Commence data collection for the study						
Optimizing Prevention and Referrals within the Antenatal (ANC) Platform: Strengthening Partner Testing and Facilitating Early Linkage to HIV Care and Treatment in Bojanala District, South Africa project	1st and 2nd	Report wrting, data available for planning and prepare manuscripts for publication	Baseline data collected, data analysis and report writing, and conduct post intervention survey	Final report of the baseline survey available, disseminate the results and data analysis for post intervention survey	Male partners of prgnant women tested for HIV, pregnant women and their male partners newly diagnosed and linked to care and defaulters tracing	**HVSI**	**$150,000**	**17033**	13. Epidemiological and Health Data (6.77)
Strengthening Data Quality Activities in 27 priority districts	1st, 2nd, 3rd	Improved accuracy of data and completeness of reporting as well as increased data usage to inform programmatic decision making	Gap analysis to identify root causes of the poor data in the 27 districts. This will assist identify appropriate interventions needed to improve the data quality.	Execute/roll-out identified interventions for identified gaps	Complete, accurate and timely reporting of indicators through both NDOH and PEPFAR systems with less need for data cleaning periods. Data quality Assessments to be conducted and made available	**HVSI**	**$300,000**	**16772**	13. Epidemiological and Health Data (6.77)
Evaluation of the AFRICARE TA model of the OVC program	First 90	Sustainability of the OVC program beyond PEPFAR	Protocol development completed	Evaluation of the TA model completed	OVC_serv	HKID	$0	18481	12. Technical and Allocative Effic iencies (8.61)
Systems Development									
Support NDOH with maintanance and development of ETR.Net and EDRWeb	1st/2nd/3rd	80% completeness & accuracy of MER TB/HIV indicators from FY 16 baseline	30% completeness & accuracy of MER TB/HIV indicators from FY 16 baseline	50% completeness & accuracy of MER TB/HIV indicators from FY 16 baseline	Routine TB and Drug Resistant TB indicators	**HVTB**	$500,000	18021	13. Epidemiological and Health Data (6.77)
[Add rows as needed]									
TOTAL							$6,595,640		